NHS
Wigan Borough
Clinical Commissioning Group

Safeguarding Children and Adults at Risk

Annual Report 2017/18

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Executive Summary

The purpose of this report is to provide an overview of Wigan Borough Clinical Commissioning Group (WBCCG) safeguarding governance arrangements and a retrospective view of the work completed by the WBCCG Safeguarding Team from 1st April 2017 to 31st March 2018 to ensure the CCG meets its statutory safeguarding responsibilities in respect of children and adults at risk.

The work activities undertaken by the WBCCG Safeguarding Team during 2017/18 have been comprehensively documented within the quarterly Quality, Safety and Safeguarding assurance reports received by both the WBCCG Clinical Governance Committee and Governing Body.

The success of the Safeguarding Team requires the full engagement of the commissioned Acute, Community and Mental Health Foundation Trusts, GP Practices, Third Sector and Private Providers, and partner agencies.

There are good safeguarding systems in place across the local health economy. There continues to be challenges in relation to training and the capacity to respond to SCRs, DHRs and LCRs within the Wigan Borough. As the safeguarding agenda is continuously developing, in both complexity and scope, it is vital that safeguarding remains in our line of sight.

The Safeguarding Team remains committed to ensuring that the population of Wigan Borough are safe, and that their health needs are met. We will continue to work collaboratively with the Local Authority, Wigan Safeguarding Adults Board (WSAB), Wigan Safeguarding Children Board (WSCB) and key partners to continuously improve systems to safeguard adults and children.

Introduction

1. This is the fifth joint Safeguarding Children and Adults at Risk Annual Report for Wigan Borough Clinical Commissioning Group (WBCCG) and will inform the Wigan Safeguarding Adults Board (WSAB) Annual Report and Wigan Safeguarding Children Board (WSCB) Annual Report.

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.

3. Safeguarding is 'everybody's business' and the WBCCG Safeguarding Team works to ensure that it continues to be the 'golden thread' running through all commissioned services.

4. 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.

5. Safeguarding comprises a broad and complex agenda that in addition to the more commonly known work streams includes the following:

   - Allegations against Healthcare Professionals;
   - Child Deaths;
   - Child Sexual Abuse (CSA) and Child Sexual Exploitation (CSE);
   - Counter Terrorism (Prevent);
   - Domestic Abuse;
   - Fabricated and Induced Illness (FII);
   - Female Genital Mutilation (FGM);
   - Hate Crime;
   - Human Trafficking/Modern Day Slavery;
   - Independent Inquiry into Child Sexual Abuse;
   - Learning Disabilities Mortality Review (LeDeR) Programme;
   - Mental Capacity Act (MCA) & Deprivation of Liberty Safeguards (DoLS);
   - Safeguarding Reviews: Serious Case Reviews (SCRs), Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs).

6. The Safeguarding Team works in partnership with key stakeholders to oversee 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 people in the Borough.

Purpose

7. The purpose of this report is to provide an overview of WBCCG safeguarding governance arrangements and the work completed by the Safeguarding Team from 1st April 2017 to 31st March 2018 to ensure the CCG meets its statutory safeguarding responsibilities in respect of adults and children.

National Context - Safeguarding

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

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

10. 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.

National Context – Safeguarding Adults

11. 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.

12. 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.

National Context – Safeguarding Children

13. 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.

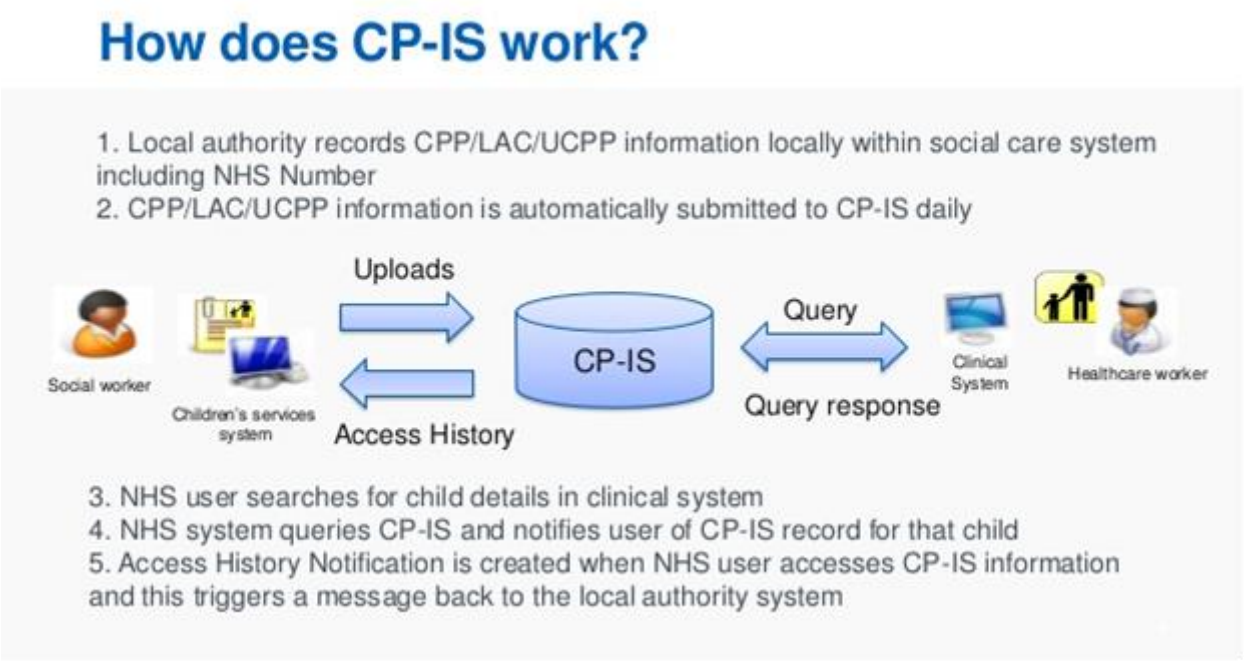
14. The statutory and supplementary guidance entitled 'Working Together to Safeguard Children, A guide to inter-agency working to safeguard and promote the welfare of children' (Department for Education, March 2015) supports the safeguarding children legislative framework.

15. 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.

16. The Department for Education is currently consulting on a significantly revised version of Working Together to reflect the legislative changes introduced through the Children and Social Work Act 2017.

National Context - Child Protection Information Sharing Project

17. All Wigan Borough unscheduled care settings have now successfully implemented Child Protection Information Sharing (CP-IS). A full overview of the CP-IS Project can be found in Appendix 3 of this report.



18. Wigan was a 'First Wave' early adopter of the CP-IS Project:

- CP-IS went 'live' in the Wigan Borough on 02/02/15 in the Local Authority and the Acute Trust (in both the Accident and Emergency and Maternity Department);
- CP-IS was successfully implemented in Leigh Walk in Centre on 02/03/17;
- The GP Out of Hours Service successfully went live on 05/01/18.

19. The Share to Care Programme Board will continue to oversee CP-IS within the Wigan Borough with the assistance of the Assistant Director Safeguarding Children.

Local Context - Greater Manchester Health and Social Care Partnership

20. The Deputy Director of Nursing for the Greater Manchester Health and Social Care Partnership (GMHSCP) is responsible for supporting and providing assurance in relation to safeguarding children and adults at risk of abuse or neglect.

21. The WBCCG Safeguarding Team previously attended the GM Safeguarding Collaborative hosted by the GMHSCP, however, at the end of 2017 this collaborative was disbanded.

22. A paper was presented to the GMHSCP Quality Board which set out that safeguarding assurance by CCGs to the GMHSCP would now be provided by the CCG Directors of Nursing at the GMHSCP Quality Board.

23. The existing Safeguarding Children, Safeguarding Adults and Looked After Children Clinical Networks would continue to meet together to identify GM safeguarding improvement priorities.

24. As part of the new arrangements NHS England North delegated attendance at Local Safeguarding Boards (Children & Adults) to Designated Safeguarding Professionals within the CCG. Designated Professionals were required to sign a 'Memorandum of Understanding' which set out the responsibilities and the process for escalation and feedback.

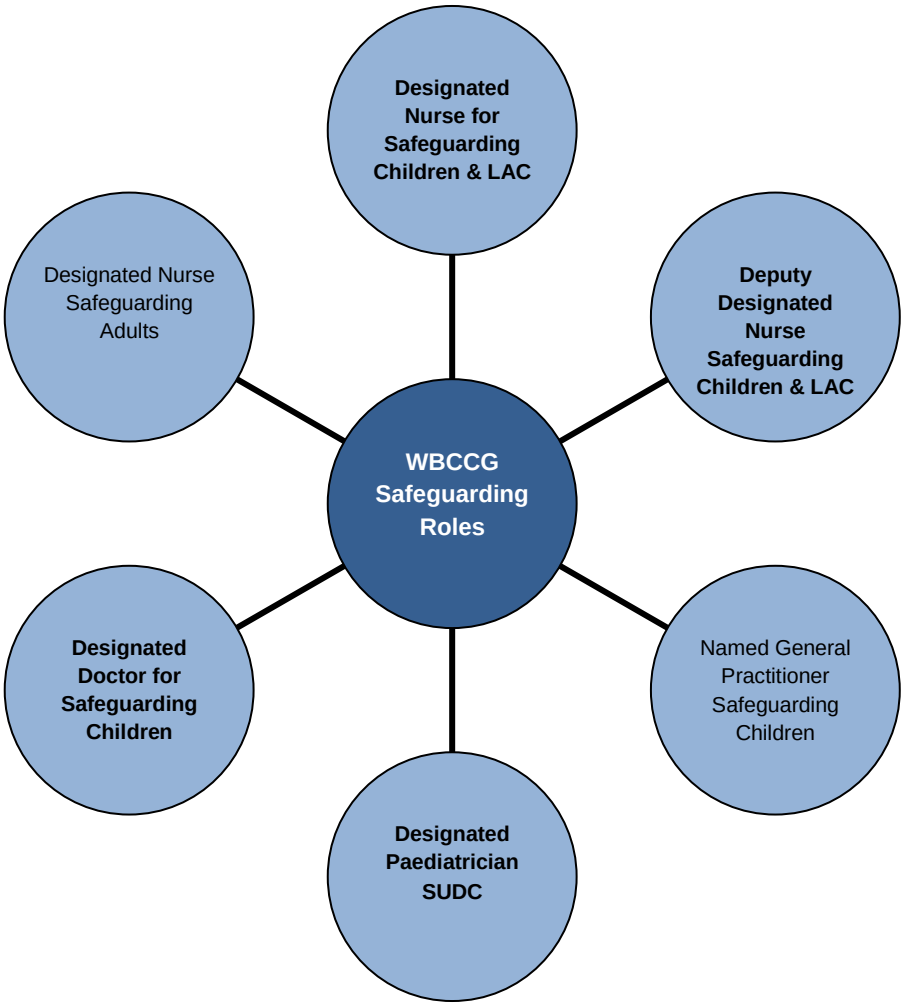
25. GMHSCP asserted that the new safeguarding arrangements:

- Ensured local ownership;
- Assured regional and national colleagues that GMHSCP has a robust assurance process;
- Promoted partnership working by reducing the duplication of work and communication channels, directing assurance back to quality board and executing relevant work to GMHSCP;
- Ensured that the safeguarding experts in the system are leading safeguarding initiatives with CCG oversight.

Local Context - WBCCG Safeguarding Team

26. The WBCCG Safeguarding Team works with partners to ensure that Providers of commissioned services fulfil their statutory safeguarding responsibilities and provide a robust response to children and adults at risk in order to ensure improved outcomes for the most vulnerable.

27. WBCCG has the following safeguarding posts in place, those which are statutory posts are indicated in bold:



28. The CCG employs both an Assistant Director for Safeguarding Adults and Assistant Director Safeguarding Children who work across the health economy to build clinical awareness of safeguarding.

29. The key aspects of these roles include:

- Working with providers of WBCCG commissioned services to ensure children and adults at risk are safe, and a cohesive organisational wide strategy is in place which reflects national policy, local guidance and best practice;
- Acting as 'expert advisors' to Local Safeguarding Boards and working with them to ensure communication and governance processes are in place between WBCCG and Local Authority in order that commissioned services 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.

Designated Professional for Safeguarding Adults and Designated Nurse for Safeguarding Children

30. The Assistant Director for Safeguarding Adults includes the Designated Professional for Safeguarding Adults role.

31. The Assistant Director Safeguarding Children role incorporates the statutory roles of both the Designated Nurse Safeguarding Children and Designated Nurse LAC.

32. In December 2017 a Deputy Designated Nurse was recruited to the Safeguarding Team to resource the team in line with Intercollegiate Document guidance. This role supports the delivery of the comprehensive statutory workload associated with both safeguarding children and LAC.

33. The Assistant Directors for Safeguarding Adults and Safeguarding Children work closely with the Local Authority and Local Safeguarding Boards in delivering the safeguarding agenda across the Borough.

Designated Doctor Safeguarding Children

34. The Designated Doctor for Safeguarding Children is commissioned from Wrightington, Wigan and Leigh NHS Foundation Trust (WWLFT) to work with the Designated Nurse Safeguarding Children at WBCCG.

35. This post is held by a Consultant Paediatrician who has the necessary knowledge, skills and expertise required in line with the Intercollegiate Safeguarding Competency Framework and a robust service specification is in place setting out clear accountability and performance management.

Designated Paediatrician for Sudden Unexpected Death in Childhood (SUDC)

36. WBCCG contribute to the administration and leadership costs for the GM Rapid Response to SUDC Service. Within this service, Paediatricians work jointly with Greater Manchester Police (GMP) and Children's Social Care to investigate unexpected deaths, report to the Coroners, Child Death Overview Panels (CDOPs) and provide support and information to the families and professionals involved.

37. In addition, WBCCG commission a Designated Senior Paediatrician for SUDC from WWLFT to complete the Wigan component of the rota for the GM Rapid Response to SUDC Service.

Named GP Safeguarding Children

38. A Named GP for Safeguarding Children is employed by WBCCG and provides three programmed activities (PAs) per week. This post is not a statutory requirement; however, it is considered good practice to secure the expertise of a GP to provide a primary care clinician's perspective to support the delivery of the safeguarding agenda.

39. The role of the Named GP for Safeguarding Children is to work with the Designated Doctor and Nurse, and GP Practice Safeguarding Leads to ensure that primary health care teams meet their safeguarding responsibilities.

40. A full WBCCG Safeguarding Team Structure Chart can be seen in Appendix 1.

Local Context - WBCCG Safeguarding Governance Arrangements

41. The Chief Officer remains the Board Executive lead for safeguarding children and safeguarding adults at risk. The WBCCG Safeguarding Team report directly to the Director of Nursing and Quality.

42. The Safeguarding Team has quarterly meetings with the Chief Officer to update her in relation to safeguarding matters and have direct access as required for example to discuss serious incidents, child deaths and agree statutory safeguarding reports.

43. Key representatives for WBCCG are statutory members of WSCB, WSAB and the Health and Wellbeing Board.

44. Quarterly reports regarding safeguarding are provided in partnership with the Quality Team to the WBCCG Clinical Governance Committee and subsequently the Governing Body.

45. Quarterly reports are also completed for GMHSCP and NHSE North which give an overview of the current active safeguarding reviews and WBCCG compliance with the CCG Safeguarding Assurance Framework.

46. The Assistant Directors Safeguarding/Designated Nurses act as expert advisors to their respective Safeguarding Board.

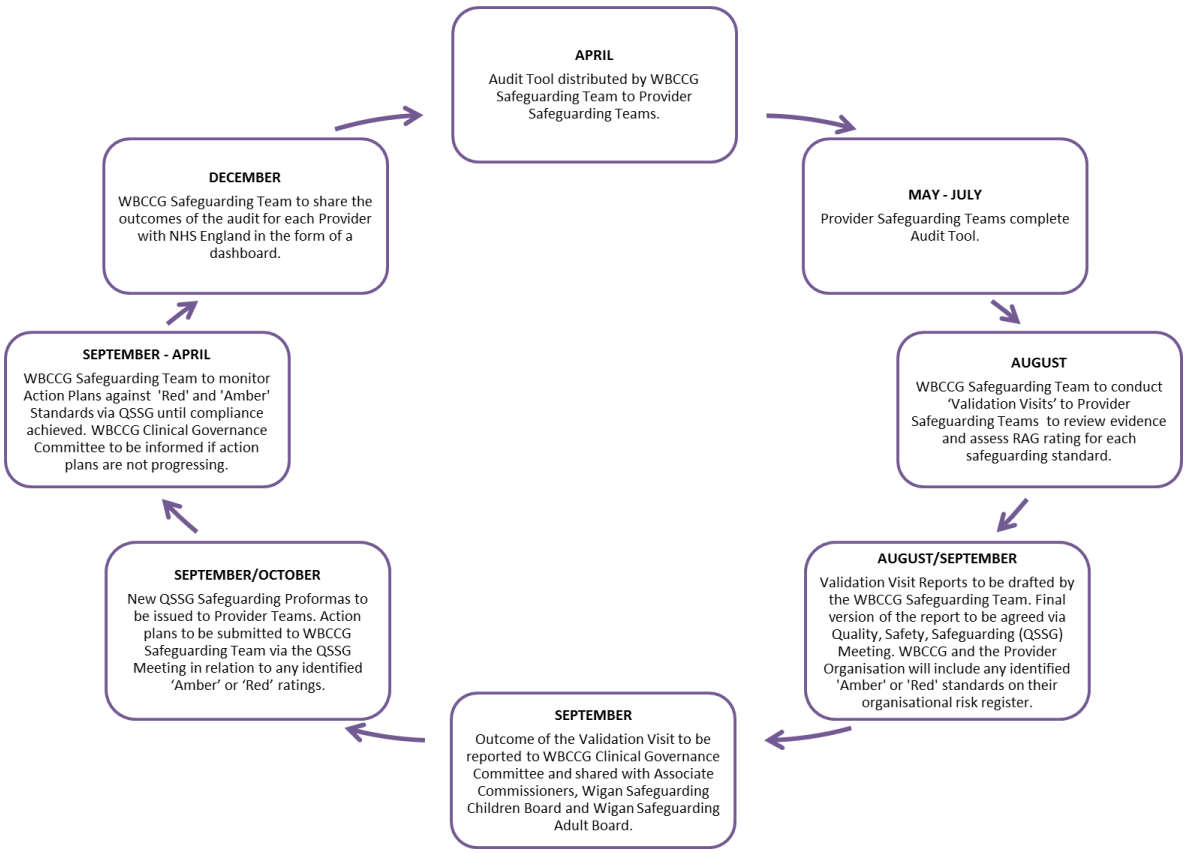
47. The Safeguarding Governance Framework can be seen in Appendix 2.

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

48. The Safeguarding Team sit within the Nursing and Quality Directorate of the CCG which facilitates the commissioning of safe care with the requisite checks and balances to ensure that local healthcare provider services meet their responsibilities.

49. Formal monitoring with our NHS Providers is undertaken through the Quality, Safety and Safeguarding Group (QSSG) meetings.

50. The WBCCG Provider Safeguarding Assurance Cycle is as follows:



51. The QSSG meets with each of our three main providers of acute, community and mental health services, separately on a quarterly basis.

52. Provider organisations' compliance with statutory safeguarding responsibilities is reviewed by assessing them against the 'Safeguarding Children, Young People and Adults at Risk Contractual Standards'.

53. This document contains a safeguarding audit framework which is based on CQC Fundamental Standards, Section 11 of the Children Act 2004 and the Care Act 2015.

54. The Safeguarding Team provides assurance to the WBCCG Clinical Governance Committee and Governing Body, GMHSCP and NHSE on an annual basis in relation to the WBCCG NHS Provider Safeguarding Audit Tool review process.

55. 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.

56. A formal report entitled 'Safeguarding Team Report: Validation of Evidence Submitted - NHS Provider Safeguarding Audit Toolkit' is produced which gives an overview of the validation process.

57. 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.

58. The final 'Red, Amber, Green' (RAG) ratings for all three providers are submitted to GMHSCP in order for them to review and benchmark providers across GM.

BLUE	Not applicable
RED	Non-compliance against standards and/or failure to progress agreed action plan within agreed time scales
AMBER	Partial compliance, action plans in place to ensure full compliance and progress is being made within agreed timescales
GREEN	Fully compliant, however remains subject to continuous quality improvement

59. The outcomes of this assurance process are included in the Quality, Safety and Safeguarding reports provided to the WBCCG Clinical Governance Committee and in turn to the Governing Body.

Wigan Safeguarding Adults Board (WSAB)

60. The WSAB arrangements are compliant with the governance arrangements set out in the Care Act (2014).

61. The WBCCG representative at WSAB is the Director of Nursing and Quality.

62. The Assistant Director Safeguarding Adults supports the work of WSAB and attends Board meetings and Sub Groups of WSAB in the capacity of an expert adviser, in accordance with Care Act (2014). Expert advisers share their knowledge and expertise to support members in carrying out their functions and duties.

63. Following the agreement of a 'Memorandum of Understanding' the Assistant Director Safeguarding Adults now also represents NHSE North at the WSCB meetings.

64. 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;
- Support 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;
- Analysis of safeguarding data to identify thematic trends to capture learning and inform service delivery;
- Assisting the Local Authority in Section 42 enquiries where expert advice is required in respect of clinical and nursing matters;
- Participating in Strategy Meetings, Case Conferences and Appeal Hearings (Local Authority) as appropriate.

WSAB Serious Adult Reviews (SARs)

65. SARs are undertaken by WSAB when:

- An adult has died, and WSAB knows or suspects that the death resulted from abuse or neglect;
- The adult is still alive, and 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.

66. 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.

67. An overview of WSAB SARs in 2017/18 are outlined in the table below:

REF ID	INCIDENT DATE	ORGANISATION	STATUS	StEIS Ref No
ADULT 13	November 2015	NWBFT	The Overview Report is completed and signed off. An Action Plan is in situation and is monitored on an ongoing basis via the Learning and Improvement Sub Group of the WSAB.	2017/2727

Domestic Homicide Reviews (DHRs)

68. 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.

69. An overview of the DHRs conducted in 2017/18 are outlined in the table below:

REF ID	INCIDENT DATE	ORGANISATION	STATUS	StEIS Ref No
DHR 4	February 2015	Health Economy	Currently awaiting publication of report. No change in status.	2015/20763
DHR 5	May 2016	Health Economy	The case has been has been presented to the Building Stronger Communities Partnership. Currently awaiting sign off of the Overview Report. Work is to commence on the accompanying Action Plan.	2017/2730
DHR 6	October 2016	Health Economy	The case has been has been presented to the Building Stronger Communities Partnership. Currently awaiting sign off of the Overview Report. Work is to commence on the accompanying Action Plan.	2017/15605

Wigan Safeguarding Children Board (WSCB)

70. The Children Act 2004 and the Local Safeguarding Children Boards (LSCBs) Regulations 2005 required all Local Authority areas to establish statutory LSCBs.

71. WSCB is the key statutory body for agreeing how organisations in the Wigan Borough will co-operate to safeguard and promote the welfare of children in the area, and for ensuring the effectiveness of what they do.

72. To carry out its responsibilities effectively, WSCB requires representation from each of the statutory agencies identified in 'Working Together' (2015).

73. 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.

74. The WBCCG representative at WSCB is the Director of Nursing and Quality.

75. The Assistant Director Safeguarding Children/Designated Nurse attends Board meetings in the capacity of an expert adviser, in accordance with Working Together (2015).

76. Following the agreement of a 'Memorandum of Understanding' the Designated Nurse now also represents NHSE North at the WSCB meetings.

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

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

- Chair of the Joint WSCB/WSAB Workforce Development and Training Sub Group;
- Representative at the Bolton, Salford and Wigan Tripartite Child Death Overview Panel (CDOP);
- Facilitation of Local Case Reviews;
- Development of WSCB Strategy Documents, e.g., Neglect Strategy and Workforce Development Strategy;
- Planning and delivery of multi-agency locality based briefings to front line staff to disseminate lessons learned from SCRs;
- Supported Named Safeguarding Children Nurses and Professionals by providing expert advice, support and quarterly clinical supervision;
- 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.

WSCB Serious Case Reviews (SCRs)

79. SCRs are undertaken by 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' (Working Together, 2015).

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

81. The Assistant Director Safeguarding Children/Designated Nurse is responsible for implementing actions identified in SCRs and LCRs for the CCG.

82. The CCG Safeguarding Team is also responsible to oversee the implementation of any actions related to Primary Care.

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

84. The Assistant Director Safeguarding Children is responsible for recording SCRs on to the Strategic Executive Information System (StEIS) to ensure any lessons learned specifically relating to the health economy are shared with GMHSCP and NHSE.

85. The CCG Safeguarding Team is required to have an overview of the recommendations made to the health economy and to support Named Nurses for safeguarding in provider organisations with implementation of the action plans.

86. The CCG Safeguarding Team maintains formal oversight of provider progress against action plans via the QSSG meetings. Provider Named Nurses for Safeguarding give updates in relation to SCR action plans as part of the QSSG safeguarding assurance proforma.

87. LSCBs are responsible to ensure that the recommendations from SCRs are completed.

88. An overview of the WSCB Serious Case Reviews in 2017/18 is outlined in the table below:

ID	INCIDENT DATE	STATUS	StEIS Ref No *If applicable*
CHILD H	March 2015	Final report has been agreed by WSCB Members. The National SCR panel has agreed that this SCR should not be published. StEIS entry has been updated and closed by GMHSP.	2016/10597
CHILD K	October 2016	Practitioners Event held on 23/03/18. Independent Reviewer is currently drafting the SCR Report.	2017/18405
CHILD L	March 2017	Practitioner Event to be held on 12/04/18. Next SCR Panel meeting planned for 12/04/18 where a draft of the report will be reviewed. Plan for final report to be presented at WSCB in July 2018.	2017/18429
CHILD M	July 2016	Final report was presented at March 2018 WSCB meeting. Decision to be made regarding publication after the Independent reviewer has met with the parents. WBCCG will update StEIS entry and request closure as soon as these details have been finalised.	2017/18440
CHILD O	October 2017	Practitioners Event held on 23/03/18. Independent Reviewer is currently drafting the SCR Report.	2017/25860
CHILD R	August 2017	Initial SCR Panel Meeting was held on 26/01/18. SCR Panel Meeting scheduled for 10/04/18.	2018/9938
CHILD S	March 2018	Critical Incident Panel held on 22/02/18, decision made that the case met the criteria for SCR. Due to the current police investigation safeguarding processes are paused. An Independent Reviewer is yet to be appointed.	2018/3013

Child Deaths and Child Death Overview Panel (CDOP)

89. The statutory requirement for LSCBs to undertake the functions relating to child deaths is set out in Working Together (2015).

90. 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.

91. 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.

92. A GM 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.

93. The CDOP carries out a multi-disciplinary review of child deaths (0-17 years inclusive) with the aim of understanding how and why children die.

94. The responsibility for determining the cause of death rests with the coroner or doctor who signs the death certificate. The function of the CDOP is to evaluate

information about the child's death, identify lessons to be learnt and inform an understanding of all child deaths at a national level.

95. 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.

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

97. The Panel membership comprises of representatives from the relevant disciplines across the three local authority areas.

98. The 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.

99. The Assistant Director Safeguarding Children/Designated Nurse acts as a 'Single Point of Contact' for all child deaths, regardless of whether there are safeguarding concerns.

100. The Assistant Director Safeguarding Children/Designated Nurse is a member of the CDOP and attends the meetings which are held every two months.

101. Bolton, Salford and Wigan CDOP produce an annual report which outlines the functions of the Panel and summarises its key findings.

102. An Annual Report of Child Deaths in GM is also produced which reviews the data taken from all four CDOPs across GM.

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

Progress against Safeguarding Team Priorities Identified for 2017/18

104. The WBCCG Safeguarding Team priorities identified in the for 2017/18 Annual Report were:

"Shape and influence the safeguarding landscape in the context of GM devolution and local integration of health and social care"

105. The Assistant Director for Safeguarding Children has led on the development of a GM standardised approach to safeguarding contractual standards. Subsequently all GM CCGs have adopted 'Safeguarding Children, Young People and Adults at Risk – Contractual Standards'.

106. The WBCCG Safeguarding Team has worked with Designated Professional colleagues in the development of a GM Safeguarding Integrated Network where the three GM Clinical Networks come together to agree GM safeguarding strategic priorities.

"Review the adult safeguarding capacity within the Safeguarding Team in line with the anticipated Intercollegiate Document for Safeguarding Adults"

107. This priority is dependent on the guidance and recommendations contained within the Intercollegiate Document for Safeguarding Adults. Further to a comprehensive consultation process, the document has yet to be published resulting in a delay in reviewing the adult safeguarding capacity within the Safeguarding Team. However, this remains a priority and a full review will be conducted as soon as the Intercollegiate Document for Safeguarding Adults is published.

"Embed the work completed to date to improve oversight and governance in relation to compliance with safeguarding contractual standards by our smaller commissioned providers"

108. The governance of smaller commissioned providers in relation to compliance with safeguarding contractual standards has progressed significantly this past year. The Assistant Director of Safeguarding Adults has implemented the Non NHS Provider Safeguarding Audit Tool to twenty Nursing Homes across the Borough a detailed narrative of which is contained in the section titled Safeguarding Team Achievements (paragraphs 118 – 122) of this report. It is planned to further progress this work stream over the next year by implementing the Safeguarding Audit Tool to Residential Homes across the Borough.

"Deliver safeguarding training to GPs, Practice Nurses and the Continuing Health Care Team"

109. Keeping GPs, Practice Nurses and the Continuing Health Care Team informed of developments in respect of key safeguarding agendas remains an important activity. The Assistant Director of Safeguarding Adults has this past year

presented to GPs in respect of LeDeR, presented to Practice Nurses in respect of the learning from Domestic Homicide Reviews and advised the Continuing Health Care Team in respect of the Mental Capacity Act and Deprivation of Liberty Safeguards.

110. The Named GP for Safeguarding Children has continued to deliver Level 3 Safeguarding Children Training sessions to GPs. In 2017/18 six training courses have been delivered to 99 GPs.

"To develop and strengthen the oversight and governance of LAC"

111. Following a successful business case the WBCCG Safeguarding Team has recruited a Deputy Designated Nurse for Safeguarding Children and LAC which has enabled an increased focus on this area of work.

112. A comprehensive review of the work completed to date has been captured in a WBCCG Annual Report for Looked After Children 2017/18.

"Ensure safeguarding remains a priority during the anticipated changes in the way services are delivered as health and social care move towards integration; and "Communicate the implications of the Children and Social Work Act 2017 which includes the abolition of LSCBs, and introduction of local arrangements for safeguarding and promoting the welfare of children."

113. The Assistant Director Safeguarding Children presented a paper to WSCB regarding the implications of the Children and Social Work Act 2017. Subsequently WSCB development days have taken place with facilitated workshops conducted using the theory of change model.

114. WSCB and WSAB have already begun to integrate and align core business functions. It has been decided that there will be some joint Board meetings in 2018.

115. WSAB and WSCB have begun to develop single joint policies and processes for key safeguarding thematic areas, such as Prevent.

116. The March 2018 WSAB and WSCB Annual Conferences both included presentations and table discussion exercises to capture frontline staff perspectives on the implications of the new legislation.

117. Further work is required and planned to explore wider options for integrating other key functions and delivery groups including learning and improvement and consultation/engagement.

118. In line with wider public service reform work under the Deal for Wigan, WBCCG Safeguarding Team significantly contributes to work on developing and implementing an Integrated Care Organisation and rolling out integrated place based working that has a life course set of principles underpinning them.

119. As part of this wider work, which includes the development of an integrated MASH function for safeguarding and up scaling of wider complex dependency workforce, both boards will work with adult and children's social care (and wider partners) to develop further thematic areas of work through a 'Think Family' approach.

120. The WBCCG Safeguarding Team also acts as advisors to Commissioners and has assisted in the recent Start Well Transformation, and sexual health commissioning.

Safeguarding Team Achievements

Nursing Home Safeguarding Assurance

121. WBCCG has a statutory responsibility to ensure that the organisations from which it commissions services provide a safe system that safeguards children, young people and adults at risk of abuse and neglect. Commissioned services are monitored against the standards identified within "Safeguarding Children, Young People and Adults at Risk – Contractual Standards 2017 – 2018".

122. To support the monitoring of the standards, Non NHS Providers are required to complete a self-assessment RAG rated "Non NHS Provider Safeguarding Audit Tool" which contains eleven standards based on the NHS Assurance and Accountability Framework for Safeguarding, CQC Essential Standards, Section 11 of the Children Act 2004 and the Care Act 2014.

123. For the year 2017 – 2018, twenty Nursing Homes across the Borough were subject to the Non NHS Provider Safeguarding Audit Tool for the first time. Each Nursing Home provided evidence to demonstrate compliance against the agreed safeguarding standards. The Assistant Director of Safeguarding – Adults reviewed and assessed the evidence before arriving at a judgement as to whether it was compliant against the safeguarding standards. All standards rated as amber (partially compliant) are accompanied by an action plan to ensure compliance within an agreed time frame.

124. A report detailing the process and findings of the Safeguarding Audit Tool was presented to and accepted by the WBCCG Clinical Governance Committee and Wigan Safeguarding Adult Board.

125. In order to progress the safeguarding assurance of Non NHS Providers moving forward, the Assistant Director of Safeguarding – Adults will repeat the process with Nursing Homes (albeit focusing on the action plans for standards rated as amber) and implement the process in full for Residential Homes across the Borough.

LeDeR (Learning Disabilities Mortality Review)

126. The Assistant Director of Safeguarding Adults leads on delivering the LeDeR work steam. Information regarding LeDeR can be found in Appendix 4.

127. The work undertaken to date includes:

- Eleven colleagues completing the reviewers training;
- Submission of an Implementation Plan to the Local steering Group (Greater Manchester);
- Submission of a Review Plan along with a bid for additional monies to fact track outstanding reviews;
- Establishing a Local Support Group where reviewers meet six weekly to discuss progress, and share learning in terms of the LeDeR process and respective reviews;
- Presenting the LeDeR Programme to the GP Safeguarding Leads meeting to ensure their contribution to reviews as and when appropriate;
- Attending the LeDeR Reviewer Bereavement Workshop in March 2018;
- Attending the LeDeR Sharing the Learning to Improve Care Event in March 2018.

128. To date, two reviews have been completed, five are in the process of being reviewed and four have yet to commence. The learning identified from reviews is presented to the Learning and Improvement Group (WSAB) in order that it can be shared across the health and social care economies respectively.

Safeguarding and GP Practices

129. In 2017/18 the Safeguarding Team have continued to work collaboratively with GPs to:

- Disseminate lessons learned from safeguarding reviews, both children and adults;
- Capture the GP voice and experience pertaining to key safeguarding agendas;
- To support their discharge of statutory safeguarding responsibilities;
- Deliver bespoke GP Level 3 Safeguarding Children Training.

130. The GP Safeguarding Leads Forum has improved communication between the WBCCG Safeguarding Team and the GP Safeguarding Leads as evidenced by the increase in contact from individual GPs and or their practices in respect of safeguarding concerns and queries.

131. In 2017/18 the GP Safeguarding Lead Forum meetings have been delivered in a themed format in response to feedback received.

- Suicide in Young People including a Local Case Review;
- Guest Speaker - Child and Adolescent Mental Health Service;
- 2017 Changes to DoLS;
- Learning Disabilities Mortality Review (LeDeR) Programme;
- Role of WSCB;
- Domestic Abuse and the Role of the GP including case studies discussion and feedback.

Multi-Agency Approach to Practice Week

132. In October 2017 the Assistant Director Safeguarding Children took part in the Local Authority Practice Week. These are viewed nationally as best practice and involve the senior management team completing case file audits alongside staff, observing practice and speaking to children, young people and families.

Collaborative Approach to Improving Access to Mental Health Services for Children and Young People

133. WBCCG Safeguarding Team worked in collaboration with the Local Authority and WSCB to review Child and Adolescent Mental Health Services.

134. This involved conducting unannounced commissioner visits to the Wigan CAMHS Services. The visiting team consisted of members from the CCG Quality, Commissioning and Safeguarding Team along with representatives from Wigan Council and WSCB.

135. The visits included:

- Staff interviews;
- Interviews with children and young people including parents/carers;
- Case file audit of children and young people attending appointments during the visit.

136. Following the visits all parties worked together with the Provider Service to develop an improvement plan. This work was highlighted as good practice by GMHSCP and WBCCG were asked to present this work to the Quality Board.

Safeguarding Team Priorities Identified for 2018/19

137. The WBCCG Safeguarding Team have discussed and agreed the following safeguarding priorities (work streams) for 2018/19:

- Integration Health and Social Care;
- Implementation of Children and Social Work Act 2017 and Working Together;
- Safeguarding Across the Life Course;
- Suicide Prevention;
- Complex Safeguarding;
- Utilising data for safeguarding, forward planning and improving service delivery.

Conclusion

138. The Safeguarding Team continues to ensure that WBCCG meets its statutory safeguarding responsibilities and has clear governance processes to monitor the arrangements of commissioned health services to provide assurance that adults and children at risk of abuse or neglect are safe.

139. Work continues with Named Safeguarding Nurses/Professionals across provider services to ensure that safeguarding arrangements across the Wigan Borough health economy are robust and fit for purpose.

140. There are good safeguarding systems in place across the local health economy. There continues to be challenges in relation to training and the capacity to respond to SCRs, DHRs and LCRs within the Wigan Borough. It is essential that a high level of priority is given to safeguarding adults and children.

141. The Safeguarding Team remains committed to ensuring that the population of Wigan Borough are safe, and that their health needs are met. We will continue to work collaboratively with the Local Authority, Wigan Safeguarding Adults Board (WSAB), Wigan Safeguarding Children Board (WSCB) and key partners to continuously improve systems to safeguard adults and children

142. As in previous years, this Safeguarding Annual Report for 2017/18 has focused on the governance arrangements in place to deliver the safeguarding agenda; and the role that the WBCCG Safeguarding Team plays in seeking assurance that Providers fulfil their statutory safeguarding responsibilities.

143. The WBCCG Safeguarding Team are mindful that in view of the changing landscape (devolution of GM and the development of a Local Care Organisation) that moving forward it is important to demonstrate the impact of safeguarding work streams on the improved outcomes for the people of Wigan. To this end, in the forthcoming financial year the Team will consider how best to reflect this within future annual reports.

Recommendations

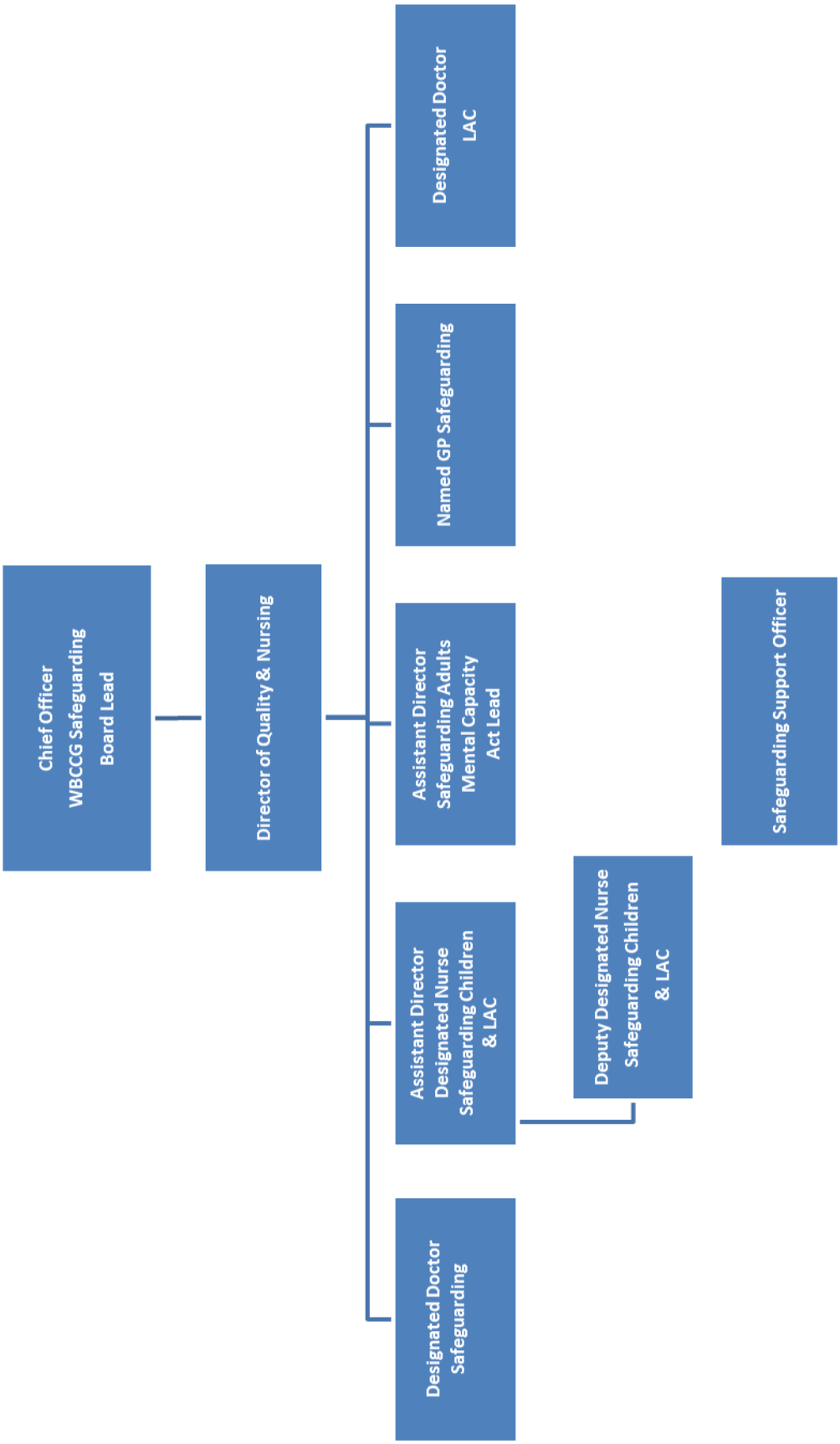
144. The WBCCG Governing Body is asked to:

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

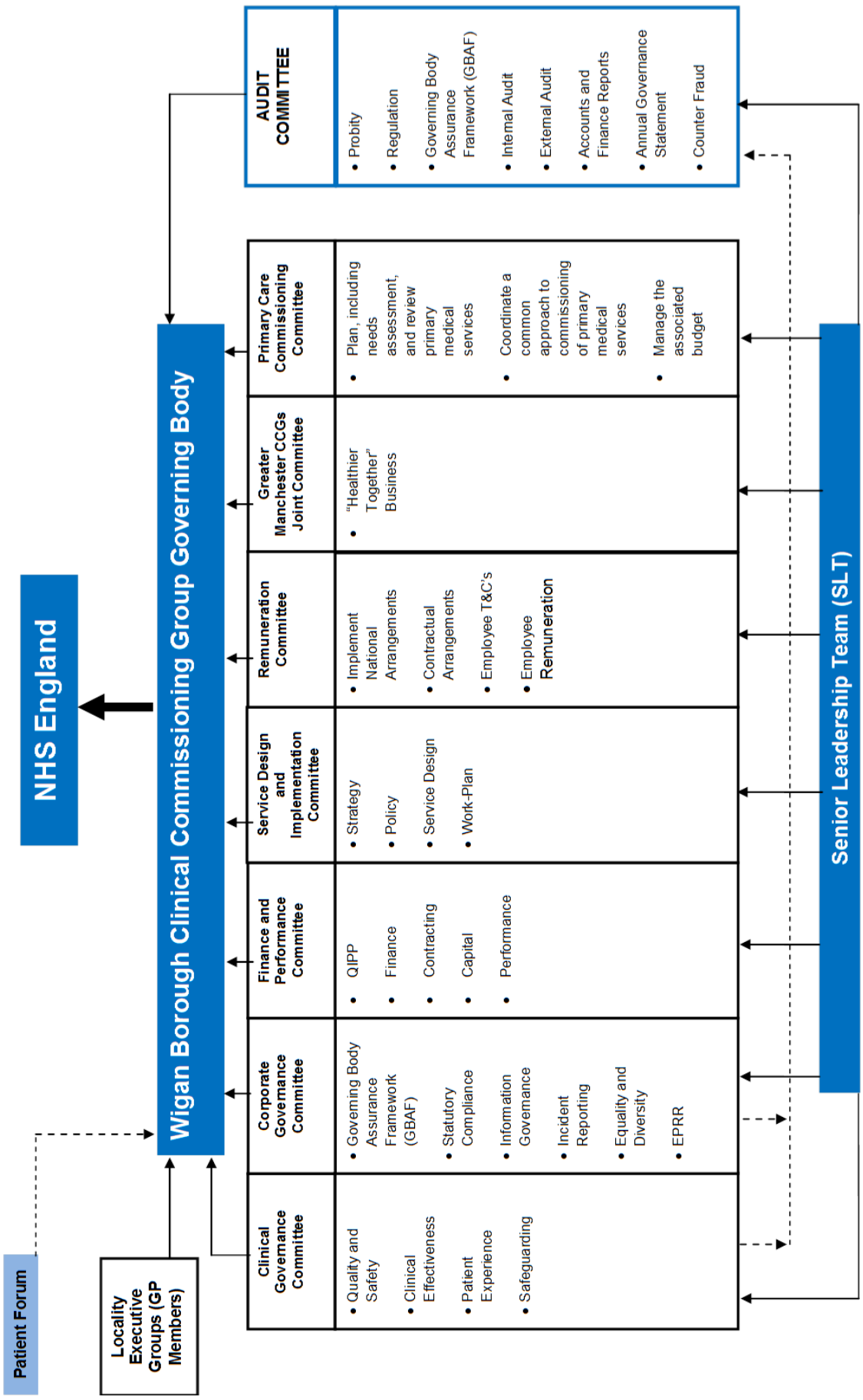
Glossary:

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 Safeguarding Team Structure



Appendix 2 - Governance Structure



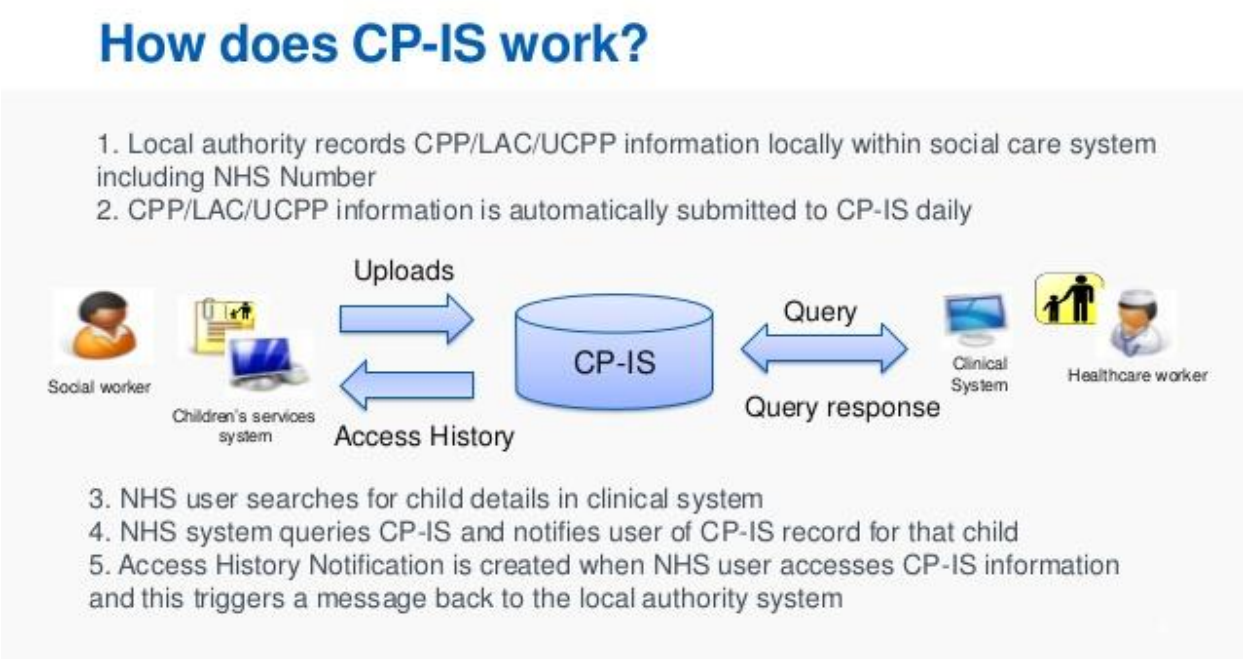
Appendix 3 - National Context - Child Protection Information Sharing Project

1. The 'Child Protection - Information Sharing' (CP-IS) project, led by the Health and Social Care Information Centre (HSCIC), focuses on improving the protection of children who have previously been identified as vulnerable by Social Services when they visit NHS unscheduled care settings.

2. 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 by linking the IT systems of NHS unscheduled care to those used by social care child protection teams.

3. CP-IS shares information about three specific categories:

   - Children with a child protection plan;
   - Children 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.



Appendix 4 - LeDeR (Learning Disabilities Mortality Review)

1. The Learning Disabilities Mortality Review (LeDeR) Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England (NHSE). It is hosted and facilitated by the Norah Fry Research Centre, School for Policy Studies, University of Bristol. The LeDeR Programme is a review process of the deaths of people with learning disabilities. It seeks to share the learning from reviews in terms of common themes and recommendations in order to improve service provision across the health and social care economies.

2. The LeDeR Programme was established as a result of the recommendations of the Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD) who reported that for every person in the general population who dies from a cause of death amenable to good quality care, three people with learning disabilities will do so.

3. The LeDeR Programme supports local areas to review the deaths of people with learning disabilities. The programme collates and shares anonymised information about the deaths of people with learning disabilities in order that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements.

4. The focus of reviews is to:

    - Identify potentially avoidable factors that may have contributed to a person's death;
    - Identify differences in health and social care delivery and ways of improving services to prevent early deaths of people with learning disabilities;
    - Develop action plans to guide necessary changes in health and social care services in order to reduce premature deaths of people with learning disabilities.