South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

# Safeguarding Adults and Children Annual Report 2018-2019

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# Foreword by the Chief Officer

NHS South Sefton Clinical Commissioning Group (CCG) and NHS Southport and Formby Clinical Commissioning Group (CCG) demonstrate a strong commitment to safeguarding within the local communities. There are strong governance and accountability frameworks within the organisations which clearly ensure that safeguarding adults, children and young people is core to the business priorities. The commitment to the safeguarding agenda is demonstrated at Executive level and throughout all CCG employees. One of the key focus areas for the CCGs is to actively improve outcomes for adults, children, young people and their families and that this supports and informs decision making with regard to the commissioning and redesign of health services within the Borough.

**Fiona Taylor**

**Chief Officer – NHS South Sefton CCG and NHS Southport and Formby CCG**

## Executive Summary

This is the annual safeguarding report to NHS South Sefton Clinical Commissioning Group Governing Body and NHS Southport and Formby Clinical Commissioning Group Governing Body. The purpose of the report is to assure the Governing Body and members of the public that the NHS South Sefton and NHS Southport and Formby Clinical Commissioning Groups (to be referred to as the CCGs throughout the remainder of the report) are fulfilling their statutory duties in relation to safeguarding adults, children and young people in the Borough of Sefton.

The CCGs safeguarding adults and children annual report takes account of national changes, influences and local developments, activity, governance arrangements and any challenges to business continuity.

The CCGs have in place governance and accountability arrangements including regular reporting via the CCGs Joint Quality and Performance Committee and to the Governing Body; there is direct access by the Designated Professionals to the Chief Officer.

The CCGs makes a significant contribution to the work of both the Merseyside Safeguarding Adults Board and Sefton Safeguarding Children Board and their sub groups.

## 1. Purpose of the report

This report provides assurance that the CCGs have safely discharged their statutory responsibilities to safeguard the welfare of adults and children at risk of abuse and the duty to ensure that the health services it commissions are compliant in this respect as outlined in the Children Acts 1989 and 2004, the Care Act 2014 and the Mental Capacity Act 2005. There is a separate report in respect of Children in Care (CIC) / Looked after Children.

Key areas of priority were established and reported in the Safeguarding Children Annual Report 2017-18 and progress against the children elements of these priorities will be highlighted within this report. A number of areas will continually be prioritised for the CCGs as they are a core component of providing safeguarding assurance and therefore they will remain ongoing in future work plans.

This report will summarise arrangements, achievements and activity undertaken in 2018-19 and highlight recommendations for 2019-20.

The CCGs work in partnership with Sefton Local Authority and other partnerships including Sefton Local Safeguarding Children Board and Merseyside Safeguarding Adults Board.

## 2. Response to Business priorities 2018-19

- Respond to changes required as a result of the Children and Social Work Act 2017
    - CCG Policy & Procedure to be reviewed (incorporating Working Together 2018) - *Update of policy completed (see section 4.1)*
    - LSCB transition arrangements to Multi Agency Safeguarding Arrangements (MASA's) - *Transition arrangements supported (see section 4.2)*
    - CDOP changes: transfer of responsibility for child death reviews from LSCBs to new Child Death Review Partners Transition arrangements supported - *Transition arrangements supported (see section 4.3)*
- Ensure that the CCGs are compliant with statutory safeguarding responsibilities and requirements, including the oversight and management of progression against any action plans including section 11, Chapter 14 Care Act (2014), SEND Improvement Plan, NHSE assurance, NICE guidance and other safeguarding inspection frameworks - *Progress and updates against Section 11/ Chapter 14 and inspection frameworks are provided in sections 6.1 and 6.3.2/ 6.3.3*
- Continue to enhance and develop arrangements to gain assurance from commissioned providers through established contract management processes - *Progress and updates against this priority are provided in section 6.3.1*
- Continue to support the agenda and the implementation of relevant guidance to improve quality in practice in relation to harmful practices, asylum seeker and refugee

programmes, trafficking and modern slavery - *progressed through Modern Day slavery statement, National Referral Mechanism in now referenced within the Safeguarding Policy*

- Embed the newly developed Safeguarding Team (adults, children and LAC) within the CCGs and ensure development of:

    - Clear Safeguarding Strategy and work plan - *This priority will continue to be progressed throughout 2019-20 within planned supervision*
    - A comprehensive safeguarding page on the CCGs intranet - *Completed (see section 4.1)*
    - Robust supervision provision to support the service - *Completed (see section 7)*

## 3. National Context

### 3.1 Safeguarding Children Reforms

The Children & Social Work Act (2017) received Royal Assent in April 2017 and set out the changes needed to support the new system of multiagency safeguarding arrangements.

The key changes include:

- Replacement of Local Safeguarding Children Boards (LSCBs) with local Safeguarding partners
- Establishment of a new national Child Safeguarding Practice Review Panel
- Transfer of responsibility for child death reviews from LSCBs to new Child Death Review Partners

The ongoing work within Sefton to achieve these new arrangements is highlighted throughout this report.

In respect of safeguarding, LSCBs must continue to carry out their statutory functions, including commissioning Serious Case Reviews (SCRs) where the criteria are met, until the point at which safeguarding partner arrangements begin to operate in a local area. LSCBs must also continue to ensure that a review of each death of a child normally resident in the LSCB area is undertaken by the established Child Death Overview Panel (CDOP) until the new child death partner arrangements are in place.

Completed plans for the new arrangements must be published and submitted to the Department for Education by 29th June 2019.

### 3.2 Working Together (2018)

The updated guidance was published in July 2018 and contained further detail as to the changes set out in the Children & Social Work Act (2017).

Key changes in the guidance highlighted specifically that practitioners should, in particular, be alert to the potential need for early help for a child who:

- Is disabled and has specific additional needs
- Has special educational needs (whether or not they have a statutory Education, Health and Care Plan)
- Is a young carer
- Is showing signs of being drawn into anti-social or criminal behaviour, including gang involvement and association with organised crime groups
- Is frequently missing/goes missing from care or from home
- Is at risk of modern slavery, trafficking or exploitation
- Is at risk of being radicalised or exploited
- Is in a family circumstance presenting challenges for the child, such as drug and alcohol misuse, adult mental health issues and domestic abuse
- Is misusing drugs or alcohol themselves
- Has returned home to their family from care
- Is a privately fostered child

The guidance also included:

- a new section on referral highlighting that anyone with a concern about a child's welfare should make a referral to local authority children's social care
- a myth busting guide to information sharing
- a new section on assessment of disabled children and their carers; young carers; children in secure youth establishments;
- a new section on contextual safeguarding

### 3.3 Working Together: Transitional guidance

This guidance was published in July 2018 to support LSCBs, the new safeguarding and child death review partners, and the new Child Safeguarding Practice Review Panel in the transition from LSCBs and serious case reviews (SCRs) to a new system of multi-agency arrangements and local and national child safeguarding practice reviews. The aim of the guidance is to support LSCBs to understand their requirements and to plan and manage their work in the transitional period

### 3.4 Child Death Review: Statutory and operational guidance published October 2018

This guidance was published in October 2018 and sets out full processes that follow the death of a child who is normally resident in England. It builds on the statutory requirements

set out in Working Together (2018) and clarifies how individual professionals and organisations across all sectors involved in the child death should contribute to reviews.

### 3.5 Adult Safeguarding: Roles and Competencies for Health Care Staff (August 2018) Intercollegiate Document (First Edition)

All healthcare staff who work with people in their greatest moments of need must have the competencies to be able to do everything that they can to ensure that adults at risk are protected from abuse, harm and neglect. Healthcare organisations must ensure that those who use their services are safeguarded and that staff are suitably skilled and supported.

The Adult Intercollegiate Document was published in August 2018 and aims to guide professionals and the teams they work with to identify the competencies they need in order to support individuals to receive personalised and culturally sensitive safeguarding. It is a new and ambitious document which sets out a framework that will help staff, practitioners, employers and commissioners understand the role and level of education/competence which correlates to a particular job purpose. It has been produced by intercollegiate endeavour and focusses on equipping the workforce with knowledge of current legislation (such as the Care Act 2014 and the Mental Capacity Act 2005) and guidance.

Similarly to the Safeguarding Children Intercollegiate document, this guidance includes education and learning logs to enable individuals to record their learning and form a 'passport' for those who move on to new jobs or other organisations. Levels 1-3 relate to different occupational groups, while Levels 4 and 5 are related to specific roles. This framework also includes specific detail for chief executives, chairs, board members including executives, non-executives and lay members.

It is expected that as this is the inaugural Adult Safeguarding Intercollegiate Document and it is ambitious in its scope, by the next iteration (expected to be 2021) all staff will be able to demonstrate the competencies commensurate to their role.

During 2019-20, the Designated Professionals will undertake a review of the CCG Safeguarding Adults and Children Training Strategy and Training Needs Analysis to ensure that any changes highlighted are reflected in local procedure and guidance. The Cheshire and Merseyside Designated Professionals Network are undertaking a piece of work to support a footprint wide interpretation of the guidance to support cross-organisational learning and pass-porting of competency.

### 3.6 Safeguarding Children and Young People: Roles and competencies for healthcare staff (2019) Intercollegiate Document (4th Edition)

All healthcare staff must have the competences to recognise child maltreatment, opportunities to improve childhood wellbeing, and to take effective action as appropriate to their role in order to protect children and young people from harm, and help improve their wellbeing.

In January 2019, the revised ‘Intercollegiate Document’ was published. This intercollegiate competency framework is for all staff groups, ranging from non-clinical staff to experts.

The latest document has been updated to include changes to legislation and statutory guidance in England and now includes education and learning logs to enable individuals to record their learning and form a 'passport' for those who move on to new jobs or other organisations. Levels 1-3 relate to different occupational groups, while Levels 4 and 5 are related to specific roles. This version of the framework also includes specific detail for chief executives, chairs, board members including executives, non-executives and lay members.

During 2019-20, the Designated Professionals will undertake a review of the CCG Safeguarding Adults and Children Training Strategy and Training Needs Analysis to ensure that any changes highlighted are reflected in local procedure and guidance.

### 3.7 Domestic Abuse Bill

The draft Domestic Abuse Bill was published on 21st January 2019. The draft bill puts a greater focus on children, the diverse identities of victims and on the interventions for perpetrators of domestic abuse. The proposed legal changes will create a new statutory definition of domestic abuse which includes economic abuse, establish a domestic abuse commissioner and provide a statutory footing for the existing scheme known as Clare’s Law (or Domestic Violence Disclosure Scheme), that allows people to request information on whether their partner has a history of domestic abuse.

### 3.8 Mental Capacity Act /Deprivation of Liberty Safeguards (MCA/DoLS)

The Law Commission’s Report published in March 2017 proposed urgent reforms to the Mental Capacity Act and the replacement of the Deprivation of Liberty Safeguards (DoLS) with Liberty Protection Safeguards (LPS). The Governments’ final response to the Law Commission’s report was published in March 2018 and broadly agreed with the Liberty Protection Safeguards (LPS) model. The Mental Capacity Amendment Bill received Royal Assent in May 2019 and will be implemented in 2020.

According to the Government the reforms will:

- Introduce a simpler process that involves families more and gives swifter access to assessments
- Be less burdensome on people, carers, families and local authorities
- Allow the NHS, rather than local authorities, to make decisions about their patients, allowing a more efficient and clearly accountable process
- Consider restrictions of people’s liberties as part of their overall care package
- Reduce repeat assessments and authorisations when someone moves between a care home, hospital and ambulance as part of their treatment.
- Apply to people aged 16 years and over

These amendments will have an impact on commissioned health providers but owing to other Government business will not be implemented until 2020 and will be accompanied by 2 new Codes of Practice.

The Designated Safeguarding Adult Manager is a member of the NHSE Regional MCA Steering Group and leads on this piece of work on behalf of the Cheshire and Merseyside Designated Professionals Network.

A presentation was delivered to Governing Body in November 2018 outlining the proposed changes and highlighting the likely impact on the CCGs. Regular updates have been received by the Governing Body and Joint Quality Committee as part of the quarterly safeguarding update paper.

The Government has also commissioned a review of the Mental Health Act. Proposals that relate to the interface between the Mental Health Act and Mental Capacity Act will be considered as part of that review.

## 4. Local Context

The latest data published by Public Health England shows the population in Sefton as 273,790, with a small population of 59,300 children and young people 0-19 years old. Almost 95% of Sefton's population are white British compared to 78% nationally. 92.3% of children in Sefton are white British.

There are mixed levels of deprivation across Sefton with some areas experiencing significant poverty. There are 21% (9,500) of children living in low income families and 17.4% living in poverty.

Nearly three quarters of all low income families are also a lone parent family which is higher than the national rate of 68%.

Life expectancy for both men and women is lower than the England average, and approximately 10 years lower for both men and women living in the most deprived areas of Sefton compared with the least deprived.

The rate of family homelessness and of homelessness in young people aged 16-24 years is significantly lower than the rest of England.

Attendances at emergency departments for injury in children and young people aged 19 years and under is higher than the England average. However, emergency hospital admissions in Sefton is similar to the England average. Alcohol and substance misuse related hospital admissions for those under 18 years old in 2017 was worse than the England average but better than the rest of the North West. Mental health and self- harm related hospital admissions for young people under 18 years old are both higher than the

England average with admissions for self-harm continuing to rise since 2013/14.

On 31st March 2018 there were 238 children subject to a Child Protection Plan. On 31st March 2019 there were 260 children subject to a Child Protection Plan. This represents a 9.2% increase over the reporting period. On discussion with the Local Authority Safeguarding Unit this may be as a consequence keeping children on a plan longer which has had the impact of reducing the child protection re-plan rate; previously acknowledged as being high in Sefton.

The highest category of child protection plan continues to be emotional abuse (42%), as has been the case for the last 5 years, although this represents a fall from 57% in 2018. Neglect remains constant (29%), physical has increased by 14% (now 22%) and sexual abuse has increased by 2% (now 6%).

NHS Digital publishes data taken from the Safeguarding Adults Collection (SAC). For the reporting period 2018-19, there were 2,010 safeguarding adult concerns raised to Sefton Local Authority. Of these concerns, 210 met the criteria for a Section 42 enquiry. The highest category of reported abuse is neglect and acts of omission (40%). Other categories include physical abuse (23%), psychological abuse (17%), financial abuse (15%) and sexual abuse (4%).

The location of abuse against adults at risk was reported as own home (27%), community setting (4.5%), care home with nursing (22%), residential care (27%), hospital (4.5%) and 'other' (15%). Individuals reported the following outcomes following safeguarding enquiries: risk remained (7%), risk reduced (54%) and risk removed (39%). 55% of individuals were deemed to have mental capacity with 45% of individuals deemed to lack mental capacity. For those who were deemed to lack mental capacity, 100% of adults had access to advocacy.

### 4.1 CCG Governance and Accountability Arrangements

Accountability for the safe discharge of safeguarding responsibilities remains with the Chief Officer; executive leadership is through the Chief Nurse who represents the CCGs on Sefton Local Safeguarding Children Board, Merseyside Safeguarding Adults Board and Sefton Corporate Parenting Board and who is also a member of the CCGs Governing Body. In addition, the Deputy Chief Nurse represents the CCGs on Sefton Youth Offending Team Management Board and Sefton Safer Community Partnership Board. The Designated Safeguarding Adult Manager represents the CCGs at Strategic MAPPA Board.

Following the transfer from a hosted to an 'in house' Safeguarding Service in March 2018, support arrangements were in place from Liverpool CCG until recruitment of the Designated Safeguarding Adult Manager and Designated Nurse Children in Care was completed. The Safeguarding Team became fully resourced on 2nd July 2018.

Separate commissioning arrangements ensure the provision of the expertise of a Designated Doctor Safeguarding and Looked After Children and Named GP. All of these professionals act as clinical advisors to the CCGs on safeguarding matters and support the Chief Nurse to ensure that the local health system is safely discharging safeguarding responsibilities. During this reporting period the Designated Doctor retired and the post was successfully recruited to, ensuring no gap in service delivery.

The Safeguarding Business Meeting, chaired by the Chief Nurse, meets on a monthly basis to review emerging safeguarding themes, ongoing work streams and agendas from a children and adult perspective ensuring the CCGs have oversight of activity.

The CCG Joint Quality Committee has full delegated authority from the Governing Body to approve all matters relating to safeguarding. A 'key issues' report advises the Governing Body of significant areas reviewed. Safeguarding reports are presented to the Joint Quality Committee on a quarterly basis to appraise the CCGs of current safeguarding activity and developments and includes performance reports for commissioned services against the specific safeguarding Key Performance Indicators (KPIs).

The CCGs have oversight of risks via the risk register which is monitored on a quarterly basis through Joint Quality and Performance Committee and is reported via the Safeguarding Business Meeting and the Quality Team Meeting.

The Safeguarding Service has ensured the CCGs remain compliant with its policies including the following updates:

- Safeguarding Policy: The CCG's Safeguarding Children & Adults at Risk Policy (v11) was received at the January 2019 Joint Quality Committee and approved by the CCGs Governing Bodies in February 2019 following a review in line with Working Together (2018).

A request was made for inclusion within Appendix 2: Information Sharing Guidance for the definition of 'legitimate' to be included in the footer in respect of *is there a clear and legitimate purpose for sharing information?*

The wording for this has subsequently been agreed and included in the policy.

- Management of Allegations Policy & Procedures: updated September 2018 to reflect the changes within revised Working Together (2018) and PiPOT (People in a Position of Trust).
- Safeguarding Supervision Policy updated August 2018 to reflect changes to the hosted service arrangements and revised Working Together (2018)

The CCGs Safeguarding Intranet page has been reviewed and extensively updated following comments received from primary care colleagues requesting the need for easier access to key safeguarding information, pathways, risk assessment tools and contact

numbers to support practice. The intranet page now provides a comprehensive range of policies, guidance and information resources in respect of children and adults safeguarding agendas and promoted as 'one click to safeguarding'.

During the reporting period the safeguarding service were anticipating the publication of the National Safeguarding Assurance & Accountability Framework (SAAF) and Commissioning Assurance Toolkit (CAT) to support the development of further assurance. The publication of this has been delayed and although outside the reporting timeframe, the final draft was received in May 2019 for review and comments.

The CCGs continue to work in partnership with statutory agencies and the third sector to support safe and effective delivery of services against the safeguarding agenda.

In line with the CCG's responsibilities under the General Data Protection Regulations (GDPR) which came into force in May 2018, the data flows of safeguarding information were reviewed and reported to Information Governance Team in the Commissioning Support Unit.

### 4.2 Multi agency Safeguarding Arrangements

Sefton LSCB is the key statutory body overseeing multiagency child safeguarding arrangements across Sefton. The Board is comprised of senior leaders from a range of organisations as defined within Children Act (2004), to:

- Coordinate the safeguarding work of agencies
- Ensure that this work is effective

CCGs therefore have a statutory duty to be members of the LSCB, working in partnership with the Local Authority to fulfil their safeguarding responsibilities.

Until the new partnership arrangements come into place from 1st July 2019, the current LSCB and safeguarding arrangements will remain in place. Each CCG has a statutory duty to work in partnership with LSCBs in conducting Serious Case Reviews (SCR) in accordance with Working Together to Safeguard Children (2015).

The Designated Safeguarding Professionals and CCGs Quality Team are members of Sefton LSCB (main and executive Board). Throughout this year, the sub groups and key priorities of the Board have been reviewed and revised in preparation of the new arrangements. The current sub groups include the Practice Review Panel (chaired by the Chief Nurse), Policy & Procedures (chaired by the Designated Nurse Safeguarding Children), Performance & Quality Assurance, Learning Development, Training Pool and Child Death Overview Panel, all of which have a function of developing and scrutinising frontline practice across all partner agencies.

The CCGs have supported the priorities of the LSCB throughout 2018-19 as highlighted in Appendix 1. These priority areas included:

- To ensure the partnership drives impact and outcome focused practice which will be evidenced through single agency and partnership Performance Management.
- Evidencing the response to the voice of the child and the community and the impact this is having within safeguarding.
- To continually support and contribute to staff development through training and audit activities by increasing the learning across the partnership through training and audit activities.
- To ensure a controlled and formal transition from the LSCB to the renewed safeguarding arrangements.

The CCG Safeguarding Service has delivered a number of presentations to the LSCB during this reporting period including:

- Healthcare offer for children in Sefton (including 1 minute briefing on 'health economy' in Sefton
- Key Performance Indicators and Safeguarding Assurance for Health Providers
- Review of Health Services for Children Looked After and Safeguarding in Sefton

The new partnership arrangements that will replace LSCBs will consist of three Safeguarding Partners and include the Local Authority, Police and NHS Clinical Commissioning Group (CCG) operating in the authority's area. These three Safeguarding Partners are charged with supporting and enabling local organisations and agencies to work together in a system where:

- Children are safeguarded and their welfare promoted
- Partner organisations and agencies collaborate, share and co-own the vision for how to achieve improved outcomes for vulnerable children
- There is early identification and analysis of new safeguarding issues and emerging themes

The CCGs, as a statutory key partner in the new arrangements, have been actively involved in the transition to the new Multi-Agency Safeguarding Arrangements. The CCGs Chief Officer supported initial discussions with accountable leaders to agree on key areas for the new arrangements, including geographical boundaries, partners involved and the consideration for continued independent scrutiny.

The 'Safeguarding Partners' initially met in March 2018 to agree the principles of the future working arrangements and proposed timetable for implementation.

The CCG Safeguarding Team (Designated Nurse and Named GP) supported and facilitated further consultation and discussion across the partnership at a multi-agency meeting in October 2018, for LSCB partners, to consider and develop the proposed arrangements that would be required to be published prior to 29th July 2019.

These arrangements were further developed and finalised by the Safeguarding Partners and presented to the LSCB, within prescribed timeframes, for partnership agreement.

Although outside the reporting period, Sefton's new safeguarding children arrangements were published on 29th June and came into operation from 1st July 2019. Sefton's partnership agreed to retain the name LSCB, retain the Independent Chair and retain the breadth of representation across the partnership. Sefton LSCB published the arrangements on 25th June 2019 and went live on 1 July 2019. The CCG, as a Safeguarding Partner, also complied with the requirements to publish the arrangements on the CCG webpage.

Alongside the changes developed on a local footprint, the CCGs have been represented at Pan Merseyside 'Transition Meetings' led by Merseyside Police, to consider what agendas could be progressed on a wider footprint. Consideration has been given to Pan Merseyside collaboration in respect of some specific work streams around Policy & Procedures, Workforce Development and Communications.

### 4.3 Child Death Overview Panel (CDOP)

Sefton LSCB has a statutory responsibility to ensure that a review of all child deaths (residents of the borough) is conducted. This is achieved within the Pan Merseyside Child Death Overview Panel (CDOP), a sub group of Sefton LSCB, to enable learning to be gained and analysed across a broader footprint. The CCGs are committed to the work of CDOP and has membership through the Safeguarding Service (Designated Nurse Safeguarding Children and Named GP) at both business and panel meetings which includes separate meetings for neonatal deaths (0-27 days).

During the period 1st April 2018 to 31st March 2019, 14 child deaths were notified to CDOP for Sefton (compared to 17 in 2017-18).

Of these 14 deaths, 8 were neonates (between 0-27 days), 5 were infants (28 days-1year) and 1 child (aged between 1-4 years). Three of the deaths were unexpected (1 neonate and 2 infants).

During 2018/19 Merseyside CDOP categorised 19 child deaths from Sefton comprising:

- 14 neonates (aged between 0 and 27 days)
- 3 infants (aged between 28 days and 1 year)
- 1 child (aged between 10 and 14 years)
- 1 child (aged between 15 and 18 years)

'Perinatal/ neonatal event' was the commonest categorisation of the death with 10 cases classified against this category. Other categories included suicide or deliberate self-inflicted harm (1 case), acute medical or surgical condition (1 case), chromosomal, genetic and congenital anomalies (4 cases), infection (1 case) and, sudden unexpected/ unexplained death (2 cases).

Eight cases were categorised as having modifiable factors in relation to family and environment and parenting including drug and alcohol misuse, domestic violence, smoking, increased maternal BMI, unsafe sleep, social integration, neglect and home conditions.

Modifiable factors in relation to service provision were also identified and included none co-location of paediatric services, infection control and pathways for response to incidents involving pregnant women and children.

i. Safe Sleep Audit

Following the initial safe sleep audit presented to the LSCB in October 2017, a further report was developed highlighting findings from a 2nd audit and presented to the Board in October 2018. It was acknowledged there were limitations to the second audit as a consequence of the timeframe between findings from the 1st audit and subsequent cohort, limiting the opportunity for learning to have been embedded. Further assurance has been sought from maternity and community health providers as to further actions taken and further audit results which have been reviewed through the LSCB Performance & Quality Assurance sub group.

ii. Suicide prevention group

Work has progressed throughout the year with Merseyside Youth Association (MYA) in developing materials and training programmes. 'Train the Trainer' events have taken place and included a review of the pilot training materials and programme developed. The materials are to be launched at a conference planned for September 2019.

The Children and Social Work Act (2017) replaces the requirement for LSCBs to ensure that child death reviews are undertaken by a Child Death Overview Panel (CDOP) with the requirement for 'Child Death Review Partners' to make arrangements to review child deaths.

Child death review partners are local authorities and any clinical commissioning groups for the local area as set out in the Children Act 2004, as amended by the Children and Social Work Act 2017.

The guidance specifies:

- That "child death review partners may, if they consider it appropriate, model their child death review structures and processes on the current Child Death Overview Panel (CDOP) framework"
- There should be reviews of all deaths children normally resident in the local area and, if they consider it appropriate, for any non-resident child who has died in their area
- That reviews have "the intention of learning what happened and why, and preventing future child deaths" and that "the information gathered … may help child death review partners to identify modifiable factors that could be altered to prevent future deaths."

(replacing the previous wording that set out that CDOPs should look to determine "whether the death was deemed preventable")

Merseyside already has a well-established Pan Merseyside CDOP, incorporating the local authority areas of Sefton, Liverpool, Knowsley, St Helens and Wirral, and chaired by an Independent CDOP Chair.

Throughout the year consideration as to the implications of the required changes has been overseen and progressed through a CDOP Transition Group which included representatives of the Child Death Review Partners across the Merseyside footprint. The Merseyside CCGs have been represented by the Liverpool CCG Chief Nurse at these meetings. A stakeholder event was also convened in November 2018 where recommendations and next steps were proposed for consideration at the 'transition meeting'.

A briefing paper was produced following the event to highlight discussions held, outline next steps and propose recommendations for key decision makers. This supported the development of the new Child Death Review Partner arrangements that were published, within required timescales, by the 29th June 2019.

**4.4 Local and national Child Safeguarding Practice Reviews**

Woking Together (2018) sets out the process for new national and local reviews. The responsibility for how the system learns the lessons from serious child safeguarding incidents lies at a national level with the Child Safeguarding Practice Review Panel (which came into operation from 29th June 2018) and at local level with the safeguarding partners.

The newly initiated Child Safeguarding Practice Review Panel is responsible for identifying and overseeing the review of serious child safeguarding cases which, in its view, raise issues that are complex or of national importance and must decide whether it is appropriate to commission a national review of a case or cases

Local safeguarding partners are responsible for making arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area. A copy of the rapid review should be sent to the Panel who decide on whether it is appropriate to commission a national review of a case or cases. Where a case is deemed to require a local review, the safeguarding partners are responsible for commissioning and supervising reviewers for this work.

Throughout this reporting period the CCGs Chief Nurse has chaired the LSCB Practice Review Panel (PRP) which includes membership from Designated Nurse Safeguarding Children, Designated Doctor and Named GP.

A number of cases have been reviewed throughout the reporting year and learning shared throughout the partnership:

- Serious Case Review: Martha, Mary & Ben (published July 2018)
- Serious Case Review: Charlie (published March 2019)
- Serious Case Review: Janet (published April 2019)
- Serious Case Review 4 (awaiting publication)

The CCG has supported each of these reviews through the Named GP completing a rapid review and Individual Management Review report for each case; the Chief Nurse chairing two of the Serious Case Review panels and the Designated Doctor, Designated Nurse and Named GP being members of each SCR Panel.

In addition to supporting the Serious Case Reviews, the Designated Nurse Safeguarding Children and Designated Safeguarding Adults Manager have led on two Practice Learning Reviews. Learning from these cases has been reviewed by agencies involved to support and embed practice changes.

Recommendations from all the reviews have been progressed through action plans overseen by the Practice Review Group and learning has been disseminated through the Board structure to relevant sub groups and to the wider the multi-agency partnership through individual 7 minute briefings.

**4.5 Merseyside Safeguarding Adults Board**

Merseyside Safeguarding Adults Board (MSAB) came into effect on 1st April 2017 and replaced all previous local safeguarding adult board arrangements. MSAB holds the responsibility for meeting the statutory requirements of SAB's as set out in the Care Act (2014). This combined board has built on the work of the previous Safeguarding Adults Boards and the valued contributions of partner agencies.

Each CCG has a statutory duty to work in partnership with SABs in conducting Safeguarding Adult Reviews (SAR) in accordance with the Care act 2014. Prior to the development of the MSAB, each of the local authority area had their own Serious Adult Review Group (SARG). Under MSAB arrangements, the SARGs have been maintained as sub-groups. However part of the MSAB work plan is to establish one SARG and process across all the local authority member areas. The combined MSAB SARG became operational on 1st April 2019.

The Chief Nurse is a MSAB board member and chairs the Performance and Audit Sub-Group alongside Named Professionals from provider Trusts. The Designated Safeguarding Adult Manager represents the CCGs at sub-group level. A number of sub-groups take forward the various work streams of MSAB, Safeguarding Adults Review Sub Group, Communication and Engagement Sub Group, Policy, Procedure and Practice Sub Group, Performance and Audit Sub Group, Quality Assurance Sub Group and Work Force Development Sub Group.

The CCGs supported MSABs key achievements for 2018-19 which included:

- Hearing the experiences of people who use our services
- Establishing a sub-group structure that reports to and from board
- Holding a Self-Neglect workshop in collaboration with Liverpool John Moores University
- Reviewing and drafting Board Policies and Procedures
- Undertaking a review of the Front Door arrangements across the four areas and recommended a good practice model
- Developing an online Safeguarding self –assessment tool for completion annually (Chapter 14 audit)
- Developing a Board Members Handbook
- Visiting and establishing links with all four Safer Communities Partnerships
- Contributing to Northwest ADASS policy development
- Developing a Board Website www.merseysidesafeguardingadultsboard.co.uk

### 4.6 Sefton Safeguarding Adults Review Group

Sefton SARG is chaired by Merseyside Police. The CCGs, via the Designated Safeguarding Adult Manager, are a statutory member of the group representing the whole Sefton health economy. Throughout the reporting period there have been 7 cases presented to the SARG for consideration of a safeguarding adult review (SAR). In 2 cases an independent review has been commissioned with completion of both expected within the 2019-20 period.

- 1 case met the criteria for a SAR and an independent review has been commissioned and is scheduled for completion in February 2020.
- 1 case was felt to require a learning review and has been allocated to an independent reviewer with completion expected in autumn 2019.
- 1 case was felt to require a single-agency review by the Local Authority.
- 4 did not meet the criteria for a SAR

### 4.7 MAPPA (Multi-Agency Public Protection Arrangements)

MAPPA are a statutory set of arrangements required to manage the highest risk sexual and violent offenders coming out of prison / hospital and returning to live within the community.

These statutory arrangements are set down under the Criminal Justice Act 2003 with Police, Probation and Prisons known as the Responsible Authorities (RAs) and other Duty to Co-operate Agencies (DTC) – Health(CCGs), Education, Children and Adult Services, Youth Offending Services (YOS) and Housing.

Locally these arrangements are governed by the MAPPA Strategic Management Board (SMB) which meets 4 times per year, and includes CCG representation as a statutory member.

The Designated Safeguarding Adults Manager represents the CCGs at the Merseyside

MAPPA SMB and acts as a single point of contact for the CCGs and commissioned services. Sefton MAPPA meets on a monthly basis and discusses up to 5 cases per meeting. Each individual who is discussed at MAPPA has a multi-agency risk assessment which is reviewed and tailored to ensure that the individual, victims and the public are safeguarded.

The CCGs are developing a process for health information sharing with MAPPA which will include primary care and commissioned health providers. This was an action from the CQC action plan and is a priority for 2019/20.

**4.8 Child Exploitation (CE)**

The CCGs Safeguarding Service continues to be represented at Regional and local forums to ensure national and local messages are received and embedded within the local health economy.

Regionally, the Designated Nurse Safeguarding Children is a member of the NHS England North Child Sexual Abuse & Exploitation Health forum, accountable to NHS England's National Safeguarding Steering Group.

The multi-agency Pan Merseyside Child Exploitation sub group has continued to meet on a bi monthly basis chaired by a Detective Superintendent of Merseyside Police with the CCGs having representation through the Designated Nurse Safeguarding Children. This group oversaw the review of the Pan Merseyside Child Exploitation Protocol and launch event delivered on 1st May 2018. In addition the group facilitated the delivery of a 'Transitions Workshop' with National Working Group NWG Network "Exploitation and the Journey into Adulthood - "It does not stop because you turn 18".

The Child Exploitation Health sub group continues to meet on a 6 monthly basis in order to share and disseminate key learning and guidance both nationally and regionally.

The Sefton Child Exploitation and Missing sub group has continued to be supported with CCGs' representation from the Designated Nurse Safeguarding Children.

The CCGs have continued to support the Child Exploitation agenda through promoting Child Sexual Exploitation awareness day on 18th March 2019 through twitter and links to #CSEDAY2019.

The CQC Review of health services for Children Looked After and Safeguarding in Sefton (July 2018) highlighted that The designated nurse for safeguarding children from South Sefton CCG and Southport and Formby CCG has carried out significant work around awareness raising and training on child sexual exploitation (CSE) for practitioners across Sefton's health services. Despite this, and with policies and guidance being in place, too many practitioners told inspectors they are unaware of CSE assessment tools; that they consider CSE to be a low risk in Sefton, and as a result the number of referrals in relation to CSE remain low.

In response to the CQC specific recommendation to ensure that a rolling programme of training is implemented for practitioners in all services on child sexual exploitation, to include identification and assessment; and seek assurance of an ongoing evaluation of its impact on practice, the Designated Nurse commissioned Catch 22 to deliver a bespoke CE Train the Trainer course for health providers including specific Sefton profile and risk tools. 19 staff attended the 1 day Train the Trainer course and a further 20 staff attended a half day bespoke training session.

The impact of this will be reviewed through the specific KPI data that will continue to be collated by commissioned services to evidence engagement in this agenda. This has been further strengthened to include reference to Child Exploitation (Child Sexual Exploitation and Child Criminal Exploitation) as per national developments.

Child Exploitation and Missing Children was also included as a specific focus area for the Primary Care Protected Learning Time event in June 2018, co-ordinated by the Named GP, where the recently launched Pan Merseyside Child Exploitation Protocol and refreshed risk assessment tools were presented.

**4.9 Harmful Practices including Female Genital Mutilation (FGM)**

The CCGs are represented at the NHS England Regional Female Genital Mutilation (FGM) network meeting. Work has been progressed within NHS England North West region around implementation of an FGM Information System to establish data from each of the health providers on the number of women accessing healthcare who have disclosed that they have undergone FGM. Proposals for a piolet of a FGM Clinic for non-pregnant women have been discussed this work will initially be trialled in areas of high reporting of FGM and then be reviewed to roll out regionally. Work has been undertaken on speaking to young people about FGM to understand how the issue is perceived amongst children and young people.

The Merseyside Harmful Practices group sits as a sub-group of the Protecting Vulnerable People Board, it is a multi-agency group attended by professionals from across Merseyside. The work plan of the Harmful Practices group has included development of a Merseyside Harmful Practices training package, identification and dissemination of relevant lessons from Serious Case reviews, Domestic Homicide Reviews and local reviews, establishing escalation processes for Harmful Practices, development , engagement and promotion of community organisations and champions and development of a Merseyside wide dataset. Work is being progressed against all of the Harmful Practice priority areas.

The CCGs are represented at the Domestic Abuse Executive by the Designated Nurse. Within this reporting period the Sefton domestic abuse protocol has been refreshed.

The CCGs publish a Modern Day slavery statement which is updated annually.

## 5. Implementation of National Guidance

### 5.1 National Institute for Health and Care Excellence (NICE) Guidance

NICE provides national guidance, advice and quality standards to improve health and social care. Guidance published during this reporting period has included Child abuse and neglect NICE Quality Standard (QS179), which has been shared across the health economy and included within the Sefton LSCB Online Procedures Manual.

### 5.2 Department of Health and Social Care: Pressure Ulcer and Safeguarding Guidance 2018

The Designated Safeguarding Adult Manager has held a series of consultation and engagement events with key stakeholders across Sefton including the Local Authority and representatives from all NHS Provider trusts to review this guidance. As part of this process the current Sefton MBC Safeguarding Adult Threshold document was reviewed and revised. A draft Sefton Pressure Ulcer and Safeguarding document has been produced and shared with the Cheshire and Merseyside Pressure Ulcer Forum. It is anticipated that this guidance will be implemented across Sefton in 2019 and will be incorporated into the Cheshire and Merseyside Pressure Ulcer Policy.

### 5.3 Interim Report of the Independent Inquiry into Child Sexual Abuse (IICSA)

The report, published in April 2018, sets out the key themes emerging from the Inquiry's work so far. In July 2017, the Inquiry sought information in writing from around 50 health sector organisations about the measures that are in place to prevent child sexual abuse within healthcare settings, such as hospitals, GP practices and clinics. In the written submissions and at a subsequent seminar, the Inquiry heard how current arrangements to protect children from sexual abuse within the health sector could be improved including the adequacy of existing training, the barriers that prevent concerns being raised about child sexual abuse and the vulnerability of children when receiving treatment on adult wards. The important role that chaperones play was also raised and the Inquiry confirmed that national policies for the use of chaperones in the NHS and other healthcare services in England and Wales are not available. As a result, the Inquiry has recommended that the Department of Health and Social Care develops a national policy for the training and use of chaperones in the treatment of children in healthcare services. This is being progressed by NHS England Safeguarding team to ensure health recommendations are considered jointly with DHSC.

## 6. Effectiveness of Safeguarding Arrangements

### 6.1 Inspection Frameworks

#### 6.1.1 Care Quality Commission (CQC) Review of health services for Children Looked After and Safeguarding in Sefton (July 2018)

The CQC undertook a review of LAC and Safeguarding services across Sefton in July 2018. The review was conducted under Section 48 of the Health and Social Care Act 2008 which

permitted the CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups. A number of services commissioned by the CCGs and Sefton Councils Public Health Team were reviewed and included children and adult A&Es, maternity services, 0-19 year services, CAMHs, adult mental health services, children and adult substance misuse services, sexual health services and GPs.

There were several key lines of enquiry the inspectors explored during the review in respect of:

- The role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews
- The contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services
- The review identified areas of strength and areas for further development with a number of recommendations to be progressed.

Prior to the publication of the report, the CCG Chief Officer commenced a task and finish group that included representation from all agencies involved, to oversee the implementation of initial recommendations and findings arising from the verbal feedback.

The final report was published on 28th November and required an action plan to be developed to address the recommendations made. The action plan developed through the task and finish group was submitted to the CQC by the required date of 4th January 2019. This was accepted by the CQC who acknowledged that the action plan clearly demonstrates shared activity planned over the coming months to drive improvement, and it is positive to note areas that have already been strengthened since the review. It is also positive to note that many of the actions are on track to be met within your target timescales.

Progress against the actions has been overseen and monitored through the task and finish group and separate scoping meetings with providers. Action plans have also been reviewed and progressed through internal Trust governance processes as well as through the CCG Quality Committee and Governing Body. Presentations have also been delivered to the LSCB and Sefton Council's Overview and Scrutiny Committee (Children's Services and Safeguarding) to provide an oversight of findings and actions being taken in response.

A further update of the action plan has been requested by the 4th July 2019 to enable the CQC to undertake a final 6-month review of progress in addressing the report recommendations.

### 6.1.2 HM Inspectorate of Probation inspection of Youth Offending Services in Sefton (February 2019)

In February 2019 the HMIP inspection of YOS was announced in Sefton. The CCG Safeguarding and Quality Team supported the inspection process through attendance at the

YOS Board member's inspection meeting. The report was published outside the reporting period in May 2019.

### 6.1.3 Local Government Association (LGA) Care Practice Diagnostic Sefton

A Care Practice Diagnostic by the Local Government Association was undertaken in Sefton at the request of the Director of Social Care with a specific focus on:

- The effectiveness of the front door
- The impact of the restructure of children's social care
- Improving the health of children looked after
- The impact of the implementation of Signs of Safety
- A review of Sefton's 'Self-Assessment'

The CCGs and commissioned health services supported the preparation process initiated in March 2018 and engagement in the multiagency audit and specific focus groups with inspectors during their site visit between 24th-27th April 2018.

This review highlighted the need to further consider the model of practice used across the partnership in order to incorporate Signs of Safety into a wider approach. Partnership review and consideration of alternative models of practice that take more account of risk management, capacity to change and wider evidence based approaches has been ongoing throughout this year.

### 6.1.4 Inspection Readiness

The CCGs have continued to support commissioned NHS health providers to be 'inspection ready' for the variety of inspections that the 'health economy' could be required to contribute to.

The Safeguarding Service and commissioned health providers, along with partner agencies, have attended planning meetings led by the Local Authority to support being prepared should any partnership inspection be announced.

On the 29th August 2018, the latest Joint Targeted Area Inspection (JTAI) theme was announced as the multi-agency response to child sexual abuse in the family environment (CSAFE). This theme had previously been identified as Intra Familial Sexual Abuse however the revised definition now encompasses abuse within the family home as opposed to solely being a family member. The CCG Safeguarding Service has also contributed to the LSCB's preparations for JTAI's in respect of CSAFE and development of Self Evaluation Framework (SEF).

Commissioned services have all received the latest guidance and requested to ensure they remain 'inspection ready' by preparing the relevant evidence that would be required from health agencies should a JTAI be announced and ensure this is progressed through their own Trust safeguarding assurance groups.

### 6.2 Multi Agency Audit

As a statutory member of the LSCB, the CCGs are fully engaged in the multiagency audit cycle, through the Designated Safeguarding Children Professionals and Named GP membership of the LSCB Performance and Quality Assurance sub group and audit pool. Throughout the reporting period, the CCGs and their commissioned services have supported the following LSCB multiagency audits:

- Q4 audit: CSAFE (child sexual abuse in the family environment)

Findings from this audit resulted in the LSCB recommending this area of work become a Board priority which is being progressed throughout the 2019-20 reporting year.

A number of 'health economy' audits were also supported by the Safeguarding Service including

- Merseyside Safe Sleep Group 2nd Practitioner audit (July 2018). The report was received at the LSCB Board in October 2018 and agreed that further assurance as to ongoing progress from health partners would be requested and overseen via the Performance Quality Assurance sub group
- From Quarter 4 2018-19, a regular quarterly audit schedule has commenced between the Designated Nurse Safeguarding Children and MASH Team Manager to review the management and outcomes of 10 referrals made from the 'health economy' into MASH. These findings are shared at the MASH Steering Group and MASH Health meeting to support strengthening the quality of referrals made and pathways in place
- Submission of safeguarding audits remains a specific metric on the Safeguarding KPIs within the commissioned health service contracts.

### 6.3 Performance and Assurance

#### 6.3.1 Quality Schedule: Review of Safeguarding Assurance processes

The CCGs have a statutory duty to ensure that that all health providers, from whom services are commissioned, promote the welfare of adults at risk and children and are able to demonstrate that outcomes for adults, children, young people and their families are improved. The CCGs remain committed to working collaboratively with commissioned services and utilise a number of approaches to ensure that there is an acceptable level of assurance provided within the system to demonstrate safe, efficient and quality services are being delivered and that safeguarding responsibilities are safely discharged. Where the level of assurance has not been evidenced and agreed progress has not been achieved then contractual levers have been evoked all of which have been agreed and monitored via the Clinical Quality and Performance Group or Contract Clinical Quality Review meetings. In more exceptional circumstance the CCGs will work collaboratively with NHS England and

other regulatory partners within a Quality Surveillance Group to gain a shared view of risks to quality through sharing intelligence.

Throughout this reporting period, Designated Safeguarding Professionals within Southport & Formby, South Sefton, Liverpool and Knowsley CCGs have been working together to review and refresh the safeguarding assurance processes and Key Performance Indicators (KPIs) that are included within the contracts of commissioned health providers.

During the CQC Review (2018) it was noted that the reliance on the provider's reporting was overly optimistic and lacked challenge for demonstrable impact which further supported the need to review the process.

As a consequence the process was revised with a focus on reducing the number of quantitative based KPIs and increasing the qualitative elements of the assurance process through the use of the Commissioning Standards and scrutiny/ validation visits. These changes were planned along with commissioned services during consultation events and positively received by safeguarding leads involved as well as safeguarding partners following a presentation of the changes delivered to the LSCB in March 2019. The revised assurance process has been agreed and incorporated into the 2019-20 contracts.

The Designated Professionals have continued to engage and support CCG wide processes which provide further opportunities to triangulate against current assurance processes. This has included:

- Membership of the CCGs Serious Incident Review Group to support safeguarding input into the review of serious incidents reported by commissioned health services through the Strategic Executive Information System (StEIS)
- Engagement in CCG Quality Site Visit team reviewing Sefton CAMHs in October 2018. This enabled a further focus on number of key areas align to the Care Quality Commission standards including safeguarding and provided an opportunity to explore progress from the recent CQC review
- Support to NHS Improvement in the "1 year post Kirkup Report Quality Services Review" within North West Boroughs to ensure services are safe and effective following transfer from Liverpool Community Health. Findings from discussions from staff were shared with the lead reviewer to support the final report to be prepared by NHS Improvement.

The Designated Professionals have continued to provide quarterly supervision to Named Professionals and attend the Trusts internal safeguarding assurance meeting which provides further opportunity to explore and progress any themes or areas identified through the various assurance processes.

### 6.3.2 Section 11 Audit

Section 11 of the Children Act 2004 places a duty on key agencies to make arrangements to ensure that, in discharging their functions, they have regard to the need to safeguard and promote the welfare of children and young people. The CCGs are one such organisation and are therefore required to demonstrate compliance against these standards.

Within the Sefton Borough the Local Safeguarding Children Board is responsible for the monitoring and scrutiny of the Section 11 audit process and the submitted 'Self-Assessment' audits from partner organisations. The CCGs Safeguarding Service collated and submitted evidence against the 'Virtual College' on line programme to support the submission in August 2018.

Of the 51 standards required to be reported against, 45 were rated by the Designated Nurse Safeguarding Children as providing significant assurance (grade 4). Six standards had been graded as 3, of which two could not be further progressed as a consequence of the LSCB not ratifying partner agency policies.

Four of the standards graded at 3 required 'spot checks' of employee knowledge of safeguarding arrangements to enable full compliance to be achieved. This was progressed and completed in October 2018 with support of the CCGs 'comms' department and the development of a 'survey monkey' questionnaire. The results of the audit were collated and shared within the CCGs at both the Senior Management Team meeting and the Operations Team meeting where staff were reminded of their responsibilities and key messages in respect of the Safeguarding Children, Adult and Children in Care agenda.

The one standard graded as 2 required 'employees involved in the recruitment of staff to work with children to have received training as part of the "safer recruitment training" programme', with an action plan developed and progressed through the CCG Quality Committee.

As part of the Section 11 assurance process, Board members, including the Designated Nurse Safeguarding, have supported the 'front line' visits to review front line practice and the links to the Board. This supports further triangulation of data to inform the assurance processes already established.

### 6.3.3 Chapter 14 Audit

Chapter 14 of the Care Act 2014 provides guidance on the requirements for adult safeguarding arrangements. Each organisation (such as the CCGs) who are members of the MSAB must ensure that they discharge their statutory duties under the Care Act, by having robust systems and processes in place.

The MSAB Performance and Audit Sub Group devised an audit tool for organisations to self-assess their adherence to Chapter 14. This is the first time that the audit has been carried

out. The audit utilised Virtual College, an online portal which supports the uploading of evidence and provides a visual RAG rated dashboard with an action plan upon completion. The audits will be analysed and collated by the MSAB Performance and Audit Sub Group and an overall report will be produced for the Mersey region covering all agencies via the MSAB. It is envisaged that the results will help shape the focus of the MSAB work plan going forward.

The audit covered 9 domains, split into 50 sub sections. The 9 domains are:

1. Senior Management and Staffing.
2. Governance, Quality Assurance and Supervision.
3. Safeguarding Policies, Procedures and Guidelines.
4. Safeguarding Training and Supervision.
5. Safer Recruitment and Managing Allegations.
6. Information Sharing.
7. Whistleblowing, Complaints and Escalations.
8. Making Safeguarding Personal.
9. Equality and Diversity.

The audit was completed and submitted on behalf of NHS South Sefton CCG and NHS Southport and Formby CCG (CCGs) by the Designated Safeguarding Adult Manager on the 3rd August 2018.

Assurance was demonstrated against the nine domains with 3 minor actions identified. Evidence against all domains was uploaded onto the Virtual College portal.

An action plan was generated and monitored by the CCGs Safeguarding Business Meeting on a monthly basis, and via a quarterly update within the CCGs safeguarding report to Joint Quality Committee.

## 7. Learning and Improvement

The CCGs continue to promote the learning and development of staff with safeguarding training being part of the mandatory schedule for all CCG employees.

The CCG sets a compliance threshold of 90% for commissioned services for Safeguarding Children, Adults and Prevent training.

A review of the CCG training data highlighted compliance as of 31st March 2019:

| | |
|---|---|
| Safeguarding Children Level 1: 83.3% | (93%, July 2018) |
| Safeguarding Children Level 2: 88.6% | (94%, July 2018) |
| Safeguarding Adults Level 1: 83.3% | (93%, July 2018) |
| Safeguarding Adults Level 2: 82.8% | (89%, July 2018) |

Prevent: 91.3% (94%, July 2018)

This data shows a fall in compliance rate over the reporting period. Steps have been taken to ensure that none compliance is addressed. At the end of the reporting period training data transferred to a new electronic recording system within the Commissioning Support Unit. Any data anomalies following transfer to the new system will be updated.

Specific training has also been delivered in October 2018 to Governing Body members to ensure compliance as per Intercollegiate Document (2014) requirements and additional briefings presented at the Governing Body development sessions to apprise members of key changes within the safeguarding agendas.

The CCG Safeguarding Service, as members of the Cheshire & Merseyside Designated Professional Network, have played an active part in the planning and development of the Safeguarding Learning Event 'Think Family! It's OK to ask' to support front line practitioners in their safeguarding responsibilities. This will be delivered in June 2019.

Throughout the reporting period, the Designated Professionals have continued to provide regular safeguarding supervision to Named Professionals throughout the health economy as well as ad hoc advice and support for partnership organisations.

Supervision is accessed by the Designated Professionals and Named GP through a number of forums including:

- Named GP network
- Quarterly supervision with Senior Safeguarding Lead, NHS England
- National Network Designated Health Professionals
- Safeguarding Adults National Network
- Cheshire & Merseyside Designated Professionals network

Throughout this reporting period, members of the safeguarding service have commenced the NHS Leadership Mary Seacole Leadership Programme, a nationally recognised development programme for leaders in heath organisations.

## 8. Safeguarding and Primary Care

### 8.1 Local Quality Contract (LQC)

As part of the Local Quality Contract (LQC) a data cleanse exercise was completed to ensure that GP practices were aware of all children subject to a CP plan, registered at their surgery. Between January and March 2019, GPs were requested to review data provided by the Local Authority in respect of children subject to a Child Protection (CP) plan and identify those they had flagged that were not on this list.

The processes supported both GPs and the Local Authority in cleansing the data they held.

In total, 22% of children on a CP plan did not have a GP, or had an incorrect GP, recorded on Local Authority child records and the process enabled both GP lists and LA data bases to be updated.

A similar position had been identified by Sefton Children's Services Research & Information Officer, where it was identified that a number of cases had a GP recorded prior to the current referral date. This may indicate that previous GP data held on the system had not been updated and assumed as being unchanged since the previous involvement with Children's Social Care.

The data cleanse exercise also highlighted a number of children registered at practices where the child protection status had not been updated and a flag still remained after the closure of social care involvement. Information was therefore able to be shared with the practice from the Local Authority as to when the plan had ceased so that child health records could be updated.

### 8.2 NHS England Virtual College Improvement Tool for General Practice

The Named GP has been instrumental in supporting the uptake, by individual practices, of the Virtual College Tool to support practices in evidencing they discharge their safeguarding responsibilities effectively. A total of 49 surgeries have signed up to use the tool.

### 8.3 Inspection Frameworks

Following the CQC Review of health services for Children Looked After and Safeguarding in Sefton (July 2018) work was initiated to strengthen and further development engagement in the safeguarding agenda. This included progressing a Named Safeguarding Leads forum for primary care on a quarterly basis which commenced in 2019-20 reporting period.

The Named GP has also supported practices following individual CQC inspections through advice, support and the oversight of action plans.

### 8.4 Learning and Improvement

The Named GP, Designated Doctor and Safeguarding Service have continued to support learning within Primary Care, through the annual Protected Learning Time Event with a specific safeguarding focus. Key topics discussed included updates of local safeguarding contacts, referral processes within Sefton, Early Help, learning from Serious Case Reviews, latest 7 minute briefings, Child Exploitation and Missing Children, consent confidentiality and information sharing, child obesity and safeguarding issues, children living with disabilities and the Learning Disabilities Mortality Review (LeDeR) Programme.

In addition, the Named GP has supported four Serious Case Reviews through the provision of chronologies, primary care Individual Management Reviews and membership of the SCR Panels.

### 8.5 Voice of the Service User

A Young Person's EPEG event 'Your Youth Health Day' was organised by Sefton Young Advisers, on behalf of the CCGs, to hear from young people about their ideas and

experiences of local healthcare.

https://www.southseftonccg.nhs.uk/get-informed/latest-news/young-people-in-sefton-help-to-shape-their-local-nhs/

https://www.southportandformbyccg.nhs.uk/get-informed/latest-news/young-people-in-sefton-help-to-shape-their-local-nhs/

The CCGs each have a communications and engagement strategy (2018-20) (Communicating health in South Sefton… and Communicating health in Southport and Formby…) which includes the work with Sefton Young Advisers to better involve children in the work of the CCGs and ensure their voices are heard. A specific section relates to 'involving younger residents' through partnership work with VCF groups and organisations.

Sefton Young Advisers are represented at the CCGs Engagement and Patient Experience Group (EPEG) as the CCGs are committed to working more closely with the team to involve children and young people, adopting the Advisers' engagement toolkit for young people and co-producing whenever possible and appropriate.

Members of the CCG Quality Team and Safeguarding Service conducted a Quality Site Visit to Sefton CAMHs in November 2018. An element of the review included the safeguarding children agenda and provided the opportunity for families of service users to highlight their experience of the service which was fed back to support service development.

The CCG completed the Section 11 audit in August 2018 and included evidence of the work that had been completed in respect of capturing and responding to the voice the child.

The voice of service users (adults) is an MSAB business priority. MSAB have employed an engagement officer who is conducting an audit on how adult's voices are heard as part of safeguarding enquiries. There is a series of workshops and a launch event being planned for 2019-20.

Adults are supported to have their say and are empowered to inform the CCGs decision making via EPEG and events such as 'Big Chat'.

The CCGs completed the Chapter 14 audit in September 2018 and included evidence of the work that has been undertaken in respect of capturing and responding to the voice of service users.

# 9. Business priorities 2019/20

- Continue to support and respond to changes required as a result of the Children and Social Work Act 2017 including:

    - LSCB transition arrangements to Multi Agency Safeguarding Arrangements (MASA's)
    - CDOP changes: transfer of responsibility for child death reviews from LSCBs to new Child Death Review Partners

- Continue to support and respond to the changes required as a result of the Mental Capacity Amendment Act (2019) including:

    - Await introduction of the Codes of Practice
    - Support the transition of responsibility for Liberty Protection Safeguards

- Continue to enhance and develop arrangements to gain assurance from commissioned providers through established contract management processes. This will include an additional validation element of the Commissioning Standards included as part of the contract.

- Strengthen the engagement of GPs in safeguarding agenda including development of a quarterly safeguarding leads forum

- Ensure the changes brought about by the Domestic Abuse Act are implemented in practice within both the CCGs and commissioned health services

- Review the CCG Safeguarding Adults and Children Training Strategy and Training Needs Analysis to ensure that the impact of changes from the Intercollegiate Documents are reflected in local policy and guidance.

- Review and update of the Safeguarding Strategy

## 10. Conclusion

This annual report provides a summary of progress against the safeguarding priorities set for 2017-18. It demonstrates the contribution to multi agency partnerships across the borough of Sefton and provides assurance to the Governing Bodies that NHS South Sefton and NHS Southport and Formby CCGs are fully committed to ensuring they meet the statutory duties and responsibilities for safeguarding adults, children and young people.

# Appendix A

**LSCB Priority 1** - *To ensure the partnership drives impact and outcome focused practice which will be evidenced through single agency and partnership Performance Management.*

The CCGs are represented on the LSCB Performance & Quality Assurance sub group by the Designated Dr and Nurse for Safeguarding Children.
A specific area of work overseen at the sub group has included the Merseyside Safe Sleep audit, undertaken by 0-19 year and maternity services across Merseyside. Progress against the safe sleep audit findings and recommendations has been reviewed by the group and service leads invited as part of a challenge session.
As members of the sub group, CCG representatives have supported the collation of narrative to support the understanding of data collated and contained within the LSCB developed data set.

Performance Management of CCG commissioned services continues to be reviewed by the CCG Safeguarding Service against specific Key Performance Indicators on a quarterly basis.
The process has been further developed throughout 2018-19 in order to further support demonstration of impact. Presentations have been delivered to the LSCB Main Board to support partners to understand

- the Assurance and Oversight Processes undertaken by the CCG of their commissioned services
- the changes made to the assurance processes to support a more qualitative and outcomes focussed assurance cycle including a quality/ validation visit

In July 2018, the CQC undertook their Review of Health Services for Children Looked After and Safeguarding across Sefton. As a result of recommendations made in the final published report, the CCGs have overseen the development and progression of a CQC Action Plan and presented the Review and recommendations to the LSCB Main Board and Sefton Overview and Scrutiny Committee (Children & Safeguarding).

A CQC Task & Finish Group has been established, with membership from across each commissioned health provider, PH commissioners, NHS England, CCG Safeguarding Service and chaired by the CCG Accountable Officer, to ensure the recommendations and actions for individual health providers and across the economy, are progressed. Progress made will be reported to the CQC, LSCB and Overview & Scrutiny Committee throughout the 2019-20 reporting period.

The Designate Nurse for Children in Care and the Assistant Chief Nurse supported and represented the CCG at the recent Sefton Youth Offending Team inspection in February 2019 conducted by HMI Probation. The final report will be published in April 2019.

The Designated Nurse and Named GP have worked with the Local Authority Safeguarding Unit as part of the Local Quality Contract in order that a data cleanse exercise is undertaken to ensure the correct GP is included on Local Authority data base thereby supporting invites to case conferences and receipt of conference minutes.

The LSCB Main Board has received an update on performance figures relating to Children in Care and on-going bi-annual updates are provided to Corporate Parenting Board.

The Designated Nurse Safeguarding Children has worked together with the Multi Agency Safeguarding Hub (MASH) in order that a multiagency audit of health agency generated referrals is initiated and completed on a quarterly basis, starting from Q4 (2018-19). The audit tool examines whether the referral was appropriate, reflective of the Level of Need document, of a quality expected and that the outcome was appropriate. Feedback from the audit will be provided to individual health providers to strengthen and support improvements in the referral process.

**LSCB Priority 2** – *Evidencing the response to the voice of the child and the community and the impact this is having within safeguarding.*

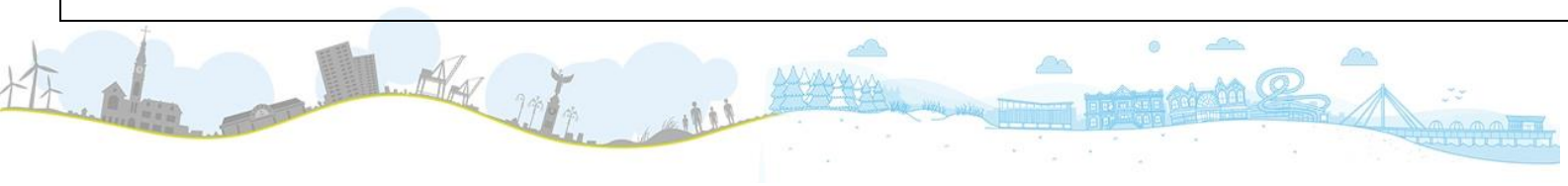
A Young Person's EPEG event 'Your Youth Health Day' was organised by Sefton Young Advisers, on behalf of the CCGs, to hear from young people about their ideas and experiences of local healthcare.

https://www.southseftonccg.nhs.uk/get-informed/latest-news/young-people-in-sefton-help-to-shape-their-local-nhs/
https://www.southportandformbyccg.nhs.uk/get-informed/latest-news/young-people-in-sefton-help-to-shape-their-local-nhs/

The CCGs each have a communications and engagement strategy (2018-20) (Communicating health in South Sefton… and Communicating health in Southport and Formby…) which includes the work with Sefton Young Advisers to better involve children in the work of the CCGs and ensure their voices are heard. A specific section relates to 'involving younger residents' through partnership work with VCF groups and organisations.
Sefton Young Advisers are represented at the CCGs Engagement and Patient Experience Group (EPEG) as the CCGs are committed to working more closely with the team to involve children and young people, adopting the Advisers' engagement toolkit for young people and co-producing whenever possible and appropriate.

Members of the CCG Quality Team and Safeguarding Service conducted a Quality Site Visit to Sefton CAMHs in November 2018. An element of the review included the safeguarding children agenda and provided the opportunity for families of service user to highlight their experience of the service which was fed back to support service development.

The CCG completed the Section 11 audit in August 2018 and included evidence of the work that had been completed in respect of capturing and responding to the voice the child.



# Appendix A

**LSCB Priority 3**- *To continually support and contribute to staff development through training and audit activities by increasing the learning across the partnership through training and audit activities.*

The CCGs are represented on the LSCB Learning & Development subgroup through the Designated Nurse Safeguarding Children.
The CCG Safeguarding Service has ensured that training has been made available and accessed by the CCG Governing Body members to support their understanding of the role in the safeguarding agendas and future role of the CCG as a statutory safeguarding partner in line with the new Multi Agency Safeguarding Arrangements

Following the CQC Review of Health Services for Children Looked After and Safeguarding across Sefton (July 2018), further training was developed and delivered by Catch 22 in respect of Child Exploitation. The training promoted a 'Train the Trainer' model to ensure that a rolling programme of courses, which included the profile of child exploitation across the Sefton footprint, could be delivered. The impact of the training will be monitored through the Safeguarding KPI's that commissioned health services are required to report against, one of which includes the number of referrals made in respect of identified Child Exploitation risks.

The contractual safeguarding KPI's, also require services to provide evidence of their training compliance data for a range of subject areas and staff groups and ensure that the Safeguarding Training Strategy is in line with the Intercollegiate Guidance (Safeguarding Children and Young People: Roles and competencies for healthcare staff)

The Named GP, Designated Doctor and Safeguarding Service have continued to support learning within Primary Care, through the annual Protected Learning Time Event with a specific safeguarding focus. Key topics discussed included updates of Local Safeguarding Contacts, referral processes within Sefton, Early Help, learning from Serious Case Reviews, latest 7 minute briefings, Child Exploitation and Missing Children, Consent confidentiality and information sharing, Child Obesity and Safeguarding issues, Children living with disabilities and the LeDer Programme.

The CCGs are represented on the Practice Review Group through the Chief Nurse (Chair), Designated Doctor and Nurse and Named GP. Throughout the reporting period, four Serious Case Reviews were commissioned. Each panel had representation from the CCGs Safeguarding Service, with two of the panels being chaired by the CCG Chief Nurse.
The Designated Nurse has also supported and led on two Practice Learning Reviews on behalf of the Practice Review Group.
The findings and learning from these reviews has been developed into specific action plans and progression is overseen through the sub group. Actions relating to the health economy and progression supported by the CCG Safeguarding Service have been in respect of reiterating the dispute resolution process and neglect strategy. The Named GP has also progressed specific actions relating to primary care through relevant networks and will present finding and recommendations from the recent Serious Case Reviews at the planned Safeguarding Protected Learning Time Event in July 2019.

The CCGs are represented on the Performance and Quality Assurance sub group through the Designated Doctor and Nurse.
The Named GP, as a member of the multiagency audit pool, has facilitated GP engagement in the multiagency audit process for Child Sexual Abuse in Family Environment (CSAFE).
Multi agency Self Evaluations (SEF) have also been supported in respect of CSAFE, domestic abuse and child exploitation to support preparation for potential Joint Targeted Area Inspections and understand the partnerships current awareness, understanding of and contribution to these safeguarding themes.
The sub group has also received updates from the work of the Merseyside Child Death Overview Panel's (CDOP) Safe Sleep Task & Finish Group. The results of the Safe Sleep re-audit have been received and health providers working across the Sefton footprint have attended the sub group in order to highlight progress made and actions to be taken to improve practice.

In August 2018, the CCG complied and submitted the response to the Virtual College 'Section 11' audit. Evidence was submitted to support the self-assessment against each standard and an action plan developed for areas that may require strengthening. Awareness of CCG employees understanding of the safeguarding children agenda was further explored using a survey monkey questionnaire and finding shared throughout the CCG.

**LSCB Priority 4** – *To ensure a controlled and formal transition from the LSCB to the renewed safeguarding arrangements.*

The CCGs, as a statutory key safeguarding partner, have been actively involved in the transition arrangements to the new Multi Agency Safeguarding Arrangements as required to be established by the Children & Social Work Act 2017. The CCGs Chief Officer supported initial discussions with accountable leaders to agree on some key areas for the new arrangements, including geographical boundaries, partners involved and the need for continued independent scrutiny.

The CCG Safeguarding Team (Designated Nurse and Named GP) supported a meeting in October, for LSCB partners, to consider and develop the proposed arrangements that will require publishing by the statutory partners (Local Authority, Police and CCG) before 29th June 2019.
The Designated Nurse facilitated table top discussion to ensure voice of partnership was consulted and included in the proposals.

As one of the three statutory partners to the new arrangements, a formal response was provided by the CCGs Accountable Officer, following discussion with the Chief Nurse and Safeguarding Team, in respect of further points for consideration. Feedback provided has been incorporated into the final draft 'plan'.

As a statutory partner, the development and progress of the transition arrangements has been taken through the CCGs internal governance mechanisms including the Governing Body. In addition, the Governing Body received a briefing and presentation on the proposed arrangements at their March (2019) Development Session.

The Designated Nurse Safeguarding Children presented the draft 'plan' to the LSCB (March 2019) where it was agreed and accepted by the partnership.

In supporting the future arrangements the Chief Nurse and Designated Nurse have supported discussions and decisions, along with police and LA, in respect of financial position statement and future decision making.

The Chief Nurse and Designated Nurse are also members of a pan Merseyside MASA group (consisting of representatives from each statutory partners across Merseyside footprint), which has considered areas that could be developed and progressed on a Pan Merseyside basis.

As chair of the LSCB Policy & Procedure sub group, the Designated Nurse has supported the scoping of the MASA Handbook, a document that will support the new arrangements and will require developing throughout the next reporting period.

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**On request this report can be provided in different formats, such as large print, audio or Braille versions and in other languages.**