ENCLOSURE 2
November 2008
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Birmingham Women's NHS
NHS Foundation Trust

SUBJECT :	Safeguarding Children
REPORT BY :	Jane Owen – Director of Nursing and Midwifery
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CONTEXT AND BACKGROUND FOR REPORT

- To advise the Clinical Governance Committee and Board of Directors on the progress made within the safeguarding arrangements for the Trust, addressing the following areas:
  - Current arrangements for safeguarding children
  - Key achievements in 2007 – 2008
  - Areas of risk identified and actions taken to manage the risk
  - Proposed developments for 2008 – 2009

KEY ISSUES FOR THE BOARD OF DIRECTORS' CONSIDERATION AND DECISION

- To acknowledge that activity within the safeguarding children field continues to escalate annually.
- Domestic abuse continues to generate an increased number of referrals warranting increased clinical hours being dedicated to this area.
- Agree the need for a framework of mandatory child protection supervision for front line staff, in line with national guidance and risk reduction.
- Confirmation that the process of updating CRB checks is being undertaken

RECOMMENDATIONS

- To note and approve the annual report
- Evidence of retrospective CRB checks is available should this be required for the purpose of external audit.
- A formal process of mandatory child protection supervision should be implemented for front line staff working directly with families and children.

1.0 Introduction:

This report has been compiled to provide both the clinical governance committee and the Board of Directors with an overview of the current position within the organisation in relation to Child Protection, now referred to as Safeguarding Children' in accordance with the statutory guidance contained in the Department for Education and Skills (DfES) document 'Working Together to Safeguard Children, 2006. http://www.everychildmatters.gov.uk/_files/AE53C8F9D7AEB1B23E403514A6C1B17D.pdf

2.0 Background:

Legislation commands that NHS Trusts have a statutory responsibility to safeguard children, to promote children's well-being and prevent them from suffering harm under the Children Act 1989 Children Act 1989 (c. 41)
Guidance for organisations about meeting their statutory duties is contained within several documents including:

- National Service Framework (NSF) for Children, Young People and Maternity Services (DfES, 2004) National Service Framework documents : Department of Health - Health care
- Safeguarding Children and Young People: Roles and Competencies for Health Care Staff, 2006. Intercollegiate document supported by the Department of Health. http://www.rcpch.ac.uk/doc.aspx?id_Resource=1535

3.0 Trust accountability for safeguarding children:

The safeguarding arrangements are linked to all the Trust's corporate objectives but specifically within the key areas of risk, quality and partnership working.
From 1st October 2005 Chief Executives and senior managers were asked to ensure that their responsibilities under the Children Act 2004 Act were carried out.
http://www.everychildmatters.gov.uk/_files/CB6A73D97A171A201EF5ED4F26B0B55D.pdf
At an organisational level, this means:
All health workers have a duty to protect children and the Trust is responsible for ensuring that all staff are familiar with the local procedures that must be followed if they have concerns about a child
Julie Burgess, Chief Executive, has overall responsibility for Safeguarding and promoting children's welfare within the Trust.
Jane Owen, as Director of Nursing and Midwifery reports to the Board of Directors on safeguarding issues and also carries the title of 'Safeguarding Champion' to support the role of the Named Professionals and drive the safeguarding agenda forward within the organisation.

4.0 Named Professionals:

In line with national guidance, the roles of the Named Professionals are clearly defined within the job descriptions.

Named (Lead) Nurse/ Midwife BWH: Elaine Giles
Named Doctor BWH: Mike Hocking, Consultant Neonatologist

4.1 Named (Lead) Nurse/ Midwife for Safeguarding Children (LNMSC)

The post of the Lead Nurse/ Midwife for Safeguarding Children is funded for 0.8 WTE The post has secretarial support which was increased to 0.8 WTE hours from July this year.
The LNMSC is professionally responsible to the Designated Nurse/ Head of Service (South Birmingham PCT) – Marie Dulewski.

Line Management responsibilities:

- 3 specialist midwives (Maternity Directorate)
- 1 specialist nurse/ midwife (Corporate)
- 1 administrator (Maternity Directorate)

This is funded for 0.2 WTE.

4.2 Named Doctor

Mike Hocking, Consultant Neonatologist continues in the post of the Named Doctor for Child Protection.
Following the development of a model job description by the Royal College of Paediatrics and Child Health and other relevant bodies, a modified job description for this responsibility in the Trust is in the final stages of approval.
The Named Doctor is professionally responsible to the Designated Doctor, Geoff Debelle (SBPCT).

4.3 Specialist Nurse/ Midwife Safeguarding Children and Vulnerable Adults

A business case for a Specialist Nurse/ Midwife Safeguarding Children and Vulnerable Adults was successful and Eleanor Newbold has been in post since 1st September 2008.
The safeguarding nurse/ midwives and Named Doctor meet monthly with the remit of:

- Ensuring the Trust meets its statutory duties to comply with safeguarding children legislation and guidance.
- Review the mandatory training strategy.
- Develop action plans following Serious Case Reviews

5.0 The Safeguarding Team:

Consisting of 3 specialist midwives:

- Heather Gray - substance misuse/ smoking cessation
- Olive Downer-Robinson – Mental health/ Domestic abuse
- Joanne Mardell – Teenage pregnancy

5.1 Substance misuse

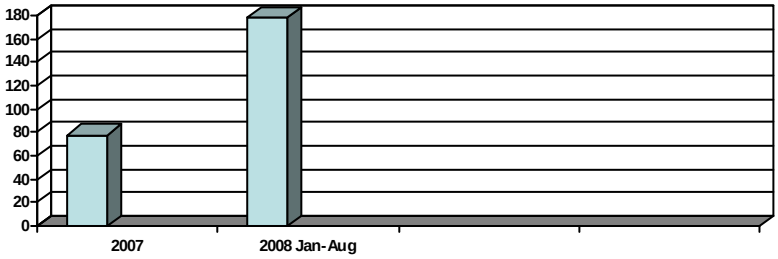
Compared to the previous 12 months, 132 pregnant women have been referred into the service. 80% of this caseload requires referral to Social Care Services. Substance misuse - Every Child Matters
Four specialist drug workers from the Mother & Baby Team, having honorary contracts with the Trust, provide additional input and expertise into the specialist clinic on a fortnightly basis.
Reducing the prevalence of smoking, especially amongst pregnant women, is a significant government target to improve public health and reduce health inequalities. £3 million boost to help pregnant women give up smoking : Department of Health - Publications. The specialist midwife works in conjunction with the smoking cessation specialist, Ann Fitchett to reduce the number of pregnant smokers within the Trust. However, smoking at the point of birth remains high (13%).
New initiatives have led to:

- Improved data collection for smoking in pregnancy.
- Quarterly staff newsletter to inform staff of the smoking statistics within service users and acts a reminder to staff in respect of data collection.
- Routine carbon monoxide monitoring being offered to all pregnant women at booking.
- Recruitment of women to a research project looking at the heart rates of babies born to mothers on drug reducing programmes.

5.2 Domestic abuse

The greatly increasing workload associated with Safeguarding Children within the Trust has been exacerbated by the requirements to act on information generated by domestic abuse referral information from the police and the Multi Agency Risk Assessment Conference's (MARAC).
.http://www.cardiff.ac.uk/socsi/resources/robinson-marac.pdf. The Lead Nurse/ Midwife and Specialist Midwife for Domestic Abuse and Mental Health currently share this responsibility due to the increasing demand.

Police referrals to health following domestic abuse incidents



5.3 Mental health

There has been an increase in the number of referrals for women with mental health issues. This suggests an increased awareness amongst health staff of the effects of mental illness on children and their families. The Mental Health Liaison Clinic run

jointly with staff from Queen Elizabeth Psychiatric Unit continues to be very active ensuring that there is a robust system in place to safeguard babies and children.

Referrals to the mental health liaison clinic:

Month	2007	2008
Jan	N/A	31
Feb	N/A	28
Mar	N/A	26
Apr	N/A	27
May	N/A	40
Jun	N/A	23
Jul	N/A	29
Aug	23	26
Sept	25	
Oct	31	
Nov	15	
Dec	18	

Number of women transferred from BWH into mental health beds:

2007	2008 (1/2 year)
3	2

There has been one maternal death related to mental health concerns.

5.4 Teenage parents

The specialist midwife for teenage pregnancy, Joanne Mardell carries a caseload of 103 pregnant teenagers under the age of 17 years. Young Parents to be Parent Education Group (Young Mumz 2B) runs every week. During the last 12 months there has been 51 young mums and 17 young fathers who have attended. In line with the government's teenage pregnancy strategy About the Teenage Pregnancy Strategy - Every Child Matters the following initiatives have been implemented:

- Introduction of new teenage pregnancy guidelines
- Birth Centre lower age limit reduced from 17 years down to 16 years.
- Specialist midwife has completed Family Planning and Sexual Health Course.
- Postnatal home visiting commenced in May 2008 for specifically vulnerable young parents within South Birmingham. To date this has incorporated 20 visits.
- Postnatal support group trialled.
- Commencement of a text messaging service to pregnant teenagers to remind them of their appointment. Although a new initiative, so far the feedback from customers has been positive.

Planned initiatives for 2008/9

- Family planning outreach clinic provided by BRASH (Birmingham Relationship and Sexual Health) within the antenatal specialist clinic.

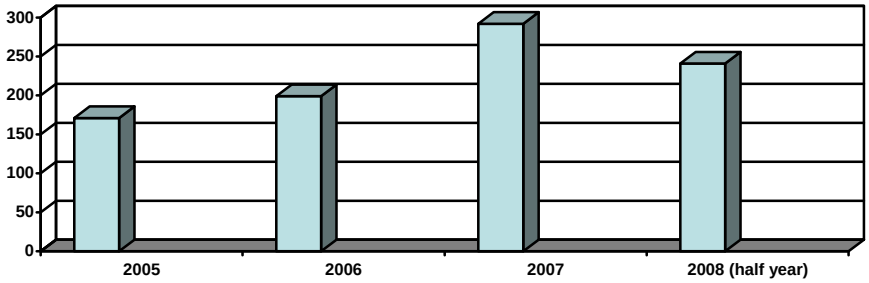
- Family planning administration on the postnatal floor prior to transfer home.
- Teenage pregnancy audit.

6.0 The Hospital Social Work Team:

The hospital social worker, Paul Wilson, is employed by the Local Authority based at Birmingham Children's Hospital. Paul Wilson is accommodated within an office in Norton Court.
The hospital team will take referrals for Birmingham residents who are in-patients and do not already have a social worker. They work closely with the Safeguarding Team and assist in the mandatory training programme.

7.0 Safeguarding Children Referrals:

Safeguarding referrals continue to increase annually (see below).The rise in reported incidents of domestic abuse has contributed significantly to this increase.



There has been a noticeable increase in the level of complexity with many cases.
120 (41%) cases in 2007 have required input from at least 3 agencies due to their complex social circumstances. This not only impacts considerably upon the leads within the safeguarding arena but also on other health professionals within the organisation, in particular, community midwifery services.

8.0 Advice and Supervision:

National guidance recommends that a framework for mandatory child protection supervision is put in place to equip front line staff to deliver safe, child-centred safeguarding activities.
The Lead Nurse/ Midwife provided advice and informal supervision on a case by case basis.
A key priority for 2008/2009 is to introduce a formal mandatory process of clinical supervision for all staff working directly with children and families.
All members of staff have access to in-house advice and support from Named Professionals.
Out of hours advice is not currently provided and staff are directed towards Social Care Emergency Duty Services.

9.0 The Safeguarding Children Training Strategy:

Child Protection training is mandatory and is delivered by the Lead Nurse/ Midwife. Recently, supported by the Hospital Social Work Team.

Trust induction:
The Trust 'Safeguarding Children' leaflet and the Every Child Matters booklet 'What to do if you're worried a child is being abused' (DfES, 2006) are given out to all new starters.

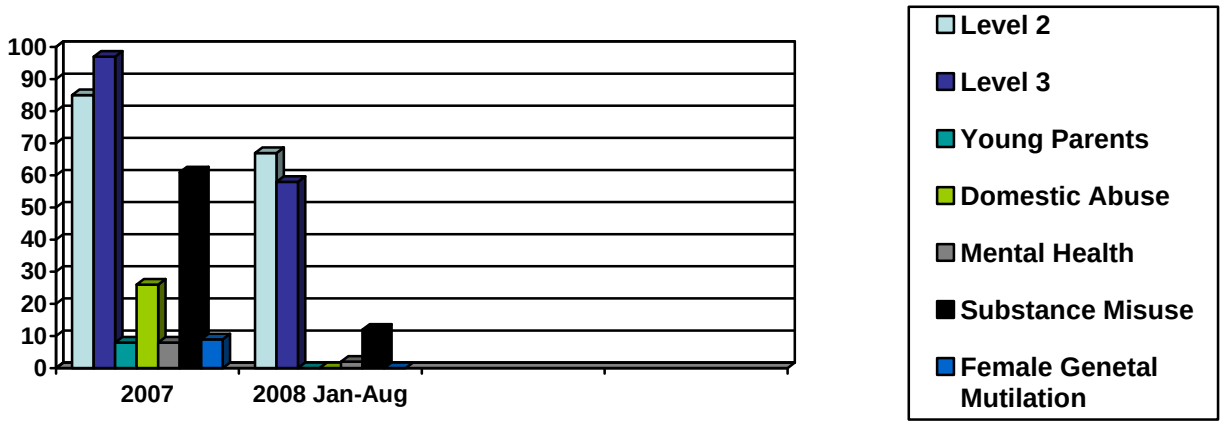
There are 3 levels of Safeguarding Children training relevant to Trust staff:

Level 1
Level 1 training is applicable to all staff, both clinical and non-clinical and incorporates an introduction as to what constitutes abuse, staff responsibilities to report concerns relating to child abuse and who to report those concerns to.

Level 2
Level 2 is applicable to both clinical and non-clinical staff who have infrequent contact with children, young people and families. This incorporates being able to recognise child abuse, understanding the barriers to recognition, culture and diversity, how to make a referral and record keeping.

Level 3
Level 3 is predominantly for those members of staff who are working directly with children, young people and families. The training incorporates knowledge of key guidance and legislation, multi-agency working, understanding child protection investigations, roles and responsibilities, serious case reviews, domestic abuse and substance misuse.

Number of staff trained in-house



10.0 Risk management:

Failure to act in an appropriate and timely manner can have serious implications for children, their families and staff.

The following areas have been highlighted as potential areas of risk within the area of safeguarding children in the Trust. Work to reduce the risk has been undertaken and continues to be addressed:

- The removal of babies from their mother's care immediately following birth.
- The increasing level of aggression facing Trust staff when involved in child protection issues.

Actions taken have included:

- The development of a multi-agency policy for the emergency protection of a child at birth which is waiting to be ratified.
- Clear child protection plans in place prior to birth.
- Closer partnership working with customers, health professionals and social care staff.
- Confirmation that retrospective CRB checks are being undertaken on existing Trust staff.

10.1 Clinical Governance

Complying with national guidance, Safeguarding Children is firmly embedded within the clinical governance framework and continues to receive regular reports, including findings from Serious Case Reviews, recommendations and action plans to change practice.

10.2 Compliance with Core Standard C2 (SfBH)

Core Standard C2 specifically relates to safeguarding children and young people http://www.healthcarecommission.org.uk/_db/_documents/Core_standard_C2_safeguarding_children_all_sectors.pdf
The Annual Health Check 2006/2007 demonstrated compliance with this standard and this is consistent in 2007/2008.

10.3 Policy and guidance development and review

BSCB inter agency policies and procedures are accessible to all staff by going onto the BSCB web site Welcome to Birmingham Safeguarding Children Board. A local policy is also available. They can be accessed on the Trust intranet.
New guidance 2007:

- Women Involved in CP Procedures Using the Birth Centre

New policies/ guidance waiting to be ratified 2008

- Emergency Protection of a Child Following Birth
- Guideline for the Care of Families Involved in Surrogacy Arrangements

New guidance in draft 2008

- Concealed pregnancy/ Late bookers/ Poor antenatal clinic attendance

10.4 Criminal Record Bureau checks (CRB):

Since February 2005, all staff seeking employment with children or vulnerable adults must be screened by the Criminal Records Bureau (CRB) in order to assist employers in making safer recruitment decisions. Vetting and Barring Scheme - Every Child Matters. All staff employed by the Trust are required to submit to a CRB

before taking up post. Staff who work directly with children are required to submit to an enhanced CRB check. The Workforce Directorate have systems in place to ensure that checks on new staff are completed. A retrospective programme of checking of existing staff is in place.

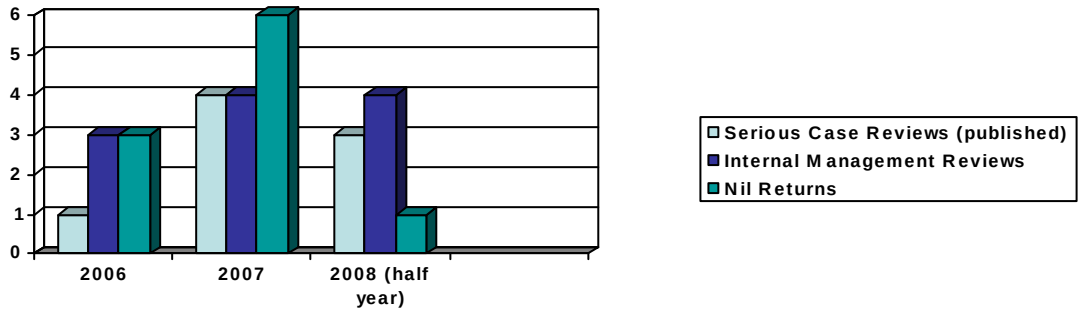
11.0 Child death review process:

Implementation of child death review processes under Chapter 7 of Working Together to Safeguard Children 2006 has resulted in greater scrutiny of all child deaths by Local Safeguarding Children Boards. This will provide an overview and identify key themes and trends for future years. Overall monitoring will be done by Ofsted. Serious case reviews - Every Child Matters
All deaths that take place in the Trust of Birmingham children are reported to BSCB as part of these arrangements.

11.1 Serious Case Reviews (SCR)

Section 8 of Working Together to Safeguard Children, 2006 describes the circumstances in which a serious case review should be undertaken. Serious case reviews - Every Child Matters
Information is fed back to BSCB by means of an internal management review. The LNMSC is responsible for completing the Trust's internal management reviews.
Themes emerging from Serious Case Reviews both nationally and locally include issues around domestic abuse and substance and alcohol misuse. Mandatory training addresses both issues.

Trust activity in Serious Case Reviews



11.2 Published Serious Case Reviews

- **Case 4**

Concerns a newborn baby found deceased and concealed shortly after birth.
No specific recommendations for the Trust.

- **Case 5 - DOB: 17.1.2005 DOD: 18.2.2006**

The child died having drowned in the bath.

Recommendation 3 states that all agencies working with a family where a child is identified as being vulnerable or in need at the point of considering referral to another agency should be asked whether the child requires a CAF assessment. The action is that organisations should raise awareness and provide training for staff.

The Trust has an action plan in place to ensure staff receive the appropriate level of training.

- **Case 6 - DOB: 9.8.1999 DOD: 10.5.2006**

Child died having been strangled.
No specific recommendations for the Trust

- **Case 7 - DOB: 19.6.2001 Date of incident: 27.6.2006**

Child died of multiple stab wounds.
Although this was not a family known to the Trust there are lessons to be learnt and liaison with mental health services is currently being undertaken in respect to this case.

11.3 Internal Management Reviews

- **Case 37**: DOB: 13.10.2007 DOD: 19.3.2008

The child died suddenly and unexpectedly. Initial investigation revealed:

1. Issues of neglect
2. Death of a child from the father's previous relationship
3. Domestic violence
4. Bruises to this baby's chin and torn frenulum

Executive summary and recommendations not yet published.
The internal management review has already highlighted a need for changes in practice and as such new trust guidance on 'Return of the Postnatal Notes' has been implemented.

- **Case 34**: DOB: 13.10.2005 DOD: 13.3.2008

The child died after an ingestion of Methadone (Heroin substitute).
Previous concerns relating to the parents' use of alcohol, concealed pregnancy, poor housing conditions and possible previous non-accidental injury.

- **Case 54**: DOB: 10.3.2004 DOD: 26.4.2008

The child died as a result of being hit by the family car.
Executive summary and recommendations not yet published

11.4 Nil Returns

Nil returns are cases where, after searching the medical records library by name, date of birth and address, no trace of attendance for care at BWH can be found. This information is shared with BSCB.

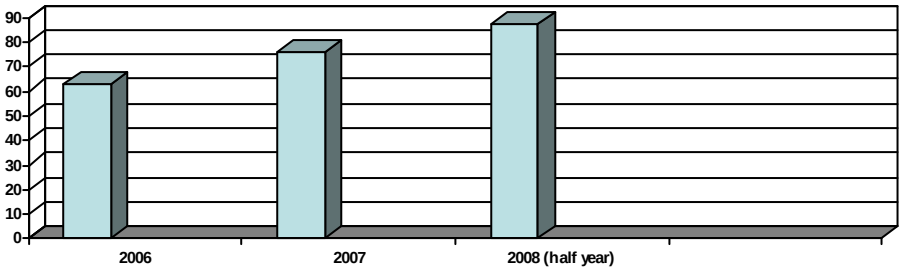
1 Nil Return for the period of this report.

12.0 Adoption Claims:

Each child born at the Trust who is being considered for permanency within an adoptive family requires a doctor or senior nurse to complete details concerning the mother and child's medical history.
This role continues to be done for the Local Authority, on behalf of the Trust, by the LNMSC, with clerical support.

There is an increase of 120% in 2007, compared to 2006 and a projected increase in 2008.

Number of adoption claims



13.0 Partnership working:

Birmingham Safeguarding Children Board (BSCB)
Requirements of Local Safeguarding Children Boards are set out in Section 13 of the Children Act 2004.
The Lead Professionals attend sub-groups of BSCB. During 2007 the Trust was represented at 77.78% of the meetings. Recommended attendance rate is 75%.

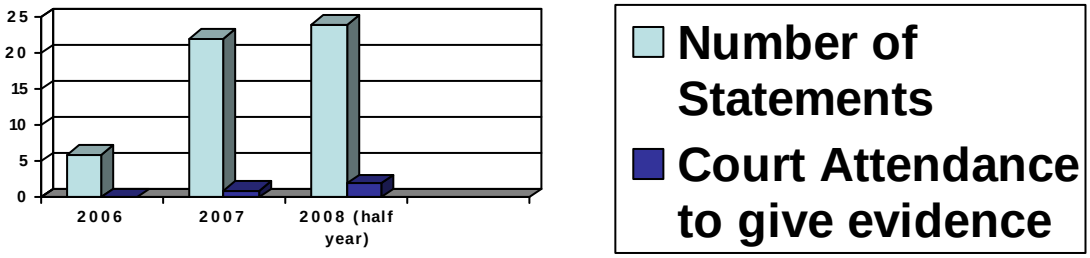
14.0 Common Assessment Framework (CAF):

CAF is one of the contributing elements to the delivery of frontline services, as outlined in Section 11, Children Act 2004 which all agencies have signed up to. Common Assessment Framework - Every Child Matters
An implementation plan is in place to ensure all relevant staff receives the appropriate level of training in CAF.

15.0 Public Law Outline (PLO):

This is a new approach to case management under the Protocol for Judicial Case Management in Public Law Children Act Cases 2003.
http://www.judiciary.gov.uk/docs/public_law_outline.pdf
Trust staff working directly with children and families will be asked to contribute to the process by the preparation and submission of reports as part of the Core Assessment process. The reports will be eligible for submission to Family Court proceedings.

Preparation of family court statements



There was 100% increase in the number of statement requests in respect of child care proceedings in 2007 compared to 2006. 2008 is already showing that statistics have doubled.
The following information relates specifically to nursing and midwifery staff.
This can be an extremely stressful process for those staff involved, which requires additional support to guide them through the process.
Line managers need to be aware and make allowances for the extra time that is required to undertake this.

16.0 Key achievements 2008- 2009:

- The Trust has robust procedures in place for identification and referral of concerns relating to the protection of children and young people.
- The Trust has robust systems in place for recording concerns and action plans to safeguard children and young people.
- There has been an increase in the number of requests for consultations from staff across the Trust as awareness has been raised through training. Activity overall has increased within the safeguarding team.
- The Trust has maintained its active participation in the safeguarding children agenda through representation and membership at BSCB sub-groups.
- The introduction of a new role, Specialist Nurse/ Midwife in September 2008 to support the LNMSC.

17.0 Future developments:

- Continue to promote the safeguarding of children and young people and raise awareness of key issues across the Trust.

- Identify the role of 'link nurses/ midwives' in operation areas to look at ways of raising awareness in individual operational areas/ teams.

18.0 Summary/ Recommendations:

- Child protection training is ongoing and whilst progress has been made, further work is required to ensure that it is further embedded throughout the organisation. This will be a key priority in 2008/ 2009.

- A key target was met by the Trust when it achieved compliance with Core Standard C2 , Standards for Better Health (which relates specifically to Safeguarding Children AND Young People and NSF Standard 5)

- A framework for a system of mandatory caseload supervision should be considered, initially for staff working directly with children and families.

- Confirmation that evidence supports retrospective CRB checks on existing staff.