

# Safeguarding and Protecting Children in Wales:

A review of the arrangements in  
place across the Welsh National  
Health Service

October 2009

## **Healthcare Inspectorate Wales**

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# 1. Background and Introduction

***“Please keep me safe”. This simple but profoundly important hope is the very minimum upon which every child and young person should be able to depend.’<sup>1</sup>***

1.1 The death of a child under any circumstances is a time of great sadness and sorrow for family, friends and all those whose lives they touched. When a child’s death is as a result of neglect and abuse the sadness and sorrow is enhanced by regret as we each ask ourselves ‘could I have done more?’

1.2 The death of Peter Connelly (Baby P), a 17 month old who died on 3 August 2007, in the London borough of Haringey, from the injuries he received having suffered months of abuse while in the care of his mother, her partner and a lodger has resulted in us all questioning how did the tragedy of his young life go unnoticed and could more have been done? Baby Peter had been subject to a child protection plan and was still subject to this plan at the time of his death. He had been seen on 60 separate occasions by various professionals, including doctors and social workers.

1.3 Sadly, Baby Peter’s death occurred only seven years after that of eight-year-old Victoria Climbié who was abused by her aunt for months before she died in February 2000. Victoria had also been on the child protection register and had been seen by a number of health and social care professionals. Following Victoria’s death an inquiry into the circumstances surrounding her death was set up and led by Lord Laming. The ‘*Victoria Climbié Inquiry Report<sup>2</sup>*’ made 108 recommendations, 22 of which related specifically to NHS organisations and procedures. On publication of the report Lord Laming

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<sup>1</sup> The Protection of Children in England: A Progress Report, The Lord Laming, March 2009

<sup>2</sup> The Victoria Climbié Inquiry Report, by Lord Laming, January 2003

stated in relation to the 108 recommendations '*that they have had to be made should be a reproach to everyone with a responsibility for the safety of children.*' Most of the recommendations made by Lord Laming were adopted in the 2004 Children's Act.

1.4 Following Baby Peter's death Lord Laming was asked to undertake a review of the progress made by English agencies against the recommendations he made in 2003. His review<sup>3</sup> concluded that child protection issues in England had not been given the priority they deserved and that many of the 108 recommendations had not been fully and appropriately implemented. In his progress report Lord Laming made a further 58 recommendations.

### **What did HIW do?**

1.5 Healthcare Inspectorate Wales (HIW) has a specific statutory responsibility to '*safeguard and promote the rights and welfare of children*<sup>4</sup> in exercising its role in relation to the inspection and investigation of NHS organisations. We therefore ensure that safeguarding and child protection are built into every review we undertake, whether it be a review of the governance arrangements of an organisation or of a specific service such as maternity or mental health. A summary of the work relevant to child protection and safeguarding that we have taken forward since 2007 is provided at **Appendix A**.

1.6 Following Baby Peter's death we decided that it was imperative that we further increased our focus on safeguarding and protection arrangements in the NHS. Our key aim was to answer 2 key questions:

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<sup>3</sup> The Protection of Children in England: A Progress Report, The Lord Laming, March 2009

<sup>4</sup> Health and Social Care (Community Health and Standards) Act 2003, Chapter 4

- Are all those working in healthcare organisations aware of their responsibilities in relation to child protection and safeguarding and do they know how to properly deal with suspected child protection/safeguarding issues?
- Are children and young people safe when accessing health services or visiting healthcare premises?

1.7 Throughout April and May 2009 we visited every NHS Trust in Wales and a sample of 88 GP practices. Our reports for individual NHS Trusts, Health Commission Wales and Local Health Boards can be accessed from our website [www.hiw.org.uk](http://www.hiw.org.uk) or by writing to us at Healthcare Inspectorate Wales, Bevan House, Caerphilly Business Park, Van Road, Caerphilly, CF83 3ED.

1.8 As part of our review of child protection arrangements in Trusts we visited:

- Accident and Emergency Departments and Minor Injuries Units.
- Paediatric Wards.
- Wards for the elderly with mental health problems.
- Medical Admissions Units (MAU).
- Medical Wards.

A full list of the departments and wards visited is provided at **Appendix B**.

1.9 For each of the above departments and wards we evaluated the suitability of the environment of care, observed how child protection procedures and processes are put into practice, interviewed staff about the level of training and awareness they have in respect of child protection and safeguarding issues and spoke to patients, service users and relatives about their experiences. We also reviewed patient records and care plans.

1.10 Similarly, at each of the GP practices we visited we interviewed staff at all levels; GPs, practice nurses, receptionists and practice managers to enable us to assess their awareness of child protection and safeguarding issues and more importantly their knowledge of the action they would take should a child protection issue be suspected.

1.11 To enable us to answer the 2 key questions we set for ourselves, we not only set in train the specific review work detailed above but also drew from work that was already ongoing; such work included:

- Feedback received from children about their experiences of the NHS. [Questionnaire issued by HIW in conjunction with Funky Dragon in 2006-07].
- Findings from our reviews of Learning Disability, Substance Misuse and Child and Adolescent Mental Health Services.
- Findings from our Mental Health Act monitoring work.
- Findings from our involvement in reviews of Welsh Youth Offending Teams.
- Findings from our reviews of homicides where the perpetrator was a mental health service user.
- Feedback from primary care practitioners; General Practitioners (GPs), dentists, pharmacists and optometrists about their safeguarding and child protection arrangements. [Questionnaire issued by HIW in October 2008].
- Annual Healthcare Standards assessment process. As part of which every NHS organisation in Wales is required to set out its safeguarding and protection arrangements and evidence its compliance with them.

1.12 For ease of reference our findings are set out in the remainder of this report under the two questions we have set out to answer.

## 2. Policy and Legislation in Wales

2.1 In January 2004, the Welsh Assembly Government published '*Children and Young People: Rights to Action*' setting out its seven core aims for all children and young people of Wales, these are for them to:

- Have a flying start in life.
- Have a comprehensive range of education and learning opportunities.
- Enjoy the best possible health and be free from abuse, victimisation and exploitation.
- Have access to play, leisure, sporting and cultural activities.
- Be listened to, treated with respect, and have their race and cultural identity recognised.
- Have a safe home and a community which supports physical and emotional wellbeing.
- Not be disadvantaged by poverty.

2.2 The *Children Act 2004* provided the legislative framework for these aims and placed a duty upon agencies and organisations to ensure that every child and young person is given the support they need to stay healthy, stay safe, enjoy and achieve through learning and are free from poverty. Section 28 of the Act places a duty on all Local Health Boards and NHS Trusts to make arrangements for ensuring that their functions are discharged in a way that pays due regard to the need to safeguard and promote the welfare of children.

2.3 In April 2007, the Welsh Assembly Government published *Safeguarding Children – Working Together Under the Children Act 2004* which set out new guidance aimed at strengthening safeguarding and promoting the welfare of children arrangements as described in the Children Act 2004. It also adopted the following working definition in respect of safeguarding and promoting the welfare of children:

***“protecting children from abuse and neglect; preventing impairment of their health or development; and ensuring that they receive safe and effective care so as to enable them to have optimum life chances”.***

2.4 *Safeguarding Children – Working Together Under the Children Act 2004* states that organisations and individuals should work together to safeguard and promote the welfare of children and protect them from harm. It is addressed to Chief Officers, senior and operational managers as well as practitioners and front-line managers who have particular responsibilities for safeguarding and promoting the welfare of children, in those organisations that:

- Are responsible for commissioning or providing services to children, young people and adults who are parents/carers.
- Have a particular responsibility for safeguarding and promoting the welfare of children.

2.5 The guidance makes it clear that *“LHBs have a statutory duty to take the overall strategic lead for all health services within the NHS (and for health services they commission) for local inter-agency working in respect of safeguarding children”*. This duty will remain unchanged under the new NHS structures that came into being on 1 October 2009.

2.6 The Children Act 2004 enabled Area Child Protection Committees (ACPCs) to be replaced by statutory Local Safeguarding Children Boards (LSCBs). In Wales these came into being on 1 October 2006. These LSCBs co-ordinate the safeguarding and welfare promotion work undertaken by their members to ensure maximum effectiveness and to establish clear lines of accountability at a variety of levels.

2.7 The requirements set out in *Safeguarding Children – Working Together Under the Children Act 2004* and the role of LSCB's are referred to in greater detail in the remaining sections of this report.

### **3. Are all those working in healthcare organisations aware of their responsibilities in relation to child protection and safeguarding and do they know how to properly deal with suspected child protection / safeguarding issues?**

3.1 *Safeguarding Children: Working Together Under the Children Act 2004* sets out the role of the NHS in relation to safeguarding and promoting the rights of children. It emphasises the importance of all health professionals, in the NHS having a role in ensuring that children and families receive the care, support and services they need in order to promote children's health and development. It further states that the involvement of health professionals is important at all stages of work with children and families by:

- Recognising children in need of support and/or safeguarding, and parents who may need extra help in bringing up their children by recognising that their parenting ability could be compromised.
- Recognising adults who may pose a risk/danger to children.
- Ensuring that all health settings are safe for children.
- Contributing to enquiries about a child and family.
- Assessing the needs of children and the capacity of parents to meet their children's needs.
- Planning and providing support to vulnerable children and families.
- Participating in child protection conferences.
- Planning support for children at risk of significant harm.
- Providing therapeutic help to abused children and their parents/carers.
- Playing a part, through the child protection plan, in safeguarding children from significant harm.
- Contributing to case reviews.

3.2 In Wales the Child Protection Service of the National Public Health Service works with and on behalf of LHBs to enable them to fulfil their statutory functions.

## **Leadership and accountability**

3.3 Every report of an inquiry into a child protection matter such as those led by Kennedy<sup>5</sup>, Carlile<sup>6</sup> and Laming have stressed the importance of there being strong leadership in respect of child protection and clear lines of accountability.

3.4 Local Health Boards (LHBs) are required to appoint a lead officer for children and young people's services (section 27(2)(a) of the Children Act) and designate a lead member for children and young people's services (section 27(2)(b)).

3.5 Similarly, NHS Trusts are required to appoint a lead executive director for children and young people's services (section 27(3)(a) of the Children Act) and to designate a lead non-executive director for children and young people's services (section 27(3)(b)).

3.6 At the time of our fieldwork all NHS Trusts and the 22 LHBs had lead officers/executive directors for children and young people's services and it was clear that those holding these positions took their role very seriously and had a true commitment to children and young people. All LHBs and Trusts had clear reporting mechanisms in place which were integrated into their governance arrangements. They also had processes and procedures in place to ensure that there was learning from serious case reviews and child protection incidents.

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<sup>5</sup> Learning from Bristol: The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984 -1995, July 2001

<sup>6</sup> Too Serious a Thing: The Carlile Review, The Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales, 2002.

## Professional Leadership and Advice

3.7 Each of the 22 LHBs had access to a designated doctor and nurse and support professionals through the National Public Health Service. The designated professionals worked closely with named professionals in the Trusts and played an important role in promoting the protection of children and young people through membership of Local Safeguarding Children Boards (LSCBs), developing and participating in training programmes, the provision of expert advice and the completion of the health component of serious case reviews. In line with the Children Act 2004, designated professionals have an important role in relation to safeguarding. They take an overarching responsibility across the LHB area which covers all healthcare providers and commissioners and are an important source of professional advice on safeguarding matters to local authority social services departments.

3.8 All NHS Trusts had a named doctor, a named nurse and where relevant a named midwife for safeguarding children who took a strategic and professional lead, contributed to safeguarding children across the Trust and provided advice and expertise to fellow professionals and other agencies. These named doctors and nurses had specific expertise in children's health and development, child abuse and neglect and local arrangements for safeguarding and promoting the welfare of children within their own organisation.

3.9 A number of partner organisations and national child protection charities have stressed that the healthcare sector plays a crucial role in providing advice and support to the multi-agency safeguarding work that the LSCBs undertake. The new LHBs need to clarify as a matter of priority the arrangements that they have in place to ensure that they support and contribute to LSCBs on an on-going basis. This issue is further explored in the report published today by Care and Social Services Inspectorate Wales; *Safeguarding and Protecting Children in Wales, The review of Local Authority Social Services and Local Children's Safeguarding Boards*.

**We therefore recommend that:**

*The structures and arrangements to be put in place across the new health service structures to support the child protection agenda are clarified as a matter of urgency. These arrangements need to take full account of the requirements of the Children Act 2004 and the recommendations arising from Lord Laming's report of March 2009. [Recommendation 1]*

## **Staff Awareness and Training**

3.10 Generally we found that staff awareness of the signs that may suggest child abuse or neglect and the actions they should take to ensure that the child is safeguarded are improving. Without exception staff on paediatric wards and in A&E departments could describe to us the triggers that would alert them to possible neglect or abuse, tell us what the policy was and explain the action they would take.

3.11 However, there are still areas and staff groups for whom further training and support is required. We are particularly concerned that some staff working in predominantly adult services such as adult mental health and substance misuse services considered that they did not need to know about child protection. It was clear that very few staff in these areas had received up-to-date training.

3.12 Further, the response rate to our Child Protection questionnaire issued to primary care contractors, in October 2008, was disappointing with completed questionnaires only being returned by:

- 38% of pharmacies.
- 37% of GP practices.
- 28% of dental practices.
- 16% of optometrists.

3.13 The above figures indicate that there needs to be further engagement with these groups. Our 2007<sup>7</sup> report noted that LHBs commissioning services for children were including specifications for child protection in their contracts with Trusts. However, with regard to primary care contractors (dentists, optometrists, pharmacists and GPs), the quality of Child Protection arrangements were only being taken into consideration with respect to primary medical services.

3.14 Our evaluation of the Healthcare Standards self-assessments submitted by LHBs for the 2008-09 financial year, highlighted that there have been some improvements made in relation to raising awareness of child protection issues across GP, dental and pharmacy contractors, however little work has been taken forward with optometrists.

**We therefore recommend that:**

*Child protection training is made mandatory for all staff groups. Update training should be provided at least every 3 years. The Welsh Assembly Government should ensure that all nationally agreed contracts reflect this requirement. [Recommendation 2]*

*The new LHBs further engage with primary care contractor groups to ensure they receive the necessary training and support in respect of child protection and safeguarding. [Recommendation 3]*

## **Information Sharing and Risk Management**

3.15 Despite guidance having been issued nationally about the sharing of information to ensure the appropriate management and response to risk, staff still continue to be concerned and reluctant to share information inside their own organisations let alone with other agencies and sectors.

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<sup>7</sup> Review of Child Protection Arrangements Across NHS Wales: Hospital Care and Commissioning

Some staff are concerned about breaking patient confidentiality and the effect this may have on their future relationship with that individual and their therapeutic needs.

3.16 In his 2009 report Lord Laming states that '*Whilst the law rightly seeks to preserve individuals' privacy and confidentiality, it should not be used (and was never intended) as a barrier to appropriate information sharing between professionals. The safety and welfare of children is of paramount importance, and agencies must lawfully share confidential information about the child or the parent, without consent, if doing so is in the public interest.*'

3.17 We have identified a number of areas where information sharing is a particular issue for staff and where we feel greater support and training is needed for those on the front line, these are set out below.

## **Substance Misuse Services<sup>8</sup>**

3.18 Our report published in August 2009<sup>9</sup> highlighted that children and young people whose parents have substance misuse problems are often in need of support and protection.

3.19 The fear of disclosure of drug use remains an active barrier to treatment for many. This can be compounded by their individual situation. One example given to us was of drug using mothers fearing that their child will be taken into care if they seek help. This raises the issue for substance misuse services of how to handle sensitively, particular child protection concerns that may arise from the use of drugs.

3.20 It was against this background that staff told us that they were concerned about the potential conflict between attempting to treat the client and the safeguarding of children and the protection of vulnerable adults.

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<sup>8</sup> The services we looked at as part of this review spanned the NHS, independent and voluntary sectors

<sup>9</sup> Substance Misuse Services: All Wales Review of Substitute Prescribing Services

Although most service providers consider the needs of both clients and dependents, we found that the primary concern for some agencies is maintaining the relationship with a client to ensure continuation with treatment, rather than addressing concerns identified about dependents. We were told of cases where specific agencies had refused to attend child protection conferences in case it damaged their relationship with clients.

3.21 Other examples were given of agencies refusing to share relevant information as this was considered to be confidential to the agency. Underpinning these concerns is a general lack of understanding of information sharing. Alternatively we were also provided with examples of when substance misuse staff had referred issues to social services but had never been told whether action had been taken.

3.22 While all agencies had appropriate policies relating to the protection of children and vulnerable adults, staff were not always clear as to the procedures that must be followed. Many of the staff we spoke to were not familiar with the All Wales Child Protection Procedures<sup>10</sup> and up-to-date guidance such as “Hidden Harm”<sup>11</sup>.

3.23 We identified occurrences of high risk injecting practices among groups of young people in some areas which had not been identified through local needs assessment. There appeared to be local awareness of such risks in some areas but there were no obvious mechanisms for sharing this knowledge in order to plan risk reduction strategies. We are concerned that some health agencies are not sharing information regarding vulnerable young people at risk with appropriate agencies.

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<sup>10</sup> 2008 All Wales Child Protection Procedures, Produced on behalf of all Local Safeguarding Children Boards in Wales

<sup>11</sup> Hidden Harm – Responding to the needs of Children of Problem Drug Users; Report of an Inquiry by the Advisory Council on the Misuse of Drugs (2003)

3.24 We consider the safeguarding systems in place for substance misuse services to be for the most part reactive, based on either the occurrence of an incident or a level of risk threshold being exceeded. We found that the perceptions of risk vary between partners and between areas.

3.25 For ease of reference and completeness the recommendations made as part of our August 2009 report on substance misuse services that relate to child protection and safeguarding issues are reaffirmed below.

**We therefore recommend that:**

*Service providers put policies in place that are in line with the All Wales Child Protection Procedures to ensure staff are aware and understand all safeguarding policies and procedures and their relevance to their area of work. [Recommendation 4]*

*Community Safety Partnerships (CSPs)<sup>12</sup> review all service level agreements to ensure that statutory requirements in relation to safeguarding are included and that review mechanisms are in place to demonstrate compliance by providers. [Recommendation 5]*

*CSPs ensure robust and well managed family centred, substance misuse care pathways into and out of children and family services.*

**[Recommendation 6]**

*CSPs ensure that information sharing agreements are in place for their local area and that these cover the protection of vulnerable people.*

**[Recommendation 7]**

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<sup>12</sup> Community Safety Partnerships are groups of local organisations working together to reduce crime and substance misuse. They are responsible for commissioning substance misuse services throughout Wales.

## Adult Mental Health Services

3.26 In relation to adult mental health services we have identified a similar picture to that for substance misuse services. The stigma that is still attached to mental illness sometimes leads to a lack of openness and information sharing about the limitations and risks that an individual's problems may cause.

3.27 *Safeguarding Children – Working Together Under the Children Act 2004* clearly states that 'All those providing mental health services must be alert to the possibility that their clients, whether adults or children, may be a risk to children. If they have such suspicions they should make a referral to social services and follow child protection procedures'. However, we have found that risk assessments and care plans undertaken and developed by health professionals do not always address the risk to or needs of dependent children and young people. As a consequence the information needed to safeguard them is not collected or shared with the appropriate agencies.

3.28 Particular issues in relation to risk assessment and the referral of concerns to child care services have been highlighted by our reviews of homicides where the perpetrator was a mental health service user. Our review of the care of Mr B<sup>13</sup> highlighted that during the day he cared for his young daughter; taking her to and from school. Despite Mr B telling health and social care staff that he had homicidal thoughts, a full assessment of the risk he may have caused to his young daughter was never undertaken and no referral to the local authorities' child care services was ever made. Mr B went on to repeatedly stab a young man in a local park.

3.29 The issue is not unique to Wales and in May 2009 the National Patient Safety Agency (NPSA) issued a Rapid Response Report on '*Preventing harm to children from parents with mental health needs*'. The report highlighted that while mental health service users are often good parents, new research from

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<sup>13</sup> Report of a review in respect of Mr B and the provision of mental health services following a homicide committed in April 2006, Healthcare Inspectorate Wales, May 2008

the National Confidential Inquiry into Suicide and Homicide (NCISH) and findings from investigations into the deaths of children have '*highlighted a rare but important risk to children when their parent or carer has delusional beliefs involving their children, or has a suicide plan involving their children. In some cases, mental health staff caring for the parent had not recognised the risk*'.

3.30 The Rapid Response Report sets out six immediate actions for Chief Executives of organisations providing adult mental health services. These actions are in line with the findings arising from our work in this area and **we therefore recommend** that they are taken forward by NHS and independent mental health service providers across Wales as a matter of priority.

**We therefore recommend that:**

*All assessment, Care Programme Approach (CPA) monitoring, review, and discharge planning documentation and procedures should prompt staff to consider if the service user is likely to have or resume contact with their own child or other children in their network of family and friends, even when the children are not living with the service user.*

**[Recommendation 8]**

*If the service user has or may resume contact with children, this should trigger an assessment of whether there are any actual or potential risks to the children, including delusional beliefs involving them, and drawing on as many sources of information as possible, including compliance with treatment.*

**[Recommendation 9]**

*Referrals should be made to children's social care services under local safeguarding procedures as soon as a problem, suspicion or concern about a child becomes apparent, or if the child's own needs are not being met. A referral must be made: If service users express delusional beliefs involving their child and/or if service users might harm their child as part of a suicide plan. **[Recommendation 10]***

*Staff working in mental health services should be given clear guidance on how to make such referrals, including information sharing, the role of their organisation's designated lead for child protection, and what to do when a concern becomes apparent outside normal office hours.*

**[Recommendation 11]**

*A consultant psychiatrist should be directly involved in all clinical decision making for service users who may pose a risk to children.*

**[Recommendation 12]**

*Safeguarding training that includes the risks posed to children from parents with delusional beliefs involving their children or who might harm their children as part of a suicide plan is an essential requirement for all staff. Attendance, knowledge, and competency levels should be regularly audited, and any lapses urgently acted on. **[Recommendation 13]***

## **Child and Adolescent Mental Health Services**

3.31 Our review of the records of children and young people who have accessed Child and Adolescent Mental Health Services (CAMHS), highlighted some good examples of where issues of concern regarding the safety of a young person, or others that he/she may come into contact with, have been identified by health professionals and appropriately referred to and shared with other relevant agencies. However, we also identified matters that were clearly child protection/safeguarding issues that had gone unreported or addressed. Where identified we ensured the necessary action was taken as a matter of priority.

3.32 In following up these issues with professionals working in the field of CAMHS identified that poor information sharing is often due to:

- Confusion as to what can and cannot be shared.
- Some professionals believing that parental consent is needed before information can be shared.
- Information sharing protocols not being in place.
- A lack of integrated records and information systems.

3.33 We identified a number of situations where children and young people have been put at risk because agencies have been either unwilling or not considered it appropriate to share information, including examples of:

- Cases where specialist CAMHS teams have 'discharged' a young person from their care as a result of them missing outpatient appointments. Other agencies, including the one that made the referral to specialist CAMHS services, are often not informed of the young person's 'discharge' and these young people can become 'lost' in the system.
- CAMHS staff being unwilling to confirm to other agencies that they are in contact with a young person.
- CAMHS staff being unwilling to advise teaching staff how they can best support young people with a mental health problem.
- CAMHS staff not attending case conferences.

3.34 Social services staff told us that they were sometimes not informed of children and young people from their area being admitted to inpatient settings, even though they meet the definition of 'a child in need' under the Children Act. Conversely, only 13 of the 24 specialist CAMHS teams we spoke to were routinely advised of safeguarding concerns by social services.

**We therefore recommend that:**

*All CAHMS teams should work with their LSCB to develop information sharing protocols. These protocols should set out clearly the type of information that should be shared, the circumstances in which information should be shared and the relevant agencies with whom it should be shared.*

**[Recommendation 14]**

## **Accident and Emergency (A&E) and Minor Injury Departments**

3.35 We found on the whole staff working in A&E and minor injury departments to be au fait with child protection procedures. They were able to describe clear the triggers that would alert them to a child protection issue and the steps they would take to escalate their concerns.

3.36 Some Trusts struggled due to a shortage of qualified and fully trained staff to ensure that at least one staff member trained in paediatric medicine and child protection issues was on duty in A&E departments at all times. Staff told us that they often sought assistance from the paediatric wards but that these arrangements were not robust or sustainable.

3.37 In our 2007 report 'Review of Child Protection Arrangements Across NHS Wales: Hospital Care and Commissioning' we highlighted that some Trusts could not identify whether a child or young adult had been attending one or more of A&E units within their own Trust, let alone in neighbouring Trusts in Wales.

3.38 Since our report a number of Trusts have put in processes for the routine monitoring of information about child attendances across its major injuries, minor injuries and inpatient units and a health visitor follows up frequent attendances for children under the age of 5 upon discharge. However, this practice is not in place across all NHS organisations. Further,

such steps do not prevent children being taken to the A&E and minor injury departments of other Trusts to conceal the fact that they had received repeated injuries. A key loop hole still remains.

3.39 *Safeguarding Children – Working Together Under the Children Act 2004* states that ‘All visits by children to an A&E department should be notified quickly to the child’s primary health care team and should be recorded in the child’s hospital notes, if there are any and/or electronic patient record. The health visitor and school nurse should always be informed’. The important role of the GP is considered later in this report.

3.40 A key check on whether a child or young person coming to hospital is at risk of harm is the Child Protection Register. Some A&E departments continue to face difficulties with accessing the Child Protection Register. The lack of fully integrated electronic Child Protection Registers contributes to the difficulty in achieving automatic checking and as we have stated in previous reports could lead to error and a vulnerable child not receiving the help and support he/she needs.

**We therefore recommend that:**

*New LHBs ensure that at least one member of staff trained in paediatric medicine and child protection is on duty in A&E departments at all times.*

**[Recommendation 15]**

*All LHBs should, where there are concerns about a child attending A&E (including to minor injuries units), follow the All Wales Child Protection Procedures and the child’s health visitor/school nurse and GP notified.*

**[Recommendation 16]**

*The Welsh Assembly Government takes further steps to ensure that the profile and level of expertise for child protection within GP practices is raised.*

**[Recommendation 17]**

*The Welsh Assembly Government puts national arrangements in place to ensure that A&E attendance records and Child Protection registers are shared between A&E departments. [Recommendation 18]*

### **Single records and 24 hour access to previous case notes**

3.41 Recommendation 78 of the *Victoria Climbié Inquiry Report* noted that ‘*within a given location, health professionals should work from a single set of records for each child*’. This recommendation was aimed at ensuring that each person working on a particular case is aware of all the facts and information about a particular child or young person, so that they can provide the best and most appropriate care. Children subject to abuse could also go undiagnosed if admitted to paediatric departments at the weekend, since access to their complete record is precluded.

3.42 A number of NHS organisations are still working with many different sets of notes and 24-hour access to all previous case notes is not available. The new LHBs need to review their arrangements to ensure that information is not overlooked and that procedures exist to access all available information on children wherever it is held.

#### **We therefore recommend that:**

*The new LHBs continue to work towards the amalgamation of children’s records and ensure that a project plan and timetable are put in place. Trusts should set a clear deadline for when they expect to complete this work.*

**[Recommendation 19]**

## **The Role of the General Practitioner, the Primary Healthcare Team and other Independent Contractors**

3.43 *Safeguarding Children: Working Together Under the Children Act 2004* recognises that important role, that GPs and other members of the primary health care team (PHCT) have, in recognising when a child is potentially in need of extra help or services to promote health and development, or is at risk of harm.

3.44 The guidance recognises that all PHCT members should know when it is appropriate to refer a child to social services for help as a 'child in need', and how to act on concerns that a child may be at risk of significant harm through abuse or neglect. It also emphasises that other independent contractors in the health service i.e. dental practitioners, pharmacists and optometrists should be aware of and comply with child protection procedures, should have safe recruitment procedures in place and receive child protection training.

3.45 As noted earlier we were disappointed with the level of response to the child protection questionnaire we issued to primary care contractors in October 2008. Our visits to GP practices confirmed that child protection policies and procedures were in place but the knowledge and understanding of practice staff was variable. While a number of GPs were able to demonstrate that they have appropriate systems in place to flag and escalate child protection issues such processes and procedures were not evident across all the GP practices we visited. The NPHS working with General Practitioners Committee (GPC) Wales issued '*A Guide for Safeguarding Children and Young People in General Practice*' in 2007 and this should be complied with by all GP practices across Wales.

3.46 Some GPs reported that joint working and communication with social services was limited and sometimes problematic. They raised with us concerns that information on 'looked after children' was not always passed to them as a matter of routine.

3.47 Further, some GPs felt that there to be a gap in the child protection system as health visitors only cover children up to the age of 5.

**We therefore recommend that:**

*All GP practices across Wales should ensure that they comply with 'A Guide for Safeguarding Children and Young People in General Practice' issued by the National Public Health Service in 2007.*

*The new LHBs ensure that local information sharing protocols comply with the All Wales Child Protection Procedures and clearly set out the arrangements for sharing information between primary care and social service departments.*

**[Recommendation 20]**



## **4. Are children safe when accessing or visiting NHS services?**

4.1 All NHS organisations and those who provide NHS services under contract are statutorily obliged to protect children in their care as well as those who enter their premises as visitors. In forming a judgement as to whether children are safe when accessing or visiting NHS services we have focused on:

- The robustness of recruitment and vetting procedures.
- The suitability of the environment of care.
- The physical security of wards.
- The security of patient information.
- Procedures for raising concerns.

### **Appropriateness of checks undertaken on the suitability of staff**

4.2 Staff recruited or contracted to undertake work on behalf of the NHS may have access to children and young people and/or their medical records. It is therefore important to ensure that this privileged position is not abused and confidential and personal information misused.

4.3 Following Sir Michael Bichard's Inquiry into the murders of Jessica Chapman and Holly Wells; published on 22 June 2004, there was much focus on the need for all public bodies employing staff who may come in contact with children and vulnerable adults to ensure that appropriate checks were undertaken prior to the employment of new staff. As a direct consequence the Welsh Assembly Government issued guidance to the NHS in March 2005 in the form of a Welsh Health Circular. WHC (2005) 029 confirmed that Criminal Records Bureau checks were to become mandatory for all new eligible staff and including all medical, nursing and other staff with direct

patient contact, as well as staff whose work provides access to patients in the course of their normal duties, such as cleaners, porters and maintenance staff. In addition, the circular advised that employers would need to consider vetting for contract staff such as electricians and plumbers and if required, the most appropriate level of Disclosure.

4.4 The NHS (General Medical Services) (Amendment) (No 2) (Wales) 2002 and NHS (General Medical Services Supplementary List) Wales Regulations 2002 introduced the first wave of “Post Shipman” reforms to general practitioner listing in August 2002. General Practitioners were required to declare criminal convictions and other investigations into their professional behaviour and provide references. The regulations enabled LHBs to ask practitioners applying for listing to provide a Criminal Records Bureau (CRB) Enhanced Disclosure. All practitioners applying for listing in Wales since 26 August 2002 have consented to a CRB check.

4.5 Since 1 April 2004, all GPs applying to join a LHB’s medical performers’ list have had to provide an Enhanced Disclosure as part of their application.

4.6 However, the visits we undertook to NHS Trusts and a sample of GP practices in April-May 2009 highlighted inconsistencies in the way CRB checks are undertaken across NHS Wales. We identified staff who had never had a CRB check and others for whom one had not been carried out for a number of years. Some of the staff we spoke to did not know whether they had an up-to-date CRB check and merely assumed that their employer had completed such a check without their knowledge. While it would appear that checks are undertaken for new employees there was no clear system in place to ensure checks are updated when staff change post and many staff who were employed prior to 2002 appear to have never been checked.

4.7 Further, responses to the child protection questionnaire we issued to primary care practitioners; General Practitioners (GPs), dentists, pharmacists and optometrists in October 2008 indicated that only approximately 50% of GP practices who responded to our survey had arranged for their staff to receive CRB checks. It was clear that very few dentists, pharmacists and optometrists had put a process of CRB checks in place for their staff.

4.8 Such findings are concerning given that back in 2002 Carlile reported the situation as being unsatisfactory stating that *'Many existing staff in the NHS in Wales have been police checked, but by no means all. Also, while it is common practice for professionals who are to have substantial contact with children to be police checked, policies and practice on checking many other people who work in the NHS in contact with children, including managers, clerical and administrative and ancillary workers, are much less clear'*.

**We therefore recommend that:**

*The Safeguarding Vulnerable Groups Act 2006 provides for a new Vetting and Barring Scheme to replace the existing arrangements for safeguarding children and vulnerable adults from harm or risk of harm by employees (paid or unpaid) whose work gives them significant access to these groups. The scheme went live on 12 October 2009 and all NHS organisations must ensure that they have the necessary systems and procedures in place to ensure compliance with the scheme. **Recommendation 21]***

## Suitability of the Environment of Care

4.9 The environment in which care is provided to children and young people needs to help and support their care and recovery and keep them safe. The paediatric wards we visited were found to be well equipped and furnished. However, as we reported in 2007<sup>14</sup> there continues to be a shortage of dedicated adolescent inpatient facilities with young people having to choose between staying on a children's ward or on an adult ward.

4.10 A particular issue that was brought to our attention during our visits to paediatric wards was the fact that paediatric wards tend to be mixed and this can be particularly uncomfortable for young people and their families when they reach their teenage years. Many young boys and girls at the ages of 13 and 14 are developing into young men and women and for them the issues of a mixed sex ward are the same as those for most adults.

4.11 We have found that children and young people with mental health problems are often looked after on paediatric wards which can be detrimental to the care of the young person and disruptive to his/her fellow patients as:

- Staff on paediatric wards can lack specialist training in mental health problems, such as eating disorders and self harm and in managing challenging behaviour, including practice and experience in restraining children and young people.
- Most inpatient paediatric services have told us that the support they receive from specialist Child and Adolescent Mental Health (CAMHS) staff is inadequate often leading to a lack of therapeutic support or treatment during a young person's stay on the ward.
- A number of paediatric inpatient services told us that they are concerned that staffing levels are insufficient to allow for competent observation of those young people who are likely to self harm.

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<sup>14</sup> Report of a Review of Child Protection Arrangements Across NHS Wales: Hospital Care and Commissioning, Healthcare Inspectorate Wales, March 2007

- Paediatric ward environments are often not appropriate for those who may self harm.

4.12 Often the only alternative for young people with a mental health problem is for them to be cared for on an adult mental health ward. This arrangement is far from ideal as often the staff working on adult mental health wards are not equipped to support and care for a young person with a mental health problem and have not received training in child protection issues.

**We therefore recommend that:**

*The Welsh Assembly Government revisits the recommendation we made in 2007 in relation to ensuring that age specific adolescent facilities are made available across Wales for all specialities. [Recommendation 22]*

4.13 Across Wales there are a number of examples of purpose built Accident and Emergency (A&E) Departments that have a separate entrance and facilities for children and young people to protect them from having to witness some of the traumas and behaviours that occur regularly in busy A&E departments. However, there are still some departments where children are admitted, triaged and treated alongside adults and where they are likely to witness various levels of injury and sometimes inappropriate behaviour. This is unacceptable and steps must be taken to ensure dedicated areas for the triage and treatment of children and young people are made available in all A&E departments.

**We therefore recommend that:**

*The new LHBs take steps to ensure that dedicated areas for the triage and treatment of children and young people are made available in all A&E departments. [Recommendation 23]*

## Physical Security

4.14 We found the physical security arrangements on maternity and paediatric wards to be generally good with the use of tagging systems and pressure mattress security systems for new born babies. All the paediatric wards we visited were locked with appropriate access arrangements in place.

4.15 All Trust staff were seen to be wearing visible identification badges and white boards on display in public areas were seen to be clear of patient identifiable information. Identification badges were not always worn by staff working in GP practices.

4.16 One issue of concern that has come to light as a result of our visits to adult mental health wards relates to the arrangements put in place when a child or young person wishes to visit a family member or close friend. The Guidance on the Visiting of Psychiatric Patients by Children (HCS 1999/222: LAC (99)32) states that *“Hospitals should have written policies on the arrangements about the visiting of patients by children, which should be drawn up in consultation with local social services authorities. A visit by a child should only take place following a decision that such a visit would be in the child’s best interest. Decisions to allow such visits should be regularly reviewed.”* Where such visits are agreed the hospital has a duty to ensure that the visiting child is not put at risk by arranging for the visit to take place in a room that is separate and away from the ward area.

4.17 While a number of wards visited had the necessary policies in place and displayed notices advising that children could only visit the ward if prior arrangements were made with ward staff many others didn’t. A number of staff told us that they found it very difficult to enforce any rules in relation to visits by children as relatives often turned up with them unannounced. On one of our visits we were particularly concerned to find a toddler playing in the middle of a ward on which there were particularly ill patients. The situation was unacceptable.

**We therefore recommend that:**

*All NHS and primary care contractor staff must wear visible identification badges when on duty. [Recommendation 24]*

*All mental health wards should implement a Policy for the Visiting of Psychiatric Patients by Children. [Recommendation 25]*

*Staff working on adult mental health wards must enforce child visiting policies in line with national guidance. They must ensure that when agreement has been given for a child or young person to visit that appropriate arrangements are made to ensure the comfort and safety of that child and for maintaining the privacy and dignity of other patients on the ward. [Recommendation 26]*

## **Security of Patient Information**

4.18 Unfortunately those who are intent on harming or abusing a child or young person will use any means or method to obtain information that will gain them access or advantage. It is for this reason that we reviewed the mechanisms adopted by NHS organisations and GPs to ensure the security of patient identifiable information. We found the arrangements relating to both computer and paper records to have generally improved with access to such records being restricted by password protocols and physical means such as locked strong rooms and archives.

4.19 That said we are aware of occasions when patient records have gone missing and all staff need to be vigilant and ensure that they do not leave patient records unattended during busy clinics or ward rounds.

## Chaperone Arrangements

4.20 All NHS organisations and GP practices visited had guidance in place to ensure that children and young people are appropriately chaperoned when receiving medical treatment or undergoing medical examinations. Such arrangements are key to ensuring that children and young people feel comfortable and safe when receiving care. They also protect the clinician from possible false claims of abuse.

## 5. Conclusion and next steps

5.1 We have identified some progress and improvement in relation to child protection and safeguarding arrangements across healthcare organisations since our last full review undertaken in 2007. We found staff to be generally alert to child protection issues and aware of the appropriate reporting and escalation procedures. However, some staff working in adult services still appear to not accept that they also have a role in child protection.

5.2 The sharing of information continues to be the biggest issue and it is clear that there is still a lot of work to be undertaken in this area. Organisations need to be clear about when and how information is shared. They need to understand that the safety and welfare of children and young people is of the utmost importance; patient confidentiality should not be used as a barrier to protecting and safeguarding them.

5.3 Sadly, few of the findings and recommendations set out in this report will be new to most of those who read it. Many of the issues and concerns have been raised in our previous reports and some go back to the Carlile report published in 2002. We can't help but share the frustration Lord Laming expresses in his latest report when he states

***'The utility of the policy and legislation has been pressed on me by contributors throughout this report. In such circumstances it is hard to resist the urge to respond by saying to each of the key services, if that is so "NOW JUST DO IT".'***

5.4 We will require all those organisations and agencies, for which we have made recommendations for improvement in this report, to prepare an action plan setting out how they intend to take the recommendations forward. These action plans will be monitored as part of the performance management arrangements for these organisations.



### **Summary of work taken forward by HIW since 2007 relevant to child protection and safeguarding issues in Wales**

#### **March 2007**

We published our report of a Review of Child Protection Arrangements across NHS Wales: Hospital Care and Commissioning in March 2007.

#### **August 2007**

We published our all-Wales report of a review of maternity services. This was the most comprehensive assessment of maternity services to be undertaken in Wales.

#### **December 2007**

We published our outcome report of learning disability services provided in Wales. The aim of the review was to ensure that services were safe and meeting the needs of those individuals with a learning disability, their carers and families.

#### **October 2008**

We issued Child Protection questionnaires to the child protection lead in all Local Health Boards (LHBs) in Wales for completion by primary care contactors including GPs, dentists, opticians and pharmacies. The questionnaire tested the level of engagement by LHBs and the application of child protection guidance by all types of primary care providers.

#### **March 2009**

As part of the annual Healthcare Standards assessments, we undertook unannounced visits to all former NHS Trusts, Powys LHB and a sample of GP practices. The purpose of these visits was to validate and test compliance and performance against the Healthcare Standard 17 (among others) by looking at how care is delivered to patients and service users.

Standard 17 states that '*Healthcare organisations comply with national child protection and vulnerable adult guidance within their own activities and in their dealings with other organisations.*'

The Healthcare Standards Annual Assessments we undertook in 2007 and 2008 also looked at compliance with Standard 17.

### **August 2009**

We published our report entitled Substance Misuse Services: All Wales Review of Substitute Prescribing Services. This review picked up a number of issues regarding child protection and information sharing.

### **Child and Adolescent Mental Health Services**

During 2007-08 we completed fieldwork to gather the views and experiences of children, adolescents and their parents when accessing CAMHs services.

## Appendix B

As part of our Healthcare Standards Assessment, the following departments and wards were visited during April and May 2009.

### **Abertawe Bro Morgannwg University NHS Trust:**

- The Accident and Emergency (A&E) Department at the Princess of Wales Hospital.
- Minor Injuries Unit at Neath Port Talbot Hospital.
- The Paediatric Wards at Singleton Hospital and the Princess of Wales Hospital.
- The Elderly Mental Health Wards at Glanrhyd, Tonna and Maesteg Community Hospitals.
- The Acute Medicine Ward at the Princess of Wales Hospital.
- The Medical Admissions Unit at Neath Port Talbot Hospital.

### **Cardiff & Vale NHS Trust:**

- The Accident and Emergency (A&E) Department at the University Hospital of Wales (UHW) and Minor Injuries Unit at Barry Hospital.
- The Paediatric Wards at the UHW and Llandough Hospital.
- The Elderly Mental Health Wards at St. David's and Barry Hospitals.
- The Medical Admissions Units (MAU) at the University Hospital of Wales (UHW) and Llandough Hospital.
- SKY Ward at the UHW Children's Hospital.
- The Elderly Medical Ward E6 and Medical Ward W1 at Llandough Hospital.
- Medical Ward C7 at UHW

### **Cwm Taf NHS Trust:**

- The Accident and Emergency (A&E) Departments at Royal Glamorgan and Prince Charles' hospitals.
- The Minor Injuries Units at Llwynypia and Aberdare hospitals.
- The Paediatric Wards at Royal Glamorgan and Prince Charles' hospitals.
- The Elderly Mental Health Ward at Dewi Sant and St Tydfil's hospitals.
- The General Medical Ward at Prince Charles' hospital.
- The Medical Assessment units at Royal Glamorgan and Prince Charles' hospital.
- The Cardiac Ward at Royal Glamorgan hospital.

### **Gwent Healthcare NHS Trust:**

- The A&E Departments at Caerphilly Miners Hospital, the Royal Gwent Hospital and Nevill Hall Hospital.
- The MIU departments at County Hospital, Chepstow Community Hospital and Monnow Vale Health and Social Care Centre.
- The Paediatric Inpatient Wards at the Royal Gwent Hospital and Nevill Hall Hospital.
- The Elderly Mental Health Wards at Chepstow Community Hospital, Maindiff Court Hospital, County Hospital Pontypool, St Woolos Hospital and Ystrad Mynach Hospital.
- The Acute Medicine Wards at Nevill Hall Hospital, the Royal Gwent Hospital and Caerphilly Miners Hospital.

### **Hywel Dda NHS Trust:**

- The Accident and Emergency (A&E) Departments at: West Wales General Hospital, Prince Phillip Hospital, Withybush General Hospital, Bronglais General Hospital.

- The Paediatric Wards at: West Wales General Hospital (Kilgerran Ward), Withybush General Hospital (Ward 9), Bronglais General Hospital (Angharad Ward).
- The Elderly Mental Health Wards at: West Wales General Hospital (Morlais Ward), Prince Phillip Hospital (Bryngolau Ward), Bronglais General Hospital (Enlli Ward) and Bro Cerwyn Hospital (St Nons Ward),
- The Acute Medical Wards at: West Wales General Hospital (Steffan Ward), Bronglais General Hospital (Iorwerth Ward), Withybush General Hospital (Ward 7 and the Acute Clinical Decision Unit),
- The Minor Injuries Units at: Llandovery Hospital, Tenby Cottage Hospital, South Pembrokeshire Hospital and Cardigan Memorial & District Hospital.

#### **North West Wales NHS Trust:**

- The Accident and Emergency (A&E) Departments at: Ysbyty Gwynedd.
- The Paediatric Wards at Ysbyty Gwynedd.
- The Elderly Mental Health Wards at Ysbyty Gwynedd, Penrhos Stanley Hospital and Llandudno Hospital.
- The Acute Medical Wards at Ysbyty Gwynedd, and Llandudno Hospital.
- The Minor Injuries Units at Llandudno Hospital and Penrhos Stanley Hospital.

#### **North Wales NHS Trust:**

- The Accident and Emergency (A&E) Departments at Wrexham Maelor and Ysbyty Glan Clwyd.
- The Medical Assessment Units at Wrexham Maelor and Ysbyty Glan Clwyd.
- The Paediatric/Children's Wards at Wrexham Maelor and Ysbyty Glan Clwyd.

- The Acute Medical Wards at Wrexham Maelor and Ysbyty Glan Clwyd.
- The Elderly Mental Health Wards at Wrexham Maelor, Ysbyty Glan Clwyd, Glan Traeth (Rhyl).
- The Holywell Hospital, Flint Hospital, Denbighshire Infirmary and Ruthin Community Hospital.
- The Minor Injuries Unit at Holywell Hospital, Flint Hospital, Mold Hospital, Denbighshire Infirmary and Ruthin Community Hospital.

**Cancer Centre of the Velindre NHS Trust:**

- The Princess Margaret, Chemotherapy Ward.
- The First Floor Ward (General Oncology).
- The Acute Support Unit (Palliative Care and Oncology).
- The Outpatients Department (OPD).
- Ambulance Patient Transport Reception (within OPD).

### Summary of Recommendations

#### **Recommendation 1**

The structures and arrangements to be put in place across the new health service structures to support the child protection agenda are clarified as a matter of urgency. These arrangements need to take full account of the requirements of the Children Act 2004 and the recommendations arising from Lord Laming's report of March 2009.

#### **Recommendation 2**

Child protection training is made mandatory for all staff groups. Update training should be provided at least every 3 years. The Welsh Assembly Government should ensure that all nationally agreed contracts reflect this requirement.

#### **Recommendation 3**

The new LHBs further engage with primary care contractor groups to ensure they receive the necessary training and support in respect of child protection and safeguarding.

#### **Recommendation 4**

Service providers put policies in place that are in line with the All Wales Child Protection Procedures to ensure staff are aware and understand all safeguarding policies and procedures and their relevance to their area of work.

**Recommendation 5**

Community Safety Partnerships (CSPs) review all service level agreements to ensure that statutory requirements in relation to safeguarding are included and that review mechanisms are in place to demonstrate compliance by providers.

**Recommendation 6**

CSPs ensure robust and well managed family centred, substance misuse care pathways into and out of children and family services.

**Recommendation 7**

CSPs ensure that information sharing agreements are in place for their local area and that these cover the protection of vulnerable people.

**Recommendation 8**

All assessment, Care Programme Approach (CPA) monitoring, review, and discharge planning documentation and procedures should prompt staff to consider if the service user is likely to have or resume contact with their own child or other children in their network of family and friends, even when the children are not living with the service user.

**Recommendation 9**

If the service user has or may resume contact with children, this should trigger an assessment of whether there are any actual or potential risks to the children, including delusional beliefs involving them, and drawing on as many sources of information as possible, including compliance with treatment.

**Recommendation 10**

Referrals should be made to children's social care services under local safeguarding procedures as soon as a problem, suspicion or concern about a child becomes apparent, or if the child's own needs are not being met.

A referral must be made: If service users express delusional beliefs involving their child and/or if service users might harm their child as part of a suicide plan.

**Recommendation 11**

Staff working in mental health services should be given clear guidance on how to make such referrals, including information sharing, the role of their organisation's designated lead for child protection, and what to do when a concern becomes apparent outside normal office hours.

**Recommendation 12**

A consultant psychiatrist should be directly involved in all clinical decision making for service users who may pose a risk to children.

**Recommendation 13**

Safeguarding training that includes the risks posed to children from parents with delusional beliefs involving their children or who might harm their children as part of a suicide plan is an essential requirement for all staff. Attendance, knowledge, and competency levels should be regularly audited, and any lapses urgently acted on.

**Recommendation 14**

All CAHMS teams should work with their LSCB to develop information sharing protocols. These protocols should set out clearly the type of information that should be shared, the circumstances in which information should be shared and the relevant agencies with whom it should be shared.

**Recommendation 15**

New LHBs ensure that at least one member of staff trained in paediatric medicine and child protection is on duty in A&E departments at all times.

**Recommendation 16**

All LHBs should where there are concerns about a child attending A&E (including to minor injuries units) follow the All Wales Child Protection Procedures and the child's health visitor/school nurse and GP notified.

**Recommendation 17**

The Welsh Assembly Government takes further steps to ensure that the profile and level of expertise for child protection within GP practices is raised.

**Recommendation 18**

The Welsh Assembly Government puts national arrangements in place to ensure that A&E attendance records and Child Protection registers are shared between A&E departments.

**Recommendation 19**

The new LHBs continue to work towards the amalgamation of children's records and ensure that a project plan and timetable are put in place. Trusts should set a clear deadline for when they expect to complete this work.

**Recommendation 20**

All GP practices across Wales should ensure that they comply with 'A Guide for Safeguarding Children and Young People in General Practice' issued by the National Public Health Service in 2007.

The new LHBs ensure that local information sharing protocols comply with the All Wales Child Protection Procedures and clearly set out the arrangements for sharing information between primary care and social service departments.

**Recommendation 21**

The Safeguarding Vulnerable Groups Act 2006 provides for a new Vetting and Barring Scheme to replace the existing arrangements for safeguarding children and vulnerable adults from harm or risk of harm by employees (paid or unpaid) whose work gives them significant access to these groups. The scheme went live on 12 October 2009 and all NHS organisations must ensure that they have the necessary systems and procedures in place to ensure compliance with the scheme.

**Recommendation 22**

The Welsh Assembly Government revisits the recommendation we made in 2007 in relation to ensuring that age specific adolescent facilities are made available across Wales for all specialities.

**Recommendation 23**

The new LHBs take steps to ensure that dedicated areas for the triage and treatment of children and young people are made available in all A&E departments.

**Recommendation 24**

All NHS and primary care contractor staff must wear visible identification badges when on duty.

**Recommendation 25**

All mental health wards should implement a Policy for the Visiting of Psychiatric Patients by Children.

**Recommendation 26**

Staff working on adult mental health wards must enforce child visiting policies in line with national guidance. They must ensure that when agreement has been given for a child or young person to visit that appropriate arrangements are made to ensure the comfort and safety of that child and for maintaining the privacy and dignity of other patients on the ward.



### Glossary of Key Terms

**Accident and emergency (A&E)** - the branch of medicine concerned with the immediate treatment of patients who have had an accident or who require medical or surgical emergency care.

**Adolescents** - young people between the ages of 12 and 18.

**Area Child Protection Committee (ACPC)** - the ACPC is an inter-agency forum for agreeing how the different services and professional groups should co-operate to safeguard children in that area, and for making sure that arrangements work effectively to bring about good outcomes for children.

**Audit** - the continual evaluation and measurement by professionals of the standards they are achieving.

**Care Pathway** - a defined set of treatment and care steps designed to meet the particular need of each patient.

**Child and Adolescent Mental Health Services (CAHMS)** - a team of people from different professions who offer a variety of therapies to help young people who are experiencing mental health problems.

**Child Protection Service/National Public Health Service (CPS/NPHS)** - the Child Protection Service / National Public Health Service team provides the strategic lead within the NHS in Wales ensuring the health service in Wales recognises its obligations under the Children Act 1989 for child protection and looked after children.

**Child Protection Register** - the child protection register is a confidential register of children living in a local authority area where an interagency child protection conference has decided they are at continuing risk of significant harm.

**Clinical Audit** - evaluation and measurement by health professionals of how far they are meeting standards that have been set for their service. Standards may be set by health professional's themselves or others.

**Clinical Governance** - a "framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish" (Welsh Office: 'Quality Care and Clinical Excellence').

**Clinical Information** - (1) information about treatments given to a patient by a health professional. (2) information about clinical practice collected by an organisation for management purposes.

**Clinicians / Clinical Staff** - a fully trained health professional – doctor, nurse, therapist, technician etc.

**Clinical Supervision** - a formal process of professionals support and learning which enables individual practitioners to develop practice and enhance patient protection and safety of care in complex clinical situations.

**Commissioning** - the purpose of identifying local health needs, drawing up plans with strategic partners to meet those needs, identifying appropriate health services and making agreements with health service providers to ensure that services are delivered.

**Commission for Health Improvement (CHI)** - an independent national body covering England and Wales to support and oversee the quality of clinical governance in NHS clinical services. CHI was dissolved in March 2004.

**Criminal Records Bureau (CRB)** - an executive agency set up to help organisations make safer recruitment decisions by providing wider access to criminal record information. The CRB helps employers in the public, private and voluntary sectors identify candidates who may be unsuitable for certain work, especially that involving contact with children or other vulnerable members of society.

**Data Protection** - a requirement upon public bodies and others to act responsibly in managing personal data. Such responsibilities are covered by the Data Protection Act 1984 and the Computer Misuse Act 1990, designed to safeguard data held on individuals.

**General Practitioners (GPs)** - medically qualified practitioners who provide healthcare in the community.

**Healthcare Standards** - nationally agreed standards for healthcare providers to achieve.

**Health Commission Wales (HCW)** - an executive agency of the Welsh Assembly, responsible for commissioning of specialised services and the provision of support to LHBs in the commissioning of acute services. A third role of providing independent advice in relationship to difficult service issues in NHS Wales.

**Human Resources (HR)** - the branch of management practice dedicated to recruitment of staff.

**Information Management and Technology (IM&T)** - the structures and systems through which an organisation manages data, information and knowledge to address the challenges it faces in providing services and ensure high quality outcomes.

**Informing Healthcare** - an information strategy commissioned by the Welsh Assembly Government to contribute directly to the achievement of 'Improving Health in Wales'.

**Learning Disability** - a term covering people with incomplete intellectual development who find some activities that involve thinking and understanding difficult and who need additional help and support with their everyday lives. People with learning disabilities have difficulties understanding, learning and remembering new things, and in generalising any learning to new situations.

**Local Authority** - a local government body that is responsible for delivering public services to the people in its community. There are 22 local authorities in Wales and they share the same boundaries as Local Health Boards.

**Local Health Boards (LHB)** - statutory bodies responsible for implementing strategies to improve the health of the local population, securing and providing primary & community health care services and securing secondary care services.

**Local Safeguarding Children Boards (LSCB)** - the Children Act 2004 requires each local authority in Wales to establish a Local Safeguarding Children Board for their area, which brings together representatives of each of the main agencies and professionals responsible for helping to protect children from abuse and neglect.

**Looked After Children (LAC)** - children for whom a local authority has responsibility, who may have to live away from their own homes and are cared for by local authority social services department.

**Lord Carlile's Report** - Too Serious a Thing: The Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales by Lord Carlile was published in March 2002. The review followed the inquiry by Sir Ronald Waterhouse into the abuse of children in care in the former county council areas of Gwynedd and Clwyd.

**National Health Service (NHS) Trusts** - a self-governing body within the NHS, which provides health services. Trusts employ a full range of healthcare professionals including doctors, nurses, dieticians, physiotherapists etc. Acute trusts provide medical and surgical services usually in hospital(s). Community Trusts provide local health services, usually in the community, e.g. district nurses, chiropodists etc. Combined trusts provide both community and acute services under one management.

**National Public Health Service (NPHS)** - an NHS body bringing together the public health resources of the five former health authorities in Wales, which includes input from academic departments, with those of the Public Health Laboratory Service in Wales, which includes the Communicable Disease Surveillance Centre.

**National Service Framework (NSF)** - guidelines for the health service on how to manage and treat specific types of disease and illness.

**NHS Direct Wales** - telephone help line providing health advice and information.

**Patient Involvement** - the amount of participation that a patient can have in her/his care or treatment. It is often used to describe how patients can change, or have a say in the way that a service is provided or planned.

**Primary Care** - family health services provided by GPs, dentists, pharmacists, opticians, and others such as community nurses, physiotherapists and some social workers.

**Protected Time** - for child protection named health professionals, this refers to sufficient time to fulfil their Trust strategic child protection responsibilities effectively.

**Quality Outcomes Framework (QOF)** - rewards primary care teams for providing good quality care for their patients. The QOF has four “domains”: clinical, organisational, patient experience and additional services. Each domain is divided into areas (ten clinical, five organisational, two patient experiences and four additional service areas) that are then further divided into individual indicators or standards in the four domains, each of which has a number of points allocated to it. The points in the original QOF reflect the amount and difficulty of the work required by the primary care team, in the area.

**Secondary Care** - specialist health care, usually provided in hospital after a referral from a GP or health professional.

**Serious Case Review** - The Local Safeguarding Children Boards (Wales) Regulations 2005 require that when a child dies, and abuse or neglect are known or suspected to be a factor in the death, the LSCB should conduct a review into the involvement of agencies and professionals with the child and family

**Social Services** - the agency responsible for delivering personal care and support that is funded by local authorities.

**Stakeholders** - a range of people and organisations that are affected by, or have an interest in, the services offered by an organisation, in relation to health services includes, for example: patients, carers, staff, unions, voluntary organisations, community health councils, social services.

**The Victoria Climbié Inquiry Report** - Lord Laming chaired the inquiry into the death of Victoria Climbié and authored the report, which was published in January 2003.

**Trust Board** - a group of people who are by statute responsible for major strategy and policy decisions in each NHS Trust. Typically comprises a lay chairman, five lay members, the Trust chief executive and executive directors.

**Welsh Health Circular** - a formal notice distributed by the Welsh Assembly Government for NHS and other interested officials.