<table>
<thead>
<tr>
<th><strong>Purpose and Summary of Document:</strong></th>
<th>This introduces a new strategic quality outcomes framework for safeguarding children across the NHS in Wales for implementation by Local Health Boards and NHS Trusts in Wales.</th>
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<tbody>
<tr>
<td><strong>Author:</strong></td>
<td>Safeguarding Children Service and Safeguarding Children NHS Network</td>
</tr>
<tr>
<td><strong>Date:</strong></td>
<td>July 1st</td>
</tr>
<tr>
<td><strong>Version:</strong></td>
<td>Final</td>
</tr>
<tr>
<td><strong>Publication/Distribution:</strong></td>
<td>Local Health Boards and NHS Trusts</td>
</tr>
<tr>
<td><strong>Review Date:</strong></td>
<td>Final. Review Date April 2014</td>
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Introduction

In his report Safeguarding and Protecting Children in NHS Wales (Cardiff University, 2010) Professor Sir Mansel Aylward identified the need for robust monitoring and evaluation in order to improve and develop services. This led to the recommendation:

Evaluation of the efficiency and efficacy of child protection and safeguarding arrangements and interventions must rest on outcome-based monitoring. This is an area that requires further attention. Consideration should be given to the inauguration of a National outcomes development and quality assurance group to establish standards, to set tangible objectives and to drive improvement on an all-Wales basis (Rec 6.16)

The acceptance of this recommendation by Welsh Government has driven the development of this framework by the Safeguarding Children Service, Public Health Wales working with all LHBs and Trusts across the Safeguarding Children NHS Network.

The effectiveness of health services in safeguarding children and young people is difficult and complex. The Outcome Based Accountability™ (OBA™) model, informed by the work of Mark Friedman has been used to develop this performance framework for implementation by Local Health Boards and NHS Trusts to self assess how well they are contributing to the delivery of good outcomes for children and young people in respect of safeguarding duties and responsibilities. This has involved identifying desirable outcomes for children and young people, agreeing the performance measure and developing a range of performance indicators and drawn upon other safeguarding audits including the reporting on Section 28 for Local Safeguarding Children Boards. Where possible indicators have been developed that:

- Are relevant to safeguarding and the NHS
- Measure outcomes for children where possible
- Are supported by evidence
- Can be analysed to tell the story
- Assess the quality of services not just the activity
- Support discussion and the need for further investigation or improvement to develop solutions.

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1 Also known as Results Based Accountability™ or RBA™
This outcome based framework has been structured to have 2 parts.

Part 1 is concerned with general measures required to audit the efficiency and effectiveness of health services in safeguarding children in respect of the provision of services, prevention from harm, protection and participation.

Part 2 is concerned with issues of current interest or concern. For this first framework this has been informed by statistical data concerning children in need (Wales Children in Need Census, Feb 2012, Welsh Government).

The intention is for the framework to be dynamic with regular review. This will ensure that the process provides a helpful evaluation of the efficiency and efficacy of child protection and safeguarding arrangements and interventions. It should also help to identify those areas in need of further development and support in finding common solutions. In so doing this will drive up practice.

The purpose of this initial framework is to gather benchmarking data. Implementation will also enable the framework to be tested for its fitness for purpose in delivering good quality information for use by Local Health Boards and Trusts.

**Implementation**

This self assessment framework should used by NHS Local Health Boards and Trusts to assess ‘how well they are doing’ in meeting the desired outcomes for children.

Evidence required for some performance indicators may be readily available and routinely collated in order to inform other audits, for example the Section 28 audit. For other areas this may be more challenging and systems may not be fully in place to capture data. In going forward, the indicators will be reviewed year on year to ensure that good quality information is accessible and data consistent in informing Health Boards and Trusts of their progress.

The RAG status is defined as:

Red: This outcome is recognised by Health Boards/Trusts, some thought has been given to achieving this but there is no active work taking place.
Amber: The Health Board/Trust is actively working towards achieving this;

Green: This outcome has been achieved, is being maintained/developed and is contributing to improved cooperation and effectiveness of safeguarding;

The self assessment should be completed by **November 1st 2013**. On completion, the Safeguarding Children Service, Public Health Wales will collate and analyse the findings. These will be considered with the Safeguarding Children NHS Network and inform a programme of work to address areas of practice requiring a common solution.
### What does good look like?

### How will we know if we are making a difference?

### How can we measure success in this?

### How are we doing on this now? Report on:

<table>
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<tr>
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#### Part 1.

1. **NHS Wales provides a safe child centred culture in the provision of services**

1.1 Children are cared for by health care staff who have been subject to safe recruitment processes.

   - Policy for recruitment and selection in place assists managers and staff in line with latest guidance:
     - 100% staff recruited in line with criteria within guidance.
   - Audit policy implementation and sample compliance with CRB checking.
   - Completion of $$.28 audit.

   - Audit 10% of total number of new LHB/Trust staff recruited and 10% GP practices 1 April 2012 - 31 March 2013 receiving correct CRB check on appointment.
   - Ref $$.28 audit findings.

1.2 Staff caring for children have access to interpreter services.

   - The process in place for access to interpreter services is used by health staff.

   - Measure use of
     - language line
     - other interpreter services

1.3 Children and young people are cared for by health professionals who adhere to professional standards of conduct.

   - Reducing numbers of allegations concerning professional misconduct against children or young people.

   - Measure the number of concerns raised in respect of professional conduct.

   - Numbers of referrals made to children’s social services in respect of allegations of professional abuse by an employee or contracted independent health professional between 1 April 2012 – 31 March 2013.
   - % of these reported to Independent Safeguarding Authority.
What does good look like? | How will we know if we are making a difference? | How can we measure success in this? | How are we doing on this now? | RAG Status
---|---|---|---|---
1.4 Children who may have been abused or neglected receive medical assessments under the AWCPP. | Standards with timescales for provision of specialist services in place. | Audit against Standard 10 Facing the Future 2, RCPCH. | Findings from audit:  - number of children referred for medical assessments in age groups.  - % offered service that met with standards |  

1.5 Children and young people requiring admission to hospital are admitted to children’s wards. | All young people receive services appropriate to their needs as children. | Audit secondary care admission pathway of children and young people aged 16 years and younger. | From 1st April 2012 – 31 March 2013  - numbers and length of stays of children and young people admitted to adult mental health wards.  - numbers and length of stays of children and young people admitted to acute adult medical/surgical wards. |  

2. NHS Wales actively prevents harm to children and young people

2.1 The needs of children and young people are a priority within the organisation. | Annual Safeguarding Reports provided to the Board. | Evidence of annual safeguarding reporting. | Date of annual report to Board.  - Evidence of decision making following receipt by Board of report for 2011 – 2012. |  

2.2 Governance arrangements for safeguarding are clear and the identified Board lead for safeguarding is known across the organisation. |  | Audit of arrangements. | Evidence of organisational chart (inc Exec and  

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<tr>
<td>are made known to staff.</td>
<td>the organisation.</td>
<td></td>
<td>Independent members) made available to all staff.</td>
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<tr>
<td></td>
<td>- Named Professionals are in substantive posts.</td>
<td></td>
<td>Sample audit 10% of practices to determine:-</td>
<td></td>
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<td></td>
<td>- Safeguarding lead for individual GPs and dental practices.</td>
<td></td>
<td>- % of GP practices with named lead.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Safeguarding role specified in all healthcare staff job descriptions.</td>
<td></td>
<td>- % of dental practices with named lead.</td>
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<td></td>
<td></td>
<td></td>
<td>- % of new employment contracts where obligations or responsibilities for safeguarding is included. (consider in HR audit for 1.1)</td>
<td></td>
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<tr>
<td>2.3 Health care staff are trained to an appropriate level of safeguarding.</td>
<td>Staff receive an appropriate level of training through implementation of the Intercollegiate recommendations. Training data included in Annual Report to the Board.</td>
<td>System in place to record staff training. Evidence that independent contractors have received appropriate level of training. Gaps in training provision identified.</td>
<td>Data from 1 April 2012 – 31 March 2013</td>
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<tr>
<td></td>
<td></td>
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<td>- % LHB/Trust staff trained at induction.</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>- numbers of employed staff accessing LHB/Trust Level 2 training and Level 3 training.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- audit sample of 10% GP practices to determine compliance with required training at Level 2/Level 3.</td>
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<tr>
<td>2.4 The organisation learns from complaints/concerns received in respect of children and young people.</td>
<td>Reducing numbers of complaints/concerns in relation to the themes.</td>
<td>Themes from complaints/concerns are shared within the organisation and safeguarding concerns included in the Annual Safeguarding Report to the Board. Learning has been identified and appropriate actions taken.</td>
<td>1 April 2012 – 31 March 2013.</td>
<td>% Board members received training within an appropriate timescale.</td>
</tr>
<tr>
<td>2.5 The organisation supports learning from the deaths of children and young people.</td>
<td>The organisation complies with the principles set out in PRUDIC</td>
<td>Evidence of health service contribution to the PRUDIC.</td>
<td>1 April 2012 – 31 March 2013.</td>
<td>Numbers of PRUDIC information sharing and planning meetings held from 1 April 2012 – 31 March 2013</td>
</tr>
<tr>
<td>3. NHS Wales protects children and young people from harm</td>
<td>Consistent representation of senior lead officer at Safeguarding Children Board, engagement, with work programme and allocation of resources. The LHB/Trust is fully compliant with Child Practice Review process.</td>
<td>Feedback from the Chair of the LSCB. Completion of S.28 audit. Evidence of health service commitment in delivery of work programme.</td>
<td>Completion of S.28 audit.</td>
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</tr>
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<tr>
<td><strong>3.2 Health care staff respond to child welfare concerns and fully participate in child protection processes.</strong></td>
<td><strong>Staff implement the All Wales Child Protection Procedures 2008 for raising concerns/issues in respect of safeguarding children and young people.</strong></td>
<td><strong>Audit child protection processes.</strong></td>
<td><strong>1 April 2012 – 31 March 2013.</strong></td>
</tr>
<tr>
<td><strong>- % conferences with appropriate representation from health service</strong></td>
<td><strong>- % conferences with provision of required reports from health services.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3.3 Children, YP and their families are cared for by staff who have access to advice and guidance at all times when responding to safeguarding concerns.</strong></td>
<td><strong>Supervision process is in place and clinical and non clinical advice and guidance is available at all times for staff caring for children and their families.</strong></td>
<td><strong>A supervision policy is in place and implementation audited.</strong></td>
<td><strong>- % of health visitors accessing safeguarding supervision.</strong></td>
</tr>
<tr>
<td><strong>- % of school health nurses accessing safeguarding supervision.</strong></td>
<td><strong>- % of paediatricians attending peer review.</strong></td>
<td><strong>- Availability of clinical supervision.</strong></td>
<td></td>
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### 4. NHS Wales seeks and supports participation

<table>
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<th><strong>How are we doing on this now?</strong></th>
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<tr>
<td><strong>4.1 The views of children and families are sought and acted upon.</strong></td>
<td><strong>Evidence of consultation processes and action planning.</strong></td>
</tr>
<tr>
<td><strong>Mechanism in place to capture views of children and families.</strong></td>
<td><strong>Evidence of commissioning of advocacy service.</strong></td>
</tr>
<tr>
<td><strong>- An advocacy service is provided for C&amp;YP.</strong></td>
<td><strong>Evidence of use of advocacy service.</strong></td>
</tr>
<tr>
<td><strong>- Organisational policies, procedures and protocols</strong></td>
<td></td>
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## What does good look like?

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<tr>
<td>have considered their impact on safeguarding children &amp; the UNCRC in their development.</td>
<td></td>
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## Part 2.

**NHS Wales contributes to the safeguarding of vulnerable children**

### 5. Children living in an environment where there is domestic abuse* are safeguarded. (*known to health services)

<table>
<thead>
<tr>
<th>5.1. Children identified as living in these circumstances can be identified by health professionals.</th>
<th>Routine enquiry is universally applied:</th>
<th>Sample audit against standards of routine enquiry.</th>
<th>Sample audit 10% of new clients from 1 April – 31 March 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine enquiry is universally applied:</td>
<td>- maternity services</td>
<td>- % of enquiries made in:</td>
<td>Sample audit 10% of new clients from 1 April – 31 March 2013</td>
</tr>
<tr>
<td>- Health visitors</td>
<td></td>
<td>- % of enquiries made in:</td>
<td>Sample audit 10% of new clients from 1 April – 31 March 2013</td>
</tr>
<tr>
<td>- Unscheduled care</td>
<td></td>
<td>- % of enquiries made in:</td>
<td>Sample audit 10% of new clients from 1 April – 31 March 2013</td>
</tr>
<tr>
<td>- Sexual health services</td>
<td></td>
<td>- % of enquiries made in:</td>
<td>Sample audit 10% of new clients from 1 April – 31 March 2013</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5.2. Children and young people are cared for by staff who are aware of impact of DA on children.</th>
<th>Where DA has been identified, there is evidence that the needs of children have been considered.</th>
<th>Audit of the implementation of the Domestic Abuse Policy.</th>
<th>Sample audit 10% GP practices</th>
</tr>
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<td>Where DA has been identified, there is evidence that the needs of children have been considered.</td>
<td>Audit of the implementation of the Domestic Abuse Policy.</td>
<td>Sample audit 10% GP practices</td>
<td>Sample audit 10% GP practices</td>
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### 5.3. Health professionals share appropriate information in a multi-agency context.

<table>
<thead>
<tr>
<th>Health professionals fully engage in multi-agency processes.</th>
<th>Engagement of health professionals in processes.</th>
<th>Sample audit 10% GP practices</th>
<th>Sample audit 10% GP practices</th>
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<td>Sample audit 10% GP practices</td>
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### 5.1. Children identified as living in these circumstances can be identified by health professionals.

- Maternity services
- Health visitors
- Unscheduled care
- Sexual health services

### Sample audit 10% of new clients from 1 April – 31 March 2013

- % of enquiries made in maternity services.
- % of health visiting services
- Evidence of routine enquiries being made in:
  - Unscheduled care
  - Sexual health services

### 5.2. Children and young people are cared for by staff who are aware of impact of DA on children.

Where DA has been identified, there is evidence that the needs of children have been considered.

### Audit of the implementation of the Domestic Abuse Policy.

- % of GPs using read codes for DA.

### Engagement of health professionals in processes.

- % health professional attendance at MARACs between 1 April 2012 – 31
6. Children living in an environment are safeguarded where mental ill health* is impacting on parental capacity. (* known to health services)

<table>
<thead>
<tr>
<th>6.1 Health professionals providing care to adult patients, give consideration to the patients’ role as a carer of children.</th>
<th>All mental health assessments identify whether the patient is the carer of a child.</th>
<th>Where appropriate, there is evidence of liaison between adult and child health workers.</th>
<th>Sample 10% of patient records new to the service within the previous 12 months.</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>- % evidence of children being considered.</td>
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<td></td>
<td></td>
<td></td>
<td>- % evidence of name of childrens’ services worker (Health or other agency) recorded.</td>
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<td></td>
<td></td>
<td></td>
<td>- % of GPs using read codes for adult mental health</td>
</tr>
</tbody>
</table>

7. Children living in an environment are safeguarded where alcohol or substance is impacting on parental capacity. (* known to health services)

<table>
<thead>
<tr>
<th>7.1 Health professionals providing care to adult patients, give consideration to the patient’s role as a carer of children.</th>
<th>All adult substance misuse health assessments identify dependent children.</th>
<th>Audit of records to determine:</th>
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<tr>
<td></td>
<td></td>
<td>- where patients have parental responsibility, a plan is in place;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- evidence of liaison between adult substance misuse health teams and child health or other services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sample 10% of patient records new to the service within the previous 12 months.</td>
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<td></td>
<td>- % evidence of name of childrens’ services worker (Health or other agency) recorded.</td>
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<tr>
<td></td>
<td></td>
<td>- % of GPs using read codes for SM.</td>
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</table>

8. Children who are looked after are safeguarded
8.1 Health professionals meet the identified health needs of children who are looked after.

| Targeted health services in place to assess the health needs of children looked after. |
|荷花 tracking’ to services for children in need and who are looked after. |

| Recognition of health needs. |
| Recognition of health needs identified in health plans. |

| Identification of gaps in service provision (to be included in report to Boards). |

| - % of LAC allocated health care professional to oversee health care plan. |
| % of LAC receiving health care assessments within timescales. |

| - % of LAC up to date with immunisations |
| % of LAC registered with a GP within standard timescales. |

| - % of LAC registered with dentist within standard timescales. |