
# Portsmouth Safeguarding Children Partnership

# Response to the Recommendations from the Serious Case Review of Child H

The case was considered by the Portsmouth Safeguarding Children Board (now called the Portsmouth Safeguarding Children Partnership) at its Learning from Cases Committee in August 2018. The PSCB commissioned a Serious Case Review to examine issues concerning the welfare of Child H and the lessons to be learnt to improve experiences for children in similar circumstances in the future. This included the degree to which decisions were child focused and the effectiveness of working arrangements across agencies and services.

The full findings of the Serious Case Review are set out in the Overview Report that has been published in full alongside this response.

This document provides the response from the Partnership to the findings made in the Child H report. It outlines the recommendations made to address the review's findings; outlines the action which has already been taken; and comments upon what more will be done. All of this work has been and will continue to be monitored by the PSCP Monitoring Evaluation and Scrutiny Committee and the Executive Committee. Recommendations have been identified for the Partnership, or for specific partner agencies as identified below.

**Recommendation 1**

To ensure the learning from this Review is disseminated across the multi-agency safeguarding partnership to practitioners and managers.

**Action taken:**

When the PSCP publishes a learning review of any kind, we create a summary briefing sheet to accompany the report. This will provide a shorter version of key learning points. In addition to this, the PSCP training team will embed key areas for learning within their existing training programme. The content for all PSCP training courses is continuously updated and refreshed to include the most recent lessons from all quality assurance activity, including Serious Case Reviews.

The PSCP will also ensure that the report and accompanying documents are widely distributed to all partner organizations and we will request that the information is disseminated through management to front line practitioners.

**Recommendation 2**

To seek assurance that the actions identified by each partner agency, as a result of this Review, have been managed, implemented and embedded in a timely manner.

**Action taken:**

The PSCP and partner organisations will develop an action plan in response to the recommendations of this report. The Monitoring Evaluation and Scrutiny Committee reviews all actions on a quarterly basis. This group has devolved responsibility for ensuring that actions are not only achieved, but change is embedded and impact is assessed.

This group will also feed back to the PSCP Executive Committee on a regular basis with updates on progress.

**Recommendations 3 and 5**

The Safeguarding Partnership to promote and increase knowledge across all services in the Portsmouth area about the different processes through which concerns about a child's welfare

might be managed, with clear explanations about the differences between Early Help, Child in Need and Child Protection processes, the potential cross-over points and threshold continuum. This should include a clear outline about what is to be expected from Children's Social Care at every stage. This may require a summary version of the PSCB Threshold Guidance to be produced. Initial efforts should target health and school settings.

The Safeguarding Partnership to review the content of the Designated Safeguarding Lead training materials delivered to all schools to ensure it reflects the findings of this review and that information about the differences between Early Help, Child in Need and child protection pathways is clear and unambiguous.

**Action taken:**

The PSCP training programme has been reviewed in response to this recommendation. Details of thresholds and the various stages of Early Help and Social Care are incorporated in to the following multi-agency training courses:

- Early Help
- Child Protection
- Supervision
- Basic Safeguarding
- Exploitation

The training team will also add a focus on ensuring 'clarity' in to these sessions. This will work to ensure that both the professional team around the child and the families themselves will be clear on their current status within the system and what that means.

Solent NHS are currently refreshing their training packages. Their safeguarding team currently offer level 3 training on Early Help, MASH and referral into Children's Social Care. The training includes details of the Early Help offer and process, the continuum of need and the threshold document, in addition to how to make an appropriate referral using the inter agency referral form. The PSCP will work alongside health colleagues to ensure that consistent messages are given across the entire Partnership.

The PSCP has recently developed a series of masterclasses for Designated Safeguarding Leads of schools within the City. This includes sessions on decision making, escalation and contacts to MASH. These classes include information regarding thresholds, cross-over points and clarity around process. These sessions will be reviewed on a regular basis to ensure that the most up to date messages are being given.

**Recommendation 4**

The Safeguarding Partnership should remind all professionals about the HIPS (Hampshire, Isle of Wight, Portsmouth and Southampton) professional challenge and resolution of professional disagreement protocol. Information should be specifically provided to all health care professionals who work in community based settings and paediatric settings and school staff about the use of professional challenge and escalation.

**Action taken:**

Escalation is a current priority area of the PSCP. A new set of guidance is currently being written to support effective use of the HIPS protocol. This guidance will have a cultural and behavioral approach and will seek to support professionals when making and receiving a challenge. Once this document has been agreed, the PSCP will share guidance with partners,

including all health care professionals.. We will also ask managers to ensure that the key messages are disseminated widely within their teams and that it has been understood. The PSCP will continue to monitor the impact of this work and will take further actions if deemed appropriate.

The importance of escalation where needed is emphasized in a number of different parts of the PSCP Training programme. Attendees have the opportunity to learn about the protocol and processes as well as exploring barriers and challenges in using them.

**Recommendation 6**

The Safeguarding Partnership should seek assurance about the use of single agency chronologies to aid assessment and decision making, generally as a tool for all agencies working at Early Help and Child in Need levels. Whilst gaining this assurance there may be merit in seeking assurance that multi-agency chronologies are also being actively used in families where there are known complexities and multiple risk factors and whether the gaining of consent from parents by the relevant professionals to share chronologies is a barrier to effective joint working.

**Action taken:**

The PSCP recognises the merit of using multi-agency chronologies, especially within complex health cases. The Partnership has agreed to add this recommendation to its annual business plan for further discussion and review. This activity will include seeking assurance on the use of both single and multi-agency chronologies.

Solent NHS have set up a task and finish group to update templates on electronic patient records. Inclusion of a chronology has been developed and will be rolled out once the project is complete.

**Recommendation 7**

The Safeguarding Partnership to commission a multi-agency audit of Child Protection Plans to gain assurance that information taken to Initial Child Protection Conferences via single agency reports accurately captures and analyses known and knowable risks to the child, that the record from the ICPC reflect such risks and these are translated in to the Child Protection Plan that is considered at the first Core Group meeting.

**Action taken:**

The PSCP undertook a multi-agency audit of child protection plans in 2017/18. It would be extremely useful to repeat this audit, driven by this recommendation and to act as a comparator to the previous audit activity. This has been added to the audit schedule for 2020-22.

**Children and Families Service**

**Recommendation 8**

Children's Social Care's local policy for the management and review of Child in Need cases, particularly those cases of children with disabilities, should be reviewed to ensure that it clearly reflects the need to involve partner agencies. Once reviewed it should be communicated to all partner agencies, with training/briefing sessions made available. The policy should make

explicit reference to the allocated Social Worker being the named lead professional and that this should be stated at the beginning of every Child in Need review meeting.

**Action taken:**

Social Care have reviewed their internal policy and have agreed to agreed to strengthen that policy to reflect the fact that the social worker is the lead professional and is responsible for oversight and coordination of the case.

There were a number of concerns in the report regarding visiting frequency, the Social Worker being clear that they were lead professional and lack of focus on safeguarding has been addressed through the restructure of the Children with Disabilities Team and integration of the team to the Localities. This places that team within the safeguarding service where this is the daily focus.

**Solent NHS and Portsmouth Hospitals NHS Trust**

**Recommendation 9**

Solent NHS Trust and Portsmouth Hospitals NHS Trust to review their policy and procedure about recognising and responding to medical neglect. Once reviewed, this should be widely disseminated to all safeguarding partners with training/briefing sessions made available.

**Action taken:**

Solent NHS Trust has developed and implemented an overarching Was Not Brought and Did Not Attend Policy. The policy aims to ensure that practitioners are aware of the importance of attempting to build a therapeutic relationship with clients and/or parents that appear to be difficult to engage with, do not attend appointments, (DNA), or do not bring children to appointments, to ensure that the Trust is able to offer an appropriate service to such individuals and families.

Portsmouth Hospitals NHS Trust (PHT) have extensively reviewed the policy and a new version was issued on 07/08/18. Guidance within this document regarding the management of 'Was Not Brought' (WNB) in the context of emerging safeguarding concerns is robust. The policy also contains the easy to use chart developed by Hampshire CCG's Designated Doctor for Safeguarding that supports practitioner decision making at a glance. The policy has been disseminated along with laminated quick guides for outpatient areas and specialist nursing teams. Supervision sessions with Paediatric Specialist Nurses include discussion about escalation and WNB process. WNB has been added to level 3 safeguarding training and linked with neglect. The WNB leaflet is now set up with the medical photography team and frontline services are able to order supplies for display in Paediatric outpatient areas and sending out to parents/carers.

A WNB presentation was delivered in the Paediatric Friday lunchtime information meeting (FLiM). Laminated posters have been produced entitled 'What to do when a child or young person is not brought to a hospital appointment' and displayed in all clinic rooms in Paediatrics. Supplies have also been shared with outpatients for display in clinic rooms where children are regularly seen outside of Paediatrics.

**Recommendation 10**

Given the extensive number of different IT systems in use across the local health economy, local health providers should provide the Safeguarding Partnership with assurance that there are adequate mitigating strategies in place to support effective information sharing between health professionals who work across more than one IT system and that information is not lost when transferring information from one system to another (whether paper or electronic).

**Action taken:**

A single electronic record keeping database is now in use across the City in all Community and Primary Care settings. This is now embedded and therefore mitigates against information sharing risks, as no record transfer is required. Health Navigators also sit within the MASH and act as a conduit between health agencies where there are safeguarding concerns.

Whilst the local acute setting use a different electronic record keeping database, they have changed Safeguarding Services processes and procedures and these have been and embedded into practice within the team. Safeguarding Service records relating to all children and young people are now all stored in a designated electronic folder. This is a central point for Consultants, senior nurses and specialist nurses to access and using the system / resources. The Safeguarding Paperwork in acute paediatrics was updated as a mitigation for shared IT structures as a consistent record keeping tool. It was shared at the peer Review, with senior and frontline staff consulted as part of the update. The use will be audited before the end of the year.

The PSCP will continue to monitor progress against this recommendation through its action tracking process.

**Recommendation 11**

For children who access both community based paediatric health services and acute paediatric health services, care pathways should be put in place and/or be reviewed to highlight any gaps or barriers that exist which may hamper effective safeguarding practices. This should include the pathway for prescribing and dispensing medication between the Acute setting, the Community Paediatric Service and GP, but also consideration of developing a Medicines Advice at Home provision to provide support for parents who have difficulty in managing their children's medicines for reasons such as mental health difficulties, learning difficulties or complexity of arrangements.

**Action taken:**

Solent NHS now have a permanent pharmacist who is available for support and advice for the children under Community Paediatric Medical Service (CPMS) who is able to contact GPs and pharmacies to clarify what medications have been dispensed when there are queries.

There is a remaining requirement to triangulate communications between health practitioners who are working with a child. The CCG are going to lead on a task and finish group which will develop a pathway for amendments to medication for children with complex health needs. This will ensure that where a child has community and acute paediatric services involved, all relevant practitioners are kept informed of any medication changes in a timely way.

The Partnership will continue to monitor this work through its action tracking process.

**Recommendation 12**

Solent NHS Trust and Portsmouth Hospitals NHS Trust should review and effectiveness of support and supervision available to all health care professionals to ensure that there is access to regular and scheduled supervision for those practitioners working with children with complex health needs.

**Action taken:**

Within Solent NHS Trust, an audit of supervision has been completed, policy has been updated and new processes for recording supervision are being implemented. A further audit is scheduled in twelve months and will be led by the safeguarding steering group.

Solent NHS Trust named doctors and PHT named doctors and nurses meet regularly along with the designated doctor for supervision and to discuss cases which span both trusts. This is occurring quarterly along with joint peer review 6 monthly between PHT and CPMS clinicians.

Within PHT, a front line registered nurse was re deployed to the Safeguarding service to support frontline practitioners in their case management on a daily basis. This involved being visible on the wards to facilitate responsive supervision. This is anticipated to become permanent and is used both on the wards and at clinic as required.

**Hampshire Constabulary**

**Recommendation 13**

The Police to review and confirm its arrangements to ensure that information and intelligence that is relevant to keeping children safe is always shared with relevant statutory partners in a timely way; this should include when concerns arise about an adult's behaviour or criminality that might lead to concerns about a child's safety and welfare.

Action taken:

a) Intelligence and Tasking Direcotrate (ITD) have adjusted their processes to ensure that intelligence processors send intelligence logs around holistic risks on the lifestyle of the child and this has resulted in more intelligence to the MASH.

b) Workshops have been held with MASH, Children's Social Care, Hampshire Constabulary's intelligence department and the Missing, Exploited and Trafficked team which has resulted in the intelligence department giving the MASH training as to how to manage and disseminate intelligence.

c) A partnership “Dare to share” meeting has been organised which will govern the progress in this area, in which the Detective Chief Inspector of Hampshire Constabulary’s Intelligence Department will be the chair. The inaugural meeting was cancelled due to COVID 19, but the attendees will be partners who attend the local safeguarding board with the intention of discussing inputs and outputs of information flow with the constabulary.