Portsmouth Safeguarding Children Partnership

Response to the Recommendations from the Local Child Safeguarding Practice Review - 'Freya'

The case was referred to the Portsmouth Safeguarding Children Partnership's Learning from Cases Committee in October 2020. A Rapid Review was undertaken which resulted in a Local Child Safeguarding Practice Review (LCSPR) being agreed. The publication of this review has been delayed by criminal proceedings.

The PSCP commissioned this review to examine issues concerning the tragic death of Freya and the lessons to be learnt to avoid this happening to 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 Safeguarding Practice Review are set out in the Learning Report that has been published in full alongside this response.

This document provides the response from the Partnership to the findings made in the Freya 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 will 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

That Portsmouth Hospital University Trust (PHUT) and University Hospitals Southampton Foundation Trust (UHSFT) assure themselves that the introduction, roll out and use of Badgernet supports and promotes information sharing so that referrals are documented, visible and communicated to appropriate professionals. Also that the outcome is available to the referring department, and any other clinical services the patient is currently under, so that continuity of care is clear and primary responsibility assured.

Action Taken:

PHUT and UHSFT are working together to review cases where patients have moved between organisations. This review focuses on the use of Badgernet to store and share information, along with the accessibility to the receiving organsiation. The use of Badgernet is under constant review and improvement cycles to ensure that it is used most effectively. Regular engagement with clevermed (developers of Badgernet) ensures that change requests are identified in a timely manner. Work is in progress to expand access to the system including to gynaecology and paediatrics. Solent Health Visiting teams are granted read only access currently. All referrals are uploaded to Badgernet and are visible to practitioners who have access to the system. There are clear documented processes and guidance available to all staff to support the use of Badgernet including information sharing and referrals

UHSFT and PHUT plan to audit six notes whereby there has been joint care since launch of Badgernet to assure current processes are effective and accurate. This will be completed in April 2022.

Recommendation 2

PHUT ensure that when referring patients to any service, whether within or out of the Trust, they include all information regarding that patient, especially such that might suggest an increase safeguarding risk or heightened vulnerability for the child or parent(s).

Action Taken:

Within PHUT, Family approach training has been rolled out across the organisation which

encourages professionals to be curious when assessing family dynamics and potential factors for vulnerability. This is included in the ongoing training strategy for 2023-2025 and will ensure the learning is fully embedded. Further training around information gathering and sharing is also included within the strategy. Referrals for maternity patients are almost exclusively within the Hampshire, Isle of Wight, Portsmouth and Southampton area and all trusts within this network now use Badgernet and so all factors recorded on here will be available to receiving trusts. Where the trust is outside of this area a PDF document will be shared via secure email to ensure all information available is transferred with the care. There is ongoing improvement work being led by the safeguarding service with support from the maternity team which is reviewing the use of Badgernet for storing in depth safeguarding information. Currently summaries of risks and pre and post birth plans, along with contact details for professionals are all stored on Badgernet routinely.

Recommendation 3

Hampshire Constabulary, as part of the Child Centred Policing programme, ensure all officers understand the purpose and importance of sharing information through the PPN/1 process which might indicate that children or vulnerable people are, or could be, at risk especially when that information indicates substance misuse or violent behaviour by parents and/ or carers**.**

Action Taken:

Hampshire Constabulary have established a PPN1 scrutiny process including independent members to continuously improve the quality of information shared with partner agencies.

Through the Child Centred policing approach, the Police are currently running a trauma informed initiative where experienced trauma informed practitioners are working alongside frontline teams to develop a trauma informed response to incidents and to articulate this to partners effectively.

Recommendation 4

Solent NHS Trust and UHSFT should assure themselves that the communication pathway between acute and community services in respect of babies under one year who are being treated in an acute setting is effective. This should ensure improved information exchanges regarding shared patients/ service users so as to provide better continuity of care and ensure that the parents' voice is heard regarding their child's treatment.

Action Taken:

At UHSFT, there are processes in place to provide assurance that Babies presenting though an Emergency Department (ED) pathway and at discharge from the Children's hospital have a discharge summary completed. This information is uploaded to SystemOne by the GP, which is accessible by Portsmouth Health Visitors. Discharge summaries for all babies under one years old presenting in ED are routinely sent to relevant Health Visiting service.

Following the recommendations from this review there is now a checklist in place which can track the date and recipient of discharge paperwork from the Neonatal unit. The discharge paperwork is now sent electronically/ via post if an email address is not available for the GP surgery. The checklist is saved in the patients notes. Badgernet is not currently set up to send neonatal discharge summaries electronically but there are future plans to set up the same process for maternal discharges on Badgernet.

Recommendation 5

UHSFT should ensure that paediatric clinicians have access to parental information, such as maternity liaison forms, so they can properly assess children's vulnerability when making clinical decisions or decisions to discharge.

It has been agreed that there will be an established audit process between acute and primary care. This will review a specific number of children from when the GP was notified of the pregnancy through to discharge.

Action Taken:

UHSFT IT systems enable paediatricians to access parental information when there are identified concerns. This would be on a basis of consent, unless the concern warranted significant risk which would support reviewing these systems, without consent, in the best interest of the child. This has now been included in the UHSFT Safeguarding Children's Policy and is in the process of finalisation and ratification.

Recommendation 6

The GP surgery, PHUT and UHSFT should review their systems to ensure notifications of pregnancies, births and discharges are sent and received as expected and to establish whether this is a case specific issue or whether other patients are affected too.

Action Taken:

UHSFT have a clear process in place for ED discharge summaries. The GP practice that Freya was registered with is not set up to receive electronic discharge summaries, so their document would have been printed and posted. UHSFT have carried out a further review of their service as to how UHSFT information is shared with the GP surgery, and assurance has been gained that there are processes in place to share this information. Current process for distributing ED discharge summaries is detailed in recommendation four. UHSFT have reviewed the information sharing process to GP's and other professionals. There are agreed processes for sending information to GP at touch points during pregnancy, postnatal discharge, and infant discharge from the neonatal unit. There are how to guides to support this process for staff and additional measures such as checklist that have been instigated to support this process. There is a clear audit trail in Badgernet, and infant records of dates information shared to reassure this process.

PHUT have carried out a further review of GP information sharing and previously unknown challenges identified and gaps closed. Communications have been sent to midwives by midwifery senior management team and they have ensured that midwifery staff are aware of the need to access GP information and use it when risk assessing and decision making. PHUT is due to undertake a review which will look at all points of requesting and sending information to other agencies as part of routine antenatal / postnatal care.

Recommendation 7

The PSCP should assure itself that the information gathering and sharing processes between partners, when completing a referral, are thorough and inclusive so, where permitted, relevant information is gleaned and shared with others following each and every request so that risk-based decisions and interventions can be considered, backed by all available information.

Action Taken:

Practitioners in Early Help and Prevention and Children's Social Care services have received several briefings underlining the importance of accessing previous information on families, to support safeguarding decisions. Information available on the electronic recording system is readily available to practitioners. Further guidance is being issued to practitioners to ensure that they know how to access historic information that isn't held on the electronic system that is part of the archived filling system. A single agency audit review is being completed in March 2022 that will partly consider how previous information on families is being used by practitioners to inform safeguarding decisions.

Within Portsmouth Hospital University Trust (PHUT) significant improvements have led to a centralised storage of records relating to safeguarding children, including all history as known to the service. This sits alongside an amended "alerts" system held in the primary EPR (electronic patient record) system: Minestrone, to direct clinicians from all areas of the trust to review the information held.

Third party information which is processed and shared in the MASH arena is not routinely shared with PHUT. Cases where a strategy meeting is held outside of the MASH and hospital representatives are in attendance will often result in minutes being shared with the PHUT.

Where children and young people attend for unscheduled care, CP-IS checks are routinely made enabling clinicians to identify whether a child is currently subject to Child Protection planning or is a Looked After Child. When this CP-IS check is positive, clinicians will make contact with the local authority if it is felt necessary based on the nature of the attendance.

Solent NHS Trust adhere to the MASH multiagency information sharing agreement that allows us to share information from our own and other health organisations for the purpose of MASH threshold decision making. 'Mash health navigators complete a comprehensive template when recording information on System One electronic health system including a comprehensive analysis, pertinent health information, risks and recommendations, and this is shared with those services open to the family on System One. Solent NHS Trust will continue to work alongside PSCP and safeguarding partners to improve the quality of health information sharing whilst remaining within our legislative frameworks.

The PSCP will continue to seek assurance that key information is shared routinely when making a referral and in a way that informs decision making for children and families.

Recommendation 8

PHUT should remind professionals of the maternity 'Did Not Attend' (DNA) escalation procedure for mothers who miss midwifery appointments, so they engage with appropriate safeguarding and primary care colleagues before making a MASH referral.

Action Taken:

Ongoing operational pressures within maternity have further delayed the provision of training sessions as planned. In order to minimise delays, the sessions are now planned to be broken down and delivered as snapshot learning sessions within the clinical environments to

capture the greatest number of midwives and support staff possible. The training material has been developed and training is due to be rolled out imminently.

Recommendation 9

Hampshire Constabulary and NHS providers involved in the Joint Agency Response (JAR) Procedures should develop guidance to allow parents of children who have died unexpectedly to receive appropriate independent bereavement support in a way that does not adversely affect the criminal justice processes but also recognises their need for support.

Action Taken:

Solent NHS has worked alongside Southern Health and Hampshire Constabulary to ensure an equitable service is offered across Hampshire when it comes to bereavement support for families after an unexpected death of a child. The keyworkers guidance and documentation has been reviewed and agreed unified bereavement information has been shared across all three organisations. If an unexpected child death is being investigated by Hampshire Constabulary then a family liaison officer is usually involved with the family. If, however, this is deemed not the most appropriate support for the family a keyworker will be requested.