Portsmouth Safeguarding Children Partnership

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

The case was referred to the Portsmouth Safeguarding Children Partnership's Learning from Cases Committee in April 2021. A Rapid Review was undertaken which resulted in a Local Child Safeguarding Practice Review (LCSPR) being agreed. The PSCP commissioned this review to examine issues concerning the welfare of Skylar 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 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 Skylar 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

The PSCP to ask all partner agencies to consider the questions included in the National CSPR published in 2021 in order to ensure that services are more effective at engaging, assessing and planning for and with men in the protection of children

Action Taken:

"The Myth of Invisible Men" report published by the Child Safeguarding Practice Review Panel in 2021 has been discussed in a number of forums within the Partnership. The Learning from Cases Committee reviewed the learning that emerged from the report and agreed to share the NSPCC summary with multi-agency colleagues. The report was also shared at the Monitoring Evaluation and Scrutiny Committee for discussion and reflection.

In light of this recommendation, it has been agreed that the PSCP Chair will write to Partnership agencies, asking them to consider the questions within the report and feedback to the Partnership meeting in June 2022. Following this conversation, any agreed actions will be monitored by the Monitoring Evaluation and Scrutiny Committee.

Recommendation 2

The PSCP executive to request a progress report on the embedding of the Re-think model

Action Taken:

Giving and receiving honest challenge about our work with families can be difficult and taking time to ‘slow down’ and consider how to go about hearing challenge is vital to ensure children and their families are kept at the centre of our work. The PSCP developed a new ‘Re-think’ approach, whereby professionals reflect on a case either virtually, on the telephone or face-to-face to explore the current concerns and find resolutions. This approach was launched to practitioners in March 2021.

In November 2021, the partnership carried out a multi-agency survey to try and understand

whether the re-think approach is being used, whether practitioner's find it useful and to understand ways in which we can improve the promotion of the model. This survey demonstrated that there was more work to do improve communications around this new way of working, to ensure that it is fully understood and utilized. Those who had held re-think meetings had found them to be a useful tool and believed that outcomes for children had improved as a result.

The PSCP Executive is now going to agree an approach to evaluating this further, in addition to agreeing the best methods for promoting its use and embedding a culture of resolving concerns in this way. This work will continue in Q1 and Q2 of 2022-23 and will be subject to frequent review by the PSCP Executive, in order to ensure ourselves that it is having the desired impact on practice and the wellbeing of children and families.

Recommendation 3

The PSCP to seek assurance from partner agencies regarding professionals having access to both the historic and current information that is required to make decisions in safeguarding work. This should include consideration being given to health professionals working with children having access to information compiled in the MASH regarding the parents.

Action Taken:

Within Social Care, practitioners in Early Help, Prevention and Children's Social Care services have received several briefings underlining the importance of accessing previous information on families, to support safeguarding decisions. However, further work is being completed to ensure that practitioners can access historical information that isn't currently available on the children's electronic case recording 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.

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.

The PSCP will review the Information Sharing Agreement within the MASH and ensure that it is fit for purpose and captures all the learning identified within this report.

Recommendation 4

That the PSCP seeks assurance from Children and Families Service that

- All of the information compiled in the MASH and held by other professionals is sought and considered by social workers undertaking assessments
- Social work assessments completed on an unborn baby include more than a one-off visit, historic information on both parents and checks with all professionals working with the family
- All social work staff are aware of the expectation that historic information (pre-Mosaic) is available and must be accessed when completing assessments

Action Taken:

Social Care have stated that all MASH information is fully available to practitioners, in both the individual report from each agency and the summary recorded within the Contact & Referral record. Managers have been briefed about the importance of considering the information collated by MASH to support the assessment and decision-making process, and this briefing will be disseminated to all areas of service in February and March. This will be revisited with practitioners and will be a part of practice audit review work to provide reassurance that it is being consistently completed.

Guidance will be issued to practitioners to support an understanding as to how to access historic archived case information (pre-Mosiac) that isn't held on the children's social care electronic system to ensure this is considered as part of any assessment Practitioners do understand how to access previous information that is held on the children's social care electronic 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.

Parents who require an in-depth pre-birth assessment will receive several visits by a social worker over a prolonged period prior to a baby's birth. This will always include access to historic information relevant to the parents. The practice guidance relating to pre-birth work will be reviewed to ensure that it supports a best practice approach to visiting. In respect of parents who don't necessarily require an in-depth assessment, good practice guidance will be issued by the Children's Principal Social Worker that will consider minimum visiting

requirements.

Recommendation 5

That the PSCP considers the RCPCH report ‘Perplexing Presentations and Fabricated or Induced Illness in Children’ and requests that the HIPS procedures are reviewed to ensure they reflect best practice in this area of safeguarding

Action Taken:

The 'Perplexing Presentations and Fabricated or Induced Illness in Children' report was published in March 2021. The Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) Procedures website does link to the latest national guidance, however there is work to do to ensure that the HIPS local guidance document makes reference to the latest best practice.

A summary of learning and a request for a full review of the local guidance will be taken to the HIPS Procedures Group meeting in May 2021 for further discussion. The request from Portsmouth will be that the four areas work together to review this guidance and ensure that the most recent learning is clearly reflected. Once this information has been updated, there will be clear communications to multi agency partners to ensure this is known and understood.

Recommendation 6

The PSCP to work with the Portsmouth Safeguarding Adults Board to plan for raising awareness about making adult safeguarding referrals when required.

Action Taken:

The HIPS Children and Adults Safeguarding Partnerships/Boards currently share a 'Family Approach Protocol' which aims to:

- Identify families with the greatest need to provide the right support at the earliest opportunity
- As far as possible, address the range of needs within a family through accurate identification and co-ordination of a family wide response
- Strengthen the capacity of family members to provide care and support to each other.

Through this work, practitioners are encouraged to avoid focussing only on the individuals to whom they have a responsibility to offer support and to liaise with colleagues in Adult Services when they identify an Adult in need of care and support.

The Family Approach Protocol was first launched in 2018 so it is timely to review the contents of this document. A Task and Finish Group is in the process of being set up across the four areas to ensure that the approach is current and reflects best practice. In Portsmouth we will ensure that the final product is well communicated across the partnership and that practitioners are fully supported to recognize and respond to concerns about any member of a family.