Hampshire Safeguarding Children Partnership

Response to the Recommendations from the

Serious Case Review – Child P

This case was considered by the Hampshire Safeguarding Children Partnership (HSCP) at its Learning and Inquiry (LIG) subgroup on 13 February 2019 under Regulation 5 of the Local Safeguarding Children Partnership (LSCP) Regulations 2006. The subgroup found that this case met the criteria for a Serious Case Review and agreed the commissioning arrangements to meet the requirements of such reviews as laid out in HM Government 'Working Together to Safeguard Children', 2018 (the statutory guidance at the time).

Working Together 2018 allowed LSCPs to use any learning model consistent with the principles in the guidance, including systems-based methodology. An independent reviewer (Alex Walters) was identified to lead the review, using a systems-based methodology to ensure full participation by the front-line practitioners who had been involved with the family.

To support the process there was a reference group of senior staff from involved agencies which the reviewer used as a sounding board and, where necessary, to provide context on organisational policies and practice. The LIG subgroup quality assured the final draft before presentation to the Board. This document provides the response from the Partnership Board, and individual partner agencies on the areas of learning highlighted to them (as outlined below).

Recommendations for Midwifery/Neonatal Services

Recommendation One:

The LSCP Unborn Baby Safeguarding Protocol should be used as the primary guideline/protocol within UHS Trust to assess/plan actions to safeguard the unborn/new-born baby. The current trust Safeguarding Children in Maternity Policy should be reviewed to compliment the protocol.

The LSCP Unborn Baby Safeguarding Protocol was reviewed and updated in March 2021. The UHS Maternity Safeguarding Team actively participated in the multi-agency review of this protocol. UHS midwives participated and joined the joint launch event in March 2021. The LSCP Unborn Baby Safeguarding Protocol is used to assess, plan and guide safeguarding practices in UHS Maternity. We have embedded its use through staff training (Level 3 safeguarding training), safeguarding supervision sessions, and communications to staff. The specialist midwife for safeguarding at UHS participates in the Unborn Protocol Strategic Group which is leading on the upcoming HIPS wide re-audit of the Unborn Baby Safeguarding Protocol.

The Safeguarding Children in Maternity Policy has been reviewed and updated in December 2021, following the re-launch of the Unborn Baby Safeguarding Protocol and introduction of 'BadgerNet' maternity information system. This policy was presented to Women's and New-born Governance in November 2021 and approved and is now being used by UHS staff.

Recommendation Two:

The Missed Appointment Policy in Maternity should be reviewed to add guidance around recognising disguised/unhelpful compliance and action that should be taken.

The Missed Appointment Policy was reviewed in April 2020 as part of UHS' response to the coronavirus (COVID-19) pandemic and is currently under review. This review will be completed by March 2022. Staff are directed to seek support and advice from the Maternity Safeguarding Team when safeguarding concerns arise alongside missed appointments.

Recommendation Three:

The Safeguarding Supervision Policy in the UHS Trust has recently been reviewed. Midwives/neonatal practitioners holding caseloads within a community practice should have access to a model of safeguarding supervision as a minimum of one session per quarter and monitored annually.

At UHS, a model of a minimum of quarterly safeguarding supervision is embedded into the Southampton continuity of care midwifery teams and Hampshire Nest Teams. The Neonatal Unit host bi-monthly group/individual safeguarding supervision sessions which are facilitated by the Neonatal Safeguarding Lead and unit psychologist. This is open to all Neonatal Unit staff and is well attended.

Community and hospital staff are encouraged to access safeguarding supervision when a need is identified, and on a case-by-case basis. There is now extra resource for supervision, and decisions are currently being assessed as to where best to direct this support.

Recommendation Four:

If visits are undertaken by staff who do not hold a nursing qualification, there needs to be documentation that the case has been discussed and has had oversight by a qualified nurse/midwife within UHS.

All unregistered staff who do not hold a nursing or midwifery qualification work within their job description and to UHSFT guidelines and policies. If unregistered staff undertake any visits (including in-hospital reviews) that involve current or historical safeguarding concerns, or where there are any medical or social concerns, they must speak to a registered member of staff and document this in relevant paperwork and any plan that has been agreed, with an agreed decision regarding who will action this.

Recommendation Five:

Postnatal Patient Contact Document by Midwifery should be reviewed to ensure they capture qualitative information, for example concerns regarding neglect and parental substance misuse, and that this has been shared with relevant professionals.

The postnatal contact was reviewed following initial scoping of Child P and changes were made to allow capture of qualitative information, as well as information offered with regards to safe sleep and ICON. The 'BadgerNet Patient Information System' was introduced into maternity in June 2021 and allows the capture of qualitative information through parenting observations and recording in the clinical narrative section, including social updates. Health Visiting Services and GPs will have 'read-only' access to this system as part of the Digital Maternity Workplan and this is currently in the final stages of implementation.

Recommendation Six:

A strategy that babies most at risk from traumatic head injury are identified and that the ICON programme is continued to be promoted and discussed with all families on discharge and highlighted to professionals through training and supervision.

The ICON programme has continued to be embedded into maternity and neonatal services. A recent joint audit between maternity and the neonatal team highlighted that safe sleep and ICON was discussed in 93% of all postnatal discharges.

All Neonatal Unit discharges have an individualised risk assessment to ensure that advice is personal to each family circumstance. Those families on a safeguarding proforma, and all Neonatal Unit families, receive a safe sleep and ICON pack in addition to verbal information. Signposting to the ICON website and The Lullaby Trust is given to all parents upon discharge from maternity and the neonatal unit.

Recommendations for Health Visitors

Recommendation One:

The need to raise awareness of the LSCP Unborn Baby Safeguarding Protocol with all the Trust staff, including those providing adult mental health services. Health visitors need to ensure at liaison with midwives, GPs, and other professional staff that the LSCP Unborn Baby Safeguarding Protocol is considered.

The LSCP Unborn Baby Safeguarding Protocol is embedded in safeguarding training and has been highlighted within Hotspot communications, which are shared with all members of the Trust workforce. The Unborn Baby Safeguarding Protocol is an embedded pathway which is considered alongside all safeguarding procedures. There is constant liaison between midwifery and GP services.

Recommendation Two:

To raise awareness amongst the Trust staff of the need to direct other professionals to communicate their evidence of concerns to Children's Services directly and to inform families themselves that they are doing this.

The Trust supports a family approach to safeguarding children and vulnerable adults. The families that the Trust interfaces with often have a combination of both children and adults that require support and protection. Safeguarding training and supervision fully supports individual clinicians and professionals to make contact directly with Children's Services and Adult Services where required. A robust safeguarding data platform is being built, which will be able to monitor this and include this data set in required reporting.

Recommendation Three:

To develop further training for staff around the analysis of historical risk and resilience factors and the potential for these to have an impact on current or future behaviours.

Health visitors receive safeguarding training to Level 3. They are also able to attend any training offered by the partnership in addition to this. The Trust Safeguarding Team offer specific training around risk and resilience. Safeguarding supervision delivered by the Safeguarding Team often explores these areas of risk and resilience within the complex case discussions.

Recommendations for GP Services

Recommendation One:

Training on the LSCP Unborn Baby Safeguarding Protocol to increase awareness and an understanding of assessing safeguarding risk as a situation evolves.

The Clinical Commissioning Group (CCG) has a statutory responsibility to employ Named GPs for safeguarding children. The Named GPs have a safeguarding training programme for primary care. This has included specific learning from cases such as Child P and understanding risk. The training raises awareness of the Unborn Baby Safeguarding Protocol. Each GP practice has a GP Safeguarding Lead who are in turn supported by the Named GPs.

Recommendation Two:

Improved information sharing between midwifery services and primary care to be addressed by development and roll out of guidance for Primary Care Vulnerable Family Meetings.

Guidance for Primary Care Vulnerable Family Meetings has been shared with GP practices. This is a crucial information sharing and assessment meeting, and as such is a priority area for the CCG. It has been impacted by shortages and challenges in public health and midwifery services.

Recommendation Three:
Development of a standardised referral form to midwifery services from primary care that explicitly outlines safeguarding risks and plans to help information sharing between these agencies.

A standardised template to record safeguarding risks and plans has been developed. This includes a decision-making flowchart for information sharing.

Recommendations for Housing

Recommendation One:
A need has been identified for improved liaison between the different district council functions and the need for enhanced training for frontline staff on professional curiosity and problem solving.

Information is disseminated through HSCP members to district/ borough/ city councils through the HSCP Virtual Training Offer. District councils are represented on the HSCP Main Board and Workforce Development Group.

Recommendations for Hampshire Safeguarding Children Partnership (HSCP)

Recommendation One:
Hampshire Safeguarding Children Partnership to review actions taken in previous SCRs and any barriers to promote awareness of the LSCP Unborn Baby Safeguarding Protocol to all practitioners, particularly in universal health services, to ensure mandatory reporting is understood and undertake relevant and proportionate auditing activity to ensure compliance.

HSCP have undertaken a survey to understand professionals' knowledge and use of the Unborn Baby Safeguarding Protocol. This survey has been completed and was fed into the updated Unborn Baby Safeguarding Protocol which was launched in March 2020. A health-led audit is currently underway which will feed into the HSCP multi-agency audit on Safeguarding Infants in Quarter One of 2022/23. This will include the Unborn Baby Safeguarding Protocol.

Recommendation Two:
Hampshire Safeguarding Children Partnership to ensure all single-agency protocols and procedures are compliant with the Safeguarding Partnership's protocols and procedures and audit through the existing Section 11 processes.

HSCP included this area of focus in the 2020/21 Section 11 audit, which was undertaken and completed. Feedback from this audit was shared with agencies. In November 2021, HSCP requested that agencies share action plan updates from the Section 11 audit, so that these can be reviewed. Feedback has been provided to agencies.

Recommendation Three:
Hampshire Safeguarding Children Partnership request health partner agencies across Hampshire to review and develop guidance on the use of Vulnerable Families Meetings to share information and assess risk.

This will be included as an area of focus in the 2022/23 GP Section 11 audit.

Recommendation Four:

Hampshire Safeguarding Children Partnership promote awareness and undertake training on the themes of professional over optimism and professional curiosity identified in Serious Case Reviews.

HSCP raised this as an area for discussion at the Workforce Development Group in 2021 as part of the Learning Needs Analysis. This has now been included in themed webinars, including the Disguised Compliance training.

Recommendation Five:

Hampshire Safeguarding Children Partnership request that health agencies review their missed appointments policies to ensure they identify this issue where these occur but there is apparent compliance as a potential risk factor.

HSCP have asked agencies to ensure that they are following the Family Engagement Policy.

Recommendation Six:

Hampshire Safeguarding Children Partnership to consider developing best practice guidance and training for universal services on responding to potential risk issues of substance misuse by parents.

HSCP raised this as an area of focus for the 2021 HSCP Learning Needs Analysis (LNA). HSCP is currently exploring options with a service provider to include this within the HSCP virtual training offer.