

<b>CITY &amp; HACKNEY SAFEGUARDING CHILDREN BOARD</b>	
<b>Report to City of London and Executive Groups</b>	
<b>Section 1 - General</b>	
<b>Date of Meeting</b>	February 2016
<b>Title of Report/Agenda Item</b>	Section 11 Peer Review - October 2015
<b>Presenter</b>	Rory McCallum

### **Introduction**

Section 11 of the Children Act 2004 places a statutory duty on key persons and bodies to make arrangements to ensure that in discharging its functions, they have regard to the need to safeguard and promote the welfare of children and that the services they contract out to others also have regard to that need.

Improving the way key people and bodies safeguard and promote the welfare of children is crucial to improving their outcomes.

As part of its statutory objective of ensuring the effectiveness of safeguarding arrangements, the City & Hackney Safeguarding Children Board (CHSCB) facilitates a Section 11 audit process that requires organisations to self-assess their performance against the Section 11 duties.

These audits are subject to scrutiny and oversight by the CHSCB. To further strengthen this oversight and provide additional support to partner agencies, the CHSCB introduced a Peer Challenge process for Section 11 audit returns. This Peer Challenge process will help partner agencies reflect on and improve safeguarding services for children and young people.

Homerton University Hospital NHS Foundation Trust (HUHFT) was the first CHSCB agency to agree to participate in this process and this report sets out the findings of the team undertaking this work.

### **Format**

In line with the proposed process, sessions were conducted in the manner of a critical friend to challenge partners on their own self-assessment of strengths and areas for improvement (as detailed in audit submissions).

The sessions were conducted in an interactive manner and were flexible enough to allow document reviews and traditional 'interviews' with identified staff members.

The on-site work was undertaken on 21 October 2015.

This report is not intended to be an in-depth analysis of the safeguarding arrangements in existence at HUHFT, but provides a focused examination of a number of areas.

## **Peer Review Team**

The Peer Review Team comprised:

- Rory McCallum – Senior Professional Advisor, CHSCB
- Mary Lee, Designated Nurse, City & Hackney CCG
- Sally Glen – CHSCB Lay Member

## **Process**

The Peer Review Process included the following:

### Review Preparation

The Peer Review Team undertook a detailed analysis of the HUHFT Section 11 audit return and the action plan submitted to the CHSCB as part of the 2014/15 Section 11 process.

As a result of this analysis, HUHFT was asked to supply the following documentation for further scrutiny by the team (the relevant S11 audit standard is set out in brackets):

- Contract for Arriva Transport (standard 2.3).
- Any documents updating on service development involving views of children and families (standard 4.2)
- Examples of referrals made by Homerton (standard 7.3)
- Example JD (across the bandings and for volunteers)
- Example of a safeguarding newsletter to staff, and
- Any reports analysing training provided to staff (who attends, who delivers, content, feedback on quality – standard 5)

The Peer Review Team used these documents as evidence supporting HUHFT's self-assessment and to develop any key lines of enquiry to take forward as part of the on-site fieldwork.

### On-Site Session

The Peer review team met with the following staff members at the outset of the on-site visit:

- Joan Douglas – Head of Midwifery / Supervisor of Midwives
- Jane Kennedy – Safeguarding Midwife / Midwife Consultant
- Sarah Webb – Divisional Head of Nursing
- Pauline Grant – Specialist Practitioner in Safeguarding Children
- Marcia Smikle – Head of Safeguarding

This was followed by a "walkabout" and direct engagement with a number of front-line staff in the following areas of Homerton Hospital:

- The Midwifery Birthing Unit
- The Post Natal Ward
- Children's A&E
- Starlight Children's Ward
- Sexual and Reproductive Health Team

## **Background to the Homerton Hospital**

The HUHFT is a well-established provider of health services for children young people and adults, with an extensive portfolio covering the life course from conception through to transition to adulthood. Since April 2011, when City and Hackney Community Health Services merged with the Homerton, services have become integrated across hospital and community sites with a wide range of universal, targeted and specialist provision.

Vulnerable children and young people may present to any service so all staff are trained to identify and address safeguarding children issues. This, together with the fully integrated model, helps to ensure that

vulnerable children and young people are identified early and information is shared with the safeguarding children team, other services and agencies as appropriate.

**The following narrative provides a brief summary of the key areas covered through the walkabout session.**

#### Midwifery Birthing Unit

- Staff in this unit spoke about good access to training and support from the Safeguarding Team always being available when required in terms of any relevant issues.
- Staff confirmed routine enquiry is undertaken regarding domestic violence and Female Genital Mutilation with patients.

#### Post Natal Ward

- Discussed cases and scenarios where concern could relate to mother wanting to abscond with baby. Staff showed a clear alertness to risk and gave examples of practical solutions that have been used to resolve / mitigate risk – i.e. placing in high visibility areas. Examples given of close working with the Police and Children's Social Care in terms of removing children from parent(s).
- More complex safeguarding cases are managed by more experienced staff.
- Issues regarding discharge planning meeting v bed requirement raised and pressures that can be felt on the ward.
- Again, confirmed good access to support regarding safeguarding children when needed, with good support for more junior staff provided by seniors

#### Children's A/E

- Blue light meant unable to meet with staff.
- Safeguarding poster was noted on staff notice board.

#### Starlight - Children's Ward

- Training for whole day easier than short periods as staff do long shifts and there is no cover.
- Story of aggressive parent referred to Children Social Care (CSC) - escalated to Head of Safeguarding and resolved - ended in case conference.
- Confidence in who to escalate to within Trust when unhappy with decisions made by CSC.
- The colocation of the Safeguarding Children Team on Starlight helps embed safeguarding in day to day practice and seen by staff as very supportive.
- New staff shadow the Safeguarding Team as part of induction and this is positive.

#### Sexual & Reproductive Health Team

- Acknowledged anxiety when dealing with complex cases but spoke of honest and frank conversations and taking advice from colleagues.
- Monthly multi-disciplinary case review/ meetings
- Would like more training regarding lessons from Rotherham and Child Sexual Exploitation
- Staff spoke that it is easy to get hold of the Safeguarding Children Team for support
- Information from MASE flagged on systems
- Staff know what to do if they are worried about children and young people and use the First Access Screening Team (FAST) for advice when needed

## **Analysis**

- The Section 11 audit return and the accompanying action plan from HUHFT were considered by the Peer Review Team to be an accurate and proportionate reflection on HUHFT's safeguarding arrangements.
- The governance arrangements for safeguarding children and young people are appropriate. There is strong leadership on safeguarding children and young people at HUHFT – reflected through internal arrangements and the engagement of relevant leads in the partnership work of the CHSCB.
- “Rounding” visits to the front-line undertaken by the Chief Nurse/Heads of Nursing/Midwifery/Senior Nurses in the company of non-executive directors (NEDs) / governors are considered to be a strength reflecting HUHFT's willingness to maintain an open and transparent culture of listening to patients, learning what needs to change and effecting this change as appropriate. The engagement of NEDs / governors was considered a significant strength in terms of ensuring an independent approach to this arrangement.
- Job Descriptions (JDs) seen were appropriate – but the team considered these could be strengthened by making responsibilities for safeguarding children and young people more explicit. As CHSCB agencies, we often use the term “safeguarding is everyone's responsibility”, but reviewing the JDs, this was not as explicit as it could be to reinforce this message.
- Examples of referrals that were seen were considered appropriate, but could be strengthened through more explicit reference to the Hackney Wellbeing Framework / City of London Threshold tool and through HUHFT implementing an audit of these on a rolling basis and to provide feedback to staff regarding the quality of the content.
- There was a clear sense of pride in all the clinicians spoken to about the work that they do.
- All staff demonstrated a clear engagement with safeguarding children and young people and reflected a culture that focussed on their needs.
- Staff were able to give clear examples of how they deliver day to day care with consideration to risk and how this is effectively and safely managed in the context of a hospital setting.
- Staff were keen to showcase their knowledge and the positive work that they undertake in this regard.
- There was an overarching theme of staff feeling well supported in terms of having to manage safeguarding concerns and knowing how to seek advice when required.
- Staff spoke about the support from and ease of access to the Safeguarding Children Team.
- The multi-agency psychosocial meetings were reflected as a positive mechanism to assist in the safeguarding functions of HUHFT.
- Strong paediatric liaison was evident at HUHFT

## **Issues raised by HUHFT**

- Senior staff acknowledged concern about the future funding arrangements of public health midwives and this should be an area the CHSCB seeks reassurance on in terms of impact on children and young people.
- There was an acknowledgement of the complexity of cases seen in Hackney and pressure on staff emerging through the growing safeguarding agenda and its focus on specific areas such as CSE, Radicalisation, FGM.
- Whilst performance against the delivery of mandatory training is broadly positive and attendance at CHSCB training good, the challenge is acknowledge by HUHFT in terms of ensuring staff keep up to date with their knowledge in this regard, whilst delivering care and responding to general safeguarding concerns too.

## **Recommendations**

The Peer Review Team make the following recommendations for HUHFT to consider:

- 1. For HUHFT to consider the possibility of appointing a non-executive director to chair the safeguarding sub-committee – this will enhance governance arrangements and provide a more independent approach towards challenge and support of this agenda – consistent with the positive approach taken in terms of the rounding visits.**
- 2. For HUHFT to review all Job Descriptions of HUHFT employees and strengthen both the narrative and profile of safeguarding children within these documents.**
- 3. For HUHFT to consider introducing a specific audit process for the referrals it makes to the First Access Screening Team and provide a feedback loop to frontline staff.**

Author(s):

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