



# Safeguarding Children

## Extending the learning across the NHS

### Summary

The extensive media coverage of events around the tragic death of “Baby Peter” have largely focussed on apparent inadequacies in social services, care, focussing far less on the many missed opportunities within healthcare which resulted in Peter’s death at the hands of members of his household in August 2007. This short article, linked to a presentation at the Safeguarding 2009 conference explains how a regulatory focus is supporting transformation of the priority of safeguarding in the NHS.

### Introduction

The Care Quality Commission is the new regulator for health and adult social care. Formed by merger in April 2009 of three previous regulators (the Commission for Social Care Inspection, the Mental Health Act Commission and the Healthcare Commission), CQC’s principal task is to make a positive contribution to improving outcomes for people and one of the ways in which this is done is through robust monitoring and review systems with a range of powers inherited from the predecessor organisations.

When news of events surrounding Baby Peter’s death came through, the then Healthcare Commission was asked by the Secretary of State to join Ofsted in a Joint Area Review of safeguarding arrangements in Haringey. In parallel with this, the nature of the events had also triggered a specific intervention by the Healthcare Commission into the four NHS organisations that had had contact with Peter and his family in the months before his death. These two pieces of work were complementary, and their findings showed worrying gaps in systems and processes within and between the organisations involved, and a failure to learn effectively from Peter’s death.

Although child protection cases like Peter’s are relatively rare in proportion to the number of children using the health service, we wanted to understand the system where despite Peter having 60 contacts with health professionals in his life, for number of reasons none of them managed to trigger appropriate protection to prevent his death.

The Healthcare Commission/CQC’s intervention was relatively short and focussed but followed a robust process. We found a number of inadequacies had occurred in the systems in terms of

- Communications between health professionals and agencies
- Awareness of staff around child protection procedures and adherence to them
- Recruitment practices and training
- Shortages of staff
- Failings in governance in three of the Trusts involved

### Compliance with Standards

Particularly worrying was that the Boards of the three organisations causing concern had all self-declared compliance in 2006-7 and 2007-8 with relevant standards in the Annual Health Check of the NHS conducted by the Healthcare Commission/CQC.

These standards include specific topics such as child protection (C2), employment checks (C10a) and training and professional development (C11a,b,c).

We found that 97% of all organisations, like those in Haringey, declared specifically that they had met standard C2, so we wanted to explore whether the concerns we found

in Haringey were unique or were replicated to a greater or lesser extent in other health communities in England.

### The review

We launched, in December 2008, a full and swift review of systems for child protection across all 392 organisations in the NHS. We wanted to assess, through a questionnaire and accompanying notes, how far organisations were compliant with the statutory guidance “Working Together to Safeguard Children”, and whether there were any steps that needed to be put in place on a national or local basis to ensure that systems were working effectively.

Following a literature review we consulted widely, albeit over an extremely tight timetable, to get the right questions in the survey, building a picture of what was important whilst minimising the burden of completion and submission. Named and designated nurses and doctors, in particular, told us their experiences and areas to explore to ascertain if boards were knowledgeable and supportive of the risks and responsibilities carried by frontline staff in child protection work. People told us the importance of effective team working, good leadership and sensitive performance management, recognising that success was in fact the absence of a failing. We recognised that measuring the quality of interventions that keep a child safe is much harder but more effective than measuring things that have gone wrong. We worked with Government Departments, Strategic Health Authorities and Ofsted to minimise overlap with other surveys and questionnaires, keeping in mind the importance of developing clear questions that were useful for staff and that would

prove beneficial as Nationally collected benchmark indicators.

We wanted to examine how well Boards were assured that they had sound systems in place, and how well those systems were working. We focussed on staffing, training, governance, working with LSCBs and processes around Serious Case Reviews. There were many more questions that we would have liked to ask or which staff told us would be useful, but we were constrained by the questionnaire length and the need to stick to examining only statutory requirements.

The resulting questionnaire was accompanied by a detailed set of notes which explained the rationale for each question and the relevant section of statutory guidance. All Chief Executives were contacted to nominate a member of staff to lead on completion of the questionnaire and all 392 Trusts completed the 114-question survey by the deadline date in late March. Soon after this, at the end of April, Boards were again asked to make declarations against Annual Health Check Standards. This time self-declared compliance had dropped around 3% to 94% which we interpreted not as a worsening of systems but a better understanding by some Boards of what compliance required. We have followed up those Trusts that declared non compliance and cross-checked the questionnaire submissions against those Trusts that declared that they met the standard.

Analysis of the findings showed worrying concerns in several areas across England, including staffing and training levels, procedures in A&E departments, Board reporting systems and the time taken to conduct Serious Case Reviews. These and wider policy developments such as the implication of Lord Laming's report and new processes for Serious Case Review reporting will be discussed in the presentation on 21st October.

#### Next steps

By April 2010, all NHS organisations will have had to register the services they provide with the Care Quality Commission. Unless certain services (such as maternity, care and treatment, surgery, etc) are registered, it will be illegal to practise. Registration requires compliance with statutory conditions of registration, which were set out in a consultation by CQC during the summer ([www.cqc.org.uk](http://www.cqc.org.uk)). One of those registration requirements is based on having robust safeguarding arrangements in place and the findings of this survey provide an important wake-up call to provider units about what they need to do to ensure they are compliant with the new procedures. This will be expanded upon further, along with other findings of the review at the CQC presentation on 21st October 2009 at the 'Safeguarding Children – Getting it right across the NHS' conference to be held in Friends House, London.

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# Safeguarding Children

## Getting it right across the NHS

Wednesday 21st October 2009, Central London

After the heartbreaking events and consequential media frenzy surrounding the catastrophic circumstances of Baby P, few healthcare organisations underestimate the imperative of putting their safeguarding house in order.

Safeguarding Children 2009 is designed to serve two vital goals; drawing together insight, information & understanding around the core issues facing health professionals in this area, whilst providing a forum for debate, collaboration and networking by the very professionals implementing child protection services at the coalface.

#### Topics & speakers include:

##### Lessons and imperatives

##### What the NHS should be learning from Baby P

Sue Eardley, Head of Children's Strategy and Safeguarding Children, Care Quality Commission

##### Child protection challenges facing healthcare professionals

Professor Terence Stephenson, President of the Royal College of Paediatrics & Child Health

##### Expectations on safeguarding children

##### The Strategic Health Authority Viewpoint

Briony Ladbury, Lead for Safeguarding Children, NHS London

### Cost & Booking Information

#### Consultants & Business Professionals

- £215 + VAT early bird
- £249 + VAT standard rate

#### Doctors in Training, SAS Grades & Nursing Staff

- £125 + VAT early bird
- £175 + VAT standard rate

#### Group Bookings

5 places for £700 + VAT early bird  
5 places for £875 + VAT standard rate

10 places for £1250 + VAT early bird  
10 places for £1400 + VAT standard rate

#### Special Nurses & Juniors deal

5 places for £600 + VAT early bird  
5 places for £750 + VAT standard rate

The early bird rate applies to bookings received more than 56 days before the course date.

Book online at: [www.safeguardingchildren2009.co.uk](http://www.safeguardingchildren2009.co.uk), email us at: [customer.services@medicology.co.uk](mailto:customer.services@medicology.co.uk) or book over the phone by calling the customer services team on 01332 821260

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