Health, Wellbeing and Local Government Committee

HWLG(3)-11-10-p3: 10 June 2010

Committee Inquiry into Local Safeguarding Children Boards (LSCBs)

Evidence From Healthcare Inspectorate Wales (HIW).

Purpose:

Healthcare Inspectorate Wales (HIW) have been invited to attend and submit supporting written evidence to the Committee in relation to "Whether Local Safeguarding Children Boards (LSCBs) are performing effectively and consistently across Wales in strengthening arrangements for protecting and promoting the welfare of children".

HIW welcomes the Committee's inquiry and for the opportunity to provide written and oral evidence.

Background: The role of HIW

HIW is the independent inspectorate and regulator of all healthcare in Wales. HIW's primary focus is on:

Making a significant contribution to improving the safety and quality of healthcare services in Wales.

Improving citizens' experience of healthcare in Wales whether as a patient, service user, carer, relative or employee.

Strengthening the voice of patients and the public in the way health services are reviewed.

Ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

HIW's core responsibility is to provide independent assurance about the quality and safety of NHS and independent healthcare organisations in Wales against a range of standards, policies, guidance and regulations and to highlight areas requiring improvement. HIW also undertakes special reviews where there may be systemic failures in delivering healthcare services to ensure that improvement and learning takes place.

HIW carries out its functions on behalf of Welsh Ministers and, although part of a directorate within the Welsh Assembly Government, protocols have been established to safeguard its operational autonomy and professional independence.

HIW's main functions and responsibilities are drawn from the following legislation: Health and Social Care (Community Health and Standards) Act 2003; Care Standards Act 2000 and associated regulations; Mental Health Act 1983 and the Mental Health Act 2007; Statutory Supervision of Midwives as set out in Articles 42 and 43 of the Nursing and Midwifery Order 2001 and Ionising Radiation (Medical Exposure) Regulations 2000 and Amendment Regulations 2006.

HIW works closely with other inspectorates and regulators in carrying out cross sector reviews in social care, education and criminal justice and in developing more proportionate and co-ordinated approaches to the review and regulation of healthcare in Wales.

HIW's role in relation to Safeguarding and promoting the rights and welfare of children

HIW has a specific statutory responsibility to 'safeguard and promote the rights and welfare of children' in exercising its role in relation to the inspection and investigation of NHS organisations (Health and Social Care (Community Health and Standards) Act 2003). We therefore ensure that safeguarding and child protection are built into every review we undertake.

A summary of the work that we have taken forward, since 2007, in relation to safeguarding and promoting the rights of children is provided at Annex A.

Following the circumstances surrounding the death of baby Peter Connelly in Haringey which became public in November 2008 we further increased our focus on safeguarding and protection arrangements in the NHS. Our key aim was to answer 2 key questions:

Are all those working in healthcare organisations aware of their responsibilities in relation to child protection and safeguarding and do they know how to properly deal with suspected child protection/safeguarding issues?

Are children and young people safe when accessing health services or visiting healthcare premises?

The HIW report "Safeguarding and Protecting Children in Wales: A review of the review of the arrangements in place across the Welsh National Health Service" is available at:

http://www.hiw.org.uk/page.cfm?orgid=477&pid=41497

Our review was undertaken in tandem with two reviews taken forward by Care and Social Services Inspectorate Wales (CSSIW) and in October 2009, HIW and CSSIW published reports on safeguarding and protecting children in Wales. The three reports bring together

the findings from each strand of work undertaken by the two inspectorates and provide an overview of the arrangements that are in place to help safeguard and protect children in Wales.

Summary of our findings as they relate to LSCBs

The work undertaken by HIW has highlighted a number of issues that impact on the effective working of LSCB's, these are summarised below:

Information Sharing and Risk Management

HIW considers information sharing to be a key issue. For LSCB's to be effective all agencies need to ensure that information relating to safeguarding is shared in an appropriate and timely way. However, despite guidance having been issued nationally about the sharing of information healthcare staff still continue to be concerned and reluctant to share information inside their own organisations let alone with other agencies and sectors. Some staff are concerned about breaking patient confidentiality and the effect this may have on their future relationship with that individual and their therapeutic needs.

We have identified a number of areas where information sharing is a particular issue for staff and where we feel greater support and training is needed for those on the front line, these are set out below.

Substance Misuse Services[1]

Our report published in August 2009[2] highlighted that children and young people whose parents have substance misuse problems are often in need of support and protection.

The fear of disclosure of drug use remains an active barrier to treatment for many. This can be compounded by their individual situation. One example given to us was of drug using mothers fearing that their child will be taken into care if they seek help. This raises the issue for substance misuse services of how to handle sensitively particular child protection concerns that may arise from the use of drugs.

It was against this background that staff told us that they were concerned about the potential conflict between attempting to treat the client and the safeguarding of children and the protection of vulnerable adults. Although most service providers consider the needs of both clients and dependents, we found that the primary concern for some agencies is maintaining the relationship with a client to ensure continuation with treatment, rather than addressing concerns identified about dependents. We were told of cases where specific agencies had refused to attend child protection conferences in case it damaged their relationship with clients.

Other examples were given of agencies refusing to share relevant information as this was considered to be confidential to the agency. Underpinning these concerns is a general lack of understanding of information sharing.

Conversely we were also provided with examples of when substance misuse staff had referred issues to social services but had never been told whether action had been taken.

Adult Mental Health Services

In relation to adult mental health services we have identified a similar picture to that for substance misuse services. The stigma that is still attached to mental illness sometimes leads to a lack of openness and information sharing about the limitations and risks that an individuals problems may cause.

Safeguarding Children - Working Together Under the Children Act 2004 clearly states that 'All those providing mental health services must be alert to the possibility that their clients, whether adults or children, may be a risk to children. If they have such suspicions they should make a referral to social services and follow child protection procedures'. However, we have found that risk assessments and care plans undertaken and developed by health professionals do not always address the risk to or needs of dependent children and young people. As a consequence the information needed to safeguard them is not collected or shared with the appropriate agencies.

Particular issues in relation to risk assessment and the referral of concerns to child care services have been highlighted by our reviews of homicides where the perpetrator was a mental health service user. Our review of the care of Mr B[3] highlighted that during the day he cared for his young daughter; taking her to and from school. Despite Mr B telling health and social care staff that he had homicidal thoughts a full assessment of the risk he may have caused to his young daughter was never undertaken and no referral to the local authorities' child care services was ever made. Mr B went on to repeatedly stab a young man in a local park.

The issue is not unique to Wales and in May 2009 the National Patient Safety Agency (NPSA) issued a Rapid Response Report on 'Preventing harm to children from parents with mental health needs'. The report highlighted that while mental health service users are often good parents, new research from the National Confidential Inquiry into Suicide and Homicide (NCISH) and findings from investigations into the deaths of children have 'highlighted a rare but important risk to children when their parent or carer has delusional beliefs involving their children, or has a suicide plan involving their children. In some cases, mental health staff caring for the parent had not recognised the risk'.

Child and Adolescent Mental Health Services

Our review of the records of children and young people who have accessed Child and Adolescent Mental Health Services (CAMHS) highlighted some good examples of where issues of concern regarding the safety of a young person or others that he/she may come

into contact with have been identified by health professionals and appropriately referred to and shared with other relevant agencies. However, we also identified matters that were clearly child protection/safeguarding issues that had gone unreported or addressed. Where identified we ensured the necessary action was taken as a matter of priority.

In following up these issues with professionals working in the field of CAMHS we identified that poor information sharing is often due to:

Confusion as to what can and cannot be shared.

Some professionals believing that parental consent is needed before information can be shared.

Information sharing protocols not being in place.

A lack of integrated records and information systems.

We identified a number of situations where children and young people have been put at risk because agencies have been either unwilling or have not considered it appropriate to share information, including examples of:

Cases where specialist CAMHS teams have 'discharged' a young person form their care as a result of them missing outpatient appointments. Other agencies, including the one that made the referral to specialist CAMHS services are often not informed of the young persons 'discharge' and these young people can become 'lost' in the system.

CAMHS staff being unwilling to confirm to other agencies that they are in contact with a young person.

CAMHS staff being unwilling to advise teaching staff how they can best support young people with a mental health problem.

CAMHS staff not attending case conferences.

Social services staff told us that they were sometimes not informed of children and young people from their area being admitted to inpatient settings, even though they meet the definition of 'a child in need' under the Children Act. Conversely, only 13 of the 24 specialist CAMHS teams we spoke to were routinely advised of safeguarding concerns by social services.

Professional Leadership and Advice

Every report of an inquiry into a child protection matter such as those led by Kennedy4, Carlile5 and Laming have stressed the importance of there being strong leadership in respect of child protection and clear lines of accountability.

Local Health Boards (LHBs) and Trusts are required to appoint a lead officer for children and young people's services (section 27(2)(a) of the Children Act) and designate a lead member for children and young people's services (section 27(2)(b)). Similarly, NHS Trusts are required to appoint a lead executive director for children and young people's services (section 27(3)(a) of the Children Act) and to designate a lead non-executive director for children and young people's services (section 27(2)(b)).

At the time of our review into Safeguarding (published October 2009) the then 22 LHBs had access to a designated doctor and nurse and support professionals through the National Public Health Service. The designated professionals worked closely with named professionals in the Trusts and played an important role in promoting the protection of children and young people through membership of Local Safeguarding Children Boards (LSCBs), developing and participating in training programmes, the provision of expert advice and the completion of the health component of serious case reviews.

A number of partner organisations and national child protection charities have stressed to HIW that the healthcare sector plays a crucial role in providing advice and support to the multi-agency safeguarding work that the LSCBs undertake. In this respect we have stated that the new LHBs need to clarify as a matter of priority the arrangements that they have in place to ensure that they support and contribute to LSCBs on an on-going basis. This issue was further explored in the report published by Care and Social Services Inspectorate Wales; Safeguarding and Protecting Children In Wales, The review of Local Authority Social Services and Local Children's Safeguarding Boards.

We have been in liaison with Professor Mansel Aylward to ensure that our findings are fed into the work that he is taking forward.

Input of General Practitioners, the primary healthcare team and other independent contractors

"Safeguarding Children: Working Together Under the Children Act 2004" recognises the important role that GP's and other members of the primary health care team have, in recognising when child is potentially in need of extra help or services to promote health and development, or is at risk of harm. However, we found that the input of GP's to LSCB's is minimal and we will be following this up as part of the future work that is planned for 2010-11.

Future Work

HIW is working with CSSIW and other inspectorates to take forward a Multi Agency Inspection of Local Safeguarding Children Boards (LSCBs). The aim of the review will be to 'assess, on a multi inspectorate basis, the progress that has been made by authorities in establishing an effective Local safeguarding children's board in accordance with guidance "Safeguarding Children" Working Together under the children Act 2004.'

The particular focus will be:

How the LSCB demonstrates improvements to the outcomes for children receiving child protection services.

How the work of the LSCB and work with other partnerships improves safety for all children.

Has the board established a strategic direction including a clear shared understanding about which elements of safeguarding it is accountable for and for which it is holding others to account.

Has the board established effective governance arrangements that specify the responsibilities, requirements and accountabilities of individual members whilst also holding member agencies to account with regard to safeguarding activity.

Has the board established capacity to undertake its roles and responsibilities .including the identification of the required resources to deliver its programme and the sub-groups needed to effectively deliver its work plan.

Has the board clear outputs in that it has developed a means of knowing about the quality of practice and actively works to promote improvement to include:

- A shared understanding of what 'good practice' looks like
- A shared understanding of what is happening in practice
- Ability to address concerns about practice
- The board has mechanisms to identify and disseminate best practice
- The work of the board is informed by stakeholders including children and young people
- To identify additional good practice
- To make recommendations for further improvement

1. The services we looked at as part of this review spanned the NHS, independent and voluntary sectors

2. Substance Misuse Services: All Wales Review of Substitute Prescribing Services

3. Report of a review in respect of Mr B and the provision of mental health services following a homicide committed in April 2006, Healthcare Inspectorate Wales, May 2008

4. Learning from Bristol: The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984 -1995, July 2001

5. Too Serious a Thing: The Carlile Review, The Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales, 2002.