Making People Safer

Safeguarding Children and Young People

A Review of Brighton and Sussex University Hospital Trust

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Jim Gamble QPM is a former Chief Police Officer and was the founding Chief Executive of the Child Exploitation and Online Protection Centre (CEOP). Mr Gamble is currently the CEO of specialist safeguarding consultancy INEQE Group and the Independent Chair of the City and Hackney Safeguarding Children Board (CHSCB)[1].

During his police service, Mr Gamble was involved at the highest level in counter terrorism and organised crime investigations. He was the Association of Chief Police Officers (ACPO) national lead for child abuse investigation, Internet safety and countering child trafficking. As the Chief Executive of CEOP he built what isnow recognised as a world-leading concept in child protection, developing a diverse set of safeguarding initiatives including the Behavioural Analysis Unit (BAU), the UK and Overseas Tracker teams and the 'ThinkUKnow' education campaign.

Mr Gamble was a co-author on the UK's first Domestic Homicide Review (Pemberton) and in 2010 was appointed by the then Home Secretary to lead the initial scoping review of the investigation into the disappearance of Madeleine McCann.

His work as Independent Chair of the CHSCB has provided him with a deep insight into learning from Serious Case Reviews as well as a practical understanding of the challenges and opportunities that multiagency partners face when working together to safeguard children and young people.

1 The City and Hackney Safeguarding Children Board is the first to receive an 'Outstanding' judgement from Ofsted (September 2016).

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1. Foreword

1.1 In 2015, I was commissioned by the Chief Executive of Brighton & Sussex University Hospitals NHS Trust to undertake an independent review into the Trust's safeguarding arrangements for children and young people.

1.2 First and foremost, I want to express my sincere thanks to all those who participated in this process and for the honest, frank and direct way in which they engaged. Having spoken with over 150 staff across the entire footprint of the Trust, I want to emphasise how impressed I have been with those that I met. Their voices have been hugely significant in crafting the detail of this report.

1.3 Words such as dedication, enthusiasm and professionalism can often be overused. In the context of the staff that I spoke to, they are not. Indeed, if their attitude is a reflection of the wider staff group, then the Trust is clearly in a strong position to move forward with both the Review's recommendations and the challenges it will no doubt face in the future.

1.4 The initial catalyst for the Review involved the circumstances of a paediatric nurse at the Royal Alexandra Children's Hospital. Mr A had been arrested by the police, charged and subsequently prosecuted for offences relating to sexual activity with a child under 16, grooming a child for the purposes of sexual activity and possession of indecent images relating to children. None of these offences took place in the hospital, nor are they known to have involved patients.

1.5 Whilst it would have been easier for the Chief Executive to limit the Review to this case, he didn't. He subsequently extended the scope to explore the Trust's broader safeguarding capabilities. This decision reflects leadership, an appetite to learn and above all, a clear focus on what matters most; children and young people themselves.

1.6 As such, the Review explores a wide range of issues and provides a broad health check against a number of areas critical to the effective safeguarding of children and young people. The lessons are neither exclusive to those who primarily work with children nor are they singularly focussed on the children's hospital. They are relevant for all Trust staff, from the boardroom to the wards.

1.7 During this Review I saw evidence of good and outstanding practice. However, given the scale of the organisation and the range of business, clinical and personnel challenges they face, I also identified a number of areas that require improvement.

1.8 That said, whilst carrying out the Review, the question I have continued to reflect upon was whether I would be comfortable with one of my own children or grandchildren being cared for by staff at the Trust?

1.9 Having completed my work, the answer to that question is unequivocal. Yes.

Jim Gamble QPM
CEO Ineqe Group Ltd

2. Introduction

2.1 Brighton and Sussex University Hospitals NHS Trust (*the Trust*) is an acute teaching hospital working across two sites: the Royal Sussex County Hospital (RSCH) in Brighton and the Princess Royal Hospital (PRH) in Haywards Heath. The Brighton campus includes the Royal Alexandra Children's Hospital (RACH) and the Sussex Eye Hospital.

2.2 The Trust provides District General Hospital services to local populations in and around the City of Brighton and Hove, Mid Sussex and the western part of East Sussex. It also provides more specialised and tertiary services for patients across Sussex and the south east of England.

2.3 Both hospitals provide many of the same acute services for their local populations, with the PRH being the centre for elective surgery and the RSCH, the centre for emergency and tertiary care. Specialised and tertiary services include neurosciences, arterial vascular surgery, neonatal, paediatrics, cardiac, cancer, renal, infectious diseases and HIV medicine. The Trust is also the major trauma centre for Sussex and the South East.

2.4 In July 2015, the then Chief Executive Officer (CEO) of the Trust commissioned an independent review into its safeguarding arrangements for children and young people (*the Review*).

2.5 The overall aim of the Review was to provide assurance to the CEO and to the Trust Board that regulatory requirements were being met and that best practice was being followed in relation to the Trust's responsibilities to safeguard children and young people. The catalyst for its commission followed the CEO considering a number of specific and related matters with colleagues from the Children's Directorate, the senior management team, staff from across the Trust and the Trust Board. These matters concentrated on two principle aspects:

(i) The Trust's progress in response to the recommendations of Kate Lampard as part of her review,
(ii) The Trust's broader capabilities in discharging its statutory responsibilities to safeguard and promote the welfare of children and young people.

2.6 In respect of point (i), in February 2015, the Department of Health (DH) published an independent report[1], authored by former barrister Kate Lampard into the themes and lessons

1 Themes and Lessons Learnt from NHS investigations into matters relating to Jimmy Savile, Lampard, Feb 2015

learnt from NHS investigations into matters relating to Jimmy Savile.

2.7 The Lampard Review made fourteen recommendations relating to access, volunteering, complaints, governance and overall safeguarding arrangements. A specific recommendation stated that all NHS Hospital Trusts should undertake regular reviews of their resources, structures and processes, alongside the behaviours and responsiveness of management and staff in relation to safeguarding issues.

2.8 The CEO was keen to establish a position on progress in this regard and how the response to the Lampard Review sat within the wider context of the Trust's work on safeguarding children and young people.

2.9 With reference to the testing of the Trust's broader safeguarding capabilities set out in point (ii), the Review considered three specific cases involving Trust employees. The three cases involved are set out below.

2.10 Case A - A Trust employee who was convicted of sexual offences relating to a child in 2014. The child had not been a patient and the known incidents and his arrest took place outside the Trust. This employee was a nurse in the Children's Emergency Department (CED) at the RACH. He admitted three offences; sexual activity with a child under 16, grooming of a child for the purposes of sexual activity and possession of indecent images of children. Upon conviction he was sentenced to three years imprisonment and struck off from the Nursing and Midwifery Council's (NMC) register.

2.11 Case B - A Trust nurse was identified, investigated and arrested as part of Operation Spade[2] for accessing indecent images of children from the Internet. He was convicted in October 2015 for offences involving the making of indecent images of children and possessing a prohibited image.

2.12 Case C - This case involved concerns being raised about a non-clinical member of staff and their interaction with a child in the presence of the child's family during a period of treatment at the RACH.

2 Operation Spade was an international investigation of individuals suspected of accessing child abuse images. Coordinated in the UK by CEOP.

3. Terms of Reference

3.1 The full Terms of Reference for the Review are in *Appendix 3*. The primary aims, objectives and scope are set out below.

Aims

(a.) To evaluate the quality and impact of the Trust's safeguarding arrangements for children and young people and, if thought to be needed, make any recommendations for improvement.

(b.) To provide staff, children and their parents/guardians with an opportunity to raise any concerns they may have in relation to safeguarding children at any of the Trust's hospital sites.

Objectives

3.2 The objectives of the Review are to make appropriate enquiries; review and report on the available evidence; and make recommendations to inform the governance and quality assurance of the Trust's safeguarding policies and procedures.

Scope

3.3 In relation to the quality and impact of the Trust's safeguarding policies and procedures the Review will examine:

- Current safeguarding policies and procedures and consider if they fully reflect national and statutory regulatory frameworks for safeguarding that are in place.
- Compliance with existing safeguarding policies and procedures.
- The extent to which existing safeguarding policies and procedures benchmark well against those of comparable organisations.
- The Trust's compliance with Section 11 Children's Act 2004 regarding whether its functions, and any services that it contracts out to others, are discharged having regard to the need to safeguard and promote the welfare of children and its self-assessment carried out in 2014 for the Local Safegaurding Children Board (LSCB).
- The extent to which the recommendations from The Lampard Review are present within the Trust's existing safeguarding policies and procedures.
- The role of the Trust Board and the executive lead for the Trust's safeguarding policies and procedures.
- The arrangements for the raising and management of concerns in relation to safeguarding

and serious incidents, current or historic.

- Information sharing and arrangements for working with partners such as the police and local authorities.
- The Trust's implementation of Serious Incident, Serious Case Review, Learning Review and multi-agency audit findings and recommendations.
- Safe recruitment practices.
- The supervision and support of staff.
- The provision of and attendance at safeguarding training, including multi-agency training.

4. Approach and Methodology

4.1 The approach and methodology of the Review incorporated a number of distinct stages. These stages were not undertaken in a strict chronological order and were supported by nine days of fieldwork at the RSCH, PRH and the RACH.

4.2 Stage 1 of the Review included developing and circulating a written briefing for Trust staff. This written briefing included a summary of the rationale for the Review and was accompanied by both an outline of the Terms of Reference and an overview of the Review process and its various stages. This written briefing (*Appendix 4*) was circulated to staff via a dedicated page set up on the Trust's website and supported by a letter from the CEO.

4.3 Stage 2 incorporated a desktop review of key information held by both the Trust and external organisations with regards to the Trust's child safeguarding arrangements. This material supported the Review by providing both evidence and key lines of enquiry to test as part of the interviews with Trust staff.

4.4 Stage 3 involved the Review, where appropriate, benchmarking aspects of the Trust's safeguarding children arrangements against those of other NHS Trusts.

4.5 Stage 4 involved the Review interviewing front-line staff and other key people engaged in or with the Trust itself. These interviews were undertaken to ensure that the voices of all key stakeholders formed part of the review process and that the experiences of children and young people, parents / carers (and associated groups), staff, managers and leaders were considered, where available, as part of the evidence gathering process.

4.6 Whilst a number of interviews were planned, a significant majority of the group sessions engaging staff were spontaneous and undertaken with no advanced warning. This is considered by the Review to have added extra weight to the validity and credibility of the views expressed, as there was little or no opportunity for any preparation. Over 150 Trust staff, both clinical and non-clinical were engaged through individual interviews or group sessions. The roles of those staff interviewed are set out in *Appendix 5*.

4.7 Stage 5 involved creating a specific e-mail account to encourage key stakeholders to engage and communicate directly with the Review. This facility was promoted with staff via communication from the CEO, via publication on the Trust website and by the Review during staff interviews.

4.8 The intention of the e-mail account was to allow individuals to approach the Review independently without friends, colleagues or managers being aware of their contact. This resulted in a number of communications, which were either followed up by telephone interviews, face-to-face meetings or both.

4.9 Stage 6 involved drafting and fact checking of the Review report in order to provide the Trust with an opportunity to challenge areas of the report in terms of factual accuracy and any interim conclusions drawn.

4.10 Stage 7 involved producing a written de-brief that was made available to highlight the key messages from the Review, including associated lessons and recommendations for action.

4.11 Stage 8 involved the report being finalised and formally submitted to the CEO and the Trust Board.

Confidentiality

4.12 This report contains a number of statements made by staff in order to emphasise particular aspects relevant to the Review and its findings. The vast majority of references are anonymous, but where appropriate identify the role of the commentator. This is consistent with the approach agreed with interviewees to ensure confidentiality.

5. Executive Summary

5.1 Given the level of detail contained within this report, the Executive Summary has been purposefully written to provide the reader with a brief synopsis of the key issues examined by the Review. A full list of the Review's recommendations is available in *Appendix 1*.

What People Say

5.2 The Review found significant evidence of positive feedback from children and young patients, their parents and carers about the care received at the Trust. High levels of satisfaction and a feeling of security were recorded in a range of internal and independent surveys.

5.3 Staff feedback reflected some concerns regarding individual relationships and culture. However, the overwhelming majority of staff engaged by the Review were positive and felt the new Behavioural Blueprint was having an impact. They were immensely proud of working for the Trust.

5.4 Formal inspections of the Trust present a mixed picture. The Care Quality Commission (CQC) graded the safety of the services in the Trust as 'requires improvement', whilst as a key member of the Brighton and Hove Local Safeguarding Children Board, the Trust can and should take some credit for the 'Good' grading it received from Ofsted.

Leadership and Governance

5.6 Leadership and Governance in the context of safeguarding children and young people were considered to be broadly sound in terms of how policy defines accountability. However, there are a number of areas in which policy, leadership and their combined influence could be better reflected in practice.

5.7 Minutes from meetings of the Trust Board did not provide evidence of the levels of scrutiny and challenge expected. Furthermore, the Review noted a distinct and unusual lack of narrative about safeguarding children and young people in the Trust's strategies and reports, all approved and signed off by the Board. This raises the question as to whether safeguarding children and young people and the associated policies and practices related to them have been given a sufficiently high priority.

5.8 The Review formed the opinion that the Safeguarding Children and Young People Committee was not operating at an optimum level and was concerned at the lack of pace

regarding training attendance and awareness, policy deficits and progress against the Lampard Action Plan. The Review holds the view that an independent chair, drawn from the Board's Non-Executive Directors, may be better placed to deliver more robust challenge and to drive change.

5.9 It was clear to the Review that Chief Executive Matthew Kershaw was widely respected and operated an inclusive style that appears to have been welcoming of challenge and able to drive change when necessary. He was largely credited with the work to consult, develop and deliver the Behavioural Blueprint.

5.10 The Chief Nurse occupies a highly influential position at both a strategic and tactical level, sitting on the Board and also engaging with staff on the frontline. Her portfolio is so wide and varied that it is reasonable to question whether one person is capable of effectively delivering all of the responsibilities, as well as capitalising on direct and indirect opportunities to influence and inspire. Staff respect and listen to what the Chief Nurse has to say. It is therefore vital that she personally reflects the importance of safeguarding the young and vulnerable when engaging staff on wards.

5.11 The Named Professionals and the Safeguarding Children Team are highly respected, known to all staff and influential across the Trust and beyond. When scenario based questions were put to staff during the Review they all invariably defaulted to seeking advice from a Named Professional or the Safeguarding Children Team.

5.12 The Safeguarding Children Team visit wards, deliver training and represent the Trust on a range of internal and external bodies, not least of which is the Local Safeguarding Children Board. This team is too small and is identified by the Review as a potential single point of failure for the Trust.

5.13 The Patient Safety Ombudsman (PSO), in post at the time of the Review, has since left the Trust. During engagement, it was clear that she was passionate about and deeply committed to the role. The PSO was also very concerned about a range of issues reported to her during her 3 years in post and was, without doubt, a key influencer in bringing about this Review.

5.14 Given the PSO's remit to provide a critical conduit to ensure issues are not hidden, suppressed or diverted from attention, it is not surprising that views differed on how those responsibilities have been conducted and managed. The Review supports the concept of a PSO (and the planned '*Freedom to Speak Up Guardians*' for all NHS Trusts) and makes a

number of recommendations to address the issues raised during evidence gathering at the Trust.

Leadership Focus - Uniforms versus Child Protection

5.15 Testing staff awareness of policy, it was clear that few had a good understanding of the content of the Safeguarding Children and Young People Policy and whilst virtually none had read it in full, nearly all said they had read and were confident in their knowledge of the Uniform Policy. The staff believed this was because the Uniform Policy was the one given the highest priority by senior managers within the Trust. The Review found evidence that the Uniform Policy was frequently mentioned and the need to comply with it routinely reinforced by line managers and the Chief Nurse. This was in direct contrast to the lack of discussion, focus and management prompts regarding the Safeguarding Children and Young People policy.

5.16 The learning from this point is simple, yet profound. Leaders need to be seen and heard to reflect the importance of safeguarding children, otherwise this will be lost in the noise of the competing priorities that staff in high pressure environments are required to balance everyday.

(Relevant recommendations 1, 2, 3, 4, 5, 6, 7, 8 and 37).

Section 11 Children Act 2004

5.17 In its last audit of Section 11 (S11) duties, the Trust self-assessed as being compliant in 96% of the safeguarding standards prescribed within the S11 audit tool. Variances were identified by the Review in three rated by the Trust as being fully compliant. The draft S11 audit for March 2016 was submitted to the Review and whilst not finalised, there was evidence of an improved approach by the Trust in setting out defined areas for improvement, alongside evidence of compliance.

(Relevant recommendations 9, 10, 25 and 26).

Policies and Procedures

5.18 A significant majority of the Trust's safeguarding policies were considered broadly sound, notwithstanding the recommendations made in the Review's section on *Policy Structure*.

5.19 The Trust Internet site could be significantly improved. It provided a poor user experience and limited access to key policies. A link provided access to 6 policies of which 4 were out of

date according to the scheduled review timetable.

5.20 The Review identified a range of strengths associated with the Trust's Intranet including quick links to key policy documents and other useful information including 'ten top tips'. However, in terms of the 26 documents examined, some were out of date and the list lacked any rational structure.

5.21 A range of other child safeguarding information was also accessible via this site. The Review concludes it would be better to consolidate this material within a 'one-stop-shop' area.

5.22 Policy is considered by staff to be too long and complicated. This view has a negative impact on the eagerness or ability of staff to access or read them thoroughly. For example, in the Employment Checks Policy, it is not until page 7 that the detail about the actual check standards begins.

5.23 The Review suggests that the Trust's policy template be reconfigured to provide immediate access to the relevant information, advice or instructions, with other information, not relevant to immediate practical application, annexed at the rear of the document. The Trust should consider embedding policy, useful clinical and appropriate non-clinical Apps on team based mobile technology.

5.24 The Trust's Children and Young People Safeguarding Policy specifies that all staff 'must read' it, however, the overwhelming majority interviewed had not seen its contents and many were uncertain of the detail it referred to. This response was reflected in a range of other policies tested during face-to-face interviews.

5.25 It is, however, important to acknowledge that concerns regarding such findings were mitigated by the fact that most staff knew where to go to access safeguarding guidance and if unsure, knew who to approach for advice.

5.26 The Trust needs to quickly move beyond the task of simply writing, publishing and circulating a policy. It needs to move to a system that embeds the required practice via easy to access and simple to understand documents, reinforced and tested during training.

5.27 Other Trusts referenced by the Review provide examples of more comprehensive and up-to-date policies and greater transparency as these are available for public consumption via their respective websites. Out of date and inaccurate policies and procedures represent a significant risk to the Trust.

(Relevant recommendations 11 - 23 inclusive).

The Lampard Review

5.28 The Lampard Review was published on 26 February 2015 and included 14 recommendations for the NHS, the Department of Health and wider government. The Secretary of State accepted all the recommendations with the exception of one relating to Disclosure and Barring checks.

5.29 In respect of the 9 recommendations that apply to the Trust, the Review found it to be fully compliant with 4;

- Regular reviews of safeguarding resources, structures and processes (including their training programmes).
- Recruitment, checking, general employment and training of contract and agency staff and review of recruitment, checking and training.
- General employment processes to ensure they operate in a consistent and robust manner.

5.30 The Trust is partially complaint with 3 recommendations;

- Developing a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors.
- Reviewing their voluntary services arrangements and ensuring that they are fit for purpose.
- Ensuring staff and volunteers undergo formal refresher training in safeguarding at the appropriate level at least every three years.
- Assessment and management of the risks to brand and reputation, including as a result of associations with celebrities and major donors.

5.31 The Review took the position that the Trust is not compliant with 2 recommendations;

- Internet access. The Trust states that where it provides Internet access to patients, a strict policy is applied and the conditions of use agreed by each patient or parent/guardian/carer in the case of under 18's. This policy, if in existence, has not been submitted to the Review.

- The second area of non-compliance deals with Disclosure and Barring Service (DBS) checks. It is imporatnt to note that as a result of the Government's decision not to accept this recommendation there are no statutory or regulatory requirements placed on the Trust. However, the Review fully supports Lampard's original recommendation regarding DBS

checks.

(Relevant recommendations 23 - 32 inclusive)

Concerns and Allegations Against Staff

5.32 The Review reflected on three cases involving Trust employees; one involving inappropriate (non-sexual) touching (tickling) and the other two involving criminal activity. None of the offences took place in the hospital, nor are they known to have involved patients.

5.33 Case A and B relate to two separate incidents, at different times involving two nurses working in different parts of the hospital. Both had a deviant sexual interest in children. Notwithstanding the fact that there is nothing to personally link the two offenders, the cases attract overlapping commentary and some identical recommendations.

Case A

5.34 Thirty-six year old Mr A was a nurse at the Royal Alexandra Children's Hospital in Brighton, East Sussex, where he had worked for nine years. From January 2011 until the time of his dismissal in September 2013, he was a Children's Emergency Nurse Practitioner.

5.35 He targeted numerous young girls by masquerading as a teenage boy when engaging them in online chat rooms. We know he lured at least one to an offline meeting. In the searches carried out following his arrest in a hotel room with a fourteen-year-old girl, a number of indecent images were recovered on his phone and other devices. These images ranged in nature of severity from level one to level five. Under contemporary guidelines this would now be classed as Category A (in both classifications this is the most serious level).

5.36 Comments from those who worked directly with or in reasonable proximity to Mr A, reflected a sense of both confusion and anger. Some staff felt a degree of guilt by association and many wondered how they might have missed signs that he was in fact a predator. However even knowing what we do now, it is hard to imagine how any of Mr A's colleagues, staff or senior managers could have predicted that he might be a risk to children.

Case B

5.37 In November 2014, a 54 year-old male nurse (Mr B) working for the Trust was arrested as part of Operation Spade, an international police investigation concerning allegations of

accessing indecent images of children. Mr B had worked at the Trust for 27 years and at the time of his arrest was employed as an Emergency Nurse Practitioner (ENP).

5.38 The Review found significant overlaps relating to the way that staff felt when Mr A's crimes were uncovered with those reflected by colleagues of Mr B. They felt confused, shocked and horrified that a person who could commit such crimes was within their midst.

5.39 Some staff reflected on an apparent 'competence issue' in Mr B's past that may have provided an insight into his subsequent behaviour. This issue related to a suspicion that he was applying preferential patient selection. The initial concern was that he was selecting younger patients, however an internal audit of records and a supervisor's review came to the judgement that his preferential selection was a competence issue. In other words, he was selecting younger patients who would be easier to manage and treat rather than what he perceived as more difficult older patients.

5.40 Whilst his choices at that time may well have been linked to competence, the failure to alert and take advice from the Local Authority Designated Officer (LADO) was an error of judgement and a failure of good practice. During the investigation, Mr B was treated as if there had never been any suspicion concerning inappropriate behaviour.

Learning from A and B

5.41 When Mr A's contact offending came to light in 2013 and Mr B's accessing images was exposed by his arrest under Operation Spade in 2014, the Trust leadership took immediate and decisive action to manage the incidents. They followed the 'Allegations of Child Abuse Against Staff' (2013), (superseded by their improved 2015 draft) policy in both cases.

5.42 This policy provided useful lists of actions and guidelines, although both the 2013 and 2015 versions place an emphasis, without explanation or example, on the '*Need to Know*' principle. Furthermore, neither version of the policy makes reference to an overriding objective to sharply focus on ensuring children and young patients are safeguarded.

5.43 Given the police investigation and the understandable tendency for caution when dealing with sensitive information, it is not surprising that the default position regarding information sharing was simply not to do so. This overly restrictive blanket approach fed rumours, created unhealthy division at a vulnerable time and played into the hands of the respective offenders who attempted to minimise their wrongdoing when communicating with staff.

5.44 A considered internal communication strategy would have ensured that staff were better informed, that those who needed to know more were properly briefed (security staff, ward managers and colleagues of the offender) and that all staff understood the Trust's position.

5.45 Whilst there was discussion and some debate about whether to engage previous patients and their parents, a lack of child/patient focus within the policy meant that proper consideration was not given to assessing the likelihood of whether or not offending may have occurred within the precincts of the Trust. This situation was compounded, in the opinion of the Review, by the ambiguity concerning what the police said and what the Trust thought they meant.

5.46 In the cases of both Mr A and Mr B the Police told senior managers that there was no evidence of any offending in the hospital. However, the Review found no indication that police actively investigated whether contact or image based offending had actually occurred within the workplace. Evidence given to the Review indicates that in Case A, additional forensics may not have been carried out on some devices, as the evidence of contact offending in the hotel was considered sufficient to achieve a prosecution.

5.47 Notwithstanding the apparent lack of investigation, it may well be that no offending took place in the Trust. That said, operating on the assumption that an individual with a deviant sexual interest in children can simply switch that instinct off at the front door of the workplace is, in the opinion of the Review, reckless.

Case C

5.48 Case C relates to an incident in which a complaint was made about the behaviour of a member of staff during 2014. The parents of a child in hospital for medical treatment for a serious illness were concerned when a staff member engaged in an overly tactile manner by tickling their child. This occurred in their presence and on more than one occasion.

5.49 The member of staff admitted that they had tickled the child on more than one occasion. They stated that they had previously interacted with the child and the mother and that the child had laughed when tickled and had not seemed to be upset. They also stated that it was not normal behaviour for them to tickle children.

5.50 Following consultation with the parents, terms of reference for the investigation were agreed, an appropriate investigator appointed and the individual involved in the incident moved to another ward. The Named Nurse liaised with the Local Authority Designated Officer (LADO),

who carried out appropriate background checks, including with police and social services. None of the agencies felt the incidents met the threshold for abuse. The member of staff had not been given Level 2 Safeguarding Training and clearly did not recognise boundaries. They have since received advice and appropriate training.

5.51 The parents received written communication concerning the outcome of the investigation and whilst it was clear that they had been concerned by the incident they readily praised staff for the medical care they provided and the manner in which the Trust responded to the compliant.

(Relevant recommendations 12, 33 - 39 inclusive).

Response to Serious Incidents, Reviews and Learning

5.52 The Trust has a defined approach to the governance and management of Serious Incidents which is set out within the Trust's Safety, Quality and Patient Experience Strategy. Processes are well supported by the named professionals' who participate in the LSCB and the Trust has developed a range of mechanisms to share learning, including the use of podcasts. However, the Trust's Strategy contains no explicit reference to safeguarding children and young people. The Review considers this to be a serious omission and a missed opportunity for the Trust to emphasise its focus on learning in the context of safeguarding children.

(Relevant recommendations 40, 41 and 42 inclusive)

Information Sharing and Working with Partners

5.53 The Trust participates in the work of the Brighton and Hove LSCB, whose Independent Chair recognised that the attendance of the named professionals (as advisors) added good value to the work of the Board. However, he also commented that the Trust weren't as visible at a strategic level as they could be and expressed concern that Trust staff were unaware of LSCB multi-agency safeguarding training. The Review concurs with his position.

5.54 The Review identifies that the biggest threat to the Trust in this regard is that if the most senior leaders aren't prioritising and seen to prioritise engagement in multi-agency child safeguarding, then front-line staff and the organisation itself runs the risk of mirroring this approach.

5.55 In respect of operational engagement, interviews with staff from partner agencies reflected a wholly positive account of the interface with staff at the Trust, particularly with

regards to the Named Nurse and the Safeguarding Team. The Review did however, hear from a number of staff about the negative impact on working relationships following the creation of the Multi-Agency Safeguarding Hub (MASH) and the withdrawal of the on-site social worker.

5.56 Whilst different views were expressed about the loss of this role by other agencies, the lasting impression on Trust staff was that this has hindered their effectiveness. Communication with the MASH was expressed as not being the same, there was a lack of relationship and Trust staff felt they were being 'filtered out' and finding it harder to get advice and the level of support they required. Given the value placed on this social work resource by Trust staff, the Review believes there is an opportunity to explore potential solutions for this alongside the recommendation for increasing capacity in the Safeguarding Children Team.

(Relevant recommendations 43 and 44).

Safer Recruitment

5.57 Evaluating the Trust's safer recruitment activities involved the Review examining a range of relevant written material, alongside interviewing a number of staff about their respective responsibilities and personal experience in this area. The Review considers that overall, there are effective arrangements in place and that the Trust is compliant with the legislation underpinning the recruitment and vetting of staff and volunteers.

5.58 The Trust's Learning and Development Team train staff involved in recruitment and learning podcasts are available to them on the Trust's Intranet. The Review considers this good practice. The Review also noted recent improvements with the Trust now keeping records of trained panel members.

5.59 The Trust's requirements to notify the DBS of relevant information is clearly set out within the Employment Checks Policy. DBS details were noted by the Review to be recorded on the respective personnel e-files of staff, with better governance surrounding this aspect cited as being 'introduced shortly' in the Trust's S11 audit in 2014. This 'better governance' relates to the introduction of a new Applicant Tracking System, understood to make it easier for managers to access relevant details of their staff. At the time of the Review, this system had not been rolled out and some managers reflected concerns about this affecting their oversight.

5.60 The Trust's internal debate concerning repeat DBS checks is likely to be a conversation that is also taking place in other organisations. The Review therefore believes there is merit in seeking clarification regarding what other partners are doing via the LSCBs with whom the

Trust engages. The lack of national appetite to prescribe any frequency around this issue is, in the Review's opinion, an opportunity for the local partnership to determine best practice in this area. The Review makes an associated recommendation on this matter.

(Relevant recommendation 45).

The Supervision and Support of Staff

5.61 Throughout the Review, staff spoke highly of the immediate support that they received and the value that they placed on supervision. Comments by staff illustrated the high confidence that they had in both their line managers and colleagues and their collective abilities to help staff deal with difficult and distressing situations when needed.

5.62 In addition to such support, a common theme repeated by many staff during interview, related to the equal value that they placed on the Named Doctor, the Named Nurse and the Safeguarding Team. All staff spoken to by the Review were aware of and familiar with this team and the Review was impressed with the support and visible leadership they provide.

5.63 Staff appraisals are a critically important tool and whilst the rates of appraisals being undertaken are improving, the Review considers it important to draw a connection between low appraisal rates, the poor take up of training and the low numbers of staff able to confirm they had read related policies. The Review considers it would be a missed opportunity for the Trust not to use appraisal (and the accompanying supervision) as a mechanism to set out a number of Trust wide expectations around safeguarding children and for these to be implemented, tracked and tested by managers across all levels.

5.64 Furthermore, another matter relating to supervision was highlighted to the Review in respect of 'significant social' relationships between some staff members. This has particular relevance to the potential impact of such relationships compromising, or being perceived as compromising, decision-making, the reporting of concerns and the tackling of poor performance. All of these issues are important factors in ensuring children and young people are effectively safeguarded. Such allegations and negative perceptions must be taken seriously and addressed; the Review makes specific recommendations in this regard. It is however important to note that the Review found no evidence of compromised decision making related to 'significant social' relationships which may exist within the Trust.

(Relevant recommendations 46 - 49 inclusive).

Child Safeguarding Training

5.65 All staff at the Trust coming into contact with children and young people have a responsibility to safeguard and promote their welfare.

5.66 The formal training sessions at the Trust are consistent with the Intercollegiate Document and are offered at three different levels.

- All new Trust staff receive Level 1 training as part of induction.
- Clinical staff who work mainly with adults receive Level 2 training.
- Staff working with children or in midwifery receive Level 3 training

5.67 Training materials produced by the Trust's Safeguarding Children Team are considered to be comprehensive in terms of addressing what might be described as the traditional themes. There is a strong focus on abuse and neglect and subjects include areas such as Child Sexual Exploitation (CSE), FGM and radicalisation.

5.68 Whilst staff value the training they received and the quality of its delivery they highlighted that the time committed to safeguarding children training was too limited. Thirty minutes every three years for Level 1 and one hour every three years for Level 2 training.

5.69 The Trust could be more aspirational in its approach to the minimum safeguarding training it provides for all staff and the Review makes a recommendation in this regard.

Addressing Offending Behaviour and Positions of Trust

5.70 Whilst basic level training was good, it was clear that important areas relating to safeguarding, such as perpetrator behaviour, grooming and allegations against staff were aspects not covered in as much depth, if at all. When tested it was apparent that whilst all staff were clear about who they would speak to if they had concerns about a colleague's behaviour, few if any knew what signs to look for in the first place. This Review recommends that a module regarding offending by individuals occupying positions of trust is included in mandatory training.

Training Attendance

5.71 Notwithstanding the significant efforts being made by the Safeguarding Children Team and Trust safeguarding leads much work remains to be done. Apart from specialist roles, performance in this area (which is measured against the minimum standards) represents a

significant weakness.

5.72 Capacity is a critical issue. The remit of the Nurse Consultant has grown whilst her team has effectively been reduced in size. This has clear implications regarding their ability to successfully deliver mandatory training to all staff to a satisfactory level. The Review is of the opinion that reliance on such a small team to provide training for over 8,000 staff is unrealistic, unreasonable and unsustainable.

5.73 Whilst the Review notes the significant impact of austerity and the growing operational demands faced by the Trust, care must be taken by them not to lose sight of the importance of training.

5.74 The Trust therefore needs to consider how it can better monitor progress and sustain and improve its training capability. This will require significant leadership commitment focused on improving access to internal provision and external LSCB multi-agency safeguarding training. The Review makes recommendations in regard to these issues.

Training Strategy

5.75 Supporting the requirements set out in the Intercollegiate Document, the Trust has delivered its training to staff within the context of a wider Safeguarding Children and Young People Learning & Development Strategy. At the time of the review, however, this strategy (dated 2012-14) was out of date. A revised draft had been completed in December 2014 to cover January 2015-17, but had not been formally agreed by the Trust.

5.76 The Review believes the Trust would benefit from revising its' Safeguarding Training strategy to reflect;

(i.) Local context via the key and emerging risks to children highlighted by their LSCB partners and
(ii.) The risk posed by offenders who occupy positions of trust.

5.77 The Review believes that a clearer focus on these issues, combined with reinforced resourcing will produce a more acutely focused strategy. This will assist the Trust meet their obligations to support staff and safeguard children and young people.

Training Evaluation

5.78 Measuring the impact of training is critical. The Review therefore recommends that a heightened focus be applied on how training is evaluated by defining a specific training analysis and evaluation framework. Initiating such a framework will assist the Trust form a better view of the quality and impact of training beyond simply looking at compliance with attendance.

5.79 The Review therefore recommends that the Trust develop a training analysis and evaluation framework, adopts a more structured approach to sharing actual experience during training and formally tests that knowledge transfer has taken place.

Multi-Agency Safeguarding Training

5.80 The benefits of multi-agency training are well established. As such, it is disappointing to see that only 1 staff member from over 8000 employees attended a core LSCB multi-agency training course in 2014/15.

5.81 During Review interviews the vast majority of staff demonstrated a complete lack of awareness about the availability of multi-agency safeguarding training. Even when awareness was acknowledged, the operational pressure on front-line staff was often cited as a reason for them not being able to attend.

5.82 Whilst it is right for the Trust to focus on ensuring their staff attend mandatory in-house training, consistent with the Intercollegiate Document, it is a missed opportunity that so few are developing their safeguarding skills and knowledge alongside colleagues from other disciplines.

5.83 The Review is without doubt that significant value would be added to the Trust safeguarding arrangements and the quality of LSCB training through increased attendance. An opinion mirrored by the Chair of the B&H LSCB. The Review makes a recommendation in this regard.

(Relevant recommendations 36, 50 - 57 inclusive).

Security, Access, ICT and Exposure to Risk

5.65 Whilst not defined in the Terms of Reference, the Review considered it important to examine a number of issues relating to the security, access and ICT arrangements at the Trust and the associated exposure to risk. This focused on four areas:

- The operating practices of the Trust's security team.

- A specific analysis of the potential risk of accessibility in the Children's Emergency Department of the RACH.
- The 'movement' of patients with regards to adults frequently sharing spaces and medical services in some parts of the Trust and;
- The compatibility of the ICT systems operating across Trust sites.

5.66 A range of approaches aimed at strengthening the Trust's performance in these areas are recommended by the Review.

(Relevant recommendations 58 - 63 inclusive).

Conculsion

5.67 The Review has highlighted some strengths, a range of good practice and a number of areas in which on-going work should be expedited, improvements made and policy amended. The Trust now needs to consider the 63 recommendations, make choices and reflect on the risk that failing to properly address them may represent.

5.68 Simply increasing the responsibilities of the few individuals within the Trust with specific safeguarding roles will only exacerbate the situation. Investment in resource and support for those who carry the greatest burden in this area, the Chief Nurse, Designated and Named Doctors and Nurses and the outstanding but overburdened Safeguarding Children Team is crucial. For too long, too few have carried a disproportionate amount of responsibility in this critical area.

5.69 A full list of recommendations can be found at *Appendix 1*.

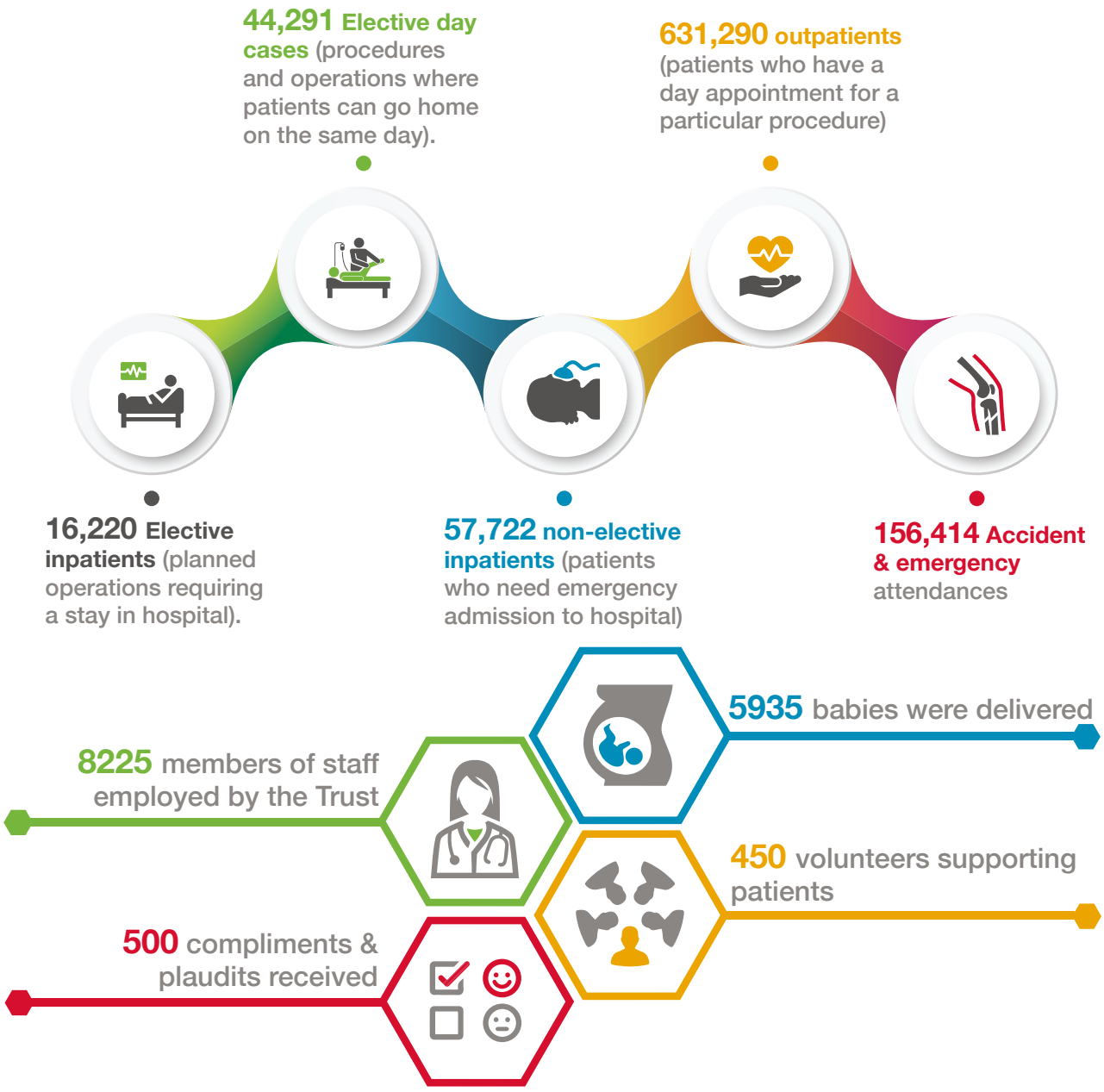
6. Safeguarding Context

6.1 In terms of key statistics, local context and an understanding of the operational demands on the Trust, the Safeguarding Snapshot provides an overview of this activity alongside key safeguarding statistics for Brighton and Hove in 2014/15.

Safeguarding Snapshot 2014/15

Data captured from a variety of sources including B&H LSCB Annual Report 2014/15 and Trust documentation.

905,937 patients were seen, including:



- Approximately 20% of the local authority's children are living in poverty.
- At 31 March 2015, 7283 referrals to children's social care (13% made by Health Services).
- At 31 March 2015, 832 child protection investigations had been undertaken.
- At 31 March 2015, 1,479 children had been identified through assessment as being formally in need of a specialist children's service. This is an increase from 1,412 at 31 March 2014.
- At 31 March 2015, 309 children and young people were the subject of a child protection plan. This is an increase from 288 at 31 March 2014.
- At 31 March 2015, the local authority was looking after 481 children (a rate of 95.2 per 10,000 children). This is an increase from 465 (92 per 10,000 children) at 31 March 2014.
- 239 allegations were made against a range of professionals working with children across Brighton and Hove in 2014/15.

50,000

Approximately 50,000 children and young people under the age of 18 years live in Brighton & Hove.

18%

This is 18% of the total population in the area

293 Referrals were made by Trust staff between July 2014 and June 2015.

1 Member of Trust staff attended core training delivered by the B&H LSCB in 2014/15.

80 Multi-agency staff attended an awareness raising session organised by the Named Nurse in June 2015.

805 Paediatric & maternity staff attended mandatory safeguarding children training in 2014/15.

170 Child protection medicals undertaken at the RACH in 2014

Daily safeguarding ward visits were undertaken to approximately 450 children and young people at the RACH

What People Say - Young Patients, Parents and Carers

6.2 During the desktop exercise, the Review considered the wealth of evidence held by the Trust and other key stakeholders concerning the views of children and young people. Reviewing this information adds important context, as it is ultimately the experiences of patients that significantly define how well (or otherwise) a service is performing.

6.3 It was noted by the Review that the vast majority of young patients considered their overall experience at the Trust as being good. In 2015, The CQC published their survey findings of over 200 young patients and their parents/carers seen at the RACH.[3]

6.4 On a scale of 1 to 10, 10 being the optimum safety score, children rated feeling safe on their hospital ward as 9.6/10 (about the same as other Trusts). With regards to the safety of younger children aged 0-7, parents and carers rated feeling their child was safe on their ward as 9.5/10. These positive results support the findings of the Trust itself, captured through a monthly feedback programme and were further echoed (notwithstanding their complaint) by the family in Case C when interviewed by the Review.

6.5 The Review also noted that the Trust seeks regular and real time feedback from patients and their representatives at the monthly Patient Experience Panel. For inpatients, the Patients' Voice survey has been adapted to incorporate the national Friends and Family Test (FFT).[4] The Trust's FFT scores are slightly better than the national averages[5], and a priority set within the Trust's Annual Plan for 2015/16 has been to increase the response rate. Small, but indicative samples of the positive comments made in the FFT are set out below:

"The activities and TV was good while my little girl was having her head looked at, helped her to remain calm".

"Wonderful and friendly staff. Could not ask for anything better, many thanks to all".

"Prompt care, made to feel at ease and given lots of attention my daughter was looked after well".

6.6 In addition to these formal mechanisms for feedback, the Review also noted a significant quantity of cards and artwork created by young patients and displayed on wards to thank

3 CQC Children and Young People Survey, July 2015
4 https://www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/
5 BSUH Annual Plan 2015/16

individual nurses and teams for their help and support.

6.7 Whilst the engagement mechanisms adopted by the Trust in seeking the views of parents and carers were not a specific focus for this Review, it is important to credit the Trust for their efforts and consistent approach in this area.

6.8 The feedback information together with the direct observations of the Review provides good evidence of the dedication and expertise of Trust staff. These positive traits were also clearly apparent to the Review through the staff interviews and provide further corroboration of the significant strengths that the Trust has within its existing workforce.

What People Say - The CQC

6.9 The latest CQC inspection report for the Trust was published in August 2014 and has an overall rating of *'requires improvement'*. In terms of the safety of the services in the Trust, this is also graded as '*requires improvement'*. The CQC team made this judgment about safety across 19 service areas at five locations. Of those, 10 were judged to be '*good*' and nine '*requires improvement'*.

6.10 This means that the Trust can and does deliver safe care to a good standard, but does not do so consistently across all services and all sites. The key findings relating to safeguarding are hosted on both the CQC[6] and Trust[7] websites and were considered by the Review for additional context to the evidence being gathered. These findings are set out below:

6.11 A&E Safeguarding

- There were effective systems in place for the reporting of safeguarding incidents so that they could be appropriately investigated by the multi-agency safeguarding team. This included a double-check of all the children who attended the CED at the RACH during the day by the night staff, as well as a social worker the following morning.[8]
- Staff working in the CED had received level 3 safeguarding training.
- There was a named consultant and nurse for safeguarding within the department. The consultant told the CQC that there were weekly peer reviews of all non-accidental injuries.
- 32 staff working with the main adult Emergency Department (ED) had attended either level 2 or 3 safeguarding children training but this had been rated as red by the Trust, meaning

6 CQC BSUH Inspection Summary, http://www.cqc.org.uk/provider/RXH/inspection-summary#overall
7 https://www.bsuh.nhs.uk/search/?q=safeguarding+children
8 Notwithstanding the recent withdrawal of the in-house social worker.

they were in need of an update.

- 51% of staff working in the CED at the RACH had received an update in safeguarding vulnerable children at level 3 within the previous 12 months.
- Staff raised concerns with the CQC about the children's social work department being moved from on-site to an off-site location in September 2014. Staff told the CQC at the time that they felt this would cause delays in a child being seen. This area is addressed later in this report under '*Information sharing and arrangements for working with partners*'.

6.12 Medicine Safeguarding

- There was a system for raising safeguarding concerns and staff in all areas explained the process clearly.
- All of the staff that the CQC spoke with had undertaken safeguarding training and felt able to raise an alert when needed.

6.13 Surgery Safeguarding

- Staff were aware of the safeguarding team and who to report any potential concerns to. The Trust had a lead doctor, a named nurse and safeguarding nurse in place that staff could access for support and guidance.
- Staff confirmed they had a safeguarding workbook to complete, as part of their training in this area.
- For individuals with learning disabilities attending the hospital for surgery, staff advised that they would be encouraged to bring a relative or carer with them. In addition, staff could also access the learning disability service within the trust, and the CQC saw contact details for arranging this.
- Patients who spoke with the CQC commented on feeling safe with staff and were confident they were being looked after safely.

6.14 Critical Care Safeguarding

- Vulnerable people were protected against abuse or potential abuse.
- Staff were aware of the signs of abuse or potential abuse when dealing with vulnerable adults in their care, or children linked to patients or their relatives.
- Staff were clear about how to report abuse and their responsibilities to do so.
- Staff gave the CQC examples of situations where this had arisen and the steps they had taken. This included robust reporting and follow-up by the responsible staff at both local and Trust-level.

- Patients admitted with, or acquiring, pressure damage to their skin would be reported to safeguarding.

6.15 Maternity Safeguarding

- Midwifery and support staff were aware of adult safeguarding and child protection reporting systems within the Trust. They had attended level 2 safeguarding training.
- The Trust had an effective system for 'flagging' an at risk woman during her pregnancy, labour and in the postnatal period.
- There were specialist midwives involved in safeguarding cases.
- The CQC saw good communication between hospital-based staff and community midwives around at risk women.
- The safeguarding midwife had a session about child protection issues and training on the Obstetrics & Gynaecology department induction programme for the new intake of doctors.

6.16 Children's Hospital Safeguarding

- The areas within children's services were supported by a safeguarding nurse who visited the areas on a daily basis.
- The CQC saw evidence that safeguarding assessments were completed by suitable staff, as appropriate. They noted that safeguarding concerns were managed in a timely manner and involved a multidisciplinary team, as required.
- All of the nursing and medical staff that the CQC spoke with could explain the safeguarding policy and procedures and knew what they should do if they suspected abuse.
- Although the medical staff understood their responsibilities concerning safeguarding, the majority of junior doctors the CQC spoke with said that they had not received any safeguarding training. However, they saw evidence that all junior medical staff received a comprehensive induction programme that included safeguarding children and vulnerable adults.
- 79.9% of all nursing staff within children's services had received safeguarding training at level 3. The CQC recommended that the Trust should ensure that all staff have regular safeguarding training.
- The safeguarding children team produced a regular 'Safeguarding Children and Young People' newsletter.
- The Neonatal Intensive Care Unit produced a 'Baby Watch' newsletter around risk in the unit.
- All of the children and parents the CQC spoke with said that they felt safe and had no concerns.

6.17 Outpatients Safeguarding

- The CQC saw evidence that 100% of care and support staff had attended safeguarding training for adults and children in the outpatient department.
- The CQC saw that patients with safeguarding and/or mental health needs were identified by staff the day before they attended the outpatient department. This ensured patients' care and support needs were known and staff provided support and guidance to patients when it was required.
- The nurse manager liaised with the learning disabilities nurse and the safeguarding team when advice and guidance was required.

6.18 As part of the CQC inspection in 2014, a number of issues were reported by staff to have impacted on safety, including staffing levels and pressures caused by problems with the flow of patients through the hospital. Whilst not relating to the Children's Emergency Department at the RACH, these factors were also highlighted during an inspection of the adult emergency department at the RSCH in October 2015. The CQC found that, at times, the adult Emergency Department did not have the capacity to ensure the safe accommodation of the number of patients present in the department.

6.19 Whilst not a discreet focus of this Review, patient flows as they relate to physical layout are discussed later in this report under *'Security, Access, ICT and Exposure to Risk'*. Specifically, this relates to the flow of children through waiting areas at Trust sites that are also attended by adults with serious health conditions.

6.20 This was raised as an issue by a member of Trust staff in the Ear, Nose & Throat (ENT) Department expressing concern that children were being exposed to extreme and distressing illnesses due to them having to share waiting areas with adult patients.

What People Say - Ofsted

6.21 In April and May 2015, The Office for Standards in Education, Children's Services and Skills (Ofsted) undertook an inspection of Brighton & Hove City Council as part of its Single Inspection Framework. This inspection focused upon services for children in need of help and protection, children looked after and care leavers. It also included a review of the effectiveness of the local safeguarding children board. Ofsted's report[9] was published in June 2015 and local arrangements were judged as *'requiring improvement'* overall, with the LSCB grading being

9 Brighton and Hove City Council - Inspection of services for children in need of help and protection, children looked after and care leavers, Ofsted, June 2015.

'good'.

6.22 The Trust is a key statutory partner of the Brighton & Hove LSCB (B&H LSCB). Ofsted identified that the LSCB partnership arrangements were working effectively at both strategic and operational levels. The B&H LSCB was noted as having strong leadership and effective governance arrangements, featuring senior managers from partner agencies chairing the majority of its sub-groups.

6.23 Ofsted also assessed the B&H LSCB as having a strong multi-agency influence and expertise for its oversight and evaluation of practice, providing an increasingly informed and diverse picture of particularly vulnerable groups of children and young people.

6.24 The Executive Summary of this inspection cites a number of strengths including:

"The LSCB has rapidly developed over the last two years from a local-authority-dominated board to a transparent, learning-focused multi-agency LSCB. The LSCB effectively monitors and influences improvements in frontline multi-agency safeguarding practice."

"The LSCB has strong leadership and effective governance arrangements…The board now has a strong multi-agency influence and expertise for its oversight and evaluation of practice….

The LSCB is outward-looking and ambitious…it has a strong presence in schools, the voluntary and private sector and in the city's health economy." (Ofsted, June 2015)

6.25 The Trust's engagement via the B&H LSCB will no doubt have contributed to the positive outcome of the inspection by Ofsted and those staff actively engaged in the LSCB should be credited for their efforts in this regard.

6.26 Notwithstanding this, the findings of this Review have highlighted a number of areas for improvement in terms of how the Trust can and should improve the effectiveness of multi-agency safeguarding arrangements at both strategic and operational levels. See 'Information Sharing and Arrangements for Working with Partners'.

What People Say - The Trust's Staff

"I like coming to work" (Health Care Assistant)

6.27 The overwhelming view from staff was that they were immensely proud of working for the Trust and proud of the positive difference that they were making to the lives of people on a day-to-day basis. The Review was both impressed and humbled by the dedication and professionalism of the staff seen as part of this process.

6.28 Those interviewed spoke of the value that they placed on one another and the help received from colleagues. In nearly all cases, staff praised their line managers as being engaged and supportive of them. There was a palpable feeling of camaraderie and mutual support and it was patently clear that whilst the operational demands on staff are significant, this was neither detracting from their morale nor their desire to provide services and help people.

"I think that we have quite a supportive team. There is no one I would not ask if I had something to ask. Everyone is open to chat about things if you're unsure what to do, we are quite supportive in that way." (Senior Nurse)

"Do you feel supported by supervisors? Yes, very much so" (Staff Nurse)

"I find my manager very approachable" (Emergency Nurse Practitioner)

"In the department as a team we're friendly, work well together and try hard to flatten the hierarchy." (Matron)

6.29 Whilst the Review found evidence of dissatisfaction amongst some staff, the overall impression gained was indicative of a predominantly healthy culture amongst the frontline workforce. Indeed, although the interviews did not reach into all areas of the Trust, it is important to note that the Review's conversations with staff did not mirror the findings set out in the Trust's 'People and Wellbeing Strategy' (May 2015) that reported 34% of staff had experienced harassment, bullying or abuse from staff in the last 12 months compared to 17% in best trusts.[10]

6.30 It was also clear that many staff valued the changes that had been brought about by the CEO and the importance that they placed upon the Chief Nurse's influence. Both these leaders were overwhelmingly respected with such accounts echoed in the findings of the 2014 CQC

10 People and Wellbeing Strategy, May 2015

inspection:

"Staff spoke very positively about the Chief Executive, who they said was highly visible, engaged, focused and committed to improvement. Staff across the trust and at every level referred to communication having been "transformed" since his arrival. Nursing staff also spoke positively about the Chief Nurse and the impact that she was having." (CQC Inspection Summary 2014)

6.31 One such 'valued change' initiated by the CEO has been the Trust's Behavioural Blueprint launched in 2014. This Blueprint sets out the agreed values and behaviours expected of all those working at the Trust.

6.32 The Blueprint was developed through the contributions of over 700 staff[11] and was initiated in an effort to prioritise and address a number of unresolved issues concerning the culture at the Trust.[12] This programme was highlighted as an area of outstanding practice by the CQC in 2014:

"The awareness of staff of the work on values and behaviours was almost universal. With very few exceptions, all the staff we talked to about this had been involved directly in this work, knew a colleague who had been involved, or were aware of the opportunities that they had had to engage with and influence this work." (CQC Inspection Summary 2014)

6.33 The Review is reassured that the Blueprint remains a live and visible programme and we saw substantial evidence of a commitment to drive this work forward. Whilst not every member of staff could recount the exact detail, it was clear that this programme was having an influence and impacting positively on front-line staff, the professional relationships that they held with each other and the care being delivered to patients.

"It is treating each other and patients with respect and valuing people." (Health Care Assistant)

"I'm aware of it and its core values. I may not be able to quote it but it's a core value we all work to." (Midwife)

6.34 The Review noted evidence that posters and relevant information about the Blueprint were available in nearly all of the areas visited across the various Trust sites, with a particularly high prevalence in staff rooms. It was also noted to have good visibility on the Trust website and a clear focus in the minutes of Trust Board meetings and related Trust reports and strategies.

11 The Trust Annual Plan 2015/16

12 CQC BSUH Overall Summary and Rating, http://www.cqc.org.uk/provider/RXH/inspection-summary#overall

6.35 However, the Review also recognises that maintaining this culture remains a work in progress, and spoke to a small number of staff who expressed deep concerns at what they saw as a disconnect between the frontline and senior management. The importance of this particular issue should not be underestimated.

"I don't see how they can support us in the current climate & with the staffing pressures." (Nurse)

"I feel I am immediately supported, but not above my line manager." (Nurse)

"We have a problem because the top of the organisation and the bottom have different agendas." (Patient Safety Ombudsman)

6.37 The 2014 CQC inspection summary points towards the Trust needing to maintain its efforts at creating the right values, principles and overall culture in the organisation. This Review concurs.

6.38 Whilst evidence indicates that the Trust has continued to take positive steps and is making progress, it is critically important that senior leadership take and are seen to take the residual issues raised by CQC and reinforced by a range of sources in this Review seriously. A failure to address this robustly will create a risk that staff will feel further disconnected and disadvantaged and therefore may be less likely to have the confidence to report relevant matters to seniors, including issues directly related to safeguarding children.

7. Leadership and Governance

Terms of Reference:
To examine the role of the Trust Board and the executive lead for the Trust's safeguarding policies and procedures.

"The leadership of a trust sets the tone for the organization"
(Professor Mike Richards, Chief Inspector of Hospitals[13])

7.1 When reflecting upon the effectiveness of the Trust in discharging its responsibilities to safeguard children and young people, the Review considered, but also looked beyond, the defined terms of reference set out above. The creation, implementation and understanding of policies and procedures are acknowledged by the Review to be important, but they form only a small part of what is expected in terms of the overall leadership and governance of this agenda.

7.2 The Review's specific findings on the Trust's policies and procedures are covered elsewhere within this report and do not need to be repeated in detail. There are clear strengths and some areas requiring improvement and to a large extent, this mirrors the findings of the Review in terms of the overall leadership and governance in the Trust as applied to safeguarding children.

7.3 The NHS Accountability and Assurance Framework[14] states: "*All staff, whether they work in a hospital, a care home, in general practice, or in providing community care, and whether they are employed by a public sector, private or not-for-profit organisation, have a responsibility to safeguard children and adults at risk of abuse or neglect in the NHS.*"

7.4 In line with this prescribed intent, and to ensure that the all Trust staff understand and apply this responsibility in practice, the Board has a critical leadership role in making sure that:

- Children and young people who use the services of the Trust are safeguarded and that staff are suitably skilled and supported,
- Child safeguarding forms part of any mandatory training in order to develop and embed a culture within the Trust that ensures safeguarding is everybody's business from 'the board to the floor'.

13 CQC - Working together to assess leadership 2014
14 Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework 2015, https://www.england.nhs.uk/wp-content/uploads/2015/07/safeguarding-accountability-assurance-framework.pdf

- The Trust has safeguarding leadership and commitment at all levels of their organisation and that they are fully engaged and in support of local accountability and assurance structures, in particular via the LSCBs,
- The Trust employs named professionals, who have a key role in promoting good professional practice, supporting the local safeguarding system and processes, providing advice and expertise for fellow professionals and ensuring safeguarding training is in place.

7.5 The Trust Board must assure itself, regulators and their commissioners that arrangements for safeguarding children are working effectively, with a particular focus on the following aspects, all of which have been considered by the Review.

- Safe recruitment practices and arrangements for dealing with allegations against people who work with children or vulnerable children as appropriate. (See '*Safer Recruitment and Concerns and Allegations against Staff*').
- A suite of safeguarding policies including a chaperoning policy. (See '*Policies and Procedures*').
- Effective training of all staff commensurate with their role and in accordance with the intercollegiate competences 2014. (See '*Safeguarding Children Training*').
- Effective supervision arrangements for staff working with children / families or adults at risk of abuse or neglect. (See '*The Supervision and Support of Staff*').
- Effective arrangements for engaging and working in partnership with other agencies. (See '*Information Sharing and Working with Partners*').
- Identification of a named doctor and a named nurse (and a named midwife if the organisation provides maternity services) for safeguarding children. (See '*The Supervision and Support of Staff*').
- Developing an organisational culture such that all staff are aware of their personal responsibility to report concerns and to ensure that poor practice is identified and tackled. (See '*Policies and Procedures*' and '*Leadership and Governance*').

7.6 The Trust must also comply with a raft of statutory and non-statutory requirements underpinning the safeguarding of children and young people[15] and whilst significant in number, these will be substantially fewer than the obligations governing the Trust's delivery of healthcare to over 900,000 patients each year.

7.7 In light of this, the Review understands that whilst the safeguarding of children and

15 Working Together to Safeguard Children (2015), Section 11 of the Children Act 2004, Care Quality Commission Health and Social Care Act 2008 Regulation 13, Standard 5 of the National Service Framework for Children, Young People and Maternity Services (2004)

young people will be *a* priority for the Trust, it won't be *the* priority.

7.8 This is why governance structures and leadership focus are so important; making sure that this vital responsibility does not get lost in the array of other projects, programmes and initiatives on-going in the Trust as part of its core business.

Governance Structures

7.9 The governance arrangements supporting the safeguarding of children and young people, are set out in the Trust's Safeguarding Children and Young People Policy and, as defined in this document, are considered by the Review to be broadly sound in terms of how they describe accountability.

7.10 However, a description of accountability in itself is insufficient. An effective governance structure must translate into effective action that makes children safer and above all, ensures a culture in which safeguarding children and young people is truly seen as everybody's business.

7.11 The following sets out the Review's findings in respect of the key governance arrangements and a range of leadership roles involved with safeguarding children at the Trust. These are intentionally focussed and it is important to note that by themselves they do not reflect the entirety of the Trust's resources engaged in this area of work.

The Trust Board

7.12 The Trust Board is defined as being ultimately responsible for child protection and safeguarding children within the Trust. A Director on the Trust Board, currently the Chief Nurse, is tasked with taking the lead on this area and keeping the Board fully informed of all related matters.

7.13 The Review saw a range of evidence about how the Trust Board maintains oversight of safeguarding children. This evidence included the Board receiving the annual Safeguarding Children Report, related information in the Chief Executive's updates, Quality and Risk Committee reports and specific agenda items at Board meetings, such as the Trust's Action Plan in response to the Lampard Review.

7.14 Whilst providing an audit trail of items received, the Review was less than certain from the minutes examined as to the extent of scrutiny and challenge applied by the Board. The lack of detail or evidence of professional curiosity and challenge raised questions about their

collective effectiveness in holding those responsible, for facilitating change and improvement, to account.

7.15 An example of this can be seen through the Board's response to reports on mandatory safeguarding training. In the last 18 months of Board minutes that were examined by the Review, poor training performance has been on the Board's agenda on four occasions. It was referenced twice in the annual reports on Safeguarding Children and Young People and twice in the quarterly reports from the Quality and Risk Committee.

7.16 The Board 'noted' the reports in January 2015 and April 2015 but it was not until January 2016 that the Board *'expressed its concern at the level of safeguarding children training, [and] agreed the need to ensure better compliance and requested a report to the next Board meeting on how this would be achieved'.*

7.17 The Review heard from some staff that this issue is not a new problem facing the Trust.

"Training figures for the children's hospital are good at 80%, but not for the rest of the hospital. When I look back it has been the same for years." (Designated Professional, CCG)

"It has been raised as a risk for a long time." (Named Professional, BSUH)

7.18 The Review acknowledges that this is only one area of improvement that the Board has to deal with. However, ensuring its workforce has the necessary knowledge, skill and ability to safeguard children should be a fundamental requirement and key priority. The Review was therefore surprised that this issue had not resulted in a much earlier and more directive approach from the Board.

7.19 Indeed, without evidence of this direction, logical questions for the Review to consider have been:

- Amongst the range of competing priorities, is safeguarding children being given sufficient priority and scrutiny by the Trust Board? and;
- What level of training has the Trust Board received to ensure that they are sufficiently skilled to understand the importance of embedding safeguarding children as part of everything that the Trust does?

7.20 The latter question is addressed in the recommendation below, reinforcing the requirements defined in the 2014 Intercollegiate Document for all senior managers and executive

leads with Board Level responsibility for safeguarding to receive appropriate training.

R1: All Trust Board members receive Level 6[16] safeguarding training.

7.21 When viewing the former question alongside other findings, the Review is concerned about the visibility of safeguarding children at the most senior levels in the Trust and whether the age-old adage of '*out of sight, out of mind*' is a contributory factor to the focus and interest in this subject across the wider Trust footprint.

"I don't think the organisation sees safeguarding as everyone's business, they think it is just the children's hospital. I think it is the whole culture." (Designated Professional, CCG)

"I don't know for 'them' if safeguarding is on their radar and I mean 'them' high up not 'them' on the ground." (Named Professional, BSUH)

7.22 For example, whilst acknowledging that safeguarding children has featured on the Trust Board's agenda, the Review noted a distinct and unusual lack of narrative about this issue in the Trust's Annual Report, Annual Plan and key strategies, all approved and signed off by the Board. For example:

- The Trust's Annual Report for 2014/15 contains 119 pages and the word safeguarding appears three times. Twice, this refers to safeguarding the Trust's assets and public funds and once, it is referred to in the glossary. There is no reference to the Trust's activity in helping to safeguard and promote the welfare of children and young people, despite for example, the Review hearing about the 170 child protection medicals undertaken at the RACH each year and the range of other positive activities led by the Named professionals and the Safeguarding Children Team.

- The Annual Plan for 2015/16 references safeguarding once in the context of improving and integrating learning from safeguarding concerns with other processes.

- The Quality Account 2014/15 doesn't reference safeguarding at all.

- The new Safety, Quality and Patient Experience Strategy 2015, despite having the aim of looking 'at safety and quality through the eyes of those who use our services' makes no

16 Level 6 has been altered from the 2010 version of the Intercollegiate Document to focus on the roles and competencies of senior managers and executive leads with Board Level responsibility for safeguarding children and young people

reference to safeguarding children although it sets out three specific priority areas on adult safeguarding.

7.23 The Review met some outstanding staff across the Trust doing a great job, with many, particularly those in the RACH, being acutely alert to the need to ensure a robust approach to the safeguarding of children and young people. They understood that safeguarding was their responsibility. However, it is the Review's opinion that opportunities to promote a wider culture reflecting these traits are being missed.

"Its not just about the nurses and doctors, its about the porters and receptionists." (Designated Professional, CCG)

7.24 The Trust Board approved all of the reports and strategies set out above and the Review has seen no evidence of any request or challenge from Board members about where the Trust's work on safeguarding children and young people might feature in these documents.

7.25 For whatever reason, if the Trust Board isn't seen to be prioritising safeguarding children in any of its key strategies or even reporting on this difficult and sensitive area as part of its annual reporting cycle, it should come as no surprise to the Trust if key messages about this area don't reach the front-line, safeguarding isn't seen as everyone's responsibility and the morale of an already pressured group of Named Professionals and the Safeguarding Team is potentially compromised. The Review makes two recommendations on this matter below:

R2: The Trust Board includes reference to its safeguarding children activity and performance in future annual reports and plans.

R3: The Trust Board amend its Safety, Quality and Patient Experience Strategy 2015 to ensure emphasis is given to safeguarding children.

The Safeguarding Children and Young People Committee

7.26 The Safeguarding Children and Young People Committee is a formal sub committee reporting to the Quality and Safety Committee and chaired by the Chief Nurse. It is defined as taking a strategic lead in ensuring systems and structures are in place across the Trust. It has the responsibility for formulating an action plan to ensure the Trust fulfils all of its requirements under the Children Act 2004, Working Together to Safeguard Children (2015),

Laming Recommendations (2003), Care Quality Commission C2 Standards, recommendations from local serious case reviews and Section 5 of the Children's National Service Framework (2004). The committee is also required to monitor the effectiveness of the implementation of the safeguarding children action plan and of the safeguarding policy.

7.27 The Review has little to comment on in terms of the structure of this forum. It is replicated across most, if not all Trusts and its constitution appears to the Review to be sound and based on solid principles. As a Committee it has significant responsibility to drive forward the safeguarding children agenda within the Trust. It has delegated authority from the Board to be the 'engine room' for scrutiny, challenge and improvement.

7.28 Based on the findings of this Review, however, the Safeguarding Children and Young People Committee is not considered to be operating as effectively as it should. Evidence to support this position is seen in the lack of traction on training attendance and awareness, policy deficits, progress on the Lampard Recommendations and the lack of capacity in the Safeguarding Children Team.

7.29 Given the membership of this forum, the Review does not believe the current chairing arrangements are sufficiently independent to robustly challenge Divisional Strategic Leads (or others) to leverage the required change. If they were, there is a strong argument that the challenges set out above would have been effectively addressed much sooner.

7.30 It is important to emphasise that this is not a critique of the Chief Nurse's capabilities as a chair, but is a view based on the collective expertise of the Review team and their direct experience of the benefits of independent chairing within the context of safeguarding children.

7.31 An independent chair with no professional or 'significant social' relationship with board members can ensure a fundamentally child-focused approach. In line with this, the Review makes the recommendation below to strengthen the effectiveness of this committee.

R4: That the Trust appoints a Non-Executive Director as chair of the Safeguarding Children and Young People Committee.

Key Roles

The Chief Executive

7.32 The Chief Executive (CEO) of the Trust plays a critical leadership role in the safeguarding of children and young people and the Review saw strong evidence of the former CEO, Matthew Kershaw, supporting a transparent approach to learning and improvement in this area.

7.33 Indeed, Matthew Kershaw decided to commission this external Review and took the extra step of widening its scope to focus beyond the services in the RACH. This willingness to self-reflect, learn and improve are values similarly reflected in the Trust's Behavioural Blueprint. They are neither exclusive to safeguarding children, nor clinical matters – but as an example of leaders practicing what they preach, the Review saw clear evidence of this in the leadership style of the then CEO himself.

7.34 Further evidence demonstrating this strong leadership was similarly reflected in the frequent and regular liaison between the CEO and the Patient Safety Ombudsman (PSO), who also demonstrated a clear vigour in drawing safeguarding matters to the CEO's attention.

7.35 The CEO remained accessible and interested in what the PSO had to say and whilst acknowledging the need for the Trust to clarify the future of the PSO role and lines of reporting, the continued accessibility of the CEO is considered by the Review as a positive arrangement in supporting a safer system.

7.36 Whilst no recommendations are made about this role, it will be important that the CEO's replacement continues with the same level of enthusiasm and visible leadership shown by Matthew Kershaw, building on his engagement and the improving culture to proactively implement the findings of this Review and further drive the awareness of safeguarding children across all staff.

The Chief Nurse

7.37 The Chief Nurse is the Board Director Lead for Safeguarding Children and Adults and represents the Trust as a statutory partner on the B&H LSCB. The Chief Nurse chairs the Trust's Safeguarding Children and Young People Committee and is also responsible for ensuring that Named Professionals are appointed.

7.38 The first and most obvious observation by the Review in respect of this role was the

sheer scale of the Chief Nurse's portfolio. This is significant and wide-ranging. Whilst having two deputies to assist with these functions, the Executive leadership sits firmly within the Chief Nurse's remit; fully set out in Appendix 6.

"Today I'm back to back. For me, trying to get through the meetings and actions I have together with the external scrutiny I'm under is hard." (Chief Nurse)

7.39 The Review acknowledges that as an Executive Director, the Chief Nurse's role is very much about senior leadership and not about technical detail. In terms of safeguarding children, there is a need for this role and the leadership it shows to be visible, focussed and influential at Board level and all the way through to the front-line.

7.40 As the Executive lead, the accountability of the Chief Nurse is considered by the Review to be transparent and clearly defined. The Board and external partners look to the Chief Nurse for both leadership and reassurance on safeguarding children. The front-line look to this role for support and direction. The Review recognises it is absolutely necessary for such governance arrangements to be in place and there are no recommendations for the Trust in this regard.

7.41 The Chief Nurse is also recognised by the Review to be in a critical position of influence and the impact of this should not be underestimated. The Review heard a range of positive comments about the Chief Nurse's engagement both from external partners and from Trust staff themselves. Indeed, many of the staff spoken to clearly respected the Chief Nurse, recounting experience of her leadership and describing her ward visits as an 'event', something which staff most definitely prepare for.

7.42 Formal and informal engagements with staff provide management with significant opportunities to demonstrate leadership commitment to, and their expectations of staff, regarding safeguarding children, young and other vulnerable patients.

7.43 During interview and to her credit, the Chief Nurse acknowledged that she had not used her influence to directly engage staff in discussion about, or to promote aspects of safeguarding children as well as she might have.

7.44 Not using such occasions to drive forward key messages about this area of responsibility may result in missing critical opportunities to engage, focus and influence staff. The importance of such demonstrable leadership is highlighted later in the Review's narrative and accompanying recommendations set out under *'Leadership Focus - Uniforms versus Child Protection'*.

The Named Professionals and The Safeguarding Children Team

"I'm very effective but I'm becoming less and less efficient." (Named Professional, BSUH)

7.45 The Review is in no doubt that the Named Professionals in the Trust, in particular the Named Nurse, are applying significant effort, enthusiasm and visible leadership to the safeguarding children agenda.

7.46 There is a clear child focus amongst this core group of professionals who are, in the Review's opinion, doing their best to deal with a range of responsibilities, whilst being under a significant pressure in terms of their collective capacity.

"The Named Nurse and her capacity is an issue. I rely heavily on the Safeguarding Team" (Chief Nurse)

7.47 Whilst the Named professionals and Safeguarding Children Team comprise only a small group of staff, they are highly respected and highly influential both within the Trust and with external partners. Being close to the ground, they are the 'go-to-point' for safeguarding children concerns, with all staff members spoken to being aware of their roles and their value.

7.48 However, their leadership focus can only extend so far and there is only so much that this group of staff can do. Alongside the Review's recommendations to increase the capacity of this team, their leadership needs equal support from across the Trust and at all levels.

"The Named Nurse isn't as supported by her Chief Nurse as she should be". (Anon)

7.49 For example, the comprehensive monthly newsletters produced by the Safeguarding Team are of no value if the Divisional Strategic Leads[17], Clinical Leads[18] and Departmental Managers[19] (defined in the Trust's Safeguarding Children governance arrangements) are not ensuring these messages are being read and understood by their staff.

7.50 Similarly, the high quality training delivered by the Named Professionals and Safeguarding

17 Divisional Lead Clinical Professionals - Lead Clinical Professionals within each division are identified to develop the skills of the division's clinical teams in safeguarding children and young people.

18 Divisional Lead Clinical Professionals - Lead Clinical Professionals within each division are identified to develop the skills of the division's clinical teams in safeguarding children and young people.

19 Departmental Managers - The Line Manager within each area is responsible for ensuring that all employees are aware of the safeguarding policy and of their role and responsibility in relation to safeguarding children and young people.

Children Team is undermined if those same leads and managers do not ensure that their staff attend. It is further weakened if the Trust's governance arrangements, from the Safeguarding Children and Young People Committee through to the Board, don't apply the focus, scrutiny or ambition to make sure attendance levels are sufficient.

7.51 To strengthen the support to the Named Professionals and Safeguarding Children Team, the Review recommends that the Trust implement a Safeguarding Children Operational Group, chaired by the Named Nurse, with each area from across the Trust being represented by a senior lead.

7.52 The Review believes this group would enable more robust reporting to the Safeguarding Children and Young People Committee, alongside improving the mechanisms for disseminating information, pursuing training performance and monitoring SCR and audit recommendations. In this regard, the Review makes the recommendation below.

R5: The Trust develop and implement a Safeguarding Children Operational Group

The Patient Safety Ombudsman

7.53 The services of the Trust's Safety Ombudsman are available to all staff and patients. Part of the description[20] of the role contained in the leaflet explaining what the Ombudsman does indicates it is:

'Dedicated to fostering an open, transparent, responsible and accountable culture, that acknowledges failings and uses lessons learned to prevent reoccurrences.'

7.54 The Safety Ombudsman, referred to across the Trust as the Patient Safety Ombudsman (PSO), was a key influencer in bringing about the current review. In her role, she listened to the concerns of patients and staff and engaged in meetings with management, providing a critical conduit to ensure issues were not hidden, suppressed or diverted from attention.

7.55 The most recent PSO left the Trust shortly after this Review began. During her interview she explained that the position was originally created following historic concerns regarding the care of elderly patients. The primary function was developed to provide a confidential and impartial intermediary service.

20 BSUH Safety Ombudsman Information leaflet

7.56 The Trust's Safety, Quality and Patient Experience Strategy 2015-2020 describes the full details of the PSO as follows:

'The PSO provides an independent, confidential service to listen to staff and patient concerns, in addition to the Trust's other processes for eliciting staff and patient concerns. The PSO is responsible for raising these concerns at the Patient Safety Ombudsman's Advisory Panel and at the Executive Safety and Quality Committee. The PSO is responsible for ensuring that concerns are handed over to the appropriate department/individual or agency for investigation and action.

The PSO is responsible for feeding back the progress of investigations to those raising concerns where those raising concern wish to remain anonymous. The PSO also has a responsibility to alert the PSO advisory panel when staff raising concerns ('whistleblowers') appear to be suffering discrimination or detriment as a result of raising those concerns'.

7.57 Key to the overall effectiveness of the PSO role is its visibility and the awareness of patients and staff to its existence, purpose and the means by which the PSO can be contacted. Leaflets highlighting the role and the options to make contact were visible in various public and staff locations across the areas of the Trust accessed by the Review. The PSO, at the time of the Review's initial visit, was confident that most staff would know who she was and what the nature of her job involved. However, the Review found the contrary to be the case, with the vast majority of staff we engaged not knowing who the PSO was and what the functions entailed.

7.58 Those who were able to identify the PSO were likely to have engaged with her directly on a specific issue or to have worked with adult patients in the Trust where the role was much more widely recognised.

7.59 It was clear to the Review that the PSO was deeply committed and very concerned about a range of issues that had been brought to her attention over the three years she had been in post. She had formed a strong, constructive and 'critical friend,' relationship with the previous CEO, however, she expressed her frustration to the Review at what she saw as the limited visible action taken in a number of cases.

7.60 As part of the role's design, the PSO is supported through a governance structure that enables the PSO to raise specific cases and relevant issues at the Trust's Patient Safety Ombudsman's Advisory Panel. This Panel, in turn, reports to the Quality and Risk Committee that directly reports to the Trust Board.

7.61 This monthly meeting is chaired by a Non-Executive Director in the Trust and attended by the Associate Director of Transformation, Deputy Medical Director, Director of Human Resources, Director of Corporate Affairs and the PSO.

7.62 The primary purpose of this meeting is to hear about those concerns raised with the PSO by staff and patients and to scrutinize and challenge the actions taken to investigate and mitigate these concerns. Where required, senior managers and Non-Executive Directors present are responsible for taking relevant actions to the appropriate forum to ensure that the concerns raised with the PSO are addressed.

7.63 Through examination of the minutes of the Patient Safety Ombudsman Advisory Panel in July 2014, the Review identified that members were clear that an improved structure was required to support the PSO role alongside better oversight and tracking of cases.

7.64 At this time, the PSO was reporting her engagement in 125 live cases, some of which were historical and were considered by the PSO to have been unsatisfactorily resolved. At the July 2014 Panel meeting, the chair emphasised:

"The importance of the Panel holding a formal log of anonymised cases, not only to encourage greater accountability within the Trust, but also to ensure that issues are dealt with in a robust and timely manner." (Chair, PSO Advisory Panel)

7.65 Subsequent minutes do provide evidence of a continued focus on cases by the Panel, tracking of actions and an appropriate level of scrutiny and professional challenge from the PSO with regards to progress. However, the Review identified several problems that are considered likely inhibitors to the overall effectiveness of the PSO role.

- The role and function was not properly understood and there was some confusion when talking to staff concerning how, where, when and from whom independent help or advice could be obtained.

- Whilst a significant majority of staff interviewed were alert to their ability to both complain and whistleblow, there was limited understanding about the role of the PSO in these processes.

- Whilst the defined functions of the PSO role clearly cover the potential for safeguarding children concerns to be raised with the post holder, the PSO does not feature in the Safeguarding Children & Young People Policy at the Trust.
- Some senior staff stated that they felt frustrated by the manner in which the PSO role was

performed i.e. the provision of an allegation without a detailed or evidenced complaint or complainant.

- That there was clear difficulty for the PSO when a partial third party allegation had been made. This often resulted in information not being sought, fully shared or investigated. It was clear to the Review that in some cases this was because no other information was available, the third party would not or could not establish further information or the complainant did not wish to take further action. Alternative routes to reconcile such matters were and remain available, but the Review established no sense of a system offering clarity to complainants on what these were.

7.66 When individuals require advice or support they should be able to readily access information that signposts the options available to them. To this end, the Review makes the following recommendation.

R6: Prompt cards explaining the options and routes for advice, support, complaints or whistleblowing should be provided to all staff and patients.

7.67 Despite these identified challenges, the Review recognises the inherent value of the PSO in providing an alternative route, through which concerns about safety, quality and patient experience can all be raised, rather than those issues remaining hidden due to a fear (or otherwise) of reporting via other mechanisms.

7.68 Such value was similarly reflected in the recommendations of Sir Robert Francis QC's Freedom to Speak Up report, with the NHS contract 2016/17 now specifying that NHS Trusts should have a nominated *'Freedom To Speak Up Guardian'* (FTSU) in place by 1 October 2016.

7.69 The FTSU is intended to work alongside Trust leadership teams in much the same way as the PSO, supporting the organisation in becoming a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.

7.70 In May 2016, the purpose and principles[21] of the FTSU were published and whilst recognising the similarities with a range of functions delivered by the PSO, the following recommendations are made in respect of the Trust's response in this area.

21 Freedom to Speak Up Guardians – Purpose and Key Principles of the role, http://www.cqc.org.uk/sites/default/files/20160525_ftsu_purpose_key_principles_final.pdf

R7: The functions of the PSO are retained by the Trust and merged with the job description of the new FTSU role. To this end the following should also be taken into consideration:

i. **That any subsequent list of responsibilities (or job description, if appropriate) is clearly defined to include the experience and skill sets that are required for this sensitive role.**
ii. **That the role's terms of reference, pathways and relationship with other reporting/ whistleblowing functions are clearly defined and set out within the Roles and Responsibilities Section of the Trust's Safeguarding Children & Young People Policy.**
iii. **Induction training for all staff, managers and Trust Board members should include input about the agreed role.**
iv. **Mandatory Safeguarding training delivered by the Trust should formally reinforce the importance of the agreed role.**

Leadership Focus - Uniforms versus Child Protection

7.71 Perhaps the most interesting observation by the Review in the context of leadership was how each and every staff member spoken to was unequivocally certain in his or her detailed knowledge of the uniform policy.

"Uniform Policy has the highest priority from management" (Emergency Nurse Practitioner)

7.72 Without question, every staff group spoken to referred to this policy as the one they were most familiar with and the one given the highest priority by senior managers within the Trust. This was explained in terms of uniforms being the main issue raised, or at least the main issue recalled, when seniors engaged with the front-line.

7. 73 Examples were provided of ward visits by the Chief Nurse that regularly focused on the importance of adherence to the uniform policy and e-mails from other senior staff reminding them of its content.

Q: *"Which policies are you aware of?"* -
A: *"The only one is the uniform policy and that was because of an email"* (Health Care Assistant)

Q: *"Which policies from management have the highest priority?"*

A: *"Uniform Policy". (Matron)*

Q: *"Does anyone think this is the right way round?"*
A: *"No"* (Nurses and non-clinical staff)

7.74 The learning from this point is simple, yet profound and reinforces the significance of the Trust's overarching approach to leadership and the direct impact that this has on what staff do or do not focus upon.

7.75 Staff will follow good leaders and if they see those leaders repeatedly emphasising the importance of a particular policy, then this will naturally become the focus of the front-line.

"When someone says 'You have to read it' then that makes us read it more. Our managers do stick to their guns." (Deputy Sister)

7.76 Notwithstanding the clinical necessity for infection control and prevention, the Review doubts anyone on the Trust Board or in any senior leadership position at the Trust would suggest a policy on how staff dress is more important than one on safeguarding children and young people.

7.77 However, based on the evidence of this Review, this is exactly what staff had concluded. Repeated communication about the uniform policy has resulted in staff believing that this is what they need to be most alert to. Combined with a lack of visible narrative about safeguarding children from the Trust as a whole, it is all too easy to see how the term '*safeguarding is everyone's responsibility'* runs the risk of becoming words on a page, rather than a culture reflecting how people behave.

7.78 The Review firmly believes that the Trust's governance structure is in place to support safeguarding being effective, but there cannot be a default position that thinks it is solely the responsibility of the Chief Nurse and the Safeguarding Children Team.

"I am BSUH out there on safeguarding." (Named Professional, BSUH)

7.79 From the Boardroom to the wards, everyone within the Trust, but particularly senior leaders, need to take their responsibility for putting children first. This will take focus and commitment. In order to achieve this, leaders and managers across all Departments must make sure their focus and narrative includes this issue when they are engaging with front-line staff.

7.80 This doesn't have to be any more complicated than talking with staff about safeguarding children when on visits to the front-line or engaging them in team meetings or other staff forums; talking with staff and asking them about the policies they should be alert to; checking with staff that they have attended training and confirming with staff that they know where to go to for support.

7.81 The detail on what staff might need to know is best left to the Named Professionals and the Safeguarding Children Team, but the Trust's leadership needs to demonstrate a genuine and visible interest in this area if it expects the workforce to do the same.

R8: The Board should seek reassurance from its members and Trust managers that they reinforce the importance of safeguarding children and young people at briefings and during formal ward visits.

8. Section 11 Children Act 2004

Terms of Reference:
To examine the Trust's compliance with Section 11 Children's Act 2004 regarding whether its functions, and any services that it contracts out to others, are discharged having regard to the need to safeguard & promote the welfare of children.

"Section 11 of the Children Act 2004 (S11) places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children." (Working Together to Safeguard Children 2015)

8.1 NHS Trusts are named organisations within S11 and as such, the Trust is bound by the duties prescribed within this legislation and must have in place arrangements that reflect the importance of safeguarding and promoting the welfare of children.

8.2 As part of its statutory objectives in ensuring the effectiveness of safeguarding children, it is standard practice for Local Safeguarding Children Boards (LSCBs) to undertake what is called a S11 audit.

8.3 The overarching aim of these audits is for LSCBs to establish reassurance that partners are compliant with their statutory duties, whilst allowing organisations the opportunity to transparently reflect on any identified areas for improvement that require action, escalation and/or support from the partnership to resolve.

8.4 The most recent S11 audits undertaken by partners of the Brighton and Hove Local Safeguarding Children Board (B&H LSCB), West Sussex LSCB and East Sussex LSCB were completed in March 2014[22], with a 'S11 Challenge Event'[23] hosted by the B&H LSCB taking place later that year. The Trust was fully engaged in this process and the Review considers this to be a positive reflection of the importance applied to this exercise.

8.5 The outcome of the Trust's audit was that it judged itself to be compliant in 96% of the safeguarding standards prescribed within the S11 audit tool. Whilst recognising the limitations and potential bias of any self-assessment, 96% compliance by any standard is indicative of exceptionally strong performance.

22 Section 11 Self Evaluation Toolkit for BSUH
23 B&H LSCB introduced a S11 challenge event process in May 2014.

8.6 However, cross-referencing this self-assessment with the findings of this Review, it is clear that the Trust could and should be more challenging of itself to provide a better and more transparent reflection on required areas for improvement. For example, clear variances were identified by the Review in a number of areas rated by the Trust as being fully compliant.

8.7 Standard 2 asks whether '*the agency has written safeguarding policies and procedures that are reviewed regularly (at least every 3 years)'.* Whilst the Trust has rated this as complete and fully compliant, the Review identified a number of gaps in the updating of some of its policies and procedures. It also identified capacity issues potentially impacting upon their production and maintenance.

8.8 Standard 2 also asks whether *'all staff and volunteers are made aware of the safeguarding policies and procedures and how they are applied in practice'.* Again, this was rated as complete and fully compliant, with a range of actions setting out the processes of how staff might be made aware of policies and procedures through induction, training or accessing them via the intranet.

8.9 However, through the work of this Review, it has been clear that not all staff are aware of the relevant safeguarding policies or procedures, few reported having actually read them and their accessibility via the Trust's Internet and Intranet sites requires significant improvement.

8.10 Standard 5 relates to staff training on safeguarding children. All standards against this section are rated as green and fully compliant despite the low staff numbers from across the Trust attending mandatory safeguarding training and the evident pressures on the Named Nurse and other key professionals in delivering this training to such a large workforce.

8.11 The overarching impression derived from the Trust's S11 audit is that there is little, if anything to do in order to demonstrate the full meeting of all the statutory requirements under S11. The majority of areas are rated as green and there is nothing in this document that would point either the Trust Board or the B&H LSCB to priority areas that require strengthening.

8.12 Furthermore, whilst positive that the B&H LSCB has introduced a challenge event to help organisations reflect upon and challenge their self-assessed progress, the effectiveness of this process is naturally compromised if audits portray an inaccurate account or if challenge is directed in the wrong area.

8.13 It is further compromised if the challenge process itself is insufficient at drilling down into the precise evidence required to effectively question an organisation's self-assessed progress.

For example, whilst the recording of the B&H LSCB challenge event in 2014 evidences discussions with the Trust on a range of issues such as training, policy and leadership, the Review was surprised that none of these areas attracted any specific recommendation for improvement.

8.14 This surprise is compounded when viewed in the context of the evidence identified by this Review, with a number of related deficits being long-standing and known to the Trust itself. Indeed, there were only two definitive actions arising from this process, which related to: 'notifications to the Disclosure and Barring Service (DBS)' and 'information being provided in a format and language that can be easily understood by all service users.'

8.15 In terms of the efficacy of this challenge process, the Review is alert to other models used by LSCBs and in order to enhance its effectiveness, a related recommendation is set out below for the Trust and the B&H LSCB. The outcome of a recent S11 peer challenge process of an NHS Trust by a London LSCB is attached in Appendix 7 to provide an example of how a more focused process could help organisations, including the Trust, develop more targeted recommendations for improvement.

8.16 Overall, based on the findings of this Review, the evidence suggests that there is more to do by the Trust in terms of actions to fully evidence compliance under S11. The S11 audit tool should be revised to better reflect the challenges facing the Trust in meeting the S11 standards and resubmitted to the B&H LSCB to more helpfully reflect key areas of pressure and to seek support from the partnership in helping find solutions.

8.17 It is important to note that the draft S11 audit for March 2016 has also been submitted to the Review. Whilst not finalised, this most recent audit evidences an improved approach by the Trust in setting out defined areas for improvement, alongside evidence of compliance.

R9: The Trust should review and revise its Section 11 self-assessment and update its action plan with specific reference to the Review's findings on Standards 2 and 5.

R10: The Trust should explore with the B&H LSCB different models of S11 peer challenge to assist with improved processes for reassurance and multi-agency support in addressing identified challenges.

9. Policies and Procedures

Terms of Reference:
To examine current safeguarding policies and procedures and consider if they fully reflect national and statutory regulatory frameworks for safeguarding that are in place.

To examine the Trust's compliance with existing safeguarding policies and procedures.

To assess the extent to which existing safeguarding policies and procedures benchmark well against those of comparable organisations.

9.1 Policy is only effective if it is easy to access and simple to understand, reinforced by training, reflected in practice and reassured via supervision, audit or inspection.

9.2 It is important that all organisations have a clear set of guidelines to help staff deal with safeguarding children concerns effectively. Policies make it clear to staff, volunteers and patients what an organisation does to keep children and young people safe and associated procedures set out exactly what staff need to do in particular circumstances.

9.3 In the context of safeguarding, policies and procedures are a critical 'reference tool' that should both inform and complement the experience and professional judgement of those who work with or come into contact with children and young people.

9.4 Policies and procedures need to be accessible, easy to read and understood by front-line staff, with the relevant content being broadly embedded as part of their day-to-day practice. For professionals dealing with often complex and highly emotive scenarios, the importance of these aspects cannot be understated and the Review has been focused on thoroughly testing these areas.

9.5 The Trust's Safeguarding Children web page states *'…the Trust's child protection policies and procedures are up to date, regularly reviewed, and are accessible by all staff via the Trust intranet on a dedicated safeguarding children page. The Safeguarding Children Policy is available on the intranet and is reviewed every three years or in line with the most up to date legislation'.*

9.6 Whilst there are a clear number of strengths in terms of the Trust's policies and procedures, the reassurance provided by the above statement was not fully reflected in the

evidence obtained by this Review.

9.7 Indeed, the Review's findings indicate that not all policies and procedures are up to date, not all are regularly reviewed and accessibility could be significantly improved. Further details and analysis are set out below:

The Range of Policies and Procedures

9.8 The Review considered a significant range of documentation relevant to the safeguarding of children and young people. Commentary against the key policies and procedures is set out below and in the main, relates to documentation expected to be in place as part of the Trust's compliance with S11 of the Children Act 2004, those bearing relevance to the three case studies examined in this Review and the Lampard recommendations.

Pan-Sussex Child Protection Procedures

9.9 Organisations engaged in safeguarding children and young people operating within the jurisdictions of the Brighton & Hove, West Sussex and East Sussex Local Safeguarding Children Boards (LSCBs), all work within the framework of the Pan-Sussex Multi-Agency Child Protection Procedures. At the time of the Review, these procedures were hosted on-line by Tri-X. Whilst the content of this site was easy to navigate and comprehensive, the Review identified a number of areas that were inaccurate and required updating (i.e. reference to old versions of statutory guidance).

9.10 No recommendations have been made in this regard, given at the time of the Review a new solution was already in development with a different company for the hosting of a revised and updated set of procedures. Phew Internet[24] launched this new platform in October 2015. Upon examination the Review considered it thorough and comprehensive.

Safeguarding Children and Young People Policy

9.11 The Review considers this policy as broadly appropriate in describing the general requirements for safeguarding children and young people within the Trust.

9.12 The 2014/15 Safeguarding Children and Young People Annual Report presented to the Trust Board confirmed that this policy had been recently updated and the Review has had sight

24 Phew Internet developed the Pan-Sussex Child Protection Procedures Website. https://sussexchildprotection.procedures.org.uk

of this amended document. One recommendation (*Recommendation 7(ii)*) is made to improve this policy through a more focused inclusion of the PSO role within its contents.

Safeguarding Children Supervision Policy

9.13 The Trust has in place a comprehensive policy setting out the supervision arrangements covering the development of practice and consequent improvement in patient care. The policy document examined has no formal date of issue and whilst the review date scheduled for March 2016 was not met by the Trust, the Review understands that this is currently being undertaken. Further details about how this policy translates into practice are described later in the report under 'Supervision and Support'.

9.14 Of note, and deemed positive by the Review, the policy builds on the narrative within the 'Behavioural Blueprint' through its stated commitment to *'developing a culture where employees are able to discuss safeguarding issues relating to children and young people in an open and transparent way where they are well supported in doing so'*. No recommendations are made in respect of this policy.

Allegations of Child Abuse Against Staff

9.15 The current policy was issued in June 2010 and updated in June 2013, although for the purposes of this Review a more updated draft version was examined. The Review considers that this revised policy draft titled *'The management of allegations made against staff'* represents a significant improvement on previous policy in this area, albeit there are some minor formatting issues that need to be changed (i.e. numbering of paragraphs).

9.16 The policy is consistent with the Pan Sussex Child Protection procedures, however there are a number of areas where the Review believe this policy could be better focused and further strengthened.

9.17 Firstly, there needs to be a child centric approach reflected in this policy that explicitly considers risk to children and young people in the context of the employment of the person about whom the allegation has been made. The Review makes the following recommendation in this regard.

R11: The Trust should amend the 'Trust Record Sheet' of an incident to include a specific risk assessment to any child, young person or vulnerable patient in the context of the person's employment, regardless of where the allegation derived or where the alleged incident took place.

9.18 Secondly, the Review welcomes the greater detail provided in paragraph 6 concerning confidentiality, and believes it would be helpful to add some practical examples regarding the *'Need to Know'* principle to promote proactive and good practice in such cases.

9.19 For example, the nature of concern and the identity of the person posing a risk (that has been suspended and excluded from hospital grounds) being shared with security staff, receptionists and anyone else who may be in a position to monitor and prevent access.

9.20 Thirdly, on the basis of learning from Case A and B it is clear that poor communication with staff, not least those who worked closely with both offenders, had a significant negative impact allowing rumour to flourish and uncertainty and anxiety to build. The following recommendation addresses this issue.

R12: A more robust section should be written concerning the support and information to be provided to staff following any related incident (ensuring this is separated from the existing statements within the policy about staff collusion).

The *'Need to Know'* principle needs to be specifically addressed and explained and practical examples provided which are role rather than rank orientated.

Employment Checks Policy

9.21 The Trust's Employment Checks Policy was issued in May 2012 and was due for review in May 2015. The Review is alert to the Trust undertaking a large piece of work reviewing and updating all relevant HR policies and procedures as part of the implementation of its new People and Wellbeing Strategy (May 2015). Whilst subject to this process, this policy is the underpinning framework supporting safer recruitment and is considered by the Review, as it stands to be comprehensive, covering all of the required NHS Check standards in full. Further commentary is set out within the Safer Recruitment section of this report. No recommendations are made in respect of this policy.

Chaperone Policy

9.22 The Trust has in place what the Review consider to be an appropriate and up to date Chaperone Policy setting out the key principles and requirements for this aspect of practice. The policy was issued in January 2015, with a scheduled review date set for January 2018. No recommendations are made in respect of this policy.

Whistleblowing (Raising Concerns in the Public Interest)

9.23 The Trust has in place a clear policy for Whistleblowing. The most up to date version missed its review date in 2013. The Review is alert to the fact a revised version is currently out for consultation.

9.24 The policy makes appropriate reference to the various routes for raising a concern, including the Patient Safety Ombudsman. There is appropriate guidance and an associated staff information leaflet. In order to ensure this policy is effective in practice and consistent with the Review's findings from staff interviews, it is considered necessary for the Trust to ensure there is improved clarity across all sites and staff groups with regards to the role and function of the PSO (should the Trust's review of the PSO role result in it being retained with the same associated responsibilities as part of the Whistleblowing Policy). Relevant recommendations in this regard are set out in this report under '*Leadership and Governance*'. No recommendations are made in respect of this policy.

Accessibility of Policies and Procedures

9.25 The accessibility of safeguarding children policies and procedures was tested by the Review through a focus on the Trust's Internet and Intranet sites.

The Trust Internet

9.26 From the home page of the Trust's Internet site, there is a dedicated link named 'Reports and policies'. Accessing this link takes viewers to a page that sets out a number of important documents including the Trust's Annual Reports and Plans. There is a further link available on this page that directs the viewer to the Trust's policy page.

9.27 The Review considers the availability of this clearly visible section, through which the public, patients and other stakeholders can access relevant policy material, as both positive and helpful. Indeed, the Review looked at a number of other NHS Trust websites and none were found to have such a 'quick link' in place.

9.28 Accessing the policy page presents the viewer with a total of six policies. These include:

- Policy for Consent to Examination or Treatment (due for review in 2015)
- Raising Concerns (Whistleblowing) Policy & Procedure (due for review in 2013)
- Lone working policy (due for review in 2017)
- Duty of Candour (due for review in 2018)

- Privacy and Dignity Policy (due for review 2011)
- Management of Formal Complaints (due for review 2011)

9.29 The first and unarguably simple observation by the Review is that the policies available through this link are undoubtedly insufficient to reflect the entirety of relevant policies known to be in place at the Trust. The second observation is that from the 6 available, 4 are out of date according to the scheduled review timetable.

9.30 Looking at the current suite of accessible policies, it would not be immediately obvious that any existed in relation to safeguarding children nor any other associated guidance that could provide reassurance to the public that this matter is considered an important area for the Trust.

9.31 Dealing with this issue provides a quick win for the Trust. A number of good policy documents exist that are clear, defined and robust. Ensuring better public visibility of these will help support the visible leadership applied to this area of Trust responsibility.

9.32 A strong example of this approach can be seen at the Mid Essex Hospital Services NHS Trust,[25] where the first available document is the local Safeguarding Children and Young People policy and where there is a clear distinction set out between clinical policies and guidelines and those relating to HR and corporate matters.

9.33 A number of other NHS Trust sites were also reviewed with some examples set out below. Whilst these sites are not presented as the 'ideal', they do provide useful examples about how the Trust can create improved transparency about safeguarding children.

- Homerton University Hospital NHS Foundation Trust[26]
- Barts Health NHS Trust[27]
- Royal Cornwall Hospitals NHS Trust[28]

9.34 The Trust's Internet site also has a dedicated page for safeguarding children, and whilst the Review considers this positive, this only provides a basic narrative describing the Trust's safeguarding responsibilities and activity.

25 http://www.meht.nhs.uk/about-us-/policies-and-guidelines/
26 http://www.homerton.nhs.uk/about-us/corporate-policies/
27 http://www.bartshealth.nhs.uk/about-us/our-governance/key-policies/
28 http://www.rcht.nhs.uk/RoyalCornwallHospitalsTrust/OurServices/AZServices/W/WhealProsper/PoliciesAndGuidance.aspx

9.35 It offers no hosting for relevant policies and procedures or pathways to other relevant safeguarding children information (other than via one hyper-link to the statutory safeguarding guidance of *Working Together to Safeguard Children 2015.*)

9.36 There are no available downloads or appropriate references to safeguarding children and young people, other than a dedicated page giving information about this Review. Similarly, there are no contact details for the Safeguarding Team, the PSO or key designated or named safeguarding professionals in the Trust.

9.37 The Review's recommends that improvements should be made to both the 'Reports and Policies' page and the 'Safeguarding Children' page on the Trust's Internet site; of those policies examined by the Review, none required restriction. Publication of such policies in this manner is likely to support the Trust's obligations under Freedom of Information (FOI).

R13: The Trust should publish relevant safeguarding children policies as part of its policy page on the Internet.

R14: The Safeguarding Children page should be enhanced to include contact details for the Safeguarding Team and the Patient Safety Ombudsman/FTSU.

R15: A link to the websites for Brighton & Hove Safeguarding Children Board (B&H LSCB), West Sussex Safeguarding Children Board and East Sussex Safeguarding Children Board from the Safeguarding Children page should be included on the Trust's Internet.

The Trust Intranet

9.38 The Trust's Intranet site 'Staff info-net' was also examined by the Review. Some, but not all staff spoken to described being able to find what they were looking for on this site if they knew the name of the document they were looking for. The overwhelming impression, however, was that staff used it infrequently and did not rely on its contents to keep them up to date on important matters relating to safeguarding children.

"Our Intranet is woefully inadequate". (Emergency Nurse Practitioner)

"I can get the Whistleblowing policy from the Intranet but its not easy". (Senior Nurse)

"Its not that easy to navigate the intranet" (Emergency Nurse Practitioners)

"When logging in to the computer using the generic email address the 'Hints & tips' relating to suicide/self/harm) are blocked. You search for something and something else comes out." (Emergency Nurse Practitioner)

"Referrals forms which are accessed through the Intranet are extremely difficult to access and find." (Emergency Nurse Practitioner)

9.39 Despite these views, the Review did identify a range of strengths associated with the Trust's Intranet, including:

- From the Home page of the intranet there is a quick link that takes the user to an Intranet safeguarding children page.
- On the intranet safeguarding children page, contact details for the Named Nurse for Safeguarding Children and Young People are clear.
- There are two links to 'Top ten things to remember' One for 'paediatrics and general' and one for 'maternity'. Both are considered by the Review as being helpful and focused prompts for staff.
- Monthly safeguarding newsletters that are produced and circulated to Trust staff. These are comprehensive with the Named Nurse advising she regularly repeats the key messages contained in each edition when engaging with staff on a day-to-day basis.
- A clear link is also available to the Pan-Sussex Child Protection and Safeguarding Procedures.

9.40 At the time of the Review, the safeguarding children page hosted 26 documents for download and links to key areas such as 'education and training', 'forms and leaflets' and 'newsletters'. The documents and links provide access to a range of strategies, reviews, national guidance and local procedures. The Named Nurse advised the Review that subsequent updates to this page have also included reference to new national reports and links to information on Female Genital Mutilation (FGM).

9.41 However, having examined each of the 26 documents, some of them were out of date and the list lacked any rational structure. This could, in the Review's opinion, discourage anyone from using it as a credible resource for policy reference. Details of the documents and their status during the review and at the time of writing this report are set out in *Appendix 8.*

9.42 A brief examination of the Intranet link; *'child health'* also identified an array of clinical policies, procedures and guidance that are understood to be primarily used by doctors and

consultants. Whilst covering a range of clinical matters, safeguarding guidance and procedures were reported by the Named Nurse as being threaded throughout.

9.43 The documents seen by the Review from this section related to guidance on child protection medicals, children not attending medical appointments and a checklist for RACH staff being part of strategy meetings / discussions. Whilst the content and structure of the documentation seen is focused and immediately dealt with practice based issues, the Review considers there is a potential risk attached to this approach in that there is no 'one-stop-shop' to ensure staff can easily navigate to policies, procedures or guidance relating to safeguarding children.

9.44 Within the existing accessibility arrangements in the Trust, material is more likely to be duplicated, inaccurate and out of date if not consistently maintained across all areas and the Review makes a recommendation in this regard.

R16: The Trust should commit to using one area on the Intranet Safeguarding Children Page as the main repository for safeguarding children policies and ensure appropriate referencing to related policies held in other sections.

Policy Structure

9.45 Improving the structure of the Trust's policies was an area supported by a significant majority of staff interviewed. Many commented that the structure of the current documentation was often unnecessarily long or complicated and that this influenced either their eagerness or ability to read them thoroughly, if at all.

"They (the policies) are all so waffly and wordy" (Staff Nurse)

"I try to pick out the bits which are relevant" (Emergency Nurse Practitioner)

9.46 One main criticism was that the policies all appeared to have a similar introduction and narrative. The Review heard that staff would find these documents more useful if they were formatted in a more succinct style and dealt with the main practice points much earlier in the narrative.

9.47 For example, in the Employment Checks Policy, it is not until page 7 that detail about the check standards to be carried out commences. The Review makes a recommendation on this point below, which if implemented should be a quick and easy win for the Trust.

9.48 A significant number of staff stated that they would value policies that could be accessed via Team based mobile technology, such as tablets or iPads. The current approach via the Trust's IT hardware, limits access to PDF and Microsoft Word documents and is not conducive to quick reference within the context of a busy working environment.

9.49 Staff interviewed held a strong belief that a shift to mobile technology would support both their clinical functions as well as facilitating and encouraging access to relevant policies.

9.50 The provision and availability of useful Apps and frequently needed policy guidance in a mobile responsive format on ward based mobile devices would remove any excuse staff might have to use their own smart phones, tablets or iPads in the working environment.

"Condensing policies [and] making them easy to access; every team should have an iPad. You have to know so much stuff that you can't know it all". (Emergency Nurse Practitioner)

9.51 The Review also identified an inconsistent pattern in the construction of the Trust's safeguarding children policies. This was considered a potential risk in terms of the focus of staff dealing with children when those policies were being applied.

9.52 It would improve the focus of all relevant safeguarding children policies if each policy adopted a primary aim which first and foremost focused on safeguarding children and young people. Such an approach will also help reinforce and drive the right culture in the Trust.

9.53 Following a policy or procedure without absolute clarity about its intended purpose could lead staff into simply following process, rather than using their professional knowledge and curiosity to help determine the right actions to safeguard children. The Review makes the following recommendations.

R17: The Trust should ensure that all relevant policies include a distinct and clear narrative that focuses the reader on their duty to 'safeguard children and young people' who visit or stay in Trust premises or those they meet when delivering services on behalf of the Trust at any other venue or place.

R18: Trust policies are structured to ensure that any narrative not associated with the main aim of the particular guidance and advice is included as an appendix and set out at the end of the document.

R19: To support and assist staff accessing policies and procedures, the Trust should create a digitised policy handbook.

R20: The Trust should consider issuing appropriate mobile technology to teams, key managers and staff.

Staff Compliance with Policy

9.54 Testing understanding of compliance with policy without thorough auditing primarily relies on direct feedback as to whether staff are aware of and follow the particular policy or procedure.

9.55 Despite some of the deficits identified in terms of accessibility, the staff interviews demonstrated most knew where to go to access relevant safeguarding children guidance and importantly, if unsure, knew to approach their immediate line-manager or the Safeguarding Children Team for advice. Furthermore, some staff expressed confidence in their knowledge of these documents and had clearly internalized the relevant key messages:

"Yes, I am aware of the Chaperone Policy." (Emergency Nurse Practitioner)

"I have read the policies and it was ages ago, but I do know where to go if I need to." (Nurse)

"I think we do it [put the Chaperone Policy into practice] without thinking" (Staff Nurse)

9.56 Whilst a small number of positive responses were received, this was not the general position of most staff spoken with. Indeed, whilst the Trust's Children and Young People Safeguarding Policy specifies that all staff 'must read' it, the overwhelming majority of staff interviewed admitted they had not seen its contents and it was clear many were uncertain of the detail it referred to.

"It is difficult getting time to read policy" (Emergency Nurse Practitioners and non-clinical staff)

9.57 This ambiguity about policy knowledge was further echoed when staff were asked specifically about the details of chaperoning, visiting and VIP visitors, the management of allegations against staff and whistleblowing.

Q: *"Are you aware of the Chaperone Policy?"*
A: *"I couldn't tell you, don't know"* (Senior Nurse)
A: *"I think I am - in mandatory training?"* (Nurse)
A: *"Not read the whole thing – just the key points."* (Nurse)

9.58 The Review identifies this as an area for improvement by the Trust. Simply creating policies that are not going to be read by staff, despite the mandated instruction that they must do so, is likely to limit their impact, undermine leadership and create a risk in the sense of their importance not being understood or the detail digested.

9.59 As such, the Review considers it necessary that a much more focused approach is adopted by the Trust in terms of policy creation that includes specific reference to how compliance is to be measured and who will be the responsible person to oversee this. The production of Trust policy needs to move beyond the tasks of simply writing, publishing and circulating a document. The Review makes the following recommendation in this regard.

R21: All policies should set out the requirement for how compliance will be measured and who the responsible person will be for monitoring this.

9.60 As part of the focus on policies and procedures, the Review also presented staff with scenario based questions to further test their knowledge and response in these areas. These scenarios related to inappropriate behaviour by staff on wards, identifying abuse and neglect, celebrity visiting, escalation and chaperoning. In every case, staff across the entire Trust were able to articulate an appropriate response by way of either direct intervention or by seeking advice and guidance via their line manager or the Safeguarding Children Team.

9.61 With regards to the Safeguarding Children Team, the Named Nurse and her staff were frequently highlighted as an invaluable resource. It is the opinion of this Review that the Safeguarding Team provide a significant, if under pressure, anchor for safeguarding activity across the Trust.

Benchmarking

9.62 Given the variability in services delivered by NHS Trusts across the UK, it is difficult to undertake like for like comparisons on the specific content of policies and procedures beyond the benchmarking already referred to in this report.

9.63 Key policies expected as part of the Trust's S11 duties are in place and this is positive.

Beyond these core policies, the Review also examined a range of other relevant documentation including the Trust's policy on Domestic Violence, Female Genital Mutilation, new guidance on Parental Responsibility and a range of policies referenced in this report under 'The Lampard Review.'

9.64 The Review did identify that improvement was required by the Trust to ensure safeguarding policies and procedures were maintained and kept up to date with improved frequency. In direct relation to benchmarking, the other Trusts referenced in this report provide examples of more comprehensive and up-to-date policies and greater transparency in these being available for public consumption via their respective websites.

9.65 Furthermore, whilst the Trust's safeguarding policy refers to policies and procedures being regularly reviewed and the Trust's Section 11 audit providing similar reassurance, the Review saw evidence of where this hadn't taken place or where it hadn't happened swiftly. This was not in the Review's opinion necessarily related to the Trust missing the defined target dates (although this was evident in a number of other policies), but more so about the flexibility of the Trust in being able to rapidly respond to national legislative and policy changes.

9.66 Out of date and inaccurate policies and procedures represent a significant risk to the Trust in terms of the ability of staff to respond correctly and the responsibilities of the Trust in supporting its staff to operate effectively. The Review believes the link between the capacity in the Safeguarding Team to either update or oversee the maintenance of these policies is a connected factor in the evidenced slippage.

9.67 Whilst recognising the pressure on public funds, the resourcing of the Trust's Safeguarding Team is considered an immediate priority by the Review. Amongst other benefits this is likely to have a rapid impact on improving the accuracy of safeguarding policies, alongside providing resource for their longer-term maintenance.

9.68 A specific recommendation in this regard is set out later in this report under *'The Supervision and Support of Staff' (Recommendation* 46). In terms of the focus specifically on policies and procedures, the following recommendation is also made to immediately improve compliance in this important area.

R22: The Trust should consider employing a temporary resource to immediately update its policies and procedures.

10. The Lampard Review

Terms of Reference
To examine the extent to which the recommendations from The Lampard review are present within the Trust's existing safeguarding policies and procedures.

10.1 Following the death of Jimmy Savile and the subsequent exposure of his abuse of individuals on NHS premises, the Department of Health launched an inquiry into his activities across the NHS. This resulted in the publication of a number of reports about allegations and proven incidences of abuse by Savile at 41 acute hospitals, 5 mental health Trusts, 2 children's hospitals, and other care settings.

10.2 In October 2012, the Secretary of State for Health asked Kate Lampard to produce an independent report on lessons learned, drawing on the findings from all published investigations and emerging themes. The 'Lessons Learnt' report examined Jimmy Savile's role as both a volunteer and a fundraiser in the NHS; and how he used and abused his celebrity status to gain access, influence and control in a number of NHS settings over a period spanning 50 years.

10.3 The report was published on 26 February 2015 and included 14 recommendations for the NHS, the Department of Health and wider government. The Secretary of State accepted all the recommendations with the exception of the one on Disclosure and Barring checks.

10.4 Monitor and the Trust Development Authority communicated to all Chief Executives of NHS Foundation Trusts on 13 March 2015, stating, *"Given the severity of this issue, it is important to be able to demonstrate the improvements made to safeguarding across the system. I therefore ask that you respond to this letter by 5pm Monday, 15 June 2015 with an overview of any necessary actions that you have taken as a result of the recommendations in the report or, where these are in progress, the date by which they will be completed."*

10.5 On 30 March 2015, the CEO reported to the Trust Board *"The Lampard report makes a number of recommendations… which the Trust will consider, building on our existing arrangements. A further report will be made to the Board in May 2015 which will provide assurance that the necessary action has been taken, or where this is in progress, the date by which it will be completed."*

10.6 At the June 2015 Board, the Chief Nurse presented this 'further report', together with an action plan detailing the progress made. *'While the Trust has procedures in place in respect*

of each of the recommendations and robust safeguarding arrangements, in some areas those arrangements need to be formalised and strengthened. The actions planned and their timescales are detailed in the appendix.' This action plan[29] has been examined by the Review. Commentary on each respective area is provided below:

Lampard Recommendation 1: The Trust is fully compliant.

10.7 This recommendation relates to all NHS hospital trusts developing a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors. The policy should apply to all such visits without exception.

10.8 The action plan reported to the Board in June 2015 stated that risk assessment and DBS checks were in place for visits to the nursery and that whilst procedures were in place, a formal policy had yet to be established for the management of visits by celebrities, VIPs and other visitors

10.9 The plan set out that existing arrangements would be formalised in a Visits Policy by The Director of Communications and the policy submitted to the Clinical Management Board for approval in June 2015.

10.10 At the time of writing this report, the Trust supplied a draft policy for the management of sanctioned visitors. The Review understands this policy has now been formally approved and is accessible via the Trust's Intranet.

10.11 The Review examined the draft document and it is comprehensive in setting out the need for staff to be aware of the arrangements for organising related visits at Trust sites, setting out responsibilities and reinforcing the need for appropriate safeguarding arrangements to be in place for patients and staff.

10.12 However, given the profile of the abuse by Savile and the importance of this particular recommendation from Lampard, the Review is surprised at the delayed implementation. Constructing such a policy is not considered to be difficult and there were numerous examples from other Trusts (set out below) that were available prior to June 2015. Any of these could have been adapted by the Trust for local use.

- The Leeds Teaching Hospitals NHS Trust[30]

29 Trust Response to Lessons Learnt Report, https://www.bsuh.nhs.uk/search/?q=lampard

30 www.leedsth.nhs.uk/uploads/tx_lthboardmeetings/28.5_-_Access_policy_for_sanctioned_visitors_to_LTHT.pdf

- Buckinghamshire Healthcare NHS Trust[31]
- Gateshead Health NHS Foundation Trust[32]

10.13 Evaluation of the Trust's response to this recommendation from Lampard also involved questioning staff about their understanding of this issue and how it should be managed. A range of different scenarios were used during interviews to test how staff would respond to celebrity or VIP visitors.

10.14 Notwithstanding the absence of defined policy and procedure, all staff reflected a confidence in ensuring there would be no unsupervised access to patients and that managers would all be alerted to any visit requests.

10.15 As an associated issue, all staff interviewed demonstrated a similar understanding about chaperoning and whilst not all were familiar with the precise details of the chaperone policy itself, there was confidence expressed in how these arrangements should work.

Lampard Recommendation 2: The Trust is partially compliant.

10.16 This recommendation specifies that all NHS trusts should review their voluntary services arrangements and ensure that they are fit for purpose; volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision; and all voluntary services managers have development opportunities and are properly supported.

10.17 The Review considers that the arrangements for the safe recruitment and selection of volunteers are adequately set out within the Trust's Employment Checks Policy issued in May 2012. Further details on these issues are also set out under '*Safer Recruitment*'.

10.18 This policy defines the requirement for all volunteers to undergo the same criminal records checks as paid staff and adds further context to seeking further information via references and, if on placement from an educational establishment, direct contact with that organisation to further check suitability. The Employment Checks policy further details that volunteers receive information on safeguarding children via their induction.

10.19 The action plan presented to the Board in June 2015 specified that existing arrangements covering all aspects of volunteering were to be formalised into a Volunteers Policy by the Voluntary Services Manager and submitted to the Clinical Management Board for approval in

31 www.buckshealthcare.nhs.uk/Downloads/policies/Approved Visitor Policy 2014.pdf
32 www.qegateshead.nhs.uk/sites/default/files/users/user10/OP58 Visitors Access Policy v1_1.pdf

June 2015.

10.20 This Volunteers Policy was not submitted for consideration at the outset of this Review, although a draft was provided at the time of writing the report.

10.21 Whilst the draft policy makes reference to the recruitment, selection, training and supervision of volunteers, it is not specific about these aspects in terms of safeguarding children (or vulnerable adults). This is an area of weakness in the existing draft and requires attention prior to the final policy being signed off by the Trust.

10.22 Acknowledging that a number of NHS Trusts have such policies in place, the Review considered the available documents from The Shrewsbury and Telford Hospitals NHS Trust to be examples of good practice – particularly the handbook that prescribes very early in the contents the focus on safeguarding children and vulnerable adults

- Policy[33]
- Volunteers Handbook[34]

R23: The Trust urgently implement the Volunteers Policy as set out within its Lampard action plan.

Lampard Recommendation 4: The Trust is partially compliant.

10.23 This recommendation sets out that all NHS trusts should ensure that their staff and volunteers undergo formal refresher training in safeguarding at the appropriate level at least every three years.

10.24 Consistent with the Intercollegiate Framework, mandatory safeguarding training and formal refresher training for employed staff is defined and expected at the Trust in line with this recommendation.

10.25 Whilst defined, ensuring sufficient attendance remains a challenge for the Trust, with the low rate of attendance attracting a number of recommendations set out as part of this Review in *'The Supervision and Support of Staff' (Recommendation 47)* and *'Safeguarding Children Training' (Recommendation* 52, 53 and 56*).*

33 http://www.sath.nhs.uk/Library/Documents/Volunteers/Volunteer_Policy.pdf
34 http://www.sath.nhs.uk/Library/Documents/Volunteers/Volunteer_Handbook.pdf

10.26 Volunteers working at the Trust receive safeguarding children training at induction. The Trust's action plan in response to Lampard cites the intention to extend this to incorporate refresher training and prescribes a target for all volunteers to be trained by the end of 2015.

10.27 The target has not been met, and whilst the Trust reports this is being actively pursued, the Trust Board should ensure immediate action in this regard. It is worthwhile reiterating that given the low take up of mandatory training by employed staff, responding urgently to this action will require strong leadership, determination and appropriate resourcing from the Trust Board.

10.28 To assist compliance, the Review strongly suggests that the Trust urgently expedite the related action under *'The Supervision and Support of Staff'* to increase the capacity of the Safeguarding Children Team. Furthermore, to ensure focus going forward, the Review suggests that explicit reference is made to the training of volunteers (including the process for recording and monitoring attendance) as part of the recommendation to implement a revised training strategy.

R24: The Trust include specific reference to the training requirements for volunteers in its revised Safeguarding Children Training Strategy

Lampard Recommendation 5: The Trust is compliant.

10.29 This recommendation specifies that all NHS hospital Trusts should undertake regular reviews of their safeguarding resources, structures and processes (including their training programmes), and the behaviours and responsiveness of management and staff in relation to safeguarding issues - to ensure that their arrangements are robust and operate as effectively as possible.

10.30 In terms of the Trust's ability to ensure safeguarding arrangements are robust and operate as effectively as possible, the Review considers that the structures in place are adequately defined to help the Trust do this successfully.

10.31 Annual and ad-hoc reporting to the Board, the functions of the Safeguarding Children and Young People Committee, the engagement with the B&H LSCB and the initiation of this external Review, all provide evidence that the Trust engages in a range of activity to review this area of responsibility.

10.32 In terms of strengthening the Trust's longer-term approach in this regard, the continued

engagement of the Trust in the S11 audit programme is considered by the Review as the most logical and effective way of doing this, providing a good mechanism to avoid unnecessary duplication.

10.33 Indeed, S11 auditing already broadly covers the areas specified in this and other Lampard recommendations and hence this process should be sufficient for the Trust to validate its compliance against these factors and other statutory requirements.

10.34 Whilst S11 compliance is reported to the Trust Board as part of the Safeguarding Children Annual Report, the full details of all areas of the Trust's S11 audit are not. The Review recommends that they should be.

10.35 Furthermore, given the S11 process operated by the B&H LSCB, West Sussex LSCB and East Sussex LSCB is not undertaken on an annual cycle, the Review also recommends that the Trust should commit to annually updating this S11 audit and for this to form part of the Safeguarding Children Annual report. This will facilitate Trust Board scrutiny on a yearly basis.

10.36 Alongside the more frequent monthly monitoring by the Clinical Commissioning Group, these proposals will strengthen the overall reviewing, scrutiny and challenge of the Trust's safeguarding arrangements, without creating new structures or projects to achieve this. Yearly updates will allow for areas of both strength and difficulty to be known, agreed and understood in full by the Trust Board.

R25: That the Trust Board receive full details of the Trust's S11 audit return for review, scrutiny and challenge.

R26: That the Trust commit to updating its S11 audit on an annual cycle and report this audit to the Trust Board on a yearly basis.

10.37 Simply reviewing the Trust's safeguarding structures, resources and processes will not on their own make children safer. It is critically important that the Trust recognise this and responds positively to the related recommendations set out under 'Leadership and Governance' aimed at improving the influence and impact of the Trust's leadership in more rapidly resolving any identified deficits.

Lampard Recommendation 7: The Trust is not compliant.

10.38 This recommendation suggests that all NHS hospital Trusts should undertake Disclosure & Barring Scheme (DBS) checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The recommendation states that NHS Employers should support the implementation of this recommendation.

10.39 Although not compliant, there are currently no statutory or regulatory requirements to repeat DBS checks every three years. NHS Employers guidance sets out that people should have the appropriate level of check for the post they are undertaking.

10.40 At present, the Trust undertakes checks on employees and volunteers in line with this guidance and its own Employment Check policy. Neither specifies repeat DBS checks as a requirement. The Trust has stated it is awaiting the outcome of a national review by the Department of Health (DH) before committing to any further decision on this matter.

10.41 During interviews with staff, a number offered their views as to why the Trust was taking this approach. Opinions on this issue ranged from some believing the Trust was not willing to commit the necessary funding, whereas others felt the Trust did not think the DBS process was effective at identifying risk.

"We have only picked up people for drink driving. That is the main reason why the Board has decided at this point not to do repeat DBS checks." (Director of Human Resources)

"The Trust didn't want to do it because of the £50 fee." (Senior Manager)

"The Board has made the decision not to re-check." (HR Professional)

10.42 Whilst recognising that different opinions will invariably exist on this issue, the Review concurs with the findings of Lampard and strongly recommends that the Trust implement a DBS re-checking process rather than maintain the position on doing none. This will be permissible as part of a local policy decision.

10.43 The learning from Case A and Case B reinforces this recommendation. Indeed, whilst the DBS process would neither have prevented the crimes of either offender nor alerted the Trust to any risk, both case studies remind us that people who pose a risk to children work in and infiltrate organisations that deliver care to some of the most vulnerable people in our society.

10.44 The perpetrators in Case A and Case B will not have been the first child sex offenders working in a Trust and they are unlikely to be the last. It is worthy of note that one of the offenders sought out a former colleague to ascertain whether they would provide him with a reference. In light of this and in light of the requirement to put the safeguarding needs of children and young people 'front and centre', it is therefore sensible for the Trust to use whatever tools it has at its disposal to mitigate any potential risk where it can. Repeat DBS checks should be one of those tools.

10.45 On the basis of staff interviews and the insight provided by '*Security, Access, ICT and Exposure to Risk*', the Review has concluded that unsupervised access to children by staff not working directly with them, however unlikely, cannot be ruled out. The Review therefore supports the opinion of Lampard that repeat DBS checks should apply to the whole staff group, not just those working directly with children and young people.

R27: The Trust should implement a DBS re-checking process on a three year cycle consistent with Lampard's recommendation

Lampard Recommendation 9: The Trust is not compliant.

10.46 This recommendation prescribes that all NHS hospital trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and Twitter is managed and where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary.

10.47 The position conveyed to the Trust Board in June 2015 was that was no action required by the Trust in this area. The Review disagrees.

10.48 In its action plan, the Trust states that where it provides Internet access to patients, a strict policy is applied and the conditions of use signed up to by each patient or in the case of under 18's by their parent, guardian or carer.

10.49 The Trust further set out that patients and visitors are advised of the Trust policy and in the Children's Hospital, posters remind parents of the dangers of internet use, although the Review did not see any evidence of these during its fieldwork.

10.50 Whilst the Review has seen examples of consent forms and the six-point advice leaflet

issued to patients concerning the use of the wireless Internet facility, it has not had sight of any comprehensive policy documentation. The opinion of the Review therefore is that the current approach is piecemeal and inadequate.

10.51 The Trust's 'Visitor's Code' makes no reference to the use of internet, to social networks and other social media activities and the Patients & Visitors booklet available from the Trust's Website only makes reference to the use of mobile phones.

'Use of mobile phones in inpatient clinical areas by patients and visitors is not generally allowed, in order not to disturb others. However, individual patients may be allowed to use their mobile phone for a limited time in inpatient areas at the sole discretion of the ward sister or charge nurse. Please do not use your phone to take photos or make video images of members of staff or other patients. At no time must the privacy and/or dignity of other patients be infringed.'

10.52 Related policies submitted to the Review as evidence of action in this area included a Photographic and Imaging Policy – An Overview, a Social Networking Advice Policy – An Overview and a Mobile Computing Policy. None of these documents are specifically targeted at patients and visitors, other than the inclusion of a section within the Photographic and Imaging Policy setting out the conditions for using cameras.

10.53 Based on issues relating to accessibility and security, unsupervised contact with patients and the growing threat of those wishing to harm children using technology as a mechanism for grooming and abusing (i.e. the *modus operandi* of the offender in Case A), it is critically important that the Trust sets out clear arrangements for the use of the internet, social networks and other social media of patients and visitors whilst on any of the Trust's sites.

10.54 Whilst acknowledging the Nursing and Midwifery Council's guidance on social media contains reference to maintaining professional boundaries, the Review also considers it necessary to enhance the existing Trust policy documentation. In order to avoid ambiguity, references regarding professional boundaries and social networking should include specific and explicit examples that relate to all staff on this issue. Professional boundaries as they relate to physical interaction are highlighted in *'Concerns and Allegations Against Staff - Case C'*.

10.55 A good 'Appropriate Use of Personal Social Media for Safeguarding Professionals' policy should cover the following issues:

- That the policy applies to all staff, agency workers and secondees.
- That individuals are personally responsible for what they communicate through social media.

- That there is a duty on all members of staff to report misconduct relating to the use of social media.
- That the policy applies at all times, in all places, on any equipment and any social media platform; in work or at home and includes Trust issued, as well as personal equipment, e.g. posting an inappropriate message on your own smart phone whilst at home may constitute a breach of policy.
- That there should be no mention online or via email or any other form of digital communication of any Trust information, which would otherwise be unknown to non-employees.
- That if conduct would breach a policy in another forum e.g. during a conversation, it would also constitute a breach in an online forum.
- That staff must not be offensive to patients, visitors or stakeholders of the Trust, other employees or other online users.
- That the Trust has the right to investigate material posted online or on social media sites.
- That the Trust can require the closure of any applications and/or removal of content, which is deemed to constitute a breach of this policy.
- That the Trust has the right to monitor Trust IT resources and therefore there can be no expectation of privacy whilst using Trust resources.
- That the Trust, do or may use social media monitoring services which seek out content relevant to the Trust.

10.56 In the context of safeguarding children, young patients and vulnerable adults a good policy should contain explicit instructions about the use of social media in work including, taking photos in wards, offices or within the precincts of Trust property, posting images, taking 'selfies' and forming relationships, becoming 'online friends' with patients, former patients and their families.

10.57 Policy should be overseen by a staff user group and reviewed every six months or by exception if circumstances change. It should also be supported by contemporary, relevant and credible scenario based training.

10.58 Policy should make clear the level of sanctions applicable to specific breaches of policy and the steps staff can take to mitigate any adverse management action. This means outlining the type of breach that may incur management advice and warning through to breaches that could result in dismissal. Advice on what would mitigate an online error of judgment should also be included, for example apologising immediately, removing the offensive or inappropriate post or friend as quickly as possible.

R28: The Trust develop and implement a clear policy consistent with Lampard recommendation No. 9 with immediate effect.

R29: The Trust update relevant policy and guidance for staff to include explicit reference about professional conduct and boundaries in the context of social media.

Lampard Recommendation 10: The Trust is compliant.

10.59 This recommendation states that all NHS hospital Trusts should ensure that arrangements and processes for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.

10.60 In its action plan, the Trust recognised variability with regard to the processes for engaging temporary staff, either individually or via agencies, with 5 categories identified - doctors (locums), nursing, Allied Health Professionals (AHP), management, clerical and admin.

10.61 In response, the Trust's procurement team have prepared a standard approach to engaging temporary staff and supporting contractual arrangements. Furthermore, HR has specified the process for clearing temporary staff for all 5 groups and this is set out within the Trust's Employment Checks Policy.

10.62 The Trust's plan to implement this is reported as having made good progress to date for locum doctors and nursing staff with further work required in the other areas. Evidence that the Review saw of the Trust's robust approach to alignment and scrutiny of contracted staff (and ex-contracted staff), involved the Trust undertaking new checks of 672 permanent and 84 casual staff following the decision to bring a range of previously contracted functions in-house.

Lampard Recommendation 11: The Trust is compliant

10.63 This recommendation sets out that NHS hospital trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director.

10.64 In addition to the focus of this Review on the Trust's recruitment and training processes,

evidence to support the Trust's compliance in this area is reflected in the new People and Wellbeing Strategy, approved by the Trust Board in 2015. This strategy describes how the Trust will *'deliver safe and great care, every time, by employing, engaging, developing and retaining skilled, dedicated people who are proud to work for Brighton and Sussex University Hospitals NHS Trust. It has been developed with key stakeholders in line with the NHS Five Year Forward View, and firmly rooted in NHS and industry best practice in staff engagement'.*

10.65 The strategy is set within a framework of a five-year 'journey', with the first year (current year) aimed at 'Getting the Basics' right. Amongst a range of defined actions, a key target for the Trust is to review all people processes and policies and this includes those processes relating to recruitment, checking, training and general employment.

10.66 Governance for these processes is compliant with Lampard, with overall responsibility resting with the Deputy Chief Executive. The creation of a People Board for all workforce, employment and training issues provides a clear line of sight and strengthened accountability within the Trust.

Lampard Recommendation 12: The Trust is partially compliant.

10.67 This recommendation requires NHS hospital trusts and their associated NHS charities to consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation. This includies considering the implications of their associations with celebrities and major donors and whether their risk registers adequately reflect such risks.

10.68 The Savile case raised *'the question of how NHS hospitals manage their charitable funds, their fundraising arrangements and the role of celebrities and donors who play a part in fundraising for NHS organisations'.* (Lampard, 2015, 4.53)

10.69 As evidence in this regard, the Trust submitted to the Review its 'Guidelines for Fundholders of the Charity' issued in November 2014, with a Review date set for November 2017. This guidance provides the framework for the fiduciary duties of the Charity.

10.70 The Review also noted in the Trust's Lampard action plan that these guidelines were scheduled for review in the 'second half of 2015'. It also noted the Trust's statement that *'due diligence is undertaken with major donors and there is appropriate scrutiny in this regard'.*

10.71 Although the most up-to-date guidelines define clear parameters for the fiscal scrutiny of

charitable donations and spending, there is an absence of prescription dealing with the related issues arising out of the Lampard report and no reference to the detail of the 'due diligence' reportedly undertaken. The Review makes a simple recommendation on this matter:

R30: The Trust expedite the updating of these guidelines to ensure Lampard compliance, with a particular emphasis on specifying the arrangements for due diligence and risk assessment processes for managing relationships with celebrities and major donors as well as those protecting the organisation's brand and reputation.

10.72 It is also worth noting that the Review deemed that the inclusion of scenarios in the guidelines' appendices were helpful and likely to support staff better understand their practical application. Two associated recommendations are made by the Review on this positive aspect.

R31: The Trust include within the revised guidelines a range of examples on how to manage relationships with individuals in positions of authority, including celebrities, VIPs and donors. Examples should focus on practical and realistic scenarios.

R32: The Trust consider the wider application of using scenarios in its training to help develop and support staff understanding of the policy in the context of their role in the Trust.

11. Concerns and Allegations Against Staff

Terms of Reference
To examine the Trust's arrangements for managing current and historic safeguarding concerns and serious incidents.

11.1 Sex offenders who target children will infiltrate all walks of life. When they occupy positions of trust, their illegal actions add insult to the extreme injury felt by the people with whom they work; staff committed to doing an important job for all the right reasons.

11.2 This section of the Review reflects on three cases involving Trust employees; one involving inappropriate (non sexual) touching (tickling) and the other two, criminal activity.

11.3 In respect of the two involving criminal activity there is no evidence of a relationship or link between the individuals involved. One was a Paediatric Nurse convicted of offences relating to sexual activity with a child under 16, grooming of a child for the purposes of sexual activity and possession of indecent images. The other was an Emergency Nurse Practitioner convicted of accessing indecent images of children. None of the offences took place in the Trust, nor are they known to have involved patients.

Case A - Overview

A.1 Thirty-six year old Mr A was a nurse at the Royal Alexandra Children's Hospital in Brighton, East Sussex, where he had worked for nine years. From January 2011 until the time of his dismissal in September 2013 he was a Children's Emergency Nurse Practitioner.

A.2 Mr A targeted numerous young girls by masquerading as a teenage boy when engaging them in online chat rooms. As he groomed his young victims, his conversations with them would invariably become sexualised and he would then ask them to send him indecent images of themselves.

A.3 In the searches carried out following his arrest, a number of indecent images were recovered on his phone and other devices. These images ranged in nature of severity from level one to level five[35] (the most serious).

35 This scale referred to as the Copine Scale has been superseded by another categorisation process for the purpose of prosecution. Those images referred to as level 5 would now be considered or referred to as Category A.

A.4 Immediately following his arrest Mr A admitted offences relating to sexual activity with a child under 16, grooming a child for the purposes of sexual activity and possession of indecent images of children.

A.5 Post arrest, Mr A demonstrated many of the characteristics found in other child sex abusers. He minimised his wrongdoing, self justified and blamed others. Mr A told police that his marriage had broken down and during his incarceration he wrote to members of staff at the hospital insisting he was in love with the child in question.

"Mr A wrote a letter to staff saying 'I thought we were in love'. We don't know anything else he has done". (Manager)

A.6 At no stage did he tell staff about the age of the girl or the extent of his deviant online behaviour. We now know he had engaged at least 13 young girls online.

A.7 None of the children, known to have been engaged by Mr A were or had been patients in the Hospital.

A.8 He was subsequently 'struck-off' the Nursing and Midwifery Council's register after the panel concluded that his fitness to practice had been impaired.

A.9 In January 2014, he was sentenced to three years and two months imprisonment.

A.10 He is currently out of prison on licence and subject to the Sex Offenders Registration requirements and management regime.

The Trust's Management of the Incident

Policy

A.11 At the time of Mr A's arrest, the 'Allegations of Child Abuse against Staff' policy, which had been ratified in June 2013, provided the guidance for dealing with incidents of this nature.

Chronology

A.12 At 2pm on Saturday the 31/08/13 the then Director of Clinical Operations Woman and Children/Head of Midwifery, received a telephone call from the police informing her that Mr A had been arrested in a hotel room with a 14 year old girl.

A.13 She maintained regular communication with the police over the weekend and on the basis of her understanding that Mr A would be held in custody until his appearance in court on Monday the 2/09/13, made the decision to wait until Monday morning to inform colleagues.

A.14 Between 06.50hrs and 07.12hrs on Monday 2/09/13 the Director was able to communicate with key staff including the Named Senior Officer (NSO) and the Named Nurse for Safeguarding Children (NNSC), to arrange an urgent meeting in the hospital. At 07.12hrs the NSO instructed the Director of IT to lock Mr A's IT account and arranged for the Local Area Team and the Clinical Commissioning Group to be informed.

A.15 At 8.30hrs on 2/09/13 the first of three meetings to take place that day began with a briefing for the key hospital personnel in attendance. The notes[36] of these meetings (complied three days after they took place), reflects the following:

Emergency Meeting - 02/09/13

A.16 08.30hrs attendees were told that Mr A had been in Police custody over the weekend on charges related to sexual activity with a minor; that he would appear in court at 9am that day and that they (the staff present) were not to speak to anyone else about the incident.

A.17 This is an important factor as it places the discussion and the priorities and actions agreed in a context of absolute confidentiality.

A.18 The meeting considered how the hospital could support staff, as news of the incident came to light. Human Resources were tasked to consider the provision of occupational health and pastoral care support, for teams and individuals affected by the incident.

A.19 The NNSC undertook to advise the Local Authority Designated Officer (LADO) and local police Child Protection Team (CPT).

A.20 Internal and external communication issues were discussed and relevant managers instructed to ensure administration, nursing and medical staff were told to be cautious when fielding telephone enquiries. Arrangements were also made to remove the entire 'Who's Who' picture gallery at the Children's Emergency Department (CED), where Mr A worked.

A.21 Following on from the direction to lock Mr A's IT accounts, further instructions were issued to disable his hospital identity card.

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A.22 The meeting was also informed that Mr A had told police he had left property belonging to him, including his laptop at a colleague's home where he had recently stayed. Mr A's line manager was present at the meeting and confirmed that Mr A had been staying with a colleague and his partner for a short period whilst he sought alternative accommodation following the breakdown of his marriage.

Update Meeting - 02/09/13

A.23 At 1300hrs a meeting of senior managers took place to review actions and progress.

A.24 From the notes available to the review[37] we know that the Chief Executive, named doctor and nurse, designated doctor and nurse, the LADO and local police Child Protection Team (CPT) had all been informed.

A.25 Steps had been taken to prevent access to Mr A's IT equipment and account and to restrict his access to the hospital. A referral to the Nursing and Midwifery Council (NMC) was underway.

A.26 Press departments from the hospital, Thames Valley Police (TVP) and Sussex Police had all been engaged and were developing 'if asked' positions.

A.27 No feedback from police concerning Mr A's appearance at court had been received at that time but a Safeguarding Strategy Meeting had been planned with the LADO, Police, Brighton and Sussex University Hospitals (BSUH) Human Resources (HR) and other appropriate BSUH safeguarding representatives for 1600hrs.

Safeguarding Strategy Meeting - 02/09/13

A.28 A Safeguarding Strategy Meeting involving Social Care, the LADO, Police, BSUH senior safeguarding staff and BUSH HR took place at 1600hrs. It followed an update from the police that Mr A had been remanded in custody until the 16th September 2013 on charges related to sexual activity with a child.

A.29 During the strategy meeting a range of issues were discussed including the fact that Mr A had engaged in sexual activity with the child, had created an internet profile masquerading as a 15/16 year old, that he knew the girl was 14 and that he had indecent images of children on his mobile phone.

37 SCNC notes 02/09/13

A.30 Details relating to the nature of the alleged offences are not appropriate or necessary to mention here. However, it is important to note that there is no indication that the likelihood of offending against previous patients was considered or discussed at this stage.

Brighton and Sussex University Hospital Disciplinary Hearing – 03/09/13

A.31 A disciplinary hearing was convened on the 3rd of September 2013 at 10.00hrs. The panel consisted of the Chief Nurse supported by the Director of HR. The management side was represented by the then Director of Clinical Operations Woman and Children/Head of Midwifery.

A.32 The Head of HR Practice was listed as a witness. Mr A, was not present as he was on remand in prison. The notes of the Disciplinary Hearing[38] reflect the proceedings and record the outcome as summary dismissal with immediate effect, on the grounds of Gross Misconduct.

Lessons

A.33 One of the overwhelming themes the Review identified during interviews with staff who worked directly with or in reasonable proximity to Mr A was a sense of confusion, anger and to a degree; feeling guilty by association. Staff were shocked by what happened and horrified as the full extent of his offending became apparent.

A.34 Good people, working in high calibre teams, who were focused on making children well and keeping them safe, were astounded that someone like Mr A could have existed in their midst. They questioned why they hadn't noticed anything; was there something they had missed or something they should have seen? Some of their comments include:

"We do all feel a bit stupid because we were taken in by him". (Senior Nurse)

"I knew Mr A, I tried to work out for a long time why I didn't see anything, I was really worried". (Critical Care Practitioner)

"…Disbelief was a big thing". (Senior Nurse)

A.35 By all accounts Mr A was a high performing individual, well regarded, respected and liked by many of his peers. He was seen, by some, as the protégée of a charismatic and

38 Notes of Disciplinary Hearing 3rd September 2013

effective leader and by association a friend of people with a high degree of power and influence in his workplace. This comment is not included as a commentary on a highly effective manager but rather an observation of a common strategy, to associate with or hide behind those with authority and power.

A.36 One medic reflecting on whether there was ever anything said or done in the past responded:

"The only thing was the questions he asked about a child's behaviour after interaction with a nursery worker". (Named Professional).

A.37 Mr A had worked in the hospital for many years and built a good reputation. He was originally subjected to a Criminal Record Bureau (CRB) check, but given the Trust's current policy on the Disclosure and Barring Service (DBS) checks, (See *'The Lampard Review - DBS Policy Recommendations'*); he had not been subjected to a recent DBS review. That said even if he had been, the check would not have flagged any concerns, as he hadn't, at that stage been detected.

A.38 The Review engaged a large number of staff at all levels who had worked directly and sometimes indirectly with Mr A. A few did notice a change in his demeanour in the period leading up to his arrest. According to some of them he had lost a lot of weight, was beginning to dress differently and in one instance a staff member thought he'd begun to act in an 'almost flirtatious manner'. It is important to note that such changes in behaviour can be associated with an individual experiencing personal difficulties during the breakup of a long-term relationship, marriage or other major incident in their lives.

A.39 Whilst there was some talk of people feeling uncomfortable or having concerns prior to Mr A's arrest, the Review found these either related to matters that were not, or could not be connected with suspicions of child abuse. Information which when sought out by the Review amounted to personal feelings, innuendo or post-incident gossip. Even knowing what we now know, it is hard to imagine how any of Mr A's colleagues, staff or senior managers could have identified him as a risk to children at that time.

Policy, Communication Strategy and the Police Investigation

A.40 The 'Allegations of Child Abuse against Staff' policy in 2013 provided a list of responsibilities, roles and directions. The structure and detail available in the current draft policy (2015) has built on the original policy adding a greater level of detail and explanation.

However the 2013 policy and to a lesser degree the new draft policy (2015) are more critically undermined by two issues:

A.41 Firstly, the inclusion and emphasis, without explanation or example, of the *'Need to Know' principle.*

A.42 In the opinion of the Review, the absence of a contextual understanding of the *'Need to Know'* principal, results in information being retained by default rather than considered and shared with the staff in roles who do actually need to know particular information to effectively carry out their jobs.

A.43 In the meetings held by Trust senior managers there was a contradiction between their good intentions to support staff and the direction not to tell anyone anything that morning. In essence, they recognised the need to inform and support staff but caveated the sharing of information, notwithstanding that after Mr A's first court appearance, the information would be a matter of public record.

A.44 In the opinion of the Review, the lack of a clear strategy in this regard left staff unsure about what had happened and what they should or could do.

A.45 Staff should have been given a specific brief on the basis of what would become public knowledge and provided with direction and advice concerning contact from or contact with Mr A during what was from the outset an investigation into serious criminal offences. Instead the briefings staff received focused on what to do if there was a press enquiry and general briefings and instructions not to talk about the case.

A.46 In the absence of a clear understanding concerning the nature of the allegations some staff who would otherwise have chosen not to, maintained contact with Mr A. One such person said:

"If I knew what I know now, then staff wouldn't have been in contact with him." (Senior Nurse)

A.47 In the opinion of the Review, the overly restrictive '*Need to Know*' approach fed rumours, created unhealthy division at a vulnerable time and played into Mr A's attempt to minimise what he had actually done when communicating with staff. It could also have undermined security had he been released on bail and then returned to the hospital. One senior manager stated:

"We know [Senior Managers names] knew information which they didn't tell us. We do all feel a

bit stupid because we were taken in by him. I am a senior nurse, that information should have been shared". (Senior Nurse)

Another manager said:

"Its all still very raw. We haven't really had anyone come and de-brief us, explain what happened, talk to us about our feelings and how we move forward". (Manager)

A.48 Senior management at the Trust had formed a sufficiently robust view to summarily dismiss Mr A on the 3rd September 2013. It is therefore hard to justify not briefing staff more thoroughly regarding the criminal allegations against him and providing them with advice not to contact him during the on-going investigation.

A.49 A considered internal communication strategy would have ensured that staff were better briefed; that those who needed to know more did and that all staff understood the hospital's position regarding Mr A's status.

A.50 The second issue is the critical omission within the 'Allegations of Child Abuse against Staff' policy of a clear and unambiguous headline aim or objective to *'Safeguard Children who have visited or stayed on the Trust's premises, or been engaged by Trust staff at any other venue or place'.* Such a statement would have ensured that at each stage of discussion and during the formulation of an action plan, the focus would remain or be brought back to safeguarding children.

A.51 The first two meetings on the 2/09/13 were focused and facilitated a strong immediate response concerning the impact on the reputation of the Trust. However, from the limited notes of the meeting made available to the Review, it did not take account of, consider or reflect upon the potential that young patients under Mr A's care in the past may have been vulnerable.

A.52 Inclusion of a headline aim within the policy to consider whether children who had visited or stayed on the Trust's premises were appropriately safeguarded in the context of the threat disclosed by the arrest of Mr A would have ensured that questions were asked and answers sought.

A.53 The initial external communication strategy was clearly focused on protecting the hospital's reputation and understandably to maintain public confidence in the institution. However as time passed and more information became apparent the issue of whether or not to share information and what information should appropriately be shared with parents of

previous patients was the subject of some debate, and disagreement. In that regard context is key and it is the position of the Review that the risk to past patients was informed by the Trusts understanding of what the police told them.

A.54 The press statement issued by CEO Matthew Kershaw clearly reflects the Trusts understanding of what the police had said to them.

"The police found absolutely no evidence or even suggestion that Mr A's offending behaviour involved his place of work. They also found no evidence that any of his colleagues were aware of his offending behaviour, they received no complaints about his work and there was no history or suggestion of previous offences ".[39] (CEO, Matthew Kershaw)

A.55 This Review is of the firm belief that the senior managers in the Trust took the view that concerns regarding any possible offending in Mr A's workplace had been addressed by the police. In fact, the available evidence indicates that they felt reassured by the police position that there was no evidence of Mr A having offended on-site at the Trust.

A.56 However, the Patient Safety Ombudsman (PSO) was aware of and engaged with concerns surrounding this case and maintained significant levels of pressure regarding the depth and breadth of the police investigation. The PSO also pressed for the families of children who had stayed in the ward during Mr A's tenure to be contacted.

A.57 The levels of potential misunderstanding in this regard are perhaps best understood by reflecting on the police engagement with the Trust and the Trust's interpretation of what police actually said, versus what they meant. Police had caught Mr A at a crime scene where he made immediate admissions to them relating to contact offences with a 14 year old girl. At the scene they seized the phone he had with him and later recovered equipment from his temporary place of residence. Whilst indecent images of children were recovered from some of his devices, none related to children who had ever visited or stayed in hospital at the Trust.

A.58 In criminal cases especially those relating to such serious crimes, people rightly defer to the police. Fellow professionals understand that the police need to be independent and that they have the authority and expertise to carry out such specialist criminal investigations. In that regard what police say in such matters is considered as authoritative.

A.59 When told by police that there was no evidence of offending in the hospital, the Trust

39 Extract of CEOs Press statement from the Argus Published in July 2014 in http://www.theargus.co.uk/news/11350236.Nurse_expected_to_be_struck_off_after_being_jailed_for_grooming_girl/

(understandably) appear to have accepted the statement as an expert reassurance. However, there is a difference between saying there was no evidence found amongst the material seized, linked to the crimes for which Mr A was arrested and saying, having carried out an investigation to establish whether he committed any offences at the hospital; we found no evidence.

A.60 No staff, other than Mr A's line manager, reported being interviewed; the CCTV available in the ward was not seized or viewed and some of his personal computing devices, which police seized, appear not to have been forensically examined. If accurate this falls short of the type of investigation and reassurance the Review would expect in such circumstances.

A.61 The Review is therefore concerned that whilst the police appear to have reassured the Trust and their senior management team that there was 'no evidence of offending in the Hospital' that no actual investigation took place to ascertain whether or not that was the case.

A.62 Statements made in a police report[40] to CEO Matthew Kershaw, indicate that decisions may have been made on the basis of the fact that enough evidence already existed to support a successful prosecution for serious charges so further evidence was unnecessary.

"The prosecutor[41] has alluded to the fact that the [contact] offences were more serious and the sentence on them would be sufficient to cover Mr A's criminality which probably explains why no further forensic examinations were carried out". (Detective Chief Inspector, Sussex Police)

A.63 If this is in fact the case, then it misses the point that safeguarding is about protecting children not simply achieving an expedient prosecution.

A.64 Multi agency working is critical in cases of child exploitation and abuse. The Review would have expected to see a greater level of engagement between the LSCB partners including the LADO, children's social care, the police and hospital safeguarding teams. Professional curiosity and challenge should have ensured that the issue concerning an assessment of potential harm to former patients was collectively and professionally considered and agreed. There is no evidence that this was the case.

"The Police said 'you don't need to do it' [inform parents] in terms of doing wider investigations. The contact [by Mr A] was external to the local authority. He set up pseudo identities external to the local authority…during the investigation police certainly didn't think it necessary to investigate inside the hospital". (Local Authority Designated Officer)

40 Email Report from Sussex Police DCI to Chief Executive of BSUH

41 The Crown Prosecution Service

A.65 The area where Mr A worked is a high priority and usually busy area, staffed by dedicated teams. Children are almost without exception accompanied by parents and whist the majority of staff felt it would be possible to be alone with a child for a short period, 'if a parent nipped to the toilets' or 'went out to the car park to get something', they felt that significant periods of uninterrupted unaccompanied time with a child were unlikely. One staff member explained that:

"We can never promise that a patient will never be alone with a staff member". (Named Professional)

A.66 That said we know Mr A had a sexual interest in children and it would have been unwise to operate on the assumption that this interest was suspended at the front door of the hospital where he worked. He masqueraded as a 15/16 year old boy online, engaged and groomed or attempted to groom at least 13 young girls, swapped indecent images with some and we also know he met at least one 14 year old twice in a hotel.

A.67 Contacting parents and children in the aftermath of an incident of this nature is a decision that needs to be balanced and thoughtfully considered, with input from a range of safeguarding professionals. It is not a straightforward process and depending on the circumstances, profile of victims and known *modus operandi* of the perpetrator, is not always sensible or necessary. However it must be a key consideration and the evidence base for action or inaction captured in a multi agency risk assessment.

R33: The Review recommends that the Trust appoint a senior safeguarding children professional to work with the appropriate LSCB partners and children's social care representatives to consider the profile of this offender's known victims: the opportunities he had to engage children of a similar profile via his work and any information relevant to such a child.

This group should then make recommendations on whether, some, all or none of the families who have used the Children's ED facility should be contacted directly.

A.68 This is not and was never intended to be a Review of the police service involved in this case, indeed the Review had no authority to examine police files or interview officers involved. Police were only engaged at the end of the Review process when they were given the opportunity to challenge the factual accuracy of the judgements formed by the lead Reviewer. No evidence has been provided to challenge the comments made

other than the reasonable assertion by officers that the decisions made by police should be placed within the context of police policy and practice. This is something that can best be done by the police themselves and the Reviewer welcomes the fact that the police have undertaken to carry out an Internal Management Review (IMR) of this case.

A.69 The Review has acknowledged that it has no remit to make recommendations concerning the police investigation and has therefore limited its narrative to observations of reported police engagement, activity and influence. Two specific issues arise out of this case.

(i) The Review is not confident that reasonable steps were taken to establish whether Mr A offended in the workplace or that police made serious attempts to identify, locate and safeguard other potential victims, including those children whose images may be held on devices within his constructive possession, including devices not yet examined.

(ii) The Review is of the opinion that the Trust made the decisions it did on the basis of an ambiguous understanding of the police assertion that there was no evidence of offending in the hospital. While the issue of investigative standards are a matter for other bodies, there is a direct impact on the safeguarding responsibilities of the Trust when ambiguous statements are made and accepted without challenge. In this case there was no challenge demonstrated or mechanism in place to ensure that multiagency partners understood the difference between what they thought police had said and what that actually meant.

R34: The Review recommends that the 'Allegations of Child Abuse against Staff' policy is amended to include the need to seek the following clarity;

The Trust's safeguarding lead must establish clarity concerning police assertions that no evidence of work place based offending exists.

The position to be determined is:

(i) That in the external investigation that the police have carried out, they have not uncovered any evidence pointing to offending within the workplace and, or

(ii) That the police actively investigated the likelihood of offending within the work place and found no evidence.

The Review believes it is reasonable to expect the police to do both.

A.70 The issues regarding the 'Allegations of Child Abuse against Staff' policy are addressed in *'Policies and Procedures'* with accompanying recommendations.

A.71 The recommendation regarding the *'Need to Know'* principle is covered in 'Policy and Procedures' *Recommendation 12.*

Case B - Overview

B.1 In November 2014, a 54 year-old male nurse working for the Trust (Mr B) was arrested as part of Operation Spade[42], an international police investigation concerning allegations of accessing indecent images of children. At the time of his arrest Mr B was also employed by Brighton College at their boarding houses as a Registered General Nurse (RGN) and sick bay school nurse. This Review concentrates solely on his employment at the Trust.

B.2 Mr B had worked at the Trust for 27 years and at the time of his arrest he was employed as an Emergency Nurse Practitioner (ENP); a role that requires a high level of skill, competence and professionalism. Despite such requirements, the evidence considered by this Review would strongly suggest Mr B fell well short in all of these aspects. Indeed, he had been the subject of a number of management interventions and would have faced a disciplinary panel hearing regarding his competence had events not overtaken him.

B.3 Mr B had also been the focus of an earlier allegation of adopting a preferential approach to engaging younger patients. The management investigation at the time of this claim found no evidence to support it, with the Trust taking the view that Mr B's patient selection was more likely an attempt to avoid the complexity found in dealing with older patients.

B.4 All of these issues provide important context about Mr B. He wasn't performing his duties as he should have been and someone in the Trust was worried enough about his behaviour to formally raise this as a matter of concern. Mr B wasn't someone operating outside of the scrutiny of his seniors.

B.5 When arrested by the police, Mr B denied the allegations, minimised any wrong doing and insisted he had simply been looking for naturist sites on the Internet. He maintained this lie to a number of Trust staff he was in contact with during his suspension, reassuring them that he was not guilty of anything.

B.6 However, in his disciplinary hearing on the 5/12/14 he admitted that the images he

42 An international investigation into child abuse images coordinated by CEOP in the UK.

accessed and purchased were of children, that they involved non-penetrative sexual acts and that even though he found them distressing he had kept them but *"viewed them on only two separate occasions"*.

B.7 In October 2015, Mr B pleaded guilty to nine counts of making indecent images of children and one offence of possessing a prohibited image between 2007 and 2014. He was given a 12-month suspended sentence and was required to pay £300 in costs. He is no longer Registered with the NMC.

The Trust's Management of the Incident

Policy

B.8 At the time of Mr B's arrest, the 'Allegations of Child Abuse against Staff' policy (2014) provided the guidance for dealing with incidents of this nature.

Chronology

B.9 On 19/11/14, the Head of Security for the Trust was contacted by the police and informed that Mr B was the subject of an investigation into an allegation of purchasing and possessing indecent images of a child. The police sought to confirm Mr B's specific role at the Trust and stated that he would be arrested and his home searched under warrant the following day.

B.10 On the 20/11/14, the police followed up by informing the Head of Security that Mr B had in fact been arrested, interviewed and released on bail. A police officer then met with the Head of Security and the Chief Nurse to whom they made a safeguarding disclosure concerning the known facts, background circumstances and Mr B's bail conditions, that set out he should have no contact with people under 16 years of age and no personal use of computers.

B.11 The Chief Nurse, who was required to get permission from the police prior to briefing the Chief Executive and Head of HR, stated that, in what was a very careful and clear statement, the police had informed them that Mr B:

"…had made 'some admissions' although there had been no offending behaviour at the Trust, merely at home and online". (Chief Nurse)

B.12 The Chief Nurse, the Chief Executive, the Head of HR and Head of Security then met

and agreed immediate actions. Each then tasked and briefed other relevant Trust staff on the basis of the *'Need to Know'* principles agreed with the police.

B.13 The Head of Security assisted the police identify Mr B's IT account and equipment as well as facilitating the identification of his Internet search history via hospital devices. A review of his account and Trust devices disclosed a browsing history that contained no inappropriate searches or Internet site visits.

B.14 Initial enquiries by the Head of Security highlighted that Mr B had worked 20 bank shifts since 2010, some of which had been assigned to the Children's Emergency Department. By examining swipe card security access records for 2014, the Head of Security was also able to establish that Mr B had made a small number of visits to the Royal Alexandra Children's Hospital (RACH), which could not be accounted for by virtue of an allocated shift.

B.15 Mr B was excluded from the Trust that day (20/11/14) and an exclusion letter sent to him by recorded delivery. On the 24/11/14, the Head of HR was able to confirm that the 'exclusion from work and invite to meeting' letter had been signed for at Mr B's home address.

Strategy Meeting

B.16 On 26 November 2014, a strategy meeting was held at the Trust. The emphasis on the need for strict confidentiality was maintained.

"I felt that the strategy meeting was shockingly bad. It was a case of people not wanting to disclose ANY info to us". (HR Manager)

B.17 Such was the emphasis on not breaching the *'Need to Know'* principle that the LADO later commented to the Review:

*"The Hospital wanted to have a separate conversation with me away from the other employer [*Brighton College]*".* (LADO)

B.18 The minutes from the strategy meeting reflect that safeguarding staff from the Trust and Brighton College, as well as the police, were represented. The Named Nurse for Safeguarding and the LADO did not attend. The LADO was on leave at the time and was represented by a senior and experienced Independent Reviewing Officer (IRO) from Children's Social Care. The acting LADO chaired the meeting, which took into account Mr B's employment status, the background to the case, immediate actions and assessment of a range of risks, as well as

agreeing and setting timescales for future actions.

B.19 The strategy meeting identified the fact that Mr B had lone access to students whilst working at Brighton College and that it was possible that he may have had access to children on their own at the RACH. However, those present appear to have been reassured that there was no suggestion of any contact offences at that time and that there had been no previous allegations or safeguarding concerns.

B.20 The on-going safeguarding plan included Mr B's exclusion from Trust property and his suspension from employment at the Trust and Brighton College. It also took account of the limits placed on his contact with children and young people and personal use of computers imposed via his bail conditions.

B.21 There is also evidence that the strategy meeting considered Mr B's welfare. The police reported that they had offered him the usual support after arrest and that they did not have any concerns regarding his presentation or mental wellbeing after his arrest.

B.22 The meeting identified that an agreed media strategy would need to be developed in the event of a trial and if so, police indicated that such preparations would need to be completed by May 2015, some six months from the date of the meeting. It is worthy of note that whilst there were limited (*'Need to Know'*) briefings, there is no evidence of any written internal communication strategy.

B.23 The strategy meeting was aware that Mr B had been invited to attend a disciplinary meeting at the Trust the following day on 27/11/14. When considering Mr B's employment status, there was some discussion concerning whether the Trust would immediately dismiss him on the basis of their understanding of his admissions post arrest.

B.24 The police representative made clear that the admissions were limited to viewing naturalist videos and that he had not admitted the actual charges against him.

"He denied any access to websites, he told us that the allegation put to him by police were about naturist DVDs. Police haven't disclosed details of the images". (Head of Security)

B.25 The Acting LADO's advice, supported by police, was that the Trust should suspend rather than dismiss Mr B.

"It was to keep him on exclusion/suspension for the next 6 months." (Head of HR)

B.26 As it transpired, Mr B did not attend the disciplinary hearing due to ill health. He did, however, attend the re-arranged hearing date on the 5/12/14.

Disciplinary Hearing on 5/12/14

B.27 During the hearing, Mr B stated that he thought the films he had sought out online were naturist. However, he also specifically admitted that the images related to children under the age of sixteen, that they were graphic and upsetting and that they included sexual activity but not penetration.

B.28 He stated that whilst he had kept them in a drawer at home he had only viewed them on two separate occasions. When asked to confirm that there had been no abuse or use of the Trusts computers? He replied. *"No, there hasn't".* (Mr B)

B.29 He informed the panel that, *"The police have been supportive and have said that I may just get a caution".* (Mr B)

B.30 Given the seriousness of the issues the panel reserved their judgment, promising to inform him of the outcome in writing. In the meantime he was instructed to remain on sick leave. The panel also reinforced the importance of Mr B being aware of the help that was available for him, the need to use it and the fact that they would send a referral letter for him.

B.31 On the 21/12/14, the Chief Nurse wrote to Mr B informing him of the outcome of the judgment, which concluded that he would be dismissed from the Trust with immediate effect.

B.32 Whilst the letter from the Chief Nurse acknowledged that the police (at that time) had not decided whether to proceed by prosecution or caution, she had clearly formed the opinion, which is supported by this Review, that given his own admissions at the hearing, his position was no longer tenable.

B.33 The following excerpts from her termination letter, dated 21/12/14, highlight the rationale for her decision:

"I have considered the evidence and your explanation of the circumstances leading up to the purchase of and the possession of the films. However, I reject your explanation that you did not know, or could not have reasonably known, about the content of the films you were purchasing. In any event this is immaterial as even if you did not know about the content of the films at the time of purchase (which I do not accept), you took no steps when you discovered

the inappropriate content. On the contrary you kept them…

...Overall your actions are extremely serious and I believe amount to both gross misconduct under the Trusts applicable Disciplinary policy and criminal activity. The particular nature of your conduct also makes your continued employment impossible. The only appropriate sanction in the circumstances is to terminate your employment with immediate effect and without notice."

B.34 The Trust immediately referred the case to the Nursing and Midwifery Council (NMC).

Conviction

B.35 On the 15/10/15, Mr B pleaded guilty to nine counts of making indecent images of children and one offence of possessing a prohibited image between 2007 and 2014. He was sentenced to a twelve month suspended sentence.

Lessons

B.36 The Review found significant overlaps relating to the way that staff felt when Mr A's crimes were uncovered with those reflected by colleagues of Mr B. They felt confused, shocked and horrified that a person who could commit such crimes was within their midst.

B.37 Some questioned why they hadn't noticed anything and others reflected on the historic concerns they had held about his behaviour and how the news of his arrest had reinforced their worst fears.

B.38 Mr B had worked at the hospital for 27 years. In that time there had been some concern about his competence and for a period, a concern about his apparent preference to treat younger men or boys.

B.39 A senior manager told the Review that in 2013, whilst she was working at the PRH as an Emergency Nurse Practitioner, a staff member had raised concerns that *"something was not right with him".*

B.40 In a follow up supervision meeting, when asked to elaborate on their concerns, the staff member stated that they thought Mr B had been '*gravitating towards seeing younger men or boys'* rather than adult patients. The manager followed up by briefing their own supervisor and arranged to review data to establish whether the records of his patient engagement could evidence the concerns.

B.41 A review of the files did not disclose the suspected pattern of preferential behaviour and the manager took the view that his preference was inclined towards easier less complicated cases, rather than age and gender.

Communication – Engaging the LADO

B.42 The Review recognises that steps were taken to address the concerns raised in 2013 about Mr B gravitating towards younger patients, including a review of patient records. However, there is no evidence that contact with the LADO was considered. Given the nature of the suspicions raised, good practice would have involved the Trust seeking the advice, guidance and support from the LADO.

B.43 The requirement for such practice was reinforced in the existing statutory guidance at the time (Working Together to Safeguard Children 2013), and underpinned by the Trust's duty, under Section 11 of the Children Act 2004, to have appropriate arrangements in place to manage allegations against staff working with children.

B.44 Working Together 2013 clearly sets out that the LADO should be informed within one working day of all allegations that come to an employer's attention; and that such allegations may relate to a person who works with children who has *'behaved towards a child or children in a way that indicates they may pose a risk of harm to children'*[43], a definition that clearly fits with the concerns being expressed about Mr B.

"No one seemed to think to pick up the phone and speak to LADO". (Independent Chair B&H LSCB)

B.45 Mr Bs' competence had been an on-going issue of concern to managers; in fact he had received a final written warning related to the quality of his written work during 2013. Six months after the warning, a further review identified that the standard of his record keeping had fallen and the Review was told that, at the time of his arrest, he was the subject of a process that would have resulted in disciplinary action and likely dismissal.

B.46 When asked about whether they had suspicions about Mr B's interest in children during this Review, two members of his then team answered emphatically "*Yes*". (Anon)

B.47 One member of staff said, *"When we asked him what he wanted to do he said he wanted to do children's training".* (Anon)

43 Working Together to Safeguard Children 2013 page 49 - Archived

B.48 Whilst not all members of staff held such a view (and the Review accepts that there may have been personality clashes or other issues impacting on individual opinions about Mr B) there were clearly a range of concerns about his suitability and competence.

B.49 None of this, however, was reflected in any of the records of the meetings held by Trust senior managers or at the strategy meeting following his arrest. In fact, the records of the strategy meeting make two clear references to there being no history of concerns.
'*All parties were able to confirm that there have been no previous allegations or safeguarding concerns that we are aware of'.*[44]

'However there is no suggestion of any contact offences at this time and no previous allegations or safeguarding concerns'.[45]

B.50 The following recommendations are made as a result of the analysis of Case B.

R35: The Trust Board seeks reassurance that all managers have read the Allegations against Staff Policy and that there is clarity about the need to seek the advice of the Safeguarding Team and / or LADO relating to any allegations that indicate a member of staff or volunteer has:

- **Behaved in a way that has or may have harmed a child;**
- **Possibly committed a criminal offence against or related to a child;**
- **Behaved towards a child or children in a way that indicates they may pose a risk of harm to children.**

R36: Safeguarding training for managers is developed to include scenario-based training incorporating the management of allegations against professionals and volunteers who work with children.

R37: Subject to the Trust's review of the PSO, that the PSO's/FTSU responsibilities regarding advice, support and signposting concerns incorporate information about the specific response to allegations made against professionals or volunteers.

44 Strategy Meeting 26/11/14 Para 2. Background information.
45 Strategy Meeting 26/11/14 Para 4. Risk to Community or Relatives.

Policy, Communication Strategy and the Police Investigation

Policy

B.51 Whilst the 'Allegations of Child Abuse against Staff' policy in 2014 provided a list of responsibilities, roles and directions, it lacked general depth and focus. Some of these areas have been addressed in the current draft policy (2015), however the 2014 policy and to a lesser degree the new draft policy (2015) has been more critically undermined by the same two issues highlighted and explained in the overview narrative in Case A:

B.52 Firstly, the inclusion and emphasis, without explanation or example, of the *'Need to Know'* principal and secondly, the critical omission within the policy of a clear and unambiguous headline aim to 'Safeguard Children who Visited or Stayed in the Hospital'.

B.53 A firm requirement within the policy to focus and reflect on *'Safeguard Children who have visited or stayed on the Trust's premises, or been engaged by Trust staff at any other venue or place'*, may have provided greater reassurance that no offending took place in any environment within which he worked or accessed due to him holding a position of trust.

Communication Strategy

B.54 In this case, the Trust senior management team worked well together, provided immediate support to the police investigation, took decisive action about supporting and managing Mr B and moved meetings forward at pace.

B.55 They also provided specific briefings (within the limits set by police) to senior managers to ensure that key actions were completed in an appropriate and timely manner. It is also clear that an external communication strategy (relating to Mr B's potential appearance in court) was discussed and timelines agreed.

B.56 However, as in Case A, internal information sharing seems to have been muted by a strict adherence to or misunderstanding of the *'Need to Know'* principle. This pattern features in both cases and can reinforce the negative view held by many staff that the Trust wished to manage its reputation rather than protect staff and patients.

B.57 It is appropriate to recognise that the reputation of the Trust is important and must be managed in the context of such events. However, poor internal communication will undermine staff confidence, feed rumour and innuendo and potentially cause more damage to the institution

by giving the impression that the protection of information is being put before the protection of people.

B.58 From the interviews carried out by the Review it is clear that many staff would have welcomed guidance. As in Case A, some staff retained contact with their former colleague throughout his suspension and others (unconfirmed except via newspaper reporting) apparently waited and embraced Mr B outside court following his conviction.

B.59 *'Need to Know'* is not about rank or position rather about context, role and responsibility. A good practical example of the application of this can be found in the strategy to exclude Mr B from Trust property by issuing an exclusion letter. If those people working in security, at reception, monitoring cameras or on the wards do not know that an individual has been excluded how is the exclusion enforced?

Communication - Ambiguity and Impact

B.60 In common with case A, the Review is in no doubt that the Trust senior management team took comfort from the fact that the police had told them and reinforced on numerous occasions that there was no suggestion of contact abuse and no evidence of downloading in the hospital or on Trust ICT.

Police Investigation and Safeguarding Priorities

B.61 This is not and was never intended to be a Review of the police service involved in this case, indeed the Review had no authority to examine police files or interview officers involved. Police were only engaged at the end of the Review process when they were given the opportunity to challenge the factual accuracy of the judgements formed by the Review. No evidence has been provided to challenge the comments made other than the reasonable assertion by officers that the decisions made by police should be placed within the context of police policy and practice. This is something that can best be done by the police themselves and the Reviewer welcomes the fact that the police have undertaken to carry out an Internal Management Review (IMR) of this case.

B.62 Operation Spade has produced a number of challenges for the police service, not least because its dissemination was delayed for at least eighteen months. This is a refection of fact not a criticism of the investigating police service.

B.63 However, as with case A, the Review is in no doubt that the Trust senior management

team took comfort from the fact that the police had told them and reinforced on numerous occasions that there was no suggestion of contact abuse and no evidence of downloading in the hospital or on Trust ICT.

B.64 Whilst the police are not subject to the findings of this Review, it is important to place the decision making of senior managers in the Trust in context. When the police tell them that there is no evidence of offending in the hospital they take that as fact. They do not consider the nature and depth of the investigation; they are simply reassured by 'professional' advice.

B.65 The Review has found no evidence that police actively investigated the likelihood of offending within the hosptial facilitated by virtue of Mr B's position of trust and access to children.

B.66 Notwithstanding the apparent lack of investigation it may well be that no offending took place in the hospital. That said, operating on the assumption that an individual with a deviant sexual interest in children can simply switch that instinct off at the front door of the hospital is in the opinion of the Review reckless to say the least.

B.67 Operation Spade, which involved thousands of suspects from the UK, has thus far been responsible for identifying a number of individuals working within the safeguarding community.

B.68 Martin Goldberg was a Deputy Headmaster, identified in Operation Spade. When eventually approached by police he took his own life but not before attempting to destroy his collection of images. The investigation uncovered the fact that he had adapted a backpack, which he used to secretly film his students whilst in the changing rooms of the swimming pool.

B.69 Deputy Headmaster Gareth Williams was also identified in Operation Spade. When arrested investigators established that he had been placing hidden cameras in the toilets and shower facilities of his primary school to capture images of pupils.

B.70 Dr Myles Bradbury, a paediatric haematologist from Herringswell, Suffolk was arrested when an allegation was made by a relative of a young patient. He too was on the delayed Operation Spade list. He had been filming young patients using a camera disguised as a pen. He admitted 25 offences including sexual assault and the making of more than 16,000 indecent images of children.

B.71 The Review has seen no direct evidence of offending within the precincts of the Trust and it is not suggesting that such offending has taken place in the case of Mr B.

B.72 However, the Review is concerned about what appears to be a lack of understanding from the police in that they appear to have failed to seriously contemplated such a hypothesis. Indeed, the Review saw no evidence of staff being questioned by the police, of CCTV images being examined or swipe card access records being considered.

B.73 The question for the Review has therefore been to establish what level of investigation was carried out to establish whether the offending behaviour infiltrated an environment populated by vulnerable young people?

B.74 It is clear that the police, with the support of the Head of Security, established that there was no evidence that Mr B had used any hospital equipment to access and download images. But what steps were taken to support the statement that there was no evidence of contact offending or offline image collection?

"The police computer team did look at Trust computers to see if he's downloaded images but not from the point of view of live abuse". (Independent Chair, B&H LSCB)

B.75 Absence of evidence is not evidence of absence and combined with the limited scope of the police investigation, the Review is clear that the unequivocal conclusion from the police that there was no contact offending was flawed. It was in the opinion of the Review an assumption.

B.76 None of the staff, apart from the Head of Security and a few senior managers the Review interviewed, had been spoken to by police, neither is there any evidence that the police knew about, reviewed or considered the previous allegations regarding preferential patient selection.

B.77 When the Head of Security offered access to the duty patterns and the electronic swipe card access records he was told they were not required as there was no evidence of contact offending or illegal downloads in the hospital.

B.78 Given that Case A involved a nurse in the RACH, the Review is clear that the police should have attempted to identify any potential crossover. Mr B was employed in the PRH, working occasional Bank shifts in the Children's ED at RACH and it is entirely reasonable to have expected the police to have considered any patterns of movement and work access via Mr B's electronic swipe card.

B.79 An examination by the Review of the electronic swipe card records for 2014 show a number of visits to the RACH for durations that cannot be accounted for on any recorded shift pattern. Whilst it is possible these records may relate to Mr B gaining access en route to the

Trust's car park, the fact this was not investigated thoroughly clearly means this explanation is only one possible hypothesis.

B.80 In so far as the nature and the impact of the police investigations are concerned Case B attracts the same recommendations outlined in Case A - Review *Recommendation 34* therefore applies.

B.81 The recommendation regarding the *'Need to Know'* principle is covered in 'Policy and Procedures' *Recommendation 12.*

R38: (i) The Review recommends that the Trust appoint a senior safeguarding children professional to work with the appropriate LSCB partners and children's social care representatives to consider the profile of offending in this case.

(ii) On the basis of the agreed profile, to establish whether he had the opportunity to commit offences within the Trust.

(iii) If such opportunities are identified, to make recommendations as to whether some, all or none of the families he engaged should be contacted directly.

Case C - Overview

C.1 This case relates to an incident in which a complaint was made about the behaviour of a Ward Clerk. The matter was resolved and the parents who have been spoken to by the Review were satisfied with the way the hospital engaged.

C.2 They spoke highly of the treatment and attention their child received whilst in the care of the Trust. They had however been concerned by the uninvited and unwelcome physical engagement (tickling) by this non-clinical staff member with their child.

C.3 Given the nature of this case and the satisfactory outcome it would be unnecessary and inappropriate to publish anything that might identify the child or family involved. Therefore, the Review provides a simple overview of what happened, the outcome and lessons learned.

C.4 The incidents occurred during 2014. The parents of a child in hospital for medical treatment for a serious illness were concerned when a Ward Clerk engaged in an overly tactile manner by tickling their child. This occurred in their presence and on more than one occasion.

C.5 A Clinical Nurse Specialist alerted the Ward Manager that a parent had complained that a staff member had allegedly touched his daughter.

C.6 The Ward Manager made immediate contact with the Named Nurse for Safeguarding and sought advice with regards to the best approach to adopt when engaging the parents.

C.7 Following consultation with the parents, terms of reference for the investigation were agreed, an appropriate investigator appointed and the individual involved in the incident moved to an adult ward.

C.8 The Named Nurse liaised with the Local Authority Designated Officer (LADO) who carried out appropriate background checks, including with police and social services. None of the agencies felt the incidents met the threshold for abuse.

C.9 The investigation concluded that the Ward Clerk had inappropriate physical contact with a patient; specifically that on two occasions the staff member tickled a child whilst they were on the ward. However, it further confirmed that there was no evidence that this could be described as physical abuse.

C.10 The Ward Clerk admitted that he did tickle the child on more than one occasion. He stated that he had previously interacted with the child and the mother and that the child had laughed when tickled and had not seemed to be upset. He also stated that it was not normal behaviour for him to tickle children.

C.11 According to other staff, the Ward Clerk regularly interacted with patients on the ward areas and at all times, this interaction took place whilst a parent was present. There had been no previous complaints or concerns regarding the Ward Clerk's professional behaviour on the wards.

C.12 The investigation recommended that the Ward Clerk ensure that he kept up to date with all of his mandatory training, in particular training relating to safeguarding children and young people.

Lessons

C.13 The Clinical Nurse Specialist and the Ward Manager responded swiftly, engaging with key safeguarding and Human Resource staff at the Trust. Good contemporary notes were made, early contact with key safeguarding staff took place and expert advice was sought,

given and followed. The Trust management instigated an investigation and took proportionate steps to remove the Ward Clerk from the children's ward.

C.14 The Ward Clerk had not been given Level 2 Safeguarding Training and clearly did not understand boundaries. He has since received advice and appropriate training.

"I think that the Ward Clark didn't understand boundaries. He hadn't had any Safeguarding Level 2 training". (Director of Human Resources)

C.15 The parents received written communication concerning the outcome. During interview with the Review, it was clear that the parents had been upset by the incident, which occurred during a very difficult and stressful time for their family. Notwithstanding those concerns they readily praised staff for the medical care they provided and the manner in which the Trust responded to the complaint.

R39: All staff who engage or are likely to engage with children and young people staying in or visiting wards, must be appropriately trained and their understanding of their safeguarding responsibilities and expectations regarding boundaries tested.

12. Response to Serious Incidents, Reviews and Learning

Terms of Reference
To examine the Trust's implementation of Serious Incident, LSCB Serious Case Review, Learning Review and multi agency audit findings and recommendations

12.1 The revised Serious Incident Framework published by NHS England in March 2015[46] builds on previous guidance that introduced a systematic process for responding to serious incidents in NHS-funded care.

12.2 This guidance replaced the National Patient Safety Agency (NPSA) National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (2010) and NHS England's Serious Incident Framework (March 2013).

12.3 The framework takes account of the changes within the NHS landscape and acknowledges the increasing importance of taking a whole-system approach, where cooperation, partnership working, thorough investigation and analytical thinking is applied to ensure organisations identify and learn what went wrong, how it went wrong and what can be done to minimise the risk of the incident happening again.

12.4 The revised framework sets out the specific criteria of Serious Incidents in the NHS describing them as broadly being: *"events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver on-going healthcare".*

12.5 Within the Trust, there is a defined approach to the governance and management of Serious Incidents set out within the Safety, Quality and Patient Experience Strategy 2015-2020.

12.6 The appendix of this strategy sets out clearly the range of key people and processes responsible for the initiation, oversight and implementation of the Serious Incident process. Also set out within this section are the *'detailed roles and responsibilities'* underpinning the Trust's activity in these areas.

46 Serious Incident Framework – supporting learning to prevent recurrence, NHS England, 2015, https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

12.7 Related to the narrative in this report under *'Leadership and Governance'*, the Review was surprised that within the context of such an important document, whilst there was visible reference in the detailed roles and responsibilities section to adult safeguarding, there was no similar or explicit reference to the safeguarding of children and young people.

12.8 This is considered by the Review to be a further missed opportunity for the Trust to emphasise its focus on this area, particularly in the context of the Serious Incident process having defined and explicit links to Serious Case Reviews involving children and young people.

12.9 It is also considered to be a serious omission and whilst not explored directly with the Clinical Commissioning Group (CCG), the Review was surprised that this issue has not been previously identified by or escalated to the CCG lead for quality.

12.10 Whether intended or not, the emerging pattern from the lack of focus on children and young people in key Trust documentation will do little to reassure patients, staff and regulators that this critical aspect is embedded in the DNA of the organisation itself. This creates a risk that safeguarding children is simply not seen as everyone's responsibility.

"Historically in health, we've really had problems getting safeguarding to be seen as a issue outside paediatrics. I think people don't understand the responsibilities around it. I don't know if the Executive Team understand what their responsibilities are". (Designated Professional, CCG)

12.11 The Review makes the following recommendation.

R40: The Trust revise and submit to the CCG its Safety, Quality and Patient Experience strategy and include explicit reference to the strategic priorities for the safeguarding of children and young people.

12.12 All Trust Board members are notified of Serious Incidents, which are also reported in the Board performance dashboard. The Review noted that the Trust Board had also received assurance of learning from Serious Incidents and from patient stories, which are discussed in the public and private parts of the Board, as appropriate. This has included discussions with patients, carers and staff.

12.13 In its 2014 inspection, CQC identified the need for the Trust to improve learning from incidents and the Trust has sought to address this through an increase in its capacity for incident investigations, which also supports its duty of candour obligations; and through the

publication of audio recordings of the key findings and lessons learned from serious incident investigations.

12.14 The Trust's Safety, Quality and Patient Experience Strategy describes all incidents graded as causing 'moderate' harm or above as being reviewed at a Serious Incident Review Meeting, chaired by the Deputy Medical Director and attended by senior clinicians (Associate Medical Directors for Safety and Quality) and expert incident investigators. The strategy highlights that *'this meeting ensures the grading of harm is accurate and that the actions being taken are appropriate. Reports relating to all serious incidents are reviewed by this group before being finalised and all reports sent to patients under the Trust's Duty of Candour are also reviewed by this group'.*

12.15 Whilst this group has not been engaged as part of the Review, it is important to reference that the revised framework specified two significant changes to the approach in the operational management of Serious Incidents:

- Removal of grading – *"we found that incidents were often graded without clear rationale. This causes debate and disagreement and can ultimately lead to incidents being managed and reviewed in an inconsistent and disproportionate manner. Under the new framework serious incidents are not defined by grade - all incidents meeting the threshold of a serious incident must be investigated and reviewed according to principles set out in the Framework".*

- Timescale – *"a single timeframe (60 working days) has been agreed for the completion of investigation reports. This will allow providers and commissioners to monitor progress in a more consistent way. This also provides clarify for patients and families in relation to completion dates for investigations".*

12.16 Whilst a minor point, to accurately reflect the revised framework, the description of the Serious Incident Review Team in the Trust's strategy should be updated to remove reference to its function being to *'ensure the grading of harm is accurate'*.

R41: Consistent with the Serious Incident Framework 2015, the Trust update their Safety, Quality & Patient Experience Strategy 2015-20 to remove reference to the grading of Serious Incidents by the Serious Incident Review Meeting.

12.17 Within the Trust, The Safety, Quality & Patient Experience Team supports the Serious Incident process. Comprised of senior professionals, clinicians and staff, the team supports

the Trust's central functions of improving quality and reducing harm. Roles include investigation and reporting of Serious Incidents, investigation of complaints and safeguarding concerns, and coordinating patient feedback.

12.18 The PSO is also named as a key component of the approach to identifying and learning from serious incidents. Providing an independent, confidential service to listen to staff and patient concerns. The PSO role is in addition to the Trust's other processes for eliciting staff and patient concerns, the PSO is described as being responsible for raising these concerns at the Patient Safety Ombudsman's Advisory Panel and at the Executive Safety and Quality Committee.

12.19 As referenced in the *'Leadership and Governance'* section of this report, a significant proportion of staff interviewed had no knowledge of the PSO role and how this related to their day-to-day working lives. In the absence of this knowledge, it can be argued that an important route for staff to escalate concerns or report Serious Incidents is potentially restricted. Should the Trust decide to retain the PSO role this issue will be addressed by the implementation of Recommendation 7 in *'Leadership and Governance'*.

12.20 In terms of the Trust's oversight of safeguarding concerns, this is tasked to the Serious Complaints and Safeguarding Meeting, with clear lines of responsibility and onward reporting set out within the governance arrangements of the Trust.

12.21 All new serious complaints and safeguarding concerns are reviewed at this meeting to ensure there is senior clinical and executive oversight of these serious issues. The progress of on-going serious complaints and safeguarding investigations is scrutinised in this meeting. Where appropriate a senior member of this team will take responsibility for a specific case in order to provide senior managerial liaison with the patient or family affected.

12.22 With regards to the implementation of learning identified from the Trust's work as part of the B&H LSCB, the Review saw evidence of good engagement by the Named Nurse with the activities of the Learning & Improvement Sub Group and involvement, as required, with the Serious Case Review (SCR) process.

12.23 Defined as part of Regulation 5 of the LSCB Regulations 2006[47] and the statutory guidance set out within Working Together to Safeguard Children 2015[48], SCRs are commissioned by a LSCB where abuse or neglect is known or suspected and either:

47 http://www.legislation.gov.uk/uksi/2006/90/regulation/5/made
48 http://www.workingtogetheronline.co.uk/index.html

- A child dies; or
- A child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.

12.24 The Trust has been included in a wide range of local learning related to SCRs and local reviews including:

- 1 SCIE[49] Themed Learning Review
- 2 SCIE Full Learning Reviews (Ben & child J)
- 1 SCIE Speed+ Learning Review
- 1 SCIE Serious Case Review (Baby Liam)
- The Trust is currently engaged in two SCRs and one learning review.

12.25 Associated actions identified for the Trust as part of the SCR process are systematically tracked through the B&H LSCB and there is evidence seen by this Review of the Trust learning lessons and implementing changes to practice as a result.

12.26 For example, the SCR into Baby Liam published by the B&H LSCB in October 2015, included specific actions for the Trust relating to the improved recording of fathers' details in maternity booking and providing the B&H LSCB with assurance regarding how local data management systems are being used to support child safeguarding. Both actions have been addressed by the Trust with appropriate reporting to the B&H LSCB.

12.27 Evidence was also seen of the effective engagement by the Trust in the B&H LSCB's multi-agency case audit process. Trust practice was being scrutinized, lessons identified and actions taken to improve the Trust's response in helping and protecting children.

12.28 For example, in September 2014, a multi-agency case audit process was undertaken looking at cases of domestic violence and abuse. These audits all identified clear strengths in the front-line practice of staff with the analysis reflecting the following positive aspects:

Staff aware in October 2013 that child on a Child Protection (CP) Plan for known DV&A and did liaise with Children's Social Work about attendance.

Child attended A&E on 3 occasions - Children's Social Work were informed.

Good communication between Children's Social Work and midwifery

49 Social Care Institute for Excellence, http://www.scie.org.uk

Good documentation of decisions made (although in one case improvements in recording were required and subsequently actioned)

12.29 In January 2015, the B&H LSCB multi-agency case audits focused on Child Sexual Exploitation. No areas for improvement were identified with the strengths of the Trust's involvement being cited as follows:

- Appropriate and timely sharing of information with Police and Social Worker.
- Liaison was made with Social Worker and Child & Adolescent Mental Health Services whenever the young person was admitted to hospital with self-harm.
- The hospital staff have always spoken to the social worker at each presentation to hospital.
- Referral made to 'ru-ok' after the young person presented at A&E for self-harm related to alcohol misuse.

12.30 Again, similar to the narrative involving SCRs, the Trust's involvement in this process continues as relevant and is considered by the Review as being effective in ensuring the on-going development of an organisational learning culture that reflects on how the Trust can improve its safeguarding practice.

12.31 Lessons from SCRs, both locally and nationally and audit findings are communicated to front-line staff by the Trust's Safeguarding Team via the Safeguarding Children and Young People's newsletter and through the face to face contact that the Safeguarding Team has with front-line staff. The Review saw numerous examples of the newsletter that were thorough and comprehensive in setting out the key messages for staff and training material that cited learning from reviews.

12.32 Whilst the Review did not test staff awareness of learning in depth, this aspect is inextricably linked to the effectiveness of how safeguarding knowledge penetrates the organisation to those working on the front-line. Evidence obtained and referenced in this Review points to there being a disconnect in this process in terms of the work of the B&H LSCB, multi-agency training and policy awareness. The obvious risk is that this will be similarly reflected in staff not learning about key messages important for their day-to-day practice.

12.33 As such, given the additional focus being applied by the Trust regarding the learning from Serious Incidents, and in line with the Trust's plan to *'integrate learning from complaints, Regulation 28, safeguarding concerns, serious and moderate harm incident investigations'* (Annual Plan 2015/15, Page 14), the mechanisms being used, such as audio recordings, should also be adopted to assist the Safeguarding Team and the B&H LSCB disseminate key

learning arising from the focused child safeguarding reviews and multi-agency audits.

R42: The Trust to use its mechanisms for sharing lessons from Serious Incidents alongside lessons arising from Serious Case Reviews, Case Reviews and Multi-Agency Audits to strengthen their impact and reach to Trust staff.

13. Information Sharing and Working with Partners

Terms of Reference
To examine the effectiveness of information sharing and arrangements for working with partners such as the police and local authorities.

13.1 It is well recognised that safeguarding cannot sit in the sole responsibility of one agency. As such, it is important to consider how the Trust provide effective partnership, leadership and clear governance arrangements to support safeguarding in this context.

13.2 Section 13 of the Children Act 2004 requires each Local Authority to establish a Local Safeguarding Children Board (LSCB) for their area and specifies the organisations and individuals (other than the Local Authority) that should be represented on LSCBs.

13.3 The Brighton and Hove Safeguarding Children Board (B&H LSCB) is the key statutory body overseeing multi-agency child safeguarding arrangements across Brighton & Hove. Governed by the statutory guidance in Working Together to Safeguard Children 2015 and the LSCB Regulations 2006, the B&H LSCB comprises senior leaders from a range of different organisations, including the Trust, which is a statutory partner.

13.4 Given that services provided by the Trust also cross other Local Authority borders, there are defined links with both the East and West Sussex LSCBs. For the purpose of this Review the primary focus has been on the Trust's safeguarding partnership with the B&H LSCB. It is however, acknowledged that there are added complexities for the Trust in being required to engage with wider safeguarding structures due to the location of some of its sites.

13.5 The B&H LSCB has two basic objectives defined within the Children Act 2004;
(i) to co-ordinate the safeguarding work of agencies
(ii) to ensure that this work is effective.

13.6 Members of an LSCB should be people with a strategic role in relation to safeguarding and promoting the welfare of children within their organisation. They should be able to speak for their organisation with authority; commit their organisation on policy and practice matters; and hold their own and other organisations to account. Local arrangements include the following:

- The Chief Nurse attends as the Trust member accompanied by the Named Doctor and Nurse as advisors.

- The Named Doctor and Nurse also represent the Trust at the B&H LSCB sub groups including monitoring and evaluation, training and development, Health advisory group and multi-agency liaison.
- Links to West Sussex and East Sussex LSCBs continue via the Designated Nurses and Designated Doctors for Child Protection for West and East Sussex.
- The Named Nurse attends a health sub group of the West Sussex LSCB.

13.7 The Trust participates in the work of the B&H LSCB via a range of actions including the Section 11 Audit process, reporting on safeguarding children audits undertaken by the Trust, participating in multi-agency case audits and contributing to the B&H LSCB annual report.

13.8 The Independent Chair of the B&H LSCB considered the attendance of the Named Doctor and Nurse (as advisors) added good value to the work of the Board citing the following during interview:

"The Named Doctor and Nurse are vocal on the board and will contribute to the Board's discussions and work". (Independent Chair, B&H LSCB)

"The Named Nurse contributes on a range of issues & not just on the ones which relate to the Trust". (Independent Chair, B&H LSCB)

"The Named Doctor is very useful in terms of her explanation/contribution on her particular paediatric role in the hospital". (Independent Chair, B&H LSCB)

13.9 However, despite this positive report, the Independent Chair's view was that the Trust were not as visible at a strategic level as they could be. The Review concurs with his position given the Chief Nurse's reported attendance at only 4 of the 7 B&H LSCB meetings held during 2014/15.

13.10 Whilst the Named Doctor and Named Nurse ensured the Trust fulfilled 100% attendance throughout the year, engagement by the Chief Nurse as the Trust's Board member needs to improve. Despite the growing demands placed on all those working in the public services, the frequency of Board meetings are such that it is difficult to justify full Board members of statutory partners not being able to field better attendance.

13.11 If the most senior leaders aren't prioritising or aren't seen to prioritise engagement in multi-agency child safeguarding, then front-line staff and the organisation itself runs the risk of mirroring this approach.

13.12 The Independent Chair expressed his concerns about the Trust's engagement and influence at a senior level in the work of the B&H LSCB. This related to the lack of awareness of B&H LSCB multi-agency safeguarding training with Trust staff.

13.13 Despite the B&H LSCB regularly sending out bulletins and communications to front-line staff about training and other important multi-agency safeguarding matters; awareness levels remain extremely low. The potential correlation with an apparent lack of senior leadership buy-in at the Trust is concerning and further reflects the findings set out in *'Leadership Focus - Uniforms versus Child Protection'*.

"What this has shown to me is that that engagement doesn't infiltrate any further. If people haven't had the opportunity to read our bulletins or if people aren't hearing about these then that is a concern." (Independent Chair, B&H LSCB)

R43: That the Trust's LSCB members meet with the B&H LSCB Independent Chair to consider mechanisms to improve wide engagement in the work of the Board, from front line staff to members of the Trust Board.

13.14 In respect of operational engagement, interviews with staff from partner agencies reflected a wholly positive account of the interface with staff at the Trust, particularly with regards to the Named Nurse and the Safeguarding Team.

"My involvement is very operationally based. I'll get on the phone to the Named Nurse to move things forward". (Head of Safeguarding, Brighton & Hove Council)

"I have a good relationship with staff in the hospital. They all know me and know my role. Coming into the hospital settings all the designated people know me". (Local Authority Designated Officer)

"Its good, I feel I can have very open honest & challenge conversation. I class my relationship with the Named Nurse as open, purposeful & useful & it gets stuff done". (Head of Safeguarding, Brighton & Hove Council)

13.15 The Review did, however, hear from a number of staff about the negative impact on working relationships following the creation of the Multi-Agency Safeguarding Hub (MASH).

13.16 Prior to this development, the Trust had an on-site social worker whose role and presence

was clearly valued by Trust staff in terms their ability to provide swift advice on safeguarding and child protection matters. The MASH development resulted in the Local Authority withdrawing this resource and whilst different views were expressed about the loss of this role by other agencies, the lasting impression on Trust staff was that this has hindered their effectiveness.

13.17 Communication with the MASH was expressed as not being the same, there was a lack of relationship and Trust staff felt they were being 'filtered out' and finding it harder to get advice and the level of support they required.

"It was best when the social workers were in-house. I like the concept of MASH but it creates a few barriers not having social workers here". (Senior Nurse)

"I think health and the Local Authority have a very different view on that. I know my position is supported by the CCG. Politically it wasn't popular to withdraw the social worker. This was due to stretched resources and a combination of activity levels being much lower, it was a duty system they operated, the work they did was much lower than what took place in our assessment team. I think we created a dependency team". (Head of Safeguarding, Brighton & Hove Council)

13.18 Given the value placed on this social work resource by Trust staff, the Review believes there is an opportunity to explore potential solutions alongside *'The Supervision and Support of Staff' Recommendation 46* for increasing capacity in the Safeguarding Children Team.

13.19 Teams comprising staff from different disciplines can add significant value to safeguarding children arrangements (the MASH itself being an example of this). Should the Trust accept the recommendation to increase capacity in the Safeguarding Team, it could seek to harness an exciting possibility by adding a member of staff from another discipline, such as a social worker, to address this.

13.20 Arrangements for hosting and providing professional supervision for a registered social worker would need to be defined and agreed in partnership with the Local Authority. If that could be done the Trust could potentially create its own local multi-agency arrangements and reintroduce some of the functions of the previous social worker, whilst adding critical capacity to the Safeguarding Team. The Review considers this would be challenging and truly innovative step.

R44: The Trust consider funding and/or appointing a registered social worker to reintroduce some of the functions lost following the creation of the MASH and to support the functions of the Safeguarding Children Team.

14. Safer Recruitment

Terms of Reference
To examine the Trust's recruitment practices in respect of safeguarding children and young people.

14.1 All NHS providers, including the Trust, are required to be registered with the CQC and, as part of this, are required to comply with the Health and Social Care Act 2008 (Regulated Activities)[50] Regulations 2014 (as amended) and the CQC (Registration) Regulations 2009[51].

14.2 The Regulations outline a set of standards that NHS providers must meet, including having robust recruitment and employment practices in place to verify a person's suitability. Employers demonstrate their compliance with these standards by undertaking the six checks outlined within the NHS Employment Check Standards.

1. Identity
2. Right to work
3. Professional registration and qualifications
4. Employment history and reference
5. Criminal record and barring
6. Work health assessments

14.3 The NHS Employment Check standards apply to all permanent staff, staff on fixed-term contracts, volunteers, students, trainees, contractors, highly mobile staff, temporary workers (including locum doctors), those working on a trust bank, and other workers supplied by an agency. Trusts using agency, contractor or other external bodies to provide services must ensure, through regular audit and monitoring, that their providers comply with these standards.

14.4 Evaluating the Trust's safer recruitment activities involved the Review examining a range of written material alongside interviewing a number of staff about their respective responsibilities and personal experience in this area.

14.5 Notwithstanding a relevant recommendation to strengthen this area by introducing a process to repeat DBS checks (See '*The Lampard Report*'), the Review considers that overall, there are effective arrangements in place and that the Trust fully complies with the legislation underpinning the recruitment and vetting of staff and volunteers.

50 http://www.legislation.gov.uk/uksi/2006/90/regulation/5/made
51 http://www.workingtogetheronline.co.uk/index.html

14.6 Compliance with safer recruitment is adequately described within the Trust's S11 audit and the Review concurs with the Trust's self-evaluation on each of the relevant sections contained within this document.

14.7 The Trust's Employment Checks Policy is the underpinning framework supporting safer recruitment and is considered by the Review to be comprehensive, covering all of the required NHS Check standards in full.

14.8 All staff who have contact with children, young people and families are properly selected and have appropriate checks in line with current legislation and guidance. The Trust's reassurance to the B&H LSCB has set out:

- References are always taken up
- Identity and qualifications are verified
- Face-to-face interviews are carried out
- Previous employment history is checked
- The appropriate type of criminal record check from the Disclosure and Barring Service (DBS) is carried out for all eligible staff, with enhanced barred list checks for regulated activities involving children and/or adults
- Any anomalies or discrepancies are taken up
- Repeat DBS checks are carried out according to organisational policy (which is currently not to undertake them)
- Records are maintained detailing checks carried out for employees and recorded on personnel files
- Personnel files are audited on a spot check basis to ensure compliance alongside a quarterly or bi-annual audit by South Coast Audit.

14.9 Staff involved in recruitment are suitably trained, with the Trust requiring that at least one member of the short-listing and interview panel be trained in safer recruitment. This training is provided through the Trust's Learning and Development Team and although not seen, it is understood that learning podcasts are also available on the Trust's Intranet. The Review considers this good practice.

14.10 Furthermore, following recent system changes in the Trust, records of those panel members that have attended this training are now available via the new IRIS learning platform.

14.11 Bridging the previous gap, were records weren't kept, has strengthened the Trust's oversight in this area. Indeed, whilst the ED in the RACH was noted as having a very stable

workforce, staff turnover across the Trust is 12.6% compared to the NHS national average of 8.7%.[52] This turnover will be generating high volumes of shortlisting and interview activity. Being able to easily confirm that panel members are appropriately trained will undoubtedly help support the safer recruitment practices already in place at the Trust.

14.12 The Trust's requirements to notify the Disclosure and Barring Service (DBS) of relevant information is clearly set out within the Employment Checks Policy. DBS details were noted by the Review to be recorded on the respective personnel e-files of staff, with better governance surrounding this aspect cited as being 'introduced shortly' in the Trust's S11 audit in 2014. This 'better governance' relates to the introduction of a new Applicant Tracking System, understood to make it easier for managers to access relevant details of their staff. At the time of the Review, this system had not been rolled out and some managers reflected concerns about this affecting their oversight:

"HR is ineffective. I don't know who in my department have DBS checks. I didn't know even I had a DBS check until two and a half years ago". (Paediatric Nurse Consultant)

14.13 Accurate, up-to-date and timely information is critical to maintaining a safe workforce. The importance of these factors is similarly illustrated in Case A, where it is understood by the Review that Mr A had approached someone at the Trust and attempted to get a reference soon after his arrest. Related recommendations on this point are set out under *'Case A'*.

14.14 Consistency is also an important factor. In terms of how the Trust approaches its safer recruitment practices, the Review believes there is merit is seeking further clarity via the LSCBs in this regard.

14.15 The Trust's internal debate concerning repeat DBS checks is likely to be a conversation that is also taking place in other partner organisations. The lack of national appetite to prescribe any frequency around this issue is, in the Review's opinion, an opportunity for the local partnership to determine and agree a joint position on best practice in this area.

14.16 Other LSCBs have managed this variance by creating locally agreed 'minimum standards' for safer recruitment that harness the collective agreement and leadership of all partners. These differ in their prescription, but are all considered to provide a sensible platform from which all partner organisations can work. Examples include:

52 BSUH People and Wellbeing Strategy May 2015

- North East Lincolnshire Local Safeguarding Children Board[53]
- City & Hackney Safeguarding Children Board[54]
- Suffolk Local Safeguarding Children Board[55] (See Safer Recruitment)

14.18 In line with the approach taken by other areas, the Review makes an associated recommendation on this matter.

R45: The Trust formally raises the issue of safer recruitment with the B&H LSCB and West Sussex and East Sussex LSCBs, with a view to developing a agreed minimum standards for safer recruitment.

53 http://www.proceduresonline.com/nelincs/lscb/files/min_stands_safer_recruit.pdf
54 http://www.chscb.org.uk/wp-content/uploads/2015/09/CHSCB-safer-recruitment-minimum-standards.pdf
55 http://suffolkscb.org.uk/procedures/lscb-policies-guidance-and-protocols/

15. The Supervision and Support of Staff

Terms of Reference
To examine the supervision and support available to Trust staff

15.1 There are clear and defined processes for the appraisal, supervision and support of staff across the Trust, reinforced by a comprehensive supervision policy focused on safeguarding children. Examples of how this supervision and support operate include:

- The Named Doctor in the Trust providing safeguarding supervision to medical staff on an ad-hoc basis, and participates in the Monday teaching sessions and the Thursday peer review meetings.

- The Named Nurse in the Trust providing safeguarding supervision to nursing/midwifery staff who carry high risk caseloads and on a case-by-case basis to all staff as required.

- The safeguarding midwife providing supervision to the substance misuse midwife.

- Daily Safeguarding Team ward visits continue at The Royal Alexandra Children's Hospital enabling improved case discussion for nurses for approximately 450 children. Documentation of these discussions are filed in the child's notes.

- The Named professionals receive supervision from the Designated professionals.

15.2 Throughout the Review, staff spoke highly of the immediate support that they received and the value that they placed on supervision. Comments by staff illustrated the high confidence that they had in both their line managers and colleagues and their collective abilities to help staff deal with difficult and distressing situations when needed.

15.3 In addition to such support, a common theme repeated by many staff related to the high value they placed on the Named Nurse and the Safeguarding Team. All staff were aware of and familiar with this team and the Review was impressed with the effort and visible leadership that they provided.

15.4 However, the Review also noted the limited capacity of this team and whilst the Named Nurse in particular is a defined single point of success, there is an inherent risk that this this role could equally become a single point of failure.

"It's a huge volume of work and with one person/small team you do always worry". (Named Professional, BSUH)

"Capacity (of this team) is an issue". (Chief Nurse)

"The Named Nurse needs support". (Designated Professional, CCG)

15.5 Operationally, this team is stretched and the Review is of the firm belief that the Trust need to immediately increase its capacity.

15.6 Evidence supporting this position can be seen in the poor take up of mandatory training across the Trust; the difficulties that the Trust has in maintaining up to date and accessible safeguarding policy and information and the pressures caused by the scope of their remit insofar as it requires frequent attendance at a range of internal and external forums.

15.7 The Review heard of further pressures on this team created by the decision of The Sussex Community Trust to cease the liaison nurse role and supporting admin (1.2 Whole Time Equivalent (WTE) and 0.8 WTE). This created immediate pressures on the Safeguarding Team having to cover these responsibilities and whilst the Trust has responded positively and appointed a 0.72 WTE replacement and 0.6 WTE admin, cover is still required for holidays and sickness.

15.8 To put these pressures into context, the Trust's Safeguarding Team is primarily responsible for the safeguarding support provided to a significantly large and varied staff group. Amongst a range of other duties, it delivered 130 training sessions in 2015, continues to attend a variety of internal and external meetings, produces the monthly newsletter and undertakes daily ward visits at the Royal Alexandra Children's Hospital. The capacity of the Named Professionals and Safeguarding Team is set out as follows:

Named Nurse	1.0 WTE Band 8
Safeguarding Nurse	1.0 WTE Band 6
Admin Support	1.0 WTE
Liaison Nurse	0.72 WTE Band 6
Admin Support	0.6 WTE
Named Doctor	1.0 WTE
Named Midwife	No ring-fenced time for safeguarding (+ 0.8 WTE Band 7 support + 0.2 WTE cover provided by the Named Nurse)

15.9 Staff in the Safeguarding Team each have a 7 week holiday entitlement (including bank holidays). Taking into account cover arrangements and the WTE capacity, the Review was advised that this resulted in the team functioning at a 1 WTE deficit for 28 weeks per annum.

15.10 *Safeguarding Children and Young people: roles and competences for health care staff Intercollegiate Document (2014)*[56] indicates that a minimum of one dedicated WTE Named Nurse for safeguarding children and young people should exist for each health care organisation with dedicated clinical nurse safeguarding specialists for each additional site.

15.11 Given that the Trust employs 8225 staff and healthcare is delivered in multiple sites, capacity of the Safeguarding Team is considered by the Review to be compromised.

15.12 The guidance itself advises that whilst it is '*expected that there will be a team approach to safeguarding children and young people, the minimum WTE Named Nurse may need to be greater dependent upon the numbers of serious case reviews, the requirement for attendance at safeguarding committees, the requirement to provide safeguarding supervision for other practitioners, the local deprivation indices, the local child population and the number of children subject to child protection plans, the size of the organisation and whether it provides tertiary services'.*

15.13 Whilst recognising the pressure on public funds, the resourcing of the Trust's Safeguarding Team is considered an immediate priority by the Review.

15.14 The Review also considers it important that the Trust develop a clear strategy for contingency and succession planning. The Named Nurse is Band 8 and the supporting members of the team, Band 6. In the Named Nurse's absence, there is a gap in the experience available to directly take on her functions and given her current remit, this should be an area the Trust considers further.

R46: In line with the Intercollegiate Document, the Trust increases the Named Nurse capacity to resolve immediate contingency arrangements and longer-term succession planning in the Safeguarding Children Team.

15.15 An associated issue for the Trust to address in respect of staff support relates to the 56% appraisal rate of non-medical staff, noted in the People and Wellbeing Strategy. This is acknowledged by the Trust, and as part of this strategy rates have risen to 73%. However, the

56 Safeguarding Children and Young people: roles and competences for health care staff Intercollegiate Document - 2014

Review considers it important to draw a connection between low appraisal rates, the poor take up of training and the low numbers of staff who could confirm they had read related policies.

15.16 Appraisals need to take place and the Trust needs to continue to address the shortfall as part of its wider focus on improving workforce and HR related issues. In parallel, the Trust should also seek to drive improvement and compliance in the key areas identified in this Review as part of the appraisal process itself, e.g. attendance at training and knowledge of safeguarding policy.

15.17 It would be a missed opportunity for the Trust not to use appraisal (and the accompanying supervision) as a mechanism to set out a number of Trust wide expectations concerning safeguarding children and for these to be tracked and tested by managers across all levels. The Review makes a recommendation on this point.

R47: In line with the drive to improve appraisal rates across the Trust, a number of specified targets are set for all staff in order to respond to the findings of this Review. As a minimum, targets should be set that address attendance at mandatory safeguarding children training and reading and understanding key Trust safeguarding children policies.

15.18 Another matter relating to supervision highlighted to the Review related to significant social relationships possibly existing between some members of staff.

15.19 Most workplaces are complex environments and the Trust is no different in this regard. It will include professional relationships where some staff inherently have more power due their management position or supervisory status. It also will feature relationships where imbalances in power arise because of the informal influence that some staff have over their colleagues. This power can consciously or subconsciously influence the actions of colleagues, with relationships becoming even more complicated when strong personal feelings are involved.

15.20 Strong personal feelings, friendship or attachment ordinarily result in a significant social relationship, and it is this dynamic that can affect an individual's behaviour, attitude and self-esteem. Such relationships usually exists within the context of a family member, spouse, child, common law partner, close friend, sexual partner, business partner or a person who may serve as a role model to an individual or a person whose acceptance and approval is sought.

15.21 The Review understands that no member of staff is simply an employee. Trust staff will naturally develop personal friendships, attachments and family relationships. However, to

protect staff, patients and the Trust itself, such relationships must not compromise the work of those involved or lead others to believe that they might.

15.22 This has particular relevance to the potential impact of such relationships affecting decision-making, hindering the reporting of concerns and limiting the veracity of challenge on poor performance. All of these issues are important factors in ensuring children and young people are effectively safeguarded.

15.23 It also has relevance to the type of professional relationship that exists between some staff, with some, such as direct line management, being so important that they should never be compromised at all by the existence of a 'significant social relationship'. This position was reinforced through the interviews involving a number of Trust staff. Their comments and the Reviews recommendations on this issue are set out below:

"W's relationship with X is a vulnerability for children. If people have concerns about X then they can't go anywhere. The Trust doesn't have a policy about people in a relationship working together in the Trust". (Anon)

"We definitely need a Trust policy. Y is a very good clinician but Y's professional relationship with Z (manager) isn't professional". (Anon)

15.24 The Review found no evidence of compromised decision making related to 'significant social' relationships, which may exist within the Trust.

R48: That the Trust develop and implement a policy covering significant social relationships and inter-professional boundaries to provide absolute clarity for all Trust staff.

R49: The Trust immediately resolve any conflicts arising from known line-management arrangements where significant social arrangements could compromise the work of those involved or lead others to believe that they might.

16. Safeguarding Children Training

Terms of Reference
The provision of and attendance at safeguarding training, including multi agency LSCB training.

16.1 All staff at the Trust coming into contact with children and young people have a responsibility to safeguard and promote their welfare. They should all know what to do if they have concerns about safeguarding and / or child protection issues.

16.2 This responsibility also applies to staff working primarily with adults, those in other support roles such as administrators, porters and cleaners right through to those in senior leadership, executive and non-executive position in the Trust.

16.3 To fulfill these responsibilities the Trust should ensure that all staff are able to access appropriate training, learning opportunities and support.

The Trust's Child Safeguarding Training

16.4 In 2006, the Royal Colleges and professional bodies jointly published *Safeguarding children and young people: roles and competences for health care staff*.[57] The document described six levels of competence and provided model role descriptions for named and designated professionals. It was subsequently revised in 2010 and again in 2014 in response to policy developments.

16.5 This Intercollegiate Document is regarded as the framework which forms the basis of safeguarding training for health care staff. The guidance is clear that it only sets out the minimum training requirements and that it should be 'used in conjunction with key statutory and non-statutory guidance and with competency frameworks and curricula relating to specific professional groups'.

16.6 The formal training sessions at the Trust are consistent with the Intercollegiate Document and are offered at three different levels. The sessions are advertised within the Trust Learning and Development Prospectus, on their intranet and via the communications department 'all staff info mail.' In terms of the target audiences for this mandatory safeguarding training;

57 http://www.rcpch.ac.uk/sites/default/files/page/Safeguarding%20Children%20-%20Roles%20and%20Competences%20for%20Healthcare%20Staff%20%2002%200%20%20%20%20(3)_0.pdf

- All new Trust staff receive Level 1 training as part of induction.
- Clinical staff who work mainly with adults receive Level 2 training.
- Staff working with children or in midwifery receive Level 3 training

16.7 **Level 1** - This training has been provided within the corporate induction programme for new employees who joined the Trust since April 2007. New employees joining continue to receive this training within the BSUH Corporate Induction. Following attendance at this session, employees who do not give direct clinical care require refresher training at this level every three years. The duration of the induction and refresher session is 30 minutes and is presented at induction by the Nurse Consultant for Safeguarding Children or by an accredited level one safeguarding children & young people trainer.

16.8 **Level 2** - New employees attend the induction session and the additional level 2 training within six months from commencement of employment. Existing employees within level two are required to attend a refresher session every three years. The individual competences should also be reviewed annually as part of staff appraisal in conjunction with their individual learning and development plan. The duration of the session is 1 hour and there is an e-learning package available.

16.9 **Level 3** - Employees within level three are required to attend a yearly refresher session. Over a three-year period, professionals at level 3 (core) should receive refresher training or undertake reflective practice equivalent to 6 hours. Over the same period, professionals at level 3 (specialist) should receive refresher training or undertake reflective practice equivalent to 12-16 hours.

16.10 At the Trust, it is the individual employee's responsibility to identify with their manager the level they require and to book themselves onto a session. The Learning and Development department are responsible for booking participants onto the Level 1 and Level 2 sessions. Named professionals will arrange and book staff onto level 3 sessions.

16.11 A variety of techniques are employed including taught sessions, e-learning & newsletter communication. Course content is modified by the Safeguarding Team to be specific to the audience.

Training Materials

16.12 Training materials produced by the Trust Safeguarding Children Team and covering all levels were seen as part of this Review. These are considered to be comprehensive and thorough

in terms of addressing what might be described as the traditional themes of safeguarding children and young people.

16.13 There is a strong focus on abuse and neglect and subject matter in the presentations include reference to areas such as Child Sexual Exploitation (CSE), FGM and radicalisation.

16.14 Interviews with staff during the review consistently reflected the value they attached to their professional development. They spoke highly of the training they received and the quality of those delivering it. However, staff highlighted that the time committed to safeguarding children training was too limited; only 30 minutes every 3 years for Level 1 and 1 hour for 3 years for Level 2.

"The infrastrusture is such that when I came out to the community, you feel a little bit in the deep water cause you don't have any deep training". (Midwife)

Q: "*Do you think that the training is adequate?*"
A: *"A. No. It has got shorter and shorter. It is not even 2 hours"*. (Midwife)

16.15 Given the complexity and growing demands that organisations face to better safeguard children and young people, the Review considers that there is scope for the Trust to be more aspirational. It should consider moving beyond the minimum level of safeguarding training it currently provides to all staff.

16.16 There is clearly an opportunity to support the consumption of policies and reinforce the importance placed on having a thorough knowledge and understanding of them by providing appropriate 'pre-read material'. Individual understanding of the material can then be tested at the commencement of sessions.

16.17 Increasing the time available for training will not only provide a powerful message to the front-line staff about the importance the Trust places on safeguarding children. It will also better equip the workforce to identify, mitigate and manage safeguarding as and when they arise. The Review makes the following recommendation.

R50: In consultation with front-line staff, the Trust should review the minimum time allocated for safeguarding children training across all three levels.

16.18 Whilst basic level training was good, it was clear that important areas relating to safeguarding children, such as perpetrator behaviour, grooming and allegations against staff

were aspects not covered in as much depth, if at all.

"I think training wise we could benefit more from a mix of training" (Nurse)

"All training is geared towards stopping signs and symptoms, not about looking at people who are in positions of trust and abusing that position". (Practice Educator)

"I'm not sure that the first three main training programs cover anything on the LADO role". (B&H LSCB LADO)

16.19 Engagement with staff tested their knowledge in areas related to perpetrator behaviour, their awareness of the LADO process and how they would manage a range of scenarios posed by the Review. Whilst the majority of staff were understandably unaware of the LADO role, they were clear about who they would speak to in the Trust if they had concerns about a colleague's behaviour. However, very few if any knew what signs to look for in the first instance.

"I think that it would be an uncomfortable topic, but it would be of value". (Staff Nurse)

16.20 Key lessons have been learned in Trust cases A, B and C, from the Lampard Review and during the examination of a number of external investigations related to the behaviour of individuals occupying positions of trust. A module focusing on this critical area should be developed and included in all mandatory training. The Review makes the following recommendation.

R51: That the Trust consider how best to integrate relevant training regarding the behaviour of people in positions of trust into their mandatory staff training.

Training Attendance

16.21 The low numbers of staff attending mandatory safeguarding training is not a new issue for the Trust.

- In the Trust Annual Report 2013/14, a key challenge was noted regarding the take up of mandatory training.
- During a CQC listening event held in late 2013 / early 2014, staff were reporting difficulties in accessing training with a lack of cover in some areas meaning training opportunities were being lost.
- The CQC rated services for children and young people at the Royal Sussex County Hospital

as good in August 2014 but cited: *"We found children's services to be generally safe. However, we had concerns about nursing and medical staffing levels and the low number of staff that had completed their mandatory training"*.

- In September 2014, members of the Trust Board expressed concerns about the reported uptake, with the Board citing recent examples which highlighted why everyone needed to attend.

Take up of mandatory safeguarding training by Trust staff

	2013	Jan 2014	May 2014
Level 1	67.9%	66.9%	65.5%
Level 2	53.6%	53.5%	55.5%
Level 3	45.5%	50.6%	55.7%

16.22 Whilst noting the significant efforts of the Safeguarding Team and safeguarding leads[58] much work still remains to be done. It is clear that apart from specialist roles, performance in this area represents a significant weakness.

"If you pull out the training figures for the children's hospital, they are good at 80%. But the rest of the hospital is 60/70%. When I look back it is the same for years. But there comes a point where staff have to be trained to the levels they need to be". (CCG)

16.23 In the present austere environment maintaining standards whilst facing growing demand will be an ongoing challenge. The Trust therefore needs to consider how it can sustain and improve its training capability. This will require significant leadership commitment and should focus on improving access to both internal provision and extrenal LSCB multi-agency safeguarding training.

16.24 When operational pressures increase, there is often a direct and understandable impact on training attendance. Whilst the Review notes the significant operational demands faced by the Trust, care must be taken by them not to lose sight of the importance of training. Care must also be taken not to assume that the introduction of other 'training methods', such as e-learning and newsletters will mitigate this risk.

16.25 Whilst staff acknowledged that learning could be facilitated in a variety of ways including e-learning, newsletters, peer-to-peer and supervision, the majority viewed formal face-to-face

58 805 paediatric and maternity staff received safeguarding training in 2014/15

training as the bedrock of Trust staff development. There was consistent confidence expressed in the quality of the training delivered by the Nurse Consultant, the Safeguarding Team and the named and designated leads in the Trust.

"I think there is an online element of training but its time consuming. For me it is also the interaction and the ability to talk". (Nurse Manager)

16.26 Capacity is a critical issue. The remit of the Nurse Consultant has grown whilst her team has effectively been reduced in size. This has clear implications regarding their ability to successfully deliver mandatory training to all staff at a satisfactory level. The Review is of the opinion that reliance on such a small team to provide training for over 8,000 staff is unrealistic, unreasonable and unsustainable.

"It has been raised as a risk for a long time. Whether it is a risk, they [The Trust] decide". (Nurse Consultant)

16.27 Performance in this regard needs to be viewed in the context of the targets having been set at the minimum standard expected and the fact that concerns have been raised regarding training attendance over a significant period of time. In the opinion of the Review, the training uptake does not provide appropriate levels of assurance that the Trust's arrangements to equip staff for safeguarding children and young people are sufficiently robust.

R52: The Trust reviews the capacity of the Safeguarding Children Team to ensure sufficient resilience exists to both improve and sustain the mandatory face-to-face training offer.

R53: That the Trust Board ensure the poor performance regarding take-up of mandatory safeguarding training is escalated to its risk register to ensure ongoing scrutiny of this aspect.

Training Strategy

16.28 Supporting the requirements set out in the Intercollegiate Document, the Trust has delivered its training to staff within the context of a wider Safeguarding Children and Young People Learning and Development Strategy.

16.29 At the time of the review, however, this strategy (dated 2012-14) was out of date. A revised draft had been completed in December 2014 to cover January 2015-17, but had not

been formally agreed by the Trust.

16.30 The strategy itself sets out what would ordinarily be expected in a health care setting and whilst not inaccurate, it would be strengthened if it provided a much clearer focus on the local context for safeguarding training within the Trust and the priorities agreed by the wider safeguarding partnership.

16.31 The safeguarding themes identified by the B&H LSCB over 2013-16 include neglect, sexual abuse and sexual exploitation and as such, these aspects should be equally reflected as Trust training priorities.

16.32 The Trust needs to take account of all known risks to children including FGM, radicalisation and the threat posed by individuals who infiltrate organisations by occupying positions of trust. The Review believes that a clearer focus on these issues, combined with reinforced resourcing will produce a more acutely focused strategy. This will assist the Trust meet their obligations to support staff and safeguard children and young people.

R54: The Trust revise the Safeguarding Training Strategy 2015-17 to ensure it provides a much clearer focus on the local context for safeguarding training in line with the priorities of the LSCB and the Trust itself.

Training Evaluation

16.33 Measuring the impact of training is critical. The Review therefore recommends that a heightened focus be applied on how training is evaluated by defining a specific training analysis and evaluation framework. Initiating such a framework will assist the Trust form a better view of the quality and impact of training beyond simply looking at compliance with attendance.

16.34 To support this development, it would be prudent to explore whether the training content itself could be better aligned with reflected practice i.e. considering contemporary, credible and relevant experiences Trust staff have faced. This will ensure that all staff can benefit from and apply lessons learned in practice.

16.35 This could be supported by requiring delegates to undertake pre-reading on relevant policies or procedures (i.e. the Safeguarding Children Policy) and for the training to provide the opportunity for them to reflect their own experience as well as specifically test knowledge transfer.

"With our mandatory training on safeguarding I can't recall the expectation of us reading the Safeguarding Policy cover to cover". (Practice Educator)

R55: The Trust develop a specific training analysis and evaluation framework to better judge the impact of the safeguarding training being delivered.

R56: Mandatory safeguarding training should be adapted to ensure there is appropriate reflection on individual experience, opportunity to share learning and reassurance via testing of staff knowledge on key safeguarding policies and procedures.

Multi-Agency Safeguarding Training

16.36 The benefits of multi-agency training are well established and do not need to be reiterated in-depth for this Review. As the figures below highlight staff from a diverse range of agencies take advantage of this free LSCB multi-agency training.

B&H LSCB multi-agency training from April 2014 to March 2015;

- 380 staff from a range of different agencies received core safeguarding training (Level1) from the Brighton and Hove Safeguarding Children Board LSCB).
- 24 multi-agency child protection courses (Level 2) were delivered by the BSCB with 380 practitioners attending.
- A further 18 specialist courses (Level 3) were delivered with 373 practitioners attending.

16.37 Following the recent inspection of services for children in need of help and protection, children looked after and care leavers and the review of the B&H LSCB that took place between 14 April 2015 and 8 May, Ofsted cited;

"Practitioners are aware of the LSCB training offer and many spoken to have recently attended training."

16.38 Whilst recognising the inherent limitations of how many staff Ofsted can engage through any inspection process, their confidence in LSCB training awareness was not mirrored through the Review's engagement with the Trust staff.

16.39 Indeed, one striking and regularly repeated aspect of staff commentary was their

complete lack of awareness about the availability of free multi-agency safeguarding training. Even when awareness was acknowledged, the operational pressure on front-line staff was often cited as a reason for them not being able to attend. It is therefore not surprising but disappointing that only 1 staff member from over 8000 employees attended a core LSCB multi-agency training course in 2014/15.

16.40 Furthermore, given the recommendation arising from the CQC inspection of Community Health Services for Children, Young People and Families undertaken in May 2014, it would not be unreasonable to conclude that attendance at multi-agency training has not been prioritised sufficiently by the Trust;

"The trust should ensure that staff are supported to attend external training courses, and are provided with time and resources that are fair and equitable to the individual staff member, department and the trust".

16.41 Whilst it is right for the Trust to focus on ensuring their staff attend mandatory in-house training, consistent with the Intercollegiate Document, it is a missed opportunity that so few are developing their safeguarding skills and knowledge alongside colleagues from other disciplines.

16.42 It is also a missed opportunity for the wider partnership in that they are not benefitting from the professional experience and input of Trust staff at these sessions.

16.43 The Review believes that significant value would be added to the Trust safeguarding arrangements and the quality of LSCB training through increased attendance. An opinion mirrored by the Chair of the B&H LSCB;

"I would like to see ward staff being on that course and sitting along side social workers, police, educators etc". Chair of the B&H LSCB

Q: "*Have you heard of LSCB multi-agency safeguarding training?"*
A: *"No" (Deputy Sister)*

"I have never done multi-agency training. I've never heard of it". (Midwife)

Q: *"Have you been on multi-agency training?"*
A: "*No, never." (Nurse)*

16.44 The Review makes the following detailed recommendation in this regard:

R57: That the Trust work with the LSCB to develop a specific plan that seeks to raise The Trust's staff attendance at multi-agency training. The following factors should be considered:

(i) The use of available rooms at Trust sites for training should be explored to make it easier for Trust staff to attend.

(ii) Building on the inter-agency training forums on FGM held in 2014/15, the BSCB should consider whether additional 'bite-size' multi-agency training sessions can be delivered at the Trust relating to key priorities that impact the partnership, but with a particular focus on Health.

(iii) Align the Trust training with the intercollegiate document to better promote health staff attaining their level 1, 2 and 3 training through attendance at multi-agency courses delivered by B&H LSCB.

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17. Security, Access, ICT and Exposure to Risk

17.1 The Trust has a security team headed by an individual with a credible security background and previous experience operating in Acute and Mental health hospitals. The team has 22 members, all of whom are DBS checked to enhanced standard.

17.2 All security staff receive child and adult safeguarding training to the Level One standard. This is a basic level and involves no child specific scenario based training. No content concerning dealing with safeguarding professionals suspected of committing breaches of trust is incorporated in their training.

The Review makes a recommendation on scenario based training in '*Safeguarding Children Training*'.

Operating Practice

17.3 The security team operates from a command and control room on site and have access to 455 overt CCTV cameras across the Trust. They are usually able to access images and share them via IP systems, however the RACH is still hardwired so images cannot be shared with staff there.

17.4 Video recordings are kept for 28 days unless they are the subject of an investigation, in which case they are retained for as long as is necessary.

17.5 The management team operates on a *'Need to Know'* basis. This principal is enshrined in policy, in particular the policy for Allegations of Child Abuse against Staff. Whilst this policy states that '…sharing of information is on a need to know basis.' the existing policy does not explain how that type of judgment should be made or give examples. Therefore, if a judgment is made that you do not need to know information it is not shared with you. The Review has had access to the new draft policy, which goes some way to addressing this issue and is subject of recommendations in the *'Policy and Procedures'* section of the Review.

17.6 The Review identified that in Case A and Case B information was not effectively shared with the security team regarding the nature of the offences both individuals were alleged to have committed and the procedures to be adopted if they were sighted on Trust property. In at least one case, no photograph of an individual banned from the site was shared with security staff charged with protecting the infrastructure, patients and staff.

R58: Security Team Standard Operating Procedures (SOPs) should be amended to include specific advice for dealing with staff and other individuals excluded from Trust property. This should cover their identification, risk assessment, actions on sighting, communication strategy and key points of contact.

Security and Access Control at the Children's ED in the RACH

17.7 Creating secure environments in which staff can work and children are safe requires a balanced approach. Children need to be in a safe and secure environment and staff need to feel safe, not least, so they are not distracted when looking after children and engaging with parents, carers and visitors.

17.8 Access to the CED at the RACH is generally through the main entrance, providing direct access to a waiting area. There is another entrance controlled by 'buzzer' access. This door is situated at the furthest end of the ward; out of natural line of sight of the nurse's station and at the opposite end to the visitors waiting area.

17.9 On the first day of the Review's visit to the Trust, access was made to the CED at the RACH without challenge. Using the entrance at the furthest most point from the nurse's station, the team gained access by pressing a buzzer. They were not challenged via the intercom as to who they were or why they required access. Once inside, they were able to walk unchallenged past the side rooms and main wards down to the nurse's station were they waited for a short time for someone to come to the desk.

17.10 In the opinion of the Review, it would have been easy to slip undetected into a side room or ward.

17.11 The Review acknowledges that making an emergency environment hard to access could have a detrimental impact on the needs of a sick child. When we asked about the dual entrances at the RACH, staff explained the 'Blue Baby Scenario'. This relates to a very credible situation in which a distressed parent or carer is rushing to the ward to get urgent help for their child who is having difficulty breathing (therefore turning blue). In such a state it is likely that the child will be taken via the fastest route a parent or carer can find and that will vary depending on which entrance they first used to access the hospital.

17.12 The Review was told of another incident during which a drunken man had fallen asleep in the toilets adjacent to the ward. This issue was managed by staff but is indicative of some of the general nuisance factors staff may sometimes be diverted to deal with.

17.13 There is a CCTV camera near the nurse's station in the CED at RACH, however security staff situated in another location monitor it. The security staff can be contacted via telephone and directed to watch or feedback on activity in a particular area, however the staff on the ward cannot see video images from the camera. The inability of staff to see images within their area of responsibility or to check identity prior to admitting visitors via the door with buzzer access represents a risk.

17.14 From a technical point of view, there are numerous solutions to secure an entrance against unauthorised access, whilst still allowing swift access for authorised users. Door entry systems that combine an intercom with door release button and CCTV coverage is an easy system to use. However, it relies on staff checking the CCTV and speaking to the person seeking access before releasing the door.

R59: Steps should be taken to introduce appropriate access controls, including the installation of a CCTV multi-channel monitor and intercom at the nurse's station to give staff access to CCTV images from both entrances to the CED at RACH and to the camera adjacent to the nurse's station.

R60: Staff should be instructed to check who is at the door and why they need access before releasing the door lock.

R61: Security staff standard operating procedures (SOPs) should be amended to ensure routine patrol checks of publicly accessible lavatories.

Movement

17.15 The RACH has been designed to consolidate the resources needed to treat children within an environment, which is child friendly and where staff are experienced and specially trained to meet their physical and emotional needs.

17.16 In the RACH this well intended approach is undermined by the harsh realities of delivering a range of services in economically challenging times. This has resulted in space that the Review was told was constructed as part of the children's hospital but was being used as a research lab for other purposes.

17.17 This results in two areas of concern. The first, that adults not associated with the children's ward frequently share space with them. This has resulted in further delays to a planed program of work, which would have integrated the children's audiology (ENT) department within the confines of the children's hospital.

17.18 The second concern therefore focuses on the views and concerns expressed by staff that children have to share medical services for this specialism with adults. In simple terms this means that young children will wait for their appointment in close proximity to adults.

17.19 Some of the adults will be suffering from highly visible disfigurements, whilst others will invariably have received very bad news concerning their illness. Staff told the review team that this can upset and distress the children waiting for their appointments in the shared waiting area. One member of staff reported that on some occasions children have been waiting in the same area as prisoners attending the hospital under guard for treatment.

"I believe there to be a safeguarding issue within the Audiology department. Currently children have to share a small waiting room area with adults, which is unacceptable. Anecdotally parents have told me that they were aware that their child was made uncomfortable by the close proximity of adults with overt mental health issues. The children frequently have complex health needs including respiratory and immunocompromising disorders; sharing a close space with numerous adults presents a health risk. I would therefore wish to log that we are not currently addressing the safeguarding needs of the children attending audiology at the RSCH. There are mature plans to move the paediatric service into the RACH. These plans include a dedicated paediatric audiology waiting room". (Consultant Clinical Scientist (Audiology), Head of Audiology)

17.20 Whilst the staff do their best to manage the throughput of children at the beginning or end of the day they made it clear that under the current system complete division and isolation from potentially distressing situations was not possible.

R62: The Trust Board formally address the issue of requiring children to transit through, occupy and wait in parts of the Trust predominantly used by adults and on occasion, people in lawful custody .

The Trust should consider placing this issue on the risk register until resolved.

IT systems at PRH and RACH

17.21 The Royal Alexandra Children's Hospital (RACH) operates as the main provision of specialist care for children and young people. However, due to the large geographic footprint that the Trust covers, other hospital premises are naturally closer to some families than the RACH itself. One example of this was seen by the Review at the Princess Royal Hospital (PRH) in Haywards Heath.

17.22 Should a child requiring emergency treatment be living closer to the PRH than the RACH, it is highly likely that families will take their children to PRH in the first instance. Some are treated and discharged. Others are transferred to the RACH depending on their care needs.

17.23 Whilst this in itself is not a significant problem in terms of the speed and quality of care delivered, the Review did hear about the difficulties created through the PRH and the RACH operating two different IT systems that had no interoperability.

17.24 The Review was told that neither hospital is able to see if children or young people have attended the other site at any previous time. Whilst being advised there is a plan to move the Trust to the IT solution in place at PRH, there are clear and inherent risks whilst these two systems remain in place.

17.25 For example, frequent accidents or injuries and repeat presentations to health settings can be one sign of abuse or neglect. Being unable to identify the frequency of such attendances across the Trust's premises could potentially result in important indicators being missed.

17.26 Furthermore, the Review was advised that whilst the decision had been made to adopt the system at PRH, this was described as being bureaucratic and adding significant pressure and time to the workload of front-line staff.

17.27 The Review was told of an example of the PRH system being designed to automate GP letters on discharge. Whilst in principle, this notion was recognised as helpful, the reality experienced by staff was that these letters were not intuitive, only listing basic demographic and clinical details. One of the Matrons at the PRH was concerned that the system did not generate a narrative about a patient's care. The absence of this context was noted by the Matron as being a potential risk in terms of poor information sharing arrangements.

17.28 The Review did not explore the details of these systems in depth, and whilst acknowledging

the significant cost that IT initiatives attract, there is an unarguable imperative for the Trust to ensure its systems are consistent, safe and support rather than hinder the challenging work that the front-line staff of the Trust undertake on a day to day basis.

R63: That the Trust Board reassure itself that the plans in place for implementing a singular IT system across the Trust are fit for purpose and do not inhibit or hinder any of its responsibilities with regards to the safeguarding of children and young people.

18. Conclusion

18.1 The Trust management, Doctors, Nurses and staff at the Brighton and Sussex University Hospital NHS Trust operate in a complex, pressurised and challenging environment. The most senior managers coordinate a vast array of services for what is a diverse community of patients, visitors and staff. The teams of Doctors, Nurses and others working with and supporting patients balance clinical, management and other duties in a routinely challenging and often emotionally charged environment, which can at times be unforgiving.

18.2 Each of the above mentioned roles carry significant responsibilities; not least of which is their duty to safeguard the children and young people who visit or reside in Trust premise. Managing such responsibility requires compassion, courage and an absolute commitment to reflect and learn. All of these qualities were apparent in the managers, Doctors, Nurses and other staff engaged by the Review.

18.3 Nowhere were these qualities more apparent than in the character of the then CEO Matthew Kershaw. When commissioning the Review he could have limited it to one incident or to a specific area of the Trust but instead chose to significantly widen its remit to encompass the entire Trust footprint. In doing so he demonstrated his own appetite for learning and a desire to ensure that safeguarding children and young people was comprehensively reviewed.

18.4 The Review has highlighted some strengths, a range of good practice and a number of areas in which on-going work should be expedited, improvements made and policy amended. The Trust now needs to consider the 63 recommendations, make choices and reflect on the risk that failing to properly address them may represent.

18.5 Simply increasing the responsibilities of the few individuals within the Trust with specific safeguarding roles will only exacerbate the situation. Investment in resource and support for those who carry the greatest burden in this area, the Chief Nurse, Designated and Named Doctors and Nurses and the outstanding but overburdened Safeguarding Children Team is crucial. For too long, too few have carried a disproportionate amount of responsibility in this critical area.

Appendix 1

Recommendations

Leadership and Governance

R1: All Trust Board members receive Level 6 safeguarding training.

R2: The Trust Board includes reference to its safeguarding children activity and performance in future annual reports and plans.

R3: The Trust Board amend its Safety, Quality and Patient Experience Strategy 2015 to ensure emphasis is given to safeguarding children.

R4: That the Trust appoints a Non-Executive Director as chair of the Safeguarding Children and Young People Committee.

R5: The Trust develop and implement a Safeguarding Children Operational Group

R6: Prompt cards explaining the options and routes for advice, support, complaints or whistleblowing should be provided to all staff and patients.

R7: The functions of the PSO are retained by the Trust and merged with the job description of the new FTSU role. To this end the following should also be taken into consideration:

i. That any subsequent list of responsibilities (or job description, if appropriate) is clearly defined to include the experience and skill sets that are required for this sensitive role.

ii. That the role's terms of reference, pathways and relationship with other reporting/whistleblowing functions are clearly defined and set out within the Roles and Responsibilities Section of the Trust's Safeguarding Children & Young People Policy.

iii. Induction training for all staff, managers and Trust Board members should include input about the agreed role.

iv. Mandatory Safeguarding training delivered by the Trust should formally reinforce the importance of the agreed role.

R8: The Board should seek reassurance from its members and Trust managers that they reinforce the importance of safeguarding children and young people at briefings and during formal ward visits.

Section 11 Children Act 2004

R9: The Trust should review and revise its Section 11 self-assessment and update its action plan with specific reference to the Review's findings on Standards 2 and 5.

R10: The Trust should explore with the B&H LSCB different models of S11 peer challenge to assist with improved processes for reassurance and multi-agency support in addressing identified challenges.

Policies and Procedures

R11: The Trust should amend the 'Trust Record Sheet' of an incident to include a specific risk assessment to any child, young person or vulnerable patient in the context of the person's employment, regardless of where the allegation derived or where the alleged incident took place.

R12: A more robust section should be written concerning the support and information to be provided to staff following any related incident (ensuring this is separated from the existing statements within the policy about staff collusion).

The *'Need to Know'* principle needs to be specifically addressed and explained and practical examples provided which are role rather than rank orientated.

R13: The Trust should publish relevant safeguarding children policies as part of its policy page on the Internet.

R14: The Safeguarding Children page should be enhanced to include contact details for the Safeguarding Team and the Patient Safety Ombudsman/FTSU.

R15: A link to the websites for Brighton & Hove Safeguarding Children Board (B&H LSCB), West Sussex Safeguarding Children Board and East Sussex Safeguarding Children Board from the Safeguarding Children page should be included on the Trust's Internet.

R16: The Trust should commit to using one area on the Intranet Safeguarding Children Page as the main repository for safeguarding children policies and ensure appropriate referencing to related policies held in other sections.

R17: The Trust should ensure that all relevant policies include a distinct and clear narrative that focuses the reader on their duty to 'safeguard children and young people' who visit or stay in Trust premises or those they meet when delivering services on behalf of the Trust at any other venue or place.

R18: Trust policies are structured to ensure that any narrative not associated with the main aim of the particular guidance and advice is included as an appendix and set out at the end of the document.

R19: To support and assist staff accessing policies and procedures, the Trust should create a digitised policy handbook.

R20: The Trust should consider issuing appropriate mobile technology to teams, key managers and staff.

R21: All policies should set out the requirement for how compliance will be measured and who the responsible person will be for monitoring this.

R22: The Trust should consider employing a temporary resource to immediately update its policies and procedures.

The Lampard Review

R23: The Trust urgently implement the Volunteers Policy as set out within its Lampard action plan.

R24: The Trust include specific reference to the training requirements for volunteers in its revised Safeguarding Children Training Strategy.

R25: That the Trust Board receive full details of the Trust's S11 audit return for review, scrutiny and challenge.

R26: That the Trust commit to updating its S11 audit on an annual cycle and report this audit to the Trust Board on a yearly basis.

R27: The Trust should implement a DBS re-checking process on a three year cycle consistent with Lampard's recommendation.

R28: The Trust develop and implement a clear policy consistent with Lampard recommendation No. 9 with immediate effect.

R29: The Trust update relevant policy and guidance for staff to include explicit reference about professional conduct and boundaries in the context of social media.

R30: The Trust expedite the updating of these guidelines to ensure Lampard compliance, with a particular emphasis on specifying the arrangements for due diligence and risk assessment processes for managing relationships with celebrities and major donors as well as those protecting the organisation's brand and reputation.

R31: The Trust include within the revised guidelines a range of examples on how to manage relationships with individuals in positions of authority, including celebrities, VIPs and donors. Examples should focus on practical and realistic scenarios.

R32: The Trust consider the wider application of using scenarios in its training to help develop and support staff understanding of the policy in the context of their role in the Trust.

Concerns and Allegations against Staff

R33: The Review recommends that the Trust appoint a senior safeguarding children professional to work with the appropriate LSCB partners and children's social care representatives to consider the profile of this offender's known victims: the opportunities he had to engage children of a similar profile via his work and any information relevant to such a child.

This group should then make recommendations on whether, some, all or none of the families who have used the Children's ED facility should be contacted directly.

R34: The Review recommends that the 'Allegations of Child Abuse against Staff' policy is amended to include the need to seek the following clarity;

The Trust's safeguarding lead must establish clarity concerning police assertions that no evidence of work place based offending exists.

The position to be determined is:
(i) That in the external investigation that the police have carried out, they have not uncovered any evidence pointing to offending within the workplace and, or
(ii) That the police actively investigated the likelihood of offending within the work place and found no evidence.

The Review believes it is reasonable to expect the police to do both.

R35: The Trust Board seeks reassurance that all managers have read the Allegations against Staff Policy and that there is clarity about the need to seek the advice of the Safeguarding Team and / or LADO relating to any allegations that indicate a member of staff or volunteer has:

- Behaved in a way that has or may have harmed a child;
- Possibly committed a criminal offence against or related to a child;
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

R36: Safeguarding training for managers is developed to include scenario-based training incorporating the management of allegations against professionals and volunteers who work with children.

R37: Subject to the Trust's review of the PSO, that the PSO's/FTSU responsibilities regarding advice, support and signposting concerns incorporate information about the specific response to allegations made against professionals or volunteers.

R38: (i) The Review recommends that the Trust appoint a senior safeguarding children professional to work with the appropriate LSCB partners and children's social care representatives to consider the profile of offending in this case.

(ii) On the basis of the agreed profile, to establish whether he had the opportunity to commit offences within the Trust.

(iii) If such opportunities are identified, to make recommendations as to whether some, all or none of the families he engaged should be contacted directly.

R39: All staff who engage or are likely to engage with children and young people staying in or visiting wards, must be appropriately trained and their understanding of their safeguarding responsibilities and expectations regarding boundaries tested.

Response to Serious Incidents, Reviews and Learning

R40: The Trust revise and submit to the CCG its Safety, Quality and Patient Experience strategy and include explicit reference to the strategic priorities for the safeguarding of children and young people.

R41: Consistent with the Serious Incident Framework 2015, the Trust update their Safety, Quality & Patient Experience Strategy 2015-20 to remove reference to the grading of Serious Incidents by the Serious Incident Review Meeting.

R42: The Trust to use its mechanisms for sharing lessons from Serious Incidents alongside lessons arising from Serious Case Reviews, Case Reviews and Multi-Agency Audits to strengthen their impact and reach to Trust staff.

Information Sharing and Working with Partners

R43: That the Trust's LSCB members meet with the B&H LSCB Independent Chair to consider mechanisms to improve wide engagement in the work of the Board, from front line staff to members of the Trust Board.

R44: The Trust consider funding and/or appointing a registered social worker to reintroduce some of the functions lost following the creation of the MASH and to support the functions of the Safeguarding Children Team.

Safer Recruitment

R45: The Trust formally raises the issue of safer recruitment with the B&H LSCB and West Sussex and East Sussex LSCBs, with a view to developing a agreed minimum standards for safer recruitment.

The Supervision and Support of Staff

R46: In line with the Intercollegiate Document, the Trust increases the Named Nurse capacity to resolve immediate contingency arrangements and longer-term succession planning in the Safeguarding Children Team.

R47: In line with the drive to improve appraisal rates across the Trust, a number of specified targets are set for all staff in order to respond to the findings of this Review. As a minimum, targets should be set that address attendance at mandatory safeguarding children training and reading and understanding key Trust safeguarding children policies.

R48: That the Trust develop and implement a policy covering significant social relationships and inter-professional boundaries to provide absolute clarity for all Trust staff.

R49: The Trust immediately resolve any conflicts arising from known line-management arrangements where significant social arrangements could compromise the work of those involved or lead others to believe that they might.

Safeguarding Children Training

R50: In consultation with front-line staff, the Trust should review the minimum time allocated for safeguarding children training across all three levels.

R51: That the Trust consider how best to integrate relevant training regarding the behaviour of people in positions of trust into their mandatory staff training.

R52: The Trust reviews the capacity of the Safeguarding Children Team to ensure sufficient resilience exists to both improve and sustain the mandatory face-to-face training offer.

R53: That the Trust Board ensure the poor performance regarding take-up of mandatory safeguarding training is escalated to its risk register to ensure ongoing scrutiny of this aspect.

R54: The Trust revise the Safeguarding Training Strategy 2015-17 to ensure it provides a much clearer focus on the local context for safeguarding training in line with the priorities of the LSCB and the Trust itself.

R55: The Trust develop a specific training analysis and evaluation framework to better judge the impact of the safeguarding training being delivered.

R56: Mandatory safeguarding training should be adapted to ensure there is appropriate reflection on individual experience, opportunity to share learning and reassurance via testing of staff knowledge on key safeguarding policies and procedures.

R57: That the Trust work with the LSCB to develop a specific plan that seeks to raise The Trust's staff attendance at multi-agency training. The following factors should be considered:

(i) The use of available rooms at Trust sites for training should be explored to make it easier for Trust staff to attend.

(ii) Building on the inter-agency training forums on FGM held in 2014/15, the BSCB should consider whether additional 'bite-size' multi-agency training sessions can be delivered at the Trust relating to key priorities that impact the partnership, but with a particular focus on Health.

(iii) Align the Trust training with the intercollegiate document to better promote health staff attaining their level 1, 2 and 3 training through attendance at multi-agency courses delivered by B&H LSCB.

Security, Access, ICT and Exposure to Risk

R58: Security Team Standard Operating Procedures (SOPs) should be amended to include specific advice for dealing with staff and other individuals excluded from Trust property. This should cover their identification, risk assessment, actions on sighting, communication strategy and key points of contact.

R59: Steps should be taken to introduce appropriate access controls, including the installation of a CCTV multi-channel monitor and intercom at the nurse's station to give staff access to CCTV images from both entrances to the CED at RACH and to the camera adjacent to the nurse's station.

R60: Staff should be instructed to check who is at the door and why they need access before releasing the door lock.

R61: Security staff standard operating procedures (SOPs) should be amended to ensure routine patrol checks of publicly accessible lavatories.

R62: The Trust Board formally address the issue of requiring children to transit through, occupy and wait in parts of the Trust predominantly used by adults and on occasion, people in lawful custody .

The Trust should consider placing this issue on the risk register until resolved.

R63: That the Trust Board reassure itself that the plans in place for implementing a singular IT system across the Trust are fit for purpose and do not inhibit or hinder any of its responsibilities with regards to the safeguarding of children and young people.

Appendix 2

The Review Team

Jim Gamble QPM, Review Author

Jim Gamble QPM is a former Chief Police Officer and was the founding Chief Executive of the Child Exploitation and Online Protection Centre. Mr Gamble is currently the CEO of specialist safeguarding consultancy INEQE Group and the Independent Chair of the City and Hackney Safeguarding Children Board (CHSCB).

During his police service Mr Gamble was involved at the highest level in counter terrorism and organised crime investigations. He was the Association of Chief Police Officers (ACPO) national lead for child abuse investigation, Internet safety and countering child trafficking. As the founding Chief Executive of the Child Exploitation and Online Protection (CEOP) Centre he built what is now recognised as a world-leading concept in child protection, developing a diverse set of safeguarding initiatives such as the Behavioural Analysis Unit (BAU), the UK and Overseas Tracker teams and the 'ThinkUKnow' education campaign.

Mr Gamble was a co-author on the UK's first Domestic Homicide Review (Pemberton) and in 2010 was appointed to lead the initial scoping review of the investigation into the disappearance of Madeleine McCann.

His work as Independent Chair of the CHSCB has provided him with a deep insight into Learning and Serious Case Reviews as well as a practical understanding of the challenges and opportunities that multiagency partners face when working together to safeguard children and young people.

Rory McCallum, Safeguarding Adviser

Providing expert advice to the Review, Rory is a qualified social worker, degree educated at Leeds University and has over twenty years experience in children's services. As a senior manager, he has held both strategic and operational responsibility for children's social care, adult safeguarding, youth offending, youth services, early years services and LSCBs. He helped design and deliver the first Multi-Agency Safeguarding Hub (MASH) in 2010 and is passionate about creating a culture where professionals from all disciplines trust each other, talk to each other aband work together to make children safer.

Hannah Paul, Principal Researcher

Hannah is the Head of Safety and Content at the INEQE Group, where she is responsible for identifying and researching key trends, themes and patterns of behaviour that impact on the health and wellbeing of young people. Working with children and young people in the UK and abroad she has developed a strong practical insight regarding the context of the risks they face. This is complimented by the academic studies and research associated with her LLM from Queens University Belfast and M.Phil from Trinity College Dublin. Most recently Hannah was awarded an E.U. scholarship to research the impact of technology on safeguarding children, young people and vulnerable adults.

Quality Assurance Team

Bill Woodside MSSc, LLB (Hons)

Bill is currently a Director at Ineqe Group, where he has been involved in the delivery of safeguarding training and consultancy. He is a former Senior Police Officer with extensive experience in multi-agency partnerships including specialist forums to engage young people and hard to reach groups.

Bill is a Prince 2 certified project manager who has conducted reviews of a wide range of policing and criminal justice functions across the globe. Bill has an honours degree in Law and a Masters in Criminal Justice Management.

Ronnie Cartmill, M.Ed. PGDip PGCE FIFL

Ronnie is the Head of Learning and Development at Ineqe Group. He has 20 years experience in training development, course construction and training management roles.

Ronnie was previously a Course Tutor with Canterbury Christ Church University on their Post Compulsory Teacher Training Programme and Head of Trainer Development at the Police College in Northern Ireland.

Appendix 3

Terms of Reference for a Review of Children's Safeguarding Practice and Procedure at Brighton and Sussex University Hospitals

Introduction and Context

Safeguarding is defined as:

- protecting children from maltreatment
- preventing impairment of children's health and development
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care and
- taking action to enable all children to have the best outcomes

It is fundamental to delivering high-quality healthcare within any setting but particularly within a designated children's hospital and Brighton and Sussex University Hospitals (the Trust) is committed to ensuring that at the Royal Alexandra Children's Hospital, and across all of our healthcare sites, the health, wellbeing and safety of the children and young people in our care are paramount.

In February 2015 the Department of Health published an independent report, authored by former barrister Kate Lampard into the 'themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile'. It makes thirteen recommendations on issues including access, volunteering, complaints, governance and safeguarding including a recommendation that all NHS hospital trusts should undertake regular reviews of:

- Their safeguarding resources, structures and processes (including their training programmes; and
- The behaviours and responsiveness of management and staff in relation to safeguarding issues; and to
- Ensure that their arrangements are robust and operate as effectively as possible.

In addition, in 2014 a Trust employee was convicted of serious offences relating to a child. No evidence was found of any wrongdoing in relation to their work at our Trust. Further work was agreed to review whether our regulatory requirements for safeguarding children are being fully met.

This review has therefore been commissioned in the context of the above factors to ensure that all regulatory requirements in relation to safeguarding children and young people are being fully met and moreover, to ensure that best practice is followed.

Governance

The review will be led by Jim Gamble, acting independently and working to Matthew Kershaw, Chief Executive. Both parties may agree to bring in further assistance as required.

Aims

There are two aims for the review:

(i.) To evaluate the quality and impact of the Trust's safeguarding arrangements for children and young people and, if thought to be needed, make any recommendations for improvement.

(ii.) To provide staff, children & their parents/guardians with an opportunity to raise any concerns they may have in relation to safeguarding children at any of our hospital sites.

Objectives

The objectives of the review are to make appropriate inquiries; review and report on the available evidence; and make recommendations to inform the governance and quality assurance of the Trust's safeguarding policies and procedures.

Scope

In relation to the quality and impact of the Trust's safeguarding policies and procedures the review will examine:

- Current safeguarding policies and procedures and consider if they fully reflect national and statutory regulatory frameworks for safeguarding that are in place.
- Compliance with existing safeguarding policies and procedures.
- The extent to which existing safeguarding policies and procedures benchmark well against those of comparable organisations.
- The Trust's compliance with Section 11 Children's Act 2004 regarding whether its functions, and any services that it contracts out to others, are discharged having regard to the need to safeguard & promote the welfare of children and its self-assessment carried out in 2014

for the LSCB.

- The extent to which the recommendations from Kate Lampard's review are present within the Trust's existing safeguarding policies and procedures.
- The role of the Trust Board and the executive lead for the Trust's safeguarding policies and procedures.
- The arrangements for the raising and management of concerns in relation to safeguarding and serious incidents, current or historic.
- Information sharing and arrangements for working with partners such as the police and local authorities.
- The Trust's implementation of Serious Incident, LSCB Serious Case Review, Learning Review and multi agency audit findings and recommendations
- Safe recruitment practices.
- The supervision and support of staff.
- The provision of and attendance at safeguarding training including multi agency LSCB training.

Process

The review will be conducted in a manner, which is transparent, and in accordance with the principles of fairness. The review must consider the views expressed and evidence provided by:

- Staff members, at all levels, both clinical and non-clinical;
- Children and their families who have received or are receiving healthcare services provided by the Trust;
- Local representatives of relevant staff representative bodies;
- Local Safeguarding Children's Board and other relevant statutory bodies;

Any person interviewed or requested to provide information to assist the review shall be provided with a copy of these Terms of Reference.

Reporting

The review will result in a written report setting out relevant, evidence-based findings and recommendations. A copy of the review report will be delivered to the BSUH Chief Executive who will share this with the Trust Board in public and with the LSCB Monitoring and Evaluation Sub Group thereafter. The report should not contain any information that would identify any patient or their family.

If, during the review, any serious concerns are raised about on-going risk to the wellbeing of a child or young person, or about serious historic incidents that have not already been the subject of investigation, then these should be reported immediately to Sherree Fagge, Chief of Nursing and Trust executive lead for safeguarding.

Timescale

The review and consequent report should be completed within three months. (this was later amended when the Review was extended to cover a broader remit).

Appendix 4

Email to BSUH staff

2 July 2015

Dear Colleague

Safeguarding Children Review

At Brighton and Sussex University Hospitals NHS Trust (BSUH) safeguarding children and young people is both an organisational priority and the responsibility of us all. The safety of all our patients is of paramount importance to us, with children and young people featuring highly in this regard.

You will no doubt be aware of the findings of the recent reviews into Jimmy Savile's involvement in certain NHS services. Each NHS Trust has subsequently been charged with ensuring that their children's safeguarding policies and procedures are robust. In addition, many of you may be aware that last year an employee of the Trust was convicted of a criminal offence involving a 14 year old girl. Whilst there was no evidence of any offences being committed at the hospital, the events have reminded us all that we can never be complacent and where there are opportunities to learn lessons, we need to take them.

Having reflected on these matters in depth with the children's directorate, colleagues across the Trust, my senior management team and the Trust Board, I have decided to commission an independent health check of our child safeguarding arrangement across all BSUH sites. This work will be led by Jim Gamble from *Ineqe*. It will be child focused, transparent, conducted in accordance with the principles of fairness and will seek to establish lessons to help improve the safeguarding response of BSUH.

Jim has significant experience in the field of safeguarding children having been the founding chief executive of the Child Exploitation and Online Protection Centre (CEOP). Jim is currently the Independent Chair of the City & Hackney Safeguarding Children Board.

The safeguarding children review has two overarching aims:

1) To evaluate the quality and impact of the Trust's safeguarding arrangements for children and young people and, if thought to be needed, make recommendations for

improvement.

2) To provide staff, children and their parents/guardians with an opportunity to raise any concerns they may have in relation to safeguarding children at any of the BSUH hospital sites.

The timescale for the completion of the review is three months. The review team are, however, targeting a more accelerated time frame and hope to complete the review within two months. The review itself involves a number of stages and is supported by an agreed set of terms of reference that I attach for your information.

One critical part of the review will be hearing from staff working for BSUH. In addition to scheduling a number of opportunities to directly engage (to be communicated at a later date), a dedicated email address: bsuhreview@ineqe.com has been set up and will be available from today. This e-mail address will be open for all staff members and is intended to offer a mechanism through which you can comment on any matters that you consider relevant to the review's focus on child safeguarding arrangements across all BSUH sites. There will also be opportunities for patients, parents and carers to contribute to this review.

We are absolutely committed to ensuring that the safeguarding arrangements for children and young people in our Trust are robust and fit for purpose and to that end, I encourage you to participate, share your positive experiences of our safeguarding arrangements, development opportunities and any concerns you may have.

On completion of the review, the team will offer a debrief session for staff. This will ensure that you hear about the findings, outcomes and any recommendations from the review first hand. Critically it will also provide you with an opportunity to ask questions prior to the review's publication.

Yours sincerely

Matthew Kershaw
Chief Executive

Appendix 5

Roles of Staff Interviewed

Administrative Manager
Administrator
Chief Nurse
Children's Care Manager
Community Midwife
Consultant Paediatrician
Deputy Sister
Designated Doctor
Designated Nurse
Director of Clinical Operations
Duty Manager
Emergency Nurse Practitioner
Head of Safeguarding
Head of Security
Health Care Assistant
HR Operations Manager
Independent Chair of the LSCB
Information Governance Manager
Local Authority Designated Officer
Matron
Medical Secretary
Named Doctor
Named Nurse
Nurse Manager
Nurse Specialist
Nurse Trainer
Director of HR
Paediatric Critical Care Practitioner
Paediatric Nurse
Paediatric Nurse Consultant
Paediatric Nurse Specialist
Paediatric Surgeon
Patient Safety Ombudsman
Play Specialist
Porter
Practice Development Nurse
Practice Educator
Reception Supervisor
Secretarial Manager
Secretary
Senior Sister
Sister
Staff Nurse
Student Nurse
Supervisor
Ward Clerk
Ward Manager

Appendix 6

Remit of the Chief Nurse

- Representing the nursing and midwifery staff at the Board.
- Being a member of the Integrated Delivery meeting - where the Trust Development Authority holds the Trust to account for its performance.
- Being the Director of Infection Prevention and Control, responsible for the hygiene code, safe water management, infection control on wards and departments and uniform policy.
- Being responsible for the professional standards of nursing teams and hold them to account through the Deputies and Directorate Lead Nurses.
- Being a member of The Quality and Risk and Safety and Quality meetings and joint lead director for Safety and Quality with the Medical Director.
- Being the lead for the Quality Review meeting with the CCG where the Trust is held to account for quality metrics and standards.
- Being the Lead Director for Security with responsibility to ensure national standards are met in this area.
- Being the joint chair of the Nursing and Midwifery BME engagement meeting to take forward the Trust's action plan in this area.
- Being a member of the project board for Race Equality.
- Attending external Director of Nursing Meetings, locally and nationally to understand the National Nursing agenda and to be an Ambassador for the Trust.
- Holding regular nursing meetings to monitor quality, safety and standards – for example the Safety Thermometer and Nursing Metrics to ensure these standards are maintained and improved.
- Being responsible reviewing and acting on patient feedback through surveys, complaints and lessons learned from incidents.
- Being responsible for nursing expenditure.
- Being responsible for Nursing and Midwifery Education and Research
- Providing comment on all other Director portfolios such as The People Strategy, Operations and Finance where this interacts with nursing staff.

Appendix 7

S11 Peer Review

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 LSCB 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 LSCB. To further strengthen this oversight and provide additional support to partner agencies, the LSCB 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.

Agency X was the first LSCB 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 Agency X, but provides a focused examination of a number of areas.

Peer Review Team

The Peer Review Team comprised:

- Senior Professional Advisor, LSCB
- Designated Nurse, CCG
- LSCB Lay Member

Process

The Peer Review Process included the following:

Review Preparation

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

As a result of this analysis, Agency X 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 Agency X Transport (S11 standard 2.3).
- Any documents updating on service development involving views of children and families (S11 standard 4.2)
- Examples of referrals made by Agency X (S11 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 – S11 standard 5)

The Peer Review Team used these documents as evidence supporting Agency X'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:

- Head of Midwifery / Supervisor of Midwives
- Safeguarding Midwife / Midwife Consultant
- Divisional Head of Nursing
- Specialist Practitioner in Safeguarding Children
- Head of Safeguarding

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

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

Background to Agency X

Agency X 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.

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.

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 Agency X 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 Multi-Agency Sexual Exploitation (MASE) meetings flagged on systems
- Staff know what to do if they are worried about children and young people and use the Multi-Agency First Access Screening Team (FAST) for advice when needed

Analysis

- The Section 11 audit return and the accompanying action plan from Agency X were considered by the Peer Review Team to be an accurate and proportionate reflection on Agency X'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 Agency X – reflected through internal arrangements and the engagement of relevant leads in the partnership work of the LSCB.
- "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 Agency X'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 LSCB 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 local threshold tools issued by the LSCB and through Agency X 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 Agency X.
- Strong paediatric liaison was evident at Agency X

Issues raised by Agency X

- Senior staff acknowledged concern about the future funding arrangements of public health midwives and this should be an area the LSCB seeks reassurance on in terms of impact on children and young people.
- There was an acknowledgement of the complexity of cases seen 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 LSCB training good, the challenge is acknowledge by Agency X 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 Agency X to consider:

1. For Agency X 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 Agency X to review all Job Descriptions of employees and strengthen both the narrative and profile of safeguarding children within these documents.
3. For Agency X to consider introducing a specific audit process for the referrals it makes to the FAST and provide a feedback loop to frontline staff.

Appendix 8

Policies available on the Trust's Intranet August 2015

- Freedom to speak up - Executive summary of The Francis Review.
- Looked after Children 2015 - Intercollegiate role framework 2015.
- Revisions to Working Together 2015 - B&H LSCB Briefing on changes.
- Child Death Process (Required updating – updated Sept 2015).
- Sending a completed child death notification.
- Notification of child death.
- LSCB Multi-Agency Training 2014 (Required updating – delay in the availability of training programme details due to LSCB training lead vacancy).
- Safeguarding CYP Policy.
- East Sussex Welfare Reform project - Welfare reform briefing on benefits.
- Managing safeguarding children allegations – (Required updating – new draft seen by the Review).
- CQC inspection of safeguarding & LAC (CQC Ofsted SLAC inspection report).
- The Munroe Review.
- Supporting Families Booklet (Required removing as out of date with changes to early help arrangements).
- West Sussex Contact list.
- East Sussex Contact List.
- B&H Contact List.
- Learning & Development Strategy 2008-10 (Required updating).
- Info sharing fact sheet (Required updating – now archived and removed).
- Info sharing questions / answers (as above).
- Info sharing – endorsement of guidance (as above).
- Info sharing – practitioners guide (Required updating – now replaced with most up to date version dated March 2015).
- Info sharing pocket guide (Required updating – now archived and removed).
- What to do if worried about child, HM Gov. 2006 (Required updating – now replaced with up to date version dated March 2015).
- Working Together to Safeguard Children (2015).
- Sussex CP Procedures – version July 2006 – different to link on page.

Appendix 9

Glossary of Terms

ACPO	Association of Chief Police Officers
AHP	Allied Health Professionals
A&E	Accident and Emergency
BAU	Behavioural Analysis Unit
BME	Black and Minority Ethnic
BSUH	Brighton and Sussex University Hospital
B&H	Brighton and Hove
CCG	Clinical Commissioning Groups
CCTV	Closed-Circuit Television
CED	Children's Emergency Departmen
CEO	Chief Executive Officer
CEOP	Child Exploitation and Online Protection Centre
CHSCB	City and Hackney Safeguarding Children Board
COPINE	Combating Paedophile Information Networks in Europe
CP	Child Protection
CPS	Crown Prosecution Service
CPT	Child Protection Team
CQC	Care Quality Commission
CRB	Criminal Records Bureau
CSE	Child Sexual Exploitation
CYP	Children and Young Persons
DBS	Disclosure and Baring Service
DCI	Detective Chief Inspector
DH	Department of Health
DVD	Digital Versatile Disc
DV&A	Domestic Violence and Abuse
ED	Emergency Department
ENP	Emergency Nurse Practitioner
ENT	Ear, Nose and Throat
EU	European Union
FAST	First Access Screening Team
FFT	Friends and Family Test

FGM	Female Genital Mutilation
FOI	Freedom of Information
FTSU	Freedom to Speak Up
HM GOV	Her Majesty's Government
HMIC	Her Majesty's Inspectorate of Constabulary
HR	Human Resources
ICT	Information and Communications Technology
IMR	Internal Management Review
IP	Internet Protocol
IRO	Independent Reviewing Officer
IT	Information Technology
JDs	Job Descriptions
LADO	Local Authority Designated Officer
LSCB	Local Safeguarding Children Board
MASE	Multi-Agency Sexual Exploitation
MASH	Multi-Agency Safeguarding Hub
NEDs	Non-Executive Directors
NHS	National Health Service
NNSC	Named Nurse for Safeguarding Children
NMC	Nursing and Midwifery Council
NPSA	National Patient Safety Agency
NSO	Named Senior Officer
Ofsted	Office for Standards in Education, Children's Services and Skills
PDF	Portable Document Format
PSO	Patient Safety Ombudsman
PRH	Princess Royal Hospital Brighton
QPM	Queen's Police Medal
RACH	Royal Alexandra Children's Hospital
RGN	Registered General Nurse
RSCH	Royal Sussex County Hospital
SCIE	Social Care Institute for Excellence
SCR	Serious Case Review
SLAC	Safeguarding and Looked after Children
SOPs	Standard Operating Procedures'

TVP	Thames Valley Police
UK	United Kingdom
VIP	Very Important Person
WTE	Whole Time Equivalent

© Ineqe Group Ltd 2016

Date of Publication 06/02/17

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