Royal College of Nursing Survey of Designated Nurses for Safeguarding Children in England

December 2015

Introduction

During 2015 the Royal College of Nursing surveyed Designated Nurses for safeguarding children across England. Designated Nurses are defined within the intercollegiate framework *Safeguarding children and young people: roles and competences for health staff* as

> 'The term designated doctor or nurse denotes professionals with specific roles and responsibilities for safeguarding children, including the provision of strategic advice and guidance to organisational boards across the health community. In England all Clinical Commissioning Groups are required to have a designated doctor and designated nurse'

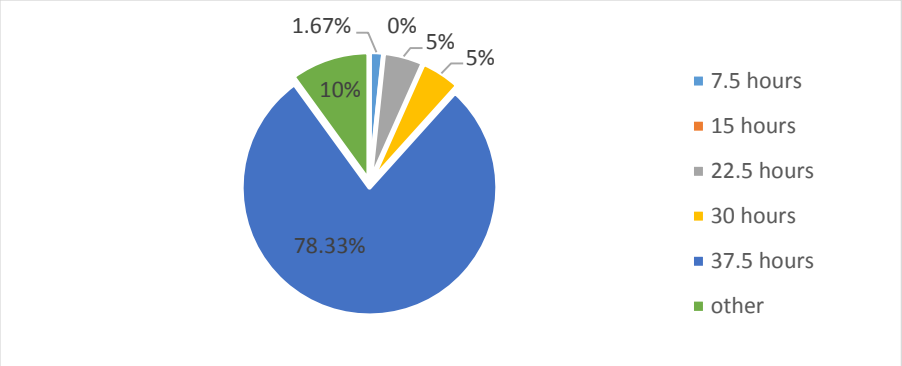
The survey was cascaded to RCN members and also through the National Designated Health Professionals network membership. The survey link was provided to others on request.

About respondents and their teams

Sixty Designated Nurses for safeguarding children and young people in England responded to the survey.

While the majority of Designated Nurses responding to the survey were contracted full-time, there was one individual that was contracted for only seven and half hours and three who stated that they were contracted to the role twenty two and half hours per week (see Figure 1).

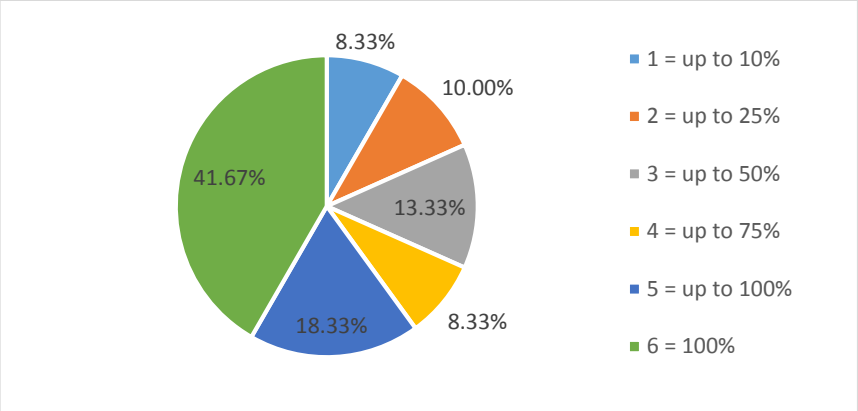
Figure 1: Contacted hours of Designated Nurses for safeguarding children



Ten percent of respondents indicated that contracted hours varied on a monthly basis. One individual reported that they worked more than fifty hours per week.

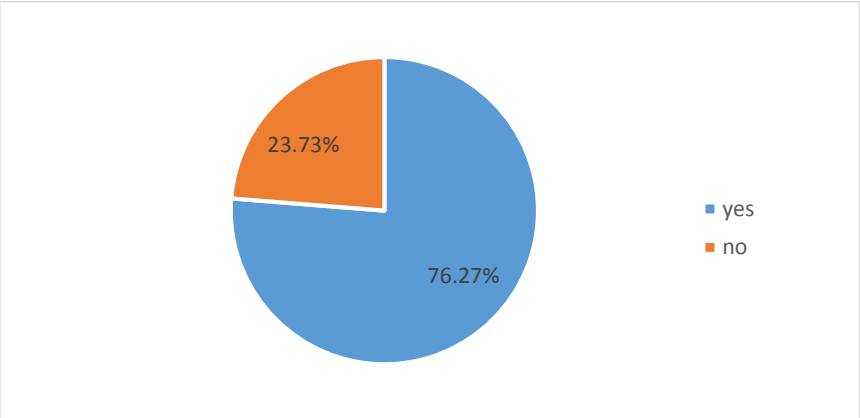
Only forty one percent of respondents advised that their role was focused purely on safeguarding children. Others indicated that safeguarding children formed less than fifty percent of the focus of their role (see Figure 2). The level of focus on safeguarding children and young people in the new structures is therefore of serious concern.

Figure 2: Percentage of role focused on safeguarding children function



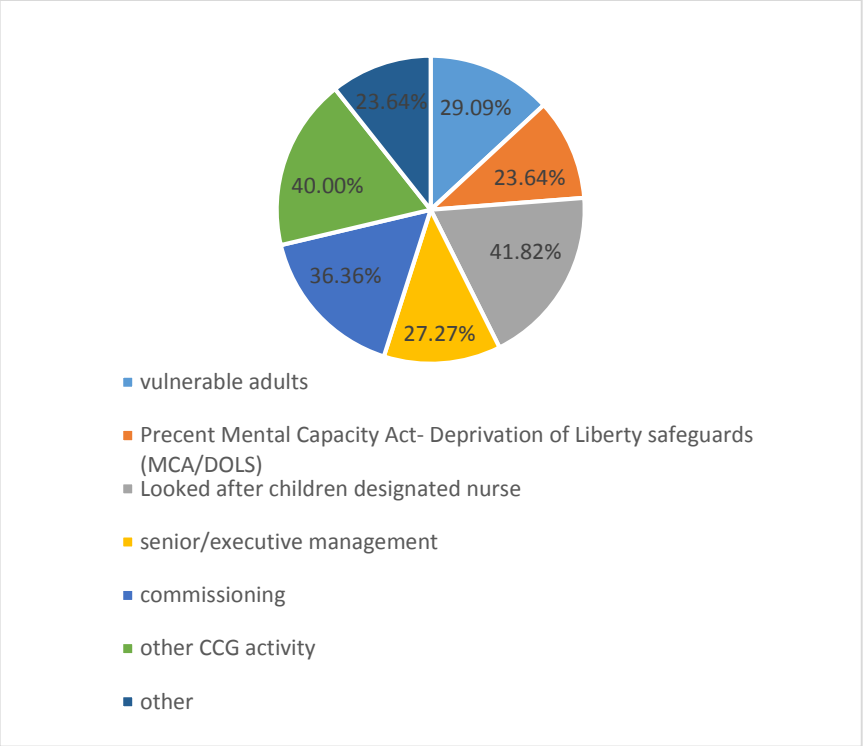
Forty five (76.27%) respondents advised they had reviewed their function in line with the requirements outlined in the 2014 intercollegiate framework *Safeguarding children and young people: roles and competences for health staff* (see Figure 3). As a result several individuals advised role descriptions were being reviewed and supervision strategies put in place, while one respondent stated they had arranged a 1:1 with their manager to discuss future arrangements for safeguarding as they were concerned.

Figure 3: Reviewed Designated safeguarding function against intercollegiate framework



Fifty five respondents advised they had additional roles and responsibilities in addition to the Designated Nurse for safeguarding function. These included responsibility for vulnerable adults, Designated Nurse for Looked after Children, senior/executive management, commissioning and other roles (see Figure 4).

Figure 4: Additional roles and responsibilities



Those indicating 'other' highlighted additional responsibilities as the lead for continuing health care, quality and safety, child sexual exploitation, domestic homicide and CP-IS. One respondent advised they held the overall organisational lead for safeguarding which included line management of the team but also oversight of adults and looked after children agenda, and as such would be the first point of contact for safeguarding by senior managers.

Several respondents commented further, many in particular indicating that they line managed the Designated Nurse for Looked after Children or had oversight of the LAC agenda:

'I line manage the Designated Nurse LAC'

'As the head of the team I manage the adult safeguarding lead and have oversight of the Prevent, MCA and DoLs. I also oversee the commissioning arrangements of the LAC post'

'I have an assistant designated nurse working with me for LAC'

'Have oversight of the LAC agenda but the designated nurse function is commissioned from a local provider. Also take a lead in domestic homicide reviews'

'I will be managing the Designated Nurse for LAC, the DASM, Safeguarding Nurse for Primary Care, plus the Safeguarding Adult Officer and our Team Coordinator'

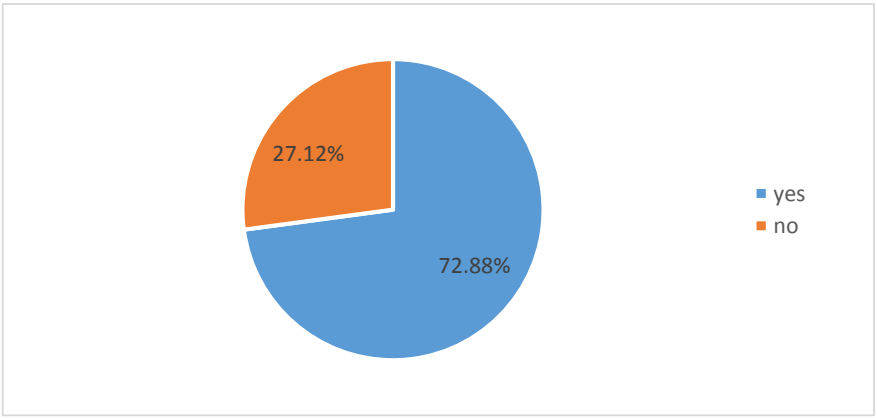
‘My current role includes elements of the Designated Nurse LAC role – however the CCG have agreed to fund the post of Designated Nurse LAC therefore my role will change going forward’

One respondent clearly articulated concerns about the trend towards additional roles and responsibilities being added to the Designated Nurse for safeguarding children which would not be the case for the Designated Doctor:

‘…it is becoming the trend to load other roles on the designated safeguarding children nurse’s role. It is noteworthy that they would not or could not do this with the designated doctor role’.

Almost 73 percent of respondents stated they had the support of a safeguarding team within the Clinical Commissioning Group (see Figure 5).

Figure 5: Support of a safeguarding team



Several respondents advised of the team composition. Examples provided included:

‘1.0 WTE Administrator/PA
0.5 WTE Designated Nurse LAC
0.5 WTE Associate Designated Nurse
1 PA per week Named GP Safeguarding Children
2 PA per week Designated Doctor Safeguarding children
0.29 PA per week Designated Doctor LAC
1 PA per week Designated Paediatrician Child Death’

‘There is not an integral safeguarding team within the CCG but the CCG commissions:
Safeguarding adult/MCA leadership
Child protection leadership
Sexual exploitation leadership
Domestic abuse leadership and health input into the multi-agency safeguarding hub from a local provider. The specification outlines the CCG outcomes expected therefore

all the functions commissioned provide some support to the CCG (some more than others)'.

'Team consists of substantive designated nurse, safeguarding trainer, safeguarding coordinator, additional resource of LAC, named GP, designated doctor child protection, designated doctor LAC, named GP are part of the team but for certain number of sessions'

While there is a team it is not collocated. The team are:
Designated professionals safeguarding and LAC, Doctors and Nurses
Named GP
CCG safeguarding lead

The NHS structural changes were seen by some as having a detrimental effect on team working:

'The commissioning and provider split destroyed the team role that the designated professionals held across the provider services'

Support and supervision

The vast majority of respondents receive supervision (see Figure 6). While some received supervision monthly, for others supervision was when requested or less frequently for example every 2 months or quarterly (see Figure 7)

Figure 6: Receive supervision

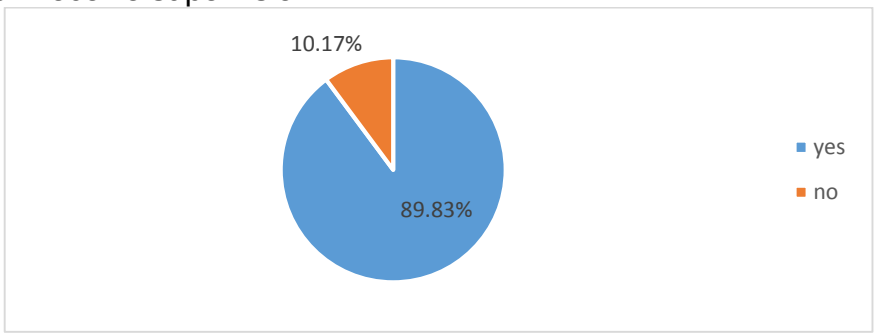
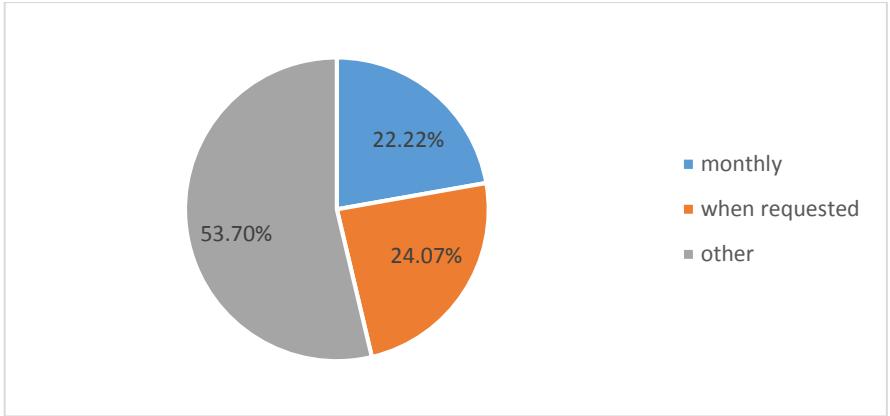


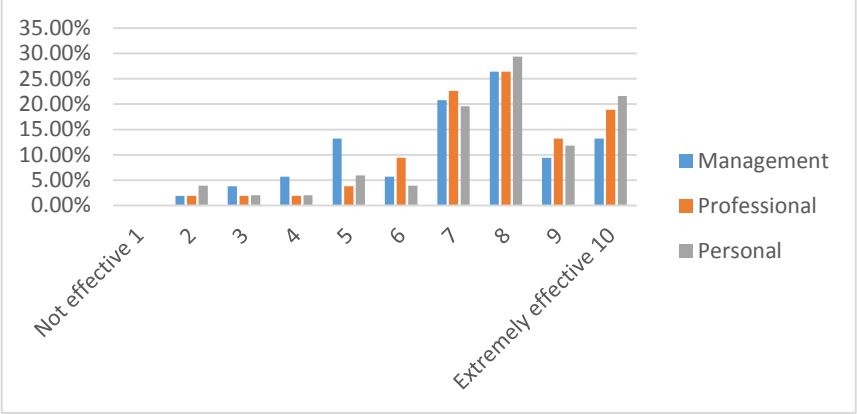
Figure 7: Frequency of supervision



While 22.22 percent (12) received monthly supervision many received supervision either when requested, bi-monthly or quarterly. The type of supervision also varied, with many Designated Nurses advising that they had peer supervision or group supervision every 6-12 weeks, with managerial supervision monthly. Some Designated nurses advised that they received external supervision from an independent commissioned provider or another Designated Nurse from outside of their area.

Respondents advised that the effectiveness of the supervision received varied, although there appears to be little difference between the type of supervision and its effectiveness (see Figure 8). Several commented that management supervision was provided by line managers whose background was non clinical and contract management.

Figure 8: Effectiveness of supervision



Of those who advised they did not receive supervision many commented on the new structures and lack of capacity and availability of an appropriate person to deliver what they felt is required.

Relationships with NHS England

The majority advised they had met regularly with NHS England as a designated nurse for safeguarding children and young people since April 2013 (see Figure 9), although the frequency, format and effectiveness varied (see Figure 10 and 11) .

Figure 9: Meeting NHS England

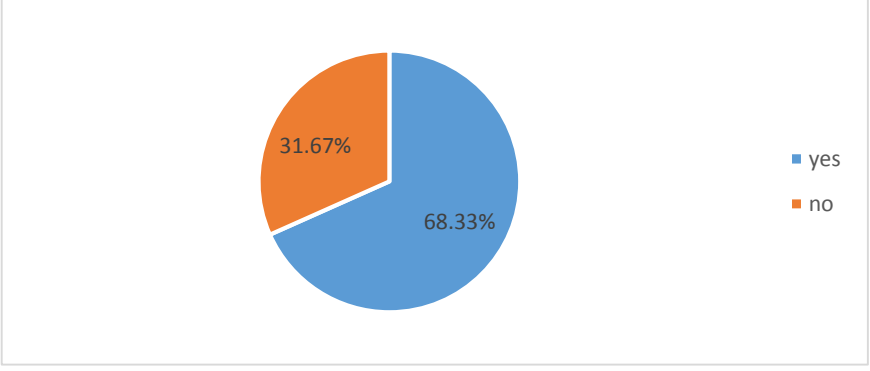


Figure 10: Frequency of meeting with NHS England

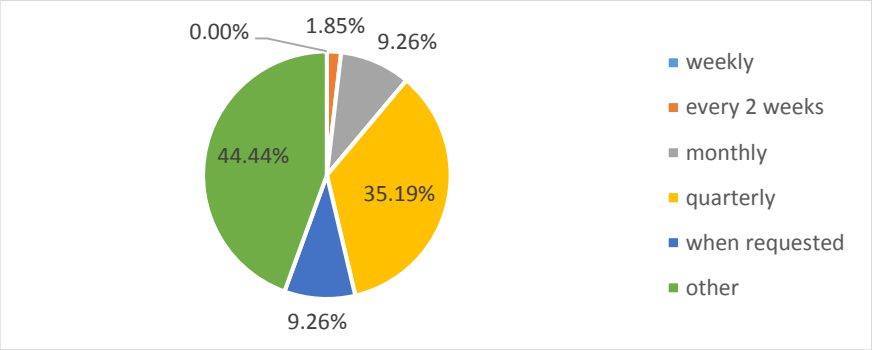
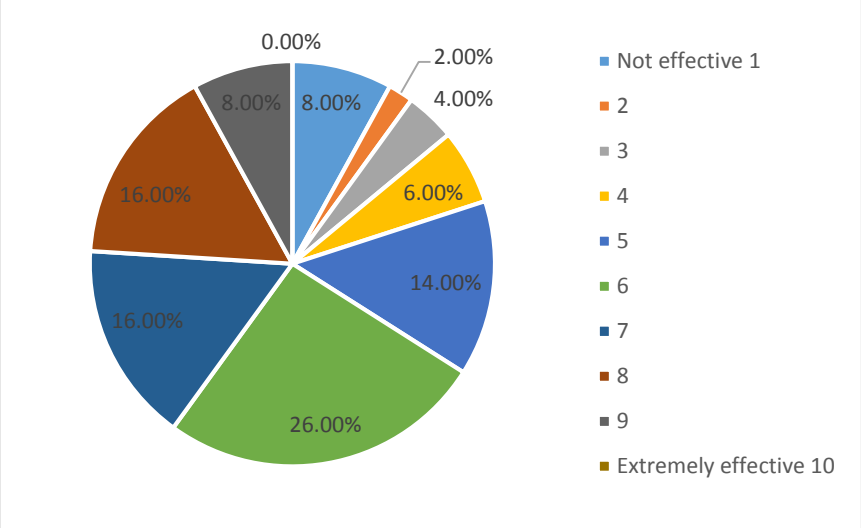


Figure 11: Effectiveness of meetings with NHS England



Some of those who advised they met with NHS England did so at study days, serious case review meetings or on an ad hoc basis as required. Comments included:

> The NHSE lead are very confused about their role and function. Sector forums are ineffective or do not take place

> We have had a number of changes in leadership for safeguarding some more effective than others. With area team managers what progress had been made appears to be taking a retrograde step

> The designated professionals meeting are effective. The NHSE safeguarding leadership is ineffective, ill-informed and has very little strategic guidance from Leeds. Recently the removal of a children's lead designate at NHSE X is indicative of the lack of understanding of the complex nature of the role and the support and supervision required for the designates

> They do not address the safeguarding governance and accountability requirements between the CCGs and NHS England

> It is interesting that NHS England has specific outcomes that CCGs have to achieve in respect of safeguarding but that they themselves as commissioners are not compliant with section 11 standards

> Information is not shared by NHSE about the safeguarding work which is being undertaken regionally and nationally or linked with that which is undertaken by designated nurses. I feel that there is little recognition by NHSE of the role of the designated professional

> The SHA networks we had were very effective. NHS England are having to build new relationships in new structures which are not easy. I think this will improve with time.

> Leadership poor and baseline knowledge of safeguarding and processes also extremely poor – good networking opportunities with others across the area

Comments from those who stated they had not met regularly with NHS England since April 2013 highlighted variation across the country and include

> Recent meetings with local team cancelled

> Lack of capacity to sustain meaningful relationship. This question has made me reflect on that

> Meetings not arranged very often

> There has been no forum set up.

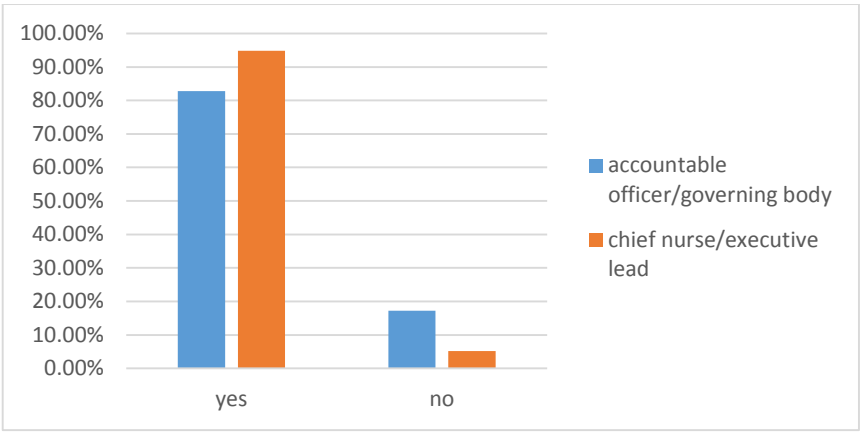
> Have not met personally on a regular basis but NHS England do attend quarterly regional forum

> Not had dedicated meetings specifically with NHS England but meet with them every 8 weeks at Designated and Named meeting

Accountability

The designated nurse for safeguarding children and young people has a key expert function within the Clinical Commissioning Group and is required to have direct contact with the accountable officer/Executive lead when necessary. The majority of respondents advised that they had a clear mandate to feedback to the accountable officer/governing body and the Chief Nurse/Executive lead (see Figure 12).

Figure 12: clear mandate to feed back



Several respondents however made comments in respect of the ability to provide feedback:

> 'The mandate is there but fulfilling this is a constant challenge. Access to executive is extremely difficult due to the size of her portfolio and capacity and meetings often cancelled. Communication with governing body directly is nil. Executive takes annual report. Following recent safeguarding training for board by designated nurse a separate section is attached to the quality report that goes to each governing body. The chief operating officer and accountable officer will make themselves available and are approachable but decisions are made with no consultation with safeguarding as executive doesn't understand'

> 'Not all CCGs have a chief nurse. The guidance does not reflect the commissioning and providers operating model. Executive leads could be from any background and may not have a clinical profession….'

> 'I present a report quarterly to a meeting where the board lead and accountable officer are present and I submit an annual report to the governing body with the chair and accountable officer'

> 'There is a memorandum of understanding in place to ensure that everyone is aware of their accountability in relation to safeguarding'

Information sharing

Over forty percent of respondents stated that the sharing of personal identifiable information had been an issue within the clinical commissioning group(s). While the Health and Social Care Act (2012) defined the legal basis for CCGs accessing and/or sharing personal identifiable information, it the interpretation of this legislation in relation to safeguarding that has seemingly presented difficulties, especially where designated nurses have moved from being part of 'hosted' model arrangement to being aligned to an individual CCG. Over seventy percent had had to escalate

concerns about information not being shared, with fifty percent indicating problems with information sharing had impacted on practice (see Figure 14).

Figure 13: problems with sharing personal identifiable information

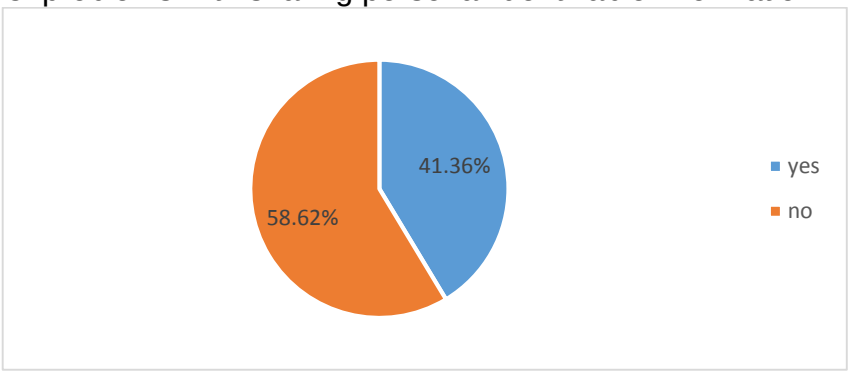
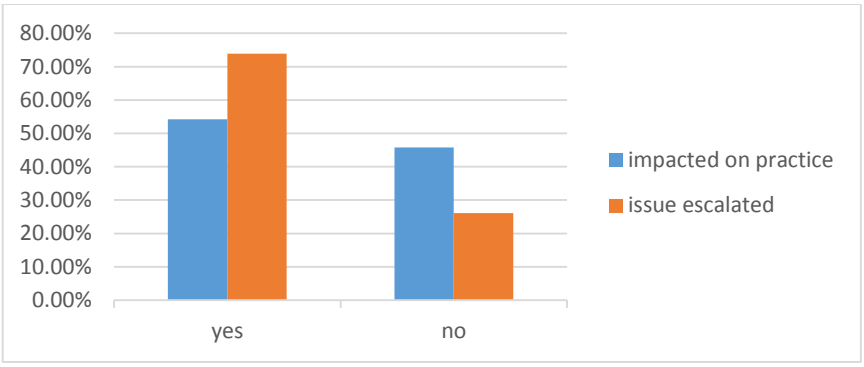


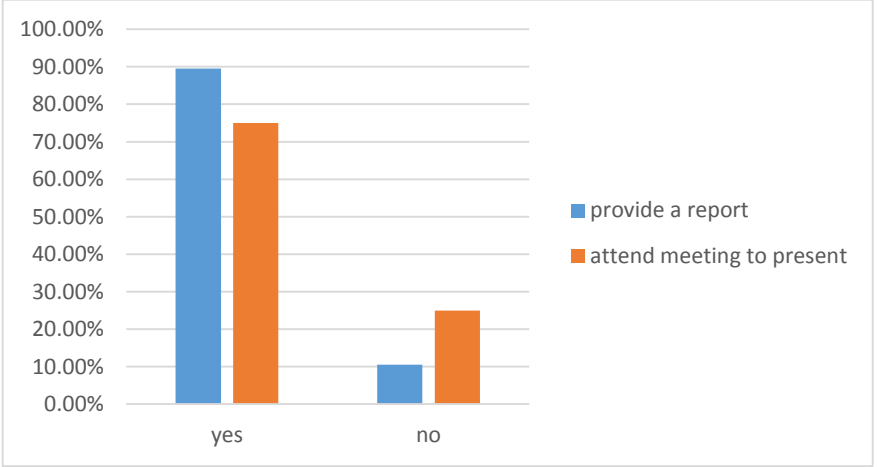
Figure 14: result of problems with information sharing or personal identifiable information



Reporting

The majority of respondents indicated that they provided a safeguarding report for the governing body/Clinical Commissioning Group quality meetings, although only seventy five percent attended in person to present the report (see Figure 15).

Figure 15: safeguarding report for CCG/governing body

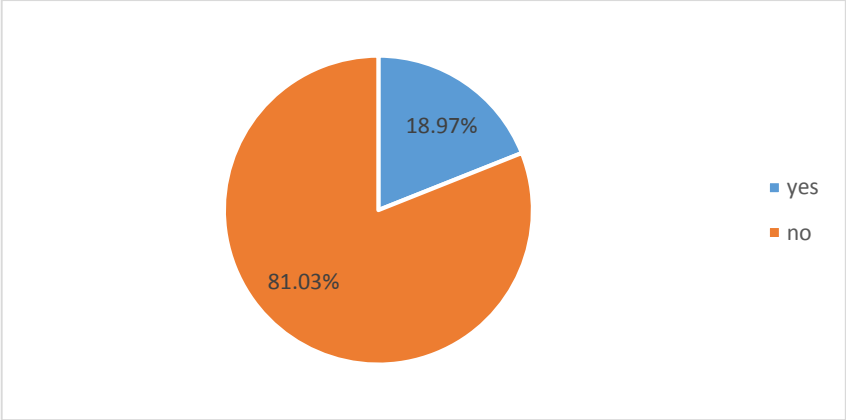


Those who do not attend in person to present their report indicated the report was presented by their line manager, chief nurse or Executive lead. One respondent however indicated that the report was no longer presented but included within papers for members to read and raise questions if needed.

Organisational operationalisation

Nearly twenty percent of respondents indicated they were part of a hosted model (see Figure 16). A hosted model is where one CCG employees Designated Nurses as a team who then provide the designated function for a number of CCGs.

Figure 16: part of a hosted model



Several respondents advised that there had been changes to the arrangements within the preceding two years. These included

> 'Additional resources have resulted in the recruitment of an Associate Designated Nurse to support the role which covers 5 CCGs'

> 'Changes are proposed but have not yet taken place due to the different models of engagement with NHS England across 3 CCGs'

While some of the changes were positive others were seen to impinge on the ability to effectively fulfil the designated function:

> 'More robust communication within the multiagency arena'

> 'The localities covered by my CCG mean that I cover two safeguarding boards and local authority areas'

Several respondents expressed concerns about expectations and the workload of designated nurses:

> 'I feel that currently the expectation of the designated nurses' workload is becoming unsustainable. There is a marked increase in the expectation from the Local Safeguarding Children's Board which now takes up a considerable part of my week – the level of demands in terms of scrutiny, case reviews, quality assurance and audit activity is impacting on my ability to deliver my CCG role as effectively as I would like to'

> 'My role is head of safeguarding/designated nurse and my portfolio includes all things safeguarding and sometimes quality. My designated children role is compromised by the massively growing adult safeguarding agenda/care homes/Prevent etc. Also I am classed as one of the senior managers within the CCG and attend management meetings etc and have had to undertake a lot of purist commissioning activity which again detracts from the designated nurse functionality'

> 'I think the role of designated professionals will expand as commissioning arrangements become more aware of safeguarding responsibilities cross border provider arrangements and more private companies providing health care and need to be assured that safeguarding arrangements are fit for purpose'

Others highlighted a lack of recognition and understanding of the role within CCGs:

> 'There is a constant challenge to recognise the role of designated nurse within the Local Safeguarding Children's Board – there is a tension across CCGs in the locality and whenever a collective decision is required (and hosted arrangement in place) there is a breakdown in communication/agreement from the chief nurses and because of the safeguarding practice is detrimentally impacted. When there has been the need to escalate concerns as a designated nurse, outside of the CCG there is little support from NHSE and lack of challenge to CCGs. The role of designated nurse is becoming increasingly weakened and absorbed into the generic quality agenda within CCGs, who do not always recognise the need for the designated nurse to engage in the multi-agency arena'

> 'The CCG does not understand the importance at times….conflict comes when working within the role they do not understand the statutory responsibility. I personally feel the children's agenda is low on the list ….I have been in this role for 15 years and it does not feel as if we have a firm understanding, and a good plan to support the roles….a lot of new staff are having this role tagged on….I work on the leadership program and we are seeing some very varied mix of roles'

> ‘The designated safeguarding nurse role should be recognised/respected by accountable officers, Executive nurses and managers, as a highly qualified role to masters level where some of their positions don’t require such qualifications and specialist skills and experience. The Designated Professionals should take their own reports to board and for it to be recognised the safeguarding agenda is constantly expanding with more complex cases/risk management/Local Safeguarding Children’s Board sub group/audits/serious case reviews and needs investment with administration and management support’

While some respondents highlighted the role was valued there was a lack of understanding about the breadth of the role and therefore a failure to appreciate the resource requirements:

> ‘The role is valued by the CCG and both children and adult designated nurses are respected clinicians, however additional duties ‘commensurate with the post’ prevent sufficient proactive work taking place’

> ‘The expertise of the designated nurse should be 1 WTE per 70,000 children. This is often not taken into account. I have recently been successful in getting the assistance of a Deputy but only 0.8WTE, we have over 180,000 child population’

> ‘My CCG still do not recognise that my role covers the entire health community and I am encouraged to focus on the providers that we commission services from. I act outside this guidance and in line with Working Together and intercollegiate document. It’s not helpful being affiliated to a CCG specifically. It would be better to be beholden to NHS England and cover a patch due to the CCG arrangements’

Part of the problem appears to be related to different operating models:

> ‘Whilst the designated nurse for safeguarding role is clearly located in commissioning organisations there are still different delivery models for designated nurse looked after children role which can cause confusion…..revised accountability and assurance framework is welcome in that it makes the role of designated professionals more explicit’

> ‘CCG as providers should not have access to patient identifiable information. Directors of Nursing and NHSE safeguarding leads need to implement as required one operating model for the system. Directors of nursing hold safeguarding vulnerable people in their portfolio of responsibilities. They have used their powers to force many designated for safeguarding children to take on adult safeguarding, Looked after Children and any other governance and/or quality agenda. This has distracted the designated nurse from being able to fully influence the provider organisation and maintain a strong strategic role within the health

economy and across the Local Safeguarding Children's Board and social care. These roles require investment and time'

Several respondents' highlighted issues related to professional development for designated nurses and also access to a lack of experts able to provide effective supervision for experienced designated nurses.

Concluding statement

The report provides an overview of the current safeguarding arrangements for children and young people across the new health structures in England. It is clear that the financial pressures may be impacting on the ability of Clinical Commissioning Groups to provide assurance around the safeguarding children agenda. With further changes afoot the Designated Nurses who responded highlighted the changing landscape and a lack of understanding about the role within many Clinical Commissioning Groups.

It is of concern that only forty one percent of respondents advised that their role was focused purely on safeguarding children, while others indicated that safeguarding children formed less than fifty percent of the focus of their role. The level of focus on safeguarding children and young people in the new structures is therefore of serious concern.

The 2014 Edition of the intercollegiate framework *Safeguarding children and young people: roles and competences for health staff* recognised the increasing complexity of both the Designated Doctor and Designated Nurses roles and made clear recommendations about the level of resource required to safeguard children and young people (see below).

DESIGNATED NURSE FOR SAFEGUARDING CHILDREN AND YOUNG PEOPLE

A minimum of 1 dedicated WTE* Designated Nurse for a child population of 70,000.

A minimum of 0.5WTE dedicated administrative support to support the Designated Nurse

*While it is expected that there will be a team approach to safeguarding children and young people the minimum WTE Designated Nurse may need to be greater dependent upon the number of Local Safeguarding Children's Boards, sub group committees, unitary authorities and clinical commissioning groups covered, the requirement to provide safeguarding supervision for other practitioners, as well as the geographical area covered, the numbers of children subject to child protection plans and local deprivation indices

Over seventy five percent of respondents advised they had reviewed their function in line with the requirements outlined in the above framework, with several advising that role descriptions were being reviewed and that supervision strategies were now being put in place. While some organisations had clearly taken on board the

recommendations and key requirements in the Intercollegiate safeguarding framework, many had not as twenty seven percent of respondents did not feel supported.

The survey highlighted that access and availability of independent supervision as opposed to managerial oversight varied considerably. It could therefore be questioned how Designated Nurses are able to supervise others if they themselves do not have access to effective supervision.

Almost seventy percent of Designated Nurses for Safeguarding Children reported that they did not meet with NHS England representatives. Questions could be asked about how NHS England monitor whether meetings are occurring and the level of support provided to frontline Designated Nurses. NHS England central Safeguarding Team need to review this situation as a matter of urgency.

While respondents reported that some regions have retained a focus on providing leadership development programmes for Designated Nurses, others have not leaving a very variable picture across the country and a lack of standardisation in the preparation of individuals for these complex roles. If those holding such positions in the future have a lack of focus, reduced capacity and lack the underpinning knowledge skills and competence it is likely that the safety of children and young people across the local health economy will be severely compromised.

The overall findings paint a concerning picture around the safeguarding of children and young people across England. It is crucial that the Care Quality Commission look carefully at structures, roles, board level awareness, reporting mechanisms and processes in place when undertaking future inspections at local level.