SHORT REPORT

Implementation of the healthcare recommendations arising from the Victoria Climbié report

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In January 2003 Lord Laming reported a widespread organisational malaise and lack of good practice within the police and social and health services that had resulted in “a lamentable failure” to protect Victoria Climbié.¹

“The investigation and management of a case of possible deliberate harm must be approached in the same systematic and rigorous manner as would be appropriate to the investigation and management of any other potentially fatal disease”.¹

Twenty seven of his 108 recommendations related to health services, with a 2-year timescale for implementation. This study examines the extent of the implementation of these recommendations. We are not aware of any other study in this area since the publication of the report.

METHODS

A questionnaire designed to ascertain the extent of implementation of the healthcare recommendations was sent to the named doctor for child protection in 165 NHS trusts in England and Wales in April 2005, and was re-sent to non-respondents in June 2005. The names were obtained through direct telephone enquiries and in conjunction with the Child Protection Committee of the Royal College of Paediatrics and Child Health (RCPCH).

RESULTS

We received 122 replies (74%). We set 70% (86 of 122) as the number of affirmative responses required for each recommendation to indicate successful national implementation.

Communication and documentation

Successfully implemented: (percentage replying “yes” noted in brackets)

- Appropriate translator services must be available (75%).
- Full discussions must be held and recorded for all child protection cases where medical opinions conflict (87%).
- All discussions (including telephone ones) regarding child protection issues must be documented for each patient (85%).
- Clinicians should make their own comprehensive and contemporaneous notes (94%).
- All CP cases must have a full examination performed and documented by a senior doctor within 24 h of admission (98%).
- All child protection cases must have a named consultant clearly documented (88%).
- Social services must receive a written statement regarding all suspected or proven CP cases (95%).

Not successfully implemented

- All children discharged should have a named general practitioner (GP) (67%) this recommendation was rejected by the government.
- Past admissions to admitting and neighbouring trusts must be traceable (66%).
- Each child within a trust must have a single set of notes (55%).

Role of the trust chief executive Successfully implemented

- Trust chief executives must ensure that only senior doctors discharge suspected CP cases from hospital (77%) and all must have follow-up arrangements documented at the time of discharge (78%).

Not successfully implemented

- Trust chief executives must ensure that systems exist to check that all agreed actions in relation to CP cases are recorded, carried through and checked for completion (66%).

Education and revalidation

Not successfully implemented

- All hospital staff dealing with CP matters must undergo revalidation in all aspects of CP and deliberate harm (29%).

Table 1 Abbreviated results from the questionnaire

Summary of selected recommendations	Yes (%)	No (%)	Don't know (%)
Do you have appropriate translator services available?	75	6	19
Are all child protection cases signed off by a senior doctor prior to discharge?	77	12	11
Do all children discharged from your trust have a named general practitioner?	67	18	15
Are you able to trace past admissions for all children to yours and neighbouring trusts?	66	13	21
Are all suspected cases reported directly and in full to social services?	94	5	1
Within your trust does each child have a single set of notes?	55	42	3
Have your trust's named staff attended revalidation courses on the subject?	29	48	23
Since Lord Laming's report, have you been given additional funding to help introduce the recommendations?	15	70	15
Has your trust carried out more strategy meetings since the publication of Lord Laming's report?	51	29	20

The complete table is available on our website at <http://adc.bmjournals.com/supplemental/>

- All hospital staff liaising with community services must have specific training in CP (55%).

Supplemental questions

- After the Laming report, are you carrying out more CP strategy meetings (51%) and case conferences (17%)?
- Has your department been provided with additional funding to help implement the recommendations (15%)?

COMMENT

Child protection practice in acute trusts has been in the spotlight since the death of Victoria Climbié and over 26 000 children nationally remain on child protection registers.²

This study shows that local CP teams are striving to improve services according to Lord Laming's recommendations. Many positive changes have been achieved in the auditable areas of translation services and in ensuring that all CP cases are dealt with fully and immediately by the best trained, most appropriate people in the correct surroundings.

More importantly, perhaps, there has also been a positive shift in more subjective areas. Respondents repeatedly stressed a change in people's attitudes towards processes such as thorough and contemporaneous nursing and medical notes. More emphasis was being placed on clear communication both within and between hospital departments; something that was repeatedly stressed as being deficient in the case of Victoria Climbié.

Communication and patient management problems will, however, continue to exist in some areas until every trust fully implements a policy to ensure that each child has only a single set of hospital notes, and access to appropriate information from neighbouring trusts is more readily accessible.

The majority of respondents felt that child protection had been better integrated into the work directly overseen by the chief executive of their trust, thereby keeping the more senior clinicians' attention firmly on such important issues and making the dissemination of information throughout the trust far easier.

They felt that gaps remained in the ability to audit events that occurred once the child had left the immediate care of the hospital, so that they could ensure that the decisions made during the admission were fully acted upon and implemented.

Many respondents suggested a potential connection between that concern and the lack of requirement to ensure a named GP for each child prior to discharge. Despite being the only recommendation rejected by the government, many trusts have tried to introduce the policy of ensuring a known contact in the community prior to discharge.

Interpreting the concerns raised, it was clear that deficiencies in the understanding of each others' working processes and communication between acute and community health and, more importantly, social services still exist. These could be addressed by forming closer ties between the departments and involving one another more in the decision-making processes, as has worked so successfully in the trusts of many respondents.

The Healthcare Commission requires acute trusts to be accountable for child protection matters, and this accountability is the subject of annual audit. Their inspectorate carries out joint reviews of child protection arrangements across services in a number of areas. They have also made available self-assessment tools with which clinical teams can review and

audit their procedures, but neither of these systems are as wide ranging as the recommendations proposed in Lord Laming's report.

A major concern raised by respondents was the lack of educational and revalidation tools available in the area of child protection. Although those most involved and interested in the procedures were taking it upon themselves to update their skills and share information and advice with their colleagues, their concerns were for those people who dealt with child protection matters infrequently, such as the non-paediatric specialities. Although the Government has responded with the publication of documents such as *Keeping children safe*³ and *What to do if you're worried a child is being abused*,⁴ it is unclear how widely these documents have been disseminated throughout acute National Health Service trusts for the assistance of other clinical and non-clinical teams.

The RCPCH has also acted positively with the production of the *Child protection handbook* and in overseeing the development of child protection courses both within the college itself and in association with the Advanced Life Support Group. Course availability will, of course, restrict the numbers of people who are able to attend such events each year.

This study shows that the workload for Child Protection specialists has increased since the publication of Lord Laming's report. Where changes have failed to occur it is too easy to simply pin the blame on lack of money. While some of Lord Laming's recommendations require additional funding in order to be fully implemented, many simply depend upon the will to change, and it is of concern that some trusts still have a distance to go.

Many respondents' comments echoed the feeling that "Child protection is only seen as an important area by the primary care trust and trust executives when something goes wrong" and "I need more help". As the public and media gaze has shifted away from child protection onto other medical matters, it is vital that the impetus is not lost, and that through continuing central assistance from the RCPCH and the Department of Health, the important improvements successfully brought about by front-line-healthcare providers spread nationally so as to ensure that "such an event may, as far as possible, be avoided in the future".¹

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- 3 **Keeping children safe: the government's response to the Victoria Climbié inquiry report and the joint Chief Inspectors' report safeguarding children** TSO ID 147033 09/03 077240, 2003.
- 4 **Department for Education and Skills.** *What to do if you're worried a child is being abused: children's services guidance.* London: DHSS, 2003 (31553).