OXFORD BROOKES UNIVERSITY

CHILD SEXUAL EXPLOITATION

An audit of staff knowledge and training needs

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AIMS

- To present the background and context to this audit of the CSE knowledge and training needs of health care staff.
- To explain the four project workstreams.
- To communicate the key messages and recommendations arising from this work.

CHILD SEXUAL EXPLOITATION

DEFINITION*:

“A form of sexual abuse that involves the manipulation and/or coercion of young people under the age of 18 into sexual activity in exchange for things such as money, gifts, accommodation, affection or status. The manipulation or ‘grooming’ process involves befriending children, gaining their trust, and often feeding them drugs and alcohol, sometimes over a long period of time, before the abuse begins.”

(Barnardo’s, 2012)

(*Used in conjunction with the statutory guidance (DCSF, 2009))

BACKGROUND

Child Sexual Exploitation (CSE) is a national issue:

Government involvement, national working group and several key reports

CSE is a local issue:

- Operation Bullfinch and the establishment of the Kingfisher Team in 2012
- Work of Oxfordshire Safeguarding Children Board, Oxfordshire Health & Wellbeing Board, Oxfordshire Safer Communities Partnership
- Work of other LSCBs and partners in the region
- Oxfordshire Serious Case Review (ongoing)

CSE AUDIT

- Aim - to audit the child sexual exploitation **knowledge and training needs** for staff required to undertake at least Level 2 safeguarding training across the 9 healthcare Trusts (including SCAS), and community healthcare providers including GPs, dentists and pharmacists

- Completed between October 2013 and March 2014

- Commissioned and funded by Health Education Thames Valley

THE WORKSTREAMS

Workstream 1: Consultation event for local safeguarding leads hosted by NHS England Thames Valley Area Team

Workstream 2: Five practitioner consultation events in the Thames Valley Region

Workstream 3: Research and policy appraisal, including a national policy analysis and a mapping of current provision across the 9 healthcare Trusts using documentary analysis

Workstream 4: An anonymous online questionnaire, informed by outputs from workstreams 1-3

KEY FINDINGS

- The very real potential of the role of universal health care services in preventing, recognising and responding to CSE;

- The importance of health care staff having an understanding of consent and information-sharing (including the notion of childhood extending to 18 years);

- Knowledge gaps across the sample, in particular around the prevalence of child sexual exploitation as a form of child maltreatment, knowledge about how to assess whether young people are engaged in exploitative or consensual relationships and accessing protocols and guidance around this issue;

KEY FINDINGS

- Whilst risk factors for, and indicators of, CSE are denoted in the national policy, the evidence that CSE is difficult to identify at both a personal and professional level must be acknowledged;

- A national Working Group looking at the health contribution has highlighted both a lack of curiosity by health care staff, as well as a tendency to assume that young people are engaging in consensual activity (DH, 2014);

- There needs to be a greater emphasis on how health care professionals can work with and engage young people, rather than local policy purely directing that this should happen;

KEY FINDINGS

- National guidance recommends that in addition to contributing to and following LCSB policy, each Trust should have a stand-alone policy/or procedure applying national and LCSB procedures to the specific health care setting. Only one Trust had such a policy, although three others were in the process of reviewing and developing their policies;

- Whilst LCSB policy documents were often very good, they rarely identified the specific contribution of the health care setting or health care staff, were often very detailed and were light on the prevention of CSE, an area that is of particular importance to health care practitioners;

KEY FINDINGS

- The on-line survey of health care staff's CSE knowledge and training needs was completed by 1344 heath care staff, with a good spread of responses from a wide variety of health care professional groups.
- There were differing perceptions across Thames Valley about which frontline staff fit the Level 2 and Level 3 training requirements. We believe that this results from confusion over the interpretation of the Intercollegiate Guidance (RCPCH, 2010)
- Survey results revealed that while many staff had received training in child sexual exploitation as part of general safeguarding training, since January 1st 2011, over a quarter of respondents had not received any training on CSE.

KEY FINDINGS

- 53.2% of the survey respondents reported that they had not accessed written protocols and guidance on CSE;
- Open-text comments indicated that while some individuals felt guidance was good, others commented that it was difficult to access;
- Even where there are excellent protocols, it is important to be able to understand how these are shared and promoted to front-line health professionals.

RECOMMENDATIONS

On the basis of the audit findings we have proposed a number of recommendations for Health Education Thames Valley to consider:

(1) A review of health care pre-registration practice education curricula is undertaken across the board (Universities and Deanery) to examine how child sexual exploitation is being addressed.

(2) Given that responses to CSE overwhelmingly focus on dealing with the consequences of CSE after it has occurred, it is vital that agencies and professionals give greater focus on prevention. This should be addressed in training and included in training strategies.

RECOMMENDATIONS

(3) Training should incorporate good practice and learning from case examples specific to health care contexts, perhaps utilising children's stories from some of the SCRs published on the NSPCC website. While multi-agency post-qualifying training on child sexual exploitation is extremely important, there is a need for single agency training, specific to health.

(4) A review of training for those in the field of safeguarding is required, as these staff may have difficulty in accessing specialist training to meet their particular needs.

RECOMMENDATIONS

(5) Health Education Thames Valley to consider how best to share the findings and learning from this audit around health staff access to policies and procedures on CSE, at a single and multi-agency level, by working with their partners and LSCB representatives from the Local Area Teams, CCGs and Trusts.

(6) Each health care organisation should have a standalone policy/or procedure applying national and LCSB procedures to the specific health care setting, as recommended in national policy guidance. Such guidance should address the prevention of CSE, alongside recognition and response to CSE. In terms of prevention, policies need to clearly signpost how this can be done.

RECOMMENDATIONS

(7) At the frontline, there should be simplified communication pathways to access local Trust guidance easily electronically, e.g. by a ‘one-click’ access button and a simple, one-sheet flow chart outlining what a practitioner should do in a case of suspected child sexual exploitation.

(8) LCSB policy documents should, alongside generic multi-agency content, consider the particular contribution of the health care setting or health care staff.

RECOMMENDATIONS

(9) Health Education Thames Valley and partners should promote a consistent approach to what constitutes the various levels of training as outlined in the Intercollegiate Guidance (RCPCH, 2010), which staff fit those levels and the required safeguarding training within the levels. This is important to benchmark staff knowledge of child sexual exploitation and to contribute to the development of future learning and development opportunities in this key area of practice.*

(10) A re-audit should occur in 12 to 18 months in order to review whether changes in staff knowledge and training have taken place

(*The third edition of the Intercollegiate Guidance was published shortly after this audit was completed.).

ACKNOWLEDGEMENTS

We would like to express our sincere appreciation to all the audit study participants across the Thames Valley Region.

Thanks also to Trusts and Clinical Commissioning Groups involved in the audit, the Thames Valley Area Team and the Milton Keynes Area Team.

Many thanks also to the Communication Leads, Managers and Training Leads of Trusts and LSCBs who were involved in disseminating information about the audit survey and to Tony Jefferis (Deputy Postgraduate Dean, Oxford Deanery).

We would also like to thank our steering group:

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DISCUSSION POINTS:

- Any questions, comments or clarification on the audit workstreams?
- How are multi-agency and single-agency CSE policies and procedures impacting on the strategic direction for health services?
- What can health professionals offer this agenda in terms of preventing, recognising and responding to CSE?
- How could the gaps identified in this audit be best addressed?

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