Care Inspectorate Review

of progress on recommendations made by the Renfrewshire Child Protection Committee Significant Case Review

Introduction

Declan Hainey was born on 17 April 2008 and he was found dead at his mother's home on 30 March 2010. Following the discovery of Declan's body Renfrewshire Social Work and Renfrewshire Community Health Partnership reviewed the involvement of both agencies with this family. Given the circumstances surrounding the untimely death of a young child the independent chairperson of Renfrewshire Child Protection Committee (RCPC) consulted with the committee's Chief Officers Group (COG) and agreed to initiate an independent Significant Case Review (SCR) in relation to Declan Hainey. They did this in the context of ongoing criminal proceedings requiring delicate negotiation with the Procurator Fiscal.

The sixteen recommendations contained within the significant case review were presented to the COG and senior officers from the Child Protection Committee in November 2010 allowing an agreed action plan to be developed to address the recommendations timeously. The action plan identifies the desired outcomes of the recommendations, action to be taken, evidence and monitoring arrangements across all partner agencies. The SCR was made public on 14 February 2012.

The Care Inspectorate is the independent scrutiny and improvement body responsible for providing assurance and protection on the quality of care, social work and child protection services in Scotland. Scottish Ministers asked the Care Inspectorate to become the central collation point and undertake qualitative evaluation on all SCRs as of 01 April 2012. The Care Inspectorate is required to report publicly on these findings to provide independent public assurance on the quality of care for children and young people; to share any learning and signpost good practice; and to support improvements to child protection practices and policy across Scotland.

The chair of the RCPC and the Chief Officer's Group (COG) invited the Care Inspectorate to review the progress services are making to implement the recommendations of the SCR action plan. The review involved reading a relevant sample of health and social work case files of children affected by parental substance misuse and speaking to staff and managers from health, social work and addiction services. Discussion also took place with a representative sample of staff from a range of services including the voluntary sector. Helpful dialogue also took place with representatives of RCPC and the COG.

Progress on recommendations

Recommendation 1. When a substance misusing mother-to-be is referred to maternity services this should be done using a proforma which includes information on their substance misuse and any other relevant issues.

A helpful proforma has been developed to be used when referring vulnerable pregnant women to the Special Needs In Pregnancy Service (SNIPS). The form prompts staff to provide all necessary information and identify reasons for vulnerability, such as, parental substance misuse. Community midwives, who are the largest referrer to SNIPS, use the referral systems well. Health visitors and social work staff have a good understanding of when and how to use the new form. A small number of addiction staff are not aware of the proforma or the requirement to use it. Regular and effective meetings take place between health visitors and community midwives to ensure vulnerable pregnant women get the help they need from relevant agencies. The senior social worker at the Royal Alexandria Hospital (RAH) also regularly meets with the SNIPS team. These meetings are ensuring that communication and sharing of information about vulnerable pregnant women who will deliver their baby in the RAH is effective. As a result women who need help and support receive this in a timely manner. Work has commenced to develop similar approaches with the Southern General Hospital (SGH) based on the learning from joint work with the Royal Alexandra Hospital.

Recommendation 2. There should be an initial case conference arranged in all cases of children being born to drug-using parents.

Following full consideration of the recommendation, Chief Officers and RCPC agreed that they would not implement this recommendation in this way. Instead they decided appropriately that an initial child protection report should be completed for every child born to a substance misusing parent, thereby including alcohol and drug misuse. A senior social work manager considers the need to convene a case conference or take any alternative action. Staff show very good awareness of the need for and reasons behind the preparation of this initial report. They are confident that in most cases this is being done within identified timescales. When this has not been the case this is usually due to the late presentation of the pregnant woman. Staff in health and social work are positive about this change in practice as they believe correctly it gives them the opportunity to have a more comprehensive picture of the risks to the unborn child. In addition to the initial report, multi agency meetings are held when a pregnant substance misusing woman is identified. The preparation of the child protection report has helped to improve the quality of discussion at these meetings providing early assessment and support for vulnerable women and their babies.

Recommendation 3. A health visitor or school nurse from the GP practice should be invited to all meetings concerning substance abusing parents and their children.

Effective systems have been put in place to ensure that health visitors or school nurses are routinely invited to meetings about substance misusing parents and their children. However in a few cases school nurses have been omitted from invitation lists to some child protection meetings. Attendance of health staff at meetings is being closely monitored by their managers to ensure attendance remains at satisfactory levels. A helpful proforma for written reports to be presented to meetings has been prepared. Practice in this area continues to be developed.

Recommendation 4. The Getting Our Priorities Right (GOPR) care plan should include specific reference to the level of direct contact to take place with children, who is responsible for maintaining this contact and, in the event of any significant variation from the programme of planned contact, the requirement for an urgent review be arranged.

Staff are aware of the need to have and record direct contact with children particularly those living with substance misusing parents. Staff are becoming better at recording contact requirements and responsibilities when producing plans as a result of a full GOPR assessment. Senior managers in social work have issued an Operational Instruction to record the level and nature of contact with children in the GOPR plan and they are stringently monitoring this for compliance. There is not always a GOPR plan in place in cases where a substance misusing parent has been the subject of an initial GOPR meeting and a full GOPR assessment is not required. Plans are well advanced to incorporate the GOPR plan into the Integrated Assessment Framework (IAF).

Recommendation 5. NHS GG&C should introduce an Unseen Child protocol in conjunction with its partner local authorities.

An Unseen Child protocol has been introduced by Greater Glasgow and Clyde Health Board and disseminated to relevant health staff. The guidance has been understood and welcomed by staff. Staff across health and social work services are aware that non engagement with a family is a risk for consideration. Although the protocol is issued by health, services across the council, including social work, have adopted the helpful advice contained within it. As a result communication across services is improving. The Clinical Services Manager will continue to work with children and families teams to embed further the use of this protocol.

Recommendation 6. Cases coming under the GOPR umbrella should be the subject of regular review and should not be closed or transferred without such a review taking place, including updating the Parental Substance Misuse Report.

Social work managers have issued a clear and helpful Operational Instruction to ensure that GOPR cases are reviewed regularly and before cases are closed or transferred. They are monitoring the implementation of this instruction closely. As a result there is continued focus on ensuring consistency of practice particularly regarding the updating of the Parental Substance Misuse Report prior to closing a case.

Recommendation 7. There should be put in place a monitoring system, such as exists in respect of child protection, to ensure that the process of completing GOPR full assessment reports and conducting reviews can be tracked, and speedy action taken where there is significant variation from the prescribed timescales.

A monitoring system has been put in place. Managers now receive information on the completion rate of GOPR full assessments and are able to report improvements in performance. Senior managers should continue to review the performance information and take corrective action where necessary to ensure the system is comprehensive, robust and accurate.

Recommendation 8. Given that GP records are likely to be the most accurate and comprehensive source of the medical history of a substance misusing parent, it is recommended that it be the responsibility of the GP to ensure that such information is made available to case discussions either by direct representation by her/himself, or a representative of the practice e.g. a health visitor, or by the provision of a written report.

GPs are aware of the need to share information with relevant services about children and their parents when there are concerns about the care children are receiving. Helpfully a secure email system has been established to invite GPs to case conferences and a proforma is provided to assist them in sending a written report for meetings. GPs are beginning to use the proforma and are sharing these reports more often with social workers. Further work is required to ensure that reports are shared routinely and consistently across the authority area. Some GPs will share information with the health visitor attending the meeting who will convey this information to the case conference or meeting. School nurses have little contact with GPs. The CHP Clinical Director and Clinical Services Manager are actively considering practical ways to improve communication between School Nurses and GPs. Further work is required to ensure that the type of information required from GPs is fully understood.

Recommendation 9. It should be mandatory for all staff and managers involved in this area of work, either directly or indirectly, including GPs and consultants within the RDS to undergo GOPR training and each agency should maintain a GOPR training record, either on a stand alone basis or as part of any existing training record.

A comprehensive package of GOPR training has been established for many years. As a result almost all staff across services, including some elected members, have accessed either a basic awareness raising session or a more comprehensive two day training programme depending on their involvement with children and families. Staff have found this training very helpful and this has improved their practice. Consideration is currently being given to extending the scope and type of training available to staff. Managers are aware that some staff were trained several years ago and now need further training to ensure they are fully up to date with current practice and developments. GPs and their practice staff continue to be invited to attend GOPR training. In June 2012 targeted training was delivered at the Renfrewshire GP Protected Learning Event. All staff groups named in this recommendation will be included in the ongoing RCPC Training Plan.

Recommendation 10. A simple paper or electronic form of communication should be introduced to ensure that there is clarity of language and intent when staff from one agency are asking staff from another agency to carry out a specific task.

Useful communication guidance produced by RCPC has been circulated and disseminated to all staff effectively. Staff have welcomed this guidance. They understand the need to share information clearly. They are enhancing their practice by sharing information verbally and now confirming the information either by email or in writing. Staff have found the communication guidance helpfully directs them on how to structure written communication. Additionally staff feel it has also helped them to be clearer about what they are trying to communicate. Secure email addresses have been shared across health and social work services resulting in quicker and more effective communication. Social workers have immediate access to emails through Blackberry phones. Health staff have still to resolve fully the

problem of having two email addresses. Revised Guidance on secure email communication will shortly be issued to all health and SW staff.

Recommendation 11. There should be a review of guidance for health visitors on interagency working, including their responsibilities under recommendation 7, and consideration of a short period of "shadowing" as part of the induction programme for new staff.

Health visitors have attended multi-agency briefings following the introduction of the National Guidance for Child Protection and subsequent West of Scotland Interagency Child Protection Procedures. These briefings promoted best practice on interagency working and highlighted the role and responsibility of health visitors. As part of their induction programme health visitors are given the opportunity to shadow social workers to gain a better understanding of each other's role. A number of staff currently in post have also been given the opportunity the shadow their colleagues in other agencies which they have found very informative.

Recommendation 12. Guidance should be introduced for health visitors on case handover practice, including an entry in the patient record, at least in all "additional" and "intensive" cases, of key issues and date of handover.

Relevant guidance is now in place which is known and understood by health visitors. Implementation of this guidance is being monitored by team leaders through supervision sessions with staff and the first audit of the process will take place in September 2012.

Recommendation 13. There should be a review of clinical and management supervision arrangements for health visitors with reference to frequency, recording of content and formalising sessions for all staff.

A Caseload Management system is in place and helpful documentation to support the process is being developed. When staff need support, they have easy access to advice and guidance from their team leaders or NHS Greater Glasgow and Clyde Child Protection Unit. There is no systematic way of managers routinely reviewing the practice of all staff working with the most vulnerable children.

Recommendation 14. There should be a review of the nurse management structure to ensure that health visitors and other nursing staff receive appropriate support and supervision.

The health team leader resource has been increased allowing them to facilitate more regular caseload management sessions. Although senior managers are monitoring the capacity of team leaders they may also wish to monitor the quality of the caseload management sessions to ensure that decisions, particularly around individual cases are robust.

Recommendation 15. Steps should be taken to ensure that GPs are familiar with RCGP/SG guidance on the management of substance abusers.

Managers across services recognise the challenge of ensuring that all GP practice staff are aware of the GOPR guidance. They continue to work hard to develop effective approaches to engage with GP

practice staff. A protected learning event has taken place to raise awareness of the GOPR protocol and the majority of GP practice staff who were available attended this event. GOPR Guidance was issued to all GP practices in December 2011 and again in May 2012. Up to date prescribing information has been re-issued to all GPs. Confidence is growing that GP practices who are involved in the prescription of substitute drugs are aware of the guidance contained in the "Orange Book". Managers in health and social work services are aware of the need to continually monitor the involvement of GPs in child protection work.

Recommendation 16. Management of social work child care practice within the RAH should sit within Child Care rather than Community Care.

Management responsibility for child care services in the RAH was very quickly and effectively transferred to a social work community fieldwork manager with child care experience. Additionally a new senior social worker post was created in the RAH and a very experienced and well respected child care senior social worker was appointed to this new post. A further social work post has recently been created to meet increased operational demands. Staff working in the hospital are benefiting from greater peer support and challenge since they have moved to a local social work office. Managers are reviewing the effectiveness of this change in structure.

Leadership and direction

Leaders initiated an immediate response to the death of this child. Across services they investigated and took appropriate remedial action quickly. Chief Officers and the independent chair of RCPC were very proactive in commissioning an independent significant case review.

RCPC, supported by Chief Officers, has taken every opportunity to promote the learning from the SCR locally through multi agency training, lunch time presentations and their annual conference. They have also taken the opportunity to share the learning from the process effectively with colleagues at a national level through the meeting of the chairs of CPCs, with Scottish Government colleagues, with the Association of Directors of Social Work (ADSW) and health fora.

Chief Officers are keen to ensure that the attitude they adopted and action they took will help to empower their staff to take forward changes in practice and ultimately in supporting and protecting children. Across services staff at all levels report that senior managers have been visible and supportive and keen to turn the experience into learning opportunities. There is evidence of strong partnership working, for example, senior and middle managers felt supported by colleagues from other agencies who did not necessarily have a direct involvement in the particular case. When developing the SCR action plan, managers have helpfully consulted staff on particular action points to check how realistic these actions are. Leaders have engaged well with politicians and the media being proactive, honest and realistic.

Encouragement and time has been given to managers and practitioners to become more reflective in their practice. There is a good recognition by managers of the need to sustain changes to practice. Managers acknowledge the need to have ongoing awareness raising and training events for staff particularly around neglect to improve the outcomes for children.

Conclusion

Chief Officers, RCPC and staff across services have taken the recommendations from the SCR very seriously. They have turned the recommendations into a comprehensive and realistic action plan which targets systems and processes used by staff across services. Chief Officers and RCPC monitor the actions closely to ensure progress is made. Most actions to meet the recommendations are progressing well although some are at an early stage of implementation. As a result, it is too soon to measure fully the impact these actions will have on children and their families.

Leaders have demonstrated, by their willingness to support and empower their staff, that they have a good understanding of the complexities involved in working with children affected by parental substance misuse. As a result they have increased resources, provided appropriate training, reviewed practice and procedures effectively and involved staff well in taking forward the action plan. Staff have demonstrated that they know their practice requires to be continually reviewed to ensure they are using best practice when working with children and families. They have responded well to taking forward changes to practice as a result of the implementation of the action plan. As a result inspectors are confident that actions to meet the recommendations will continue to be progressed and reviewed for effectiveness.

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