EAST AYRSHIRE COUNCIL

SOCIAL WORK COMMITTEE : 27 MARCH 2003

"IT'S EVERYONE'S JOB TO MAKE SURE I'M ALRIGHT"
Report of the Scottish Executive Child Protection Audit and Review

Report by the Director of Educational and Social Services

1. PURPOSE OF REPORT

1.1 To advise elected members of the terms of the Scottish Executive Audit and Review of Child Protection (the review);

1.2 To seek authority to submit a response to the Scottish Executive, with further report to follow when the Scottish Executive has published its own response to the review;

1.3 To seek approval for a package of service developments to improve Child Protection services in East Ayrshire.

2. BACKGROUND

2.1 On 25 November 2002, the Scottish Executive published the report of its audit and review of child protection services in Scotland. The Executive had commissioned the review in response to the enquiry into the death of the child Kennedy McFarlane in Dumfries and Galloway.

2.2 The review incorporated an audit of practice of medical, nursing, social work, Children's Reporter and education staff, research to ascertain the views of children, their parents and the public, a literature review and consideration of child protection arrangements in other countries.

2.3 Local agencies were invited to respond and comment on the review as part of the implementation process.

3. REVIEW FINDINGS AND RECOMMENDATIONS

3.1 The review recognises the positive outcomes for children where services are working well together. In particular, it highlights the positive outcomes where good social work practice is involved, acknowledges that there are many instances where children are being protected well from harm and indicates that the evidence suggests that there have been real improvements in child protection services over the past 20 years.

3.2 However, the review also draws attention to a number of shortcomings in present child protection arrangements, in particular that :

- Many children are living in conditions or under threats that are just not tolerable in a civilised society;
- Neglect is a major cause for concern;
- There is a lack of confidence in the system;
- Some children were not getting the help they needed and some were not being protected adequately by the child protection system;
- There is duplication of effort and energies being diverted into meeting system requirements rather than focusing on better outcomes for children.

3.3 The review makes 17 recommendations, focusing on 7 areas for improvement :

- Better information;
- Developing quality standards and strengthening monitoring and inspection arrangements;
- Strengthening the role of child protection committees, particularly in respect of information provision and quality assurance;
- Better knowledge about effective practice, staff training and competence;
- Promoting the rights of all children to life decency and development and tackling the needs of the most vulnerable children as early as possible;
- Ensuring resources follow need;
- Reviewing the grounds of referral to the Children's Reporter.

3.4 The review indicates that a national implementation team will be established to support local agencies in improving child protection arrangements. A follow–up review will take place in 3 years time, with annual reports on progress being made in the interim period.

3.5 On 18 February 2003, the First Minister addressed a summit conference attended by Leaders and Chief Executives of local authorities to reinforce the expectations of the Scottish Executive in terms of action to achieve improved performance in child protection services.

3.6 A summary of the report and a full list of recommendations is attached as Appendix 1. A copy of the full review report is available in the Members Information Point.

4. RESPONSE TO THE REVIEW

4.1 The East Ayrshire Child Protection Committee has met in special session and prepared a multi-agency response to the review. The response broadly welcomes the review, in particular its focus on improving frontline services. However, it also points out the resource issues which affect the capacity of local agencies to improve services and the need not to lose sight of earlier reports which have suggested improvements. It also indicates the need for a clear baseline to be established against which local progress can be measured in a meaningful way over the next 3 years.

4.2 A copy of the Child Protection Committee response to the review is attached as Appendix 2. It is proposed that the Child Protection Committee response should form the basis of the Council's response to the review.

4.3 The need to identify additional resources with which to improve child protection services in East Ayrshire is crucial to achieving the outcomes promoted by the Scottish Executive. It has therefore been agreed that a specific package of service developments should be proposed for funding from part of the Council's additional allocation of Changing Children's Services Fund monies announced by the Scottish Executive for the period 2003/04 to 2005/06. The proposed package of measures is attached as Appendix 3. The proposed package of service developments will be included in a separate report making recommendations for using the full allocation of Changing Children's Services Fund monies. That report will be considered by the Policy and Resources Committee on 10 April 2003.

5. POLICY/LEGAL/FINANCIAL IMPLICATIONS

5.1 The review focuses on improvements in multi-agency practice. There are no immediate policy implications arising from this report. If any practice developments are made over the 3 year implementation period which carry policy implications, they will be the subject of separate reports at the relevant time.

5.2 There are no legal implications arising from the review, which reinforces existing responsibilities of the Council and its partner agencies.

5.3 The additional cost (£305,000 per annum) of the proposed service developments detailed at Appendix 3 can be met from the additional allocation of Changing Children's Services Fund monies which will come to the Council. Consideration will need to be given in due course, however, to sustainability beyond the term of that funding, which will be available until 31 March 2006.

6. RECOMMENDATIONS

6.1 Committee is requested to:

a) note the terms of the Scottish Executive review, as summarised in Appendix 1;

b) authorise the Director of Educational and Social Services to forward to the Scottish Executive as this Council's submission the response to the review, attached as Appendix 2 ;

c) support the package of service developments attached as Appendix 3 for inclusion in the overall package of service developments being submitted to the Policy and Resources Committee on 10 April 2003;

d) note that this report will also be considered by the Education Committee at its meeting on 1 April 2003;

e) note that annual progress reports on implementation of improved arrangements will be presented to Committee;

f) otherwise, note the contents of the report.

John Mulgrew
Director of Educational and Social Services
7 March 2003

For further information, please contact John Alexander, Principal Officer (Quality and Planning) (Tel. 6978)

IMPLEMENTATION OFFICER : STEPHEN MOORE, HEAD OF SOCIAL WORK

Background Paper

"It's Everyone's Job to Make Sure I'm Alright" – Report of the Scottish Executive Audit and Review Child Protection

EAST AYRSHIRE COUNCIL

DEPARTMENT OF EDUCATIONAL AND SOCIAL SERVICES

Departmental Summary Of 2002 Child Protection Audit And Review: "It's Everyone's Job to Make Sure That I'm Alright"

1. BACKGROUND

1.1 "Its Everyone's Job to Make Sure That I'm Alright", was completed by a multi-disciplinary task group commissioned by the Scottish Executive to explore current child protection issues. The group compromised representatives from education, medicine, nursing, the Scottish Children's Reporter Administration, police and social work.

1.2 Children and parents with experience of the child protection system, a range of voluntary organisations and Child Protection Committees, (as well as public comment), informed the report through interviews and consultation.

1.3 "Its Everyone's Job to Make Sure I'm Alright" is the largest study of its kind undertaken in Scotland.

2. METHODOLOGY

2.1 A range of analysis tools were used by the task group including:

A literature review,
Analysis of child protection guidance,
Analysis of deaths of looked after children
Information obtained from a conference on child protection in other countries informed the report.
Case audit and review were undertaken by a multi – disciplinary team.

2.2 A range of individual and organisational stakeholders were consulted.

3. FINDINGS

3.1 <u>The Circumstances of Abused and Neglected Children</u>

Many of the children in the audit had experienced more than one form of abuse or neglect. Large numbers were living with parental substance misuse or witnessing domestic abuse on a regular basis. Sibling or peer abuse was also a feature of the cases.

3.2 Protecting Children

The review found that some children remained at risk of significant harm, even although known to agencies for a considerable time. Children and young people expressed mixed feelings about whether or not the child protection system had protected them. Parents expressed similar doubts.

In some instances the abuser had not been prosecuted or convicted. In other cases children intimated that they had been taken away from the person who abused them and were now vulnerable to other risks.

The analysis of deaths of looked after children indicated that in some cases more might have done more to protect the children who died.

Health visitors and education staff often perceived that their referrals were not taken seriously by Social Work. Emergency protection measures were an identified issue. Social Workers were found to be reluctant to apply for Child Protection Orders unless they could demonstrate immediate risk. In some cases they were concerned about appearing and being cross examined in Court. Social Workers felt there was little point in seeking Exclusion Orders which placed responsibility on the other adult in the house to keep the abuser out.

The report identified children as being at serious risk:

- From males who were not living in the family home (but visited) or lived nearby;
- Where Reporters had difficulty framing grounds of referral;
- Due to delays in the Hearing System e.g. for Proof Hearings;
- Hearing System delays due to late presentation of reports by Social Workers.

3.3 Meeting Needs

The review found that children and their families do not always get the help they need when they need it. Most of the abuse and neglect experienced by the children in the audit was caused by poor parenting skills. There was evidence of high levels of home support offered (with family centres, nurseries and sometimes Health Visitors playing a significant part) particularly where there were problems with substance misuse. Examples also included the use of therapeutic services where children had the opportunity to work through what had happened to them and move on emotionally. Remedial health care included optical and dental provision.

In many cases the audit found they were not receiving the services they needed. Many children could not access services such as health care if their parents did not co-operate. There was little evidence of long term success where intensive remedial work was provided at home. In some cases where regular day and occasional evening domiciliary support services were provided the reality was that the local authority was parenting the child.

A few authorities provided or commissioned therapeutic support from voluntary agencies. On the whole however, there was a shortage of skilled workers with time to offer children practical and emotional support. Psychology, psychiatry and specialist counselling waiting lists were so long that children could not gain access to them in a reasonable timescale.

Some parents were frustrated that they could not access counselling services for children or themselves. The audit found that the needs of child perpetrators were particularly neglected.

It additionally found that while professionals had children's "best interests" at heart, they often failed to consult them re what their "best interests" were. Children's views were often not fully considered at Case Conferences or were only presented through third parties.

The audit found examples where parents highly valued the support given. Some parents in the audit and those who rang Parent Line often felt they were not kept fully enough informed about what was happening. Some experienced case conferences as overwhelming. Arrangements to provide families with support were variable as was practice in ensuring they fully understood the outcomes of meetings. Sometimes key family members, such as grandparents, were often omitted from discussions. Relatives who took on the long term care of children regularly felt unsupported and that their requests for help were ignored.

4. CONCLUSIONS

4.1 The review findings suggest that many adults and children have little confidence in the Child Protection system and are consequently reluctant to report concerns about abuse or neglect. Ultimately, the child protection system can't help those children who never enter the system and do not receive help. The system is not always well understood by the public. Many adults were concerned that children would be removed from their families if they reported abuse. Even when people were willing to report abuse they found that gaining access to help was not easy.

4.2 The review findings suggest that the Child Protection system does not always work well for the children and adults involved in it. Forty children in the audit were found to be unprotected following agency intervention. A further sixty-two children were only partially protected or only had their needs partially met. Children's needs were only protected in seventy-seven cases and their needs well met in twenty-four of these cases.

4.3 Good practice included: the provision of help to parents and children when it was needed, timeous responses, early thought and preparation, coupled to properly addressing the source of risks.

4.4 Outcomes for children were found to be highly dependent on Social Work doing well. Where Social Work performed well outcomes were generally good. Where they performed less well outcomes were generally poor. While good outcomes were assisted by the work of all agencies they were less dependent on other agencies.

4.5 Where children were not protected or their needs were not met this was often the result of inquiries which were not sufficiently extensive and/or poor assessment. Longer – term assessments of risk were often particularly poor. Reasons for this included:

- Insufficient use of inter-agency information, especially from health and education;

- Insufficient attention paid to the role of at least one key person in the child's life;

- Lack of focus on the child and inadequate assessment of parents' ability to make use of the support on offer to provide children an acceptable level of care.

4.6 Practice was generally better for new babies where parents had a learning disability, mental health problem or drug problem. In such cases health services arranged for pre-birth or pre-discharge meetings with other key agencies. These worked well. When all the key agencies attended, a multi-agency plan was made with the worker from each agency playing their part in its implementation.

4.7 Successful placement in foster care, often led to material, health and attitudinal improvement for children. However, there were cases where foster carers could not cope with the behaviour of children. Occasionally children were sent back home from foster or residential care against their will.

4.8 Good workers made a difference to outcomes for children. In a number of instances, particularly in relation to drugs or alcohol misuse, strong supportive relationships between Social Worker and parents allowed problems to be addressed, with the parents positive about the support received.

4.9 Where the Child Protection system relied on criminal prosecution to protect children, outcomes were not always good, especially where the abuser remained a threat. Where the abuser was not prosecuted or convicted, the victims remained vulnerable and felt they had not been believed.

4.10 Parents do not always feel that the Child Protection system is working effectively. They are not always happy with the response from Child Protection Agencies. People contacting Parent Line were concerned about:

A perceived lack of activity by agencies
or
Felt they received a lack of feedback after a referral.

5. RECOMMENDATIONS CONTAINED IN THE REPORT

5.1 The report contains 17 recommendations, identifying action that can be taken immediately to protect children and improve services, and action that needs to take place over a longer time. These include:

School, police, health and social work should maintain succinct, easily accessible, chronological records on children;

Linked computer based information systems should be developed, including a single integrated planning and review report framework for children in need.

Health should share information with relevant professionals in line with General Medical Council and Scottish Executive guidance.

The Scottish Executive Committee should revise the remit of Child Protection committees.

Local Authority chief executives, in consultation with other services, should review the structures, membership and scope of Child Protection Committee.

The Scottish Executive in partnership with regulatory bodies should consult on minimum standards of professional knowledge and competence on the part of practitioners who undertake child protection investigations, assessments and clinical diagnosis.

The Scottish Executive should advise on how agency resources can be pooled and what systems may be best developed to ensure the most effective joint commissioning of services.

A list of the recommendations is reproduced in full and attached.

RECOMMENDATIONS FOR "IT'S EVERYONE'S JOB TO MAKE SURE I'M ALRIGHT"

Recommendation 1

Agencies should review their procedures and processes putting measures in place – to ensure that practitioners have access to the right information at the right time particularly ensuring that:

Where children present to medical practitioners with an injury or complaint, practitioners must consider what further information is available from their own or other agencies *before they rule out* the possibility of continuing risk.

Where children present to any hospital, there should be mechanisms in place for checking other health records to ensure a pattern of injuries is not being missed.

Where there have been concerns about possible abuse or neglect, Schools, Police, Health service and Social Work service files should contain a succinct, readily accessible chronology of events or concerns which can easily be referred to should a further incident or concern arise. This chronology should contain information relating to the child, and where known, information relating to other people in the child's life, for example, any previous deaths of children of a mother's new partner.

Courts should ensure bail address suitability checks are undertaken in cases where the alleged offence is against children, or in the case of domestic abuse, where children may be at risk.

Caldecott guardians in Health Boards and Trusts should ensure that health professionals are aware of their responsibilities towards the care and protection of children. In particular they should ensure that where children are at risk of abuse and neglect information is shared promptly with other relevant professionals in line with the General Medical Council and the Scottish Executive guidance on when medical confidentiality can be breached.

Recommendation 2

Agencies should improve access to help for children who have been abused or neglected by through Child Protection Committees:

Providing for single-page information for telephone directories, public phones, and the web, which identifies local contact points in health services, local authorities, police services, SCRA and the voluntary sector;

Providing information for service users and referrers about how to access help for children about whom they are worried. This should include details of how and when children and young people will be consulted, what will happen after a referral is made and what, and how, feedback will be provided to people who refer concerns.

Recommendation 3

The Scottish Executive should, in consultation with service providers, draw up standards of practice that reflects children's rights to be protected and to receive appropriate help. All local authorities, health boards, police services and SCRA should undertake regular audits of practice against these standards and report on them annually to the Scottish Executive and local Child Protection Committees.

Recommendation 4

The Scottish Executive should revise the remit of the Child Protection Committees to include:

Annual auditing and reporting, to constituent agencies and to the Scottish Executive, on the quality of agency and inter-agency work.

The provision of information to members of the public, volunteers and other professionals.

Assisting a wider range of organisations to help prevent abuse and neglect through training for staff and volunteers.

The development of safe recruitment practices for agencies working with young people.

Recommendation 5

Local Authority Chief Executives, in consultation with other services, should review the structure, membership and scope of Child Protection Committee covering their authority. They should report to their Council and partner agencies on whether it is best constituted to take on the responsibilities for assuring the quality of agency and inter-agency services and make recommendations about their role contained in this report.

Recommendation 6

The Scottish Executive should consult on how child fatality reviews should be introduced in Scotland. This should include consultation on how they should be conducted, how review teams should be constituted, to whom they would report and what legislative framework is required to ensure their effectiveness.

Recommendation 7

The Scottish Executive should strengthen the current arrangements for the development and dissemination of knowledge about abuse and neglect. In particular it should identify:

The most effective arrangements for recording and collating examples of effective practice;

The delivery of staff training across all disciplines or agencies;

The best means of disseminating research findings and best practice: and

The links between research and knowledge and staff education and training and how this can be consolidated.

Recommendation 8

The Scottish Executive should initiate a long-term study of the effectiveness of current methods of responding to abuse and neglect. The study should follow children from infancy to adulthood.

Recommendation 9

Children's Service Plans should be developed so that they include clear plans for the implementation of national priorities and demonstrate the application of resources to these outcome targets set out in *Building a Better Scotland.*

Recommendation 11

The Scottish Executive should:

Advise on how agency resources can be pooled and what systems may best be deployed to ensure the most effective joint commissioning of services on behalf of children.

Commission a study of the costs and benefits of the current child protection system in Scotland and identify costed alternative options for improving outcomes for children.

Recommendation 12

There needs to be a new approach to tackling risks and the needs of the most vulnerable. As a first step this should start with assessment of the needs of all new-born babies born to drug or alcohol-misusing parents; parents who have a history of neglecting or abusing children and parents where there have been concerns about previous unexplained deaths in infancy. The inter-agency assessment and subsequent action plan in respect of each child should clearly state:

Standards of child care and developmental milestones the child is expected to experience or achieve;

Resources to be provided for the child or to assist the parents in their parenting role; and

Monitoring that will be put into place along with contingency plans should the childs needs fail to be met.

Recommendation 13

In keeping with the philosophy of the Children (Scotland) Act 1995, agencies referring to the Reporter should indicate what action they or their agency has undertaken to achieve change through consent and why compulsory measures of supervision may now be necessary.

Recommendation 14

The Scottish Executive should review the grounds for referral to the Children's Hearing's System. Specifically it should explore the feasibility of grounds being framed to reflect the needs of the child more clearly and to be more closely aligned with definitions of need outlined in the Children (Scotland) Act 1995.

Recommendation 15

Measures to address the shortcomings identified in this report include: developing linked computer-based information systems which include a single integrated assessment, planning and review report framework for children in need. The framework should include reasons for concern, the needs of the child, plans to meet them (and protect them when necessary), as well as progress since any previous meetings. This core assessment, planning and review framework should be accessible and common to all partner agencies, multi-agency case conferences and the Children's Hearing. Arrangements should be made for appropriate access to information by agencies in other areas should children or their families move.

Recommendation 16

The Scottish Executive in partnership with the regulatory bodies should consult on the minimum standards of professional knowledge and competence required of practitioners who undertake investigations, assessments and clinical diagnosis when working with children and their families. In particular it should establish the minimum necessary qualifications and experience needed by those making decisions that fundamentally affect the future well being of children.

Recommendation 17

The Scottish Executive should:

- Establish a national implementation team to take forward the recommendations in the review, particularly the development of standards and local auditing processes.

- Establish a review process for annual reporting on progress and improvements.

- Implement a further national review of child protection in three years' time to be undertaken by a multi-disciplinary inspection team using this report as a baseline against which progress can be assessed.

APPENDIX 2

EAST AYRSHIRE CHILD PROTECTION COMMITTEE

RESPONSE TO RECOMMENDATIONS FROM

"IT'S EVERYONE'S JOB TO MAKE SURE I'M ALRIGHT"
Report of the Child Protection Audit and Review

Introduction

On 29 January 2003, East Ayrshire Child Protection Committee (the Committee) held a special meeting to consider the findings and recommendations of the report of the Scottish Executive's Child Protection Audit and Review (the report).

The Committee's comments on the findings and recommendations contained in the report are set out in section 2 of this paper, based on full discussion involving representatives of all the agencies which make up the Committee.

In submitting comments, the Committee wishes to emphasise its full support for child protection being the shared responsibility of a number of agencies at local level. That multi-agency responsibility includes a formal mandate and accountability to ensure that the welfare of the child is paramount, in accordance with the provisions of the Children (Scotland) Act 1995 as the relevant legal underpinning for agencies' practice in this regard.

The Committee welcomes the opportunity to comment on the report. However, at the outset it wishes to place on the record two caveats which provide a framework for its detailed comments.

Firstly, whilst the individual findings and recommendations within the report deserve close attention, so too does the wider context within which child protection practice takes place. Long term, sustainable improvements in practice will only occur if those broader factors are recognised and appropriate action taken to address them. This comment echoes the response of the Association of Directors of Social Work (ADSW), which pointed to the need to:

- Implement those recommendations of Lord Clyde's 1993 report of the Orkney inquiry which have not been actioned to date;
- Improve public understanding of social work practice in general and child protection work in particular;
- Tackle the shortage of qualified, skilled children and families social workers, and;
- Adopt a more systematic approach to multi-agency training, including clear standards and specific additional resources allocated for that purpose.

Secondly, since the report will serve as the baseline against which progress will be measured when the follow up review takes place in three years time, it is imperative that the proposed national implementation team starts its work by specifying the current state of practice in

clear, evidence-based terms. Unless that is done at the outset, it will not be possible to evaluate progress over the next three years meaningfully and credibly.

Findings and Recommendations

The Committee welcomes the clear recognition that good social work practice is associated with better outcomes for children.

Recommendation 1

The Committee believes that the appointment of Child Protection Committee Co-ordinators across Scotland would assist local agencies in implementing the measures proposed in the report. In particular, the co-ordinator would have a major role to play in increasing public understanding of child protection issues and developing and delivering training packages to meet a broad range of need, from basic awareness-raising to inter-agency practice and procedures.

The Committee also believes that a common definition of "vulnerability" across all agencies with a responsibility to protect children would help to focus the inter-agency response to the problem.

The Committee supports the implementation of a succinct, readily accessible chronology of events as proposed in the report. The Department of Health guidance on risk assessment offers a useful model for developing guidance in Scotland.

The Committee supports the proposals for suitability checks for bail addresses. Current local practice in this regard already meets the proposed standard in large measure. In implementing such arrangements, local experience suggests that account needs to be taken of the risk to alleged perpetrators whose bail address may be in or close to the locality in which the alleged abuse has taken place.

The reference to the role of the Caldicott guardians is supported. NHS Ayrshire and Arran will ensure that the recommended practice standards are met locally.

Recommendation 2

The Committee supports the provision of single page contact information and the provision of information for service users and referrers.

Recommendation 3

The Committee welcomes the development of national standards against which local agencies should audit their practice. However, it is important to recognise that individual agencies can audit only their own practice, although Child Protection Committees should take an overview of the effectiveness of child protection practices as a whole in their area, based on the sum of those individual audits.

Recommendation 4

The Committee fully supports the emphasis on quality of practice, both at agency and inter-agency level, as a major focus of Child Protection Committee responsibilities. The emphasis on information-giving and training is also welcomed, although the Committee believes that the appropriate role for Child Protection Committees should be strategic rather than operational.

The Committee notes the proposed role for Child Protection Committees in developing safe recruitment practices. It believes that the primary responsibility for developing and implementing safer recruitment practices needs to remain with individual agencies as employers. However, Child Protection Committees would be the appropriate body to undertake quality assurance of agencies' performance in this regard as part of their wider quality assurance responsibilities.

Recommendation 5

The lead role given to local authority Chief Executives is welcomed. The Committee believes that its own structure and membership could be enhanced by the addition of general practitioner and acute health sector representation. It would also benefit from the wider participation of relevant voluntary organisations.

The Committee believes that inter-agency ownership of child protection would be enhanced if constituent agencies assumed responsibility for chairmanship of Child Protection Committees on a rotational basis. If participation in Child Protection Committees was at chief officer/senior manager level, direct access to agency Chief Executives outwith committee meetings would be facilitated and thereby ownership of child protection across all agencies would be strengthened. It should be noted that child protection co-ordinator posts should not chair Child Protection Committees.

Recommendation 6

The Committee looks forward to contributing in due course to the consultation on how child fatality reviews should be introduced in Scotland. In preparation, it will consider experience of how current Part 8 arrangements in England and Wales operate.

Recommendation 7

The Committee supports the initiative proposed for the Scottish Executive in respect of development and dissemination of knowledge. It believes that the best means of delivery will be through Child Protection Committee structures at local level.

Recommendation 8

The Committee supports this proposal.

Recommendation 9

The Committee strongly supports the need for Children's Service Plans to be focused on better outcomes for children, with particular emphasis on meeting the needs of vulnerable and socially marginalised children.

Recommendation 10

The Committee supports these proposals but believes that they will be effective only if they are backed up with specific, earmarked resources.

Recommendation 11

The Committee welcomes the proposal for *advice* from the Scottish Executive in respect of best use of resources and the most effective joint commissioning of services. However, there is a need to recognise that *decisions* on what arrangements to put in place must be made at local level by the constituent agencies, who are best placed to assess and meet need in their localities.

The proposal to commission a study of the costs and benefits of the current child protection system would be strengthened by involving, through their national representative bodies, the statutory agencies and the frontline professionals responsible for child protection services at local level in the framing of the terms of reference for the study. In that way, the study would be informed by the detailed knowledge and experience held by frontline service agencies and thereby firmly focused on delivering practical and realistic proposals for practice improvements.

Recommendation 12

The emphasis on prevention and proactive intervention is welcomed. The inter-agency action plan should be binding on the agencies and any difficulty with implementation should be referred back to the inter-agency level for resolution.

Recommendation 13

This recommendation is welcomed. Current pilot activity in Ayrshire in respect of Fast Track Hearings is following this approach and it is intended that this practice will be extended to mainstream practice following evaluation of the pilot stage.

Recommendation 14

The Committee welcomes these proposals.

Recommendation 15

Further development of electronic information and communication systems will be crucial to improving the appropriate flow of information across agencies. Local activity is already focusing on improving information-sharing between Social Work and Education. The Committee believes that priority access to Modernising Government Fund resources would greatly assist the implementation of this recommendation.

The Committee welcomes the recognition of the need to improve our technology in this regard but believes that many of the barriers to appropriate information-sharing are attitudinal and

cultural and, as such, need to be tackled through inter-agency training and staff development activity as much as through the provision of technical resources.

Recommendation 16

The Committee welcomes this recommendation. In going about the task, there may be lessons to learn from current work on this agenda in respect of the nursing profession.

The Committee believes that the emphasis on standards of knowledge and competence needs to be backed up by a clear and formal commitment from the Scottish Executive to provide additional resources to support the higher standards and to increase the capacity of the training institutions to provide the workforce desperately needed to fill unprecedented levels of frontline vacancies, particularly in children and families social work.

Recommendation 17

The Committee welcomes the prospect of working with the proposed national implementation team on improving standards. The role of the team needs to be practical and focused on measurable improvements and our introductory comments at para. 1.5 of this paper set out our view of how the team should set about its work.

Conclusion

In conclusion, the Committee welcomes the report and looks forward to working collaboratively and constructively with the Scottish Executive to deliver real, practical improvements in child protection practice in East Ayrshire.

Any requests for clarification or further information about this submission should be directed to :

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APPENDIX 3

Scottish Executive Child Protection Audit and Review Report

Bid Areas from Education & Social Services for Changing Children's Service Fund

1. Child Protection Training Co-ordinator.

The post would report to the Child Protection Committee. As well as lead for multi-agency training the post would also support the CPC in terms of reports and information on updated practice, liaise with training staff in other agencies. Requires a qualified social worker, with Diploma in Child Protection and significant experience of Child Protection work.

2. Child Protection Training Budget.

Budget for multi-agency training to address concerns regarding multi-agency working and the concerns that non-social work staff are failing to identify child protection concerns.

3. Health Visitor Secondment to Social Work.

Report highlighted concerns about communication between health and social work in relation to children at risk and the reluctance of Caldicott guardians to share information. To be addressed in the initial phase by seconding a Health Visitor to social work who would be the liaison point between teams and health agencies for data gathering. Could also provide practical assistance in terms of health screening.

4. Training

a) Training of social workers in Certificate in Child Protection in order to meet minimum requirements of the Scottish Executive for trained and competent staff. Training time is one calendar year and we would second five staff a year.

b) Back filling of posts to allow staff to undertake point 4 above equivalent to 2 whole time social workers.

5. Information Technology.

The Scottish Executive requires all agencies to develop and commit to joined up assessment completed electronically with sharing of information electronically. Experience of joined up electronic records sharing on Community Care would suggest I.T. infrastructure expenditure. Scottish Executive at a national level have a preferred provider, Channel One in Glasgow who have the National Health Service contract for this work. There are also pilots in data sharing on children's information.

6. Independent Chair, Child Protection.

We currently have around 40 children on the register at any one time, twenty families. 122 children were referred last year resulting in approximately 60 investigations. The increase in

workload is significant and there is a need fro independent scrutiny of the work as the current chair of the case conferences is also the line manager for the service. This closeness poses the potential for lack of objectivity as the chair can also be the person who directs the investigation. Creation of the post to chair the initial case conferences, ensure effective/accurate minutes, liaise with training post in 1 above to highlight areas for improvement in practice. The post holder will require in preparation for case conferences and reviews to read case records and interview children, families and workers as appropriate in order to ensure best practice for individual cases.

7. Administrative support for the post at 6.

Post holder will minute all meetings which will require to organise case conferences, collect reports and disseminate them prior to the meetings, attendance at case conferences, produce draft minute and then final minute.

8. Flexible Support Budget.

The report highlights that many children are left unprotected and the intention is to develop a budget that will allow flexibility for staff to purchase appropriate services to meet need at specific times. For example, if a drug taking parent goes into rehabilitation as part of a child protection plan we could put staff into the family home to support the child/children as an alternative to accommodating the child/children. Potential for short-term packages of care. The budget would supplement existing service provision. The level of budget required is equivalent of £40 per week per family on the register.

9. Child Protection Library.

Develop a resource which could be accessed by all staff in the Council. Would be maintained by the post holder at 1 above and would include journals, other publications and video/audio material.

10. Public Information.

The report is critical of the lack of public information on child protection. This should include publication and update of child protection guidelines as well as leaflets etc.

Total Cost £305,000p.a.