Inquiry into Child Protection Services in Northern Ireland – The Community Practitioners' and Health Visitors' Association Submission

1. Casework

1.1 Case Recording

Case recording/record-keeping has been a controversial and much debated subject within our organisation particularly in relation to child protection issues. Record keeping and report writing are serious matters and very relevant to the working lives of health professionals engaged in the care of children and families in the community. Record keeping has traditionally been viewed by busy and over-stretched practitioners as less of a priority than other aspects of their practice involving practical support and intervention for vulnerable families. However they are increasingly becoming aware of the necessity of allocating time to this important area of their work. The importance of keeping accurate concise and contemporaneous records has been highlighted in various inquiries into child protection cases. Failure to do so has frequently contributed along with other factors in poor outcomes for children. From the health professional's perspective it has often led to disciplinary action been taken against them and indeed some nurses have been struck off the professional register as a consequence of poor record keeping.

Maintaining good case records is dependant on a number of factors. Initial training should be multidisciplinary particularly in relation to child protection. This should enhance understanding of individual roles and responsibilities in relation to this area of work among key individuals with responsibility for child protection. However, in terms of documenting in case records and report writing community nurses should have clear guidelines during their initial training and delivered in a uni-professional setting to ensure that their specific input in this area is recognised and supported. Regular updating is also an important aspect of ensuring practitioners are familiarised with new information, legal aspects and guidelines pertaining to child protection.

Community nurses often express concern relating to documenting negative observations about child protection issues and sharing these with parents. There is clearly a need for specific training and support in this area for nurses to feel more confident in confronting parents about matters of

concern in a constructive and sensitive manner. Nurses must receive regular clinical supervision to allow them to reflect on practice, receive informed objective advice and address areas of concern in a safe environment.
Presently there is no regional standard for child protection documentation guidelines. This is also true of storage, location and duration of storage for child protection files. We therefore recommend the standardisation of child protection guidelines and documentation at regional level. This could be co-ordinated through R.U.A.G. (Regional Users Advisory Group), which is responsible for advising on documentation.

1.2 Professional Judgement

Professional judgement is something that all health visitors and community nurses have to use regularly in the course of their work. However it must be backed by appropriate **training**, regular **updating** of knowledge and skills and **clinical supervision**. The designated Child Protection Nurse Specialist should carry out clinical supervision on a regular basis, either in a group setting or on an individual basis. However, the maintenance of confidentiality is important if cases are being discussed in peer group supervision sessions.
Audit should be an integral part all health service provision and could enhance record keeping and ultimately improve services in this area if it is carried out in a 'no blame' culture.
There should also be a designated **Child Protection Nurse Specialist** based in each Community and Acute Trust to offer advice, support and ongoing training on child protection issues to nurses and health visitors.

1.3 Assessment and analysis of information

Regional protocols should be implemented in relation to standardising the use of the Multidisciplinary Framework Assessment Document in child protection. This would help reduce ambiguities in relation to roles and responsibilities for health professionals engaged in this area of work. Currently there appears to be wide variations in the way it is used within Trusts. It appears that in some Trusts this assessment tool is used effectively with comprehensive input requested and given from members of the core group dealing with a particular child protection case. Conversely, in other Trusts there is minimal input from professionals other than social workers. This may be due to a very narrow view by some social services personnel that child protection is the sole responsibility of social workers.

Guidelines should be regularly reviewed and updated in tandem with changes in legislation and lessons learnt from child protection enquiries. This should be the remit of those professionals from health visiting, social services and users who have a specific role in child protection and could be drawn from a sub-group of the Area Child Protection Committee (ACPC).

2 Communication

Communication in relation to child protection has often been fraught with difficulties. Lack of communication amongst professional has often been cited as a contributory factor in past child protection inquiries.

Undoubtedly this situation is beginning to change but as yet there is no room for complacency.

Health visitors and nurses often complain about the lack of notice given to them about attendance at child protection meetings, court requests for reports or court attendance as witnesses. There also appears to be a lack of clarity about who is responsible for notifying nursing and health visiting staff when a decision is made requiring them to be present in court or provide a witness statement. Central Services Agency should take lead responsibility for notifying the relevant Child Protection Nurse Specialist and or relevant community nurse manager in the Trust concerned if community nurses are required to input to the legal arena. This would ensure that effective communication systems are in place with the ultimate aim of improving outcomes for children within the child protection process.

The designated Child Protection Nurse Specialist should also sit on the ACPC in each Board to ensure that nursing is fully represented. This should serve to ensure effective communication in both directions and improve partnership working.

GPs are often missing from child protection proceedings. Again it may reflect the past perception of the narrow role that health professionals were expected to play in this area. However, new legislation rightly puts a stronger emphasis on the broader responsibility of all those health and social service professionals who work with families to play their part. However, this situation will not improve significantly until health professionals/GP's are given ownership of this process and are equally represented in decision-making in child protection at strategic level.

2 Linkages

Surestart schemes will hopefully play a part in improving the life chances of children in disadvantaged areas and may help reduce child abuse and neglect. However, these schemes are limited at the present time to 23 and are mostly confined to urban areas. Children of families living in rural areas where few of these schemes exist are often further disadvantaged because of poor transport infrastructures making access to services difficult.

There is clearly a need to review current service provision in terms of health visiting and school nurse services. In the present system the emphasis has been on counting contacts as opposed to a needs led service approach. The ways in which services have been organised have not always supported nurses and health visitors to work flexibly to tackle local health problems or encouraged them to work in partnership with others in teams to address the causes of ill health.

The 'Investing for Health' public health document highlights the need for a partnership approach and joined up working with a wide range of stakeholders to improve the population's health. Health visitors and school nurses have a key role in contributing to this process.

Currently parenting programmes are run in most Trusts by health visitors for new parents but there is a need for coordination of this type of service to avoid duplication. It is important to work with others including local parents, community groups and other statutory agencies to ensure that that these courses are acceptable to parents. They should also be evidenced based and accessible to all parents who need them.

Parents suffering from mental health problems require the skills and expertise from a range of disciplines in assessing effective parenting. GP's and health visitors have a key role in supporting parents with mental health problems and need to be fully involved in assessment and case planning in child protection cases.

The ad hoc nature of other services provided by health visitors that are important in reducing child abuse including behaviour clinics and postnatal depression intervention should be governed by regional guidelines to ensure a standard approach.

Health visitors and school nurses must not only work with individuals and families but also with communities. Their knowledge of local needs based on their health needs assessments and community profiles can contribute to the Local Health and Wellbeing Improvement Plans in the new Local Health and Social Care Groups. These plans will form the basis for improving

health and targeting services in which community nurses and health visitors will play an integral part. However, they will need support, leadership and additional resources to make this transition.

Currently the school nursing service here is grossly underfunded. Although some enthusiastic school nurses are involved in innovative practice most of there efforts are currently concentrated on immunisation clinics and screening programmes due to large caseloads and inadequate training opportunities. In other parts of the United Kingdom school nurses are involved in successful programmes to reduce teenage pregnancies, alcohol/drugs programmes, promotion of healthy eating, involvement with 'looked after' children and drop in health clinics for teenagers. A high teenage pregnancy rate, psychological difficulties that may be exacerbated by the 'Troubles' and alcohol and illegal substance abuse at an early age are just some of the problems that our young teenagers are exposed to in Northern Ireland. There is a clear need for school nurses to be recognised for the potential contribution they can make in partnership with others to making a difference in these areas and ultimately improve the life chance of children and young adults here.

3 Workforces Issues

If the health service is to play an active role in partnership with others in earlier identification and intervention to support children in need the health visiting and school health service needs to be strengthened.

In recent years the demand in terms of the higher level of health visiting and school nursing intervention required by families of children in need has continued to grow. In tandem with this extra pressure in terms of clinical input is the burgeoning of activity related to comprehensive assessments, report writing and attendance at case planning, looked after reviews, case confernce meetings and court attendances.

5 Resources

The child welfare and family support component of the work of health visitors and school nurses has increased significantly since the introduction of the Children NI Order. Whilst this work continues to escalate it has not been resourced through Children Order funding. The enhancement of the role of the health visitor outlined in the policy document " Supporting Families" has not been translated into policy action in Northern Ireland. These evidence based policy developments are essential if the aspiration of

"Co-operating to Safeguard Children " document that emphasises the shared responsibilities of services, professionals, and the wider community in safeguarding children and promoting their welfare is to be realised.
Resources need to be ring fenced for the early preventative work and family support that can be provided by health visitors, school nurses, midwives and other non-stigmatising services in the community.
The Multi-Disciplinary Assessment Framework Document should be standardised throughout Northern Ireland. Health and social services professionals frequently assess similar aspects in child protection cases including parenting abilities, child development and the need for social support. Utilising this framework could enhance understanding of roles, provide more accurate statistics of thresholds of need, promote better working arrangements and avoid duplication.

6 Lessons Learnt

More cooperation is necessary between ACPC's in sharing information in relation to previous child protection cases where mistakes have been made in order to help prevent similar events recurring. Poor communication between professionals involved and inadequate record keeping are just some of the problems that tend to re-appear in the various case inquiries that involve child death or serious injury. However the rhetoric around better communication and cooperation must now be backed with clear policies at regional level and adequate funding to make the business of safeguarding children a priority for all.

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August 2002