ATTACHMENT E

Report to Joint Health and Social Care Board - 31 July 2003

Subject: Aggregated Audit Position of Agencies in Milton Keynes in respect of the Victoria Climbie Inquiry

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Summary:

This report outlines the audit processes undergone by the relevant agencies as well as the key areas for action identified by each.

Consultation Process:

It has not been necessary to consult directly with the relevant agencies in relation to the writing of this report, as the appropriate consultation has take place within agencies as part of the process of completing the audit reports.

Recommendations:

That the Board notes and agrees the current audit position and the proposed actions of the agencies concerned.

Background

The report of the inquiry into the death of Victoria Climbie was published on 28 January 2003. There were 108 recommendations broken down into the following categories:

General recommendations – relating to proposed structures for national and local arrangements for accountability in respect of services for children and families.

Social care recommendations – relating to issues of good practice regarding how individual cases are managed and monitored.

Healthcare recommendations – largely relating to health professionals' role in the diagnosis of deliberate harm and to inter-agency communication in such circumstances.

Police recommendations – covering good practice regarding the role of the police in safeguarding children and the priority this issue should receive in policing plans.

In addition, Lord Laming indicated against each recommendation whether they should be implemented within three months, within six months or within two years.

The Audit Process

Subsequently a number of audit tools were issued, although the questions posed did not always exactly mirror the recommendations of the Inquiry.

The Department of Health Social Services Inspectorate (SSI) issued a self- assessment tool covering the social care recommendations, which had to be returned by 30^{t}April 2003. The results of this audit were evaluated and responded to by the SSI.

Commission for Health Improvement (CHI) Audits were completed by the Acute Trust, The PCT and NHS Direct by 28 April 2003. General feedback in relation to this process is still awaited.

The Police are preparing a Thames Valley wide response, to address the relevant recommendations.

The government is due to respond to the general recommendations of the Inquiry report in an annex to the Green Paper on Prevention, which is now expected in September 2003.

Children's Services Audit

The audit tool was divided into seven standards. At the end of each standard, councils were asked to assign an overall rating to the service delivered under that standard. The available ratings being between 'serious concerns' and 'very effective.'

The standards and overall ratings assigned through this self assessment were as follows:

- Referral: very effective
- Assessment: satisfactory
- Allocation, service provision and closure**:** satisfactory
- Guidance: satisfactory
- Training and development: very effective
- Organisation and management: satisfactory
- Governance: satisfactory

As a result of the audit a number of tasks were identified that required completion these included:

Further refinement of procedural guidance, due to be completed by the end of July 2003.

The role of the Hospital Social Work Team in respect of child protection issues. The timescale for the resolution of this issue is the end of July 2003.

Audit of compliance with the induction process. To be undertaken by October 2003.

More systematic contact for senior managers and councillors, with frontline services. Following further discussions a system will be put in place before the end of October 2003.

The SSI evaluation of the self-audit has now been completed. This evaluation awarded the maximum rating to Milton Keynes on four of the seven standards, and one less than the maximum on the other three. It concluded that Children's Services “were serving most children well and had excellent capacity for improvement”.

The CHI Audits

These audits linked eleven audit statements with the recommendations of the Inquiry report. Ratings were made against two scales:

- To what extent is this statement met for your organisation?
  With ratings ranging from: ‘scarcely if at all’ through to ‘fully’
- How much influence do you have to improve this situation?

Ratings here were between ‘none’ and ‘full’

The Acute Trust

The Trust achieved a self rating of ‘substantially’ or better on 5 statements in relation to the first scale and ‘strong’ or better on 8 statements in relation to the second scale.

Key areas for action 1) incorporated improving monitoring and accountability for child protection issues by: having a designated executive director with responsibility for child protection, annual feedback to the Clinical Governance Committee as well as ad hoc reports on issues such as Part 8 Reviews. 2) To strengthen the role of the Designated Nurse, the Named Nurse and the Named Midwife by developing a role specification, meeting training needs and improving support networks. 3) To develop and implement a Trust training strategy for child protection which complements the work of the ACPC.

The PCT

The PCT achieved a self rating of ‘substantially’ or better on 9 statements in relation to the first scale and ‘strong’ or better on all 11 statements in relation to the second scale.

Key areas incorporated 1) strengthening monitoring/audit process. Ensuring clinical governance procedures are strengthened. 2) Develop a training strategy. 3) Develop stronger inter-agency working.

NHS Direct

Key areas incorporated 1) future arrangements for child protection to increase capacity to influence strategic direction of children and young peoples issues within all areas covered by NHS Direct at TVN – appointment of a lead nurse to facilitate this. 2) Increase information sharing to ensure that all relevant agencies have access to pertinent information. 3) User Involvement, staff training.

Thames Valley Police Force

TVP set up a dedicated project to ensure implementation of the relevant Inquiry recommendations. In addition the force is reviewing how it responds to child protection concerns raised by all staff. The structure and remit of Child Protection and Sexual Crime Units is also to be reviewed to ensure that the best service is provided to child victims.

An action plan has been submitted in relation to the three- month recommendations which will be implemented by the end of July 2003 and these are likely to be externally audited.

The following areas are being considered: management of referrals, auditing and monitoring systems, use of police protection orders, safeguarding children as everyone's business, domestic violence and training.

Conclusions

It is clear that all relevant agencies have given appropriate consideration to the Inquiry recommendations and although a generally positive picture has emerged there are specific issues, which require attention. These have been identified and in some instances timescales have been agreed for completion. The Board may whish to consider further up date reports in respect of this issue in order to chart further progress.

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