Community Pracrtitioners' and Health Visitors' Association Response

Every Child Matters: Children's Green Paper

The Community Practitioners' and Health Visitors' Association welcomes the opportunity to comment on the Children's' Green Paper. The CPHVA is the UK professional body that represents registered nurses and health visitors who work in a primary or community health setting. The CPHVA is an autonomous section of Amicus trade union. With over 19,000 members, it is the third largest professional union and is the only one with public health as its foundation.

The CPHVA views the Green Paper as an innovative and far reaching document as a significant step in the provision of services for children, young people and their families. In particular we welcome the appointment of a Commissioner for Children; the move to integrated information systems across agencies and the necessary legislative changes required to make this happen; the emphasis on multi-agency working; we also look forward to contributing to the review of health visiting and school nursing that is to be undertaken by the Chief Nursing Officer.

In relation to the Children's rights Commissioner for England the CPHVA fully supports CREA's proposals on the powers and duties, which should include;

- Independent of government
- Promotes full respect on the Convention of the Rights of the Child
- Promotes understanding and respect for children and young people and their views
- Can improve advice, advocacy and complaints procedures
- Can influence law and policy
- Has the powers of investigation and take legal action

The CPHVA however, is concerned about the low prominence given to health. We would like to see equal status between health, education and social services. This is particular evident in the lack of attention given to the early years (pre-school). The universality of the health visiting service is vital for the early identification of problems, in addition to preventative programmes.

We were also interested to see that Children's Trusts are now a given, as currently there are a number of pilots around the country that have not been evaluated. This model will have implications for health visitors and school nurses, the vast majority of whom are our members.

The CPHVA finds it very disappointing that no real attention has been given to private fostering. The proposals for producing the Green Paper were reported to be as a result of Lord Laming's enquiry into the tragic death of Victoria Climbie. One

important factor in her case was that she was part of a private fostering arrangement, which at the time, and is still the case, not regulated in any way.

Chapter 2

The CPHVA has the concerns that the main emphasis is on GP practices and that funding for development is concentrated through local authorities. There is no recognition that the health visiting service provides in the main initial access and that child health clinics are a principle focus and accessed more frequently than GP surgeries. There is also no mention of the prevention and public health roles of health visitors, school nurses and other community nurses.

How can we improve support for unaccompanied asylum-seeking children, building on the work of the Children's Panel?

- More availability of interpreters who have had at least some basic training in child care/development and cultural sensitivity.
- Work in partnership with community leaders from ethnic minority groups that are more established to co-ordinate exchange of information/advice and provide mentoring and support to newly arrived asylum seekers. Those families who are longer established might be in a better position to offer suitable temporary fostering/placement arrangements for children who are unlikely to have English as their first language.
- Need for improved communication between Social Services, Health, Housing and Education to ensure that all of these areas are addressed and that children do not slip through the safety net. Those PCT's who have significant numbers of asylum seekers should appoint a Liaison School Nurse/Health visitor to co-ordinate health services in tandem with social services, education and housing.
- Protocols should be agreed between all the stakeholders so that there are clear lines of accountability and responsibility for all of the agencies involved.

The proposal to improve the identification of children at risk and build on joint working between statutory agencies is commendable but the proposal failed to outline a health involvement when assessing these children although it was mentioned that some of these children were in poor health!

How can we ensure that serious welfare concerns are appropriately dealt with alongside criminal proceedings?

- The CPHVA feels very strongly about the proposal to remove the restriction, which prevents children of 14 years being held in juvenile custody institutions

along side 15 – 18 year olds. Younger offenders should be held in smaller institutions close to home.

- We would also urge that a health worker is attached to each Local Authority Young Offenders Team in order to facilitate a full health assessment at the first point of contact for these young people who potentially amongst the most vulnerable and deprived in our society.
- Child assessment referrals should always be undertaken to identify serious welfare concerns when criminal proceedings are going ahead.
- Provide support packages for parents/carers to address some of the contributory factors such as substance misuse, behavioural difficulties, and poor housing and financial difficulties. These packages could include:
  - Parenting classes that address behavioural issues
  - Alcohol and substance misuse counselling for parents and children
  - Family therapy through CAMH services
  - Youth service support
  - Education welfare service support
  - Housing needs assessment.

How can we encourage clusters of schools to work together around extended schools?

- Building links between secondary and primary schools e.g. through joint meetings of governors.
- Need for a co-ordinator to be appointed to work within clearly defined strategic aims. Such a role could include identifying what the community need and would benefit from of schools as a community facility. Monitoring activity to ensure it meets local needs. Also marketing of schools' strengths.
- Incentives need to be made available to encourage schools to co-operate - funding could be dependent/linked to co-operating with extended school co-ordinator
- Community and user (pupils) involvement is key to ownership of this process
- Should be designated teacher, school nurse and student representative in each school to link in with extended schools co-ordinator.
- There should be access to school nurses in extended schools throughout the school year. Also the provision of programmes during the school holiday period covering such issues as raising self esteem, anger management, how to handle your parents? Etc.

Chapter 3

How can good quality decision-making by social services in relation to achieving permanence for the children for whom they are responsible best be achieved?

Good communication is essential between social services and the various stakeholders involved with the care of the child including, health professionals, guardian *at litem*, foster carers and the child' biological parents to determine the best possible outcome for the child. The child's views should also be taken into account if old enough to express a preference. In addition there should be independent visitor / mentoring schemes for young people, mentoring scheme for foster carers, and mandatory training on 'parenting'.

Building on choice protects, what more can we do to recruit and retain more foster carers who are able to meet the needs of looked after children?

There is popular perception that foster carers are middle class 'do gooders' who engage in this activity as a charitable endeavour. However, if fostering was perceived as more of a 'proper job' with mandatory training on child care issues, better accountability, support/supervision and appropriate remuneration it may appeal to a broader range of the population. There is also a need to pay a retaining fee if there are periods that the services of foster carers are not required to provide some form of economic stability.
Currently, professionals who already have experience in working with children e.g. teachers and nurses, tend to take early retirement and this may be an appropriate pool to target as potential foster carers.
All newly registering child minders should be sent information on becoming a foster carer.

How can local authorities, working with the voluntary, community and private sectors; develop a range of specialist parenting support services?

Local authorities need to carry out an audit of current need and existing service provision within their localities to comprise:

- Establish the extent and range of specialist parenting support needs within the locality
- Establish a data base of existing parenting support services
- determine the accessibility and equity of distribution of these services for the population to be served
- assess the cost-effectiveness and efficacy of these services
- set standards/protocols for an effective range of suitable parenting support services

- Commission as appropriate those services which meet the specific requirements set within the defined standards
- Evaluate on a regular basis those services commissioned to establish their continued effectiveness.

Encourage Adult Education Centres to offer free parenting programmes using specialist input e.g. CAMHS, health visitors. Provision could be at local schools and nurseries to ensure accessibility.

Having one central parenting forum in each area (could link with Children Trusts) to ensure a co-ordinated delivery of services and targeted to areas of greatest need.

Offer more financial support to identified volunteer groups, placing them under 'existing wings' e.g. health; it could also provide a resource to allocate to those with identified need.

The 'Sure Start' model also offers a good framework – but needs to be mainstreamed.

Working with local authorities and other existing providers what steps should the Government take to make home services more widely available?

Research has demonstrated the effectiveness of intensive home visiting programmes to parents of young children in the United States. The First Parent Programme and the Community Mothers Programme here in the UK have also been found to be effective. However, further research into the effectiveness of these programmes needs to be undertaken before they could be rolled out nation-wide. There is also a resource implication involved in providing this type of service. More health visitors than are currently employed would be needed to carry out intensive home visiting. Lay visitors e.g. community mothers also need training and continuous support, to be able to provide the necessary support to mothers. School nurse could also provide a very useful home visiting service to families of vulnerable children. However, the ratio of school nurses per head of the school age population is very low and would therefore need to be substantially increased in order to provide this service. Other services like Newpin and Homestart provide a very useful support service for parents but are often dependant on short term funding and are not widely available to all families in need.
Surestart is also key to providing targeted support to vulnerable families, although not yet fully evaluated. There are also concerns that Sure Start is not universally available. There are many areas with pockets of deprivation or 'less well off', which do not qualify for Sure Start funding. This creates an inequitable service.

We would urge that existing services be adequately funded so that they can be extended / improved e.g. health visiting service, rather than constantly funding new initiatives.

Voluntary home visiting services are very valuable but there are issues around public protection, accountability and supervision. Close working relationships with regulated professionals is crucial.

What further action could be taken to extend the use of direct payments by families with disabled children?

Having one lead worker for each family whom can assist with access issues. More guidance in how to interview candidates and handle difficulties related to employing carers directly could help to build confidence. This could be achieved by issuing a booklet containing employment guidance and/or providing a short training course on the subject for families with disabled children. Local libraries or schools could provide a suitable setting for such courses. In addition a local website of resources available could be established.

There is also a need to ensure that all written information is more readable and translated into other languages.

What more could be done to improve services for children and families of offenders?

Improve communication between prison family liaison officer, social and youth services to support and help finance regular visiting for children and families of offenders. Ensuring family friendly environment for visits – children's areas – establishment of Prison Visitors Centres with access to health advice.

Youth service/education could endeavour to provide a designated worker to act as 'role model' or mentor for children whose parent is in prison.

Establishment of a 'discharge planning programme' related to the age of child / children and the family needs / circumstances. Including follow up support around parenting / relationships.

Chapter 4

Health seems somewhat divorced from the proccess for protection. Currently health visiting and school nursing are the most active services working alongside social services.

The CPHVA would like to stress that we feel the clear missing link in the package relating to Early Intervention and Effective protection is removal of the defence of "reasonable chastisement" to fulfil children's human rights and to give children equal protection from assault.

What currently gets in the way of effective information sharing, and how can we remove the barriers?

Lack of an effective information system that allows appropriate access to patient records by professionals from health, social services and other agencies. Legislative barriers as well as organisational cultures.
Poor access to ICT equipment and training for health and social services professionals. Lack of multidisciplinary training for health and social services staff to improve understanding of roles and responsibilities. Lack of clear unambiguous protocols for assessing and managing risk that are jointly agreed by health and social services staff and which need to be disseminated to frontline staff.

What should be the threshold and triggers for sharing information about a child?

It should always be in the best interest of the child to share information. For instance, if the child is deemed to be a 'child in need' for whatever reason following an agreed risk assessment then it may be in the interest of the child to share information about him with education, health and social care professionals and other agencies as appropriate.

We would suggest the introduction of some form of 'flagging system' where say three or more agencies are involved then the sharing of information should be sought.

A&E attendance and paediatric admissions should be routinely shared with health visitors and school nurses.

What are the circumstances (in addition to child protection and youth offending) under which information about a child could or must be shared without the consent of the child or their carers?

Domestic violence, also consider extreme animal cruelty, as evidence shows there are links with child abuse, chronic debilitating ill health, substance misuse, alcoholism and serious mental health disorders in parents or carers could place a child at risk. Any agency in possession of this information should pass it on to those other professionals on a need to know basis to help ensure that appropriate support is put in place to alleviate any detrimental effects on the child.

Should information on parents and carers, such as domestic violence, imprisonment, mental health or drug problems, be shared?

We believe that information should be shared if a child / children may be affected or at risk. Or where the Human Rights of another may be affected. This then put a

question mark on sharing information for imprisonment, unless it was due to a violent crime. Any decision to share information must be made within clear protocols.

How can we ensure that no children slip through the system?

Having one record that follows the child in addition to a unique identifying number.

Effective tracking systems for newly arrived immigrants should be formalised – immigrant officials should have a standardised protocol for informing health, housing, education and social services particularly of immigrant children under the age of 16 years. Local authority housing associations and private landlords should be obligated to inform social services of new tenants who have young children.

In fact we believe that there should be several tracking systems, interlinked. The school age child often slips through the net. Foe example, if all school age children were allocated a healthy visitor via the GP, then the health visitor could notify the school nurse for a school age child, or retain the child if under school age.

Agencies should be able to challenge family relationships to properly establish parental responsibility. For example when a child registers with a school often a different name between the child and carer is not questioned.

Should a unique identifying number be used?

Yes - a unique identifying number which is shared by hospital, child health, social services and GP records could be used for children who are assessed to be at risk of harm as defined by an agreed assessment framework. We would suggest the NHS number.

Multidisciplinary teams:

What are the barriers to developing multi-disciplinary teams further in a range of settings?

- Lack of clear understanding of role boundaries, levels of accountability and responsibility between health and social services staff.
- Professional protectionism about ‘ownership’ of particular cases/knowledge.
- Fear of breaching patient confidentiality. Perceived differences in confidentiality.
- A range of IM&T systems.
- Time constraints.

How can we ensure multi-disciplinary teams have greater leverage over mainstream and specialist services?

- Professionals in a multi-diciplinary teams should use a common assessment framework which would ensure that identified need is universally agreed and therefore professionals within that team should have equal access to refer and access other specialist services.
- Need for a bottom up approach with a shared vision.
- Need to increase links between acute and community services.
- Community nurse / liaison working directly in paediatric wards and A/E departments – someone who is able to have a holistic view of the child, family and community organisations.

Chapter 5

How can we encourage better integration of funding for support services for children and young people?

- By the various agencies using a common assessment framework, a better picture of need can be assessed, thus allowing individual agencies to assign funds for children's services as appropriate.
- Funding has to be in one place and ringfenced so that joint goals are formulated.
- Existing services should be used rather than creation of additional specialist and separate services.

Should all authorities and other relevant local agencies have a duty to promote the wellbeing of children?

Yes – children and their families are an integral part of society and cannot be divorced from mainstream policy of any authority, which inevitably impacts on children's lives.

How best can young people are involved in local decision making and should the Government, for example, establish minimum standards for this?

Young people could get involved in decision-making by having representation on the policy making bodies of a range of services including; Education, Health, Social Service, Connexions and Youth Service. The young people's representatives should have a forum where they are supported in capacity building and be able to link directly to the Director of Children's Services and the Children's Commissioner. In addition young people can be involved through school councils and youth services. It is essential to ensure a broad mix with different ethnic and cultural representation.

Should Children and Young People's Strategic Partnerships and Local Safeguarding Boards be statutory, and what should their powers and duties be?

The Local Safeguarding Children's Boards should have statutory powers to give them the authority to make changes as necessary rather than just making recommendations or issuing guidelines that are often ignored. However, Boards need to be representative of the services that are provided in order to ensure that any one professional grouping do not impose their perception of need and how it should be met on other stakeholders.

How can we develop, enhance and encourage the Children's Trust model?

The CPHVA is surprised to see the Children's Trust model as a given when currently there a number of pilots around the country which have not been evaluated.

- Multidisciplinary training at different levels is necessary to improve understanding of roles and responsibilities.
- Co-location of key services such as health, education and social services can help foster better working arrangements and improve relationships.
- Utilising a common assessment framework is important in being able to standardise need assessment and resource allocation.
- A whole systems approach could help facilitate this process supported by an appropriate change management regime to help professionals make the necessary transition to this way of working.
- Inclusion of representatives from housing and police service, important that all agencies are involved in the planning stage with strong links in implementation phase.

What services should be required to form part of Children's Trusts, and what are the risks involved in involving more services – for instance, aligning Connexions geographical structures with Children's Trust?

- Potentially any service that is working for children and young people.
- Need to be small manageable geographical areas with similar needs.

How can inspections be integrated better?

- Multi-disciplinary team with expertise in each of the areas to be inspected should draw up standards based on best practice and agreed at regional level. The multidisciplinary inspectorate team carrying out the inspection could then operate a rating system, make recommendations for improvement as necessary and impose penalties if these are not carried out in a specified period of time. Agencies will need to make clear what if any extra resources (human resources,

buildings, training ICT and equipment) are needed to ensure that they are able to meet the necessary standards set.

Chapter 6

What are the priorities that the workforce reform strategy should tackle to improve recruitment, retention and incentives for those working with children?

- targeting a wider age entry to include mothers returning to the workforce
- supporting workers already in childcare either in paid or voluntary work through training bursaries and informal courses to move horizontally and vertically within a developmental framework to increase career choices/flexibility
- rewards both monetary and by way of extra leave for long service
- more emphasis on good leadership in all areas of childcare services
- better dissemination and rewarding of good practice
- extra payments linked to areas with high vacancy rates to encourage recruitment
- high quality supervision for all staff working in childcare

Should all those working with children share a common core of skills and knowledge?

Yes – this would help to; increase understanding of roles and responsibilities, standardise knowledge and skills, reduce duplication of some services and improve relationships between the various professionals working in childcare. Common core skill could include, child development, effects of abuse and neglect, parenting, engaging and communicating with children. In addition all staff working with children should have basic knowledge of child psychology.

Should there be a common qualification structure for all those in key roles working with children? If so, which roles should it cover?

The range of staff working with children and families including health visitors, school nurses, social workers, youth workers, and Connexions staff have common learning needs in relation to areas like child development, family dynamics, child protection, domestic violence, mental health and substance and alcohol misuse. There is no reason why these areas could not be covered within a number of shared modules in courses undertaken by these professionals. Specialist qualifications should build on the common qualification, as you cannot have one person expert in all things.