Response to Green Paper Every Child Matters

SIG Health Informatics Welcome this document and We welcome its vision focusing on prevention, the voice of the child and a Commissioner for Children. Also welcome its views on clearer accountability and concentration work force issue- the critical success factor for this initiative will be having adequate staff on the ground. This paper we believe cannot be looked at in Isolation, and Informatics terms there will have to be a clear strategic vision across all agencies to make this happen. Furthermore national developments with our own professional silos continue e.g. ICRS for Social Services and the NHS Care Record through NPfIT. Integration and common standards will be required

- **the Green Paper focus on four main areas:**
- **Supporting parents and carers**;
- **Early intervention and effective protection;**
- **Accountability and integration locally, regionally and nationally;**
- **Workforce reform.**

CPHVA see community practitioners, health visitors and nursery nurses as central
to delivering this goal. Already work and believe in early intervention and prevention- further investment and acknowledgement of CPHVA members roles existing already - part of the doc make it sound as if it's a new concept

CHAPTER ONE – The Challenge
Sets the policy challenge context and the need for:
Better prevention – The need to mainstream preventative approaches such as Sure Start and increase attention on the early years and the beginning of secondary school – identified as key transition points
Stronger focus on parenting and families – The need to focus more attention on the critical relationships between children and their families and on developing stable, loving relationships between children and their carers
Earlier intervention – The need to ensure children at risk are identified earlier through better information sharing
Improvements in accountability and integration – The need to ensure improved co-ordination across agencies and clearer accountabilities
Workforce reform – The need to increase the attraction of working with children, and improve training, skills and inter-professional relationships

CPHVA have a central and pivotal role in all of this . Evidence Based Practice

CHAPTER FOUR – Early Intervention and Effective Protection
This chapter focuses on:

Improving information sharing between agencies
Establishing a Common Assessment Framework
Identifying "Lead Professionals"
Integrating professionals through multi-disciplinary teams
Co-locating services
Ensuring effective child protection

Excellent =
Better and effective communication will be central to effective protection,
•Time scales to be realistic
•Clear road map to improved information sharing looking at
•Human Systems (understanding each other roles/responsibilities)
•Mutual Trust and Respect
•Joined Training for Children Services Staff
•Clear child focused training programme on understanding legal issues of
•confidentiality and privacy of both the CHILD and Third party information
•DPA98, Human Rights, Children's Act, European Convention, Consent Issues
•Electronic Systems - user lead focus and Design
•Co location - need defined who education/social work and joint Resourcing plan
•Good strategy will define Costs/Funding and Time scales for Delivery
•Currently children Trust trying to deliver this agenda on current budget - not
•achievable

CHAPTER FOUR – Key Proposals & Facts [1]
Improving information sharing between agencies by:
Developing a local information hub in each local authority listing all children living in the area and basic details
including name, address, date of birth; school attended or if excluded/refused access; name of the child's doctor; whether known to agencies such as EWO, Social Service, Police or YOT and details of professional dealing with the case; and where known to more than one agency – name of lead professional
Taking forward developments around information sharing systems by:
Setting out the lessons from the IRT trailblazers by December 2003
Removing legal barriers to allow information sharing to happen at an earlier stage

Clearly legal issues and professional issues need explored. Currently the legal framework does not exist. See recent BMA
response to IRT projects, legal status of Trust. Most of the IRTs have failed because of the lack of focus on these issues at planning stage.

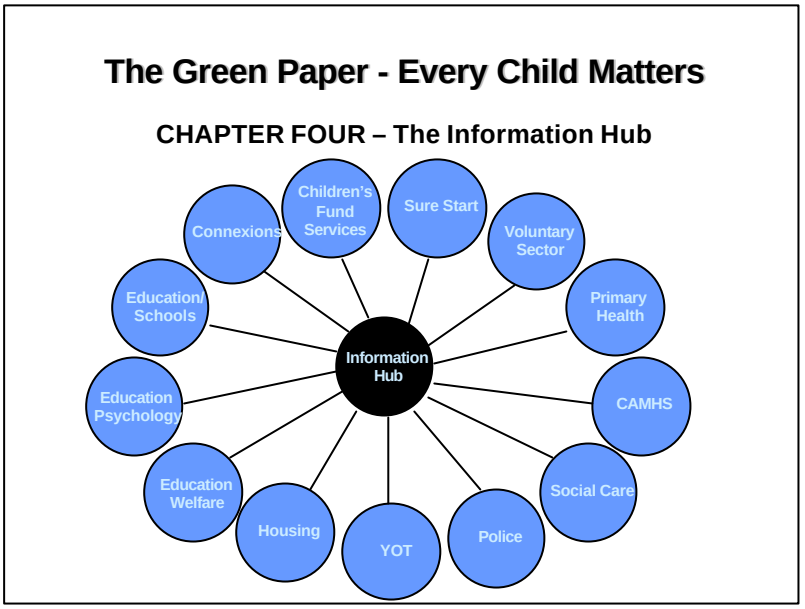
If Prince 2 our public sector project management had been used (The importance of standards), the RISKS , including levels of risks, would have been fully explored
and mitigating circumstances explored with the professional bodies at Feasibility study phase. CPHVA find it wholly unacceptable that there is clearly no evidence or involvement of the organisation looking at these risk. Potentially £10 million will be wasted, finding out issues that the organisation could have identified BEFORE project had been piloted.
Critical lesson must be learnt for future integration.
Involvement and strict Project Life Cyle/Management must be carried out .

CHAPTER FOUR – Key Proposals & Facts [2]
Improving information sharing [continued]:
Removing technical barriers to ensure systems are able to exchange information securely
Removing organisational boundaries to enable the changes proposed in Chapter 5, aimed at improving integration across services to take place in the context of information sharing
Removing professional and cultural barriers in recognition of the fact that technical solutions alone will not secure change

In addition, local authorities are expected to appoint an IRT project manager [or other named individual] and by autumn, to have carried out an audit of existing local service provision and practice, building on the work by the Connexions Customer Information System and the Integrated Children's System

Technical barrier - realistic development and scope required
Clear evidence of optional appraisal required. Time scales to be defined

Managing cultural change is organisation with different education, belief systems and philosophies will take time…Research highlights that this can take many years.. Training and education systems at higher education level has to be developed now - which organisation will deliver this agenda - through NHSU or new child focused organisation. Requires consideration - most work work with children but adults and wider society



Life times work
At present one organisation is unable to communicate - e.g. health . The NPfIT plans for England wide core functionality, test results, referral, outpatient booking and (cost £340 million over the next 3 year.)
This is anticipated to take until 2010 to deliver the whole agenda.
Phase 2 will include even social services ,
Have feasibility studies and time scales been explored to look at this hub
Where does the vision for a national hub lie and meantime how would Information move from hub to hub. In reality one of our main difficulties with children at risk is that they frequently move around, and will move between hub - how do we get 'out of area data'
This models is simplest , technology and not legal or clinically lead.
Furthermore it is not evidence based as this functionality has not been achieved any
where in the world.

CHAPTER FOUR – Key Proposals & Facts [3]
Development by March 2004 and introduction by September 2004, of a "Common Assessment Framework"
To enable core information to follow the child between services to reduce duplication, drawing on the current framework for the assessment of children in need and their families; Connexions Assessment, Planning, Implementation and Review System, YJB's Asset tool, the SEN code of practice and assessments by health visitors.
Identification of a "Lead Professional"
To co-ordinate service provision where a child is known to more than one specialist service and act as a "gatekeeper" for information sharing purposes

Timescales based on evidence . CPHVA suggest from evidence base that this goal
is unachievable - maybe 2006. Organisation and development issues require urgent
Attention and funding .

Lets look at similar models for single shared assessment for elderly in Scotland to be delivered on electronically by April 2001, most sites do not even have paper systems by 2004. Paper systems don't allow for interagency sharing
Lessons learnt

1. Culure
2. New ways of working
3. Key worker scheme introduction
4. Information Sharing Protocols legal interagency document -take ages!
5. Caseload issues SW average caseload 24, health visitor may have 300.
6. SW dealing with a specific group e.g. vulnerable child, disability team
7. Health visitor working with well population, prevention, nationally screening, chronic and acute illness, adult health, issues about distribution of work load.
8. Dependency on supplier DFES should develop and crown copyright national eGIF standards based tools

CHAPTER FOUR – Key Proposals & Facts [5]
Development of more effective protection
Although some steps have already been identified in the Government's response to the Victoria Climbie Inquiry Report, and the booklet, *What to do if you're worried a child is being abused'* the Green Paper identifies long-term barriers to implementing effective child protection procedures
Immediate steps identified include:
revising and shortening Children Act 1989 Regulations and Guidance;
auditing safeguarding children activity of local authorities with social services responsibilities, NHS bodies and police forces;
raising priority of safeguarding children among all relevant agencies/ organisations.

Audit fine but further funding required . Professional often working with limited resources, staff shortages, and under stress.

Resources required - e.g. number of staff required to deliver this agenda must be explored by Workforce planning. Current audit highlights failing of systems in delivery of care. Further audit needs to explore resource needed to deliver this care. Without this the working with children and families will remain a service unattractive to staff.

CHAPTER FOUR – Consultation questions [1]
In particular, views are invited on:
What currently gets in the way of effective information sharing, and how can we remove the barrier?
What should be the threshold and triggers for sharing information about a child?
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 parents?
Should information on parents and carers, such as domestic violence, imprisonment, mental health or drug problems, be shared

Look at the evidence - Culture (normal reaction) Trust - not understanding each other
Although all care providers each with different beliefs management structure
E.g. council to elected members and , NHS to wider England wide
NHS organisations
Technology wise inside an NHS wide security firewall,
Common terminology's, well structure codes of conduct and professional regulation, Caldicott etc . These remain embryonic in some of the
other disciplines
Language understanding different
Q2 legislation very clear, and Killick competencies cover age of consent - why ask the question. What is required is that DFES develop educate and train staff
on this in relation to DPA, HRA, privacy and European convention on rights of the child and Children's Act
Q3 Privacy Impact Assessment should be done to assess this issue - as been done by
the eCare National team in Scotland in relation to integration of child health information
Elaine.McKinney@scotland.gsi.gov.uk Legislation very clear. What about third party
information

CHAPTER FOUR – Consultation questions [2]
How can we ensure that no children slip through the system?
What issues might stand in the way of effective information transfer across local authority boundaries?
Should a unique identifying number be used?
Views are also invited on the proposals relating to multi-disciplinary teams:
What are the barriers to developing them further in a range of settings?
How can we ensure multi-disciplinary teams have greater leverage over mainstream and specialist services?

National identifier as crucial . This national number should be NHS number, universal service, and mandated for children under 19.

Community wide approach and awareness campaign to wider society on their duty
to protect and be responsible
Very difficult to prevent child falling through the net in the short term-
Need flags for missing children,
moved out of area

(see previous answers)

CHAPTER FIVE – Key Proposals & Facts [1]
Changes at local level - Key services for children should be integrated within a single organisational focus, facilitated by:
Appointment of a Director of Children's Services in all local authorities - accountable for education and social services and overseeing services for children delegated to the local authority by other services
Appointment of a lead council member for children to ensure greater accountability
In the long term, integration of key services under the Director of Children's Services as part of a preferred "Children's Trust" model [With a single planning and commissioning function, supported by pooled budgets and bringing together, as a minimum, education, children's social services, and community and acute health services]
Development of Local Safeguarding Children Boards as the statutory successors to Area Child Protection Committees

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Once legal issues sorted may be possible. In Scotland we are pretty far down the
line of pooled budget and joined commissioning for some services but what is this
organisation know as - currently can't even agree on common email format, grading structure (Agenda for Change), interagency post or nursing G grade or equivalent in SW- ??? Qualifications, skills, knowledge. This mapping does not exist. Currently Diploma level SW no further qualifications, on same level health visitors

CHAPTER FIVE – Key Proposals & Facts [3]
Changes at national level [continued]
introducing an integrated inspection framework and lead inspectorate for children's services [Ofsted taking the lead, with services assessed on how well they work together to meet overall objectives for children]
introducing an intervention and improvement mechanism to drive up performance everywhere, by establishing a network of pathfinder authorities, sharing effective practice, rewarding success and authorising local interventions, where appropriate

appointing a Children's Commissioner, with a duty to report to Parliament through the Secretary of State for Education and Skills and continuing to ensure the active involvement of children and young people in the development of policy and services

How will this work for health - we are managed by NHS standards and CHAI at present

Children Commissioner great- definition and model to be decided . Varies across Europe from celebrity lead/advocate , to politicians …..