NNDHP

National Network of Designated Healthcare Professionals for Children

The National Network of Designated Healthcare Professionals for Children (NNDHP)

Evidence for the Children's Wellbeing and Schools Bill (CWSB178).

The basis of why NNDHP are responding

1. The NNDHP membership is all NHS Designated Professionals (doctors and nurses) who work in the areas of children's safeguarding, looked after children (LAC) and child death overview panels (CDOP).

2. The network is the national voice of these subject matter experts and strategic leads. By virtue of it leadership responsibilities, the NNDHP advocates for all aspects of health as applied to children and as a challenge to partners in other national entities.

3. NNDHP's overarching aim is to reflect the paramount of children's needs in efforts to improve child safeguarding practice, and the overall health and wellbeing of children and looked after children, by recognising, respecting and advocating for children's rights under the terms of amongst other things, The United Nations Convention on the Rights of the Child (UNCRC, 1989), and the Children's Acts 1989 and 2004.

4. The NNDHP has consulted its members about the Children's Wellbeing and Schools Bill, collating and condensing views and responses. Concerns raised and the details of these national responses are presented below as an executive summary and in detail.

Executive Summary

5. NNDHP applaud the ambition and the policy direction outlined in 'Keeping Children Safe, Helping Families Thrive' and the way this is being taken forward so quickly through the Children's Wellbeing and School Bill. Some of the measures could start to improve children's lives almost immediately.

6. Safeguarding children from harm and abuse is a fundamental human responsibility, and is critical for the best health and well-being of all children. Health professionals fulfil a pivotal role in identifying children at risk of, or experiencing, harm and abuse, including identifying families who need support to avoid or stop such harm.

7. NNDHP consulted it membership by convening a virtual national meeting dedicated to the Children's Wellbeing and Schools Bill. The leading consensus was that the health contribution to the wellbeing and safety of children is not referred to or considered enough, either in either the policy document or the Bill.

8. This observation is part of what is perceived in the network as a more global failure to recognise of the importance of health to the experience of childhood, and how in the absence of good health, a child is unable to enjoy the full benefits and developmental opportunities childhood presents.
9. For example, as a relatively common occurrence, a child with poorly managed asthma, can not enjoy as good a quality or experience of education, growth, sport and relationships as their healthy peers; this has a negative effect on their overall physical, social and emotional health and wellbeing. This highly unsatisfactory outcome is almost always entirely remediable with modern therapy, but promoting this aspects of child welfare is not seen as a safeguarding priority.

10. This disappointing lack of focus in the Bill on the health needs of children is concerning; by ignoring child health in this fashion, health deficits remain unidentified until they come to the attention of safeguarding and child protection services by which time they commonly present as chronic, complex, and requiring more intense support from health providers and health teams.

11. These concerns substantiate the critical nature of the health interventions and safeguarding functions of public health nurses (health visitors and school nurses), in maximising and improving health and wellbeing outcomes for vulnerable children at risk of abuse and neglect. It is therefore critical that any legislative change, and associated statutory guidance and frameworks arising from this Bill, are underpinned by an explicit requirement for the commissioning of a robust and effective public health nursing workforce, including accountability for their unambiguous statutory safeguarding responsibilities.

12. Similarly, it is imperative that the new combined threshold/category of Family Help is informed by an expert understanding and analysis of the capability of all health teams; and specifically public health nursing teams who are the professionals most commonly involved with children and families at the proposed Family Help level of intervention.

13. Without a fully staffed public health nursing workforce, Family Help teams will be limited in their ability to meet statutory safeguarding responsibilities to identify and/or reduce the risk of harm and to meet their statutory public health functions including the delivery of the health child programme.. As expressed above, this will increase the need for intervention by statutory safeguarding and child protection services rather than reducing them.

14. Whilst NNDHP are particularly delighted to see the focus on family decision making and support for the expansion of kinship care, it is anticipated that a substantial barrier to the implementation of this plan will be the significant rise in demand for the statutory adult medical assessments.

Response to specific clauses in the Bill

Clause 2: Inclusion of education and childcare agencies in safeguarding arrangements

15. The NNDHP applaud the notion that home educated children have the same right to be safeguarded as those who attend school. The network also agree that parents who wish to home educate a child who is either subject to a safeguarding enquiry or has a child protection plan (CPP) in place, must first seek consent from the Local Authority. We would suggest that such a decision must include the consideration, by safeguarding health partners, of the health experience of such a child

16. However, the NNDHP seeks further clarity and assurance regarding children who have a Child in Need (CIN) plan in place and are home educated, and what Safeguarding measures will be in place for such children. The recent Childrens Commissioner Report regarding Death of Children in need (December 24), highlights the significant increases in mortality rate over the last decade for this cohort of children. It is the network view that the focus on increased Child Protection level concerns, has reduced the focus on children on the edge of child protection risk. The network urges that this identified risk for children on a Child in Need plan must also be addressed when home education is being considered by the parents.

17. Given plans to consolidate targeted early help and CIN into a single category for Family Help, is it likely that support and oversight of this group of children will fall further away from the oversight of statutory children's services, and more to the family health level of identified need and model of care. If so the expectations of health teams, specifically public health nurses and Primary Care teams, must be clearly spelled out given the Children's Commissioners' Report cited above.

Clause 3: multi-agency child protection teams

18. Clause 3 would require that the Local Authorities and safeguarding partners for an area establish one or more multi-agency child protection teams (MACPT), with the main purpose of supporting the local authority in delivering its child protection duties under section 47 of the Children Act 1989. It is envisaged that the MACPT will work alongside professionals operating at this level, reducing the need for onward referral. It is purported that the MACPT would ensure expert, multi-agency responses to child protection concerns, by addressing the current lack of joint working across agencies, which often leads to missed opportunities to protect children and families in a timely way.

19. NNDHP has noted that how the health professionals (including mental health) will be sourced and resourced to support the MACPT model has not been clarified. This is important because the health service is approaching the end of a prolonged period of transformation and organisational restructuring, which has been driven by the need for

cost improvement. This has commonly required staffing reductions. It is foreseen that the new arrangements in the Bill will require more health input (rightly so) but from a reduced workforce. It is the network perspective that this will be a major hindrance to achieving the positive outcomes that the Bill is designed to achieve.

20. That said, by improving the resource and operational model within local Multi-agency Safeguarding Hubs (MASH) services, achieving the aspiration inherent in this clause will be more realistic and sustainable. Such a shift in model would avoid the risk of a single point of failure, as Business Continuity will be supported by a model based on a well resourced team with a broad skill and expertise mix. NNDHP suggest such a tiered approach to MASH team structures and their functions, with representation from a wider range of professionals and that must include education.

21. Such an approach and model for MASH could also incorporate and address the aspiration to have an expert Child Protection (CP) Social Worker (SW) operating in a n advisory capacity at Section 47 level, supporting and maintaining oversight of the child and family. Structuring MASH with a novel to expert skill mix will help address the desire to develop a just and decisive child protection system, with health reinforcing the importance of assessment by a paediatrician as indicated.

22. The NNDHP also notes that the Bill refers to the benefits of delaying commencement of Clause 3 and its associated regulations until 2027, to enable "learning and evaluation" from the Families First for Children Pathfinders. The network view is that it is not clear how the new category of Family Help will align with new S17 duties and proposed multiagency lead professional decision making, detailed in Working Together To Safeguard Children 2023 (WTG 23). The particular concern is the demand for health professionals, specifically public health nursing teams.

23. Any further increase in the workload for the existing public health nursing workforce, will only drive a further reduction in overall health and wellbeing of vulnerable children; and will further increase both the need and demand for intervention by statutory safeguarding and child protection services.

Clause 4: Information-sharing and consistent identifiers

24. The NNDHP welcomes the introduction of a single unique identifier (SUI), most likely the NHS number. Without a doubt this is likely to enable more timely and effective responses and solutions across partner agencies, who will be able to feed information into a single place/platform.

25. At the same time the NNDHP urges that the experience of the introduction and implementation of the national Child Protection Information System (CP-IS) across health, is used to support the development of a SUI model and its functionality.

26. The NNDHP also believes that there is a need to consider how to disseminate information about the scope and use of a new platform, in order that staff are confident

in their information sharing bearing in mind that this will be yet another patient level information system for them to deal with.

Clause 5: Information: children in kinship care and their carers

27. The NNDHP is particularly appreciative of the expansion of the kinship care offer, supporting children and young people to remain together within family networks where it is safe to do so and where they already may feel safe and loved.

28. However, NNDHP are particularly concerned about what this means for health in relation to demand and capacity for adult medical assessments for prospective adoptive/foster/connected and other kinship carers.

29. This planned expansion is likely to include both primary and extended family members, and is in addition to the aspiration to recruit 9000 additional foster carers.

30. These medical assessments are not core business in the General Medical Services (GMS) contract for GPs, and are thus classed as private work. Therefore, there is no requirement for GPs to complete these medical assessments, with the current position being that almost all localities across England are experiencing increasing challenges to complete these assessments within statutory timescales.

31. This deficit results in delays to the completion of processes including court scheduling and thereby the capacity to safely place children with appropriate and approved carers as quickly as possible, and in line with the identified needs of children.

32. This is further compounded by the lack of a national tariff for payment of these adult fostering medical assessments (both initial and review), which results in unwarranted variation and a mixed model for commissioned provision, resulting in assessments not always being undertaken by the adult's own GP.

33. As a result of the escalating and significantly variable payment for these medicals, NNDHP recommends a national and standardised approach that renumerates fairly and consistently and will potentially avoid further deterioration of this position, at a point in time where it is now predictable that demand will inevitably increase through expanded kinship care.

Clause 8: Local offer for care leavers

34. NNDHP recognise that Care Leavers experience some of the greatest inequalities in England and that all statutory and non-statutory partners and agencies need to step up to help minimise or stop this.

35. The Bill's call for wider Corporate Parenting and the recognition of care leaver status as protected characteristic therefore is welcomed.

36. However, NNDHP is unclear what wider corporate parenting means for health, and urges further elaboration to inform current discussions and commissioning intentions for any care leaver offer.

37. NNDHP recommends consideration of robust transition arrangements across health and into Primary Care as children become adults, flagging care leaver status with the consent of the individual.

Clause 9: Accommodation of looked after children: regional co-operation arrangements

38. The requirement to establish Regional Care Co-operatives (RCCs) is ambitious, specifically in the context of the requirement to evidence compliance with a regional sufficiency duty.

39. Given the Local Authority leadership role in much of this transformation, NNDHP urges hat health joint commissioning responsibilities are made clear, and that arrangements will recognise and include all statutory partners in decision making about expansion and governance arrangements of the new care market.

Clause 10: Use of accommodation for depriving liberty

40. An area of concern for the NNDHP is the welcome but challenging review of the legal framework for the use of Accommodation for Deprivation of Liberty.

41. The NNDHP believes that greater scrutiny and regulation in relation to illegal placements risks increases to both the number and extent of delayed hospital discharges. It is critical that there are effective pathways for children who are medically fit for discharge and for whom there is no social care placement that is viable, but for whom remaining in the hospital environment will cause harm.

A final comment relates to the Bill's aspiration to introduce a system that is relentlessly focused on children and families, and a system that is underpinned by a national data technology taskforce.

NNDHP is concerned that the challenge for the use of existing provider, commissioner and NHSE datasets interface with new LA frameworks and datasets, given that many are only recently embedded and are siloed in respective services. NNDHP urges that the aspiration of joint health and social care information systems be vigorously pursued.

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