NSPCC
Cruelty to children must stop. FULL STOP.

NSPCC

Response to

Equity & Excellence for Children

Consultation

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Introduction

The National Society for the Prevention of Cruelty to Children (NSPCC) is the UK's leading charity specialising in child protection and the prevention of cruelty to children. The NSPCC aims to end cruelty to children in the UK over future generations. In pursuit of our vision we will:

- create and deliver services for children which are innovative, distinctive and demonstrate how to enhance child protection most effectively
- provide advice and support to ensure that every child is listened to and protected
- provide advice and support to adults and professionals concerned about a child and if necessary take action to protect the child
- work with organisations which work with children to ensure they effectively protect children and challenge those who do not
- campaign for changes to legislation, policy and practice to ensure they best protect children
- persuade everyone to take personal responsibility for preventing cruelty to children
- inform and educate the public to change attitudes and behaviours towards children
- use our statutory powers as necessary to protect children.

We welcome the invitation to engage with the topics outlined in *Achieving Equity & Excellence for Children*. Our focus in responding is on how and why safeguarding and child protection should form a key component of health service commissioning and providing.

1. **Are there examples of good local best practice from LInks or other groups or organisations in engaging with children, young people and their families?**

   No comment.

2. **How can HealthWatch England and the CQC best collect evidence from local HealthWatch on the issues facing children, young people and their families, and engage them in influencing the quality of those services?**

No comment.

3. **What might the NHS Commissioning Board need to consider when developing a plan for promoting and extending choice and how might it best include children and families?**

No comment.

4. **How might GP practices best demonstrate particular expertise and knowledge in caring for children and young people?**

The NSPCC considers that awareness of safeguarding and child protection should be a continuous thread running through clinical practice, such that child protection is included in NHS and General Practitioner contracts and linked to disciplinary procedures. As a minimum we consider the contractual obligations of General Practitioners (GPs) should be revised to include minimum expectations concerning the attainment and maintenance of training in safeguarding and child protection to a minimum level 2[1].

In the family context, it is not possible to separate risk to children from the problems of their parents or carers. There is a need for significant improvement in the co-ordination of adult and children's care services. The impact of parental mental ill health, substance and alcohol misuse and domestic violence are such that a minimum expectation concerning good practice in "flagging" links between parents and children and siblings would assist health professionals, particularly in a health system where individuals are less and less likely to present to the same doctor on each visit, perhaps *most* particularly where there are issues of abuse or neglect. As a minimum we consider GPs should be required to demonstrate to the Department of Health and / or inspectors the presence of robust electronic flagging systems linking parents and carers, children, siblings and significant others in a household.

Finally we consider the appointment of a Safeguarding Lead, preferably a role fulfilled by a General Practitioner with Special Interest (GPwSI) in child protection should be a clear requirement of good practice and preferably mandatory. Single practitioner surgeries should be expected to actively link to a cluster arrangement and a GP Educator[2] identified within commissioning clusters to co-ordinate child protection training and peer support. Such arrangements might be enforced through the GMC's revalidation process, thereby providing regular assurance that licensed doctors are up to date and fit to practice.

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[1] Royal College of Paediatrics & Child Health (2009) @ http://www.rcpch.ac.uk/Policy/Child-Protection/Child-Protection-Training. Retrieved 10 October 2010.

[2] Details of the Framework for GP Educators are available @ http://www.bma.org.uk/employmentandcontracts/doctors_performance/GPEdCompetencies.jsp retrieved 20th August 2010

5. **How can we best encourage and enable third parties including community groups, charities and the private sector to provide information or support to families?**

   The voluntary and community sector is well positioned to provide locality-based information and support to families, and indeed has done so for many years. It is a sector widely used and generally more welcomed by vulnerable groups than statutory sector agencies, but encouraging and enabling small third sector organisations to fulfil this function will require effective engagement and on-going investment in the development of an appropriate skill-set.

   Consideration should be given to harnessing the strengths of large voluntary sector organisations, such as the NSPCC, which are well known and largely trusted, to broker relationships within communities. The NSPCC's *Safe network*[3] and the *Child protection in Sport unit*[4], for example, are in the sector and by and large trusted by the sector, but they also benefit from an infrastructure that enables them to make government messages understandable to small and diverse organisations, collate the views of those organisations and communicate them to government.

   Models such as this might usefully be adapted but will require local health commissioners to be both more creative and more flexible in the way they work and use their resources.

   In the meantime, during the transition period to GP consortia, consideration should be given to commissioning pathfinder projects to establish best practice in encouraging and enabling community groups and charities to provide information or support to families. These should be commissioned by the NHS Commissioning Board and independently evaluated before wider rollout.

6. **We would welcome thoughts on appropriate outcome measures for children both for the NHS, as part of the NHS Outcomes Framework consultation, and in relation to public health for children, young people and families.**

   The competing pressures of the NHS are well understood, as is the fact that safeguarding and child protection, although crucial make up a tiny percentage of the services the NHS is expected to deliver. In this respect the Operating Framework for the NHS in England 2010-2011 is encouraging in that it states:

   "*Safeguarding children should be an integral part of all NHS organisations' governance and commissioning arrangements, and this should include a board-level focus and support*

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[3] http://www.safenetwork.org.uk/Pages/default.aspx

[4] http://www.nspcc.org.uk/inform/cpsu/cpsu_wda57648.html

for all frontline staff. NHS organisations should contribute to effective partnership working locally, in particular in relation to local safeguarding children boards. In addition, they should continue to monitor and embed the minimum arrangements set out by David Nicholson and build on this to improve services and outcomes for children, taking into account developments such as guidance on looked after children and safe recruitment".

(*The Operating Framework for the NHS in England 2010-2011, paragraph* 2.31)

Notwithstanding, there are few drivers in the current Outcomes Framework, and those which do exist relate principally to broad public health targets such as immunisations and dental health. It must be acknowledged that the Care Quality Commission (CQC) continues to engage in a programme of joint inspections (with OfSTED) of safeguarding and looked after children and while this is to be welcomed it is far from clear if or for how long it might be sustained. Nor does it provide robust assurance of the service that is actually being *provided,* focusing as it does on an inspection of the commissioning body and *"… chosen provider units …"* in the relatively limited context of board assurance, and staff skills and experience[5].

Furthermore the impact of further structural change (both within and without the NHS) being implemented during a period of financial constraint will contribute to potential instability in a system that is fundamentally about engagement with partner agencies (perhaps most particularly the local authority) and may not, therefore, be regarded as *'core'* business.

It is not possible, then, to overstate the need for constant vigilance in an area of work that is widely regarded as a low risk / high impact activity, meaning that the lens through which safeguarding and child protection is viewed tends to be magnified following an incident and allowed to recede again relatively quickly. If this pendulum effect is to be addressed, safeguarding and child protection need to become the focus of good practice and continuous improvement rather than crisis management. To achieve this it is necessary to ensure that there are some key drivers in place to stimulate commissioners and providers, to drive creative and committed work with partners and to inform the inspection process, with the aim that safeguarding and child protection activity will affect judgements of overall performance.

With this in mind, the NSPCC recommends that consideration be given to how the following might be developed for inclusion as indicators within the forthcoming Operating Framework and / or within any new performance framework that may accompany the forthcoming White Paper on public health. Outcome measures in these areas would, we consider, drive safeguarding in the NHS in its widest context; focus commissioners and

5 Care Quality Commission (2010). *Integrated inspections of safeguarding and looked after children services: Information for PCTs* @ http://www.cqc.org.uk/_db/_documents/20100506_final_PCT_Guide_v2.pdf and retrieved 7th October 2010

providers on the more specific needs of the child protection system and drive the partnership ethos that is so critical to robust delivery of these services.

Training

Commissioning consortia will need to provide assurance as to the extent to which they are enabling provider trusts to meet training requirements by, for example, demonstrating a reasonable and transparent budgetary commitment for 'back-fill' to release staff for initial and refresher training.

In addition to the mandatory requirement for Level 1 training for all staff (a requirement that should be retained), training requirements should include:

- A mandatory requirement for Level 2 (RCPCH, 2009) training for all staff with contact with children, young people and families, including General Practitioners, and
- A mandatory requirement for refresher training at 3-5 yearly intervals

Designated and named professionals

Designated professionals have most recently been moved into the commissioning arm of health services, in line with HM Government guidance in *Working Together to Safeguard Children, 2010.* It is not clear where these roles might sit in the new structural arrangements, but the need to maintain them is critical to leadership at strategic level and to expertise at operational level. Wherever these posts sit, commissioning consortia must be required to provide assurance that provider trusts are being enabled to fulfil their statutory requirements by demonstrating a reasonable and transparent budgetary commitment to the discharge of these roles.

The effectiveness of designated and named doctor and nurse posts might be assessed at provider level through consideration and scrutiny of:

- Employment contracts, to ensure child protection is an explicit element of the post with an appropriate number of clinical sessions to support it
- Time in post and continuity of service
- Experience and training.

Non-attendance

The Confidential Enquiries into Maternal and Child Health report *Why Children Die*[6] recommends that when a child or young person fails to attend an appointment they should be contacted and the appointment rearranged. Persistent failure to attend should alert health professionals to possible safeguarding or child protection concerns. Some

[6] CMACE (2008). *Why Children Die.* www.cmace.org.uk/Publications/.../Child-Death-Review.aspx. Retrieved 10th October 2010.

assessment of the activity and outcomes associated with failure to attend appointments should form part of core reporting for provider trusts.

The Common Assessment Framework

Engagement with the multi-agency environment is critical to effective delivery of safeguarding and child protection services. Implementation of the Common Assessment Framework (CAF) is a good proxy-indicator of the extent to which health partners are embracing their duties to co-operate in the context of preventative work. At the moment take-up of the CAF is scrutinised by local authority Children's Services, without any accompanying levers to improve performance in partner agency contributions where indicated. Improving services to vulnerable children might usefully include outcomes measures focused on:

- Quantitative analysis of the number of CAFs undertaken by healthcare professionals, and
- Qualitative analysis of the activity and outcomes of such assessments.

Such information might usefully be shared with local authorities to ascertain the impact of more robust implementation of the CAF on 'inappropriate' referrals i.e. those referrals that do not meet the threshold for social care interventions.

Child Protection Conferences

Commissioning consortia must be required to provide assurance that provider trusts are being enabled to fulfil their statutory requirements by demonstrating a reasonable and transparent budgetary commitment to the discharge of *ad hoc* requirements to engage in the child protection process, for example, attendance at Child Protection Conferences (CPC) and / or the provision of medical notes and / or reports on a child and family.

Poorly attended conferences do not indicate an effective multi-agency response, whilst the provision of hastily prepared, incomplete or sometimes non-existent reports, lacking any analysis of risk or resilience, hinder Conference Chairs' capacity for robust planning.

Engagement with multi-agency processes might be usefully scrutinised by:

- Quantitative analysis of attendance at CPCs, including a breakdown of *who* attends, and
- Qualitative assessment of outputs, through scrutiny of the direct contribution to the conference of participants and / or through scrutiny of written reports to conference, which might be ascertained through engagement with Conference Chairs
- Outcomes measurements should focus on the implementation of health recommendations in Child Protection Plans (CPP) within the required timescale.

Serious Case Reviews

Implementation of recommendations from Independent Management Reviews (IMR) and Serious Case Reviews (SCR) is currently monitored by the Local Safeguarding Children Board (LSCB) and graded by OfSTED. The most significant impact of an inadequate grading for an IMR or SCR is felt by the local authority, notwithstanding that neither the local authority nor the LSCB has any significant degree of control over the quality of other agencies' inputs. Some scrutiny of both the quality and implementation of recommendations from IMRs and SCRs has been provided by Strategic Health Authorities, but since these bodies are to be discontinued some means of holding health services to account for the provision, quality and implementation of IMR and SCR recommendations must be built-in to outcome measures.

Engagement with this process might usefully be scrutinised by:

- Qualitative assessment of outputs, through scrutiny of individual IMRs, and
- Outcomes measurements which focus on the implementation of health recommendations in IMRs and SCRs within the required timescale.

Preventable Deaths

National Indicator 70: Hospital admissions caused by unintentional and deliberate injury to children and young people is a useful indicator of local preventable child deaths. We would wish to see this maintained as an indicator, but revised to record 'episodes' rather than simply 'admissions' and for unintentional injuries to be disaggregated from deliberate injury. Such information might usefully inform both public health and child protection strategies at local and national levels.

7. **We would welcome thoughts on appropriate areas for quality standards and the balance between inclusion within adult standards and child-specific standards**

The purpose of standards is to help create a safe environment for children and young people and protect them from harm; to provide a benchmark to assist professionals to make informed decisions and to promote good practice and challenge. The NSPCC considers that quality standards for child protection should be developed as a matter of urgency. *However,* we do not consider that such standards can be developed and implemented within a traditional single service-focused model.

In Northern Ireland the Department of Health, Social Services and Public Safety (DHSSPS) published standards for child protection services in 2008[7]. Rooted in a multi-disciplinary, inter-agency approach to child protection, the standards promote a shared commitment to child protection and establish a framework for best practice. Such a model might usefully be considered for the development of quality standards in child protection in the NHS.

[7] http://www.dhsspsni.gov.uk/standards_for_child_protection_services.pdf

Our own standards for Child Protection in Sport[8] might also provide a useful platform from which to consider the development of quality standards. Based on current good practice and informed by legislation and guidance, evidence from research, and experience of what works, these standards were developed in consultation with a range of stakeholders, including children, young people and families, and have been operating successfully since 2002. We would be pleased to offer further assistance in this respect.

8. **How might we continue to expand and develop Payment by Results to benefit children and young people, including any potential areas for best practice tariffs?**

   This is not an area of expertise for the NSPCC. However, the development of a best practice (as distinct to a minimum requirement) tariff in child protection would give a clear message to commissioners concerning indicative spend in this area of work. This is an area that requires much thought, and does not altogether lend itself to a traditional cost / benefit model. However we would welcome an opportunity to discuss the development of a best practice model in greater detail.

9. **We would welcome thoughts on aligning outcomes for children and young people across the NHS, public health systems and other services.**

   Please refer to our comments at (7) above.

10. **How can we support and enable GP consortia and their partners to overcome these challenges during the transition to the new system?**

    No comment.

11. **How can GP consortia pool risk and expertise for the purposes of commissioning children's services?**

    Please see point (4), paragraph 3, above. We consider these arrangements would be a significant step forward in the pooling of expertise, and, to some degree at least, of minimising / managing risk.

12. **What practical steps need to be taken to enable local partners to realise their joint commissioning plans? Are there unnecessary central bureaucratic barriers that can be removed to facilitate this?**

    Far from the presence of unnecessary bureaucratic barriers, the NSPCC is concerned that the absence of shared drivers will hinder effective safeguarding and child protection. The

[8] http://www.nspcc.org.uk/inform/cpsu/resources/publications/publications_wda60545.html

Children's Trust partnership model provided a platform for joint service commissioning while the requirement to deliver identified services through a statutory Children and Young People's Plan (CYPP) provided the mechanism for monitoring and accountability, and also for consulting with children, young people and their families. There is now a hiatus. The role and governance of proposed Health and Wellbeing Boards (HWB) is yet to be clarified, as is their relationship with existing Children's Trust arrangements, the CYPP and LSCBs. Joint Strategic Needs Assessments (JSNAs), whilst a potentially powerful tool, are not used with sufficient sensitivity to identify the unmet needs of children and young people suffering abuse, at risk of abuse, or requiring therapeutic support to recover from abuse. This is dangerous for children and young people. Whilst structural delivery mechanisms are clarified it is critical that joint commissioning plans are driven by something, and we would suggest that our proposals under point (6) above, concerning outcomes measurements for the forthcoming Operating Framework, may be the best, if not the only mechanism that will act as an enabler for local partnership commissioning.

13. How should existing local authority leadership responsibilities for children and young people and health duties to co-operate fit with the proposed Health and Wellbeing Board?

We understand that the proposed health and wellbeing boards are intended to be established as a new statutory partnership *or* within existing strategic partnerships to take on the responsibility of commissioning NHS services. We would therefore wish to see the broad purposes of Children's Trust arrangements to be secured within such a body. Thus, improving outcomes for children and young people by identifying need, and commissioning and providing services to meet that need, should be the over-arching purpose of health and wellbeing boards.

14. What should / should not central government do with regard to Children's Trusts and potential Health and Wellbeing Board arrangements?

See comment at (13) above.

15. How can GP consortia best be supported and enabled to play their part in local arrangements to safeguard children and young people?

See comment above.

16. What specific safeguarding and child protection responsibilities should be taken into account as part of local partnerships?

Safeguarding and child protection are part of a continuum and should be seen as such. Much of the discussion above outlines the areas the NSPCC considers critical to recognising this continuum, but the idea that there are specific responsibilities that will capture and secure safeguarding and child protection is misinformed. What is clear is that

“ *… an organisation dedicated wholly to meeting the needs of children and young people and which exists to bring local services together …”* (Kennedy 2010) is fundamental to achieving equity and excellence for children.

In conclusion, safeguarding and child protection are not discrete activities, they must run as a thread through all health services, and be recognised as the partnership activity they are if they are to be delivered well and consistently. The NSPCC would welcome a further opportunity to share our extensive experience of safeguarding and child protection through more detailed discussions with the Department of Health as the proposals for Health Service reform develop.

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