Response ID ANON-RZFY-NMQH-Y

Submitted to **Working Together to Safeguard Children: changes to statutory guidance**
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Introduction

What is your name?

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What is your organisation?

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Would you like us to keep your responses confidential?

No

Reason for confidentiality:

Revisions to chapter three: Multi-agency safeguarding arrangements; and new regulations on relevant agencies

1 As set out in paragraphs 4-7 of Chapter 3 of the draft 'Working Together to Safeguard Children' 2018 it will be the responsibility of the safeguarding partners' representatives to determine how they work together in respect of their arrangements. All three partners have equal and joint responsibility for local safeguarding arrangements, and each safeguarding partner will appoint their own representative. We do not propose to set out in statutory guidance who these representatives should be, as it is a matter for safeguarding partners. Do you agree with this approach?

No

Question 1 - Leadership - reasons :
While it is useful for local areas to develop their own partnerships and safeguarding arrangements, it a concern that there is no guidance and a lack of clarity on the structure, functions and accountability of these proposed new arrangements, particularly if the police and health are to have a statutory responsibility as "joint and equal partners" alongside the local authority.

More clarification is required around CCGs being identified as the lead partner for 'health'. This covers an increasingly complex and varied landscape of service providers, organisational forms (including the private sector and not-for-profits, such as social enterprises) and commissioning arrangements. The statement, 'Safeguarding partners can choose specific agencies which they believe to be relevant' implies they are also free to choose specific agencies which they DO NOT believe to be relevant. We are concerned that there should be a principle of inclusion of agencies that over-rides any of these variants that may be embodied in new and emerging commissioning and contracting arrangements such as those that may be established by Sustainability and Transformation Plans (STPs). The application of such a principle should be robust, for example with the force of the paramountcy principle established in the Children Act, 1989.

We address the specific issue of health visiting and related services in response to Question 2, below.

2 Safeguarding partners can choose specific agencies which they believe to be relevant to the work of safeguarding and promoting the welfare of children in their area. The 'Local Safeguarding Partner (Relevant Agencies) (England) Regulations' details the specific agencies which safeguarding partners can choose from. It is important to note that certain key agencies are not listed, as their functions are commissioned or otherwise overseen by one or more of the safeguarding partners - for example, general practitioners come under NHS England, and housing under the local authority. Do you agree with this indicative list?

Not Answered

Question 2 - Relevant Agencies reasons:
It is clearly the intention of the revised Working Together (WT) that the Statutory Guidance should reflect and be inclusive of all relevant agencies, services and providers as indicated by the welcome explicit inclusion of all schools. However, consistency and relevancy in terms of listing the professionals/others who contribute to safeguarding children needs attention. As providers of universal services to young families (including prenatally) we wondered if reference to health visiting should be more explicit at several junctures, including at the outset of Chapter Three.

Where schools are referenced the iHV would also wish to ensure that this is inclusive of 16-18 year-old provision and particularly the arrangements concerning children missing education/educated otherwise (e.g. home-educated). More clarification is needed, though, on how all schools will be required to work with the 3 safeguarding partners. Specifically, clarification is needed on how health visiting and school nursing will be enabled to work together effectively as a 0-19 service

(as per PHE Commissioning Guidance) when health visiting and school nursing are sometimes commissioned by different local authorities or commissioned from different provider organisations.

The Institute of Health Visiting recommends that the 2018 revision of WT removes ambiguity about the relationship of local authority commissioned public health services to the requirements of and support for other health services commissioned by the NHS (NHS England or CCGs), or provided by the NHS, in order to deliver their safeguarding and child protection functions. WT, 2018 refers to:

"Section 11 of the Children Act 2004
Places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children."

Various other statutory duties that apply to other specific organisations working with children and families are set out in Chapter 2: Organisational responsibilities. This includes:
'NHS organisations, including the NHS England and clinical commissioning groups, NHS Trusts and NHS Foundation Trusts.'

The Children Act, 2004 (as cited above) precedes the transfer of public health functions from the NHS to Local Authorities. NHS England's 'Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework'
https://www.england.nhs.uk/wp-content/uploads/2015/07/safeguarding-accountability-assurance-framework.pdf states:

"4.3.6 Local authority commissioners
The commissioning of public health services for children is undertaken by local authorities and includes sexual health services, school nursing services, and, from October 2015, health visiting and family nurse partnership services. These health services have an integral role in safeguarding children and young people which should be clearly reflected within the relevant service specifications.

As commissioners of these health services, local authorities should liaise with the relevant Designated Professional as part of their assurance process to ensure that effective safeguarding arrangements are in place within these services to safeguard children and young people.

As with all organisations which are subject to the Children Act 2004 section 11 duty, local authorities are responsible for ensuring that their staff receive appropriate supervision and support, including undertaking safeguarding training. This applies to professionals delivering public health services commissioned by local authorities. "

The iHV proposes that Chapter 2 of WT, 2018, Chapter 2, para 3 should specify:
NHS organisations, including the NHS England and clinical commissioning groups, NHS Trusts and NHS Foundation Trusts and public health services commissioned by local authorities, including health visiting, school nursing, family nurse partnership and sexual health services.

Likewise, these services should be represented in Annex A: The Local Safeguarding Partner (Relevant Agencies) (England) Regulations – the Local Safeguarding Partner (Relevant Agencies) (England) Regulations [2018].

Question 2 - Relevant Agencies - agencies to add or remove:
See above.

3 All schools (including maintained schools, special schools, independent schools, academies and free schools) have key duties in relation to safeguarding children and promoting their welfare. As set out in paragraphs 18-19 of Chapter 3 of the draft 'Working Together to Safeguard Children' 2018 we expect all local safeguarding arrangements to contain explicit reference to how the safeguarding partners plan to involve, and give a voice to, all local schools and academies in their work. Do you agree that this expectation should be stipulated in statutory guidance?

Yes

Question 3 - Schools and other educational partners - reasons:
The Institute of Health Visiting wishes to ensure that these explicit arrangements are inclusive of 16-18 year-old provision and particularly the arrangements concerning children missing education/educated otherwise (e.g. home-educated). More clarification is needed, though, on how all schools will be required to work with the 3 safeguarding partners. Specifically, clarification is needed on how health visiting and school nursing will be enabled to work together effectively as a 0-19 service (as per PHE Commissioning Guidance for Children's Public Health) when health visiting and school nursing are sometimes commissioned by different local authorities or commissioned from different provider organisations.

4 The safeguarding partners must include arrangements for scrutiny by an independent person of the effectiveness of safeguarding arrangements, and how best to implement a robust system of independent scrutiny will be a local decision. Paragraph 20 of Chapter 3 of the draft 'Working Together to Safeguard Children' 2018 states that safeguarding partners should involve a person or persons who are independent, for example by virtue of being from outside the local area or having no prior involvement with local agencies. Do you agree with this?

Not Answered

Question 4 - Independent Scrutiny - reasons:

5 Paragraph 24 of Chapter 3 of the draft 'Working Together to Safeguard Children' 2018 makes it clear that safeguarding partners should agree the level of funding secured from each partner and relevant agency, to support the new safeguarding arrangements. Decisions on funding are for local determination, but contributions should be equitable and proportionate to meet local needs. Do you agree that this is

the right approach?

Not Answered

Question 5 - Funding - reasons:

6 Safeguarding partners must publish a report at least once in every 12 months, setting out what they (and their relevant agencies) have done as a result of the arrangements, and how effective the arrangements have been. These reports will be a key element of local accountability and self-assessment. At paragraph 29 of Chapter 3 of the draft 'Working Together to Safeguard Children' 2018 we have set out a non-exhaustive list of parameters for these reports in guidance, to ensure a nationally consistent set of useful and high quality publications. Do you agree with this approach?

Not Answered

Question 6 - Reporting - reasons:

7 The safeguarding partners should consider carefully how multi-agency safeguarding arrangements will work in their area. This includes determining how best to ensure that clear criteria for taking action are made available to relevant agencies and others in a transparent, accessible and well-understood way. Currently, Local Safeguarding Children Boards are required to produce a threshold document. We are not proposing to specify in statutory guidance how, and in what format, the safeguarding partners should make their criteria for action available. Do you agree with this approach?

Yes

Question 7 - Threshold document - reasons:
The iHV supports explicit criteria for action being jointly developed and shared by all partners in the safeguarding arena. Evidence from the iHV survey of members suggests that thresholds for acceptance of referrals to children's services are rising; and that HVs are managing risk unsupported by LA children's services to a greater degree than has previously been the case (HVs' caseloads include the whole child population including ALL children in receipt of Early Help or Statutory Intervention i.e. those with a Child in Need or Child Protection Plan). Hence, with increasing case-load size and intensity, HVs report difficulty in being able to provide the mandated 5 Healthy Child Programme contacts and respond sufficiently to the needs identified. The term 'threshold' implies a clear demarcation between where there are needs or risks and where there are not. This does not reflect the reality of the lives of infants and children. Health visitors as universal service providers, provide care to all young children, including those unknown to or not accessing other services. In order to fulfil their public health preventative function it is essential that health visitors are able to both identify and mobilise proportionate and effective forms and levels of supportive intervention. In this context chapter 3 of WT, 2018 needs to be considered with Chapter 1 and Early Help (EH), and therefore more clear guidance is needed.

The iHV's members report that completion of EH assessments (WT Chapter 1) is being used in some areas as a measure of organisational performance by Children's Services and that health visitors are required to complete them in order to facilitate their clients' access to help of importance to health and /or development. Families may be motivated to access such help but not to undertake or consent to an EH assessment. EH assessments should meet the needs of children and families, rather than children and families meet the organisational requirements of service providers, in keeping with Eileen Munro's intention that reforms do not 'create a work environment full of obstacles to keeping a clear focus on meeting the needs of children' (Munro, 2011: 1.16). From the perspective of families, they should not be denied access to help with their children's health or developmental needs (to which they are agreeable) because they are not agreeable to an EHA; from the perspective of organisational leads for EH, they should work with all partners to ensure that there is a range of assessments and pathways that lead to such help. EHA's should not serve as a measure of organisational performance when this is to the detriment of practitioners such as health visitors facilitating children and families to access the help that they need from any service or agency. Research into service user experience of services (Donetto et al, 2013) indicates that families value highly the support of health visitors along the 'service journey' that can include a multiplicity of services within the wide array of health and other providers. The iHV believes that it is indeed desirable that:

'The safeguarding partners should consider carefully how multi-agency safeguarding arrangements will work in their area. This includes determining how best to ensure that clear criteria for taking action are made available to relevant agencies and others in a transparent, accessible and well-understood way'.

The effectiveness of these arrangements should be scrutinised to ensure that they do not function perversely at the level of a) individual children or families not accessing help in a proportionate and timely manner and b) at a systemic level, by so increasing the level of risk managed by health visiting services that they do not have the capacity to lead and deliver their core function of universal preventative child public health through the Healthy Child Programme.

Revisions to chapter four: Learning from serious cases; and new regulations on local and national reviews

8 Paragraphs 15-17 of Chapter 4 of the draft 'Working Together to Safeguard Children' 2018 set out the actions the safeguarding partners should take on receipt of a notification of a child safeguarding incident, and the relationship between the safeguarding partners and Panel from then on. Do you agree with the procedure as set out?

Not Answered

Question 8 - procedure - reasons:

9 The Act makes clear that the Panel and safeguarding partners respectively have responsibility to determine whether a review is appropriate, on the basis of whether the review may identify improvements that should be made to safeguard and promote the welfare of children. Regulations may require the Panel and safeguarding partners to take certain matters into account when taking the decision on cases to review, and guidance may support this. Regulation 4 sets out national review criteria which the Panel would be required to take into account when deciding whether to commission a national review. Regulation 18 sets out local review criteria which safeguarding

partners would be required to take into account when deciding whether to commission a local review. Paragraphs 20 and 37 of Chapter 4 of the draft 'Working Together to Safeguard Children' 2018 set out additional circumstances for consideration. Do you agree with these criteria and circumstances?

Not Answered

Question 9 - criteria and circumstances reasons:

10 Paragraphs 23-24 and 41-42 of Chapter 4 of the draft 'Working Together to Safeguard Children' 2018 set out the factors which the safeguarding partners and the Panel respectively should consider when commissioning reviewers for local and national reviews. Do you agree with these factors?

Not Answered

Question 10 - factors - reasons:

11 Paragraphs 25-28 and 43-46 of Chapter 4 of the draft 'Working Together to Safeguard Children' 2018 set out the procedures which the safeguarding partners and the Panel respectively should follow when supervising local and national reviews. Regulations 12-14 of the 'National and Local Child Safeguarding Practice Review (England) Regulations' add requirements regarding the Panel's supervisory powers.We do not propose to include further details in the regulations relating to procedures for reviews. Do you agree with these proposals?

Not Answered

Question 11 - proposals - reasons:

12 Paragraphs 30-33 and 48-52 of Chapter 4 of the draft 'Working Together to Safeguard Children' 2018 set out the expectations for the final report which the safeguarding partners and the Panel respectively should follow. These paragraphs also cover timescales for publication and arrangements for submitting final reports. Do you agree with these expectations and timescales?

Not Answered

Question 12 - expectations and timescales - reasons:

13 The Act allows the Secretary of State to make regulations to set up a list of reviewers, from which safeguarding partners could be required to select reviewers for local reviews. To maintain maximum flexibility in the system, we do not propose to set up such a statutory list at this time. Do you agree with this approach?

Not Answered

Question 13 - approach - reasons:

14 Do you have any comments on the content of the 'National and Local Child Safeguarding Practice Review (England) Regulations which you have not already covered above?

Not Answered

Question 14 - content of Review Regulations:

Revisions to chapter five - Child death reviews

15 In reviewing the circumstances around the death of a child, the overarching aim is to prevent future child deaths. We have heard from stakeholders that the term "preventable" has posed a hindrance to learning. Instead of asking about preventability, we propose that the child death review process should consider and identify "modifiable factors". That is, contributory factors to a death, that could be modified to reduce the risk of future child deaths. Do you agree with this approach?

Not Answered

Question 15 - modifiable factors - reasons:

16 We have heard from stakeholders that the distinction between 'expected' and 'unexpected' child deaths can lead to confusion (partly because it may depend from whose viewpoint the question is being considered). We propose a new approach, which allows each individual death to be responded to appropriately, rather than determining whether or not a death meets certain criteria for investigation. This is about working differently, and changing the initial stages of the process. It does not imply an additional burden. Do you agree with this approach?

Not Answered

Question 16 - expected / unexpected - reasons:

17 The Wood Review recommended that the area covered by child death reviews should cover 'a population size that gives a sufficient number of deaths to be analysed for patterns, themes and trends of death'. The new legislation gives the child death review partners flexibility to agree that two or more local authority areas may work together as a single area. We are proposing that the geographical 'footprint' of the arrangements should be locally agreed, based on patient flows across existing networks of NHS care. Child death review partners should come together to develop clear plans outlining the administrative and logistical processes for their new arrangements. Child death review 'footprints' should typically cover a child population such that they review 80-120 child deaths each year Do you agree with these proposals?

Not Answered

Question 17 - areas - reasons:

18 We propose that families should be assigned a "key worker" to act as a single point of contact who they can turn to for information on the child death review process, and who can signpost them to sources of support. This is already best practice and should not imply an additional burden. More information on the role of the key worker is available in chapter 6.5.1 of the Child Death Review Statutory Guidance. Do you agree with this proposal?

Not Answered

Question 18 - key workers - reasons:

19 We propose that every child's death is reviewed at a child death review meeting involving practitioners directly involved in the the child's care, prior to being discussed anonymously by the Child Death Overview Panel (CDOP). The nature of this meeting will vary according to the circumstances of the child's death and the practitioners involved. It would (for example) take the form of a final case discussion following a Joint Agency Response to a sudden unexpected death in infancy; or a hospital-based mortality meeting following a death on a neonatal unit. The purpose of the child death review meeting is to ensure local learning and reflection. In contrast, the purpose of the CDOP is to provide independent scrutiny of each case, ensuring this is from a multi-agency perspective. Do you agree with this proposal?

Not Answered

Question 19 - child death review meeting - reasons:

20 Practitioners involved in the care of the child who died should be invited to attend the child death review meeting. If they cannot attend, they should submit a report, for which a Form B may be used. We propose that Child Death Overview Panel administrators work closely with child death review partners to gather and collate these reports. Please see Chapter 4 of the Child Death Review Statutory Guidance for more information on this process. Do you agree with this proposal?

Not Answered

Question 20 - reports for the child death review meeting :

21 A revised Form C is proposed at Appendix 5 of the Child Death Review Statutory Guidance. We have heard from stakeholders that two of the form's domains - 'family and environment' and 'parenting capacity' - are not helpful distinctions. We propose changing these domains to 'Social environment including family and parenting capacity', and 'Physical environment', respectively. Do you agree with this proposal?

Not Answered

Question 21 - revised Form C - reasons:

22 We have heard from stakeholders that in many cases reports from child death review meetings (particularly hospital mortality meetings) are not routinely sent to CDOPs. We propose that all child death review meetings should routinely send a report to the CDOP, to inform its independent review of the case. This approach is intended to strengthen the link between the local review and the CDOP process, while also allowing for the right balance between local reflection and independent scrutiny of practice. Do you agree with this proposal?

Not Answered

Question 22 - Child death review meeting report - reasons:

23 Chapter 7 of the Child Death Review Statutory Guidance outlines expectations in a number of specific circumstances, including: deaths of UK-resident children overseas; deaths of children with learning disabilities; deaths of children in adult healthcare settings; suicide and self-harm; deaths in inpatient mental health settings and deaths in custody. Do you feel we have covered an appropriate range of specific situations?

Not Answered

Not Answered

Question 23 - expectations - reasons:

24 We have heard from stakeholders that some types of deaths (e.g. suicides) may best be reviewed at a themed CDOP meeting. This may apply when deaths from a particular cause are of small number and/or require specialist expertise to inform the discussion. In these circumstances, we propose that neighbouring CDOPs and designated doctors for child death liaise and co-ordinate their approach. Do you agree with this approach?

Not Answered

Question 24 - child death review process focus - reasons:

Transitional arrangements

25 Paragraphs 14-15 of the transitional guidance explain the proposal that child death overview panels have a 'grace period' of up to two months following the start of the child death review partner arrangements in their area in which to complete any outstanding child death reviews. Do you agree with this proposal?

Not Answered

Question 25 - grace period - reasons:

26 Paragraphs 23-25 of the transitional guidance explain the proposal that Local Safeguarding Children Boards should have a 'grace period' of up to 12 months following the start of the safeguarding partner arrangements in their area in which to complete and publish outstanding serious case reviews. Do you agree with this proposal and with the guidance on handling information?

Not Answered

Question 26 - publish SCRs - reasons:

27 Paragraphs 27-31 of the transitional guidance set out how safeguarding partners should manage information emerging from serious case reviews. Do you agree with these proposals?

Not Answered

Question 27 - info from SCRs - reasons:

Any other comments

Are there any other comments you wish to make concerning the changes proposed?

Any other comments: