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23 April 2015

Dear Mr Davidson

RCN Response to Scottish Government consultation on draft statutory guidance on Parts 4 (Named Person), 5 (Child's Plan) and 18 (Section 96, Wellbeing) of the Children and Young people (Scotland) Act 2014 and draft Orders to be made under that Act

The Royal College of Nursing (RCN) Scotland is a professional body and trade union for nurses and health care support workers, with around 39,000 members in Scotland.
We welcome the opportunity to respond to this consultation. Our response is informed by the views of our members working across health visiting, school nursing, children's services and child protection.

We fully support the introduction of the Named Person role and the principle of health visitors being the Named Person for pre-school children. Some of the issues we raise are around the implications and challenges, in practice, of enacting the legislation. As our feedback crosses over different areas of the guidance and expands beyond some of the specific consultation questions, we have set out our comments below, as opposed to in the consultation form. However we have put in references to the relevant section of the guidance that the feedback relates to, which we hope will aid analysis of the response.

Our main comments are as follows:

1) **Current pressure on workforce capacity of health visitors:** The current pressure faced by health visitors puts the implementation of the Named Person provision at risk. Scottish Government must fully assess NHS Boards' health visitor workforce analysis (using the caseload weighting tool) and their state of 'readiness' to implement the proposals. This must be considered alongside the timings for training additional health visitors and of them entering into the workforce, and used as the basis for establishing the implementation dates for the Named Person provision and the new health visitor pathway.

2) **Lack of clarity around roles and responsibilities:** The guidance needs to clarify the roles of the Named Person and the Lead Professional and how they relate together. It also needs to emphasise that the responsibilities of the Named Person role does not detract from other agencies' responsibilities.

3) **Support to do the Named Person role:** Current systems are not fit for purpose to support the Named Person to undertake the duties of the role. This includes IT/information sharing systems and the need for dedicated administrative support for the Named Person role.

Health visitor workforce capacity

A fully resourced and trained workforce is vital to implement the Named Person provision of the Children and Young People (Scotland) (CYP) Act 2014. Without this, there is a risk that the Named Person will not be able to fully promote, safeguard and support the wellbeing of children.

However the Scottish Government is starting from the assumption that there will be sufficient capacity within the health visiting workforce to implement the additional duties of the Named Person role for pre-school children.

The vast majority of feedback we received from members raised concerns over current pressures faced by health visitors due to staff shortages, staff retiring, staff on secondment and high vacancy rates. From what is identifiable in the feedback we received[1], members raised significant concerns about health visitor capacity in at least five separate Health Boards, with one Health Board working with a 40% reduced pool of health visitors because of staff retiring and staff working reduced hours. Some Health Boards are using other staff, such as community staff nurses, to carry out some health visiting activity because they do not have sufficient qualified health visiting staff. The Named Person role - and the Lead Professional role - will bring additional pressures to an already stretched workforce, in addition to the further visits being introduced by the new health visitor pathway over the next three years. We have previously raised these concerns with the Parliament's Finance Committee[2] and Education and Culture Committee[3] as the Bill was scrutinised at Stage 1.

NHS Boards are currently re-running the case load weighting tool to identify shortfalls in their health visiting workforce[4]. This is due to be complete in May 2015. They will then be developing local plans to achieve agreed trajectories for maximising the health visitor workforce, including the number of new students required over the next 2-3 years. We welcome the Scottish Government's funding for training of additional health visitors. However this is being introduced in phases. The implementation plan for the new health visiting pathway states that the additional health visitors will be recruited by March 2018. However the intended implementation date for the Named Person provision of the CYP Act, which relies on the full capacity of the health visiting workforce, is August 2016. The recruitment of the additional health visitors will therefore not be completed by the introduction of the Named Person.

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[1] We informed members that we would keep their feedback confidential and not attribute any comments to individuals

[2] http://www.scottish.parliament.uk/parliamentarybusiness/28862.aspx?r=8505

[3] http://www.scottish.parliament.uk/parliamentarybusiness/28862.aspx?r=9018

[4] We would like to ask for clarification of whether the case load weighting tool includes the increased workload of both the Named Person and Lead Professional role that health visitors will need to take on?

The Scottish Government should fully assess the results of NHS Boards' health visitor workforce analysis and any gaps identified. If Boards have identified a shortfall in health visitors, there must be plans in place to mitigate the risks resulting from this. The Scottish Government must carry out a thorough assessment of the impact that this will have on the introduction of the Named Person role. This must be taken into account when setting the implementation date of both the Named Person and the new health visiting pathway and considering how best to align the two.

Alongside this, we believe that the statutory guidance should state that NHS Boards must use the recently developed national caseload weighting tool for health visitors, alongside the national mandatory community nursing workload and workforce planning tool and professional judgement, to determine the health visitor workforce needed to implement the Named Person service. There must be plans in place to mitigate risks identified from any shortfall.

The health visiting workforce is also reliant on having enough Practice Teachers. Feedback from our members show there are concerns over the current number of Practice Teachers and there are challenges in recruiting and training additional ones. This will need to be addressed when assessing the future capacity of the health visiting workforce.

We welcome the Named Person role and the positive impact that health visitors as the Named Person will bring to promoting, safeguarding and supporting the wellbeing of pre-school children. However to implement this vital role effectively, the workforce must be fully resourced and supported.

If the job description of health visitors (and potentially other staff) is going be changed to include additional responsibilities of being the Named Person, and potentially also the Lead Professional, then their jobs will need to be re-evaluated to see if the role is suitably remunerated under Agenda for Change.

Training, qualifications, experience required of the Named Person *(Named Person Order and guidance sections 4.1.5 – 4.1.7)*

We recognise that the Scottish Government is trying to be clear that the Named Person for pre-school children should routinely be the health visitor, while also providing flexibility for this to be another professional in exceptional circumstances.

However we are concerned that the way the draft Ministerial Order defines the requirements of who can be a Named Person for pre-school children is too wide. There is a risk that Health Boards could appoint staff who are not best placed to be the Named Person because of other factors such as pressure on resources, as opposed to what is in the best interests of the child, as the Scottish Government intends. For example, under the current wording of the draft Order, it is possible for a service provider to appoint a staff nurse with a day's training in child development and speech and language to be the Named Person.

The draft Order also states that the Named Person must have training in child development and in assessing speech, language and communication. Some health visitors will not have had formal training in child development as this was not covered in their health visiting course. They may also require training around speech, language and communication to carry out the role effectively. Some of the feedback from our members questioned the need for a specific focus on assessing speech, language and communication as opposed to a more holistic assessment of child health.

We therefore suggest that the requirements for who could be a Named Person in the draft Ministerial Order should be as follows:

The Named Person for pre-school children must be a registered nurse with a post-registration qualification in child health, UNLESS there is an exceptional circumstance, as defined in the statutory guidance, in which case the Named Person for pre-school children must be either a registered midwife, a registered nurse or a registered medical practitioner AND have undertaken pre-registration, post-registration or professional training in child health.

There should be a comprehensive list of training qualifications that staff should have so that NHS Boards can be certain they are fulfilling their remit.

The statutory guidance should then provide detail on the types of exceptional circumstance where the Named Person for the pre-school child should not be a registered nurse with a post-registration qualification in child health (i.e. a health visitor). The guidance should make it clear that it is an exceptional circumstance only when it is not in the best interest of the child for the Named Person to be the health visitor and include the following circumstances:

- Where a mother is enrolled in a Family Nurse Partnership (FNP) programme, and an FNP nurse is best placed to be the Named Person
- Where a family opts out of the health visiting service
- Where there may be a conflict of interest, for example where a family member is the only available health visitor

From the feedback we received, some members thought that where a child has severe medical needs, a severe disability or is terminally ill, then this is an exceptional circumstance where a health visitor may not be best placed to be the Named Person. However there needs to be clarity in the guidance whether in these circumstances the intention is for the health visitor to remain the Named Person and another professional be the Lead Professional, or whether another professional should be the Named Person.

The statutory guidance should also make it clear that where a FNP nurse is the Named Person this will only be until the family has left the programme when the child is two years old. The NHS Board will need to ensure that there are arrangements in place for the Named Person role to be handed over from the FNP nurse to the health visitor.

Named Person for children aged from day 0 – day 10 *(guidance section 5.1.3-5.1.4 and Appendix A)*

We acknowledge the Scottish Government has changed its position and is now proposing that the health visitor should be the Named Person from birth, not the midwife. While the RCN agrees with the stance that the Scottish Government has taken, there was not unanimous support from all members we consulted. Health visitors had strong concerns about this that will need to be addressed in order for them to be confident in their role and be able to implement it effectively. Their concerns include:

- capacity to make antenatal visits
- how health visitors can be the Named Person for a child where they have not met the family
- confusion over the role of the Named Person in the antenatal period and concern that the health visitor is expected to be the Named Person before the baby is

born. Being involved in antenatal care is outside their remit and is the midwife's role
- if the midwife is not the Named Person, then there is a concern that they will not be fully involved in the GIRFEC process

To address these issues, the health visitor workforce needs to have sufficient capacity that they are able to carry out antenatal visits and be the Named Person from day 0. The guidance needs to be made much clearer about the role of the midwife and the role of the prospective Named Person and prospective Lead Professional in the antenatal period. The guidance should make it explicit that though a health visitor may be *identified* as a prospective Named Person, prior to the baby being born, they are the Named Person only *once* the baby is born. The guidance is unclear, for example, around the responsibilities of developing a Child's Plan pre-birth. It states that the Named Person will have *"a lead role"* alongside the prospective Lead Professional and named midwife to manage and review the draft Child's Plan, but does not state what this lead role is and who is to appoint a Lead Professional, initiate, develop and manage the pre-birth Child's Plan.

Support, skills and development of the Named Person *(guidance sections 4.1.3 – 4.1.7; 4.1.15-4.1.7*

We received mixed views from members about whether health visitors would need additional training in the skills and knowledge listed in the draft guidance. Some felt they would need further training as they were not covered in depth during their health visiting course.

In addition to the skills listed, the Named Person will also need skills in setting up and chairing interdisciplinary meetings, appointing a Lead Professional and resolving disputes. This should be included within the training on the Named Person role that service-providers will have to provide.

Section 4.1.4 of the guidance sets out good practice for the Named Person service provider. These points should be a 'must'. In addition certain aspects need to be strengthened or added, including:

- **Administrative support:** The guidance should make clear that service providers need to provide dedicated administrative support to carry out the Named Person and Lead Professional roles. The Named Person role carries a huge administrative burden around increased paperwork, correspondence, arranging meetings, writing minutes and drafting plans. With the existing pressures on health visitors and other staff, the extra time needed on administration places a real risk to the role being carried out effectively.

- **Support and supervision:** Named Persons will require additional support and supervision to what they currently receive, in order to carry out the role effectively. Supervisors will also need to have additional training in the issues around the Named Person role and in providing support where the Named Person may need to challenge decisions made by other services.

- **Ongoing training and CPD:** Though the guidance states that Named Person service-providers have to provide training for staff undertaking the Named person role, it does not make a requirement for them to provide ongoing training and CPD. Staff also need to have time and permission to access this, which currently is difficult because of pressures on the workforce.

- **Governance:** There must be clear governance of the Named Person role, which is integrated into existing governance arrangements. This includes staff being able to raise concerns.

Continuity of Named Person Service (*guidance sections 4.1.30-4.1.31)*

The Named Person will need to formally know which children they are the Named Person for, so they can take on their responsibility and be accountable. Currently many health visitors are part-time or work on a bank, and health visiting services are configured in different ways to maximise access for children and families, for example corporate caseloads, hubs or clusters. This could potentially impact the ability to provide families with actual 'named individuals' who will take on the role of the Named Person. There needs to be absolute clarity as to whether the legislation and guidance is intending in practice for there to be a 'named individual' or whether it is actually referring to 'named caseload holders', as that is the way that children are currently allocated to health visitors via GP services.

The guidance must clarify whether part-time and bank staff can be the Named Person. If this will impact on the availability of staff who can be the Named Person then this will need to be factored into appropriate workforce planning. If part-time health visitors or bank staff can be a Named Person, the guidance needs to be clear how this would work in practice.

Roles and responsibilities *(guidance sections 4.1.19-4.1.27)*

We received strong feedback from health visitors already carrying out the Named Person role, that there is a lack of understanding of their role from other agencies. They reported that there is an assumption that other services can direct everything to the Named Person instead of fulfilling their own responsibilities. For example, there are concerns that other agencies do not refer children to services as they would have routinely done previously, but will pass this on to the Named Person to assess and make the referral. Health visitors, who are early implementers of the Named Person role, have already reported having been expected to deal with non-health issues since becoming the Named Person.

As this has been highlighted as a particular concern, we feel that this is an area that the statutory guidance can help make much clearer. The guidance should clarify the interactions between the Named Person and other agencies and that having the Named Person does not negate others services' own responsibilities. Unless this is made clear, there is a risk that the Named Person will become overloaded and this will impact their ability to carry out their role effectively. The guidance should require training of other professionals about the Named Person role and the Lead Professional role and the relative responsibilities of the Named Person, Lead Professional and the agencies that interact with them.

The guidance should also provide further detail about the link with child protection and the relative roles and responsibilities of different agencies, for example social work, where there are child protection concerns.

The Lead Professional (*guidance sections 11.4.1-11.4.6, 11.7)*

There needs to be greater clarity and demarcation between the roles and responsibilities of the Named Person and Lead Professional. It would be helpful if the guidance gave more detailed definitions and responsibilities of both roles and how they should work together.

Feedback from our members currently in the Named Person role has shown that there can be resistance from other agencies to take on the Lead Professional role. This may then fall to the health visitor, as the Named Person, even when the health visitor is not best placed to be the Lead Professional. The guidance, as drafted, is unclear on how the Lead Professional will be appointed, where the decision-making power lies and how that decision will be made. It would be helpful to provide further guidance on when the Named Person is expected to be the Lead Professional and when this should be another professional, as there is some confusion and inconsistencies in the guidance currently. Section 11.4.6 should be strengthened to require robust procedures for escalating and resolving disputes.

Further practitioner guidance would also be helpful around particularly complex scenarios, for example where a child is being treated in a hospital outwith the Board area within which they normally live and where their Named Person is based.

The Lead Professional will also need training, CPD and ongoing support and supervision. This training will need to include leading interagency meetings and managing and reviewing a Child's Plan. Feedback from health visitors was clear that they needed training in being the Lead Professional before being able to take on this role.

Duty to help Named Person *(guidance sections 9.1)*

The guidance should make clear that staff from other agencies need to be aware of their duty to help the Named Person, in order to foster a common understanding and willingness to carry out the duty.

The guidance states that there should be processes and procedures in place including "*providing dialogue"* where a request for help is declined. This should be developed further, with the Named Person having a formal mechanism for challenging the reason given for declining to help. In addition there needs to be a clear process for escalating and resolving disputes.

In order for this duty to function effectively, local policies also need to allow referrals from all relevant professionals. For example, some agencies will not currently accept referrals from health visitors or from other professionals who may be taking on the Named Person role.

Information sharing *(guidance section 10)*

Though the guidance is clear about the duty to share information, there also must be processes in place to ensure that the Named Person will actually receive all relevant information from other agencies. This will require greater collaboration between and within agencies.

Current IT systems are not set up in a way that supports information sharing. This is a major concern. Currently there are issues sharing information even within health, let alone between agencies. There needs to be national investment in shared IT systems. However we understand from the Scottish Government that they will not be meeting any additional IT costs as part of the implementation of the CYP Act. We would therefore like assurance that other national IT projects will be addressing this. For example, how will the work going on under the refreshed eHealth strategy support this? Or will any of the funding for integration of health and social care also support development of IT infrastructure for child-focused services?

The feedback we received around information sharing was mixed. Some members were confident around their role in information sharing, others felt that they will need further training and guidance around this.

Further professional/practitioner guidance around information sharing, which encompasses case studies and scenarios, would be helpful. This could cover areas where there are particular concerns, for example around informed consent to share information, duties of confidentiality and around whose information it is to share. In addition there should be training on other agencies' duties to share information with the Named Person.

When there is a Lead Professional, the guidance should provide more detail about whether information should be directed to the Named Person or to the Lead Professional, and about the relationship between the Named Person and Lead Professional in terms of who holds and shares information about the child.

Further detail on the roles and responsibilities around sharing information from adult services, for example information about the parents that will impact the child, would also be helpful.

The high volume of information coming through to the Named Person is another reason why there needs to be administrative support for the Named Person and processes in place for when information comes through outside of core hours. There should be processes for appropriately recording information being shared, who is sharing it, their role, whether they have discussed sharing it with who it relates to and have their consent, where the information is to be shared and whether it is factual information or professional opinion.

Child's Plan (*guidance sections 11.4, 11.7 – 11.10)*

The guidance about the preparation of the child's plan is hard to follow. Phrases such as 'initiate the preparation', 'prepare', 'co-ordinate delivery of', 'review', 'manage' are not always used consistently or are unclear. Feedback from our members who are currently in the Named Person role has shown there is confusion around the roles and responsibilities of initiating, preparing and managing child plans.

For example, there is confusion around when to hold child planning meetings, with meetings not just being held when there is a 'targeted intervention' and some services refusing to be involved unless a child's planning meeting is called. The guidance could be clearer about the roles and responsibilities around initial meetings to discuss a child's wellbeing concerns and assessing whether a Child's Plan needs to be instigated and then holding subsequent child planning meetings. Currently some health visitors are finding that other professionals will demand that they, as the Named Person, set up meetings even if there is a Lead Professional from another agency. There needs to be clearer guidance on who prepares, manages, reviews and ends the Child's Plan, and the processes for escalating and resolving disputes need to be strengthened.

There is also some confusion about whether there needed to be a Child's Plan when only one agency e.g. health, are involved. Though the guidance makes it clear that a Child's Plan is needed when there is a targeted intervention, it may help to state explicitly that this could be when there is just one or multiple agencies involved. Another area where it would be helpful to have further guidance is where there is more than one child involved and where parents have complex needs.

Different services have different thresholds and understanding of wellbeing concerns, which may impact on how concerns are managed. This often comes down to professional judgement and this is where there will need to be training.

As has already been raised during the Scottish Government consultation events, we feel that there needs to be further guidance about what is a targeted intervention. There also needs to be clarity about what happens if an ordinarily routinely available service does not have capacity. Does this then become a targeted intervention?

It would be useful if the guidance made clear how a Child's Plan and a child protection plan should align together.

Additional issues

- **School nurses:** The introduction of the Named Person role will also have a big impact on school nurses. We have concerns over the capacity of school nurses, especially if there is an expectation that school nurses will take on the Lead Professional role for school-aged children. There will need to be clear communication and information sharing of health issues between the school nurse and the Named Person for school-aged children, with school nurses involved in child planning meetings.

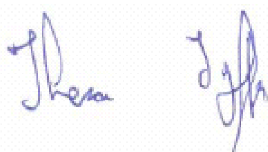
- **Further guidance:** Some of the areas of concern our members have raised will be best addressed by professional/practitioner guidance. There will need to be both national guidance and local procedures that respond to local context and support good collaboration between different professional groups.

- **Communications plan:** The Named Person role will create certain expectations from parents about what the role can provide. Given the perceptions of the contentious nature of the Named Person role, we ask whether there is a communications plan around the implementation of this CYP Act and how the expectation of parents, carers and others will be managed? When this part of the Act comes into force, is there a national communications plan for the agencies and professionals who will be affected?

- **Evaluation:** An evaluation plan of the proposals brought in by the CYP Act should be built into the implementation of the legislation.

We recognise the importance and complexity of implementing this part of the CYP Act and welcome having the opportunity to contribute to the development of the statutory guidance. We would be happy to be involved further in developing the statutory guidance and in further professional/practitioner guidance. If you would like to discuss any of the points we have raised in this response in more detail, please contact Helen Richens, Policy Officer: helen.richens@rcn.org.uk.

Yours sincerely,



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