Safeguarding the neglected child in Cambridgeshire

Cambridgeshire LSCB, University of East Anglia & the NSPCC

Dr Ruth Gardner and Dr Fiona Colquhoun
with
Emma Mc Manus M. Phil & Dr Julie Young

February 2010

For LSCB Internal use only
Not for reproduction in any form without the authors' permission

Acknowledgments

The authors:

Ruth Gardner PhD, MA Cantab is Senior Research Fellow at the centre for the Study of the Child and Family at the University of East Anglia, funded by the NSPCC.
A member of the UEA team commissioned by DCSF to produce the Biennial Analyses of Serious Case Reviews 2003-05, 2005-07 and 2007-09, she has also researched and published on current practice and policy on child neglect in England. This has included visits to over twenty LSCBs and development work with three of them. She is currently leading the NSPCC's strategy and development in relation to neglect.

Fiona Colquhoun PhD was Evaluation Officer with NSPCC and is currently a Business Benefits Manager with the Metropolitan Police.

Major contributors to this report are:
Emma McManus M.Phil, Evaluation Officer NSPCC.
Julie Young PhD, Research Associate at the centre for the Study of the Child and Family, University of East Anglia

The authors would like to thank all those professionals within Cambridgeshire who gave their time and ideas to this work - sixty- six who attended groups and completed questionnaires, plus four other interviewees. We are particularly grateful to Carol Wells (Training and Practice Development Manager) who set up most of the interviews and who has supported the project throughout.

Contents

Acknowledgments 2
Executive Summary 4
Timeline 4
Summary of Actions based on the Findings 5
Why have an LSCB strategy on neglect? 7
Serious incidents and deaths 8
ISSUE 1: Risk assessment 11
Prioritise 11
Learning 13
Action 14
ISSUE 2: Improve data and the information base on neglect 16
Prioritise 16
Learning 17
Action 18
ISSUE 3: Graded Care Profile (GCP) 20
Prioritise 20
Learning 21
Action 22
ISSUE 4: Thresholds/ CAF/ LP 24
Focus 24
Questions about the CAF process 26
The care proceedings threshold 27
Learning 28
Action 28
ISSUE 5: Inter agency communication 31
Prioritise 31
Learning 32
Actions 32
ISSUE 6: Increase learning from best practice and innovation in Cambridgeshire 34
Focus 34
Learning 35
Examples of preventive work 37
Action 40
Appendices 43

Executive Summary

This project is a joint learning exercise between the LSCB, the University of East Anglia and the NSPCC. The NSPCC funded the major part of the work.

Timeline

Our interim report was delivered to the LSCB in late September 2009. It presented findings of a baseline study of practice on neglect in Cambridgeshire, from discussions with seventy practitioners and managers from LSCB partner agencies at meetings held across the county in 2009. Sixty six questionnaires were completed and much of the resulting material, responses and discussion notes, has been analysed independently of the evaluators at the University of East Anglia using a qualitative search tool, nVivo.

The findings covered current interventions and strengths and gaps in joint work with child neglect across the county. The interim report was sent to all the respondents as a draft with a feedback form.

At the time of its presentation a new LSCB chair had just taken up post and Children's Social Care were in the middle of an Ofsted inspection. We received feedback on the report from two respondents, plus the LSCB chair and one senior manager in social care.

We have been asked to identify any gaps we found in LSCB partner agencies' response to child neglect, and secondly to set out a strategy linked to the evidence on practice seen to work well with neglect. We have structured the report around six key issues or themes raised by practitioners and managers in all the LSCB partner agencies.

Although we have spent some thirty days in the county we have inevitably missed examples of good practice. Such practice seems at times to be too well hidden in Cambridgeshire.

Summary of Actions based on the Findings

Our main findings fall into six areas for action:

1. Develop a clear model of risk assessment;
2. Improving data on child neglect and Q/A information on inter agency practice with neglect;
3. Support the use of the Graded Care Profile as a specialised assessment tool across Cambridgeshire. This includes applying consistent standards to, and evaluating, its use;
4. Clarify and communicate common thresholds for action on neglect concerns across all LSCB. This will include links to the Common Assessment Framework and Children in Need procedures and will specify how concerns about a child are escalated eg following referrals from within the community;
5. Improve inter and intra agency communication in cases of neglect;
6. Demonstrate a learning cycle so that best mainstream practice and practice innovations are used equally to stimulate improvement.

We believe these are practical aspirations, arising directly from practitioner concerns and relate to LSCB priorities, which are listed below:

1. An LSCB that is passionate about safeguarding and can deliver the vision and purpose.
2. An LSCB that is fit for purpose and cares about doing the job well.
3. An LSCB that takes responsibility and is business like.
4. An LSCB that can tell the story by developing comprehensive management information, performance management and quality assurance systems.
5. An LSCB that recognises that members of the work force are the solution to safeguarding children.

In the body of the report each of these issues is presented in a separate section, linking them to a *learning cycle approach* (focus, prioritise, learning and action). Each section contains explanatory text to support a series of diagrams depicting the core elements of

the learning cycle. Evidence is drawn from themes emerging from the fieldwork and where possible, supporting quotations from practitioners.

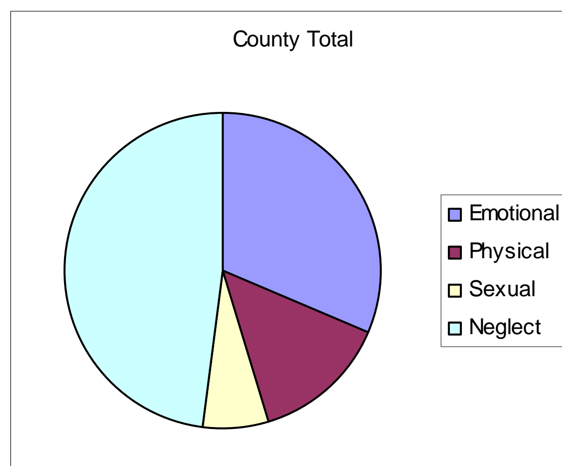
We have been very impressed by the dedication and energy brought by Cambridgeshire's practitioners and managers to the demanding task of safeguarding children. Our observations are intended as those of a "critical friend" to assist in this.

Why have an LSCB strategy on neglect?

Firstly, the very high incidence (occurrence) of neglect, at the level of significant harm, in Cambridgeshire is of concern and demands closer analysis.

The available data for October to December 2009 indicate that of the 349 child protection plans in that period, 244 or over two-thirds (69.9 percent) involve neglect as one category of concern. When considering the incidence of neglect within child protection work, this figure of two thirds is most helpful in our view as it applies to plans /individual children.

Cambridgeshire uses multiple categories on some children so there are 508 categorisations in total used on the 349 plans. Thus the pie chart below shows the proportions of those 508 categorisations by type of harm, of which neglect categories (244 out of 508) are just over half.



The breakdown by area of Cambridgeshire is also shows the proportion of categorisations, NOT the proportion of plans, that falls within different types of harm. Some areas use multiple categories more than others.

Huntingdonshire appears to use more "extra" categories than other areas, (136 plans with 225 categorisations). Cambridge and South Cambs use fewer "extra" categories (90 plans with 118 categorisations) and in East Cambs and Fens the figures are 123 plans with 165 categorisations. We do not have figures for the proportion of *plans* in the areas which show neglect as the main (or second/third) category. One disadvantage of multiple categories is that data is less easy to relate to incidence, the head count of cases.

There is strong national evidence that the threshold for a protection plan in neglect cases is high ie severe or acute developmental damage has occurred or/and is apprehended. These figures represent a major challenge in terms of family difficulties to resolve, developmental damage to treat and future costs.

From these figures we can also infer that at least a half of all "children in need" cases include concerns actual or likely child neglect. If the LSCB were to use numbers of children currently assessed as in need across the county as well as sampling assessments where neglect is the major issues, it should be possible to profile fairly accurately the scale of the preventive task with regard to child neglect identified as requiring a response, but beneath the significant harm threshold.

For further comments about data availability see Issue 2 .

Serious incidents and deaths

The national analyses of serious case reviews have found that neglect plays a major part in child deaths and serious injuries, both directly and as a contributory factor.
Often harm through neglect has featured for years, with a cycle of the case being opened and closed. Where the child's experience remains detrimental overall (ie improvements are not sustained) this lack of consistency takes a toll on the child's health and development.

There is now a convincing research base for the long-term damage caused by an erratic pattern of care-giving (eg Sroufe et al, 2005)

Across England up to 22% of incidents result directly from neglect or/and up to a third follow a history of neglect. The incidents include deaths by fire or smoke inhalation, drowning, ingestion of toxic substances, overlying, lack of required medication, and suicide. (Brandon et al, 2006, 2008)

Understandably there is a growing interest both among professionals and the concerned public in methods by which the number and severity of these incidents can be lowered.

Although many overview reports start with the words "this was a tragic accident", it is possible to identify points where firstly, a better understanding of the parenting challenge and secondly, a relatively straightforward intervention might well have altered the sequence of events.

Four such cases are sampled below, and we understand that very recent Serious Case Reviews and press reports from Cambridgeshire repeat the messages here and indicate areas for improvement in recognition, communication, risk and assessment, decision-making and follow up where neglect is a feature.

"Charges of child cruelty and neglect relate to the period 2002 to 2008 – the family had been known to Children's Social Care since 1999. Neglect included leaving the children on the streets all night and not feeding them" (Press report, 2009).

"An anonymous referral re the children being possibly left alone was not dealt with in line with procedures and went unaddressed. Background information was not fully collated and analysed…concerns (were) too readily downgraded" (SCR (A) Summary, 2009)

"Scrutiny of the files revealed evidence of neglect and abuse in relation to all the children in the family over a lengthy period." (SCR (B) Summary, 2006)

"The constant chaos in the home seriously disrupted the children's health and education...it seemed very difficult for practitioners to develop an over view to inform decision-making…the absence of more "concrete" evidence meant that the (children's) expressed opinions did not result in a more protective approach"
(SCR C Summary, 2006)

Even at a later stage of neglect, interventions can reduce the degree of harm suffered. A recent inspection of safeguarding services in Cambridgeshire notes that "*there is evidence that earlier intervention could have been significant in addressing the safeguarding needs of children where longstanding emotional harm and neglect were factors."* (Ofsted, 2009). These interventions exist in Cambridgeshire (see section); but they are not consistently available.

The local and national evidence therefore indicate that child neglect presents multiple challenges in terms of scale, variable presentation, unpredictable outcomes and lack of validated interventions. The greatest challenge however is one of losing the momentum needed to improve outcomes for children in this group. There is evidence that a joint strategy based on local knowledge can join up and reinforce otherwise disconnected pieces of work, increasing their overall impact. (Oliver et al, 2001)

ISSUE 1: Risk assessment

Prioritise

Lack of adequate risk assessment is a frequent criticism voiced in Serious Case Reviews at a national level. The criticism applies both at the early stages of contact with a family, when "risk " is sometimes not considered at all, through to later stages when sadly the focus can sometimes shift away from the child's immediate safety to resolving adult problems or to the decision making process.

Child neglect can present as a crisis, without obvious warning signs, and to a practitioner who may not have seen a similar case before. Practitioners in all agencies - education, health, adult services etc - have to be ready to make an preliminary risk assessment, if only in order to seek advice on their concerns.

Brandon et al (2006, 2008) found that a proportion of serious incidents occurred near to a key decision eg while a case was already in the court system. The issue has been raised in Cambridgeshire in three separate Serious Cases:

"an audit of single and inter agency training in risk assessment should be undertaken and) inform the…use of available models of risk assessment within and across LSCB partner organisations" (2006)

"historical knowledge about abuse and vulnerability (in the family) was not fully considered when professionals were undertaking risk assessments...all agencies should have mechanisms for monitoring and assessing risk" (2006).

"The LSCB should ensure that all agencies have mechanisms for monitoring and assessing risks".(2006).

In Joint Area Review of "good" and "outstanding" safeguarding services, the following is a typical judgement:

> *"there are strong protocols and good evidence of work to identify risks early…for example during a Family and Schools Support Team allocation meeting where intervention plans across agencies were agreed with innovative input from health colleagues."*

Risk assessment was infrequently mentioned in our interviews but respondents felt that it should be better integrated into wider assessments eg the CAF. More systematic use of the CAF and Graded Care Profile both across LSCB partner agencies and geographically across Cambridgeshire, could assist with this.

Some thought that it was sometimes less than clear how concerns about care of a child would be resolved. For example at the completion of a CAF, if the parent declined to have information passed on and the issue did not appear to be at the significant harm threshold, some interviewees were not confident that their concerns would remain on record or that any further action would be taken (see Issue 4 Thresholds, page 24).

Some replies put the case for clearer requirements for all agencies to report and record unresolved concerns, and improved training in, and understanding, of information sharing protocols (see references HM Government 2006).

There was felt to be a lack of a common language for risk assessment; currently different professionals use different approaches and some avoiding the idea of "risk" altogether. A common approach, or at least sharing approaches, could improve preparation for care proceedings and save costly postponements. (see thresholds/courts)

Learn: what works?

Some managers had made use of **multi agency chronologies** on cases of concern. This tool, an abridged form of that used in case reviews, has been used to demonstrate patterns of care that a single agency record may not reveal. (see References to Gardner, 2008 and Blackpool LSCB Procedures appendix 10 multi agency chronologies).

Such efforts to develop practice in risk assessment in Cambridgeshire should be identified, tried out and then if helpful, applied more widely by the LSCB. It may be that specialist services also have risk assessment processes that could be adapted for mainstream use.

One example of a risk assessment tool is **Signs of Safety,** now taken up by a number of LSCBs we have visited, and is use across northern Europe and North America. It was originally developed in Australia with child protection workers, in response to:

"One of the most consistent complaints made by families investigated for child abuse… that they did not know what the statutory agency wanted of them." (Turnell and Edwards, 1997).

In England some children's departments are adopting this approach to improve decision making in child protection. In the national study (Gardner, 2008) interviewees from all agencies involved (Police, Social care with adults and children, Children's Guardians) thought it especially useful with neglect because:

1. parents say they are clearer about what is expected of them and receive more relevant support;
2. the approach is open and encourages transparent decision-making;
3. the professionals had to be specific about their concerns for the child's safety;
4. this encouraged better presentation of evidence;

5. the degree of protective elements and of actual or apprehended risks could be set out visually on a scale, easier for all to understand than lengthy reports;
6. once set out, the risks did not have to continually be revisited;
7. fluctuating levels of risk and patterns of risk to children can be monitored and represented more straightforwardly;
8. the group could acknowledge strengths and meetings could focus on how to achieve safety.
9.

See Appendix (Signs of Safety) for more detail.

Action

1. The LSCB to identify and develop a consistent approach to risk assessment across the partner agencies, linked to other essential guidance on thresholds, escalation and de-escalation of concerns and contingency planning.
2. If it has not already done so the LSCB should learn about the Signs of Safety model in order to make an informed decision about its applicability.
3. Ideally one model of risk assessment will be used by all agencies, to develop shared understanding. If this cannot be achieved the models their application need to be communicated.

ISSUE 1: Risk assessment

Prioritise

Why is it important?
Poor or non existent risk assessment has regularly been a feature of serious incidents and deaths of children due to neglect, both nationally and locally.
Staff who undertake initial assessments are often unsure what information they can access or how to record or communicate any unresolved concerns.

Relate issue to LSCB priority area
The LSCB will demonstrate its responsibility for best practice in safeguarding at all levels of practice.
Other priorities
The introduction of a specific model of risk assessment would make quality assurance and audit much more practical

Relate to project findings
Interview/questionnaire respondents expressed uncertainty as to how the level of risk to any particular child is firstly assessed, secondly reported and thirdly monitored across Cambridgeshire.
There is evidence of local work in this area that has not been evaluated or developed.

Learn: what works?

What works well in Cambridgeshire?

The review officers identify/ monitor risk and safeguarding actions with timelines for action, and this role could be developed.
Multi agency chronologies are used by individual managers and should be considered as a tool.
The GCP if used consistently can identify risk related to inadequate care that requires safeguarding action (particularly with neglect) and should be developed (see section below)

What works well elsewhere?
"Signs of Safety" has been tested in practice with trained staff elsewhere and is part of many LSCB procedures. It has been written up and has clear guidelines. Our research found high approval rates in terms of clearer protection plans.
Multi agency chronologies are also increasingly used to reveal patterns of behaviour that may present risk, particularly important with neglect. There are other models.
Some LSCBs have effectively included community services such as Fire Services, Accident Prevention etc to consider joint approaches to safeguarding children in geographical areas where risks are high.

Action

How to take this issue forward?

A Learning Set on multi agency risk assessment that includes any/all of

eg social care managers, review officers, health and education professionals, domestic violence officers, substance misuse workers, police, and other services as appropriate; to consider some of the models outlined above, and their added value to current practice.

A working presentation to the LSCB and practitioners from partner agencies, of one or more models of risk assessment and their strengths and weaknesses.

LSCB to trial and monitor a single approach to risk assessment reviewing participant's (including families') experience and effectiveness of CP plans before and after. Implement with regular monitoring of CP plans.

ISSUE 2: Data and the information base on neglect

Prioritise

The recent inspection of safeguarding services in Cambs (2009) found:

"relatively weak and locally generated systems for monitoring performance and driving improvement…appropriate quality assurance arrangements are in place. However, at the operational level these are inconsistently applied and are compounded by the limitations of the information systems."

An SCRs recommended: (2006 Case C) *"a multi agency audit process which involves regular sampling of referrals and responses"*

We heard from many interviewees that ICS (the Integrated Children's System) has presented problems, in terms of both input and access to case information, and from some that it is underused as a result. With regard to child neglect there is a real issue here. Information which as an isolated incident appears to be "soft" and below the child protection thresholds, (for example about substitute caretaking, police call-out, attendance at A & E, non attendance of a child at health appointments etc), can as a *pattern of child rearing behaviour* be critical to assessing risk and safeguarding. Such information has to be available and readily shared by all partner agencies if the need arises. Staff who undertake a CAF have to know whether a family is already in contact with other agencies.

We asked all respondents whether cases of neglect are identified and counted, and if so where the data is held. A minority counted such cases in their own caseload or team, and a further group thought data were held centrally in Social Care, either as child protection data or as a need code. Over half of respondents had no idea what the proportion of neglect cases was at any level (locally, county-wide or nationally) and the rest gave us varying estimates from "a lot" to " about two-thirds" to "85 per cent of those on a CP plan".

We would argue that monitoring can only be effective if there are sound baseline data from which to focus in on particular groups (for instance, under 1 year olds) and set realistic targets for improvement. There do not appear to be sufficient resources invested in robust systems to deliver the necessary detailed data. We found it impossible, despite officers' best efforts, to achieve a clear comparable picture of child neglect incidence across Cambridgeshire (and by extension the same would be true of any other group). We can compare the way cases are categorised here, but that is not the particularly helpful.

It is also essential to be able to track children who go missing or who attend a number of different services and it is unclear whether information systems assure this.

Learn: what works?

The LSCB should be able to see how many children are on plans for neglect in each locality, and profile them by age, gender, ethnicity, school attended, etc. We know that even more micro data is available to many LSCBs with mapping of CP plans that show clusters of safeguarding concerns of various types.

At another level, profiling assessments of children in need (even in a sample) could provide a wealth of further information about children whose development and welfare are compromised without services, and which of these become children in need of safeguarding.

We know of LSCBs with access to such data by category of need who have found it invaluable for service planning and commissioning as well as targeting support to practitioners. To do this it is essential to have electronic CAF available so that data can be collated regularly. Electronic Tracking systems are in place in some agencies eg in Sunderland, a child's attendance at any hospital Accident and Emergency Department is recorded electronically and three attendances trigger a referral to Primary Care and, if there is no GP, to the Trust.

Action

We suggest that single (rather than double and even treble) categories of harm should be used as recommended by DCSF. If this is not going to happen then primary categories should be presented in data so that actual incidence, as defined by the numbers of children on plans for neglect can be compared area by area and locality by locality.

If it has not already happened, links should be sought with comparable LSCB's for development ideas. Some of these examples are on the DCSF website: http://www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/integratedchildrenssystem/integratedchildrenssystempresentations/presentations/

ISSUE 2: Improve data and the information base on neglect

Focus

Why is it important?
The limitations of current information systems (both generally and in relation to cases of child neglect) have been focussed on both internally and externally.
LSCB priority area
"An LSCB that can tell the story by developing comprehensive management information, performance management and quality assurance systems".

The LSCB cannot measure improvement and hence cannot fulfil this priority without up to date, high quality, and detailed analysis of data on children at risk and in need.
Such data is used to inform service improvement targets and locating new services.
Inter-agency working is hampered by a lack of common understanding of the scale and distribution of child neglect.

Project findings
We found the majority of respondents did not know whether, how and where data on child neglect (or other needs) were collected, stored and used.
The few who did gave varying estimates.

Learn: what works?

What works well in Cambridgeshire?
Individuals have invested much time and effort to supply adequate data for day to day planning.
Reviewing officers provide a helpful monitoring role and much needed consistency .

What works well elsewhere?
Using child protection data protection by category and demographics (without using any identifying information) to map and profile where and in what ways children are at risk.
See EG City & Hackney LSCB report data "http://www.hackney.gov.uk/chscb"
http://www.hackney.gov.uk/chscb and follow link to Annual Report 08/09 pages 34/35
The same has been done for children in need ie profile neglect concerns and outcomes.

Electronic tracking systems for children who go missing from home or school, for attendance at A and E , for Did Not Attend (DNA) at health appointments and for automatic escalation of these cases for follow- up.

Action

How to take this issue forward?

Revise Information Aims, Sources and Resources to set Improvement Targets.
Ask manager s and practitioner what data would be helpful.

Commission short comparative evaluation of CP data systems and tracking systems.
Agree outcomes, resources and plan.

ISSUE 3: Use of the Graded Care Profile (GCP)

Prioritise

This tool has now been deployed in over sixty local authorities to help identify and intervene in cases of child neglect. It is included in many Child Protection manuals as contributing to risk assessment.

The GCP was designed by a health professional with child neglect in mind, and has been refined with practitioners over several years. Where a child's development and/or parental care give active cause for concern, the GCP is a way of achieving greater clarity and transparency about the nature and degree of those concerns, for *both professionals and family members*. As a result it can help to specify responsibilities, actions and services needed to meet the concerns.

Like the Signs of Safety approach (see Risk Assessment above) the GCP is based on a continuum of care. It uses a qualitative linear scale based on child development theory. This profiles the child's care in a range of developmentally sensitive areas or "dimensions". Each of these can be constructed along a continuum.

In discussion with parents and carers (and children in some cases), professionals draw the evidence together to grade the child's care on four broad areas or dimensions of care: 1) physical care, 2) safety, 3) love and 4) esteem. Each of these has sub areas. Each dimension and sub-area can then be graded, as follows:

Grade 1	All child's needs met; child first; best care
Grade 2	Essential needs fully met; child priority; adequate care
Grade 3	Some essential needs unmet; child and carer at par; equivocal care
Grade 4	Most essential needs unmet; child second, care poor
Grade 5	Essential needs entirely unmet/parent hostile; child not considered; worse.

Learn: what works?

The Graded Care Profile in Cambridgeshire

GCP was officially launched in Cambridgeshire from Luton in 2008 and disseminated across South and East Cambridgeshire by practitioners, who passed on their training to others in a range of settings. It is a positive example of inter-agency practice development in the field of neglect that has been supported by managers and undertaken by practitioners across LSCB partner agencies, especially family support workers, health visitors and school nurses. It fits well with the LSCB strategy commitment to developing safeguarding practice.

Among respondents to our survey, the GCP was by far the most frequently mentioned example of good practice development in the field of child neglect, and the only one referred to and/or used by every professional group, including health, education, the police, and social care. Some practitioners in all these groups have trained in its use.

Examples of its benefits included:

1. *It helps you to observe and look;*
2. *It gives a common language across agencies;*
3. *It can help parents understand the reasons for concern;*
4. *It allows us to look at the whole spectrum of neglect, not just one aspect;*
5. *It can inform a CAF, support a referral or initiate a CP investigation.*

Because GCP helps practitioners to establish evidence of concern relating to a child's unmet needs, it can improve interagency communication about thresholds for action and escalation.

These are all issues regularly raised in Serious Case Reviews as areas of practice deficiency. In addition to the main survey we interviewed seventeen practitioners and managers in depth about the GCP. They overwhelmingly considered that it had

improved practice in terms of quality of information, recording, interagency communication and response to the family.

We occasionally came across the view that *we do not need this tool as there is very little child neglect in our area.* We suggest that this view should be challenged by the LSCB. Skills in identifying neglect are even more vital where it is less frequently encountered .

Action

We conclude that there is a strong rationale for continuing to develop the Graded Care Profile in Cambridgeshire as a powerful aide to need and risk assessment. The following points raised by staff, concerning training needs, consistency of use and learning from use offer Next Steps:

1. We need a rolling programme of training and refresher courses across the county;
2. Training should apply to all agencies working with children and, all should supply trainees; It should be part of staff induction;
3. Training should include magistrates;
4. Training should include more education (nursery/school) based staff;
5. The staff who champion it and provide advice move on, so there should be a central group who are replaced as necessary;
6. It is being used differently and being modified; we need a review of the wording and consistency of use;
7. An electronic version would be good
8. It needs to be clearly linked to the CAF and procedures
9. We should evaluate the first years of its implementation and its impact on practice.

ISSUE 3: Graded Care Profile (GCP)

Focus and Prioritise

Why is it important?
This was the single most frequently mentioned aide to good practice with child neglect.
Many of the respondents referred to this tool across the partner agencies and all found it helpful in inter agency practice with child neglect, with a few qualifications.

LSCB priority area

Cambridgeshire is one of many LSCBs using the GCP, many having recommended its systematic use within their procedures . Its use is extending slowly across the county and across agencies within the county.

Relate to project findings
"We use it as a benchmark of how well a child's needs are met and can then measure change, evidencing improvement , no change or deterioration"
"Parents can see exactly what is working and what they need to do differently"
"We are all talking in the same terms, that makes such a difference".

Learn: what works?

What works well in Cambridgeshire?

GCP helps to:
Identify and respond to specific areas of unmet need (eg physical care, emotional care, home environment etc);
Identify areas of high potential risk;
Achieve consensus between agencies and with families on level and reasons for concern and WHTBD;
Increase practitioner and parent confidence.

What works well elsewhere?
GCP has been written up, has a website for reference, many LSCBs have guidance.
It needs local and national evaluation.

Action

How to take this issue forward?
Include GCP in induction
Rolling programme of training across agencies -needs to be managed and reviewed
Briefly evaluate its current use then taking account of views produce guidelines for consistent application.
Consider extending its with EG children in the LAC system: parents with learning difficulties, parents with substance abuse problems
Collated data from (a sample of) GCPs could provide an invaluable profile of levels of neglect from mild , intermediate and severe to focus interventions/ service development more efficiently.

ISSUE 4: Thresholds, the Common Assessment Framework and the Lead Professional role

Focus

Thresholds were frequently mentioned throughout the fieldwork and became a common theme.

Neglect seemed to be a subject that created anxiety in referrers. Firstly, there was concern about how best to communicate what they had seen and/or heard, and secondly about the outcomes. For instance would doing this jeopardise relationships with the family? What action might be triggered? Confusion about what the thresholds were for an agency accepting a referral were frequently mentioned, along with geographical differences among agencies about the thresholds they used. Lost preventive opportunities were mentioned with processing referrals in some instances taking so much time that the family situation had deteriorated:

"You are trying to keep parents on board but if six weeks pass after referral and nothing has happened it gets difficult. Where the process between locality teams and social care is relatively seamless, it works well but sometimes a case can go to meeting after meeting with nothing changing for the child, or indeed it's getting worse."

"we need common standards and thresholds across agencies and a safe place to discuss any disparity".

"we need consistency of thresholds – a series of actions the professional response) to concerns
needs to move quicker; we need to set a deadline and if that's not met a threshold is reached for action".

The issue has also been raised in SCRs, of which this is just one example:

"Publish criteria for making referrals and the way these should be responded to" (Case C, 2006)

"Agencies who did not agree with the "family support" approach to the family did not seem clear how to take forward their continuing concerns"
(Case C, 2006)

"Review the thresholds used across the county in order to highlight any differences between areas" (Case C, 2006)

Given the development of locality teams there are bound to be areas where a number of roles and possible interpretations of threshold apply;

"it is possible that services will have been provided by the locality team prior to assessment by Social Care and that the Locality Team may be involved after the Area Social Care team have been involved. There may also be a point at which the Social Care team and the locality team are involved. At this point the Social worker rather than the locality worker will be the main case holder /lead professional." (Revised procedures re Children In Need, 2009)

Despite this guidance for Children's Social Care staff, our responses indicate that this is not always clear to other agencies on the ground and that neglect cases often involve many agencies working at different levels of intensity with different issues .

The issue has been raised externally:

"Children and young people most at risk are adequately protected…further work is required to ensure greater consistency of approach in respect of children and young

*people who are in need, particularly where chronic neglect and emotional harm are continuing features of their lives. In this context the LSCB is required to review page 10 of the interagency procedures in order to achieve greater clarity on thresholds". (*Joint Area Review 2007 p 19)

*"Agencies appropriately identify children at risk and make timely referrals…agencies that refer to children's services are not consistently informed of the outcome." (*Joint Area Review 2007 p 19)

Respondents told us that should early stage problems not be resolved or the situation deteriorate, an initial assessment using the Common Assessment Framework may (but is not required to) be undertaken either by the concerned agency or the locality team. We are not clear as to whether Children's Social Care will accept referrals without a CAF. CAF practice nationally is divided between areas where Children's Social Care only accept referrals supported by an initial assessment and those where the process is a negotiated one. Each approach has drawbacks but the advantage of the former is that a range of agencies become expert with the CAF tool. In Cambridgeshire, the Common Assessment Framework was referred to infrequently and Lead Professional role was mentioned only once in our interviews, whereas elsewhere (see below) both are key to early intervention with child neglect.

Questions about the CAF process

A potential difficulty with the CAF is its voluntary nature and that information (about the child or the parent) cannot easily be obtained from other agencies or via ICS. If provided by a child or family member it was thought that information cannot be shared without the parent's agreement. There was a view that perceived criticism or challenge to a parent could be difficult within this framework, yet if this was not done a situation might quickly deteriorate.

Some respondents took the view that short of child protection concerns, agencies could not become involved with the family if either the child or the parent did not consent.

Others thought that if a child wanted or needed help, a way should be found to provide it. They thought the "service around the child" demanded this approach.

Some said that when a CAF was completed they could and would register unresolved concerns with a manager. Others were less sure of this process being effective.

Some felt that there was a risk of an assumption that the CAF itself would address all potential concerns, whereas this was not always the case. They were worried that some assessments were delayed, incomplete or had to be repeated.

The care proceedings threshold

Workers who had been involved in family proceedings in neglect cases had a mixed experience. Some respondents commented that magistrates appeared more inclined to see neglect as reversible with additional support and to take the view that to make an Order would be unduly punitive, particularly where the parent had health or learning difficulties.

They would have liked more training, preparation and rehearsal for presenting evidence in such cases, including sharing courtroom experience and/or shadowing colleagues in court:

"…it was only after the court case which was very difficult that I found a colleague had similar experience; as it is quite a rare event for most of us, I think it would help if we could get together with those who have been to court recently or do so regularly."

Articulating the threshold for consideration of proceedings in neglect cases across the partner agencies, including most importantly adult services, could greatly assist in these decisions which are often taken on short notice.

Learn: what works?

There were many positive comments about the **Contact Centre** and locality teams in terms of their speedy response to concerns. New **Children in Need procedures** have recently been produced by Children and Young People's Services (November 2009). They reiterate a **Model of Staged Intervention** (MOSI) introduced in 2006 to provide a framework *for developing a common understanding of children's needs and the roles and responsibilities of services*. The stages are tiers one (universal services) to tier four (child protection). There is a resource pack *to help practitioners understand the roles and responsibilities of their own agency.* This work is very timely in clarifying roles and responsibilities in Children and Young People's Services.

The **Windscreen Model** as used in Hampshire and elsewhere, which uses the complexity of the case on a continuum as an indicator for a lead professional to be involved either in single agency or integrated work, is helpful here.

A booklet available from Worcestershire LSCB as hard copies and on their website (Mercia) called **Interagency Threshold Guidance** does this very effectively .The LSCB there have found the product useful but more importantly the process of producing it has been invaluable (see refs) .

Several authorities have trained family support workers in a range of settings (health, schools, children's centres) in consistent use of the CAF and its tool-kit of measures, in use of information, and in child protection awareness and actions. Lead professionals have also emerged in a range of disciplines.

Bristol LSCB has produced an **escalation policy and flowchart** to resolve professional disagreements in safeguarding children. See References.

Action

The Lead Professional role needs to be clarified, given authority and supported as a key role in co-ordinating plans for children and families where child neglect is an issue and preventive support is under consideration. Review new approaches to this role in other authorities.

Build on excellent work on CiN procedures and guidance. Bring agencies together to provide examples of child neglect that illustrate how agencies work together and how concerns are escalated at key points.

The Strategic Partnership could support or restate a common set of thresholds for all agency engagement, with clear guidance as to when and who needs to intervene. This should be used alongside clear escalation and de-escalation procedures. (see References/ Bristol)

This is especially true for neglect. A succinct set of guidelines about indicators of early and severe signs of neglect with pointers to the relevant procedures should be attached. A short multi agency practice guide on thresholds would reinforce interagency communication on thresholds. It should include vignettes of the kind of situation that fits the levels or tiers of need, and the appropriate actions to take and illustrating roles and responsibilities. It could use neglect as the main topic or use examples of neglect to illustrate levels of intervention or escalation (see References /Worcestershire).

ISSUE 4: Thresholds/ CAF/ LP

Focus

Why is it important?
Features of neglect SCRs are; confusion and disagreement over thresholds of intervention; repeat assessments; lack of awareness of risk or child focus (child's views sought) within assessments

LSCB needs to promote clear understanding of thresholds in the context of neglect across agencies, including adult services.
If linked to clear inter agency thresholds CAF will enable consistency of approach, challenge in terms of where to focus early intervention and inter agency communication.
The lead professional role needs to be developed and supported by multi agency reference or consultation groups to improve co-ordination and planning of early interventions.

Learning: what works?

What works well in Cambridgeshire?

Model of Staged Intervention and revised Children in Need guidance (Children's Social Care)
Work to link locality team and CSC processes as seamlessly as possible

What works well elsewhere?
Multi agency extended schools work and wrap around family support (including weekends)
eg Luton, Leicestershire, Milton Keynes has been extremely effective in picking up early neglect concerns and addressing them constructively. SEE ALSO Issue 6 below and the Red Hen Project in Cambridgeshire.

Worcestershire Strategic Partnership's Handbook and web page on Shared Multi Agency Thresholds, using neglect case examples.

Action

How to take this issue forward?

LSCB needs to link up with current work on Staged Intervention/ CiN guidelines to provide agreed thresholds for safeguarding across member agencies that are ,monitored /audited and updated
The Lead Professional role needs to be clarified, given authority and supported as a key role.
Clear escalation procedures for swift resolution of differences of view on thresholds etc.

ISSUE 5:unication

Prioritise

Sustained evidence has been supplied by successive child death enquiries such as Laming, and serious case reviews such as Baby P. concerning for defects in interagency communication.

Government has called on *all* services to establish safeguarding children as a priority with the associated obligations:

"Even the most effective integrated responses from children's services will only ever ameliorate the impacts of parent-based risk factors on a child. ***To reduce the actual risk at source, joint working with adults' services is required to tackle the parents' problems."***

"We know that the more disadvantages a family has the greater the risks of negative outcomes. However, service responses do not usually take into account the accumulated needs identified by different services as each agency is restrained in its intervention by its own eligibility criteria. It may be possible for some families to have a range of problems, all of which fall just below eligibility thresholds but which in combination pose very significant risks. One example was of mental health services not working with an adult in the family as their needs were not deemed severe enough. This was hindering the effectiveness of drug treatments with the parents and affecting the child's school attendance."

Reaching Out: think family: analysis and themes from the Families at Risk Review (Cabinet Office, 2007).

Respondents to our questionnaires in Cambridgeshire frequently referred to these issues, both from the adult and children's services perspectives. There was concern that services had ended up giving evidence on opposite sides of a care proceedings case, when better earlier communication might have avoided this.

"I think that substance misuse agencies are not always involved until crisis point when they might have done more earlier on."

"Drugs Teams often do not know about the extent of drugs problems in children's social care cases until a late stage… there may be a lot of unmet need due to concerns about being referred in for treatment".

"We need to ensure that all *the relevant agencies are round the table."*

Learn: what works?

We used the **Every Child Matters outcomes** as a tool to structure inter-agency discussion of how to share practice and procedure in meeting the needs of neglected children in Cambridgeshire. This was well received.

London Safeguarding Children Board Procedures give useful examples of joint aims, protocols and working practices across a very large number of local authority areas and partner agencies within them, including Adult Mental Health, Disability, Drugs, Alcohol and other services. The primacy of child safety and communicating concerns is clearly stated, and linked to agency responsibilities for sharing information. See References.
http://www.londonscb.gov.uk/procedures/

Actions

Develop and audit a **Working Protocol for Safeguarding Children** between LSCB agencies and services for adults (mental health, drugs and substance misuse, probation, learning disability etc) with joint oversight and opportunities for learning on its operation outside of particular cases (ie neutral venue, composite case examples etc) . If such a protocol already exists it needs high level interagency promotion and enforcement across the relevant services .

Consider **Every Child Matters outcomes** as a tool to establish a joint core agenda on neglect with distinct sub- agendas as necessary, both between agencies and across the three main regions of the county.

ISSUE 5: Inter agency communication

Focus and Prioritise

Why is it important?

Successive child death enquiries such as Laming, and serious case reviews such as Baby P. show a lack of collaboration and services unaware of one another's involvement until after a tragedy.
Relate issue to LSCB priority area

Relate to other priorities
Government has indicated the need for Team Around the Family in complex cases where there are several problems (MH, drugs, child neglect) none of which merit compulsory intervention but which require assertive approaches (Think Family)

Reaching Out Think Family. NTA guidelines just published on safeguarding.

Relate to project findings
Our interviews found in Cambridgeshire that despite the intention to work collaboratively there are still varying perceptions of safeguarding responsibility, and in particular both Adult and Children's services express uncertainty about
information sharing and joint work.

Learn: what works ?

What works well in Cambridgeshire?

Review lessons for neglect work from Family Intervention projects and CAMHS

What works well elsewhere?
National Treatment Agency Safeguarding Guidelines
London CP Procedures
http://www.londonscb.gov.uk/procedures/

Coventry Personality Disorder Multidisciplinary Team

Action

How to take this issue forward?

Articulate desired outcome eg all Adult Services (Mental Health, Probation, Substance Misuse, Alcohol Misuse, Learning Disability etc have working protocol and understanding of safeguarding children priority actions (information sharing, joint assessment etc)

Identify any good practice and use as template.

ISSUE 6: Increase learning from best practice and innovation in Cambridgeshire

Focus

There is evidence that earlier intervention could have been significant in addressing the safeguarding needs of children where long standing emotional harm and neglect were factors. Those parents and carers confirm that earlier and more consistent support is needed in such circumstances. (Ofsted inspection, 2009)

We were told of innovative practice with child neglect in Cambridgeshire both at the preventive and treatment levels. The table below (p.35) gives some examples.

Short accounts of some of this practice are also given below (see Learn: what works?). Much of this work was underpinned either by formal research and evaluation or, in a less structured way, by practitioners observing positive outcomes.

Respondents frequently mentioned their frustration that excellent local work was not disseminated and so remained very limited in its availability and hard to sustain over time.

Table 2: A sample of packages of support offered to families

* denotes services not consistently available across the county (according to interviews)

Package 1	
Family support to assist the parent in recognising and addressing issues	1. practical and financial support 2. encourage the extended family to offer support through Family Group Meetings (FGM)* 3. voluntary care for children if necessary 4. School- home links & extended school (eg Red Hen) *
Package 2	
Psychological support	1. learning difficulty nurses for behaviour management * 2. one to one education with individual learning plans* 3. short breaks 4. community support. 5. CAMPIP mother and baby relationship* 6. Nurse Family Partnership *
Package 3	
A "first steps" meeting with CSC	1. health and education colleagues 2. Graded Care Profile* 3. CAF / Child in Need Plan 4. social work support 5. parent training * 6. benefits/finance advice 7. outlets for children* 8. clinic/drug advice.
Package 4	
Intensive treatment	1. mother to residential drug unit to ensure engagement* 2. address housing problems 3. family therapy.* 4. child and adolescent mental health (CAHMS)*.
Package 5	
Treatment and intervention options	1. Multi Agency Risk Assessment (MARAC) 2. public law office and court 3. multi systemic therapy (MST)* .

They also thought that national pilots such as the Family Nurse Partnership reached only a few families. Mainstream workers sometimes felt undervalued and de-skilled by developments that they thought were given far greater resources per family and also higher status.

There are several important issues here for the LSCB. See Action (p. 40) below

Learn: what works?

Child neglect is acknowledged as one of the most challenging and gruelling areas of work for practitioners in all fields. It demands multiple skills; engagement with families, unrelenting observation, interagency communication, analysis and judgment. But as if this was not enough, it also calls for personal attributes such as patience, optimism with realism, consistency and courage. Practitioners can easily become de-motivated and/or de-sensitised. Some ideas about best practice are summarised briefly here. We would suggest reviewing them all with these questions in mind:

What outcomes did the project or role set out to achieve in Cambridgeshire?

Do these outcomes relate to preventing and/or treating neglect and if so how?

Have we measured achievement* and if so has the project/role been successful to date?

*e.g. Has the work supported parents who might otherwise have raised professional concerns about neglect of a child?

* e.g. Has it contributed to the wider safeguarding agenda and prevented costly and traumatic interventions? Can this be evidenced in at least a sample of their work and if so, could the work be extended?

Is the project /role available and applied consistently and if not why not?

Examples of preventive work

Parent Support Advisors (PSA)

One example of local support for universal services is that of Parent Advisors attached to locality teams and primary schools. PSAs were referred to in our interviews as helpful in terms of engagement with parents, communication with schools, and early identification of and response to signs of neglect.

The national evaluation of the PSA pilot (DCSF, 2009) found a relative reduction in persistent absenteeism in PSA schools and that PSAs are highly regarded by schools and parents. It found that budget holding PSAs (up to £3K pa) helped with situations we associate with potential risk of child neglect such as *children travelling to hospital appointments and house clean for a parent with mental health problems who was not cleaning the house*. The evaluation recommended further roll-out of this service *with priority to parents in the greatest need.* This would include targeting early neglect cases. In Cambridgeshire, PSAs are currently used in various ways and only with primary schools. It would be worth reviewing their use specifically in relation to neglect but also more widely. For example, are PSAs budget holders? If not should they be, since the national evaluation shows this to be a cost-effective use of resources.

CAMPIP

"I am quite passionate that infant mental health work may have a profound impact on neglect. We have a very small group called CAMPIP here that works on basically helping parents to love their babies (not how they would put it) – which I think is key to preventing neglect."

The quotation above was typical of those that referred to CAMPIP or Infant Mental Health.

The Red Hen Project

This was referred to frequently as a very popular and effective intervention with children who might otherwise be at risk of neglect, and one that merited being replicated. It could assist learning about the development of community based wrap around support and a the continuum of **popular family support and confident safeguarding** so essential to effective intervention with child neglect (see paragraphs below**) .

The Red Hen Project works with children and their families attending three local Primary Schools. The children's ages will range from 4 - 11 but younger and older siblings in a family would also benefit from the support. In a year the project supports up to 40 families and the number of children will depend on the size of the families. We have supported families with up to seven children.

We offer parenting support on an individual basis as well as offering parenting groups. Our parenting groups are also opened up to anybody else in the community who wishes to come. The children are often offered 1 : 1 sessions in school. The cases vary from support with bereavement, divorce and separation, non attendance at school, behaviour management, physical or mental health problems with either the parent or child, domestic violence, drug and alcohol misuse, neglect and other child protection issues.

During the work with the parents, we look at the children holistically, their situation in school, at home and in the community and try to put a package together for them. We try to engage the children in community groups, we do home school liaison with school to try to ensure that they stay in school and we work on routines, behaviour management, finances, housing and parent child relationships at home.

We partly fund breakfast clubs in two of the schools to ensure children have a healthy and positive start to their day and we run an after school cooking group to give young people a positive activity as well as looking at healthy eating. This has proved positive in inspiring a number of parents to try some home cooked healthy food as well as showing the young people that healthy can be tasty too.

***We work in a multi agency way; we hold fortnightly multi agency link meetings to discuss any children giving cause for concern. The cases are then passed to the appropriate professional and they then feed back to the group to ensure the children do not slip through the net. We also attend child in need and child protection meetings and are part of child protection plans for children that we work with.*

***Cases of neglect or abuse are referred to social care if this is the appropriate agency. If there are concerns that health issues are being neglected, we work closely with the school nursing team as well as health visitors at local surgeries. We would be working with the family to address these issues, particularly if we have a good relationship with them as they are likely to be more open to support from somebody they know. We will*

also stay involved with families who are referred on and help them to access other services and make the best use of them that they can.

At present we are funded jointly by Children and Young Peoples Services, The Children's Fund and BBC Children in Need as well as applying for smaller grants to fund holiday activities, our after school cooking group and other materials we use with the children and families.

In order to ensure that we are offering what is needed, we ask for feed back from the children and their parents and this is very positive feed back. We also ask for feedback from schools, who also report that the input for families is helpful to them as well as the children and families.

Examples of Treatment Services

Multi Systemic Therapy (MST)

The aims of this specialist project are to:

Eliminate physical abuse and/or neglect.
Eliminate or significantly reduce the frequency and severity of the abusive and or neglectful behaviour(s) of the carer(s).
Empower parents with the skills and resources needed to independently address the inevitable difficulties that arise in raising children and young people.
Empower the children and young people to cope with family, peer, school, and neighbourhood problems.
Eliminate or significantly reduce the frequency and severity of the family's referral behaviour.
Increase or improve the family's capacity to develop social networks and to utilise those networks to support parenting.

While this work is resource intensive and cannot easily be replicated, there is much learning here about how to address chronic neglect eg re-engaging families and agencies, which would benefit all practitioners.

Mainstream practitioners also spoke of their own practice development in child neglect eg some had **adapted assessment tools for adults with learning disabilities**; others used **multi-agency chronologies**; others had used **family group meetings** to good effect . This hard-earned learning should be shared alongside more high-profile project work

To interrogate practice developments for useful learning for future service planning, the following questions might be asked:

Do these interventions address cases of child neglect and what specific outcomes are being sought?
If so what is the target population in this respect (eg age, gender, ethnicity, location, school)?
What aspects of neglect are being addressed and how?
Do those involved (child, family, professionals) believe the intervention is effective?
Are the effects (on the child, on parenting, on services) being measured and with what tools over what time period?
Can we compare outcomes with groups of similar children receiving non specialised services?

Action

Firstly, find systematic ways of drawing out and integrating the learning from these initiatives for the LSCB and partner agencies and for practitioners on the ground; to increase their impact; to encourage debate about what works: and to avoid duplication and waste.
One way of drawing out learning would be by an overview of projects and their distribution, reach and impact.

Secondly, highlight mainstream best practice with neglect in order to encourage its wider dissemination and challenge the perception of "two tier" services (ie specialist projects and business as usual) of which only the first is perceived to be "best practice". Regular, even if infrequent, learning events outside the regular training calendar could combine all services including Disability and Adult services that address aspects of child neglect and associated concerns. Area and county-wide events can stimulate wider contact and offer a platform for practice and a sense of cohesion.

Key strategic messages can also be communicated swiftly.

ISSUE 6: Increase learning from best practice and innovation

Focus and Prioritise

Why is it important?
Ofsted has called for the development of earlier interventions with child neglect in Cambridgeshire.
SCRs locally and nationally find that interventions have not been based on thorough assessment and have been "too little , too late".
While locating and reviewing best practice is time consuming initially, not to do so leads to de-motivation and duplication as well as loss of learning for others.

LSCB priority area
Seeking to develop excellence and effectiveness in safeguarding
Developing the workforce.

Project Findings
Some mainstream staff in all agencies were "under the cosh" of day to day work with child neglect and felt they did not receive the status or support of some high profile projects.
Some staff in all agencies had "gone the extra mile" to develop practice in this area of work and thought they had done so to good effect.

Learning: what works?

What works well in Cambridgeshire?

GCP (see above); multi systemic therapy; Infant Mental Health ; Family –Nurse Partnerships ; Extended and Home – School link work;
Use of Multi Agency chronologies ; Family Group Meetings ; work with children and adults with disabilities etc etc

What works elsewhere?

Service re-configurations; EG use of speech therapists, counsellors and family support in the home as a Wrap Around service for short periods EG use of small teams with consultancy to address complex cases/large families; Use of Extended School Services.

Action

How to take this issue forward?
Time Out and Learning Set on practice development , could select a theme eg parents who do not want contact with services .
Give practitioners a platform for their work .
Possible extended lunchtime seminars in each area then county seminar, with facilitator.

Conclusions

Our main findings fall into six **areas for action**:

1. Develop a clear model of risk assessment;
2. Improving data on child neglect and Q/A information on inter agency practice with neglect;
3. Support the use of the Graded Care Profile as a specialised assessment tool across Cambridgeshire. This includes applying consistent standards to, and evaluating, its use;
4. Clarify and communicate common thresholds for action on neglect concerns across all LSCB. This will include links to the Common Assessment Framework and Children in Need procedures and will specify how concerns about a child are escalated eg following referrals from within the community;
5. Improve inter and intra agency communication in cases of neglect;
6. Demonstrate a learning cycle so that best mainstream practice and practice innovations are used equally to stimulate improvement.

We believe these are practical aspirations, arising directly from practitioner concerns and relate to LSCB priorities, which are listed below:

An LSCB that is passionate about safeguarding and can deliver the vision and purpose;
An LSCB that is fit for purpose and cares about doing the job well;
An LSCB that takes responsibility and is business like;
An LSCB that can tell the story by developing comprehensive management information, performance management and quality assurance systems;
An LSCB that recognises that members of the work force are the solution to safeguarding children.

Appendix 1:

Methodology and timeline

The project draws on the national Analysis of Serious Cases 2003/5 and 2005/7 (see references) covering 464 cases. Additionally Gardner conducted a national study on neglect in 2008 including a literature review and interviews with 100 practitioners and managers[1]. This found a high level of concern across LSCBs to move practice with child neglect on, and many new ideas on how this might be done. Colquhoun has developed a model of risk for suicide as part of a literature review on the subject. This means we can relate findings in Cambridgeshire to a much wider body of current knowledge and practice experience.

We have seen a number of policy documents, child protection data relating to 2007 to 2009 and LSCB newsletters. We also read three Executive Summaries to Serious Case Reviews in Cambridgeshire.

We devised a short questionnaire and attended twelve meetings in Cambridgeshire at which it was completed by a total of 49 participants, each answering separately and without prior discussion. Participants then shared views using a similar format for each meeting and notes were taken. Interviews about the Graded Care Profile were held with a further 17 managers and there were four additional interviews.

The answers and notes were analysed for themes and issues using three routes; each of the report authors separately and a researcher at the University of East Anglia who has had no other contact with the project. She has used a computerised analytical tool for qualitative research, nVivo.

[1] Gardner (2008) Developing an effective response to neglect and emotional harm to children

Appendix 2: Risk Assessment: Signs of Safety

(extracted from Gardner (2008))

The model aims to engage practitioners in supportive networking and learning from successful practice (Turnell A and Edwards S, 1997; Myers S, 2005).

The Signs of Safety approach asks the statutory agency for greater transparency, and to specify exactly what will indicate enough safety to close the case. Family members' perspectives on their competencies, existing safety and goals are actively sought. The goal is to *build partnerships with parents and children in situations of suspected or substantiated child abuse and still deal rigorously with the maltreatment issues*. (Turnell and Edwards,1997).

A risk assessment and case planning format are used that set out all elements of safety and danger to the child. The child's current situation is scaled using a simple format (see below). This is available to all involved including parents, and the child can be involved if he or she is willing and able to be. The decision-making group can then set goals for both the family and agencies that will increase safety and reduce danger to the child.

The benefit of a scale or continuum from extreme risk to safety is that it focuses all minds on the child and brings detail and specificity to an endeavour that otherwise can easily become polarised into "them" and "us".

Professionals we interviewed who had used this approach with cases of serious child neglect said that it was helpful.

> *"Signs of Safety is a useful approach because it makes everyone, the family and the professionals, think about what success would look like - i.e. how to make sure the child will stay safe. Everyone at a case conference, or core group meeting or review, including family members if they are there, has the opportunity to say how safe or otherwise they think the child is with their reasons. It is put up on a white board so*

it's there, it's transparent and we do not need to repeat the problems again and again - we can move on to how we are going to improve the situation."
(Child Protection Conference Chair).

"We see the Signs of Safety work very helpful as we can assist with the risk assessment aspect and it looks at protective factors as well, and gets the parents involved" (Police DC, CIAU).

Scaling questions are also helpful in giving detail and specificity:

"It is useful to ask family members routinely a question like: "on a scale of 1 to 10 – where 10 means things in this family are just the way you want them and 1 is the worst they can be - where would you rate things right now?" This can be complemented by a specific safety scale "where 10 means you are certain this sort of incident won't happen again and 1 is you think there is every likelihood it may". The reality is the work is carried out somewhere in the space between total risk and complete safety. Scaling questions tap this sense of continuum and by the nature of their construction embrace the possibility of change." (Turnell and Edwards, 1997).

<u>Signs of Safety Assessment and Planning Form</u>

- Danger: list all aspects that demonstrate likelihood of maltreatment past, present or future
- Safety: list all aspects that indicate safety (exceptions, strengths, resources, goals, willingness etc)
- Safety and context scale: rate 1= not a situation where any action would be taken to 10 = the worst case the agency has seen
- Agency goals: what will the agency need to see occur to be willing to close this case?
- Family goals: what does the family want generally and regarding safety?
- Immediate progress: what would indicate to the agency that some small progress had been made?

Appendix 3: References

Effects of neglect

Sroufe LA et al (2005) The development of the person: the Minnesota study of risk and adaptation from birth to adulthood. The Guildford Press

Issue 1: Risk Assessment

HM Government (2006) Information sharing: Practitioners'guide. DfES

HM Government (2006) What to do if you're worried a child is being abused. DfES

Multi- agency chronologies

htp://www.blackpool.gov.uk/HealthandSocialCare/LocalSafeguardingChildrenBoard/

(CP Procedures Appendix 10 Multi Agency Chronologies)

Issue 2: Improve data and the information base on neglect

http://www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/integratedchildrenssystem/integratedchildrenssystempresentations/presentations/

Intra and inter agency communication

Issue 3 : Use of the Graded Care Profile

Field trial of the Graded Care Profile (GCP) Scale: a new measure of care of children. Srivastava O.P. & Polnay L; Archives of Disability in Childhood; v76; p337-340; April 1997.

Graded Care Profile: A measure of care. Chapter in Assessment in Child Care; eds Calder M & Hackett S; Chapter 13, p227-246; pub Russell House Publishing; 2003.

Structured user evaluation of the GCP scale after 5 year in use. Luton ACPC 2004 (unpublished).

Common operational approach using the Graded Care Profile in cases of neglect. In Child Neglect; eds Daniel B & Taylor J; chapter 8, p 131 – 146; pub Jessica Kingsley; 2005.

Issue 4: Thresholds

Worcestershire LSCB: Threshold Guidance for Practitioners

http://www.proceduresonline.com/west%20mercia%20consortium/chapters/g_worc_threshold_prac.htm

The Windscreen Model see Hampshire under
http://www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/integratedchildrenssystem/integratedchildrenssystempresentations/presentations/

Escalation Policy www.bristollscb.org.uk
www.bristol.gov.uk/ccm/cmsservice/download/asset?asset_id=3135223

Issue 5: Inter agency communication

London Safeguarding Children Board Procedures
http://www.londonscb.gov.uk/procedures/
Sections on parental mental illness, parents with learning disabilities and parents who misuse substances.