SCIE Learning Together

social care institute for excellence

To what extent is Early Intervention in Halton child-focused in addressing adolescent neglect?

SERIOUS CASE REVIEW REPORT FOR HALTON SAFEGUARDING CHILDREN BOARD ON YOUNG PERSON

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Section 1

1.1 Why this case was chosen for review

In December 2014, the Young Person had an exacerbation of his asthma, which went untreated overnight and into the following day, whilst he was staying with a family member. By the time an ambulance was called, the Young Person's life was at risk. The Young Person was admitted to hospital, and the information gathered by professionals raised concerns about whether this teenager had been neglected.

Working Together 2013 was the child protection guidance in use at the time that a decision was made about taking the Young Person's case forward for review. All processes went through the structures of the Halton Safeguarding Children Board, and complied with *Working Together*. Children's Social Care division at the local council sent in a notification to the Safeguarding Board and requested that the Critical Incident Panel, which is part of the Board, met to consider the case. The Critical Incident Panel recommended on 22nd January 2015 that the criteria for a SCR were met - and the independent Chair of the Board agreed with this.

Section 2:

Methodology and the review process

2.1 The purpose of Serious Case Reviews

Working Together 2013 said the following about the purpose of Serious Case Reviews:

Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children. (Working Together 2013:65)

and

Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children. (Working Together 2013:66)

Once the board chair had agreed that the criteria were met for a Serious Case Review (SCR), a further decision was made to use a systems methodology called *Learning*

Together, developed by, and commissioned through Social Care Institute for Excellence, for the SCR.

Merseyside and Cheshire safeguarding children's boards had recently agreed to build their capacity to carry out systems reviews, and were part way through training in the Learning Together methodology at the time the SCR for the Young Person was commissioned. The Lead Reviewers were: Fran Pearson an independent safeguarding professional and accredited and experienced Learning Together reviewer, and being mentored by Fran following the regional training - Professor Jan Horwath - recently retired, but at the time the review started, Professor of Child Welfare at the University of Sheffield. Neither are employed by organisations involved in the review, nor have any conflicts of interest. Previous contacts in the region amount to Jan Horwath having done some development work around neglect, and Fran Pearson having delivered the Learning Together foundation course to a regional group.

The following professionals made up the Review Team of local managers to support the Lead Reviewers:

Business Manager	Halton Safeguarding Children Board
Operational Director Children & Families	Halton Borough Council
Safeguarding & Quality Assurance Manager	Halton Borough Council (first part of the review only)
Headteacher of the Virtual School	Halton Borough Council
Detective Inspector (reviews)	Cheshire Police
Designated Nurse, Safeguarding Children	NHS Halton Clinical Commissioning Group
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An introductory workshop took place on 22nd April 2015, and the final meeting of the Review Team took place on 26th November 2015.

The Review Team met five times to steer the work. The Lead Reviewers and Review Team carried out individual conversations with a total of 10 professionals who had worked with the Young Person. A workshop was held with a wider group of professionals and their managers to gather more data about local practice. An

extraordinary meeting of the Halton Safeguarding Children Board on 2nd October 2015 allowed the Lead Reviewers to share early Findings with the Board and develop the strategic implications of these findings as a result. The following professionals made up the Case Group

Paramedic	North West Ambulance Service
Paramedic	North West Ambulance Service
Family Support Worker - a role in existence at time of work with the Young Person - now in a different role	Halton Borough Council
Social Worker	Halton Borough Council
Social Work Team Manager	Halton Borough Council
Common Assessment Framework Adviser - a role in existence at time of work with the Young Person - now in a different role	Halton Borough Council
Learning Mentor	Secondary School
Assistant Head and Safeguarding Lead	Secondary School
Consultant Dermatologist	Hospital NHS Trust
Dermatology Nurse	Hospital NHS Trust
School Nurse	Community Services NHS Trust

The child's perspective: involving the Young Person and his family in this Serious Case Review

The Young Person agreed to meet with members of the Review Team. His mother and partner also met with the same Review Team members. The Young Person is a thriving young man now, and his very troubling eczema is improved almost beyond recognition. He very helpfully was able to give an account of some of the day-to-day difficulties of living with eczema when he was younger, which are reflected in the Findings. The Review Team would like to thank the Young Person, in particular, for his participation.

2.4 Documents read during the review

The Lead Reviewers checked out or clarified some of the impressions formed during

individual conversations and workshops by reading:

Closing Summary - Family Support Service

Consultation by CAF Support Worker x2

Because the response to the Young Person was around early help, and because assessments and documenting of professional responses were at a much less developed stage for early help in Halton than they are now, there was relatively little written material available to the Review Team. The record from a Strategy Meeting about the Young Person was also used for reference.

2.3 Case reviews and the light they shed on systems and reliability

A case review plays an important part in efforts to achieve a safer child protection system. Consequently, it is necessary to understand what happened and why in the particular case, and go further to reflect on what this reveals about gaps and inadequacies in the child protection system. Using the Social Care Institute for Excellence (SCIE) Learning Together methodology, the particular case acts as a 'window on the system'[1].

For this to happen, the review uses the case of the Young Person as its starting point - but the review itself was in equal part about trying to understand what the usual practices in Halton are, and to give some messages about them to the board. These messages are presented as 'Findings', and the aim of structuring the report in this way is to give the LSCB some insights into what commonly influences professional practice, and outcomes for children.

The Safeguarding Children Board in Halton can then potentially use the findings as the basis to change how the local safeguarding system works, and to make it safer. The Learning Together systems model categorises findings as follows:

- Tools
- Family-professional interactions
- Management systems
- Patterns of multi-agency working in response to incidents/crises
- Patterns of multi-agency working in longer-term work
- Innate human biases (cognitive and emotional biases)

This is so boards can identify and prioritise which areas of their multi-agency safeguarding systems present the most risk - and in turn, which are the greatest priority to address and change.

In what way does this case provide a useful window into our systems?

[1] C. Vincent : Analysis of clinical incidents: a window on the system not a search for root causes 2004

The local Critical Incident Panel identified the following questions as ones that the Serious Case Review could usefully cover:

- The cumulative effect of neglect
- The appropriate use of the safeguarding framework - as the case was managed solely within the CAF framework despite child welfare concerns being evident
- Use of escalation processes between agencies
- Supervision and support of staff working with families at the lower end of the levels of need framework
- A possible lack of child-centred focus in multi-agency partnership working
- The impact of parental mental health
- Understanding adolescent development and promoting resilience
- Disguised compliance/measuring the sustainability of any improvements in the care of the young person
- The approach of professionals to men in the family network (which the Review Team later extended to a consideration of other family members and friends)

These questions are addressed in the report.

The Critical Incident Panel raised two other aspects of the Young Person's case for consideration:

- To understand whether the young person was a Young Carer
- To consider the role of the GP

The Young Person's case did not provide sufficient information to draw conclusions about either of these two issues.

Section 3: The Findings

3.1 Succinct summary of the case

Between Christmas 2014 and the New Year the Young Person , a teenager, experienced a life-threatening asthma attack. The Young Person was sleeping at the house of a relative when his asthma became problematic. Adults in the house did not seek medical help for around 18 hours. An emergency call was eventually made to the ambulance services but no staff were available to respond. A rapid responder arrived 34 minutes after the call was made, followed by two paramedics in an ambulance. The Young Person at this stage was near death. The Young Person responded quickly to the interventions of the paramedics and was taken to hospital and admitted. The paramedics and medical staff were worried about the Young Person's low weight, poor physical appearance, acute eczema and the lack of concern by his mother for his health and well-being. A referral was made immediately to Children's Social Care by one of the paramedics.

The Young Person, at the time of the incident, was living with his mother and her partner. He did not know his father. The Young Person had been living with both asthma and eczema

since early childhood. Although the asthma was controlled, the eczema flared up constantly, despite increasingly specialised and targeted interventions at a 'satellite' dermatology clinic. Satellite clinics are now an established health service practice, where members of a specialist team come out of their main base and see patients for appointments in other settings.

The Young Person had been the subject of a CAF (a multidisciplinary plan to provide early help services on a voluntary basis to a family) for 3 years between 2009 and 2012. The CAF support consisted of parenting and family support work and was discontinued because the case was considered 'stuck': a range of services had been provided with little effect on parenting and the relationship between the Young Person and his mother. At no point, prior to the life-threatening episode, did the Young Person's situation trigger professional concerns to warrant escalation to a s17 or s47 assessment under the Children Act 1989.

3.2 Key dates in the practice by professionals

2009 - end of 2012	The Young Person is offered help via the Common Assessment Framework
Summer 2010	The Young Person begins attending a dermatology clinic because his eczema is of a severity that can no longer be managed via the GP practice *First attendance from hospital chronology was 10/06/10*
Sept 2012	Last known CAF meeting: professionals discuss whether the CAF is effective, and agree to ask advice from the 'Think Family' forum
Oct 2012	The 'Think Family' forum considers The Young Person's case. Escalation to safeguarding is not recommended.
December 2012	The Young Person's eczema is flaring up and steroid treatments continue
January 2013	Eczema clinic – steroid treatment ended and the Young Person's skin described as 'much better on body but not face'. 'treatment reviewed and advice given'
Feb 2013	Family support worker writes closing summary
June 2013	Dermatology satellite clinic; eczema has cleared up
July 2013	A new partner has moved in with the Young Person's mother; so housing benefit has stopped
Nov 2013	The Young Person is back to the dermatology satellite clinic - his skin has deteriorated again and he has a

	secondary infection
Jan 2014	Seen at dermatology satellite clinic and meets specialist dermatology nurse for first time
March 2014	First visit to the main hospital Dermatology clinic to start what are intended to be 25 sessions of light treatment
March 2014	Same day goes to hospital satellite Dermatology clinic for education session
April 2014	Education Welfare Officer becomes involved because of drop in school attendance. Requests a health care plan from dermatology clinic
June 2014	The Young Person is seen at dermatology satellite clinic, and his eczema is infected. Undertaking Light therapy, and advised to take antihistamines. The consultant worries that the Young Person is not following his treatment plan because of a reluctance to take tablets, and refers him to psychology services - the referral is sent back because it is made to an adult team who do not see under 18s
1 July 2014	The Young Person is seen at dermatology satellite clinic and the area of infection has improved though his eczema is still extensive. The light therapy has been discontinued due to infection. His treatment plan is reviewed, and he is started on steroids.
18 July 2014	The Young Person is seen at dermatology satellite clinic. The nurse sends his treatment plan, with a covering letter, to school nurse, GP and Education Welfare Officer, specialist light therapy nurse and mum. The Review Team tracked this, and only GP records showed it logged on files, with no trace of it in the other services.
August 2014	The Young Person is seen at the dermatology satellite clinic. His eczema had completely cleared after steroids but is deteriorating again. A new treatment is discussed to commence after blood tests
Sept 2014	The Young Person is seen at the dermatology satellite clinic and his eczema is stable
7 October 2014	The Young Person has an asthma review – by healthcare assistant at the GP practice

30 October 2014	The Young Person is seen at dermatology satellite clinic - his eczema is under control
18 December 2014	The Young Person attends the nurse led blood monitoring clinic – because he is on immuno-suppressants. His ears are noted to be red and crusty, with active eczema on his face and torso. His medication reviewed and treatment plan provided. Last day of school term - and although the Young Person did not attend school due to his medical appointment, school staff did deliver a hamper to the family home and saw the Young Person briefly on the doorstep.
28th December 2014	Incident of a life-threatening asthma attack for the Young Person and admission to hospital
29th December 2014	Social worker visits the Young Person on the ward; professionals hold a strategy meeting

2.2 Appraisal of professional practice in this case

2.2 Appraisal of professional practice in this case

In late 2012, when the review period begins, the use of the Common Assessment Framework - the voluntary early help process for children and families - was not having the effect it was meant to have on the lives of families and children in Halton. This had already been recognised by the Halton Safeguarding Children Board, and substantial changes were under way to support professionals in using the process more extensively and more effectively. **Finding 4** explores the extent to which the efforts to change the way early help is delivered in Halton has been effective; and what safeguarding risks still exist in relation to the early intervention process. The Young Person and his mother were receiving early help interventions during the period when the LSCB identified the CAF process was not operating effectively.

By the end of 2012, the Young Person had been 'on a CAF' for longer than any other child in Halton and the case was considered 'stuck' by the workers. Whilst the Young Person's mother remained in contact and engaged superficially with professionals, interventions were having little impact on improving the Young Person's mother's parenting and the quality of her relationship with the Young Person. Amongst the changes to early help services in Halton at the time was the creation of a panel of managers to advise on situations like the one with the Young Person, where early help interventions were having little impact. The Panel met in October 2012 and made the decision to close the case to the Family Work Service as there were no obvious ongoing concerns and there was no reason to escalate to Children's Social Care. But the decision was made with limited understanding of

the Young Person's life, the extent of neglect, and the world as he experienced it - as considered in **Findings One and Three**. The Review Team found that from a very early age, professionals held information about the Young Person that did not come to the attention of the Lead Professional CAF - for example, the Social Landlord, who managed the family home; the Housing Officer who was aware of the family's debts; the School Nurse who had history dating back some years; the GP practice and CAMHS (child and adolescent mental health services) who received a referral from the GP. The consequence was that a number of practitioners were working with the family on specific problems in a vacuum. **Finding Three** considers the ways in which children and their needs can become invisible or forgotten when this takes place. In addition, the two main professionals allocated to work with the Young Person and his family were quite inexperienced, and did not appreciate, at the time, that the superficial engagement by mother with professionals did not necessarily lead to changes to the lived experience of the Young Person. **Finding Two** considers the issues of identifying superficial compliance by parents, particularly in relation to assessing behaviour change in early help programmes. **Finding Four** also explores why the status given to early help work at the time may have inhibited these professionals from asking more forcefully for the engagement of colleagues in other agencies with the Young Person's CAF, and considers what the latest signs are that early help work is gaining more status in Halton.

After the closure of the CAF and the ending of family support work, there was, for much of 2013, what to professional eyes looked like 'a period of calm' in the Young Person's life. On closer examination though, the Review Team considered that this was a period when the Young Person was being neglected. For example, in July 2013 there was a significant development at home, as the new partner of the Young Person's mother moved in and as a consequence Housing Benefit ceased which caused the family financial problems. The Review Team did not think that professionals were aware of this and therefore could not assess the impact that this might have had on the Young Person. **Finding Three** covers this, as does **Finding Five**, which considers the impact of hidden household members on the lives of young people, and how effectively this is assessed in early help services.

Throughout the period under review, the Young Person was seen regularly at a predominantly adult dermatology 'satellite' clinic, rather than at a location further away with more paediatric services. Most NHS trusts operate satellite clinics in an attempt to either provide services closer to patients' homes, or to share specialist expertise more widely - for example Moorfields Eye Hospital has a growing network of satellite clinics. In the Young Person's case, the professional decision to use the satellite clinic was to try and make it easier for the family to keep appointments. The 10-minute slots allocated for each patient meant that discussion had to focus on the medical condition and its treatment and did not leave sufficient time to explore wider issues although the Young Person was not getting the help at home to consistently manage his eczema, and the environment at home was not one that made this likely. The consultant made a referral to adult psychological services because the Young Person complained that he could not take tablets easily and this was impacting on his treatment. The referral was, however, declined because the Young Person was under 18. No advice was given, however, to the consultant as to an alternative and more appropriate source of support for the Young Person. **Finding One** addresses the importance of recognising and addressing the impact of a chronic health condition on a

young person's lived experience. There was a mismatch between the Young Person's needs, resulting from his eczema, and the services provided - for example an education session delivered by dermatology professionals to the family emphasised the importance of regular routines when the concerns were more about the Young Person and his mother's motivation to engage with the treatments. **Finding Two also** explores this.

By January 2014 the Young Person's eczema was out of control again and he subsequently began light treatment, which required frequent attendance at hospital during school hours. In April 2014 an Education Welfare Officer noted the Young Person's falling attendance during a routine check of pupils whose attendance had dropped by more than 10%. The Education Welfare Officer contacted the dermatology nurse, who in turn sent out copies of the comprehensive health care plan for the Young Person. The plan did not reach the Education Welfare Officer, key individuals at school, nor the school nursing service. This was a missed opportunity to identify the ways in which these agencies, together with the GP and the dermatology clinic could work together to develop a multidisciplinary approach towards meeting the Young Person's health needs. Part of the difficulty in directing information to the correct person resulted from organisational change - as did other examples during the period under review. **Finding Six** explores how information about children and young people is not shared when robust systems do not exist for multi-agency information–sharing during times of organisational change.

On the 28th December 2014 the life-threatening event that triggered this Serious Case Review took place. The Young Person was staying with a relative and had a severe asthma attack - from the Young Person's account at the time, his asthma had become problematic at least twelve hours previously, and it does not seem that the adults he was staying with appreciated the risks attached to this, or responded until he became so ill that someone dialled 999. It subsequently emerged that the Young Person did not have at least one, if not both of his prescribed asthma inhalers with him as one had run out and the adults around him had not made arrangements to replace it. When a Rapid Response Vehicle and ambulance arrived (outside timescales for such a callout) the Young Person was dangerously ill. Significant efforts were made at the Ambulance Trust to identify professionals who could respond, and the paramedics who attended were very experienced. All their expertise was needed to stabilise the Young Person and get him to hospital. **Finding Seven** examines the risks to children's lives that can arise at exceptional periods of demand when the whole local system for emergency and urgent care is lean and efficient, but very occasionally does not have the slack in the system to respond. One of the ambulance staff appropriately made a referral immediately by telephone to the trust's central point for reporting concerns about children or vulnerable adults. This professional also confirmed when making the referral that it should be graded as 'urgent' despite the Young Person currently being in a place of safety. This was tenacious and good practice because it reflected accurately the level of concern that the professionals from the trust felt about the Young Person.

The paramedics noticed that the Young Person was significantly underweight, as well as being struck by the severity of his eczema. At a strategy meeting the following day, professionals began to address a discrepancy which for the Review Team remains unanswered. This discrepancy was between the view of the professionals working with the

Young Person prior to the incident, and of those who saw him during and shortly after it. For example, the social worker visited the Young Person on the ward before the meeting. She noticed immediately that he was very thin, and had severe eczema on the parts of his body that were visible. She was, like the hospital staff and paramedics, also concerned by the lack of interest in the Young Person shown by his mother. School staff who saw The Young Person daily, had not had cause for concern about his eczema when they last saw him, ten days previously. They were also more positive about the relationship between the Young Person and his mother. One of the paramedics went above and beyond anything that was expected by bringing in some of her own children's Christmas presents to the Young Person on the ward, as a result of hearing the Young Person's account of his Christmas at home.

Professionals were provided with an account of the referral, concerns relating to eczema and asthma. All professionals agreed that the current situation would raise concerns for the Young Person's safety, were he to return home. The conclusion of the meeting was to take the unusual step in Halton, of removing a teenager from his mother's care. This was not the initial view of all the professionals, but willingness to examine the evidence and listen to the professional opinions of others enabled consensus to be reached.

2.3 **Summary of Findings**

Findings	**Category**
Finding 1: **Treatment of young people with eczema, focuses on their physical health needs when they are seen in adult satellite hospital outpatient clinics in Halton. The consequence is that their other needs are marginalised or neglected.**	Management systems
Finding 2: **With the early help aspects of all services in Halton, there is a balance to be struck in the system between accountability for what is delivered, and making sure that those things which are most easily measurable do not become the only things that are counted.**	Management systems
Finding 3: **The presssures of work for those delivering early help services in Halton mean practitioners work in isolation rather than collaboratively, with the consequence that professionals focus on their own, agency-specific tasks, and are less likely to prioritise the**	Patterns of multi-agency working in longer-term work

need to work with other professionals.	
Finding 4: **Practitioners within the multi-agency network perceive the role of Lead Professional to be one with limited status, with the consequence that individuals in the role do not feel confident to escalate concerns about colleagues in other agencies - inhibiting multi-agency efforts to provide the right help at the right time.**	Patterns of multi-agency working in longer-term work
Finding 5: **Are professionals in Halton who deliver universal and early help services sufficiently confident to raise questions about family and household members who could pose a risk of harm to the child or young person - with the consequence that they leave these young people vulnerable to abuse and neglect?**	Family / professional interaction
Finding 6: **There is not a robust system for multi-agency information sharing during organisational change, with the consequence that information about individual risk to children can be passed on, but does not always receive the analysis of risk that is needed for safeguarding decisions.**	Management systems
Finding 7: **The whole emergency and urgent care system that includes Halton, is designed to be lean and efficient - and the risk in the system is that exceptionally, when the whole system is under extreme pressure, the efforts of dedicated individuals in the ambulance service cannot compensate for the risk that arises from having such a lean system.**	Management systems

2.4 The Findings in detail

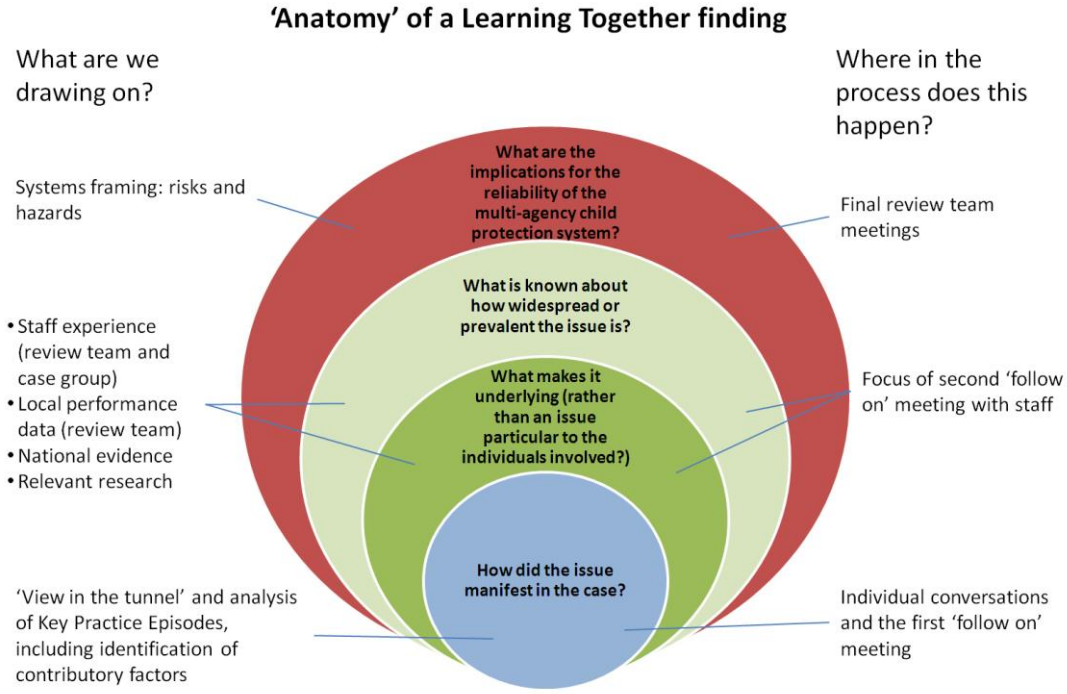
This section represents the main learning from this case review for the LSCB and partner agencies. Each finding is set out in a way that illustrates:

1) How does the issue feature in this particular case?
2) How do we know it is not unique to this case? What can the Case Group and Review Team tell us about how this issue plays out in other similar cases/scenarios and/or

ways that the pattern is embedded in usual practice?

3) How prevalent is the pattern? What evidence have we gathered about how many cases are actually or potentially affected by the pattern? How widespread is the pattern? Is it found in a specific team, local area, district, county, region, national?
4) What are the implications for the reliability of the multi-agency safeguarding system?

The evidence for the different 'layers' of the findings comes from the knowledge and experience of the Review Team and the Case Group.



Finding 1:

Treatment of young people with eczema, focuses on their physical health needs when they are seen in adult satellite hospital outpatient clinics in Halton. The consequence is that their other needs are marginalised or neglected.

Category of Finding: Management Systems

The service for young people with eczema in satellite clinics in Halton is commissioned in such a way that provision is by a medical team with expertise primarily of working with adults. When this occurs the focus is on addressing medical needs. Yet, chronic health conditions, such as eczema and asthma, can affect every aspect of a child or young person's health and development. For example, Suris et al., (2004. P.941,) in a systematic review of the literature, found that chronic health conditions such as eczema,

can have an effect on adolescent development, self-image, identity, educational attainment, family and peer relationships. They conclude that adolescence is a time of rapid change and turmoil and *'that teenagers with chronic conditions have an additional burden'.*

If the 'burden' is to be minimised it is essential that commissioners and providers of medical services for young people with eczema and other chronic health conditions, either through satellite or mainstream clinics, ensure staff are in a position to identify the effects of the condition on the general wellbeing of the young person. Moreover, having identified these wider needs, the services should be responsive and support young people with these conditions and their families.

How did this feature in the case?

The Young Person gave the Reviewers a vivid, detailed account of the impact of eczema on his daily life whilst he was living at home. He described how painful it can be when the eczema flares up and that he has a complex treatment regime that needs to be completed at least three times daily. The regime is lengthy and tedious and sets him apart from his peers. He talked about the problems he sometimes has sleeping, wearing clothes, walking and carrying things. When his eczema is evident he is embarrassed about his appearance and described wearing long-sleeved tops to cover both his eczema and the special garments he has to wear. He also described how he did not go swimming and disliked undressing for sports activities because he was embarrassed by his appearance. Indeed, he only began to swim, an activity he stated he really enjoys, when he moved to the foster home and his eczema had cleared up.

Although the Young Person described his experiences to the Reviewers with very little prompting he was not provided with opportunities at the satellite clinic to explore the impact that his condition and treatment regime was having on his life. The Young Person told the Reviewers that the focus was on the physical management of his treatment regime. Indeed, the Consultant only referred the Young Person to the Adult Psychology Services because the Young Person became aggressive when informed swallowing tablets would be part of his new treatment regime: the Young Person has difficultly taking tablets. Further, the health care plan constructed by the Specialist Nurse only focused on the conditions necessary - regular bathing, application of creams and so forth – required to ensure the Young Person gained maximum benefit from his treatment regime.

How do we know the issue is not peculiar to this case?

The Review Team heard from the case group that the satellite service is constructed in such a manner that consultations with doctors are limited timewise– ten minutes – for each patient. Bearing in mind the short time available and the number of patients the Consultants are expected to see at these clinics, they prioritise medical assessments and interventions. In addition, the Review Team was informed that the satellite eczema clinic is a clinic for both children and adults, and the area of expertise of the staff is

predominately in the treatment of adults. The staff, however, have all received Level Two safeguarding children training – that is training for those in direct contact with children and their families covering indicators of abuse and neglect and referral processes. Although Hospital 1 has a range of children's and adolescent services the clinic operates under adult services delivered by another trust. As a consequence data regarding the number of children and young people seen at this clinic was not made available to the named nurse at Hospital 1. Hence, other young people with eczema may not have had their broader needs identified or met.

In terms of the different chronic health conditions, the Review Team heard that practice was variable depending on the way that agencies commissioned and structured services. As a consequence those commissioned, provided and delivered as part of one Trust's children and adolescent services, such as clinics for young people with diabetes and epilepsy, were far more likely to identify and know how to meet the developmental needs of the young person. Those provided by other trusts in outreach clinics may not come under the same scrutiny.

Since the Review was initiated a safeguarding pro-forma has been developed by the Specialist Dermatology Nurse and will be used to identify any potential or existing safeguarding concerns amongst young people seen at the clinic. These concerns are then raised with the Named Nurse at the hospital. It appears that the consultant and specialist nurse in the dermatology clinic were not aware of the role of the named nurse. Has anything been done to ensure raised awareness for staff in clinics such as the dermatology clinic?

Members of the case group recognised that staff, such as the Specialist Nurse and the Consultant should be aware of the CAF process and be expected to participate in this if they have a part to play. But information regarding the existence of a CAF is often not known by hospital staff. There was a view that the GP and/or school nurse should ensure that the Lead Professional is informed about hospital involvement in order to ensure hospital staff can play an active role.

How widespread is the pattern?

Satellite outpatient clinics are becoming increasingly common as a response to Government expectations of local services for local people. In these cases the providers may be from different trusts and as a consequence there is limited whole system overview. Senior agency representatives in Halton also recognised the lack of accessible, onsite paediatric support and guidance can lead to a dominant medical focus in the management of chronic health conditions amongst young people. The Review Team heard from the Case Group that the situation can be exacerbated if a satellite clinic caters for both adults and children and is staffed by a medical team with adult expertise. The Review Team recognised that there are distinct advantages for families of locally based out-patient clinics. Children with chronic health conditions are likely to have to attend out-patients frequently and local clinics mean easy access, lower transport costs, and for young people, less time out of school for appointments. However, for

commissioners and providers of outpatient services for young people with chronic health conditions, these considerations have to be balanced against ensuring the provision of a child-centred service. Such a service requires immediate access to the diverse range of services that are on hand in a regional hospital, such as paediatric dermatologists, social work and psychological services. The Review Team heard, for example, that young people seen at Alder Hey Children's Hospital are serviced by a multidisciplinary team who aim to provide a 'holistic care to patients, families and carers.' (Alder Hey Children's Hospital, 2015). Children and young people receiving treatment at the dermatology clinic at another nearby hospital - Hospital 2 - are seen by a medical team who have ready access to onsite advice and guidance from the named professionals and social work team.

The Review Team were informed that the Trust have begun to consider how service provision can be improved for children with chronic health conditions. They have identified a need to review the information provided to the Named Nurse regarding children and young people seen in adult clinics. Second, they intend revising the provision of safeguarding training. Those who see children in adult clinics will receive training for those working with children and families (Level3 training) rather than the Level 2 training for those in contact with children and families, which is the case currently.

How prevalent is this issue?

The local, regional and national prevalence of chronic health conditions, including eczema and asthma, amongst young people is difficult to assess because of the lack of data. However, researchers estimate between 7-15% of the adolescent population are affected depending on the conditions included (Suris et al., 2004; Compas et al., 2012). Moreover,

> *'Chronic illnesses and medical conditions present millions of children and adolescents with significant stress that is associated with risk for emotional and behavioural problems and interferes with adherence to treatment regimes'* (Compas et al., 2012 p. 455)

In April 2013 there were estimated to be 31, 200 children between 0-19 years of age living in Halton. Taking an average of the estimated prevalence of chronic health conditions, 3,000 children and young people could be living with such a condition.

Why does it matter?

A safe system is one in which commissioners and providers of health services recognise the impact or potential impact of chronic health conditions on the child's emotional, behavioural and psychological needs. With this in mind, they should ensure that those delivering services, albeit it centrally or from satellite clinics, have the time, resources, knowledge and skills to identify these young people's additional needs and ensure an appropriate response. The response could be through the provision of direct services such as support groups, multi-agency working or referral to other agencies. If satellite

clinic provision does not facilitate the identification and response to these additional needs young people may not have the opportunities to achieve their potential. In addition, it is well understood that those whose needs are neglected during childhood and adolescence are vulnerable to mental health and other problems. These are likely to not only affect their lives but will have repercussions for their families and wider society.

Finding 1: Summary of risks

Children and young people with chronic health conditions are likely to have a variety of additional needs as a result of the *'burden'* (Surris et al. 2004) of their condition. A failure to recognise and address these needs can result in child neglect. A safe system will reliably identify and respond, not only to medical needs, but also to the wider needs of young people with chronic health conditions. Finding One, however, has identified that professionals in contact with children and young people with these health conditions in satellite clinics focus on meeting medical needs and do not consider or address the young person's other needs.

Questions and considerations for the Board

Does the Board know how many children and young people with chronic health conditions who are seen in clinics that do not come under the Child and Adolescent Service umbrella?

Does the Board agree commissioners and providers should ensure those working in satellite clinics treating young people with chronic health conditions have a responsibility to identify and, where appropriate, address the young person's wider needs?

Are those responsible for commissioning and providing satellite clinics attended by young people who have chronic health conditions aware that a failure to identify and address the young person's wider needs constitutes neglect?

Can Board members provide evidence that young people with chronic health conditions seen in satellite clinics for chronic health conditions have their needs, over and above medical needs, identified?

What services are available to support young people with chronic health conditions explore and address the impact of the condition on their daily lives?

How responsive are services in allowing young people to discuss wider needs and to understanding how chronic health conditions impact upon their daily lived experience?

Finding 2:

With the early help aspects of all services in Halton, there is a balance to be struck in the system between accountability for what is delivered, and making sure that those things which are most easily measurable do not become the only things that are counted.

There is an early help component to most children's services in Halton, and currently the effectiveness of such services is measured by indicators that relate to service throughput rather than child-focused outcomes. As a consequence the impact of the family's involvement with the service on the quality of life for each child in the family is marginalised or ignored and children may continue to have unmet needs.

Parents who receive early help services need to have both motivation and ability to work on a voluntary basis with service providers to meet the needs of their child. Some parents who do not have this capacity may present as dis-engaged, aggressive or non-compliant and are relatively easy to identify. There are, however, parents who do appear to engage with services and complete tasks, such as attending every session of a parenting programme, yet, this does not necessarily lead to improvements in outcomes for children. This may occur because the parents do not have the ability to ensure the needs of the child are met. Alternatively, they may lack the motivation to make changes and therefore engage tokenistically: this is known as 'superficial compliance' and may result in little changing for the child or young person.

Category of Finding: management systems

How did this feature in the case?

There is evidence, throughout the period under review, that professionals were working in organisations delivering early help services that did not use child-focused outcomes to measure effectiveness. Moreover, because of the lack of attention to child-focused outcomes the staff had not received adequate guidance and training to assess meaningful engagement by the Young Person's mother with services. The Family Support Worker, for example, commented that at the time she was working with the Young Person she was not aware of superficial compliance. Both the Learning Mentor and Family Support Worker, implementing the CAF during the period under review, equated parental engagement by the Young Person's mother with her maintaining regular contact with them regarding the Young Person, taking the Young Person for hospital appointments and contacting them for assistance. However, during this period the Young Person's mother did not actively work with these professionals to meet the Young Person's needs. For example, her attendance at CAF meetings was sporadic and she focused on her own unmet needs rather than those of the Young Person. As a consequence the home conditions and general physical care of the Young Person were

not addressed and he continued to be neglected. The CAF ran for three years before the workers viewed the case as 'stuck'. Their reasoning for this was that they had exhausted the services available and did not know what other services could be provided. The CAF was closed at the Think Family Forum. The failure by the Young Person's mother to engage meaningfully with existing services and the impact this failure was having on the Young Person and the quality of his lived experience was not taken into account.

How do we know it is not peculiar to the case?

Members of the Board, the Review Team and the Case Group recognised that for a number of agencies, quantitative measures are required by regulators, commissioners and providers to demonstrate service effectiveness. This in turn encourages a focus on measurable indicators such as service throughput. They gave a number of examples of this occurring in health, education and voluntary services. These measures included: levels of school attendance; attendance at hospital clinics; keeping appointments; attendance at parenting groups; information provided to families. The Review Team heard from the Case Group that the focus on these types of measures results in the marginalisation of the impact of service input to qualitative outcomes for children.

How widespread is the pattern?

The Review Team were informed by the Case Group that task completion and compliance by parents are frequently used by service commissioners, providers and regulators as indicators of effective practice across Halton: for both early help and child protection interventions. However, tools such as the Graded Care Profile, introduced by the LSCB, are enabling different services to provide practitioners with a standardised multi-disciplinary tool enabling them to focus more on outcomes in cases of neglect of younger children. The tool, however, is not designed to identify signs of adolescent neglect. In addition, the Review Team learnt that the introduction of chronologies into CAFs makes it easier for practitioners to establish what works with a family. What is crucial, according to the Case Group, is that all service providers ensure staff are aware of these tools and how to use them.

The Case Group also told the Review Team that service providers have not provided practitioners with standardised tools to assess either parental engagement or the impact of interventions on outcomes for children.

Since the period under review lead professionals involved in CAF who believe they are 'stuck' with a case can present the case at a Working Together meeting. The purpose of the meeting is to:

> *Review CAFs…. in circumstances where they are facing barriers to achieving positive outcomes for the child and family. Multi-agency colleagues can advise how to eradicate barriers to progression including allocating additional early intervention services, where appropriate.* (Halton Working Together Meeting Guidance)

The Review Team recognised whilst this may ensure the needs of children in 'stuck' cases are identified others may be ignored. For example, when parents have completed

a parenting programme the case may be closed as a successful intervention without any evidence being obtained that the learning from the programme has resulted in improved outcomes for children.

How prevalent is the issue?

The prevalence of early help interventions focusing on completing actions alone is evident in the findings of the recent Ofsted (2015p.18) inspection of early help interventions in 56 cases taken from 12 local authority areas. Where CAFs were in place they found:

> *'Plans were too often a list of actions that did not identify the outcome to be achieved for the child or how these actions would improve the child's circumstances. Many made the assumption that the issue would be remedied with the action taken; for example, many required a parent to attend parenting sessions. While the parents may have attended, there was rarely subsequent analysis about whether this attendance had improved either the parenting or the child's circumstances and experiences'.*

With regard to child neglect, Ofsted (2014) in a report based on evidence drawn from 124 cases, found that in almost half the assessments practitioners did not convey or consider the impact of neglect on the child. They also found parental lack of engagement was a common feature with few multi-agency groups having clear strategies for tackling non-compliance. They also found that professionals did not consistently challenge parents and as a consequence cases drifted.

Woolmore (2016) has written about 'The Safeguarding Blindspot' when 'Collaborative early help intervention services are being offered to families with complex needs who often do not cooperate, creating the "No Further Action" child' . Woolmore says that:

> *Early help practitioners usually lower paid than colleagues who deal primarily with child protection cases, find themselves working with 'targeted families' who are complicated.*
>
> *It's not uncommon for families being offered early help to have been previous, if not frequent, users of statutory services. There may also be a history of 'disguised compliance' in previous relationships with professionals.*

Why does it matter?

A safe, safeguarding system is one in which the emerging developmental needs of children are identified and met by universal and early help services. When this takes place children and young people are more likely to achieve their full potential.

Identifying and meeting emerging needs is particularly important in potential cases of child neglect to avoid drift, neglectful behaviours becoming entrenched and a deterioration in the child's situation. As Daniel et al., (2011p.17) note:

> *'In relation to ongoing child development and well-being it is the chronic nature of neglect that is particularly corrosive'*

A safe system, for identifying parental neglect should be accountable for its effectiveness. One of the things that such a system needs to do is to create the best chance of neglect being identified and addressed before the circumstances become chronic. Such a system needs to strike a balance between accountability for delivery, but also making sure that the things that are easily measurable do not become the only things that are measured. If service effectiveness continues to be measured in terms of through-put alone then the maximum benefits of the service to children and families may not be realised. As a consequence managers and practitioners may be deceived into assuming they are being effective. In the words of one member of the Case Group we will just continue:

> *'putting square pegs into round holes'.*

Finding 2:

With the early help aspects of all services in Halton, there is a balance to be struck in the system between accountability for what is delivered, and making sure that those things which are most easily measurable do not become the only things that are counted.

Summary of risks

A safe system, for identifying parental neglect should be accountable for its effectiveness. One of the things that such a system needs to do is to create the best chance of neglect being identified and addressed before the circumstances become chronic. Such a system needs to strike a balance between accountability for delivery, but also making sure that the things that are easily measurable do not become the only things that are measured.

Questions and considerations for the Board

Is the focus on task completion and service throughput as measures of service effectiveness a known issue?

Is there consensus amongst Board members that this is an issue that matters?

Has the Board made previous efforts to ensure that service providers and commissioners use child-focused outcomes?

Are tools and frameworks made available by providers of early help services so they can measure outcomes for individual children?

Are guidance and tools made available by service providers so that practitioners assess parental engagement?

Does the Board know what kind of information it should collect in order to learn if the multidisciplinary early help system is improving in terms of measuring child-focused outcomes?

Finding 3

The presssures of work for those delivering early help services in Halton mean practitioners work in isolation rather than collaboratively, with the consequence that professionals focus on their own, agency-specific tasks, and are less likely to prioritise the need to work with other professionals.

Category of Finding: Patterns of multi-agency working

This finding recognises the pressures placed on those delivering universal and early help services. This can result in different services focusing on the immediate problem they are presented with rather than taking a more multi-agency holistic approach to the child and their family. When practitioners focus purely on the immediate issue they are working in isolation and the needs of neglected children may become marginalised or forgotten rendering the child and their situation invisible to the workers. When this occurs the health and development of the child is affected in both the short and longer term.

How did this feature in the case?

During the period under review the Young Person's repeated eczema flare-ups exercised the Dermatology Team. Rather than identifying what may be causing these flare-ups, the Young Person and his family received an 'education' session with the Specialist Dermatology Nurse. They attended the session but it centred on the application of creams, garments etc. A number of professionals held information that would have enabled the Dermatology Team to make a more informed and appropriate intervention. The Learning Mentor, for example, had knowledge, gained from the Family Support Worker and Child and Adolescent Mental Health Services Worker, that the relationship between the Young Person and his mother was impacting on his treatment regime. The Housing Officer was aware of the home conditions and financial issues, the Education Welfare Officer knew about school attendance, and the GP had knowledge about the asthma and its management. Despite the involvement of these other agencies the Dermatology Team worked in isolation, as did the other professionals. When the Specialist Dermatology Nurse did attempt to share information, through the circulation of the comprehensive health plan, the information was only received by the GP: it did not reach the other practitioners in contact with the Young Person and his mother. As a

consequence valuable information about the Young Person and his situation was not exchanged and the Dermatology Team continued to work in a vacuum.

How do we know it is not peculiar to the case?

The Review Team heard that all too often professionals providing universal and early help services, because of the pressures of work, focus on their specific role and area of expertise. As one participant put it *'we end up taking a silo approach'*. As a consequence they are not alert to other factors that indicate a child is being neglected. This situation can be exacerbated if systems are not in place to ensure practitioners are aware of the involvement of other professionals. The Case Group reported that it also occurs when practitioners are so busy they do not prioritise attendance at CAF meetings. Also, the Lead Professional may struggle, because of conflicting demands on their time, maintaining ongoing contact with all the practitioners interacting with the family.

The Review Team also heard from the Case Group that one of the consequences of routine use of the *Framework for the Assessment of Children in Need and their Families* is that professionals, even though they may work collaboratively, tend to focus on the needs that they are primarily responsible for addressing rather than taking a holistic approach. Hence, health care professionals will pay attention to health needs and tend to focus on keeping appointments, picking up prescriptions etc. As one practitioner stated at the group they do not ask 'so what?' for example, is attendance at appointments making a difference? Are the family using the creams prescribed?

Service leaders in Halton, who made up the Review Team, recognise some of the challenges identified above and have begun to address these through multi-agency investment in the Contact and Referral Team that initially assess the needs of children and families . This investment is already beginning to improve the mapping of local needs and co-ordinated delivery of early interventions through CAF. Key to this development is increased oversight and collaboration between adult and child service providers.

How widespread is the pattern?

The Review Team and Case Group indicated the focus on addressing immediate, seemingly relevant issues was widespread amongst early help service providers. Whilst recognising professional curiosity is important, they identified a number of organisational influences that can lead to practitioners working in isolation on the problem that is presented to them. These include: hospital doctors in out-patients only having a ten minute slot for each out-patient at clinics and as a consequence they do not have the time to explore issues in-depth; practitioners, such as housing officers, not being clear about who to go to for advice and how to share information; teaching unions varying in terms of what teachers and other school staff can do with regard to home visits; the various family members seeing different doctors in the same practice so no-one gets a comprehensive overview; practitioners not having access to supervision and support within their work setting that goes beyond exploring the presenting problem. A

reluctance on the part of some practitioners, such as nurses in hospitals to question and challenge parents was also highlighted, with some practitioners feeling they do not have the confidence because of a lack of knowledge and skills to *'probe'*.

The Review Team also heard about good practice. For example, the ambulance crews described, at the Case Group, how they are called out to people who really do not need an emergency ambulance service but have other needs such as loneliness, fear of being ill or not knowing who to turn to. They recognise that they need to be curious as to why people are presenting in the way they do in order to get to the cause of the problem and prevent it re-occurring.

How prevalent is the issue?

The Ofsted (2014) study of neglect found that assessments often focused on parents' problems and needs meaning the impact of these issues on children were marginalised. Brandon et al., (2013) found, in their analysis of serious case reviews involving child neglect, that practitioners often lack the confidence to take responsibility for assessing the impact of particular problems on a child and their development. The workers believe they do not have the expertise to do so and that other practitioners are better placed to act in these cases.

A study by Nfer, LARC and RiP (2015) of early intervention in cases of neglect found teachers and early help practitioners were less likely than those working in health services to contact other practitioners about early concerns. Multi-agency working was considered to be a significant barrier to early help provision for those working in education services. Health practitioners in particular identified workload and time pressures as significant barriers to providing early help. The researchers also found staff shortages, high caseloads and pressure to meet targets meant practitioners have less time to work collaboratively with the family and other professionals.

Why does it matter?

This finding is not about the effectiveness of the Common Assessment Framework in Halton, but is about a broader pattern of how the pressure of work in any particular agency can make it more likely that people focus on their own agency-specific tasks, and are less likely to prioritise the need to work with other professionals.

Neglecting families often stagger from one crisis situation to another. Moreover, the parents can present as very needy and lead chaotic lives (Crittenden, 1995; Horwath 2007; 2013; Daniel et al., 2011). As a consequence it is all too easy for practitioners to work in isolation and focus on the crisis situation or the presenting problem, such as rent arrears, practical problems with medical treatments and so forth. When this occurs practitioners fail to gain a comprehensive picture of what is taking place and do not tackle the underlying issues. This matters because as a consequence early help practitioners are missing opportunities to identify and tackle underlying neglect and the

impact of this on the child. As this quote from a young person who used ChildLine (2015) highlights:

> *'No one asked me what was going on. I felt worthless and alone. Nothing was working in my life.'*

Collaborative working is particularly important in cases of child neglect because of the complex nature of the family problems and the different ways in which it can impact on the children in the family.

Bearing in mind what is known about the behaviour of neglectful carers a safe system is one in which service commissioners and providers recognise that a holistic approach is required if early help provision is to be effective in cases of child neglect. A safe system is one in which agencies value multi-agency working and ensure practitioners' have the opportunity to work collaboratively to share information and gain a comprehensive appreciation of the presenting and underlying issues impacting on the health and wellbeing of the child.

In a safe system practitioners have the time and opportunity through, for example, reflective supervision to question why parents behave as they do and how this behaviour affects the individual children in the family. Providers also ensure that practitioners have the knowledge and skills to challenge family members and demonstrate a healthy scepticism questioning what is actually going on within the family and why.

Finding 3:

The pressures of work for those delivering early help services in Halton mean practitioners work in isolation rather than collaboratively, with the consequence that professionals focus on their own, agency-specific tasks, and are less likely to prioritise the need to work with other professionals.

Summary of risks

This finding is not about the effectiveness of the Common Assessment Framework in Halton, but is about a broader pattern of how the pressure of work in any particular agency can make it more likely that people focus on their own agency-specific tasks, and are less likely to prioritise the need to work with other professionals.

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Questions and considerations for the Board

Are the pressures on those providing early help such that they need to be addressed in order to ensure a safe system?

What are the barriers to delivering comprehensive early help interventions that address fundamental problems?

Is the Board clear about the role of individual agencies with regard to providing early help in cases of neglect?

What evidence is there that those delivering early help services have quality training, supervision and support?

Does the Board know what type of information might tell them about improvements in relation to this finding?

Does the Board have access to this information currently? What changes to information collection and analysis is required?

Finding 4

Practitioners within the multi-agency network perceive the role of Lead Professional to be one with limited status, with the consequence that individuals in the role do not feel confident to escalate concerns about colleagues in other agencies - inhibiting multi-agency efforts to provide the right help at the right time.

Category of finding: Patterns of multi-agency working in longer-term work

Despite guidance and a comprehensive programme of work in Halton to change the way Early Help is delivered, this work is not yet embedded, and individuals taking on the crucial role of Lead Professional do not always have the confidence to challenge those in a child's network who they see as expert around a particular aspect of a child's needs.

Findings 1, 2 and 3 have addressed qualitative aspects of practice in relation to Early Help and adolescents. This Finding seeks to get underneath the issues of professional status and confidence in carrying out a role that is central to the provision of Early Help - that of the Lead Professional.

How did this feature in the case?

The member of school staff who was given the role of Lead Professional felt as though other professionals disappeared, and the school was left managing the Young Person's CAF. This was a risk given the flow of information from specialist services, for example dermatology, involved with the Young Person. Rather than pursuing these individuals the Learning Mentor took a view that it was other professionals' job to cover expert or specialist assessments, so he did not escalate any concerns he might have been holding about others in the Young Person's network, nor did he feel able to tackle the issue that during the time of the Young Person's CAF up to the decision in October 2012 to close it that there was "Never one stable set of people round the table - and as a partner, that is disheartening".

How do we know this Finding is not peculiar to the case?

Practice has changed in some respects now - for example the Lead Professional in the Young Person's case told the Review Team that in 2015 it was much easier to escalate a 'CAF' case than it had been in 2012.

The Halton Levels of Need Framework was revised and launched in April 2013 to support all agencies and services to meet the needs of children, young people and their families to ensure the best possible outcomes. The Early Help Strategy was revised in 2014, which in turn led to the introduction of early intervention locality teams from 1st September 2014.

The Lead Professionals Procedures, revised in September 2014, state clearly that

> *"Remember that when you undertake the Lead Professional role you are accountable to your home agency for delivering the Lead Professional functions. You are NOT responsible or accountable for the actions of other practitioners or services. If a Lead Professional encounters problems or barriers with other services, then the HBC Escalation Policy should be referred to and implemented as appropriate."*

However the Lead Reviewers heard from members of the Review Team - service managers in Halton in 2015 - that although there have been systems changes and investment in all aspects of the Common Assessment Framework, some of the culture remains the same.

This was backed up by practitioners in the Case Group who talked about the "big role" of the Lead Professional and the challenges faced by any individual who takes on that role. Even today 'people have different ideas of what a CAF is'. The practitioners suggested that those in the Lead Professional role today still struggle to challenge others in multi-agency networks: "what if you are leading a CAF, what is your capacity to question other people?". Another member of the Case Group with a more supervisory role said: "It's lost in Halton - the idea of Lead Professionals". And Review Team members agreed that another aspect of the role that is " a real tussle", is for the Lead Professional to keep challenging parents. From the Lead Professional procedures, the two most relevant aspects of the role for this Finding are

> *Co-ordinate the delivery of the actions agreed by the practitioners involved, to reduce overlap and inconsistency in the services received*
>
> *Identify where additional services may need to be involved and put processes in place for enabling their involvement*

Amongst the extensive changes since the Young Person's CAF was closed, CAFs are now all on Care First and an eCAF system is scheduled to start in October 2015. In addition, the Family Support Service now compiles specific chronologies that assist with CAFs. However, despite process and IT changes, it is the cultural change of shifting

expectations about the role of other professionals in the CAF process that feels less secure. This in turn links to the issue about the status of the Lead Professional and their confidence to escalate concerns. Lead Professionals have as their starting point "the information we get before a CAF; [and you] can't test out a hypothesis If you've not got a steady team around you as Lead Professional *and you are not the expert".*

The Review Team was left with questions about not just the support available for Lead Professionals, but also, what levels of oversight exist for the role in Halton, and how such oversight fits with any standards of competence required to take on the role. Using the Young Person's case as a starting point, the Review Team asked about practice now in secondary schools, and what oversight there is.

Management information about safeguarding and levels of need amongst pupils in any school is reported by the headteacher to the governing body each term, including figures on CAF, and numbers of children on Plans. The minutes have to be produced for inspections - but there are no minimum standards, which is in line with the revised version of Keeping Children Safe in Education of July 2015. The Safeguarding Children in Education Officer in Halton has supplied schools with standardised material to put in their safeguarding policies and procedures. The material does not, however, include any recommendations for qualitative feedback from Lead Professionals that might highlight the difficulties of escalating concerns about other professionals. Nor does it cover the type and effectiveness of oversight that such a professional receives from their manager within the school. Although schools were chosen as an example, the Review Team thought that the lack of a competence framework for Lead Professionals would have effects in all settings not only in schools.

How widespread and prevalent is this issue?

In Halton, the Safeguarding Children Board has been scrutinising and trying to understand the issues that lie behind the use of the CAF. November 2015 analysis, reported to the performance subgroup of the Safeguarding Children Board addressed questions about the consistency with which the CAF is used as a tool across all agencies, and what the implications are for other parts of the system.

The report stated that:

> *Halton's Early Intervention Strategy and framework requires all partners across the children and families workforce to take responsibility for supporting children, young people and families and to take the lead responsibility for CAFs when appropriate. Whilst CAF audits show that over a number of years the quality of CAFs has consistently improved, the number of CAFs being completed by, and the proportion of CAFs that are led by, agencies other than some primary schools and Halton Borough Council staff remains at a consistently low level. A high number of cases discussed at Working Together Meetings and/or at CART early intervention level where CAF advised is the outcome, do not seem to progress to a CAF being completed.*

The implications of this are two-fold

> *"42% of referrals that other agencies/partners are referring in have needs that can be met through signposting and/or referral to a single agency that should be taking place directly from partner agencies or via advice/guidance at the front door* "- and this picture was similar for both Widnes and Runcorn teams so there is not wide variation in the two areas of Halton.

and

> " *Another area of some concern is the number of CAFs advised that do not result in a CAF being carried out– over the time period looked at 51 CAFs were advised for children in Runcorn and 60 in Widnes, with no evidence of a CAF currently uploaded or sent in to the CAF inbox. Whilst a proportion of these will have been advised recently so not yet underway this is a significant number of CAFs advised that are not leading to a completed CAF."*

The report to the Safeguarding Children Board concluded with an action plan to address different elements of the concerns that were outlined in the report. Along with a recommendation about the action plan, there was a second recommendation:

> *That all partners take responsibility for ensuring that their workforce understand and take on their responsibility for early intervention, advice guidance and support, and in particular take on lead professional role for CAFs***.**

What are the implications for the wider safeguarding system?

The November 2015 analysis that was reported to the Halton Safeguarding Children Board comes in the context of plans for substantial investment in early help across the whole of Cheshire. This makes it more important than ever that the full range of professionals who could potentially carry out CAFs and take the role of Lead Professional do so. If the range of assessors and Lead Professionals increase, the safeguarding system could be working with many more practitioners who are inexperienced and lack confidence in identifying neglect in teenagers.

Finding 4:

Practitioners within the multi-agency network perceive the role of Lead Professional to be one with limited status, with the consequence that individuals in the role do not feel confident to escalate concerns about colleagues in other agencies - inhibiting multi-agency efforts to provide the right help at the right time.

Summary of risks

The role of Lead Professional remains one that practitioners are reluctant to undertake. The identification of safeguarding issues at an early point is limited if only some professionals feel able to take on the role of Lead Professional. Agreed oversight arrangements for Lead Professionals in Halton, and minimum standards for the CAF are not in place, but could assist with both skill and confidence of practitioners. Planned investment in early help across the whole of Cheshire in 2016 means that the role of Lead Professional will become even more crucial, as will the training and guidance available to those taking on the role

Questions and considerations for the Board

Have Board members previously encountered concerns that the role of Lead Professional is not one that all relevant practitioners feel confident to take on?

How much of a priority is it for the Board to address this?

How does the LSCB ensure that all agencies have an understanding of the Lead Professional role, and what to do if cooperation is an issue?

How does the LSCB ensure that all agencies are putting in the right level of support and oversight to Lead Professionals?

Can the HSCB consider the value of a supervision process for Lead Professionals?

And do board members have any suggestions about the sort of professionals that might provide this oversight?

Finding 5

Are professionals in Halton who deliver universal and early help services sufficiently confident to raise questions about family and household members who could pose a risk of harm to the child or young person - with the consequence that they leave these young people vulnerable to abuse and neglect?

Category of Finding: Family / professional interaction

This Finding is about the importance of creating a culture where professionals are not naive. Serious Case Reviews of recent years have promoted the importance of identifying "hidden men" but this has not extended to the wider members of families and households.

How did this feature in the case?

The Review Team initially thought that there had been two different adult males in the Young Person's life, as partners of his mother. This was due to a very definite description from professionals at the Young Person's school that his mother had two different partners - one 'good' and one 'bad'. Only on interviewing the social work professionals,

and then confirming it through a meeting with the individual in question, was it absolutely clear that one person only was involved.

On the day of the incident that triggered this review, the Young Person was staying at the home of a member of the wider family. This was not a one-off, and the Young Person spent time there periodically. One of the paramedics who attended knew, from a previous attendance at the address that there was some reason why children should not be at the property. This was confirmed by the social worker initially allocated to work with the Young Person, who was in fact already involved with children who had been living at that address.

How do we know this is not peculiar to the case?

The Case Group, the Review Team, and the members of the Halton Safeguarding Children Board all provided information that there is no system in place for supporting professionals with this dilemma. Moreover, practitioners indicated that they are uncertain about when it is appropriate to make enquiries about wider members of the family and household.

How widespread and prevalent is this issue?

Although there is a growing body of work about "hidden men" (NSPCC 2015), the identification of a wider group of significant adults in a child or young person's life, is less well explored. The NSPCC's analysis of Serious Case Reviews that involved "hidden men" pointed to two categories of 'hidden' men:

- men who posed a risk to the child which resulted in them suffering harm
- men, for example estranged fathers, who were capable of protecting and nurturing the child but were overlooked by professionals. The same issues probably apply to a wider group of individuals in the lives of children, but the hidden nature of this problem makes it particularly difficult to quantify. In addition, practitioners' lack of clarity about their roles and responsibilities in terms of gathering information and sharing it, means that it remains hidden and that more children may be in vulnerable positions than is recognised. The Review Team acknowledged the question for practitioners of how one would legitimately gain information about these hidden members of a household.

What are the implications for the wider safeguarding system?

For a safeguarding system to work effectively, professionals need to be equipped to ask questions about every adult who is part of a child or young person's life, and never to be narrow, naive, or make assumptions about who those adults might be. Without this understanding of the significance to the child of family members and associates, professionals cannot assess risk to the child, nor establish who is a source of support or protection for that child or young person.

Finding 5: Summary of risks

There is a substantial body of work about "hidden men", and the safeguarding implications are likely to be the same for a wider group of extended family members, neighbours and associates who feature in some children's lives. Without professional curiosity and confidence to explore who these individuals might be, and without the support of the HSCB for professionals to exercise this curiosity, the scale and impact of both potential risk and potential support from this extended group cannot be understood or mobilised.

Questions for the board

How much of an issue is the identification of wider family and household members and associates for early help professionals?

Are there any demographic or social changes to complexity in family networks in Halton that might impact on children and young people who need early help?

Why does this matter to children and young people and their lived experience?

CAFs now have chronologies, would genograms also help professionals in understanding a child's wider networks?

What sort of messages might the HSCB want to give about this issue?

What sort of measures might the HSCB use to track positive changes in this area?

Finding 6:

There is not a robust system for multi-agency information sharing during organisational change, with the consequence that information about individual risk to children can be passed on, but does not always receive the analysis of risk that is needed for safeguarding decisions.

Category of Finding: Management Systems

Findings 6 and 7 move away from direct consideration of adolescent neglect and move on to two distinct issues which came to light during the review, that also have an impact on the safety of children and young people in Halton. As such, the Review Team had questioned whether these two findings might be of relevance to the Children's Trust as well as the Safeguarding Children Board.

Finding 6 covers information-sharing risks arising from the scale and continuous nature of organisational change in health and social care. There is not a system for keeping multi-agency networks up to speed with two regular aspects of change - restructure in organisations, and the award of new contracts and ending of existing ones.

How did this feature in the case?

During the period under review, the commissioning arrangements for School Health services changed. Review Team members felt that this was an example of a situation where service redesign should have included communication to professionals such as the Lead Professional in the Young Person's case, explaining changes in approach - the move to being a public health service, and on a more administrative basis, during the review it was said that information had not been received by School Health because of service changes.

How do we know it is not peculiar to the case?

Members of the Review Team gave the example of a recent change to the Speech and Language Therapy provision for the area. Briefings on this did not reach professionals who needed to know, and consultation about the changes when they were at the proposal stage could have been further reaching.

Review Team members also heard that with the 'lift and shift' of School Health services to Public Health, the Clinical Commissioning Group is trying to monitor the safeguarding aspects of that service in a situation where the contract for the service has not changed- but there has been an internal reorganisation of delivery.

Substantial changes to CAF support services form the backdrop for this review, and the Review Team heard that 'people are still getting used to [them]'. Another example was that CAF support workers no longer carry out visits which are more akin to welfare checks in response to concerns from other agencies - instead there is more focused assessment, but balanced with a telephone consultation line to advise on the sort of partner concerns which previously triggered requests for these visits. This has implications for all agencies, in terms of providing information to the Contact and Referrral Team – in 2014 there were 'massive partner briefings' about changes in Children's Social Care and what that meant for other agencies, but this most recent development is another example of change that communication strategies need to keep abreast of.

How widespread and prevalent is the issue?

The delivery of early help in Halton brings with it organisational change and restructuring. A March 2015 presentation in Halton for the Early Intervention Development day stated:

> *Early Intervention requires effective collaboration and co-ordination at all levels and across services, adopting common service delivery models, tools and processes and the development of multi-agency multi-professional teams.*

Nationally, *What makes change successful in the NHS? (Gifford et al 2012)* reviewed 15 systems change programmes - and although the language here is about clinicians, it

could be applied to practitioners in early help services, especially as Halton is on the verge of systems change in this area

"Change programmes also benefit from a genuinely collaborative process in which clinicians fully engage with diagnosing problems and designing solutions."

Finding 6: Summary of risks

Extensive changes are planned to the system for delivering early help in Halton in 2016. The information provided to this Serious Case Review suggests that previous changes have not always been communicated to professionals working with children and young people, with the direct consequence that practitioners do not always know where to send information about risk to a child. The forthcoming changes, because of their scale, have the potential to cause similar problems.

Questions and considerations for the Board

Are Board members aware that some organisational changes of recent years have not been fully understood by practitioners in the period after reorganisation?

How much of an issue do Board members think this is?

Extensive change to early help systems is planned - has the Board considered its role in the safeguarding implications of this change?

Based on the issues that this Serious Case Review has highlighted, how can the Board support communication about organisational change?

How will the Board know if communication about the early help systems changes are effective in getting messages across about any new safeguarding processes?

How will the Board work with other strategic partnerships, both in Halton, and across Cheshire, on this issue?

Finding 7

The whole emergency and urgent care system that includes Halton, is designed to be lean and efficient - and the risk in the system is that exceptionally, when the whole system is under extreme pressure, the efforts of dedicated individuals in the ambulance service cannot compensate for the risk that arises from having such a lean system.

Category of Finding: management systems

The challenge for an urgent and emergency care system is to provide safe care but also to be lean and efficient. The Review Team heard about changes to the system in Halton to make it as efficient as possible, and were also impressed by the skill and experience of ambulance trust professionals who attended the scene following the 999 call about The Young Person.

However it is an intrinsic risk in any lean system that when there is exceptional demand, that demand cannot be met.

How did this feature in the case?

On the day between Christmas and New Year when The Young Person had a life-threatening asthma attack, local crews and Accident and Emergency departments were on 'Red' alert, with ambulances queuing outside A&E departments in the surrounding area. When an adult dialled 999 stating that the Young Person was not completely alert, having an asthma attack and having difficulty speaking, exhaustive attempts were made by the ambulance service controller to find a crew. Ambulance staff were either engaged or not cleared as they were waiting at hospitals for patients to be admitted to A&E. Eventually professionals who were officially on breaks responded, above and beyond what was expected of them. A rapid response vehicle reached the house 34 minutes after the call was made, followed by an ambulance. This was outside the eight-minute response target for a callout to a child with the severity of asthma exacerbation that the Young Person was experiencing. However the Review Team heard that the pressure which was affecting callout times was due to ambulances being unable to hand over adult patients at the surrounding hospitals and having to queue, with the figures of eleven and twelve ambulances respectively being quoted as waiting at the two nearest hospitals at the most pressured part of that day.

How do we know this is not peculiar to the case?

A manager from the ambulance trust told the Review Team that in early September, winter pressures start to build – with cardiac and respiratory conditions such as Chronic Obstructive Pulmonary Disease and asthma requiring admission. The manager said that the affected services 'don't have a lull any more'. This seasonal increase in demand takes place alongside a growing list of calls in relation to legal highs, cocaine, alcohol, and people 'who don't take their pain relief'. Despite advertising campaigns such as '999 what's your emergency (filming in Warrington during September 2015), the demand on emergency services remains high from members of the public who cannot, or do not wish to, use the range of services set up to deal more appropriately with some of their out-of-hours illnesses. The Review Team also heard about schemes set up by the ambulance trust to address some of the pressures that arise from adult patients, but which then impact on the whole urgent care and emergency system. One of these was the Advanced Visiting Service, where the ambulance trust was in certain situations that met clear criteria, using a GP service to visit patients at home as an alternative to hospital admission.

The issue exists for every part of the country. On 3rd September 2015 Polly Toynbee wrote in the Guardian [of a hospital trust in the southeast of England]

> *Every service has targets to hit, waiting times and waiting lists to meet, but they all depend on one another. A week earlier, there had been 14 ambulances lined up outside the emergency department. They had to wait, caring for people inside their vans as they couldn't offload patients for lack of cubicles and staff inside the hospital. When that happens, the ambulance service misses their target times for*

answering other calls, damaging their own inspection scores, knocking down the skittles from one service to another.

On the day of the incident involving the Young Person - 28th December 2014 - the Review Team heard that the pressure on the service was normal for Christmas. The Young Person was admitted to hospital in the early afternoon but by 9.05 pm, there were still pressures at one of the nearby hospitals, with 9 ambulances outside unable to leave their patients. The agreed plan of action for such a situation was set in motion, and the strategic manager for the ambulance trust sent the operations manager in to work with the hospital.

The Review Team heard about the volume of calls to the ambulance service on the day of the Young Person's asthma attack and how this fitted with the pressure on the whole system. There were 72 outstanding calls at the time of the call about the Young Person. The pressure had been relentless all day. At 1.13am there were 25 outstanding calls, 18 of which were life-threatening 'Red' calls (the same priority that was given to the call about the Young Person). The preceding night had seen ambulances queuing at the majority of hospitals in the region. The Review Team questioned whether services were fully staffed, to be told that not only were they fully staffed across the 'east' sector but that services were also supplemented with funding put in by the ambulance trust itself. Practitioners who were usually office based were out in cars as well.

How widespread and prevalent is this issue?

The Review Team were in no doubt that the issue is one that affects the whole region of north west England and the impact is much the same for Halton as is it for the other authorities in the region. Northwest Ambulance Service's Annual Report for 2014/2015 begins:

To say 2014/15 was challenging would be a gross understatement. The NHS found itself under unprecedented pressure and in its nine year history, NWAS dealt with a rise in activity that had never been seen before.

Outside the region, the pressures and issues are the same. One of the lead reviewers for this case has recently interviewed ambulance trust staff from another part of the country in the context of an adult safeguarding review, and the issues described were strikingly similar. The Polly Toynbee article quoted in the previous section, illustrates how each part of the urgent care system depends on another - '*knocking down the skittles from one service to another'.* In terms of opportunities, from October 2015, NWAS will also be running the non-emergency call centre for the region - the NHS 111 service. The Trust's annual report says:

Obtaining the contract gives the Trust a real opportunity to fully integrate the services offered by NHS 111 into NWAS so the advice and help provided to patients, whether they dial 111 or 999, is consistent and tailored to their needs. We are also pleased that this contract offers longer term stability to the NHS 111 staff.

For some time now, the Trust has been mindful that we must look at the different ways we can respond to 999 calls as a blue light emergency response and conveyance to hospital is not always in the best interests of the patient or the wider health system.

What are the implications for the safety of the multi-agency safeguarding system?

A safe system has some slack in it so that children's health emergencies can be responded to. However an efficient system also has to make the best use of resources and strike a balance about the amount of slack that can be available. If members of the community - either families or professionals - remain unable or unwilling to use emergency and urgent care services in different ways, and to respond to national and local messages about alternative points of access - then the pressure on the urgent and emergency care system will continue to follow its upward trend, meaning that on exceptional days such as the one between Christmas and New Year in 2014, there is a risk that response times for children will not be met.

Finding 7:Summary of risks

A safe system has some slack in it so that children's health emergencies can be responded to. However an efficient system also has to make the best use of resources and strike a balance about the amount of slack that can be available. Pressures on the system are rising and are usually managed, but a period of exceptional demand may occasionally mean that agreed response times for children cannot be met.

Questions and considerations for the Board

How much of an issue does the Board consider this risk to be?

Where does the Board think the oversight for this risk should sit? (For example with the Children's Trust Board, and / or the Health and Wellbeing Board?)

Does the Board have any existing concerns about the impact of ambulance response times as a safeguarding issue?

The ambulance service is one part of a complex urgent and emergency care system - would the Board want updates from North West Ambulance Service about safeguarding issues identified once NWAS takes on the contract for the 111 number?

Conclusions

This Serious Case Review was commissioned in response to events that are uncommon. First of all it, involved a young person and an exploration of neglect that had affected the whole of that young person's life. Neglect cases and referrals much more typically involve younger children. Secondly and thankfully, the young person had survived the incident that triggered this Serious Case Review and was able to contribute to the review process. Most of the Findings from this review reflect these distinctive factors, and address the research question:

> *To what extent is Early Intervention in Halton child-focused in addressing adolescent neglect?*

The events that triggered this Serious Case Review, and the period when the Review was being carried out, occurred at a time of significant planned change for the Early Help services in Halton. The systems challenge, now that the change is being implemented, is to create an environment where professionals are not so pressured that they work in isolation as a response to that pressure - but instead to use the frameworks, training, and the data from Halton Safeguarding Board's audits of early help, to embed multi-agency safeguarding practice that is accountable, but is not measured solely in terms of figures that are easier to capture - such as throughput and timeliness. Instead, it is hoped that the questions for the Board in this report help with a discussion about what it is that a Safeguarding Children Board should have oversight of , and what responsibilities lie with individual agencies that belong to the Board.

With the investment and attention being put into early intervention services in Halton, which have already incorporated learning from this review, adolescent neglect should in future get more of a whole-system response than it did in the case of the Young Person.

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