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TACKLING NEGLECT IN SALFORD

ASSESSMENT OF THE PREVALENCE, CAUSES AND SERVICES TO ENSURE CHILDREN'S NEEDS ARE MET

OCTOBER 2019

FINAL TO SSCP 16 DECEMBER 2019

Contents

1 Introduction

Tackling Neglect has been one of the Salford Safeguarding Children Partnership (SSCP) priorities for the past five years. The last Neglect Strategy for the local area (2016 to 2019) set out the strategic aims to *improve the recognition of neglect in families; to improve agencies' responses to these families; and to ultimately improve positive outcomes for children, young people and families.* The objectives were:

1. Improve the awareness and understanding of neglect, both within and between agencies working in Salford and including adult services. This includes a common understanding of neglect and the thresholds for access to services.
2. Improve the recognition and assessment of children living in neglectful situations before statutory intervention is required, including the use of appropriate assessment tools.
3. Develop and sustain an agreed, early multi-agency response to neglect.

A needs assessment has been commissioned from Carole Brooks Associates Ltd to consider current prevalence, services and outcomes to assist developing the new strategy. This recognises that it is vital we gain a better understanding of the causes of neglect and the needs of Salford's children and families, what works well and what we can do better in order to have a strategy and services in place which improve the lived experiences and lives of our children into adulthood.

The SSCP vision that *"all partners are committed to working together so that every child in Salford is safe, well and able to reach their full potential"* reinforces the whole systems approach which is particularly relevant to tackling neglect and importantly to how parents are supported to successfully meet the needs of their children at the earliest point before it is deemed 'neglect'.

2 Methodology

2.1 Scope and Timescales

All children pre-birth to 18 years of age in Salford and who fall under the remit of the SSCP were included in the needs assessment. Whilst 'neglect' is the core subject of the needs assessment, this cannot be considered in isolation of other issues that families face and other presenting needs such as domestic violence, parental drug and alcohol abuse, and other adverse childhood experiences (ACEs) that may be causal factors in parental inability to meet the needs of their children.

The needs assessment was undertaken between July and October 2019, directed by the SSCP Neglect Sub-Group and supported by a short-term strategy group consisting of volunteer professionals to provide both a partnership steer and a reference group.

The timeline for the needs assessment and strategy is shown below.

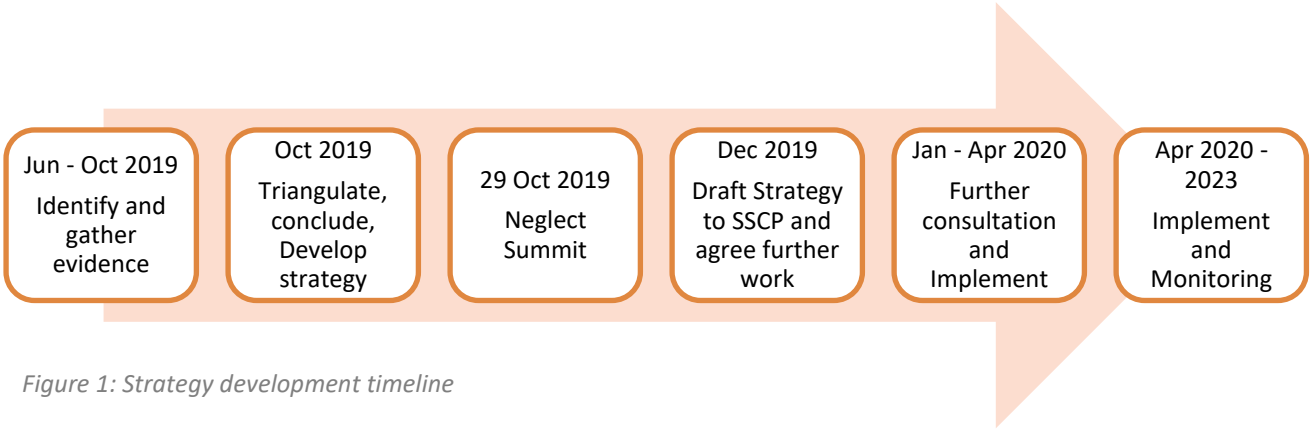


Figure 1: Strategy development timeline

2.2 Research Questions

Appendix A provides a list of questions which were compiled to focus the needs assessment and strategy development. They are based on the six principles of the safeguarding children partnership; the Ofsted Neglect Joint Targeted Area Inspection (JTAI) criteria for 'good'; and good practice. This will also help to measure progress and effectiveness of the new strategy post-implementation.

2.3 The Evidence Base

A range of methods were used to conduct the needs assessment, triangulate and draw conclusions including options for the new strategy. There is an extensive research base on neglect and associated issues which we do not attempt to include here apart from where we believe it adds value to the needs assessment. A literature review was undertaken and findings from the evidence sources are included in the relevant sections of the report.

Figure 2: Evidence base

2.3.1 Professionals survey

There were 92 respondents to the professionals survey from a range of services (figure 3) with most responses from Education including 12 Head Teachers (25%), Children's Services (24%), Early Help (21%) and 19% across a range of Health services. 3% were from the voluntary sector.

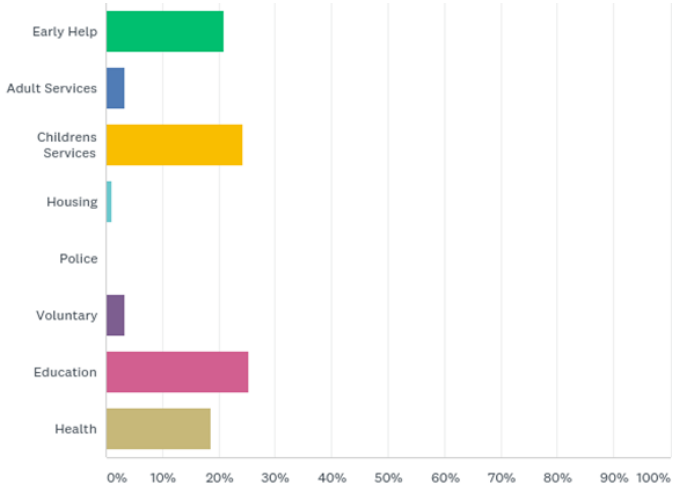


Figure 3: Survey respondents

52% of respondents were professionals / practitioners, 27% senior / strategic managers and 13% team managers. 80% of respondents have worked in Salford for over five years and therefore well placed to comment on changes in the last three years and their experiences.

Nearly all respondents stated that their service remit in tackling neglect is to understand family needs and work with the family and support the child.

- 31% of respondents said they work in a service which would refer to other services if they are worried about neglect.
- 65% of respondents work in a service where child neglect may be present.
- 4% work in a service specifically for neglect.
- 36% had less than a quarter of their caseload/families where aspects of neglect were a feature
- 30% of respondents had more than half of their caseloads featuring aspects of neglect.

2.3.2 SSCP Roadshow discussions about neglect

Roadshows attended by approximately 200 professionals were held in May 2019 as part of the introduction of new multi-agency safeguarding arrangements. During these, a short explanation of neglect as an SSCP priority and group discussion generated views of Salford professionals about what is working well, what they are worried about and what needs to happen.

2.3.3 Review of cases in children's social care

An audit of 40 cases where there were additional and underlying risk factors of neglect was undertaken by the Principal Social Worker following an Ofsted inspection in 2018. The objective was to identify actions for the local authority children's services and to gather evidence about early identification of neglect and the impact on children for the partnership. The recommendations and elements relating the latter are included here.

2.3.4 Practice week

A social work practice week focussed on neglect took place in the first week of September, led by the Safeguarding Quality Assurance Unit. Activities included:

Reflective practice sessions	**Individual case discussions and observations:**
• Lived experiences of practice in the Bridge – looking at neglect cases • Drift and delay – the role of the Safeguarding unit (11 professionals): • Deans Youth Centre – SPY project meeting with young people • Case discussion - 'Stuck case' • Case discussion – a good case • Reflective learning circle with Principal Social Worker – themes around neglect • Head of Service reflective session on practice week as a whole	• 7 case audits • Reflective case discussions with social work practitioners and managers about their cases • Observations of child protection conferences • Observation of a supervision order review meeting • Observation of a core group
• A lunchbowl session in October presenting the findings and implications for practice.	

The findings reinforce existing knowledge about neglect and offer areas of good practice as well as where there is a need to understand and address underlying parental factors, achieving a greater consistency, the importance of stable professional relationships for the family and access to the right services. Further specific findings are included in the relevant sections.

2.3.5 Engaging Young People and Parents/Carers

Young people's views are one of most important areas on which to build any strategy or service development and they have been involved in a number of ways. Sessions specifically on meeting children's need and neglect were held with the Salford Youth Council as well as feedback from other groups over the summer and as part of the Practice Week, about what young people in Salford need in order to grow up safe, well and thrive. The Youth Council were involved in the Tackling Neglect Summit.

A questionnaire to parents was administered through the professionals working with families who are receiving support for parenting, or where there are elements of neglect. However, there were no responses which could indicate that parents were not engaging or the methodology was not effective. It is critical to find ways to engage parents during the strategy development and implementation.

2.3.6 Tackling Neglect Summit

On 29th October 2019, 71 professionals and 7 young people attended Salford's Tackling Neglect Summit co-hosted by a member of the Youth Council. The evidence base nationally and for Salford, challenges and enablers as well as specific areas such as poverty, children in specific circumstances, adolescents, education and parental factors prior to formulating actions and potential models for the future and the strategy were presented and discussed. Evaluation was very positive:

- 91% of evaluations said that objectives had been fully met, 100% fully or partly met.
- 59% said they found the Summit very good and 100% very good or good.

- Delegates provided reflection points and the impact that the learning from the Summit will have on their work.

2.4 Format of report

Three overarching categories have been used to order the evidence of a myriad of elements influencing the prevalence of, presenting factors, root causes and impact in reducing impact of childhood neglect:

- **Social factors**: the underlying needs faced by local communities in Salford that result in changes to the numbers of children and families asking for help.
- **System factors**: leadership, and the way that the system of services across and within Salford responds to families asking for help.
- **Practice factors**: the way that professionals work with children and families.

The final sections of the report provide a summary and reflect on challenges and considerations.

Carole Brooks Associates and the SSCP Neglect Sub-Group are grateful to all of those who both enabled and took part in this review.

3 What is neglect

In simple terms, neglect is when a child is not getting the important things that they need like clean, warm clothes or enough to eat, or love. It is when a child is not being looked after properly by their parents and it might include not being kept away from dangerous situations or not being taken to the doctor when they are ill or hurt.

Whilst statutory definitions below refer to *'persistent failure to meet needs'*, neglect can be episodic or cumulative. It can also be intentional or unintentional, which is an important difference to consider.

3.1 Statutory Definitions of Neglect

The main statutory definition of neglect is laid out in Working Together to Safeguard Children (DfE, 2018) and has not altered since The Children Act 1989:

> The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:
>
> a. provide adequate food, clothing and shelter (including exclusion from home or abandonment)
> b. protect a child from physical and emotional harm or danger
> c. ensure adequate supervision (including the use of inadequate caregivers)
> d. ensure access to appropriate medical care or treatment
> It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

This is supported by the definition of criminal neglect:

The College of Policing (2019) defines criminal neglect as outlined in section 1(2)(a) of the 1933 Act. They state that "an offence is committed if a parent or the legal guardian, or other person legally liable to maintain a child or young person has wilfully neglected the child in a manner likely to cause injury to health by failing to provide adequate food, clothing, medical aid or lodging or, if having been unable to provide such items, they fail to take steps to procure them".

"Under section 1(2)(b), an individual aged 16 or above is deemed to have neglected an infant (under three years), where it is proved that the death of the infant was caused by suffocation while the infant was in bed with that individual, and that the same individual was under the influence of alcohol or a prohibited drug at the time. The definition of 'bed' includes any kind of furniture or surface being used by the adult for the purpose of sleeping".

The definition of child cruelty is given as:

"The offence of cruelty to persons under 16 years incorporates neglect, as set out in the Children and Young Persons Act 1933 section 1(1). Under the Act, if anyone who is 16 years or over wilfully assaults, ill-treats, whether physically or otherwise, neglects, abandons, or exposes a child, or procures a child to be assaulted, ill-treated, whether physically or otherwise, neglected, abandoned, or exposed, in a manner likely to cause unnecessary suffering or injury to health, whether the suffering or injury is of a physical or psychological nature, they are guilty of an offence.

There is no statutory definition of wilfully, but the term has been interpreted by the courts. In Attorney General's Reference No 3 of 2003 [2005] 1 Q.B. 73 it was said that wilful misconduct means, 'deliberately doing something which is wrong, knowing it to be wrong or with reckless indifference as to whether it is wrong or not'. Although there is no definable threshold for when a minor neglectful act becomes a criminal offence, each single incident must be examined in the context of other acts or omissions and the possibility of a criminal offence should be considered. See definition of 'reckless' in R v G [2004] 1 AC 1034.

There will be occasions when the issue is one of poor parenting and/or the carer's lack of knowledge, rather than a deliberate and wilful act. The decision to record wilful neglect as a crime should be made in light of all available evidence and information".

3.2 Types of Neglect

Commonly categorised types of neglect are listed below. These are likely to be present together rather than in isolation, but research and Salford's evidence tells us that we don't always identify these specifically at an early enough stage, or in terms of the impact on the child's well-being.

Neglect type	Features associated with type of neglect
Educational neglect	Where a parent/carer fails to provide a stimulating environment or show an interest in the child's education at school/education provision. They may fail to respond to any special needs and fail to comply with state requirements about school attendance.

Emotional neglect	Where a parent/carer is unresponsive to a child's basic emotional needs. They may fail to interact or provide affection, undermining a child's self-esteem and sense of identity. (Most experts distinguish between emotional neglect and emotional abuse by intention; emotional abuse is intentionally inflicted, emotional neglect is an omission of care.)
Medical neglect	Where a parent/carer minimise or deny a child's illness or health needs and/or fails to seek appropriate medical attention or administer medication and treatment.
Nutritional neglect	Where a child does not receive adequate calories or nutritional intake for normal growth (also sometimes called 'failure to thrive'). At its most extreme, nutritional neglect can take the form of malnutrition or obesity.
Physical neglect	Where a parent/carer does not provide appropriate clothing, food, cleanliness and/or living conditions.
Supervisory neglect	Where a parent/carer fails to provide an adequate level of supervision and guidance to ensure a child's safety and protection from harm. For example, a child may be left alone, abandoned, left with inappropriate carers, or they may not be provided with appropriate boundaries about behaviours (for example, under-age sex or alcohol use) may not be applied

3.3 Graded Care Profile Definiitons

The Graded Care Profile, one of the most commonly used tools to assess neglect, currently includes different categories which partly align to the types of neglect but do not currently include educational neglect - education features under the category of stimulation. The revisions planned at present address this. These categories and the tool are being revised at present (see relevant section below).

A) PHYSICAL	1 Nutrition	C) RESPONSIVENESS	1 Carer
	2 Housing		2 Mutual Engagement
	3 Clothing	D) ESTEEM	1 Stimulation
	4 Hygiene		2 Approval
	5 Health		3 Disapproval
B) SAFETY	1 In Carer's Presence		4 Acceptance
	2 In Carer's Absence		

3.4 Framework for Assessment

The dimensions of child development needs triangle, which features in Working Together to Safeguard Children 2018 (DfE, 2018), provides a model which should be used to examine how the different aspects of the child's life and context interact and impact on the child.

Figure 5: Assessment Framework (Source: Working Together 2018)

3.5 Other Definitions and Descriptions

National Institute for Clinical Excellence (2017) guidance chapter *1.3 Neglect – failure of provision and failure of supervision* includes the same definitions as in the Children Act 1989 and Working Together to Safeguard Children 2018, but expanded to indicators that clinical practitioners may identify. There are also specific guidance for health visitors and there are likely to be more 'definitions' used by different professionals, and what parents/carers understand by 'neglect'. It is therefore critical that there is a common core understanding of neglect supported by specialist definitions or terminology, but that is widely and consistently understood.

3.6 Challenging the Definitions

Many definitions, descriptions and discussions of neglect imply a deficit approach, which sits largely at the 'high end' of thresholds. We know that this does not sit well with professionals or parents, for those who need 'a bit of help' on any of the areas, or children who may be at risk of neglect, and where neglect can be prevented. One group at the Neglect Summit commented that 'neglect' itself is an abusive word for parents, but we heard how in Bolton, the parents they asked about the term 'neglect' felt it is fine to use it, but tell us what you mean by it.

NSPCC (2012) proposed that the wording of the definition of neglect currently outlined in the Working Together guidance be amended to reflect our understanding of the nature of neglect and the challenges professionals face when taking appropriate action for children suffering neglect. They assert that the use of the term "persistent failure" within the definition of neglect is problematic and neglectful behaviour is not always constant. With support, neglectful parents may demonstrate improvements in behaviour only to relapse once support is reduced or withdrawn. As a result, neglectful behaviour may be more appropriately defined as a "pattern of behaviour".

The Neglect Sub-Group and professionals in Salford also challenge terminology and were clear that utilising a more strengths based approach, to include language such as 'level of care provided', 'needs met', 'grow well' or 'thrive', provide greater aspirations and objectives for parents and professionals than 'neglect'. There was agreement that the term neglect spanning from 'parent needs a temporary bit of support or advice' to intentional neglect resulting in significant impact, is too broad.

However, at that 'high end' of the levels of need (levels 3 and 4), where the definitions of neglect are met, it is absolutely right that we are clear about neglect as a form of abuse and treat it accordingly at the earliest point.

The Neglect Sub-Group were therefore in favour of a clear focus on children's needs being met, that understanding what we mean by neglect and recalibrating our language and attention for the future is critical.

> *"Everyone has different standards and views on what neglect is. Everyone is neglectful to a certain extent, but it's the impact that has on the child. For example, I don't remember the last time I mopped my kitchen floor…Hoovered, but not mopped. But that has no impact on my children as I don't feed them off the floor."*
>
> Source: Focus Group Attendee

Recommendations and Key Lines of Enquiry:

3.1) Consider the different facets of definitions including Working Together 2018, the graded care profile, framework for assessment, NICE guidance, and criminal definition so that there is simple strengths based terminology at the lower levels of need, that is inclusive of all types of neglect in our work, including assessment tools.

3.2) Ensure that there is clarity across the system about what we mean by 'neglect' and 'meeting children's needs' so that every young person, parent, professional and leader is able to understand the standards / levels of needs therein.

4 Why Is This A Priority?

We know that neglect is currently the most prevalent form of child abuse and have evidenced prevalence in a later section. Wolock and Horowitz (1984) drew attention to what they described as 'the neglect of neglect' in the understanding of and responses to child maltreatment. Whilst this expression cannot be said to remain true given the amount of research and that considerably more is now known about the causes, identification and assessment of neglect, it remains a challenge to tackle conclusively in a timely manner.

4.1 Progress on Last Strategy

Neglect has been one of the SSCB/SSCP priorities since 2014. The annual reports from 2014-15 to 2017-18 detail activities including events, 7 minute briefing, development of Graded Care Profile, Maram Tools and development of neglect training. Whilst the 2016-18 strategy laid out methods to measure progress of the strategic objectives, measurement and monitoring was not sufficiently robust and the needs assessment did not generate any discernible evidence of sufficient improvement albeit in a changing context.

4.2 A Whole City Issue

There is no Greater Manchester (GM) approach to neglect at present. There was GM wide activity and strategy in June 2015, with a further draft proposed by Greater Manchester Safeguarding Board in June 2017 but it appears that this did not go live and work did not progress any further.

It is clear that ensuring children are cared for appropriately and tackling neglect is a whole city issue and already embedded in many priorities, strategies, plans and initiatives across Salford. These include the 'Great 8' and Anti-poverty Strategy as well as inherent in other Boards priorities, to name but a few. It is important that the 'golden threads' and activities between these and other strategic plans align and are used to drive the Neglect Strategy across the city. The table below highlights some of the relevant elements followed by a diagram of the 'golden threads' for 0-25 transformation programme in Salford.

Strategy	Priorities (those linked to neglect/meeting children's needs in bold.
Great 8	• **Tackling poverty and inequality** – Significant levels of poverty continue to exist in many parts of Salford. Working with our partners, we will take action to make things better for the many households struggling to make ends meet. We must also look to prevent people from falling into poverty in the first place, building on what we know is already working, as well as developing new ways of doing things. • **Education and skills** – Developing skills and a strong education offer. We want productive local jobs with real career progression and opportunities to develop skills and talents. • **Health and social care** – Working with our partners to improve health and wellbeing. • **Economic development** – Investment that provides jobs with decent wages. We will use our power and influence to target employers who have a commitment to giving something back in return – those who offer local jobs, look after their employees and pay them well. • **Housing** – Tackling soaring rents and a lack of affordable housing. • **Transport** – Connecting affordable transport with jobs and skills. • **A transparent effective organisation** – Delivering effective and efficient council services. • **Social impact** – Using social value to make the most difference in Salford. Making sure council money gets the most 'bang for its buck' for Salford residents.
Anti Poverty Strategy	"**Our vision is for a fairer and more inclusive Salford where everyone is able to reach their full potential and live prosperous and fulfilling lives free from poverty and inequality"** Supported by Better Off Salford
Community Safety	Aim to: • build safer, stronger, more resilient communities in Salford

Partnership	• reduce the fear of crime. Priorities: • Driving down crime • Tackling anti-social behaviour • **Building resilient communities** • **Protecting vulnerable people** • Reducing offending.
Health and Well-being Board	Ambition to: • improve life expectancy in Salford so that the gap between Salford and the UK average is reduced, and • **improve health and well-being at every stage of life – starting**, living and aging. Purpose to: • **improve health and well-being across the city and reduce health inequalities** • **create an integrated system that responds to local needs and assets, and gains public confidence** • **empower people to improve their own quality of life, improve the long-term health of communities and promote individual responsibility and behaviour change**.

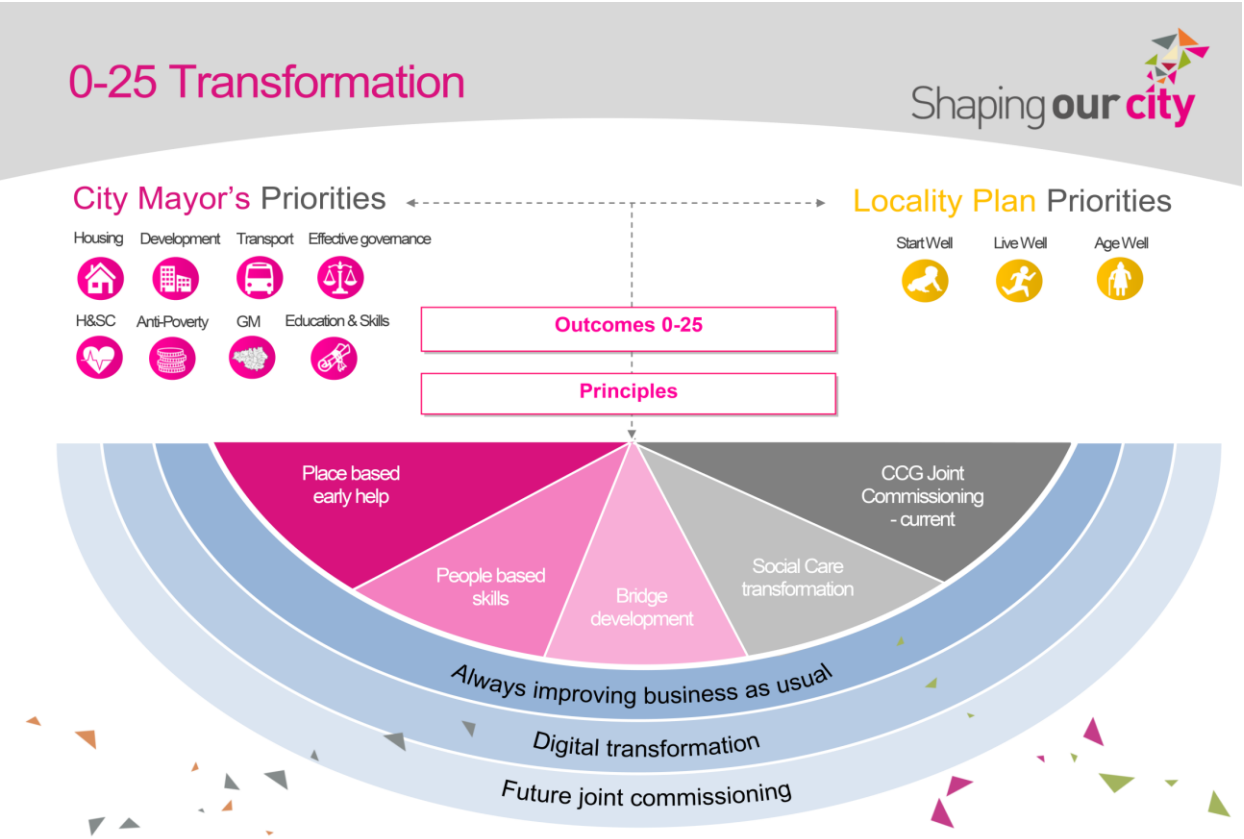


Figure 6: 0-25 Transformation Programme links

There are also a range of other programmes or strategies underway, which also include elements of preventing and tackling neglect and ensuing children's needs are met. These include Adverse Childhood Experiences, Trauma-informed practice, The Learning City, FACT project, Integration of CCG and Local

Authority children's services, No Wrong Door, and a number of pilots, to name but a very few. Work is also underway to implement the Unified Public Services for the People of Greater Manchester integrating provision in a place. As with overarching city strategies and priorities, all of these need to be considered together to avoid duplication and create an effective whole system approach which is clearly understood by professionals.

4.3 Financial Imperative

We know that the cost of late intervention to the public sector in England and Wales in 2016 was £17bn per year (Chowdry and Fitzsimons 2016).

An economic evaluation (NSPCC, 2017) gives a conservative estimate for the financial average lifetime cost of non-fatal child maltreatment by a primary care-giver, in terms of health care, social care, education, the criminal justice system, and the impact of lost productivity on the economy. The estimated cost per person is £89,390, with a 95% certainty that the costs fall between £44,896 and £145,508. The largest cost elements are social care, short-term health-related, and the costs resulting from a lower probability of employment. It does not, and cannot, capture the significant intangible costs of abuse to the individuals involved, such as the emotional trauma.

The University of Kent's Personal Social Services Research Unit (2018) provide average national unit costs that indicate the lower costs for prevention and early intervention in terms of community or school based staff compared to higher costs for CAMHS, foster care or residential placements, and reunification home after a care episode. The small selection of unit costs below can be viewed in terms of how much it costs to provide the service, but also the cost of missed appointments, which, as covered later in this report, is a significant factor in Salford.

Service	Unit	Cost per unit
Community Based or School Nurse	Per Hour	£36-45
GP	Per surgery appt lasting 9.22 minutes	£31
Social worker	Per Hour	£43
Support or outreach worker	Per Hour	£23
Hospital/Community Based Physiotherapist, Occupational therapist, Speech and language therapist	Per Hour	£34-£55
CAMHS	Per Patient Contact	£238-£336
Paediatric outpatient appointment	Per appointment	£151-201
Children's residential home	Per resident per week	£4,705
Foster Care	per child per week	£660
Costs to the public purse of providing services to support successful reunification of all children and families following a care episode (Holmes, 2014)	Average weighted cost per case.	£8,941

There is substantial evidence nationally that early intervention works to improve outcomes and reduce costs to the public sector and Salford has invested in early help.

4.4 Children's Rights to a Positive Childhood Experience

Children have the right to a positive childhood experience, including having their basic needs met. In sessions with young people to inform the strategy, they told us that they want to be listened to and heard; for professionals to talk to them and take them seriously; to care and show it; to give them choices; to build trust, for example talking about themselves so that children can get to know the professional better. What helps them is family places and people; having a safe space to go, for example a library; music and love.

Section 14 (what good looks like) includes the results of work they have undertaken.

> *"It doesn't help when it takes an hour on the bus to get to an appointment that takes 20 minutes".*
>
> Source: Practice week session with young people

Recommendations/Key Lines of Enquiry:

4.1) Work with leaders of key strategies, plans and initiatives to ensure they understand the evidence base around neglect, are linked into and able to champion children's needs as part of their work and ensure the neglect strategy and subsequent actions are linked.

4.2) Consider whether funding can be directed to ensuring children's needs are met earlier to tackle neglect and create efficiencies in the system through reducing missed appointments and escalation.

5 Prevalence in Salford

In this chapter, we explore what we know about the prevalence of unmet need and neglect in Salford , how many children and families are engaged with services where they either may require a little bit of help or are experiencing significant harm through neglect. This section provides analysis only, with further description about the services themselves later in the report.

5.1 Overall Prevalence

Ofsted (2018) in a summary of joint targeted inspections on neglect say that "The government considers neglect to be the most common form of maltreatment of children. Many different measures of the proportion of children living with neglect support this view, but the exact level of prevalence is unclear.

An NSPCC study (Rawson et al, 2011) found that 4% of under 11s and 11% of 11- to 17-year-olds had experienced neglect at some point during their lives. "This suggests that older children are almost three times more likely to have suffered neglect than younger children". The report also notes, however, that previous research had identified widely differing estimates of prevalence.

Brandon (2013) in a review of 46 serious case reviews (SCRs) nationally found that:

- Lack of supervision and guidance with catastrophic consequences were in 9 cases.
- Physical neglect – Unexplained deaths occurred in the context of neglectful care and a hazardous home environment were in 10 cases. Further assumptions about neglect were found to mask the danger to a child's physical safety in 7 cases; physical assault led to death or serious injury in all.

- Medical neglect was associated with catastrophic consequences in 5 of the cases.
- Nutritional neglect was linked to 8 cases with catastrophic consequences.
- Emotional neglect – Some young people who were the subject of SCRs had attempted or committed suicide (7 of 46 cases); in those, a long term history of neglect or extreme isolation was found to be part of their circumstances.

As part of Salford's needs assessment, a review of 17 case review referrals between 2015 and 2018 identified that 10 of these were solely or partly related to neglect. Key factors which are expanded further in the report included:

- **Root Causes:** Child's disability, nutritional neglect, parental mental health and alcohol and drug misuse, previous domestic abuse, parental separation, working across borders, diverging opinions about risk and thresholds by professionals, housing issues, debt issues, chaotic lives, parental capacity/understanding, professionals not taking into account historical concerns
- **Presenting Factors:** Behaviour, poor communication skills, obesity, not engaging with professionals or attending appointments, self-reporting and disguised non-compliance, episodic neglect (bouncing), drift.
- **Effects/Impact:** Developmental delay or disability, focus on parental needs change, not outcomes for the child, poor health, poor self-esteem or emotional literacy, poor educational attainment, poor life chances into adulthood, death.

Professionals responding to the survey reported that they see more children experiencing all types of neglect now than they did three years ago, as well as more children experiencing neglect alongside other needs. Of note, 73% of respondents agree that they see more children experiencing emotional neglect, of which 44% strongly agree. 71% stated they see more children experiencing neglect alongside other needs than they did three years ago. Further detail about these needs are provided later in the report.

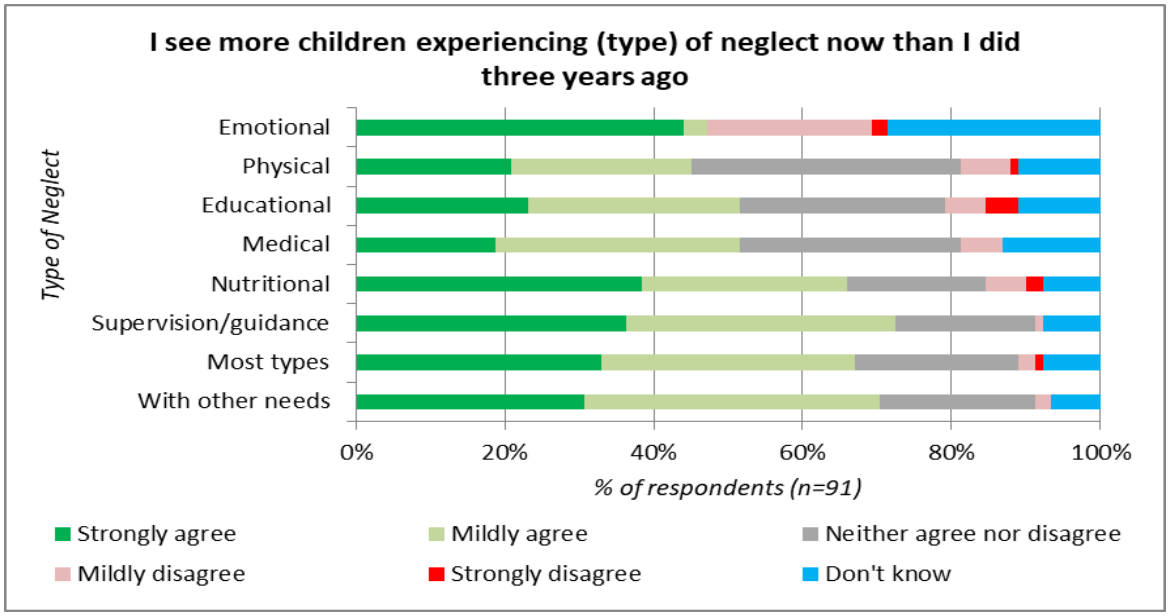


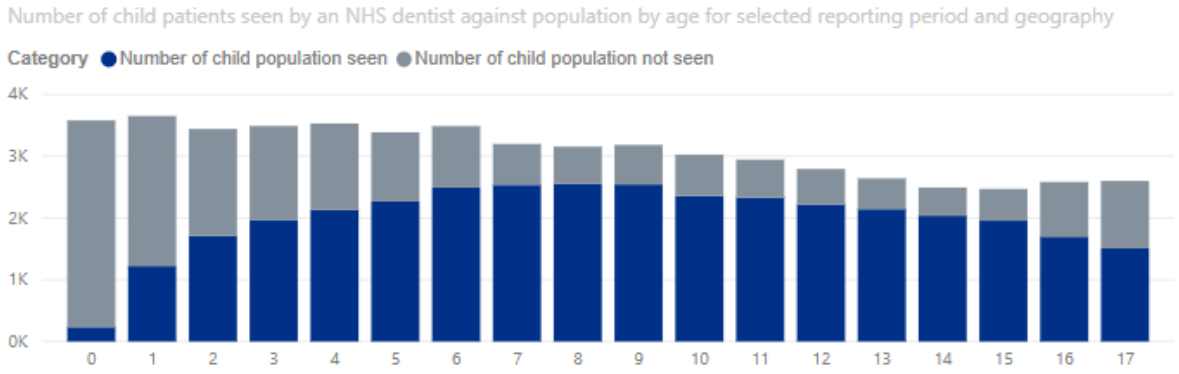
Figure 7: Professional Survey Responses: Change in prevalence of neglect.

The existence of one or more possible risk or outcome indicators does not necessary point directly to neglect, hence the need for specialist assessment led by professional curiosity. Risk indicators associated with neglect which chimed with professionals in the survey and focus groups included: children not attending school; children not brought for appointments, and lack of dentist involvement. Other outcomes that could possibly be relevant to neglect, include those listed below.

5.2 Well-being and Wider Determinants

Child Health Profiles provide important context that:

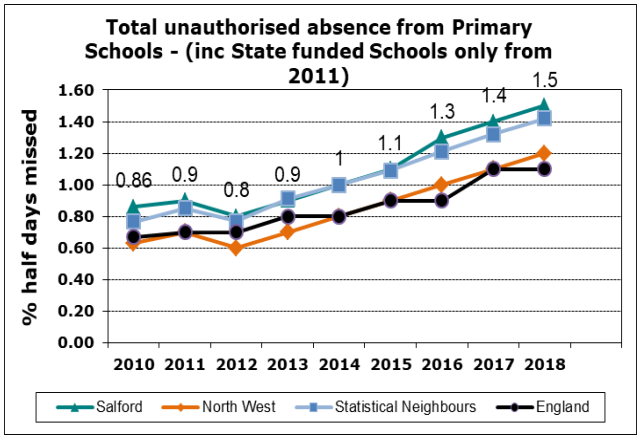
- The rate of children in low income families in 2016 was higher in Salford (21.1) than nationally (17).
- There were more statutory eligible homeless people not in priority need in Salford in 2017/18 than England (4.6 compared to 0.8).
- Family homelessness in Salford in 2017/18 was the second highest in GM at 2.9 compared to 1.7 nationally.
- School readiness: the percentage of children achieving a good level of development at the end of reception in 2017/18 was lower than nationally at 67.4% compared to 71.5% nationally.
- Childhood obesity (Year 6) in 2017/18 was higher at 22.7% compared to 20.1% nationally.
- More children per 10,000 population attended the dentist to June 2019 in Salford (64.5%) than nationally (59%), but fewer younger/older children are seen (Source: NHS Dental statistics England 2018/19).
- There were 44.6% children with one or more decayed, missing or filled teeth in 2016/17 compared to 23.3% nationally.



- In terms of health into adulthood: 66.2% of adults classified as overweight or obese in Salford in 2017/18 compared to 62% nationally.
- The estimated diabetes diagnosis rate in 2019 was 80.9 compared to 78 nationally.

5.3 Education

To 2018, there was a higher proportion of children with unauthorised absences in Salford state funded schools than nationally and across the North West. This does not take into account non-maintained schools, any lateness, exclusions, persistent absence, or other educational data that may be relevant. There has also been a significant increase in children who are electively home educated.



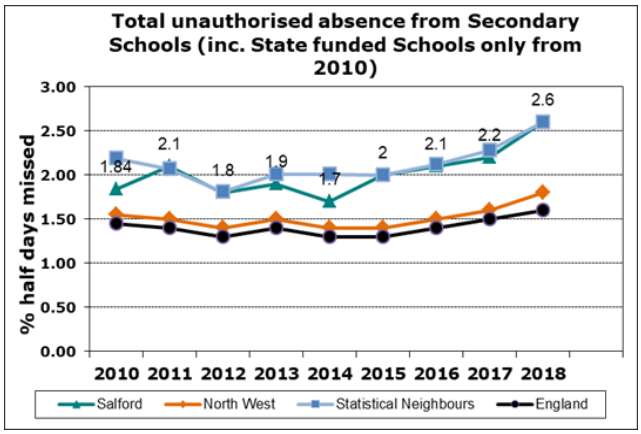


Figure 8: Absence data. Source: DfE Local Area Interactive Tool, October 2019

5.4 Early Help

During 2018/19 the local authority Early Help Service received a total of 2,549 new requests for early help. The majority of these (73%) were recorded at 'Early Help' level which likely reflects the re-design of the service, bringing together Family Support, Children's Centres and Youth Services to enable a greater focus on early intervention. The remaining cases were step down or joint work with Social Care.

Health partners were the highest source of requests for early help in 2018/19 (793, 31%), of which half were from health visitors. There were 517 (20%) requests from Children's Social Care, 142 (13%) from education, and 12 (1%) from Housing.

Whilst 'neglect' is not a category of need within Early Help Services, the work undertaken with families whatever category is used, will support appropriate identification of risk, including neglect.

Across the city the top five category of needs identified within families accessing support from the Early Help Service during 2018/19 were:

- Behaviour/Positive Activities for Social Development (42%)
- Parental Wellbeing/Capacity (28%)
- Housing Support (18%). More referrals for came from health than other referrers
- Emotional Wellbeing/Mental Health (18%)
- Domestic Abuse (12%)

During April 2018 – March 2019, the service provided support to a total of 3,022 families, with 1,620 cases remaining active at 1st April 2019.

24 cases were identified as requiring escalation to Children's Social Care in the year, with 12 (50%) related to neglect. Of these, the majority were accepted and allocated to Child Protection/Children In Need teams. There is evidence from a range of sources, including focus groups and escalation meetings, of cases receiving support from multiple services across the threshold of need and respondents talked about families 'bouncing' between early help and social care and back to referrer. This is covered in more detail further in the report.

5.5 Social Care

5.5.1 The Bridge (Front door to local authority early help and social care)

Salford City Council and its partners have a multi-agency hub called the Bridge Partnership that screen all contacts concerning the welfare or safety of a child to children's services, which may be directed as a referral to early help or social care services. Referrers are able to select one main category and one subcategory indicating reason for contact. There has been an increase of 749 (13.1%) contacts in the first three months of 2019/20 compared to the first three months of 2018/19.

Of the 20,500 contacts to the Bridge in 2018/19, 1,437 (7%) were categorised as 'neglect'. However, we know this is significantly under-reported, as contacts are self-selected by referrer and can be categorised for different presenting reasons. It is likely that there were elements of neglect in other reasons. For example, there were:

- 4,239 (2%) for 'parenting issues'. This includes contact issues, criminal behaviour, early help, mental health, suicidal thoughts, sexual offences, other
- 557 (2.7%) 'general family issues'. This includes behaviour management, family breakdown, lack of routine, school attendance.
- 3,467 (16.9%) 'early help'. There are no sub-categories and the reasons for these contacts is therefore not known from the data.

The main categories and sub-categories which could include neglect show that there is no discernible way to measure accurately the prevalence of neglect from the contact reasons, but we can generate a better picture by looking at the relevant main categories and sub-categories together (figure below).

Main Category ⇨ Sub-Category ⇩	Early Help	Finance and debt Issues	General Family Issues	Neglect	Parental Issues	Total main categories inc those not listed
Autism						17
Behaviour Management	1		115			119
Child Home alone				153		153
Contact issues					147	147
Criminal Behaviour					277	277
CWD and Send Pathway	138					138
Debt/Benefit Issues		60				60
Drugs					552	552
Early Help	3,172					3,173
Family Breakdown			354			354
Inappropriate language towards children				143		143
Lack of routine			13			13
Lack of supervision				677		677
Mental health					483	483
Not in Employment or Training			8			8
Other			2		2,104	2,106
Risk of Eviction		4				110
School attendance			64			64

Self Harm					38	126
Sexual Offences					152	152
Suicidal thoughts and tendencies					180	180
Unclean, hungry or tired in school				179		179
Unsafe home conditions				285		285

Figure 9: Categories of contacts to the Bridge 2018/19. Colour relates to prevalence: red = most, green = least.

A Bridge transformation analysis report in September 2019 which included data to June 2019 provided more detailed information. Important to this needs assessment is the category by source indicating Health, Housing and Other as the main source as a proportion of the contacts they make.

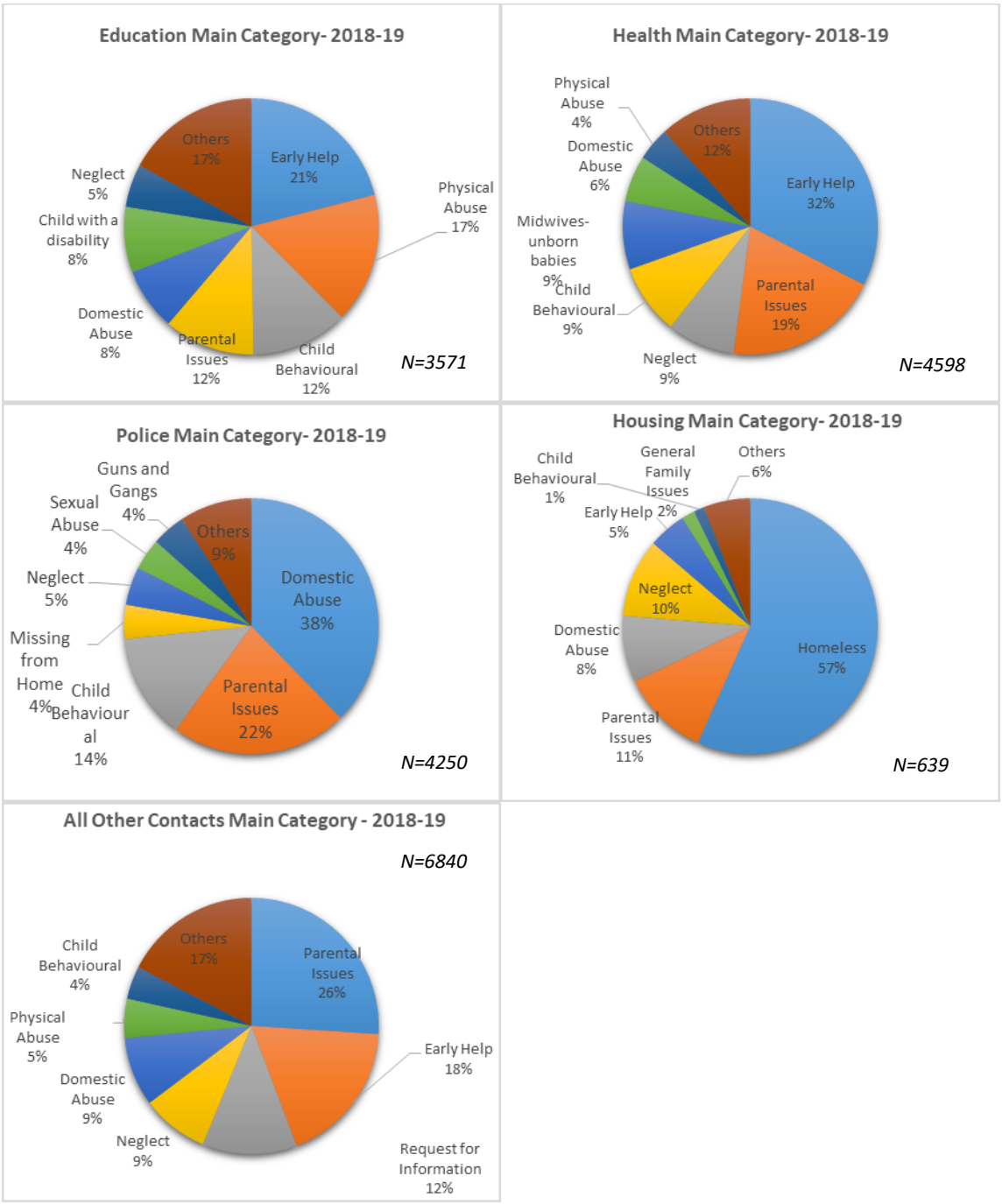


Figure 10: Contacts to the Bridge by category 2018/19. Source: Bridge CRM report Oct 2019

5.5.2 Assessments and children in need

In 2017/18[1], 16.8% of social care assessments completed in Salford had a presenting factor of 'neglect' compared to 18.4% nationally. Provisional 2018/19 data indicates this is now 12% of assessments. An assessment can have many presenting factors identified and other presenting factors, such as Alcohol misuse, Drug misuse, Domestic violence, Mental health. The presence of Learning disability and Physical disability or illness factors were higher in Salford than the England average.[2]

In 2018/19, analysis of reason for assessment shows other presenting factors in assessments where neglect is a factor, with an average of four other factors in addition to neglect. The 'trigger trio' of parental mental health, domestic abuse and parental drug misuse are the top four factors alongside the impact of emotional abuse on the child.

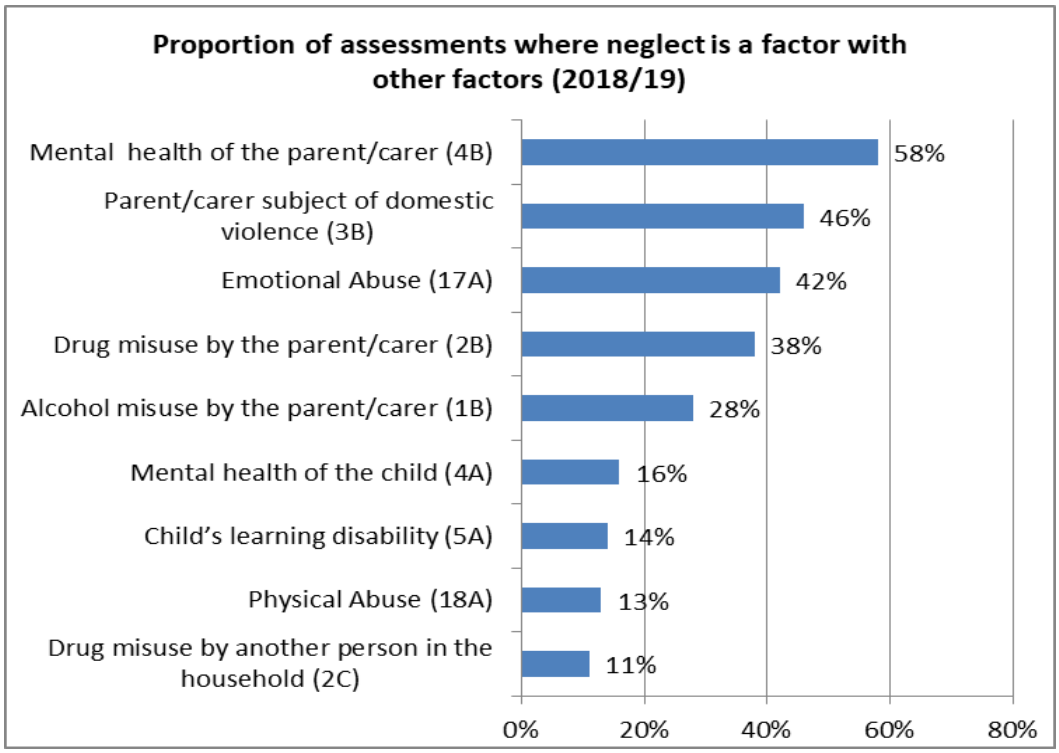


Figure 11: Factors in Assessment 2018/19. Source: CiN Census data

In terms of outcomes of assessments, 16% were closed and the majority (78%) were ongoing casework, which could be as a child in need, child protection plan or as a looked after child. Of the assessments where neglect was the only assessment factor, half were closed after assessment and half ongoing casework.

5.5.3 Child Protection Plans

In 2017-18, 46.3% of all child protection plans in Salford at any time in the year had an initial category of neglect compared to 40.1% latest category. This is a greater range that nationally, where 47.3% of the

[1] National 18/19 data is not available until Nov-Jan normally.
[2] Source: DfE SfR Characteristics of children in need 2017/18 table C3

initial category was neglect compared to 46.6% latest category. The change in category of plan is less apparent in 2018-9 where this is 41.5% to 40.1% for Salford respectively indicating that fewer plans are for the category of neglect, and the category changed on fewer plans.

	2018/19			2017/18			2017/18
	SALFORD			SALFORD			NATIONAL
	Total Plans	Neglect	% of all plans with category of Neglect	Total Plans	Neglect	% of all plans with category of Neglect	% of all plans with category of Neglect
Total number of plans at 31st March	523	222	42.4%	347	144	41.5%	48.0%
Total number at any time during the year	870	361	41.5%	456	211	46.3%	47.3%

Figure 12: Analysis of child protection plans - initial category of abuse. Source: CiN Census data

A higher proportion of plans under the category of Neglect are repeat plans. 29% of all child protection plans starting in the year where the category of abuse was Neglect had previous plans compared to 24% of all plans starting. This chimes with findings about episodic neglect.

The average length of plans ceasing in the year was an average of 297 days (all plans), and 280 days (neglect latest category). However, 25 plans for Neglect ended in less than 3 months, some as few as a day which we presume were transfer in/outs or children becoming looked after. This is skewing the duration of plans for neglect but we cannot make any assumptions as to reason. Further exploration of reasons for short term neglect plans would be useful to understand the child's journey through the child protection process and decision making.

41/125 (33%) of plans ceasing for neglect were open longer than a year compared to 116/385 (30%) of all plans. This variation is not statistically significant and there is no comparable national data.

5.5.4 Children looked after

We do not know from existing data the number or proportion of children looked after as a result of neglect, as the DfE categorisation is 'abuse or neglect' without further detail. We do know that at 7th October 2019, there were 47 out of 580 (8%) children looked after living at home subject of a care order that had Abuse/Neglect identified as the main category.

Recommendation/key lines of enquiry:

5a) Consider whether picklists from systems in early help, social care and other services need to be amended to better reflect neglect or parenting as a presenting issue or concern

5b) Investigate professionals reporting of 'bouncing' of families between Early Help and Childrens Social Care and identify any improvements.

5c) Recognise that the increase in contacts and referrals means that there is likely to be more children receiving early help and social care services, including neglect.

6d) Explore what is meant by the reason of referral of 'inappropriate language to children', whether these are serious enough presenting factors or are a) they a symptom of underlying needs that need to be categorised better or b) we can prevent these coming to the local authority by better understanding of thresholds.

5e) Child Protection: understand the child's journey through the child protection system where CP Plans for neglect were for short durations only.

6 Identifying Unmet Needs and Neglect

6.1 Identification

There is a significant body of information about identification of neglect. Neglect typically builds over time, often without an identifiable 'trigger' event that would lead to specific action. What works well and areas for improvement in identifying neglect and the tools in place to do so are a major factor in tackling neglect and ensuring child's needs are met at the earliest opportunity.

Research suggests that physical and visible aspects of neglect are the ones most often identified by professionals. Ofsted (2018) state that the appearance of home conditions, a failure to address a child's medical needs or delays in physical development are common ways of identifying neglect. These can be easier to identify than other forms of neglect a child may experience, such as emotional neglect.

The identification of the signs of neglect in young children is more apparent. For example, they may have delays in reaching developmental milestones (such as speech delay, failure to gain weight) and appearing dirty and/or hungry.

Ofsted add that neglect of older children may look very different to that of a younger child. When older children suffer long-term neglect, the impact may be less evident and the problems they present with may not be recognised as being the result of neglect. Older children may be skilled at hiding the impact of neglect by seeking support from places other than the family or by spending more time away from home, which in itself may put the child at more risk. They may appear 'resilient' and to be making choices about their lives, when in fact they are adopting behaviours and coping mechanisms that are unsafe. For example, they may look for support from inappropriate and dangerous adults or use alcohol and drugs as a form of escape.

The evidence from both the professionals survey and focus groups reiterates that this is the case in Salford. The section on Adolescents later in the report provides further details.

There are a range of lists of what to look for to determine if a child is experiencing neglect or their needs are not met. Caution is needed to understand that the existence of one or more of these indicators does

not necessary point directly to neglect, but may be due to other reasons, hence the need for specialist assessment.

NICE (2017) provide a 600+ page guidance of recommendations based on evidence on how to recognise and respond to child abuse and neglect centred on 'a robust and rigorous review of the literature, in addition to lessons from practice'.

6.2 Assessment Tools and Methods

There were mixed views about the assessment tools and methods in use, specifically the Graded Care Profile. Professionals were mostly positive about using the Home Conditions Tool and Capacity to Change assessment but more critical about elements of the Graded Care Profile in Salford and the need for two professionals to complete it. This has been recognised and a revision is in progress.

Other assessment tools and methods are in use in specific professions, and it is important to realise that any specific neglect tool needs to be able to seamlessly sit alongside/within these. The table below provides a summary of those which appear to be in use in Salford specifically for neglect, but there may be others.

Tool	Notes
Leaflet for Parents	Easy to read information for parents.
Risk Screening followed by the Risk Assessment	Checks cases for indication of concerns about significant harm in relation to children. These will be implemented in different ways by different agencies. Risk Assessment is a detailed framework for undertaking an assessment of the risk of significant harm. It explores components including the capacity of parents, the child's needs, level of harm, prediction for the future and what may make harm, significant. Assessing the threshold of significant harm guidance is also available to accompany the Risk Assessment form.
Home Conditions Tool	Assessment of the home conditions and their impact on the children who live there.
Capacity to Change Tool	Capacity to change guidance is based on Prochaska and DiClimente's Comprehensive Model of Change (2007), which is not considered by some as the best for parental capacity to change. There are more up to date guidance and models, including from Research in Practice. There was feedback that this also needs to be updated.
Chronologies	An up to date chronology was identified as essential to provide an insight into root causes of neglect and also history of patterns.
Eco-maps	Eco-maps were also felt to be useful, providing a visual map of a family's connections to the external world. They provide a useful tool for assessment of family, social and community relationships and highlight the quality of these connections.
Graded Care Profile (GCP)	The GCP is a common tool used specifically to assess Neglect. There are two versions available nationally. The original adapted in GM which Salford is currently using, and GCP2 which is adapted, evaluated and licenced by the NSPCC. Salford has been promoting use of, training and conducting GCPs for many years, with recognition earlier this year that it can be improved. This work by a working group of professionals led by a member of the Early Help service is now aligned to the neglect strategy revision. The improvement proposed in this work chime with the results of the professionals survey.

We do not know how many graded care profiles are completed with families. The Early Help system has a GCP recorded for 14 children (7 families) in 2018/19, and we do not know how many were completed by other agencies. This could be because they are not being done, or they are not being recorded centraly.

Only 15% of professionals responding the Neglect needs assessment survey had used the graded care profile in the last six months. 19% had used it over six months ago and the remainder had never used it. Of those who had it, just under half said it was helpful and using it was positive compared to 15% who said their experience was negative and it not helpful, the remaining being neither positive or negative.

> *"It gives a picture of issues that may need support & evidence and a structure to conversations & plans - as long as it doesn't become too formal."*
>
> Source: Professionals survey response

The strengths of using the GCP are well documented. However some respondents felt that it was too long, language too complex, form is not easy to understand and did not add to the overall assessment of the young person / family or have impact. Professionals in contact with families outside of the home (such as A&E) who may have justified concerns were not able to use the tool. One respondent felt that it can be 'invasive' for families and parents do not see it as a positive tool. The most common comment was that more training required/guidance on how to complete it.

Recommendations/Key Lines of Enquiry:

6a) Ensure that methods for identifying when children's needs are not being met, and neglect, are refreshed through a campaign to promote/prevent neglect escalating and a pathway of support that is widely known across the City, including people who come into contact with families including communities, people with access to houses such as broadband and tv providers.

6b) Provide additional resource to finalise at pace up to date assessment tool(s). This includes work on the graded care profile and roles therein, training on identification and tools as appropriate, and aligned to the new strategy and the current/future context for families.

6c) Consider if the neglect assessment tool can be a dynamic document that integrates well into multi agency planning review of progress.

6d) Consider if GCP needs to be renamed to facilitate engagement with it and show it is different from previous.

6e) Ensure chronologies are used and maintained, especially where there are long term concerns or multiple episodes where children's needs are not met.

7 Causes and Presenting Issues: Overview

There is significant evidence about the root causes of parental inability to meet their child's needs to varying degrees and that tackling the root causes and their cumulative effect is the key to tackling neglect.

This is not specific to Salford. Ofsted (2018) stated that across England, alcohol misuse, drug misuse and unmanaged mental health problems in the household were all recorded as factors at the end of assessment more often than neglect. However, from the child's perspective, neglect may be the biggest issue arising from the problems their parents are facing.

Turnbull (2015) summarising children contacting Childline states that lack of food, often linked to parental alcohol or substance misuse or mental health problems, is the top issue that children mentioned. Parent's misuse of alcohol or drugs was also a growing concern reflected in adults calls. A third of children talked about being left home alone frequently and many Childline callers had problems at school as a result of neglect – they said they are hungry all day, often they were bullied and they lack any parental support with their education.

Understanding the Salford Picture is critical to ensure we are tackling the most prevalent local causes effectively. In this section, we build on the prevalence data provided and explore a range of reasons why parents/carers may not be able to meet these needs, what is already happening to tackle these in Salford, and what the evidence tells us we can do better.

Professionals responding to the survey selected their top five causes or presenting factors that they see most commonly alongside neglect, which not only chimes with other evidence but also places the impact of poverty and parental mental ill health as present in over 75% of episodes of neglect.

Other factors included:

- Risk taking behaviour, criminality, high probability of criminal exploitation and other abuse.
- Lack of clarity and awareness about the roles and responsibilities of parenting, and lack of understanding about the impact on their child.

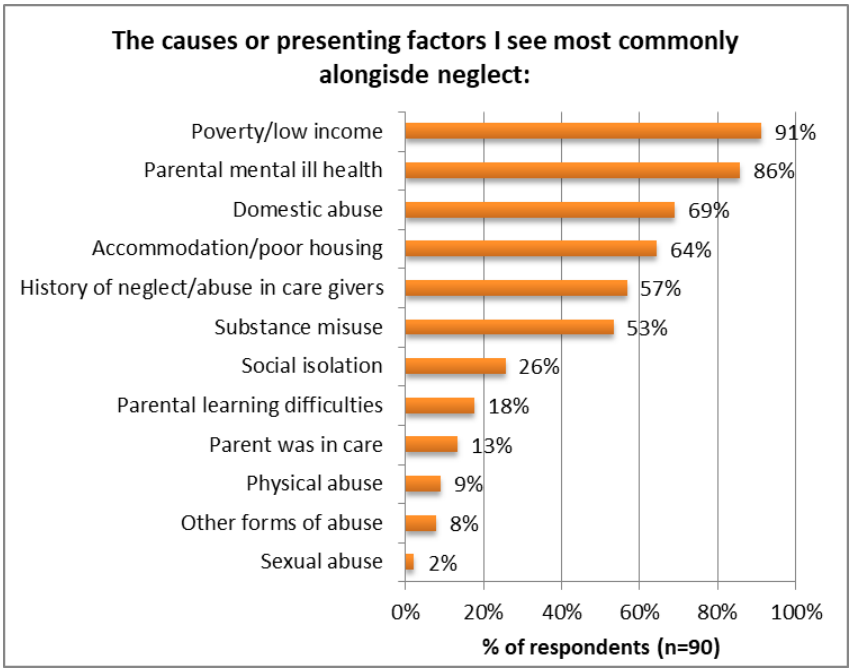


Figure 13: Professional's survey question result

The influencing factors have been categorised into the three types referred to earlier:

SOCIAL FACTORS: *changes to the underlying needs faced by the local community and parents in Salford that results in changes to the numbers of children and families requiring help*	**SYSTEM FACTORS:** *the way that the system of services in Salford responds to families requiring help*	**PRACTICE FACTORS:** *the way that professionals work with individual families.*
• Population and demographics • Poverty • Housing • Adverse Childhood Experiences • Social Isolation and support • Cross LA border living/access to services	• Perceptions of thresholds • Partnership working • Information gathering and sharing • Co-ordination of support and appointments • Leadership • Service commissioning and provision across the system	• Models of practice • Doing 'to' or 'with' - relationships • Skills and knowledge of professionals • Consent, disguised non-compliance and self-reporting

8 Causes and Presenting Issues: Social factors

Some of the causes of neglect as well as the presenting issues can be attributed to the underlying needs faced by families that are connected to national/local policy, demographic, social or economic factors that are not in their control.

Dubbed 'State neglect' or 'institutional neglect' , this result of national policy and regulations, for example universal credit, housing regulations, or failure by public or private sector organisations to remove some of the barriers to enable parents to meet their children's needs are a current factor. National evidence was reiterated by professionals in Salford and an example given of how the City can inadvertently do this by schools fining parents for non-attendance at school when the parents are facing severe financial hardship.

> *"When the level of need tips over from level 1 or 2 into 3 or 4, if parents are not able to meet their children's needs because of systemic issues such as benefits, housing etc and they are otherwise competent, well-intentioned loving parents. If you as a professional and the parents try to sort those systemic issues out and it's still not getting any better, that's when you need to look deeper into things. If we can sort out the systemic stuff then it can leave competent parents that may have just needed a bit of extra support because stuff outside their control has happened."*
>
> Source: Focus Group Attendee

8.1 Population and Demographics

Changes to the size of the population has, and will continue to have, a major impact on demand for all services in Salford, simply by having more children and young people resident in the city. For example, there will be more people requiring housing, school places, health services, social care and other services

for children with significant needs. How the local authority plans for and manages the predicted increase should be a central part of plans going forward both in terms of prevention and support.

In the 10 years between 2007 and 2017, the child population in Salford has increased by 7,700 children[3]. The latest ONS population projections based on mid-2016 data estimate an increase of 12% in the child population between 2016 and 2026.

The increase in the number of adults in Salford is equally important, as the demand for services for parents such as domestic abuse, drug and alcohol misuse, parental mental health increases pressure on services.

8.2 Poverty

There is much research about neglect, poverty and early intervention. Joseph Rowntree Foundation (2018) report that more than one and a half million people were in destitution at some point in 2017, including 365,000 children with the main factors tipping people into destitution as: low benefit levels, delays in receiving benefits and sanctions; harsh and uncoordinated debt recovery practices by public authorities and utility companies; pressures caused by poor health or disability; high costs for housing and other essentials.

Baynes, Bowyer and Godar (2019) is a current key reference for childhood neglect in the context of poverty and austerity. They report that child poverty has risen by 15% since 2011, almost all within working families and as changes to tax credits and universal credit continue to roll out, this number is expected to rise further. Other recent sources report a larger increase in poverty, as high as 38%. This Research in Practice publication, although focussed for children's social work, defines poverty, the impacts on children and families and urges 'poverty-aware practice' that is applicable to all professionals and reiterates many of the findings from this needs assessment, and provides helpful pointers for Salford.

The Child Welfare Inequalities Project (Bywaters et al 2016) found that children in the most deprived ten per cent of neighbourhoods in the UK are at least ten times more likely to be in care than children in the least deprived ten per cent and 24 times more likely to be subject of a child protection plan. Knowing that nearly half of child protection plans are for a category of neglect, we should continue to apply a geographical lens to tackle neglect in those in the most deprived areas in Salford.

91% of professionals responding to the survey cited poverty as a cause or presenting factor they see mostly with neglect. This is significant. Focus group discussions concluded that there are indications that the least financially secure families may be facing increased pressures on their finances which impact on their ability to meet their child's needs. Family debt that causes a child's needs not to be met, whether unintentional or intentional, can be the result of parental illness and inability to work, parental separation with no support from the separated parent, use of aggressive targeting by loan sharks, with a high number facing financial difficulties because of the benefit cap. We know that as one of last GM councils to fully implement universal credit, the impact is yet to be fully felt.

[3] Source: SGP/ONS

Those families facing 'in-work' poverty are less visible to services, but rising living costs and stagnant wages are very likely to be affecting the financial well-being of these families. We heard how families receiving advice through the Welfare Rights and Debt Advice Service are living on a "deficit" or "negative" budget.

As an indicative measure of destitution, figures from Salford Food Share network show 3,025 foodbank vouchers issued and 1,941 children fed in 2017/18 of which children's services was the largest referrer (1,669 children fed). We heard also that referrals to food banks can also be stigmatising for families and research shows it is a last resort.

The anti-poverty strategy and taskforce in Salford, chaired by the City Mayor and a longitudinal study into the impact of universal credit in Salford and inform future planning was launched in October 2019 for 18 months. However, until the longer-term benefits of the anti-poverty strategy is felt across Salford, there may need to be some consideration about how these families are supported now.

The continued impact of the Welfare Rights and Debt Advice Service on assisting families who are experiencing financial difficulties and struggling to meet their children's needs cannot be under-estimated. See section 10.2 for more detail about their role.

8.3 Housing

There is evidence that the changes to housing legislation has had an impact on families, including in the growing number of households referred to Housing Options and through the Bridge as a result of potential or actual eviction. Eviction or risk of eviction, overcrowding and poor home conditions were common factors contributing to neglect. Housing difficulties can also affect the journeys of families getting help, when unstable or inappropriate housing or the threat of eviction destabilises families' progress in improvement in meeting their child's needs.

Whilst no data is included here, we know that the number of families in temporary accommodation or homeless is startling and the impact will be felt throughout the system, including a major contributory factor to the rise in neglect and parental issues.

The Children's Society (2016) found that children living in families struggling with debt are five times more likely to be unhappy than children in families who don't have difficulty with debt, putting them at risk of developing mental health problems.

Discussions during the needs assessment included the distress and fear of having bailiffs coming to the house or being evicted from the family home, moving to temporary accommodation with no privacy or room to play, do homework, eat properly and witnessing parental stress and distress can have a direct and lasting impact on a child.

Housing is a factor in its own right in neglect, but the evidence from a range of sources showed that the housing and financial difficulties are often inextricably linked, as illustrated in the example below.

"B lives on her own with her 5 children age between 2 and 18 in 3 bedroom terrace house. The house is overcrowded but she has not been considered for a move or exchange due to rent arrears. The family is subject to the benefit cap and have lost almost £70 per week from their housing benefit. As a result they owe £1800 in rent arrears. The family were referred to Salford Debt Advice Service by their housing provider, worried that she had not had independent advice about her forthcoming eviction and thankfully agreed to an adjournment to allow us to provide this advice.

At the first visit B was visibly very thin and told me that she had lost 7 stone in the past 10 months due to worrying about losing the home and her children becoming homeless. Her eldest daughter (18) had just started further education college and was feeling very positive about her future and to her credit B had been encouraging all of her children and had been putting a great front on so as not to worry them .She struggled to put food on the table and heat the property and often went without food herself which also contributed to her weight loss.

We identified that she was indeed living on a deficit or negative budget and experiencing extreme hardship. We applied for full payment of her rent shortfall via a discretionary housing payment and she had also incurred a fine to pay for lateness at her sons' school. This is still being considered but we are hopeful that payment of the ongoing rent shortfall will help the family and remove the worry of the uncertainty over their home. We have also been able to provide Christmas gifts to all the children as well as offering support via Salford Assist and I will advocate for them at the next court hearing.

Source: Debt Adviser

More detailed consideration and involvement with Housing professionals is required to understand the high contacts to the Bridge and parental experiences of eviction or threat of eviction, housing issues, and homelessness in contributing to neglect, and how this can be prevented or at the least impact on children mitigated.

8.4 Living and Provision of Services Across Local Area Boundaries.

The effect of migration and moving across authority borders for housing, work, school, services, whether a long or short distance, was reported as challenging. It features in a number of serious case reviews relating to neglect. Specific local areas identified were Rochdale, Bolton, Manchester, Bury, and Wigan. Three of these participated in the Neglect Summit.

The impact for Salford is not simply a change in volume if inward migration increases, as families new to the area may also be socially isolated and unaware of services available, change in professionals to whom they need to tell their story again, and the possibility of falling through the net. Salford has good relationships and history of working in partnership with its neighbouring authorities in Greater Manchester, which is a strength.

At the Tackling Neglect summit, we also heard that the neighbourhoods in Salford are different, and this diversity across the city needs to be taken into account when planning services to support parents to meet children's needs. The new strategy may wish to look whether there are services targeted enough in these areas to identify and tackle neglect early on.

8.5 Adverse Childhood Experiences, Domestic Abuse, Parental Conflict

There is evidence from a number of sources about adverse childhood experiences and Salford is already focussed on these issues, with specific programmes and attention across the partnership, and efforts have been made to ensure there is join up between them and the new neglect strategy.

We know from the needs assessment findings and research that there is a strong correlation between parental inability to meet the child's needs leading in some cases, to severe and/or long term neglect and exposure to trauma and adversity, including but not exclusively due to domestic abuse, physical violence, sexual abuse, parental separation, parental mental health issues, parental substance misuse, emotional neglect, physical neglect, verbal abuse, and social experiences, such as bullying, homelessness, child sexual exploitation, crime (known as Adverse Childhood Experiences or ACEs).

As evidenced in the data provided about assessment factors in an earlier chapter, these factors, often present together, are a significant cause of parents' inability to meet their child's needs, sometimes unintentionally. We heard how some services who address these, specifically parental mental health and drug and alcohol abuse, are under a strain to meet the need in Salford.

The Children's Services 40 case audit found that parental mental health was the most common underlying factor in the neglect cases reviewed and the prevalence chapter provides evidence how ACEs and other factors are significant as a root cause of neglect. Links to the Salford Living Well model are in development and work will be piloted in a specific area in Salford in 2020.

Continued investment, and the impact of these programmes or developments, and when it will be fully realised, is an important factor in tackling neglect.

8.6 Other Social Factors

The role of the wider family, communities and today's social norms on parenting generally was found to be a factor in parents being able to meet their child's needs.

There was some evidence that wider families living together can be a protective factor where grandparents/other family members share the parenting and provide support, and there were other instances (including a SCR) where the other adults in the house contribute to the abuse. This is also borne out by the assessment factors data which categorises mental health, drug and alcohol abuse, or domestic abuse by another adult in the house. This highlights the importance of ensuring all members of the household and adults who are potentially contributing to the parenting are included in both assessment and interventions.

Isolation can take many forms as a cause as well as outcome of neglect. Focus group discussion and research centres on the ability of a community to support its citizens and of a parent/carer to engage with their child. Current social context and norms have changed and look to continue to change in this fourth industrial revolution of technology and social media. Focus groups discussed how some parents do not interact with their children and build attachment due to the isolation caused by individuals (parents and children) engaging with technology, whether phones, tv, tablets/computers or gaming. The impact of lack of supervision allowing children to spend long periods of their days/nights on technology and social media, and the risks therein has been the subject of much recent research.

This is a growing, and very real form of neglect for children and one which the impact of has not fully been realised as these children reach adulthood. Assessment tools and work with families need to be in tune with these and other aspects of people's lives today and tomorrow, and both identify and propose solutions for parents in engaging with their children more. Every professional, community, can be made aware and given ideas how to overcome this.

Kotch and colleagues (2014) report on analyses undertaken on the effects of different aspects of what they define as social capital on neglected children. They note that social cohesion and trust significantly reduced the impact of caregiver depression on externalising behaviours and alcohol use of neglected children at age 18.

We know that in Salford, the role of neighbourhoods and involving communities is a strength. Leaders may wish to consider and identify the opportunities for developing and maintaining relationships that form social networks willing to help each other and new norms regarding family functioning and attachment in a digital age.

Recommendation/key lines of enquiry:

8a) The population of Salford will continue to grow. Consider the impact that the increase in population in Salford alone has.

8b) Consider the impact of financial difficulties in relation to neglect on all aspects of meeting children's needs, including the emotional abuse.

8c) Utilise Research in Practice 'poverty-aware practice' guidance in policy and workforce development.

8d) Apply a geographical lens to check there is effective cross-border/different neighbourhoods response.

8e) Consider how the negative impact of social media and technology can be identified by parents and professionals, and encourage or prescribe activities to mitigate this, for example 'phone free family time' .

8f) Consider the impact of/review the issuing of fines to parents for child's non-attendance at school who are in financial difficulties such as housing arrears.

8g) Ensure Housing is as involved as it needs to be in avoiding circumstances that contribute to child's needs not being met, and the emotional impact of eviction and homelessness.

9 Causes and Presenting Factors: System Factors

In order to ensure the new neglect strategy and associated activity focus on understanding what is working well and what changes are required to the way that the whole system across Salford, and GM, responds to families asking for help, we need to consider system factors. These include partnership working, information sharing, commissioning, thresholds and the synergy across the whole system.

9.1 Leadership and Governance

Respondents to the professional's survey and focus groups reported that there is very good strategic leadership and partnership working across Salford. This is also reflected in many other sources.

We know that good leadership and governance are critical in order to be successful. There are a range of boards, groups and people who have neglect as part of their remit, with the SSCP taking a partnership lead. Changes this year in strengthening the Neglect Sub-Group of the SSCP with a Chair from Public Health, increased membership and focus via the neglect strategy work are positive. Apart from the SSCP Neglect Sub-Group there is no single person(s) or team responsible for this area, leading, championing and guiding across the system, such as in other areas, for example complex safeguarding and domestic abuse.

From the evidence gathered, it also appears that the number of initiatives, pilots and programmes and strategies or policies which touch on neglect, indicate a 'busy' City with many good and innovative elements. Ensuring there is a clear picture of purpose and intended impact of these is important to ensure the system is efficient, cost effective and professionals and citizens are able to see the connectivity and pathways clearly to either drive, influence or inform their work. A 'timeline' and summary document is underway to assist in our understanding of these.

9.2 Professionals and Partnership Working

We know that partnership working in Salford is a strength. A high proportion of professionals responding the survey felt that agencies work well together when finding solutions for children experiencing neglect in Salford. Examples were given of GP/HV meetings, dedicated and caring professionals across the City.

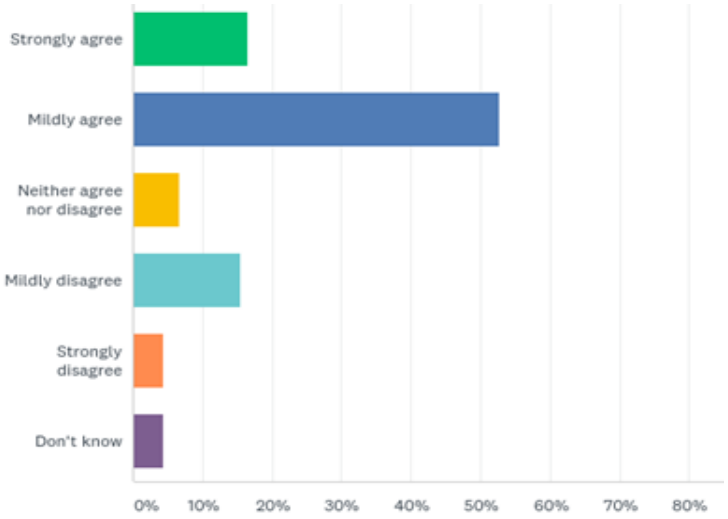


Figure 14: Professional's survey question result

The Children's Social Care 40 case audit evidenced that all of the audited child protection neglect cases evidenced good multi agency collaboration with neglect interventions, responses and resources shared.

We heard how there are a number of panels or multi-agency meetings at which individual children and/or families are discussed on a whole family or specific factor basis, and from which outcomes are achieved. Sometimes children are the subject of more than one panel/multi-agency meeting and key professionals don't always turn up.

The Education On Track Panel is an example of a panel which was created out of a need to address children not accessing education or electively home educated. It consists of a range of health, education, early help and social care professionals to pool intelligence about the child following referral to the panel where there are education concerns.

We need to understand any duplication in discussion and attendance at the range of panels and multi-agency meetings, be clear re pathways, whether the child's life as a whole is considered, the value of the role of the lead professional in having oversight if a number of panels involved and reasons why professionals may not attend.

All sources of evidence, including the Tackling Neglect Summit, identified that not all professionals are as aware of other elements and services that they could be and this is linked to thresholds and sometimes understanding each others' roles. We heard how important it is for professionals to maintain responsibility and a relationship with the family and ensure a smooth 'transfer' of information' but a retained sense of involvement, when referring to other services and to ensure the onward-referral path is as smooth and timely as possible for the family. There were some suggestions that 'referral' should be replaced with 'request for services'.

The new strategy would be well placed to reinforce how the system for ensuring and supporting parents to meet their children's needs will work; guidance on responsibilities and when to request services/step up or step down, as well as support through a toolkit which will work within any agencies own model of practice or assessments.

9.3 A systems approach and thresholds

The 'windscreen' showing levels of need was used within focus groups to discuss thresholds and what support is available at which level.

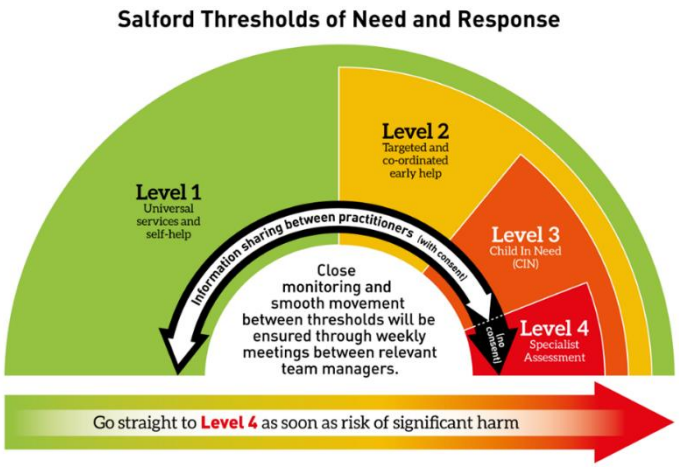


Figure 15: Salford thresholds

Respondents to the roadshows, focus groups and survey stated strongly that there is not the clarity required about thresholds around neglect, especially at the point of referral to the Bridge.

40% of respondents to the professional's survey did not agree that the thresholds for accessing specialist neglect services are appropriate, compared to 32% who agree.

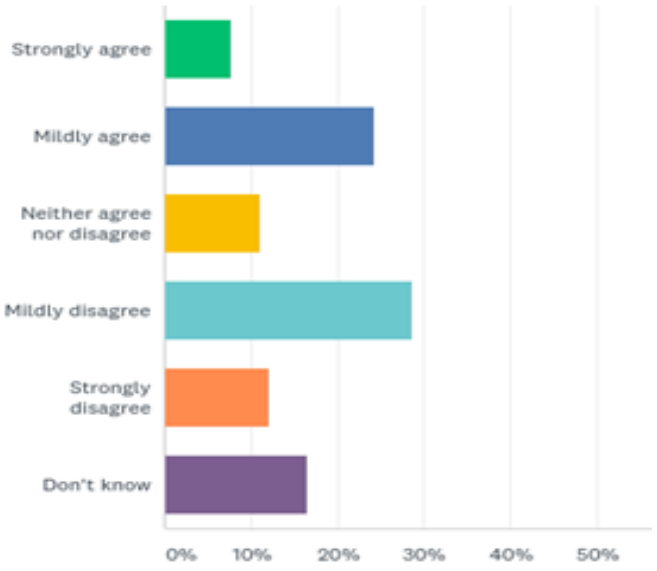


Figure 16: Professional's survey question result

Whether thresholds are clear, or appropriate, was one of the biggest areas of discord between professionals, most noticeably universal services such as schools, early help and social care. There was agreement that robust early assessment is key to ensuring appropriate services are in place at the point of identification that there is potential for neglect to occur. We heard how some referrals to social care are 'batted back' because they do not meet threshold but the referrer feels they have done absolutely everything that they can do.

> *"Lack of consistency means that some families remain around threshold for years without any significant improvement, while others are challenged & held to account more rigorously. Thresholds need to be explored & a strategy for standardisation established".*
>
> Source: Professionals survey response

In the Children's Social Care 40 case audit, at least three of the cases on the matrix were referred in by partners when they were in a state of high risk mainly due to unsanitary and unacceptable living conditions. These cases required rapid responses from social care and in one case a life impacting decision had to be made by social care which led to the removal of children from their parents for a short time.

There was, however, no evidence of inappropriate application of thresholds for social care intervention, evidenced by the Ofsted inspection in 2018 (Ofsted, 2018/2) which stated that *"Thresholds in response to referrals are consistently applied, supported by good management oversight and decision-making. Each referral is appropriately rag-rated (red, amber, green-rated) to ensure that there is a tailored and timely response. Although the quality of referral information is variable, an effective screening and information-sharing system leads to a swift transfer of cases to the duty and assessment team (DAT) as soon as it has been determined that a social work assessment is required. Information sharing continues in the DAT, with*

clear management direction in response to identified risk and harm. This means that most children receive the right help at the right time".

This would suggest that further exploration in the difference in views of social care thresholds for neglect is required to understand and resolve these experiences.

> *"The lower the level of neglect, the less people that are involved but actually it needs to be the other way round to prevent and support".*
> Source: Focus Group Attendee

Linked to this, is understanding of professional roles. Views from professionals as well as reviewing pathways shows mixed experiences in expectations of intervention by schools. We heard how a call to the Bridge from a school who is worried about a child in relation to neglect could result in the Bridge asking them to do a graded care profile if the threshold appears to the Bridge to be below level 3 or 4. However the school response can be we've done this and things haven't improved.

There appears to be a gap between what it is expected a school can do and has capacity to, and what they are being asked to do in some cases. Whilst it the responsibility of all professionals to work with families to support the child's well-being and safety, we can conclude from the evidence that schools can be asked to undertake assessments and work with the family that they do not have the capacity or the right skills to undertake. The fairly recent roll out of four School Co-ordinators will help this, but each co-ordinator covers a significant number of schools.

Young people were asked who they would go to if they, or a friend, were being neglected. Their trusted professionals were school counsellors, teachers, people in safe areas they go to regularly, such as the librarian, or other parents.

Clarification of thresholds of need and roles across professionals and organisations, escalation and dispute resolution, opportunities for multi-professional case discussions may be beneficial to include professional's own attitudes, values and beliefs and how this impacts upon their professional judgement – assessing neglect can be subjective based on professional's own perception.

9.4 Information Sharing, Client Record Systems and Record Keeping

There were different views about the efficacy of sharing information about a family across professionals at the right time, and Salford is no different to many other local authorities in this.

We heard of some good examples of information sharing and professional discussions that were appropriate. However, there was evidence from some professionals that the introduction of GDPR has caused issues in doing so, especially pre-statutory intervention. The development of multi-agency place based hubs and links to the Living Well model may seek to address this issue.

In terms of record keeping and sharing information about interventions with a family, we heard how it is helpful to have a good understanding of what has been done and critical analysis of what has worked and what hasn't worked. This not only builds up a picture of previous involvement and contributes to a more

seamless intervention for parents, but we heard that it is also helpful for evidence for Court if the case did eventually come into Court Proceedings.

Salford may wish to undertake a 'true to us' exercise on the following findings from Ofsted's analysis of joint targeted area inspections by Ofsted (2018) on this subject:

- GPs who were involved in safeguarding activity, where neglect was a feature, were not consistently recording and sharing information about the child to inform wider partnership working
- Alert systems that provide good oversight and tracking of risks to children who fail to attend hospital appointments, miss their immunisations or are not brought to routine appointments
- Police officers were not consistently identifying older children as potentially vulnerable to neglect or abuse. Often, police officers focused on other complex factors such as drug offences and anti-social behaviour. Quantitative police performance information drives leaders and officers to concentrate on the quantity of child protection incidents as opposed to the nature and quality of decision-making
- Adult services need to recognise neglectful parenting. There is variability in how effectively adult services identify parents who may be neglecting their older children. Too often, adult mental health and substance misuse services are not focused enough on thinking about the whole family and the impact of adult behaviours on children, including the risk of neglect to older children. Information on adults who have limited parenting capacity due to mental health or substance misuse is not always shared. We saw many examples where risks of neglect were not identified early enough. In some cases, information on changing patterns of adult behaviour was not shared. This is a theme that has been identified in two previous thematic reports in 2013 and 2014.

Recommendation/Key lines of enquiry:

9a) Consider whether a dedicated resource and named strategic lead for neglect across Salford help to provide this critical issue with the drive it needs in the same way as ACES and Domestic Abuse.

9b) Consider the role of 'champions' across the partnership at various levels in different agencies at service manager level in key roles to support the strategy.

9c) Clarify thresholds across the system for all professionals and citizens so that the child's journey through the system is as effective as possible and professionals feel confident in onward referral/signposting or working with families.

9d) Complete and adopt the levels of need 'windscreen' related to child's needs and neglect, (focussed on lived experiences of the child), aligned to thrive model and Early Help pathway.

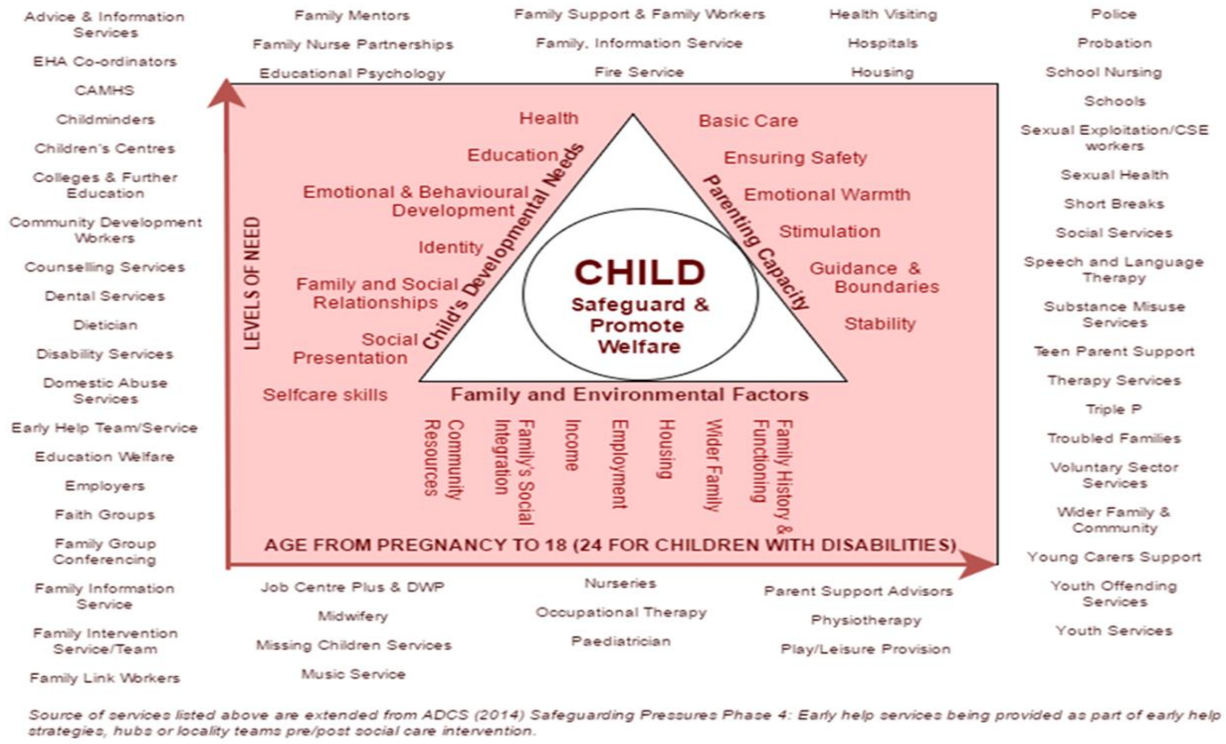
9e) Ensure that those professionals who adults and children say they would turn to if they need help for themselves or someone else know what to do.

9f) Ensure adult services are an intrinsic part of the system including workforce development.

9g) Further develop place based multi-agency 'clinics' and meetings with an approach around dynamic risk management.

10 Service Provision

In any local area, there will be a myriad of services across, or specific to different levels of need, age, and factors, as illustrated in the diagram below.



Source of services listed above are extended from ADCS (2014) Safeguarding Pressures Phase 4: Early help services being provided as part of early help strategies, hubs or locality teams pre/post social care intervention.

Figure 17: Range of services around age and needs.

In Salford, there are a range of services to support parents to meet their children's needs and tackle neglect including:

- Universal services such as schools, primary health services such as the 0-19 service which includes health visitors, family nurse partnership and school nurses.
- Services where parents may need a bit more support to either address their own needs, or their parenting such as mental health, drug and alcohol abuse.
- Family support through early help and commissioned services such as Humankind, based around locality hubs, providing support at the earliest opportunity to families in need of additional help, including co-working with social care services.
- Social work services, accessed through The Bridge

As part of the needs assessment and at the Tackling Neglect Summit, mapping what this means in terms of different professionals views across the system was created. (See Appendix C – what we do and what we see).

Professionals largely felt that there were good services in Salford. One focus group discussed the importance of ensuring they are being used in the right way, at the right time, which is not overly bound by processes and procedures, a compliance culture, or targets. They stressed that sometimes these can hinder staff, who always want to do a good job, to relationship-based practice, constrain professional curiosity and an intuitive level of practice.

We heard how some services do currently have waiting lists which impacts on the families receiving the help they need and provides a risk of deterioration. Drift in working with families and delay in achieving the required outcomes for children was evidenced for some children / services.

We asked professionals how far you agree that effective support services are available for the following groups:

a) Children under 5 years of age
b) Children aged 5 to 14
c) Children aged 15 and over
d) Preventative work with parents on parenting and support prior to identification of neglect
e) Parenting support once neglect is identified

The figures below show their responses, indicating that more professionals believe there are effective services than do not.

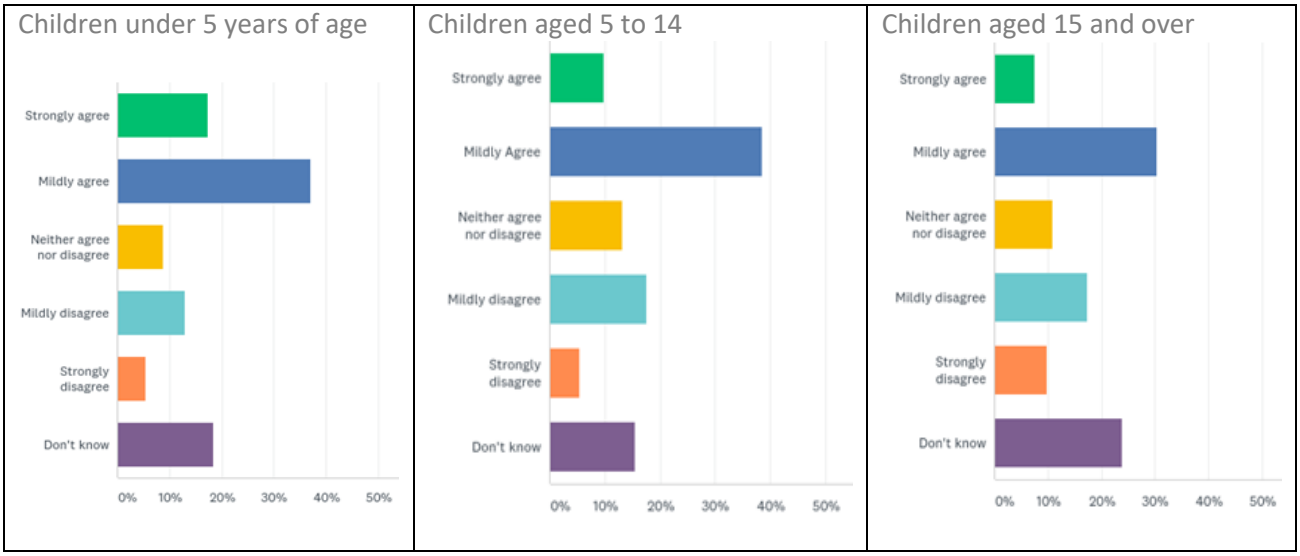


Figure 18: Professional's survey questionnaire results.

Respondents provided examples both of what is working well, and what could work better. The Tackling Neglect Summit identified that for some children, there is a gap in oversight after the two-year old health visitor check to commencing school and there needs to be a better contact for all children during these formative years.

Some professionals felt that where the impacts of neglect have been experienced, smooth transition into, and preparation for adulthood including preparing to be parents themselves is critical. The new NHS Long term plan suggest where appropriate moves to a 0-25 years service (NHS, 2019).

For under 5s: "More targeted interventions to address parenting support, isolation and managing child developmental milestones productively i.e feeding, social interaction, introducing learning and appropriate stimulation.

Source: Professionals survey response

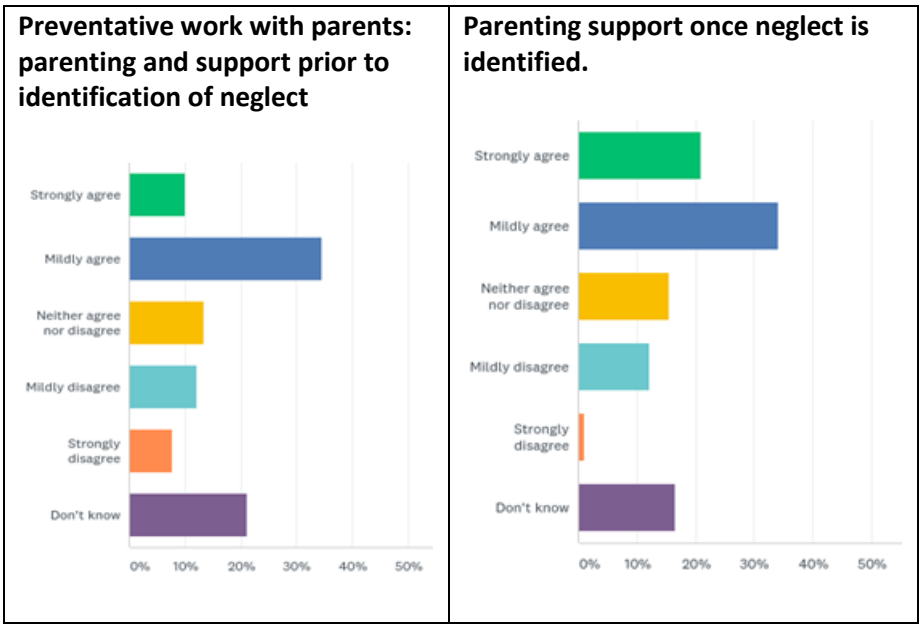


Figure 19: Professional's Survey Questionnaire Results

Focus groups were all in agreement that support for parents in universal settings and professionals supported by specialists, as required, is critical. Midwives, health visitors, schools, and communities have a critical role in providing the support to parents at present, often without the resources to do so.

There is a significant amount of information about services which is not included here, as not all services were discussed or evidenced in detail during the needs assessment and it has been necessary to keep the scope to multi-agency or key presenting factors. This is certainly the case with health services and the voluntary sector. Additional information from partners should inform discussions and actions in implementing the strategy.

10.1 Welfare Rights and Debt Advice Service

The specialist Welfare Rights and Debt Advice service take on complex cases, often referred by adult social care, mental health services and increasingly, children's services, with a specialist advice pathway designed for Early Help and the pilot of a welfare rights specialist within the Bridge. They work together with families using a rights-based approach and particularly around complex debt, ask families what they want to happen. The provision of specialist advice alongside supporting people to feel back in control, living with insecurity and long-term debt is important because feelings of powerlessness are known to be a common feature within mental health issues.

The Welfare Rights Service had active involvement through casework with 424 families with children between April 2018 and March 2019, and the Debt Advice Service had 221 active casework for families with children in the year from October 2018 to October 2019. Two thirds of the families the Debt Advice Service supported were headed by a lone parent reflecting the national evidence that lone parents have been disproportionately impacted by welfare reform (both non- working parents and working parents).

10.2 Schools and education

Educational neglect and the role of schools in identifying and working with families as well as non-attendance at school were strong features of the needs assessment. Parents may not recognise the importance of school attendance and reported as an issue in many families where other needs are not being met. We heard how this could be related to the parents own experiences of school and not seeing its' value; having issues with the school itself and not wishing to send children; cost, or a symptom of a chaotic lifestyle. We also heard how in some cases, children may be worried about leaving their parents as they take on a caring role, and opt to stay at home with them.

The ability and capacity of schools to work with families in these instances varies. We heard that on occasion, the head teacher is the only non-teaching member of staff and therefore needs to take on all the designated lead roles. Other specialists such as Education Welfare Officer, Educational Psychologist and Speech and Language Therapy are commissioned as required.

Schools are providing support to children whose needs are not met in the form of food, uniforms, and taking on a pastoral role to support parents but we heard how few schools have the capacity nor resource to do so, putting pressure on their budgets.

> *"If parents say their child is always late as they are struggling to get into a routine, then I'll go out to the home but often it's the last thing they are dealing with as you'll get everything out then, that they are not getting help with like mental health, there is domestic abuse going on, terrible home conditions, rent arrears, and debt, so sorting out the lifestyle then instead of supporting the lateness of the child to school. It happens so frequently."*
>
> Source: Focus Group School Staff Attendee

Attending education provision during statutory school age is critical for many reasons outlined here, and we know that non-attendance can be an indicator of other aspects of neglect. We did hear that parents could be receiving fines for not attendance at school, which can exacerbate their already poor financial status.

There is evidence from professionals, documentation, and the Association of Directors of Children's Services (ADCS, 2019) that the number of children who are electively home educated (EHE) is growing at a significant rate in Salford as nationally (41% in caseloads between 2016/17 and 2018/19), and is a factor in some case reviews where children are 'invisible' and experiencing neglect. Whilst elective home education may be appropriate for some children, reasons for such an increase are varied but may range

from the recent curriculum reforms and expectations of schools/students, to parents/carers seeing EHE as a solution to prosecution for poor attendance or as a temporary solution to not receiving their desired school place.

Development of an Inclusion Strategy as part of the Education Strategy is underway to be implemented early 2020. This will focus on behaviour strategies, exclusions, etc. and there are opportunities to align the Neglect Strategy with this.

10.3 Health

There are numerous indicators of neglect in health, for example children not brought to appointments, physical presentations, repeated headlice, nappy rash, delay in presentation, dental decay, emotional presentation, self-harm, eating disorders, not being given medication as prescribed, malnutrition and obesity. Those most commonly referred to during the needs assessment are provided below.

Universal 0-19 service caseloads have increased. At February 2019, the total caseload was 49,391 with average caseload per health visitor of 356 and average caseload per school nurse of 3,428.

Dental: Interventions have been implemented which include fluoride varnish application and tooth brushing in schools, this will improve dental outcomes but may not address home circumstances around oral hygiene. We heard how Dental Practices are better at recognising and managing dental decay and work in Salford on a 'family friendly dental practice scheme' was launched in July 2019 after consulting local parents about some of the barriers which families said prevents them from taking their children to the dentist. The main reasons were fear (adults and children), inconvenient appointment times and not all having family members being able to register with the same dentist. These barriers are likely to be the same for other interventions and appointments.

Drug and alcohol services: We heard in the focus groups, roadshows and professionals surveys that drug and alcohol services are 'decimated' and whilst there are some committed staff providing this service in Salford, they are stretched too thinly. Substance misuse treatment often focuses on those adults with extreme addiction and those families who are 'functioning' but still unable to adequately meet the needs of their children are not detected. Further focus is needed on this cohort.

Mental health services: The importance of mental health services in neglect cannot be underestimated. We know that parental mental health is one of the key factors in not being able to meet their child's needs. We know there is pressure on mental health services in Salford as nationally, and triage services such as those offered by Six Degrees are key. However, as with many appointment types, parents are asked to travel to the clinics when they may be struggling financially and appointment times conflict with taking/picking children up from school. One of the issues with mental health services is that they are reliant on self-reporting and limited background information about the adult, and who else is involved in the case.

We heard about a CAMHS link pilot in some schools in Salford, with feedback that other schools would also like this rolled out to them. Plans are in place to ensure there is provision across the City.

Midwifery: We heard how midwifery services are very time pressured, but how this is a key opportunity to assess and provide guidance and early detection of needs such as substance misuse directly ante- and

post-natally, so that parents are supported at an early stage to know how to meet their child's needs. All universal health services are in a good position at this time in the child's life to ensure robust early assessments and promoting attachment as well as monitoring health and development to detect early indicators or risks of neglect.

There are policies and campaigns across Salford and GM which will impact positively on meeting children's needs and tacking neglect such as the Child Not Brought policy, and whilst we have not listed the detail of all health services here, they continue to provide the most significant opportunities for prevention, identification and intervention.

10.4 Early Help

Roadshow attendees spoke positively about the role the Local Authority Early Help services play in helping families and other professionals in meeting children's needs. The service takes an asset based approach to engaging and supporting families in line with the 'Family Partnership Model'. Practitioners work with families following the 'Helping Process' to explore and understand their strengths and needs, informing the completion of an Early Help Assessment. Where families being supported by the Early Help Service are identified as requiring escalation to Children's Social Care, these cases are discussed at escalation meetings to manage case transfer.

10.5 The Bridge

There was evidence from a range of sources that The Bridge generally works well and professionals appreciate that they can get advice from someone on the end of a phone. However, there was discussion in roadshows and elsewhere that 'worried about a child' as the contact address for the Bridge for both early help and social care may cause anxiety and contribute to non-engagement by families if they just need a bit of support.

Recording contacts and referrals to early help and social care are generally online, or by phone. Contacts from police are via an email inbox which means that Bridge staff select the categories and input into the system whereas for online referrals, the referrer selects the category meaning there is a lack of consistency and inaccurate selections.

Referrals from the hospital A&E Department where neglect is the issue tend to be lack of supervision, with a hypothesis that the contact is more of a check than raising a concern. This may need to be investigated further.

Categories are screened by a Social Worker and RAG rated for urgency of response with Neglect categories 'child home alone' and 'unsafe home conditions' being red, the remainder Amber. It may be helpful for referrers to have more guidance on which categories to select in order, very much like DfE have done for categories of need.

10.6 Social Care

10.6.1 Evidence from Inspection and Post-Ofsted actions

In October 2018, a short ILAC inspection of the local authority children's services in Salford was undertaken, finding that "*The response to neglect requires improvement. The local authority's neglect tool is not consistently used to good effect by social workers or partners. This sometimes leads to delays in escalating concerns about children who experience inconsistent and neglectful parenting. Senior leaders are aware of this and have a plan in place to sharpen management oversight through existing multi-agency escalation meetings in early help and a recently revised management alert system for child protection conference chairs*"(Ofsted 2018a).

Actions were put in place to improve and the findings from the review of 40 neglect cases include learning relevant to other agencies:

- Neglect casework management at Child Protection and Children In Need level included services and support from Early Help and outreach. There is plenty of evidence that Outreach and Family Support Workers are committed to putting routines in place and visiting regularly.
- Practice seen was task centred and reliant on achieving desired and set goals with families such as meeting health appointments, cleaning and clearing within households. This is commendable but achieves mainly immediate results and disguised compliance often accompanies this, with the risk that this is not recognised until later in the involvement.
- It was difficult to evidence within assessments the impact on the children or their daily lived experiences, how the parent felt about the neglectful circumstances they found themselves in and how it affects their daily lived experiences.
- Effective conversations with parents were evident in setting goals with a quick turnaround expected, which may be productive in the short term but less so in addressing the cumulative issue of neglect or assisting the parent in sustained behaviour change that can be evidenced by motivation. However, the objective of this task based approach is appropriate in the short term as the children need to be safeguarded as a priority, with immediate risk assessed and have basic appropriate living conditions in place.

10.6.2 Practice Week

Strengths in social care practice were highlighted during practice week. For example, assessments in DAT are effective, reports for child protection conferences are done well, and tools are used well.

10.6.3 Other findings

Professionals responding to the survey and one focus group felt that there could be a disparity between looked after children who are placed with carers and those who remain at home with parents under a Care Order.

Farmer and Lutman (2014) report on a recent study undertaken in England. The sample in this study consisted of 138 neglected children who had been returned to their parents following an episode of care

and followed up after five years to examine how risks were managed over time. The authors note that there is a need to counteract or deliberately interrupt what they describe as the otherwise 'inevitable errors' that occur in case management over time, as a result of various processes. For example, parents were difficult to engage and the neglect was often minimised to the extent that sufficient protective action was not taken.

10.7 Voluntary Sector and Communities

The voluntary sector have been involved in the needs assessment and been part of the strategy steering group, and the strong partnership working in Salford includes the voluntary sector. A number of voluntary sector organisations are commissioned to provide support for families, and discussions during the needs assessment included their role as equally important as statutory services in ensuring parents are able to meet the needs of their children. The possibilities of how communities are engaged in supporting families and social prescribing were discussed as potential activities to deliver the new Neglect Strategy.

Recommendations / Key Lines of Enquiry

10a) Understand the cost to schools of welfare provision such as uniforms, breakfast etc (the 'hidden' cost of meeting children's needs and tackling neglect).

10b) Consider whether strengthening support or earlier help around and within schools will be beneficial or appropriate.

10c) Continue to recognise dental health as an indicator and an important part in the child's needs and working with the dental service to develop effective pathways for sharing information and understanding of thresholds.

10d) Consider how current provision and pathways between services addresses at the earliest stage parenting support, isolation, and managing child development milestones such as nutrition, social interaction, appropriate stimulation and learning and school attendance.

10e) Consider if 'worriedaboutachild' remains the most appropriate contact address for early help and social care.

10f) Align the new Inclusion Strategy with the Neglect Strategy and Early Help Strategy.

10g) Ensure there is clarity about early help – when referring to 'early help' generally or the Local Authority Early Help Service'.

10h) Consider whether Midwifery services or resource ante- or post-natal can play a greater role in preventing neglect.

10i) All services to audit a sample of their own cases as Children's Social Care have, share good practice and implement any improvements identified.

11 Practice Factors

11.1 Models of Practice

A 'model of practice' is a particular way of, or approach to, working with children and families which focus on building respectful collaborative relationships, solution focussed, and should be evidence based. There can be significant variation in how well some models are implemented and the same approach is not necessarily right for every local area. There are a number of models of practice in use in Salford, which tend to be 'strengths based' and centred on relationships with the service user (parent, carer, child), as well as initiatives to understand root causes, impact and how organisations and professionals can have the most impact in improving the lives and experiences of children and their families. These include:

Model	Used By	Date implemented
Solihull	0-19 Service (Health)	Not known
Family Partnership	Early Help	2019
iThrive	Early Help	2018
Signs of Safety	LA Children's Services, Early Help, SRFT 0-19 Service	2015
Restorative Practice	Children's Social Care	Not known
Lambeth/Living Well Model	Adult services linked to children's services	February 2020
No Wrong Door	LA Children's Services	2019

Whilst there is much new research and publication about strengths-based practice, we refer to Stanley (2016; 2017) in Department for Health and social care publication, *Strengths-Based Approach Practice Framework and Practice Handbook* (2019). They state that an agreed framework needs to reinforce ideas of up to date practice and co-produced knowledge, research, promote our values and ethics, render visible theories and methods, and promote a range of practice skills. The practitioner's experiential learning is also recognised and promoted. This firmly puts the importance of learning, knowledge and culture as critical infrastructure in tackling neglect in a strengths-based way.

Discussions as part of the needs assessment concluded that it does not matter that each profession / service may have their own strengths-based approach as long as the common factors above are integral, and the purpose and pathways of using specialist tools across the partnership, such as graded care profile, are clear and suite in. The diagram below illustrates how this may look.

We heard how these strengths based models of practice are beginning to change the discussions and practice with parent, for example the Family Partnership model.

Whilst it is critical that each profession works to a model of practice that suits their organisation and the outcomes they need to achieve, we can see that this may be a little confusing for families who may be accessing a range of services, as well as professionals in understanding what else is being done.

11.2 Working with Parents

The evidence identified several areas for focus when working with parents, with examples highlighting the criticality of getting this right.

Professionals parenting: The balance between supporting parents to meet their own children's needs, and the professionals actually undertaking the parenting themselves is a fine line, according to professionals. Many survey and focus group professionals talked about the need to increase parental resilience. This needs to be on a multi-agency basis which deals with the various stressors on the family and encourages families to identify solutions without doing everything for them, whilst taking firm action where required to safeguard and not leave children in abusive circumstances. A focus on fathers and wider support from families would be beneficial.

> *"Initially parenting support may be required, sometimes intensively. However, we have to be mindful that we do not parallel parent or disempower parents. Consequently we should ensure that we wean of support gradually to ensure that parents are capable and confident and have increased capacity to care for their children. We should also ensure fathers are included in this as they are often absent in assessments."*
>
> Source: Professionals survey response

Parental abilities and learning disabilities: There was evidence from case reviews and the data of children whose parents/carers have learning disabilities experiencing neglect, and this contributed to non-engagement for simple reasons such as not being able to read appointment letters. Several sources cited in Turney et al (2018) evidence that parents with learning disabilities may experience a range of other pressures that make parenting more of a challenge, such as poverty, poor mental health, physical health problems, social isolation or inadequate housing, summarising that these parents re potentially very marginalised and vulnerable.

> *"Cognitive and mental health assessments need to be considered before undertaking standard parenting assessments as sometimes learning difficulties and mental health problems can be masked."*
>
> Source: Professionals survey response

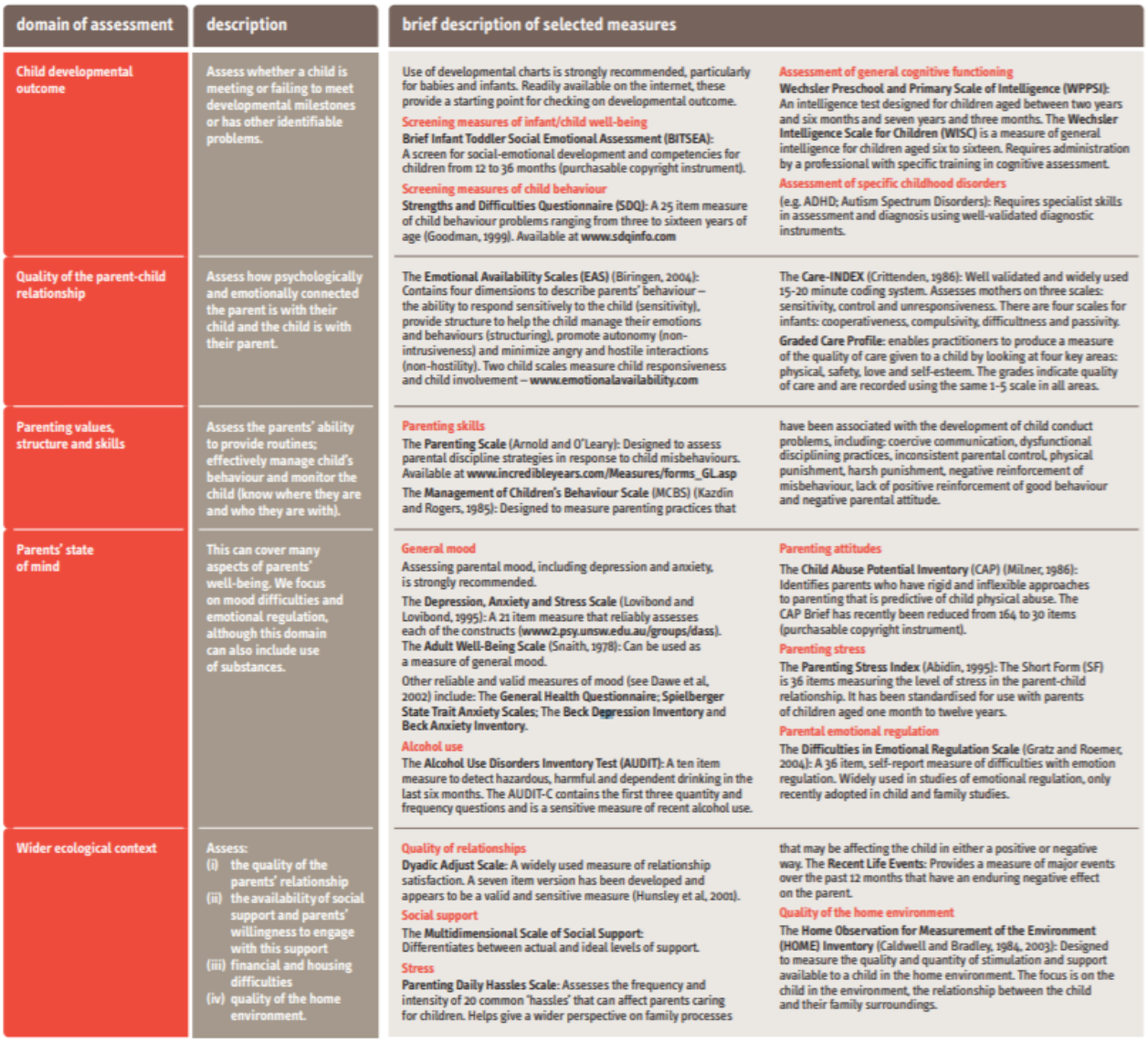
The assessment, understanding and mitigation by all professionals working with parents and their children of the capacity and ability of the parent at an early stage is important to ensure success.

Parental non-compliance and self-reporting were also evidenced as factors impacting on tackling neglect in Salford as well as nationally. Disguised compliance, resistance and denial are common features and apparent resistance may be the result of fear, stigma, shame, denial, ambivalence, or the parent's lack of confidence in their ability to change or lack of insight into their parenting capability and the impact on their children and is the subject of much research and guidance, including a Salford disguised non-compliance policy.

There was evidence that some services or professionals rely on parents self-reporting what other services they are working with, how they are doing, feeling etc. which can be challenging for professionals to navigate. We heard how there is good practice in some areas in Salford where professionals will ask the Bridge for a check on a family before they visit so that they are going in with a full picture.

There was recognition that as professionals, we need to ensure that relationship-based practice with elements of professional curiosity and clarity about whether parents understand/are able to make the changes required. We can make 'compliance' difficult if we put parents in an impossible position by asking them to make multiple changes concurrently that they either don't understand the rationale for, or can't cope with, including requiring them to attend multiple appointments (as one professional said – "…asking them to be in three places at one time with no way of getting to any of them as well as picking their kids up from school"). Suggestions also included practical support around individual budgets to pay for cleaning or support from bodies such as Home Start.

Other examples were provided about working with all family members who have a parenting role, including split parenting, and attendance at an intensive programme of parenting and how parents ae supported to remember/sustain what they have learnt.



domain of assessment	description	brief description of selected measures	
Child developmental outcome	Assess whether a child is meeting or failing to meet developmental milestones or has other identifiable problems.	Use of developmental charts is strongly recommended, particularly for babies and infants. Readily available on the internet, these provide a starting point for checking on developmental outcome. **Screening measures of infant/child well-being** **Brief Infant Toddler Social Emotional Assessment (BITSEA):** A screen for social-emotional development and competencies for children from 12 to 36 months (purchasable copyright instrument). **Screening measures of child behaviour** **Strengths and Difficulties Questionnaire (SDQ):** A 25 item measure of child behaviour problems ranging from three to sixteen years of age (Goodman, 1999). Available at **www.sdqinfo.com**	**Assessment of general cognitive functioning** **Wechsler Preschool and Primary Scale of Intelligence (WPPSI):** An intelligence test designed for children aged between two years and six months and seven years and three months. The **Wechsler Intelligence Scale for Children (WISC)** is a measure of general intelligence for children aged six to sixteen. Requires administration by a professional with specific training in cognitive assessment. **Assessment of specific childhood disorders** (e.g. ADHD; Autism Spectrum Disorders): Requires specialist skills in assessment and diagnosis using well-validated diagnostic instruments.
Quality of the parent-child relationship	Assess how psychologically and emotionally connected the parent is with their child and the child is with their parent.	The **Emotional Availability Scales (EAS)** (Biringen, 2004): Contains four dimensions to describe parents' behaviour – the ability to respond sensitively to the child (sensitivity), provide structure to help the child manage their emotions and behaviours (structuring), promote autonomy (non-intrusiveness) and minimize angry and hostile interactions (non-hostility). Two child scales measure child responsiveness and child involvement – **www.emotionalavailability.com**	The **Care-INDEX** (Crittenden, 1986): Well validated and widely used 15-20 minute coding system. Assesses mothers on three scales: sensitivity, control and unresponsiveness. There are four scales for infants: cooperativeness, compulsivity, difficultness and passivity. **Graded Care Profile:** enables practitioners to produce a measure of the quality of care given to a child by looking at four key areas: physical, safety, love and self-esteem. The grades indicate quality of care and are recorded using the same 1-5 scale in all areas.
Parenting values, structure and skills	Assess the parents' ability to provide routines; effectively manage child's behaviour and monitor the child (know where they are and who they are with).	**Parenting skills** The **Parenting Scale** (Arnold and O'Leary): Designed to assess parental discipline strategies in response to child misbehaviours. Available at **www.incredibleyears.com/Measures/forms_GL.asp** The **Management of Children's Behaviour Scale** (MCBS) (Kazdin and Rogers, 1985): Designed to measure parenting practices that	have been associated with the development of child conduct problems, including: coercive communication, dysfunctional disciplining practices, inconsistent parental control, physical punishment, harsh punishment, negative reinforcement of misbehaviour, lack of positive reinforcement of good behaviour and negative parental attitude.
Parents' state of mind	This can cover many aspects of parents' well-being. We focus on mood difficulties and emotional regulation, although this domain can also include use of substances.	**General mood** Assessing parental mood, including depression and anxiety, is strongly recommended. The **Depression, Anxiety and Stress Scale** (Lovibond and Lovibond, 1995): A 21 item measure that reliably assesses each of the constructs (**www2.psy.unsw.edu.au/groups/dass**). The **Adult Well-Being Scale** (Snaith, 1978): Can be used as a measure of general mood. Other reliable and valid measures of mood (see Dawe et al, 2002) include: The **General Health Questionnaire**; **Spielberger State Trait Anxiety Scales**; The **Beck Depression Inventory** and **Beck Anxiety Inventory**. **Alcohol use** The **Alcohol Use Disorders Inventory Test (AUDIT):** A ten item measure to detect hazardous, harmful and dependent drinking in the last six months. The AUDIT-C contains the first three quantity and frequency questions and is a sensitive measure of recent alcohol use.	**Parenting attitudes** The **Child Abuse Potential Inventory** (CAP) (Milner, 1986): Identifies parents who have rigid and inflexible approaches to parenting that is predictive of child physical abuse. The CAP Brief has recently been reduced from 164 to 30 items (purchasable copyright instrument). **Parenting stress** The **Parenting Stress Index** (Abidin, 1995): The Short Form (SF) is 36 items measuring the level of stress in the parent-child relationship. It has been standardised for use with parents of children aged one month to twelve years. **Parental emotional regulation** The **Difficulties in Emotional Regulation Scale** (Gratz and Roemer, 2004): A 36 item, self-report measure of difficulties with emotion regulation. Widely used in studies of emotional regulation, only recently adopted in child and family studies.
Wider ecological context	Assess: (i) the quality of the parents' relationship (ii) the availability of social support and parents' willingness to engage with this support (iii) financial and housing difficulties (iv) quality of the home environment.	**Quality of relationships** **Dyadic Adjust Scale:** A widely used measure of relationship satisfaction. A seven item version has been developed and appears to be a valid and sensitive measure (Hunsley et al, 2001). **Social support** The **Multidimensional Scale of Social Support:** Differentiates between actual and ideal levels of support. **Stress** **Parenting Daily Hassles Scale:** Assesses the frequency and intensity of 20 common 'hassles' that can affect parents caring for children. Helps give a wider perspective on family processes	that may be affecting the child in either a positive or negative way. The **Recent Life Events:** Provides a measure of major events over the past 12 months that have an enduring negative effect on the parent. **Quality of the home environment** The **Home Observation for Measurement of the Environment (HOME) Inventory** (Caldwell and Bradley, 1984, 2003): Designed to measure the quality and quantity of stimulation and support available to a child in the home environment. The focus is on the child in the environment, the relationship between the child and their family surroundings.

Figure 20 Assessing parents capacity to change frontline tool. Source: Research in Practice

Consent and parental engagement: Parental consent is a variable in nearly every service apart from social care and the criminal justice system. Parents need to consent to welfare and debt advice, early help, support from voluntary sector, and health services. There is strong evidence that the number of parents who either do not consent, engage or who disengage from working with professionals and/or achieving improvement to meet the needs of their children and reinforcing good practice re: improving consent and engagement should be an area of focus in the new strategy. This includes the number of parents who do not attend appointments.

In Early Help, for example 192/1244 (15%) closed early help cases in 2018/19 were due to 'services declined' and 154 (12%) 'family disengaged'. Where consent is not obtained, and where there is sufficient concern of neglect to meet social care thresholds, statutory services will take over. However, the outcomes for children where those families who do not consent or engage and are below the statutory threshold.

Lead professionals and relationships: Parents and children require time to build relationships with a single worker that they can trust and can contact if they have 'a wobble'. We heard how the types of professionals that parents are more likely to want to work with are those in their everyday life, for example, working with professionals who are associated with services such as school pastoral team, health visitor or GP, is more palatable for parents than someone from 'social services'. The stigma and worry about working with statutory services is still a worry for many parents. As part of strategy implementation, consulting parents to determine the terminology, relationships and type of worker that would be able to best work with them to achieve required outcomes and sustain it will be important. Redefining the role of the lead professional is a key element of future work.

11.3 Working with children and young people

Whilst direct work with young people who have experienced neglect was not undertaken, the young people spoken to during the needs assessment displayed a mature and thoughtful approach to recognising and supporting their peers whose needs may not be met and national evidence was used (DfE, 2012). One example was given by Salford young people of a group of friends paying for another friend's lunch as she never had packed lunch or lunch money. Children said they would go to a youth worker, other family member, sibling, teacher, or their best mate if they were worried. They said they would not post on social media, as 'social media is for happy things'. They were keen to see a campaign at child level to improve this, to include posters, assemblies, inclusion in school mentoring programme.

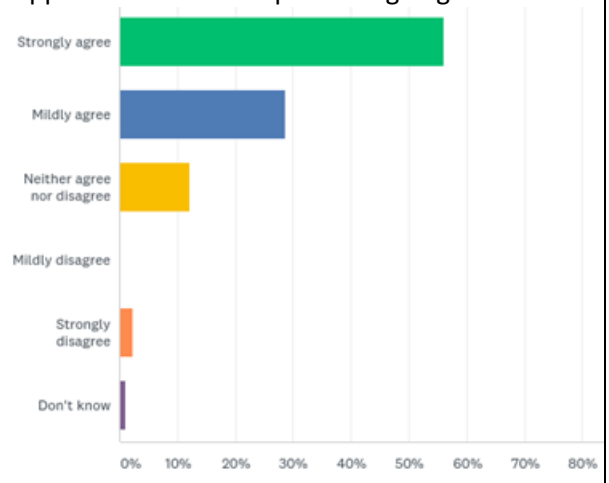
11.4 Professionals knowledge and skills

Working with children and families in the context of neglect and other adversities can place high emotional demands on professionals, especially where there may be complex causal factors, and in understanding pathways and support. Trauma faced by professionals when working with children and families, referred to as vicarious trauma, is defined as 'the stress resulting from helping or wanting to help a traumatised or suffering person' (Figley, 1995 in Research in Practice 2018).

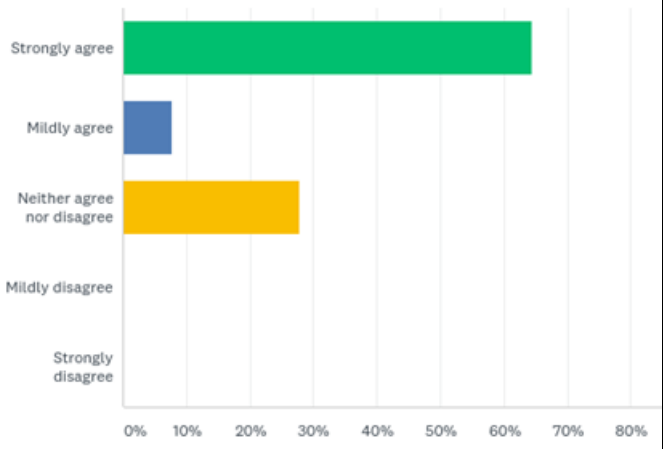
It is therefore important that professionals who may not usually receive regular supervision and case management activities, or where there is a culture where professionals can ask for support relating to their own feelings and experiences, have somewhere to go with difficult cases. This can especially be the case with universal services such as schools where onward referral does not provide the relationship-based practice that other agencies have.

Professionals responding in the survey were very positive about knowing how to access specialist advice, how well agencies work together, having a supportive manager and feeling equipped to work with children at risk of, or experiencing child neglect and their families were positive.

I know how to access specialist advice and support for children experiencing neglect



My manager supports me to manage risks associated with neglect on my caseload



I feel equipped to work with children at risk of or experiencing child neglect and their families

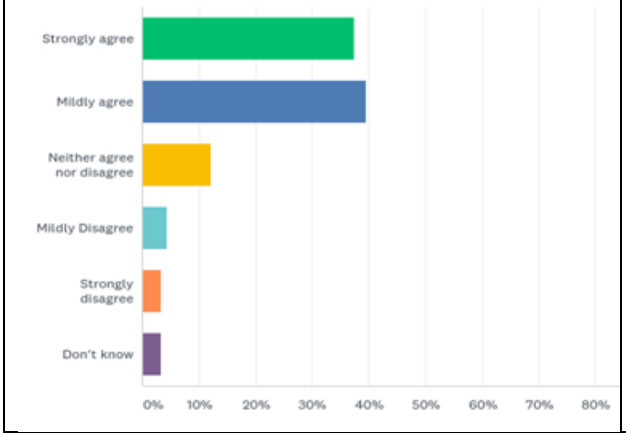


Figure 21: Professional's Survey question

52% had participated in a case review or learning event involving neglect.

Initial discussions with the University of Salford indicated that there could be opportunities for ensuring better understanding of neglect and the factors raised within this needs assessment, improving skills and knowledge in this area. For example, through their newly implemented Safeguarding Framework; their safeguarding champions starting in Sept 2019, and collaboration on initiatives such as 'child safe' initiative.

Recommendations / Key Lines of Enquiries:

11a) It is acceptable to have more than one model of delivery but identify the common ground between them, that they are strengths based models and ensure there is clarity what is the model of delivery and toolkit for working with families in which circumstances. Learn from what works across the system and all models.

11b)Engage parents in finalising and implementing the strategy.

11c) Across the partnership, learn from where there is best practice in relationship-based practice with families and develop guidance and learning opportunities for all staff in understanding best practice in

working with families, including identifying parents cognitive ability and capacity, self-reporting, disguised non-compliance, capacity to change and getting engagement and consent.

11d) Improve professional understanding of the Lead Professional Role and establish support systems via place-based working to alleviate the pressure on those individuals supporting families with complex needs.

12 Specific Areas of neglect

There was evidence specific to a child or families characteristics or circumstances for further attention and consideration as part of the strategy. In addition to those evidenced below, there will be other presenting factors which touch on neglect such as safe sleep advice as part of an integrated advice and integrated strategies with neglect and substance misuse.

12.1 Disabled Children

Research by Jones et al (2012) estimated that disabled children were 4.56 times more likely to experience neglect than non-disabled children. In another study, Sullivan and Knutson (2000) found that disabled children were 3.8 times more likely to be neglected than non-disabled children. Disabled children featured in a disproportionate amount of safeguarding case reviews where neglect is an element, over the past three years in Salford.

Reasons could include attitudes and assumptions, barriers to provision of support services, impairment related factors, child's lack of awareness, barrier to communication and seeking help, barriers to identification of concerns and effective child protection response.

12.2 Young carers

We heard that where parents are not meeting their children's needs, older children are unintentionally or intentionally taking on the role of carer for the parent and siblings, including taking them to school, getting them out of the way when parents are in conflict.

12.3 Obesity

There is evidence from case reviews, focus groups and other sources that childhood obesity as a form of neglect is an issue, not just in Salford but nationally. In one serious case review, the impact of neglectful parenting in causing obesity resulted in a child's death. The Manchester Serious Case Review this year has resulted in learning points about obesity and a GM strategy, as well as work for the coming year on this topic by the GM Children Network.

12.4 Adolescents

While there has been a great deal of focus on the neglect of younger children, there is much less research and practice development to address the neglect of older children. Ofsted (2018) examined the multi-agency response to older children who are living with neglect concludes that in the six local areas inspected, much has been done by agencies to address neglect of younger children but it calls for a greater awareness of the neglect of older children and a focus on trauma-based approaches to tackling it. It also calls for a greater awareness among professionals in adult services of the risks of neglect of older children who are living with parents with complex needs.

What older children require from their parents is also different to what younger children need. Older children face risks outside of the home in ways that younger children do not. Parents may not always be equipped to help their older children deal with increased risks outside the home. Ofsted 2018 state that the signs of neglect of older children may be more difficult to identify than signs of neglect in younger children, and older children may present with different risks. For example, older children may want to spend more time away from a neglectful home, and, given their experience of neglect, they may be more vulnerable to risks such as going missing, offending behaviour or exploitation.

When older children who have experienced neglect come to the attention of agencies, the most obvious risks of, for example, exploitation or offending behaviour may elicit an appropriate response from professionals initially. But, without understanding and addressing the underlying impact of neglect, the effectiveness of any work to support these children will be limited. Professionals and parents can sometimes view the presenting issues older children face as the problem: this was often an unconscious assumption. When a child's presenting issues become the sole problem, professionals do not always consider their behaviour in the context of the impact of neglect on the child and they can fail to take action with parents regarding any ongoing neglect.

Ofsted found that agencies focus on the presenting issues without either addressing neglect in the home or the impact of neglect on the child. They reiterate that while agencies robustly work together to tackle knife crime and gang activity, they must also address the underlying vulnerabilities of the young people that expose them to grooming by gangs/dangerous adults. The way in which we, as a society, view older children and their behaviour is not always in the context of their lived experiences.

Meeting the needs of older children was a strong area from the evidence for further attention within the strategy, with questions around pathways and service provision that adequately look at their needs being met and neglectful parenting.

For 16 and over age group: "In my experience as a clinician this group are probably the least likely to receive an appropriate intervention and so often, are perceived by professionals and adults as abusive, aggressive, 'choosing' to behave badly and making poor decisions without a real understanding why they are struggling to deal with and engage in the world around them. I think all services need to address this issue, particularly for those aged 16 + as we treat them according to their chronological age and not their emotionally developmental age. From a CAMHS perspective, these are also the young people who haven't received a formal assessment, diagnosis and consistent treatment for their difficulties as parents have not been able to support them to engage and make the changes they need to, to prepare them for adult life. Accessing children's service support for the 16+ age group is also very difficult as is housing, financial support and a nurturing approach to engagement. Quite frankly, I think we really let them down!

Source: Professionals survey response

12.5 Childhood Neglect and its Relationship to Other Forms of Harm

In section 2.1 we stated that neglect cannot be viewed in isolation to other. Research in Practice (Floor & Holmes, 2016) have drawn together key messages from three studies considering the potential relationship between neglect and other forms of harm and what this tells us about responding effectively to meet children's needs, concluding that there is no direct or straightforward link between neglect, child sexual exploitation, intra-familial child sexual abuse or HSB but the evidence does suggest a number of ways in which the impacts of neglect may interact with other factors and adversities to increase children and young people's vulnerability to harm. A hypothesised model of how the impact of neglect may increase vulnerability to CSE is shown below.

Figure 1: Hypothesised model of how neglect may increase vulnerability to CSE

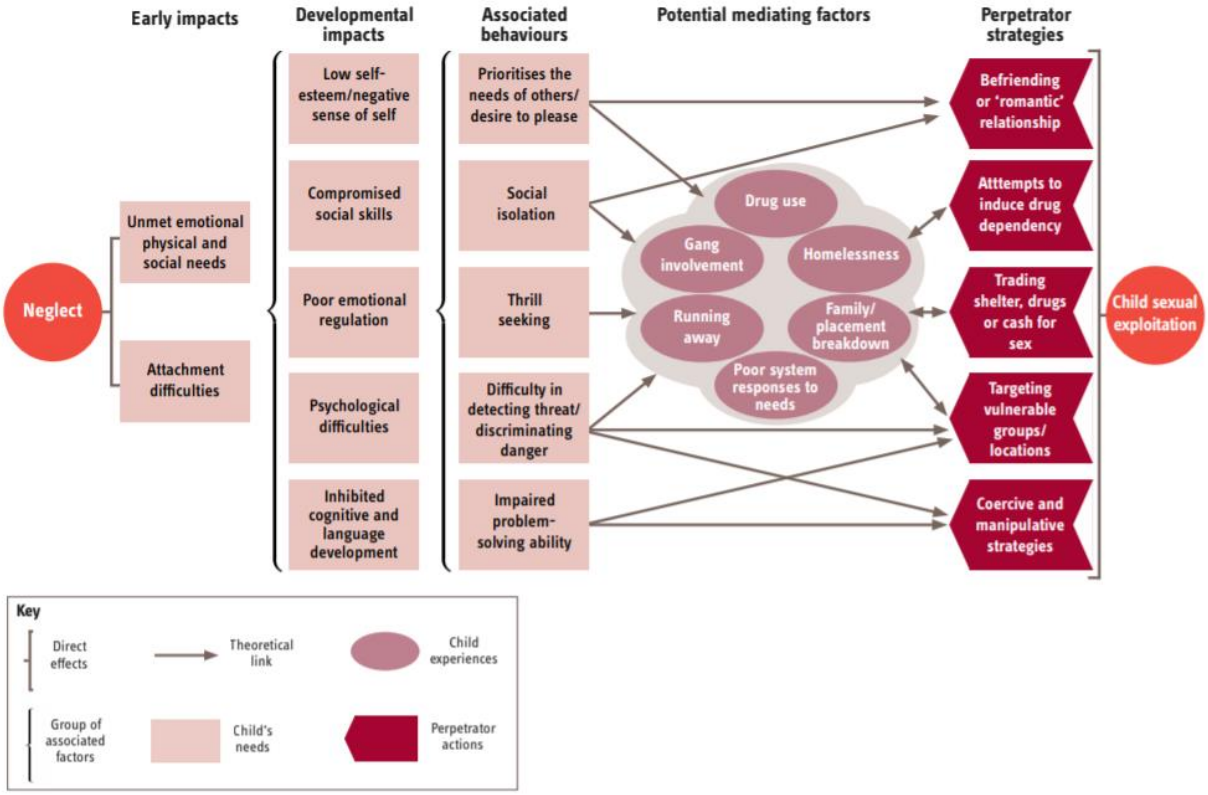


Figure 22: Source: Flood & Holmes (2016) Child Neglect and is relationship to other forms of harm – responding effectively to children's needs, Research in Practice

12.6 Episodic neglect

National and local evidence describe a pattern of episodic neglect where families are not able to meet their children's needs all the time. As professionals, we expect separate episodes of neglect to diminish once parents have made improvements. However it is important to also value the positive nature of families who may re-request help from any service if they are struggling. This recognises that stopping further escalation and periodic support is part of building resilience and sustainability. We would

recommend that identification of how episodic neglect can be improved, and ongoing support to meet children's needs that takes into consideration previous periods of neglect is essential.

12.7 Institutional neglect

Institutional Abuse is more commonly considered in adult services, and described by The Care Act as one of the 10 types of harm including neglect and poor care practice within a specific care setting such as hospital, children's home or care. Whilst this does not appear to be a feature in the case reviews in the past three years, the safeguarding partnership, commissioners and professionals need to continue to be diligent in this area.

Recommendations / Key Lines of Enquiry:

12a) Improve understanding of, and response to neglect in older children that considers and mitigates impact on life chances through better transition between child and adult services.

12b) Consider how episodic neglect and the factors that cause this can be mitigated, for example improvement in getting consent to work at early help; use of chronologies; sustained support; places for parents to go for support if they feel a wobble and addressing risk and resilience.

12c) Continue to consider institutional neglect as an area of focus

13 Impact

The impact of not having needs met and neglect can be significant on a childhood as well as life chances. The child can carry the legacy and impact of neglect at a younger age with them into adolescence and adulthood. This means they are often not well equipped to cope with the many challenges and there is evidence of poor parenting from adults who were received poor parenting themselves. We know from research that the impact of long-term neglect can result in children experiencing trauma and the repeated experience of trauma can lead to post-traumatic stress. The emotional impact of neglect, of children not having their emotional needs met was felt to be significant and sometimes overlooked.

The impact of neglect on the lives of children and into adulthood can include, but is not limited to:

poor mental and physical health
poor behaviour and mood control
learning and/or other disabilities
substance misuse
intergenerational continuation
reduced educational achievement
suicide
difficulties with interpersonal relationships
poor confidence and social skills
offending behaviour
a high propensity for risk-taking behaviour
low expectations of their parents
greater difficulty with communication and learning
death

It is challenging to measure the impact of neglect and understand the lived experiences of children. We heard how sometimes the focus can be on supporting the parents and their presenting or causal issues and what it's like for the child is lost. Some examples have been provided through this needs assessment. Better understanding and mitigating against the child's experience of these events could help to reduce the emotional trauma. For example, can we do more to help parents think about the impact of what they are doing on their child's emotional health and how they might be experiencing it. It was suggested that if we can prevent and tackle emotional neglect and attachment first, there may be a knock on effect and there will be less other types of abuse as parents connect emotionally more with their children.

Howarth (2013) suggests that understanding the child's lived experience, especially in assessment, requires greater time specificity, for example the child, parent and professional view first thing in the morning, at weekends, at bed-time.

Case studies have been produced to illustrate how the child's journey from presenting needs through assessment, provision of service, and what has changed for the child produces learning and improvement opportunities for professionals and system leaders. (see Appendix C).

We asked young people what is important to them. Love, a sense of belonging and attachment came out strongly for young people as part of their ***Ten Points in Jazz Hands*** in the pledge. Young people commented that children may not realise what their 'grown ups' are doing is neglect, because you care for them and put them on a pedestal, not thinking that they could do it to you. Professionals and young people stated that ways of identifying emotional neglect could be challenging as children will react in different ways. We therefore need to ensure that those professionals and adults in touch with children, whom they would go to, are able to recognise the signs.

> *"…being pushed away by people when you need help and they are not there..parents/family member..people who should give you love".*
>
> Source: Member of the Youth Council

Recommendations / Key Lines of Enquiry:

13a) Consider how the impact of parental and stress factors can be minimised, and ensure all professionals, including Adult Services, Housing, Benefits, Bailiffs, etc, are provided with guidance/training on minimising the trauma for them.

13b) Ensure that engagement with children where parents need support, or are experiencing neglect, is done so in a way that does not minimise their attachment to their parent.

13c) Develop an outcomes framework and evaluation that includes the voices of children and young people, and review by The Youth Council.

14 What Works to Improve

To be effective in identifying the neglect, especially in older children, there needs to be a whole-system approach which ensures that staff across agencies (especially non-children's services such as housing, adult services) have the support, training and tools they need to tackle root causes of neglect.

14.1 Comparing to Other Local Areas

In England, some local authorities appear to have reduced the prevalence of neglect as measured by rate of children subject of a child protection plan for neglect. A brief review of local authorities who have reduced the number of children becoming subject of a child protection plan for the category of neglect by more than 25% between 2014/15 and 2017/18 (ADCS, 2018) reveals that large reductions in child protection plans for neglect are evident in some areas. We cannot presume from the data that all of these have been successful in tackling neglect and it is critical to understand from the LAs the reasons for reduction, including whether there have been changes in recording. We know that for some, including Hertfordshire, there is evidence that this is as a result of the family safeguarding model as part of the DfE Innovation Programme.

Barnet	Halton	Shropshire	Westminster
Barnsley	Hertfordshire	Southend-on-Sea	Wigan
Bedford Borough	Lancashire	Stockton-on-Tees	
Bexley	Norfolk	Wakefield	
Bradford	North Tyneside	Warrington	

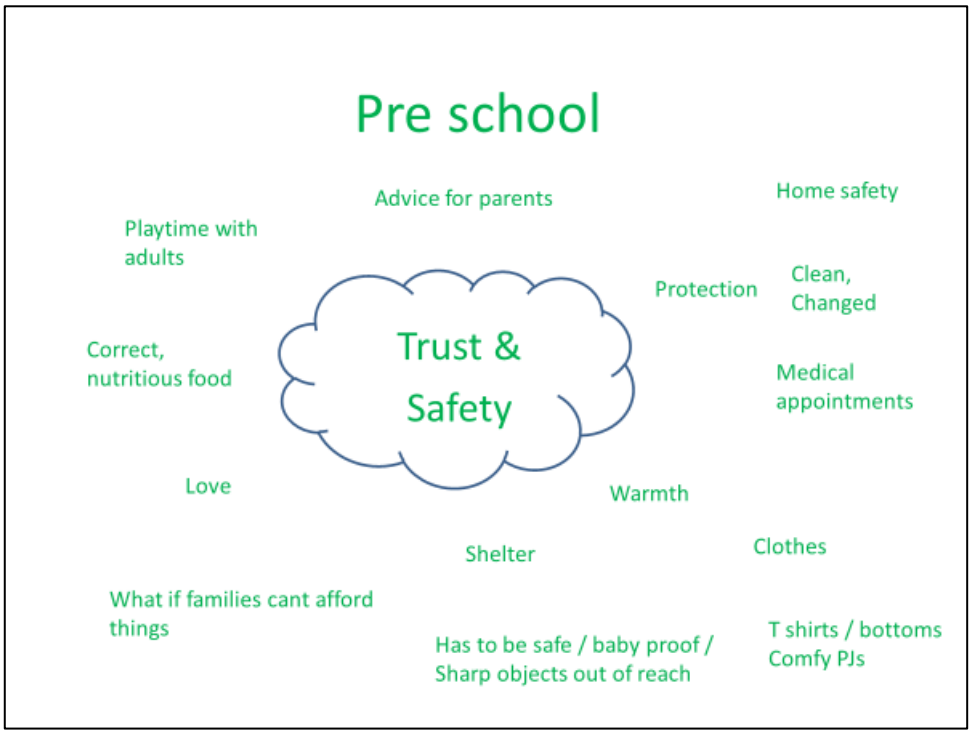
14.2 Regulatory and Salford's standards

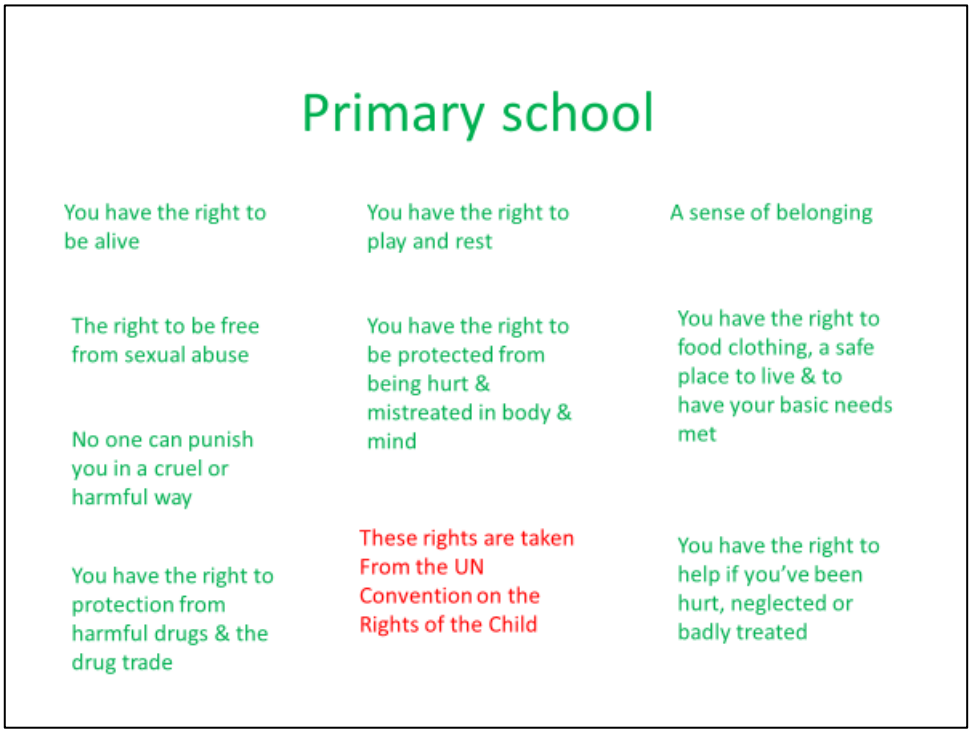
Our research questions (Appendix A) and Ofsted (2014 and 2018) suggest what good practice and outcomes looks like:

- Children living with neglect receive the right help and protection at the right time so that their individual developmental needs are met;
- Families are helped to engage with the work and children's views are sought and recorded; openness is encouraged as part of early help;
  There is proactive engagement with parents over the now and ongoing developmental needs of each child and clarity as to roles in meeting those needs;
- Plans are SMART – in other words they clearly and succinctly evidence and record current concerns, what needs to change from this baseline, how, and by when (how urgent for the child);
- Actions to carry out the plan and results meeting the child's needs, or a change of plan, are recorded;
- Families and professionals have access to evidence-based approaches, tools and services; staff are well trained, confident and knowledgeable;
- There is good communication with and between professionals.

14.3 Young People

Salford Youth Council presented to the Tackling Neglect Summit what having their needs met and not being neglected means to them, splitting into three age groups:





Teen

A voice – To talk freely & openly about things

Explore – Right to explore different pathways

Act – eg. If friend being abused, act to stop it.

Freewill – Allowed your own privacy for things

Support – eg. An extra person to help with a problem.

Medical needs – Addiction / problem able to talk to someone trustworthy look beyond the behaviours.

The ten most important things they came up with for all children, for professionals to pledge to was presented as their 'jazz hands of trust'.

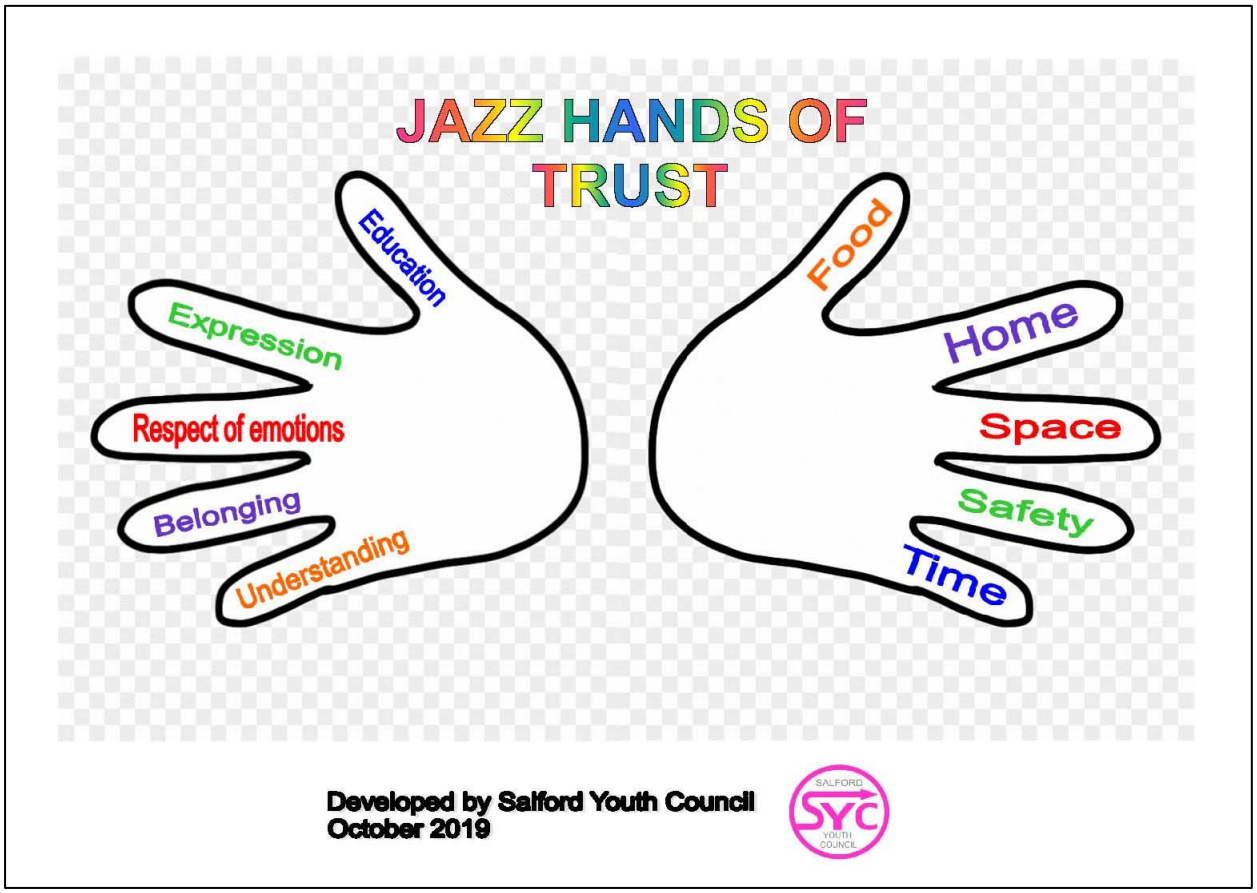


Figure 23: Salford Youth Council evidence re neglect

15 Considerations, Challenges and Enablers

The following points arose for consideration, which present challenges or are enablers for tackling neglect and the new strategy:

- Evidence sources from professionals cited funding, capacity of current staff, lower case loads and recruitment and retention of staff, specifically social work, parental mental health and drug and alcohol services as some of the challenges. In the current public sector funding situation, local authorities, including Salford, are considering and acting on how they can be more innovative, efficient and future proof provision. During the needs assessment, discussions ranged from apps for parenting (but see previous evidence about the amount of time spent on technology rather than interactions), to wider use of self-book appointments and interactive parenting guidance.
- We heard how services need to be as mindful of their own 'start again' syndrome as we note there may be for families, and to get basics right and ensure there is time to embed any new ways of work to generate impact.
- The Salford-centric evidence about neglect and meeting children's needs is substantial, but there are gaps in our knowledge. For example, the voice of parents, voice of communities and wider voice of children experiencing neglect is not as strong as it needs to be.
- The evidence indicates that neglect needs to be viewed as an 'adaptive challenge' and not a 'technical problem'. That is to say that we cannot diagnose and solve this, generally within a short time frame, by applying established know how and procedures. New learning, time, and a cultural shift may challenge some professionals' values and perceptions. (Heifetz, 2009).
- Measuring impact of the strategy: It is important that we agree success measures for the new strategy from the beginning. We propose a new outcomes framework based around the Young Peoples pledge agreed at the outset of the new strategy which is implemented immediately with baselines completed. We would also propose that evaluation is built into any strategy and at a reasonable period after implementation.
- We must be cognisant of, and use the six principles of the SSCP to ensure we empower, prevent, work in partnership, are proportionate and accountable, providing protection to those in greatest need.
    - Empowerment: People being supported and encouraged to make their own decisions and with informed consent.
    - Prevention: It is better to take action before harm occurs.
    - Partnership: Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting safeguarding issues.
    - Proportionality: The least intrusive response appropriate to the risk presented.
    - Protection: Support and representation for those in greatest need.
    - Accountability: Accountability and transparency in safeguarding practice.

15.1 Future Proofing

This needs assessment has 'looked back' to assess prevalence, need and services. However, the context and lives for children and families is ever changing and the impact of external factors and legislation will impact in the future over the life of the new three year strategy and beyond. To truly understand how neglect can be more effectively tackled in the future, consideration of emerging or predicted factors, horizon scanning, is critical. For example:

SOCIAL AND DEMAND FACTORS	
Population:	***IF*** we have more children living in the local area, ***THEN*** there will be a need for more school places, other services and proportionate increase in children and families in need of help.
Poverty:	***IF*** there is greater poverty, ***THEN*** there will be more children in need of help.
Housing:	***IF*** the availability of affordable suitable housing does not increase ***THEN*** there are likely to be more children at risk of homelessness and in the social care system.
Health:	***IF*** universal child health services are not available to promote, prevent or treat health issues, ***THEN*** there are likely to be more children and families who will develop more serious problems which will require attention from higher tier, more specialist health services and children's social care.
Mental Health:	***IF*** there is limited improvement in accessing services that prevent and treat mental ill-health for children, young people and adults, ***THEN*** there are likely to be more parents and young people suffering acute distress, requiring access to higher cost in-patient services and there will be a greater negative impact on children's future life chances.
RESULTING SERVICE DEMAND FACTORS	
Increased caseloads:	***IF*** demand increases, with no additional funding for services or workers, ***IF*** difficulty recruiting & retaining workers continues, ***IF*** the number of workers decreases ***THEN*** it is likely that the caseloads of existing workers will increase, ***THEN*** there will be greater drift in the system, ***THEN*** we have more children in the system for longer. ***IF*** demands increase and recruitment and retention of skilled social workers decline, ***THEN*** there will be an increased reliance on agency staff at a greater cost. ***THEN*** children and young people's needs will not be met.
RESULTING OUTCOMES FOR CHILDREN AND FAMILIES	
Escalating issues:	***IF*** needs cannot be met in a timely way, by supporting the child and family at the earliest possible stage***, THEN*** problems will escalate and require more costly intervention. Most importantly, the quality of children's future adulthood will be poorer.

16 Conclusion

There has been a wealth of evidence provided which concludes that Salford has good multi-agency working, good working and support to families is positive and there are a number of great initiatives and changes and services. However, we also heard how rising neglect is a national issue as well as in Salford, and there are areas where Salford can do better.

We challenge a need to define parents/carers abilities to meet the needs of their children on the wide spectrum in a strengths based way, from 'need a temporary bit of help' to chronic and abusive neglect.

Prevention and early identification of parental inability to meet their children's needs start at the earliest possible opportunity and there are missed opportunities to do so ante-natally. The notion of additional parenting support resource pre-birth, in the first 1000 days, and 'early early help' to work alongside existing universal and level 1 services professionals where neglect can be prevented is being tested.

Professionals talked about basic parenting skills and self-care in schools, getting into communities and local activities such as sports events and providers such as Rugby and football to target fathers. Subjects that can be prevented include loan sharks, caring for children, nutrition, the importance of attending school, where to get support from

Support is required for those parents who do not know how to parent their children, who may be socially isolated, or to help signpost to services such as debt advice, nutrition and food, the importance of going to school, or more specialist services such as accessing and the importance of attending mental health or drug and alcohol appointments. In essence, a refresh of the lead professional role, but where families would identify with and consent to work with – we heard about the 'Salford Nanna'.

From this perspective and the evidence provided, greater attention and focus is required on meeting children's needs and neglect much more preventatively, as a public health approach, responding to the causal chain to promote health, well-being, prevent neglect, develop resilience and foster equality, from pre-birth to transition to adulthood. There are opportunities to strengthen the lead professional role, specific neglect tools and understanding/implementation of thresholds for neglect across the system so that there are places where professionals can take concerns without onward referral.

In terms of strategic approach and resources in the future, there was a consistent message of a greater understanding that early help is greater than that provided by the Local Authority early help services, and the pressure on 'universal' and some specialist services such as schools, mental health and drug and alcohol services require urgent attention.

From the evidence gathered, root causes, presenting issues and effects of not meeting children's needs can be visualised as follows:

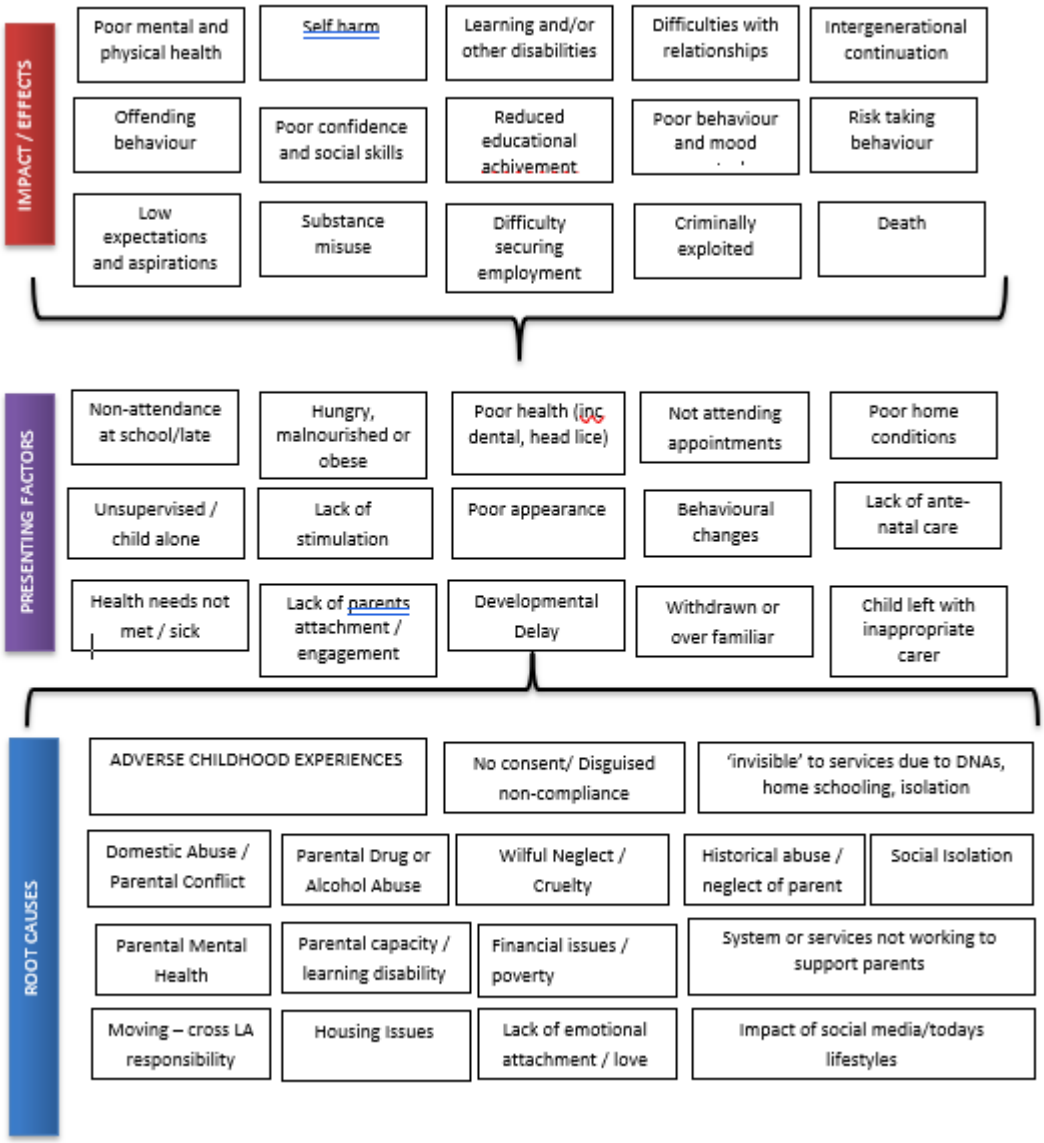


Figure 24: Summary of root causes, presenting issues and impact

Our needs assessment chimes with Turney and Taylor (2014) and Brandon et al (2008) who conclude that child neglect is a complex phenomenon with a range of possible inter-connecting 'causes', and this complex interplay of factors can compromise parents' abilities to offer satisfactory care to their children.

The strategy, as well as providing a strong reinforcement of the statutory requirements in Working Together 2018, should focus on addressing the root causes, whilst recognising the presenting factors and mitigating against impact at a pace which is in the child's time. The recommendations herein, and draft action plan and strategy take into account all the findings from the needs assessment.

The Youth Council reminded us that collectively, all grown-ups everywhere have a duty to uphold Article 27 of the Convention on the Rights of the Child: the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development. This should underpin the Neglect Strategy.

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Appendix A: Neglect Strategy Assessment Questions

Prevalence (all levels)
1. Are we clear about different types of neglect, understanding is definition and pathways across the partnership and communities? Is the 'system' and processes in Salford across the levels of need effective and understood?
2. Do we know how many children and young people are living in families who may need extra help, or are receiving support for parenting or factors that can lead to neglect? How many are at risk of, or living with neglect in Salford and what services they are accessing, for how long? Is it episodic?
3. Do we know the impact of neglect for children, including the emotional harm caused by all types of neglect and its effects on their behaviour and learning? When we are intervening, what outcomes are we achieving for them and are we improving life chances?
4. What does additional evidence tell us about prevalence and outcomes, such as poor health, non attendance at school or medical appointments?
5. Are we clear about prevalence and factors for all ages and circumstances, including those living in poverty? (The latter will be determined by national deprivation indices (IDACI), a range of local DWP data, research and qualitative information.
Empowerment and Prevention
6. Are there local solutions through services working with their communities? How can communities have a part to play in preventing, detecting, supporting and reporting safeguarding issues due to neglect?
7. Are professionals and support staff including the voluntary sector at all levels of need (from schools to social care) well trained, confident and knowledgeable? Do they understand the impact of neglect on children's daily lives as well as the long-term and cumulative impact on their health, development and well-being, which enables them to identify how to help and protect children and to take action to do so? Do professionals have a clear understanding of how the behaviour of parents and carers affects children, including the impact of parent/carer own experiences on the needs of children (Trauma Informed)?
8. Are there earlier interventions such as parenting support in different forms so that parents can be empowered to seek support early? Do parents know where to go for extra help, and is it accessible/effective in preventing Neglect?
9. Do agencies work together to identify children where additional support may be required to support parents and prevent needs escalating? Are those professionals providing this support able to reduce risk of escalation, improve parental capacity to meet the needs of their child and to monitor effectively the impact of interventions?
10. Are practitioners able to intervene early when potentially neglectful causative factors are known (e.g. parental substance misuse).
Support and Intervention Early – A proportionate response
11. Are the needs of the child and their family met at an early stage through timely access to effective

help?
12. Are needs and risks to children assessed effectively and responded to appropriately at different levels of the system? Where different types of assessments are undertaken, do they consider family history and the cumulative impact of neglect, and show that there is a clear understanding of the ways in which different forms of neglect affect children. Are plans SMART and are they shared with those involved?
13. Do schools and health services have effective systems to identify children at risk of or subject to neglect? Do schools contribute effectively to inter-agency working to improve outcomes for children who are at risk of or are being neglected. This includes providing appropriate support, contributing to a coordinated offer of early help or inter-agency plans for children in need of help and protection? Do they make timely referrals to early help or children's social care where appropriate and children receive support within the school and/or from external agencies where required?
14. Do children at risk of, or living with neglect receive the right help or protection because of application of appropriate thresholds, effective information sharing and timely intervention? This includes ensuring there is no drift, there is effective decision making at all levels, especially in social care
15. Do children living with neglect benefit from evidence-based approaches, tools and services that reduce risks and meet their needs? Is the impact of neglect on children reduced because they and their families can access a sufficient range of local services, including therapeutic help that improves children's emotional well-being and safety? This may include help provided by community and voluntary services.
Neglect as a Safeguarding Issue (above social care thresholds)
16. Is there assessment of any strengths and risks in parenting and the extended family? Where changes in parents' and/or carers' behaviour are required, are clear timescales for change agreed? Are these timescales are based on the child's needs, and improvements in parenting are closely monitored?
17. Do police work in partnership with other agencies to appropriately identify and address the needs of children who have been or are neglected? Do they investigate effectively cases of neglect in families with children?
Child-Centred
18. Do children experience a child-centred approach from all professionals?
19. Do we really understand each individual child's lived experiences 24/7, their history and their aspirations?
20. Are the views of the child are clearly recorded and central to the work with the family? Do children and their families feel that their views have been heard and understood?
Accountability and Leadership
21. Do professionals challenge each other appropriately to ensure good practice, and do they challenge and support parents/carers where poor parenting is resulting in neglect?

22. Do leaders and managers understand the experiences of children at risk of,or living with neglect that live locally. Does this lead to effective action to meet children's needs and improve the help and support provided to children and their families?
23. Do leaders and managers recognise the challenges involved in responding to neglect and provide effective support, training and challenge to practitioners? Is progress and outcomes monitored? 24. Does the SSCP actively monitor, promote, coordinate and evaluate the work of the statutory partners that help and protect children at risk of neglect, including working effectively with other multi-agency groups that have responsibility for responding to neglect.
25. Are risks to children living with neglect prevented and reduced? Are we having an impact?

Appendix B: What we see and what we do

This represents some of the perspectives on supporting families to meet the needs of their children and tackling neglect. It is by no means comprehensive, but from a variety of sources from during the needs assessment and summit. The SSCP may wish to revise and utilise as part of awareness raising and workforce development.

Child's Perspective	Adult's Perspective
 **All ages** I'm unhappy and don't know how to get help, I need you to notice me and show that you care. I want to feel safe and loved, I want you to understand what my life is like. I expect you to help and not just leave it to someone else. If I trust you I might be able to explain but sometimes the way I act is me showing you what's happening and how I feel.	**We may see**: If a child was being physically neglected, we may notice that their basic care needs to not appear to be being met. They may not have appropriate food, age and gender appropriate clothing, they may not be being supervised appropriately or kept safe. A child may appear smelly or dirty. They may seem hungry- they could physically present with a swollen or thin stomach. They may appear tired. They could have unwashed clothes or inappropriate clothes for the weather. They could have recurring and untreated head lice. A child may not be in education and may be under achieving if their educational needs are being neglected. A neglected child may struggle to interact with others and could have poor language or social skills. They may have limited friends. If a child's emotional needs are being neglected we may notice that they are not receiving the nurture or stimulation that they need. There may be a lack of age appropriate toys or books in the family home. They may be ignored by their parents, intimidated or humiliated by them. We may observe inappropriate or inconsistent interactions between child and carer that raise concerns. An emotionally neglected child may appear clingy, aggressive, withdrawn or anxious. If a child's medical needs are being neglected this may be evident through their physical presentation. They may have dental decay, poor hygiene or have weight and growth issues. **We would all** think of the impact of the situation on the child at every hour of the day, every day (weekdays, weekends, holidays) and their emotional needs, looking at trauma informed approaches. We will support the young person and hear the voice of the child, asking if the parent or the child would need an advocate. We would address practical issues and immediate issues, gaining a beter understanding of he cause of the

	presenting issues. **As a Housing Provider,** I would make visits and see home conditions. I would develop a plan with other workers and use 'injunction tool' as a last resort where family have not stuck to the agreed plan and home conditions are still a problem. If I am worried, I will contact The Bride. **As a Social Worker**, I would ensure I am open and honest with the family to build trust and work with the family to ensure the child is safe and well**.** **As a mental health practitioner,** I would work with adults and young people. If I had concerns about a child under 16, I would discuss with the family member I m working with, in a compassionate way and be honest about my concerns and the action I am going to take. **As an Early Help Assessment Co-ordinator:** I would identify their strengths and their worries, from which I will support the family to create an action plan that addresses their needs. I will reassess threshholds of need and we would request an early help escalation meeting if I am worried. **As a Duty and Assessment Team Social Worker:** I undertake assessments where there are concerns that a child may be at risk of suffering significant harm. If a child was being physically neglected I may notice that their basic care needs to not appear to be being met. If I had concerns, I would aim to address these without delay. If the child is verbal, I would speak with them and try to gain an understanding of their lived daily experience and what life is like for them at home. I would speak with the parents/ carers and gather their views and consider the wider family support network. I would explore what support may be required to improve the situation and consider referrals to early intervention services/ family support. I would use MARAM tools to support my assessment and complete a graded care profile. I would gather information from professionals involved with the family and compile a chronology of significant events. A multi-agency strategy meeting may need to be convened to consider threshold for future case direction and whether any immediate action is required to safeguard the child. **As a Family Nurse,** I listen and try to understand what life is like for you? What is going well

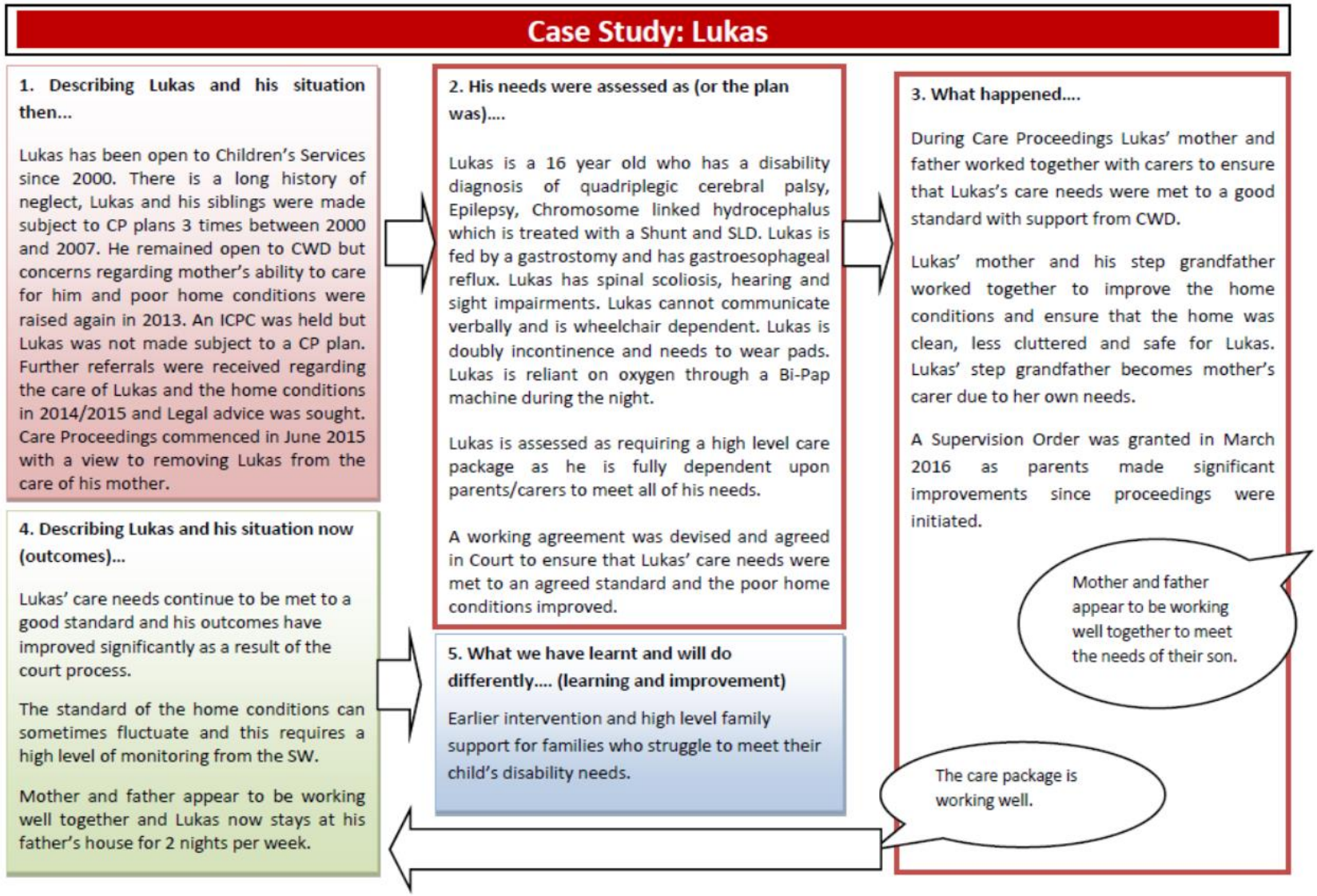
	and what you feel you need help with? I'm interested in your hopes and dreams for the future and how you might plan to make changes to achieve the things you want for yourself and your child. I'll tell you if I'm worried about you or your child. I'll share with you if I need to ask for help from other services. I will work with you as you grow as a parent and as a person.
 **Baby** My nappy needs changing. I am in pain and no-one is cuddling or soothing me. There are loud noises that scare me at first, then it is normal. I learned quickly to accept that I am hungry a lot of the time. I didn't have my routine immunisations and sometimes I have coughs, colds or am not well but I don't get taken to the doctors. My parents don't seem interested in me.	**We may see** a pregnant mum who is not taking care of herself during pregnancy or attending ante-natal appointments. We may see a baby who is not smiling, not spoken to, is not content or calm or played with or soothed by parents. A parent may be struggling to bond with a baby or speaking negatively of them. The baby may have persistent nappy rash, no nappies, not fed, be failing to thrive, not meeting milestones. **We would** all give advice in a non-judgemental way and signpost to services. We would look at barriers, use motivational interviewing to empower parents to work through the main issues and signpost to services. **As a social worker I would:** have a conversation with the parent, provide what is needed in terms of basic care such as milk and nappies. **As a Midwife** I will provide information and support during pregnancy so that you and your baby can be as healthy as possible, I will listen to you and if you need help I will let you know who can support you, for example with money worries. If I'm worried about you or your baby I would let you know and ask children's services for advice or support if needed. **As a Health Visitor I would:** look at family support and work with the family giving tips. I may do a child's needs jigsaw tool or graded care profile. If I was still worried I would contact children's social services.
 **Pre-School**	**We may see** attachment difficulties, delayed speech and underdeveloped social skills. , withdrawn and sad, or overly friendly and seeking affection. frustrations, , focussed on TV, not toilet trained. I would see few toys unable to play

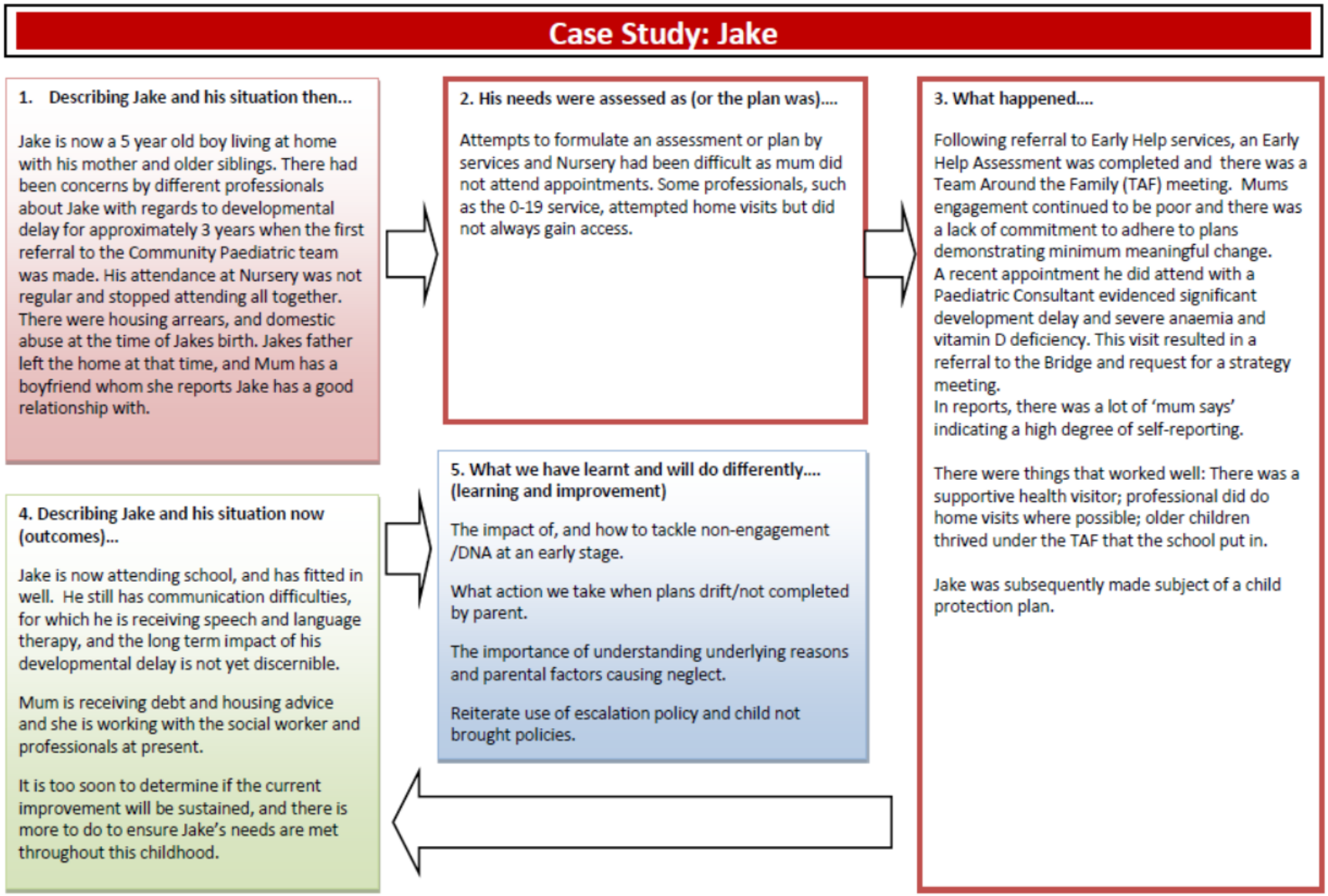
I struggle to get people to understand what I need. I cry a lot and I am scared. Sometime mum and dad hug me, but then they will shout. I don't know what they want from me. Sometimes the medication I need runs out and I don't feel well. My parents let me watch TV or use their phone or ipad to keep me busy. I don't have many toys. No-one plays with me.	**We would** all try to understand what life is like for you? Notice and 'listen' to all the cues and ways you have to signal how you feel. Consider carefully if you have what you need to be safe? well? and thrive? Do you have the love you need from those around you, do your caregivers respond to your needs so that you feel secure? Can you learn and develop through play having fun and feeling valued? Do you know what's happening through your day or is it confusing and unpredictable? We will think about your needs and do everything we can to make sure they are met. **As a Health Visitor** I will monitor how you are growing and learning and try to understand how you feel. I will share information and support your parents to meet your needs. We will look at your development together using questionnaires and tools to check how you are doing and I will offer advice or referral if you need more help.
 **School Age** I am not ready for school. I have had lots of different schools and its hard to make friends. I am often late or don't go at all as mum does not get me out of bed on time and I have to get my own breakfast, and I don't want to go. Especially there is something special going on which I can't do. The other children call me smelly. I don't know how to use the toilet like the other children. I don't have a nice bag like some children. I can sometimes be very tired, as I go to bed when I want and when I do, I can't sleep as my bed is uncomfortable and I am cold and my brothers and sisters sleeping in the room keep me awake. I don't know who is picking	**We may see** poor school attendance or lateness, including a child who is 'invisible' to services through home schooling for the wrong reasons. We would see children absent or not prepared for special events like book day, fancy dress or seasonal events and trips. Poor self-help skills, lack of routine, unhealthy food and drinks, inappropriate language and concentration. Lack of parental engagement. **We would all** understand the impact of not attending school or an education provision and work with others to encourage or plan for this. We would liaise with other professionals, support the family. **As a school,** I will support the family and take action when the child does not attend or is late for school. I will observe 'issues of concern'. I will identify at a low level additional needs, recognise vulnerability. I look for patterns, and flay and challenge what this is telling me. **As a paediatric nurse,** I will signpost to other services if needs or concerns are identified, discuss the child with services to ensure concerns are discussed. **As a health visitor** I will see families in their home and liaise with schools and would challenge whether intentional or unintentional neglect.

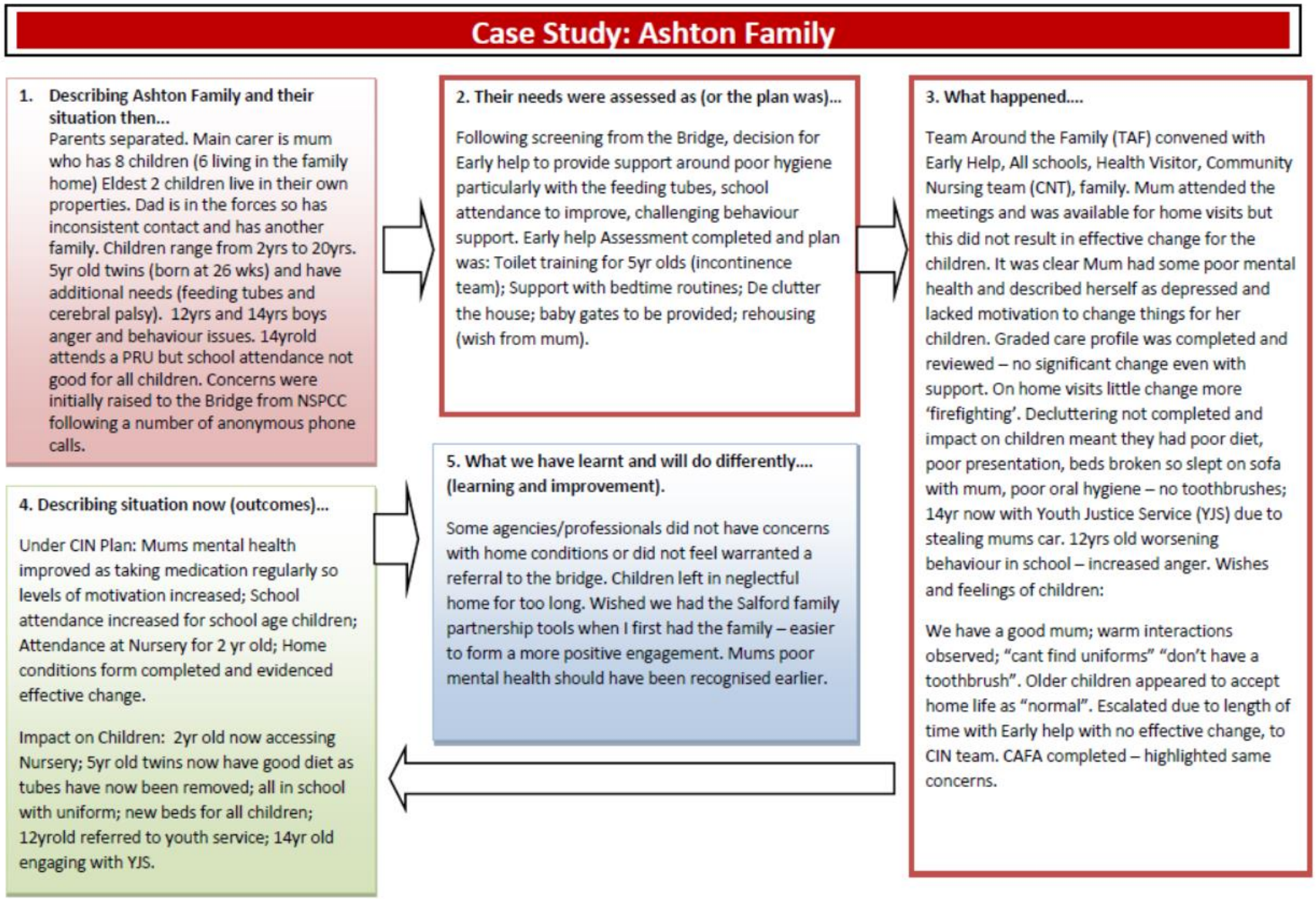
me up after school. I am very hungry by the time school finishes. I have head lice a lot and they itch and hurt.	
 **Adolescent / Young person** I don't want to talk to people and wish they would butt out and leave me alone. I feel everything and nothing and have got used to fending for myself. I can't even have somewhere to crash out as I share a bedroom with my two younger brothers and I let them sleep in the bed, and I sleep on the mattress on the floor. At least we have a house, last year we had to leave our old house when the bailiffs came. They are always shouting and ignore me. I have to get my own tea. If I am lucky parents give me money to go to the chippy. Some days, I feel like I am worthless. I know my parents don't love me. I will find someone who wants me.	**We may see** poor or lack of school uniform, refusal to attend school, late or withdrawn from school. Low self-esteem, mental ill-health and self-harm, eating disorders, including young people who put a mask on their emotions. We see young people who are vulnerable to getting into difficulty and exploited, at risk of CSE, CCE, radicalisation, gang association. We may see young people who run away from home. **We would all** recognise that you might show how you feel in lots of different ways – we will listen to you and try to understand. We will value your feelings and what you tell us. We will be open and honest with you and do what we say we will do. We will ask how you are and listen to what you say. If we are worried about you we will talk to you about what's happening and let you know if we need to let anyone else know so we can work together to make sure your needs are met.
 **Parents** I'm trying my best. You have no idea how hard it is to	**We may see** someone who is struggling, up and down, sad or angry in 'freeze or fight'. Parents who haven't had their own needs met and need help with immediate problems like debts, housing and money. Parents who are struggling with depression and anxiety. Parents who are living with domestic abuse. Parents who are having a hard time and don't know who to trust or ask for help. **We would** all help parents to recognise the impact of their circumstances, and create a

care for my kids, just doing the stuff that people think is easy like getting them up and in uniform and out the door fed in the morning when I feel like I can't face getting up and it's another day. I'm tired and I'm skint and I can't ask for help because all people do is judge me, for being a young parent, for not managing my money when there's not enough money to manage, for being late, for my kid having the wrong colour cardigan or no kit, like that even matters…I'm drowning and I love them.	culture where parents feel able to ask for help.

Appendix C: Case Studies – understanding the child's journey and learning from individual experiences




Case Study: Jake
1. Describing Jake and his situation then...
Jake is now a 5 year old boy living at home with his mother and older siblings. There had been concerns by different professionals about Jake with regards to developmental delay for approximately 3 years when the first referral to the Community Paediatric team was made. His attendance at Nursery was not regular and stopped attending all together. There were housing arrears, and domestic abuse at the time of Jakes birth. Jakes father left the home at that time, and Mum has a boyfriend whom she reports Jake has a good relationship with.
2. His needs were assessed as (or the plan was)....
Attempts to formulate an assessment or plan by services and Nursery had been difficult as mum did not attend appointments. Some professionals, such as the 0-19 service, attempted home visits but did not always gain access.
3. What happened....
Following referral to Early Help services, an Early Help Assessment was completed and there was a Team Around the Family (TAF) meeting. Mums engagement continued to be poor and there was a lack of commitment to adhere to plans demonstrating minimum meaningful change.
A recent appointment he did attend with a Paediatric Consultant evidenced significant development delay and severe anaemia and vitamin D deficiency. This visit resulted in a referral to the Bridge and request for a strategy meeting.
In reports, there was a lot of 'mum says' indicating a high degree of self-reporting.
There were things that worked well: There was a supportive health visitor; professional did do home visits where possible; older children thrived under the TAF that the school put in.
Jake was subsequently made subject of a child protection plan.
4. Describing Jake and his situation now (outcomes)...
Jake is now attending school, and has fitted in well. He still has communication difficulties, for which he is receiving speech and language therapy, and the long term impact of his developmental delay is not yet discernible.
Mum is receiving debt and housing advice and she is working with the social worker and professionals at present.
It is too soon to determine if the current improvement will be sustained, and there is more to do to ensure Jake's needs are met throughout this childhood.
5. What we have learnt and will do differently.... (learning and improvement)
The impact of, and how to tackle non-engagement /DNA at an early stage.
What action we take when plans drift/not completed by parent.
The importance of understanding underlying reasons and parental factors causing neglect.
Reiterate use of escalation policy and child not brought policies.


Case Study: Ashton Family
1. Describing Ashton Family and their situation then...
Parents separated. Main carer is mum who has 8 children (6 living in the family home) Eldest 2 children live in their own properties. Dad is in the forces so has inconsistent contact and has another family. Children range from 2yrs to 20yrs. 5yr old twins (born at 26 wks) and have additional needs (feeding tubes and cerebral palsy). 12yrs and 14yrs boys anger and behaviour issues. 14yrold attends a PRU but school attendance not good for all children. Concerns were initially raised to the Bridge from NSPCC following a number of anonymous phone calls.
2. Their needs were assessed as (or the plan was)...
Following screening from the Bridge, decision for Early help to provide support around poor hygiene particularly with the feeding tubes, school attendance to improve, challenging behaviour support. Early help Assessment completed and plan was: Toilet training for 5yr olds (incontinence team); Support with bedtime routines; De clutter the house; baby gates to be provided; rehousing (wish from mum).
3. What happened....
Team Around the Family (TAF) convened with Early Help, All schools, Health Visitor, Community Nursing team (CNT), family. Mum attended the meetings and was available for home visits but this did not result in effective change for the children. It was clear Mum had some poor mental health and described herself as depressed and lacked motivation to change things for her children. Graded care profile was completed and reviewed – no significant change even with support. On home visits little change more 'firefighting'. Decluttering not completed and impact on children meant they had poor diet, poor presentation, beds broken so slept on sofa with mum, poor oral hygiene – no toothbrushes; 14yr now with Youth Justice Service (YJS) due to stealing mums car. 12yrs old worsening behaviour in school – increased anger. Wishes and feelings of children:
We have a good mum; warm interactions observed; "cant find uniforms" "don't have a toothbrush". Older children appeared to accept home life as "normal". Escalated due to length of time with Early help with no effective change, to CIN team. CAFA completed – highlighted same concerns.
4. Describing situation now (outcomes)...
Under CIN Plan: Mums mental health improved as taking medication regularly so levels of motivation increased; School attendance increased for school age children; Attendance at Nursery for 2 yr old; Home conditions form completed and evidenced effective change.
Impact on Children: 2yr old now accessing Nursery; 5yr old twins now have good diet as tubes have now been removed; all in school with uniform; new beds for all children; 12yrold referred to youth service; 14yr old engaging with YJS.
5. What we have learnt and will do differently.... (learning and improvement).
Some agencies/professionals did not have concerns with home conditions or did not feel warranted a referral to the bridge. Children left in neglectful home for too long. Wished we had the Salford family partnership tools when I first had the family – easier to form a more positive engagement. Mums poor mental health should have been recognised earlier.