15 January 2018

Martin Gray, Director of Children's Services, Stockton-On-Tees Borough Council
Ali Wilson, Executive lead of the CCG
Barry Coppinger, Police and Crime Commissioner for Cleveland
Simon Nickless, Temporary Chief Constable of Cleveland Police
Miriam Sigsworth, Manager, Stockton-On-Tees Youth Offending Team
Bronwen Elphick, Chief Executive Officer, Durham Tees Valley Community Rehabilitation Company
Linda Marginson, North East Divisional Director, National Probation Service
Dave Pickard, Chair of Stockton-On-Tees LSCB

Dear **local partnership**

Joint targeted area inspection of the multi-agency response to abuse and neglect in Stockton-On-Tees

Between 20 and 24 November 2017, Ofsted, the Care Quality Commission (CQC), Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) and HMI Probation (HMI Prob) undertook a joint inspection of the multi-agency response to abuse and neglect in Stockton-On-Tees.[1] This inspection included a 'deep dive' focus on the response to children experiencing neglect. This letter to all the service leaders in the area outlines our findings about the effectiveness of partnership working and of the work of individual agencies.

The joint targeted area inspection (JTAI) included an evaluation of the multi-agency 'front door' for referrals: when children who may be in need or at risk of significant harm become known to local services. In this JTAI, the evaluation of the multi-agency 'front door' focused on children of all ages who are being or have been neglected. Also included was a 'deep dive' focus on children between seven and 15 years old who have been neglected. This group of children will be referred to as 'older children' for the purpose of this letter. Alongside this, the inspection considered the effectiveness of the multi-agency leadership and management of this work, including the role played by the local safeguarding children board (LSCB).

The local partnership of agencies has a strong shared commitment to tackling neglect. This commitment is within a wider context of increasingly effective multi-agency arrangements to address abuse and to enhance the welfare of children. This is exemplified by the developing children's hub, which acts as the 'front door' for

[1] This joint inspection was conducted under section 20 of the Children Act 2004.

referrals for children who may be in need or at risk of significant harm, and by a comprehensive early help offer for children and families. Partners have a keen awareness, not only of what they are doing well but also of those services which need further development. Against this background of shared commitment, action by partner agencies to tackle neglect is a work in progress. Measures such as the ongoing roll-out of a nationally respected, child-centred and outcome-focused model of working with children and families and a well-regarded evidence-based tool for identifying neglect are making a positive difference, but not currently at the level to which local agencies aspire. However, with these initiatives and other measures, such as a well-considered LSCB 'statement of intent' to tackle neglect, the partnership has put in place many of the key building blocks necessary to support further progress.

Key Strengths

- In addition to the LSCB conference, statement of intent, neglect training and roll-out of the evidence-based tool for identifying neglect, individual agencies are focused on enhancing the knowledge and skills of front line staff to tackle neglect. Recent initiatives include the local authority's 'topic of the month' focus on adolescent neglect in August and September, neglect training delivered in termly forum meetings with school-designated safeguarding leads and quick awareness-raising measures, such as Cleveland police's child neglect screensaver. Alongside the roll-out of the neglect assessment tool, the ongoing adoption of the family work model across agencies is beginning to support a sharper focus on both neglect and the lived experiences of children. During the inspection, inspectors saw the assessment tool being embraced by voluntary sector groups, and being used with confidence by some school safeguarding leads to identify neglect.
- The partnership shares a learning culture that supports continuous improvement, not only through the work of the LSCB but also through external peer review. For example, recent reviews undertaken by another local authority and a well-respected national charity are helping to inform the ongoing development of the children's hub and the early help offer.
- The LSCB has a strong and independent identity. This means that challenges to agencies that arise from the board's monitoring and scrutiny role carry a sufficient degree of authority to ensure that the agencies respond positively and work to address areas of weaker practice. This is modelled by the chair, whose strong and effective leadership has played an important part in developing the influence and efficacy of the board, including when it comes to tackling neglect. For example, recent challenge has enhanced the multi-agency domestic abuse strategy's focus on children and helped to ensure a very significant improvement in police attendance at strategy discussions. Important as the role of the chair is, this healthy culture of challenge is progressively embedded in all aspects of the functioning of the board. Recent examples of this include 'thematic challenges' on

safeguarding in education and on the extent to which agencies have ensured that their staff understand and apply the threshold document. This approach is increasing awareness of, and focus on, neglect, but has the capacity to have a greater impact over time.

- The board has been effective in ensuring that staff across agencies are aware of the learning from the 'child H' serious case review (SCR), in which neglect was a significant feature. The learning from this review was an important factor in changing the recording by health agencies from 'did not attend' to 'was not brought' when parents do not bring children to appointments. This small change in language is an important indicator in identifying when children's needs are possibly being neglected by parents or carers.
- The comprehensive early help offer is well supported by agencies across the partnership. A broad range of professionals take on the 'lead professional' role, coordinating 'teams around the family'. Services are targeted well to the needs of particular groups, for example in the bringing together of youth offending service and targeted youth support (TYS) staff to create a new service for young people. This includes older children experiencing neglect who may be on the edge of education and lacking sufficient parental care and oversight.
- The children's hub benefits from the engagement of a broad range of professionals and agencies. The very large majority of children benefit from timely and appropriate decisions in response to concerns for their welfare or safety. Inspectors saw no examples of decisions that left children at immediate risk of significant harm. They were particularly impressed by the video conferencing being used to support timely child protection strategy discussions that involve the right professionals. This supports decision-making that is well-matched to children's individual levels of need and risk. Attendance by the right range of professionals is of particular importance when identifying the risk and impact of chronic neglect on older children. In these complex situations, risk of neglect can be more difficult to identify when it sits alongside more acute and immediate concerns, such as parental mental ill health or children's own challenging behaviours.
- The Vulnerable, Exploited, Missing and Trafficked approach (VEMT) shows the partnership's considered and effective approach to child protection, particularly for vulnerable adolescents. Inspectors saw a number of examples of this approach being used well to intervene and protect children experiencing neglect.
- Strong and effective leadership in the local authority's children's services drives the development of child-focused practice in response to neglect. The director of children's services has a thorough grasp of strengths and areas for development across the range of services for children. Effective engagement with partner agencies at a strategic level means that the local authority is progressively exercising system leadership that is enhancing services for children.

- The local authority has a mature and successful approach to workforce management. Effective workload management ensures that social work caseloads are largely manageable. The council is investing in supporting its social workers in more flexible working through the provision of tablets and smart phones. As a result of this and other measures, such as 'step-up to social work', 'frontline' and a regional cap on agency social work pay-rates, it has secured a stable and appropriately experienced workforce. Children do not often experience changes of worker and their social workers are able to visit them regularly. As a result, they are able to build relationships of trust that help achieve better outcomes for them. This is particularly important for older neglected children who may have poor emotional health and be harder to reach. The local authority's 'S Work Project' sets out a well-thought-out framework for supporting and developing its social work resource for the future.
- A good development package for social workers includes formal training, less formal drop-in sessions and good access to a range of online research through a respected national provider. With a strong focus on neglect, and on enhancing child focus and analysis through the family work model, this is helping to ensure that social workers have the right skills and knowledge. Although further progress is required, the local authority's own systemic audits and the evidence seen by inspectors show that more recent practice is making more consistent and better use of the family work model to tackle neglect.
- The council plan and children's services strategy for 2017 to 2020 are well aligned, with a clear set of priorities and a strong focus on the most vulnerable children. Both documents contain an explicit focus on neglect and on its causal links with the 'toxic trio' of parental mental ill health, drug, alcohol and substance abuse and domestic abuse. This provides a foundation for creating an environment in which good practice and improved outcomes are more likely. These plans are, however, very recent and any impact is necessarily limited at this early stage.
- Although neglect is not a specified priority, it is recognised as a cross-cutting theme in the Cleveland police and crime plan. In 2016, £2 million of additional funding provided by the police and crime commissioner led to increased resources in specialist teams, including those responsible for delivering child protection. This financial commitment, now well-embedded in enhanced staffing, is matched by the drive of senior police leaders to enhance working practice across the partnership, with a strong focus on protecting vulnerable people, including older children who are suffering neglect. The introduction of an additional detective chief inspector specialist crime role is strengthening the force's ability to manage demand and risk more effectively. This will help to provide senior leaders' oversight and focus on children at risk.
- Cleveland police have developed and delivered training called 'Through the eyes of the child'. This has been designed to help frontline officers and staff to identify risk more effectively, and at the earliest opportunity, by capturing and evaluating

the views of children who are affected by incidents of domestic abuse, an area of concern that has a strong correlation with neglect. This has the capacity to help improve the assessment and prioritisation of risk and as a result the service provided to children, young people and adult victims. The police 'adopt a shift' initiative, giving sergeants from specialist teams responsibility for facilitating learning and interaction between frontline resources and those specialist teams, is part of a continuous improvement drive.

- Police leaders have worked hard to ensure the force control room is providing frontline officers with information concerning children at risk while they are en route to addresses to deal with incidents. By providing officers with this information, they are better able to assess any cumulative risk factors for children, including from neglect.
- The National Probation Service (NPS) has developed a range of tools to strengthen its management of child safeguarding, including neglect. These include audit tools and a safeguarding risk register, both of which help to identify trends and inform improvement. A form updated with the children's hub is helping to ensure that it has relevant information when it receives requests for information from the NPS and Community Rehabilitation Company (CRC).
- Despite the main organisational focus of the NPS being on adults, protecting children from neglect has been recognised by the organisation as an important aspect of its safeguarding role. NPS practitioners attend LSCB safeguarding and family work training, and NPS training on vulnerability, exploitation and neglect. Despite stretched resources limiting senior managers' ability to attend LSCB meetings, they ensure that initiatives to enhance learning and development with regard to safeguarding children are prioritised.
- The CRC is aware that its performance at a strategic and practice level requires improvement in this important area of work. It has begun to implement measures to support better outcomes in cases involving neglect. Examples include a strengthened management structure to enhance strategic leadership and the recent introduction of a quality team. Recent indicators of improvement include improved attendance at LSCB meetings and the completion of a quality audit.
- Governance arrangements in the clinical commissioning group (CCG) help ensure good oversight of safeguarding arrangements in the provider services that it commissions. The CCG is actively involved in partnership working at a strategic level and leads on a number of areas of work related to neglect. Designated and named health professionals provide effective and valued leadership to their professional colleagues and the wider partnership.
- Good progress has been made to engage dentists in the safeguarding agenda. For example, the targeted approach for children with the highest level of dental cavities, seen through their prioritisation for fluoride varnish treatment, is a positive initiative. This has led to positive engagement with dental practices by school nurses and health visitors. Inspectors heard clearly from dentists that they

have a role to play in using their specialist skills to identify neglect. Following on from this, it is positive that NHS England has discussed with the local authority how integration in this area of work can be better-supported.

- Midwifery services have recently started a universal service visiting all pregnant women at home during their second trimester. These visits are undertaken by a midwifery care assistant with additional training. They provide an important opportunity to engage with women and consider how they are preparing for their parenting role, any vulnerabilities and whether early help is needed.
- The 0–19 service commissioning arrangement, although targeted at those in greatest need, has retained elements of a universal offer. This is especially evident in strong school nursing provision. School nurse advice and information is readily available to parents and professionals, and inspectors saw many cases where nurses were working well with children to advocate for their well-being.
- The children's hub is providing an effective integrated response to concerns about children at risk of neglect. Decision-making is timely and well informed by multi-agency information sharing. Operation encompass ensures that schools are aware of domestic incidents at pupils' homes and has led to children and families being put in touch with appropriate services, including therapeutic support for children.
- Inspectors saw evidence of effective multi-agency work with children at risk of going missing and at risk of exploitation. A wide range of partners participate in the monthly vulnerable practitioners group (VPG) including child and adolescent mental health services (CAMHS). An increasing number of children are benefiting from return interviews. At the time of the inspection, 75% of children who had been missing had received a return home interview.
- Partners attend a family work model meeting alongside families at the start of assessments and before initial child protection conferences, to identify concerns and any immediate steps required. This supports sharper and more child-focused identification of need and means that, for children at risk of neglect, there is now more rapid improvement in home conditions and having their assessed needs met.
- The developing use of the neglect assessment tool is increasingly informing planning for children at risk of neglect. It is being used to support parents to recognise the needs of their children and is informing better multi-agency decision-making. This commitment to increasing the use of the neglect assessment tool is reflected in the training of large numbers of practitioners across agencies in the use of this tool, including school pastoral staff.
- Children in Stockton-On-Tees can access early help services in their communities. There is effective support for universal services to lead targeted help in a way that is not stigmatising for families. Inspectors saw examples of how this is addressing neglect at different levels for children, particularly for those with parents with mental ill-health, with problems with alcohol use or in abusive adult relationships.

- Children at risk of significant harm are protected through prompt decision-making at strategy meetings. In all examples seen, the key professionals were active participants, facilitated by the effective use of video technology. For children at risk of neglect, meetings draw on previous family history.
- The local authority has taken important steps to help social workers address the challenge of engaging parents when the risk of neglect has been assessed. This includes funding new qualified social work roles of 'step across' and early help workers. These professionals work with families subject to assessment alongside the child's allocated social worker and can remain involved should statutory social work involvement in the children's cases close. Early feedback from parents is positive.
- Cleveland police have now started using authorised professional practice in relation to missing children and no longer use the 'absent' category. This means that risks for children who go missing are assessed more accurately. All missing children's cases are reviewed on a daily basis by missing person coordinators within the VEMT team. It is their role to liaise with partner agencies, build a rapport with the child and use a problem-solving approach to try and reduce the missing episodes. While there is a formal policy that a child subject of three missing episodes within a 90-day period is allocated to a missing person coordinator, any episode that has a cause for concern also triggers further work. Inspectors saw evidence that coordinators recognise that children who are regularly missing may be at risk of neglect.
- Unlike NPS and CRC, YOS staff have access to the local authority's electronic children's case recording system. Inspectors found that this supports a swifter and more consistently effective process for safeguarding checks.
- A new specialist worker role for pregnant women in the Change Grow Live (CGL) substance misuse service has resulted in closer working with midwifery, including a joint antenatal clinic. As a result, some pregnant women who have engaged sporadically with substance misuse services in the past are now well engaged with support. Their better understanding of the impact of substance abuse and parental neglect on the development of their unborn babies has given some of these women greater motivation and ability to stay clean.
- There is a good local public health school nurse offer and school nurse information is readily available to child protection strategy meetings. The provision of a school nurse with a defined lead for elective home educated children (EHE) is helping to ensure that the needs of this cohort are identified and addressed when neglect may be a concern. The positive and well-established relationships between school nurses and dental practitioners provide a good opportunity to engage practices more strongly in safeguarding arrangements.
- Most GP practices hold regular multi-agency vulnerable families meetings. All GP practices have an identified link health visitor and adult alcohol misuse practitioners. Additionally, adult mental health practitioners regularly hold clinics

in practices. This ensures that there are good opportunities to share information and concerns about families with which neglect may be a concern.

- Once children and young people have been accepted for a CAMHS service, their access to these services is timely, with most young people having their mental health needs assessed through an initial appointment within four weeks. This means that young people who are experiencing mental health difficulties have prompt access to therapeutic intervention.

Case study: highly effective practice

Strong partnership working and timely and effective intervention to tackle neglect have resulted in significantly improved outcomes for Mark, a highly vulnerable seven-year-old boy who had been living with serious and chronic neglect.

A prompt and comprehensive referral to the children's hub by his school identified significant concerns about neglect for Mark. The subsequent social work assessment further substantiated these risks. It set them in the context of his wider needs and family circumstances and clearly highlights the impact on Mark of living with neglect. This led to swift and appropriate decision-making and intervention by a well-coordinated range of agencies to ensure his safety and promote his welfare. Recent child protection planning has been effective and focused on both current and historic risks. This led to a timely decision for Mark to come into the care of the local authority as a child looked after, which means that the impact of neglect on Mark's life has now been recognised and understood and action taken has improved his current life experience and future prospects.

The way that professionals from different agencies worked together, in particular his school and his social worker, to make sure that Mark was safe and to improve his present and likely future circumstances has been highly effective. The school were instrumental in escalating recent concerns and, in conjunction with the social worker, identified the harmful impact of neglect on Mark in his daily life. This has meant that Mark is now thriving and receiving the support that he needs in school and in his foster home.

Areas for improvement

- There is a lack of resilience in some of the partnership teams within the children's hub. Staff sickness and capacity issues caused health services to become virtual partners for several months, while workload pressures mean that police child protection support officers regularly carry out work from the central protecting vulnerable people support team (PVP). This has created delay in considering the cases of a few children. Some professionals, such as CAMHS and probation staff, are either not fully integrated or are virtual partners. This means that their valuable professional judgements and information are not always best used to support decision-making.
- The attendance of children at child protection conferences is not at the level it could be. Between April and September 2017, just eight of 222 children who could have attended did attend. Work to improve this is underway, but is currently at too early a stage to have had an impact.
- The children and young people's plan 2015–18 is coming to its end and is not well aligned with current strategic priorities or multi-agency bodies. Multi-agency strategic partnerships are strong, supporting service-specific collaborations such as the children's hub, CAMHS and the 0–19 service redesign. However, the local area lacks an up-to-date multi-agency plan that sets out the shared aspiration of agencies for children, against which services can be planned, commissioned and progress measured. An updated Health and Wellbeing Board strategy and multi-agency strategic plan for children would further enhance the ability of the partnership to deliver effective services for children.
- The current joint strategic needs analysis (JSNA) does contain relevant information about vulnerable children. However, much information dates from 2013–14 or earlier, and wider information to support understanding of risk to children and the commissioning of services is absent in some key areas. Agencies have understood this and are working on a refresh of the JSNA. Better structured to focus on unmet need and supported by current information and analysis, this work is intended to provide a solid foundation for commissioning and assessing the impact of services going forward. A September 2017 overview of levels of need and services to tackle child sexual exploitation exemplifies this approach.
- Regular supervision and management oversight of social work practice means that, for most children, progress in improving their welfare is tracked closely. Support and guidance helps social workers to take effective alternative action if this stalls or their welfare deteriorates. However, inspectors found that the supervision and managerial overview was less effective for children suffering from neglect who are being supported through a child in need plan. This matches the local authority's own recent audit finding that nearly a third of children subject to child in need plans were experiencing delay.
- Despite the helpful breadth of information presented, the children's services performance framework lacks sufficient analysis and qualitative audit and

feedback information to best support interventions to tackle weaker performance. Not making the best use of the wealth of information available is making it more difficult for senior managers to have a clear line of sight to frontline practice. For example, although decisive action taken to address poor performance in the provision of return home interviews has led to significantly improved take up of interviews, further improvement is needed in the oversight of this work before the local authority can be confident that children are consistently receiving timely interviews that accurately assess risk. The new children's continuing improvement framework (planned for implementation from December 2017 onwards) recognises the need to make better use of data and, alongside enhanced analysis and use of audit and children's feedback, use it to drive improvement.

- Although there is evidence of a shift in the police towards a more explicit focus on the reduction of risk and vulnerability, this has not yet been translated into consistent improvements in operational delivery across all areas of practice where the police come into contact with children. Much of the work to improve is at a very early stage or not yet fully implemented and, as a consequence, the intended benefits have not been fully realised.
- While it is positive that Cleveland police have developed additional training for officers, inspectors found that inconsistencies remain in the quality of child safeguarding decision-making at the frontline, including when children are suffering from neglect. Incidents are often dealt with in isolation rather than consideration being given to the previous history of incidents and the wider context of the children's vulnerability. Further action is needed to ensure that officers consistently recognise children in need of intervention.
- The police Niche electronic information system allows the use of flags to highlight areas of vulnerability. However, when a child has previously been subject to a child protection plan or when they are a child in need, flags are not routinely used. This may impede risk assessments being made by officers for children experiencing neglect, for example when they give insufficient consideration to signs that the behaviour of some children may be linked to vulnerability and potential neglect issues.
- Senior leaders, supervisors and managers in the police are not currently able to test the effectiveness of practice at every stage of a child's engagement with the service. While multi-agency audits are used to evaluate the effectiveness of practice, this is not replicated on a single-agency basis within the police. The absence of routine scrutiny of the nature and quality of decision-making is inhibiting the potential to strengthen intervention with children.
- Cleveland police are experiencing difficulties in managing demand linked to vulnerability and in the protection of children in particular. This needs close monitoring to ensure that staffing levels in the PVP and children's hub remain appropriate to demand in order to provide assurance that the level and quality of police contact with children at risk remains sufficient.

- There is no process within the police to ensure compliance in the submission of referral forms when a child may be in need or at risk of significant harm. There is no supervisory oversight of the process, which is wholly reliant on individual officers submitting the relevant form after they have dealt with an incident which has given rise to concerns for a child's welfare. Some checking mechanisms exist, linked to the submission of referral forms for children who are affected by domestic abuse. However, this approach is not taken in cases that involve other child safeguarding matters. This gap means that children are potentially being exposed to protracted periods of risk without the appropriate intervention from key agencies, such as the local authority.
- Although current CRC cases in which there are child safeguarding concerns are assigned to qualified probation officers, there are no systems in place to raise the profile of neglect and ensure that practitioners have sufficient knowledge to consistently recognise neglect, understand levels of risk and make appropriate referrals to the children's hub.
- Current national guidance has reduced the number of, and time provided for the preparation of, court reports and to pass child safeguarding information to the probation service managing the sentence. This has a negative impact on the quality of child safeguarding information provided to prisons, particularly in cases managed by the CRC, potentially leaving children at risk of harm. The CRC's 'through the gate' team includes qualified probation officers, increasing the potential to identify child safeguarding issues during a prisoner's induction to custody. Family support provided through the presence of the north east prisoners after care service (NEPAC) at the time of release provides the opportunity to observe family dynamics and identify child safeguarding issues. However, the CRC does not have a system in place to assure itself of consistent identification of child safeguarding concerns in custodial cases.
- Arrangements supporting information sharing between the YOS and probation services do not always work effectively. More effective mapping of families working with both adult services and the YOS is needed to help identify and analyse any indicators of harm and to enhance work to safeguard children.
- Safeguarding arrangements and quality assurance processes within health organisations are generally robust. However, the evidence to measure the impact on children, especially those suffering neglect, is less well developed across these services.
- Agencies are not sharing information sufficiently in some cases when a child becomes a 'child in need'. As a result, strategic and managerial leads within health services cannot always be assured that those children supported by the local authority as children in need due to neglect are known to the health services. This is both a potential deficit in joint working to support individual children and their families and a strategic gap in understanding how best to shape services for this cohort of vulnerable children. Additionally, data

inaccuracies in a few areas mean that neither health organisations nor the wider partnership always have a fully accurate understanding of practitioner safeguarding activity. Work is in hand to correct this, but was not yet implemented at the time of the inspection.

- Work is progressing through the named GP to support primary care services in their understanding of the impact of neglect on children and young people. A number of initiatives have been undertaken through training and practice visits. Primary care settings will benefit from continued guidance to support a consistent approach to safeguarding practice and focus on identifying neglect.
- Multi-agency information sharing and decision-making is generally effective, although this is not consistently the case for all agencies. For example, dental practitioners recognise that they have a key role in identifying early signs of neglect. They are keen, able and willing to play a full role in safeguarding arrangements, but they are rarely included in relevant meetings. Further to this, the CRC report that, due to a lack of understanding of their distinct and separate role from the NPS, they are often omitted from the list of invitees to children's meetings at which they could add significant value. Although inspectors did see positive evidence of referrals, risk assessment and intervention by both NPS and CRC in cases in which there were potential risks to children, their status as a 'virtual' partner within the children's hub and the lack of clear understanding of their distinct roles by some partner agencies means that this remains an area for continuing scrutiny.
- While a process has been agreed to support NPS information requests from the children's hub at the pre-sentence stage of work with adult offenders, officers described difficulties in receiving timely information in practice. Although no specific examples were seen by inspectors, these delays have the potential to lead to sentences being imposed without full consideration of children's needs.
- The pathway for the children's hub to obtain information about adults using mental health services is not working effectively. Adult mental health professionals are not always invited to children's meetings when their presence could add value. As a result, information about a parent's mental health does not always inform plans to address the neglect of children.
- The use of evidence-based tools and structured models of intervention are not yet sufficiently well-established across all agencies. The local authority is making good use of the family work model in more recent assessments, child protection conferences, core groups, child in need meetings and the plans that arise from them. This means that meetings are inclusive, involve parents well and incorporate strengths and weaknesses. However, children are not as well involved in these meetings so that, despite the strong child focus within the family work model, their voices are not always as well heard as they could be. Children's heritage and cultural identity is not consistently well considered in assessments and does not sufficiently inform the support they receive. Lack of adequate

consideration of these key elements of children's identity and daily lived experience limits the effectiveness of work to enhance their welfare.

- When neglect concerns for children reach an acute stage, responses to improve their safety are almost always appropriately swift. However, lower level concerns about children are not always shared in a timely way, either by not being passed to the children's hub or not being shared between agencies. This means that there are missed opportunities to see patterns of incidents and changes in children's presentation over time. Additionally, there is no current systematic information sharing about domestic abuse incidents with key health providers, such as GPs and community health services.
- Specific risks which could indicate children are suffering from chronic neglect are not always recognised by the children's hub. A lack of focus on the lived experience of a small number of children has meant that the needs of parents receive the greatest attention. The voices of children, increasingly well-captured in referrals are 'drowned out' by adult needs in a very few cases. More work is needed to understand how to manage the difficult balance between addressing the needs of children suffering chronic neglect and seeking parental consent and engagement.
- Steps taken by the local authority have improved the feedback that the children's hub provides on referrals. However, partner agencies report that there is still some way to go to ensure that this happens consistently. Core group minutes are not distributed to partners quickly enough, so that professionals may not know the latest actions to support children and parents.
- Children's chronologies within local authority electronic case files are not yet of a consistent quality to be effective tools in identifying patterns of neglect and tipping points at which the impact of neglectful parenting becomes harmful for children. Although the local authority has identified this through its own audits, and is mindful of this in its work to develop a new social care database, the completion and use of chronologies remains an area for development.
- Some children's plans, in particular child in need plans, are not sufficiently explicit about what needs to change for children. This makes them less effective as tools to drive and measure real change in the quality of care for children. Inspectors saw several examples in which needs were framed in the context of what services would be accessed, and in which needs that do not 'fit' with an available service were overlooked or dealt with in a superficial way. A lack of professional curiosity, including not looking at living conditions upstairs in the family home, was evident in some cases. In one child's case, this meant acute neglect was not identified soon enough.
- Partner agencies are not consistently made aware of children living in potentially neglectful environments by Cleveland police. The police have made a decision not to re-risk assess 580 'standard risk' domestic abuse incidents. These incidents have been subject to a triage process that is said to capture, for example, any

children living with domestic abuse. If a referral has not been submitted by the reporting officer at the time of dealing with the incident, the child protection support officer within the PVP hub, acting as a gatekeeper, should complete one. Inspectors sampled records of 65 domestic abuse incidents from the backlog and saw a number of examples in which officers had completed a domestic abuse risk assessment form but not a referral form in relation to children. It was then unclear whether all had been subsequently referred to the children's hub. This was the case for two children's cases seen by inspectors.

- The daily search of closed domestic abuse incidents is reliant upon cases being closed within the control room with the code QL23. If incidents are closed with another qualifying code or they are not closed within the 24-hour period, there is a possibility that children might be missed and so not become subject to the operation encompass process.
- The child protection support officers within the PVP hub are expected to research the previous history of domestic abuse incidents. The sampling of this work by inspectors demonstrated an inconsistent approach, so that domestic abuse incidents are often considered in isolation with little recognition of the escalating risk for children and the negative impact this can have upon their emotional well-being.
- CRC risk assessments are not consistently well-focused on child safeguarding, including neglect. In weaker examples seen by inspectors, risk assessments were not sufficiently analytical. They lacked detailed information about the nature of the risk of harm to children and of specific risk factors in relation to neglect.
- Given the considerable expansion of the CGL service since August 2016, significant capacity pressures are impacting on the service's ability to migrate key information about children known to the service onto the children and families module in their new case recording system. Until this is completed, there is an elevated risk that key information about children is not well secured within the adult's case record or informing day-to-day child safeguarding practice. CGL managers are, however, aware of the priority and urgency of this task.
- Staff across health services acknowledge that communication and information sharing between frontline staff does not happen routinely outside of formal safeguarding meetings. Relapse indicators are developed as routine practice in adult mental health and substance misuse services. However, these are not shared with practitioners such as health visitors or school nurses. This means that these practitioners are not always equipped with the full information and this limits how effectively they are able to identify risk to children.
- Improving health visitors' performance on achieving the five key contacts of the healthy child programme is a key goal for service managers. Given the decommissioning of the specialist family nurse partnership service, the need to strengthen the early identification of children's needs that may by the result of neglect makes this a particularly important priority.

- Tees, Esk and Wear Valleys NHS Trust (TEWV) managers are aware that there is more to do with partner agencies to ensure that notification pathways work well and that the monitoring of practitioner attendance at child in need and child protection meetings is robust. Currently, managers cannot be fully assured that mental health expertise consistently informs child safeguarding decision-making in all cases in which children are known to be at risk.
- Dental practices do make referrals for children about whom they have concerns, but numbers of referrals are low in proportion to the size and complexity of needs of the communities they serve. Dental practitioners recognise that the level 2 safeguarding training that most undertake currently is not equipping them well to discharge their safeguarding responsibilities.

Case study: areas for improvement

A lack of coherent partnership working and the absence of a full and detailed assessment or sufficiently strong planning at a child in need level meant that the impact of neglect for John was not adequately addressed. As a result, he did not receive the right support to meet his needs from the relevant agencies, for example from child and adolescent mental health services and his school.

Each agency was working separately to try and meet John's needs. There was no shared understanding between agencies of what would be most helpful to support him and to ensure his medical and educational needs were well met. While the local authority assessment considers the wider issues of the quality of parenting and being part of a large group of brothers and sisters, it does not focus enough on the particular experience of neglect for John, or on his specific health and educational needs. A lack of meaningful engagement with John, to understand his wishes and feelings, has meant that his views, and those of his parents, have not informed assessment and planning well enough. As a result, a weak child in need plan is not well-focused on John's needs, does not sufficiently consider all relevant information from the full range of partner agencies involved, and the causes and impact of neglect have not been clearly enough identified and addressed. Very recent intervention by health agencies to address John's significant health needs and by the school have led to a more coherent and multi-agency plan to meet his complex needs.

Next steps

The director of children's services should prepare a written statement of proposed action responding to the findings outlined in this letter. This should be a multi-agency response involving NPS, CRC, the clinical commissioning group, and health providers in Stockton-On-Tees and Cleveland Police. The response should set out the actions for the partnership and, where appropriate, individual agencies.[2]

The director of children's services should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 18 April 2018. This statement will inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

Yours sincerely

Ofsted	**Care Quality Commission**
Eleanor Schooling National Director, Social Care	Ursula Gallagher Deputy Chief Inspector
HMI Constabulary	**HMI Probation**
Wendy Williams Her Majesty's Inspector of Constabulary	Helen Mercer Assistant Chief Inspector

[2] The Children Act 2004 (Joint Area Reviews) Regulations 2015 www.legislation.gov.uk/uksi/2015/1792/contents/made enable Ofsted's chief inspector to determine which agency should make the written statement and which other agencies should cooperate in its writing.