NSPCC

Realising the potential

Tackling child neglect in universal services

Alice Haynes

EVERY CHILDHOOD IS WORTH FIGHTING FOR
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Acknowledgements

Thank you to all the practitioners, children and young people involved in the research for giving their time so generously and for sharing their experiences with us.

Thank you to colleagues at the following organisations who offered advice and helped us reach our sample:

4Children
Guardian Teach
Institute of Health Visiting
Primary Care Child Safeguarding Forum (PCCSF)
Queen’s Nursing Institute
Royal College of Midwives
Royal College of GPs
School and Public Health Nurses Association (SAPHNA)
UCL Institute of Child Health
University of East Anglia

Thank you also to colleagues at the NSPCC – Chris Cuthbert, Helen Brookes, Denise Coster, Denise Derbyshire, Ginny Donnelly, Ruth Gardner, Lisa Harker, Dawn Hodson, Sally Hogg, Mandy Jones, Sarah Lambley, Sherry Malik, Chris McMullen, Charlotte Moss, Annemarie Newbury, Sue Proudlove, Gwynne Rayns, Aliya Saied-Tessier, Kate Stanley, Paula Telford and Fiona Westwood.
Executive summary

Introduction

Child neglect is a prolific and pressing challenge for policy makers, practitioners and society as a whole. It is the most common reason for a child to be on a child protection plan in England and can have a profound and long-lasting negative impact on a child’s development. There are currently substantial pressures on the child protection system and it is increasingly being required to act as an emergency service. We urgently need to find additional ways to get help to children as early and efficiently as possible.

Early help is about providing support as soon as a problem emerges at any point in a child’s life. Providing effective early help can prevent children from suffering unnecessary harm, improve their long-term outcomes, allow child protection services to be more available to provide intensive support and interventions, and is more cost effective than reactive services. We have a large and skilled workforce in universal services who, given the right ingredients of clear role expectations, adequate resources and access to quality training and supervision, have the potential to play a leading part in tackling child neglect as soon as possible.

We draw on a large and unique data source comprised of the views of 893 health visitors, school nurses, GPs, midwives, teachers and early years practitioners in England, as well as 18 children and young people, to explore:

- How universal services practitioners see their role and responsibilities in providing early help;
- What early help is currently provided in universal services;
- What barriers practitioners face to providing early help; and
- How services can be better supported to provide early help.

A model for the provision of early help in universal services

Drawing from this research, we propose a model for the way in which those working in universal services can provide early help for child neglect (see Figure 1).

Effective early help provision that tackles neglect at the earliest possible stage requires universal services practitioners to:

- Identify parental risk factors for neglect or neglect itself;
- Understand the child’s unmet need by talking to the child, their parents and other practitioners — this in turn requires practitioners to have the opportunity and be equipped to develop relationships;
- Assess the child’s and parents’ needs and formulate a plan through a formal or informal assessment, to identify which services might be best placed to help a child or family, within or external to universal services;
- Address the child’s needs through directly providing practical and/or emotional support where possible (continuing to develop and maintain relationships with the child and/or parent), and/or through signposting to other services or agencies if more specialist services are required;
- Monitor the child and/or parents throughout the period of concern, to assess whether problems escalate further or improve; and
- Review and reflect on progress, considering whether the child’s needs have been met.

This process will depend on the age of the child and the context that has brought about the need for early help, and it must occur within the timeframe of the child. When the concern is low-level, a referral to children’s social care should only be made when early help has not been successful within the child’s timeframe or when the concern escalates.
The research findings

What does the guidance say about universal services practitioners and early help?

Statutory and non-statutory guidance states that universal services practitioners have a role to play in providing early help for neglect. However, this requirement is often set out in vague and broad terms, and the guidance can fail to clarify what it means in practice. In addition, the guidance tends to focus on the responsibility of practitioners to identify neglect, share information and signpost families to other services; there is a lack of explicit guidance on how practitioners can directly respond to concerns.

Did the practitioners see early help as their responsibility?

All the practitioner groups in our study believed that they and other universal services practitioners have a responsibility to be able to both identify neglect and to provide early help in some way. On average, health visitors, school nurses and early years practitioners tended to see early help as more their responsibility than midwives, teachers and GPs, reflecting the extent to which their roles are more traditionally seen as early help providers. However, we found that there was often a lack of consensus within professions about their responsibilities to provide early help.

What early help did the practitioners say they provide?

We asked the practitioner groups to tell us how they would normally respond if they were concerned that a child they were working with might be experiencing low-level neglect and may benefit from early help. All groups said that they provide early help in a variety of ways. However, there were interesting differences between the groups, and while some of those differences related directly to the nature of the service that each practitioner group provided, others highlighted significant gaps in provision. The key findings were as follows:

- The most common way of providing early help across the practitioner groups was signposting families to other agencies. While signposting is an important component of early help provision, it needs to be done alongside other aspects of early help, like taking time to understand a child and family’s needs, and developing a relationship with them that supports them to engage with other services. Other findings from this research show that this is not always happening, which raises concerns that signposting can sometimes be about ‘passing the buck’.

- Teachers and early years practitioners were less likely than those working in health services to contact other practitioners about an early concern. While between 82 per cent and 89 per cent of health practitioners said that they normally contacted other practitioners, only 64 per cent of education practitioners said that they did. Multi-agency working was considered to be a significant barrier to early help provision for those working in education services.

- The practice of routinely monitoring a child in response to early concerns about neglect was more commonly done in education settings than in health services, with 84 per cent of early years practitioners and 76 per cent of teachers saying that they routinely monitor children. The higher rate in education settings is likely to be because monitoring is facilitated by the regular daily contact that they have with children. Nonetheless, health practitioners have a role to play in monitoring children, but, worryingly, only 20 per cent of midwives, 37 per cent of GPs, 52 per cent of school nurses and 66 per cent of health visitors said that they would normally monitor a child about whom they had early concerns.
Talking to a parent about a concern was relatively common practice, with 90 per cent of health visitors, 83 per cent of GPs, 74 per cent of school nurses, 72 per cent of early years practitioners, 69 per cent of midwives and 66 per cent of teachers respectively saying they would do so. Providing practical and emotional support to these parents was very common for health visitors and early years practitioners, of whom 96 per cent and 79 per cent respectively said that they would do so. It was less common for GPs (67 per cent), school nurses (66 per cent), midwives (59 per cent) and teachers (53 per cent). There seems to be a missed opportunity here, particularly in relation to those practitioners who have the greatest contact with parents. The findings highlight the need to look at how GPs can be supported to build relationships with parents through, and following on from, talking about a concern. The findings also suggest the need to consider how to support midwives to both raise concerns and provide direct support to parents.

When the concern is low-level, a referral to children’s social care should only be made when early help has not been successful within the child’s timeframe or when the concern escalates. However, we found that a high number of participants said that they would refer a low-level, early concern about neglect to children’s social care. This included 75 per cent of midwives, 47 per cent of school nurses, 35 per cent of GPs, 32 per cent of health visitors, 31 per cent of early years practitioners and 29 per cent of teachers. These findings raise a number of issues for discussion: they may suggest a need to further support practitioners in understanding when a referral to social care is appropriate; they may reflect perceptions around responsibility to provide early help, and they also suggest that practitioners’ have low confidence in their own ability to respond to early concerns. Whatever the case may be, this finding highlights the need for clear role expectations, adequate resources and access to quality training and supervision to support the provision of early help.

Relatively high percentages of early years practitioners (87 per cent), school nurses (73 per cent) and teachers (73 per cent) said that they would provide practical and emotional support to a child. However, we found strikingly low percentages of practitioners who said that they would normally talk to a child about an early concern: 88 per cent of early years practitioners, 69 per cent of teachers and 67 per cent of school nurses said they would not normally talk to the child about an early concern. This raises concerns about how child-centred practice is.

What are the barriers to the provision of early help in universal services?
The practitioners and young participants identified a wide range of barriers that can prevent the provision of early help or can reduce the effectiveness of that help.

For health practitioners in particular, workload and time pressures were considered to be a significant barrier to providing early help. Staff shortages, high caseloads and pressures to meet targets mean that practitioners have less time, for example, to consider the wellbeing of children in a more holistic way, to develop relationships with children and parents or to monitor children when they have concerns.

Problems with multi-agency working and information sharing – historic but persistent barriers to providing effective safeguarding – were again raised in this research. Specific examples given were practitioners not understanding one another’s roles and not valuing each others’ expertise and contribution, as well as simple physical barriers to multi-agency working, like unreturned telephone calls.

Having the opportunity and being equipped to develop constructive relationships with parents was also raised as a barrier to early help provision, particularly in the context of early help being non-statutory.
• Not all practitioners are receiving training on neglect, which may be hindering their ability to identify and provide early help for neglect. In particular, 18 per cent of health visitors, 15 per cent of midwives and 14 per cent of early years practitioners reported that they had not received training in the past three years.

• Practitioners also need to be aware of local thresholds for intervention. However, we found that many practitioners with specific safeguarding responsibilities had not read their Local Safeguarding Children’s Board (LSCB) threshold document; this applied to between 20 per cent and 50 per cent of GPs, teachers, midwives and health visitors.

• Most of the 18 children and young people we spoke to, who were aged between 14 and 24, said that they would not seek support for neglect from a universal services practitioner. Having a safe and trusting relationship with practitioners was crucial for young people, and many felt that their contact with universal services practitioners did not enable these relationships to develop.

What examples of promising practice and ideas for best practice were given?

Examples of promising practice and ideas for better practice from the professional participants included:

• Training that focuses specifically on neglect, its impact on child development and effective working with parents;

• Prioritising the provision of home visits in health visiting, midwifery and early years;

• Improving the provision of postnatal care;

• Enabling family support workers to provide early help through increased training and supervision;

• Establishing ‘contact windows’, during which practitioners make themselves available to answer telephone calls about safeguarding concerns;

• Holding regular internal team meetings and supervision;

• Government financial investment in early help in universal services (for example, a commitment to recruiting more school nurses) and in targeted early help provision; and

• LSCB-wide neglect strategies.

For the young participants, service provision could be improved through a greater focus on building relationships with young people.

Recommendations

For an effective model for the provision of early help in universal services, we need:

1. Adequate resources: The UK government, local government and commissioners must ensure that there are necessary resources available to enable universal services practitioners to undertake early help.

   Therefore, there should be financial commitment to the provision of early help for neglect in universal services and targeted early help services. National and local governments should reduce the £17 billion ‘late intervention’ spending by 10 per cent by 2020 through better and smarter investment in early help. There should be a drive and commitment by the Department of Health to recruit additional school nurses.

2. Clear role expectations: Individual professions within universal services need to be clear about their role in providing early help for neglect.

   Therefore, government and professional membership bodies should clarify the role of universal services practitioners in providing early help for neglect and set out these role requirements clearly in statutory, professional guidance and professional job descriptions. More explicit guidance should be developed on how practitioners can provide direct support to children and parents.
3. **Clear pathways:** There needs to be clear and accessible pathways for the provision of early help, including between different universal services and between universal services, targeted services and children’s social care. LSCBs should develop a neglect identification and intervention pathway that helps practitioners identify and access targeted early help services. They should also lead a drive on awareness of the LSCB threshold document among practitioners with a specific safeguarding responsibility. LSCBs, Health and Wellbeing Boards, and Clinical Commissioning Groups (CCG) should recognise and draw on in-service planning and commissioning the role that universal services practitioners can play in responding to neglect.

4. **High-quality training, support and supervision:** Practitioners need to be confident and able to take early action before referring their concerns to children’s social care. LSCBs and safeguarding practitioners should ensure that all practitioners working with children receive specific training on neglect during their pre-qualification training on neglect during their pre-qualification training and at least every three years while practising. This should include:

- the impact of neglect on child development, and how to articulate concerns about neglect to other practitioners;
- how to convey concerns to parents and challenge harmful behaviour;
- how to develop relationships with parents; and
- how to develop relationships and address early concerns with children and young people.

All practitioners should also receive training that actively encourages them to always share information with other practitioners where there is a legitimate purpose and with the child in mind. Safeguarding practitioners in school nursing, health visiting and midwifery should ensure that regular internal team meetings are held (at least every two weeks) to discuss early concerns about children and their parents, in which practitioners feel able to challenge one another and reach a consensus about appropriate responses. In addition, all practitioners should have regular supervision with their manager in which they are supported and encouraged to reflect on their day-to-day practice in providing early help to children and parents.

5. **Effective information sharing and multi-agency working:** There needs to be open, professional and respectful dialogue and information sharing among different universal services practitioners, and between universal services practitioners and children’s social care (where in the child’s best interest). LSCBs should ensure that regular multidisciplinary meetings are held to discuss early concerns about children and their parents in the local area, in which practitioners feel able to challenge one another and reach a consensus about appropriate responses. They should introduce formal expectations of handovers at a non-statutory level when families move into a new area or their care passes from one professional to another, and should introduce ‘contact windows’, in which safeguarding practitioners within universal services agree a regular time slot during which they are contactable regarding safeguarding issues.

6. **Relational services:** Universal services need to be delivered with a focus on the importance of relationship building between practitioners and families.

The government should support the development and promotion of community budgets, which allow providers of public services to pool their budgets. Postnatal services should be routinely available for all women, at an appropriate level of intensity and for as long as is required. Models of case allocation should facilitate continuity of care across all services. Further consideration should be given to the potential opportunities of employing adequately trained and well supervised family support workers in both health and education settings.
Figure 1: Model of early help provision for neglect in universal services

This figure, developed from the discussion group data and literature review, sets out a model for the provision of early help for neglect within health and education services/teams. Effective early help requires practitioners to have the opportunity and ability to develop relationships with children and/or parents. ‘Provision of direct support to the child and/or parents’ includes practical and/or emotional support. This runs throughout the process, alongside monitoring the child and/or parents. At each stage, practitioners should refer to their LSCB threshold document. This process is time-limited and the time frame given for change to be evident will depend on the child’s age and their specific needs. A referral to children's social care is positioned at the end point on the pathway, when early help has not been successful. However, if a concern escalates at any point, a referral should be made to children's social care. The early help activities that individual practitioners are able to carry out will depend on their role, the age of the child, and the particular context of the child and family.
Early help for neglect in universal services

Sample: 893 practitioners from universal services

We asked: What do you normally do if you are concerned that a child you are working with might be experiencing low-level neglect and may benefit from early help?

- 64% of teachers and early years practitioners contact other practitioners to get more information, compared to 82%-89% of health practitioners.
- 82%-94% of health practitioners and 70%-76% of education practitioners monitor children, compared to 20% of midwives, 37% of GPs, 52% of school nurses, and 66% of health visitors.

We asked: What barriers do you face to providing early help?

- 18% of health visitors, 15% of midwives, and 14% of early years practitioners hadn’t had training on neglect in the past 3 years.
- 50% of GPs, 48% of teachers, and 36% of midwives with safeguarding responsibilities hadn’t read their LSCB threshold document.
- 69% of teachers, 67% of school nurses, and 63% of GPs don’t talk to the child about the concern.

Early help is about getting support to children and families as soon as a problem emerges.
1 Introduction

Why focus on child neglect?
Neglect is the most common reason for a child to be on a child protection plan in England (Department for Education, 2015a). Research by the NSPCC indicates that one in 10 young adults (9 per cent) were severely neglected by parents or guardians during childhood (Radford et al, 2011). Child neglect can have a profound and long-lasting detrimental impact on a child’s development and can, at its worst, result in a child’s death (Brandon et al, 2013). As such, neglect is a prolific and pressing challenge for policy makers, practitioners and society as a whole.

Why focus on early help?
A wide body of research has emphasised the importance of early help. Providing children and families with help at an early stage prevents children from suffering unnecessary harm, improves their long-term outcomes and is more cost effective than reactive services (Allen, 2011; Davies & Ward, 2011; Easton et al, 2013; Field, 2010; Knapp et al, 2011; Munro, 2011). The Early Intervention Foundation has estimated that nearly £17 billion per year is spent in England and Wales by the state on short-term ‘late intervention’, defined as the ‘fiscal cost of acute, statutory and essential benefits and services that are required when children and young people experience severe difficulties in life’ (Chowdry & Oppenheim, 2015, p5). Channelling resources towards early help for neglect within health and education services also helps those services to meet their goals of ensuring the physical wellbeing and educational attainment of children. This is because neglect has a significant impact on the physical and emotional wellbeing of children, and their ability to learn.

Governments in the UK have recognised the benefits of focusing on preventative rather than reactive services and have pledged their support for this goal, but there is a need to ensure that this rhetoric is translated into practice in the current economic climate (Cuthbert et al, 2011; Jütte et al, 2014).

Why focus on universal services practitioners?
This report comes at a time of immense pressure on the child protection system, both as a result of a reduction in funding (there has been a 27 per cent reduction in the spending power of local government in England since 2011 [Hastings, et al, 2015]), and more demand for services. As a result, children’s social care are increasingly being required to act as an emergency service (Jütte et al, 2014). Large numbers of referrals, many of which do not meet the threshold for intervention, are overwhelming children’s social care. This is leading to a significant backlog of cases and a failure to respond quickly to the needs of children and their families (Munro, 2011). For every one child who has a child protection plan, the NSPCC estimates that another eight children have suffered maltreatment (Harker et al, 2013).

This means that we urgently need to draw on additional ways to get effective help to children as early and efficiently as possible. The role of universal services has traditionally been seen as the identification of neglect and the referral of concerns to children’s social care. However, the death of Victoria Climbié in 2000 brought to a head long-standing failures in the child protection system, and prompted a shift in the system’s ethos from response to prevention in the form of the Children Act 2004. Since then, there has been increasing recognition of the need for universal services practitioners to play a greater role in tackling early signs of neglect.

Every universal services practitioner, whether they have a specific safeguarding responsibility or not, can play a role in providing early help for neglect. All children, young people and their families will come into contact with practitioners in universal services. Often, these practitioners see children and parents regularly and can compare their development and wellbeing with that of other children (Burgess et al, 2013; Munro, 2011). There is also less stigma attached to parents accessing universal services for help compared with children’s social care; parents may feel that they can go to them without the fear that their children will be removed.
Realising the potential: tackling child neglect in universal services

There is no doubt that, like children’s social care, universal services are under pressure. In many areas, they too are encountering crises of capacity and funding. However, the universal services workforce is vast in comparison to that of the social work workforce. In 2014 in England, there were around 24,620 full-time equivalent (FTE) children’s social workers (Department for Education, 2015b), compared to 454,000 teachers (Department for Education, 2015c), 32,080 GPs1 (Centre for Workforce Intelligence, 2014), 22,360 midwives (HSCIC, 2015), 10,740 health visitors (HSCIC, 2015), 1,240 school nurses (HSCIC, 2015) and 208,300 early years practitioners2 (Department for Education, 2014a). In addition, many of the components of early help are already core to the work of universal services. Given the right ingredients of clear role expectations, adequate resources and access to quality training and supervision, this workforce has the potential to play the foremost part in tackling child neglect at an early stage.

The aims of this report

This report draws on a large and unique data source to address the following questions:

• What does the policy and practice guidance tell us about the expectations of universal services practitioners to provide early help?
• How do practitioners view their own responsibilities in providing early help?
• What barriers to early help provision do the practitioners face?
• What ideas and examples of promising practice do the practitioners have for improving the provision of early help in universal services?
• What do young people think about the effectiveness of teachers, school nurses and GPs at providing early help, and how do they think services could be improved?

Definitions of terms

Neglect

In Working Together to Safeguarding Children 2015, neglect is defined as “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:

• provide adequate food, clothing and shelter (including exclusion from home or abandonment);
• protect a child from physical and emotional harm or danger;
• ensure adequate supervision (including the use of inadequate caregivers) or ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs” (p93).

Child neglect happens at different levels of severity, as described in Table 1. ‘Mild’ or ‘low-level’ neglect can be deeply damaging to a child if it occurs over a long period of time.

The causes of child neglect are multifaceted and complex. Risk factors for child maltreatment include: parental mental health difficulties; parental substance misuse; parental learning difficulties; parents experiencing adverse childhood experiences (particularly abuse or neglect in their own childhoods); young parenthood; domestic abuse; poverty (although neglect also occurs in affluent families [Action for Children, 2010]); an absence of social support; a child’s disability; and babies born before term, with low birth weight or with complex health needs (Belsky, 1980; 1993; Slack et al, 2003; Stalker and McArthur, 2012; Strathearn et al, 2001).

1 Figure available for 2013
2 Figure available for 2013, refers to paid staff working in full day care settings
Table 1: Levels of neglect

<table>
<thead>
<tr>
<th>Level of neglect</th>
<th>Description</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>No neglectful parenting</td>
<td>Consistent good quality parenting where the child’s needs are always paramount or a priority.</td>
<td>Normal universal services access.</td>
</tr>
<tr>
<td>Mild or low-level neglect</td>
<td>Failure to provide care in one or two areas* of basic needs, but most of the time a good quality of care is provided across the majority of the domains.</td>
<td>Likely to require a single agency targeted short-term intervention until resolved, or a referral to local authority children’s services if situation deteriorates or remains unchanged.</td>
</tr>
<tr>
<td>Moderate neglect</td>
<td>Failure to provide good quality care across several areas, some of the time. May occur when less intrusive measures, such as community or single agency interventions, have failed, or some moderate harm to the child has or is likely to occur, for example the child is consistently inappropriately dressed for the weather, such as being in shorts and sandals in the middle of winter.</td>
<td>Requires a formal targeted single or multi-agency intervention (for example a Common Assessment Framework). This would coordinate support where needed. All cases will need a formal monitoring for referral to children’s social care if there is no improvement. However, if there is already evidence of no improvement, and it is associated with domestic abuse, mental health, substance misuse, learning difficulties or other parental risk factors, then a referral to local authority children’s services should be made from the outset.</td>
</tr>
<tr>
<td>Severe neglect</td>
<td>Failure to provide good quality care across most of the domains most of the time. Occurs when severe or long-term harm has been or is likely to be done to the child, or the parents are unwilling or unable to engage multi-agency support.</td>
<td>Referral to local authority children’s services will be required. If the child is already known to statutory services, Child Protection procedures should be instigated followed by legal planning if there is no further improvement.</td>
</tr>
</tbody>
</table>

* ‘Area’ refers to four basic domains of care: physical care, safety, love and esteem. (Amended from DePanfilis, 2006)
Neglect can affect children in a range of ways. Physical and emotional neglect during the early years of life can also have a profound impact on the development of the brain and body (Glaser, 2000; Center on the Developing Child, 2013). As a child grows older, both their physical and psychological development can be affected by neglect. Poor diet can impede both continued brain growth and physical development, and can lead to obesity (Horwath, 2013). Children who are not kept clean can develop skin conditions and dental problems, and a lack of supervision can result in injuries or death (Brandon et al, 2013; Coohey, 2003).

Optimal physical development also requires a child to be stimulated and encouraged to develop gross motor skills, which may not occur when a parent or carer is neglectful (Horwath, 2013). Children who have been neglected are more likely to experience mental health problems, including depression and post-traumatic stress disorder (Lazenbatt, 2010). As children go into their teenage years, feelings of being unloved and unwanted may lead to suicidal feelings, running away, anti-social behaviour and offending (Hicks & Stein, 2013). They may find it difficult to maintain healthy and loving relationships with others later in life (Howe et al, 1999) and may be at more risk of sexual abuse and exploitation (Hicks & Stein, 2013).

**Early help**

Early help and early intervention are contested terms that have a range of meanings in different contexts and are often used interchangeably (Cuthbert et al, 2011). We use the term ‘early help’ in this report in accordance with _Working Together 2015_, and define it as:

\[
\text{Providing support as soon as a problem emerges at any point in a child’s life.}
\]

When deciding if early help is the best course of action for the child, there are two considerations to take into account. First, for early help to be appropriate, the severity of the neglect should be considered ‘low-level’. Early help is help that families receive prior to the formal identification of a child as ‘in need’ (section 17) or ‘in need of protection’ (section 47), requiring statutory intervention from local authority children’s social care.

Second, because even ‘low-level’ neglect can be deeply damaging to a child if it occurs over a long period of time, early help is appropriate as long as it is given within the child’s time frame and there is evidence of positive change in parents’ behaviour and the child’s daily lived experience (Horwath & Tarr, 2014). Early help can be delivered by universal services or by specific specialist services, and by one agency or by multiple agencies. The context will determine which response is most appropriate.

Effective early help provision that tackles neglect at the earliest possible stage requires universal services practitioners to:

- Identify parental risk factors for neglect or neglect itself;
- Understand the child’s unmet need by talking to the child, their parents and other practitioners – this in turn requires practitioners having the opportunity and being equipped to develop relationships;
- Assess the child’s and parents’ needs and formulate a plan through a formal or informal assessment, to identify which services might be best placed to help a child or family, within or external to universal services;
- Address the child’s needs through directly providing practical and/or emotional support where possible (continuing to develop and maintain relationships with the child and/or parent), and/or through signposting to other services or agencies if more specialist services are required;
- Monitor the child and/or parents throughout the period of concern, to assess whether problems escalate further or improve; and
- Review and reflect on progress, considering whether the child’s needs have been met (see Figure 1 for model).
This process will depend on the age of the child and the context that has brought about the need for early help, and it must occur within the timeframe of the child. When the concern is low-level, a referral to children’s social care should only be made when early help has not been successful within the child’s timeframe or when the concern escalates. It is unlikely that universal services would work with both the child and parent as a dyad, but this may occur in more specialist services.

**Universal services**

The term ‘universal services’ covers a huge range of services, roles and organisational settings within health and education services. In this report, we focus on six practitioner groups: GPs, midwives, health visitors, school nurses, teachers and early years practitioners. We look at whether different work settings impact on professionals’ perceptions and actions, including:

- midwives working in a community setting, those in a hospital setting, and those working across both settings;
- teachers working in infant, primary and junior schools, compared with those working in secondary schools; and
- early years practitioners working in nurseries compared with those working in children’s centres.

Those with a specific safeguarding responsibility were also compared with those without specific safeguarding responsibilities.

While in this research we focus on universal services, there are a vast range of other services who have a role to play in providing early help for neglect. These include specialist services, such as drug and alcohol services, domestic abuse services, speech and language therapists, adult services, housing services, advice and welfare services, voluntary organisations, faith-based organisations and community organisations.
This chapter sets out the policy and delivery landscape within which health and education practitioners in England identify and respond to child neglect. It sets out the statutory requirements of universal services practitioners and the professional guidance documents for individual services. Alongside this, it sets out the potential role that these practitioners could play and the issues that are currently preventing this work being fully carried out across the services.

The role of universal services in identifying and responding to neglect at an early stage has altered in recent years. Traditionally, their role has been to identify the signs of abuse or neglect, and refer that concern on to children's social care. More recently, statutory guidance has begun to set out the role of these services in providing early help. However, while the expected response of universal services practitioners to concerns that a child is suffering, or is at risk of suffering, significant harm, is well embedded and well understood (with practitioners being required to refer the case to children's social care), both the role of universal services in providing early help, and the process through which this is achieved, are more opaque.
for safeguarding arrangements, promoting a culture of listening to children, information sharing, safe recruitment practices, training for staff, and the named practitioners responsible for safeguarding. Local authorities must also have a Local Safeguarding Children Board (LSCB), the purpose of which is to act as a co-ordinating body for all safeguarding work within each of the member organisations (which includes NHS commissioners, Clinic Commissioning Groups [CCGs], NHS trusts and NHS Foundation Trusts and schools), and to ensure their effectiveness in this area (Sections 13 and 14).

In addition, Section 175 of the Education Act 2002 sets out specific requirements for education services. These are that school governing bodies, local education authorities and further education institutions make arrangements to safeguard and promote the welfare of children (this provision is outlined under Section 157 for independent schools). An amendment to the Children Act in 2006 extended the duty to cooperate to schools. Early years providers have a duty, under section 40 of the Childcare Act 2006, to train staff in safeguarding and to have a practitioner who takes lead responsibility for safeguarding children.

Overarching safeguarding guidance for practitioners: early help responsibilities

The legislative requirements in the Children Act 2004 and Education Act 2002, alongside additional guidance, are set out in the government’s statutory guidance, Working Together to Safeguard Children. When guidance is statutory, it means that practitioners are required by law to follow the guidance that applies to them. Three versions of Working Together have been published, in 2010, 2013 and 2015, and all show a move towards implementing a greater role for universal services to provide early help where there are concerns about neglect.

The 2013 and 2015 Working Together guidance are more streamlined version of the 2010 document. This reflects the government’s aim of decentralising guidance on safeguarding in order to promote professional judgement and encouraging services to respond to the specific needs of their communities, but it also then means that safeguarding guidance can be opaque (Bird, 2014). The guidance describes a continuum of help and support to meet the needs of families and children, of which universal services are a key part.

Working Together 2015 states that effective early help relies upon local agencies working together to:

- “Identify children and families who would benefit from early help;
- Undertake an assessment of the need for early help;
- Provide targeted early help services to address the assessed needs of a child and their family which focuses on activity to significantly improve the outcomes for the child.” (p12)

Working Together states that all universal services practitioners have a responsibility “to identify the symptoms and triggers of abuse and neglect, to share that information and work together to provide children and young people with the help they need” (p13). Following this statement, the focus of the document moves to the lead professional and their role in undertaking early help assessments. The way in which universal services practitioners should meet their responsibility to “work together to provide children and young people with the help they need” is unclear.

In addition, while the guidance on the role of the lead professional is more explicit than for other universal services practitioners, greater clarity is still needed. Working Together states that a lead professional could be a GP, family support worker, teacher, health visitor or special educational needs coordinator and sets out their role as to “provide support to the child and family, act as an advocate on their behalf and coordinate the delivery of support services” (Department for Education, 2015d, p14). Guidance on how lead practitioners “provide support”, what this support entails and what being an advocate means in practice is not given.

“High quality” early help support is required to be provided by universal services alongside local targeted services, but again there is a lack of clarity about what this means in practice (Department for Education, 2015d, p14).
Information sharing is a key component of safeguarding, and Working Together 2015 states that “Fears about sharing information cannot be allowed to stand in the way of the need to promote the welfare and protect the safety of children” (p17). Working Together 2015 signposts practitioners to the guidance, Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers (2015), which sets out the expectations around information sharing in more depth.

The guidelines in Information Sharing are broad, stating that each circumstance a professional encounters will be different, which requires them to make a professional judgement. However, they clearly state that: “The most important consideration is whether sharing information is likely to safeguard and protect a child” (p8). The guidance states that information about a child or family that allows that child or family to be identified or is confidential can be shared if there is a legitimate purpose. Where possible, consent should be sought for sharing information; however, if sharing the information is deemed to “to fulfil a public function or to protect the vital interests of the information subject”, it can be shared without consent. Professionals are called on to use their professional judgement in order “to provide early help and to keep children safe from harm” (p5).

Information sharing continues to pose a problem for early help provision. There are many reasons why professionals are anxious about sharing information, including the fear of undermining confidence placed by them by the family, the fear of complaints from the family, or a simple desire to honour client confidentiality. Practitioners need support and supervision to make decisions about information sharing, but this is often not readily available.

Working Together 2015 also set out the role of children’s social care in providing early help. On the one hand, they have a role in supporting and advising universal services practitioners: a professional “should be able to discuss concerns they may have about a child and family with a social worker in the local authority” (Department for Education, 2015d, p14). On the other, they can have a direct role in providing support where a need cannot be met by universal service provision but it is not considered that a child is suffering or likely to suffer significant harm. For example, case work can be done with children, young people and families through early help hubs and early support services run by the local authority.

The use of a continuum in safeguarding and child protection, through which different agencies are responsible for providing help in response to different levels of need, requires transparent and clearly defined thresholds for each stage of service involvement. Working Together 2015 sets out the requirement that each LSCB publish a threshold document setting out thresholds, and that this must be agreed with the local authority and its partners. Children’s social care have the responsibility for clarifying the process for referrals. The document should outline the process for early help assessment, and the type and level of early help services to be provided, as well as the criteria, including the level of need, for when a case should be referred to children’s social care for assessment and for statutory services.

Threshold documents vary according to local authority and this has implications for responding to children at all levels of need. It is important to emphasise the variation across these documents, not only in terms of the number of levels of need identified and the thresholds themselves, but in the wording and level of detail provided. Often, the response pathways for children who sit below the ‘significant harm’ threshold are more complex than for those who sit above it.

Content specifically on neglect (as opposed to referring to ‘abuse and neglect’) only appears in the guidance in relation to the assessment of neglect in families by children’s social care. The guidance acknowledges the complexity of assessing neglect in families, citing the propensity of neglect to fluctuate in severity and over time, and warns that “professionals should be wary of being too optimistic. Timely and decisive action is critical to ensure that children are not left in neglectful homes” (Department for Education, 2015d, p26). It sets out the need for practitioners to be “rigorous in assessing and monitoring children at risk of neglect [and] should act decisively to protect the child by initiating care proceedings where existing interventions are insufficient” (Department for Education, 2015d, p20).
Working Together 2015 signposts practitioners to other key safeguarding guidance. These include the government guidance *What to do if you’re worried a child is being abused* (2015) and NICE guidance *When to suspect child maltreatment* (2009), both of which provide guidance on identification of abuse and response to concerns about likely or significant harm to a child.

The guidance and delivery context for individual professions

As well as *Working Together to Safeguarding Children 2015*, there are a number of other documents that provide safeguarding guidance to health and education practitioners (all of which should comply with *Working Together 2015*). The following section sets out guidance from those documents that relates to early help provision, including both general guidance for all practitioners working in either health or education, and profession-specific guidance. Generally speaking, like *Working Together*, there tends to be a focus on the identification of neglect, information sharing and signposting to other services, with little or no clear guidance on how practitioners can directly respond to concerns.

Health services

<table>
<thead>
<tr>
<th>Key safeguarding guidance documents across health services</th>
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<tr>
<td>Royal College of Paediatrics and Child Health (2014) <em>Safeguarding Children and Young people: roles and competences for health care staff</em>. London: Royal College of Paediatrics and Child Health</td>
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The guidance for health practitioners beyond *Working Together* is non-statutory, which means it provides advice to practitioners about good practice, but they are not required by law to comply with that advice. The *Safeguarding children and young people: roles and competences for health care staff* guidance (2014) sets out the core safeguarding competencies expected of nurses, midwives, health visitors and GPs among other health practitioners. The term ‘early help’ is only used once in the document, where it states the need for training to include the importance of early help for all staff at level two or above (GPs, health visitors, midwives and school nurses are required to operate at competency level three of five).

However, much of the guidance implies that health practitioners have a role to play in providing early help role. Specifically, they are required to be “able to act proactively to reduce the risk of child/young person maltreatment occurring”. They are required to document concerns, act as an effective advocate for the child or young person, ensure young people have the opportunity to participate in decisions affecting them as appropriate to their age and ability, work with other agencies when concerns are identified, know how to refer to children’s social care, and share information. GPs, health visitors, midwives and school nurses are required to receive safeguarding training at least every three years.

Named healthcare practitioners (level four) must support safeguarding within the organisation, by communicating safeguarding knowledge to others, facilitating organisational audits, assessing training needs, and providing supervision and advice. Designated safeguarding doctors and nurses (level five) take a strategic and professional lead across the health community on all aspects of safeguarding and child protection.

Responsibility for safeguarding children in health services operates at three tiers. Responsibility for ensuring that the health commissioning system as a whole meets its requirements to safeguard children lies with the NHS Commissioning Board. Clinical commissioning groups (CCGs), consisting of local GPs, are the key commissioners of local health services within local authorities (NHS Commissioning Board, 2013), and are responsible for ensuring that local health services employ designated practitioners for safeguarding, who provide strategic advice and guidance to organisational boards across the health community. Specific NHS-funded health services (for example, NHS trusts and GP surgeries) are then also required to identify named doctors and nurses within their organisations who hold responsibility for safeguarding.
GPs

Key safeguarding guidance documents for GPs


General Medical Council (2012) Protecting children and young people: the responsibilities of all doctors. Manchester: GMC


GPs are potentially in a strong position to identify and respond early to parental risk factors and child neglect; they often treat families over many years, see multiple members of the same families, manage illnesses that can put children at risk of neglect, and often command respect from patients (Tompsett, et al, 2009; Woodman, et al, 2014; Woodman, et al, 2012).

Some of the professional guidance for GPs focuses on their role to identify neglect, share information and signposting to other services. The Department for Education document, Supporting Families in the Foundation Years, states that “GPs can often identify the need for both prevention and early intervention when they see a child or young person and/or their parents in the surgery or by receiving information from other health services. They can have a key role in helping family members access local early help services, working closely with other health practitioners, such as health visitors and other services including children’s centres” (Department for Education, 2011, p19). The GMC safeguarding guidance (2012) sets out the expectation that GPs will signpost families to appropriate services in their area, and will work and communicate effectively with other practitioners to safeguard children (GMC, 2012).

Other guidance for GPs, such as the RCGP and NSPCC toolkit for GPs (2014), recognises that early help can be provided directly by GPs. The toolkit positions GPs as having “an important role in identifying families where issues are emerging and ensuring that they are given the support within primary care if possible or encouraged to access help (RCGP, 2014, p30).

While GPs, like all practitioners, should aim to get consent to share information from their patient, the guidance states that “confidentiality is not an absolute duty” (p22): information can be shared without consent when it is in the public interest (GMC, 2012). Where GPs are asked to provide information about a patient to other practitioners, the guidance requires them to consider all requests both quickly and seriously, but to follow a number of safety checks before providing the information, for example checking the identity of the person requesting information, and the validity of the request. If the GP decides that information should not be shared, they are responsible for reviewing the situation regularly. However, it is unclear how this can occur in cases where the immediate medical need has been met.

The British Medical Association’s Children and young people tool kit states that GPs should make efforts to include children and young people in decisions that closely affect them, listening to them and respecting their views in accordance to their competence and the level of their understanding (BMA, 2010).

While it is not often recognised in the guidance (with the exception of the RCGP and NSPCC toolkit for GPs [2014]), GPs’ core skillset lends itself well to providing early help to families where there are concerns about neglect (Woodman et al, 2014). GPs are in a position to both develop and maintain a strong doctor–parent and doctor–child relationship. Through this relationship, they are well placed to coach parents, encourage their engagement with primary care or changes in their way of thinking, and advocate on their behalf to ensure that they access the necessary early help services (Woodman et al, 2014). They are also potentially in a position to monitor families; through recording concerns about child maltreatment, they can contribute to decision-making around neglect and help build a picture of a family over time (Woodman et al, 2012; Woodman, et al, 2013).
Research has suggested that GPs’ motivation to provide direct early help increased when they perceive neglect to be the result of incompetent parenting rather than purposeful maltreatment. In addition, the relationship between GPs and children’s social care plays a part; if a GP does not trust children's social care to make the ‘right’ decision, they are more likely to take a lead role in the case (Woodman et al, 2013).

There are a number of barriers that have been highlighted by previous research to GPs providing early help for neglect. Information sharing is a key part of responding to child neglect, but it can be a complex issue for GPs due to the extent to which the profession is founded on the principle of confidentiality (Bastable & Horwath, 2004). GPs can also be concerned that they may damage relationships with the family as a whole by identifying child protection concerns (RCGP, 2011; Woodman et al, 2013). In addition, the child’s needs might be overshadowed by those of the parent (RCGP, 2013).

Finally, GPs have acknowledged that health visitors play a central role in helping them to safeguard children (Woodman, et al, 2013), and the low numbers of health visitors and the fragmentation of primary health teams have been highlighted as barriers to GPs carrying out effective and early responses to child neglect. The government’s commitment to increasing the number of health visitors provides an opportunity for more effective early help in the future (Department of Health, 2011).

Alongside this, general practice is facing a capacity and funding crisis. In November 2013, the Royal College of GPs and the National Association for Patient Participation (NAPP) launched the ‘Put patients first: Back general practice’ campaign, in response to reduced funding for general practice coupled with an increasing patient population. Polls of family doctors commissioned by the RCGP have suggested that GPs do not feel adequately resourced to provide their desired level of care to patients, and the campaign is demanding that government increases funding from a historic low of 8.39 per cent of the UK NHS budget to 11 per cent by 2017 (RCGP, 2013). A survey of GPs by the BMA (n=15,560) found that 37 per cent of GPs think that their current workload is unmanageable (BMA, 2015).

Nursing and midwifery

Key safeguarding guidance documents for nurses and midwives

Royal College of Nursing (2014a) Safeguarding children and young people – every nurse’s responsibility: Guidance for nursing staff. London: Royal College of Nursing


There are two guidance documents on safeguarding that span nursing and midwifery. The Royal College of Nursing’s Safeguarding children and young people – every nurse’s responsibility (Royal College of Nursing, 2014a) acknowledges the concept of early help as a key principle underpinning safeguarding practice, and draws attention to the requirement on LSCBs to publish guidance and thresholds for early help. It sets out nurses required core competencies as identifying signs and risk factors for abuse and neglect, documenting safeguarding concerns, sharing information and promoting inter-agency working, and referring to children’s social care where necessary.

Alongside this, the Nursing and Midwifery Council (NMC) sets the standards for conduct, performance and ethics of nurses and midwives who are on the professional register. This document is broad in scope, covering adults and children, and states only that the expectation is that nurses and midwives disclose information if it is believed that someone may be at risk of harm (NMC, 2008).
Health visiting and school nursing

Key safeguarding guidance documents for health visitors and school nurses


Key guidance documents for health visitors

Department of Health (2013a) SAFER communication guidelines. London: Department of Health


Key guidance documents for school nurses

Department of Health (2012b) Getting it right for children, young people and families. Maximising the contribution of the school nursing team: vision and call to action. London: Department of Health


Royal College of Nursing (2014b) An RCN toolkit for school nurses: Developing your practice to support children and young people in educational settings. London: Royal College of Nursing


The role of health visitors and school nurses in providing early help is more well-established than the role of GPs and midwives, and this is reflected in the guidance. As well as the guidance set out in Working Together 2015 and the RCPCH intercollegiate document, the role of health visitors and school nurses is set out in guidance around the Healthy Child Programme (HCP). The Department of Health’s HCP is an initiative focusing on a universal preventative service providing a “programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting” (Department of Health, 2009), and provides a good example of guidance that includes information on how to provide direct support in relation to early help.

Responsibility for children aged 5–19 years old is then transferred from health visitors to school nurses. The framework calls on both health visitors and school nurses to promote continuity of service and a smooth transition from 0–19. The HCP acknowledges that health visitors and school nurses make a “unique contribution to safeguarding children”, and that, through health visitors and school nurses, there must be a “utilisation of the clear evidence base that supports the positive impact of early help on a child or young person’s life course” (Department of Health and Department for Education, 2012). The HCP will move from being commissioned by NHS England to local authorities commissioning from October 2015 (NHS England, 2014).

Health visiting

Health visitors, working in collaboration with GPs, early years services and midwives, are responsible for leading and delivering the HCP for children between the ages of 0–5 years (Department of Health, 2012a).

The HCP model operates at four levels: community, universal services, universal plus, and universal partnership plus (Department of Health and Department for Education, 2012). At the community level, health visitors work to link families and services, for example to Sure Start and more locally-led services, and to build community capacity. Immunisations, health and development checks, and support for parents operate at a universal level.
Expert help is provided at the universal plus level, for example for postnatal depression or concerns about parenting. Finally, at the high end of the continuum, health visitors work with a range of other organisations to respond to complex family issues, such as significant risk of harm to children.

Safeguarding by health visitors at the universal plus level can include evidence-based interventions or a specific package of care for identified health needs, for example a sleepless baby, feeding problems, referral to support services, and planned structured home visiting programmes that strengthen the parent/carer-child relationship (Department of Health and Department for Education, 2012).

Health visitors are also guided by the SAFER communication guidelines, which set out a framework for health visitors for communication with children's social care when a child may be suffering or is likely to suffer significant harm. Health visitors are expected to work closely across health and early years services, including Sure Start centres and GPs. This should be overseen by the local Health and Wellbeing Board, and by the profession and regulating bodies themselves.

Health visitors tend to be well equipped to recognise both the parental characteristics associated with neglect and the developmental signs in children because of their knowledge of the family, their circumstances and the child as gathered during home visits (Appleton, 2011). Through the HCP and with proper funding, health visitors are not only well placed to identify children who are experiencing neglect (in particular pre-school children, but also older siblings), but also to provide parenting support and education about child development, thus positioning them as key players in responding to child neglect at an early stage. Observation and listening skills are key; a struggling parent may seek help or advice from a health visitor, setting up a platform for preventative work (Appleton, 2011). Many family nurses working as part of the Family Nurse Partnership programme, a voluntary preventative home-visiting programme for first time young mums (Family Nurse Partnership, 2014), also have a health visiting background.

However, there a number of issues that present barriers to the provision of early help within health visiting. Health visitors are understaffed and overstretched (Burgess, et al, 2013). They are not able to visit expectant parents or new parents as frequently as they used to. They are also unable to spend adequate amounts of time in families’ homes; instead, families tend to visit clinics, where health visitors are less able to get a full understanding of the care a child is receiving and they are less able to develop a relationship with the family.

In 2010, the coalition government made a commitment to recruiting an extra 4,200 health visitors by 2015, with closer partnership working with children’s centres. The aim of increasing the number of health visitors is to allow for greater interactions at a community level, to support their central role in HCP, and to provide additional services for vulnerable families requiring support (Department of Health, 2011). Crucially, the increase in numbers is also aimed at ensuring that “the appropriate health visiting services form part of the high intensity multi-agency services for families where there are safeguarding and child protection concerns” (Department of Health, 2011, p10). As of March 2015, the health visitor workforce had increased from 8,092 in May 2010 to 11,495, an increase of 3,403 fte (HSCIC, 2015).

While there are clear signs of progress in increasing the number of health visitors in England, it is likely to take a number of years to fully rejuvenate the service through effective training and the development of expertise and experience (Appleton, 2011). The high caseloads of health visitors is another factor impinging on their ability to respond effectively to neglect at an early stage, as is a low level of supervision (Appleton, 2011).

**School nursing**

As with health visitors, the role of the school nurse in the HCP positions them as key providers of early help. Responsibility for children is transferred from health visitors to school nurses when children reach the age of five, until they are 19 years old. School nurses work in collaboration with GPs and schools to provide the HCP programme (Royal College of Nursing, 2014a; Department of Health, 2012b).

Like health visitors, the safeguarding responsibilities of school nurses operate across the safeguarding continuum model. School nursing is a universal service, but one which can also be intensified as a more targeted service (universal plus). School nurses also play a key role
in coordinating services in response to children and young people with higher levels of need (universal partnership plus). Their role is set out as providing universal public health interventions to reduce risk, including “providing therapeutic public health interventions for the child and family, and referring children and families to specialist medical support where appropriate”, and “supporting safeguarding and access and contribution to targeted family support, including active engagement in the Troubled Families Programme” (Department of Health, 2014a, p19).

The Royal College of Nursing’s Toolkit (RCN, 2014b) also emphasises the importance of training and supervision for schools nurses, and the need for them to link into LSCBs and the named nurse for child protection/safeguarding children and young people. The Department of Health’s school nurse practice development resource pack (2006) sets out more specific advice to school nurses on identifying and responding to safeguarding concerns (again, there is an absence of specific guidance on neglect). Particularly relevant to early help is the requirement that school nurses provide ongoing preventative support and work with children, young people and their families.

However, the school nursing workforce is small, consisting of approximately 1,200 practitioners (HSCIC, 2015), which is about one for every 7,000 children and young people. The Department of Health guidance to support the commissioning of public health provision for school aged children highlights the need for local workforce plans to take into account workload capacity alongside population health needs.

Concerns have been raised that school nurses are being drafted into working as health visitors, as the government seeks to meet its aim of 4,200 extra health visitors by 2015 (RCN, 2011). Because of their small numbers, school nurses tend to have caseloads that cover multiple schools; they can have responsibility for all children in a number of schools, or work on a corporate basis, in which case loads are shared among practitioners. Research has also indicated that there is role confusion within school nurses, particularly in relation to safeguarding, and that there is a need for more safeguarding training (Hackett, 2013).

### Midwifery

#### Key safeguarding guidance documents for midwives

- NICE (2010) Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors. NICE clinical guideline 110. Manchester: NICE (also relevant for other primary care providers, social care and education practitioners)

Midwives have a duty to care for both infants and women during pregnancy and up to 28 days after the birth, and thus have a key role to play in the early detection of neglect and risk factors for neglect, and in supporting women during this time. Increasingly, midwives work in the community as well as in hospitals, providing care for services in women’s homes, local clinics, children’s centres and GP surgeries (NHS, 2014). In particular, they are in a key position to identify and support women with perinatal mental health difficulties.

There are no professional guidance documents that are written solely for midwives and specifically about safeguarding. However, NICE guidelines set out the general principles on which antenatal care should be provided, and specific guidance for working with pregnant women with complex social factors. The Antenatal Care guidelines are founded on the principle of woman-centred care: “Every opportunity should be taken to provide the woman and her partner or other relevant family members with the information and support they need” (NICE, 2014a, p7), but clarity is needed to establish what this ‘support’ entails.

The NICE guidelines, Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors (NICE, 2010) provides greater clarity on how to provide early help, including direct support, within the context of women with complex social factors. It targets women who misuse substances, who experience domestic abuse, who are newly arrived in the UK,
The policy and delivery context

and those who are young mothers. The guidance recommends that midwives record the number of appointments women attend, consider initiating a multi-agency needs assessment (it specifically mentions this in relation to safeguarding), provide each woman with a one-to-one consultation without other family members present, share information with other agencies, and discuss a woman’s difficulties and concerns in a non-judgemental manner. Midwives should also offer appropriate information for other support services to those women. It is recommended that midwives are given training to work with these vulnerable groups of women. The Antenatal and postnatal mental health: clinical management and service guidance (NICE, 2014b) also offers guidance for midwives and other health professionals around recognising and specifically assessing antenatal mental health difficulties in pregnancy.

Additional safeguarding guidance includes pre-birth risk assessment guidance, which each LSCB will set out, but pre-birth risk assessments tend to be carried out at the high end of the child protection spectrum. In addition, some hospitals have specialist safeguarding midwives, and there has been a commitment by the government to ensure that there are specialist mental health midwives available for every birthing unit by 2017 (Department of Health, 2013b; Hogg, 2013; Maternal Mental Health Alliance, 2013).

There is a national shortage of midwives (National Audit Office, 2013). This has put pressure on staff, causing low morale, and “nearly one third of midwives with less than 10 years’ work experience are intending to leave the profession within a year” (House of Commons Committee of Public Accounts, 2014, p5). In 2012, the Royal College of Midwives estimated that there was a shortage of about 4,800 midwives, and stated that although numbers are increasing, there were not enough midwives to guarantee good quality or continuous care (RCM, 2013). In 2014, for the first time in its history, RCM members voted to strike over pay. A recent report by the RCM has also highlighted the need for better provision of postnatal care (RCM, 2014).

Research suggests that the setting in which midwives work can also impact on their ability to provide early help. Some evidence suggests that midwifery practice in hospital environments may be more focused on physical care, compared with a more holistic, psychosocial approach to care in community settings (Lazenbatt & Greer, 2009).

In addition, research has indicated that, due to a reduction in service provision, midwives feel that they are now less able to visit expectant parents or new parents, and feel that they need to justify making an extra visit to follow-up on concerns (Burgess et al, 2013).

Education services

While the available additional safeguarding guidance for health practitioners is non-statutory, the government has produced further statutory guidance for education practitioners.

Schools

Key safeguarding guidance documents for teachers


The Department for Education guidance Keeping children safe in education: Statutory guidance for schools and colleges3 (2015d) states that school staff have a central role in identifying neglect and providing early help but again, requires greater clarification of the terms used. The guidance states that “school and college staff are particularly important [in safeguarding children] as they are in a position to identify concerns early and provide help for children, to prevent concerns from escalating” (Department for Education, 2015e, p6). It highlights the need for early identification of abuse and neglect, stating that: “It is important for children to receive the right help at the right time to address risks and prevent issues escalating” (p8). “All staff have a responsibility to take appropriate action, working with other services as needed” (p7). However, key terms such as ‘appropriate’, ‘help’ and ‘as needed’ are not defined. The guidance goes on to say that “Where a child and family would benefit from coordinated support from more than one agency (for example, education, health,

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3 This applies to all schools whether maintained, non-maintained or independent (including academies and free schools, alternative provision academies and pupil referral units)
housing, police) there should be an inter-agency assessment” (p8).

In addition, staff should receive “appropriate” and “regularly” updated training, but while it states that the safeguarding lead should receive training every two years, it does not dictate the desired regularity of training for other staff. The guidance explicitly requires teachers to request help from children’s social care when they are unsure of how to respond to a concern at an early stage. The guidance also states that schools must ensure “the child’s wishes or feelings are taken into account when determining what action to take and what services to provide to protect individual children through ensuring there are systems in place for children to express their views and give feedback” (p21).

There are a number of structures and provisions already in place that respond to children with additional needs, and, therefore, have the potential to provide early help for neglect. The pupil premium is additional funding given to publicly funded schools in England, designed to raise the attainment of disadvantaged pupils (Department for Education, 2014c). For each pupil registered as eligible for free schools meals (at any point in the last six years), primary schools receive £1,320 and secondary schools receive £935. Schools are required to publish details online each year of how they are using the pupil premium and the impact it is having on pupil achievement. Special education needs support in schools can also help children who are neglected, if neglect is impacting on their ability to learn. The Children and Families Act 2014 also requires all state-funded schools to provide free school lunches on request for all pupils in reception, year 1 and year 2.

In addition, schools tend to have a pastoral team whose role it is to support children and young people’s learning, growth and social development in a healthy and safe environment. Some schools also have support programmes that deliver direct help to children and parents, such as breakfast clubs. These resources have the potential to play a big role in the provision of early help for children and young people experiencing neglect. However, in some schools, they are managed by head teachers, and, therefore, the way in which they are used is dependent on the individual management team and ethos of a particular school. In others, and on particular issues, the local authority maintains a high degree of control.

While teachers are well placed to provide early help for neglect, there are a number of significant issues that impact on this ability. There seems to be a lack of clarity in the teaching profession about how to respond early to low-level child neglect; in research with a wide range of frontline practitioners, Action for Children found that teachers were having ‘sleepless nights’ worrying over what to do about children they suspected were being neglected (Burgess et al, 2012). The extent to which the new statutory guidance has improved this has yet to be seen.

Research indicates that neglect can be easier to identify at primary school, as can meeting a child’s immediate physical needs, in part because staff tend to know the families of pupils and have better relationships with parents when children are younger. The transition from primary school to secondary school can be a time of particular risk for young people who are experiencing or have experienced neglect. Indeed, neglect can become more complex to discern or define as young people develop, enter adolescence and reach maturity (Hicks & Stein, 2010). Safeguarding issues that arise in secondary schools are often different in nature to those experienced in primary schools, as a result of the increasing maturity of the young people involved; difficulties can often manifest in behavioural difficulties and may not be picked up (The Office of the Children’s Commissioner, 2013). Older children also tend to be better at concealing neglect than younger children (Burgess, 2013). The current focus of education policy on academic attainment (for example, see Department for Education, 2015f) may also be impacting on the ability of school staff to take on early help provision for neglect. It has been argued that this focus might be to the detriment of a broader focus on children and young people’s wellbeing, personal development and health (Bonell et al, 2014). There has also been a high level of dissatisfaction among the teaching profession in recent years due to government reforms to pay and pensions, and a heavy workload (increased by regular curriculum changes, administrative tasks and school inspections) (ComRes, 2013). A survey of teachers by the Department for Education in 2013 found that they reported working, on average, over 50 hours per week, with secondary school headteachers reporting more than 60 hours (Department for Education, 2014b).
Teachers, alongside other public sector workers, held a day-long strike in July 2014, resulting in 21 per cent of schools in England being closed. Research has highlighted that the recent period of austerity has meant that there are less targeted services for schools, and others, to refer to (Office of the Children’s Commissioner, 2012). Other issues identified by schools included thresholds being too high for some external organisations, different timescales at which other organisations operate, a lack of understanding about how to refer to external services, and not knowing which particular people to contact for services or their contact details (Office of the Children’s Commissioner, 2012).

Factors that facilitate good safeguarding practice in schools have been identified by the Office of the Children’s Commissioner (2012, 2013) and Ofsted (2011a), and it may be beneficial to consider this learning in relation to all universal services. The research found that good safeguarding practice is facilitated by a whole school approach to safeguarding, backed by strong leadership, good communication and relationships with other organisations within the community. Factors that facilitate the building of strong relationships included tenacity in pursuing their relationships with other agencies, giving safeguarding leads and other staff specific time to develop these relationships and developing positive attitudes to multi-agency working through openness, honesty, clear expectations and an implicit understanding that all agencies were working for the same goal.

The importance of staff getting to know their students well, and ensuring that a focus on safeguarding occurs alongside attention to students’ wellbeing more generally, was also cited. This is also highlighted by Ofsted (2011a), who identify “a curriculum that is flexible, relevant and engages pupils’ interest; that is used to promote safeguarding, not least through teaching pupils how to stay safe, how to protect themselves from harm and how to take responsibility for their own and others’ safety” as an effective means of safeguarding.

Other recommendations for good practice in schools includes conducting holistic family assessments, ensuring that there is a consistent member of staff to work with a family, helping colleagues to develop skills of openness, honesty, trust and being non-judgemental, in order to better engage with families about neglect (National Foundation for Educational Research, 2014). The need for increased educational psychologist, family support work and mental health provision in schools has also been identified (Baginsky, 2008; Easton et al, 2013).

Schools are managing increasingly complex work, seeing themselves as hubs for their communities’ activities and services, as well as fulfilling their core purpose as places of excellent teaching, learning and achievement.

(Office of the Children’s Commissioner, 2012, p6)

### Early years providers

**Key safeguarding guidance documents for early years**

Department for Education (2014b) Statutory Framework for the Early Years Foundation Stage: Setting the standards for learning, development and care for children from birth to five. London: Department for Education

Early years providers are vital in identifying and providing early help for neglect because they can intervene both in response to risk factors for neglect, and at an early stage in a child’s life. Children’s centres in particular are a “key mechanism for improving outcomes for young children while reducing inequalities between the poorest children and their peers, as well as helping bring an end to child poverty” (Department for Education, 2010, p3). ‘Early years’ tends to refer to children from birth to the age of five.

Early years education is provided by public, private and voluntary organisations, and is not compulsory. All three- and four-year-olds are entitled to government-funded early education for 15 hours a week and this has recently been extended to disadvantaged two-year-olds. The government has also introduced an early years pupil premium, giving providers an additional £300 a year for each eligible child (Department for Education, 2015g).

The Early Years Foundation Stage (EYFS) is statutory guidance that sets the standards for all early years providers in relation to safeguarding children (Department for Education, 2014c). The guidance on safeguarding is basic, and does not...
explicitly set out a role for early help. It states that providers must be able to identify abuse and neglect and "must be alert to any issues for concern in the child’s life at home or elsewhere" (Department for Education, 2014c, p.18). In addition to designating a lead professional for safeguarding, the framework requires early years providers to ensure that all staff have up-to-date knowledge of safeguarding issues. It also sets out the requirement for child-staff ratios, which contribute to the ability of staff to safeguard.

However, one requirement in the guidance that does have direct implications for providing early help for neglect is the requirement that every child has a ‘key person’. “Their role is to help ensure that every child’s care is tailored to meet their individual needs, to help the child become familiar with the setting, offer a settled relationship for the child and build a relationship with their parents” (p.21).

A number of barriers influence the ability of early years practitioners to provide early help for neglect. The statutory nature of the service provided by children’s centres does offer some protection against government funding cuts; the Child Care Act 2006 requires that there is a sufficient provision of early childhood services and that there are consultations before services are changed or children’s centres are closed. However, children’s centres have been acutely affected by the substantial cuts to local authority funding in recent years. Local authorities have merged some centres to create clusters of several centres under one management team.

Figures obtained during parliamentary questions revealed that between April 2010 and April 2013, the number of children’s centres in England had been reduced from 3,631 to 3,116 (a reduction of 515) (Truss, 2013). There were thirty-five outright closures, with the remainder being formally merged with other children’s centres to create strategic partnerships. At the same time as this reduction in funding, the demand for the services provided by children’s centres in the UK is increasing (4Children, 2014).

The quality of early years provision has been called into question. The Nutbrown review (2012) found that the current early years qualifications system is not systematically equipping practitioners with the skills to give adequate care to babies and young children. According to Ofsted, which is responsible for inspecting early years provision, the quality of early years provision has improved over the past four years (Ofsted, 2014). In October 2013, Ofsted inspections deemed 66 per cent of early years providers as ‘good’ and 21 per cent as ‘satisfactory’, compared with 56 per cent of early years providers being deemed ‘good’ and 30 per cent as ‘satisfactory’ in August 2009. However, Ofsted has also stated that “satisfactory provision is not effective enough to close the attainment gap sufficiently quickly” (Ofsted, 2013).

**Cross-professional barriers to identifying and providing early help for neglect**

The research literature provides insight into barriers that cut across the practitioner groups in relation to providing early help for neglect.

- Early help is a voluntary, non-statutory process, and families can be unwilling to engage with help (Burgess et al, 2013; Easton et al, 2013).
- The complexities around defining and identifying child neglect are well documented, and it remains a "grey area" for practitioners (Easton et al, 2013). Challenges to identifying neglect include a lack of clarity around what constitutes acceptable standards of care (DePanfilis, 2006), the complexities of identifying emotional neglect in particular (Burgess et al, 2013), the nature of neglect as an act of omission (Horwath, 2007), the extent to which neglect often co-exists with other forms of abuse, and the tendency to consider neglect to be less harmful and serious for a child if it is perceived to be unintentional (Gardner, 2008). However, the most recent research findings are optimistic that practitioners’ ability to identify neglect is improving (Burgess et al, 2013).
- Child neglect, along with all forms of child maltreatment, is distressing and this can sometimes result in practitioners shutting out the signs that they see (RCGP, 2013).
- Problems with multi-agency working can impede more effective and timely interventions in child neglect cases. Issues include the failure of other organisations to share information or other practitioners not being willing to engage in discussions and meetings about concerns (Easton et al, 2013). There can also be anxiety
among practitioners around information sharing (Baginsky, 2008).

• There is a lack of understanding about what services were available to families within the local area, or a lack of services to signpost to (Easton et al, 2013; Baginsky, 2008).

• There are tensions between children’s social care and universal services around perceptions about the level of intervention needed in a family. Universal services practitioners can have difficulty in determining what level of concern warrants a referral (Munro, 2010) and some practitioners consider the threshold for intervention too high for a referral to services (Easton et al, 2013). Having referrals rejected can make universal services staff more cautious about making a referral in the future (Burgess et al, 2013). Some practitioners working in universal services have reported that it can be hard to access advice and help for children and families from children’s social care for early concerns (Burgess et al, 2013). However, from the point of view of children’s social care cases, if concerns about neglect are automatically referred to them, this creates a backlog and children’s social care cannot then reach the children most in need of help (Munro, 2010).

Social workers could offer support for the health visiting role whilst offering direct intervention for families with higher levels of need. At the same time, it could be argued that the skills of social workers in relationship building and assessment are crucial for early intervention and family support. Certainly, there is a need for more clarity about the envisaged role of social work within a more integrated system. (Daniel et al, 2010)

What do we know from children and young people about universal services and their provision of early help for neglect?

Research has been conducted with young people about what hinders them from disclosing neglect. Research by Action for Children (2014) found that there were a range of reasons why children and young people might not disclose neglect, including: being unsure where to seek help; fear that their story will be manipulated by practitioners or that practitioners will speak to their parents/carers; and being worried that other children or young people will find out and bully them.

Research has also been conducted to explore what helps young people to disclose neglect, and this centred on trusting relationships (Cossar et al, 2013). “Young people value practitioners they can trust, who are effective, knowledgeable and available. Teachers and youth workers were found to be particularly important as people to tell, and they and social workers were valued as being able to provide holistic support” (Cossar et al, 2013, pii). This included being seen as good sources of information and advice, emotional support, and people who could provide practical strategies to minimise harm. Stein et al highlighted the need to better enable practitioners to identify adolescent neglect in particular (Stein et al, 2009).

Summary

Statutory and non-statutory guidance for universal services practitioners gives them a role in providing early help for neglect. The extent to which this role is explicitly and clearly set out, however, varies. In addition, much of the guidance focuses on the role of practitioners to identify neglect, share information and signpost to other services; more explicit guidance should be developed on how practitioners can directly respond to concerns, for example through developing and maintaining relationships with a child and/or parent, and providing practical and emotional support.

In addition to a lack of clarity on roles and responsibilities, a range of barriers have been identified to the provision of this help, in particular pressures on resources and staff shortages across universal services.

The following chapter draws from a large sample of universal services practitioners and a group of children and young people to explore how early help provision works in practice.
3 Findings

The findings of this study explore:

- Professionals’ perceptions of their responsibility to identify neglect and provide early help;
- Current provision of early help in universal services;
- Barriers to the provision of early help for neglect in universal services; and
- Promising practice and ideas for better practice: ways to improve the provision of early help for neglect in universal services.

This is a mixed method study. We draw from a unique quantitative and qualitative data source, compiled from an England-wide online survey and discussion groups and interviews with practitioners and young people.

3.1 Demographics of the sample

A total of 852 practitioners responded to the survey. These comprised:

- Early years practitioners, n=107
- Health visitors, n=93
- Midwives, n=227
- School nurses, n=89
- Teachers, n=290
- GPs, n=46

The label 'teachers' includes a range of practitioners working in a school setting, including head teachers, deputy heads, class teachers, SENCOs and those with a pastoral role, such as family support workers. The majority of teachers who took part in the study were primary school teachers (80 per cent), with the remainder working in secondary schools (11 per cent), junior schools (9 per cent) and infant schools (1 per cent). The majority of early years practitioners who took part were working in nurseries (85 per cent), with the remainder working in children’s centres. 46 per cent of midwives were working in a hospital setting, with the remainder working in the community (34 per cent) or both a hospital and community setting (20 per cent).

The percentages of those completing the survey that reported having specific safeguarding responsibilities were:

- 68 per cent of teachers
- 46 per cent of school nurses
- 33 per cent of midwives
- 27 per cent of health visitors
- 48 per cent of GPs
- 79 per cent of early years practitioners

There must be caution applied to interpreting these statistics, as in a small number of cases those indicating that they held a specific safeguarding responsibility went on to explain that they were referring to their belief that all practitioners working with children have a safeguarding responsibility. These are included in the total given (for further detail, please see Appendix A).

The percentages of those completing the survey that were in a managerial position were:

- 40 per cent of teachers
- 10 per cent of school nurses
- 10 per cent of midwives
- 2 per cent of health visitors
- 44 per cent of GPs
- 65 per cent of early years practitioners

The majority of the teachers, midwives, early years practitioners and GPs in the study had been practising in their profession for over 15 years, unlike the health visitors and school nurses, who tended to be more newly qualified.

We spoke to a total of 41 practitioners during discussion groups or one-to-one interviews. This included six health visitors, eight midwives, three GPs, one senior safeguarding nurse, six school nurses, two local safeguarding business managers, four early years practitioners, one infant school teacher, five primary school staff, three secondary school teachers, one local authority designated officer, and one designated safeguarding nurse.

4 Percentages have been rounded to the nearest whole.
We also spoke to a total of 18 children and young people, who were recruited via NSPCC service centres. The young people were aged between 11 and 24, and had experienced neglect in the past but were in a safe and settled environment at the time of the discussion groups.

All the participants who took part in the project comprised a convenience sample and were self-selected. Therefore, it is likely that the data is vulnerable to selection bias in that those who took part in the study may have been those with an interest in safeguarding and neglect.

Because this research focused on universal services practitioners, we did not capture the views of social workers; however, there is scope in the future to explore social workers’ perceptions of the role of universal services practitioners in providing early help for neglect. In addition, we did not speak to parents; however, this is also recommended in future research to add additional insight.
3.2 Practitioners’ perceptions of role responsibilities

**KEY FINDINGS**

- All the practitioner groups believed that they and other universal services have a responsibility to be able to both identify neglect and to respond directly in some way.
- Health visitors, schools nurses and early years practitioners perceived themselves to have the greater amount of professional responsibility across the four identified types of early help, rather than midwives, teachers and GPs.
- The extent to which the participants saw the early help activities as their responsibility did not seem to be affected by whether they reported having a specific safeguarding responsibility, with the exception in some instances of GPs and teachers.
- Signposting and monitoring were commonly seen across the groups as a professional responsibility, while working directly with children and with parents were less commonly seen as a professional responsibility.
- There was a relatively high degree of variation on perceptions of responsibilities within professions.

As set out in the previous chapter, statutory and non-statutory guidance for universal services practitioners requires them to play a role in providing early help for neglect, but this expectation is relatively new and what this requirement means in practice can seem unclear.

In this section, we looked at the way the different practitioner groups perceived their professional responsibilities. Gauging practitioners’ own perceptions of their role in providing early help provides insight into whether the guidance is influencing professional perceptions of role, gives an indication of whether perceptions are acting as a barrier to the provision of early help for neglect, and could support future guidance in capitalising on existing thinking around roles.

We asked the practitioners to rate a range of statements from 1 to 7, with 1 indicating that they strongly disagreed with a statement, and 7 indicating that they strongly agreed with it. From these ratings, we have displayed the averages. In addition, because averages can mask variation in the data, we also looked at the spread of the data. This tells us the extent to which there was agreement within professions. We looked for differences between those working in the same profession but in various settings, and those with a specific safeguarding responsibility (for further detail on the method, see Appendix A).

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I don’t think there’s a shared understanding in terms of what the responsibility is.

Local Safeguarding Children’s Board Business Manager
Perceived responsibility to provide early help

**Statement:** It is a health visitor’s/school nurse’s/midwife’s/early years practitioner’s/teacher’s/GP’s responsibility as a professional to know how to identify child neglect.

The vast majority of the participants strongly agreed with this statement, rating it at 7, and analysis indicated a relatively small range of responses. There were some small differences between midwives and teachers working in different settings; those midwives working in hospitals rated this statement at 6, as did those teachers working in infant, primary and junior schools. However, these differences between midwives and teachers working in different settings were not found to be statistically significant. There was no difference between those with or without a specific safeguarding role.

**Statement:** It is only the responsibility of the named safeguarding person to provide early help where there are concerns about child neglect.

Most groups strongly disagreed with this statement, rating it at 1, and analysis indicated a relatively small range of responses. Teachers were the only exception to this, rating the statement at 2. However, there was a statistically significant drop back down to a rating of 1 by those teachers with a specific safeguarding responsibility.

**Statement:** It is only the job of social care to provide early help where there are concerns about child neglect.

There was also strong disagreement across the group with this statement, who on average tended to give it a rating of 1. The exception was GPs, who also disagreed with the statement but to a lesser extent, rating it at 2. Analysis also showed that secondary school teachers disagreed less strongly than primary school teachers with this statement, and this finding was statistically significant (rating at 2).

**Statement:** It is a health visitor’s/school nurse’s/midwife’s/early years practitioner’s/teacher’s/GP’s responsibility to identify neglect and refer the concern to social care, but not to provide early help to the child or family.

Chart 1 shows the median ratings for this question. The responses of health visitors and schools nurses to this statement suggested that they felt strongly that providing early help for neglect was their professional responsibility. Midwives, early years practitioners and teachers also saw themselves as having a role in providing early help, but to a lesser extent than health visitors and school nurses. The average rating for GPs, however, indicated that they neither agreed nor disagreed with the statement, positioning them as the professional group least likely to see themselves as having a role in providing early help for neglect.

However, the practitioners’ views on their role in providing early help were by no means unanimous, with analysis showing that there was a wide range of views on this statement within most of the practitioner groups. There was consensus in only two groups of practitioners, with the first being health visitors. The second group showing consensus in their response to this statement was GPs with safeguarding responsibilities, who rated the statement at 3; however, this finding was not statistically significant.

**Question:** To what extent do you think each of the following groups have a role to play in providing early help for neglect: teachers, health visitors, school nurses, early years practitioners, GPs, midwives?

Participants were asked to respond to this question by choosing a number on a scale of 1 to 7, with one indicating that they felt a particular professional group had no role in providing early help, and 7 indicating that they felt a particular professional group had a significant role to play. On average, each professional group rated the remaining five groups as having a significant role to play in providing early help (rating 7).
The participants’ views of their responsibilities to undertake specific types of early help activities were also explored. These specific types of early help provision were identified during the discussion groups and interviews. They comprised:

- Signposting families to relevant support services;
- Monitoring children;
- Working directly with parents/carers (for example, providing help by talking through their issues with them, giving them advice and building a relationship with them); and
- Working directly with children.

* indicates where there was a wide range of responses around the average rating.
Perceived responsibility for early help: health visitors

The chart below shows how health visitors perceive their responsibilities for providing early help.

On average, health visitors said that they strongly agreed that signposting families to other services, monitoring children, working directly with parents and working directly with children were their responsibility, giving these responses a rating of 6 or 7. Analysis showed a wide range of views within the group about the extent to which working directly with parents was their responsibility. There were no noteworthy differences between those with a safeguarding responsibility and those without.

I would transfer the family to an enhanced service, signpost, support, monitor, discuss with other agencies and colleagues and ensure a high standard of record keeping.

Health visitor

Chart 2: Perceived responsibilities – health visitors

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*Working directly with parents
Perceived responsibility for early help: school nurses

The chart below shows how school nurses perceive their responsibilities for providing early help.

The average ratings show that school nurses reported that they strongly agreed that signposting families to other services, monitoring children, working directly with parents and working directly with children were their responsibilities. Analysis showed a wide range of views within the group about the extent to which monitoring children was the responsibility of a school nurse. There were no noteworthy differences between those with a safeguarding responsibility and those without.

*Safeguarding is everybody’s business: therefore, everyone has a role to play.*

School nurse

Chart 3: Perceived responsibilities – school nurses
Perceived responsibility for early help: early years practitioners

The chart below shows how early years practitioners perceive their responsibilities for providing early help.

On average, early years practitioners strongly agreed that signposting families to other services, monitoring children, working directly with parents and working directly with children were their responsibility (ratings of 5 to 7). Analysis showed a wide range of views about the extent to which working directly with children and parents was the responsibility of an early years practitioner. There were no noteworthy differences between those with a safeguarding responsibility and those without.

As far as I’m concerned, we all have a role to play.
Early years practitioner

Chart 4: Perceived responsibilities – early years practitioners
Perceived responsibility for early help: midwives

The chart below shows how midwives perceive their responsibilities for providing early help.

On average, midwives said that they strongly agreed that signposting and working directly with parents was their responsibility, rating them at 7 and 6 respectively. They said that they felt less strongly that monitoring was their role, rating it at 5. Midwives disagreed that they had a role in working directly with children, giving it a rating of 3. This is likely to be because midwives work with very young babies. Analysis showed a wide range of views within the group about the extent to which three of the four statements were the responsibility of a midwife, namely the responsibility to monitor children, work directly with parents and work directly with children.

Among those midwives working in both a hospital and community setting, there was a statistically significant commonly shared perception of their responsibility to monitor children, which they rated at 3.

The qualitative data revealed further insight into this complex picture. Some midwives reported that the nature of the role meant that they did not routinely spend enough time with a family to provide early help, due to short consultation times in which there was inadequate time to develop a relationship with families. Working on labour wards also meant that the opportunity to identify concerns could be time limited. Other midwives raised the issue of constant changes in case allocations that prevented them from developing a relationship with a family.

In addition, some noted that a relative absence of postnatal work meant that midwives were not well placed to deliver early help for neglect. While in the qualitative data for each professional group there were some practitioners who commented that they did not feel that early help was their responsibility, this was a stronger theme for midwives.

It would be good if more midwives could take on that role of additional support for the parents, but there’s not time in the traditional role of the clinics and things like that, but it’s a shame that there isn’t because you’re building up that relationship with somebody to then sort of refer them on to another agency that might not always be.

Midwife

Chart 5: Perceived responsibilities – midwives

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Perceived responsibility for early help: teachers

The chart below shows how teachers perceive their responsibilities for providing early help.

On average, teachers strongly agreed that it was their responsibility to monitor children, giving this a rating of 7. They felt that signposting families to other services, providing direct support to children and directly working with parents were responses that were less their responsibility, giving ratings of 5, 5 and 4 respectively. Analysis showed a wide range of views within the group about the extent to which it is a teacher’s responsibility to signpost families to other agencies, work directly with children and work directly with parents. There were no noteworthy differences between those with a safeguarding responsibility to those without.

The problem is when you deal with so much on such a regular basis you can become overwhelmed and also time to give parents can be limited because ultimately we are teachers not social workers.

Headteacher, primary school

Chart 6: Perceived responsibilities – teachers
Perceived responsibility for early help: GPs

The chart below shows how GPs perceive their responsibilities for providing early help.

On average, GPs reported that they saw signposting and working directly with parents as key professional responsibilities, giving both of these activities a rating of 6. They said that they felt less strongly that monitoring children was their responsibility, rating it at 5, and even less that providing direct support to the child was their responsibility, rating it at 4, which indicated a neutral response. Analysis showed a wide range of views within the group about the extent to which it is a GP’s role to monitor children. Those without a specific safeguarding responsibility did not agree as strongly as those with a specific safeguarding responsibility that working with parents was their responsibility (giving a rating of 5 compared with 6). GPs without safeguarding responsibilities tended to perceive the early help responses to be marginally less their responsibility than those with a specific safeguarding responsibility. However, neither of these findings were statistically significant.

Early response can be a whole manner of things, and we may have a role to play but it’s highly likely that someone else in the multidisciplinary team will have roles to play as well, so an early response is treating a mum’s depression or signposting a dad or a mum to drug and alcohol services, and that all comes under the early intervention banner, so we certainly have a big role to play in early intervention, but probably not on our own.

GP

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<tr>
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<table>
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<tr>
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<td>2</td>
<td>3</td>
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<td>5</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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</tbody>
</table>
Summary and discussion

The data suggested that all the practitioner groups believed that they and other universal services have a responsibility to be able to both identify neglect and to respond directly in some way, and that the responsibility does not lie only with children’s social care. On average, health visitors, school nurses and early years practitioners perceived themselves to have the greatest amount of professional responsibility across the four identified types of early help, compared with midwives, teachers and GPs (see Table 2). This is not surprising as these roles are traditionally seen as early help providers.

The extent to which the participants saw the early help activities as their responsibility did not seem to be affected by whether they reported having a specific safeguarding responsibility. We anticipated that those with a specific safeguarding responsibility would be more likely to see early help activities as their responsibility; this finding seems to contradict that assumption. There were exceptions to this, most notably among GPs. In addition, teachers without a specific safeguarding responsibility were more likely to see the provision of early help as the responsibility of their named safeguarding professional than participants in the other practitioner groups.

As well as showing which activities practitioners saw as within their remit, the table also highlights the aspects of early help that practitioners did not see as in their remit. Compared with signposting and monitoring, working directly with children and working directly with parents were less commonly seen by the participants as their professional responsibility. In particular, teachers did not see working with parents as within their remit, and likewise, GPs did not see working with children as within theirs.

The extent to which teachers saw working directly with children as their responsibility in response to low-level neglect also stands out as being lower than perhaps would have been expected, given the frequency of contact and time spent with children.

The data also highlighted the extent to which there was a relatively high degree of variation on perceptions of responsibilities within professions. This was particularly the case for midwives and teachers. This perhaps reflects the absence of clear guidance on the role of universal services practitioners to undertake early help. Overall, these findings suggest that there is work to do across all practitioner groups to clarify their role in providing early help for neglect.

Table 2: Comparison of the average Likert scale ratings for each type of activity across the professions

<table>
<thead>
<tr>
<th></th>
<th>Monitoring</th>
<th>Working directly with children</th>
<th>Working directly with parents</th>
<th>Signposting to other services</th>
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<td>Health visitors</td>
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<td>School nurses</td>
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<td>Midwives</td>
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<td>Teachers</td>
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<td>GPs</td>
<td>5</td>
<td>4</td>
<td>6</td>
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</table>

(1 = strongly disagreed that the activity is their responsibility and 7 = strongly agreed that the activity is their responsibility)
3.3 Current provision of early help for neglect

**KEY FINDINGS**

- All practitioners are undertaking a variety of early help responses for children showing signs of low-level neglect.
- Signposting families to other agencies was a common response across all practitioners.
- Teachers and early years practitioners were less likely than those working in health services to contact other practitioners about an early concern. While between 82 per cent and 89 per cent of GPs, midwives, school nurses and health visitors said that they normally contacted other practitioners, only 64 per cent of education practitioners said that they did.
- The practice of routinely monitoring a child in response to early concerns about neglect was more commonly done in education settings than in health services. Eighty-four per cent of early years practitioners and 76 per cent of teachers said that they routinely monitored children, but, worryingly, only 20 per cent of midwives, 37 per cent of GPs, 52 per cent of school nurses and 66 per cent of health visitors said that they did.
- Talking to a parent about a concern was relatively common practice, and most common in health visitors, GPs, school nurses and early years practitioners. Providing parents with emotional and practical support was very common for health visitors and common for early years practitioners, of whom 96 per cent and 79 per cent respectively said that they would do so. It was less so for GPs (67 per cent), school nurses (66 per cent), midwives (59 per cent) and teachers (53 per cent).
- The practitioners’ perceptions of their professional responsibilities mostly matched their reported practice.
- Referral to children’s social care as a method of early help was common in midwifery and school nursing, with 75 per cent and 47 per cent respectively saying that they would normally refer. Among the other practitioners groups, the averages were still relatively high, ranging from between 29 per cent to 35 per cent.
- There were strikingly low percentages of practitioners who said that they would normally talk to a child about an early concern. 69 per cent of teachers, 67 per cent of school nurses and 63 per cent of GPs said they would not normally talk to the child about an early concern.
- Specific tools to identify child neglect are not commonly used in universal services. Where they are, they are used by health visitors and school nurses.

In this section, we describe the types of early help responses that the practitioners in the study said they currently carry out in everyday practice. Understanding what early help is already being provided in universal services allows us to learn about what can be built on and further supported, and what provision is missing.

We asked participants about their everyday practice in providing early help for neglect with the model (see Figure 1) in mind. We asked them to indicate from a detailed list of set responses which of those responses they would normally employ in response to the following scenario:
You are concerned that a child you are working with might be experiencing low-level neglect and may benefit from early help.

• We don’t have many neglected children in this area, so this is an issue I rarely face.
• I would normally contact other practitioners to gather information about the family.
• I would normally provide direct support to the child by giving them emotional and practical support.
• I would normally provide direct support to the parents/carers by giving them emotional and practical support.
• I would normally ensure a Common Assessment Framework was completed.
• I would normally signpost the family to other agencies or practitioners for help.
• I would normally talk to the child about my concern.
• I would normally talk to the parent about my concern.
• I would normally start formally monitoring the child.
• I would normally escalate my concern to another person in my team.
• I would normally make a referral to children’s social care.

We would only expect a referral to children’s social care to occur after early help has been offered but not engaged with by parents or carers, when a child is considered to be a child in need as defined in the Children Act 1989, or when it is considered that the child has suffered significant harm or is likely to do so (Department for Education, 2015d). Therefore, we would not expect the participants to choose this option in response to an early help scenario. In addition, we know that neglect is widespread and occurs in both areas of affluence and deprivation; therefore, we would not expect practitioners to state that they have low numbers of neglected children in their area.

The participants could choose as many responses as applied to them, and were also able to add additional responses in an open text box. This question aimed to generate data on everyday practice in each profession; the participants’ answers are discussed here in the knowledge that responses to neglect and other forms of maltreatment depend on the particular context of each child and family. It was unfeasible to determine the sequence of their responses to low-level neglect; therefore, this data can only provide an impression of current practice.

We also asked participants if they had regular internal team meetings to discuss early concerns about maltreatment, including neglect, and if they knew about or used specialist tools for identifying neglect.

We analysed the data for differences between those with safeguarding responsibilities and differences within roles in different professions, and differences are noted where they arose.

Practitioners’ understanding of the prevalence of neglect

Statement: We don’t have many neglected children in this area, so this is an issue I rarely face.

A small number of early years practitioners (7 per cent), teachers (5 per cent) and midwives (4 per cent) reported that the scenario set out in the question was one they rarely faced because of low numbers of neglected children in their area. Analysis of the Index of Multiple Deprivation for the areas in which these practitioners were working showed an even spread across deprived and affluent areas (Communities and Local Government, 2011), suggesting that these figures reflect individual perceptions of neglect. Only 2 per cent of GPs, 1 per cent of health visitors and no school nurses chose this response.

These findings suggest that education practitioners and midwives may benefit from further training or greater opportunity for reflective discussion in order to fully understand the range of ways that child neglect can manifest and the ways in which children and young people often seek to disguise their situations.

6 The term ‘education practitioners’ refers to those working in schools and in early years settings
Common practice in school nursing

School nurses reported employing a range of early help responses to low-level neglect. Particularly common were signposting a family to other agencies or practitioners (90 per cent) and contacting other practitioners to gather information (88 per cent). They listed health visitors, school teachers and learning mentors, named safeguarding leads in schools, their managers and GPs as practitioners with whom they routinely worked with and accessed support from.

Other relatively common responses identified by school nurses were talking to the parent about the concern (74 per cent) and providing direct support to the parent (73 per cent). However, this also means that about 1 in 4 school nurses said that they would not talk to or provide direct support to parents when they had early concerns about neglect.

School nurses also reported that they would regularly complete a CAF (73 per cent), although some concerns were raised about the length of the CAF process. Again, about 1 in 4 said that they would not complete a CAF.
School nurses also completed holistic school nurse assessments in response to low-level neglect and it was also noted by some that their response could depend on the clinical scenario. Fifty-five per cent of school nurses reported attending regular internal team meetings to discuss early concerns about child maltreatment and these tended to be held when it was deemed necessary, rather than at a set time.

While making a referral to children’s social care was a less common response than others, at 47 per cent, this was still high in light of the focus of the scenario on the provision of early help. Some were keen to emphasise that a referral would not be made unless the family did not engage with early help. Some also said they would refer the family to their local early intervention team.

While only a relatively small percentage of school nurses said that they would talk to the child about their concern (33 per cent), this positioned them as the second most likely professional group to do so, after secondary school teachers. There are important findings across all the practitioner groups about the extent to which they speak to children about their concerns, and these are discussed throughout the chapter.

The relatively high percentage of school nurses reporting that their normal responses to early child neglect included signposting to other agencies and working with parents was in line with their perception of their professional responsibilities. However, while school nurses strongly agreed that monitoring children was their responsibility, only 52 per cent said that they would normally monitor. There were no noteworthy differences in the responses of those who reported having a safeguarding responsibility and those who did not.

I am based within the same building as the health visitors and GP and we have regular meetings so that we have joined working and have more knowledge about the families we work with. We work closely with the multi-agency teams and social care are in regular contact with us for agency checks on any referrals they have.

School nurse

I think if we have concerns about these children, we do need to make good relationships with the parents or the carers because if it does get escalated and they do end up on plans, we don’t really want to be enemies, we need to be working with these parents to improve these kids’ lives. So we need to be open and honest with them. I think. When [parents] do come to work with you, the ones that you have good relationships with, they do work better, the plans do work better, and hopefully they get maintained when everyone else backs out. But with our service, even when other services back out, the school nurse is always kind of there. Not necessarily at the forefront but we’re in the background.

School nurse
Common practice in health visiting

Health visitors said that they, like school nurses, employed a range of early help responses to low-level child neglect. Particularly common responses were providing direct support to the parents (96 per cent), signposting (94 per cent), talking to the parents about the concern (90 per cent), and contacting other practitioners to gather information (82 per cent). Examples of direct work with parents were supporting parents to develop secure attachments with their babies and supporting parents to devise workable solutions to problems themselves.

Some health visitors also spoke about increasing the frequency of home visits to the family when they had early concerns in order to provide additional face-to-face support for vulnerable mothers.

Some said that they would also refer to their early intervention team. Fifty-three per cent of health visitors reported that they attended regular internal team meetings, and these tended to be held weekly or monthly. Almost half of health visitors said that they would not normally provide direct support to a child.

Again, like school nurses, the two responses that health visitors were less likely to report were making a referral to children’s social care (32 per cent) (although this was a considerably lower percentage than school nurses) and talking to the child about their concern (17 per cent). For health visitors, this is presumably linked to some degree with the infant being pre-verbal. They noted that a referral to social care would only occur when parents were not engaging with services offered.

Graph 3: Health visitors’ early help responses to low-level neglect
The high percentage of health visitors reporting that their normal responses to early child neglect included signposting to other agencies and working with parents was in line with their perception of their professional responsibilities. However, while health visitors said that they saw monitoring children as a key professional responsibility, only 66 per cent said that they would normally monitor.

Some statistically significant differences were found between those who reported having a safeguarding responsibility and those who did not. Those who reported having a safeguarding responsibility were more likely to say that they would monitor a child (80 per cent), with 40 per cent of those without a specific safeguarding responsibility saying that they would not. Those without a safeguarding responsibility were more likely to escalate a concern within their team. They were also more likely to make a referral to children’s social care, but this finding was not statistically significant.

I would make additional visits to the family to further assess the situation and offer support to the family. I would encourage the family to engage with other services and make referrals. This would vary depending on the needs, for example a mother who is depressed might be unable to meet the needs of her children and I would refer to the GP for possible referral to adult mental health services. I would also refer to the children’s centre for outreach work. If these interventions fail I would then refer to social services.

Health visitor

Use of tools for identifying neglect in health visiting and school nursing

**Question:** Do you know about specialist tools for helping practitioners to identify neglect? Please list the specialist tools for helping practitioners to identify neglect.

There are a range of specialist tools that can be used by practitioners to identify neglect, for example the Graded Care Profile (GCP), locally-devised neglect and ‘quality of care’ toolkits and the Action for Children neglect assessment model. These tools allow practitioners to produce an objective measure of the quality of care given to a child.

Specialist tools to identify neglect were not commonly used, and where they were reportedly used, this tended to be within health visiting and school nursing. We asked the participants if they knew about specialist tools for helping practitioners to identify neglect, and around half of the school nurses and health visitors reported that they did. Conversely, in the remaining practitioner groups, only about 20–30 per cent of participants reported knowing about these specialist tools.

The majority of the tools listed were generic ones for identifying safeguarding issues, rather than neglect-specific tools. Participants identified the CAF or Early Help Assessment Tool (EHAT), local authority threshold documents and organisational safeguarding policies as tools for identifying neglect, as well as child protection training itself.

The GCP was the most frequently reported neglect-specific assessment tool mentioned. However, with only 4 per cent of participants across the practitioner groups reporting that they had used the GCP, it was not commonly used. Again, the majority of this small number of users consisted of school nurses and health visitors. A small number of participants also spoke about using a specific neglect assessment tool provided by their local authority.

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7 P<0.05
8 P<0.01
9 It was not clear whether participants were using the GCP or an adapted form.
Common practice in teaching

The most common responses to early concerns about neglect by teachers were reported as monitoring the child (76 per cent), providing direct support to the child (73 per cent) and signposting the family to other services (70 per cent). Providing direct support to children included providing food or clean clothes, initiating school-based interventions (for example, breakfast clubs) or engaging with the child through activities like circle time. One teacher described their process of monitoring:

We would monitor, telling staff to note on behaviours but not necessarily telling them why, [complete a] diary of how they are coming into school and speaking to parents informally, trying to see if there is a link to behaviour.

Teacher

Other responses by teachers included ensuring that they were a visible and accessible presence to the child and setting up an independent plan for the child. Sixty-eight per cent of teachers reported attending regular internal team meetings, and these were commonly said to be held as and when necessary. The two responses teachers were least likely to report were talking to the child about the concern and making a referral to children’s social care.

Sixty-eight per cent of teachers would not normally talk to a child about their concern, perhaps suggesting a lack of confidence or time in schools to address these issues with children and young people, or fears about how their parents or carers may respond. Twenty-nine per cent of teachers said that they would make a referral to children’s social care as a form of early help, equating to the lowest percentage across the groups.

Graph 4: Teachers’ early help responses to low-level neglect
Unlike other practitioners, those teachers with a safeguarding responsibility said that they more regularly undertook most of the early help responses listed; there tended to be a relatively large difference between the two groups, and these findings were statistically significant\(^\text{10}\), with the exception of talking to the child. Those without a safeguarding responsibility were more likely to escalate the concern within the team, an action that 92 per cent of teachers without a safeguarding responsibility said that they would do\(^\text{11}\).

Escalating a concern within the school meant speaking to the Designated Safeguarding Professional (DSP), informing other teachers of the concern and asking them to report further concerns, and referring the concern to a range of support staff (including learning mentors, emotional wellbeing support officers, parent-liaison officers, home-school workers and teaching assistants).

Those with a safeguarding responsibility were also more likely to attend regular internal team meetings to discuss early concerns about maltreatment (72 per cent) than those without (61 per cent), and this finding was also statistically significant\(^\text{12}\).

How do different settings affect practice?

Notable and statistically significant differences in responses between the different school settings were that secondary schools were more likely, compared with schools for younger children, to talk to a child about their concern. Fifty-three per cent of secondary school staff reported that they would talk to a child, compared with 25 per cent in junior schools and 28 per cent in primary schools\(^\text{13}\). Secondary school teachers were also almost twice as likely as primary school teachers to make a referral to children’s social care (at 47 per cent, compared with 26 per cent)\(^\text{14}\). Those working in primary and junior schools more commonly reported monitoring children (78 per cent and 79 per cent respectively) compared with those in secondary and infant schools (63 per cent and 25 per cent respectively)\(^\text{15}\). These could be explained by the small percentage of those in the sample of teachers working in these settings, or by the age of the children.

We would obviously call the parents; invite them in. We’d offer one-to-one support, so the parents would come in weekly and meet with myself and another family support worker to discuss the areas of concern and how we can support them. We’d offer home visits. We’d offer a CAF if we felt it necessary.

Family support worker, primary school

The variability in teachers’ views of their responsibilities in providing early help in cases of neglect was reflected in the variability in their normal practice. It may also be the result of the number of different roles that participants had within schools.

\(^{10}\) p<0.01  
\(^{11}\) P<0.01  
\(^{12}\) P<0.01  
\(^{13}\) P<0.01  
\(^{14}\) P<0.01  
\(^{15}\) P<0.05
**Common practice in early years**

The most common responses to early concerns about neglect in early years were providing direct support to the child (87 per cent), monitoring the child (84 per cent), providing direct support to parents (79 per cent), signposting families to other agencies (76 per cent) and talking to the parent about the concern (72 per cent).

Direct work with parents and children included helping parents to find parenting courses, accessing Sure Start centres and providing children with food. Some early years practitioners also said that they would undertake home visits when they were concerned about a child or would refer to their early intervention team.

**Graph 5: Early years practitioners’ early help responses to low-level neglect**
Seventy-nine per cent of early years practitioners said that they had regular internal team meetings to discuss early concerns about maltreatment, and these were said to be held as and when necessary. While the vast majority of practitioners said that they would provide direct support to a child, 88 per cent said that they would not commonly talk to a child about their concern.

The high percentage of early years practitioners reporting that their normal responses to early child neglect included signposting to other agencies and monitoring children was in line with their perception of their professional responsibilities. While the data indicated that there was a wide range of views from the practitioners about their responsibility in working directly with children and parents, the data on normal practice indicates that this is a common response.

Those who reported having a safeguarding responsibility were more likely to monitor the child and escalate the concern within the team than those without, and these findings were statistically significant\textsuperscript{16}.

The findings that those who reported having a safeguarding responsibility were more likely than those without to ensure a CAF was completed, were less likely to refer to children’s social care and were more likely to have meetings about concerns, were not statistically significant.

Early years practitioners were less likely to report making a referral to social care (31 per cent) and talking to the child about the concern (12 per cent). Therefore, 88 per cent of early years practitioners would not normally speak to a child about a concern. While the age and verbal ability of the child will impact on whether this is appropriate, it does again raise questions about how child-centred practice currently is.

\textbf{So we’d have cause for concern, then we’d work with the family to see what was happening at home. We’re in the privileged position to have the family support worker and the outreach staff, that they’re able to go and do that at home, and that would be our system.}

\textbf{Early years practitioner}

\textit{I would observe and support the child and family, take a holistic view and gather information, provide information on supportive services that may help the family, begin a multi-agency approach with a view to providing additional information and support.}

\textbf{Early years practitioner}

\textit{I would ensure [that the] child had enough to eat whilst at nursery, and ensure that the child was not excluded by peers.}

\textbf{Early years practitioner}
How do different settings affect practice?
While there were clearly large differences in practice between the two settings, it is important to note the small percentage of participants who worked in a children’s centre (15 per cent) compared with in nurseries (85 per cent), which means we must be cautious about overemphasising these statistics. In addition, the majority of differences were not statistically significant.

Analysis within the group showed that there was a statistically significant difference between nurseries and children’s centres in relation to one response; children’s centre staff were less likely to make a referral than nursery staff (13 per cent compared with 34 per cent\(^{17}\)). As noted, the remaining differences were not found to be statistically significant.

Analysis showed that children’s centre staff were more likely to contact other practitioners (81 per cent compared with 60 per cent), escalate the concern (81 per cent compared with 60 per cent), talk to the child (20 per cent compared with 11 per cent), and complete a CAF (69 per cent compared with 48 per cent).

They were also less likely to monitor children (75 per cent compared with 86 per cent) and have meetings to discuss concerns (69 per cent compared with 80 per cent).

Graph 6: Early years practitioners’ early help responses to low-level neglect: by setting
Common practice in midwifery

The most common responses to early concerns about child neglect by midwives were contacting other practitioners to gain information about the family (89 per cent) and signposting families to other agencies (82 per cent). Forty-nine per cent of midwives reported that they attended regular internal team meetings, and these were most commonly said to be held monthly.

There is an early help and advice hub where midwives can discuss concerns and glean advice as to how to support and signpost a family for support. More than one service is likely to become involved, with a ‘team around the family’ approach using shared family assessment and a lead professional.

Midwife

Making a referral to children’s social care was cited by many midwives as an appropriate response to early concerns about neglect, with 75 per cent saying that they would take this course of action. This was by far the highest percentage across the practitioner groups. Where more detail was given about this course of action by the participants (and only a small number did expand on this), it revealed that, for some, referring to social care about any safeguarding concern was their first course of action. However, it seemed that in other cases, ‘making a referral to social care’ meant contacting social care to gather information about a family and gain advice about the best course of action.

If any midwife fills in our internal form then we phone social care to find out if there are any existing children, if they’re known, or if the mother has ever been known or the partner.

Midwife

Graph 7: Midwives’ early help responses to low-level neglect

<table>
<thead>
<tr>
<th>Activity</th>
<th>Average (n=227)</th>
<th>Safeguarding responsibility (n=74)</th>
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<td>Contact professionals</td>
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</tr>
<tr>
<td>Direct support: child</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Direct support: parents</td>
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<td></td>
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<tr>
<td>CAF</td>
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<td></td>
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<tr>
<td>Signpost</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Talk to the child</td>
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<td></td>
<td></td>
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<tr>
<td>Talk to the parent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitor child</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Escalate concern</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Referral to social services</td>
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<td></td>
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<tr>
<td>Other</td>
<td></td>
<td></td>
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</tbody>
</table>
As a midwife, if we felt a baby was being neglected by its carers, we would refer this matter to social services.

Midwife

If we have concerns at booking those referrals, go in and we get our response. My job every other Wednesday is if we haven’t heard anything within two weeks to find out where they’re up to, and I’m back on the phone again to the referral and assessment unit: where are you up to?; has this case been allocated?; what’s going on? And follow it through.

Midwife

Midwives were also likely to escalate the concern within their team (71 per cent), often to specialist safeguarding midwives (where this service was available), who were highly valued by many.

Safeguarding midwifery team provides care for the most vulnerable families and are able to offer additional support to families in need, as universal midwifery services are unable to offer intensive support.

Midwife

Much of the qualitative data from the survey also indicated that midwives would refer the concern on to others. As well as children’s social care, other services that midwives reported working closely with and referring families to included health visiting, children’s centres, Citizen’s Advice Bureau and early help hubs.

The data showed statistically significant differences between those who reported having a safeguarding responsibility and those who did not. Those without a safeguarding responsibility were more likely to refer to social care (79 per cent compared with 66 per cent), and to escalate a concern within the team. They were also twice as likely to say that they would provide direct support to a child, although these figures were still very low at 24 per cent and 12 per cent respectively. Those with a safeguarding responsibility were more likely to report being involved in team meetings (64 per cent) than those without (41 per cent).

The high percentage of midwives reporting that their normal responses to early child neglect included signposting to other agencies was in line with their perception of their professional responsibilities. Providing support to parents was commonly undertaken by 59 per cent of midwives, which to some extent reflects that the data showing that there was a wide range of views within the sample of midwives over whether this was a professional responsibility.

It is important to note that the responses of the midwives to the survey may have been influenced by the wording of the scenario given; the word ‘child’, rather than ‘baby’, was used, in order to present each professional group with an identical scenario to allow comparison.

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18 p<0.01 for all three findings
19 p<0.01
How do different settings affect practice?
Some statistically significant differences were found between midwives working in different settings. Compared with those working in a hospital, midwives working in both the community and a hospital setting were more likely to say that they would respond to early concerns about neglect via CAF (76 per cent compared with 62 per cent in hospitals).

In addition, those working in both the community and hospital were more likely to say that they would signpost the family to other services (93 per cent compared with 80 per cent in the community and 78 per cent in hospitals). Working in a hospital environment meant that midwives less commonly talked to parents about their concern (60 per cent) than those working in the community (79 per cent).

Another difference that was not found to be statistically significant was that midwives working in both the community and hospital were less likely to say that they would talk to the child about their concern (4 per cent compared with 13 per cent in the community and 12 per cent in hospitals). Clearly, it is not possible to ‘talk’ to a baby. This item was included in the survey for midwives in order to ensure continuity across all the professions.

Those who reported that they did talk to the child may have been referring to older siblings with whom they had contact, or they may be referring to non-verbal interaction with the infant.

Graph 8: Midwives’ early help responses to low-level neglect: by setting

- Community (n=76)
- Hospital (n=102)
- Both (n=45)

20 P<0.01
21 P<0.05
22 P<0.01
Common practice in general practice

There are all sorts of opportunities to think in many ways about neglect in all our consultations, to be quite honest with you; I’d say it’s massive.

GP

Common reported responses to early neglect by GPs included signposting the family to other agencies (91 per cent) and contacting other practitioners (87 per cent). Practitioners with whom GPs said they normally liaise included health visitors, school nurses, teachers and children’s social care. Some also spoke about raising the concern in an internal meeting, reviewing the families’ records, and attempting to ensure that they had a follow-up appointment with a family to develop a relationship.

Like school nurses, some GPs noted that the response would depend on the clinical scenario. Holding internal team meetings was reportedly common practice in GPs surgeries, with 72 per cent of GPs saying that these meetings were held, and usually on a monthly basis. The response that GPs were least likely to report was completing a CAF (26 per cent).

Another common response was talking to the parent about the concern (83 per cent), but while a high number of GPs said they would normally talk to a parent about a concern, less said that they would provide direct support to parents (67 per cent). At 37 per cent, GPs were the group most likely to report discussing their concern with the child.

Graph 9: GPs’ early help responses to low-level neglect

- Contact professionals
- Direct support: child
- Direct support: parents
- CAF
- Signpost
- Talk to the child
- Talk to the parent
- Monitor child
- Escalate concern
- Referral to social services
- Other

- Average (n=45)
- Safeguarding responsibility (n=22)
- No safeguarding responsibility (n=24)
It’s a very difficult call about whether that was a social services referral straight off, with everything happening in the family, or whether you can hold on to that family and support them, being a GP and in regular contact with that family, and using other members of the team. And so the health visitor was contacting the school nurse and the health visitor and I speak about the family quite regularly, but it’s when does that then slip into a social care referral, and I guess it’s about whether the family are playing the game with us!

GP

We have a monthly meeting with the health visitor to discuss any families that are cause for concern and look to coordinate an approach [that the] Positive Parenting Program provided as part of early help.

GP

GP

GPs perceived their main responsibilities to be signposting families to other services and working with parents, which is reflected in the data on their normal practice in response to providing early help for low-level child neglect.

There was some variation in the responses of those who reported having a safeguarding responsibility and those who did not, but these findings were not statistically significant. Those with a safeguarding responsibility were more likely to say that they would provide direct support to the child, talk to the child and parent about the concern, monitor the child, and have regular internal team meetings, and those without were more likely to make a referral to children’s social care.

Comparing the findings across groups

Comparing the findings across the groups provides us with additional insights. On the whole, GPs reported providing early help for low-level neglect in a smaller range of ways than school nurses, health visitors, teachers, early years practitioners and midwives. The types of responses differed across professions too. The tables and descriptions below explore the key differences across the groups in further detail.

Across the board, a common theme was the low numbers of practitioners talking to the child about a concern, as shown in Table 3. This was most common in secondary school teachers, followed by GPs and school nurses, with midwives being least likely to talk to a child about a concern. Undoubtedly, talking to the child about concerns is a more feasible response for some professions, such as school nurses, GPs and teachers, who might first be more likely to see a child alone (although this is more complex in the case of GPs) and second, are likely to be working with children who are old enough to discuss concerns.

However, the data shows that even within these professions, many practitioners are not monitoring children. 47 per cent of secondary school teachers, 63 per cent of GPs and 67 per cent of school nurses said that they would not normally speak to a child about a concern. In addition, while health visitors and midwives work with infants and young children, they are likely to come into contact with older children in families who may also be in need of early help and who are more able to articulate their experience. This raises concerns about how child-centred practice across all six professions currently is, and whether practitioners feel confident in broaching these subjects with children of all ages.

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23 The small percentage of the participants from the teachers group working in secondary schools (11 per cent) means it is important to be cautious with this finding.
24 Throughout this comparison section, where differences between practitioners working in different settings, and those with and without safeguarding responsibilities are highlighted, these differences were found to be statistically significant. For further details, see the previous sections on individual professions.
Realising the potential: tackling child neglect in universal services

Research has shown that when responding to safeguarding concerns, too often the focus of practitioners is on the parent or carer, not the child (Brady, 2011; La Valle et al, 2012; Ofsted, 2011b). The child can then become lost and his or her views are not heard. In Working Together 2015, the requirement that practitioners obtain the child’s views is clearly set out.

As would be expected, education practitioners – in particular, early years practitioners and school nurses – were the practitioners most likely to provide direct support to the child. It is interesting that these practitioners were not commonly talking to the children about their concerns, suggesting that support is being provided to children but that they may not understand why. Providing direct support to children was not common practice among the other practitioners.

Monitoring children was most common in education practitioners, in particular those working in primary and junior schools. Again, monitoring a child is likely to be easier for those practitioners working day-to-day with the same children in the same setting. Nonetheless, there are strikingly low levels of monitoring occurring in other professions. Thirty-three per cent of health visitors, 48 per cent of school nurses, 63 per cent of GPs and a substantial 80 per cent of midwives said that they would not normally monitor a child when they had concerns about low-level neglect.

As Table 4 shows, talking to a parent about a concern was most common in health visiting, followed by general practice and those midwives working in the community – for all of whom this was considered common practice. For midwives working in hospitals and teachers in particular, talking to a parent about a concern was not common practice.

Providing direct support to parents was only common practice in health visiting and in early years settings. Again, teachers were least likely to say that they provided direct support to parents, with nearly half saying that they would not normally provide this support.

Indeed, across school nursing, midwifery and general practice, between 33 per cent and 41 per cent of participants said that they would not normally provide direct support to parents when they had early concerns about neglect.

Contacting other practitioners to gather information about a family and signposting families to other agencies were less common in schools than in general practice, health visiting, school nursing and midwifery (see Table 5).

Table 3: Average percentages for talking to, providing direct support to, and monitoring a child

<table>
<thead>
<tr>
<th></th>
<th>Average percentage that would normally monitor a child in response to an early concern</th>
<th>Average percentage that would normally talk to the child in response to an early concern</th>
<th>Average percentage that would normally provide direct support to a child in response to an early concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health visitors</td>
<td>66%</td>
<td>17%</td>
<td>53%</td>
</tr>
<tr>
<td>School nurses</td>
<td>52%</td>
<td>33%</td>
<td>73%</td>
</tr>
<tr>
<td>Early years practitioners</td>
<td>84%</td>
<td>12%</td>
<td>87%</td>
</tr>
<tr>
<td>Midwives</td>
<td>20%</td>
<td>11%</td>
<td>20%</td>
</tr>
<tr>
<td>Teachers</td>
<td>76%</td>
<td>31%</td>
<td>73%</td>
</tr>
<tr>
<td>Infant schools</td>
<td>25%</td>
<td>28%</td>
<td>20%</td>
</tr>
<tr>
<td>Primary schools</td>
<td>78%</td>
<td>28%</td>
<td>73%</td>
</tr>
<tr>
<td>Junior schools</td>
<td>79%</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>Secondary schools</td>
<td>63%</td>
<td>53%</td>
<td>20%</td>
</tr>
<tr>
<td>GPs</td>
<td>37%</td>
<td>37%</td>
<td>39%</td>
</tr>
</tbody>
</table>
Table 4: Average percentages for talking to and providing direct support to parents

<table>
<thead>
<tr>
<th></th>
<th>Average percentage that would normally talk to the parent in response to an early concern</th>
<th>Average percentage that would normally provide direct support to a parent in response to an early concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health visitors</td>
<td>90%</td>
<td>96%</td>
</tr>
<tr>
<td>School nurses</td>
<td>74%</td>
<td>66%</td>
</tr>
<tr>
<td>Early years practitioners</td>
<td>72%</td>
<td>79%</td>
</tr>
<tr>
<td>Midwives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the community</td>
<td>69%</td>
<td>59%</td>
</tr>
<tr>
<td>In a hospital</td>
<td>79%</td>
<td>60%</td>
</tr>
<tr>
<td>Teachers</td>
<td>66%</td>
<td>53%</td>
</tr>
<tr>
<td>GPs</td>
<td>83%</td>
<td>67%</td>
</tr>
</tbody>
</table>

Table 5: Average percentages for contacting other practitioners and signposting to other services

<table>
<thead>
<tr>
<th></th>
<th>Average percentage that would normally contact other practitioners to gather information about a family in response to an early concern</th>
<th>Average percentage that would normally signpost families to other agencies in response to an early concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health visitors</td>
<td>82%</td>
<td>94%</td>
</tr>
<tr>
<td>School nurses</td>
<td>88%</td>
<td>90%</td>
</tr>
<tr>
<td>Early years practitioners</td>
<td>64%</td>
<td>76%</td>
</tr>
<tr>
<td>Midwives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both the community and hospital</td>
<td>89%</td>
<td>82%</td>
</tr>
<tr>
<td>In the community</td>
<td>93%</td>
<td>93%</td>
</tr>
<tr>
<td>In hospitals</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Teachers</td>
<td>64%</td>
<td>70%</td>
</tr>
<tr>
<td>GPs</td>
<td>87%</td>
<td>91%</td>
</tr>
</tbody>
</table>
The CAF was not being routinely used across the professions, as shown in Table 6. In response to early concerns about low-level neglect, the groups most commonly using a CAF were school nurses and health visitors, although 27 per cent of school nurses and 32 per cent of health visitors said that they would not normally use a CAF. GPs were the least likely to use a CAF; 26 per cent of GPs said they would normally ensure a CAF was complete, compared with between 51 per cent and 73 per cent in the other practitioners groups.

Practitioners were asked if they had regular internal team meetings to discuss concerns about early signs of maltreatment, including neglect. These meetings (Table 7) were mostly held by early years practitioners, GPs and schools. Only around half of school nurses, health visitors and midwives said that they regularly attended internal team meetings. Meetings were more commonly had by those with a specific safeguarding responsibility in midwifery and teaching.

Making a referral to children’s social care (see Table 8) was not, in comparison with other actions, identified as a common course of action by most practitioners (with the exception of midwives); however, given that the participants were asked to give details on if and how they normally provide early help, the percentages of participants saying that they would refer to social care was relatively high (between 26 per cent and 47 per cent).

Table 6: Average percentages for initiating CAF

<table>
<thead>
<tr>
<th>Profession</th>
<th>Average percentage that would normally ensure a CAF is completed in response to an early concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health visitors</td>
<td>68%</td>
</tr>
<tr>
<td>School nurses</td>
<td>73%</td>
</tr>
<tr>
<td>Early years practitioners</td>
<td>51%</td>
</tr>
<tr>
<td>Midwives</td>
<td>63%</td>
</tr>
<tr>
<td>Teachers</td>
<td>51%</td>
</tr>
<tr>
<td>GPs</td>
<td>26%</td>
</tr>
</tbody>
</table>

Table 7: Average percentages for attending internal team meetings

<table>
<thead>
<tr>
<th>Profession</th>
<th>Average percentage that normally attend regular team meetings to discuss early concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health visitors</td>
<td>53%</td>
</tr>
<tr>
<td>School nurses</td>
<td>55%</td>
</tr>
<tr>
<td>Early years practitioners</td>
<td>79%</td>
</tr>
<tr>
<td>Midwives</td>
<td>49%</td>
</tr>
<tr>
<td>With safeguarding responsibility</td>
<td>64%</td>
</tr>
<tr>
<td>Without a safeguarding responsibility</td>
<td>41%</td>
</tr>
<tr>
<td>Teachers</td>
<td>68%</td>
</tr>
<tr>
<td>With safeguarding responsibility</td>
<td>72%</td>
</tr>
<tr>
<td>Without a safeguarding responsibility</td>
<td>61%</td>
</tr>
<tr>
<td>GPs</td>
<td>72%</td>
</tr>
</tbody>
</table>
The most striking finding here was that 75 per cent of midwives said that they would normally provide early help for low-level neglect in this way. School nurses were also more likely than other practitioners to refer to children’s social care (47 per cent). While 47 per cent of secondary school teachers also said that they would refer to social care, the sample size was small and, therefore, this finding should be treated cautiously. Indeed, on average, teachers were the least likely group to refer to social care.

The participants’ reported everyday practice was mostly in line with their reported perceptions of their responsibilities. This was with the exception of monitoring children within school nursing and health visiting; while most participants felt that this was their responsibility, it was less common for them to report doing it.

Having a specific safeguarding duty did seem to have some effect on the types of early help responses the participants said they undertook, depending on the profession. For teachers, it meant undertaking more early help responses than those without a safeguarding responsibility, including working with parents and children, monitoring, signposting and contacting other practitioners.

Health visitors and early years practitioners with a specific safeguarding duty more commonly monitored children than those without. In midwifery, those without a specific safeguarding responsibility more commonly referred concerns to children’s social care than those without.

### Summary and discussion

The data clearly show that all practitioners are undertaking a variety of early help responses for children who are showing signs of low-level neglect. The findings also indicate that there are aspects of early help which are less commonly provided within and across the practitioner groups. While, as noted, some of these findings will relate directly to the nature of the service that each professional group provides, others need further unpicking to understand.

Why is the reported likelihood of referring to children’s social care higher in midwifery than elsewhere across universal services? Midwives work with babies, whose increased vulnerability means that they are particularly at risk of neglect. There is also a particular lack of services available for early help in the perinatal period to which midwives can refer families.

However, with analysis showing that those midwives without specific safeguarding responsibilities were more likely to say they would refer the concern to children’s social care, there may be a need to increase understanding of early help across midwifery. Alongside this, it may be that it is felt within the service that early help is not the responsibility of midwives (considering this finding in the context of the findings on perceptions of responsibilities, which indicated high levels of variation in midwives’ views).
School nurses and secondary school teachers were also more likely than others to refer concerns to children’s social care. While school nurses said that they do undertake a range of early help responses alongside referrals, the finding that they regularly refer early concerns about child neglect to children’s social care is of concern given their integral role in the Healthy Child Programme. The findings suggest issues around the practitioners’ confidence in their own ability to respond to early concerns.

There is also a propensity not to talk to children about early concerns of neglect, with between 63–89 per cent of practitioners saying that they would not normally do this. Indeed, research has suggested that this is also the case in social work (The Office of the Children’s Commissioner, 2011). These findings suggest a lack of confidence among practitioners about how to talk to children about sensitive and complex issues and when it is appropriate to do so.

No matter what age they are, you need to figure out a way of obtaining their voice and making sure that that specific child’s voice is heard, and that can be done in lots of different ways in terms of assessing the physical signs and the non-verbal cues from that child with the interaction that you have.

School nurse

Recommendation
LSCBs and safeguarding practitioners should ensure that all practitioners working with children – but particularly health visitors, midwives, GPs, early years practitioners and family support workers – receive specific training on neglect during their pre-qualification training and at least every three years while practising, which includes:

- Seeing the situation from the child’s point of view
- How to develop relationships and address early concerns with children and young people

Providing parents and children with emotional and practical support did not tend to be a common way of providing early help for neglect in universal services. Working directly with parents is not common practice among GPs, teachers, school nurses and midwives, and working directly with children is not common practice amongst health visitors, GPs and midwives. This perhaps reflects the absence of a requirement within policy and practice guidance to do such work. However, providing this support and developing relationships with children and their parents is a vital component of providing early help.

A number of other questions were raised by the findings. Why do GPs seem to enact a smaller range of early help responses than the other practitioners? GPs play a central role in the provision of primary care and, therefore, are seemingly well-placed to provide early help (Woodman et al, 2014). They are often a first and ongoing point of contact for families and are holders of primary healthcare records. This position should also provide them with the chance to build relationships with families; yet only 67 per cent said that they would normally provide direct support to parents.

Why are education practitioners less likely to report working with other practitioners around early help provision? This could be the result of difficulties around multi-agency working or a lack of knowledge of available services. In addition, further discussion needs to be had around the usefulness of the CAF for practitioners, and whether all professionals are aware of the tool and its purpose. Finally, while the difference between those professions commonly holding internal team meetings compared with those who are not may be in part the impact of the working environment (where work is not necessarily conducted from one location), more could be done to find ways to facilitate these meetings for school nurses, health visitors and midwives.

In the following sections, we unpick these issues by examining both the barriers to early help provision and the ways in which practitioners can be better supported to provide it.

Recommendation
LSCBs, Health and Wellbeing Boards and Clinical Commissioning Groups should recognise and draw on in-service planning and commissioning the role that GPs, teachers, midwives, health visitors, school nurses and early years practitioners can and do play in responding to neglect.
3.4 Barriers to the provision of early help for neglect

KEY FINDINGS

- Workload and time pressures were considered to be the greatest barrier to early help provision for health practitioners.
- For those working in education settings, the biggest barrier they reported was multi-agency working and information sharing. Multi-agency working was rated as the second biggest barrier in health.
- Being and feeling equipped and able to develop constructive relationships with parents was also raised as a barrier to early help provision, particularly in the context of early help being non-statutory.
- Not all participant groups had received training on neglect in the past three years. In particular, 18 per cent of health visitors, 15 per cent of midwives, and 14 per cent of early years practitioners reported that they had not received training in that time period.
- Between 20 per cent and 55 per cent of practitioners with a specific safeguarding responsibility had not read their LSCB threshold document.
- The young participants did not tend to see universal services practitioners as well placed to help them with neglect.

The findings on perceptions of roles and everyday practice suggest that universal services practitioners see some aspects of early help provision as their responsibility and that they are undertaking some of this work on a daily basis. However, the participants also identified a range of issues that can both prevent the provision of early help occurring or can reduce the effectiveness of that early help.

We explored the barriers to providing early help for child neglect with the practitioner groups through the discussion groups, interviews and surveys. We asked them to rate the extent to which a number of issues posed a barrier to providing help. Open text boxes also allowed them to describe additional barriers.

There were a number of common barriers identified by the 893 practitioners we spoke to:

- Knowing how to identify neglect: an enduring problem?
- Knowing how to respond to neglect: an emerging problem in universal services?
- Time and workload pressures
- Multi-agency working and information sharing among practitioners
- Strained relationship between universal services and children’s social care
- Universal services practitioners’ familiarity with their LSCB threshold document
- Limited availability of accessible early help provision
- Engaging parents and carers in early help
- Engaging young people in early help
- Families moving in and out of areas
- CAF: a hindrance rather than a help?

In addition, we asked the 18 young participants who were involved in the project to give their views of universal services practitioners in relation to early help provision. They did not tend to see the practitioners as well placed to help them with neglect, and the barriers they described to the provision of support are set out towards the end of this section.
Knowing how to identify neglect: an enduring problem?

The findings from this study indicated that while those practitioners who took part in the research reported feeling confident in identifying neglect, they held a range of views on the extent to which identifying neglect could present a barrier to early help provision, and felt that identification continued to be a problem in universal services more widely.

The participants’ reported confidence in identifying neglect

Statement: I feel confident in my ability to identify the physical signs of neglect.

Statement: I feel confident in my ability to identify the emotional and behavioural signs of neglect.

On average, each group of practitioners reported that they felt confident in identifying the physical, emotional and behavioural signs of child neglect, giving these two statements a rating of 6. GPs reported feeling slightly less confident in identifying these signs, giving a rating of 5. There was consensus within the groups on these ratings.

Statement: I feel confident in my ability to identify parental behaviours that are risk factors for neglect.

On average, participants also reported feeling confident in their ability to identify parental behaviours that are risk factors for child neglect, giving a rating of 6, and there was consensus within the groups on this rating. There were some slight differences identified within the groups but these were not found to be statistically significant. These were that those working in secondary schools and junior schools reported that they had less confidence in identifying parental behaviours, giving a rating of 5, as did those midwives working in a hospital.

Confidence ratings were also explored in relation to the length of time that participants had been practising in their profession, and the results did not show noteworthy differences.

The participants’ confidence in identifying neglect may reflect the extent to which those taking part in the study were self-selected and, therefore, likely to have an interest in and knowledge about child neglect. Alongside this, social desirability bias may have influenced their responses; as government policy requires practitioners to be able to identify neglect, participants may have over-stated their confidence.

Question: Does difficulty identifying neglect make it harder to provide early help when you have concerns about neglect?

The participants’ confidence in identifying neglect was also explored in relation to the extent to which they felt that difficulty identifying neglect was a barrier for them to providing early help. The average ratings are shown below.

These average ratings indicated that difficulty in identifying neglect did not tend to be seen as a particularly significant barrier by the groups. This was particularly the case in education services, with teachers and early years practitioners rating this statement at 2. GPs were the group who saw identification as the greatest barrier, rating it at 4.

However, by looking beyond the average ratings, the range of responses from GPs, early years practitioners, health visitors and school nurses suggested a more varied view of the extent to which identifying neglect is a barrier to early help provision than shown by the average ratings. Teachers and midwives, on the other hand, tended to be in agreement that identification of neglect is not a significant barrier to the provision of early help.

Through open text boxes throughout the survey, we were able to gather more detailed data on the difficulties the participants felt that others might face in identifying neglect. Their comments echoed the findings from a wide range of existing research on this issue, particularly emphasising the complexity of identifying emotional neglect and the lack of clarity around what constitutes acceptable standards of care. Because these issues have been well documented elsewhere, it is not described in detail here.
It’s quite interesting when you see physical and sexual abuse, it’s quite clearly in that category that you’ve got to do something about it pretty damn quickly, it’s significant harm, but when we talk about neglect and we talk about emotional neglect, there’s all these shades of grey really. And I think that’s why it’s such a difficult area to deal with because people’s perceptions, even our own perceptions of what is neglect and emotional abuse will differ won’t it because of our own personal circumstances and our own nurturing and upbringing. I think it is very, very, very complex and I think that’s part of the problem.

GP
Training on identifying neglect

**Question:** Have you received training on child neglect in the past three years?

The participants were asked if they had received training on child neglect within the past three years, which is the minimum amount of training recommended in government guidance. Overall, 12 per cent of participants had not received training within that time period. As Table 9 shows, nearly 1 in 5 health visitors (or 18 per cent) said that they had not received training on child neglect in the past three years. In addition, 15 per cent of midwives and 14 per cent of early years practitioners had not received training in the time period. The findings in relation to the effect of having a specific safeguarding responsibility were only statistically significant in relation to midwives (in bold below), where the data showed that those with a specific safeguarding responsibility were more likely to have had training in the past three years than those without.

**Statement:** The training I have received has given me the confidence and skills to identify early signs of neglect.

Of those who had received training on neglect in the past three years across the six professions, on average they reported that they felt the training they had received had given them the confidence and skills to identify early signs of neglect, giving a rating of 6. There was consensus within the groups on this rating.

> My staff and I are involved regularly in dealing with neglect-type issues with pupils in our school. As it has such a high profile, I would be really keen to have further training just focusing on neglect issues to ensure that we are being as rigorous as possible in our practice. Most courses focus on a range of issues so may not go in as much depth.

Teacher

---

**Table 9: Percentage of practitioners receiving training on neglect in past three years**

<table>
<thead>
<tr>
<th></th>
<th>Overall percentage receiving training in last three years</th>
<th>Those with a specific safeguarding responsibility receiving training in last three years</th>
<th>Those without a specific safeguarding responsibility receiving training in last three years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early years practitioners</td>
<td>86%</td>
<td>86%</td>
<td>86%</td>
</tr>
<tr>
<td>GPs</td>
<td>93%</td>
<td>91%</td>
<td>96%</td>
</tr>
<tr>
<td>Teachers</td>
<td>92%</td>
<td>93%</td>
<td>88%</td>
</tr>
<tr>
<td>School nurses</td>
<td>92%</td>
<td>95%</td>
<td>90%</td>
</tr>
<tr>
<td>Midwives</td>
<td>85%</td>
<td><strong>91% (p&lt;0.05)</strong></td>
<td><strong>82% (p&lt;0.05)</strong></td>
</tr>
<tr>
<td>Health visitors</td>
<td>82%</td>
<td>88%</td>
<td>79%</td>
</tr>
</tbody>
</table>
Through the qualitative data, we gained a more in-depth view of the extent to which participants felt equipped to respond to identify neglect, and a range of shortfalls in training were identified. Many participants spoke about desiring further in-depth training specifically on neglect, with some noting that despite the prevalence of neglect, the emphasis of training is often placed on other types of abuse. Training on neglect could be too broad, without attention being played to the specific context within which the practitioners were working, or could seem out of date.

Some commented that statutory training for practitioners was sometimes completed only to satisfy requirements, without practitioners being given the time and space to unpick and consider the implications of the training for them as a professional. Practitioners identified the need for more tailored training that could be easily applied to specific work settings and roles.

Particularly telling was the assertion from some participants that good practice in identifying neglect at an early stage came from having experienced staff. While experience of safeguarding, and working with families more generally, is a valuable resource, these comments may suggest the need for a shift in thinking and practice around training, with a focus on ensuring all staff are adequately trained.

**Recommendation**

LSCBs and safeguarding practitioners should ensure that all practitioners working with children, but particularly health visitors, midwives, GPs, early years practitioners and family support workers, receive specific training on neglect during their pre-qualification training and at least every three years while practising, which includes:

- The impact of neglect on child development
- Seeing the situation from the child’s point of view
- How to articulate concerns about neglect to other practitioners
- How to convey concerns to parents and challenge harmful behaviour
- How to develop relationships with parents, children and young people
- How to develop relationships and address early concerns with children and young people
- Multi-agency training across health, education and children’s social care.
Knowing how to respond to neglect: an emerging problem in universal services?

The literature review, policy review and discussion groups suggested that a barrier to early help provision in universal services may be a lack of knowledge among practitioners about what ‘early help’ constitutes and how to deliver it.

Question: Does being unsure how best to respond to neglect make it harder to provide early help when you have concerns about neglect?

The quantitative data suggested that this was not seen as a significant barrier for practitioners. However, there was wide variability in the ratings of all the practitioner groups, indicating a lack of consensus on the extent to which this is a barrier to early help provision. One group proved the exception to this; the responses of GPs without specific safeguarding responsibilities displayed consensus that this was a fairly significant barrier (with a rating of 5)\textsuperscript{25}.

Chart 9: Extent to which being unsure how to respond was a barrier to early help provision

<table>
<thead>
<tr>
<th>*Early years practitioners</th>
<th>1</th>
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<table>
<thead>
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\textsuperscript{25} P<0.05
Training on how to respond to neglect

Statement: The training I have received has given me the confidence and skills to provide early help for neglect.

Those participants who had received training in the past three years were asked whether that training had given them the confidence and skills to provide early help for neglect, and most agreed that it had. Health visitors, school nurses, teachers and early years practitioners were marginally more likely to report feeling that the training had equipped them with the confidence and skills to provide early help (with an average rating of 6) than midwives and GPs (with an average rating of 5). There was only a small level of variation within the groups to this question.

Analysis within the groups showed that secondary school teachers felt less strongly than other teachers that the training had given them the confidence and skills to provide early help for neglect, rating this at 4.5. This was statistically significant for secondary school teachers compared with primary school teachers. Midwives who worked in both the community and hospital settings felt more strongly that their training had given them the confidence and skills to provide early help for neglect, rating this at 6, but this finding was not statistically significant.

Chart 10: Extent to which training gives practitioners confidence and skills to provide early help for neglect

<table>
<thead>
<tr>
<th>Group</th>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Strongly agree</th>
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<tr>
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<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Strongly agree</td>
</tr>
<tr>
<td>Teachers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Strongly agree</td>
</tr>
<tr>
<td>School nurses</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Strongly agree</td>
</tr>
<tr>
<td>Health visitors</td>
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<td>4</td>
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<td>6</td>
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<tr>
<td>Midwives</td>
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<td>4</td>
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<td>7</td>
<td>Strongly agree</td>
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<tr>
<td>GPs</td>
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<td>2</td>
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<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>Strongly agree</td>
</tr>
</tbody>
</table>

26 P<0.05
It’s coming back to basics. It’s that professional curiosity; it’s questioning.

LSCB business manager

These findings were unexpected; as in most cases, policy and practice guidelines for universal services do not clearly specify how early help should be provided, it is unlikely that training will include this content. The qualitative data was more in line with expectations, and some shortfalls in training were identified. One issue raised by a small number of participants was the need for training on what services were available locally to provide early help to families and how the services could be contacted. Practitioners emphasised the need for this information to be updated on a regular basis due to frequent changes in thresholds and available services.

It would be helpful to know of the different support systems outside the local authority I could draw upon for advice and support. Equally how I could support their work by passing on contact details to parents/carers who may wish to access this help and support independently.

Early years practitioner

Some midwives criticised current training for not equipping new midwives with an understanding of neglect or how to undertake a CAF, and also criticised senior supervisors for not providing adequate support to enable midwives to undertake early help provision. An issue raised in the discussion group with midwives was the attitude of midwives to certain mothers exhibiting risky behaviours. It was noted that some midwives condemn the behaviour of women coming into their care, for example if they are known to be a prostitute or drug user, which in turn creates barriers to developing relationships with vulnerable women and providing early help where it is needed.

I think the barrier can be that you disapprove [of the woman], the staff blame the woman.

Midwife

Alongside this was the extent to which neglect can be considered to only occur in certain types of families. One midwife described her own experience of giving birth.

I had three young children and my daughter was a week old and my mum died suddenly. I lived in rented accommodation, but because I was a midwife I never saw half the staff. My children could have been buried under the patio. I was so high-risk with postnatal depression, but because I was a midwife I was alright, but if I’d been a heroin user, living in the inner-city, they’d have been on me, weekly visits. So we are judgemental and we need to really break this.

Midwife

Named safeguarding practitioners can struggle to receive an adequate level of training because they are holding multiple roles that all require additional training. For example, a SENCO in a school might be required to undertake a range of training course, such as special education needs training, equal opportunities training and ICT training, as well as safeguarding training. Increasing time and workload pressures can make this unfeasible. A local authority designated officer commented that some schools were relying on home school link workers or other non-teaching pastoral staff to undertake early help with families, but that these workers do not necessarily have the appropriate level of training required.

We’re creating across schools a host of people who are known as pastoral support workers, learning mentors, home school link workers, none of whom are trained because they’re all paid a pittance and they’re all trying to do what they can without any real guidance or steering.

Local authority designated officer

There was also some confusion about the role of the named GP. One commented that because the role of the named GP is not defined in statutory guidance, and particularly following the recent restructuring of the health service, there was a lack of clarity about the role. Others commented that having a named GP is sometimes “a bit like a tick box on the CQC form”.

Recommendation

Government should ensure that any investment in universal services for early help is matched by building capabilities and confidence in relation to the early help role.
**Time and workload pressures**

**Question:** Do time and workload pressures make it harder to provide early help when you have concerns about neglect?

The limited capacity of universal services practitioners to undertake early help was cited as a key factor in determining practice. Time and workload pressures were rated as the most significant barrier to providing early help for cases of neglect for GPs, school nurses, midwives and health visitors, which they rated as a 5 or 6. These pressures were considered less of a barrier by teachers and early years practitioners. The variability in the responses of all the practitioner groups, with the exception of health visitors, suggested a more diverse view of the extent to which time and workload pressures were a barrier to early help provision than shown by the average ratings.

Analysis within the groups showed some differences between those with safeguarding responsibilities and those without, and between settings; however, these were not found to be statistically significant. GPs with safeguarding responsibilities reported feeling that time and workload pressures were a less significant barrier than those without (shown in Chart 11: Extent to which time and workload pressures are a barrier to early help provision).

### Chart 11: Extent to which time and workload pressures are a barrier to early help provision

<table>
<thead>
<tr>
<th>Practitioner Group</th>
<th>Rating 1</th>
<th>Rating 2</th>
<th>Rating 3</th>
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<td>3</td>
<td>4</td>
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<td>School nurses</td>
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<td>Health visitors</td>
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<td>6</td>
<td>Significant barrier</td>
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<tr>
<td>Midwives</td>
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<td>6</td>
<td>Significant barrier</td>
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<tr>
<td>GPs</td>
<td>Not a barrier</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>Significant barrier</td>
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through an average rating of 5). Those midwives working in both hospitals and the community reported feeling they were a less significant barrier than those working elsewhere (with a rating of 4). On the other hand, secondary school teachers felt that this was a slightly more significant barrier than in other schools (with a rating of 4). Again, there was relatively wide variability in responses within these averages.

Time and workload pressures were frequently raised by participants in the qualitative data, with particular issues including staff shortages, pressures to complete administrative work, competing priorities and high caseloads. These pressures impacted on the provision of all types of early help.

Ten minute consultations are simply insufficient to identify signs of neglect, broach the topic with parents/children, talk about notification to social services and then also provide early help! Particularly when the reason the child has been brought in is often a separate issue (eg they have tonsillitis), which needs dealing with in its own right. In an ideal world this would happen but we need much longer with patients.

GP

Some also felt that GPs’ work could be overly driven by Quality and Outcomes Framework (QOF) targets around, for example, recording blood pressure and weight, to the detriment of a more holistic approach to general practice.

I have many skills that could be used but I do not have time to use them.

GP

Health visitors, midwives and school nurses spoke about large caseloads within which safeguarding concerns could not always be prioritised despite best efforts. They spoke about not having time to follow up on concerns or to contact other agencies to communicate families’ needs. The requirement to complete large amounts of paperwork was also noted as a barrier to providing early help.

Early years are given too much documentation to complete so children do not get to learn to play and have the social skills to be able to communicate needs and feelings. Children are still expected to meet milestones rather than just play and learn skills to benefit them for the rest of their lives. There is too much tracking and not enough interaction!

Early years practitioner

GPs spoke about short consultation times and not having time to follow up on concerns as key ways in which time pressures could impact on their ability to provide early help. Time pressures when treating parents for risk factors for neglect, such as depression or substance abuse, meant that concerns about children were prevented from being addressed. Even when a child’s ill health was the purpose of the appointment, short, ten minute consultations could mean that there was little time to go through the process of identifying and responding to neglect.
It’s obviously been recognised that social care have got problems with capacity, but from what you’re talking about, you’re looking to bring some of that workload to already burnt out midwives and health visitors. I mean the health visitor teams are being boosted, but midwifery teams are not, and I don’t understand that. A lot of the shift seems to have gone towards the health visiting teams.

Midwife

A barrier is having the capacity within current caseloads to pick up on very early low-level neglect. It is an area where I feel frustrated as a practitioner as I believe school nurse input very early on could have a positive effect on outcomes for the child.

School nurse

Because of lack of resources and time I would have to refer into other agencies to provide support but as an accountable professional I would like to monitor this child and family as well also completing a CAF.

Health visitor

The reduced capacity to do home visits was also highlighted as a key barrier. Some health visitors commented that they were no longer visiting families more than twice, and that there were often large gaps between visits. Some midwives also commented that midwives are completing fewer home visits than previously due to time pressures (and changes to guidance), which has resulted in less ability to identify concerns early. Some school nurses also said that they saw home visits as essential in preventing neglect escalating, and were keen to conduct more of them.

Recommendation

Senior management within health visiting, midwifery and early years settings should ensure that practitioners are facilitated to conduct regular home visits.

Like GPs, health visitors also raised concerns about the pressure to achieve targets. One health visitor stated that while she welcomed the new influx of newly trained health visitors, she was concerned that they were not being adequately trained to respond to the complexities of child neglect.

I think the general consensus is because we’ve got so many students coming through now and they are kind of doing this fire-fighting way of health visiting that they’ve not necessarily developed the awareness of neglect and then, therefore, what to do with it.

Health visitor

An issue raised frequently by school nurses was their low numbers and the need for greater future investment in the service. It was felt that this investment would enable school nurses to take on more responsibility for early help, for example, by undertaking regular school drop-ins, being more visible in schools to develop relationships with young people, engaging further in CAFs, and offering advice and support to parents. School nurses frequently reported that it felt impossible to reach all the families who needed early help.

[I have] a diary that is so full to capacity that if I were to see a child in a school who I suspected was being neglected I would struggle to act in a timely manner due to other caseload commitments. This worries me every time I go into a school as I just don’t have the time for any additional work in that day.

School nurse

Recommendation

Following on from the example set in health visiting, there should be a drive and commitment in the Department of Health to recruit additional school nurses.
School nurses also raised the extent to which their working day is taken up with child protection work, which prevents early help being given. School nurses spoke of attending multiple child protection meetings a day, often throughout the week.

The absence of appropriate settings to undertake meetings with children or parents was also raised as a barrier to providing early help. Examples were given of holding consultations in toilets and science labs, and of assessments being cancelled when the space allocated by the school was required for another activity.

"You can do 15 meetings just doing child protection, three meetings every day, five days a week, with really some complex families."

School nurse

The quantitative data showed that, on average, time and workload pressures were seen as less of a barrier to providing early help within education. For those who did see it as a barrier, issues were around high expectations on teachers to both educate children and safeguard them. Time and workload pressures could increase the response time to concerns, make contacting other practitioners problematic, and taking away opportunities for teachers to speak directly with children.

"Sometimes, the daily tasks and constant demands in a classroom environment can be so overwhelming that we fail to follow up on issues which have been nagging at us, not because we don’t think they are important, but because there are only so many hours in a day. This is, I understand, unacceptable, but also a reality. The increasing amount of paperwork that a teacher has to provide daily is ridiculous."

Teacher

Time and workload pressures are also likely to contribute to the finding that not all practitioners are receiving training on neglect at least once every three years.
Multi-agency working and information sharing

Question: Do problems about multi-agency working and information sharing make it harder to provide early help when you have concerns about neglect?

Problems with multi-agency working and information sharing are frequently cited as barriers to more effective practice in all spheres of safeguarding and child protection, and again, it was repeatedly raised by practitioners in this research in relation to the provision of early help in universal services. These issues were around being able to contact other practitioners, but also having confidence in knowing what information can be legitimately shared.

Communication seems good when problems escalate to child protection team level. Below this it is rare to know what is happening, e.g. a social worker and health visitor might be involved with a family but I wouldn’t necessarily know about it or of their concerns.

GP

Chart 12: Extent to which multi-agency working and information sharing are barriers to early help provision

<table>
<thead>
<tr>
<th>Professional Group</th>
<th>Not a Barrier</th>
<th>Significant Barrier</th>
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<td>*Teachers</td>
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<td>*School nurses</td>
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<td>Health visitors</td>
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<tr>
<td>*Midwives</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>*GPs</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>
These two barriers were rated as the most significant to providing early help for teachers and early years practitioners (who rated them at 4), and multi-agency working tended to be rated as the second most significant barrier for the other practitioner groups. The variability in the responses of all the practitioner groups (with the exception of health visitors and school nurses in relation to multi-agency working) suggested a more diverse view of the extent to which these issues were a barrier to early help provision than shown by the average ratings.

A statistically significant finding was that those with safeguarding responsibilities in schools saw multi-agency working as more of a barrier than others, rating it at 5 rather than 4. However, again there was a relatively large range of responses to the question from the practitioners.

Participants from all the practitioner groups reported that they did not feel that they had sufficient contact with other practitioners who were working with the same family or child. This included not being able to speak to practitioners on the telephone and practitioners failing to attend meetings about the child.

Participants also noted that professional disagreements about the best course of action for children could present a barrier to early help. Communication could be “a one way process” and speaking to the right person in other agencies was difficult.

Some health visitors felt that other practitioners, in particular social workers and GPs, did not adequately communicate with them (particularly in a timely manner), and they viewed themselves as “shouldering the burden” of early help. School nurses commented that multi-agency working and information sharing was inadequate, finding it hard to contact other practitioners by phone.

Some early years practitioners highlighted a need for more contact with health practitioners, particularly health visitors and GPs. This included having up-to-date contact information for practitioners, being able to contact them via the telephone rather than leaving answerphone messages, and agreeing on a course of action.

A particular concern for early years practitioners was feeling that their expertise and potential for input was dismissed by other practitioners, manifesting in the failure of other practitioners to share information with them.

I would personally pay for more training for myself and staff to show we are just as qualified and serious about our roles when dealing with other practitioners. Information should be shared with us on the child starting in our setting; parents should lose their rights and say the day they neglected/abused their child/children.

Early years practitioner

Some teachers, early years practitioners, school nurses, midwives, and health visitors in particular commented that working with GPs could be difficult. GPs were seen by some as failing to share information adequately, and failing to play their part in multi-agency early help responses to signs of low-level neglect. GPs were aware of the perception that they failed to share information with other universal services practitioners around safeguarding concerns.

For GPs, the line between maintaining patient confidentiality and safeguarding children was a complex issue, particularly in relation to early help as opposed to responses to significant harm, where it was felt that they have a duty of care to parents/carers as well as the child.

The extent to which GPs are better placed to ‘manage’ risk than other practitioners was also raised. There is a tension between what GPs see as ‘holding a case’ and what others perceive to be withholding information.
I think GPs traditionally manage a lot more risk than other practitioners do, and I think part of what we’re prized for and celebrated for, but also can be a bit of a problem [...] It does come into conflict sometimes when we’re managing some of these safeguarding issues, where we’re seen to have not done something, because we feel we’re managing the risk as opposed to sharing the management of that risk with other agencies.

Recommendation

All practitioners should also receive training that actively encourages them to always share information with other practitioners where there is a legitimate purpose and with the child in mind.

Many participants lamented the absence of a shared IT system with other universal services practitioners and social care. For example, in one area, GPs were able to see records online of health visitors and school nurses, but not vice versa. Professional disagreements about the most appropriate course of action for a child and their family were also highlighted as a barrier to providing early help. Incidences where universal services practitioners disagreed with each other, and where support from children’s social care was not accessible, could result in inaction.

Strained relationship between universal services and children’s social care

I think there is a lot that could be done within universal services; but I think that there needs to be a greater confidence in the conversation between social care and universal services. And that conversation needs to be quite dynamic.

LSCB business manager

Recommendation

Government, professional membership bodies and practitioners should have an open discussion about who is best placed to provide advice to universal services on safeguarding.

While some participants had positive experiences of working with children’s social care (outlined in the following section), many spoke about feeling unsupported by children’s social care in relation to the provision of early help. Many acknowledged the extent to which children’s social care were understaffed and under-resourced, and while they
often sympathised with this context, they also felt frustrated. Participants from all the practitioner groups reported that they found it difficult to contact children’s social care or to speak to a social worker regarding a concern about a child or family, and reported that their telephone calls were frequently not returned.

I understand that children’s social services have a huge workload and that some of the cases that I see are not that bad compared to what they do see. But I do not think that it is right when they do not answer queries that I have, worse when they promise to do so!

GP

Some participants spoke about their frustration about contacting children’s social care and finding that a child about whom they had concerns was already known to children’s social care. Some also described being reluctant to contact children’s social care about a concern due to anxiety that inappropriate action would be taken.

[I have] concerns that matters will be escalated out of control without reasonable thought and discussion.

Early years practitioner

Thresholds for intervention from children’s social care were considered to be inconsistently applied. This meant that practitioners were unsure of when to refer cases to children’s social care. Raising a concern when they felt that there was not likely to be any intervention on the part of children’s social care meant that universal services practitioners were less inclined to risk damaging their relationship with the family.

The participants spoke about thresholds for children’s social care intervention as being too high. This resulted in the feeling that children were unduly suffering, and that the responsibility for protecting these children was laid unfairly on their shoulders. These criticisms were linked to some degree to the practitioners’ perception of their role in safeguarding. While universal services practitioners see some aspects of early help as their role, there was a feeling that they were needed to be supported by the statutory body who had overarching responsibility for this area.

Children’s social services say it is my responsibility to challenge uncooperative and challenging parents and, therefore, ignore requests for help. There is no follow up to meetings with children’s social services.

Teacher

Perhaps as a result of increasingly high thresholds for children’s social care intervention in a family, and the subsequent frequent bounce back of referrals from children’s social care to universal services practitioners that this results in, the participants reported feeling “belittled” and dismissed.

Some felt that their professional judgements were not respected or valued. This was particularly felt by those working in education settings (early years practitioners especially) and midwives, who felt that pre-birth risk assessments and CAFs were not taken seriously.

I feel that as an early years setting manager, our concerns about children can be ‘brushed off’ by social workers. I have had experiences where a social worker has not taken into account the setting staff’s concerns, which was very frustrating as we saw the children everyday whereas the social worker had only seen them on pre-arranged home visits. In this particular incident the children were originally considered ‘children of concern’ but then went on to become a full blown child protection case. I feel strongly that if the social worker had taken the nursery’s concerns more seriously, early intervention could have prevented this or at least the children could have been protected at an earlier stage.

Early years practitioner
Participants also stated that when they made a referral to children’s social care, they often encountered long waits for feedback. This then meant that there was a longer wait for any intervention or support to be put in place. Other problems raised included the high staff turnover within children’s social care, which prevented relationships from being formed, and children’s social care refusing to share information on families with universal services practitioners but expecting information sharing in return.

Finally, when children’s social care do not accept a referral, some practitioners felt that this then damaged their relationship with the family.

When a referral’s not taken on, that just reinforces the parents’ ideas that they didn’t need referring and we were making a bit of a fuss. And then it is an immense amount of work to get your foot through the door again and just keep chipping away really.

Health visitor

**Universal services practitioners’ familiarity with their LSCB threshold document**

**Question:** Do you know about your Local Safeguarding Children Board threshold document?

There was a worrying lack of familiarity of universal services practitioners with their LSCB threshold document. The table below shows these findings. Where marked in bold, the differences were statistically significant between those with safeguarding responsibilities and those without.

This indicates that a substantial proportion – between 20 per cent and 55 per cent – of practitioners with a safeguarding responsibility had not read their LSCB threshold document. A smaller, but still noteworthy, number of practitioners with safeguarding responsibilities had not heard of the document – particularly among GPs, early years practitioners, midwives and teachers. The lack of familiarity with threshold documents is concerning, in particular for those with a specific safeguarding responsibility. Depending on the quality and clarity of the threshold document, it is likely that not reading it will result in confusion and misunderstandings around thresholds for local services and, therefore, may well contribute to barriers to more effective early responses to child neglect.

**Recommendation**

LSCBs should lead a drive on awareness of the LSCB threshold document among practitioners with a specific safeguarding responsibility, especially among GPs, early years practitioners, school nurses, midwives and teachers.
Table 10: Percentages of practitioners’ familiarity with their LSCB threshold document

<table>
<thead>
<tr>
<th></th>
<th>% of those who had <strong>read</strong> it</th>
<th>% of those who had <strong>heard of</strong> their LSCB threshold document</th>
<th>% of those who had <strong>not heard of</strong> their LSCB threshold document</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Early years practitioners</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>21%</td>
<td>38%</td>
<td>41%</td>
</tr>
<tr>
<td>Specific safeguarding responsibility</td>
<td>45%</td>
<td>38%</td>
<td>18%</td>
</tr>
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<td>41%</td>
<td>32%</td>
</tr>
<tr>
<td><strong>GPs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>26%</td>
<td>41%</td>
<td>33%</td>
</tr>
<tr>
<td>Specific safeguarding responsibility</td>
<td>50% (p&lt;0.01)</td>
<td>32%</td>
<td>18%</td>
</tr>
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<td>No specific safeguarding responsibility</td>
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<td>50%</td>
<td>33%</td>
</tr>
<tr>
<td><strong>Teachers</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
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</tr>
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<tr>
<td>No specific safeguarding responsibility</td>
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<td>29%</td>
<td>54% (p&lt;0.01)</td>
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<tr>
<td><strong>School nurses</strong></td>
<td></td>
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</tr>
<tr>
<td>Average</td>
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<tr>
<td>Specific safeguarding responsibility</td>
<td>59%</td>
<td>34%</td>
<td>7%</td>
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<td>No specific safeguarding responsibility</td>
<td>48%</td>
<td>42%</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Midwives</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>25%</td>
<td>46%</td>
<td>29%</td>
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<tr>
<td>Specific safeguarding responsibility</td>
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<tr>
<td><strong>Health visitors</strong></td>
<td></td>
<td></td>
<td></td>
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<td>Specific safeguarding responsibility</td>
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<td>47% (p&lt;0.01)</td>
<td>34% (p&lt;0.01)</td>
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</tbody>
</table>
Limited availability of accessible early help provision

The participants saw early help as a multidisciplinary responsibility. A barrier frequently raised by all of the practitioner groups was the availability of other agencies, resources, services and practitioners to assist with this work. While on average, there was broad agreement from the participants across the professions that they had a good knowledge of what early help services were available to them in their area (a finding that was consistent across those with and without safeguarding responsibilities), the participants spoke about the limited availability of services. These included targeted early help services, such as Multi-agency Safeguarding Hubs (MASH), early intervention teams, family resilience teams, family support teams, domestic violence services, substance misuse services, CAMHS and mental health services. They also spoke about the diminishing resources for early help provision in universal services, in particular the closure of children’s centres, and the lack of funding for specific roles carrying out important aspects of this work, such as school nurses, education and attendance welfare officers. Participants saw early help services, and in particular mental health services, as being faced with high levels of demand and insufficient capacity, coupled with low levels of investment.

In some local areas, participants reported that services to support families below the threshold for statutory intervention were either minimal or absent. Where there were services, some reported that they encountered long waits to access them for children and families, or received no response at all from their referral. Long waits for early help services meant that families’ problems often escalated. The quality of services available was also questioned by practitioners; however, they did not elaborate further. Participants commented that the rise in thresholds in social care had impacted on a rise in thresholds for early help services, meaning that services were no longer providing early help but responding to cases at a more critical level. Another concern for some practitioners was that due to these high caseloads for services, some cases were being closed by targeted early help services when parents failed to cooperate.

It is often those that have low-level need who could really benefit – those who we could help avoid needing more intensive input – who miss out. It sometimes feels like things need to be really bad before help is given, which is counterproductive and frustrating.

Midwife

A particularly key concern for participants across the practitioner groups was the reduced capacity of children’s centres to provide early help. School nurses, midwives, GPs and health visitors were concerned that the closure of children’s centres and a reduction in their funding was preventing families accessing early help, as they were seen as a crucial player in engaging and supporting vulnerable families.

Those that can, and those that want to, go to seek out the voluntary services for help, which are all voluntary. You don’t have, universally, parenting classes pre-delivery. Preparing for the baby, what’s it going to be like? It’s gone away from being part of the statutory offer to being an additional add-on. Those that want to will, those who need it won’t. It was seen as a nice-to-do.

Designated safeguarding nurse
The trouble is the Sure Starts have gone, the Family Support workers in the Children’s Centres, a lot of them have been served their notice and they’ve depleted, so there are less bodies on the ground to do the more preventative work.

School nurse

There was also concern expressed by participants about the capacity of other universal services, such as schools, to provide early help. Because of the non-statutory nature of early help, those employed within universal services to provide early help, and services commissioned to do so, are often the first to be cut when funding is reduced. Early help provision can, therefore, become contingent on the views of the relative importance of certain services and roles. In addition, the absence of early help services can mean that practitioners are tempering their responses to children in relation to what services are available.

I look at what the services can manage rather than for the families need and to be honest, I have to pull myself up on it time and time again.

Health visitor

Overall, there was a strong sense that there was a significant gap in provision for families who needed early support to prevent problems escalating.

Recommendation

There should be financial commitment to the provision of early help for neglect in universal services and targeted early help services. National and local governments should reduce the £17 billion 'late intervention' spending by 10 per cent by 2020 through better and smarter investment in early help.
**Engaging parents and carers in early help**

The nature of early help as non-statutory provision requires universal services practitioners to engage with parents on a voluntary basis. The participants spoke about the complexity of trying to engage parents at the same time as achieving their own specific professional objectives, such as ensuring a child or parent has good health or ensuring a child is well educated. Providing early help in this context means reaching a challenging and delicate balance between ensuring the wellbeing of a child, maintaining a trusting and positive relationship with parents, and preventing over-reliance on services.

**Question:** Does worry or anxiety about a parent’s behaviour problems make it harder to provide early help when you have concerns about neglect?

Worry or anxiety about a parent’s behaviour did not tend to be seen as a barrier to providing early help across the groups. GPs rated this most highly across the groups, while school nurses rated it lowest. The variability in the responses of all the practitioner groups suggested a more varied view of the extent to which worry or anxiety about a parent’s behaviour was a barrier to early help provision than shown by the average ratings.
In our discussions with practitioners, we were able to identify a range of behaviours of parents or carers that practitioners felt were a barrier to early help provision. There was concern that addressing an issue with a parent may result in them physically withdrawing from the service or in the relationship between the parent and the professional being “destabilised”.

Participants spoke of how parents could respond defensively to any discussion of concerns, impacting on all future conversations and attempts to maintain a relationship.

A health visitor is often faced with the dilemma of discussing concerns and never being able to access the family again.

Health visitors

Participants were also anxious about hostile or aggressive responses to their concerns. They reported feeling intimidated and frightened by parents, which made them reluctant to raise concerns. This parental aggression could also make them feel increasingly concerned about the children living in the family, leaving the participant feeling unable to protect the child.

You are trying to have a general conversation and do the motivational bit and try and draw things out and it’s just obvious that the door is going to get slammed in your face never to be darkened again. That is so frightening as a practitioner as well, and because you know that’s how you feel, what is it like for those children?

Health visitor

One health visitor noted that parents sometimes complain about services in order to avoid early help provision. A Local Authority Designated Officer also raised this issue, saying that practitioners in the education sector do not feel supported to challenge parents, for fear of complaints made against them.

For some, raising a concern and trying to instigate the provision of early help felt like betraying the trust of the families they had worked with and risked “upsetting” families. Participants felt that they worked hard to develop relationships with parents and that raising concerns with them might upset them. This was particularly the case for those working in close community settings or caseloading practitioners.

I think [neglect] touches the emotions of practitioners in a way that is different when a parent is just being physically abusive to a child.

LSCB business manager

Some found it difficult to adequately convey a concern to parents so that it was fully understood. Emotional neglect was raised as particularly hard to communicate to parents. Some participants noted that many parents struggled to understand the concerns that they put forward because they had themselves had similar upbringings.

Others spoke about parents not understanding, or disagreeing with the concern raised. Because early help is non-statutory, parents can, and do, refuse to comply. As one GP noted, being able to provide early help is “very dependent on whether the parents are receptive to offers of help”. Participants frequently raised the concern that when families do not meet the criteria for social care involvement, but will not comply with early help offers, further help for children can only be accessed when problems escalate.

They [the family] do not meet the criteria for referral to social services, so we’re stuck because we’ve intervened and we are doing what she will allow us to do. We’ve got a wonderful children’s centre; there’s a really good staff in there but you get to the point where you are almost waiting for something to happen.

Health visitor
Parental disguised compliance and dishonesty could also present a barrier to providing early help, where parents who “talk a good job” are able to persuade other practitioners that they do not require help. Others spoke about how some parents seem to respond well to concerns raised by universal services practitioners when other more targeted services, including children’s social care, are involved, but see these improvements decline again once these services are no longer involved.

Finally, an issue raised by family support workers in a primary school was the extent to which providing early help could mean that parents become dependent on those services. There is a need for universal services practitioners to be skilled in engaging and supporting families, but also in equipping parents and carers with the ability to parent with family or community-based support.

**Engaging young people in early help**

Certain behaviours of young people were raised as a barrier to providing early help. These were raised predominately by teachers, as well as several school nurses, which is likely to be because these practitioners work with older children. As with parents and carers, some young people’s aggressive behaviour could prevent practitioners being able to develop a relationship with that young person. It was also noted that some young people are not aware that the care they are receiving is inadequate, while others want to protect their parents.

As a school we like to think we are observant but I think we rely on obviously young people telling us information, or disclosing information. For young people, I think they still have a fear, should they tell a member of staff, they may be taken away, there may be consequences for them at home. They will say, “Mr Smith, listen I don’t want you to pass it on. I don’t want to make the situation worse.” So still I think it is about us the school, us as a community reinforcing that it is not their fault, it is not their responsibility.

Secondary school teacher

**Families moving in and out of areas**

Many practitioners spoke about the difficulties caused by families moving in and out of geographical areas, both between local areas and across the country. It was also a concern in the context of those families who were reliant on and engaging with early help services, and those families who were perceived as attempting to avoid early help services.

Families are banking on us not finding them. A lot of the families who we’ve got massive early intervention concerns about will disappear, and they know that we won’t be able to find them for a while.

School nurse

When a family moves area, the absence of a formal expectation of a handover at the non-statutory level from the practitioners working previously with a family was felt to be a barrier to early help provision, as was the absence of common IT systems across boroughs. One GP commented that there have been drives to put all practices on the same IT system within CCGs, but problems then occur when patients move into a new CCG.

Young people might also be fearful of disclosing a concern, in case parents are then informed and that disclosure results in an escalation of the level of maltreatment that the young person is experiencing.
At the moment it’s infuriating that patients can leave your surgery, they don’t have to tell you they’re leaving, let alone where they’re going, you just get the notes recalled from you and that’s it, they’re gone, and you don’t know where.

GP

Recommendation

Local authorities should introduce a formal expectation of handovers at a non-statutory level when families move into a new area or their care passes from one professional to another.

Practitioners commented that when families move across boroughs, this can cause conflict over which local authority was responsible for those families. Even when efforts are made to contact the practitioners in the receiving area, problems with information sharing, as already highlighted in this report (for example, only being able to leave an answerphone message), cause additional barriers.

Information sharing across borders is very weak and often does not happen in my pre-school. We are on the border with Scotland and England and I have in the past had to instigate two separate cases as information often cannot be shared and I have had to argue my case for support for a family.

Early years practitioner

CAF: a hindrance rather than a help?

Some participants, in particular school nurses, felt that the Common Assessment Framework, or Early Help Assessment Tool, was a helpful way of identifying neglect and responding to it at an early stage. However, the CAF was also described by some participants in all the practitioner groups as being an overly long and complicated process, making it a barrier rather than a facilitator for the provision of early help for neglect. Examples were given of CAFs being bypassed in order to more effectively meet the needs of families.

A lot of these issues are quite instant, if they need action they need action. You are not going to hang about and oh, let’s have a big meeting and see who can come and let’s write a CAF. If it’s a situation where we think we can offer the support as a school and it’s not the threshold of children’s services, then we might have a meeting as a school and not do the CAF.

Family support worker, primary school

CAFs were spoken about as a cause of contention in all the practitioner groups in relation to who takes on the role of lead professional. Some practitioners were said to be reluctant to start a CAF as those who do so tend to become the lead professional, resulting in considerable time and resource implications. This is indicative of the extent to which, where procedures and professional responsibilities for child protection are well established, procedures for early help are less so, causing confusion and reticence among practitioners.

It can be difficult to assess who should lead a CAF/TAF early help group due to reluctance to accept the responsibility of the documentation required, which is time consuming for practitioners with no admin support.

Midwife

Recommendation

Government and professional membership bodies should set out clear guidance on which practitioners should undertake the lead professional role in Common Assessment Framework and Team Around the Child meetings.
Universal services’ provision of early help for neglect: the perspectives of young people

We spoke to 18 children and young people aged between 11 and 24 to gain their views of how effective teachers, school nurses and GPs were in providing early help to young people experiencing neglect. These young people were recruited via NSPCC service centres and were young people who had experienced neglect or other forms of maltreatment in the past. In this section, we set out the barriers that young people said prevented them from seeking help from universal services practitioners. In the following section, we set out their ideas on how practice could be improved.

Overall, school nurses and GPs did not tend to be seen as practitioners to whom young people would go to in order to seek help for neglect. There were a range of views about teachers; some young participants commented that they were more likely to go to teaching staff than GPs and school nurses, but many also spoke about a number of barriers that made this difficult. These are described in this section, and their ideas for how these practitioners could improve their practice are set out in the following section on promising practice and ideas for better practice.

Barriers to getting help early for neglect

The young participants discussed a number of barriers that influenced young people’s help-seeking behaviour, as detailed below.

- Some young people do not realise that they are experiencing neglect and, therefore, will not seek help because “most people assume that, well, how you’ve been treated in your life, this is how most people are being treated”.
- Young people might want to protect their parents from the possible punitive consequences of a disclosure about neglect.

- Others may be too frightened to disclose problems at home, and afraid that practitioners will then repeat the disclosure to parents.
- Young people experiencing neglect may not feel that they can trust any adults, regardless of who they are. Some of the young participants said that young people might, therefore, be more likely to speak to ChildLine or another young person about problems at home. It was also felt that young people may find it particularly hard to speak to an adult face to face. As one young participant commented:

  I think if the child is already neglected by their parents or by the adults, I do not think they would go to another adult. They might start to think that the adults are not going to listen.
  
  Young participant

- Trusting adults to respond quickly to a disclosure was also key; one young participant described feeling let down by repeated delayed reactions. She said:

  Because all the parents might neglect you and stuff, at the end of the day you’re always going to love them no matter what they’ve done. No matter if they’ve locked you in a room for ten days by yourself and you’ve not eaten whatever, you still love them no matter what. And you still trust them because they’re yours; they’re your people. So, if they’re going to tell you, ‘Don’t tell the social worker that I locked you in a room’; you’re not going to tell that social worker.
  
  Young participant
I do find it hard to trust people at first because so many people have let me down. So, why should I trust them when they say, ‘If we tell someone, it will be sorted out’, because it might not be sorted out. [...] And then you’re waiting for weeks and weeks thinking: ‘What’s going to happen? What’s going to happen?’ And then eventually, like six weeks down the line, you’ve forgotten you’ve even told them that because it was such a distant memory and you had so many problems since then, that when somebody eventually speaks to you about it you’re like, ‘What? I don’t know what you’re on about. It don’t matter to me anymore because it’s been so long it should have been sorted out then and not now’.

Young participant

They also talked about a range of issues pertaining specifically to seeking help for neglect from teachers, school nurses and GPs.

**Young participants’ views on GPs**

GPs tended to predominantly be seen as healthcare providers by the young participants. Many commented that they would only go to their GP if they were unwell, and said that they were unaware that the GP might provide other support. Psychological wellbeing was not considered to be within the remit of GPs.

I think a lot of kids would just feel like that isn’t something a doctor is meant to be looking out for, they think that, ‘Oh, it’s a doctor, I go there when I’m ill’. Maybe if they were injured in some way, or had something actually physically wrong with them because of whatever was going on, but otherwise I don’t think they would. [...] Because that’s what people are taught to go to doctors for.

Young participant

However, a minority of the young participants did think that GPs had a role in providing early help for young people experiencing neglect. One felt that GPs had a role to play in identifying physical signs of neglect, such as malnourishment, but that they would be less well able to identify other more subtle signs. Some young participants said that they were more likely to go to their GP with disclosures if they had a good relationship with that doctor. However, the young participants described a number of reasons that prevented them developing this relationship. It was felt that GPs did not listen to them, were not interested in their problems and did not take their worries seriously. Seeing a different GP each time they came to their practice also infringed on the capacity to build relationships, as well as short consultation times, which meant that “they don’t have enough time to have a chat”, and a lack of available appointments.

I don’t know this person, you know, like I’m seeing him or her the first time, I don’t really feel comfortable to tell my issues with him. So I think it’s very important to have consistency, that that person has that, like, this family, you know, has this GP.

Young participant

For one young participant, the failure of the health system more widely to act in response to what she felt were clear warning signs of neglect had damaged her faith in their ability to help young people experiencing neglect.

When I was at home living with my parents my little sister, she was only two, you get your first injections, measles, mumps and rubella and all that lot, and everything you’re meant to have done and everything like that, well there was a lot of them that she didn’t have. And I think that’s maybe why she was so unhealthy and caught a lot more illnesses than a normal child. So, actually the doctors should have picked up on that and looked back at things like that and made sure. They do these health checks and stuff; well they obviously don’t do them very well if they’re not picking up on things like that.

Young participant
Young participants’ views on school nurses

School nurses were not a visible presence to the young participants. Often, the young participants did not know who their school nurse was and said that they felt this was common among most young people.

_Half the time you don’t even know them. I’ve been at my school nearly two years now and I’ve only ever met the school nurse once. I only knew she existed this year and I’ve been there two years._

Young participant

Some said that they knew their school had a school nurse but did not know where she/he was located or how to access the service. Like GPs, school nurses were considered to have a health-focused role and young people did not see them as a resource for emotional support or someone to confide in.

_I also think with the school nurse that they don’t really deal with children in a real sense or basis like their job says it will. They mostly turn people away._

Young participant

Some experienced their school nurse as rude and unwelcoming, which they believed to have been a result of school nurses being too busy to spend time talking to them. One young participant spoke of feeling intimidated by the school nurse because of her position of authority, and another said they felt that they were ignored by their school nurse because they were young, and, therefore, not taken seriously.

_In my primary school the school nurses were really rude. They didn’t care about how you felt. They didn’t have any time. They were so busy that we had to wait half an hour until they actually got to talk with us._

Young participant

Several young participants said that they would also be anxious about speaking to a school nurse about neglect because they felt that a common response to concerns from the nurse was to either call parents or send the young person home. This worried the young people, who did not want their parents contacted.

_[School nurses] wouldn’t talk to you. They would call your parents, and sometimes you don’t want to talk to your parents, but they would tell your parents, so you wouldn’t go to them._

Young participant

Young participants’ views on teachers

There were a range of views expressed by the young participants on the extent to which teachers were a good source of support for children experiencing neglect. Some young participants said that they would not seek help from teachers because they felt that teachers were more focused on their role as educators, rather than caring about the young person’s wider wellbeing.

_They feel like teachers don’t care and that they’re just there for, like, the pay rather than like...they just see them as one extra person to teach rather than an actual person themselves._

Young participant

As with GPs and school nurses, it was felt that the extent to which young people would seek help from a teacher would be dependent on their relationship with that teacher. Young people said that they were more likely to disclose a worry to a teacher they liked, and those teachers tended to be those who were perceived to be more laid back and easy going. Conversely, one young participant commented that if a teacher showed kindness and interest, this would be enough for some young people to make a disclosure.
I think if you’re a neglected child, I think if they’re nice to you then that’s amazing really; because if your parents are neglecting you and you have no relationship with them whatsoever then the teachers are the best people to go to.

Young participant

Others said that they did not think teachers were trustworthy. On the one hand, some said that young people might wish to discuss a concern with teachers but might fear that what they say will be escalated to others, including parents. On the other hand, one young participant spoke about disclosing to a teacher that she had been bullied, and the inaction that followed this disclosure meant she no longer trusted teachers to help her with other concerns.

More or less all my life I’ve been bullied, and every time I’ve told a teacher nothing’s happened. And then my trust has just gone down and I just don’t trust them. Nothing happens.

Young participant

One young participant commented on how teachers can sometimes fail to look beyond what may seem like a young person’s bad or disruptive behaviour to try and understand the causes behind it. This was felt to be damaging to relationships.

It all depends on the teacher. I can remember when I was like 14, 15, I was doing my GCSEs and there was this book of poems that we were allowed to take home, and I’d got this book of poems and didn’t do it, just lost the book because we were moving house left, right and centre, and then every time I went into an English lesson it was automatically picked on, “Where’s your book?” and an argument. So, that to me was basically like get lost and stuff you. Whereas if she’d have taken the time to have said, “Why haven’t you got your book?” Maybe I would have. But in the end it was that sort of antagonistic relationship where I just stopped going to the English lesson and I didn’t go to English any more for a year or so because it was just that she just looked at the issue rather than what my issue was. It’s not a case of why haven’t you got it; it’s just you haven’t got it.

Young participant

It was also suggested that teachers might be nervous about raising concerns about child neglect with parents or young people for fear of misunderstanding a situation or for fear of being seen to impose their own parenting values on a family. One young participant described an incident in which a learning mentor had collected her from home when her mother had recently been using drugs. She spoke about how the worker’s decision not to speak to her about her mother’s blatant drug use had made her feel abandoned.

Teachers are embarrassed as well, sometimes. It must be hard for them to know whether to go and say to someone, or if they’re just being judgemental. You’ve got to trust your judgement sometimes. I know once when they came to my house, my mum was obviously out of her head, and the learning mentor came to the house to pick me up to take me to school, and on that car journey they never mentioned it. We both knew but it was never spoke of; forgotten about. So, to me that kind of broke my… I don’t know. To me it proved my point that obviously she’s noticed it, knows it’s happened; does she not care?

Young participant

When asked what she would have liked to have happened, the young participant replied:

Just acknowledge it I think. I mean, even if she’d acknowledged it would probably have defended it. But at least I’d known that she’d acknowledged it. But no acknowledgement broke my trust I think.

Young participant

The young participants felt that it was more difficult to speak to a teacher about neglect at secondary school than at primary school. This was for a number of reasons. There was felt to be a greater emphasis placed on rules and authority in secondary schools, for example with less leeway in terms of uniform and remembering equipment, and this could lead to friction and could curtail relationship-building. As one young participant commented, in order for young people to feel comfortable talking to staff, “the teachers have to act more like people and less like police.”
It’s sort of like because students there will know less about the world and are less liable to make up lies about that sort of thing. Whereas in secondary school, they know more about neglect, lying. They know how to lie and are more liable to lie.

Young participant

Having a different teacher for each lesson was also considered to be a barrier to talking to teachers at secondary school, because close relationships were less likely to be developed. Having a private conversation with an adult could also be harder at secondary school than at primary school.

Young participant

Teaching assistants, school counsellors and those giving extra learning support through, for example, academic tutorials were identified by young participants as being more accessible members of staff in schools than teachers. These staff members were felt to be more caring and a source of help. This may be a reflection of the benefits of one-to-one or more intensive support. One young participant commented that informal staff at schools, for example dinner ladies, could be more approachable than formal teaching staff.

Young participant

[In academic tutorials], they say if you have any problems to talk to them. They’ll lend you a pen if you don’t have one; they’ll help you out. Say if you go to GCSEs, obviously I’m not doing them yet but when I do, they say if you’ve lost your revising book, which normally they don’t give another, they tell you to find it, she can help you out by trying her best to get you another one. She’ll try and persuade them. Just help you out with things. [...] They ask background information, like how many brothers and sisters you’ve got and who you live with and stuff, try and get the background information of what’s happened, anything that has gone on and stuff. They try their best to get all the information.

Young participant

The young people were not asked specifically about health visitors; however, two young people described feeling failed by the service. It was felt that practitioners failed to consider children and young people when they were made aware of parental drug misuse.

Young participant

I think health visitors should do a lot more because they’re the ones that visit your house, especially like going to your house and you get weighed and measured and make sure that you’re healthy. Whereas at 11 I was this tiny little bod, I weighed just nearly six stone, I was really underweight, everything, my height and stuff. Surely they should notice that. Why didn’t they notice that? Why didn’t they notice that my little sister that was only two wasn’t nourished enough and stuff like that? Why didn’t they notice that? Why didn’t they say, ‘Actually this isn’t right; something needs to be done about it’? Why didn’t they say about the state of the house?

Young participant
Summary and discussion

Clearly, universal services practitioners face a wide range of barriers that can make early help provision difficult. Time and workload pressures were significant obstacles to the provision of early help, in part because they presented practical restrictions to the amount of help that could be given and in part because they could make participants feel uncared for and unsupported, which then impacted on their ability to care for and think about children.

I’ve talked to and heard of midwives who are crying in the kitchen at the end of a shift, and one midwife actually said to me, ‘I feel awful, but I try not to catch anybody’s eye, because then I know I’ll have to stop’, because they’re tearing round like scalded cats, which is heartbreaking.

Midwife

Also rated highly as barriers were multi-agency working and information sharing. This was particularly felt in education settings, which may explain the findings in Section 3.3 of this report that education practitioners are less likely to respond to low-level neglect by contacting other practitioners and signposting families to other agencies than health practitioners. The absence of available early help services was also flagged up as needing urgent attention.

Another substantial barrier to early help provision in universal services raised by the participants was the strained relationship between universal services and children’s social care. On the one hand, children’s social care is clearly under-resourced and not always able to provide support to services. On the other, the findings suggest that universal services practitioners can feel undervalued and undermined. The role that children’s social care can and are willing to provide advice on in relation to early help needs to be further explored.

The large number of practitioners with a safeguarding responsibility that had not read their LSCB threshold document and the smaller, but still noteworthy, number of practitioners with safeguarding responsibilities who had not heard of the document, is concerning. This may well impact on the strained relationship between children’s social care and universal services, as well as the ability of universal services practitioners to provide early help.

There is evidence in this research to suggest that some practitioners have difficulty identifying neglect. While, on average, the participants reported feeling confident in their ability to identify neglect and felt that the training they had received was sufficient, some said that they felt that difficulties identifying neglect could present a barrier to providing early help. Furthermore, some participants suggested that while they did not have difficulty identifying neglect, they felt that other universal services practitioners did. It was clear that not all practitioners are receiving training every three years (in particular health visitors, midwives and early years practitioners). The qualitative data provided a more in-depth view of the extent to which participants felt equipped to respond to identify neglect, and a range of shortfalls in training were identified.

These findings suggest that some practitioners continue to struggle with the identification of neglect. However, the extent of this problem is less clear. The confidence reported by the participants in identifying neglect could reflect the nature of the sample as self-selected and, therefore, likely to have an interest in and knowledge about child neglect. In addition, the degree to which practitioners feel able to admit to difficulties in identifying neglect will have influenced their responses; professional and statutory guidelines require universal services practitioners to be able to identify neglect, and admitting this is a barrier to helping children may be difficult to do.

There is also a feeling among these practitioners that their judgement is questioned or undervalued by children’s social care, and therefore, may feel pressured to overstate their confidence in identifying neglect.

Across the practitioner groups, GPs tended to report being less confident about identifying neglect and saw difficulty identifying neglect as a bigger barrier to providing early help than other professions. This may mean that GPs feel less supported than other practitioners in understanding and identifying
neglect. Conversely, it may indicate that they feel more confident in admitting the difficulties they face, due to their established position as figures of authority.

Participants also reported that they felt relatively confident in how to provide early help for neglect. On the whole, they felt that the training they received on this was sufficient, with GPs and midwives being less confident than others. This is a surprising finding, given that the role of universal services to provide early help is not embedded in policy or practice and, therefore, it is unlikely to be embedded in training.

While the participants focused on a need for further training, the ability to effectively identify and respond to neglect is also influenced by the extent to which practitioners receive regular and high-quality supervision. Supervision should support practitioners in reflecting on the training that they have received and their daily practice of providing early help to children and parents.

**Recommendation**

All practitioners should have regular supervision with their manager in which they are supported and encouraged to reflect on their day-to-day practice in providing early help to children and parents.

The views of the young participants on what factors facilitate and prevent young people from seeking and accepting help from universal services practitioners highlighted additional barriers to the provision of early help for neglect. The young participants did not feel that the current structure of provision of general practice and, in particular, school nursing facilitated close relationships with practitioners. Minimal contact time, a lack of continuity of care from one professional and a lack of understanding about how these practitioners might be able to support young people were key barriers to help seeking by young people. Teachers and school staff were more likely than health practitioners to be seen as people who could help young people who were neglected. However, alongside GPs and school nurses, it was felt that teachers did not always take the time to understand what was happening to the young person from their perspective. These findings are not surprising considering the infrequency with which practitioners said that they talk to children about their concerns.

These findings echo those in a study commissioned by the Office of the Children’s Commissioner about how children and young people recognise abuse and neglect, disclose abuse and neglect, and seek help (Cossar et al, 2013). The study found that while it is important that professionals notice signs and symptoms of neglect and not rely on young people to disclose distress, “If a trusted professional responds sensitively and shows concern for the child, they may then begin to talk about underlying problems”. The young people in the study described “how conversations prompted recognition [of abuse] and relationships of trust promoted telling and help” (pii).

Interestingly, however, while the young participants in this study said that young people might be more likely to speak to another young person rather than an adult about problems at home, Cossar et al found that young people could be wary about confiding in a friend, for example because they feared that friends would gossip about them. The findings from this study and that of Cossar et al’s clearly highlights the need to help practitioners to build their confidence and skills in talking to and listening to children and young people about early concerns.

The next section explores ways of overcoming some of these barriers through examples of promising practice and ideas for better practice as put forward by the participants.
3.5 Promising practice and ideas for better practice

KEY FINDINGS

Examples of promising practice and ideas for better practice from the professional participants included:

• Training that focuses specifically on neglect, its impact on child development and effective working with parents;
• Prioritising the provision of home visits in health visiting, midwifery and early years;
• Improving the provision of postnatal care;
• Enabling family support workers to provide early help through increased training and supervision;
• Establishing ‘contact windows’, during which practitioners make themselves available to answer telephone calls about safeguarding concerns;
• Holding regular internal team meetings and supervision;
• Government financial investment in early help in universal services (a commitment to recruiting more school nurses) and in targeted early help provision;
• LSCB-wide neglect strategies.

For the young participants, service provision could be improved through a greater focus on building relationships with young people.

Promising practice and ideas for better practice are grouped in the following themes:

• Improving training on neglect
• Improving practice around engaging parents in early help
• Providing direct help to children and young people
• Home visits and postnatal care
• Overcoming time and workload pressures
• Improving multi-agency working and information sharing among universal services practitioners and with children’s social care
  • Improving relationships with children’s social care
• Effective internal team working
• Investing in early help
  • Increasing investment in targeted early help provision
  • Increasing investment for early help provision in universal services
  • Third sector early help provision
• An LSCB-wide approach to neglect

We also asked the 18 young participants who were involved in the project to give their views on how universal services practitioners could improve their practice in providing early help. Key themes were:

• Establishing relationships
• Education on child neglect

Throughout the following section run themes around increasing professional capabilities, facilitating the development of relationships between services, and between services and parents and young people, and high level calls for government investment.
Improving training on neglect

Participants suggested ways in which both the content and the process of training delivery could be improved. It was felt by some that more and better quality training on neglect was necessary to improve universal services practitioners’ understanding of, and, therefore, ability to respond, to neglect. There was a call for training that specifically focused on neglect, as well as training that helped practitioners to understand and then describe the impact on the child and their development, because this meant that referrals were more likely to be taken seriously by children’s social care. Others wanted to develop a greater understanding of attachment. Ensuring that all non-clinical or non-teaching staff members, such as cleaners, school lunchtime supervisors and school kitchen staff, are well trained in identifying neglect was also felt to be an effective way of providing timely responses to neglect.

I try to speak to them at least in the first week here just to make them aware. A lot of them that haven’t come from education or have come from education in a different part of [this city], or maybe not even [this city], just to make them aware of what the school is like. Obviously not to scare them off; but just to make them aware that this is an issue; it’s an issue everywhere, not just here, and they do need to be vigilant. And just about how we work things here, because the school they might have come from might work things very differently.

Head teacher

Recommendation

Safeguarding practitioners in each service setting should ensure that new members of staff are trained in the organisation’s safeguarding policy within two weeks of the post commencing.

Another approach to training staff that was considered to be useful was analysing the organisation’s safeguarding policy as a whole staff team. This process involved breaking off into groups to discuss certain aspects of the policy, and then feeding back to the whole group about possible improvements that need to be made. This approach was felt to help avoid training being ‘just an exercise’, but rather something that was relevant to day-to-day practice.

Some participants recognised that further training might be necessary in order to develop skills in how to work more effectively with parents. They wanted help in developing the skills to work with aggressive parents but also, more generally, help to increase confidence to question parents and address sensitive topics.

How do you communicate. what sort of things do you say to parents when you’re actually dealing with such a sensitive subject? It could be a young nurse who’s actually got no skill and knowledge. As soon as you get a parent saying, ‘Who do you think you are?’, oh my goodness, you’re frightened to death. [...] It’s just how you deal with all that and being as supportive as possible, because you want to have a relationship with that family.

School nurse
Being trained in antenatal and postnatal promotional interviewing was identified by health visitors as an effective way of providing early help to parents (Day, 2012a; Day, 2012b). Promotional interviewing is recommended in the Healthy Child Programme guidance. The promotional guide system promotes the early development of babies, the transition of mothers and fathers to parenthood, and better informed practitioners and parental decisions about the baby’s needs. It aims to help parents to think about and reflect on their situation and experiences, and to develop problem-solving skills.

**Improving practice around engaging parents in early help**

Participants who reported that they were successful in engaging parents with early help felt that it was contingent on developing compassionate, open and honest relationships with them. Creating positive relationships and knowing parents well meant that concerns could be more easily raised and parents were more likely to take on board offers of help. Tactics to improve parent–professional relationships included: presenting to the parents as non-judgemental; not overreacting to disclosures of difficulties at home; empowering parents to make positive changes; treating all parents the same; and bearing in mind that some parents may have an “aggressive defensive mode of dealing with institutions” (teacher). Building a trusting relationship is clearly not always easy, and more practical examples are given below of ways in which this can be supported.

One teacher described her school’s Year 7 transition programme, which is held during the school summer holidays. Referrals to this programme come from primary schools, parents or by the child themselves. The transition programme was described as a powerful way to build relationships with parents. The Behaviour Support and Prevention Manager either telephones the parents of those children, visits them at home or invites them into the school. This means that if s/he needs to make contact with parents at a later date about concerns, a positive relationship with the family has already been established. This was labelled as a ‘Positive Pass’ rule of care, in which efforts are made to build a relationship with parents via positive feedback.

> I always say that’s half my work done, building a relationship with the families. [...] In a situation where I am dealing with some of the negative side of things, such as pupil’s behaviour, I make sure that I constantly make phone calls to the parents about the positive things they do.
> 
> Teacher

Other promising practice in educational settings included going out into the community to developing links with families, a regular drop-in sessions for parents that creates an “informal time to meet, support and chat to parents and their children” (teacher), and attending external health or social care appointments with parents. Within health, one suggested way to improve the engagement of parents with early help was to present to the family as a multidisciplinary team, rather than as individuals. A midwife described how her local children’s centre developed a one-page leaflet for parents that named and gave a photograph of their team of practitioners, including the local midwifery and health visiting teams:

> So, I’ll say: ‘Hi, I’m Susie, your midwife. But I also work with Tim, Sally and Kate. So, you might see me hopefully, but if not it’ll be one of these, and this is their pictures, and also these are the health visitors.’
> 
> Midwife

Continuity of care from health practitioners was also highlighted as a potential way of improving relationships with parents. Returning to a system of family GPs, increasing the numbers of caseloading midwives and named family health visitors were suggested as ways to give families consistent care and allow supportive relationships to develop.
Providing direct help to children and young people

Schools working with younger children also often spoke about offering practical support to children, such as offering free breakfasts and affordable second-hand uniforms. As with parents, building a trusting relationship with young people was cited as a crucial way of helping them feel able to disclose problems at home. The transition programme described on the case study box below not only helps teachers to develop relationships with parents, but also with young people.

Case study: The powerful potential of pastoral work in schools

A Year 7 student was part of the school’s transition programme. This programme ran over the summer holiday and supported vulnerable students in their transition from primary to secondary schools by enabling them to meet staff and develop relationships with them before school began. During her time on the transition programme, the student built close relationships with the Behaviour Support and Prevention Manager and her team. They helped her to become part of the larger school community and, following the programme, she had little contact with the team. When the student was in Year 9, she learnt that she and her family were moving to another country, news that she found very upsetting. When she felt ready to talk to someone, she chose to go back to the Behaviour Support and Prevention team rather than another member of staff to talk about her worries and to find support.

It just shows, two years’ later she came back to tell us that she was so unhappy, could she speak to someone? So I think that is an example of the pastoral side and how it is important that, forming those relationships.

Teacher

Another example of promising practice was having in-school counselling services, whether this was linked solely to one school or paid for and shared between a cluster of schools based on need.

Home visits and postnatal care

Home visits were identified by many participants as a key tool for universal services practitioners when identifying and responding to neglect at an early stage. They allow the professional to see the home environment, meet and assess extended members of the family for risk and build a relationship with the family on their terms. One health visitor described a recent change in their local guidance, which allowed them to see families in their home on multiple occasions antenatally, for the birth visit and at 6–8 weeks in the home. The health visitor felt that this allowed her the opportunity to build a therapeutic relationship with the parents. It was also felt that best practice would be ensuring that home visits are prioritised as essential professional practice in early years and midwifery.

Antenatal care is currently provided mainly in clinics rather than home visit – [best practice would be] ensuring that at least one visit is at the patient’s home and try to ensure at least one appointment is with the patient on her own.

Midwife

Alongside home visits, a key facilitator of engaging with families, and more generally preventing neglect raised by midwives, was extended and improved provision of postnatal care. The practitioners spoke about an increasing reduction of postnatal care in midwifery, which both limited the extent to which relationships could be developed with parents, and also the extent to which neglect could be identified at an early stage.

Recommendation

Postnatal services in midwifery should be commissioned and provided in a way that ensures that midwives are supported to provide women with individualised postnatal care plans and that they receive the level of postnatal care that they require.
Overcoming time and workload pressures

A clear message from many schools was that the average teacher does not have the time to undertake much early help provision beyond identifying neglect and referring on concerns within their schools. With this in mind, some schools employ their own pastoral support staff to take on the role of providing early help to families. This was frequently cited as an example of promising practice in education settings where there were concerns about neglect. This work is carried out by a range of people in different job titles, including family support workers, learning mentors, parent liaison workers, pastoral mentors, parent support advisors, family intervention workers, education welfare officers, home-school link workers, parental involvement workers, emotional literacy support assistants and inclusion workers. In some areas, an initial grant was provided by the local authority for this provision, and where the funding had been terminated, family support workers were kept on because they were seen as a vital resource.

Workers within these roles were undertaking a range of activities. They worked directly with children to support their emotional wellbeing, including tackling bullying and running nurture groups, and provided practical support for children in school and at home, for example conducting home visits before breakfast to help with getting children up and ready for school. Workers also provided parental support, from “having a word” with a parent about a concern to “challenging and supporting parents to tackle the issues”, as well as signposting parents to other agencies and building relationships with the community. Some were lead practitioners in Common Assessment Frameworks. The role of family support workers was often described as increasing children’s mental wellbeing and in turn increasing their capacity to learn.

The participants raised two difficulties in relation to provision of early help through family support workers. First, they emphasised the extent to which they are contingent on available funding. Managerial priorities within schools and early years settings play a part in whether the provision of these services is feasible. One way suggested for funding these positions within schools was through the Pupil Premium:

As the headteacher of a large primary school, I have invested in a family liaison manager who undertakes all of this work as I and my senior teachers do not have the capacity to undertake all of this work. In my previous headship of a slightly smaller school, I tried to do this work – it was exhausting and I was unable to focus properly on ensuring that teaching and learning was good. Pupil Premium has enabled schools to provide extra staffing to support with safeguarding concerns.

Headteacher

Second, it was also acknowledged that these workers must be sufficiently trained to work with vulnerable children, parents and families. Family support worker positions are traditionally low paid and do not often require qualifications, although some of the family support workers we spoke to were trained in a range of parenting programmes, including Strengthening Families, Webster Stratton and the Positive Parenting Program, and had counselling skills and training in the Human Givens approach. Nevertheless, there is a risk that inadequately trained staff may indeed pose a risk to children’s wellbeing, particularly if they are solely relied upon as the providers of support to families and do not receive adequate supervision. One local authority designated officer commented:

In terms of the actual home visits and the day-to-day work, that pastoral work with bullying or feeling unhappy gets referred to our learning mentor.

Teacher
We’re creating across schools a host of people who are known as pastoral support workers, learning mentors, home school link workers – none of whom are trained because they’re all paid a pittance and they’re all trying to do what they can without any real guidance or steering. There’s no real supervision about ‘Okay, so what are you trying to achieve? What model are you using to achieve it?’ There’s none of that, so people are very basically being sent out to a home address without knowing what they’re getting into and without really knowing what they’re trying to do.

Local authority designated officer

In one area, this concern is being addressed through the provision of supervision of family support workers from locality social workers. However, challenges associated with this model have been identified; the fact that locality social workers are not line managers for these workers means that they are, therefore, restricted in the extent to which they can dictate the work they do. In addition, this model puts further pressure on social workers by asking them to provide an additional service. Another method of addressing this concern is through a national approach to the training of these workers, with the potential of creating a powerful and influential workforce to tackle parental risk factors for neglect and child neglect early. It was suggested that a qualification could be developed, perhaps in an NVQ format, based on a workplace programme supported by lectures and tutorials. An obvious barrier to this would be convincing schools of the value of this training, in order for them to invest their workforce. There would also need to be a shared agreement on the roles of these practitioners across schools following qualification, to ensure that the skills and training were used appropriately.

The benefits of pastoral support staff was also raised by several midwives, and the potential opportunities of employing family support workers across a range of different universal service settings should be explored further. It was acknowledged that nurses and midwives in hospitals can struggle to provide adequate bedside care to patients due to competing demands on their time, which can require them to act as technicians and undertake purely medical work. It was suggested that rather than expecting nurses to continue to undertake more pastoral work, this conflict could be recognised and bedside care could be delegated to support workers.

Recommendation

Headteachers should recognise the role that family support workers can play in preventing neglect. Headteachers should ensure that family support workers are given adequate training and supervision to reflect the skill required to take on this role.

Other solutions to overcoming time and workload pressures in health were often around the need for further financial investment in the services to increase the number of practitioners. This was particularly the case for school nurses, and indeed health visitors who, despite the government’s pledge to increase the number of health visitors, still felt that more investment was needed. Additionally, a highly valued resource for midwives was safeguarding midwifery teams, which seemed to take responsibility for all safeguarding beyond the ‘identify and refer’ model.

Our safeguarding midwife is a fantastic help and always available for advice, support and willing to see women and families, so in this way I feel confident that I can do my job properly as I have excellent support.

Midwife
The suggestion was also made for the introduction of caseloads that reflected the area in which practitioners were working. Those working in areas of high deprivation would have smaller caseloads than those working in more affluent areas, giving practitioners time to “spend with the families and make the millions of phone calls that you need to that come out of just one family” (health visitor). Linked to this was the idea of rotating practitioners around geographical areas every five years. While these ideas partly rest on the assumption that neglect is linked to poverty, they may help practitioners avoid ‘burn out’.

Another suggestion put forward to tackle the barrier posed by time and workload pressures on practitioners was to change the role of the named person in each setting to solely include safeguarding and child protection work.

We have been asking the managers if they will do a rotation even every five years but nobody wants to come and work in our area. We have such high caseloads of child protection so they don’t want to come and work here. We enjoy what we do otherwise we wouldn’t be there but it is desensitising.

Health visitor

I think there should be in every school a person that’s their job, not an add-on. Because yes, we do our best to cater and deal with as many cases as possible but because of the time involved in dealing with and speaking to, I think there should be a dedicated person to deal with that role within school, not just a bolt on or an add to person. And that would maybe send a message across to society or to individuals that this is an important role.

Teacher

Improving multi-agency working and information sharing among universal services practitioners and with children’s social care

Multi-agency working has to improve instead of everybody just protecting themselves. I know we are all busy but we can all support each other and share our knowledge and experience.

Early years practitioner

Good multi-agency working was cited by some practitioners as an aspect of their professional practice that supported the provision of early help for children experiencing neglect. But how is good multi-agency working achieved and what ways could it be further supported?

The co-location of key services was raised as an effective way to facilitate multi-agency working. For example, the co-location of nurseries with children’s centres meant that children could be referred for specialist services in either setting. School nurses and health visitors sharing offices meant that health visitors were more easily made aware of concerns about older children within a family. Examples were also given of community midwives being located with social workers, health visitors, school nurses and GPs, making information sharing easier.

In addition, health visitors being based in children’s centres and undertaking shared home visits with early years practitioners could mean that health visitors in that area were able to contact every child under five. On the other hand, a key issue for some GPs and health visitors was the fragmentation of health visiting teams and other nursing teams within primary care, which was noted to have “significantly hindered the communication process regarding children who are cause for concerns” (GP). A facilitating factor for the provision of early help through work between these two services was having both services in the same building.
One of the most useful things as a health visitor is being based within a GP surgery, where there are any concerns, e.g. when a child presents for immunisation or sees GP then I am immediately notified. I have worked in central bases where we cover more than one GP and despite our best intentions the levels of communication are not as good.

Health visitor

Another frequently raised issue was the extent to which there are multiple IT systems across universal services and children’s social care, creating a barrier to information sharing. There was a desire for a shared IT system that enabled practitioners to rapidly share their worries and develop plans to monitor and prevent escalation. Secure email communication between practitioners involved in a family was also cited as promising practice between practitioners involved in a family. While this was raised as an example of practice for children on child protection plans, it may be useful to consider in relation to early help provision.

Regular multidisciplinary meetings were also cited as practice that facilitated effective early help for children showing signs of neglect. These included regular meetings between GPs and health visitors in which, for example, social care team managers also attended and patient records were shared. It also included regular meetings between health visitors and children’s centre staff, health visitors and midwives, and teachers with police, social care and youth offending workers. The transition of responsibility for children from one professional was identified as a point at which concerns might not be adequately communicated. Holding meetings to discuss vulnerable families as they move from one professional’s responsibility to another could fill this gap.

Next week we’ve got a meeting where we’re sharing with the school all the families that we know of that have used the children’s centre. We can pass huge information that can help them. They’ve attended toilet training etc, or that family we’ve really struggled with – they’ve got this issue and this issue, they’re going to need further support.

Early years practitioner

This could be adopted more commonly by health visitors and school nurses, if capacity allowed it. However, practitioners can be anxious about information sharing. One way suggested of facilitating confidence among practitioners in information sharing was the adoption of an ‘opt out’ clause for information sharing as opposed to an ‘opt in’ clause for families.

With health, with the new families, if you do not want us to share this information with children’s centres or something, tick this box or opt out rather than opt in. Like they say to you at the bottom of a form: if you do not wish to receive any promotion or whatever. So could it be an opt-out thing that would work?

Early years practitioner

Recommendation

LSCBs should give consideration to the trialling of an ‘opt out’ clause for information sharing as opposed to an ‘opt in’ clause for families.

However, while it is likely that many practitioners acknowledge the need and value of regular meetings with other universal service staff, ensuring that these take place can be complex. In one area, a way of facilitating multi-agency meetings via
smaller clusters of health teams was being piloted. Changes were made to the way GP surgeries were attached to the children centres, resulting in smaller teams. This then facilitated a weekly meeting between midwives and health visitors, in which the new smaller team of four midwives and four health visitors could meet once a week at a local children’s centre to discuss all new pregnancies. Efforts were also being made to include GPs in this meeting. It was hoped that these meetings would mean that practitioners would gain an in-depth knowledge of local families and any concerns that other practitioners had about them.

The children’s centre has given us computer access, we have a noticeboard, we have room availability, they give us our own passes to go in. So, we’ve just all realised that we have missed things over the years or gone by the skin of our teeth, and we can’t let that happen anymore. It was just quite a simple solution to talk. But we’ve made a point that Monday mornings is our time to get together... It just took energy and enthusiasm really, and people’s commitment.

Midwife

Promising practice example

Proposed Local Enhanced Service (LES) for Safeguarding Children, Wyre Forest Clinical Commissioning Group

Local Enhanced Services are services that are commissioned by Primary Care Organisations (PCOs). They are optional and are intended to be services that respond to a need in a local area. Payments are made to each participating practice by the local CCG.

The purpose of this LES is to improve communications with the wider healthcare team to achieve more robust safeguarding mechanisms in the area.

The model proposes that safeguarding meetings are held initially once every eight weeks. Attendees consist of the lead GP for safeguarding in the practice, a health visitor, a school nurse, and an administrative employee to take minutes. During the meetings, the following issues are discussed:

- Children already identified as being ‘in need’
- Children who have been the subject of a recent child protection conference
- Children who have a child protection plan
- Children who have been identified as a cause for concern by any member of the practice team
- Children who live in homes where domestic violence has recently been reported, usually via communication from the police

Once the meetings have been established, if a team member has a concern regarding a child that does not amount to the need for a referral to children’s social care, they should:

- Discuss the case with the lead GP for safeguarding (to exclude the need for referral to children’s social care)
- Email the assigned administrative support person to ask for that child or family to be considered in the next safeguarding meeting

Minutes of the meetings should be accessible to all members of the practice team via the surgery intranet or shared drive, and this document will then serve as an up-to-date list of the children about whom there is a concern. An alert message is placed on the notes of each child about whom there is a concern to alert other clinicians (and this alert is removed when no further concerns exist).

For further information, see: Brodie, T., & Knight, S. (2014). The benefits of multidisciplinary safeguarding meetings. British Journal of General Practice, 6, 364–365
It was suggested that a weekly meeting could be made statutory for any professional working with children. It was also noted that multi-agency professional meetings were likely to be regularly attended by key practitioners if they were established as a requirement and not an option, as in the following school:

"It does involve different agencies giving up their time to attend this meeting but long term, if we are working together, that will cut down some of their hours down the line. So people think, well that’s another two hours I’ve to attend a meeting but because it’s been part of the school’s history for many years, it’s the norm."

Teacher

Promising practice example

Facilitating multi-agency working: Specialist Case Planning Service, Health Visiting, Children’s Community Services, Central Manchester University Hospitals NHS Foundation Trust

The role of the Specialist Case Planning Service is to facilitate multi-agency working at Level 2 to 3 on Manchester’s Levels of Need, by coordinating multi-agency meetings with practitioners and parents. The aim is to tackle neglect at the earliest stage to reduce adverse health outcomes for the child and prevent escalation.

A referral can be made by any professional working with the family, via a Manchester CAF (MCAF).

The service contacts the relevant practitioners working with the family and arranges multi-agency meetings. The meetings are chaired and recorded by the Specialist Case Planning Lead and the case plan is distributed to all those involved with the family. The case plan is then reviewed in subsequent meetings, where the lead’s role is to monitor and challenge progress, and support an individualised package of care for the family.

The service is available for families with a child aged from 0–4 years old, where there is one child indicator and one adult indicator present from the following:

**Child indicators**
- Missed appointments/poor engagement
- Poor hygiene
- Weight abnormalities
- Numerous addresses
- Inappropriately dressed
- Multiple minor injuries/A&E attendance
- Poor dental/oral hygiene
- Disability
- Low birth weight/prematurity
- Unexplained developmental delay

**Adult indicators**
- Mental health
- Domestic abuse
- Alcohol and substance misuse
- Learning disability
- Looked After Children
- Teenage parents
- Concern from family, friends and neighbours
Another way to facilitate good multi-agency working for some practitioners, in particular midwives, health visitors and early years practitioners, was to conduct joint home visits. In one area, an early years practitioner spoke about a local ‘Family support network’. This model involves families being visited by their health visitor and being asked to sign up to the support network, which gives permission for their details to be given to the local children’s centre. This in turns facilitates outreach to the family from the children’s centre.

Some pointed to the need for multi-professional training to facilitate a more comprehensive early response to neglect. Participants felt that this would enable a greater understanding between professions of different roles and capabilities, including service pressures.

Multi-professional training could include service commissioners, who may then be better placed to understand the role that universal services have the potential to play in providing early help. It was noted that training with social workers might also enable universal services practitioners to develop a clearer understanding of thresholds. An example of promising practice in one area was the establishment of a joint half-day training session specifically on neglect, which was being developed for school nurses and health visitors with caseloads. However, enabling practitioners to attend multi-agency training was identified as a challenge. One suggested making multi-agency training statutory, which when practitioners are under significant time and workload pressure, has obvious complications.

Getting through to a health visitor can be really hard, and maybe that needs to be changed, and we need to be available to them equally. Say, ‘Throughout these two hours of the day, there’s a doctor on this phone number, who’s going to be by that phone, and you can call him if you’ve got a concern,’ and the health visitors do the same, and the lead nurse for safeguarding does the same. If it was easier, if you knew you could just pick up the phone and someone would speak to you there and then.

GP

Effective transitions of children from the care of health visitors to school nurses could be facilitated using different coloured sheets of paper for handover files, which indicated where there were low level concerns about a child or family. School nurses commented that, given time shortages, it was necessary to prioritise on which case files were read in depth, and if concerns were on different coloured paper, those children could be easily identified as those who needed to be prioritised.
Improving relationships with children’s social care

Of those who were able to contact children’s social care in their area for advice, some reported this to be a vital resource in providing early help to children. Family support work teams, advice lines without the need for a referral, no name consultations, multi-agency screening teams (MAST) and Single Point of Access referral procedures were all highlighted as helpful services.

We’ve got an initial assessment team that just deal with referrals. So, what we would do is we would call up the initial assessment team and say, ‘We’re thinking of doing a referral on this child. Can you check on your system; are they known?’ And they would ask for the name, date of birth, check on the system if they’re known, and then ask for the concerns. And I’d say, ‘These are our concerns’ and I would take advice from them. And if they then said, ‘Right, after your concerns I’d like you to do a referral’, we would put the referral straight in. Or they might say, ‘Actually we don’t think it meets a referral. Have you tried this?’ […] And we would go and do that. And if it didn’t work we would go back to them and say, ‘Look, you suggested this, it hasn’t worked. What do you suggest now?’ And that’s how we would do it.

Primary school staff

However, clearly some participants felt that they needed greater support from children’s social care in order to provide early help to children experiencing neglect. There was a sense that more needed to be done to repair the relationship between the two services, and from a universal services point of view, this could be achieved by social workers being encouraged to take on board the concerns raised by universal services practitioners. It was felt that this could be achieved by building personal relationships where possible.

More practical ways in which it was felt that children’s social care could improve their support of universal services practitioners were also suggested. It was suggested that there was a need for greater investment within children’s social care for family support workers to take the pressure off social workers and universal services practitioners to conduct this work. Others talked about the need for advisory support services from children’s social care specifically dedicated to each universal service. This includes locality social workers, who work directly with a group of schools. In areas with locality social workers, this system was praised if the two professions were able to develop a robust and trusting relationship.

Working in an EBD school with a full-time social worker works very well. She is able to monitor the pupils, attend all meetings relating to them and liaise with the staff about the pupils.

Teacher

However, this system can encounter difficulties if there continues to be ongoing points of tension in the relationship between social workers and education practitioners. One suggestion for overcoming this problem was to employ non-social work staff in this position, for example the local authority designated officer or designated safeguarding nurse.

Myself and my colleague who is in the school safeguarding team as well are the point of contact for every school in the county. So if they are not sure about what to do they will often contact us rather than go to the county social worker because, one, I’ve worked in the county long enough to know every headteacher and they all know me and, again, that points to the relationship thing but, two, they also see me as somebody who isn’t coming to it with that straightforward social work head that has a balanced view that takes all of the things into consideration.

Local authority designated officer
Effective internal team working

Having regular internal team meetings was highlighted by many participants as an effective way to safeguard children. These could occur daily, weekly or monthly, depending on the working context and need. In some settings, every child in the organisation’s care was discussed, and in others, only ‘priority’ children and families were discussed. The benefits of these meetings were to raise other practitioners’ awareness of emerging concerns to enable them to monitor the child or family, to allow space for concerns to be voiced and challenged, and for practitioners to develop confidence in their response to the child and family from being supported by others:

*When you discuss problems through with people and you get a slightly different perspective it really does help you in your decision-making.*

**GP**

**Recommendation**

Safeguarding practitioners in school nursing, health visiting and midwifery should ensure that regular internal team meetings are held (at least every two weeks) to discuss early concerns about children and their parents, in which practitioners feel able to challenge one another and reach a consensus about appropriate responses.

Using colleagues as a ‘critical friend’ and having effective supervision were also seen as key parts of effective internal team work. Exploring other team members’ perspectives on a child or family and having the confidence to challenge each other was crucial. Additionally, using ‘personal reflection’ to examine practice and to explore reasoning in a one-to-one session with a supervisor was also considered important.

Investing in early help

**Increasing investment in targeted early help provision**

Clearly, the participants felt that there was a need for increased funding of targeted early help services. However, in cases where early help services provided by the local authority were running, and where those services were felt to be accessible, they were often considered to be effective. Some examples given of effective early help services provided by the local authority included:

- Early help hubs, which consist of a range of practitioners and agencies who are involved in the provision of early help. Early help hubs are not service delivery points; they facilitate a multi-agency response to children and families requiring interventions beneath the threshold of statutory social care.
- Multi-agency Safeguarding Hubs (MASH), which provide a first point of contact for new safeguarding concerns. They bring together a multidisciplinary team, collate information about a child and family to assess risk, and decide what action to take.
- ‘Front Door’ services, which were described as a pathway to accessing services, support and advice from early help through to safeguarding and child protection, through which practitioners can contact social workers and support officers to discuss concerns.
- SAFE – Supportive Action for Families in Ealing, consisting of psychologists, therapists, counsellors, pupil/school workers, family workers and other experts.
- Responses to the government’s ‘Troubled Families’ workstream, including the Building Resilient Families and Communities programme in Staffordshire, which brings together partners from across the county to work together and build on current strengths to create sustainable solutions within families and the wider community.
- Family support localities service.
- Family Nurse Partnership (FNP), a voluntary home-visiting programme for first time young mums, aged 19 or under (and dads). A specially trained family nurse visits the young mum regularly, from early in pregnancy until the child
is two. Commissioning responsibility for the FNP will transfer from NHS England to local authorities in October 2015.

**Increasing investment for early help provision in universal services**

Education services were seen as a vital source of early help provision for neglect. Children’s centres were frequently identified across the practitioner groups as a key source of early help provision, and many cited their close working with children’s centres as an example of best practice.

*Children’s centres play a vital role, helping parents to engage with their children and access support. This helps to prevent isolation.*

**School nurse**

Programmes and activities based in schools and children’s centres that were considered to be examples of good practice by the participants included ‘Parents and Partners in Early Learning’, Family Links, parenting groups, the Thrive programme, breakfast clubs, pre-school groups and assisted places in after-school play scheme. Family support workers in schools were also considered key to early help provision. The necessity of parental education programmes was highlighted by participants, in particular in relation to “how emotional aspects of parenting are crucial to children’s mental health” (midwife). Examples included the importance of antenatal parent education around attachment and emotional care for babies, and one-to-one support for parents with low self-esteem who may find groups more difficult to access.

*These programmes can take the pressure off parents at critical times. Neglect isn’t a consistent thing in many families; it can be related to circumstances and the pressures faced by families. Depression is a really big issue, which leads to low level neglect. We work hard to engage parents, boost their self-esteem and support them with purposeful activities, such as school volunteering. This helps us to build relationships so that parents are more likely to confide and seek/accept help.*

**Teacher**

The Quality and Outcomes Framework (QOF), introduced in 2004, is a voluntary incentive scheme for GP practices in the UK that rewards them financially for meeting targets for certain aspects of general practice, including managing common chronic diseases, patient feedback and the provision of additional services. One way suggested for increasing the extent to which GPs respond directly to neglect at an early stage was to incentivise the work by introducing safeguarding as a target on the QOF. This might also raise the profile of early help within general practice.

*The QOF is here to stay, and there is quite a lot of evidence that it may have improved quite a few markers in healthcare, and could we not join their bandwagon and say that maybe child safeguarding could be put forward as a QOF, because then it would raise its profile.*

**GP**

**Third sector early help provision**

Additionally, a number of third sector programmes were also identified by the participants as effective in providing early help for neglect:

- The Triple P – Positive Parenting Program® is a parenting and family support system designed to prevent – as well as treat – behavioural and emotional problems in children and teenagers.
- PIP UK, which use psychotherapeutic interventions to help parents or carers form a more secure bond with their babies.
- Baby Steps is a nine-week perinatal education programme delivered to expectant and new mothers and fathers, developed by the NSPCC in partnership with parenting experts at Warwick University.
- Home-Star, a national family support charity.
An LSCB-wide approach to neglect

Implementing a specific focus on neglect within LSCBs was identified as one way that practice can potentially be improved in this area. LSCB neglect strategies can ensure that neglect is prioritised, and could involve setting out and developing recognised pathways for responding to neglect at all levels, providing neglect toolkits for practitioners, creating a neglect subgroup within the LSCB and ensuring that all subgroups are working with neglect in mind. This can be particularly powerful if coupled with a focus on early intervention. However, neglect strategies require regular audit and evaluation to assess effectiveness.

Recommendation

LSCBs should develop a neglect identification and intervention pathway that helps practitioners identify and access targeted early help services.

Example of promising practice

Local Safeguarding Children Board neglect strategy: North East Lincolnshire LSCB

Neglect and multi-agency early help are two issues that have been prioritised by the North East Lincolnshire LSCB in response to a historically high number of referrals for neglect. This led to the development of a neglect strategy that aims to equip practitioners across public services to provide earlier and more effective help to children, young people and families by describing and developing clear pathways to responding to neglect. The neglect strategy consists of:

- Introducing a neglect assessment tool, which is an adaptation of the Graded Care Profile.
- Aligning the assessment tool to the Child Concern Model to achieve clearer thresholds for early help and support.
- The neglect identification and intervention pathway.
- Professional’s capabilities framework for neglect aimed at universal providers, identifiers, assessors and interveners.
- The development of practice guidance and multi-agency protocols.
- A public/community awareness-raising campaign that is ongoing and being embedded.

The neglect pathway and Child Concern Model aim to help practitioners to identify the best agency to support a particular family in respect of a particular element of neglect. They also seek to facilitate multi-agency working by mapping where each service fits into the neglect pathway. Particular attempts have been made to ensure the use of simplistic language in the documents, and events were held when the strategy was launched in an effort to embed the strategy by informing and involving practitioners.

The strategy also aims to join up local agencies who lead on early help, including the Health and Wellbeing board, the Children and Young Person’s Partnership Board, the Youth and Crime Board, the Strategic Partnership Board and the LSCB. This is to ensure an economy of scale in the face of financial cuts, for example through a single assessment and planning process. Future plans also include exploring the extent to which children’s centres can be transformed into family hubs to enable them to support children and young people of all ages.
The young participants' views on improving practice

The young participants outlined a number of ways in which GPs, school nurses and teachers could improve their practice in order to better provide early help for neglect to young people, and these are described below.

Establishing relationships

A key message underpinning these suggestions was the extent to which having one consistent person in a young person’s life could make a significant difference to the likelihood of them disclosing neglect and accepting support.

Long-term relationships are the best cure I’d say. For someone to speak to, the ideal person is someone that has built up a long-term relationship and is friendly.

Young participant

Recommendation

Models of case allocation that facilitate the continuity of care in services, so that children and parents/carers see the same health professional at each contact where possible.

The young participants suggested a number of ways in which they felt that GPs could improve the way they work with young people experiencing neglect. They commented that GPs should be friendlier, more empathetic and show more interest in young people. Another commented that the role of GPs in supporting young people should be made clearer. As noted, good relationships were key, and feeling valued and believed when disclosures were made was essential for young people. One young participant suggested that GP surgeries should provide information leaflets about neglect.

Like with GPs, some said that it would be helpful if school nurses enquired more about their emotional wellbeing, rather than asking “Why are you here? Aren’t you supposed to be in lesson?” (young participant). The young participants suggested that school nurses asked about their home life, about their feelings, and about whether their problem started at home or at school, in order to encourage disclosure. One young participant noted that she had had a positive relationship with a matron at her school, who was based in school on a more permanent basis.

Ways for teaching staff to develop trusting relationships with young people were also described by the young participants. It was suggested that teaching staff could have ‘bonding sessions’ with...
students in which they played games. Another suggestion was for teaching staff to capitalise on the opportunity presented by school trips, where it was felt that young people might feel more relaxed and were more likely to see them as ‘normal people’.

Even if you saw school staff as more human as well. I remember when I was at school I never thought of school staff as normal people; I don’t know what they did, I just didn’t see them as normal. I think the best chance I would have had is like on a school trip or something like that when you see them, a residential or something like that, that informal chance when you’re not in a classroom.

Young participant

Recommendation

Teachers should recognise and capitalise on the opportunity provided by non-teaching activities to develop relationships with the children and young people in their care.

A young participant also suggested that in primary schools, emotion wheels could be used as a way of helping children express their feelings to staff. Each child would have their own spinning wheel with feelings marked on it, and would set it to the emotion they were feeling that day. The teacher could then speak to the child about how they were feeling. This young person also suggested that there could be a book in which primary school children could write to their teacher if they were feeling upset and the teacher could reply.

So, say if I said: ‘I’m feeling upset because my mum said I can’t watch TV for a week’, then the teacher could write: ‘why?’ And then I could write: ‘because I was naughty’. And then the teacher could write back: ‘well, that’s quite understandable; your mum’s upset with you because of this. Try to be careful next time or don’t do it again’ kind of thing. It’s just to understand it. So, it’s not speaking but it is speaking.

Young participant

Some of the young participants felt that having someone to talk to who was not responsible for another part of their development (for example, their education or their health) would be most beneficial, for example youth workers.

Education on child neglect

Some young participants felt that more needed to be done in schools to teach young people about what constitutes neglect.

I also think that it should be in the school curriculum at least, like, one lesson, you know, children with neglect. […] Like if anyone is dealing like with this, this is who they should contact, you know like a PowerPoint. […] I think these sorts of lessons, they more focus on things like don’t smoke. Don’t smoke, don’t drink and that sort of thing.

Young participant

Recommendation

Specific content on what neglect is and how children and young people can get help when they need it should be compulsory in the PHSE curriculum.
Summary and discussion

The participants raised a number of interesting and potentially powerful examples of both promising practice and ideas for improving practice. The desire of practitioners to receive more in-depth training on the impact of neglect and how to articulate concerns should be taken on board, even in light of the additional resources this would require and the possible additional pressure on services it might create. Practitioners also called for help with conveying concerns to parents, challenging them and supporting them.

Unsurprisingly, positive relationships between parents and practitioners were said to be effectively developed by practitioners spending time with and being a constant presence in the lives of parents as much as possible, and this should be considered in relation to policy. Home visits, improved and increased postnatal care, outreach work and ensuring continuity of care from one professional all seem to be facilitating factors in the provision of early help.

Problems around multi-agency working and information sharing are longstanding and there have been repeated attempts in the past in research, policy and practice to overcome these difficulties. There is clearly no one answer. However, the participants provided concrete and specific examples of ways they felt that practice could be improved, including shared IT systems, regular multidisciplinary meetings, joint home visits, multi-agency training and ‘contact windows’. The relationship between children’s social care and universal services practitioners is particularly complex and, again, there is no simple answer. However, it seems that a greater clarification of the role of each agency in providing early help may go some way to repairing the relationship.

Solutions to overcoming time and workload pressures tended to either be around increased investment in services or around better enabling specific practitioners to take on the role of providing early help within services. In light of this, there were calls for increased funding in targeted early help services, and greater support for roles within universal services to undertake this work.

Running throughout these examples of promising practice and ideas for better practice was the extent to which organisational and professional attitudes and ethos to safeguarding plays a role. There is no doubt that the vast majority of universal services practitioners work with a fundamental commitment to ensuring the best interests of children and families. When services are overstretched and underfunded, it is usually the non-statutory provision that is cut first. However, in some examples given here, non-statutory early help provision continues in the face of these cuts, and this requires the prioritisation of funding.

Examples that reflect a managerial or whole-organisation commitment to the holistic wellbeing of children and practitioners include the following: the attendance of practitioners at multi-agency meetings about vulnerable children when they are hugely overstretched; the practice of channelling scarce funding in schools to provide family support workers; and ensuring that practitioners are given adequate supervision and are nurtured and supported. This raises some questions: if early help is contingent on the ethos of particular individuals, how can policy support its provision? Should we be trying to achieve a system in which the provision of early help is less left to chance, through the articulation of concrete professional requirements? Or should we be training practitioners in such a way that ensures early help is prioritised?

The young participants’ views on how to improve services should be as equally valued as the practitioners’ views if a better system of responding to neglect is to be reached. The potential role that GPs, teachers and school nurses can play in providing direct support to children and young people needs to be communicated not only to other practitioners, but to young people themselves. Equally, young people want to be heard, believed and treated with respect and empathy, and practitioners need to be supported to do this.

Work with children and young people can’t be tokenistic; it is about how we get the voice of children and young people, and I think we need to incorporate that into ongoing audits.

LSCB business manager
Recommendations

In order to play an effective role in tackling neglect, universal services practitioners need to be able to:

• Identify at an early stage risk factors and signs of neglect in young people and their parents and carers.
• Develop relationships with parents, children and young people in order to understand their needs, convey concerns, provide support, and in the case of parents and carers, challenge behaviour.
• Develop and maintain positive working relationships with other practitioners.
• Access advice where required about appropriate responses to neglect.
• Access targeted services for parents, children and young people.

These abilities are influenced by:

• The quality, frequency and accessibility of professional training on identifying neglect.
• The quality, frequency and accessibility of professional training on working with, and developing relationships with, parents and young people in response to neglect.
• The extent to which the working environment facilitates and supports the use of these skills.
• The extent to which the working environment facilitates and supports multi-agency working.
• The funding of targeted services and roles external to universal services.
• The extent to which national and local frameworks support universal services practitioners to provide early help.

While the government recognises the importance of early help both for the wellbeing of children and for the public purse, the current child protection system seems to be geared towards reaction to severe neglect rather than early help. This research highlights the pressing need to make more resources available for early help, to ensure that we avoid a system in which practitioners are forced to wait until a child is suffering from significant harm before help can be given.

We argue that all practitioners, whether they have a specific safeguarding responsibility or not, can and should be supported to provide some form of early help for neglect. Many of the ways in which universal services practitioners can provide early help for neglect are already integral to their roles: building relationships with parents and children, providing ongoing and consistent care to parents and children, working with other practitioners to determine a best course of action, and putting families in touch with other services all constitute the basic principles of providing care and ensuring wellbeing within the public sector. Yet, current policy and practice guidance can undermine, rather than facilitate, this work.

To overcome this, first there must be an explicit articulation of expectations for the provision of early help for each profession. While Working Together 2015 places universal services practitioners as providers of early help and many see their role as encompassing at least some provision of early help, this expectation needs to be clearly articulated.

Alongside this, there needs to be a discussion about how universal services and children’s social care can support the work that each other does. There is a clear role for children's social care in providing early help, be that providing advice or, for example, support for housing, but universal services practitioners should also hold the skills to provide help. Equally, there needs to be debate and clarification on the role of universal services practitioners in undertaking child protection work. School nurses, health visitors and family support workers in schools in this study spoke about being overwhelmed by work at a statutory level and being left with no time to work with children and families when concerns first emerge.

Together with universal services and statutory services, there is also a crucial role to be played by the communities in which children and their parents are living; the prevention of child neglect can only be achieved when friends, family, neighbours and civil society as a whole take responsibility for the wellbeing of all our children (Jütte et al, 2014).

A more radical solution to the problems around the interface of the two systems is a one-system approach, which sees all practitioners working in the public and voluntary sector as part of one safeguarding and child protection system, supported by civil society.

Second, in addition to the opacity around responsibilities, there is tension between the pressures on these services to meet targets around physical health or educational attainment outcomes and a rounded focus on wellbeing and health promotion. This can mean that practitioners do not
have the time or capacity to consider and address the wider needs of children and families, which is essential in tackling neglect at an early stage.

To achieve a system that safeguards children and promotes wellbeing more effectively, we need to move towards an approach to health and education services that is more founded in relational values (Mulgan, 2012; Muir & Parker, 2014). The concept of relational service provision operates both at the macro and micro level. At a macro level, it entails more interconnected services, obtained through the decentralisation of budgets to a local level, greater use of multidisciplinary teams, and the merging of individual services' resources. At a micro level, it means a greater focus on the quality of relationships between service users and service providers, fostered through continuity of care and personalised care (Muir & Parker, 2014).

Third, alongside a lack of focus on the wellbeing of those who use services is a lack of support for those who provide them. Staff shortages and large workloads prevent practitioners from providing early help, but they also mean that practitioners can feel undervalued. A key part of moving the agenda forward must focus on ensuring that government policy gives universal services practitioners the message that they are valued and supported. For a more relational system to operate, it requires a motivated and skilled work force (Muir & Parker, 2014).

Nursing has supposedly become more professional – I would argue it’s become more technical. So are we actually losing sight of why we were there in the first place?

Designated safeguarding nurse

In conclusion, there are opportunities being missed for direct provision of early help for neglect within universal services. We need a fundamental review into how we see early help, whose responsibility it is, and how universal services should be responding.

What success looks like

Our vision is that all universal services practitioners play a role in providing early help for neglect. This is with the aim of tackling child neglect at the earliest possible opportunity, allowing child protection services to be more available to provide high level support where necessary.

Clear focus and clear accountability

- There is recognition among policy makers, practitioners and the public of the prevalence of child neglect, the harm it can do, and the ways in which it can be prevented.
- There is recognition among policy makers, practitioners and the public that early years practitioners, health visitors, midwives, school nurses, teachers and GPs can play a role in providing early help for neglect.
- Universal services are delivered with a focus on the importance of relationships.
- Children and young people’s voices are sought and heard in the development, commissioning and implementation of early help provision.
- There is clear accountability for the provision of early help. The UK government, local government and commissioners ensure that there are necessary resources available to enable universal services practitioners to undertake early help.

Clear role expectations and pathways

- Each individual profession within universal services is clear about their role in providing early help for neglect.
- There are clear and accessible pathways for the provision of early help, including between different universal services, and between universal services, targeted services and children’s social care.
- There is open, professional and respectful dialogue and information sharing among different universal services practitioners, and between universal services practitioners and children’s social care (where in the child’s best interest).

High-quality training, supervision and support

- Practitioners are confident and able to take early action before referring their concerns to children’s social care.
Policy calls

Adequate resources
• There should be financial commitment to the provision of early help for neglect in universal services and targeted early help services. National and local governments should reduce the £17 billion ‘late intervention’ spending by 10 per cent by 2020 through better and smarter investment in early help.
• Following on from the example set in health visiting, there should be a drive and commitment in the Department of Health to recruit additional school nurses.

Clear role expectations
• Government, professional membership bodies and practitioners should have an open discussion about who is best placed to provide advice to universal services on safeguarding.
• Government and professional membership bodies should clarify the role of universal services practitioners in providing early help for neglect and set out these role requirements clearly in statutory, professional guidance and professional job descriptions. More explicit guidance should be developed on how practitioners can provide direct support to children and parents.
• Government and professional membership bodies should set out clear guidance on which practitioners should undertake the lead professional role in Common Assessment Framework and Team Around the Child meetings.
• Government should ensure that any investment in universal services for early help is matched by building capabilities and confidence in relation to the early help role.

Clear pathways
• LSCBs should develop a neglect identification and intervention pathway that helps practitioners identify and access targeted early help services.
• LSCBs should lead a drive on awareness of the LSCB threshold document among practitioners with a specific safeguarding responsibility, especially among GPs, early years practitioners, school nurses, midwives and teachers.
• LSCBs, Health and Wellbeing Boards and Clinical Commissioning Groups should recognise and draw on in-service planning and commissioning the role that GPs, teachers, midwives, health visitors, school nurses and early years practitioners can and do play in responding to neglect.
• Specific content on what neglect is and how children and young people can get help when they need it should be compulsory in the PSHE curriculum.

High-quality training, support and supervision
• LSCBs and safeguarding practitioners should ensure that all practitioners working with children, but particularly health visitors, midwives, GPs, early years practitioners and family support workers, receive specific training on neglect during their pre-qualification training and at least every three years while practising that includes:
  - The impact of neglect on child development
  - Seeing the situation from the child’s point of view
  - How to articulate concerns about neglect to other practitioners
− How to convey concerns to parents and challenge harmful behaviour
− How to develop relationships with parents
− How to develop relationships and address early concerns with children and young people
− Multi-agency training across health, education and children’s social care.

• All practitioners should have regular supervision with their manager in which they are supported and encouraged to reflect on their day-to-day practice in providing early help to children and parents.

• All practitioners should receive training that actively encourages all practitioners to always share information with other practitioners where there is a legitimate purpose and with the child in mind.

• Safeguarding practitioners in each service setting should ensure that new members of staff are trained in the organisation’s safeguarding policy within two weeks of the post commencing.

• Safeguarding practitioners in school nursing, health visiting and midwifery should ensure that regular internal team meetings are held (at least every two weeks) to discuss early concerns about children and their parents, in which practitioners feel able to challenge one another and reach a consensus about appropriate responses.

Effective information sharing and multi-agency working

• Local authorities should introduce a formal expectation of handovers at a non-statutory level when families moves to a new area or their care passes from one professional to another.

• LSCBs should introduce ‘contact windows’, in which safeguarding practitioners within universal services agree a regular time slot during which they are contactable regarding safeguarding issues.

• LSCBs should ensure that all agencies hold regular multidisciplinary meetings to discuss early concerns about children and their parents in the local area, in which practitioners feel able to challenge one another and reach a consensus about appropriate responses.

• LSCBs should give consideration to the trialling of an ‘opt out’ clause for information sharing as opposed to an ‘opt in’ clause for families.

Relational services

• Government should support the development and promotion of community budgets, which allow providers of public services to pool their budgets.

• Postnatal services in midwifery should be commissioned and provided in a way that ensures that midwives are supported to provide women with individualised postnatal care plans and that they receive the level of postnatal care they require.

• Models of case allocation that facilitate the continuity of care in services, so that children and parents/carers see the same health professional at each contact where possible.

• Senior management within health visiting, midwifery and early years settings should ensure that practitioners are facilitated to conduct regular home visits.

• Teachers should recognise and capitalise on the opportunity provided by non-teaching activities to develop relationships with the children and young people in their care.

• Headteachers should recognise the role that family support workers can play in preventing neglect. Headteachers should ensure that family support workers are given adequate training and supervision to reflect the skill required to take on this role.
Bibliography


Centre for Workforce Intelligence. (2014). In-depth review of the general practitioner workforce: Final report. London: Centre for Workforce Intelligence.


Appendix A: Methods

A desk-based research exercise was first carried out to map the existing delivery landscape for providing early help in universal services. This included a review of national and local policy frameworks and professional guidance, as well as a brief literature review.

Data collection and sampling
Quantitative and qualitative data collection was carried out between April and June 2014.

Discussion groups and one-to-one interviews
The first stage of data collection comprised discussion groups, face-to-face interviews and phone interviews (n=41). The practitioners were recruited via flyers through a range of networks, including professional membership organisations, the NSPCC professional partnerships (including the NSPCC school service), charities and the Guardian Teacher network. The request for participants was then published on organisations newsletters, social networking accounts and general correspondence with practitioners.

Topic guides were used for the discussion groups and interviews to help ensure consistency. The following issues were explored within each group or interview:

- The practitioners’ understanding of neglect, and the signs of neglect that presented to them in their particular profession
- The meaning of early intervention/early help
- Training on neglect
- Roles and responsibilities in providing early help in cases of neglect
- Current practice in providing early help in cases of neglect
- Barriers to providing early help in cases of neglect
- Best practice in providing early help in cases of neglect
- Potential opportunities or ideas for improving practice

Two focus groups were also held with young people (n=18), who were recruited via NSPCC service centres. All NSPCC service centres were contacted with information about the project. NSPCC practitioners identified potential participants and discussed the project with them. The sampling criteria was as follows: young people aged between 11 and 24 who had experienced neglect in the past, who were happy to share their experiences and thoughts on universal services, and who were in a safe and settled environment now. In reality, not all of the young people who attended the groups had experienced neglect directly, but all had been NSPCC service centre users.

Both groups discussed the following topics:

- What is neglect?
- Who do you think a child or young person should go to for help if they are not being looked after well by their parents or carers?
- Do you think teachers/school nurses/doctor are good at noticing when young people are not being looked after well at home?
- Do you think young people are likely to go to teachers/school nurses/doctor for help?
- What happens, in your experience, when a young person asks a teacher/school nurse/doctor for help?
- Do you think teachers/school nurses/doctor are good at helping young people?
- Can you think of any other practitioners who are good at helping young people who are not being looked after well at home, apart from social workers?

One group consisted of four young people aged between 14 and 24 from Yorkshire and the Humber. The group discussion was facilitated by the lead researcher on this project, alongside three NSPCC practitioners. Notes were made on paper throughout the discussion. The second group consisted of 14 young people aged between 13 and 17 from London and the surrounding area. This group was facilitated by a number of NSPCC practitioners and a development manager. In this group, the young people moved between three tables, offering their thoughts on each of the three practitioner groups identified. All the young people were given a £10 voucher to thank them for their time.
The discussion groups and interviews were recorded, transcribed and anonymised. The data was analysed using thematic analysis using the qualitative software programme NVivo. Additional written notes from the focus groups with young people were also analysed using NVivo.

Online survey
The second stage of data collection comprised a survey of each of the practitioner groups involved in the study: early years practitioners (those working in children’s centres and nurseries), health visitors, midwives, GPs, school nurses and teachers (those working in infant, primary, junior and secondary schools). ‘Teachers’ comprised headteachers, deputy heads, class teachers, SENCOs and those with a pastoral role. Practitioners invited to complete the survey were those working directly with children.

The findings from the discussion groups were drawn from to design the survey. Broadly, the same questions were used across each of the six surveys, with minor changes to tailor each survey to the appropriate professional group.

The practitioners were asked about six broad areas:
- Confidence in their ability to identify neglect
- Training on neglect
- Roles and responsibilities in providing early help in cases of neglect
- Current practice in providing early help in cases of neglect
- Barriers to providing early help in cases of neglect
- Best practice in providing early help in cases of neglect

The survey took about 15–20 minutes to complete. The survey links were disseminated via professional membership organisations, the NSPCC professional partnerships (including the NSPCC school service), charities, CCGs, contact data for early years providers obtained from the Early Years Census, published in 2012 by the Department for Education, accessed via a previous FOI, and the Guardian Teacher network. The recipients were also asked to circulate the links more widely. Each of the six surveys was distributed via Snap Survey and was open for the same two-week period.

The survey collected both quantitative and qualitative data. The quantitative data was analysed using Snap Survey and NVivo was used to analyse the qualitative data. All data was anonymised.

A total of 852 responses were collected:
- Early years practitioners, n=107
- Health visitors, n=93
- Midwives, n=227
- School nurses, n=89
- Teachers, n=290
- GPs, n=46

The survey consisted of a range of types of question. For some questions, the participants were asked to rate on a scale of 1 to 7 the extent to which they agreed with a statement, with 1 indicating that they strongly disagreed with the statement, and 7 indicating that they strongly agreed with it. The survey also incorporated simple yes/no questions, multiple choices questions, demographic information and open text boxes. The responses to multiple choice questions were randomised to reduce bias. Participants were also reminded at several points in the survey of the anonymity of their responses, in an attempt to reduce social desirability bias.

Analysis on the survey data was conducted using Snap Survey. Where participants were asked to rate to what extent they agreed with a particular statement, a median rating for each professional group was calculated. The Interquartile Range (IQR) for those medians was also calculated. A range of 1–2 was identified as a relatively small range of responses to a question, and a range of 3–4 was identified as a relatively wide range of responses. All figures were rounded to the nearest whole number.

Within-group analysis was conducted looking at the impact of the following dependent variables:
- Whether the participant reported having a specific safeguarding responsibility
- The work setting of particular practitioners

Midwives were divided into three groups: those working in a hospital setting, those working in a community setting, and those working across both settings. The data from teachers was also examined in relation to different work settings: infant, primary, junior and secondary schools. Early years
practitioners were divided into those working in nurseries and those working in children’s centres.

The Mann-Whitney U test was used to determine the statistical significance of median ratings, and a Z test was used to determine the statistical significance of percentage scores. It is assumed throughout that p values of less than 0.05 represent statistically significant differences, and where the p value was >0.01 it is also noted.

The role perceptions of the participants were explored through a range of questions in the survey, and during the discussion groups and interviews. They were asked to rate statements on perceived responsibilities on a scale of 1 to 7, with 1 indicating that they strongly disagreed with a statement, and 7 indicating that they strongly agreed with it. The median ratings for each statement were calculated.

Limitations of the study
All the participants who took part in the project comprised a convenience sample and were self-selected. Therefore, it is likely that the data is vulnerable to selection bias in that those who took part in the study may have been those with an interest in safeguarding and neglect. With any data collection on a contentious topic, there is a risk of social desirability bias in the responses. Attempts were made to limit this as far as possible by emphasising the anonymity of the responses and by requesting that participants give an accurate reflection of their everyday practice, with the acknowledgment that safeguarding practice is affected by a number of pressures.

This is a complex subject that cannot easily be captured via a survey. However, this is the quickest way to get an overview of practice, and subtleties have to some degree been captured by open text boxes.

Safeguarding responsibility
There must be caution applied to interpreting the percentages given for those practitioners who said that they held a specific safeguarding responsibility. First, not all those reporting they had a specific safeguarding responsibility went on to give a description of that responsibility, meaning that it was difficult to verify how they were defining ‘specific safeguarding responsibility’. Second, a small number of health visitors, school nurses, early years practitioners, midwives and GPs reported that they did have a safeguarding responsibility but when asked for details, commented that they were referring to their belief that all practitioners working with children have a safeguarding responsibility. These are included in the total given.

Those GPs, teachers, early years practitioners and midwives reporting that they had a specific safeguarding responsibility mostly said that they held the position of the named person for safeguarding (in health) or designated safeguarding professional (in education). This was slightly different for health visitors and school nurses, in part because safeguarding is often seen as a more integral part of their role than in the other professions. Those who reported having a specific safeguarding responsibility and described that role said that they were case holders, named practitioners, safeguarding supervisors or specialist nurses.

Ethical approval
Ethical approval was sought and granted by the NSPCC Research Ethics Committee for the discussion groups with young people.
Find out more about our work at nspcc.org.uk