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Dear **local partnership**

Joint targeted area inspection of the multi-agency response to abuse and neglect in Cheshire West and Chester

Between 25 and 29 September 2017, Ofsted, the Care Quality Commission (CQC), Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and HMI Probation (HMI Prob) undertook a joint inspection of the multi-agency response to abuse and neglect in Cheshire West and Chester.[1] This inspection included a 'deep-dive' focus on the response to children experiencing neglect.

This letter to all the service leaders in the area outlines our findings about the effectiveness of partnership working and the work of individual agencies in Cheshire West and Chester (CWAC).

There is strong partnership working in Cheshire West and Chester and a clear and collective commitment to improving responses to children who suffer neglect. Collaborative and well-coordinated work at a strategic level to address neglect has been in place for some time and the impact is evident in effective partnership working at an operational level. This is resulting in many children receiving a timely and appropriate response to reduce risk and the impact of neglect.

There is clear evidence in many agencies that professionals are supported to identify neglect early, for example through the good use in some health services of neglect assessment tools. A shared approach to building and maintaining effective working relationships with families, together with a good level of understanding about

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

children's experiences of neglect, is leading to highly effective practice in some cases and is making a real and positive difference for many children. Professionals working in CWAC ensure that they know the children they work with well, and adapt approaches to meet the specific needs of children, with some very strong examples of professionals 'going the extra mile' to make sure children's needs are met.

Many professionals in CWAC receive good-quality supervision and have access to a range of training on neglect. The Cheshire West Local Safeguarding Children Board (LSCB) has taken the lead in developing and promoting the use of evidence-based tools to support practice, and there is a cycle of continual review and sharpening of responses to tackle neglect. For example, learning from audit is leading to a further refinement of these tools, including the development of an assessment tool for older children. A wide range of agencies are involved in LSCB audits and the findings are widely disseminated across partner agencies, leading to improvements in practice.

Professional challenge between partners, an effective LSCB and strong leadership in many agencies mean that there is recognition that there remain a number of areas for improvement. These include ensuring consistent and appropriate responses to the initial indicators of risk of neglect by all professionals at all times. There is a need to ensure further rigour to promote effective and timely information sharing between all agencies working with children and adults where there are concerns about neglect, including within health services. Further work is needed to ensure consistently rigorous and timely evaluation of the progress of multi-agency plans to reduce the risk and impact of neglect on children. In addition, there is a need for a clearer focus on parental motivation and ability to make and sustain improvements in parenting. There is insufficient management oversight of the quality of decision-making in Cheshire police, and senior leaders in the police cannot be assured that staff are consistently making the best decisions for vulnerable children in all cases.

Key Strengths

- There is clear drive at a strategic level in Cheshire West and Chester to embed a shared approach across partners to tackle neglect. This is resulting in effective practice at the frontline of many services to identify and support children suffering neglect. Strong partnership working and mature relationships, where there is challenge between agencies and from the LSCB chair, are driving improvement and leading to effective multi-agency working in many cases seen during this inspection.
- Professionals across many agencies understand the need for good engagement with families and the importance of understanding the needs of neglected children, including older children, if positive change is to be achieved. A lack of complacency means partners recognise that, while many aspects of practice are strong, there is more to do to ensure a consistently robust approach to neglect across all agencies.

- Effective multi-agency working within the integrated access and referral team (i-ART) means that the vast majority of children who are subject to neglect receive a timely and appropriate response. In most cases, agencies work well together to ensure that information is shared and decisions are timely, so that children get the right help and obtain it quickly. A range of professionals, including the police, health, family case worker and independent domestic violence advocacy (IDVA), have weekly meetings, chaired by children's social care and facilitated by Integrated Early Support, to discuss children referred for early help. Decision-making for those children referred for early help is therefore a joint activity. Good information sharing provides a solid base for decisions about early support for families where there is neglect.
- The police officer flags crucial information relating to families that require early help and support, so frontline officers are alerted to any risks and needs and are able to respond effectively to cases where neglect is a concern. Frontline police officers who identify neglected children in need of support are routinely seeking consent to enable them to be considered for additional help.
- The i-ART consultation service is available to professionals across CWAC, and is well used and valued. Professionals across agencies, including schools, report the effectiveness of this support in helping them to make decisions in cases of neglect as to when to refer or to seek additional early help support for children. Good examples were seen of the National Probation Service (NPS) and the Community Rehabilitation Company (CRC) appropriately seeking advice from children's social care in cases allocated to them where there were concerns in relation to neglect.
- There is clear evidence, across many partners, of approaches that support the early identification of neglect. Where probation services (NPS and CRC) and Youth Justice Services (YJS) identify any safeguarding concerns in relation to the adults or young people with whom they are working, they will undertake home visits. This is helping to inform a wider understanding of adults and young people's family circumstances and risk of neglect. Probation services then work closely with the i-ART team to keep them informed of any emerging or new concerns. These agencies also use the information they obtain from children's social care to inform assessments and risk management plans in cases where neglect is a concern.
- Practitioners across all health services use a range of risk assessment tools provided by the LSCB, alongside specific health assessment tools, to support them in assessing the risk of neglect and to inform decisions to refer to i-ART. This was seen, in cases, to help practitioners understand the specific needs of children and the impact of neglect on children across age ranges.
- Child and adolescent mental health services (CAMHS), 'Turning Point' (adult substance misuse service) and adult mental health practitioners record and use family chronologies well to support the understanding of safeguarding risks, including neglect. Initial screening tools in adult services help professionals to

obtain detailed information about children and young people with whom adult users have contact. This approach enables them to make decisions about when to refer to children's social care for early help and statutory intervention.

- In the dental practices visited during the inspection, dentists were well aware of local policies on safeguarding, the different forms of neglect and the procedure for making a referral. In one case seen, a dentist was taking a proactive approach to the lack of attendance at appointments by a family in which the children have a history of poor dental health. They consulted with i-ART and agreed a clear plan of follow up and liaison with children's social care to ensure that the child received the treatment required.
- The large majority of referrals where risks to children suffering neglect are first identified are dealt with in a timely manner. Management oversight by children's social care in i-ART is consistently thorough, from the first point of contact through to decisions about next steps. Inspectors saw evidence that managers in this team have a good understanding of the impact of neglect on children. Decision-making is increasingly better informed by recognition of patterns of chronic concern and cumulative neglect, rather than driven by single incidents. In only a very few cases did inspectors see evidence that services could have been provided sooner or escalated earlier.
- When strategy meetings take place, as opposed to telephone discussions, they are well attended by statutory agencies and those that are involved with the family, such as NPS and YJS. Decisions resulting from these meetings are well informed about different family members and risks of neglect. Child protection investigations take place swiftly, including joint investigations by police and children's social care.
- When children require statutory intervention, they are quickly allocated a social worker. Social work assessments include appropriate input from a range of agencies, the identification of key risks and protective factors, and a clear rationale for the outcome. Almost all children's services and YJS assessments are well focused on children's experiences and an understanding of their life in their family. YJS assessments demonstrate a good understanding of the impact of neglect on older children, and any offending behaviour is considered in this context. Many social work assessments are grounded in direct work with children, and some use evidence-based tools to support a good understanding of children's behaviours and emotional well-being. Together, this provides a comprehensive picture of children's experiences of neglect, including patterns of neglectful parenting and the impact of cumulative neglect.
- Health, children's social care, schools and the YJS take a shared approach, working diligently to build trusting relationships with children and their families where neglect is a concern. Professionals in these agencies recognise the importance of hearing children's views and understanding the individual needs of all children in brother and sister groups, including the needs of older children. There are many examples of creative and coordinated approaches to working

directly with children, including work to engage older children, focusing on their interests and using methods and tools designed for their age group. In some cases, children were consulted about which professionals in the multi-agency group would take the lead in direct work. This approach was seen to be particularly beneficial for older children.

- Persistent efforts by professionals were seen in many cases to engage and maintain involvement with parents, including those who are reluctant to receive support or who struggle to engage with services. The effectiveness of this is particularly evident where there is appropriate and consistent membership of the multi-agency core and child in need (CIN) groups overseeing children's plans. In these neglect cases, information is shared effectively and approaches to the family are well coordinated.
- Specific examples were seen of professionals' dedication and determination to maintain effective oversight of children at risk of neglect. This included a neighbourhood police officer speaking regularly with family members, including children, where there were concerns about neglect, and a school nurse accompanying a child and parent to ensure that the child accessed dental treatment, and undertaking a range of planned and unannounced home visits to check on children's well-being.
- Schools understand and act on their responsibility to gather information on pupils, where there are concerns, in order to assess any risks to children due to neglect. Good attendance by schools at multi-agency meetings means that they are well informed about issues of neglect in the home and better able to support children with specific needs in school. Clear communication between agencies and shared decision-making enable constructive challenge to partners by schools, for example when important decisions are made about future plans for children at risk of neglect. In one case, constructive challenge by the school about the pace of change in a child's family led to the development of a clear timeframe for the work to be completed, and for consideration of alternative plans if the required change in the family was not achieved.
- A wide range of services are available to meet the needs of different family members when neglect is identified. This includes services for adult family members, as well as the children, along with whole-family-based approaches. Support for parents to address parenting issues is readily available, as is direct work with children to explore the impact of neglect. Services for parents to help to address the causes of neglect are mostly accessible, for example domestic abuse and substance misuse services.
- The further development of local authority services, such as the CIN project, the expansion of the edge of care service and family group conferencing, has extended the range available, including intensive interventions to assess and meet need. It is too early to assess the overall impact of these services, but positive indicators of the involvement of those services are seen in tracked cases. The engagement of the extended family through family group conferences, for

example, is having an impact in some cases, enabling practical support to be provided to parents and improving emotional support for neglected children.

- The LSCB chair and members provide strong leadership, direction and challenge through building a shared approach to identifying and improving outcomes for children and young people at risk of neglect. Promoting wide awareness of the risks of neglect and of the lived experiences of children, including older children, is at the heart of new approaches to strengthen timely recognition of their needs. This includes good links with schools and general practitioners (GPs) and engagement with parents to promote a whole-system approach to safeguarding children from neglect. For example, in 2016, following a serious case review, 80 parents attended a conference to promote awareness of the importance of the emotional well-being of children, with a focus on older children.
- The recently revised LSCB neglect strategy has been informed by feedback from young people and learning from other local authority areas. Good engagement by most agencies in the work of the neglect task and finish group of the LSCB has enabled collective ownership of the neglect action plan and sharing of expertise to strengthen shared recognition and support for neglected children. LSCB audits identified that not all agencies were using the existing LSCB neglect tools. These tools have now been adapted and further developed, following consultation with staff. The new suite of tools includes a risk assessment tool to be used with adolescents and, although this has yet to be implemented, its development demonstrates the partners' recognition of the specific needs of this group.
- The LSCB and the local authority have worked collaboratively to develop a suite of neglect indicators. This has enabled them to map early help and children's social care activity in relation to neglect, and to assess demand and need across the area. This information has been reported to the LSCB, and has been used to inform the development of the neglect strategy and to begin to develop targets and map trends, and so measure the impact of the new strategy.
- A comprehensive programme of LSCB audits provides good assurance of organisational risks and the progress being made in securing a consistently high standard of safeguarding practice in relation to neglect. Audits actively encourage shared reflection on the effectiveness of working together arrangements, using suitably experienced facilitators from a wide range of partner agencies such as NPS and CRC. This means that frontline staff, including those from adult services, are engaged in reflecting on their practice with children. The findings are widely shared and the impact of audit is evident in cases seen, for example professionals' engagement with and knowledge of children was impressive in many of the cases seen during this inspection.
- There is strong and very effective leadership in children's social care, and a clear approach to developing innovative and child-focused practice to support children living with neglect. Performance management and a wide range of audit activity are well embedded, leading to the identification of areas for improvement as well as informing service development. The impact of audit includes thorough and

robust management oversight at the 'front door' of children's social care, and assessments that are analytical and present the child's lived experience well. Recent audits are focused on further developing practice, including identifying and responding at a much earlier stage to parental factors that result in neglect.

- Senior managers in children's social care have developed an environment where social workers can provide a high-quality service to children and their families, with a key focus on knowing children well and building a clear understanding of their wishes, feelings and their experiences of living in their family. Social workers receive regular, reflective supervision, and are supported further by regular management oversight of their work.
- The local authority demonstrates its commitment to children and families through significant investment in staff to ensure a well-qualified and skilled workforce with a range of skills to meet differing needs, including the needs of children who have experienced trauma as a result of neglect. An effective workforce development strategy is in place and is ensuring the workforce has the right skills and knowledge base. A stable and skilled workforce within children's social care is supported by clear planning for career progression and a wide range of development opportunities. Neglect training features in many courses, and is further supplemented by a three-day training course on trauma and adversity, which focuses on neglect and the impact on children of all ages, including older children. Social workers reported on the real benefits of this training in their work with complex cases of neglect, and of the monthly 'peer reflection' sessions with senior practice leads.
- The impact of this approach was clear in children's experiences of building effective and stable relationships with workers, which means that children's social care staff working on the frontline with children and families know and understand them well.
- A strong leadership push for excellence and innovation is evident in the work of health leaders. Good progress has been made on the key areas for improvement identified in the last children looked after and safeguarding inspection undertaken by CQC in 2014. Audit activity undertaken by NHS trusts has helped to strengthen recognition of the risk of neglect to children who are not brought to their health appointments. Improvements in levels of vigilance and recording practice are evident in the re-audit of missed appointments that was undertaken by the Countess of Chester NHS Hospital Foundation Trust.
- The contribution of health professionals to promoting early identification and timely access to specialist support to reduce harms associated with neglect, including risks to children's and young people's health and development, is generally well managed. There is good recognition of the areas where further work is required to consolidate practice on a multi-agency basis. Health staff's commitment and perseverance in engaging children, young people and their families are clearly evident in most cases seen, with a strong focus on listening to and acting on the voice and experience of children.

- Designated and named health professionals provide effective and valued leadership. Most health professionals receive supervision of their safeguarding children casework, and can access further advice and support from designated and named safeguarding professionals as and when they need it. Supervision is having a positive impact in helping to promote an increased use of assessment tools, and ensures prompt escalation where there are differing views about the levels of risk that children and young people are exposed to.
- Health professionals have a comprehensive knowledge and understanding of neglect, including the impact of neglect on older children. There is good awareness and understanding of learning from serious case and practice learning reviews. Regular safeguarding supervision and targeted support are available to continuously enhance the expertise and confidence of frontline professionals in managing the complex casework associated with neglect safeguarding practice.
- Police leaders are committed to the partnership and have prioritised the protection of vulnerable children. There is a clear determination to reduce the risks to those identified as being vulnerable, and there is evidence of police leaders working with partners to engage and contribute to the development of a shared culture of continual improvement in order to enhance decision-making and protective practices.
- For example, police leaders have recognised the critical importance of effective and integrated joint-working arrangements when seeking to identify, assess and respond to the risks faced by children at risk of neglect and other forms of abuse. The police and partners have invested significant time and resources in the development of the i-ART, including the response to early help with a police officer is dedicated to this area of work.
- There is evidence of police leaders working to ensure that risk can be identified and responded to more effectively. The police have made a significant investment in new information and communications technology systems, and recently implemented new and more effective risk assessment processes, such as THRIVE (a risk assessment tool), to support more effective and timely decision-making. While some of these systems are new or are yet to be implemented, this is indicative of the commitment of senior leaders to improving the service provided to those at risk.
- Senior managers in NPS and CRC have put in place practices to support staff to identify indicators of neglect. For example, staff are encouraged to make home visits to adult offenders who are parents, or who have children living with them. Staff have a good understanding of neglect, and have received appropriate training to support them when making home visits to recognise the indicators of neglect. Staff have also received specific briefings on i-ART, and they understand its function and how to make safeguarding and early-help referrals. The quality of referrals to children's social care seen during this inspection was appropriate.
- There is good management oversight in both the NPS and CRC, and high-risk cases, including those where neglect is identified, are appropriately prioritised.

Regular supervision of staff in NPS has a clear a focus on the quality of work with offenders, and risk management plans include actions to address the risk to children.

- In the YJS, there is good awareness of the indicators of neglect, and clear evidence that the impact of previous and current neglect on young people is informing assessments and being included in court reports. Supervision is regular and of good quality. The oversight of children is enhanced by specific high-risk meetings to oversee young people with the most complex needs, promoting good management of risk and a comprehensive understanding of needs. This is particularly useful in neglect cases.

Case study: highly effective practice

Jamie was referred to the Youth Justice Service (YJS) following an offence of actual bodily harm (ABH). The key worker in the YJS immediately checked with children's social care to see whether he was known to them. She identified a history of neglect, and spoke with the allocated social worker prior to meeting with Jamie. The worker completed an assessment using interview and self-assessment tools with Jamie. She interviewed his family and included information from his school and social worker. This approach enabled her to place and understand Jamie's behaviour in the context of his experience of living with neglect. It enabled her to understand that Jamie's home environment did not support him to moderate his emotional responses and behaviours, and that the neglect he had experienced had a direct impact on his behaviours.

As a result of this thorough assessment, Jamie was provided with support from the CAMHS worker located in the YJS. This worker adopted an empathetic approach, working with Jamie to identify where he would like his appointments to take place and agreeing on a venue where he feels most comfortable. The work focused on enabling Jamie to develop skills to manage his emotions within the context of his past experiences.

The intervention with Jamie has seen him very much as a young person who has lived with neglect, recognising the impact this has had on his emotional responses rather than simply regarding his behaviour as criminal and delivering a more traditional anger management response.

Areas for improvement

Identifying and managing risk of harm at the 'front door'

- There are a number of ways in which responses to children experiencing neglect can be further developed and improved to ensure a consistently timely and appropriate response from all professionals in CWAC. For example, in a small number of cases where there were concerns about neglect, frontline police officers did not complete vulnerable person's assessments (VPAs) so that information was not then passed to children's social care. In these cases, increasing incidents of concern eventually resulted in a referral by the police to children's social care, but the opportunity for a timely referral and earlier intervention had been lost. In addition, police officers completing VPAs do not

always check all relevant police intelligence systems to ensure that they have the full context of the family background.

- When VPAs are received in the i-ART service, although staff in the police referral unit have access to social care electronic recording systems, they are not all well trained in retrieving all relevant information. Inspectors found examples of where officers were unclear as to how to access significant information. While no children were found to be left at risk of harm as a result of this, there were delays for neglected children in receiving services that matched their level of need. For example, referrals had been assessed as 'standard risk' by the police, as the full information about the child had not been considered or known, and this resulted in a less timely response by children's social care.
- In police referrals to i-ART (VPAs), the voice of the child is not routinely recorded, or recorded effectively. In addition, the electronic system of recording does not allow an officer to record information about a child's experience if the child is not present at an incident. This limits information sharing and the potential for early identification of concerns about neglect.
- There are a number of further ways in which systems for accessing information and communicating information between agencies could be improved in the early stages of the identification of risk of neglect to children. For example, effective systems are in place for the i-ART to undertake initial checks with NPS on whether children at risk of neglect are known to probation services. However, when more detailed information is required for early help assessments, there are often delays in CRC and NPS responding. This results in delays in decisions about next steps for children.
- The outcome of early help assessments is not routinely shared with probation services. This means that NPS and CRC are not always included in early help planning and multi-agency approaches to manage neglect. They are not then able to use findings from early help assessments to inform their assessments and plans with adult offenders and ensure a coordinated approach to the management of risk.
- The NPS court teams recognised gaps in safeguarding checks being undertaken at the pre-sentence stage, following learning identified in a previous joint targeted area inspection (JTAI). Work has been carried out with report writers to clarify the process for 'front door' checks to be completed. In most cases seen, appropriate checks were made with children's social care to identify any safeguarding concerns about adults who were about to be sentenced, although NPS and CRC reported that there are sometimes delays in i-ART responding to requests for this information. In one case seen, the NPS court team did not make the appropriate safeguarding checks when they should have done.
- When strategy discussions need to take place urgently, it is not always possible to secure the involvement of health or other relevant agencies, and plans to use Skype or similar technology to facilitate this are not yet in place. To limit the impact of this, managers hold telephone strategy discussions with police that are

followed up by more broadly attended strategy meetings, usually within two or three days. This means that initial decision-making is not always informed by the presence of all statutorily expected partners. Strategy discussions and meetings are not always being recorded on police systems. This means that joint plans to safeguard children are not always visible across the force.

- While partners are committed to increasing the use of evidence-based tools, further progress is required before they are embedded in the everyday practice of professionals. Inspectors did not see examples of completed tools accompanying multi-agency referral forms to i–ART, and their use to inform social work assessments is improving but remains the exception.
- Dentists are not fully engaged or included in safeguarding working arrangements. When there are safeguarding concerns about a child, systems and processes for sharing information between dentists and school nurses and health visitors are not formalised. In one case seen, the dentist had correctly identified issues about a child's failure to attend appointments, given the family history of neglect. While the dentist had taken appropriate action in this case, communicating the concerns to the school nurse would have provided an additional opportunity to monitor the health and well-being of this child.
- Electronic children's records across health visiting and school nurse services do not always clearly record significant adults with whom children may have contact, even where, for example, domestic abuse or neglect is indicated. When this information is recorded, it is not easily accessible on the child's record. This means that a practitioner unfamiliar with the family might find it difficult to identify adults who might pose a risk to those children and young people.
- 'Turning Point' makes appropriate safeguarding checks of children and young people at the point of referral but follow-up treatment and recovery work do not consistently consider or review risks to children and young people. The impact of substance misuse on their parenting capacity is not always clearly recorded. Risk assessments of adults where there were concerns about neglect are not always timely, and this limits the agency's ability to inform multi-agency planning to protect and support children. Practitioners would benefit from support and training to ensure that they fully understand their role in monitoring the progress made by parents and carers in their services, and the implications of this for children experiencing neglect.
- There is a lack of routine information sharing between adult mental health services and 'Turning Point' when adult service users are provided with care and support by both agencies. This limits a coherent approach to the assessment of the progress of parents and carers who access both services, and a shared understanding of the impact of parents'/carers' mental health and/or substance misuse where there are concerns about neglect. While adult services recognise this gap, there are no plans in place to address this need.

Response to children experiencing neglect

- A key area for improvement is the timeliness and rigour of evaluating the progress of multi-agency work to reduce risk and the impact of neglect on children. In a small number of cases, there was drift and delay in ensuring that the plans to reduce neglect were making sufficient progress and meeting children's needs. In addition, there is a need for more focus on the ability and motivation of parents to make and sustain improvements in parenting to reduce neglect and to improve the lives of children.

- Plans for children experiencing neglect do not contain clear measures by which their progress will be monitored. The vast majority of plans for neglected children appropriately identify key areas of risk and need and the actions to be taken, including services to meet need. The measures by which improvement is to be evaluated are not, however, sufficiently detailed in plans. This means that both parents and professionals may not be clear about what needs to be achieved by when and how progress will be measured. In complex cases of neglect, such clarity is essential if professionals and parents are to work together and children effectively protected.

- This inspection highlighted that, while some professionals are using tools to assess the risk of neglect effectively, no instances were seen of these tools being used at different stages of intervention with children and families to monitor and track progress. In addition, there was limited evidence in neglect cases of assessment at an early stage of parent's ability and motivation to make and sustain improvements in parenting. Re-assessments and/or updating of assessments in neglect cases were not seen during this inspection. These are therefore key areas for further improvement, to ensure that partners are routinely focused on the pace of change in neglect cases, parental motivation and the ability to sustain change, and what this means for the child. This would improve the quality, rigour and timeliness of decisions about next steps for children experiencing neglect.

Leadership and management

- Senior, middle and frontline managers in children's social care, child protection chairs and those managing CIN meetings and core groups need to focus on the key findings of the inspection in relation to children's plans, and the use of tools and updating of assessments to sharpen the focus on progress of plans and parental motivation to change and sustain improvements.
- Information sharing and joint working between some health professionals and other health and partner agencies are not sufficiently strong. For example, GPs have limited contact with school nurses and schools, which means that there may be missed opportunities to identify and support older children who are experiencing neglect. School nurses and CAMHS practitioners are not always aware of each other's involvement in supporting specific children who are

experiencing neglect, and are not routinely sharing relevant information. Details of the CAMHS YJS worker are not recorded on the NHS Trust system. This means that important information about health professionals' interventions with and knowledge of neglected children is not always shared.

- There is a lack of timely availability of 'dual diagnosis' support for adults who misuse substances and have mental health needs. Parents of neglected children who are experiencing these difficulties are therefore not able to access timely support for their complex needs. This causes delays in progressing work with families to reduce the risk of neglect.
- While the level of submission of GP reports to child protection conferences is improving, GPs' attendance at conferences remains relatively low, overall. Both the quality of analysis in GP reports to conference and the sharing of reports with parents and young people who experience neglect are areas for further improvement.
- Although there is evidence of a shift in the emphasis of Cheshire Police, at a strategic level, to a more explicit focus on the reduction of risk and vulnerability, this has not yet been translated into consistent improvements in operational delivery.
- The focus of police performance measures is currently the quantity of child protection and neglect incidents and cases. There is insufficient management oversight of the quality of decision-making by police in CWAC, and senior leaders cannot be assured that staff are consistently making the best decisions for vulnerable children in all cases. Inspectors found that some of the cases tracked and sampled showed that there remain inconsistencies in the quality of decision-making at the frontline. Incidents are often dealt with in isolation, rather than consideration being given to the history of incidents and the wider context of risk and vulnerability faced by those affected. Further work is required to ensure that senior leaders have oversight of the effectiveness of police practice at the frontline with vulnerable children, including those suffering neglect, and that appropriate and effective supervision of police staff is in place.
- There is no data or performance management information relating to neglect held in the police protection unit. This would assist the force to understand performance, demand, resource allocation and impact on outcomes for children and young people.
- i-ART does not have access to the YJS case management system and, as a result, staff are unable to quickly ascertain if YJS are involved in new referrals of young people.
- The role of the seconded police officer in the YJS is too narrow, and is not currently supporting effective information sharing in all cases. Intelligence sharing is focused on information on offending and police intelligence, and the information held by the police on young people's vulnerability, for example concerns about neglect, is not shared.

The Local Safeguarding Children Board

- The LSCB is not providing robust monitoring and evaluation of the effectiveness of initial responses by the police to children experiencing neglect, or the interface between the i-ART service and CRC and NPS, to ensure that there is a consistent and timely response to the needs of children when risk of neglect is first identified.
- Partnership working with dental services and other independent NHS contractors, such as pharmacists and optometrists, is an area for development to promote better vigilance and a shared approach to the management of neglect within wider health services.

Case study: area for improvement

Police officers do not always fully assess the risk of neglect to children or take full account of historical information and cumulative risk in deciding when to contact children's social care.

In one case, police officers failed to recognise potential risks when a child was repeatedly involved in violent incidents, both as a victim and an aggressor. The history of neglect suffered by the child was not taken into account. The police officers were focused on investigating each individual incident of violence and safeguarding the children involved. They did not notify children's social care of their concerns until the violent incidents escalated, therefore the family did not benefit from the early intervention of other professionals to address the cause of the young person's behaviour.

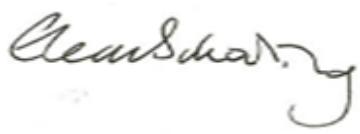
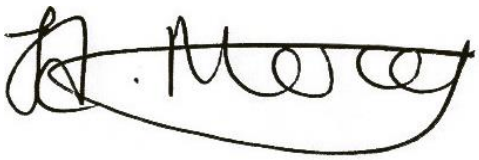
Police officers are given guidance on safeguarding and child protection as part of their initial training. There are gaps, however, in their knowledge and understanding of the impact of neglect and, in particular, of cumulative neglect. As illustrated in this case example, some frontline police officers lack an understanding of the context of behaviours of older children, such as antisocial behaviour that may be as the result of neglect, including a lack of appropriate boundaries in the home. This means that police officers do not always make timely notifications to social care in relation to children or young people.

Next steps

The director of children's services should prepare a written statement of proposed action, responding to the findings outlined in this letter. This should be a multi-agency response, involving NPS, CRC, YJS, Clinical Commission Group and health providers in Cheshire West and Chester and Cheshire Police. The response should set out the actions for the partnership and, where appropriate, individual agencies.[2]

The local authority should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 19 February 2018. This statement will inform the lines of enquiry at any future joint or single-agency activity by the inspectorates.

Yours sincerely

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

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