



Tackling child neglect in Shropshire: a practitioner support pack

Date Completed	21/04/2021
Status	FINAL
Date of Approval	20/01/2021
Approving Body/Group	Shropshire Safeguarding Community Partnership Executive Group
Review Date	31/03/2023

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Acknowledgements

With thanks to Jan Horwath, to local partners and South Gloucestershire Children's Safeguarding Board who have contributed to the creation of this support pack.

1. Introduction and Purpose

- 1.1 The aim of this document is to establish a common understanding and provide guidance for intervention in cases where the neglect of children is a concern. For the purposes of this document, a child is a person under the age of 18 years.
- 1.2 Nationally, between 80-100 children each year are estimated to die because of abuse and neglect with a high degree of overlap between neglect and other forms of abuse (Brandon et al, 2008).
- 1.3 This document provides practice guidance and outlines the local multi-agency procedure in Shropshire for tackling the neglect of children.
- 1.4 It applies to all front-line staff and managers in member organisations of the Shropshire Safeguarding Community Partnership and Shropshire Safeguarding Children Network.
- 1.5 The document should be read alongside:
 - West Midlands Safeguarding Procedures, [1.5 Referrals](#), [2.9 Neglect](#) & [3.11 Pre-Birth Tools and Pathways](#), 3.13 Substance Misuse Tools and Pathways
 - Thresholds document
 - [Neglect Screening Tool](#)
 - Neglect strategy
 - Information Sharing Procedure
 - Escalation policy
 - Neglect specific tools including Graded Care Profile 2
- 1.6 This practice guidance aims to highlight some of the difficulties experienced when working to combat neglect and suggests ways to avoid or resolve them. Research and literature has captured the high levels of anxiety that practitioners feel when working with neglected children (Burgess et al, 2013; Daniel et al, 2011).
- 1.7 Whilst no guidance can provide answers to all circumstances or difficulties, the aim of this support pack is to support the use of professional judgment at all stages during interventions with families. Resources and reports available from agencies/organisations such as [Action for Children](#) and the [Wave Trust](#), again highlight the complexities but also offer some suggested interventions.

Practice Guidance

2 What is Neglect?

Definitions

Neglect

- 2.1 Neglect is generally considered to be the omission of specific behaviours by caregivers, though it can also include acts of commission. There are variations in how neglect is defined across the UK, however. In England, 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 in 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 adequate care-givers)
- Ensure access to appropriate medical care or treatment

It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs. (Working Together to Safeguard Children 2018)

- 2.2 Neglect can be defined from the perspective of a child’s right not to be subject to inhuman or degrading treatment, for example in the European Convention on Human Rights, Article 3 and the United Nations Convention on the Rights of the Child (UNCRC), Article 19.
- 2.3 Child neglect is rarely an intentional act of cruelty, however there are occasions when neglect is perpetrated consciously as an abusive act by a parent/carer. More often neglect is defined as omission of care by the child’s carers, meaning that the needs of the child or children will be consistently unmet. There may be many different reasons parents are unable to consistently meet the needs of their child or children. For example, this may occur as a result of parental mental ill health, substance misuse or learning disabilities.
- 2.4 The current definition of neglect refers to children and young people up to the age of 18, but the ‘neglect of adolescent neglect’ contributed to the following as part of a neglect guide aimed at those working with teenagers (Hicks and Stein, 2010). These are points for consideration but highlight some of the issues around defining and working with adolescent neglect.

Themes from research review	Issues for practitioners
Neglect is usually seen as an act of omission	For adolescents in particular, some acts of commission should be seen as neglect, or contribute to young people being neglected e.g. being abandoned by parents, being forced to leave home, being exposed to others who may exploit the young person
Neglect from different viewpoints	There may be different viewpoints, for example between the views of social workers, other professionals, parents and young people themselves. Awareness of these different viewpoints and what may contribute to them (e.g. culture, own experiences of being parented, beliefs, values and so on) is a starting point for establishing a working consensus
Young people may underestimate neglect	This may be related to young people's acceptance of their parents' behaviour, young people's sense of privacy, or their loyalty to their families
Neglect is often seen as a persistent state	It is necessary to look at patterns of neglect over time and recognise the impact of both acute and chronic neglect
There is a difficulty in making a distinction between emotional abuse and neglect	These are associated, inevitably, especially when neglect is seen as an omission of care. What matters is not the label but the consequences for the young person's health and development
Neglectful behaviour and experience of neglect	Defining neglect should include both maltreating behaviour as well as how the young person experiences neglect i.e. the consequences for them

2.5 Horwath (2013) identified neglect as follows:

Medical neglect is where carers minimise or deny a child's illness or health needs, or neglect to administer medication or treatments. It includes neglect of all aspects of health care including dental, optical, speech and language therapy, and physiotherapy.

Nutritional neglect is usually associated with inadequate food for normal growth leading to "failure to thrive". Increasingly another form of nutritional neglect from an unhealthy diet and lack of exercise can lead to obesity, which increases the risks to health in adulthood.

Emotional neglect where parents provide a low warmth environment, often with high criticism. Research in this field often concludes that it is the emotional and/or psychological neglect that causes the most lasting damage.

Educational neglect includes carers failing to comply with state requirements, but also include the broader aspects of education such as providing a stimulating environment; showing an interest in the child's education and supporting their learning including that any special educational needs are met.

Physical neglect refers to the dirty state of the home, lack of hygiene, lack of heating, inadequate and/or broken furniture and bedding. It may include poor or inadequate clothing, which mark a child as different from his peers resulting in isolation or bullying. It also refers to a lack of safety in the home, exposure to substances, lack of fireguard or safety gates, and exposed electric wires and sockets.

Supervisory neglect happens when the carer fails to provide the level of guidance and supervision that ensures the child is safe and protected from harm including online activity

Identity Neglect refers to a carer failing to recognise or address the child's needs which include cultural, religious, gender and sexuality.

Social Neglect occurs where children are not given the opportunity to develop relationships outside of their home.

Reasons for Child Neglect

- 2.6 It has been acknowledged that, often in difficult circumstances, the majority of parents care well for their children with the support of their family and friends. However, some parents will require extra support from services to ensure that their children are cared for adequately. It has also been identified that a small number of children will require comprehensive support services, as a result of the complexity or seriousness of their family circumstances, in order to ensure that their needs are met during these difficult periods.
- 2.7 Many children in our communities are at risk of having their health or development neglected for a number of reasons such as homelessness, unemployment, poverty or a particular difficulty within the family. Local and national research has identified a number of factors that may feature in relation to the profile of those parents of children at risk of being neglected. These factors can include any or a combination of the following:
- domestic violence and abuse
 - parental alcohol and substance misuse
 - parental learning disability
 - parental mental ill-health
 - episodes in local authority care as children
 - maternal low self-esteem and low confidence
 - own childhood experiences of poor parenting
 - health problems during pregnancy, pre-term and low birth weight baby
 - experiences of significant loss or bereavement
 - isolation and lack of support
 - being a young/adolescent parent
- 2.8 Difficulties experienced by parents as a result of underlying features can link to the neglect of children for reasons such as:
- parents lack the capacity to provide care physically or emotionally
 - parents' own problems are so overwhelming or intractable that they cannot prioritise their children's needs above their own
 - parents do not have the knowledge or skills to provide safety and supervision within the home environment
 - parents have no childhood experiences of positive models of parenting to draw on
 - parents do not make use of available support networks

These lists are not exhaustive, there are many factors that can contribute to neglect.

Identifying Neglect

- 2.8 See appendix 1: Categories, Indicators and possible Solutions for more information about identifying Neglect and what to look for as practitioner.
- 2.9 The first step for practitioners in working with neglect is identifying those children who may be at risk and being able to state the evidence base for this using the Neglect Screening Tool and if needed, Graded Care Profile 2. Concerns at this stage may have arisen from a one-off event (e.g. a young child being left unsupervised); a change in behaviour or presentation of the child; or it may be that concerns have been building for some time.
- 2.10 The use of an accumulative [chronology](#) can be useful for demonstrating the evidence base for identification of neglect. There may be concerns about:
- the way a child/young person looks in terms of hygiene, grooming, and clothing
 - the child/young person not being adequately or appropriately fed
 - levels of hygiene in the home environment
 - the child/young person not being kept safe e.g. vulnerable to sexual exploitation
 - the child's/young person's emotional and behavioural responses
- 2.11 Due to the pervasive nature of neglect, **the importance of collating seemingly small, un-dramatic pieces of factual information in order to present an overall picture of the child/young person cannot be understated.**
- 2.12 The Assessment Framework (appendix 2) demonstrates the organisation of a system for gathering information in relation to three main areas of family life. The areas are:
- Child's developmental needs
 - Parenting capacity
 - Family and environmental factors
- 2.13 Appendix 3 gives examples of what a child/young person needs to thrive and develop. Practitioners should think holistically across the framework making links between the domains to consider how one feature or element may be influencing another. This may be in a positive or negative way; the way that factors inter-relate may increase or mediate our concern(s).
- 2.14 Appendix 6 provides another framework for assessment "A day in the life of the child (The Horwath Model)" and appendix 7 "The Neglect Screening Tool" should be completed from your professional view about the extent of the presence of Neglect and what action should be taken next.

3. Immediate and Long-term Impacts of Neglect on the Child

- 3.1 Practitioners and academics are agreed that chronic and serious neglect can have disastrous effects upon childhood and child development. The persistent nature of neglect is corrosive and cumulative and can result in irreversible harm (Hildyard and Woolfe, 2002; Davies and Ward, 2011). Research clearly identifies that if babies and young children are exposed to neglectful care giving and poor stimulation in the first 3 years of life, the neuronal pathways requiring stimulation are likely to wither and children may never achieve their full potential (Perry, 2004).
- 3.2 The impact of neglect upon a child's development is uniquely experienced by each child depending upon their individual circumstances, the nature of the neglect and the existence

of resilience. Amongst the challenges that may be encountered by children who are exposed to neglect are:

- Development delay and failure to thrive
- Hunger and thirst
- Low weight
- Being overweight, obesity
- Lack of appropriate medical care, missed medical appointments and pain caused by untreated condition(s)
- Inadequate protection from emotional, physical or sexual harm
- Pain/embarrassment caused by ill-fitting or inappropriate clothes
- Difficulties concentrating and making friends at school/other setting
- Lack of opportunities for socialisation
- Elevated likelihood of poor mental health and low self-esteem
- Feelings of isolation and rejection

3.3 Additional challenges faced by children living in neglectful circumstances where parental alcohol or substance misuse feature include (see Hidden Harm, 2003):

- Addiction to substances at birth
- Anxiety about the wellbeing of carers/parents
- Exposure to dangerous adults and frightening or inconsistent adult behaviour
- Exposure to dangerous substances
- Expectation to keep secrets
- A feeling of isolation from within the family home and wider community
- Involvement in the supply of substances
- Early involvement in use of substances

3.4 Neglect can have a significant impact on a child's emotional and physical development, the effects of which can last into adulthood. It impacts on all aspects of a child's health and development including their learning, self-esteem, ability to form attachments and social skills. The long-term impacts continue into adulthood and can be far reaching.

4. Keeping the Child's Needs in Focus

4.1 Parental Substance Misuse and Neglect

Evidence has shown children of substance misusing parents tend to come to the attention of services through neglect issues rather than their parents substance misuse. The work of Hidden Harm (Advisory Council for Misuse of Drugs, 2003) highlights the relationship between parental substance misuse and child neglect. Practitioners should be mindful when carrying out assessments of the potential for parents to try to conceal their substance/alcohol misuse. This may present itself as hostile or uncooperative responses by the parents.

4.2 Poverty and Neglect

Neglect often occurs in families living in poverty. However many parents who encounter poverty provide safe homes and high standards of parenting. Poverty in itself is never an indicator of neglect. The question often used to illustrate this is if a new fridge were provided would the children receive better nutrition or improved emotional care? The

children at greatest risk are those whose parents' own emotional impoverishment is so great that they do not know how to parent or understand their children's needs. Whilst neglected children will not inevitably become neglectful parents, research and practice experience clearly identifies the inter-familial nature of much neglect. Appropriate intervention can therefore contribute to the prevention of the cycle of inter-generational neglect.

4.3 Affluence and Neglect

In Professor Claudia Bernard's paper (Goldsmiths, University of London) "[An Exploration of How Social Workers Engage Neglectful Parents from Affluent Backgrounds in the Child Protection System](#)" she states there is growing evidence to show that child neglect also occurs in significant amounts in families from the highest social class (Bellis et al. 2014). Other research has found that neglectful parents in affluent circumstances rarely come under the radar of child protection services, so they do not show up in official reported statistics (Watson, 2005).

In her study, practitioners reported that active engagement techniques, such as having a formal signed agreement and goal setting, often did not work with affluent parents; the parents essentially used formal complaints as a strategy to deflect attention away from doing a robust assessment, a finding also identified in other research (Laird 2013).

She concludes, "With regards to interventions that are effective for families that are highly resistant to social work intervention, some practitioners found that risk assessment tools such as the neglect toolkit were useful in helping them to stay focused on the child to assess levels of risk and in evidencing assessments in order to escalate concerns when there was a need to do so. However, it is important to recognise that whilst standardised assessment tools such as the neglect toolkit is a necessity for assessing risk, social workers also need to be confident and assertive in their professional judgements to identify and name deficits and neglectful caregiving in affluent families. Thus, if practitioners are to engage with the complexity of safeguarding children in affluent families, they also need to be able to acknowledge and discuss the power of social class and how it impacts the child protection processes. As a number of serious case reviews point out, class does get in the way of child protection work (Brabbs 2011; Nicolas 2014)".

4.4 Parent and Child Relationships and Neglect

The formation of positive attachments is seen to be fundamental across all domains of child development. A secure attachment in particular enables children to gradually learn to become independent and confident when dealing with new experiences and challenges. Good attachments are dependent upon the child's parents being physically and emotionally available, dependable and benevolent (see Fahlberg, 1994). These qualities may be absent in some parents for a variety of reasons, and consequently the attachments their children make will be distorted.

It is important to recognise that there may be particular challenges around positive formation of attachments that are specific to a particular child. An example of this may be where a child may have a specific severe disability or chronic illness, particularly if there has been long-term hospitalisation.

It is increasingly recognised that there has been insufficient emphasis on the significance of emotional neglect and the relationship between emotional neglect and negative patterns of attachment. As part of the assessment process, practitioners should look closely at difficulties or distortions in the patterns of attachment and bonding between a child and his or her primary carers as this may lie at the heart of issues around child neglect.

Negative patterns of attachment are particularly evident in neglected children where parents maybe 'psychologically unavailable' to their children. This can result in emotional and behavioural disturbance in their subsequent development.

Local Arrangements & Procedure

5. Procedure

- 5.1 In some circumstances, it will be necessary to refer immediately to the Police or the Children's Social Care if significant harm to a child/ren has been identified. Although the process outlined below is linear and structured, it is acknowledged that some situations will need a different response based on risk.
- 5.2 Ideally, the procedure for when a concern relating to child Neglect is identified is summarised in three stages as follows:

(i) Identification of Neglect by Universal Services and/or Early Help

It is the responsibility of **ALL TEAMS AND ORGANISATIONS** to work with children and their families where there are indications that suggest neglect is a risk factor to encourage them to accept the support they need to improve and maintain their child's health, well-being and development.

Real names have not been used in the following case examples

School example

Alex, a year 8 pupil at secondary school has 20% school attendance.

Alex has diagnosed medical issues and is medicated but it is unclear if this condition affects their ability to attend school as no clear medical evidence has been provided to this effect.

Alex's parents have engaged well with school, attending meetings to discuss Alex's attendance but have advised staff that professional visits to the home address are not required.

Alex has been seen in school within the last week.

School have offered Early Help support for parents and have arranged several meetings to complete a Webstar. The parents have initially agreed to support but this but have cancelled all meetings at short notice.

Medical evidence has been received from the GP stating that the child is not fit to attend school, therefore the absence will be recorded as authorised, but the Education Welfare Officer will still undertake a visit as a supportive intervention, the primary aim is to have sight of Alex.

The parents have expressed to school staff that they have concerns about Alex's mental health, but they have not contacted the doctor as advised to do by school.

The parents are working with the school to a degree, but concerns remain regarding:

- attendance
- parents not accessing appropriate medical support for their child
- the reluctance of the parents to fully engage in accessing Early Help support
- discouraging professional visits to the home

To tackle concerns about potential neglect, the following actions have been agreed by the school:

- School to continue to encourage parents to engage in the Early Help process
- School to complete the Neglect screening tool with Alex and parents
- Education Welfare Officer to undertake a supportive home-visit to see the child and family
- Meeting to be arranged with Alex and parents involving all those professionals known to be currently working with the family, to develop a plan of support and share relevant information
- School to refer to the threshold document and submit a Multi-Agency Risk Assessment Form (MARF) if required

Early Years Example

Sammi is three years old and started to attend the setting four months ago. Sammi is in receipt of 30 hours Extended Free Early Years Entitlement and has a place 5 days per week, 9am -3pm, term time only.

Sammi's attendance has become sporadic over the past two months. Sammi has been monitored since starting at the setting due to concerns around lateness, appearance (dirty, ill-fitting clothes) and constant hunger when in the setting. Sammi is a quiet, withdrawn child and seems to try not to be noticed or draw any attention, playing alone and not joining in with other children's play.

Sammi's Mum Heidi also has an 8-month-old baby and the father of both children left 4 months ago. She has not seen him since, and he has no contact with the baby or Sammi. Heidi was spoken to previously about the concerns Sammi's key worker had and she always provided a reason, for example:

- Sammi slept in so didn't have time for breakfast
- the washing machine is broken
- Sammi's seems fine and is happy and chatty at home

Yesterday, Sammi came into Nursery and as usual was hungry, looked tired, dirty and unkempt. Heidi said, "we've overslept again, and the washing machine broke down yet again, and I'm waiting for it to be fixed."

Sammi was given breakfast and became upset saying, "mummy said I can't tell you". Sammi was comforted and reassured.

Eventually Sammi said that "at the weekend big scary men came into the house and took some of mummy's stuff because she had no money," "my house is dark and cold, and I'm always hungry cos there's not much food to eat."

The setting considered the following questions:

- what should be done immediately?
- where should the information be recorded?

- what actions are needed in the longer term?
- what further advice is needed?

To tackle concerns about potential neglect, the following actions were agreed by the setting:

- Immediately discuss with the Designated Safeguarding Leads/Manager
- Log concerns and disclosure on the settings safeguarding log and add to the chronology
- Speak to Heidi when collecting Sammi to discuss concerns
- Provide information on the potential Early Help available from the setting and other agencies e.g. Health Visiting Service
- Discuss and obtain consent for Early Help
- Ensure Sammi has 1:1 key worker time and is given breakfast on arrival each morning
- Share Neglect Screening Tool with Heidi and discuss how this could be used to identify areas where support could be provided
- Discuss with Heidi other professionals who could offer support to the family and arrange meeting

Early Help Example

Maddison is a single mum with two children aged 2 and 5 years. She has been diagnosed with Depression, for which she is medicated and has frequent contact with her GP.

Maddison has a non-resident partner who is not related to her children. The children have no contact with their biological father or his family due to Domestic Abuse so that the risk of significant harm to the children is managed.

Concerns for the family were initially raised by the children's nursery who completed an Early Help Assessment which was sent to Targeted Early Help. The needs identified were about parenting, routines and the delayed speech and language development of the eldest child who at this time was age 3 years old. The nursery setting engaged the Public Health Nursing Service on the advice of Targeted Early Help to address the developmental delay and monitored the needs of the family through an Early Help plan.

Concerns began to escalate with the children starting to present at pre-school as unkempt. Maddison disclosed financial hardship and relationship issues with her partner to the setting. At this stage, there was also a reported Domestic Abuse incident which resulted in a Child in Need (CIN) Social Work Assessment being conducted under Section 17 of the Children Act.

On completion of the Social Work Assessment the case was stepped down to Targeted Early Help to manage with a recommendation of support around Domestic Abuse and keeping the children safe through adequate parental supervision. On commencement of Targeted Early Help support the following areas of need were assessed by the Family Support Worker:

- Maternal mental health and the impact on parenting capacity, especially her ability to supervise the children
- Home safety; the family home was damp, had exposed electrical wires, was cluttered, dirty, in a poor state of repair, had inadequate heating and there was no safety equipment in place
- Domestic abuse
- Financial hardship

The family are still on the caseload although the situation is much improved, and the risks of neglect have reduced with support:

- The family have been re-housed in a Social Housing property and Maddison used this as an opportunity to de-clutter and improve the home environment
- Maddison and her ex-partner are no longer in a relationship therefore the Domestic Abuse is no longer a concern at this point. Maddison now spends more time parenting effectively as she is no longer living in fear of her partner and his differing parenting approach
- The family's financial situation has improved. There were challenges during the first National Lockdown as Maddison's benefits were stopped. The Strengthening Families Department for Work and Pensions Advisor supported her to apply for the correct benefits, which she is now in receipt of. The Family Support Worker has provided support around budgeting as this was an area that Maddison hadn't managed previously due to coercive control in her relationship
- The relationship, attachment and emotional warmth between Maddison and her children has improved. The Family Support Worker has delivered the Solihull Approach 'Understanding Your Child' programme with her on a one to one basis which has helped her to better supervise her children through having a more realistic expectation of them for their ages and stages of development
- Emotional containment provided to Maddison by the Family Support Worker has been invaluable in supporting her wellbeing and understanding of Neglect and its impact

Although support needs were identified at an early stage by the pre-school who completed an Early Help assessment, the specific neglect factors could have been highlighted more clearly through the use of a [Neglect Screening Tool](#). This may have enabled targeted support to have been put in place earlier to reduce Neglect risks and prevent the family escalating to a Social Work Assessment.

Health Visitor Example

The Health Visitor undertakes a new birth home visit to baby Stas, his sister Ava (2 years) has not been seen by the Health Visitor service in last 12 months. When entering the home, it appeared cluttered with piles of clothing around the living space making it difficult for Ava to play, there were broken toys which could have injured Ava, and in the kitchen the work surfaces were covered with household items providing little space for preparation of food.

During the visit Stas's Mother Bela explained that she was finding caring for both children difficult and that Stas was not feeding well. The Health Visitor encourages Bela to consider who could help her with the children. She offers advice about Stas's feeding and arranges a time later that week to return to meet with the family to review Stas's feeding and to complete a holistic health assessment of both children's needs.

On completion of the assessment at the return home visit the Health Visitor identified that this family would benefit from a more targeted Health Visitor service from the Universal Plus Team. A number of factors were discussed:

- Having asked specific questions to help understand Bela's mood (the WHOOLEY questions) and completed an Edinburgh Post Natal Depression

Score questionnaire the Health Visitor is alerted that Bela may have post-natal depression and has asked her to attend her GP for further consideration. The Health Visitor offered to visit the following week as a support for low mood. She declined this along with a referral to the virtual support group for Mothers with low mood following the birth of their child

- The completion of a developmental assessment with Ava has identified some potential language delay resulting in a referral to Speech and Language Therapy Service
- Parents are provided with the necessary information to enable them to apply for 2 4 U funding, enabling Ava to access free nursery provision
- Parents Bela and Mike agree for a Healthy Child Practitioner to visit the family home weekly for six weeks, to establish a positive sleep routine for Ava and to support mother with positive play activities
- The Health Visitor discusses with Bela and Mike, about what they thought was the poor cleanliness of the home, and the positive impact on the children of improving this. They identify a family member who can help with the housework. The Health Visitor advised that she would review this on her next visit. The parents and Health Visitor have agreed to review the impact of the changes on the children's daily lived experience in 6 weeks' time and to identify any further support for the family.
- The Health Visitor will make regular contact with the Healthy Child Practitioner to discuss changes being made over the next six weeks and remind Bela about the support group available to support her with postnatal low mood. Consideration will be given throughout this time by the Healthy Child Practitioner and the Health Visitor to the threshold of neglect using the Neglect Screening Tool and the GCP2 to support future assessments and conversations with the family.

Practitioners, teams and organisations should refer to the case examples, Practice Guidance section above, the Appendices below and Graded Care Profile 2 when working with children and their families to assist them.

Every effort should be made to get the child and their family's involvement before progressing to multi-agency meetings. However, even at this early stage, it may be necessary for an organisation who is working with the child to call a multi-agency meeting to share and gather information relevant to the situation and work in partnership to work out how to move forward. This is particularly important if the family is not engaging or early interventions are having a limited effect. Any organisation can arrange such a meeting rather than referring on for another service or organisation to initiate. Shropshire Safeguarding Community Partnership members are committed to providing staff resources for such meetings. The Roles and Responsibilities section below provides information to help identify who is best placed to be included.

The family should be made aware that a meeting is taking place and what information is likely to be shared. They should be given the opportunity to attend, give their views in advance of the meeting or for someone to attend with or on behalf of them. If the family state they do not want a meeting to take place or information to be shared between agencies but it is felt that a multi-agency meeting should still take place, this does not mean that a meeting cannot take place. However, organisations involved should be clear about the lawful basis upon which they are sharing information (please refer to Shropshire Safeguarding Children Network Information Sharing Procedures).

The family's involvement, consent and lawful basis of the meeting should be clearly recorded in organisational case records.

(ii) Targeted Early Help

If following the attempts made at stage (i) there is still no engagement from the family and significant concerns exist, the child should be referred to Targeted Early Help (via First Point of Contact) for consideration of a Whole Family Assessment (if one hasn't been done already). If such an assessment exists already, the allocated Family Support Worker should ensure it is up to date and incorporates the views and wishes of the child and their families.

If it has not been possible to get consent, this should be a reason for **increased** concern and **not closure**. At this point, workers should consider increasing their involvement with the child and their family or moving to stage (iii) if there are significant concerns about a child.

(iii) Raising a safeguarding concern (s17 Child in Need or s47 Child Protection)

Concerns can be raised by any organisation working with the child. A safeguarding concern should be raised when:

- Where appropriate, all reasonable attempts though stages (i) and (ii) have been made to assess and engage the child and their family in meeting the child's needs **and**
- there is the possibility of significant harm to the child/ren. If there are concerns about the abuse an adult with care and support needs, organisations should follow the [Adult Safeguarding](#) process.

If the decision is to make a referral to children's social care, a telephone referral via First Point of Contact (FPOC) 03456 789021 should be made in the first instance followed by a completed Multi-Agency Referral Form (MARF). All completed Multi-Agency Referral Forms (MARFs) should be sent securely to Compass.Referrals@shropshire.gov.uk

Appendix 4. provides a flowchart summary of the local procedure. For meetings at all stages a standard agenda is provided at appendix 5.

6 Roles and responsibilities

- 6.1 All agencies and teams who work with or come into contact with children have a responsibility to work together to safeguard and promote the welfare of all children in Shropshire. Please see appendix 7. which summarises the responsibilities of a range of organisations and teams.

Appendix 1: Categories, Indicators and Possible Solutions

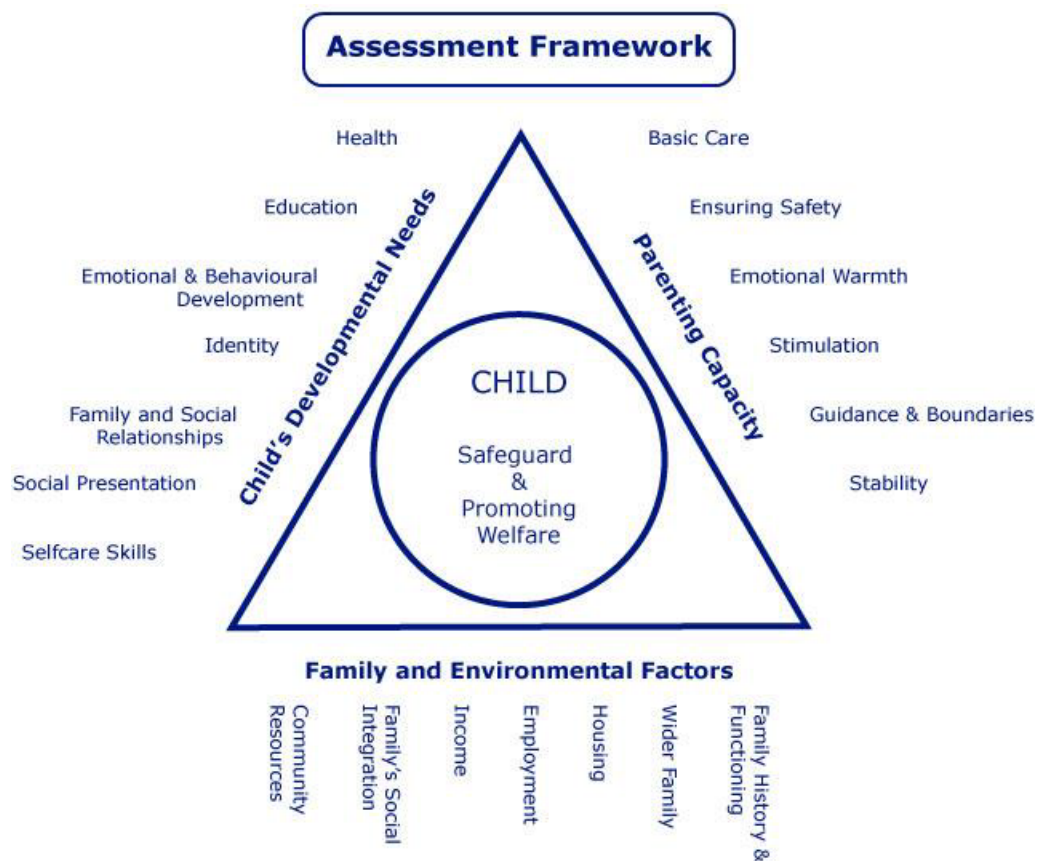
The following categorisations based upon research (Crittenden 1999, cited in NCH Action for Children, 'Action on Neglect' 2013) may help to plan and manage neglect cases. The research suggested that neglect can be grouped as follows:

	Disorder Neglect (driven by chaos and crisis)	Emotional Neglect (absence of empathy, not good at forming relationships)	Depressed Neglect (withdrawn and dulled parental characteristics, unresponsive)
Indicators	<p>Families have multi problems and are crisis ridden</p> <p>Care is unpredictable and inconsistent, there is a lack of planning, needs have to be met immediately</p> <p>Parent appears to need/ want help and professionals are welcomed, but efforts by professionals are sabotaged by the parent</p> <p>Generational abuse</p> <p>Children become overly demanding to gain attention Families constantly recreate crisis, because feelings dominate behaviour</p> <p>Parents feel threatened by attempts to put structures and boundaries into family life</p> <p>Interpersonal relationships are based on the use of coercive strategies to meet need</p> <p>Families respond least to attempts by professionals to create order and safety in the family</p>	<p>Opposite of disorganised families where focus is on predictable outcomes</p> <p>Family may be materially advantaged and physical needs may be met but no emotional connection made</p> <p>Children have more rules to respond to and know their role within the family</p> <p>High criticism/low warmth</p> <p>Parental approval/ attention achieved through performance Children learn to block expression/or awareness of feelings</p> <p>They often do well at school/other setting and can appear overly resilient /competent mature</p> <p>They take on the role of care giver to the parent which permits some closeness that is safer for the parent</p> <p>Children may appear falsely bright, self-reliant, but have poor social relationships due to isolation</p> <p>Parent may have inappropriate expectations in relation to the child's age/development</p>	<p>Parents love their children but do not perceive their needs or believe anything will change</p> <p>Parent is passive and helpless</p> <p>Parent is uninterested in professional support and unmotivated to change</p> <p>Parental presentation is generally dull/withdrawn</p> <p>Parents have closed down awareness of children's needs</p> <p>Parents may go through the basic functions of caring, but lack responsiveness to child's signals</p> <p>Child is likely either to give up through lack of response and become withdrawn/sullen, or behaviour may become extreme</p>

	Disorder Neglect	Emotional Neglect	Depressed Neglect
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Possible Solutions/ Interventions	<p>Feelings must be attended to in order to develop trust, express empathy and reassurance, be predictable and provide structure in the relationship</p> <p>Mirror the feelings</p> <p>Gradually introduce alternative strategies to build coping skills</p> <p>Support will be long term</p>	<p>Parents need to learn how to express feelings/ emotionally engage with the child</p> <p>Children will benefit from socially inclusive opportunities</p> <p>Help parents to access other sources of support to reduce isolation</p> <p>Child needs support from non-abusing family member</p>	<p>Children benefit from access to outside stimulation e.g. day care</p> <p>Parents unlikely to respond to strategies which use a threatening approach that requires parents to learn new skills</p> <p>Medication may be helpful but beware side effects</p> <p>Emphasise strengths</p> <p>Parental education needs to be incremental and skills practised and reinforced over time</p> <p>Support likely to be long term</p>
Practitioner Caution	<p>Practitioner can become easily absorbed into the family, resulting over-optimism and feeling positive about minimal change when in fact the needs of the child remain unchanged</p>	<p>Practitioners find this type of family difficult to work with because of the lack of understanding of emotional warmth by the parent.</p> <p>Removal of the child will reinforce their feelings of rejection</p> <p>As families may appear successful, there is less likely to be professional involvement</p>	<p>Often linked to substance misuse or mental health problem.</p> <p>Practitioners need to be realistic about the level of change.</p> <p>Easy for practitioners to get caught up in the sense of 'hopelessness'</p>

Appendix 2: The Assessment Framework

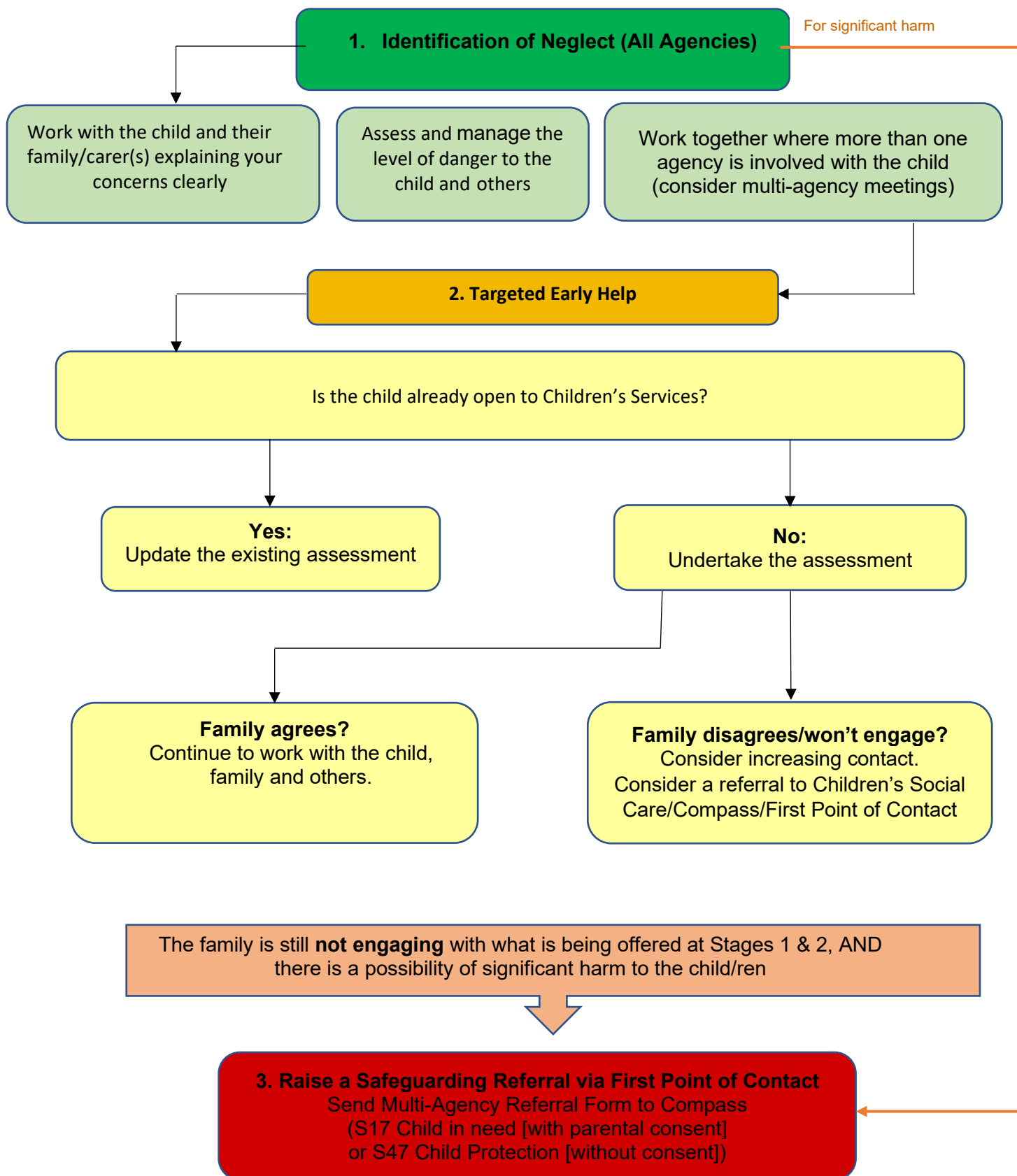


Appendix 3: Development, Parenting and Other Factors

Child Development Needs	Parenting Capacity	Family and Environmental Factors
<p>Health: To be clean To receive medical care To receive dental care Feeding appropriate to age and stage of development Warmth Shelter</p> <p>Education: Play Stimulation Friendships Experience of success and achievement Access to books and toys Support with special educational needs</p> <p>Emotional/Behavioural: Love Security Boundaries Attachment to a key individual To feel valued</p> <p>Identity: To feel valued To feel that they belong An understanding of their cultural heritage Access to positive reflections of themselves in society</p> <p>Self-Care Skills: To wash and dress unless prevented by disability Independence appropriate to age and development To feed self unless prevented by disability</p>	<p>Basic Care: Meeting child's physical needs Medical and dental care Providing suitable clothing Personal hygiene</p> <p>Ensuring Safety: Protection from harm or danger Protection from unsafe adults Supervision Boundaries Selecting responsible babysitters Giving children an understanding of potential dangers</p> <p>Emotional Warmth: Meeting child's emotional needs Offering a positive sense of child's racial and cultural heritage Appropriate physical contact Stability Praise and encouragement</p> <p>Stimulation: Play/reading/talking Experience of success School attendance</p> <p>Guidance/Boundaries: Enabling child to regulate own behaviour and emotions Modelling appropriate behaviour</p> <p>Stability: Developing and maintaining secure attachments where possible Consistency of emotional warmth Contact with family members and significant others</p>	<p>Family History and Functioning: Strengths and difficulties Childhood experiences of parents Family functioning Sibling relationships Absent parents</p> <p>Wider Family: Who are these people? What role do they play?</p> <p>Housing: Is it suitable? Does it have basic amenities?</p> <p>Employment: Who is working? How does employment or lack of employment impact on children?</p> <p>Income: Do financial difficulties affect the child?</p> <p>Social Integration: Integration or isolation?</p> <p>Community Resources: Are they present in the area? Can the family access them? Does the family access them?</p>

Appendix 4: Local Procedure Flowchart

Ensure that every attempt is made to engage with and inform the child and their family at all stages of the process using the Neglect Screening Tool and if needed, Graded Care Profile 2



Appendix 5: Standard Multi-Agency Meeting Agenda

Introductions

Apologies

Background (include what's been tried with what outcomes)

The views of the child

The views of the parents/carers

Presenting needs

Risks to child/children/others

Strengths/Abilities (of the child, family and/or existing sources of support)

Assessments required

Actions and decisions

Lead team and lead manager

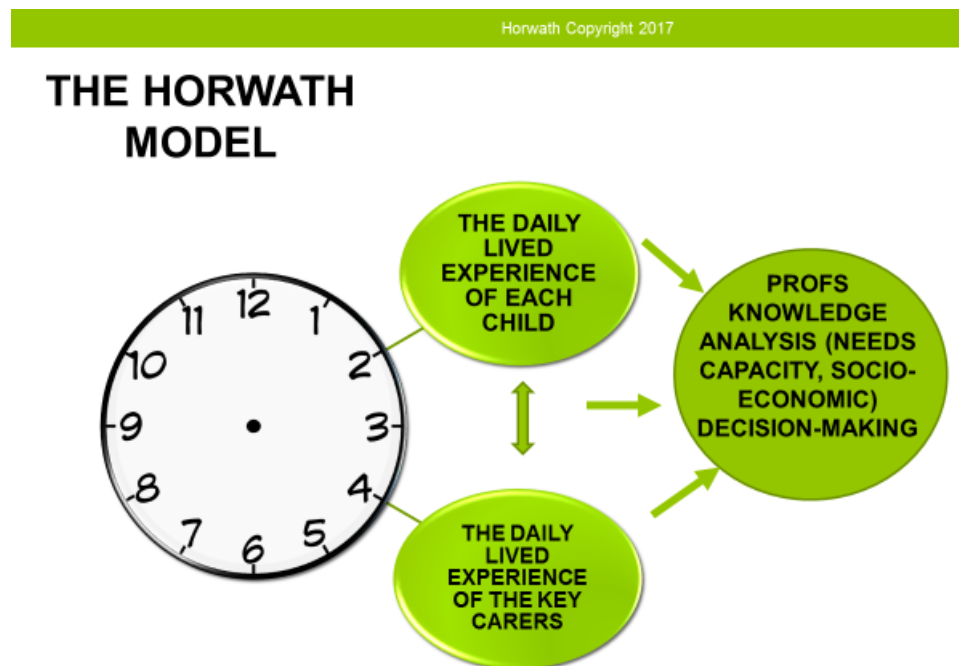
Date of next meeting (if required)

Appendix 6: A Day in the Life of a Child (The Horwath Model)

The Model has been designed to promote child-centred practice by ensuring the lived experience of the child and key family members informs assessments, interventions and evaluations of effectiveness. Briefly, using the Model, practitioners establish what a day is like in the life of EACH child in the family where there are concerns.

To meet the needs of each child in the family it is necessary to not only understand what a day is like in their lives, but also their feelings about the day and what the child would like to change. It is also important to know how the day changes at weekends, holidays and when different people care for them.

It is only by understanding their daily lived experience that practitioners can appreciate how abuse and neglect is affecting the individual child, the needs of the child, areas of resilience and the risk factors.



Using the Model, practitioners also need to find out about a day in the life of the parents and or carers. This enables practitioners to begin to appreciate how daily parenting is impacting on the child. Additionally, by understanding a day in the life of the parent or carer practitioners can learn how parenting issues and socio-economic factors are impacting on their capacity to meet the needs of the child. To change their behaviours, it is important for the parent to have information about the impact of neglect on their child day in day out. Often by being specific about the consequences of their behaviours on the daily experiences of their child parents begin to understand what needs to change.

Children and young people, who have experience of being asked about their daily lives, suggest that practitioners should recognise that:

- A formulaic approach is boring.
- The child should understand why practitioners are interested in finding out about their lives.
- The child needs to feel they are in control and are not going to be judged on what they say.
- One cannot assume that all siblings experience family life in the same way.
- Open-ended questions such as 'What happens next?' are useful.
- Many children lack routine and stability.
- Experience differs depending on who is in the house, whether it's a school day or weekend, if other family are involved in their care.
- Some children have a limited sense of time.
- Children as young as three can give practitioners some insights

When capturing the daily lived experience of the parent practitioners should recognise:

- The parent needs to understand why practitioners are asking for the information and know how it will be used.
- In a child protection situation, parent/s may put a positive spin on the day.
- Parents may be defensive about supplying information.
- Many of these parents lead chaotic lives and may not have any established routines.
- Parents with a learning disability may struggle with the concept of time.

(From Horwath the Child's World 3rd Ed 2019)

Parent/s need to not only understand why practitioners want them to change they must be motivated to change and can do so. All too frequently, parents are told what needs to change. When this occurs, they may fail to understand why these changes are necessary and comply with plans merely to get professionals out of their lives. By drawing on what practitioners have learnt about the parent/s day and that of the child/ren it is possible to be really clear about professional concerns and indeed the concerns of the parent/s themselves. To engage parents in the change process practitioners should:

- Have an understanding of a model for change such as the Prochaska and Di Clementi model and draw on this to assess both ability and motivation at each stage of the change process.
- Recognise the importance of reading the family way. That is understand the unique way in which the parents process and make sense of information. Having established this, practitioners can then assist the parent in constructing this differently to appreciate the needs of their child. For example, 'going to school never did me any harm' can be reconstructed if a worker demonstrates how the daily lived experience of their child is negatively affected by not going to school/other setting.
- Have the time to build up a relationship with the family members and as part of this relationship demonstrate consistency, empathy, warmth and genuineness whilst providing clear boundaries.
- Ensure practitioners prioritise actions so that parents are not bombarded. For example, focus initially on concerns related to significant harm.
- Provide clear timescales and markers of progress so that parents understand how they are working towards.
- Provide the necessary support to make and maintain the changes. All too often professional support is reduced at the first sign of change.

Focus on child-centred outcomes. To work effectively with children and their families it is worth considering the following questions:

- What are our concerns about the lived experience of the child?
- What do we (family and professionals) need to do to improve the child's lived experience?
- How can we build on family strengths?
- What can we as practitioners do to support the parents make the necessary changes?
- How will we draw on the lived experience of the child to measure progress?
- What will a day in the life of the child look like if we are effective?

Feedback from practitioners and families indicates that by using the Model:

- decision-making is child centred
- each child in the family is visible and their particular needs are identified
- parents have increased insight into the impact of their behaviour on their child
- professionals learn about parental ability and motivation
- parents and professionals can hold specific, evidence-based discussions about what needs to change and why
- success or failure of interventions in terms of the impact of children is easier to identify and can be used effectively in court

The Model is relevant not only in cases of neglect but also other forms of maltreatment. It is also relevant when assessing for early help and child in need services. Several safeguarding boards have taken the Model and applied it to practice using a systems approach. This means that their systems, forms, assessment tools and decision-making fora have been changed to ensure that the Horwath Model is central to information gathering, assessment, planning, actions and reviews. This all system approach is known as *Supporting Families Enhancing Futures*.

Using the Horwath Model: Pointers for Practice

1. Give the family member some control over venue, time etc.
2. When recording the lived experience use 'I' and words of the family member when possible
3. Use age-appropriate tools: clocks, strip cartoons, drawings
4. Establishing the lived experience may need to be done over a period of time. If an assessment of change is to be made then it is important to record the lived experience at regular intervals: three months appears to work well.
5. Find out how day varies if the child is at school, at weekends, with different carers etc. 'yesterday'
6. Neglectful families can live chaotic lives with no routine. So, asking about a typical day may be meaningless. Asking them what happened to them yesterday may be easier to manage.
7. Don't let children become bored, use a variety of approaches
8. Ask open questions: don't take anything for granted and don't jump to conclusions
9. Parents and children might be guarded. When this occurs begin by explaining that you are trying to understand something about their lives and why the maltreatment has occurred. If this does not work begin by asking them about the circumstances that led to the professionals' concerns. With children ask them to describe part of the day, for example being at school, with friends that may not be too threatening.
10. Much can be learnt about the lived experience of young children through observation, what the parents/carers have to say and professional knowledge. For example, if a mum indicates she change a baby's nappy every 24 hours then a health visitor is well placed to describe the consequences of this for a child.

Appendix 7: Agency Roles and Responsibilities

Social Care for Children: Shropshire Council

There are a range of teams within Social Care providing statutory, preventative, assessment, reviewing and support services. They include:

- Compass
- Assessment Teams
- Independent Reviewing Officers
- Case Management Teams
- Court Team
- Targeted Early Help
- Family Information Services
- Disabled Children's Team
- Residential/Respite Cares services
- Fostering
- Adoption

Shropshire Fire and Rescue Service

Core functions are:

- Fire Safety: Community Safety information and resources can be found on the Shropshire Fire and Rescue Service website: <https://www.shropshirefire.gov.uk>. Shropshire Fire and Rescue Service can carry out free Safe and Well Visits to any adult in their own home to ensure that they are aware of potential hazards within the home and can take appropriate actions. These visits include a discussion on the person's health and wellbeing relating to their safety.
- Fire Fighting - extinguishing fires and protecting life and property in the event of fires.
- Road Traffic Accidents - rescuing people in the event of road traffic accidents and protecting people from serious harm in the event of road traffic accidents.
- Emergencies - when necessary deal with emergencies, other than fires and road traffic accidents relating to people's safety (such as flooding and adverse weather)

The Fire Service also has a legal responsibility to undertake periodic inspections or audits of non-domestic premises (including residential homes, the common parts of blocks of flats or houses in multiple occupation (HMOs). If it is considered that the responsible person has failed to comply with any provision of the order, further action can be taken.

Housing Services: Shropshire Council

The functions of Housing Services include:

- Assisting in making the home of a person with disabilities more suitable to live in, further information and resources can be found on the Shropshire Council website: <https://shropshire.gov.uk/private-sector-housing/>
- Dealing with property conditions in homes that are owner-occupied and assess properties for hazards under the Housing, Health & Safety Rating System. Other than

in exceptional circumstances, the Council expects owner-occupiers, including long leaseholders to take their own action to remedy hazards at their own properties.

Hoarded properties cannot be properly assessed as much of the fabric and services cannot be seen. If the owner occupier is uncooperative, court warrants may be required to gain entry, (any enforcement action is taken only when all other avenues have been exhausted.) Often extensive repairs become apparent, Housing Services can serve legal notices, do work in default and place a charge on the property. In some cases, however, costs may be exorbitant and such works may be deemed unreasonable and impracticable. Action may also be taken when properties are in a filthy or verminous condition. Regardless of the condition of the property, Housing Services do not have legislative powers to remove someone from their own home or to prevent them from returning home.

- The Housing Options team can offer support in finding alternative accommodation and preventing homelessness.
housing.options@shropshire.gov.uk 0345 678 9005 (If you're made homeless outside of office hours please call 0345 678 9000).

Further information and resources can be found at:

<https://www.shropshire.gov.uk/housing-options-and-homelessness/>

- Housing Services do have some discretionary funding. This assistance is means tested and is available for emergency repairs only, to aid discharge from hospital; or to aid the installation of works under a Disabled Facilities Grant. It is not for extensive refurbishment.

Regulatory Services: Shropshire Council

Services provided by regulatory services include:

- *Private Rented Sector Housing Standards*
Respond to service requests about the condition of private rented properties and seek to resolve the issue focusing on risk, harm and vulnerability, whilst encouraging those affected to try and resolve issues with their landlords. Use the Housing Health and Safety Rating Scheme to identify hazards
Protect and help vulnerable members of the community by reducing the risk of injury and ill health of occupiers of such properties caused by unsatisfactory living conditions. Provide advice and guidance to both tenants and landlords.
- *Investigating Statutory Nuisances*
Investigate Service Requests regarding statutory nuisance, such as noise, light, animals, smoke, dust, fumes, insects and accumulations and seek to resolve the issue focussing on risk, harm and vulnerability and encourage those affected to try and resolve issues themselves where appropriate. Work with other services and organisations to resolve issues.
- *Public Health*
Protect and help vulnerable members of the community by reducing the risk of ill health of occupiers of such properties caused by unwholesome living conditions and by signposting them to other support agencies where appropriate.
Investigate premises which may be considered to be filthy & verminous and take appropriate action where they are considered to be verminous, or they are causing a

statutory nuisance to neighbouring residents. Work in partnership with other teams and agencies, organising and participating in multi-agency meetings where the risk determines that this approach is needed. Work to maintain improvement. Reduce the amount and level of council and state resources, while supporting continued independent living.

Take appropriate action to ensure steps are taken to control rats & mice under the powers contained in the Prevention of Damage by Pests Act 1949 by keeping land free from vermin. Protect residents from pest related diseases. Bring about a cleaner, safer and healthier environment. Protect against a deterioration in neighbourhoods due to refuse accumulations likely to attract rodents.

- *Pest Control Service*

We provide practical treatments for a wide range of nuisance pests for domestic and commercial customers. There are charges for services and prices are maintained at a competitive rate. The team of specialist pest control officers with a great deal of expert knowledge in dealing with a wide range of pests, and can offer advice on preventative solutions tailored to suit most commercial or business premises. Without proper control, pests can cause costly damage and contamination to property, spread disease as they carry bacteria, viruses and parasites which can be passed onto people.

- *Insecure premises*

Take appropriate action to ensure buildings are secured against unauthorised access or to prevent them becoming a danger to health. Require owners to secure, including assessment of the need to carry out works in default and recover costs.

- *Anti-Social Behaviour Co-ordination*

Assess incidents of ASB, assessing the risk harm and vulnerability. Ensure early intervention when problems are identified while also preventing duplication of efforts. Ensure all teams and agencies work together to ensure a co-ordinated approach and partnership working with the Police in a co-located team. Lead on reports of ASB where issues have links to Environmental Health. Organise multi agency meetings and produce action plans on the most complex ASB cases or where they involve vulnerable people. Reduce the need for future interventions.

Adult Social Care: Shropshire Council

Shropshire Council provides a range of services that aim to meet people's social care needs including advice and guidance.

Adults are entitled to an assessment of their needs but for someone to be supported by the local authority they must be eligible to receive services.

There are a range of teams within Adult Social Care (usually area based) providing assessment, reviewing and support services. They include:

- **First Point of Contact (FPoC):** provides a single point of contact. The team provide advice, guidance and onwards signposting into other Adult Social Care or other Shropshire Council services on queries relating to care and support for adults to individuals, carers and partners and professionals. This includes safeguarding concerns.

FPoC Telephone: 0345 678 9044

FPoC Email: firstpointofcontact@shropshire.gov.uk.

- Social Work Teams
- Mental Health Social Work Team
- Hospital Teams
- Emergency Social Work Team
- Safeguarding Team
- Occupational Therapy Team
- Appointeeship and Deputyship Team
- Financial Assessment Team
- Short Term Assessment and Reablement Team
- Day Services
- Nursing Home

Primary Health Care: General Practitioners and other providers

Every child and adult registered with a General Practice must have a named General Practitioner (GP) who has responsibility for the co-ordination of all appropriate health services required under the Standard General Medical Services (GMS) contract and ensure they are delivered to each of their patients where required, based on the GP's clinical judgement.

A child's General Practice is often the first point of contact for them and their family identifying concerns relating to Neglect. They can provide general medical advice and intervention, as well as complete referrals to secondary health care provisions.

There are other forms of primary health care, such as community pharmacists, dentists and opticians who can also be accessed by child and their family.

5.8 Midland Partnership NHS Foundation Trust (<https://www.mpft.nhs.uk>.)

- Shropshire Primary Care Psychological Therapies Service: aims to improve health and wellbeing by offering a range of help, advice, life skills courses, supported self-help, other groups and individual therapies for everyone aged 16 and over. People can self-refer or be referred through their GP. The website: <https://shropshireiapt.mpft.nhs.uk> offers online resources and further links/websites that can be accessed by the person or professionals supporting them.

Self referral telephone number: 0300 123 6020

- Bee U is the emotional health and wellbeing service for people up to the age of 25, living in Shropshire and Telford & Wrekin. It is designed to help young people:
 - cope
 - get help
 - get more help
 - manage in times of crisis

<https://camhs.mpft.nhs.uk/beeU>

We Are With You

Shropshire Recovery Partnership offers information, advice and support for adult and young people with drug and alcohol issues. Shropshire Recovery Partnership is based at Crown House in Shrewsbury but offer services from a number of hubs around the county, including Oswestry, Whitchurch, Ludlow and Bridgnorth.

Services offered include:

- Advice and Information
- Assessments
- One-to-One Work
- Group Work, Detoxification
- Substitute Prescribing
- Needle Exchange
- Blood Borne Virus support
- Residential Rehabilitation
- Probation Clinic
- Family Work
- Young Person Work

The person can self-refer. Professionals can also refer to the service on a person's behalf or for professional advice and information.

Website: <https://www.addaction.org.uk/services/shropshire-recovery-partnership>

Telephone: 01743 294700

Secondary Health Care

Secondary healthcare is usually delivered in hospital settings but can also be provided in the community. Most people who attend or are admitted to a hospital or community provision are there:

- because of a referral from their General Practitioner; or
- through accident and emergency departments; or
- from a telephone and Internet-based help system, NHS 111 (<https://111.nhs.uk>).

Hospitals and community health services have developed, and continue to develop, based on government planning for health care needs. Since the NHS changes of 1991, hospitals are managed by health care trusts that not only provide hospital and mental health care services, but also deal with ambulances and special services. In Shropshire we have:

- Acute hospital services (Shrewsbury and Telford Hospital Foundation NHS Trust: <https://www.sath.nhs.uk>.)
- Emergency Ambulance Service and patient transport (West Midlands Ambulance Service: <https://wmas.nhs.uk>.)
- Specialist orthopedic services (Robert Jones Agnes Hunt: <https://www.rjah.nhs.uk>.)
- Specialist mental health services (Midlands Partnership Foundations Trust: <https://www.mpft.nhs.uk>)
- Community health services and hospitals (Shropshire Community Health Trust: <https://www.shropscommunityhealth.nhs.uk>.)

Clinical Commissioning Group

CCGs are clinically led statutory National Health Service (NHS) bodies responsible for the planning and commissioning of healthcare services for their local area. CCG members include GPs and other clinicians, such as nurses and consultants. They are responsible for about 60% of the NHS budget, commission most secondary care services and play a part in the commissioning of General Practitioner services.

CCGs can commission any service provider that meets NHS standards and costs. These can be NHS hospitals, social enterprises, charities or private sector providers. However, they must be assured of the quality of services they commission, taking into account both National Institute for Health and Care Excellence (NICE) guidelines and the Care Quality Commission's (CQC) data about service providers.

Both NHS England and CCGs have a duty to involve their patients, carers and the public in decisions about the services they commission.

The Shropshire CCG Safeguarding Team provides safeguarding support and advice to all Shropshire GP practices. This includes dissemination of safeguarding related information as required.

West Mercia Police

Core duties include:

- protecting life and property
- preserving order
- preventing the commission of offences
- bringing offenders to justice.

In cases where -neglect may be present, the Safer Neighbourhood Team covering the area that the person lives can often be a good source of information to try and prevent legal intervention taking place; and so it may be useful to engage with the relevant officer at the earliest stage (particularly when considering multi-agency meetings); in order to avoid the need for an emergency Police response.

Appendix 8: Neglect Screening Tool

<https://westmidlands.procedures.org.uk/local-content/xkjN/neglect-tools-and-pathways/?b=Shropshire>

Appendix 9: GCP2 Leaflets

<http://www.safeguardingshropshireschildren.org.uk/media/1278/nspcc-resource-gcp2-promo-poster-professionals.pdf>

<http://www.safeguardingshropshireschildren.org.uk/media/1275/nspcc-gcp2-resource-info-for-young-adults-leaflet.pdf>

<http://www.safeguardingshropshireschildren.org.uk/media/1276/nspcc-gcp2-resource-parent-guide-easyread-leaflet.pdf>

<http://www.safeguardingshropshireschildren.org.uk/media/1277/nspcc-gcp2-resource-parent-guide-english-leaflet.pdf>