

Greater Glasgow and Clyde NHS Board

Board Meeting

Tuesday 20th October 2009

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Director of Corporate Planning and Policy/Lead NHS Director Glasgow City CHCPs
Director of Public Health

MIND THE GAPS: IMPROVING SERVICES FOR VULNERABLE CHILDREN

Recommendation:

The Board:

- **consider the issues raised in relation to children and vulnerable families.**

1. INTRODUCTION AND PURPOSE

- 1.1 This short covering paper introduces for the Board's consideration a detailed paper on improving services for vulnerable children. The paper sets out the challenges faced in protecting children, the evidence base for effective intervention and proposes a series of developments which would improve the protection of children in partnership with Glasgow City.
- 1.2 The paper has been endorsed by the Glasgow City Child Protection Committee and Chief Officers Group and the Glasgow Community Planning Executive Group. Within the community planning process we are continuing to promote the programmes outlined as a priority use for resources available for community planning. The proposals are in line with recent agreement to refocus community planning on addressing the causes on social problems rather than their consequences, with a particular focus on early intervention.

2. CONCLUSION

- 2.1 The key messages of this paper are the:
 - high level of need and vulnerability among children in our Board area;
 - strong evidence base for the earliest possible intervention to give vulnerable children the highest chance of successful life outcomes;
 - significant current gaps in the services provided;
 - medium to long term cost effectiveness of the developments which the paper outlines.
- 2.2 The issues and responses highlighted in this paper have been developed as part of the response to the inspection of child protection in Glasgow City. However, the conclusions and recommendations are significant for the whole of NHS Greater

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Glasgow and Clyde. There are particular challenges for the NHS and Local Authorities in addressing these issues at a time of significant financial pressure but this paper sets out an agenda for change which we must be able to positively progress and ensure vulnerable children have access to effective and appropriate services at the earliest possible stage.

Recommendation:

The Board:

- **consider the issues raised in relation to children and vulnerable families.**

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Author: Catriona Renfrew, Director of Corporate Planning and Policy/Lead NHS Director
Glasgow City CHCPs
Linda de Caestecker, Director of Public Health

MIND THE GAPS: IMPROVING SERVICES FOR VULNERABLE CHILDREN

1. PURPOSE

- 1.1 This paper seeks to outline the context of vulnerability in Glasgow, describes the impacts of vulnerability on children, society and services, explores the evidence-base for responses to reduce the impact, and proposes action
- 1.2 The HMIE child protection report noted positive services, but it judged services to be weak in the planning and delivery of interventions to support vulnerable children whose risk factors were below the threshold for ongoing statutory child protection support, or for those children whose circumstances had improved sufficiently to be removed from formal child protection arrangements (HM Inspectorate of Education, 2009).
- 1.3 Services to protect vulnerable children are at the top of the public and political agenda. Recent criminal cases within Scotland and throughout the UK have demonstrated the high standards the public expects from services in this regard. Serious case reviews consistently cite unmet need as a causal factor in significant child protection failures.
- 1.4 There is a consensus within both health and social care staff that the thresholds for intervention within vulnerable children and families are too high. While this paper identifies opportunities to reshape the use of our current resources, these high thresholds are directly related to the levels of resource relative to the scale of need within Glasgow. Concerns about high thresholds and inadequate support for intervention are echoed within the HMIE report.
- 1.5 To achieve a shift in thresholds will require substantial additional resources, over a sustained period. Unmet need will not be addressed through simply driving improvement and efficiency, although that drive must be a parallel activity to investment and development. The two must not be regarded as choices or as mutually exclusive.
- 1.6 As a result of inadequate resources and excess need, attention and effort are inevitably directed towards the immediate protection of children at very high risk. This unavoidable service response reduces the capacity to deliver the most effective response to children's problems: early intervention. This paper outlines the rationale and evidence for early intervention.
- 1.7 As a result of our limited ability to intervene within children's lives at an early stage, responses usually occur when children have suffered developmental consequences. At that point responses are more costly and less effective than earlier interventions would be. The consequences of limited and late intervention include educational failure, anti social behaviour, crime and violence, and responding to these problems consumes increasing sums of public money. The most effective interventions to improve the lives and opportunities of vulnerable children will be delivered before they are three years old.
- 1.8 The message this paper carries about resources is a tough one in the present economic climate. However, it is a matter of fact that a recession will increase and

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intensify the scale of need and the consequences of failing to meet it, both for vulnerable children and for the wider communities of Glasgow City.

2. CONTEXT

2.1 This paper defines a number of factors which increase the vulnerability of children. These are risk factors which can affect parents, the socio-economic environment the child is living in, the family structure or the may be specific to the child themselves.

- parental risk factors: young parental age; poor education; parents abused as children; psychiatric problems; and substance abuse;
- socio-economic risks: poverty;
- family risks: single parents; step-parents; larger families; and domestic violence;
- child-related risks: premature birth; poor health; and disability.

The most significant risk factor which makes children more vulnerable is poverty. The relationship between poverty and vulnerability reflects the range of other risk factors associated with poverty including those listed above. It does not imply a causal relationship between being materially poor and poor quality parenting.

2.2 Indicators of vulnerability include:

- 1 in 3 children within Glasgow City Council area live within workless households in comparison with 1 in 5 nationally;
- 64% of Glaswegian children live within low-income families (Walsh, 2008);
- around 38% of children live in poverty, one of the highest rates in the UK;
- of Glasgow women giving birth around 58% live in the most deprived circumstances;
- substance misuse affects around 20,000 children in Glasgow;
- around 10,000 children are known to social work but only 300 are in formal child protection procedures;
- the City has 20%, or 3000, of Scotland's looked after children;
- more than 25,000, or 34% of Glasgow's children have significant educational challenges, and this results in around 25% of Glaswegian children attaining at least 5 SCVQ qualifications in S4, compared with 35% nationally.

Using Health Plan Indicator data, **almost 17,000 families resident within Glasgow City were classified as vulnerable**, and in need of additional support from services (NHSGGC Health Visitor Workforce Review, 2008).

3. IMPACTS AND POTENTIAL RESPONSES

3.1 Whilst child abuse can take a number of forms, the commonest in Glasgow is parental neglect. This is strongly associated with poverty, poor parenting, and significant levels of substance abuse. The reasons for this association are still uncertain. Children who are neglected suffer profound developmental consequences which affect their potential, create a significant drain on future public resources, and reduce their future contribution to society. Furthermore, without supportive intervention, the next generation are more likely to develop similar needs.

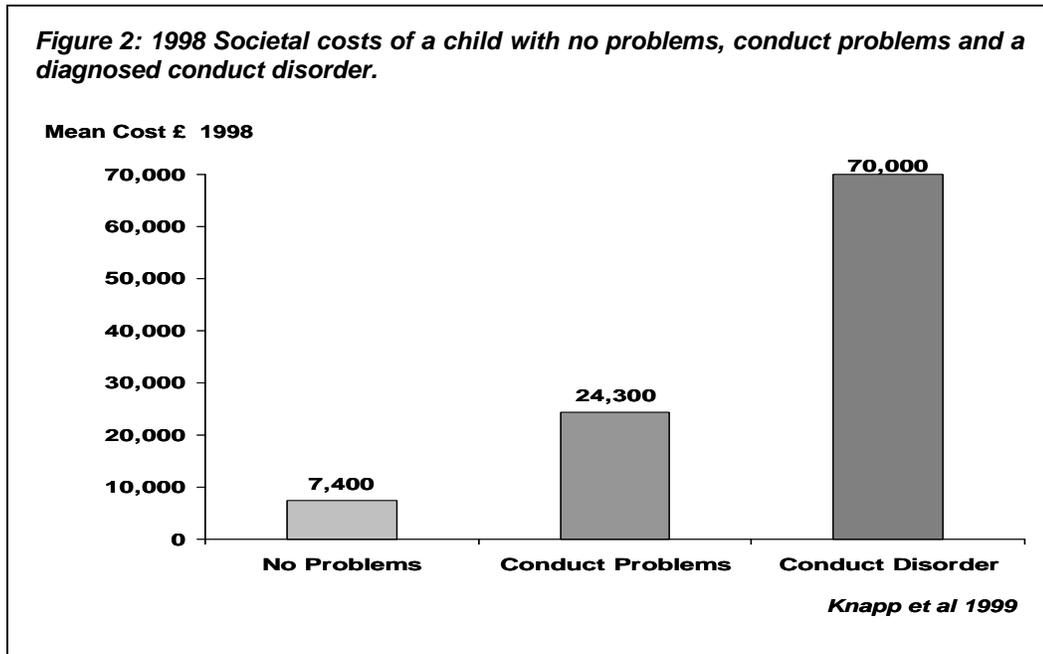
3.2 The biological, developmental and psychological impacts of vulnerability factors experienced in children on their later physical and psychological health is an area of

active research. The slide below (Figure 1) illustrates the physiological impact of neglect. The brain of an extremely neglected child aged three is already significantly damaged. Early stress can have a profound effect not only on the structure of the brain, but on the way it functions. McEwan has shown that long term stress during early development affects memory and reasoning. Early intervention in cases of neglect can allow a child to recover developmentally, and reduces the impact of the neglect on their future potential. Moreover, the ability of a vulnerable child to benefit from interventions is greater in early life.

Figure 1: CT scan comparing the brain of a 3 year old child affected by neglect with a normal child aged 3.



- 3.3 Children who experience abuse are far more likely to develop behavioural and psychological problems, and to become involved in the criminal justice system than their counterparts who do not suffer abuse. The relationship is strongest for those experiencing sexual abuse, but around a third of neglected children exhibit symptoms including difficulties with anger containment, physical aggression, threatening behaviour towards others, use of weapons, cruelty towards animals, vandalism and fire-setting. This link between abuse and future behaviour is strong, with a large proportion meeting the criteria for conduct disorder or other psychological problems within adult life.
- 3.4 The consequences of conduct disorder on society are significant, with violent behaviour increasing the use of health, social care and justice systems, as well as having an impact on the wellbeing and prosperity of others. In addition, conduct disorder reduces the ability of affected individuals to be financially self-sufficient. Crime is one of the most significant costs of failure to intervene, imposing additional costs of up to £60 billion per year on society. Figure 2 illustrates the total extra cost to age 28 of a child developing a conduct disorder.



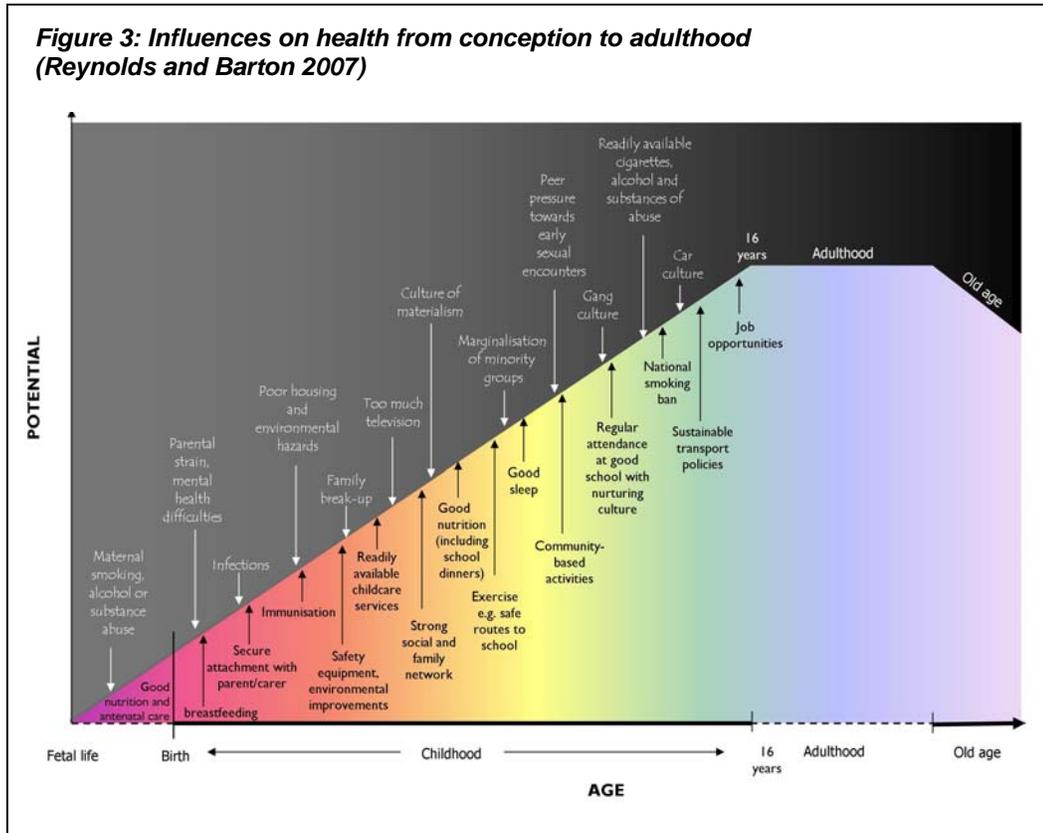
3.5 Children with persistent antisocial behaviour aged 10 **cost society ten times as much as children without the disorder by age 28**. The consequences of vulnerability in childhood are increased costs of health, social care and education in childhood, and in adult life, increased costs of crime and disorder, substance misuse, worklessness and intergenerational poverty, with all the financial consequences on health and social care which this entails.

3.6 Poor parenting has immediate and longer-term impacts on the child:

Immediate Impact	Long Term Impact
<ul style="list-style-type: none"> - Feel emotionally excluded - Don't learn social skills - Feel stupid and incompetent - Little persistence - Feel frustrated and angry 	<ul style="list-style-type: none"> - Low attachment to family, school - No 'good' friends, fail in love - Poor confidence, touchy - Low qualifications, poor work - Antisocial, criminal, drug misuse

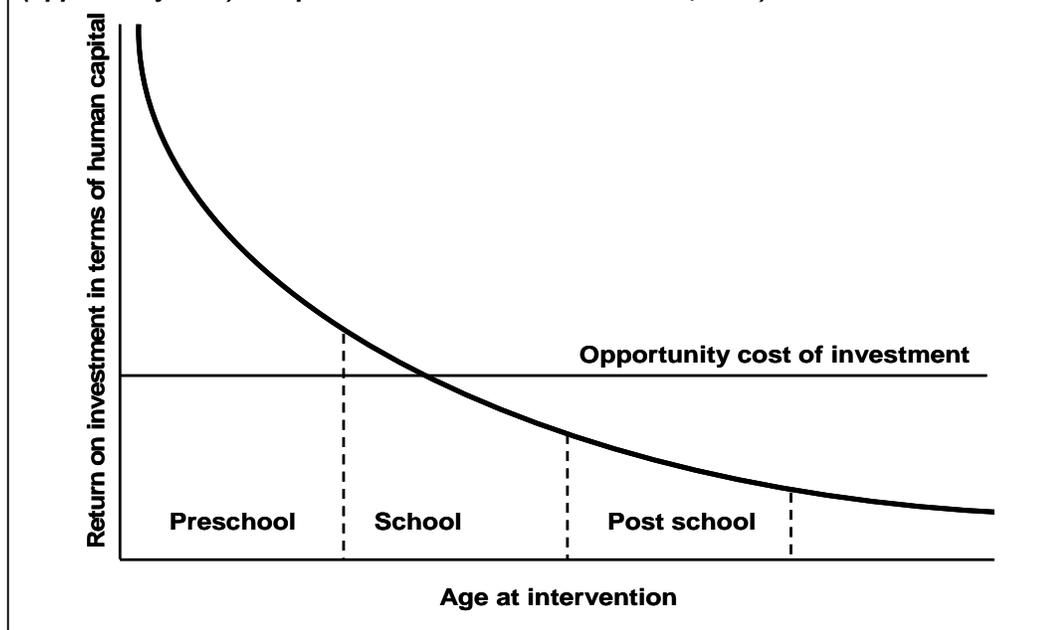
3.7 For vulnerable children, their progression from infancy towards adulthood is marked by a series of lifecourse stressors, which pose actual risks to them as children, and endanger their ability to reach their full potential as productive members of society. However, we also know that there are supportive interventions at the level of society and targeted towards vulnerable families which can reduce the impact of these risks (Reynolds, 2007), see Figure 3.

Figure 3: Influences on health from conception to adulthood
(Reynolds and Barton 2007)



- 3.8 The outcomes from early intervention are achieved across a number of different agencies, but include: reduced use of health and social care services; reduced contact with criminal justice; improved personal income and home ownership; and improved profiles for risk taking behaviours around smoking, alcohol and numbers of sexual partners.
- 3.9 Economic evaluations of the rate of 'return' from investment in interventions at different stages of child and adolescent development has concluded that the maximum impact is obtained by intervening in the preschool and early primary school stages (Carneiro and Heckman, 2003) - see Figure 4.
- 3.10 The population-based intervention using the Triple P Programme (Positive Parenting Programme), which aims to use an incremental model to improve parents' capacities to provide appropriate parental support for their children, and to tackle early signs of problematic behaviour in a positive manner. Other countries have implemented such programmes, and Triple P, delivered via health and social care professionals working in concert with the Parenting Co-ordinators appointed in each CHCP have the capacity to effect change in family environments which will reduce antisocial behaviour, with reductions in the demands on health, care and justice systems.
- 3.11 The conclusion reached by examining a number of different lines of evidence is that early interventions represent the most cost-effective solution for tackling the intergenerational effects of poverty within vulnerable families. The analysis also demonstrates that the impact of failing to intervene is profound: significantly increased costs throughout childhood and adult life and a high risk of the next generation having the same problems, the intergenerational transmission of poverty.

Figure 4: Schematic showing the economic analysis of returns from investment in family and educational interventions across the lifecourse of children. The returns are greatest with the earliest interventions and greatly exceed the return from alternative uses of the same resources up to the mid point of schooling (opportunity cost). Adapted from Carneiro and Heckman, 2003).



4. WHAT SHOULD HAPPEN IN GLASGOW

4.1 Section A of this paper emphasised that to break the cycle we are in, where we do not meet the needs of the vulnerable children, we need a sustained, comprehensive, coherent programme of development and investment with strong political leadership and full commitment, most particularly from the Council and the NHS, but with the essential support of the Police, the Reporters administration and the Voluntary sector.

4.2 Glasgow also needs to respond positively to the HMIE report. We are proposing a number of elements of response for consideration. These are:

- building on the existing commitments to implement the parenting strategy;
- developing family support services; and
- investing in workforce development to provide a more effective culture of early intervention.

4.3 This section outlines in more detail the proposed actions in these four areas, which taken together will represent a step change in the outcomes we can achieve for these children and concludes by setting out an approach to assessing progress.

4.4 Parenting: estimated additional resources required £2 million

4.4.1 Glasgow's recently agreed Parenting Framework represents an evidence-based approach to tackling vulnerability at the level of the population. Given Glasgow's very high levels of vulnerability, such an intervention should be prioritised, and we would

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argue that it should receive recurrent and increasing funding to facilitate its objectives, subject to its successful evaluation.

- 4.4.2 The Children's Services Executive Group has identified parenting support as a key driver to improve educational, social and health outcomes in Glasgow's children. The central model to support parenting must be Triple P (Positive Parenting Programme) (Sanders RS *et al*, 2003), as only this programme offers a range of universal and more intensive, specific interventions to meet the needs of Glasgow's population.
- 4.4.3 Delivering support for parenting will require a number of changes across children's services, and the focus on parenting and parenting interventions must be a visible priority for all staff groups in these services. Implementing the Parenting Framework will require both strong leadership, multi-agency commitment and the support of front-line staff if it is to deliver the improved outcomes seen internationally.
- 4.4.4 A focus on support for parenting provides a coherent link between all the services supporting children and families in Glasgow. Additional interventions such as multi-systemic therapies; functional family therapy; home-based treatment; and treatment foster-care all have robust evidence-bases and are coherent with the overall parenting framework and Triple P. This group of parenting interventions has the potential to deliver real changes in the educational, social and health outcomes of Glasgow's children, and will require all agencies to collaborate to ensure that they are embedded within the children and families framework.
- 4.4.5 A detailed plan and financial framework for full implementation of the Triple P programme has recently been prepared with a cost of just over £1m. The universal element of Triple P involving information and medial campaigns and increases engagement across the population will be an additional cost. We will also trial an antenatal and early postnatal version of parenting support which will require funding to roll-out if effective. Funding is also required for intensive assessment of attachment and parenting skills for the most vulnerable families to allow early permanency planning as discussed in paragraph 4.7.4. This intensive assessment process may need to be residential with highly skilled staff. There is a growing evidence base on the content and effectiveness of such assessments.

4.5 Family Support: estimated additional resource assuming a degree of realignment £5 million

- 4.5.1 There are a number of elements of analysis and work in relation to family support services. In terms of making the best use of current resources, health and social care staff operating within level 1 and 2 services can be considered as three broad groupings: upper grade professionals (health visitors and social workers); intermediate grades such as staff nurses; and lower skill workers such as home-support staff. Extending work redesign across health and social care staff could result in three broad grades of staff across operating at levels 1 and 2. This approach could provide ways of enhancing social work capacity to address the very high levels of need found in Glasgow.
- 4.5.2 GCC is currently auditing the numbers, location and employment status (directly employed or contracted) of staff in support roles. These resources could be realigned to focus these staff. Staff could be moved to support vulnerable families, or cost-savings which may occur from this review could be reinvested within family-support.
- 4.5.3 The Health Visitor Review analysed the support workforce indicating that only one support worker was in place for every 206 vulnerable families. This ratio is too low

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given the level of need and it is proposed that the ratio should incrementally shift to one worker per 30 families – based on an assessment of both the work of David Olds from the US using nurses, and experience from the local implementation of Starting Well, which used staff analogous to band 3/4.

- 4.5.4 This approach would require additional band 3/4 employees embedded within children’s and families teams, operating in a co-ordinated manner. The estimated additional costs to meet this level of family support are shown in Table 1.

Table 1 Projections of additional costs required to increase staff levels over the next 3 years to provide a ration of 1 support worker for 30 vulnerable families. *81 band3/4 staff are already allocated in the Health Visitor Workforce document (2008). Their costs are not included in this estimate, which uses the midpoint of the band3/4 spine, with 20% on costs and no annual uplift.

Year	No of support staff	Annual additional cost	Ratio of staff to vulnerable families
2009/10	86 posts (81 existing*)	£1.9M	1 to 100
2010/11	253 (plus 81*)	£5.5M	1 to 50
2011/12	477 (plus 81*)	£10.4M	1 to 30

- 4.5.5 Notwithstanding the potential for reshaping existing staffing, significant new investment will be required to address the deficit in family support staff. These staff would represent a solution to HMIE’S direct criticism of risk management for vulnerable children and families below the threshold for formal child protection registration.

4.6 Early Intervention: estimated additional cost for a range of developments and a degree of realignment £5 million

- 4.6.1 All staff in health and social care must develop a focus on the early identification of, and support for vulnerability. While families without vulnerability factors can negotiate and access the array of services provided across the organisations, this is not the case for vulnerable families, who often exist at the margins, have low levels of support, and are often characterised by chaotic lifestyles. For vulnerable families, co-ordination, contact, ongoing evaluation of the impact of interventions, and support are critical. Whilst family support staff can provide general support and can attend to some of these needs, such as advocacy and co-ordination of services, more highly skilled staff will need to adapt and provide ongoing evaluation of the impact of their interventions.
- 4.6.2 Simply providing further support staff without a change in the culture of working will not achieve the full impact. The purpose of redesign is to facilitate cultural change. Therefore, additional expenditure must be tied to ongoing redesign of services. The culture of work within the children and families teams must change, and must be centred on the needs of vulnerable children and their families. This will require all staff, but particularly the family support staff to develop styles of working which foster relationships with vulnerable children and their families.
- 4.6.3 Glasgow City has developed nursery provision for vulnerable children. A pilot of additional places for vulnerable 2s has shaped the admission policy which will link admission to wider financial inclusion including the uptake of tax credits. There is ongoing work to expand nurseries so that they can accommodate the 0-5 age group.

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Work is also underway to further develop the links between nursery staff and vulnerable families.

- 4.6.4 Glasgow City Council has been developing an integrated workforce strategy with the aim of expanding the roles of existing employees to improve their ability to contribute to the early years agenda. Previous experience within education has utilised locally-led workforce development events which have a focus on integrated working practices. This approach could mainstream the early years focus within the wider workforce, and contribute to an improvement in integrated working within children's services.
- 4.6.5 Investment in regular, locally-led workforce development processes could culminate in staff agreement around a minimum basic training package for health and social care workers within children's services, and the development of joint induction and training packages for staff.
- 4.6.6 The development of new methods of working within children's services is a complex but necessary process which must be informed by research. It will be important to link workforce development to a limited research budget to underpin such work.
- 4.6.7 There is also scope for redesign within the specialised services provided by both health and social care. This activity needs to ensure that costly interventions such as residential units can be replaced by safe and effective alternatives, where that is appropriate.
- 4.6.8 It is particularly important that we can secure early and high quality permanency arrangements for abused and neglected children.
- 4.6.9 The evidence suggests that vulnerability can be identified either prenatally, or in the early postnatal period. Clearly this would be advantageous, as interventions and support could start almost immediately. Whilst midwives and health visitors provide a universal contact, and are the key group for identifying vulnerability factors, additional approaches including the provision of new mums groups in localities might represent a method of providing support more informally. It is recommended that approaches to enhance pathways for vulnerability should focus on vulnerable women from the antenatal period. Given the scale of vulnerability in Glasgow, the launch of the parenting framework and any plans to introduce family support services must take account of the need to raise awareness of vulnerability across all staff groups. All staff must develop a focus on the early identification of vulnerability, and recognise the additional practices which are needed to help this group. Given the value of early intervention, methods of identifying vulnerability, particularly in new first time mums should be developed in each CH(C)P.
- 4.6.10 Achieving the earlier intervention which is essential to address the issues outlined in this paper will also require additional qualified social work staff to ensure that there is capacity to retain a focus on early intervention alongside dealing with immediate crises and child protection issues.

4.7 Assessing Progress

- 4.7.1 Vulnerability is a complex issue, with some families having a number of different risk factors, and with vulnerable children and their families coming into regular episodic contact with almost all agencies. Serious case reviews regularly point out the number of missed opportunities to intervene in the lifecourse of a child. However, how these children's contacts with services compare with those of the general population is

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unknown. There is a need to build on partnerships in the children's analytic network to develop linked multiagency work addressing this area. Scotland's public services have excellent information systems, and the capacity to anonymise and link data across agencies to explore the relationships between the use of services and outcomes needs high-level interagency agreement. The Children's Analytic Network should be tasked with developing proposals to analyse the contacts of vulnerable children with health, social care and justice services in comparison with the contact rates of the non-vulnerable population. This work will require the linkage of data across services. In addition, a group should be convened to set a small number of indicators to guide progress on developing services addressing vulnerability.

5. CONCLUSIONS

- 5.1 Significant numbers of Glasgow's children are vulnerable, largely as a result of poverty and substance abuse. Early intervention will enable them to reach their full potential, and will break the intergenerational cycle of poverty.
- 5.2 In order to address the issues identified in this paper and highlighted by HMIE there needs to be an early commitment to start a major programme of investment, with funding building up over a number of years. We propose that to make an immediate and visible commitment to address these challenges, £5M of funding should be earmarked to underwrite the proposed developments during the next financial year and that this allocation should rise to £10M and then to £15M in subsequent years. In the longer term it is clear that the focus on early years will require a fundamental reprioritisation across the city to see all organisations refocusing their budgets on these services

**C M Renfrew
L de Caestecker
JJM O'Dowd**

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REFERENCES

HM Inspectorate of Education. 2009. Joint inspection of services to protect children and young people in the Glasgow City Council area. HMIE: Edinburgh.

Walsh D. 2008. GoWell Areas – deprivation based analyses (GoWell ecological monitoring group). Glasgow Centre for Population Health: Glasgow.

NHSGGC. 2008. Health Visitor Review Workforce Report. NHSGGC: Glasgow.

Reynolds L, Barton P. Influences on health from conception to adulthood. From Chief Medical Officer's Annual Report 2006. 2007. HMSO: Edinburgh.

Carneiro P and Heckman J. 2003. Human Capital Policy (occasional paper). IZA (Institute for the Study of Labor): Bonn.

Sanders RS, Markie-Dadds C and Turner KMT. 2003. Theoretical, Scientific and Clinical Foundations of the Triple P Positive Parenting Program: A Population Approach to the Promotion of Parenting Competence. Parenting Research and Practice Monograph 1. Parenting and Family Support Centre: Queensland.