Evaluation of the Introduction of Inter-agency Referral Documentation (Children in Need and in Need of Assessment Consent Form) in North East Lincolnshire

CRSP 469

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1 AIM

In November 2000, North East Lincolnshire Local Authority introduced 'Children in Need and in Need of Protection Assessment and Consent' (A&C) forms[1], a tool to be used by agencies when referring children to social services. The aim of the study was to evaluate the impact of the introduction of the A&C form on the pattern and quality of child care referrals made to social services by health, education and 'other' agencies (e.g. police and other statutory and voluntary agencies).

2 METHODOLOGY

2.1 Data Collection

The study is informed by quantitative research and consultative discussions with key professionals.

2.2 Quantitative Research

This approach involved the comparative analysis of information provided to social services from other agencies on referrals made across North East Lincolnshire prior to, and following, the introduction of the A&C form in November 2000. Information was gathered directly from 'anonymised' social services case records using a specially developed *pro forma* to ensure consistency. For cases referred prior to the introduction of the A&C form, information was drawn from the 'Referral and Initial Information Record' form and contact/diary sheets. For cases referred following the introduction of the A&C form, information was taken directly from the A&C form. As discussed below, even after its introduction, the A&C form was not always used. For these cases, information was taken

[1] A copy of the A&C form is in the annex.

from equivalent referral tools used by other agencies, or other available sources in case files[2]. The data gathered on the *pro forma* has been analysed using SPSS.

2.3 Consultation

Between seven and nine months after the implementation of the A&C form, the research team held a series of meetings to consult with key professionals on the impact of the new forms and procedures. A total of ten meetings took place, ranging from one-to-one interviews to large discussion groups, which included: RAS staff and management, school-based child protection coordinators, education welfare officers, a further education study support co-ordinator, health visitors, midwives, school nurses and paediatric nursing staff. Data from these meetings provide qualitative information on how the new procedures had been implemented and how they had impacted on practice.

3 BACKGROUND

3.1 Local Context

North East Lincolnshire lies on the north east coast of England by the Humber estuary. It has a population of over 150,000, including about 40,000 children and young people aged 0-18. Table 2.1 shows that North East Lincolnshire has a higher incidence of children in need than that found both nationally and regionally. At the time of the Department of Health's 2000 census, 37 per cent of children in need in the Authority were being looked after (see Table 2.2.). As such, North East Lincolnshire is among the 20 per cent of authorities (outside London) with the highest concentration of looked after children.

[2] Information was also taken from Initial Assessments. However, this data is not considered here, as the purpose is to evaluate inter-agency referrals using the A&C forms. Initial Assessments are completed as an outcome of referrals by social services.

Table 3.1 Total Children In Need Receiving A Service Per 1000 Of The 0-18 Population (February 2000)

England	19
Yorkshire and Humberside	19
North East Lincolnshire	21

Department of Health, Children in Need in England Census, http://www.doh.gov.uk/cin/cin2000latables.htm

Table 3.2 Numbers of Children Receiving Services In Children In Need Census Week (February 2000)

	Total children in need receiving services in week	**Children supported in their families or independently receiving services in week**		**Children looked after receiving services in week**	
	n.	n.	%	n.	%
England	229300	171400	75	57900	25
Yorkshire and Humberside	23211	16197	70	7014	30
North East Lincolnshire	846	536	63	310	37

Department of Health, Children in Need in England Census, http://www.doh.gov.uk/cin/cin2000latables.htm

3.2 Project History

The study was funded by the North East Lincolnshire Area Child Protection Committee. The original purpose of the project was to develop an inter-agency approach to the assessment of children in need, following the success of the Multi-Agency Project in a neighbouring authority (see Ward and Peel, 2002). However, during the initial stages of introducing an inter-agency approach, the local authority also introduced its own, in-house A&C form. All agencies were required to complete this form when referring a child to social services. It would not have been feasible to continue with the original plans for replicating the previous study while the same agencies would have also been required to begin using the A&C forms. At the very least, this would have resulted in agencies having to deal with two different sets

of forms and staff development programmes. For this reason, the aim of the project was revised to focus instead on evaluating the impact of the introduction of the A&C forms.

3.3 Assessment & Consent Forms

In 2000, the Department of Health (DoH) launched the 'Framework for the Assessment of Children in Need and their Families'[3]. The Framework aims to develop partnerships between statutory and non-statutory agencies to promote the welfare of children. Moreover, by aiming to 'provide a new emphasis on looking more widely at the needs of all children and families in the community' (DoH, 2000, p. x), the Framework encourages services to alter their focus so that child protection work is firmly placed within the context of the identification of and provision of services for all children in need.

In terms of the Children Act 1989, a child is taken to be in need if '(a) he[/she] is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority under this Part; (b) his[/her] health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or (c) he[/she] is disabled' (Children Act 1989, Section 17, paragraph 10).

A&C forms were introduced in North East Lincolnshire in November 2001. They were developed within the local authority, and based on the Framework's 'Referral and Initial Information Record'[4]. Reflecting the aims of the Framework, a goal of implementing the A&C forms in North East Lincolnshire was that they would represent a new approach to inter-agency referrals, in which health, education, voluntary and other statutory agencies would provide more extensive, written information when referring children to the social services' Referral and Assessment Service (RAS).

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[3] Department of Health, 2000, *Framework for the Assessment of Children in Need and their Families.* London: Stationery Office.

[4] See Department of Health, 2000, *Framework for the Assessment of Children in Need and their Families. Guidance Notes and Glossary for: Referral and Initial Information Record, Initial Assessment Record and Core Assessment Record*, London: Stationery Office. A copy of the DoH 'Referral and Initial Information Record' is available at http://www.doh.gov.uk/pdfs/qprefinit.pdf.

In general, prior to the introduction of the A&C forms, when staff in health, education or 'other' agencies had concerns about a child, they would have contacted a RAS duty officer. The duty officer would have recorded the information given by the staff member on a referral form[5]. The social work manager would have made a decision, based on the information on this form, as to whether further action was to be taken.

Following the introduction of the A&C forms, when staff in health, education or 'other' agencies have concerns about a child they are required to complete the A&C form themselves. The completed A&C form is then be passed to the RAS, where the social work manager decides whether further action is needed. This procedure is not followed where there is immediate concern that a child is experiencing or is at risk of significant harm. In these cases, the referral is 'fast tracked', a separate 'S47' assessment procedure (shared by police and social services) is used, and the A&C referral form is by-passed.

The purpose of introducing the A&C form was to standardise the procedure used by a range of agencies in referring cases to social services in North East Lincolnshire. An anticipated benefit of using the A&C form was that it would provide the RAS with standardised information on selected variables, and more extensive and higher quality data. It was hoped that the improved quality and quantity of information would help with decisions about the action to be taken. For example, it was expected that more detailed information would assist the RAS in differentiating between 'enquiries' requiring advice and information only, and 'referrals', cases in which the local authority had a duty under Section 17 of the Children Act 1989 to take action. It follows that better information would help not only in identifying children in need but also in beginning to identify their specific needs and the type of action required to safeguard and promote their welfare.

Whilst it has always been good practice to seek the consent of parents before a referral is made to social services, the implementation of the Data Protection Act and Human Rights Act requires explicit evidence that consent has been sought, except in exceptional cases. Thus another purpose of the A&C form was to ensure that agencies were aware of this requirement, and to provide a means by which this could be evidenced.

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[5] The referral form used before the DoH Framework was also called a 'Referral and Initial Information Record'; the Framework-version of the referral form kept the same title.

3.4 Referrals In North East Lincolnshire

3.4.1 Number of referrals

The total number of referrals made in North East Lincolnshire in the ten months prior to the introduction of the A&C forms (January to October 2000) was 2538. The total number of referrals made during the ten months following the introduction of the new forms (December 2000 to September 2001) was 1497. However, this 41 per cent fall in the number of referrals between the two periods cannot be attributed solely to the A&C forms, although they may have had some influence. During the same period in which the new forms were introduced, a number of other initiatives begun and these would also have had an impact on inter-agency referrals:

- The RAS introduced a new duty system with dedicated staff, which improved skills at handling referrals, increased consistency in response and prioritisation of cases, and reduced duplication.
- There were changes in recording practices, and a clearer distinction was made between enquiries and referrals. As a result, fewer initial contacts were defined as referrals on the local authority's management information system.
- Around 50 per cent of referrals were made using the telephone[6]. However, the RAS had only one incoming telephone line and it was suggested in consultative meetings that some callers might give up trying to refer a case when the line is engaged continuously.
- There were changes to inter-agency protocols. For example, previously all police and Youth Offending Team '125 forms' – which record incidents of domestic violence, youth offending, or any incident where there was a general concern about a child – would have been logged automatically as enquiries or referrals. Such forms are now screened and only referred to the RAS when appropriate.
- Changes to the number and range of alternative second level preventive services in the area, such as Sure Start, Connexions, the Children's Information Service and the Youth Offending Team. It is likely that these addressed some of the needs of and concerns about children directly, making a referral to the RAS unnecessary.

[6] According to the data collected for this research 51 per cent of referrals made prior to the introduction of the A&C form and 46 per cent of those made after its introduction were made using telephone or telephone and fax or letter. The difficulty in contacting the RAS because of the single telephone line was also highlighted in the consultative discussions with other agencies.

3.4.2 Source of referrals

In both 2000 and 2001, the majority of referrals originated from five sources (see Table 3.3). In order from the most to least common referral sources these included: non-agency sources (relatives, neighbours or anonymous individuals), social services, 'other' (police and other statutory and voluntary agencies), education and health. As the table shows, between 2000 and 2001 there had been little change in the sources of referrals.

Table 3.3 Local Authority Referrals: Referral Sources And Decrease In Number Of Referrals Between Jan-Oct 2000 And Dec-Sep 2001

Referral source	Referrals made in Jan-Oct 2000	Dec-Sep 2001	Per cent of decrease between Jan-Oct 2000 and Dec-Sep 2001
Non-agency referrals, i.e. concerned relatives or neighbours, or anonymous	845 (33%)	435 (29%)	49%
Social Services	445 (18%)	329 (22%)	26%
'Other', i.e. police and other statutory and voluntary agencies	467 (18%)	226 (15%)	52%
Education	433 (17%)	227 (15%)	48%
Health	191 (8%)	162 (11%)	15%
All other referral sources	157 (6%)	118 (8%)	25%
Total	2538 (100%)	1497 (100%)	41%

Compared with the 41 per cent decrease in the total number of referrals between January-October 2000 and December-September 2001, there was a 49 per cent fall in the number of non-agency referrals. As members of the public do not use A&C forms, this decrease is not associated with the introduction of the new forms but might have resulted from the other new initiatives discussed above. The number of education referrals fell by 48 per cent and 'other' referrals were down by 52 per cent. Police referrals, which do not involve the A&C forms, decreased by 47 per cent.

In contrast, however, the introduction of the A&C form and other new initiatives does not appear to have had the same impact on either social services or health referrals. That is, the

number of referrals by social services fell by only 26 per cent. More striking, the number of health referrals remained relatively constant with only a 15 per cent decrease.

3.4.3 Outcome of referrals

Table 3.4 ranks referral outcomes and shows that in both 2000 and 2001, the vast majority of referrals resulted in routine action taken by social workers (e.g. Initial Assessments). This action would have been focused on children in need.

The next most common outcome was S47 enquiries: priority action focused on child protection, relating to Section 47 of the Children Act 1989 which establishes local authorities' duty to investigate where a child is or is at risk of experiencing significant harm. In 2001, there was a slight increase in the number of referrals resulting in both S47 enquiries and child protection register procedures, as well as in the number of referrals resulting in no further action. The main difference in outcomes between 2000 and 2001 is the decreased number of referrals in which no outcome was recorded. This could suggest that the RAS were making decisions more consistently than before and so referrals were more likely to have definite outcomes.

Table 3.4 Local Authority Referrals: Referral Outcomes Ranked

Referral outcome	Referrals made in Jan-Oct 2000	Referrals made in Dec-Sep 2001
Action by social worker	2259 (89%)	1314 (88%)
S47 enquiry	154 (6%)	149 (10%)
No outcome selected	80 (3%)	6 (0.4%)
No further action	14 (0.6%)	14 (0.9%)
Child Protection Register registration	13 (0.5%)	15 (1%)
All other outcomes	18 (0.7%)	1 (-%)
Total	2538 (100%)	1499 (100%)

Given the potential of the A&C form for assisting the RAS in assessing levels of concern, it is further possible that a number of the 2001 cases which resulted in no further action were those which had been filtered out as enquiries, rather than treated as referrals.

3.4.4 Age of children and young people referred

The introduction of the A&C form and other new initiatives does not appear to have had an affect on the pattern of the ages of the children and young people referred to social services. For example, Table 2.5 shows that a constant 34 per cent of referrals were for children and young people aged 10-15 years, and about eight per cent were aged under one year old.

Table 3.5 Local Authority Referrals: Referrals By Age

	Jan-Oct 2000	Dec-Sep 2001
Unborn child/no d.o.b.	4%	1%
Under 1	7%	9%
1-4	15%	17%
5-9	29%	28%
10-15	34%	34%
16-18	10%	8%
18 and over	1%	1%
Total	100% (n. 2538)	100% (n. 1498)

4 THE SAMPLE

4.1 Three Sample Groups

The original aim of the study had been to examine 120 referrals made between January and March 2000, prior to the introduction of the A&C form, and compare these with a similar number of referrals made between January and March 2001, after the introduction of the new form. The samples were to include comparable numbers of children from different age-groups, and from each of three sources: health, education and 'other agencies in the authority' (e.g. police, housing, voluntary bodies). Within these parameters, referrals were to be selected randomly, although care was taken not to include more than one child per 'incident' referred.

However, various practical difficulties were experienced when attempting to obtain the required numbers of referrals which met the selection criteria. As a result, the time-frames for gathering referrals were extended. Moreover, the target numbers for referrals were revised to about 100 each of referrals made before ('pre-refs') and after ('post-refs') the introduction of the A&C form. The 'post-refs' were further divided into two samples: referrals made using the A&C form, and those in which it was not used.

The quantitative research thus involved three sample groups.

- **'Pre-Refs':** 92 cases referred prior to the introduction of the A&C forms in November 2000. 78 cases had been referred between January and March 2000. To make up numbers, one case referred prior to 2000, and 12 cases referred between April and October 2000 were included. The referral date for one case is missing. The PreRef sample consists of 14 (15 per cent) health referrals, 39 (42 per cent) education referrals, and 41 (42 per cent) 'other' referrals.

- **'PostWithA&C':** 57 cases referred after the introduction of the A&C forms in which the A&C form was used. All 57 cases were referred between January and August 2001. The PostWithA&C sample consists of 15 (26 per cent) health referrals, 37 (65 per cent) education referrals, and five (nine per cent) 'other' referrals.

- **'PostNoA&C':** 42 cases referred after the introduction of the A&C forms but in which the A&C form was not used. As with the PostWithA&C cases, all 42 PostNoA&C cases were referred between January and August 2001. The PostNoA&C sample consists of seven (17 per cent) health referrals, nine (21 per cent) education referrals, and 25 (60 per cent) 'other' referrals.

Groups 2 and 3 can sometimes be treated as one 'post-ref' group.

4.2 Case Histories

The data provides information on the general background of the cases in terms of social services involvement and registration. Table 4.1 shows that the backgrounds of the cases in the PreRef and PostRef sample groups are relatively similar.

Table 4.1 Case Histories Compared (number of cases)

	PreRefs	PostRefs
Total number of cases	92	99
Cases which are repeat referrals	44	37
Ever on CP Register	9	15
Child/children in family have been looked after	5	6
Child/children on Disability Register	1	5
Child/ children in family are currently looked after	1	2

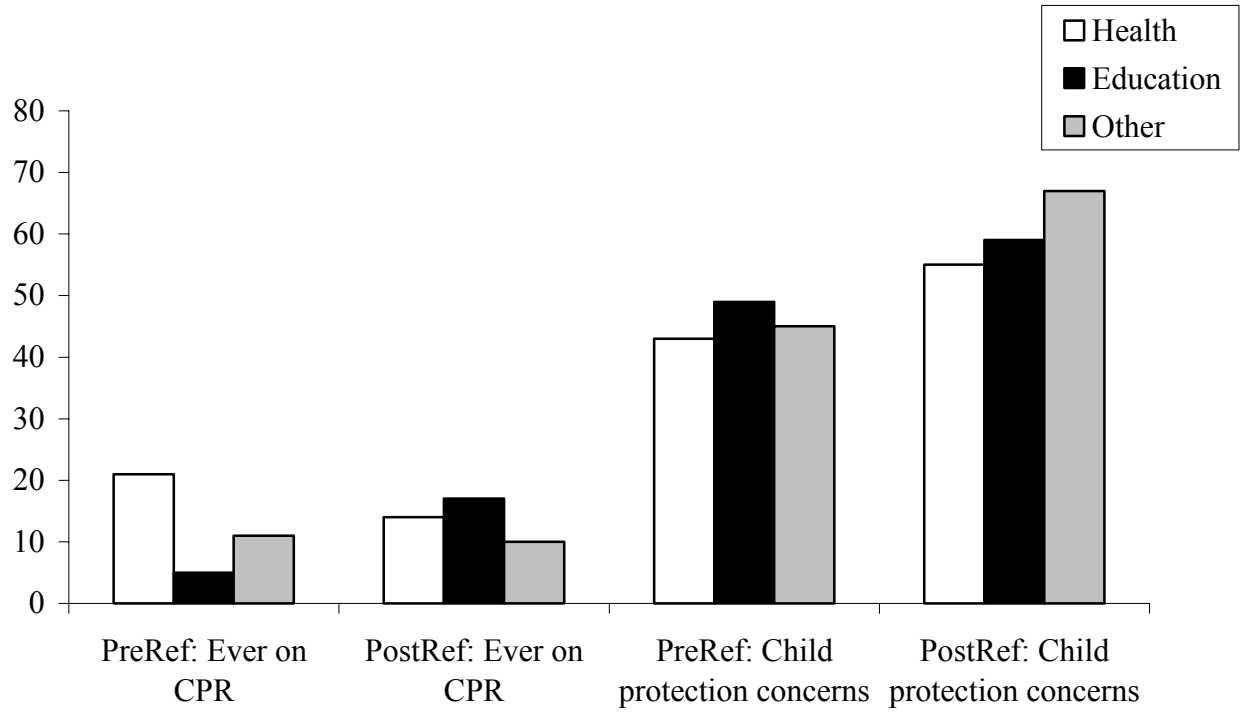
Table 4.2 shows that PostRef cases generally - and PostWithA&C referrals especially – were more likely than other referrals to have resulted in Initial Assessments. These would have focused on all children in need. They were less likely to have resulted exclusively in information and advice. The provision of information and advice is associated more with enquiries, rather than referrals, so this suggests that more enquires had been 'weeded out' of the PostRef cases, especially the PostWithA&C cases.

Table 4.2 Outcome Of Cases: Initial Assessments, And Provision Of Information And Advice

	PreRefs	PostWithA&C	PostNoA&C
Initial Assessments	n. 17 (19%)	n. 42 (72%)	n. 27 (64%)
Provision of information and advice	n. 29 (32%)	n. 2 (4%)	n. 3 (7%)

Figure 4.1 shows the proportion of health, education and 'other' referrals in the PreRef and PostRef samples in which the child at some time had been on a child protection register, and which were made due to current child protection concerns. The table shows that a higher percentage of PostRef than PreRef cases were referred due to child protection concerns; this is discussed below. Figure 4.1 also shows that – insofar as it suggests the nature of referrals made by health, education and 'other' referrals - child protection cases are not concentrated in any one referral source. For instance, in the PreRef sample, health referrals included a higher proportion of cases in which the child previously had been on the child protection register, and there were more child protection concerns among education referrals. In the PostRef sample, education referrals included a higher proportion of cases in which the child had been on the child protection register, and there were more child protection concerns among 'other' referrals.

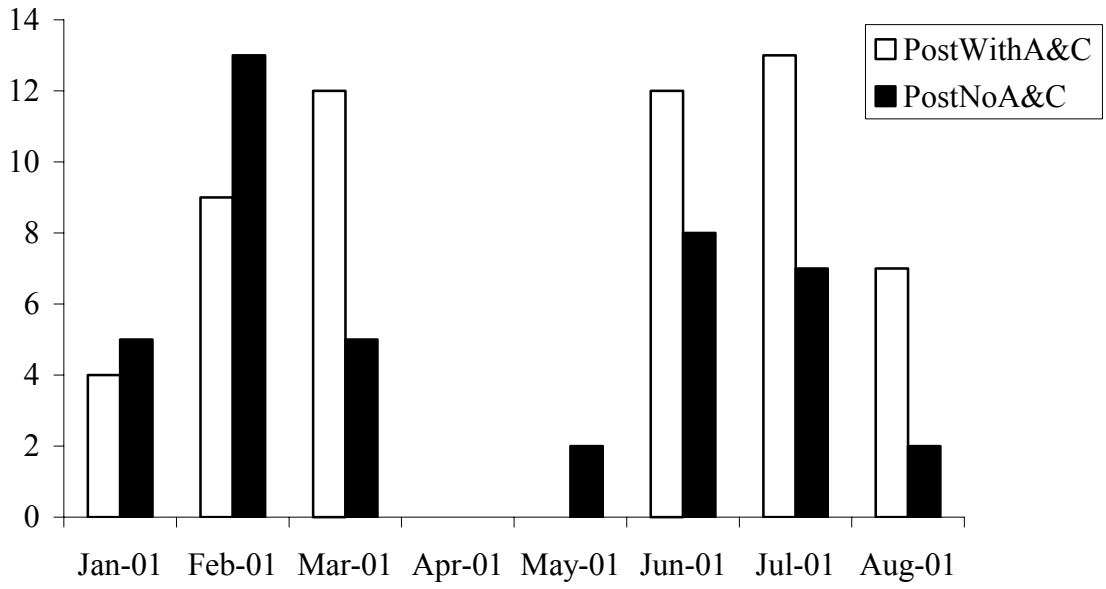
Figure 4.1 Case Histories: Cases in Which Child Had Been On The Child Protection Register, And Cases Which Were Referred Because Of Child Protection Concerns



4.3 Month of Referral: PostRef Cases

Figure 4.2 shows that referrals in the PostWithA&C and PostNoA&C samples occurred in two waves: in total, 48 cases were referred in January to March, and 49 in June to July. On the one hand, cases that did not use the A&C form were more concentrated in the earlier wave, while cases that did use it were concentrated in the later wave. This could reflect the fact, as explained by RAS staff in a consultative discussion, that there was a phased roll-out of the A&C form and it was not available to all agencies from the outset. On the other hand, in a substantial number of cases – i.e. 19 PostNoA&C cases – the A&C form was still not being used six months after its introduction.

Figure 4.2 Month of Referral: PostWithC&A and PostNoC&A



4.4 PostNoA&C: Reasons Why The A&C Form Was Not Used

Table 4.5 shows the reasons why the A&C forms were not used. It is to be remembered that all of the PostNoA&C cases had been referred by agencies (e.g. rather than by families) and so all potentially could have been made using the A&C form.

Where the A&C form had not been used, it was mainly due to the nature of the concerns about the children. Of the 42 cases referred without using the form, 13 had required immediate S47 enquiries. In seven other cases, the requirement for consent was waived. That is, it was claimed that levels of concern in these cases, while not sufficient to warrant S47 enquiries, nevertheless called for immediate attention and outweighed the requirement for the A&C form to be completed.

In some cases, certain agencies used their own referral procedures instead of the A&C forms. For example, three cases were referred using the police's SN17 form, and four were referred using NSPCC procedures. (As consultative discussions were not held with the police or NSPCC there is no data on these agencies' own referral procedures). In three cases, social

services departments in other local authorities had received referrals about children who had subsequently moved into the North East Lincolnshire catchments area. As the A&C form were developed within North East Lincolnshire, they would not have been used in cases referred in other authorities.

In two cases, agencies had referred children to social services without using the A&C form where it was alleged that parents/carers had not consented to its use or refused to participate in its completion. In 10 cases there was no apparent reason why the A&C form had not been used.

Table 4.5 PostNoA&C: Reasons Why A&C Form Was Not Used (number of cases)

Direct to S47	13
Consent waived	7
NSPCC	4
Referred via SN17	3
Referral made outside NE Lincolnshire	3
Consent refused	2
No obvious reason	10
Total	42

5 THREE SAMPLE GROUPS COMPARED WITH LA STATISTICS FOR ALL REFERRALS

5.1 Number Of Referrals

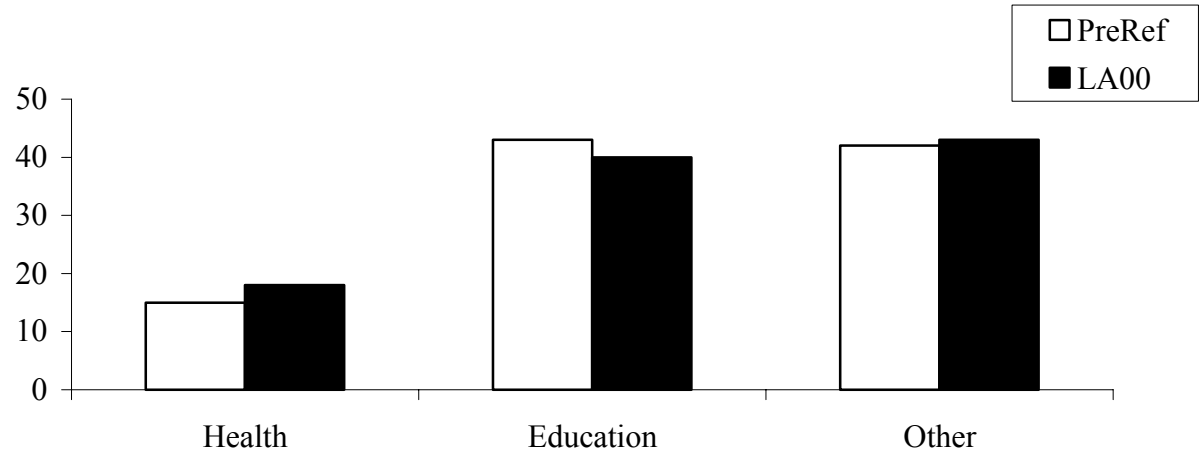
Overall, the three sample groups represent similar proportions of the total referrals made within the authority. The PreRef sample represents 3.5 per cent of the total number of referrals made between January and October 2000. The PostWithA&C sample represents 4.6 per cent of the total number of referrals made between January and August 2001. The PostNoA&C sample represents 3.4 per cent of the total number of referrals made between January and August 2001.

5.2 Source Of Referrals

The study focuses on referrals made by three types of agencies: health, education and 'other'. Overall, the most common health referrals in the sample were those made by health visitors, most education referrals were made by schools, and the number of police referrals dominated among those made by 'other' agencies.

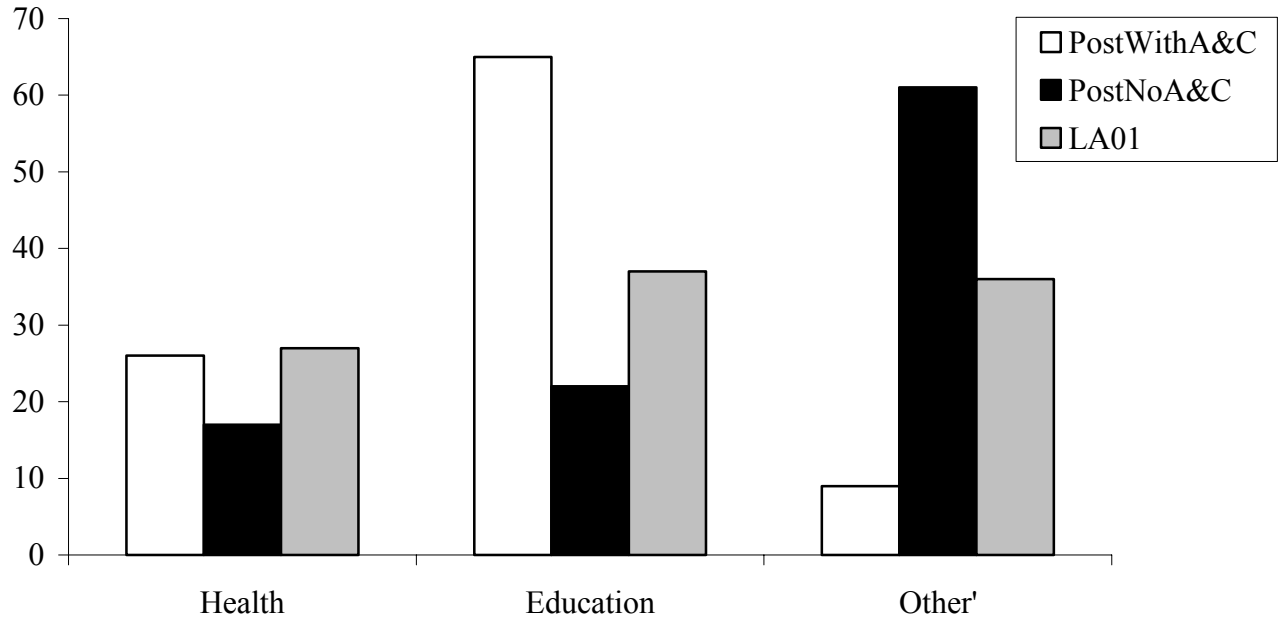
Figure 5.1 shows that the balance of referral sources in the PreRef sample is representative of the balance of the total health, education and 'other' referrals made in North East Lincolnshire between January-October 2000. The main referral sources of PreRef cases were the 39 education and 38 'other' referrals. The PreRef sample included 14 health referrals.

Figure 5.1 Percentages Of Health, Education And 'Other' Referral Sources: Preref Sample Compared With All Health, Education And 'Other' Referrals Made In The Authority In January-October 2000



In contrast, Figure 5.2 shows that, compared with the balance of all referrals made in North East Lincolnshire, the PostWithA&C sample is strongly over represented by education referrals and under represented by 'other' referrals. It also shows that the PostNoA&C sample is strongly over represented by 'other' referrals and under represented by health and education referrals. This could well reflect the fact that while education and health workers used the A&C form, it was not used by the police, the most common source of 'other' referrals.

Figure 5.2 Percentages Of Health, Education And 'Other' Referrals: PostWithA&C, PostNoA&C And All Health, Education And 'Other' Referrals Made In The Authority In January-August 2001



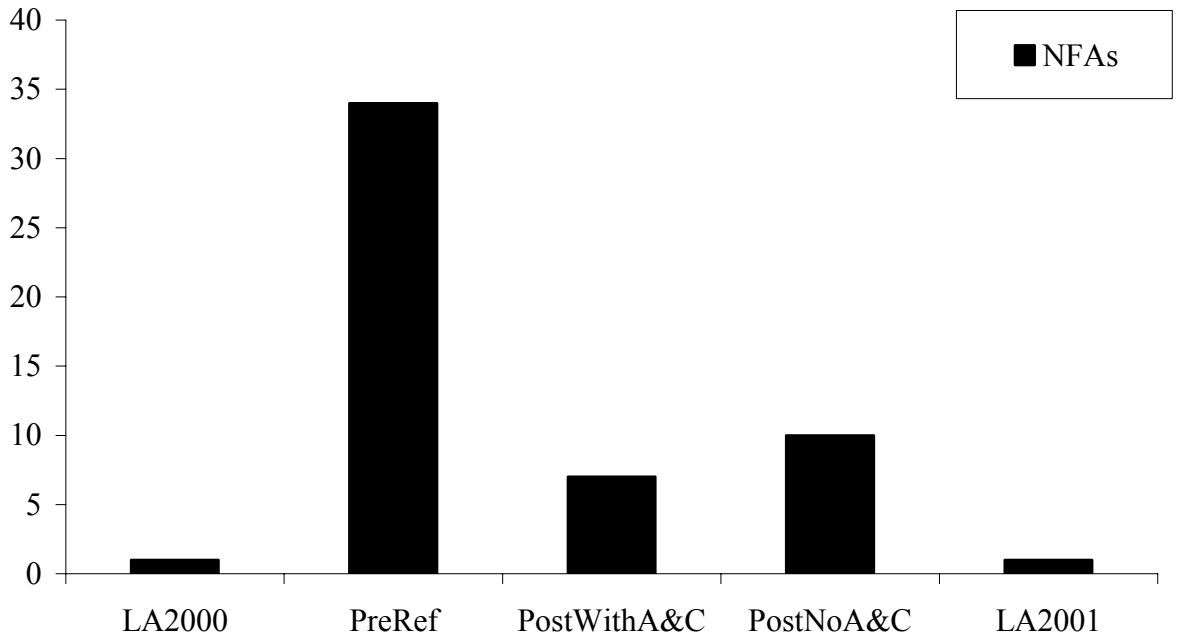
5.3 Outcome of Referrals

The main outcomes of PreRef referrals were no further action (34 per cent of outcomes), and provision of information and advice (32 per cent of outcomes).

Referrals are distinct from enquiries in that they (referrals) require action to be taken. Thus, if a referral results in no further action, it is possible that it has been made inappropriately. Given the potential of the A&C form for enhancing the RAS's ability to assess levels of concern, it might be expected that its introduction would cause a decrease in the number of referrals resulting in no further action. It was reported above (Section 3.4.3) that no change was apparent, with no further action outcomes accounting for about one per cent of the total referrals made in North East Lincolnshire in Jan-Oct 2000 and one per cent of those made in Jan-Aug 2001. However, it was further suggested that a number of the 2001 cases which resulted in no further action could well have been those in which the A&C form had been used to distinguish them from referrals and filter them out as enquiries.

Figure 5.3 shows that, in comparison with the total number of referrals made in the authority, both the PreRef and PostRef samples are over-represented by referrals which resulted in no further action. However, the table also shows that PostRef cases generally, and PostWithA&C cases especially were notable less likely than PreRef cases to result in no further action. While findings on this point are inconclusive, it remains likely that the A&C form assists in 'weeding out' inappropriate referrals, such as those which would result in no further action.

Figure 5.3 Percentages Of Cases Resulting In No Further Action



No statistics are available on the total number of referrals in the local authority which resulted in the provision of information and advice. It has been noted previously (Section 4.2) that the provision of information and advice is associated more with enquiries than referrals, and accounted for outcomes in 29 of the 92 PreRef cases but only five of the 99 PostRef cases.

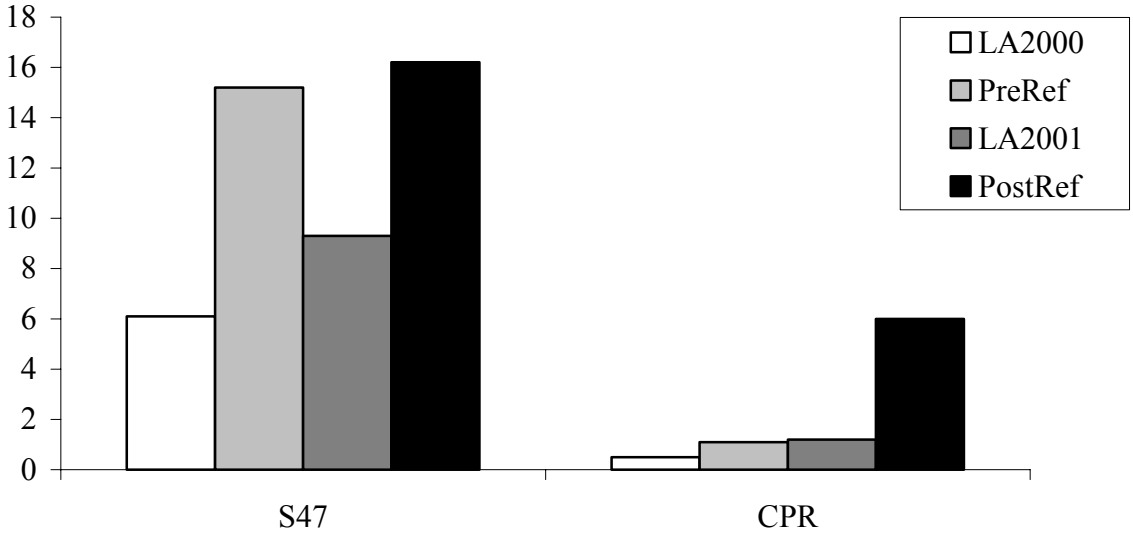
Given that the introduction of the A&C form reflects a re-focusing of services on children in need (as promoted in the DoH Framework[7]), it might be expected that its introduction would be accompanied by an increase in the number of cases resulting in Initial Assessments, as these are key to casework with children in need.

Again, there is little change in the total number of referrals in the local authority which resulted in Initial Assessments, but there is a marked change across the sample. By far the most common outcome of the total referrals made in North East Lincolnshire was routine action by social workers in both Jan-Oct 2000 (89 per cent of all outcomes) and Jan-Aug 2001 (88 per cent of all outcomes). Much of this action would have taken the form of Initial Assessments of children in need. While only 19 per cent of PreRef cases resulted in Initial Assessments, they were the main outcome for both the PostWithA&C sample (72 per cent of outcomes) and PostNoA&C sample (64 per cent of outcomes).

Figure 5.4 shows the proportions of cases resulting in S47 enquiries and those in which the child was placed on the child protection register (CPR). As this shows, compared with statistics for all referrals made in the authority, both the PreRef and PostRef samples are over-represented by referrals resulting in CPR and S47 investigations.

[7] Department of Health, 2000, *Framework for the Assessment of Children in Need and their Families.* London: Stationery Office.

Figure 5.4 Percentages Of Referrals In S47 Investigations And Child Protection Register (CPR) Procedures



5.4 Age Of Children And Young People Referred

As Table 5.1 shows, there is some variation in the distribution of ages between LA figures and sample groups. The three sample groups are similar, and representative of the LA figures, with most referrals made with respect to the 10-15 age group, then to the 5–9 and 1-4 age group, and then to the under one age group.

Table 5.1 Local Authority Referrals And Three Sample Groups Compared: Age Of Referred Children Ranked

Age Bands	LA referrals Jan-Oct 2000	PreRef	LA referrals Jan-Aug 2001	PostWithA&C	PostNoA&C
10-15	1 (34%)	1 (45%)	1 (35%)	1 (52%)	1 (33%)
5-9	2 (29%)	2 (28%)	2 (28%)	2 (29%)	3 (25%)
1-4	3 (15%)	3 (21%)	3 (17%)	3 (13%)	2 (28%)
Under 1	5 (7%)*	4 (5%)	4 (%9)	4 (7%)	4 (15%)

*The 4th most common age band in LA referrals for January-October 2000 was the 16-18 (eight per cent)

6 FINDINGS

6.1 The Possible Effect Of The A&C Forms In Lowering The Number Of Referrals

As mentioned above, the introduction of the A&C forms coincided with a number of other initiatives, making it difficult to disentangle the reasons for the 41 per cent decrease in the number of referrals between January-October 2000 and December-September 2001. However, a number of ways in which the A&C forms possibly could have contributed to this decrease were highlighted during consultation with key staff.

The manager and staff of the RAS agreed that the new duty system (see 2.4.1) had more of an impact on their work load than the introduction of the A&C forms. Nevertheless, they found that the new forms helped to 'weed out' enquiries from referrals, i.e. cases which could be dealt with immediately, or redirected to other agencies, from those requiring a more involved response. In consultative discussions with school nurses, the point was made that social services used to accept more referrals before the introduction of the A&C forms, implying that the RAS had become more discriminating about what was accepted as a referral and what was accepted as an enquiry.

The RAS manager also believed that the A&C form contributed to the decrease in number of referrals because – faced with having to complete a form, instead of only making a referral by telephone - referring agencies were forced to 'think twice' and consider more carefully the most appropriate form of action. This view was reflected in other consultative discussions. For example, one health professionals remarked that the 'form really made me think about whether or not I needed to make a referral'. Another health professional suggested that the new form had a positive impact on her professional practice, explaining that it helped her to reach a decision herself – and to make an informed decision - about whether to refer a case to social services or whether it was more appropriate to refer elsewhere. A few professionals felt cynical about the purpose of the new forms, and perceived that they were intended to reduce referrals and to gate-keep services.

A few staff also mentioned that the length and complexity of the A&C form could discourage professionals from making referrals. One education professional described how, in one case,

the process of making a referral using the A&C form had taken up a large part of three days, plus several telephone calls, and that 'very busy people might let it slip'.

Moreover, some education professionals mentioned that they advised parents to refer themselves to social services, to avoid using the A&C form and to ensure that they would be in control of their information themselves rather than having it passed on 'second hand'. Although this does not appear to be a widespread practice, the fact that the new, standardised procedures generate a perverse incentive to redirect work raises concern.

6.2 Training And The Introduction Of The A&C Form

Training for referring agencies on the use of the new A&C form took place over a period of two weeks in the autumn of 2000. Half day sessions were organised to introduce agencies to the DoH's 'Framework for the Assessment of Children in Need and their Families'[8], along with Data Protection and Human Rights Act training. A slot at the end of the session was used to discuss the A&C form and the new process for referring families to the RAS.

In the consultative discussions, several professionals from referring agencies explained that they had received no training. For example, some of the child protection co-ordinators claimed that their schools had not received any information about training. Others complained that training had been inadequate. One health worker described that following a training meeting she was then expected to pass the information on to another 70 colleagues within the health trust:

> *'I don't think they appreciate how difficult it is to communicate with 70 staff working on different sites on rota shifts. We were expected to cascade the information down through the organisation. Because of that we didn't use the forms properly for a long time. … Because of the way it came across in training – or rather lack of it – with no real input from social services, health staff felt that they were being put upon.'*

We were told that training on the A&C form for midwives consisted of one overhead:

> *'we didn't come away from the session feeling very clear about what we were supposed to do.'*

[8] Department of Health, 2000, *Framework for the Assessment of Children in Need and their Families.* London: Stationery Office.

Some staff felt that they needed further training and clarification. The child protection coordinators, for example, wanted more training about seeking consent, the balance between fact and professional opinion, the distinction between children in need and child protection concerns, and how to deal with accumulating routine concerns (e.g. at what point should a referral be made).

Consultative discussion with referring agencies also revealed that some staff were unhappy with the timing and way in which the A&C form had been introduced. The paediatric nurses noted that they had to deal with introduction of the A&C forms at the same time as other new initiatives.

> *'There was so much going on at the same time, it was very confusing. For example, the new Sure Start programme [and] the family assessment form[9] that was piloted but then didn't take off. We were also working on the new multi-agency pathways of care for children so it was a difficult time generally.'*

For some agencies, confusion caused by a lack of information about the new form had been compounded by confusion about the start date for using it.

Some felt that the A&C form had been imposed in a heavy-handed manner by social services, without adequate inter-agency consultation. The educational welfare officers related that they had been given a copy of a 'draft' A&C form at the end of their training session. They had suggested certain revisions, but the form was issued before their opinions could have been considered and their views had not be taken on board.

6.3 Reason For Intervention

Given that a quarter of the PreRef cases had required immediate S47 enquiries, while none of the PostWithA&C cases had done so, it might be expected that the former would be more likely to have been initiated because of child protection concerns. However, as Table 6.1 shows, the PostWithA&C sample has a higher incidence of cases in which there were child protection concerns at the outset than the PreRef sample.

[9] This refers to the original assessment tool which was commissioned from Loughborough University by the Area Child Protection Committee and put on hold following the implementation of the Authority's own A&C form.

Table 6.1 Cases Referred Due To Child Protection Concerns

PreRef	PostWithA&C	PostNoA&C
43 (47%)	31 (54%)	29 (69%)

Table 6.2 further shows that the PreRef and PostWithA&C samples share a similar proportion of cases in which the grounds given for intervention were abuse and neglect.

Table 6.2 'Primary Need Codes': Main Reasons For Intervention

	PreRef	PostWithA&C	PostNoA&C
Abuse or neglect	51 (55%)	31 (54%)	35 (83%)
Family in acute distress	11 (12%)	5 (9%)	-
Family dysfunction	9 (10%)	9 (16%)	-
Socially unacceptable behaviour	7 (8%)	5 (9%)	2 (5%)
Other family problem	6 (7%)	-	-
Parental illness/disability	-	5 (9%)	-
All other primary need codes	8 (9%)	2 (4%)	5 (12%)
	n.92 (100%)	n.57 (100%)	n.42 (100%)

It is possible that this could reflect the various new initiatives in North East Lincolnshire which meant that contacts were classified more distinctly as either referrals or enquiries. That is, the PreRef sample could include cases which - following the changes - would have not been recorded as referrals but as enquiries. In contrast, the PostWithA&C sample, dated after the introduction of the new initiatives, includes only referrals and no enquiries: the relative proportion of child protection concerns/abuse and neglect needs is higher because of the absence of enquiry-type cases.

It is also possible that the new A&C forms assisted the RAS in distinguishing enquiries from referrals. Certainly, in consultative discussions with school nurses, it was suggested that the RAS had become more discriminating about what was accepted as a referral and what was accepted as an enquiry since the introduction of the A&C forms. Nevertheless, the data does

not include cases in which completed A&C forms were re-classified by the RAS as enquiries rather than referrals. As the data deals only with those A&C forms which were accepted as referrals, the research is unable to comment further on the role of the new forms in assisting the classification of and differentiation between enquiries and referrals.

In all three samples, a similar proportion of health, education and 'other' referrals have child protection concerns. There are no marked differences between the proportions of health, education and 'other' referrals in which there were concerns about abuse and neglect.

Regarding the PostNoA&C sample, Table 6.2 highlights that - compared with the other samples – only a narrow selection of primary needs codes (predominantly abuse or neglect, and socially unacceptable behaviour) describes the reasons for the referral.

Tables 6.1 and 6.2 also show that the PostNoA&C sample has the highest percentage of cases which were referred because of child protection concerns, and on the basis of concerns about abuse or neglect. In part, this is explained by the fact that the PostNoA&C sample includes cases which required direct S47 enquiries, i.e. cases which would be likely to concern child protection, neglect and abuse. However, as Table 6.3 shows, the majority of the non-S47 referred cases in the PostNoA&C sample were also referred because of child protection concerns and concerns about abuse or neglect.

Table 6.3 Reasons For Intervention: PostNoA&C Sample

	Direct to S47	Consent waived	NSPCC	Other reason	No reason
Total number of PostNoA&C cases	13	7	4	8	10
Number of PostNoA&C cases referred due to child protection concerns	11	4	4	4	6
Number of PostNoA&C cases referred due to concerns of abuse or neglect	12	6	4	6	7

This might suggest that cases in which the A&C was not used were those in which there were higher levels of immediate concern (thus necessitating a 'fast-track' response which by-passes the A&C procedure). However, it is perhaps more likely that referrals made without using the A&C form could not benefit from its comprehensive scope and thus failed to take the holistic approach necessary for the assessment of children in need. While the primary reason given for a referral might be abuse or neglect, in some cases this might not be the most accurate description, and more sensitive definitions of need could have been obscured due to the lack of a holistic perspective. This finding therefore can be interpreted as indicating that, as intended, the introduction of the A&C form encouraged a more holistic approach to the assessment of needs.

6.4 Child Protection Referrals And S47 Enquiries

The consultative discussions found that referring agencies generally were aware that when they had concerns of a child protection nature they should inform social services immediately, rather than use the A&C form and procedure. The RAS manager outlined that the requirement for parental consent (for a referral to be made to social services) was over-ridden in certain situations, such as where access could not be obtained, there were significant concerns over substance misuse, previous experience of the specific case warranted it, or there were child protection concerns. However, some professionals were uncertain about what constituted child protection concerns or 'significant harm'. For example, in consultative discussion school nurses felt written guidance was needed to clarify the criteria for making a referral to social services. In a similar vein, it was suggested in discussion with school-based child protection co-ordinators that training for the A&C forms was not clear enough about the distinction between children in need referrals and child protection referrals. This was implied further in discussion with RAS staff, where the comment was made: 'we still get a few people not seeking consent on the grounds of child protection when clearly there is not enough information to warrant a S47'.

Both the RAS and paediatric nurses mentioned the guidance in the original inter-agency materials on identifying levels of concern, indicating that they had found this very helpful and that it should be included in the A&C form.

Cases in which there are child protection concerns require S47 enquiries. In terms of all referrals made in North East Lincolnshire, the proportion of cases resulting in S47 enquiries remained stable across 2000-2001 and had not been affected by the introduction of the A&C forms. Compared with all referrals made in North East Lincolnshire, all three sample groups were over-represented by cases which resulted in S47 enquiries.

Of the PreRef sample, 21 of the 92 cases immediately required S47 enquiries on referral. The two most common referral sources for these 21 PreRef cases were schools (6 cases) and police (five cases). The reason for 13 of the 42 PostNoA&C cases not using A&C forms was that they required immediate S47 enquiries. Over half of these 13 cases had been referred by police.

It might be expected that cases which required immediate S47 enquiries would result in different outcomes to less urgently referred cases. However, the findings reveal no sharp difference between S47 cases and other referrals, and suggest that S47 cases were not necessarily more likely than less urgently referred cases to result in child protection-oriented outcomes. For example, the one case in the PreRef sample to result in CPR procedures had not been classed as requiring immediate S47 enquiries. Another five PreRef cases resulted in immediate action to protect a child, although they had not involved immediate S47 enquiries.

A clear distinction between the outcomes of S47 and non-S47 cases might be expected particularly among referrals made after the introduction of the A&C forms and new procedures. Part of the rationale for the new procedures was to refocus services to develop work on children in need referrals and to reduce the immediate recourse to S47 referrals (such as by those who perceived that this was the only option which guaranteed that concerns would be acted upon). Nevertheless, such a distinction is not apparent in the PostRef sample where, for example, the numbers of cases which were referred to other agencies, resulted in CPR procedures, or led to no further action are divided equally between S47 cases and non-S47 cases.

The similarities in outcomes between cases, whether or not they had been referred as immediately requiring S47 enquiries, raises questions about the criteria and decision-making process which determine whether they are investigated immediately under S47 or whether the A&C form procedure is followed. On the one hand, an implication of initiating immediate

S47 enquiries unnecessarily is that the quality and quantity of information attainable via A&C forms would not be recorded. Further, as the focus of S47 enquiries is on child protection, there would be a risk that children in need concerns would be over-looked. On the other hand, the use of A&C forms in cases which instead should be investigated immediately under S47 would delay action to protect children. In either case, this emphasises the importance of inter-agency training on identifying the point at which a child in need requires protection.

6.5 Consent

The 'consent' element of the A&C forms deals with the new requirement for the referring agency to seek the agreement of the child's parent or guardian for the referral to be made. The A&C form includes a section in which parents or guardians are asked to sign the statement, 'I agree to the information in this report being provided to the social services department and for them to share information with other relevant service providers in order to achieve a positive outcome for the needs of my child'.

According to the RAS, the introduction of the new requirement for consent was met with some resistance from referring agencies. However, in most cases, this initial reluctance was overcome. Where reluctance persists, it was explained by the RAS as either resulting from a lack of confidence and training, or because there are some professionals 'who clearly find it difficult to discuss their concerns with families and do not regard it as their responsibility to do so.'

It was reported in discussion with the RAS that some professionals in referring agencies felt inhibited when writing assessments in the presence of parents. Occasionally, professionals have followed up their A&C forms with a telephone call to the RAS, explaining that they had felt unable to be completely frank about their concerns about the family in an assessment written with them present. A similar point was made in discussion with the education workers who explained that, while they recognised that parents had a right to know what was happening with their child, the thought that parents would read their A&C forms made them feel uncomfortable and 'could hinder the process for some families'. The RAS staff were sympathetic, and commented that this was a regular challenge for referring agencies, and that skills for dealing with such situations developed with experience.

On the other hand, the RAS observed that the new requirement for consent has been appreciated by and empowering for parents. As it was remarked, 'families like the idea of having to give consent, gives them a position of power, gives them a sense of control, knowing they have to be consulted before agencies can be contacted'. School nurses perceived that the new A&C forms were introduced with the intention of moving away from a relationship in which agencies did what they considered to be in families' best interest and towards one in which service-users had more rights and more of a say in what happened. Moreover, some staff from health agencies highlighted how seeking consent can enhance their working relationship with parents. For example, a comment made in discussion with paediatric nursing staff was that 'a lot of families are grateful to be able to discuss family problems with someone, and [they] appreciate the acknowledgement of their difficulties'. According to these nurses, the introduction of the A&C form has raised awareness among staff about how to work with families because of the need to get consent: 'it's made us go a step further than we might have done before'.

Given that this new requirement is a specific element in the A&C form, it is not surprising that (as Table 6.4 shows) PostWithA&C referrals were more likely to have been made with the knowledge and consents of parents/guardians than PreRef and PostNoA&C referrals. PostWithA&C referrals were also more likely to include the views of parents/guardians and children/young people.

However, Table 6.4 also shows that in over a quarter of the PreRef sample parents/guardians had been made aware of the referral and had given consent. In two-fifths of the PostNoA&C cases, parents/guardians had been aware of referrals and about a third had given consent. Both PreRef and PostNoA&C samples include cases where parents'/ guardians' and children's/young people's views are recorded. The fact that PostNoA&C referrals were more likely than PreRef referrals to have been made with the knowledge and consent of parents/guardians could suggest that the introduction of the A&C forms was associated with a 'culture shift'. That is, even when the A&C form was not used, there was still a greater commitment to making parents aware that referrals had been made and to seeking their consent.

Table 6.4 Three Sample Groups: Consent And Involvement

	PreRef	PostWithA&C	PostNoA&C
Parent/Carer aware of referral	29%	65%	40%
Consent given to refer case to SSD	26%	61%	31%
Parent's/carer's views recorded on form	13%	35%	5%
Child's/young person's views recorded on form	5%	25%	2%
	n.92	n.57	n.42

On the difference between referring agencies in securing parental consent, it was observed in discussion with RAS staff that 'there's no pattern to it, although I think, on the whole, education have struggled most …primary schools appear better at obtaining consent than secondary schools'. It is likely that this is because primary schools tend to have more regular contact with parents than secondary schools.

Indeed, Figures 6.1 and 6.2 show that education referrals were consistently least likely to have achieved parental awareness or consent. There is no clear pattern of difference between health and 'other' referrals in this respect. As Figures 6.3 and 6.4 illustrate, secondary schools in particular were least likely to gain parental awareness or consent. The rate of other education referrals to have been made with parental consent and awareness – including those made by education welfare officers and primary schools – is comparable with other referral sources in the PostWithA&C sample. This suggests that the low rate of education referrals to have achieved consent or awareness reflects specifically the low rate of secondary school referrals to have done so.

Figure 6.1 Percentages of Referrals Made in the Knowledge of Parents/Guardians, by Referral Source

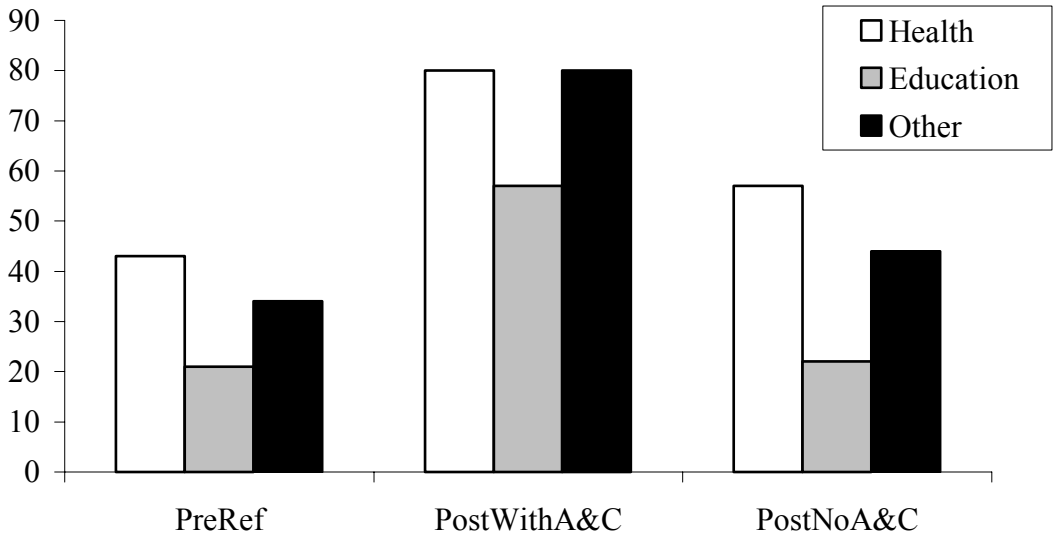


Figure 6.2 Percentages of Referrals Made With the Consent of Parents/Guardians, by Referral Source

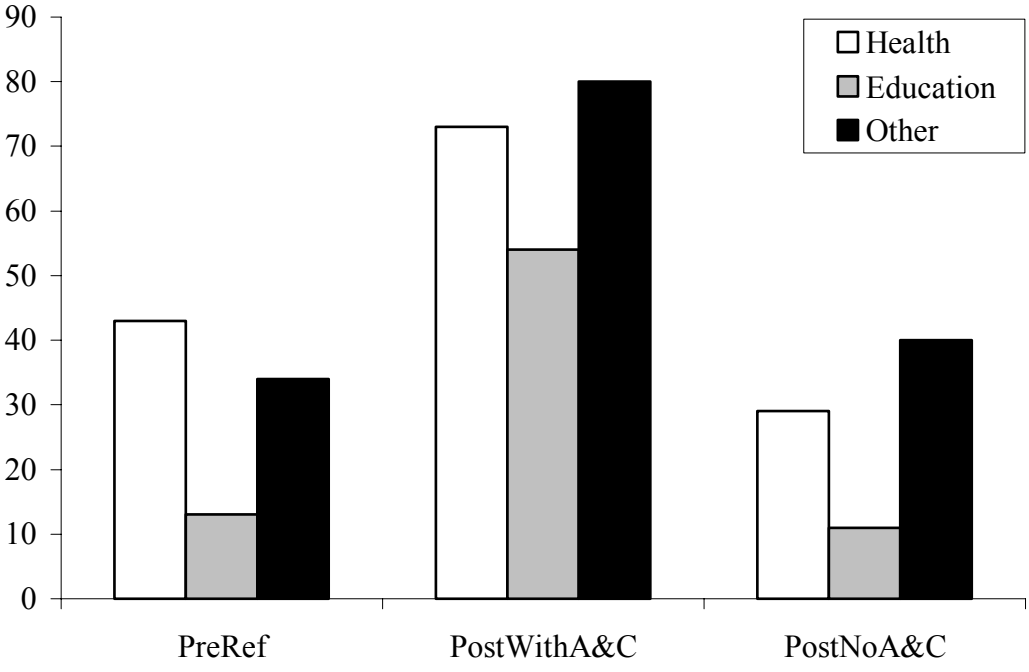


Figure 6.3 **Referrals Made With Knowledge Of Parents, Comparing Secondary School Referrals With All Other Education Referrals And Referrals From Health And Other Agencies**

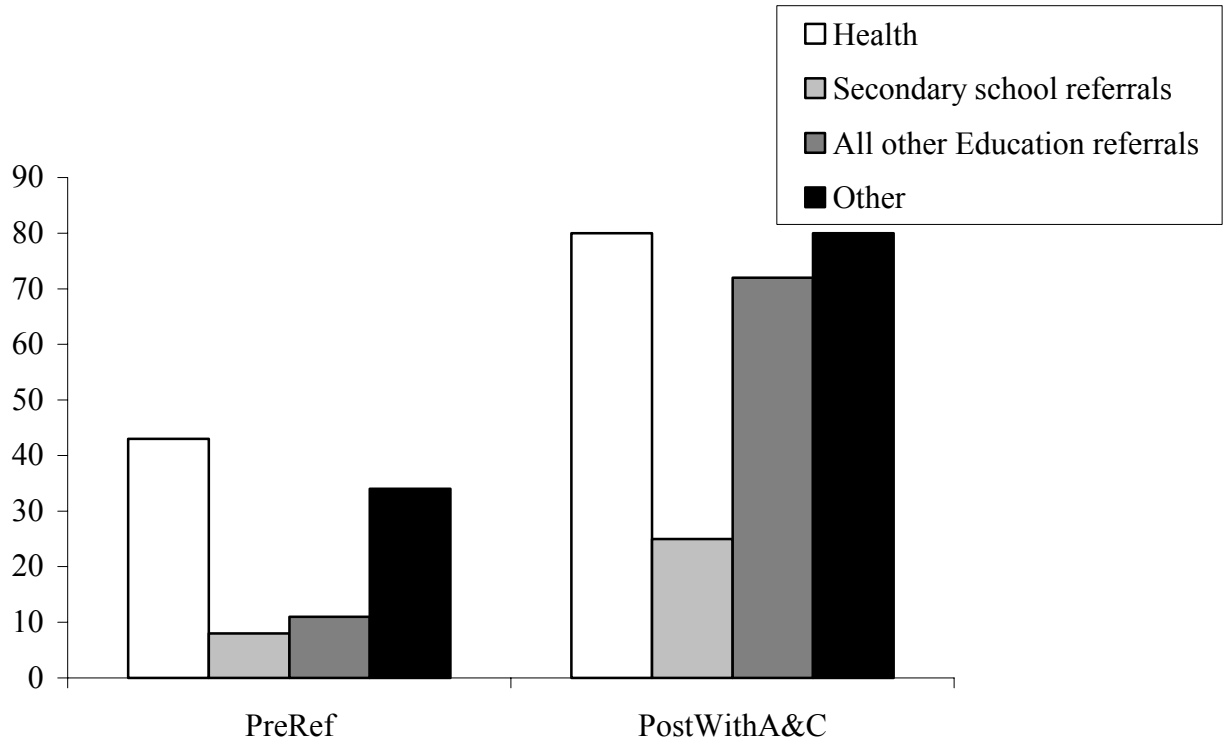
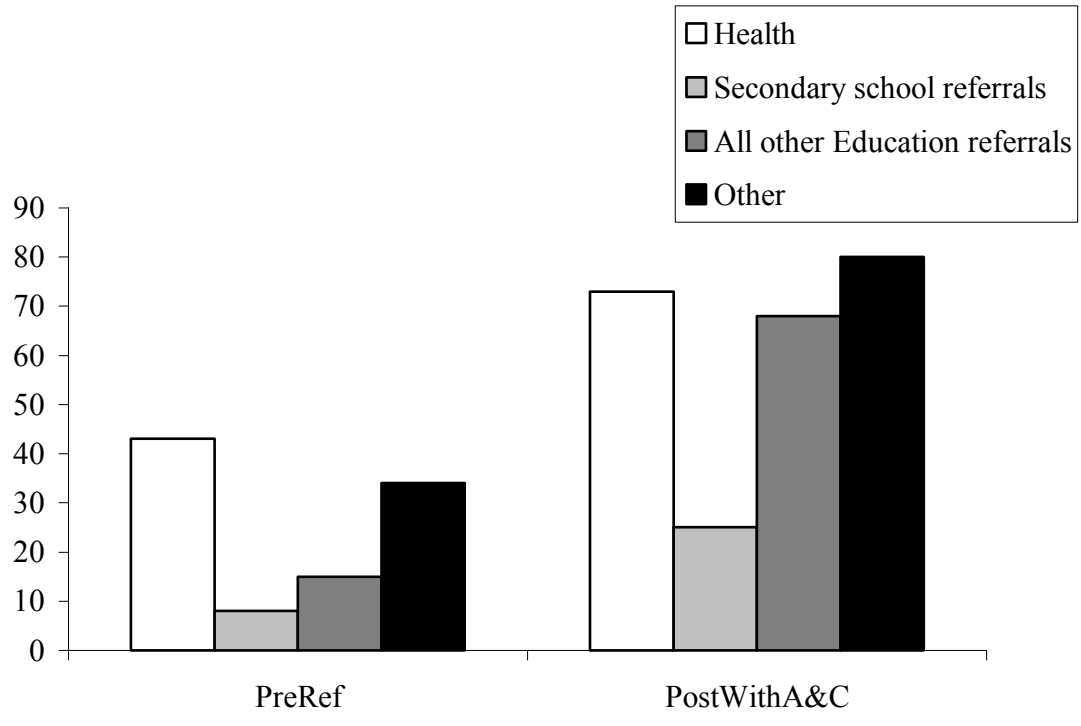


Figure 6.4 **Referrals In Which Consent Had Been Given, Comparing Secondary School Referrals With All Other Education Referrals And Referrals From Health And Other Agencies**



Overall, health visitors were the most likely main referral source to acquire parents'/carers' consent and to make them aware about referrals. Police, along with Education Welfare Officers, were the next most likely main referral sources to do so.

From the perspective of the RAS, schools were reluctant about discussing their concerns with families for fear of jeopardising their relationships with parents. This was reiterated in discussion with the school-based child protection coordinators. The child protection coordinators were the only professionals consulted who specified the need for more training on seeking consent (particularly written consent). Of twenty child protection coordinators, only one reported having had a request for consent for a referral rejected by a parent. However, the group conceded that they tended only to ask those parents who could be expected to give their consent freely. For example, parents would be willing to agree to a referral if they had themselves identified concerns relating to their child. The child protection coordinators also expressed concerns over their personal safety when sharing concerns with and seeking consent from abusive and volatile parents and those with histories of drug-use, domestic violence or previous social services involvement.
Other concerns were shared more broadly across referring agencies. Along with the child protection coordinators, the health visitors explained that seeking written consent (i.e. a parent's signature on the A&C form) rather than just verbal consent can cause parents to 'panic'. As discussed by the child protection coordinators, seeing consent 'in black and white frightens parents', it can be 'threatening' and embarrassing, evoking 'fears of having kids taken away and the stigma of using social services'.

Child protection coordinators and clinic-based nursing staff highlighted that an obstacle in securing parental consent was the lack of contact they had with families. As one of the clinic-based midwives explained, 'if they don't come to an appointment we can't get consent from them, even if we have concerns'. This relates to further anxieties, expressed mainly by education welfare officers. First, there were fears that getting written consent could delay referrals, especially when professionals are busy and parents cannot be contacted. Second, despite the fact that the RAS would if necessary accept referrals for which consent had not been given (e.g. the PostNoA&C sample), some staff still perceived that the RAS 'won't accept a referral without consent' and as a result some children would 'slip through the net'. Finally, there were doubts about how appropriate it was to seek parental consent for referrals for older teenagers, presumably because it would seem more relevant and important to seek

the consent of the person being referred where he/she is able to make an informed decision on the subject.

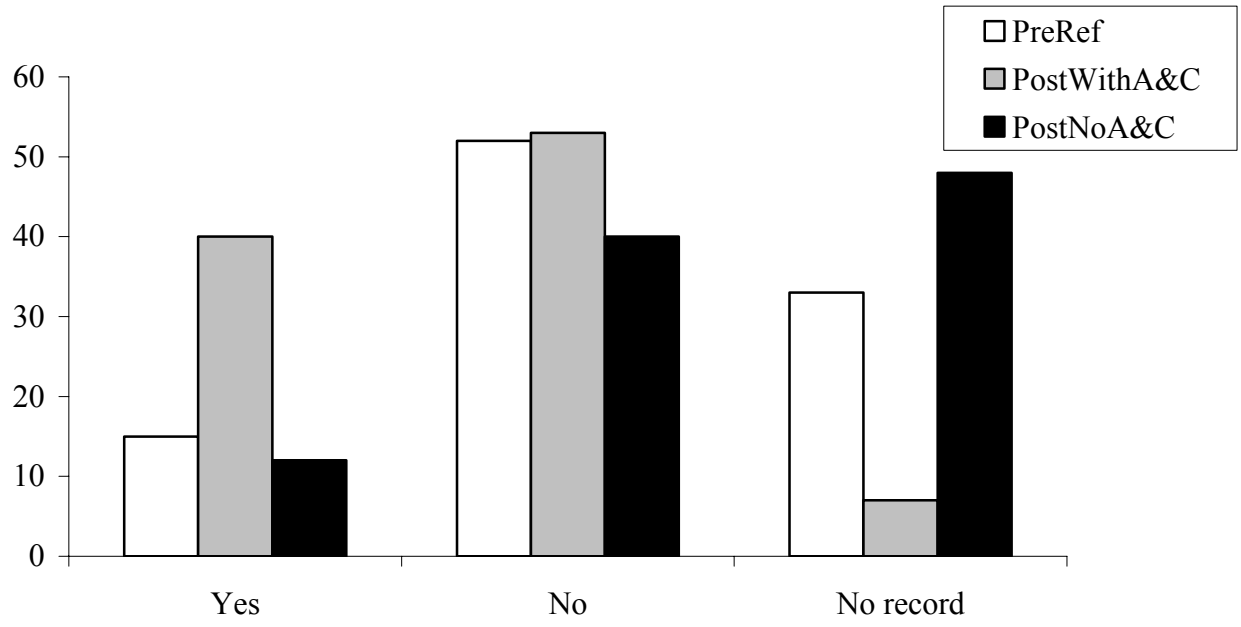
6.6 Home Visits

This section considers how evidence for referrals was gathered by referring agencies.

It is likely that the optimum conditions for undertaking an assessment and gathering evidence for a referral is when a professional from a referring agency visits the child and family at home. Figure 6.5 shows the percentage of those referrals in which there was a home visit, those in which there was not a home visit, and those in which it was not recorded whether or not there was a home visit. The table shows that it was clear in about half of both the PreRef and PostNoA&C referrals that home visits had not taken place. However, PostWithA&C referrals stood out as being the most likely both to have involved home visits and to have had records about whether or not these had taken place. The increased likelihood of PostWithA&C referrals having a recorded home visit is attributable mainly to health agencies: 11 of the 15 health referrals recorded these visits. Although findings here are inconclusive[10], what evidence there is suggests that referrals made using the A&C form were more likely to include information coming directly from the child's home, with health agencies leading the way in this regard.

[10] The findings on this topic are inconclusive because it is uncertain how many referrals without records about home visit were cases in which the family home was not visited, and how many were cases in which there was an unrecorded home visit. However, it is reasonable to hypothesise that it is more likely that where there were home visits these would be recorded, whereas the absence of a home visit would result in a lack of records either way.

Figure 6.5 Was visit to family home recorded? Percentages of PreRef, PostWithA&C and PostNoA&C referrals



6.7 Available Data

The RAS was generally pleased with the quality of referrals made by health, education and 'other' agencies. In consultative discussion with RAS staff it was agreed that the new A&C forms

> *'have improved the quality of the information coming in… Some of the forms from other agencies are of a very high standard and are basically Initial Assessments… Others clearly still have problems completing some sections, particularly staff who do not do home visits, they generally can't comment on what is going on at home. On the whole though, the forms we get in are good.'*

Approaches to completing the A&C form seem to have varied among the referring agencies. While most relied on 'professional interpretation' of what they are told by children and parents, one education worker, for example, explained that he recorded children's and parent's words verbatim. Some staff commented on the length and complexity of the A&C form. For at least one person working within the health service this meant that there was not always time to complete the assessment before passing it on to social services.

This section looks at the extent of available information in case records. Four areas of information are considered: core data and basic case details; detailed information on the child's background and family; details about the agencies involved with the family at the time of referral; and information for the assessment of the child's welfare and health.

6.7.1 Core data and basic case details

The data suggests that there is little difference between the PreRef, PostWithA&C and PostNoA&C samples in terms of the extent of core data that is available. For instance, there are no missing records for children's date of birth, or the circumstances which triggered the referral. Also, the samples are similar in terms of the extent of available details for referrals where there were initial child protection concerns. That is, about two-thirds of each of the three samples included details about the nature and extent of significant harm involved.

However, in terms of other basic case details, referrals in which the A&C form had been used attained a more complete record than those where it had not been used. Table 6.10 shows that PostWithA&C cases had more available key data than PreRef and PostNoA&C cases. This was most marked in relation to whether files recorded details of the adult with parental responsibility for the child, and whether or not:

- Parents/carers had given consent for a referral to be made to social services
- Parents/carers were aware that a referral had been made
- Child/young person had expressed views
- Parents/carers had expressed views
- The family home had been visited

PostNoA&C cases were a little more likely than PreRef cases to have available key data.

Table 6.10 Available Basic Case Details (selected examples)

	PreRef		PostWithA&C		PostNoA&C	
	n.	**%**	**n.**	**%**	**n.**	**%**
Parental responsibility	49	*53*	51	*89*	32	*56*
Child ever looked after	71	*77*	54	*95*	37	*88*
Child ever on CP register	82	*89*	56	*98*	0	*0*
Consent given to refer to SSD	57	*62*	52	*91*	30	*71*
Parent/carer aware of referral	58	*63*	52	*91*	29	*69*
Child's views recorded	51	*55*	47	*82*	15	*36*
Parent/Carers' views recorded	54	*59*	49	*86*	15	*36*
Recorded visit to family home	62	*67*	53	*93*	22	*52*

The data does not show a link between the extent of available data and the outcome of referrals. There is nothing conclusive about differences between health, education and other agencies in relation to the extent of data provided in referrals and case records.

6.7.2 Detailed information on the child's background and family

Table 6.11 shows that the PreRef sample included the least information about children's families and backgrounds. The PostWithA&C sample provided most data.

Table 6.11 Available Details About Child's Background And Family (selected examples)

	PreRef		PostWithA&C		PostNoA&C	
	n.	%	n.	%	n.	%
Child's ethnicity	40	43	48	84	32	76
Child's 1st language	16	17	50	88	29	69
Parent's 1st language	14	15	47	82	32	76
Mother in household	71	77	57	100	39	93
Father in household	72	78	57	100	39	93

The RAS perceived that education referrals tended to be most likely to lack details about the child's home-life: 'schools have problems with the family history and home situation part of the form, they often don't know enough about the situation at home or what preceded it to comment so they tend to leave this blank or write "no info" in that section'. However, the data suggests that this is not an accurate generalisation. There is no marked difference between the different referral agencies in the extent of available detailed information on the child's background and family in the PostWithA&C sample. In both the PreRef and PostNoA&C samples, health referrals were slightly more likely than those from education and other agencies to lack these details.

6.7.3 Information for the assessment of the child's welfare and health

In the research, over 30 categories of information relating to the assessment of the child's welfare and health can be identified. As Table 6.12 shows, the introduction of the A&C form and procedures marked an increase in available information on many developmental dimensions, including for example education, identity and social presentation. Similarly, information about family and environmental factors which affect the child has substantially increased, including family and social relationships, social and community resources, housing and debt.

Table 6.12 Available Information On Child's Health And Welfare (selected examples)

	PreRef		PostWithA&C		PostNoA&C	
	n.	%	n.	%	n.	%
Evidence of child's health/development strengths	5	5	19	33	3	7
Evidence of child's educational strengths	5	5	19	33	5	12
Evidence of child's family and social relationships strengths	0	0	18	32	1	2
Evidence of child's identity and social presentation strengths	1	1	12	21	1	2
Family history & functioning deficits	22	24	29	51	7	17
Basic care – strengths	2	2	22	39	0	0
Emotional warmth-strengths	0	0	21	37	0	0
Social and community resources – evidence of strengths	2	2	16	28	2	5
Housing – strengths	0	0	13	23	2	5
Employment & income - deficits	4	4	7	21	2	5

While overall the A&C can be associated with an improvement in recorded information at referral, there remain a few discreet pockets of unrecorded data. There is little difference between referrals made before and those made after the introduction of the A&C form with regard to a) details specifying whether assistance from social services or other agencies was required to meet particular needs, b) evidence of parents' capacity to meet particular needs, and c) data on certain performance factors, such as health and education records. Examples of these areas of missing data are provided in Table 6.13.

Table 6.13 Areas Of Limited Available Data

	PreRef		PostWithA&C		PostNoA&C	
	n.	%	n.	%	n.	%
Need for assistance from social services re child's identity and social presentation	0	0	1	2	0	0
Evidence of parents' capacity to meet child's health/ developmental needs	14	15	8	14	4	10
Dental checks in last 12 months	1	1	0	0	0	0
Immunisations up to date	1	1	3	5	0	0
Evidence of school attendance recorded	28	30	18	32	17	40

It is noteworthy that some data on performance indicators are not recorded by the relevant professionals. For example, of the 15 referrals from health agencies which were made using the A&C form, only three recorded whether the child's immunisations were up to date, two recorded whether there had been health checks within the last year, and none reported on whether there had been recent dental checks. Of the 37 referrals from education agencies which were made using the A&C form, only seven reported on the child's school attendance, one recorded whether or not the child ever had been permanently excluded from a school, and none recorded the child's target level in SATs.

More generally, in both the PreRef and PostWithA&C samples, referrals from 'other' agencies were most likely to contain missing information relating to the assessment of the child's welfare and health. There is no consistent difference between referring agencies in the PostNoA&C sample.

6.7.4 Details about the agencies involved with the family at the time of referral

The final pocket of unrecorded data relates to information about agency involvement. As Table 6.14 shows, referrals made prior to the introduction to the A&C form were more likely

than those made after its introduction to have records of the agencies in contact with the child/family at the time of the referral.

Table 6.14 Available Data About Agency Contact At Time Of Referral (selected examples)

	PreRef		PostWithA&C		PostNoA&C	
	n.	%	n.	%	n.	%
GP	44	48	10	18	6	14
Nursery	38	41	10	18	5	12
Community Mental Health	38	41	10	18	5	12
Community Paediatrician	41	45	9	16	4	10
Youth organisations	38	41	9	16	5	12
Police	40	43	10	18	6	14

In both the PreRef and PostNoA&C samples, referrals by 'other' agencies were most likely to have missing data about agency contact. In the PostWithA&C sample, education referrals were most likely to have these details missing.

The findings here conflict with the expectation that the A&C form would result in the routine recording of such data, and this may be an area the local authority needs to address.

6.8 Inter-agency Concerns

Overall, the views of staff from referring agencies about the A&C form were mixed. On the one hand, some perceived that the form enhanced their own practice and helped them to make more considered referrals. On the other hand, a number of concerns were highlighted. These include views on the form as a tool, communication with the RAS, monitoring the accumulation of concern, and repetition in Initial Assessment.

6.8.1 The form as a tool

Some staff from education agencies were critical of the order and structure of the form. In particular they wanted the section used to describe what had triggered the referral brought to

the first page of the form, rather than on page four where it is located currently. One child protection coordinator felt that the form did not cover this crucial question at all: 'why we feel we have to refer the child now is the most important thing, and the form doesn't ask that'.

Education staff also felt that there was insufficient space for certain sections (e.g. child's household members), whereas other sections required information they could not provide. Staff from health and education agencies indicated their concern that to complete these sections – for example, assessments of the child's health or family's financial situation – would often either be to risk making assumptions and value judgements, or mean delaying the referral while the required information was researched. Discussion about the level of information required by the form, highlighted that some staff saw their role as being to refer cases to social services and not to undertake assessments.

Other staff commented on the length and complexity of the form. In the view of a professional from an education agency, it 'feels as if they are doing all they can to make it difficult to refer'. Concerns were expressed that this would deter young people and professionals from going through with a referral.

As noted elsewhere in this report, a number of staff felt that further guidance was required on assessing levels of concern and distinguishing between children in need and child protection cases.

6.8.2 Communication with the RAS

The RAS staff explained that, where possible, they would discuss a case with the person making the referral before deciding whether it represented a referral or an enquiry. If it is accepted as a referral and an Initial Assessment is made, the referrer should always be informed of the outcome. The RAS was aware that some agencies have complained of not receiving feedback, and that it needed to remain vigilant about this. However, sometimes feedback was problematic because of the need for confidentiality. The point was made in consultative discussion with the RAS:

> *'Some agencies often want to know more than we are able to tell them, particularly if the family are working with another agency, we can't always pass details of that work on. There's occasions when we've asked schools to monitor a situation for us,*

following a referral, and the schools clearly want to know more about our assessment. Sometimes it's simply not possible to share that information with them, which can cause difficulties.'

Some staff in referring agencies did indeed comment on the lack of feedback they received. The midwives in consultative discussion stated that they had never received feedback from the RAS but, as written communication would have been sent to their team leader rather than themselves, it was not necessarily the fault of the RAS. Others were more critical:

'The feeling is that we have a responsibility to refer on, but they don't have a responsibility to communicate with us. It's very poor at the moment.'

In a similar tone, one of the health visitors remarked:

'You don't always get a response from social workers about what has happened to the referral, which doesn't incline you to go to a great deal of trouble with the form.'

It was suggested that there should be a routine system for feedback so that, within a defined period of making a referral, the referring agency is informed on action taken.

Some professionals, especially those from education agencies, were unclear about the process following the submission of their A&C forms to the RAS. In particular, they did not know whether the forms were shared with other agencies. This lack of clarity contributed to feelings of unease about using the new form, and would benefit from greater information and feedback from the RAS.

A shared sense across the referring agencies was that the introduction of the A&C form and new RAS duty system had inhibited opportunities for direct, informal contact with the RAS. The single telephone line was constantly busy. Moreover, since referrals now had to be made via the form rather than by telephone, there was a perception among some staff that they could no longer contact social workers to discuss and seek advice on cases informally. This was clearly something which had been valued. There was now a sense that staff had to 'do a form' or referrals would be rejected.

6.8.3 Monitoring the accumulation of concern

As one of the education welfare officers asserted, 'it is the number of concerns, the history, that is crucial in making a referral'. There was some confusion about what happened when professionals had concerns which, in isolation, would not warrant a referral, but would do so

in combination with other such concerns. Since it was perceived that the agencies' relationship with social services had shifted away from informal contacts and towards formal referrals, there was unease about the fact that there was no inter-agency approach to logging the accumulation of concerns.

6.8.4 Repetition in Initial Assessment

Although not a dominant theme in the consultative discussions, there was some concern about the fact that the A&C form and the Initial Assessment undertaken by social workers cover several of the same areas of information. One of the health visitors related:

> *'On one occasion I'd done a fairly lengthy assessment with the family and asked the social worker if we could do a joint home visit if it went to an Initial Assessment and they didn't they just went out and did it again. That undid a lot of good work that I'd done with the family.'*

Potentially, both the A&C form and Initial Assessments can deal with the same 30 categories of information relating to the assessment of the child's welfare and health (see Section 4.6.4). Clearly this means that referring agencies and social services could duplicate assessments, resulting in a waste of recourses and unnecessary intervention in the lives of children and their families. Therefore, the two procedures need to be better aligned.

7 CONCLUSION: SUMMARY OF FINDINGS AND RECOMMENDATIONS

Using quantitative analysis of case records and consultative discussions with professionals, the research examines the impact of the A&C (Children in Need and in Need of Protection Assessment and Consent) form on the pattern and quality of referrals made in North East Lincolnshire. The study compares referrals made by health, education and other (police and other statutory and voluntary) agencies, prior to and following the introduction of the A&C form in November 2000.

7.1 Implementation

There was a phased roll-out of the A&C form in the autumn of 2000. The reaction of consulted workers from health, education and other agencies towards the new form was mixed. Some perceived that the form enhanced their own professional practice and enabled them to make more considered referrals. Generally, initial concerns about the new form and procedures were overcome with experience of using the forms, although professionals would have welcomed more training,

A few professionals felt cynical about the A&C forms, and perceived that they had been introduced to reduce referrals and gate-keep services.

A consistent theme in consultative discussions was that training for the new procedures had been inadequate. At best, training had encompassed - in one half-day session - an introduction to the DoH Assessment Framework, the Data Protection and Human Rights Acts as well as the new referral procedures. This left insufficient time for dealing with the A&C form. Staff felt that there was a particular lack of guidance on a) 'benchmarking' and assessing levels of concern, and b) seeking parental consent. At worst, staff had received no training because sessions had been organised in such a way that not all relevant staff had been able to attend and some, who worked away from mainstream sites, had been overlooked.

Difficulties in implementation also may have been related to the fact that some professionals perceived that the new procedures had been imposed, rather than introduced after consultation.

7.2 Pattern Of Referrals

7.2.1 Decrease in the number of referrals

There was a 41 per cent drop in the number of referrals between 2000 and 2001. The extent to which this decrease can be attributed to the A&C form is not known. (There was a comparable drop in the number of referrals made by members of the public, which would not have been affected by the new procedures). The following are also likely to have been contributory factors:

- A new duty system was introduced with dedicated staff, and there were changes in recording practices. This led to a clearer distinction being made between enquiries and referrals. As a result, fewer initial contacts were defined as referrals on the local authority's management information system.
- Although this duty system created a sharper focus and reduced duplication, some professionals also pointed out that some callers would be discouraged from trying to refer a case because the one telephone line had been constantly engaged.
- There were changes to inter-agency protocols. Formerly, all police and Youth Offending Team '125 forms' – which reported all incidents in which there was some concern about a child – were logged automatically as enquiries or referrals. Now, such forms are screened and only referred to the RAS when appropriate.
- There were changes to the number and range of alternative second level preventive services in the area, such as Sure Start, Connexions and the Children's Information Service. It is likely that these met some needs of and concerns about children directly, making a referral to the RAS unnecessary.

The introduction of the A&C form could have contributed to the decrease in the number of referrals in several ways.

- The higher quality and quantity of information in A&C forms meant that they assisted RAS staff to 'weed out' enquiries from referrals.
- The A&C forms encouraged professionals to make more considered referrals and to 'think twice' about whether a referral was necessary.
- Some professionals suggested that the length and complexity of the A&C form could discourage the making of a referral. Some education workers explained that they

advised parents to refer themselves so that they (the education workers) would avoid having to use the A&C form.

7.2.2 Use of the A&C form

The A&C form had been used by well over half of the referrals made after November 2001. Of the 99 'post-ref' cases, 42 referrals had not used the new form. However, in 23 of these referrals, the A&C form had not been used because of legitimate or unavoidable reasons: cases had warranted immediate child protection or 'S47' investigations, referrals had been made by agencies outside of North East Lincolnshire, or the referring agency (police and NSPCC) used their own referral procedures.

7.2.3 Appropriate referrals

More appropriate referrals now appear to be being made. The proportion that proceeds to Initial Assessment has substantially increased, while the proportion offered information or advice, or referred on to other agencies, has fallen.

Following the introduction of the A&C form, there was a marked decrease in the number of referrals in which no outcome was recorded. It is possible that the A&C form assisted the RAS in making decisions more consistently than before and so referrals were more likely to have definite outcomes.

However, the outcomes of cases in which there were immediate S47 investigations did not differ sharply from the outcomes of routine referrals. This suggests that some professionals are still using S47 procedures inappropriately. (Given this, and the fact that there had been an increase in the proportion of S47 enquiries between 2000 and 2001, it also seems unlikely that the workload of the RAS would have declined in line with the fall in referrals).

7.3 Quality Of Referrals

The RAS assessed that, in general, the A&C forms have improved the quality of information about referrals. This view is substantiated by the quantitative data collected in this study.

There has been a substantial improvement in recorded information on basic case details and detailed information on the child's background and family, for example including the child's

previous care experiences and previous child protection registration, the views of the child and parents, the child's ethnicity and language, and the domicile of parents.

There has also been an improvement in recorded information at referral on children's health, welfare and social development. In particular there is more information on children's strengths and needs on most developmental dimensions, including for example education, identity and social presentation. Similarly, information about family and environmental factors which affect the child has substantially increased, including family and social relationships, social and community resources, housing and debt.

While there has been a marked increase in the quantity of information overall, there remain discreet pockets of unrecorded data.

- Some data on performance indicators are not recorded by the relevant professionals – e.g. health visitors are not recording data on immunisations; educational welfare officers and teachers are not routinely contributing data on school attendance, school exclusions or SATs.
- There is little difference between referrals made before and those made after the introduction of the A&C form with regard to a) details specifying whether assistance from social services or other agencies was required to meet particular needs, and b) evidence of parents' capacity to meet particular needs.
- Referrals made with the A&C form were less likely than those made before its introduction to have records of the agencies in contact with the child at the time of the referral.

7.4 Consent

Under the new procedures, referring agencies are required to secure the consent of the child's parent or carer for the referral to be made to social services. Referrals using the A&C form were more likely than other referrals to have been made with the knowledge and consent of parents. They were also more likely than others to have recorded the views of the children and parents. Some secondary schools still appear to have problems with seeking consent.

Referrals made after November 2000 but which did not use the A&C form, were still more likely than referrals made before November 2000 to have been made with the knowledge and consent of parents. This suggests that the introduction of the A&C form was associated with a 'culture shift' towards the enhanced involvement of parents.

The RAS reported that referring agencies' initial reluctance or resistance to seeking consent had been overcome in most cases. Concerns expressed by many referring agencies that families would be reluctant to give their consent to the sharing of information were largely unsubstantiated. While some professionals felt that sharing information with families compromised their assessment, others emphasised that it empowered parents and enhanced their own professional practice with families.

7.5 Recommendations

1. It is possible that a) avoidance of using the A&C form, b) inappropriate S47-referrals, c) failure to record certain data, and d) reluctance to seek parental consent are largely the result of inadequate training. More comprehensive and more widely accessible training is required on the A&C form and the rationale, procedures and issues associated with its use.

2. The A&C forms would be more useful to referring agencies if they provided some guidance as to agreed criteria for concern/ levels of urgency (as in the Loughborough/North Lincolnshire Children and Family Assessment Materials).

3. The A&C form would also benefit by the inclusion of a reason for referral or the immediate circumstances that prompted the referral at the front of the form.

4. Staff from referring agencies are basically being asked to undertake an assessment as part of the A&C referral. This can then be duplicated when social workers undertake an Initial Assessment. The overlap between these two procedures needs to be addressed.

5. The police and NSPCC are still outside the process and use a different procedure and pro forma to refer cases. These systems need to be integrated.

6. The availability and accessibility of the RAS to other professionals - for both making referrals and seeking informal advice - could be improved. This could be helped significantly by an increase in the number of telephone lines to the duty desk.

7. Referring agencies claim that they receive little or inconsistent feedback concerning the action taken by social services following their referral and would like reassurance about how the information is logged and acted upon.

8. The SSD may need to explore the potential for a computerised template, which might allow some of the information on the forms to be aggregated and would avoid duplication of information in separate word documents.

9. Some agencies (e.g. education welfare officers) may have particular concerns about individual cases which, by themselves, are not serious enough to warrant a formal referral. A system may need to be devised which enables these concerns to be monitored and aggregated with a view to informing future, formal interventions, including referrals.

10. Procedures and principles for sharing confidential information between professionals – or for withholding it – need to be clarified.