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Report of Director of Children's Services

Report to Scrutiny Board (Children and Families)

Date: 11th October 2012

Subject: Session 2: Foundation Years - providing the best start in life for children to succeed

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

1. Summary of main issues

This report is to inform the second meeting of the Scrutiny Board Following into the inquiry into the foundation years (age 0- 5). The June meeting identified term of reference, around the inquiry, whilst the September meeting considered the overview of services, existing provision, outcomes and any gaps in services. The focus for the meeting in October is around how services support and engage with families. The board will consider evidence from health around the healthy child programme, the family nurse partnership, commissioning of services, communication and information sharing, access to the Early Start Teams through Children's Centres and health visiting services, an overview of Targeted Services for children and the new 'Families First model, funded through the Troubled Families programme and more information on the profile of young children becoming looked after.

2. Recommendations

Scrutiny Board are asked to consider and note the contents of the report as part of their wider inquiry.

1. Purpose of this report

1.1 This report provides an overview to Children's Scrutiny Board of the key issues relating supporting and engaging with families:

- Access to services and the provision of support through Childrens Centres such as 'Early Start'.
- Targeted Services, early intervention.
- Parental support and parenting programmes.
- Service commissioning, links between practitioners and professionals, provision and the delivery of integrated services, communication and information sharing.
- Families First, funded from the Troubled Families initiative.
- Service commissioning, links between practitioners and professionals, provision and the delivery of integrated services, communication and information sharing.
- More detail around the profile of young children becoming looked after by the local authorities.

2. Background information

2.1 As presented in the initial report for Scrutiny Board a wide range of partners across health, Leeds City Council, the maintained, voluntary and private sector deliver provision and services to support children in the foundation years. This includes health, early learning, child-care, leisure and support services. The child-care market in Leeds is delivered through a mixed market economy with a maintained sector element through schools and Children's Centres and a vibrant and strong private and voluntary sector, including over 900 childminders. Partnerships across the stakeholders have been developed over time and have been effective in improving services. However significant challenges for Leeds remain. Although attainment of young children overall has improved, infant mortality rates have decreased and 95% of 3 and 4 year olds take up the offer of

free early education there are still considerable issues for improvement:

- The birth rate in Leeds is increasing significantly with 2,434 (32%) more babies born last year than ten years ago; and 821 (9%) more last year than five years ago (academic years);
- The detrimental effects of deprivation on health and wellbeing, both direct and indirect, is a strong and consistent theme;
- The attainment gap at the end of the Foundation Stage, between the lowest 20% of achievers and the median level remains significantly wider than the national figure;
- The level of take up a free early education is lower in areas of significant disadvantage;
- There has been a significant increase in the number of under 4's becoming looked after in the last 6 months.

3. Main issues

3.1 Access to services and the provision of support through Childrens Centres - 'Early Start' Teams.

There are 57 Early Start Children's Centres across the City and these are integrating with Health Visiting services to create 25 Early Start Teams. They provide a range of services for families including childcare either provided on site or in a formal agreement with a near by provider. The teams deliver family outreach and support services both in the Centre and in family homes. The integration with health visiting is enabling information to be shared (through a formal information sharing agreement) between Health and Children's Centres so that no families are missed. The Healthy Child Pathway is then delivered by the right member of the team and resources are maximised to ensure all families receive the right service at the right time. A key feature of Early Start Teams is the joint allocation of cases, a universal, universal plus and universal partnership plus level of service, better working between Leeds Community Health care Trust and LCC and a streamlined service for families. The Early Start Teams contribute to the three obsessions – all LAC and those on a CPP are registered and invited to engage with the centre, attendance and attainment are monitored. Young parents are supported into readiness for employment, there are good relationships established with Job Centre Plus support this.

More recently working with social care colleagues has been a focus for development, a lead social worker has been identified for each Children's Centre; a referral pathway from social workers to Children's Centres has been established for pregnant women who have significant issues and Children's Centre will ensure

that children with child protection plans, or who are Looked After by the local authority are offered services. They are also working with social care colleagues to develop 'family assessment' skills, where the child is at risk of becoming looked after, to contribute to court proceedings if required, but primarily to engage the family in good models of parenting.

The Early Start information sharing agreement between Leeds Community Health Trust and LCC is being used by the Department for Education as a model of good practice nationally in, 'Information Sharing in the Foundation Years' a report from the task and finish group led by Jean Gross, to be published later this year. The case study explains some of the process undertaken:

3.2 Targeted Services, early intervention

For school age children, we are developing our local partnerships, or clusters, which bring together a range of services involved in providing universal services for school aged children and families. Our clusters are local partnerships that include, amongst others, schools, governors, Police, Youth Service, Youth Offending Service, Children's Centres, Housing services, third sector, health, local elected members and a senior representative from children' services.

We are growing the capacity of clusters to provide Early Intervention and Prevention support to local children and families by developing the role of the Targeted Services Leader.

Targeted Services Leaders (TSLs) will work with clusters using a 'TOP 100' methodology to identify children and families who need additional support. The "top 100" methodology is a fluid record of the families who are identified as vulnerable with multiple additional needs in the locality. To be effective, input into the top 100 process should come from all cluster stakeholders across education settings, children's settings, health settings, community safety settings, housing settings and adult settings.

TSLs are tasked to ensure that each family on the top 100 list benefits from

- A shared assessment (CAF or equivalent assessment)
- Requisite team around the family
- Lead family practitioner
- Shared intervention plan
- Team around the family communication strategy

TSLs are tasked to ensure that robust "support and guidance" processes are in place within the cluster to galvanise local cluster resources to provide appropriate early intervention. Where available, access to targeted mental health support

(TAMHS) is secured through support and guidance. Where more specialist interventions are required such as multi systemic therapy, family group conferencing, Signpost family intervention programme or support from the Leeds family intervention service, TSLs will broker these arrangements, ensuring that these resources are appropriately targeted.

Referrals that do not require the support of a Specialist but needs are identified require a different level of support. In these circumstances cases will be referred directly to a cluster, or if below school age, to the local children's centres.

For families whose level of support is to be de-escalated help is provided at a stage beyond early intervention, and is built around preventing problems from re-occurring. Another element of the role of Targeted Services and Early Start Teams is supporting the safe de-escalation of support for children and families from specialist intervention to less intensive cluster based care and support. Cluster based support and guidance or other multi agency meetings are the conduit for developing safe de-escalation plans.

3.3 Parental support and parenting programmes

The Family support and Parenting service came together in January 2012 and brought together staff from 4 teams including the Family Information Service at the Parent Partnership Service. The service is building up relationship with staff in clusters who deliver a range of parenting and family support services with the aim of improving practice .These staff will have a variety of employers and job titles but are key personnel in terms of delivering the improved outcomes required in line with the 3 obsessions .

Resources vary across clusters in line with the funding formula and this can mean that in smaller clusters there may be fewer staff to support staff of school aged children . This means that they need to have the skills, resources and support to in place to maximise their impact and to work well with targeted and specialist services when the need arises

Leeds Education Challenge has a vision of a strong and successful network of well trained family practitioners, providing collective leadership, sharing best practice, and providing peer support and professional development is at the heart of this strand.

Progress to date:

- An engagement and consultation exercise has taken place with cluster mangers and children's centre managers on their priorities for support
- A similar exercise is taking place with schools through a survey and the recent Primary heads conference.

- A steering group has come together made up of Head teachers, Cluster managers , Children's centre managers, Targeted service leaders, and Community representative to ensure that this work has a joined up approach and work/ fits with the targeted services developments and the Families first work.

- A menu of a cluster family support and parenting offer has been developed and is with clusters for them to identify and feed back on their provision

In partnership with targeted services the service is delivering a City and Guild qualification "Working with parents to family support and parenting staff initially focussed o n the family intervention services.

Support for Evidence based parenting course for parents /cares and families is now being targeted in line with the 3 obsessions .

Staff teams are focusing on clusters /areas to ensure that they are able to best support practitioners in the areas whether they are employed by schools, clusters, children's services or partner agencies .

3.4 Service commissioning, links between practitioners and professionals, provision and the delivery of integrated services, communication and information sharing.

The DfE funded TaMHS project which was successfully piloted in 3 clusters in Leeds 2007-10, then expanded to 9 clusters 2010-12. It aims to improve the mental health of school age pupils. The model is based on: building on existing effective universal practice; evidence based approaches; capacity building in schools; specialist mental health 'in-reach' support in local multi professional teams; early Intervention. The expansion had a broader remit to work with families where necessary, with a number of family support workers commissioned to offer mental health approaches to resolving family issues alongside specialist mental health professionals.

Summary of outcomes: Both the pilot and the current expansion demonstrate "good" measurable improvements in school age children's mental health using Goodman's Strength and Difficulties Questionnaire[1] (average points improvement of 5.1 in pilot; 3.5 in expansion year 1). Outcomes from 355 pupils supported through individual, group and one off sessions and 140 families, in the current expansion, include:

"Good" measurable improvements in family issues: average Goals Based Outcomes improvement of 4.2

A greater than average reduction of child protection plans in a cluster: gap between the Leeds' average and the TaMHS expansion average reduced from 18

(Rates per 10,000 children) to 2. Sample comparisons to statistical neighbours without TaMHS improvement in gap of 5.4.

A greater than average improvement in school attendance: 2.4% increase compared to annual Leeds average, of Primary: 0.9% Secondary: 1.4%.

Feedback shows swifter and easier access and high levels of satisfaction from users, families and school staff. 'The results have been phenomenal and had made an enormous difference - a definite shift in cases which previously would have escalated to social care.' - Jill Wood, Head Teacher Little London Primary and Cluster Chair.

Further Expansion Funding 2013-15

The 2010-12 expansion of TaMHS was funded through a Joint Investment fund – seed funding. Leeds City Council and Schools Forum have now agreed the proposed contributions for a further expansion to the remaining 14 clusters in the city from April 2013. NHS Leeds partnership commitment will soon be confirmed. Clusters will then be invited to submit expressions of interest, demonstrating a commitment to matched funds.

3.5 Families First, funded from the Troubled Families initiative

Government estimates put the number of troubled families in Leeds at 2190. A figure of £4,000 per family will be made available in payment by results and some upfront funding (approx £8m over three years). The Department for Communities and Local Government (DCLG) have now confirmed Troubled Families that fall within the baseline[1] for PbR's over the three years is 1800.

Year one to start work with 600 troubled families. DCLG would make £3,200 per family (80% of the 40% payment by results) available up front with the remaining £800 per family to be paid on meeting the success criteria. In the region of £1.9m up front and £0.5m in arrears (PbR) when success criteria achieved.

Year two to start work with another 600 troubled families. DCLG would make £2,400 per family (60% of the 40% payment by results) available up front with the remaining £1,600 per family to be paid on meeting the success criteria. In the region of £1.4m up front and £1.0m in arrears (PbR) when success criteria achieved.

Year three to start work with another 600 troubled families. DCLG would make £800 per family (40% of the 40% payment by results) available up front with the remaining £3,200 per family to be paid on meeting the success criteria.

The Targeted Service Leader role in each cluster and the use of the Top 100

[1] The funding provided under the Troubled Families payment by results arrangements will be available for five out of six troubled families in each upper-tier local authority. This is to avoid paying twice for the same outcomes. Government funding has already been provided to support these remaining families. For example, the DWP's £200m+ European Social Fund provision, the Work Programme and existing Government-funded Multi-Systemic Therapy pilots.

methodology which we are rolling out to all clusters and the recently developed data set is the basis for our confidence in delivering this service and meeting the criteria for the upfront funding.

Leeds has some of the best evidence based practice services in the country, such as Multi Systemic Therapy, Family Group Conferencing, the Family Intervention Service (modelled on the evidence base of the previous national family intervention programme) and a nationally recognised Youth Offending Service. Additional funds would enable us to add capacity to our offer and reach more families at pace.

The Troubled Families Programme strategically fits with and complements our local approaches and obsessions in the ways we work 'with' families and focussing on our three obsessions and improving outcomes: reducing LAC; increasing school attendance; and decreasing NEET. The National Troubled Families Programme fits as part of what we do and how we do it rather than as a stand alone initiative and must not be seen as such. The additional funds will not only enable us to increase capacity of our front line services but it also enables Leeds to further strengthen our 'architecture' by rolling out and with increased pace: Targeted Service Leaders; the Top 100 methodology; and local cluster guidance and support panels. It is crucial, in this current financial climate, to get any investment right first time.

The initial identification of the cohort of families who fit the Troubled Families criteria (national and local filters) has been completed. The lists are now placed on a secure website. Targeted Services Leaders have now been appointed to 20 out of the 25 clusters and they have been tasked to verify the data relating to their cluster. An information sharing protocol has been developed which will enable TSLs (over a period of time) to coordinate a risk assessment meeting for each of the families on the list. This will include appointing a lead practitioner and ensuring that a shared assessment is in place. Work is underway to utilise Troubled Families money to expand the intensive family support offer in Leeds including commissioning a further MST team and a further Signpost FIP team. The police, probation and prison services have agreed in outline to second staff to a central coordinating team to enable new ways of working with families with multiple additional needs which include an interface with the criminal justice system.

3.6 Service commissioning, links between practitioners and professionals, provision and the delivery of integrated services, communication and information sharing.

A range of services are commissioned by Children's services, more information can be provided, including:

- Family Intervention Service, east, west/north west, south
- Support for young carers

- Bookstart
- ESOL for parents
- Homestart
- Leeds counseling
- Oxford Place

4. Corporate Considerations

4.1 Consultation and Engagement

There will be implications for consultation with providers and stakeholder dependent on the findings of the report.

4.2 Equality and Diversity / Cohesion and Integration

There are key areas of equality and diversity that will need full consideration in relation to issues raised.

4.3 Council policies and City Priorities

There are no immediate implication for council policy and governance

4.4 Resources and value for money

Dependant on the outcome of the inquiry.

4.5 Legal Implications, Access to Information and Call In

None

4.6 Risk Management

The issues outlined in this report highlight some of the potential risks in terms of wider city priorities

5. Conclusions

5.1 This Scrutiny Board (Children and Families) inquiry the foundation years will help to identify further investigation and next steps into narrowing the achievement gap, supporting the most vulnerable families more appropriately and achieve the vision for Leeds to become a Child Friendly City for all of its children. There is good progress in many areas to be built on and learned from. By identifying the needs of children at the earliest stage, even before birth, then the right services can be provided at the right time to break the cycle of disadvantage experienced by some families.

The inquiry will help to identify where services are working well together and promote this, and also identify gaps or areas where services are not fully co-ordinated.

6. Recommendations

6.1 Scrutiny Board are asked to consider and note the contents of the report

7. Background documents[2]

7.1 LAC report – appendix 1.

[2] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

APPENDIX 1

Children's Services – Leeds City Council
LAC Research Project

Background

The vision for Leeds is to have a child friendly city by 2030 and the key to start delivering this ambition is the Leeds Children and Young People's Plan (CYPP) 2011 to 2015. The CYPP describes five strategic outcomes, 11 priorities and 15 key performance indicators (KPIs) that will guide and underpin the work and measure impact. An approach called 'outcomes based accountability' will be the tool to drive improvement and change. The plan is owned by the Leeds Children's Trust Board (CTB).

One of the five strategic outcomes is that 'children and young people are safe from harm'. This is supported by two specific priorities; to help children to live in safe and supportive families and to ensure that the most vulnerable are protected. The two KPIs that will be used to measure the impact of our actions are; to reduce the number of looked after children in the Leeds area – the baseline at January 2011 was 1,434 and to reduce the number of children and young people with child protection plans – the baseline at January 2011 was 778.

The CYPP covers a broad and complex agenda so to focus efforts in a way that makes the greatest impact three KPIs have been chosen as 'bell weathers' to provide a way to make significant improvements in a relatively short timescale. Rapid progress on these three 'bell weathers' or 'obsessions' will have a knock on effect in other areas. Reducing the number of looked after children is one of the three 'obsessions'.

The 103 list refers to the number of children and young people that came into care between 1st January and the 27th March 2012. Nearly half of this list included children who were under the age of one year old. A piece of research has been undertaken to explore why these children have come into care – what's the story?

Research project objectives

The research objectives are to:

- Quantify parental factors that contribute to children becoming looked after such as alcohol / drug use, domestic violence, mental health and learning disabilities
- Identify the presenting child protection concerns for this group of children
- Quantify when referrals are made to CSWS and by whom
- Explore how the assessment processes is conducted with particular emphasis on pre-birth assessment and planning
- Identify the involvement of / support given by Children's Services such as children's centres and family group conferencing
- Quantify the involvement of the child's extended family network
- Identify outcomes for previous children
- Explore the child's journey from initial concerns, assessment, through to placement and then permanence - focusing on purpose, time scales and long term planning
- Success stories and challenging cases

The sample

The sample has been drawn from the LAC 103 list and refers to those children who came into care between the 1st January 2012 and the 27th March 2012 and were aged under one year old at the time. Initially there were 46 children within the cohort. On investigation one child did not have LAC status and there were two sets of twins. The cohort was amended to reflect the twins as belonging to single birth events therefore the sample group consists of 43 births.

Methodology

The initial data set was obtained from ESCR and contained information about the child's name, ESCR reference number, first and subsequent legal status, care start date and the social work team with case responsibility.

This data was expanded to provide a broader picture of the household, parental factors, presenting health and social issues, involvement from social care and other agencies, the child's journey from assessment through to care planning and options for permanence.

The additional information was obtained by interviewing the lead social worker practitioner / team manager. The interviews were over the telephone and took between 15 and 30 minutes to complete.

Initial findings

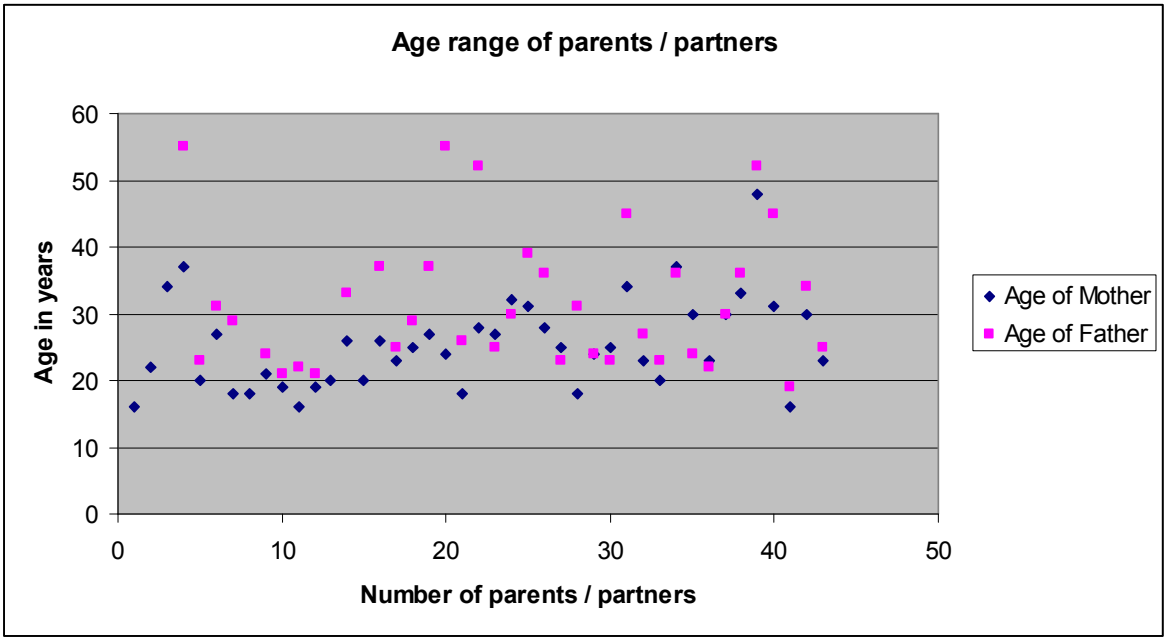
The initial findings have been collated into the following key themes to promote initial discussion:

- Age
- Parental factors
- Child protection concerns
- Previous children
- Referral
- Support and extended family

Age

The data shows a distinct difference in age bands between mothers and fathers although the average age of mothers and fathers is similar.

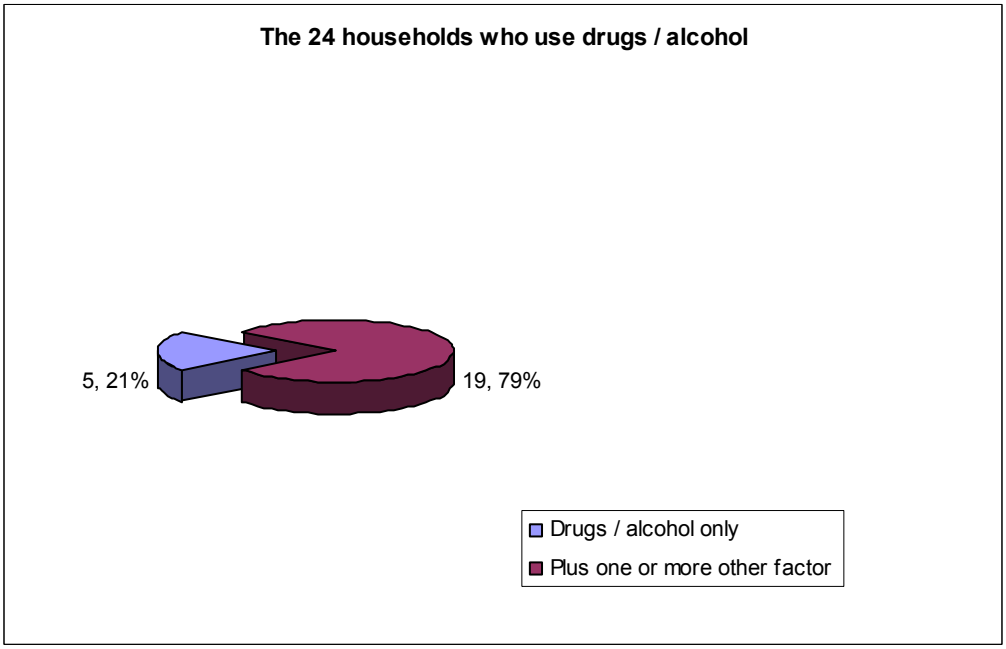
Average age of mothers is 26	Average age of fathers is 28
Youngest mum is 16 (pregnant at 15)	Youngest father at 19
Oldest mother at 48	Oldest father at 55



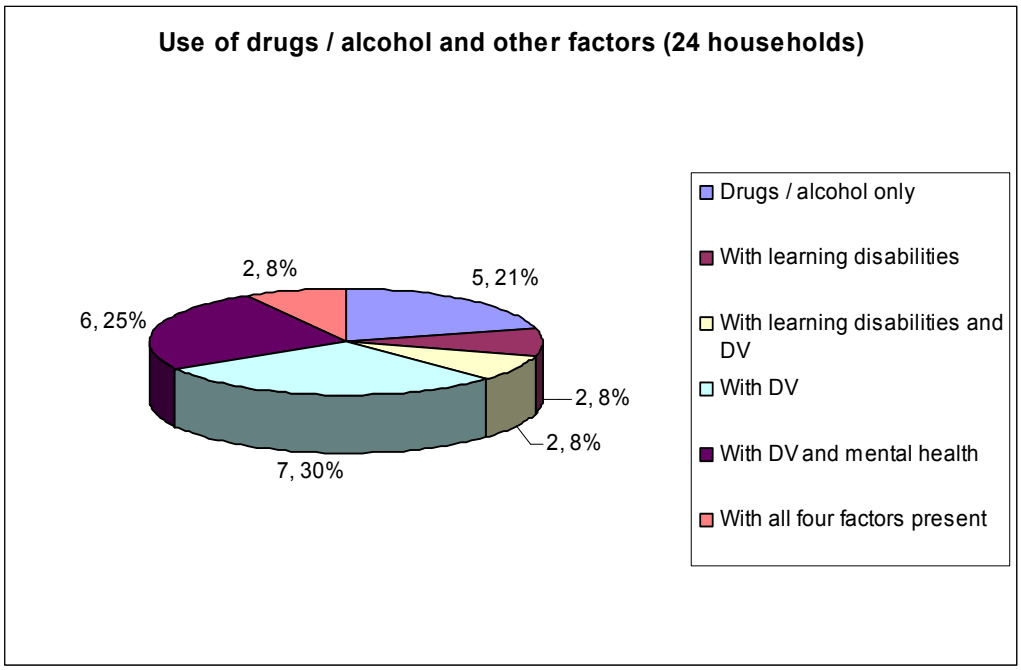
Parental factors

Drug and alcohol use

24 (56%) out of the 43 households use drugs / alcohol. Both parents use drugs in 50% of the 24 households identified as using. Of the 24 households where parents use drugs / alcohol, 19 (79%) experience one or more other factors.

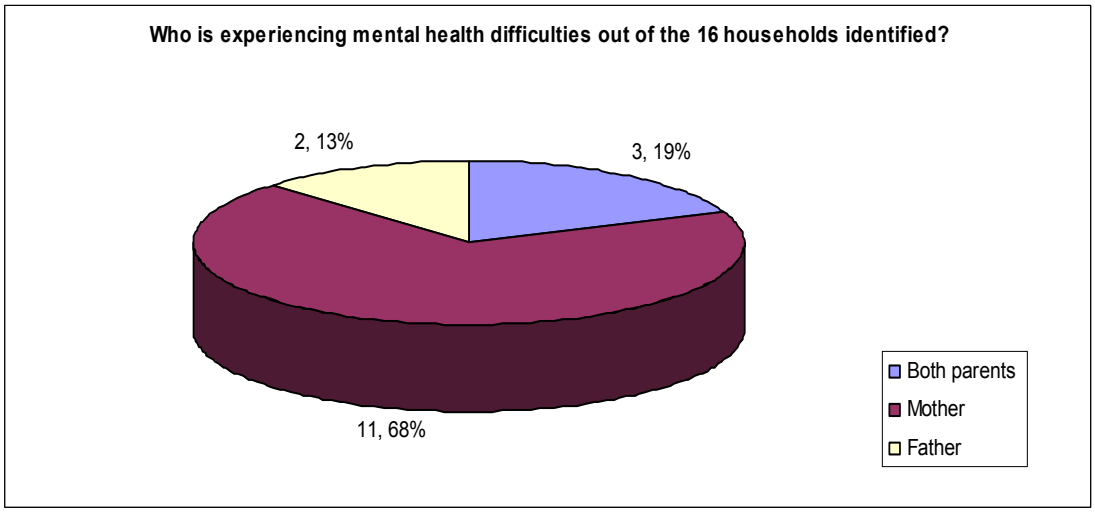


The other factors include mental health, domestic violence and learning disability.

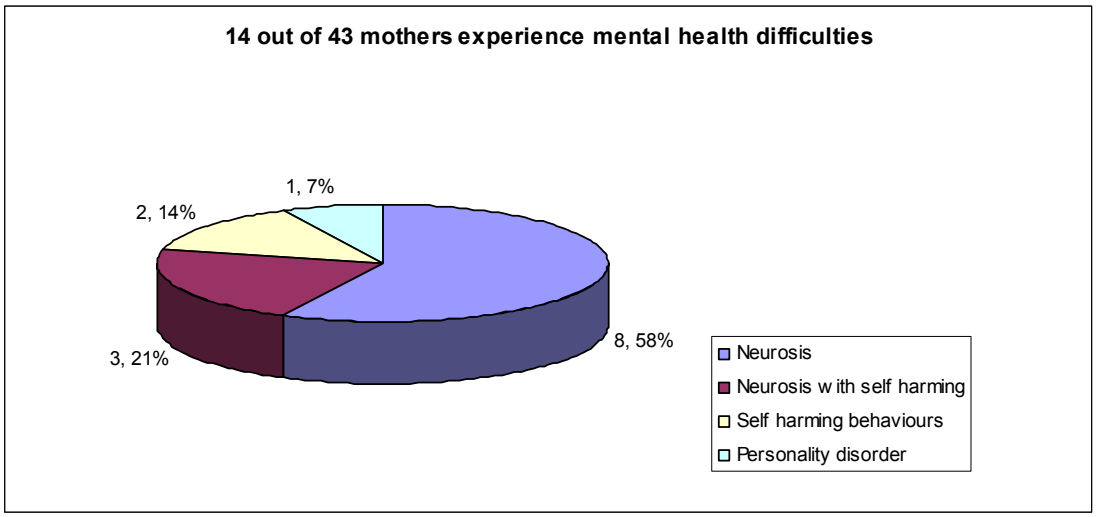


Mental health

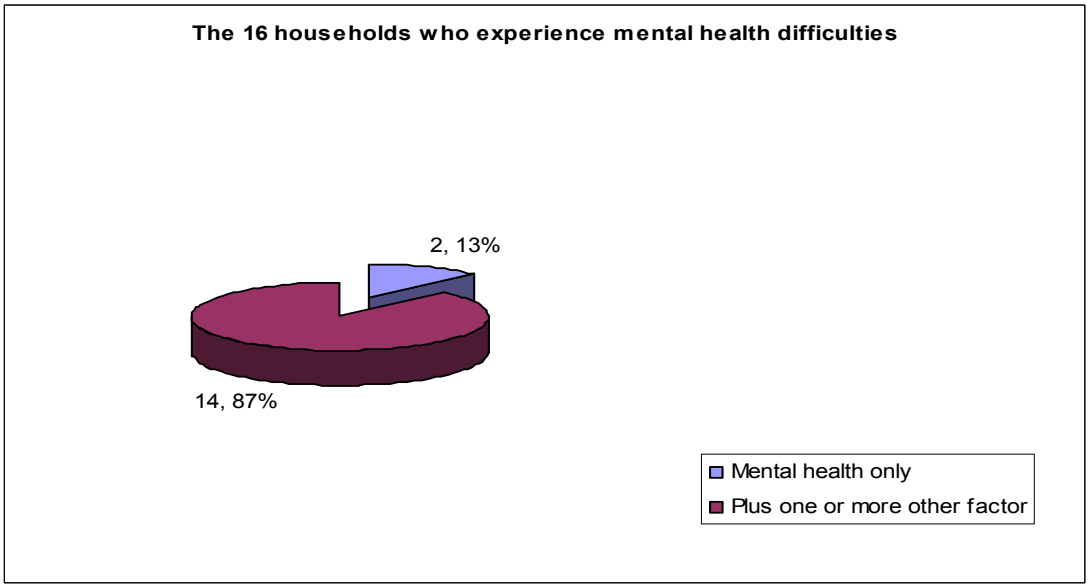
16 out of 43 (37%) households experience mental health issues (this excludes drugs / alcohol use). Nearly three times as many women experience a mental health issue in comparison with fathers / partners.



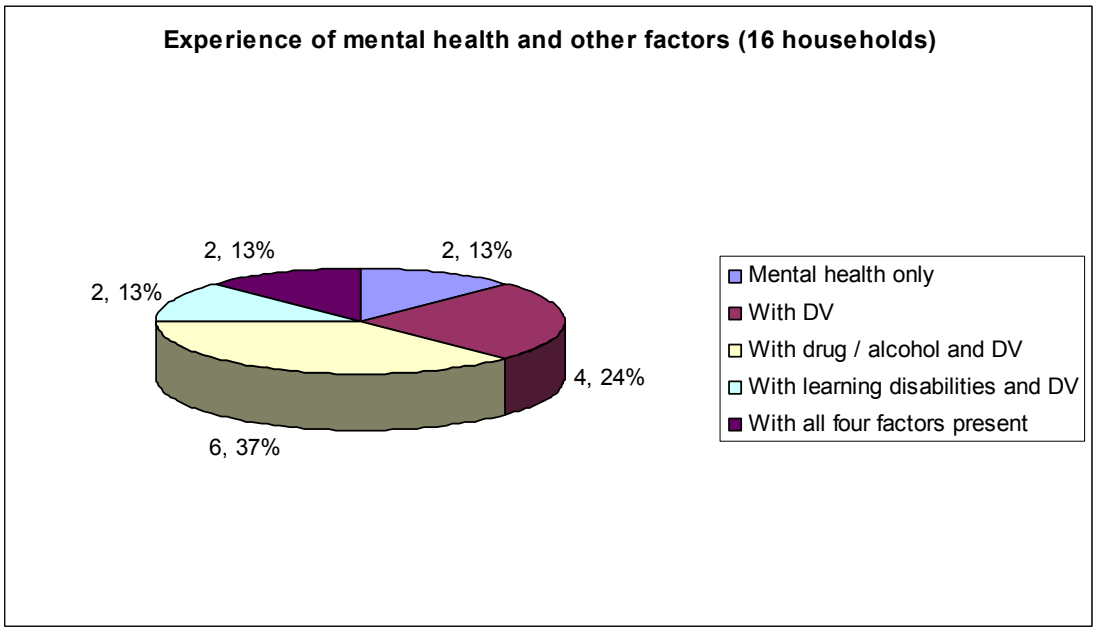
Women are more likely to experience neurosis ie depression, anxiety and cutting behaviours and men are more likely to experience both neurosis and psychosis ie schizophrenia.



14 (87%) of these 16 households also experience one or more of other factors as shown below.

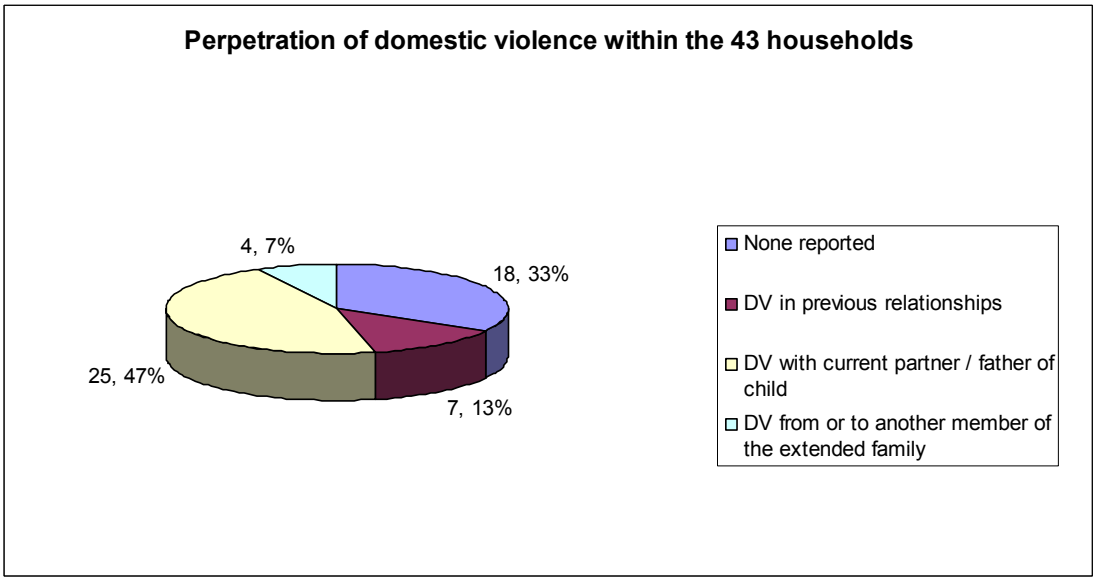


The other factors include domestic violence, drug / alcohol and learning disability.

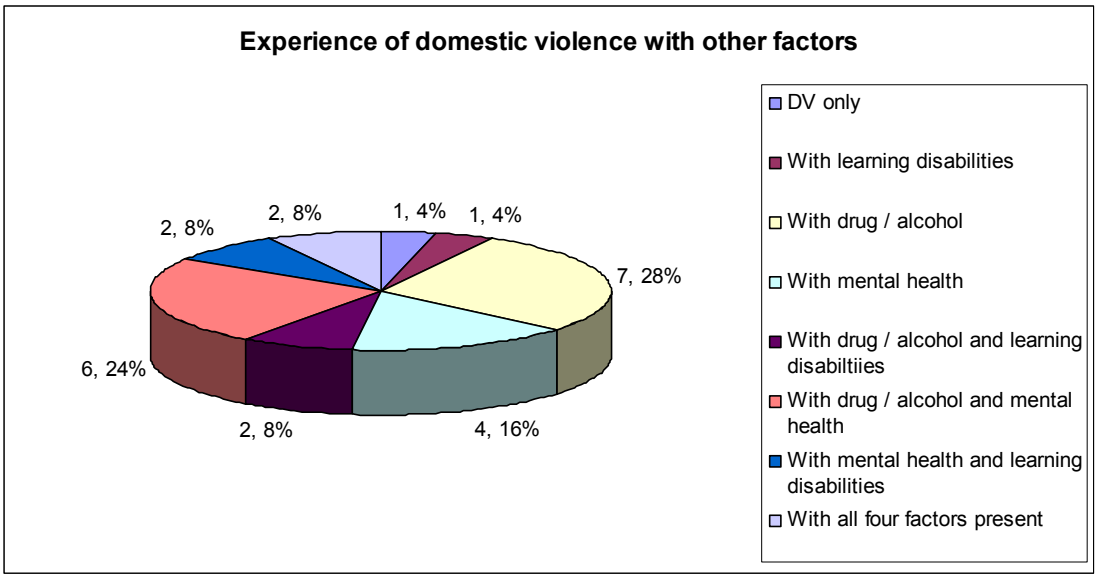


Domestic violence

Domestic violence has or continues to feature in 25 (58%) of the 43 households. The perpetration of domestic violence can be broken down further by source which includes members of the extended family ie grandmothers to daughters and mothers to their children, brothers to sisters as well as fathers / partners to mothers.

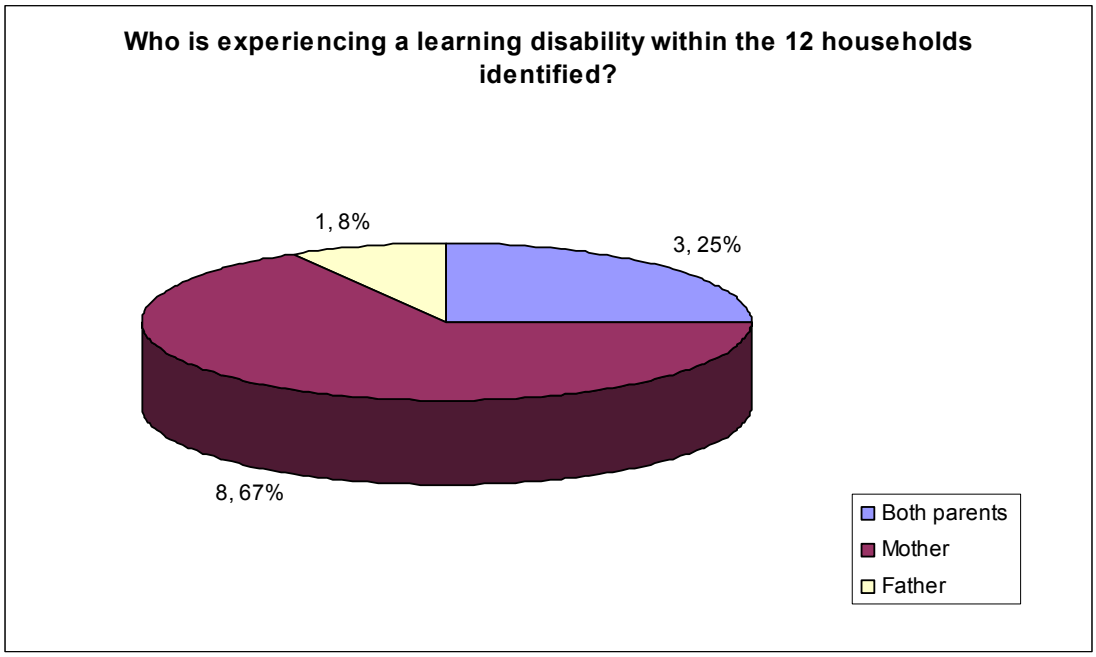


24 (96)% of these 25 households who experience domestic violence also had one or more other factors presenting such as drug / alcohol, mental health issues and learning disability.

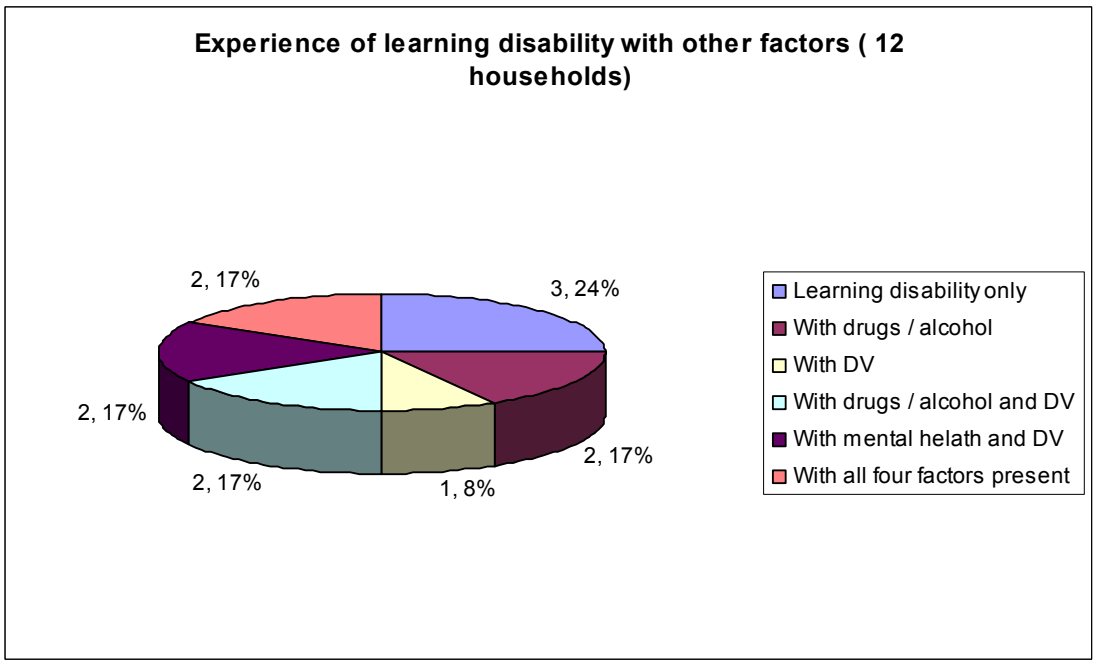


Learning disability

11 (26%) mothers and 4 (9%) fathers / partners from the 43 households have a mild learning disability.

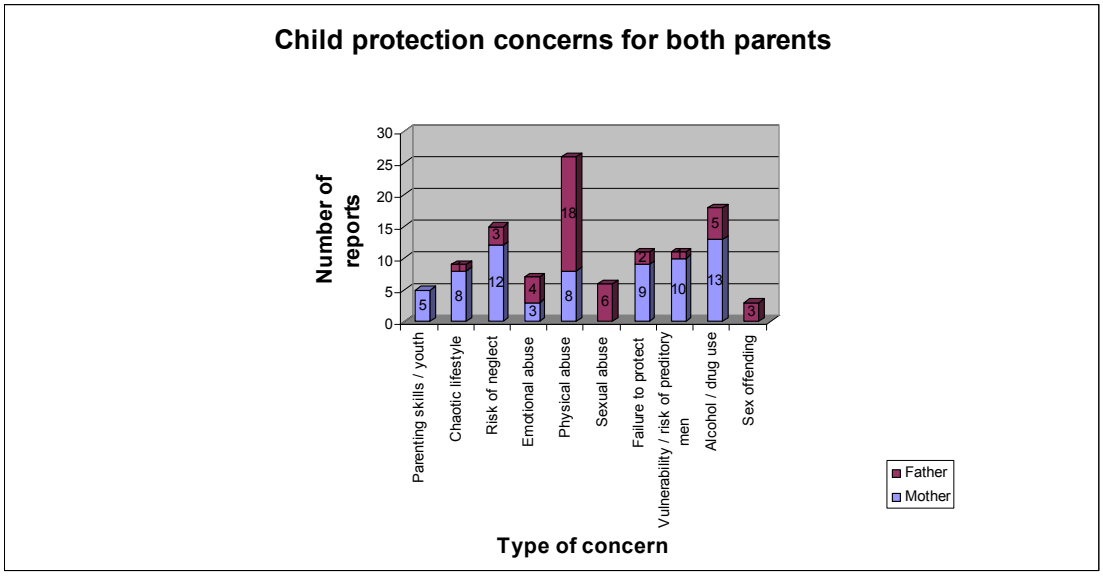


12 (28%) of households in the cohort experience learning disabilities and of those 12 households, 75% experience one or more other factors such as drug / alcohol, mental health issues and domestic violence.

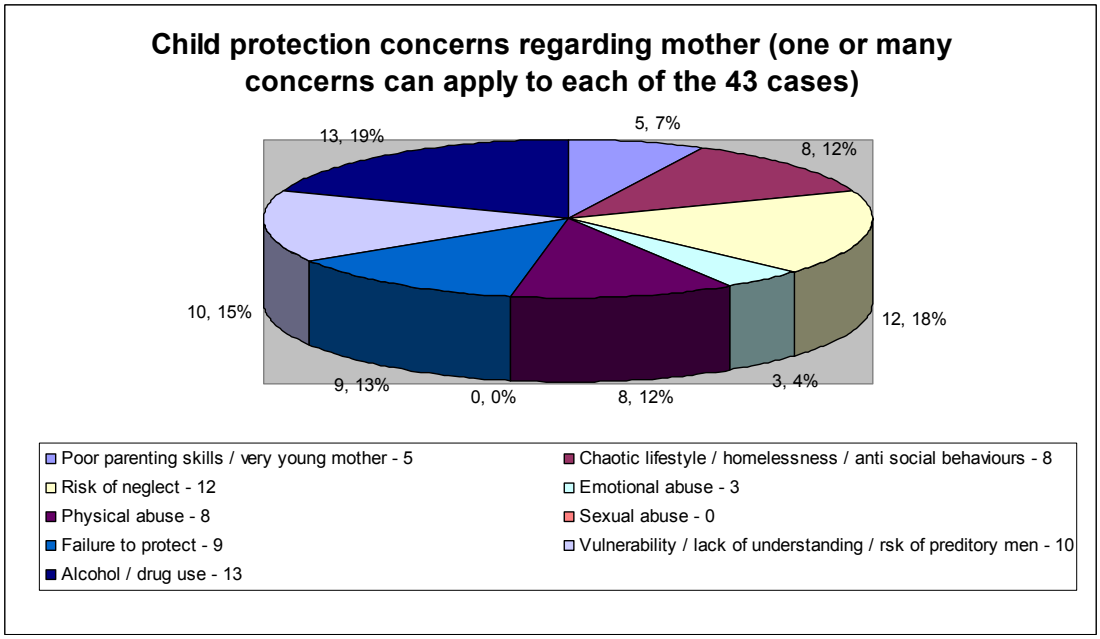


Child protection concerns

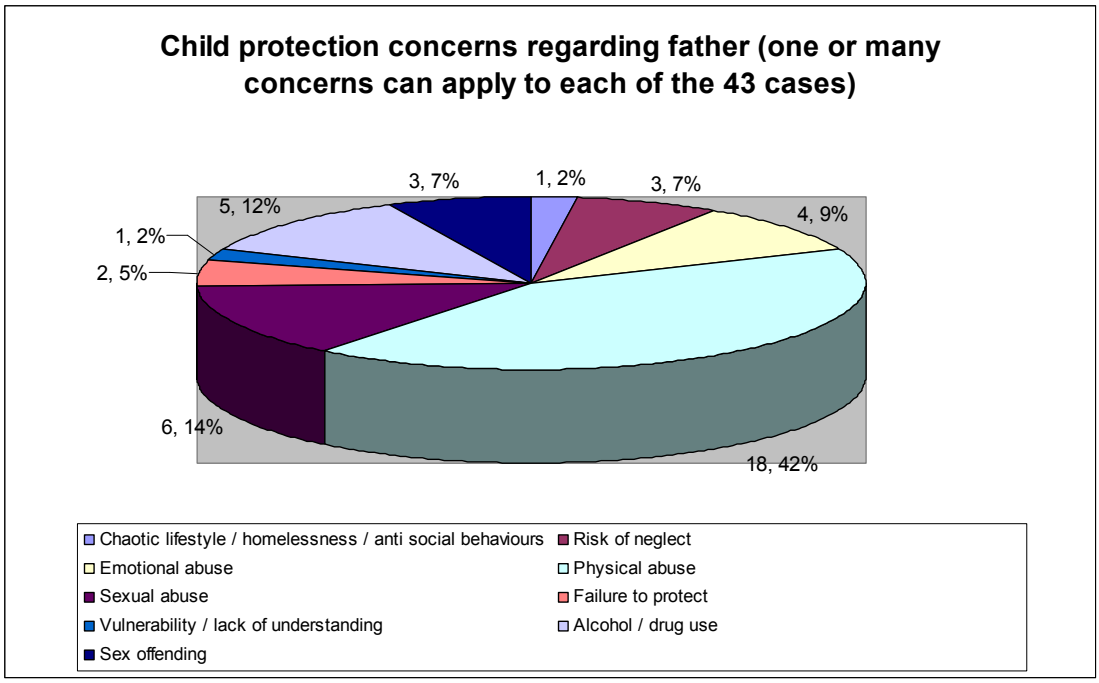
When looking at child protection concerns there are variations between the genders. These are regarding physical abuse, sexual offences, drug / alcohol use and failure to protect.



Children protection concerns regarding mothers

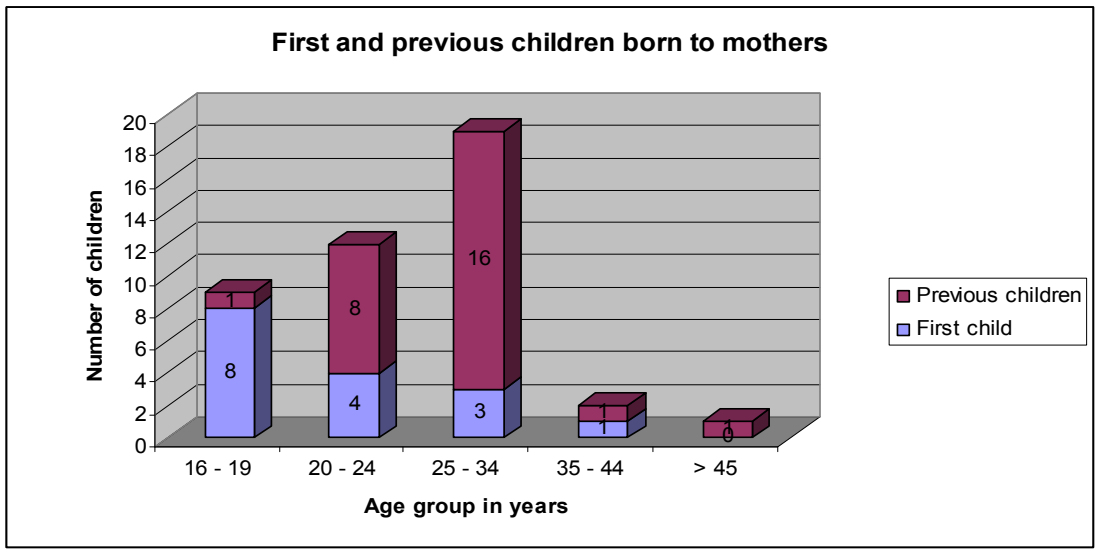


Children protection concerns regarding fathers / current partners



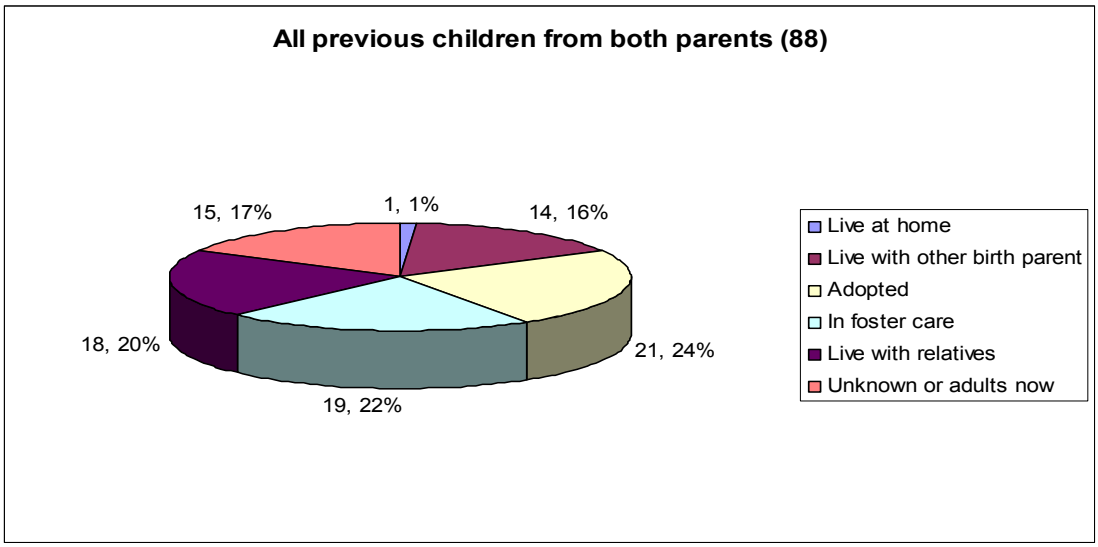
Previous children

The table below shows the number and age range of mothers where this is their first child or an additional child. For 16 (37%) out of 43 mothers this is their first child. There are 27 (63%) out of 43 mothers who have had 64 previous children between them.

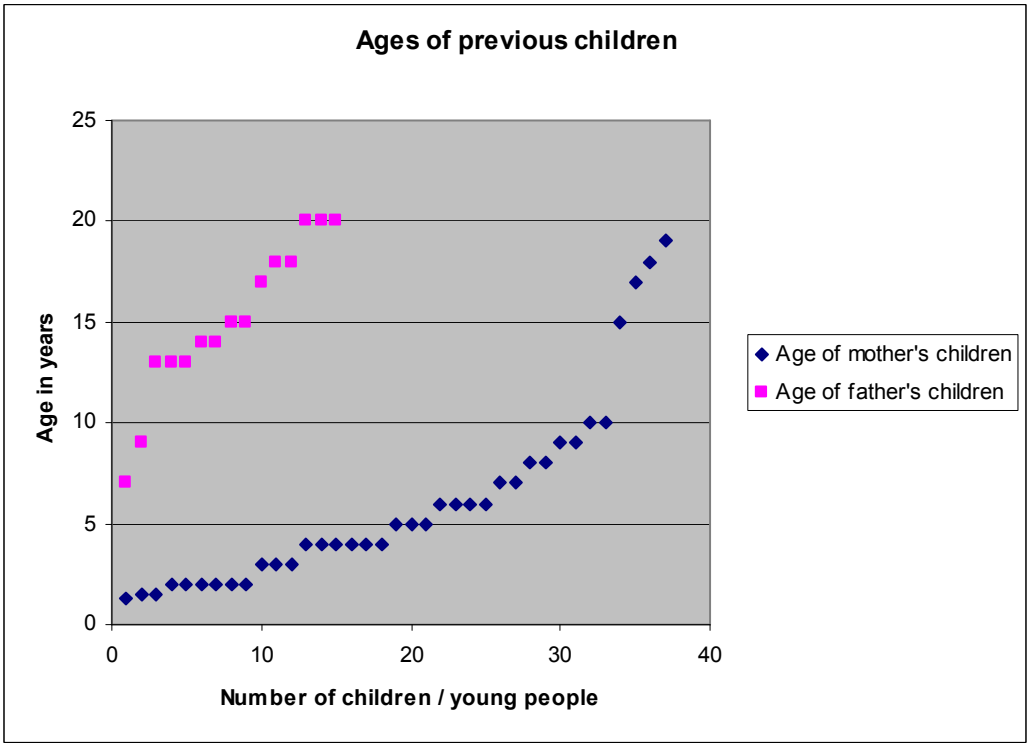


The situation is less clear for fathers / partners as there is less known information about these men than with mothers. There are 24 previous children paternally. This provides a total number of 88 children (born from the current or from past relationships that can be

considered as previous children). Out of the 43 households studied, 27 (63%) of those households have had previously born children removed.

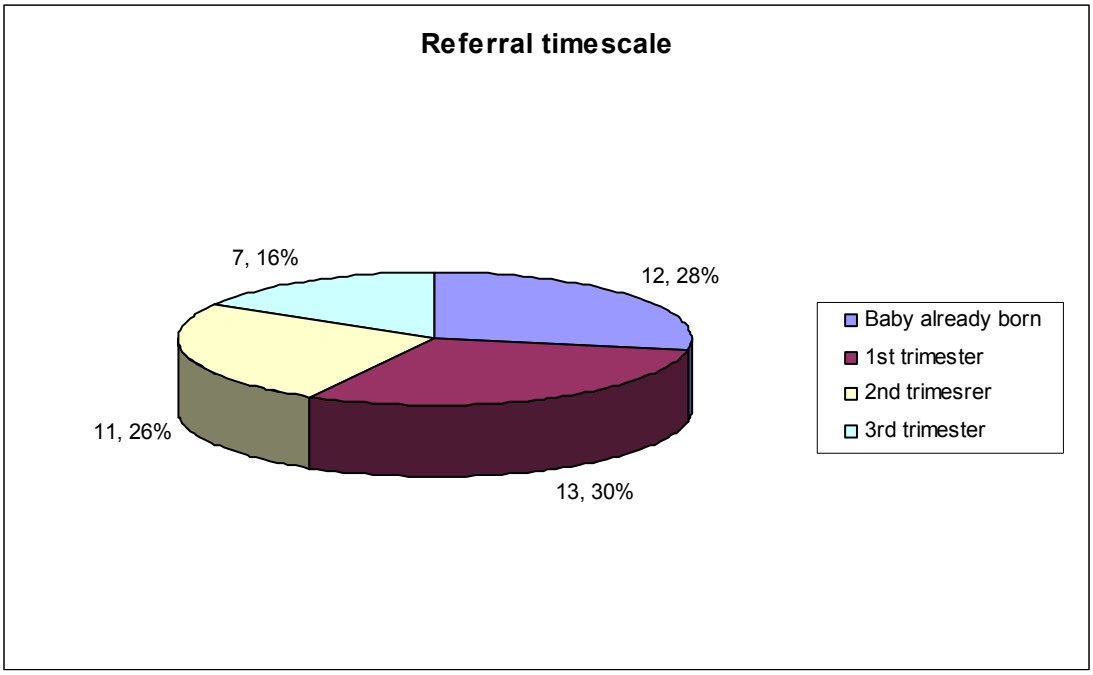


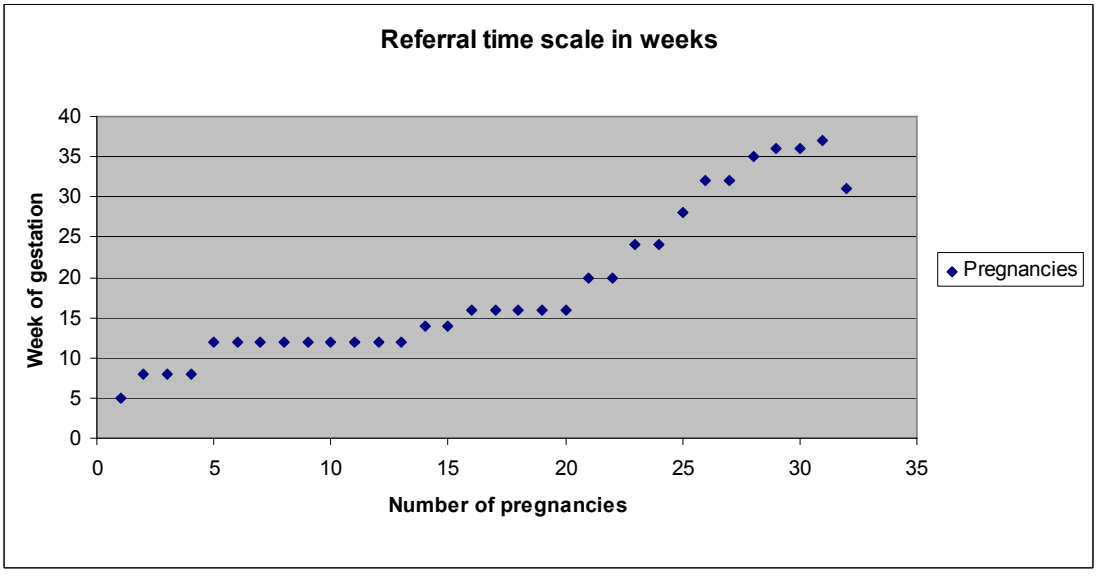
As with the age differences shown earlier between mothers and fathers, there are age differences between the sets of previous children born to parents. The average age of previous maternal children is 6yrs old with an age range between 15mths and 19 years. The average age of previous paternal children is 15 years with an age range of seven years to 20+



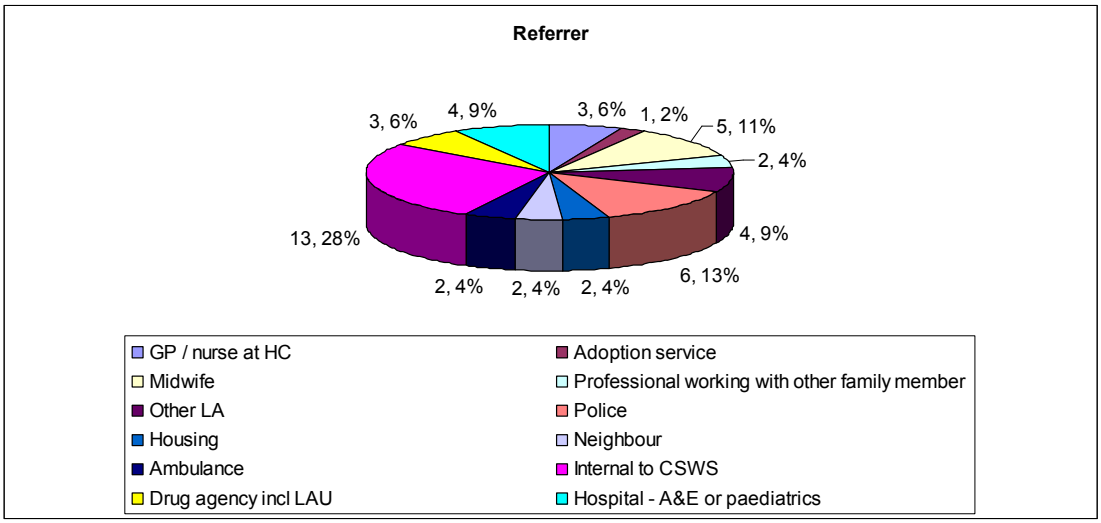
Referral

31 (72%) children from the 43 households were referred to CSWS as unborn children. 12 (28%) children from the 43 households were under the age of one year between 1st January and the 27th March 2012 when they came into care. Below is a breakdown of when the unborn child was referred to CSWS – in which trimester and also weeks into pregnancy.

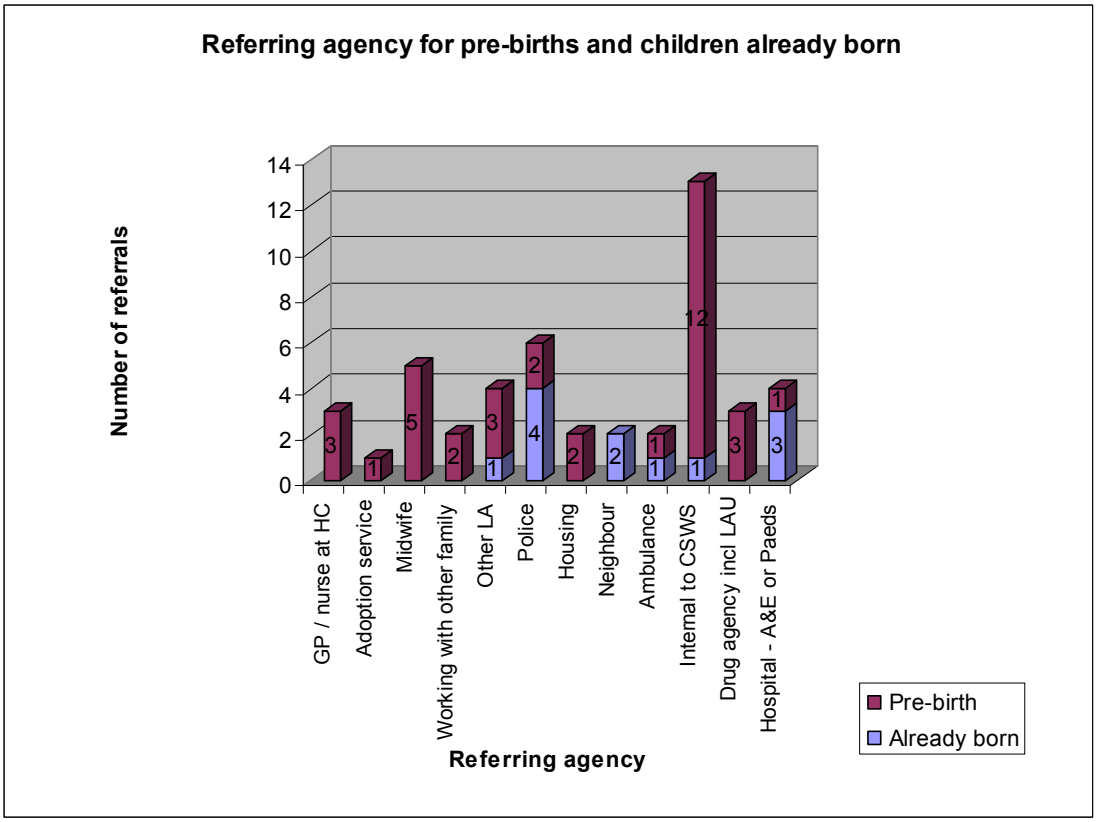




Referrals were received from a variety of sources and in some instances more than one referral was made on the same day for a specific child by different referrers eg. Ambulance service and a neighbour.



Where a child had already been born the referring agent was more likely to be the police, hospital or a neighbour.

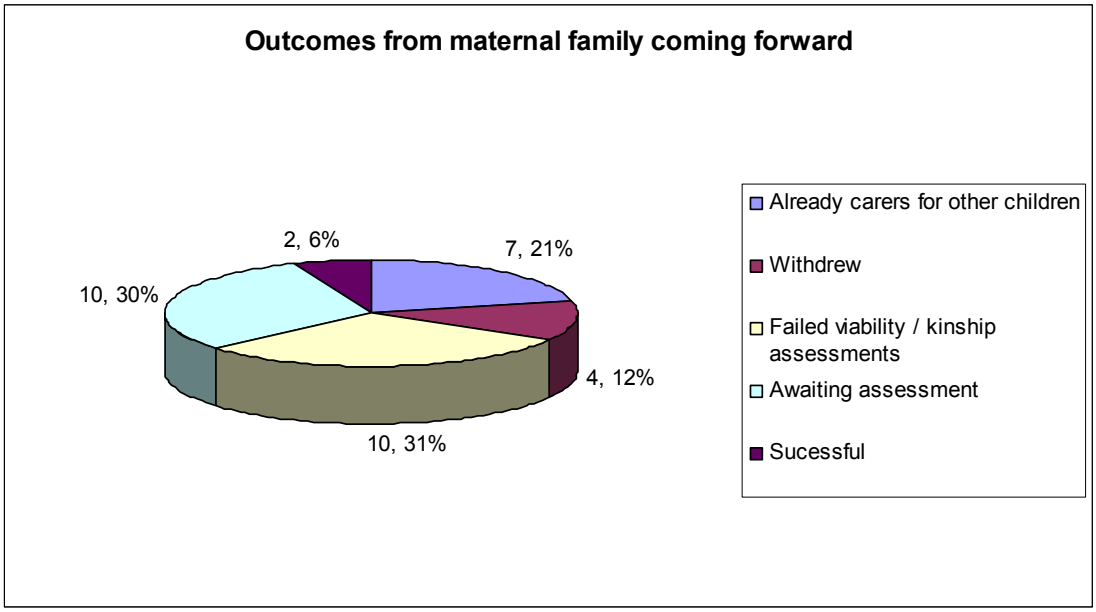


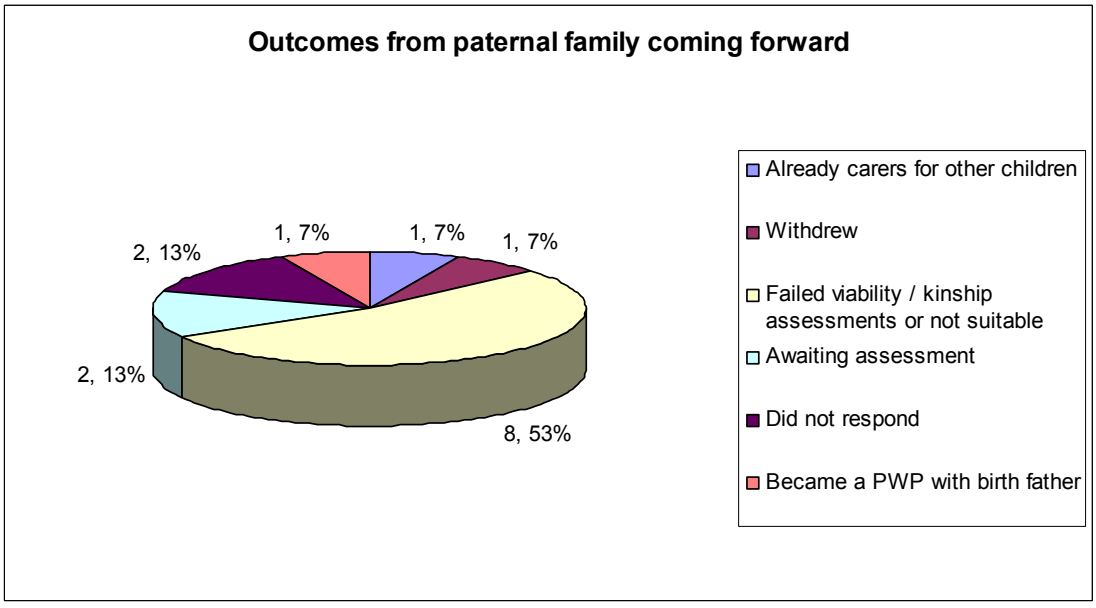
Support and extended family

20 (46%) out of 43 mothers were referred to a children's centre, one mother self referred. Where a baby was subsequently removed from the parent and placed in care the support from the children's centre stopped. Social work practitioners raised this as an issue in that pro-active parenting work could be done for children rather than waiting for the next pregnancy before resuming support.

Nine (21%) out of the 43 families were referred to or had involvement with family group conferencing.

The extended family was approached in 35 (81%) of the 43 families.
33 approaches to maternal relatives were made for 29 of the 35 families and 15 approaches to paternal relatives were made for 13 of the 35 families. On the paternal side there were less relatives being approached or coming forward. This may be due to CSWS and other agencies having less involvement / contact / knowledge about fathers. The outcomes from maternally generated approaches were more positive than paternally generated approaches as shown below.





Summary and initial conclusions

Age

Although the average ages of mothers and fathers / current partners was similar 26 and 28, the spread of ages between genders showed older men and younger women. For example, are there are 18 men and only 11 women aged 30 years and plus. There is one man age 20 years or under compared with 13 women in this age group.

Parental factors

Of the 24 households that use drugs / alcohol 19 households (79%) experience one or more other factors. The main 'other' presenting factor is domestic violence in 17 (71%) of these 19 households. Ten parents in six households are receiving support from addiction services to reduce / withdraw from Class A drug use ie Heroin and or Cocaine.

Of the 16 households that experience mental health issues 14 households (87%) experience one or more other factors. The main 'other' factor is domestic violence which features in all of these 14 households. Nearly one third (14) of the women from the original cohort of 43 households experiences a mental health issue, with this taking the form of depression and self harming behaviours. Support mainly comes from the GP or not at all.

Of the 25 households that have or continue to experience domestic violence 24 households (96%) experience one or more factors. The main 'other' presenting factor is drugs / alcohol use in 17 of these 24 households. In all 25 of these households the father of the baby or the current partner is a perpetrator of domestic violence and in seven of these households' police or court / prison has been involved.

Of the 12 households that experience learning disabilities nine households (75%) experience one or more other factors. The main 'other' presenting factor is domestic violence within seven of these 12 households. More than twice as many women (9) experience a mild learning disability compared to fathers / partners (4) and nearly one fifth of the women from the original cohort of 43 households experiences a learning disability. Further investigation is required to establish what specific if any support is available to this group of mothers to care for and protect babies considering their own vulnerability to sex offenders and drugs / alcohol culture.

Two (5%) out of the 43 households experience all four factors of drugs / alcohol, mental health issues, learning disabilities and domestic violence.

Child protection concerns

The most prevalent child protection concerns are split by gender. When looking at mothers the main concerns that social work practitioners have focus on:

- The impact of drugs / alcohol
- Vulnerability, poor relationship choices and a failure to protect the child
- Neglect

For fathers and/or current partners the main areas for concern are physical abuse and previous sex offending history.

Previous children

For mothers under 20 years old this is likely to be their first child. Older mothers between 25 and 34 years are very likely to have had one or two previous children. Of all the 27 mothers who have had previous children only one child still lives at home. All other previous children are either placed in foster care, have been adopted or are with the other birth parent / extended family.

One mother has had her eleventh child as part of this cohort and all 11 children have been individually removed from her care over previous years. Based on the outcomes for the older group of mothers it is entirely feasible that the youngest group of mothers will repeat these outcomes unless change can be made.

Fathers and current partners have also had a number of previous children removed from their care. This group of children tend to be older than for the cohort of mothers and are now adults. The data concerning fathers / partners is less robust due to the lack of engagement that these men have with families and services.

Referrals

31 (72%) children from the 43 households were referred to CSWS as unborn children. Seven (23%) were referred during the third trimester, 11 (35%) were referred during the second trimester and 13 (42%) were referred in the first trimester. The earliest referral was five weeks into pregnancy and the latest four referrals were made after 35 weeks. Several of the later referrals to CSWS were made following concealed pregnancies or failed appointments with the Leeds Addiction Unit midwife. The most extreme scenario was that of a referral made at 28 weeks following 18 missed appointments.

Referrals were received from a variety of sources. Those made by the police (following incidents of domestic violence), ambulance service, neighbours, A&E and paediatric services related to children already born. Only 5 (11%) of referrals came from midwifery services and only 3 (6%) came from drug / alcohol agencies. The majority of referrals at 13 (28%) were made by internal CSWS staff.

These findings highlight that referrals are not made early enough for effective pre-birth assessment and planning to take place. Further investigation of the data is required to assess how early pro-active support is being put into place for these families. For example access to children's centres and intensive family support. There are indications from the initial data that parenting foster care placements are having good outcomes.

Support and extended family

20 (46%) of the 43 mothers were referred to a children's centre. Where a baby was subsequently removed from the parent and placed in care the support from the children's centre stopped. Where this support has included parenting skills work the implication is that the mother will not be prepared or more adequately equipped to parent for likely future children.

Only 9 (21%) out the 43 families were referred to family group conferencing services. However, contact with extended family members is taking placing outside this arena by social work practitioners. When looking at where a child can be placed whilst parenting assessments are undertaken or as a permanency option / alternative to adoption.

Most of the contacts made with extended family are with maternal family members rather than paternal family. Again this could be due to the lack of long term involvement from fathers / partners and lack of data.

Most placements made with the extended family are with maternal grandparents then maternal aunts. In some families, grandparents are already caring for other children in their family. This raises an issue that the burden of care is being taken up by an older and potentially less economically well off section of society that will require more ongoing support and access to funding as these children grow older.

From the data gathered so far, it shows that many viability and kinship care assessments are being undertaken. However, the conversion rate is low and is more likely to positive on the maternal side of the extended family.