Early Help Panel Evaluation Report

(Six Month Review)

24th June 2015 – 23rd December 2015

Buckinghamshire County Council

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Glossary of terms

BSCB: Buckinghamshire Safeguarding Children Board

CAMHS: Child and Adolescent Mental Health Service

CIN: Child in Need

CP Plans: Child Protection Plans

EHP: Early Help Panel

FRS: Family Resilience Service

MARF: Multi-Agency Referral Form

NSPCC: National Society for the Prevention of Cruelty to Children

SEN: Special Educational Needs

TVP: Thames Valley Police

YOS: Youth Offending Service

Executive Summary

There are some useful conclusions that can be drawn from the in-depth research and analysis that has been completed for this report. These outcomes can be used as a basis for the development of new strategies and to inform future executive decisions. The aim of this section therefore is to summarise the main learning points:

- 203 families have been through the EHP process between 24th June and 23rd December 2015.
- 111 families were classified as having multiple and complex needs (meeting Level 3 on the BSCB threshold document.)
- In December 2015, 32 of the 41 families discussed had multiple and complex needs (78.05 %.) This demonstrates a significant improvement in the quality of referrals, when compared to figures from the initial months.
- The main referrer to the EHP was education, with a total of 74 referrals from 58 different schools.
- A lead agency was allocated to 111 families from 14 different agencies.
- The primary / main reason for referral was significant behavioural problems, which accounted for 62 out of 210 referrals.
- 47 of these 62 referrals were made for the behaviour of a male child (75.80%) and 18 of these fell within the age bracket of 11 to 13 years.
- Domestic violence and poor attachments were identified as the two issues most likely to have an impact on a child displaying signs of emotional and behavioural disorder.
- Within the 111 families who were classified as Level 3 complex needs, there were 564 problems identified, in relation to the BSCB threshold document. This is an average of **5.08 problems per family**.
- Of the three areas outlined on the BSCB threshold document (child development needs, parenting capacity and family/environment) parenting capacity was the area of greatest concern.

Background Information

The aim of the Early Help Panel (EHP) is to improve positive outcomes for families with complex issues, who require a co-ordinated multi-agency response. This is achieved by creating tailored plans that strengthen protective factors in the family and mitigate against risk factors. The panel aims to offer help and support to a family to prevent the need for statutory intervention, relating to safeguarding.

Since the three month review, there have been some notable changes to the panel. From 30th September 2015 the panels were extended to include Chiltern and South Bucks districts and from 11th November 2015 this was furthered to Wycombe. Following this progression, it was agreed that there would be a single combined 'Super Panel' once a fortnight, covering all four of these district council areas. This outcome was reached to effectively manage the time of professionals and therefore maximise efficiency. As a result, in 2015 there were 12 panel dates covering a total of 23 panel papers. There were 12 panels for Aylesbury, seven for Chiltern / South Bucks and four for Wycombe.

The previous evaluation report confirmed that the EHP was working well but at the same time allowed us to identify areas for improvement. In particular, the quality of referrals was prioritised; with less than half of the total cases meeting the appropriate Level 3 threshold from the first six Aylesbury panels. This statistic is in relation to the Buckinghamshire Safeguarding Children Board (BSCB) threshold document, which is included on page 22 of this report.

To improve the quality of referrals we introduced an Early Help Panel Decision Maker on a five month secondment from November 2015. This will be formally reviewed in March 2016. Early indications are that this role has had some limited success but that its function and remit need to be more closely defined, if it were to be a permanent post.

Our action in developing and funding this post demonstrates the fluidity that is, and will, continue to be fundamental to our agile project management; in order to achieve the best outcomes for children and their families. This evaluation report will therefore assess the impact made from these changes.

Demographics

This section will highlight the reach of the panel and the positive potential it has had in such a small space of time. In order to understand this analysis, it is important to mention that for dependants we will focus on the primary household. This includes all individuals aged 18 and under, as well as those with a learning or physical disability up to the age of 25, as they may require additional parental support.

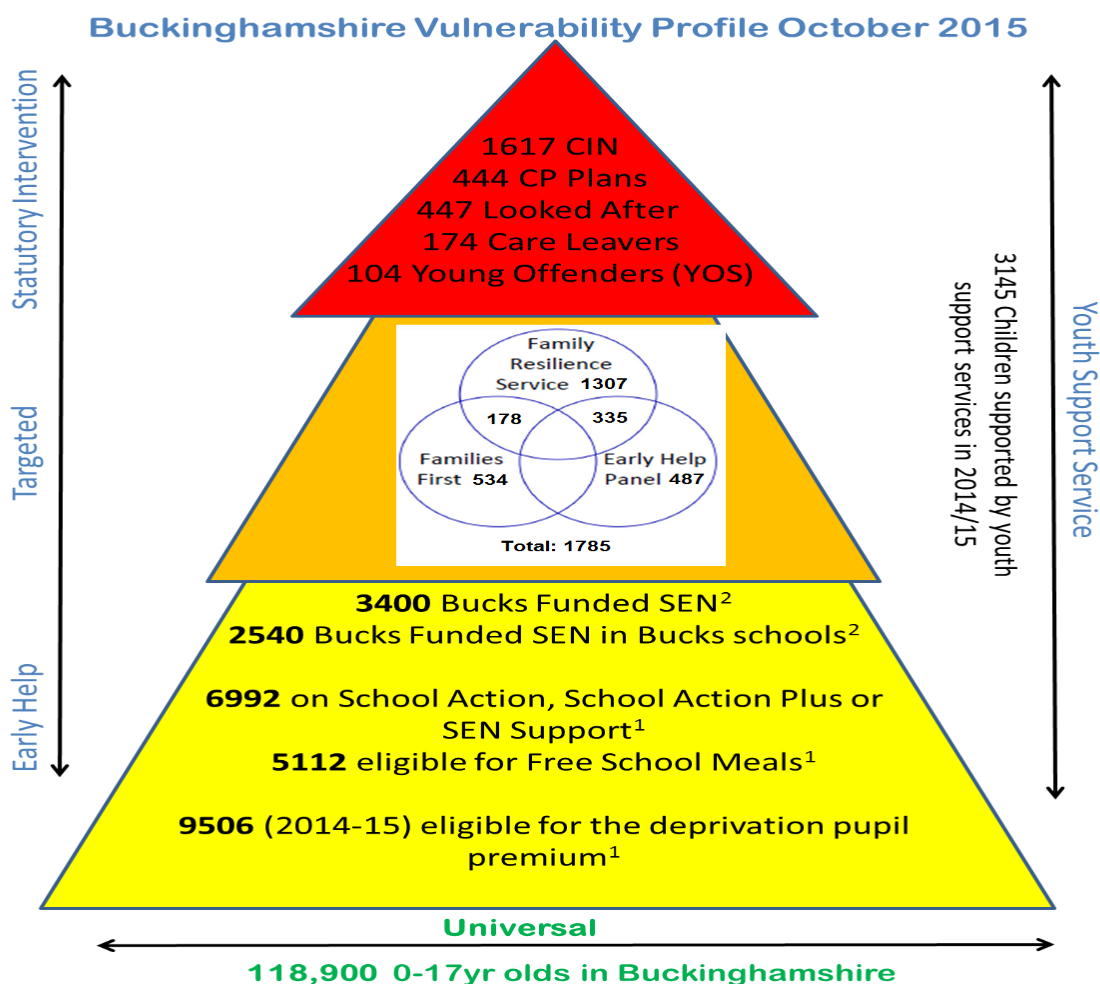
Based upon this between 24th June 2015 and 23rd December 2015, the EHP has had a significant impact in Buckinghamshire:

- 203 families have had their needs discussed at the EHP
- This included 487 dependants with an average age of ten
- 441 of these were children under the age of 16

Once we include extended family members, who were relevant to the case:

- There were 1,125 people who had been through the EHP process
- Within this number, there were 761 individuals from the Aylesbury Vale District, 233 from Chiltern / South Bucks and 131 from Wycombe.
- 576 of these were male and 545 were female (4 were unrecorded)

The diagram below further represents how the EHP combines with other services across Buckinghamshire to address the needs of the most vulnerable in society.



[1]Pupils attending Buckinghamshire maintained Schools only ,including those residing outside of Buckinghamshire
[2] The numbers have been rounded to the nearest 10
Funded SEN numbers refer to children with current statements of SEN or Education, Health and Care Plans that are the financial responsibility of BCC and includes those where there may not be any additional funding.
The 2540 is a count of children recorded in BCC maintained schools, PRU's and academies and does not include placements in other settings within BCC for example pre-schools, independent/non-maintained schools, colleges or free schools.

Panel Efficiency

Before moving onto more complex analysis, this element of the report will focus upon panel efficiency. At the moment, the EHP has agreed to run to similar timescales as Child in Need (CIN) cases; 45 working days from referral to assessment. Therefore, this section will determine whether or not the process is currently operating within these defined parameters.

Month	Average duration from referral to EHP (working days)
June	16
July	15
August	23
September	20
October	19
November	18
December	21
Overall Average	**19**

From this table, it can be concluded that once a family has been referred it will take an average of 19 working days for the case to be heard at panel and for a lead agency to be allocated, where appropriate. This is exactly the same outcome as the previous evaluation report and therefore the current timescale seems to be consistent. It should be reiterated here that two EHP's were cancelled on the 22nd August 2015 and 16th September 2015 and this explains the increase in duration around these periods. This is in line with our initial projections and recognises the fact that Early Help is neither a rapid response, nor an emergency service.

However, there is always room for improvement and as we can see in recent months the average duration from referral to EHP has risen slightly. This may be because as the EHP has become more embedded in the county, the volume of referrals has increased. This is a trend that is expected to continue and a greater demand means a greater average duration from referral to EHP. Therefore, in order to further reduce this figure, in the future the EHP could consider having a weekly 'Super Panel.' This would need careful consideration, in order to balance the need for a swifter response with the considerable additional demand on agencies. Partners were consulted on this and agreed that unless demand exceeded 45 families per panel it would not be cost effective to move to a weekly panel. .

In addition, the Early Help Decision Maker has not managed to reduce this duration and there has been some initial analysis of the reasons for this, bearing in mind that the role is due to be reviewed formally in March 2016. It is already apparent that the Early Help Decision Maker has spent a considerable proportion of time gathering additional information not provided by referrers prior to panel, and also in gaining

informed consent from families. This has tended to delay the bringing of families to panel. It has also been noticeable that the administrative burden on the panel co-ordinators has not been reduced by the introduction of this post.

Panel Meetings

There has been a very high level of representation at panels with the majority of agencies providing a regular attendee, and, where necessary, a deputy at manager level. This has been of great value and has led to increased interagency cooperative working.

Furthermore, we acknowledge the considerable additional work contributed by members and other staff in their organisations in checking records, providing information and preparing for panel.

Nevertheless, we have noted some gaps in the provision of information or panel attendance and are already taking steps to address some of these early in 2016. This includes Educational Psychology and Adult Mental Health Services. It also remains difficult to engage other agencies, such as Secondary Schools and Adult Social Care.

Observers have been able to attend all panels, with prior notice and clear expectations of their role, and we remain grateful to both Clinical Commissioning Groups for the use of their high quality facilities.

All panels in 2015 have been chaired by the Head of Early Help, Buckinghamshire County Council, except one which was chaired by the Service Manager for CAMHS. From January 2016, the EHP's will be chaired in turn by a senior officer from Thames Valley Police, the Service Manager from CAMHS and the Head of Early Help, Buckinghamshire County Council.

Referral Agencies

In this part of the report, we will conduct comparative analysis between the referral agencies up until the three month review on 30th September 2015, with all subsequent cases. This will enable us to determine whether there has been an increase in the spread and amount of agencies referring to the EHP's, as well as where there may need to be further awareness-raising.

It is important to mention here, that since the three month review there has been a change in the method of recording referrals, with the aim of improving consistency. From now on, all original referrers will be recorded as opposed to First Response. This is because in practice all referrals will come through First Response and therefore

should not be recorded as such. As a result, these figures have been slightly adapted from those in the first evaluation report.

Three Month Review

This table covers the first six panels in Aylesbury from 24th June 2015 to 30th September 2015.

Referral Agency	No. of referrals	Proportion
Education: 5+	18	25.35%
Social Care	18	25.35%
CAMHS	8	11.27%
GP Surgery / Hospital	5	7.04%
Other	5	7.04%
Adult Mental Health Services	4	5.63%
Thames Valley Police	4	5.63%
Education: Under 5	3	4.23%
Paediatrics	2	2.82%
Health Visiting	2	2.82%
Addiction Services	1	1.41%
Connexions	1	1.41%
TOTAL:	**71**	

Following Three Month Review

This table covers EHP's for all four district council areas from 14th October 2015 to 23rd December 2015, including the panel for Chiltern & South Bucks held on 30th September 2015.

Referral Agency	No. of referrals	Proportion
Education: 5+	56	40.29%
Social Care	26	18.71%
Other	10	7.19%
CAMHS	10	7.19%
Self - Referral	9	6.47%
GP Surgery / Hospital	8	5.76%
Thames Valley Police	6	4.32%
Adult Mental Health Services	4	2.88%
Paediatrics	3	2.16%
Connexions	2	1.44%
Health Visiting	2	1.44%
Education: Under 5	1	0.72%
Housing	1	0.72%
Youth Offending Service	1	0.72%
TOTAL:	**139**	

When comparing these two datasets, there are some apparent differences. The most obvious of these is the significant surge in referrals from those classified as **Education 5+** following the end of September, with a 14.94% increase in proportion. This statistic is unsurprising given the fact that the school summer holidays were from 21st July 2015 to 5th September 2015.

In addition, there was a substantial increase in the amount of self-referrals following the three-month review. As a result, we will discuss these cases in more detail at a later point in the evaluation report, to determine how they could be managed more effectively in the future. This information will be included in **Appendix B.**

The final trend observed in these combined datasets is the low number of referrals from Connexions, Health Visiting, Housing, Addiction and Youth Services. Therefore, it could be worth prioritising these agencies for further Early Help Approach Awareness training in the future.

Overall Data

The graph below represents the total number of referrals made to the EHP in 2015. It is important to mention here that despite there being only 203 families who have been through the EHP, there were 210 separate referrals recorded in the data. This is because some families were referred to the EHP by more than one agency. These specific families will be analysed further in **Appendix C** of the report.

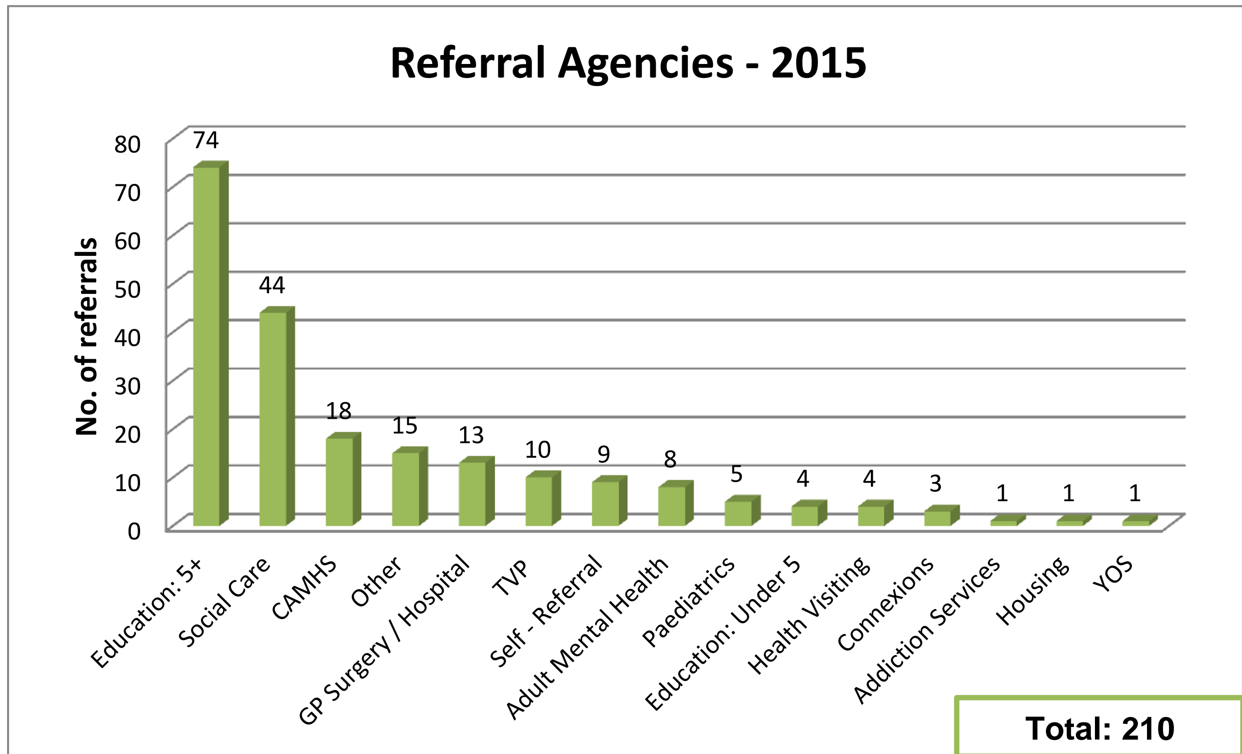
For the purposes of this graph, the following agencies have been categorised as Other:

Three Month Review

- Anonymous
- Aylesbury Women's Aid (x 2)
- CAF Suffolk Safeguarding Board
- Carers Bucks

Following Three Month Review

- Brighton and Hove Children Services
- Bucks Floating Support
- NSPCC (x 3)
- Safeguarding Adults Board
- Time to Talk Bucks (x 2)
- Young Carers (x 2)



From this graph, it is clear that a large proportion of referrals to the EHP originate from Schools (35.24 %) or Social Care (21.15%), which together account for 56.39% of all referrals. Within these 74 referrals from Education: 5+, there were **58 separate schools**. Amongst these organisations, Oak Green School had the greatest amount of referrals with five individual cases.

At the same time, from looking at the overall data, it is clear that there is a good spread throughout the referral agencies. This information therefore emphasises how well ingrained the EHP has become in Buckinghamshire within its six month period and how agencies continue to engage for the benefit of families.

Panel Decisions

As mentioned earlier in this document, the main cause for concern from the previous evaluation report was the significant proportion of cases that were not meeting the appropriate Level 3 threshold, based upon the BSCB document. This is a requirement for the case to be discussed at panel and subsequently allocated to a lead agency. Consequentially, the aim of this section is to determine whether the changes made since the three month review have seen the desired improvement. This will be achieved by comparing data from the district areas as well as analysing the percentage of appropriate referrals on a monthly basis from June 2015 to December 2015.

Aylesbury - Panel start date 24th June 2015

Decision	No. of families	Proportion
Level 2	32	23.70%
Level 3	66	48.89%
Escalated to Level 4	16	11.85%
Not enough information	19	14.07%
No decision required	2	1.48%
TOTAL	**135**	

Chiltern & South Bucks – Panel start date 30th September 2015

Decision	No. of families	Proportion
Level 2	8	17.39%
Level 3	28	60.87%
Escalated to Level 4	7	15.22%
Not enough information	2	4.35%
No decision required	1	2.17%
TOTAL	**46**	

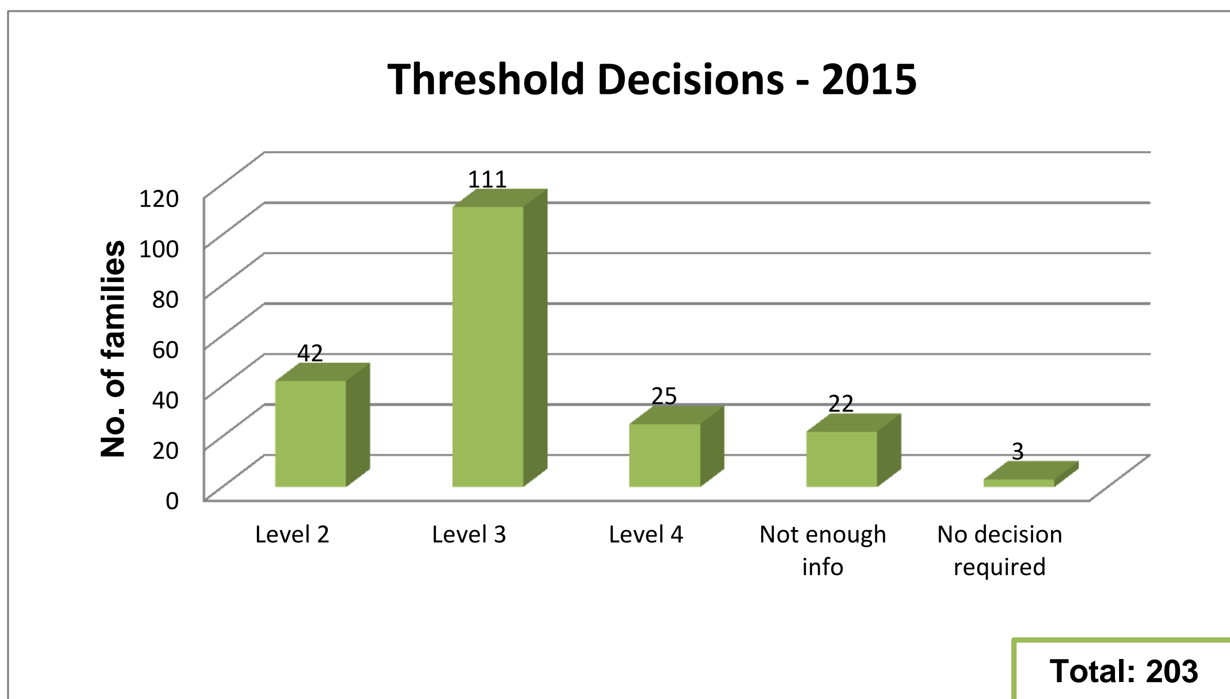
Wycombe – Panel start date 11th November 2015

Decision	No. of families	Proportion
Level 2	2	9.09%
Level 3	17	77.27%
Escalated to Level 4	2	9.09%
Not enough information	1	4.55%
No decision required	0	0.00%
TOTAL	**22**	

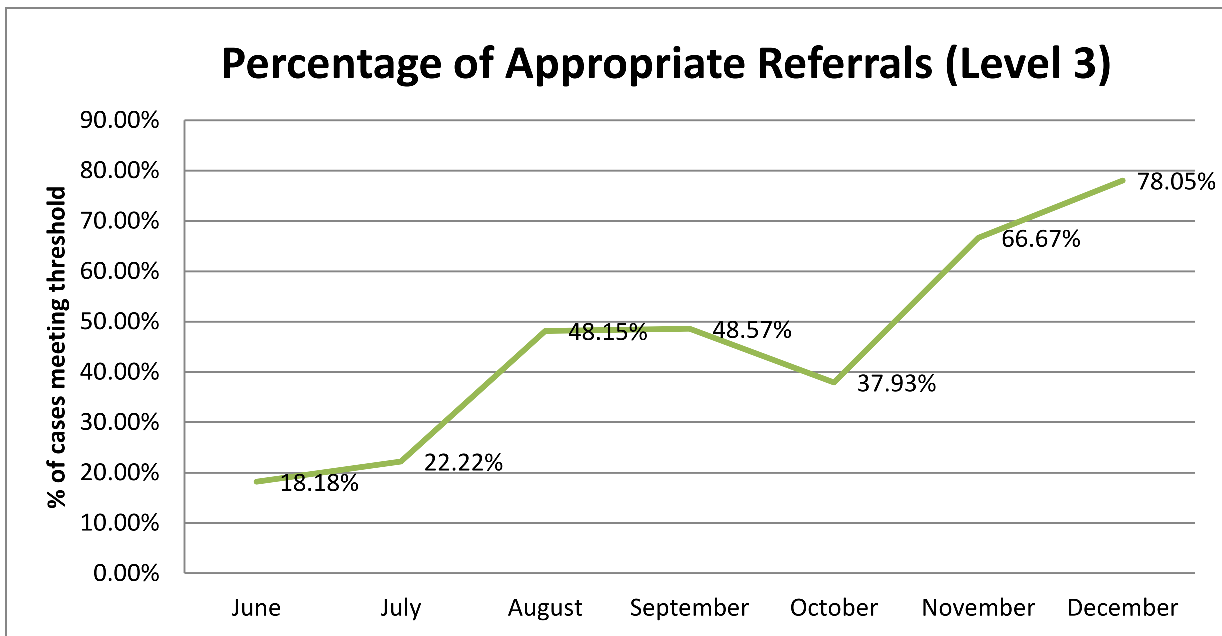
From comparing these datasets, it is clear that there is a difference in the quality of referral based upon district area. The Aylesbury Vale District has a visibly lower proportion of cases meeting the required Level 3 threshold. However, there is a straightforward explanation for this statistic. Aylesbury was the pilot area for the EHP and therefore was very much a learning curve. The process was regularly adapted and amended in its initial phase, until the best outcomes were achieved. As a result, the early EHP's had a considerably lower percentage of appropriate referrals. For example, in June and July only 18.18% and 22.22% of referrals were appropriate, compared to 63.64% in December.

In addition, the figure that was particularly striking in the Aylesbury area was the number of referrals classified as having not enough information for the panel to reach an informed decision. These cases also occurred very early on in the process with 15 of the 19 recorded arising prior to the three month review, on 30th September 2015. Following the review, we began to filter out single issue referrals leading to a significant improvement in these numbers.

This graph combines the information from the four separate district council areas to represent the overall data for 2015.



From this graph, we can see that from a total of 203 families discussed at the EHP's 111 met Level 3 criteria and qualified for a multi-agency coordinated response. Although this only accounts for 54.68 % of the cases, this figure is expected to rise significantly within the next few months. The reason for this expected increase will become more apparent, upon viewing the following data.



This graph demonstrates the instant and positive impact made by filtering out the single issue cases. Furthermore, the recommendation reached following the three-month evaluation of introducing an EHP Decision Maker came into force from 23rd November 2015. This will have had a further effect on the figures.

Above all, November and December show substantial improvement and this positive trend is expected to continue. This will considerably increase the overall percentage of appropriate referrals in the coming months. To put this into context, 32 of the 41 cases progressed to the EHP in December, were subsequently classified as Level 3.

Despite this, October is somewhat of an anomaly and does not follow the general positive correlation we have seen on a month-to-month basis. However, there are a number of possible reasons for this unexpected outcome. Firstly, the situation will have had an influence. As mentioned when analysing the referral agencies, there was a significant surge in the number of school referrals following September 2015. At the same time, October is the first month after the extended school summer holiday. A combination of these factors will have contributed to the following outcomes. During the summer holidays teachers and pastoral support officers would not have had access to important training on Early Help Awareness, provided by the Families First team. Secondly, each school will have had a number of new and unfamiliar pupils. This could have resulted in a referral being made to the EHP before the individual fully understood the entire picture of the child and their family dynamics. Finally, there were a number of families where schools hoped that the specific situation would resolve itself over the summer. Upon return, the schools concern over a lack of progress resulted in a referral.

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The Quality of Referrals

Using a combination of data from the previous two sections of the report, we can conduct further analysis. In order to continue to improve the quality of referrals, it is important to ensure that each individual referral agency has a good understanding of the EHP process. To achieve this, it is necessary to identify where the less appropriate referrals are originating from. This will enable us to target areas that need development and will therefore contribute to practice improvement. As a result, this section of the report will include a comparison between the referral agency and the subsequent panel decision. This will establish whether or not any specific agencies are more prone to referring inappropriately.

For the purposes of this analysis, any agency that has only referred one case to the panel has been excluded from the dataset, as the outcomes would be inconclusive and unrepresentative. Indeed, all agencies that have below ten referrals are probably difficult to analyse. Nevertheless, these cases have been included for interest. In addition, one referral from social care has been excluded from this table, as no decision was required by the panel. This case had been sufficiently allocated before progressing to discussion, at the relevant EHP.

Referral Agency	Level 2	Level 3	Level 4	Not Enough Info	Appropriate
Adult Mental Health	2	3	3	0	37.50%
CAMHS	3	14	1	0	77.78%
Connexions	0	0	0	3	0.00%
Education: 5+	12	46	9	7	62.16%
Education: Under 5	0	4	0	0	100.00%
GP Surgery / Hospital	6	1	2	4	7.69%
Health Visiting	1	2	1	0	50.00%
Paediatrics	2	3	0	0	60.00%
Self – Referral	2	6	0	1	66.67%
Social Care	8	19	11	5	44.19%
TVP	1	9	0	0	90.00%

CAMHS, Education: Under 5 and TVP had the highest proportion of appropriate referrals. Meanwhile, Social Care, Connexions and GP Surgery / Hospital had the lowest proportion. This could well be because the main reason for referral for TVP was domestic violence and referrals from CAMHS often had mental health present. These are two problems that rarely existed in isolation and both tended to contribute to a family having multiple and complex needs. Additionally, the involvement of TVP and CAMHS in the panel in chairing roles from the beginning is likely to have increased their understanding of thresholds; and therefore will have contributed to the quality of referral. At the same time, Education: Under 5 referrals concern

children who will typify those in need of early help intervention; in order to achieve their full potential in the future. Finally, given the large amount of referrals received from Education: 5+ it is encouraging to see that 62.16% of cases were appropriate. More in-depth analysis around these issues will be conducted in the thematic aspect of this evaluation, from page 18 onwards.

However, we note that we are not yet receiving any referrals accompanied by an Outcomes Star. This is the Early Help Assessment adopted by the BSCB in 2015 and would increase the understanding of the family, once they are progressed to the EHP.

Lead Agencies

Before moving onto the thematic aspect of the evaluation report, we will now look at where the panel cases are typically placed once they have been classified for Level 3 multi-agency coordination. In particular, we will focus upon lead agency allocation.

It is important to note in some cases it is necessary to have a co-lead, in which two agencies share the lead role for a single family. Where this has occurred both agencies have been recorded in the dataset. Therefore, despite there being only 66 families who qualified for multi-agency intervention in the Aylesbury Vale District, there were 71 cases where a lead agency was allocated. This method of recording will continue throughout this section.

Aylesbury

Lead Agency	No. allocated	Proportion
Family Resilience Service (FRS)	40	56.34%
CAMHS	7	9.86%
Children's Centre	6	8.45%
Youth Services	5	7.04%
Health Visiting	4	5.63%
ADDaction	2	2.82%
Other	2	2.82%
Connexions	1	1.41%
Youth Offending Service	1	1.41%
Family Group Conference (FGC)	1	1.41%
FRS Parenting	1	1.41%
Educational Psychologist	1	1.41%
TOTAL:	**71**	

Other:

1. **Early Help Panel Coordinator**
2. **No role for EHP** (This specific case was classified as meeting Level 3 criteria but had already been directed to the appropriate support)

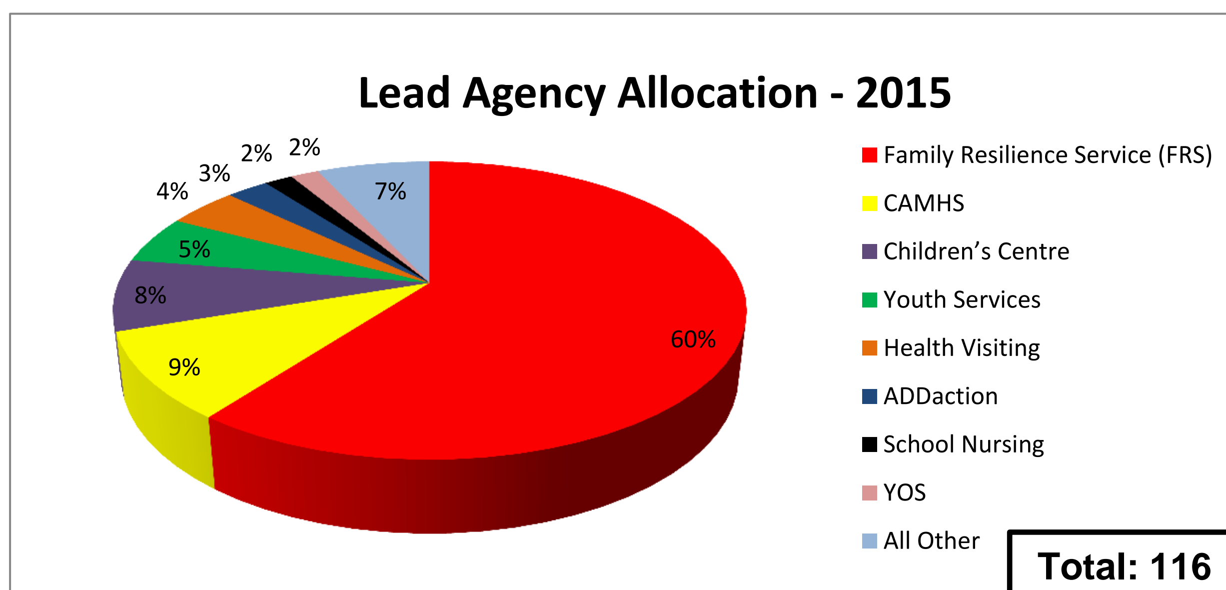
Chiltern & South Bucks

Lead Agency	No. allocated	Proportion
FRS	19	67.86%
Children's Centre	2	7.14%
School Nursing	2	7.14%
ADDaction	1	3.57%
Youth Services	1	3.57%
Health Visiting	1	3.57%
Permanence Team	1	3.57%
CAMHS	1	3.57%
TOTAL:	**28**	

Wycombe

Lead Agency	No. allocated	Proportion
FRS	11	64.71%
CAMHS	3	17.65%
Children's Centre	1	5.88%
Youth Offending Service	1	5.88%
Young Carers	1	5.88%
TOTAL:	**17**	

Combined Statistics



All Other:

- Connexions
- Early Help Panel Coordinator
- Educational Psychologist
- Family Group Conference
- FRS - Parenting
- No role for EHP
- Permanence Team
- Young Carers

From this data, it is evident that the trend first identified in the previous evaluation report has continued. As expected, FRS remains the most frequent lead agency, currently accounting for 60.34% of all lead agencies. This means FRS is working with 70 of the 111 families who qualified for a coordinated multi-agency approach. This figure is not surprising as the agency was established to specialise in supporting families who have multiple and complex needs, who will generally fall within the Level 3 threshold.

Despite this, going forward, this pattern of lead agencies needs to be monitored to ensure that one agency does not continue to take the majority of all cases.

With relation to specific district areas, there does not appear to be any significant deviation in the data.

However, since the previous report there has been one noticeable change. Up until 30th September 2015 CAMHS had not been allocated as the lead agency on a single EHP case. Yet, by December, CAMHS had become the second most common lead agency.

Thematic Review

Primary Reason for Referral

In this section of the evaluation report, we will discuss the themes that have become apparent in the first six months of the EHP process. Initially, we will concentrate on the primary reason for referral for all 203 families that have been through the EHP process. This will therefore pinpoint the single main concern of the referral agency in each individual case. This information will then be analysed further to determine whether there are any noticeable trends between the primary cause for referral and the respective referral agency.

This data was difficult to capture as many of these families had multiple and complex needs, which often had an equal impact on their situation. In fact, there were often many underlying issues, which had a direct impact on the principal concern. Nevertheless, the main cause for referral was significant behavioural issues within the family.

As mentioned on page nine of this report, there were 210 referrals in total, despite there being only 203 families. 62 of these 210 referrals (29.52%) were made primarily as a result of unmanageable behaviour. The statistic that is particularly striking, however, is that within these 62 cases, the child displaying signs of emotional and behavioural disorder was male on 47 occasions (75.80 %.) Furthermore, they were typically aged between 11 and 13, with 18 of the children falling within this age bracket. To put this into context, this was only 1 less than the total amount of children below ten, who were displaying similar behavioural issues. More of the main reasons for referral have been included below:

- 31 families were referred for high – level mental health issues and 20 of these were for child mental health
- 20 families were referred for domestic abuse
- 18 families were referred for parenting concerns
- 13 families were referred due to a risk of family relationship breakdown
- 8 families were referred for concerns of child neglect
- 7 families were referred for persistent absence from school
- 7 families were referred for substance misuse

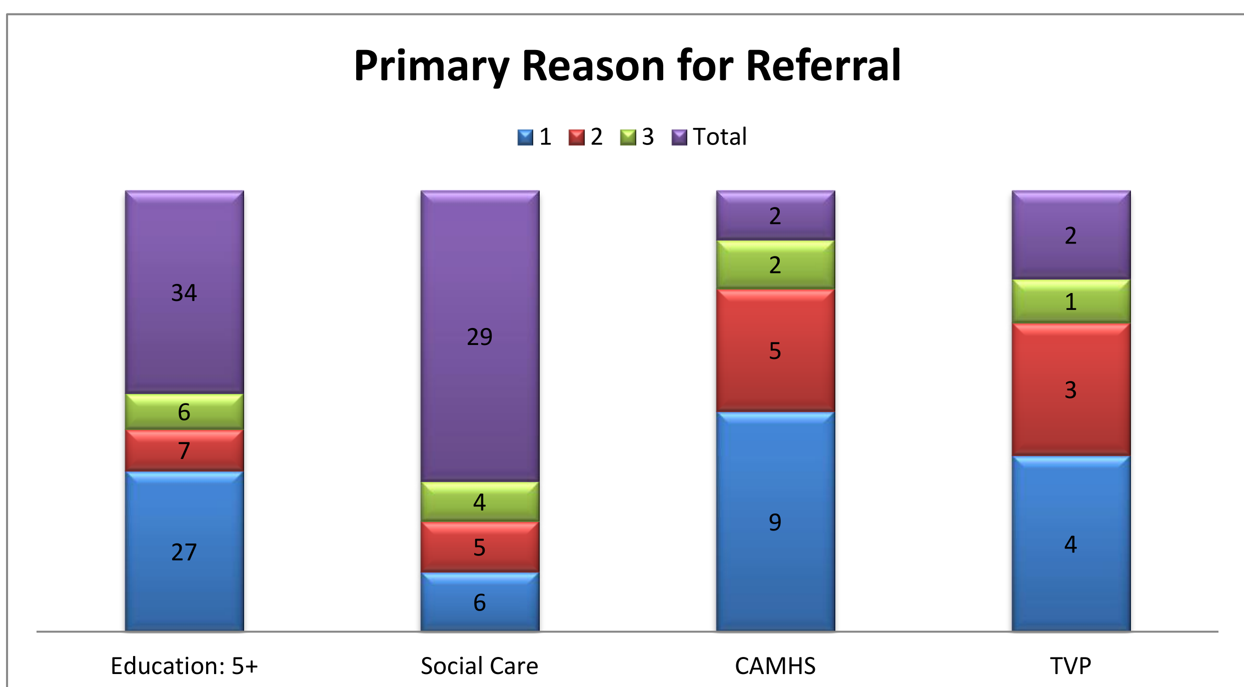
These statistics demonstrate that as expected there is a huge diversity in the primary reason for referral. Even within the 30 families who were referred for mental health there existed a variety of symptoms, ranging from depression and low mood (nine cases) to fabricated illness by proxy (one case.) It is interesting that within the cases that were referred for child mental health, the majority were again male. Boys accounted for 13 of the 20 cases (65.00 %) referred on this basis. Yet, at the same time, all 11 cases of adult mental health were primarily referred for the mother's

symptoms. This is a stark contrast. We will now look at how these outcomes correlate with their respective referral agencies and examine what themes may exist.

In order to develop these themes, the following table will identify the three primary reasons for referral for each of the main agencies. Those that are not included in the table will be discussed within the text, where relevant. For the purposes of this specific dataset, the referral agencies that were classified as other have been excluded. In addition, the cases that were self–referred will be discussed in more depth at a later point in the evaluation report.

Agency	Main Reason	Amount	Proportion
Education: 5 +	1. Behavioural problems	27	36.49%
	2. Parenting	7	9.72%
	3. School Attendance	6	8.33%
Social Care	1. Domestic Abuse	6	13.64%
	2. Behavioural Problems	5	11.36%
	3. Family Relationship Breakdown	4	9.09%
CAMHS	1. Behavioural Problems	9	50.00%
	2. Mental Health	5	27.78%
	3. Family Relationship Breakdown	2	11.11%
TVP	1. Domestic Abuse	4	40.00%
	2. Missing Person Report	3	30.00%
	3. Substance Misuse	1	10.00%

This graph represents the information in the table above. It includes the three primary reasons for referral for each of the four agencies. These are highlighted in the blue, red and green. Meanwhile, the purple outlines the remaining total amount of referrals for each agency that did not fall into any of these categories.



From this data, we can identify that there are observable trends for some agencies where there are not for others. For instance, Education: 5+, CAMHS and TVP all tend to refer a family to the EHP for specific issues, whereas Social Care referrals appear to be more varied and diverse. We can reach this conclusion based upon the graph as Social Care has a much higher proportion of purple than the other three agencies. Despite referring to the EHP on 44 separate occasions, Social Care’s primary reason for referral (domestic abuse) only amounted to six cases. Therefore, there was a much larger spread of referrals within this agency.

On the other hand, it is not surprising to see that 70.00% of all TVP referrals were made for domestic abuse and missing person reports, when it is considered that the agency has an obligation to respond to all allegations of this nature. The fact that schools mainly referred for behavioural issues could also have been predicted. It is likely that pupils displaying signs of emotional and behavioural disorder will have a disruptive impact on the learning environment. When this situation becomes uncontrollable schools will often require further support.

What may be considered surprising though is the fact that CAMHS also referred primarily for behavioural problems. One might have expected mental health to be the main reason for the agency to refer to the EHP. However, upon completing further analysis, this outcome becomes clearer. Within these nine behavioural referrals there were some recurring themes. For example, six of the nine cases were referred for children who were presenting aggressive / violent behaviour and these were often linked to a recent diagnosis of ASD or ADHD. Furthermore, we should remember that CAMHS is an agency that specialises in mental health; therefore it would be unusual for them to refer a case to the EHP for this issue alone. CAMHS is more likely to progress a family to the EHP with multiple and complex needs, of which mental health would be just one issue amongst many. This is where behavioural problems could arise as the main concern for the agency and gives further explanation to this statistic.

Now that we have analysed the dataset, it is important to briefly discuss the remaining agencies and their main cause for referral. Unlike CAMHS, Adult Mental Health Services followed the expected pattern of referral, with 50.00% of their cases being primarily as a result of mental health. As mentioned above, all of these four referrals were in relation to the mother. Three were due to low mood and depression, whilst the other was for suicidal ideation. These often had an impact on the care givers ability to parent effectively, and this may explain the need for progression to the EHP.

Meanwhile, Health Visiting referrals were primarily for emerging development needs and poor attachments, resulting in possible neglect and Education: Under 5 were largely families referred for parenting concerns. In particular, these families needed assistance with routines and boundaries for their young children, who were demonstrating aggressive behaviour and in some cases high level mental health

issues. These are both fitting with the expectation for the agency. Finally, Connexions and Paediatrics were more sporadic ranging from family finances and social isolation for Connexions to ASD diagnosis and the risk of family relationship breakdown for Paediatrics.

We have also noted an increasing trend in the referral of families where there is at least one child with a significant, ongoing disability or health need. This includes children with physical and/or mental health needs, as well as severe learning disabilities or difficulties.

Threshold Document Analysis

Having discussed the main reason for referral, the report will now move onto identify the most frequent family problem. As mentioned earlier, the EHP will accept referrals for families, who meet the Level 3 threshold having been identified to have multiple needs based upon the BSCB threshold document. Therefore, in this section we will focus solely upon the 111 families who were classified as Level 3, through the EHP process. This data will record if the family has experienced each specific problem in any capacity and as a result will not necessarily correlate with the singular main reason for referral, analysed above. In order to fully understand the following data, the key features of the BSCB threshold document have been included on the next page. For a more detailed version of the document it is also possible to visit http://www.bucks-lscb.org.uk/professionals/thresholds-document/.

Please refer to page 22

Level 2 Threshold *In addition to universal services ………*	**Level 3 Threshold** *Despite intervention at 2, evidence of continuing*
Child Development Needs 1. Poor attachments 2. Language and communication difficulties 3. Disability or additional special needs 4. Absence/truancy/exclusions 5. Incidence of absence/missing from home 6. Potential for becoming NEET (not in education, employment or training) 7. Delay in meeting developmental milestones 8. Missing health checks/immunisations 9. Minor health problems 10. Early signs of offending/anti-social behaviour 11. Underage sexual activity 12. Early signs of substance misuse 13. Poor self-esteem/mental health issues 14. Teenage Pregnancy	**Child Development Needs** 1. Child not meeting some of their developmental milestones 2. Displaying some signs of emotional and behavioural disorder 3. Chronic recurring health problems 4. Missed appointments affecting developmental progress 5. Disabilities affecting access to mainstream services 6. Teenage pregnancy 7. Risky sexual behaviour 8. Risk of entering youth justice system 9. Fixed term/permanent exclusions/no school place 10. Persistent absence from school 11. Missing from school/home regularly 12. Displaying extremist views 13. Continuing substance misuse 14. Very low self-esteem/eating disorders 15. High level mental health issues 16. Poor skills resulting in social exclusion 17. Poor/ ill-fitting clothes
Parenting Capacity 16. Inconsistent care arrangements 17. Poor supervision by parent/carer 18. Inconsistent parenting 19. Poor response to emerging needs 20. Historic context of parents/carers own childhood	**Parenting Capacity** 18. Learning or physical disability impacts on parenting 19. Substance misuse 20. Mental health issues 21. Parental non-compliance / cooperation 22. Persistent poor/inconsistent parenting / care arrangements 23. Being prosecuted for offences under the Education Act 24. Historic context of parent /carers own childhood
Family and Environment 21. Young Carers 22. Poor parent/child relationships 23. Children of prisoners/parents with community orders 24. Bullying 25. Poor housing and poor home environment impacting on child's health 26. Community harassment / discrimination 27. Low income affects achievement 28. Poor access to core services 29. Risk of relationship breakdown 30. Concerns about possible domestic abuse 31. Risk of social exclusion 32. Risk of child sexual exploitation (CSE)	**Family and Environment** 25. Domestic abuse 26. Overcrowding or temporary housing/hostel 27. Poverty/worklessness 28. Poor attachments 29. Socially excluded family / harassment / discrimination 30. Child being asked to undertake caring role of parent 31. Privately fostered child 32. No recourse to public funds 33. Transient families not accessing services 34. Significant risk of CSE

Now that you have looked at the BSCB threshold document above, this analysis will make direct reference to its contents. Within the 111 Level 3 families that were classified at the EHP, there existed 564 problems. **This is an average of 5.08 problems per family.** 292 of these 564 (51.77%) issues fell under the category of child development needs. However, as mentioned in the previous EHP evaluation report, this is almost certainly due to the fact that this section of the threshold document has the greatest number of criteria for the families to meet. This is a total of 17 out of the 34 criteria outlined (50.00%) and therefore is almost directly proportional to the percentage of problems identified within this area. This statistic means that there was an average of **1.08 development needs per child** within the 111 families. This figure is based upon children who are living in the primary household and does not include extended family members.

Meanwhile, concerns related to family and environment had ten criteria (29.41%) yet only accounted for 109 (19.33%) of the EHP problems. This means that despite only having seven criteria (20.59%) on the threshold document, parenting capacity had 163 issues identified. This amounts to 28.90 % of all problems and therefore proportionally parenting capacity remains the greatest area of concern for the EHP families. The following pages will cover these aspects in more detail.

Threshold Document

In order to better understand the most frequent family problem, it is important to identify the five most common concerns across all three categories in the threshold document. Once this is achieved, we can compare these five issues and see how they might be interconnected. This analysis will be based upon the overall statistics for the 111 families. However, this information will also be broken down further into district council areas in **Appendix D,** for comparison.

Rank	Problem	No of cases	% of Total Families (111)	% of Total Family Problems (564)
1	**2:** Displaying some signs of emotional and behavioural disorder	87	78.38%	15.43%
2	**22:** Persistent poor / inconsistent parenting / care arrangements	61	54.46%	10.82%
3	**10:** Persistent absence from school	46	41.07%	8.16%
4	**20:** Mental health issues	40	35.71%	7.09%
5	**25**: Domestic Abuse	30	26.79%	5.32%

The statistics in this table are rather compelling. As we can see from the data, a substantial 87 of the 111 (78.38%) families had children who were displaying some signs of emotional and behavioural disorder. When we analysed this information further, it became apparent that this issue rarely existed in isolation and was often triggered by another situation in the family, such as domestic violence. The extent to which will become clearer in the comparative analysis below.

As in the three-month evaluation report, domestic abuse and mental health continued to be prominent within the EHP families. This is important as these issues are largely under reported and consequently both are likely to have existed in a greater proportion of families, than those which can be recorded. At the same time, **20** (mental health issues) as presented in the table only relates to adult mental health. There were also 19 cases of high–level mental health concerns amongst children within these 111 families.

We will now compare these five most common concerns and the most informative outcomes have been included below:

- 80.56% of families that experienced domestic abuse also had a child who was displaying some signs of emotional and behavioural disorder.
- Yet only 32.95% of families with a child displaying some signs of emotional and behavioural disorder had domestic abuse in the family.

The following two statistics are proportional:

- Children displaying some signs of emotional and behavioural disorder and persistent poor / inconsistent parenting / care arrangements were the two issues most likely to exist together (29.33% of total cases)
- Domestic abuse and persistent absence from school were the least likely to exist together (16.09% of total cases) For example, only 38.89% of families experiencing domestic abuse also had a child with persistent absence from school

From these bullet points, we can conclude that domestic violence has a substantial impact on the behaviour displayed by children within the family. Where there was domestic abuse in the family there was nearly always behavioural concerns, but where there were behavioural concerns there was not usually domestic abuse. Therefore, these issues were not mutually interdependent. In fact, children who were displaying signs of emotional and behavioural disorder and inconsistent parenting were the two problems that were the most likely to exist together. This is because the latter two were interdependent, with each having an impact on the other.

This analysis has helped to give us an understanding of these five most frequent concerns and how they are inherently linked. However, in order to fully understand the complex nature of our most vulnerable families this report will conduct further research. This will involve continuing to compare these five most frequent problems with the following important issues:

- **1 :** Child not meeting some of their development needs
- **19:** Substance Misuse
- **13:** Continuing Substance Misuse
- **28:** Poor Attachments
- **34:** Significant risk of CSE (Child Sexual Exploitation)

Although these issues were not identified as the most frequent problems amongst our EHP families, they continue to be areas of significant concern for families in Buckinghamshire and beyond. The outcomes of the further analysis are again detailed below:

- 80 families (72.07%) had experienced three or more of these issues
- Only 7 of the 87 (8.05%) families that had children displaying some signs of emotional and behavioural disorder had this issue in isolation, when cross-matched with these other nine areas.
- **10:** Persistent absence from school was the only area where the average number of girls in the family surpassed boys (1.5 per family to 1.3, respectively)
- In the 24 families where there was a child not meeting some of their developmental milestones, there was an average of 1.71 boys but only 0.96 girls
- 78.95% of the families with poor attachments also had a child displaying some signs of emotional and behavioural disorder

The following statistics are all proportional:

- Within the families who had poor attachments, domestic abuse was the most common
- Within the families who had substance misuse issues, persistent absence from school was the most common. However, this was closely followed by domestic abuse.
- Within the families at significant risk of CSE, children displaying some signs of emotional and behavioural disorder were most common
- Within the families where a child was not meeting some of their development milestones, persistent absence from school was the most common
- Significant risk of CSE and a child not meeting some of their development milestones were the only two issues that did not interlink

From this further analysis, we can begin to comprehend many of the themes that exist in a typical EHP family. In particular, it is evident that domestic abuse and poor attachments have a substantial impact on a child showing some signs of behavioural disorder. Furthermore, from the previous section on the primary reason for referral we were able to identify the typical age range and gender of a child who may present this issue (11 to 13 year old male.) This is important as a combination of this information gives us a much better understanding of the problem that was the primary reason for referral to the EHP. However, through combining the previous two datasets, it can be concluded that on a proportional basis mental health is more likely to be the primary concern of a referrer, given the substantial amount of behavioural difficulties identified in the EHP families.

Recommendations

A formal six month multi agency review of the Early Help Panel took place on the 10th February 2016. Based upon this document, the following recommendations were made by professionals:

Panel process / Functioning

1. It was agreed that the Early Help Panel Decision Maker role is vital. However, following the review, the role must be redefined. This will include the scope of the role, how it will be funded, where the position will sit and the seniority of the employee.
2. An updated MARF has been created with the addition of the Family Outcome Star. From September 2016, the EHP should expect all referrals, where appropriate, to include this assessment tool.

Communication / Training

3. The EHP should support the BSCB Learning and Development subgroup to deliver additional and revised training around the MARF and Threshold Document.
4. The availability of Early Help Awareness training should be advertised further to all partners.
5. Where appropriate, targeted training should be developed for specific groups such as GPs and schools

Membership / Partner engagement

6. Secondary schools will be approached regarding panel membership. BCC school liaison officers should be invited to attend the EHP, as observers.
7. Adult Social Care will be approached regarding panel membership
8. The engagement of Children Centres should be monitored as the method for them to refer in for Level 3 families has recently changed
9. The Families First team are currently in the process of negotiating a secondment from Educational Psychology from September 2016. Their membership at panel should be strongly considered.
10. The potential for the joint membership of CAMHS and Adult Mental Health should be explored further.
11. The YOS Management Board should be approached regarding panel membership and lead agency status.

Future research

12. The next evaluation report should include the following research and analysis:

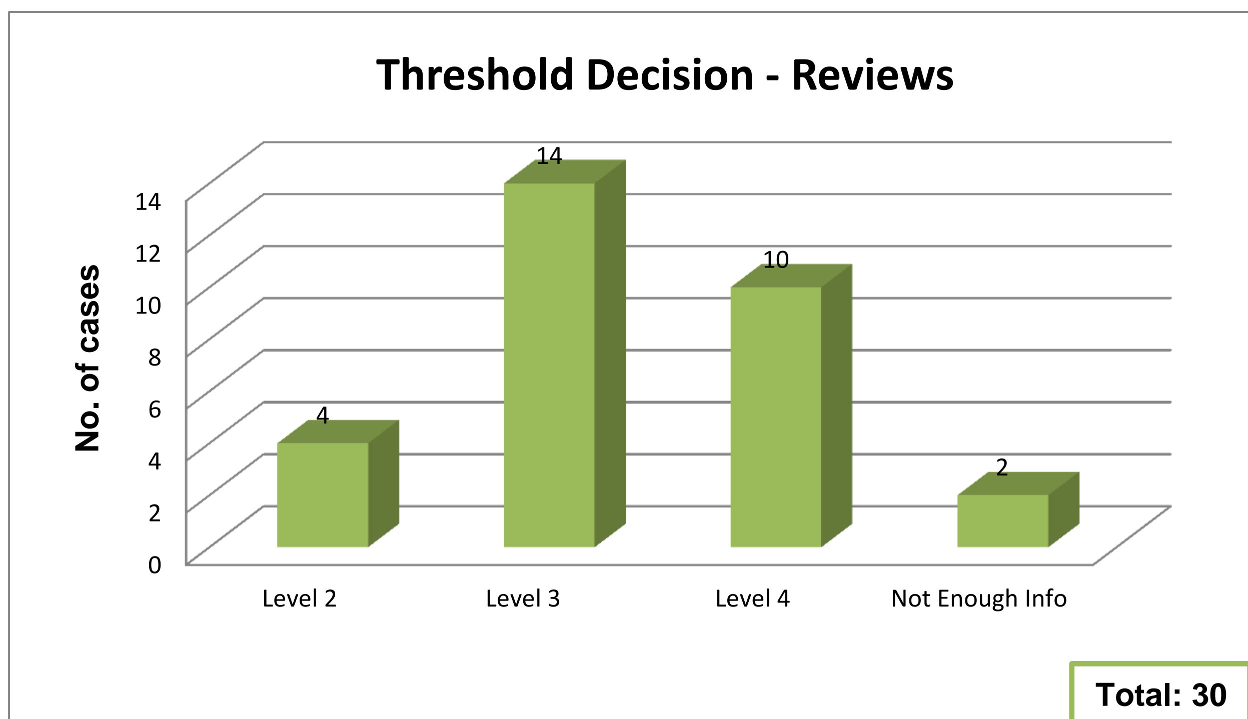
- the outcomes of intervention, as then sufficient time will have passed to monitor this progress. This will determine if the EHP has had a positive impact on the support received by children and families.
- information on those families coming through the EHP with children who have physical and / or mental health needs, as well as severe learning difficulties. In particular, the report should include further analysis on children with a diagnosis of ASD or displaying some signs of ASD.
- a focus on the structure of the family unit, including the impact of children living across two or more households, and the impact of inconsistent parenting as a result of this.
- an analysis of consent issues in the light of the changes to the MARF.
- cases which are at Level 3 but which can be managed outside the EHP process to see if there are themes emerging
  .

Identified Risks

- **Early Help Decision Maker:** There is a risk that should this position cease to exist following the five month secondment that the quality of referrals coming to panel would relapse. Following the adoption of the recommendation made at the three month review, it is clear that there has been a substantial improvement during November and December. This has been due to the successful filtering of inappropriate referrals, and signposting, resulting in a greater proportion of Level 3 cases going to the panel. There is insufficient capacity for the co-ordinators alone to undertake this role. Feedback from partners indicates that panel membership and engagement would suffer if the quality of referrals regressed.
- **Training:** Without refresher / revised training it is predicted that the quality of referrals will remain constant or even regress. This is because there are still issues around a lack of consent and information for some MARFs. Basic questions are not being asked by some practitioners at the referral stage, and this could be amended through training. GP's have been targeted as a key area for development.
- **Membership:** There is the potential risk that the EHP will not become fully embedded within agencies, if the membership is not extended to those specified within the recommendations. This risk of non-engagement is greater in agencies that do not have a panel representative.

Appendix A – Reviews

An important part of the EHP process is the review phase. This section will therefore be dedicated to analysing the relevant cases. There are several possible reasons for a family to be subject to a review at panel. The first scenario is when the panel members are unable to make an informed decision on a case, due to a lack of information. When this happens, the case will be returned to the EHP coordinator for further investigation and should only return once the appropriate additional information is acquired. Another potential reason for a review is a change in family circumstance. This could result in the case needing to be 'stepped down' or escalated. Consequentially, this section aims to determine how the review process is working in practice and whether its outcomes are effective. The graph below represents the threshold decisions for each of the cases reviewed at the EHP.



To date, there have been 30 cases reviewed at the EHP, but only 27 families. This is because three of these families were reviewed on two separate occasions. This explains why there were cases that continued to require additional information in this section. The third family that was reviewed twice remained Level 3 on both occasions. As mentioned on page 12 of the report, 22 of the 203 new EHP families were deemed as not having sufficient information for the EHP to reach an objective decision. 12 (54.55%) of these 22 cases have since been reviewed and subsequently directed to the required support. These 12 cases were equally distributed with four cases meeting each of the three threshold levels. Nevertheless, this means that ten families are yet to

have their cases allocated at panel, but are expected to return for review in the immediate future.

The remaining information on the review cases is included below:

13. Five Level 3 cases returned for review and subsequently escalated to Level 4
14. One Level 2 case returned for review and escalated to Level 4
15. Two cases that initially required no decision from the panel were returned for review and later allocated to a lead agency (Level 3)
16. There were only two cases that were reviewed and had no change to their level

From this information, it is clear that the review process is working effectively. It is this aspect that allows the EHP to adapt and reconsider the ever changing needs of the families. Through reviewing these cases, the EHP is able to ensure that families continue to receive the right help at the right time, regardless of their circumstance.

This means that once we include the reviews **124 families** have met the Level 3 threshold since 24th June 2015. It should be noted here that one of the Level 3 cases from the reviews has been excluded from this overall figure, as the same family was allocated twice.

Appendix B – Self – Referrals

The remit of the EHP is not strictly to accept self-referrals and a parent or relative who has a concern about a specific issue or family member is advised first to consult the opinion of an appropriate professional, such as a school teacher or GP. If the professional agrees the case needs to be escalated the professional can then refer on behalf of the individual via First Response. Between September and December 2015, there were nine separate self-referrals to the EHP. In this Appendix, our aim is to examine any themes or trends that may exist between these cases, to see how they could be effectively managed in the future. On page 14**,** we have already discussed how appropriate these self–referrals have been for the EHP, in relation to the BSCB threshold document. This was relatively high with six of the nine cases (66.67%) meeting the required Level 3 classification. Consequentially, it is not that these cases should not be progressing to panel altogether, but how they should be referred that is in question. It should be noted that these cases create considerably more work for the panel coordinators, who must confirm consent, and the necessary detail that will enable panel to give the case the required consideration. However, as First Response accepts self-referrals, the EHP will continue to receive them

The core analysis in this section will concentrate on the main reason for referral in these cases and lead agency allocation for the Level 3 cases. Seven of these nine self–referrals (77.78%) were primarily referred due to the parent being unable to cope with the behavioural difficulties of their child and subsequently requesting further

support. In four of these seven cases the child had an underlying health condition that was impacting on their behaviour. Two of the children had a diagnosis of ADHD, one had autism and the final child had 22Q syndrome. The two cases that were not referred primarily for behavioural difficulties were both related to a 13 year old male. The first was for substance misuse and the latter for emotional wellbeing. Both had an impact on the individual child's behaviour and the capacity of their carer to parent them effectively.

Meanwhile, with regard to the lead agency, there was no observable pattern. In fact, the lead agencies were very diverse ranging from the permanence team to YOS and school nursing. However, from this analysis it could be concluded that the majority of these families may have benefited from a parenting course, prior to their case progressing to the EHP.

Appendix C – Multiple Referrals

In this Appendix, we will look at the cases in which the family has been referred on more than one occasion from separate agencies. We are doing this to determine whether or not these families are more likely to have multiple and complex needs. Up until 23rd December 2015 there had been five families who were referred to the EHP by more than one agency simultaneously. Within these five families none were subsequently classified as Level 2. This means none of these cases were appropriate for a single agency response compared to 20.69% of the overall 203 families. Three (60.00%) of the five cases met the Level 3 threshold, whilst one case was escalated to Level 4 and therefore qualified for statutory intervention. The remaining case required additional information for an informed panel decision. However, this does not necessarily mean that the case will not have multiple and complex needs, once an outcome is reached. Therefore, this limited data would suggest that these cases are more likely to have high level needs.

Appendix D – Threshold Document Analysis (District Breakdown)

As mentioned on page 24 of the report, in this section the five most frequent problems for the EHP families have been broken down into the relevant district council areas.

Aylesbury – Average number of problems per family: **5.61**

Rank	Problem	No. of cases	% of Total Families (66)	% of Total Family Problems (359)
1	**2:** Displaying some signs of emotional and behavioural disorder	49	74.24%	13.65%
2	**22**: Persistent poor / inconsistent parenting / care arrangements	37	56.06%	10.31%
3	**10:** Persistent absence from school	33	50.00%	9.19%
4	**20:** Mental health issues	26	39.39%	7.24%
5	**25:** Domestic Abuse	21	31.82%	5.85%

Chiltern and South Bucks – Average number of problems per family: **4.52**

Rank	Problem	No. of cases	% of Total Families (28)	% of Total Family Problems (122)
1	**2:** Displaying some signs of emotional and behavioural disorder	24	85.71%	19.67%
2	**22**: Persistent poor / inconsistent parenting / care arrangements	13	46.43%	10.66%
3	**20:** Mental health issues, **5:** Disabilities affecting access to mainstream services	10	35.71%	8.20%
4	**4:** Missed appointments affecting developmental progress, **28**: Poor Attachments	8	28.57%	6.56%
5	**1:** Child not meeting some of their development milestones	7	25.00%	5.74%

Wycombe – Average number of problems per family: **4.88**

Rank	Problem	No. of cases	% of Total Families (17)	% of Total Family Problems (83)
1	**2:** Displaying some signs of emotional and behavioural disorder	14	82.35%	16.87%
2	**22:** Persistent poor / inconsistent parenting / care arrangements	11	64.71%	13.25%
3	**10:** Persistent absence from school **5:** Disabilities affecting access to mainstream services	7	41.18%	8.43%
4	**1:** Child not meeting some of their developmental milestones, **9:** Fixed term / permanent exclusions / no school place	5	29.41%	6.02%
5	**20:** Mental health issues, **25:**Domestic abuse	4	23.53%	4.82%