MAYOR OF LONDON
OFFICE FOR POLICING AND CRIME

The Lighthouse: 9-month interim evaluation report

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MOPAC Evidence & Insight

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Executive summary

The Lighthouse, London's Child House, opened at the end of October 2018 as part of a two-year pilot. Bringing together a range of organisations under one roof, the Lighthouse intends to be a child friendly, multidisciplinary service for victims[1] of Child Sexual Abuse and Exploitation (CSA/E). Based in Camden, it will replace the existing services to date and serve the five surrounding North Central London boroughs of Barnet, Camden, Enfield, Haringey and Islington. The Lighthouse intends to offer more enhanced features than previous services, with the foremost aim to be focused on the child.

The Evidence and Insight (E&I) Unit are MOPAC's in-house social research and analytical team and were commissioned to evaluate the Lighthouse. The E&I evaluation focuses on four distinct areas for analysis; a performance review; a process evaluation; impact evaluation and an economic evaluation. This report concentrates on the first two areas, looking at the first 9 months of operation of the Lighthouse.[2]

Early findings to date

Process: Summary of performance review

The data used for the performance review came from two main sources. The first was provided by the Lighthouse data officer and included aggregate data around referral month, borough and referral source, in addition to age categories and gender of the referrals. The second, and more comprehensive, data source was individual-level data produced from Excelicare, the case management system for the Lighthouse. This data was only for clients who specifically consented to have their data included in the MOPAC evaluation; and due to the amount of data provided (over 300 variables) this will enable the evaluation to present a more richly detailed picture of these clients and the services they receive[3].

The Lighthouse received **276 referrals** between the end of October 2018 and June 2019, which is an average of 35 referrals per month. Most referrals originated from Camden, Enfield and Islington, who each referred 21% (n=58 or 59) of all referrals. Children's Social Care made over half of all referrals (53%, n=146). There were no notable differences in the type of referrals received across the five boroughs. Out of the 276 referrals, 164 reached the stage of an initial assessment at the Lighthouse, which is where support begins for the clients. If these levels were matched for the remainder of the year, the Lighthouse would receive around 420 referrals, and would carry out 252 initial assessments within its first year. These two figures are somewhat lower than the estimated demand (i.e., 700 young people a year[4] with support to 544 children and young people a year) but over twice the number of referrals in the CSA Hub in 2017 (118 referrals per year).[5] It is unclear at present, why the number of referrals is lower than initially predicted. This may be because the original estimation was too high, that the original police data was not the most suitable to base predictions upon or could be linked to wider factors such as the communication across referrals agencies, or that it takes time for a service to be established and build awareness. The evaluation will explore this more going forward.

[1] Referred to as victims throughout the remainder of the report
[2] Details of the rationale for the establishment of the Lighthouse, and E&I's overall evaluation approach are contained in E&I's first evaluation report, published in April 2019
[3] Several questions emerged when working with the data drawn from the case management system. Particularly, there were issues in the consistency of data entry among staff, as well as limitations to using the system itself. These issues will be worked upon moving forward with Lighthouse staff. However, the data herein is the best snapshot of learning there is at present regarding the Lighthouse.
[4] Conroy *et al.* (2018) used police data to estimate the potential demand.
[5] NHSE (2018)

Most children and young people (CYP) referred to the service were female (78%, n=216) and just over half (55%, n=151) were between 13-18 years of age (overall age range was between 0-18). Of the 276 referrals that reached an Initial Assessment (n=164), 92 consented to their data being used for the evaluation (therefore the rate of consent at the time of writing is 56%). Upon examining this data, it is evident that this is a highly vulnerable group of CYP with complex needs. For example, 27 were assessed at being at risk of further sexual abuse; over a third of service users have anxiety and/or depression (n=34), and 13 were reported as being at risk of suicide.

The results of the Adverse Childhood Experience Questionnaire (ACE-Q) further highlighted that the service users (a sample of 54) have experienced a disproportionate amount of adversity in their lives so far; sexual abuse (n=42), parents divorced (n=29), domestic violence against parent (n=21) and emotional abuse (n=18) were among the most frequent experiences reported. Furthermore, the nature of the offences that brought the CYP to the Lighthouse show that most of the abuse was intra-familial (n=36) which reinforces the sheer lack of a safe or stable household for many of the service users.

Process: Summary of learning from early implementation

Findings related to the process of the Lighthouse were drawn across several sources, including: interviews with 7 Lighthouse practitioners, focus groups with 15 individuals (all but one were staff members), and written feedback from one other staff member, a survey with professionals who work within the 5 pilot boroughs which received 75 responses[6], and finally feedback from service users and parents collected via paper questionnaire by Lighthouse staff.

Service users and parents reported feeling very positive with the service they had received at the Lighthouse, that the staff engaged well, were easy to talk to and took their views seriously and sought to help effectively. The facilities themselves and the wider convenience of the location/appointment was also raised as a positive.

Staff felt that the Lighthouse was achieving or working toward achieving its objectives. They recognised the benefits of having different agencies working together under the same roof – both in terms of benefits for the service user (access to different services on the one site, quicker access, and reduction of the need to repeat their story) and practitioners (easier access to other agencies, different areas of expertise available to them, and exposure to different cultures/understandings). Equally there was a recognition that having different agencies working together created some tensions (around terms and conditions of employment, working cultures, and operational norms) which has been identified before in partnership projects, and staff highlighted the plans being established to reconcile this in order to develop 'the Lighthouse way'.

The first nine months has seen some developments and changes in operational practice at the Lighthouse, principally around opening hours, service user's circumstances following referral, and the initial assessment process. Some staff members also mentioned that the roles they were currently undertaking differed substantially from what they had anticipated at the outset of the project. This appeared to be the case particularly for the advocates, Social Care Liaison Officers and Police Liaison Officers.

[6] The response rate was low. The survey was sent by E&I to 322 school contacts. It was also sent to 22 contacts within the NHS, social care and voluntary sector, who were also requested to send the survey onto other contacts within their area. Finally, it was also sent to police safeguarding contacts in North Area, North West, and Central North although it is unknown how many contacts were reached. It is not possible to accurately calculate overall response rate.

Certain elements of the Lighthouse model that were anticipated *to form part of the service* have been delayed and are yet to be implemented. Some of these are due to factors beyond the Lighthouse's control (i.e., Section 28 and the Live Link) and others have been subject to minor delays. For example, it was intended that the service would be providing psychologist-led (rather than police-led) Achieving Best Evidence (ABE) interviews, whereas, the training for the psychologists has taken longer than anticipated and psychologist-led interviews have only recently begun.

Lighthouse staff expressed some ongoing challenges pertaining to the Lighthouse's infrastructure. The strongest theme to emerge here was the reported lack of sound-proofing throughout the Lighthouse building (i.e., within interview suites, medical rooms or the staff kitchen) which was an issue for staff and was highlighted as a risk to confidentiality. There were also some issues raised around the limitations of the case management system that had been introduced, with being described as 'clunky' and 'cumbersome' and reports of it being prone to crashing.

Staff also raised the issue of capacity of the service, (particularly the mental health service provision) and whether existing service levels would be able to be maintained in the future (particularly if the number of self-referrals increased). They suggested several ways that this demand might be managed more effectively, such as ensuring appropriate referrals, more effective triage, and sign-posting individuals to alternative services outside the Lighthouse, and groupwork, when and where appropriate.

This is the second in a series of MOPAC E&I Lighthouse evaluation reports to be released, enabling learning both internally as a catalyst for improvement, and externally to advance the evidence base. Future reports are expected in summer 2020, and a final evaluation report in 2021 which will aim to explore the effectiveness of the Lighthouse initiative against criminal justice, health and wellbeing outcomes.

1. The Lighthouse evaluation

The Lighthouse, London's Child House, opened in October 2018 as part of a two-year pilot. Bringing together a range of services under one roof, the Lighthouse intends to be a child friendly, multidisciplinary service for victims and survivors of Child Sexual Abuse and Exploitation (CSA/E). Based in Camden it replaces the existing services[7] and serves the five surrounding North Central London boroughs of Barnet; Camden; Enfield; Haringey; and Islington.

The Lighthouse builds on the CSA Hubs, but offers enhanced support to children and young people (CYP) aged between 0 – 18 years old (or those aged over 18 to 25 years of age with learning delay or disability for whom a child or young person-oriented service appears more suitable)[8], as well as non-offending parents/carers/family for up to two years. The service was commissioned to be open extended hours (initially Monday to Saturday 10:00 to 20:00 and by outreach Sunday 10:00 to 13:00) and is provided by University College London Hospitals NHS Foundations Trust (UCLH) in partnership with the Tavistock and Portman NHS Foundation Trust and the National Society for the Prevention of Cruelty to Children (NSPCC). It offers a joined-up approach where, if required, service users can get access to medical, social care, police, advocacy and therapeutic support 'under one roof' (for example, the service has two dedicated Metropolitan Police Service (MPS) liaison officers and two Social Care Liaison officers (SCLOs) working from the building). Although recognised as logistically challenging, this approach is paramount to providing a smooth and efficient service to the CYP and one of the unique elements of the model.

Methodology

The Evidence and Insight (E&I) Unit is MOPAC's in-house social research and analytical team which has been commissioned to undertake an evaluation of the Lighthouse. The two-year evaluation will cover the processes of the Lighthouse (from design through implementation), monitor routine performance, as well as seek to robustly explore impact and cost benefit.

As previously documented, the primary outcome for the Lighthouse broadly cover:

- Enhanced referral pathways into and out of the Lighthouse
- Enhance CYP, family and carer experience of support received post disclosure
- Enhance CYP experience of the criminal justice process post disclosure
- Enhance mental health and well-being outcomes for CYP
- Enhance professional awareness, competence and confidence
- Increased likelihood of charge or conviction for those cases within the Lighthouse
- Enhance partnership working
- Providing CSA victims care and support to reduce the long-term impact of victimisation

The evaluation uses a mixed methodology approach – balancing qualitative context from staff, stakeholder or client feedback, particularly in the shorter-term, with the 'harder' performance figures indicating how the service is running on a day-today basis. It focuses on four distinct areas; *performance monitoring*; *process*; *impact* and *economic analysis*. The ability to successfully complete each element will depend on the quality and quantity of data and will be reviewed throughout the life of the research, as it is subject to change. Details of the evaluation plan are provided in E&I's first evaluation report.

[7] NB CYP Havens will continue to provide the acute/Forensic Medical Exam (FME) service.
[8] Although no referrals were received for those aged between 18 & 25 during the period covered by this report.

Over the course of the two-year pilot there are four E&I evaluation reports planned, of which this is the second. Taking a broad action research perspective - findings from the evaluation are routinely fed back to the programme teams, the academic advisory group set up to advise the evaluation, to update partners at the official Partnership Oversight Board and other relevant meetings to ensure learning is continually shared within an active feedback loop.

This report focuses upon the **performance monitoring** and **process** aspects of the evaluation, exploring the first six to nine months of the Lighthouse's operation and draws from the following data:

- **Performance management data**. This includes aggregate performance data provided by the Lighthouse as part of its reporting to the service commissioners. This provides an overview of service delivery between go-live (October 2018) and June 2019 (numbers of referrals, sources of referrals, number of assessments etc). In addition, data taken from Excelicare (Lighthouse's case management system (CMS)) provides details of the service received by individuals at the Lighthouse, and about the individuals themselves. However, it should be noted that these data only relate to individuals who have consented to participate in the evaluation, a subset of those who have received the service overall. The number of individuals to consent is a potential evaluation risk and is explored in greater detail in the results.

- **Focus groups and interviews** were held in April and May 2019 with Lighthouse staff to explore their perceptions of the early implementation of the Lighthouse (see Appendix 1 for focus group/interview schedule). Data were collected from 23 individuals (all but one were staff members); 15 people attended one of two focus groups, in-depth face to face interviews were undertaken with 7 practitioners, and written feedback to the interview questions was obtained from a practitioner with whom it proved impossible to arrange an interview. The staff who participated were from a range of occupations and included paediatricians, advocates, psychologists, admin staff, social care liaison officers and police liaison officers.

- **An online survey to stakeholders** designed by E&I distributed in April and May 2019 to professional stakeholders *(e.g., police, social care, medical, and education)* who work within the five Lighthouse boroughs and who may have come across CYP who have experienced CSA/E (see Appendix 2 for survey questions). The survey in total includes 17 questions and covers themes such as confidence in identifying and addressing CSA and CSE, knowledge and awareness of the Lighthouse service, and if applicable experience of the Lighthouse service. There was a total of 75 respondents from several occupations, predominantly schools and police but also included some medical professionals.[9]

There are two further evaluation reports planned to track the lifecycle of the Lighthouse; another interim report planned for summer 2020 and a final evaluation report in 2021. The final report will aim to examine the impact of the Lighthouse in terms of criminal justice, health and welfare outcomes, comparing the Lighthouse to a control site.

[9] The response rate was low. The survey was sent by E&I to 322 school contacts. It was also sent to 22 contacts within the NHS, social care and voluntary sector, who were also requested to send the survey onto other contacts in their area. Finally, it was also sent to police contacts in North Area, North West, and Central North however it is unknown how many contacts were reached. It is not possible to calculate overall response rate.

2. Performance review

Performance data sources

This section seeks to present a picture of the Lighthouse service in terms of its internal workings and processes, throughput, activities, and the demographics of its clients using data such as:

- Numbers of referrals
- Referrals by month
- Number of initial assessments
- Referring borough
- Referral source
- Service allocations
- Client demographics
- Client vulnerabilities and disabilities

The evaluation team had two main data sources for this report. The first was provided by the Lighthouse data officer and which included aggregate data around referral month, referring borough and referral source, as well as the age categories and gender of the CYP. The second, and more comprehensive, data source was individual-level data produced from Excelicare. This data was for all clients who consented to have their data used in the MOPAC evaluation. At the point of writing this report, this was 92 individuals. This data was much more detailed and provided over 300 variables, although at this stage of the evaluation not all fields have been completed. Appendix 3 provides further detail of the journey and process of support a service user receives from the Lighthouse, through a fictional case study.

Referrals to the Lighthouse

Between the end of October 2018, when the Lighthouse launched, and the end of June 2019 there were a total of **276 referrals to the service**, which works out as an average of around 35 referrals per month (see Figure 1). This number peaked (with 42 referrals) in December 2018; and otherwise remained generally stable across the first 9 months. At this level, the Lighthouse is on track to receive around 420 referrals within its first year, somewhat below the original estimation of 700 (Conroy *et al*, 2018)[10]. Camden, Enfield and Islington were the highest referring boroughs, each referring 21% (n=58-59) of all referrals (more details of referrals by borough are provided in Appendix 4). Children's social care made over half of the referrals to the service (53%, n=146), whereas medical sources (GPs, A&Es and sexual health clinics) made up only 5% (n=15) of referrals. Referrals from the CSA Hub make up 10% (n=28) of the referrals, however the majority of these were in the first three months of opening, and there have only been two referrals from there since February.[11] The majority of CYP referred were female (78%, n=216), and just over half (n=151) were in the higher age bracket of 13-18 years. overall, there were no notable differences across boroughs or organisation in terms of who they were referring (such as gender and age variation).

[10] It is unclear why the number of referrals is lower than initially predicted. This may be because the original estimation was too high, that the original police data was not the most suitable to base predictions upon or could be linked to wider factors such as the communication across referrals agencies or awareness of the service.
[11] This pattern of CSA referrals is due to the transference of CSA cases to the Lighthouse service upon opening.

Initial assessments at the Lighthouse

Once the CYP have been referred to the service, the referral applications are assessed by one of the two Social Care Liaison Officers (SCLOs), who may then need to gather further information from the referrer. After discussing (for example, whether an initial assessment is appropriate for the CYP at this time) the referral at the daily allocation meetings, an action plan is made which includes assigning the case to the lead practitioner. The CYP is then invited in for their assessment by the initial assessment (IA) team (and these become allocations on the case management system).

Between the end of October 2018 and the end of June 2019 the service carried out **164 IAs.** After October (where 1 IA was conducted)[12], the level of IAs remained consistent with an average of 21 per month. If this continues, the Lighthouse will carry out 252 IAs within its first year, which (as discussed before in terms of overall referrals) is somewhat lower than the 544 CYP that the service was commissioned to support in one year.[13] Moving forward the evaluation will track throughput set against the predictions and seek to understand this distance in more depth.

For the remaining 112 referrals that did not reach an IA between October and June, there were several reasons documented (although 50 did not have a reason recorded[14]) - to illustrate, 23 have since attended an IA; 11 are pending further information; 10 CYP and/or parents/carers did not want the service; 5 referrals did not meet the criteria; 5 received a consultation-only service; 3 are pending CYP availability; 1 CYP is not ready yet; 1 has ongoing court proceedings; 1 has ongoing consultation; 1 was referred elsewhere and 1 received Havens support.

At each IA there may be several practitioners in the room,[15] in the first nine months of service there were on average three professionals present at each IA. Most frequently this profession was a Paediatrician (n=79), followed by a Play Specialist (n=51). A category of 'other' was present for 44 IAs, and this includes individuals such as Social Workers, foster carers, or family members.

At the IA stage, additional information is recorded about the CYP on the case management system by the Lighthouse staff (to supplement any information gathered at the referral stage), including information on medical history, vulnerabilities and disabilities and further assessments. Analysis of these details will be presented within the *client background* section coming up in this report.

Consent

It is also at the IA stage that the staff ask the CYP for consent to engage in their services, and in addition, this is also the point where consent is gained for their data to be incorporated in the evaluation. The issue of consent is crucial, without it, the evaluation will not be able to access personal data nor measure some of the key outcomes (particularly around the impact of the service) and as such low levels of consent would hinder the analytic ability of the evaluation, which could influence future decision making around the Lighthouse.[16]

Over the first 9 months of the evaluation a total of 92 CYP gave consent for the evaluation. Outside of the first month of October (which in terms of consent rate is an outlier given the low

[12] The service opened to referrals on 23rd October, therefore it was unlikely to start seeing children until after at least a week in order to give them enough notice to attend.
[13] As outlined earlier, this difference could be related to a variety of factors.
[14] This is due to data quality issues which are being addressed by the Lighthouse and their Data Officer.
[15] These may include a paediatrician, play therapist, advocate, sexual health nurse and clinical psychologist.
[16] See Conroy *et al.* (2018) report for more detail on the Lighthouse evaluation and ethics.

number of clients at this point; n=1), through November to February the consent rate was an average of 24%. To promote consent levels, in February 2019, the evaluation team worked closely with Lighthouse staff on the issue (i.e., conducted a training session around consent and the evaluation and providing visual aids for the staff to use with clients to explain consent). After the session, and for the following months (i.e., February through June) consent levels increased (an average of 66% for these months; see Figure 1 for consent rate). Consent levels will continue to be monitored throughout the evaluation.

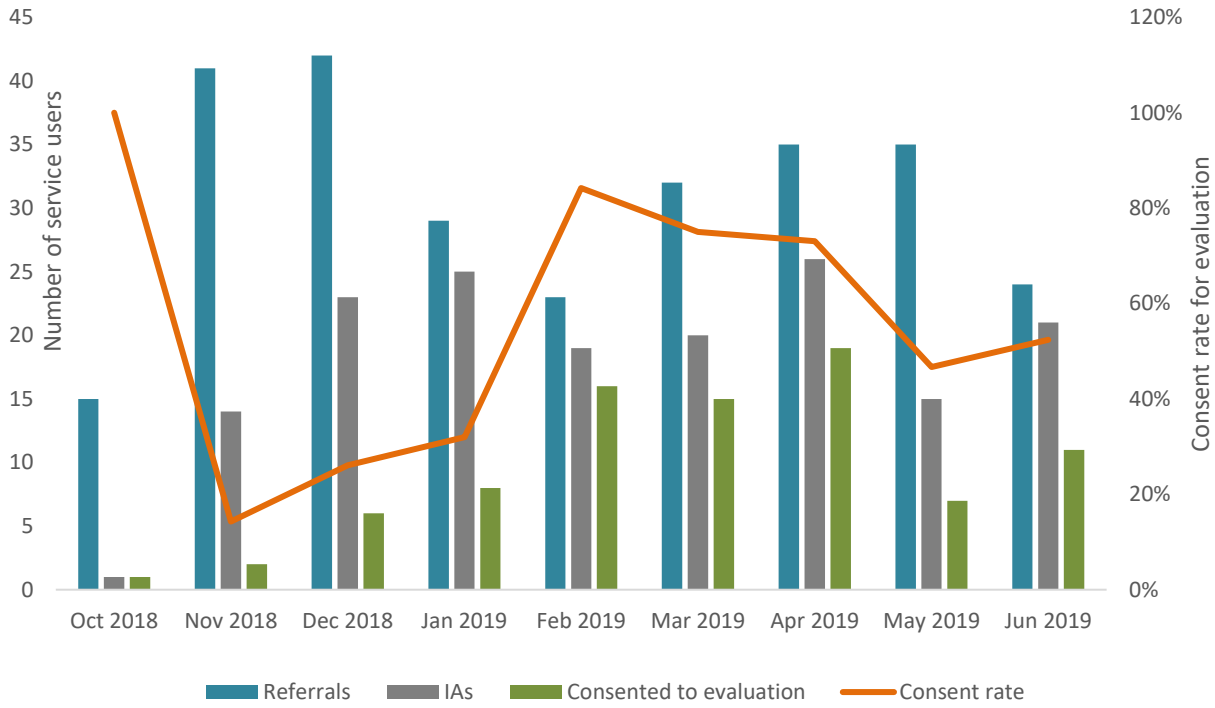

Figure 1. Total number of referrals, IAs, number of services users who consented to the evaluation, and consent rate per month

Once consent is given by the service user, this enables the evaluation team to use individual-level data to conduct more in-depth analysis, exploring throughput in more detail as well as presenting a broader picture around the background and needs of the Lighthouse clients. For example, drawing upon cases that consented[17] we can identify that on average there were 31 days between a referral and an IA (the median was 23.5 days).[18]

Before exploring the individual-level data in more detail below, the evaluators conducted some preliminary analysis to compare the general characteristics of those that *did* consent to those that *did not*, to explore any potential biases (i.e. certain client types *may* have been more likely to not give consent, which if so would limit our analysis). These two groups were compared (at an aggregate level) on age category, gender, borough, and referral source. Overall, there were no significant differences between the two groups. Even with this comparability, at this stage limitations remain given the relatively low number of service users, and so there are limitations about the ability to generalise from this group to the overall Lighthouse cases. None-the-less, there is still value in exploring these characteristics to generate insights. Findings from this specific analysis on those to consent is outlined below.

[17] This is based upon 89 cases for whom this data was available. Although 92 service users consented, the data captured for these individuals will vary due to data quality issues around the case management system.

[18] For service users overall, the Lighthouse reported that for the period from May to July 2019 the average time from referral to IAs was 47 days (range 11-182 days) compared to 20 days the previous quarter.

Background of clients who consented to evaluation

This section will provide a summary of the demographics, backgrounds, and needs for the service users who consented for their data to be used in the evaluation.

Demographics

Of the 92 service users, the majority were female (n=72); and their ages ranged between 2 to 18, with an average age of 11 years. The most common age was 16 years. Ethnicity data was recorded for 67 service users and there was an almost equal split between BAME and non-BAME clients (n= 32 and n= 35 respectively). From a total of 89 clients; most (n=73) were in full time education.

Vulnerability

Data presented in this section is taken from three sources: a self-report questionnaire conducted by Lighthouse staff (the Adverse Childhood Experiences Questionnaire (ACE-Q); practitioner assessments of vulnerability; and practitioner assessments of future risk. Looking across these in summation we see (as expected) a highly vulnerable client group[19].

The first source, The Adverse Childhood Experience Questionnaire (ACE-Q), is an internationally validated self-report tool encompassing 10-items across 10 areas which cover household dysfunction (parental separation/divorce, parental domestic violence, parental substance misuse and mental illness, and parent incarceration), child abuse (sexual and physical), and child neglect (emotional and physical). [20] The more events that a person experienced before the age of 18, the higher their ACE 'score' will be, and literature demonstrates that the higher the score (a maximum of 10) the greater the risk of health issues (i.e., mental or physical), substance misuse, victimisation and offending in adulthood.[21] This emphasises the importance of providing holistic, integrated support to these young people to mitigate the risk of health and lifestyle problems in adulthood.

As a baseline, a nationally representative survey of adults in the UK found that 46% of respondents reported at least 1 ACE, and 8% reported at least 4.[22] Comparatively, in a study that looked at vulnerable young people with mental health problems in Scotland (who present serious harm to others), there was a much higher prevalence of ACEs; 93% (out of 130) had experienced at least 1 ACE, and 59% had experienced at least 4.[23]

At the Lighthouse, the ACE-Q was completed by 54 service users[24], whose ages ranged from 3-18. For these service users, the ACE scores ranged from 0-9, with an average of 3. The majority

[19] The number of service users recorded within each of the three data sources varies widely (again, which is due to data quality issues that arose in the first few months of service). Therefore, at this stage the analysis of this data has been limited and we cannot cross-reference individual clients across these three data sources. As such, this section presents a summary of the three data sources separately to provide an overall picture.
[20] The ACE questionnaire has been used internationally and the original ACE study used a 10-question tool (Felitti *et al.* 1998), however the ACE-Q has sometimes been adapted by other organisations or researchers and has either been shortened or lengthened in terms of the number of items (Bethell et al. 2017)
[21] Felitti *et al.* (1998); Hughes *et al.* (2017); Zarse *et al.* (2019)
[22] This was undertaken by Bellis *et al.* (2014) with 3885 18-69-year olds in the UK. There have also been many other studies, in various populations and nationalities, which have also shown that most adults (between 52%-75%) have experienced at least one ACE (Zarse *et al,* 2019)
[23] Vaswani (2018).
[24] ACE-Qs should be completed for all clients, however in the first few months of opening data completion was an issue as the service adjusted to using a new patient record system and ways of working. It is expected that this will improve as the service continues.

(n=48/54) of service users had a score of *at least* 1, and almost half (n=24) had a score of 4 or more which literature has considered to be 'high risk'.[25] This places the Lighthouse ACE scores above non-clinical national populations, but closer to other at-risk youth populations. The most common ACE for the Lighthouse service users was sexual abuse (n=42/54), followed by parents divorced/separated (n=29/54; see Figure 3 in Appendix 5 for the prevalence of all ACEs).

The second data source here is taken from the documentation that Lighthouse staff record on the service users' background including vulnerabilities, disabilities and medical history.[26] Again, this data showed that a large proportion of service users have vulnerabilities (n=69 out of 89). These 69 service users presented a total of 163 vulnerabilities between them (at an average of 2.4). 40 service users have at least 1 vulnerability. Among the most frequent categories were anxiety and/or depression (n=34/89), followed by history of domestic violence (DV, n=16/89) and CSE (n=15/89). There were also 13 service users who had a history of self-harm, and 13 who were reported as a suicide risk. A full breakdown of service user vulnerabilities is presented in Table 3 within Appendix 5.

Client disabilities, where applicable, are also recorded on the system. Out of the sample of 89 service users, 23 have a known disability, and 9 have more than one. For these 23 service users, there were a total of 36 disabilities between them. Learning disability categories were most commonly recorded such as autism, communication speech and language therapy, and mild, or moderate learning difficulties, and 16 service users were recorded having at least one of those areas.

The third source of data from the CMS concerning vulnerability are risk assessments which are completed by a primary care worker at the Lighthouse, and are updated as and when a service users' risk changes.[27] There's a variety of valuable information captured to further the knowledge on vulnerabilities, including whether a CYP is *currently* known to children's social services (n=44/61), or whether they have *previously* been known to children's social care or early intervention support services (n=26/61). The assessments also show that 6 of 61 service users are subject to care order or child arrangement orders.

A key part of the risk assessment is also for the worker to assess whether there is further risk to the CYP or others. There were risk assessments recorded for only 41 service users.[28] As such, it is apparent that many of the service users are still at risk, particularly of further abuse; there is at least 'some' risk or concern of this for 27 service users (see Table 4 in Appendix 5). Two CYP were assessed at being a high risk of suicide. Only two were assessed for concern of being a risk to others.

Service allocation and addressing vulnerability

At the IA, the team will discuss options and seek to support. Therefore, based on the needs and wants of the CYP and their families, they may be allocated to different aspects of the service. The case management system records the types of Lighthouse worker that the clients are allocated to. However, due to the methods that cases are allocated to staff on the case

[25] Glowa *et al*. (2016)
[26] In most cases, the information at IA is recorded by the Doctor or Health and Wellbeing practitioner. Data is also provided on medical histories, although there is a lot of overlap between the categories recorded there, and the categories recorded on vulnerability areas. For this reason, only one dataset has been reported here.
[27] It is unknown how regularly the risk assessments are revised at present.
[28] As mentioned previously, this appears to be due to data quality issues in the early stages as the service adjusted to a new case management system and ways of working. The numbers of risk assessments completed in the first 3 months of 2019 was over 3 times the number completed in the last 3 months of 2018.

management system (CMS; see Appendix 6 for overview of these methods), there are some implications for what conclusions can be drawn from this dataset for the evaluation at this stage.

Table 1 below presents the output from the CMS in terms of how many CYP (again, only those who have provided consent for the evaluation) have been allocated to a Lighthouse worker/service, the caveat is that it could be for several reasons which are currently unknown given the data entry. The top appears to be Paediatrician (n=77), followed by advocacy (n=59) and CAMHS (n=42). Given the data quality at this stage, the evaluation is not able to assess any links between the needs of the service users and the Lighthouse services received. These issues will look to be resolved for the next stage of the evaluation, and E&I will work with the Lighthouse to find an alternative way of accurately measuring the volume of services received.

Table 1. *Number of CYPs allocated to services on the case management system*

Service	Number of CYP allocated
Paediatrician	77
Advocacy	59
CAMHS (Children and Adolescent Mental Health Services)	52
Play specialist	42
Letting the Future In (LTFI) [29]	35
Sexual health nurse	11
Protect & Respect (P&R) [30]	9
Social Care Liaison Officer	7
Police Liaison Officer	6
Duty case worker	5
Total	**303**

Offence details

The Lighthouse's Police Liaison Officers record data on Excelicare around criminal justice details, including characteristics of the offence, and key dates in the criminal justice processes (i.e., police actions and decisions, CPS actions). At this stage, it is too early to examine criminal justice processes and timeliness through the system, however some analysis has been undertaken to understand the nature and types of offences that the service users were victims of.

This analysis focusses upon the 92 cases where service users provided consent for the evaluation. The most frequent offence was intra-familial sexual abuse (n=36/92), followed by peer-on-peer sexual abuse (n=26/92). [31] Around half (n=49/92) of offences occurred within the five Lighthouse boroughs, 7 were within another London borough, and 8 occurred outside London (including 2 other countries).[32]

[29] LTFI is an NSPCC service within the Lighthouse which supports children aged 4-17 to recover from the impact of the sexual abuse: https://learning.nspcc.org.uk/services-children-families/letting-the-future-in/
[30] P&R is an NSPCC service within the Lighthouse offered to CYP aged 11 to 19 who are either experiencing exploitation, or require support to learn about healthy relationships: https://learning.nspcc.org.uk/services-children-families/protect-and-respect/
[31] No distinction was made between rape cases or other child sexual abuse cases.
[32] The remaining 28 are unknown.

In 73 cases the CYP made a *disclosure* of the offence, most commonly to someone in their family (n=31/73). Other individuals disclosed to were someone in their school (n=10/73), 7 were police, 3 were friends/peers, 3 were social services, 3 were health services, and 16 were either recorded as 'other' or unknown. For a further 10 cases the offence came to light due to *suspicion* from either a family member (n=6), health service (n=3), or social services (n=1). For the remaining nine cases it is not recorded how the offence came to notice.

26 out of the 92 CYP were recorded as being repeat victims, and for 9 of the cases it was noted that there were other people within the family who are at risk from abuse.

Summary of performance review

Over the first 9 months, the Lighthouse has received 276 referrals and delivered 165 IAs (which is a 60% conversion rate). Although both figures are below the predictions at the onset of the service, the number of referrals represents over twice the number of referrals (118) per year from the CSA hub in 2017. The difference could be for a variety of reasons such as the validity of the predictions, linked to an aspect of early implementation, or referral awareness. Most referrals came from Camden, Enfield and Islington, and from Children's Social Care.

The theme of vulnerability was clearly seen across a range of data sources (psychometric, staff capture and risk factors) and they have experienced a disproportionate amount of adversity in their lives so far. This clearly demonstrates the need for a service that seeks to integrate multiple strands of support. Effective partnership working, regular training and adequate support for the Lighthouse staff are key in ensuring this. These issues will be expanded upon within *Section 3*. The nature of the offences that brought the CYP to the Lighthouse show that most of the abuse was intra-familial. This reinforces the lack of safe and stable household that some service users are in.

Several wider issues also emerged – such as the case management system itself and needing to learn more about how data is entered onto the system, so details such as an accurate understanding of those accessing services can be gained. This is not unique to the Lighthouse as CMSs are not designed as research tools. The issue of consent is also worthy of note – positively, this improved over the nine months with support from the researchers and lighthouse staff working together. Nonetheless, it should be continuously monitored.

3. Learning from early implementation

This section explores learning from a range of sources, notably focus groups carried out with Lighthouse staff, a survey with professionals, and feedback from service users at the Lighthouse (parents and CYPs), with the aim of presenting learning related to the set-up and continued implementation of the Lighthouse. As the evaluation progresses, the aim will be to track these issues over the course of the Lighthouse. In the current fieldwork - six themes emerged; these were:

- General perceptions of the Lighthouse;
- Consistency to the developed model;
- Ways of working;
- Referrals and demand;
- Partnership working; and
- Challenges ahead.

General perceptions of the Lighthouse

Members of staff have been collecting feedback from parents and CYPs about their experiences at the Lighthouse. Between February and June data was collected from 66 people - 20 parents, 27 young people aged between 13 and 18, 11 young people aged between 8 and 12, and 8 children aged under 8.[33] The questions asked of the service users, and their format, varied depending on the age of the respondent, so it has largely only been possible to combine the responses from the parent and 13-18 groups (47 respondents) but overall, respondents reported feeling very positive about the service they had received at the Lighthouse, the facilities that were available there, and the convenience of the location/appointment.[34]

In terms of the support provided by the Lighthouse, respondents felt that they had been listened to at the Lighthouse (46/47 reported this statement to be 'certainly true'), that it was easy to talk to the Lighthouse staff (43 'certainly true', 4 'partly true'), and that their views and worries had been taken seriously (46/47 'certainly true'). They also felt that the staff at the Lighthouse knew how to help with the problem (38 'certainly true', 8 'partly true'), that they had been given enough explanation about the help available (44 'certainly true' 3 'partly true'), and that the staff at the Lighthouse were working together to help with the problem (43 'certainly true', 3 'partly true', 1 'untrue').

Service users aged 8-12 were asked to indicate which of a number of elements of the Lighthouse's service they liked (choosing from 'Drinks/snacks', 'Game/toys/activities', 'People', 'Rooms', 'Reception', or 'Everything'). Of the 11 CYP to respond, 'reception' was mentioned by 6 respondents (5 of which were under the 'everything' banner), 'drinks/snacks' were selected by 7 respondents, 'games/toys/activities' and 'rooms' by 10 people, and 'people' by all 11 respondents.

As with the first report, the feedback from the professionals' survey showed a positive response to the opening of the Lighthouse.[35] Many described it as being 'good' or 'fantastic' whilst

[33] All four groups of service users were asked how many appointments/visits they had had at the Lighthouse. Of the 61 who replied, 29 had attended once, 20 had attended 2-4 times, and 12 had attended 5 or more times

[34] The respondents overwhelmingly felt that the facilities at the Lighthouse were comfortable (46/47 'certainly true'), that their appointments had been at a convenient time (36 'certainly true', 6 'partly true'), and that it was 'quite easy' to get to the premises (40 'certainly true', 6 'partly true'). Overall, when asked if the service received at the Lighthouse was good 45/47 felt the statement was 'certainly true'

[35] Feedback was received from 19 respondents who had said they were aware of the service.

commenting that the service is very much needed within the community. Similarly, when staff members were asked whether they felt that the Lighthouse was meeting its objectives they either felt it was or was working towards meeting them.

> "I think it is extraordinary, I think if you think about where we were a year ago which was a piece of paper with our bid, and then we got it and in a very short space of time 6 months the building was transformed…So the point about it is that you are going from, in a year where you have gone from nothing to an all running service which is absolutely extraordinary".

Lighthouse staff reported that awareness of the service was good, but that there was still scope for improvement. Not only were there differing levels of awareness among boroughs, but across many organisations as well. The findings from the professionals' survey showed that more than half of respondents were 'aware' of the Lighthouse service (n=25/47). The most common reason for being made aware of the service (n=11) was through safeguarding training or a Lighthouse staff member attending a meeting or forum of teachers and social workers. Of those aware of the service, about a third said it was well known within their respective organisations (n=8/25). Eight also said that they had made a referral to the Lighthouse, either via email or phone or via social worker; most of them found the process easy.

Consistency to the developed model

Certain elements of the Lighthouse model that it was anticipated would form part of the service have been delayed and are yet to be implemented. As outlined in the first evaluation report, Section 28 (s.28) of the Youth Justice and Criminal Evidence Act 1999 sets out a range of special measures which should be available to help vulnerable and intimidated witnesses give their best evidence at a criminal trial, including pre-recording cross-examination, and it was anticipated that the pre-recorded cross-examination would take place at the Child House rather than a child having to give evidence at court. While this remains the long-term ambition, the delayed implementation of s.28 *nationally* due to technological issues has prevented this happening in the Lighthouse. Similarly, the use of the Lighthouse as a Live Link location, allowing children to give evidence remotely without attending court has still not yet been implemented, although discussions are on-going with the judiciary/HMCTS. In addition, it was intended that the service would be providing psychologist-led (rather than police-led) Achieving Best Evidence (ABE) interviews. In the event, the training for the psychologists has taken longer than anticipated and psychologist-led interviews have only recently begun (psychologists were trained in December 2018, and from January 2019 had a period of six months of supervised interviewing as part of the quality assurance process).

In addition, over the first nine months several changes have been made to operational practice at the Lighthouse. For example, the initial intention had been to open the Lighthouse on Saturdays. However, this proved impossible between October and December 2018 because security staff were not available at weekends. Once security had been hired, the Lighthouse opened on Saturdays between January and March 2019. However, in April 2019 the decision was taken not to open the Lighthouse on Saturdays because of low levels of usage and feedback

received from service users about their preferred hours of operation[36]. However, the weekend is still available for *ad hoc* activities (i.e., running a group if requested by parents), and members of staff will still attend case conferences off-site at the weekend.

Similarly, there have been changes made to the initial assessment process in terms of staff attendance (which are discussed in greater detail in the '*Referrals and Demand*' section later in this report). In addition to these, a weekly whole team case review of all open cases began in June 2019 (following the need for this being identified in the staff survey in March 2019). In May 2019 the Lighthouse ran a parents' groupwork course. The course was based on the 'circle of hope' model, with the contents agreed in advance with the CPS (contract with families to not talk about their own abuse). Ten parents attended, and there was 100% attendance for the whole course. It was asserted that the offer to parents overall had been more substantial than originally anticipated due to the complex needs they presented. The majority of IAs resulted in parent work alongside the intervention to the child, which could include one-on-one work for one or both parents, as well as access to the 10-week parent psycho-education group, work which was not reflected in Excelicare.

Some staff members also mentioned that the roles they were currently undertaking differed from what they had anticipated at the outset of the project. This appeared to be the case particularly for the advocates, Social Care Liaison Officers (SCLOs) and Police Liaison Officers (PLOs). Staff suggested that they had anticipated that each child would be allocated an advocate who would stay with the child throughout their time at the Lighthouse, but that this did not always happen pre-IA, with implications particularly for the SCLO role to take a lead in coordinating the referral process and liaison with local social care. The advocates themselves had expected that there would be more information sharing in the Excelicare system, and user access was revised six months into the pilot. A similar situation arose for the PLOs who were not doing the role they anticipated in terms of data access/provision, but whose role had expanded to encompass several other aspects, most prominently the training of psychologists for psychologist-led ABE interviews. Whilst this training was originally identified as part of the PLO role, upon initiation of the service it became a more significant part of their role, and as such it was anecdotally reported to have taken approximately 120 hours of the PLO's time.[37] Specific reasons for the unexpected growth in the PLO role are unknown however the service is brand new, and not everything can be predicted; this is important learning for the service model.

The need for better feedback and communication from the Senior Leadership Team (for example via regular team meetings) was one of the six improvement workstreams that emerged in late 2018 from the first team away day[38], and led to a team briefing starting in January 2019. A staff survey in March 2019 identified further learning about ways of working together, culture and values. Positively, as a result, there had been a number of attempts on the part of management to try and improve relationships within the Lighthouse.[39] Nevertheless, the issue still arose at the point that E&I's interviews and focus-groups took place suggesting this work needed to continue.

[36]When asked in the feedback when they would prefer their appointments at the Lighthouse to be, of the 50 respondents who replied (the question was asked of parents, 13-18-year olds and 8-12 year olds), 25 indicated it would be 'during the day', 20 'after school', 4 on Saturday, and one at another time.
[37] Training activities carried out by the PLO included formal training, observations, role-playing training, and supervised ABEs.
[38] The other workstreams were the appointment system, building issues, lack of supervision, Initial assessment and Excelicare). The communication workstream had identified the following as areas for improvement; lack of regular meetings for; speciality team updates and discussion – including feedback to and from the Operational Meeting for team leads, reflective space in addition to the Weekly Case review, allocation meetings not working.
[39] These included breakfast with the Service Manager between October and December 2018, boxing in the park after work, yoga, swimming before work, team breakfasts, eating lunch together, a team afternoon (shared lunch, training and activity afterwards) and 2 team building days (in December 2018 and July 2019).

There were mixed messages across staff about the extent to which there were clear written processes/policies at the Lighthouse, particularly in the very early stages. Some staff felt there was a lack of clarity around procedures, and described the uncertainty that resulted, however, this was disputed by others who pointed to the written Lighthouse guidelines that were in existence. In all likelihood, this is more likely to be a factor of how effectively Lighthouse guidelines are communicated and then embedded into working practices.

Initial assessment

The IA process was also one of six workstreams for improvement identified in late 2018, and it was clear that this was an area of work where practice had evolved during the 9 months since the Lighthouse had gone live.[40] It was suggested by Lighthouse staff that a number of changes had been made to the IA process, including better preparation for the CYP about what to expect, changes to where the IA was held initially, and the choice about which staff attended the IA being given to the CYP/ parents/ carers.[41]

At its inception, the model introduced had assumed that representatives of all the services present in the Lighthouse would attend IA meetings. Staff highlighted that the processes for the IA had evolved over time. While the core offer from the Lighthouse was for children and young people to have a 'menu' of services to choose from, the logic of having staff present from each service was deliberated, in terms of the impact this had on resources and staff availability, and in terms of the child's experience, whether it was 'too many people' to meet at once, although it was acknowledged that this was difficult to predict case by case.

> "I think at the beginning there was an attempt to have like a 'perfect' offer to families and as time has gone on, and you're aware that you have got to be really careful about resources and that you can't have 5 people deciding on what the offer is going to be right at the beginning, you might need 2 people to meet the family first, and then other people come in as they're needed and adapting things, for example, in terms of the initial meetings with the families, then things have needed to change"

Ways of working

The Lighthouse has now been operational for nine months (six months at the point the focus groups and interviews were undertaken with the staff) giving practitioners the chance to reflect on factors that impact on the day to day working of the initiative. It should be stressed that the comments that follow appeared in a context where staff were keen to emphasise the strengths and achievements of the Lighthouse. Indeed, as one member of staff put it, 'for many of the

[40] The six workstream areas identified were: the appointment system, building issues, lack of supervision, Initial assessment, team meetings and Excelicare. Issues identified by staff in relation to the IA had been; lack of clarity about who was responsible for what task, whether assessments should take place at visits or referral, gaining agreement for service, who should take a lead in the assessment, advice or assessment tasks, who was responsible for documenting what on Excelicare, who was accountable overall, and held risk in mind, and who should meet the child on arrival.

[41] The changes in full were; better preparation in advance for the CYP, the provision of snacks/drinks and free fruit in the IA, breaks in the IA, choice being given to the CYP and family about who was in the room for the IA, starting the sexual health element of the appointment, starting the IA in the therapy room rather than the medical room, better documentation on Excelicare, the introduction of a post-IA review meeting, and debrief in the allocation meeting.

team, despite the challenges, it is an absolute privilege to be working at the Lighthouse' describing her peers as 'outstanding professionals in their field' with a unique level of expertise 'dedicated to getting the offer to children right'. Nevertheless, staff raised some issues relating to the equipment and infrastructure of the Lighthouse. These are not new as they had been identified in the first evaluation report, and 'building issues' had been one of the work streams for improvement identified in late 2018 suggesting more needs to be done on the topic.[42]

Inadequate sound-proofing in parts of the building was the concern identified most frequently by staff, particularly in the ABE suite, the mezzanine/staff kitchen area on the second floor, and the medical examination and therapy rooms on the 4th floor.

> 'the biggest issue with the estates is the soundproofing. So, it's shocking. I mean the ABE suite, obviously, is really bad. But we're finding out more and more that if someone is in one of the therapeutic rooms and you are outside waiting you can hear everything that is being said… If you've got a young person that is having a confidential conversation and their mum has been asked to wait outside the room, but mum can hear everything that they are saying, that's not confidential. So, there's just no soundproofing.'

Subsequent to the focus-groups/interviews remedial sound-proofing has been provided for the ABE suite, involving the insulation of and carpeting for the rooms above the suite. However, at the time of the interviews/focus groups staff described how they worked around these soundproofing problems, such as walking around the office without shoes during ABE interviews (which are held on the floor below the main office area) or talking quietly in the kitchen area (staff were aware that service users coming into reception could hear talking and laughing from the staff-kitchen). However, other staff members stressed how important it was for them, in what was a stressful environment, to have access to an area where they could relax, and there was concern that the absence of such an area might have an effect on staff's wellbeing and ability to carry out their roles as effectively as they would like.

Staff also mentioned problems relating to telephony (i.e., poor mobile phone signal in the building, and a lack of land-lines) and there was some criticism of Excelicare, the Lighthouse's case management system, with people describing the system as 'cumbersome', 'time-consuming and clunky' and prone to crashing. Respondents reported difficulties finding data on the system, frustration that the same data had to be input more than once, and generally felt that it compared unfavourably to other systems they had previously used.[43] It was hoped that some of the existing flaws in the system would be addressed by future planned changes to the system in subsequent versions of the CMS (for example, the absence of a suitable appointment system in Excelicare, which was felt to be a particular limitation), and it was suggested that staff were getting used to

[42] The 'building issues' specifically mentioned were lack of shelving in cupboards, need for 'engaged' door signs to stop interruptions of therapy sessions, open kitchen area causing issues with confidentiality, lack of soundproofing in ABE suite, CCTV cameras to be removed and feed
viewed in reception, need for lockable drugs and DVD cupboards, need for blinds in ABE suite).
[43]Excelicare was one of the six improvement workstreams identified in December 2018. Factors mentioned in the workstream document were; the system crashing, staff being unable to share case notes, and difficulties in recording telephone contacts/initial assessments that did not become assessments, visits, pre-assessment work, medical follow ups on the system.

the system.[44] It was also suggested that some of the problems with Excelicare had been caused by the tight timescale for implementation, and a perceived lack of involvement of Lighthouse staff in its design, although practitioners had been involved in the process.[45] As expected, to a degree, problems with the system, and their resolution, had only become apparent following go-live and the operational use of the system. Staff were, however, keen to praise the role played by the part-time data officer (recruited in April 2019) in assisting with issues around the use of Excelicare, providing training, and encouraging completion of consent forms and data compliance generally.

Respondents also identified additional facilities they felt were needed at the Lighthouse, or where existing facilities should be reconfigured (i.e., the knocking-through of one of the rooms adjacent to the medical examination room to enlarge the latter, and the need for an additional examination room), although again, staff stressed that they did their best to work around existing arrangements. Issues with aspects of the medical infrastructure were also raised (colposcope, curtains, bins). Again, notwithstanding the fact that before and during the mobilisation stage of the project professionals had been involved in the design of the premises, some respondents still perceived there to have been a lack of Lighthouse staff involvement[46] Another frustration expressed was the length of time taken for issues within the building to be remedied, and it was suggested that these combined had a detrimental effect on staff morale.

The staff spoke frankly on these issues and expressed a keenness for the various challenges around building design and electronic systems to be captured and recorded as crucial learning, particularly if the service were to be replicated elsewhere. These are key aspects of the service that could be overlooked while designing and developing a service such as this but are integral to the staff being able to carry out their jobs effectively. The staff's flexibility and willingness in finding ways to work around these building and soundproofing issues (such as walking without shoes on, or not booking two adjacent therapeutic rooms at the same time) should also be noted.

The importance of reception at the Lighthouse as the first point of contact for service users and parents/carers was stressed by a number of respondents, and the need to recruit administrative staff who had experience of working in a safeguarding context, above and beyond clerical skills (although again, the detrimental impact on the service user's impression of the reception area by the lack of sound-proofing was stressed)[47].

"we have traumatised people coming into the building so the response that you have for people, the way you greet them, the way you answer the phone, the way you think about what might be going on for the person, all that stuff is quite high-end don't you think?"

[44]The (lack of) an appointment system was another of the improvement workstreams identified, which was described in the workstream document as 'leading to issues with visibility of staff availability, appointment booking and reporting'. While a workaround had been introduced (an Excel based 'appointment scheduler' for all staff to complete and the sharing of Outlook diaries) this was described as 'frustrating for staff, difficult to use and therefore is not being used consistently'.

[45] Involvement with practitioners was carried out in a condensed period and there was less time for operational testing to identify problems with the system, and their resolution, prior to go-live. These challenges were recognised early on and are the reason why a development budget for the CMS has been provided to be utilised for the second stage of user acceptance testing (UAT2).

[46] It should be noted that, because the design process took place before staff had been recruited, the professionals concerned were not necessarily those now working in the Lighthouse.

[47] Lack of administrative support was also identified by medical staff, particularly around the sending out of letters and booking appointments. Again, it was suggested that admin staff had been recruited at the wrong level, and with the wrong sorts of skills, it was suggested the need was for people with experience of working in a medical environment.

Supervision, or rather the lack of it, had been another of the areas of concern identified by Lighthouse staff at their away day in December 2018 and had subsequently been adopted as a workstream for improvement.[48] Some respondents felt they were well supported in their current roles both internally by Lighthouse peers and managers, and externally to the Lighthouse (i.e., respondents mentioned support from their parent/host organisations, and the part played by support from outside their direct line management). There was also positive feedback on the quality of the whole team training which is provided monthly.

Things are going in the right direction, however there were some staff who felt the level of support could be improved upon. Factors mentioned were the absence of the Senior Leadership team, the absence of reflective space, and the need to provide support beyond operational meetings.

Referrals and demand

Referrals

As has been seen, in the period under study there were 276 referrals to the Lighthouse, at an average of 35 per month. Practitioners *broadly* felt that levels of referrals coming in had been as they expected. Again, reflecting the performance data, staff reported that most referrals had been received from social services, with some from education and GPs. Staff were aware that there had been few self-referrals, and were keen to address this, to *"reach the true unmet need"*. Some staff also asserted that the type of referrals being made to Lighthouse were different to those in other services they had worked in before (CSA hubs for example). The Lighthouse cases were described as more 'raw' and 'complex', in that the children and young people had deeper mental health needs with incidents of serious self-harm and suicidality; this reinforces the findings outlined within the performance data. In addition, it was asserted that the service increasingly recognised the need to collect data about the referral prior to the Initial Assessment taking place, something that placed more emphasis on the role of the social care liaison officers (SCLOs).

As the performance data indicated, respondents identified that there had been differences in the numbers of referrals from the five pilot boroughs. Camden and Islington were consistently reported as making the most referrals (which was the case when the interviews and focus groups were completed), with Barnet and Haringey reported to be making very few referrals. As suggested earlier, staff believed there was variation in the awareness of the service across boroughs and organisations, and it was further suggested by staff that distance might be the explanation for the lower levels of referrals from these two boroughs.

Capacity

In terms of staffing and recruitment, during the period covered by this report there was only one unfilled post at the Lighthouse (the senior advocate role - although part-time cover for the role was in place). However, one of the two PLOs left the service at the beginning of May 2019. The Lighthouse were able to obtain 2 weeks cover for the post in June, and part-time cover (one week on and one week off) from mid-July onwards. Notwithstanding the reduction in PLO staff, the remaining officer was still required to provide up to 1.5 days a week cover for the CYP Havens as previously agreed. In addition, the departure of the PLO came at a time where the other PLO

[48]The factors mentioned in the workstream document were staff concern about lack of supervision and lack of spaces to feel they can contain case management and risks. Lack of clinical supervision in LTFI or Advocacy teams and staff felt that was a gap and a risk. Concerns also raised about proposed frequency of 35 days, whereas 2 weekly felt more suitable.

had already organised four-weeks annual leave. In addition, during the period one of the SCLOs was injured in an accident at work and off sick for 3-4 weeks. There has been a vacancy in senior administration since May. It was suggested that certain elements of the service (CAMHS in particular) was already working at capacity, although there was some discussion about what being at full 'capacity' meant, as different roles were contracted for different caseload numbers.

Notwithstanding the fact that levels of staffing were largely as anticipated, and as outlined by performance data the numbers of referrals and IAs were below expected; staff expressed concerns about the ability of the Lighthouse to sustain the current level of service in the future. There is a strong possibility that staff already feeling worked to maximum capacity is related to the complexity of the cases that they are seeing which need more attention and time than previously anticipated.

Staff were aware that most of the referrals to the Lighthouse had come from within the system, particularly from social services, and were concerned that if the level of awareness of the service increased in the community and a wider audience was reached, then there was potential for the demand to increase (especially on top of an increase in self-referrals).

> "People talk about, you know, opening the floodgates, and you open a new service and people come. I think as I said, to begin with we scooped up what we should have always had. I think that if we promote it, we'll be blown away by the number of children that come forward, I think that's a real issue."

Suggestions were made as to how any increase in demand should be managed through day to day work. For example, better onward signposting or having fewer staff attend the initial assessment. It was acknowledged that a balance needed to be struck between providing a good quality service that retained its core aims and values but ensuring that the pace of work is achievable and managed appropriately.

Partnership working

The literature around child advocacy centres and *Barnahus* suggests that one of the benefits of the approach is the improved partnership working it brings (Herbert & Bromfield, 2016, 2017) together with improved awareness and confidence in dealing with CSA on the part of professionals (Landberg & Svedin, 2013). This has also been documented across many other disciplines (i.e., offender management). Feedback form Lighthouse respondents echoed many of these advantages' such as partnership working and information sharing.

Respondents were especially positive to the range of services and partners in terms of benefits to the service user. It was described as "quite wonderful …when it works well the benefits that has on the child and family in the room and the fact we can coordinate everything under one roof".

Staff were positive that the partnership working had resulted in earlier communication between Lighthouse colleagues across different disciplines. It was suggested this was particularly useful when there was a need to gather further information from colleagues, rather than *"having to wait on the end of the phone or wait for an email in regard to getting a bigger broader picture of what could be going on"* as had been the case in the past. Staff also appreciated the opportunity to benefit from the expertise and different viewpoints of agencies other than their own; enabling

them to build a broader and more detailed understanding of how other agencies functioned: "it's good for staff learning as well, I've learned stuff about medicine that I wouldn't have known, and the criminal justice system".

More specifically, the benefits of having individuals who understood how other agencies worked was particularly stressed. For example, the ability to create easier pathways into services that beforehand would not have been possible was very well appreciated. For example: *"trying to get [a] pathway into CAMHS when you're not a CAMHS person is, well it's impossible… whereas if you've got CAMHS practitioners talking to other CAMHS practitioners then I think there's a real hope that that can happen"*.

Members of staff were asked to identify if there were any agencies who were not currently located in the Lighthouse who they felt should be. The potential additions mentioned were education liaison staff, a CPS case worker, for the Lighthouse to undertake the forensic examinations, and to have a presence of local social workers in the Lighthouse, although it was cautioned that there might be issues around space.

Similar to the evidenced benefits of partnership working, there can also be challenges in bringing individuals from a range of organisation together – for example, differences in language, terminology or organisational cultures that often result in working tensions. For example, respondents described staff had different terms and conditions and pay levels for often doing ostensibly similar jobs or tensions between the medical model and social work perspective. Staff were keen to discuss the process of determining the 'Lighthouse way of doing things', to reconcile the different cultures and bring all their approaches together and find a way of working for the service as a whole, described as a significant, and on-going, learning process.

"'People are really highly qualified in this organisation there is so much experience and everybody has a clear idea of what it is, it is just bringing it together as a cohesive – 'This is the Lighthouse and this is the way that we do it', and it is not CAMHS, it is not paediatrics and it is not social care, it's unique because people are not going to want to hear how we have modelled a social care system here, or a health system here, they want to hear about something that is different that they can take from"

Challenges for the future

When asked to identify the main challenges to be faced by the Lighthouse in the future the most popular responses were the uncertainly about future funding, the ability of the service to manage any increase in demand (i.e. if self-referrals increase) especially in relation to mental health support. This does raise an important issue of how the Lighthouse will adapt to any future change. Suggestions of developing some form of triage were made to manage capacity and the requirement to sign-post individuals more effectively to outside services where appropriate, or the use of a 'hub-and-spoke' model where certain aspects of the service would be provided centrally, but other elements offered in the local boroughs.

"you need to get much more efficient about not accepting cases that actually are not right for here. You need to be clearer about, if we are saying cases are not right for here, what's the offer in terms of networking and plugging people into other services, and we have done that and we've had great success in plugging people into places like the Portman, maybe NCATS but actually saying, we will take the responsibility now you have made the referral, we're going to help progress that"

4. Discussion

The focus of this report has been to highlight findings and issues relating to the process of the first nine months of the Lighthouse's implementation. Data for this report was gathered from several sources, including the Lighthouse's case management system, interviews and focus groups with Lighthouse staff, a survey with professionals within the community, and service user questionnaires.

The service has had steady levels of referrals within its first few months which have averaged as 35 referrals per month, and the number of IAs carried out has averaged at 21 per month. These numbers suggest the referral rate is lower than was originally predicted – however, there may be several reasons for this, ranging from the original predictions being incorrect, to awareness levels of the service still improving, to its full potential yet to be reached. In their interviews and focus groups, staff discussed how the current levels of demand and referrals 'felt' for them on the ground, and they were of the perception that referral levels were as expected, albeit cases were more *raw* and *complex* than their previous experience. This suggests the issue here, is more likely than not, to be the limitations in the original predictions. Indeed, staff acknowledged that there had been very few self-referrals to the service so far and expressed a keenness to increase this to reach an 'unmet need', although with the knowledge that this would have further implications on increasing demand and capacity. Staff are clearly concerned about issues of sustainability, and the capacity of the service (especially mental health) and whether existing service levels will be able to be maintained in the future.

Nevertheless, the demand and capacity will need to be addressed and managed. Amongst the methods suggested by staff to manage this demand more effectively were ensuring appropriate referrals, more effective triage, and sign-posting individuals to alternative services outside the Lighthouse where appropriate. It is a recommendation that the service put plans in place to mitigate problems around capacity and demand, staff themselves highlighted some possibilities to begin this discussion (i.e., more effective triage, better signposting to alternative services) which could themselves lead to changes in how the Lighthouse works – something that will be tracked in future reports.

E&I obtained individual-level data for service users who reached an IA stage *and* who consented for their data to be used within the evaluation; this number was 92 service users. The amount of data fields received from the CMS (over 300 variables) provides details on the backgrounds of the clients, their needs, some medical history, services they are allocated to, and details of the criminal justice cases. At this stage, E&I cannot work with all variables as some of the data is incomplete (either due to data quality issues, or because certain case details haven't yet been entered onto parts of the CMS). An additional caveat for the data is that the consent rate (calculated using the total number of IAs) is at 56% and there is room for improvement here. The consent issue will be crucial for the evaluation's ability to robustly evaluate the impact of the service on health and wellbeing and criminal justice outcomes and will be monitored on an ongoing basis.

Looking across a variety of data captured (e.g., ACE-Q scores, risk assessments and medical histories) it is clear they are a very vulnerable group, far more so than non-clinical populations. Again, these findings are echoed in the interviews and focus groups with staff who also highlighted the high level of need across the group and how the cases are more 'raw' than experienced before. This also reinforces the importance of having a service that integrates multiple strands of support to appropriately meet each need of the CYP. Effective partnership working, regular training and adequate support for the Lighthouse staff are key in this.

Staff felt that the Lighthouse was achieving or working toward achieving its objectives. There was a recognition by Lighthouse staff of the benefits of having different agencies working together under the same roof – both in terms of benefits for the service user (access to different services on the one site, quicker access, and reduction of the need to repeat their story) and practitioners (easier access to other agencies, different areas of expertise available to them, and exposure to different cultures/understandings). Equally there was a recognition that having these different agencies working together created tensions (around terms and conditions of employment, working cultures, and operational norms) which the organisation was seeking to reconcile, an ongoing process described as developing 'the Lighthouse way'.

There have been several aspects of anticipated service delivery at the Lighthouse that have not yet been delivered (psychologist-led ABEs, and the introduction of the Live Link facility, for example). In addition, certain operational practices at the Lighthouse have evolved during the first 9 months of operation – the opening hours of the service, the role played by the SCLOs (particularly in relation to service users' early contact with the Lighthouse), and practice around the initial assessment (largely due to the recognition that there was a balance to be struck between the stated aims of the Lighthouse, logistical issues (the resource implications of all services being present), and the impact on the CYP/parents/carer).

As in the first evaluation report, staff raised issues about elements of the Lighthouse's infrastructure/estate. Their major being the reported lack of sound-proofing throughout the building, particularly in the ABE suite, the medical rooms on the 4th floor, and the mezzanine floor/staff kitchen on the first floor. The absence of soundproofing was felt to be of concern because of the potential risk it posed to patient confidentiality, and because of the impact it has on staff's operational practice and morale. There were concerns too about the poor mobile phone signal in the building, and the limitations of the case management system (CMS) that had been introduced.

Several data quality issues arose from the CMS, through this which generated further work and discussion with the Lighthouse manager and staff to help E&I understand the context around how data is entered onto the system. This further highlighted the limitations of the system for the staff, and its limitations as a research tool. A particular issue is the inability to accurately calculate the number of services accessed by CYP. The evaluators will seek to address this for future reports.

Next steps

The current document is the second published report within the MOPAC Evidence and Insight two-year evaluation of the Lighthouse to have access to data on those who received a Lighthouse service. However, as mentioned previously, at this point the available data is on a relatively small number of service users (and a relatively small percentage of those who have been referred overall) which has limited the analysis possible. The next evaluation report is planned for the summer of 2020, at which point it is anticipated that details of many more service users will be available for analysis. The next evaluation report will also contain findings from the service users' perceptions of the Lighthouse.

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Appendices

Appendix 1: Focus group interview schedule, April 2019

1. Now that the Lighthouse has been open for a few months, do you think it is currently meeting its aims and objectives?
    a. (Prompt: Improved partnership working between police and social services; improved therapeutic outcomes for children and their families; improvements in children's and families' experiences of the criminal justice process; and improvements in the quality of investigations)

2. What do you think of the referral pathways?
    a. *Is the level of referrals what you expected?*
    b. *Are the referral pathways working well? (Any areas for improvement?)*
    c. *Do you think there's enough external awareness/knowledge of the service? if not, with whom, and how could this be improved*

3. One of the claimed benefits for the Lighthouse is improved partnership working arising from co-location. We'd like to ask you some questions about partnership working at the Lighthouse
    a. What are the benefits of co-location?
    b. Any challenges that have arisen from co-location?
    c. Anybody not co-located who should be?
    d. How would you say the way you work here differs from the way you worked in previous roles/organisations?

4. We'd like to ask you some questions about the physical infrastructure, IT systems and telephony at the Lighthouse
    a. Do the systems/infrastructure enable you to do your job?
        i. If not, how could they be improved?
    b. Have you been provided with enough training to use these systems effectively?
        i. If not, what additional training is needed?

5. How confident do you feel carrying out your role?
    a. How do you feel about the level of support you've received in your role? (Prompt – is support provided formally/informally? Any training/CPD needed?)

6. While you've all joined the service at different points, have these first few months/weeks/days been what you expected?
    a. (Prompt: if not, why not? Any surprises?)
    b. Any changes to service delivery that you would make? (Prompt, hours of opening).

7. What do you think the main challenges for the Lighthouse will be;
        a) Over the next 6 months?
        b) In the longer term?

8. Any other comments?

Appendix 2: Professional survey, March 2019

Section 1: About You

1. Please tell us your job role [free text]

2. Which area do you work in? [list boroughs]

3. What type of organisation do you work for?

    a. *Health – A&E*
    b. *Health – Sexual health*
    c. *Health – Mental health*
    d. *Health – Maternity Units*
    e. *Health – GP Surgery*
    f. *Health – Other*
    g. *School – Secondary education*
    h. *School – Primary education*
    i. *Community group*
    j. *Victim support agency*
    k. *Youth club*
    l. *Police*
    m. *Other (Please specify)*

Section 2: Experience of dealing with cases of CSA/E

1. Have you ever been involved personally with cases of CSA/CSE? *(Yes / No / Don't know)*

2. How would you rate your confidence in: *(Scale – 1 = Not very confident to 7 = Very confident)*
    a. *Overall knowledge in regard to CSA/CSE*
    b. *Identifying CSA in a CYP*
    c. *Identifying CSE in a CYP*
    d. *Knowing who to report CSA/CSE cases*
    e. *Knowing how to report CSA/CSE cases*
    f. *Knowing how to support a CYP who may have experienced CSA/CSE*
    g. *Knowing where to find further support for a CYP who may have experienced CSA/CSE*

3. How do you think your organisation addresses CSA and CSE? (*Scale – 1 = Not very well to 7 = Very well)*

    If you have answered '6 = Well' or '7 = Very well' can you tell us why?

    If you have answered '1 = Not Very Well or '2 = Fairly well' can you tell us why?

4. What services are you aware of that are currently available in your area to support children and young people experiencing CSA/CSE?

5. To what extent do you agree or disagree: *(Scale – 1 = Strong Disagree to 7 = Strongly Agree)*

    h. *I have received training about CSA/CSE*
        i. *<u>If 'YES'</u> - What training have you received and how long ago?*
    i. *I would appreciate more training on CSA/CSE*
    j. *There are suitable services to support CYP that experience CSA/CSE in our area*
    k. *The organisation I work for has a clear policy about cases of CSA/CSE*
    l. *CSA/CSE is a problem in our area*
    m. *The police should do more around CSA/CSE in our area*
    n. *Social services should do more around CSA/CSE in our area*

o. *Health should do more around CSA/CSE in our area*
p. *The pathways to accessing CSA services in our area are clear to use and follow*
q. *The CSA pathways are effective and work well*
r. *I know what the CSA pathways in our area are for referring children and young people to specialist services*
s. *Partnership working around CSA/CSE could be improved*

6. What do you think could be improved in the pathway for children who have been sexually abused/exploited? [Tick all that apply]

- Training of practitioners working within child protection/safeguarding roles
- Providing a child friendly environment
- The facility for the child to only tell their account once
- A clear referrals pathway for treatment & support
- Multi-agency working under one roof
- Holistic health assessment offered to all children and young people
- Early emotional support immediately after disclosure or abuse
- Longer term therapeutic support for the child
- Long term advocacy support up to and including the court trial
- Providing services so the child does not need to attend the police station
- Improved support for the child to give their criminal justice account (from disclosure to cross examination at trial)
-Child Psychologists leading the main police interview
- Providing services so the child does not need to attend court
- Support for the non-offending family/carer
- All services in one place for the child
-Longer opening hours, including evenings and weekends
- Other please state:

Section 3: The Lighthouse

1. Are you aware of The Lighthouse, a service providing support for CYP in the boroughs of Barnet, Camden, Enfield, Islington or Haringey who have experienced CSA/E?

2. *If yes to q1* - please detail below how you were made aware of the Lighthouse. *E.g. media communications, direct email, word of mouth? [free text]*

3. *If yes to q 1* - What are your thoughts on the opening of the Lighthouse?

4. *If yes to q 1* - What do you believe are the main aims of the Lighthouse?

5. If yes to q 1 – how well known would you say the Lighthouse is within your organisation/where you work? [scale 1=not known at all, 7=Very well-known]

6. *If yes to q1* - have you made any referrals to the Lighthouse?

7. *If yes*, how did you make the referral?
   Phone
   Email
   Website

8. *If yes to q6*, how did you find your interaction with the Lighthouse/how easy was it to make a referral – scale of 1-7?

9. Has your interaction with the Lighthouse increased your knowledge/confidence of dealing with cases of CSA/E?

Appendix 3: Case study of progression through the Lighthouse.

The case study below has been developed by Lighthouse staff to illustrate the progression of a 'typical' service user through the service and is used in presentations to external partners. It is a composite example and the details of the case, and name, are fictitious.

Teah is a 11-year-old girl, eldest of three siblings. Her family have been supported previously by Children's social care when there were concerns regarding DV, emotional abuse and neglect. There has been no involvement for the last 18 months.

Social Care Liaison Officer

- Reported to school that she had poor relationship with stepfather and previously reported Incidents of verbal chastisement and name calling by parents. School reported a change in presentation since the beginning of the year with Teah presenting as more anxious and withdrawn and isolated from peers.
- This week after a 'stay safe' workshop in school Teah disclosed to her class teacher that she problems sleeping and waking up at night.
- Teah discloses being woken by her step father who 'did things to her'. She became very upset during the discussion and the teacher became anxious about exploring this with her. Teah not asked about the timescales of last contact with her stepfather

➢ **The school make an immediate referral to Children's social care.**

- The Lighthouse received a copy of the 87A and SCLO and Paediatrician dialled into strategy meeting.
- Further information shared regarding children's and family circumstances, social care, and health in order to establish forensic/medical issues.
- Police information revealed historical concerns regarding Teah's mother being victim of physical assault by Teah's father. Also unrelated criminal convictions of current stepfather and historical police merlin relating to DV incident with stepfather's birth children and partner.
- Referral to progress to a joint Section 47 investigation. Allocated social worker and OIC to visit the school before end of school day to speak to Teah.
- Lighthouse advice on establishing timelines as if contact with suspect had happened within 7 days the Haven would be contacted to establish if forensics may be obtained which would require attendance at the Haven. Lighthouse ABE facilities discussed.

➢ **Initial investigation visit with OIC and ASW to school.**

- Teah minimally disclosed that her stepfather gets into her bed at night. She shares bedroom with a younger sibling Kiely aged 8. Discloses made to touch his genitals and he had touched her on the 'chest and between her legs'. She was very anxious about her mother finding out and what would happen to her stepfather.
- The last reported incident two days ago. Mother attends school and with Leah is taken to the Haven by the OIC and social worker.
- The younger siblings Kiely aged 8 and Paul aged 7 are taken to Grandma's and spoken to by other officers. Kiely confirmed to SW that stepdad got into Teah's bed but was reluctant to say anything else.

Police Liaison Officer

➢ **Haven Medical**

- Finding show an obvious red scar in the fossa navicularis which is between the hymen and posterior fourchette. Medical follow-up required to review findings further details and Teah and mother advised about the Lighthouse.
- Teah and her mother agree to stay overnight with maternal grandmother.
- Stepfather is arrested and bailed away from the home.

- Lighthouse referral is made with Teah & mother's consent
- Allocation meeting and Teah allocated a primary case holder and IA team

➢ **ABE at the Lighthouse**

- Psychologist Led ABE at the lighthouse is requested and organised by OIC and in partnership with Lighthouse PLO Teah & mother supported on day by Lighthouse Advocate
- Child discloses ongoing episodes of digital penetration and being forced to masturbate suspect.
- Occurs almost weekly for a period of three months.
- 8-year-old sister Kiely present in the room when the abuse happens

➢ **Witness Kiely's ABE.**

- During social care assessment discloses that on a number of occasions she had woken and found stepfather in Teah's bed.
- Mum reports to SW finding Kiely looking at pornography on stepfather's phone two months previously. School also report incident of other children complaining of being followed into a toilet cubicle by Kiely.
- As it is a child sibling, they are suitable for psychologist led ABE too

Clinical Psychologist

➢ **Initial health and wellbeing assessment**

- Teah attended for Initial health and wellbeing assessment including medical 'health' review.
- Before Teah arrived, the team planned the assessment and who will be involved. The team consisted of the Advocate who was present for the ABE, Play specialist, Consultant Paediatrician, clinical nurse for sexual health and Clinical Psychologist. The IA team agreed to meet with the SW for half an hour first to agree with advocate who has already met family who would be the best people to be part of the assessment.
- The IA team then met with mum and Teah initially together, before separating off. Leah with play specialist in prep for the health review, and Clinical Psychologist with mum and doctor initially. (IA lasted full morning).
- Mother disclosed to us that she is feeling very distressed and 'triggered' by her previously undisclosed her own experience of childhood child sexual abuse and current chronic depression and anxiety which has been further exacerbated by the disclosure. Last episode of Post-natal depression after third child. Never engaged with mental health services apart from some PND support organised through health visitor.
- We discussed what mum might benefit from (options) and also gave some psycho ed materials about disclosure, how to support your child, possible emotional impact on parents. We then discussed mum's own needs as an adult separate from her daughter: rape crisis friends and family service/ Tavistock trauma adult service.
- Psychologist offered mum separate follow up and time to think about what she might want/ need.
- Mum explained that Teah has been suffering with anxiety and low mood more recently, picking at scabs on her arm. However, she is very engaged with her school-based art therapist – who now knows about the disclosure.
- Assessment of Teah: 'bag of feelings' – she talked about home, school, hopes and lessons. She described her sleeplessness, social isolation and ongoing worries and 'tummy aches' at school and home.
- Our screen for anxiety and low mood (Rcads parent and child measures) indicated clinical levels of anxiety and low mood, but not significant mental health risk to Teah.
- The IA team came together at the end of the morning with mum and Leah and SW to clarify our understanding, agree what to write to family (and copy to GP and network with their consent), and check agreed next steps. We all agreed (including Teah) that the therapy at school work feels important and continues and offered consultation to the therapist at primary school - and

school pastoral lead meeting if that would be helpful in thinking about the impact of trauma on learning.

- Mum said she felt that she would like some more ongoing work with her to understand and support Leah. We explained that LTFI parent work offer and that this might be a bridge to future parent course access. Mum attended the Light House psychoeducational course for parents 'circle of hope' run by advocacy and CAMHS jointly.
- We continued to discuss and revisit the pre-trial therapy guidance and consent issues and we also discussed these with the school clinician. We continue to link regularly with the school clinician.
- Ongoing work with siblings including Psychology support for ASW in engaging in direct work with siblings
- Advocacy agreed to continue to engage with school and social worker and OIC.
- Adult based trauma service was able to start work with mum six months after this referral and this is ongoing

Appendix 4: Number of referrals by borough, Oct 2018 - June2019

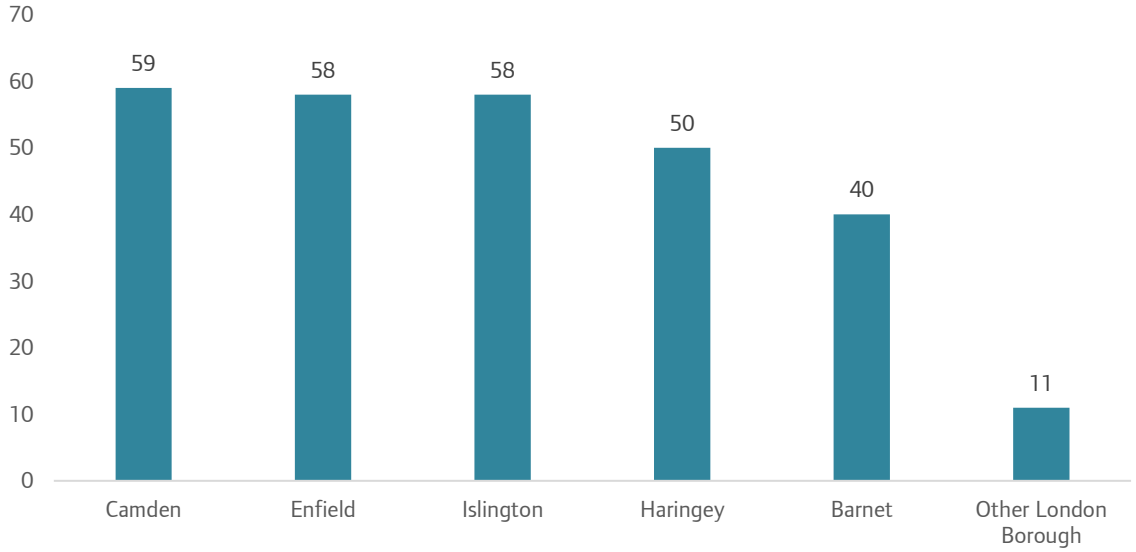

Figure 2. Number of referrals by borough

Table 2. *Referrals per borough, per month*

	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019
Camden	7	9	9	9	3	6	7	4	5
Enfield	2	4	10	6	6	6	7	9	8
Islington	3	10	7	5	7	7	5	8	6
Haringey	0	10	10	6	2	8	6	5	3
Barnet	3	7	4	3	5	3	5	9	1
Other London Borough	0	1	2	0	0	2	5	0	1

Appendix 5: Data from the case management system on service user vulnerabilities

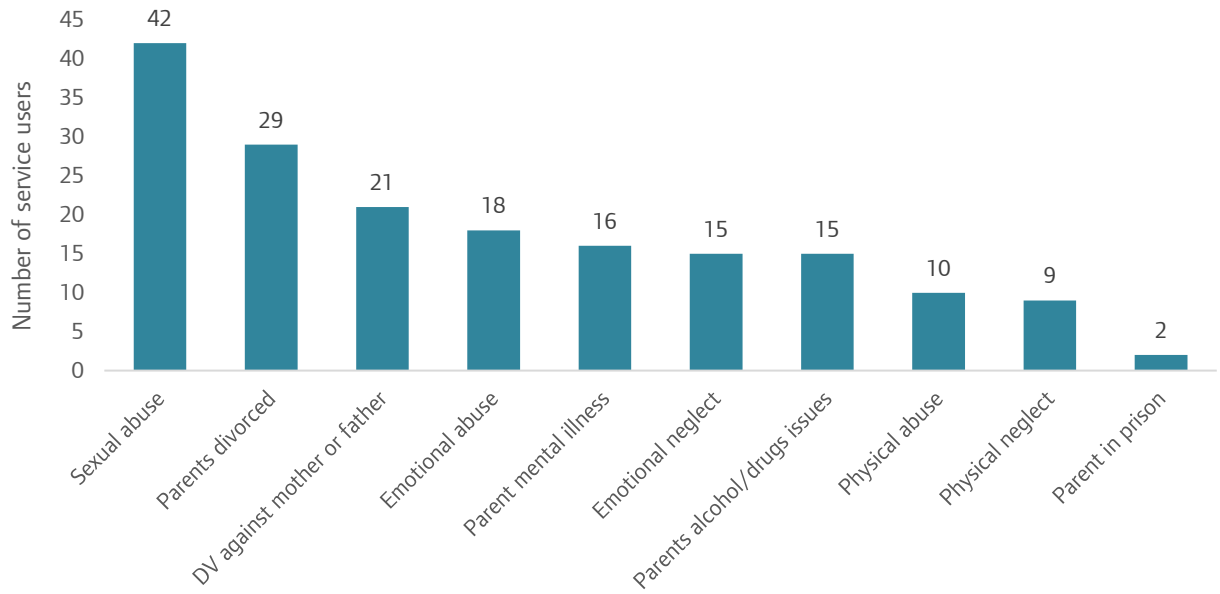

Figure 3. Breakdown of ACE scores for 54 Lighthouse service users

Table 3. *Number of service users with each vulnerability present*

Vulnerabilities documented	No. of CYP (n=89)
Anxiety/Depression	34
Other	25
History of DV	16
CSE	15
History of self-harm	13
Suicide risk	13
School/education problems	13
Concerns over safety	8
Eating Disorder	6
Risk of further harm	5
Sexualised behaviour	5
Local Authority care order	4
Drugs/Alcohol	3
Missing from home	3
Repeat attender	0

Table 4. *Risk assessment results for 41 service users*

Risk	Ongoing/potential immediate risk	Some risks/concerns	No identified risk
Further abuse	5	22	14
Self-harm	7	9	25
Suicide	2	12	27
Risk to others	0	2	37

Appendix 6: Anecdotal information from staff on reasons for creating service allocations on the case management system

Anecdotal evidence was gathered from the Lighthouse staff around data entry practices with the case management system (CMS), particularly with allocating service users to various Lighthouse services. On the CMS, a Lighthouse worker could be 'allocated' to a case for several reasons outlined below.

1. As stated already, during one of the daily allocation meetings, several workers may be allocated to cases on the CMS as the 'IA (initial assessment) team'. This would occur prior to the CYP being officially worked with by the service, however it is not possible to differentiate between when a worker has been allocated a case in an IA capacity, or if they have formally received the CYP as a client to their individual service.
2. An additional reason for a system allocation is when the child and/or family visit for a 'show around' of the Lighthouse by the staff, which would occur prior to the CYP officially being seen by the service, and the staff involved at this early stage may still receive the 'case' on the system.
3. Additionally, if a parent receives a service from the Lighthouse (e.g. LTFI), then the worker will be allocated to the case of parent's child on the system, and it's not possible to differentiate between a child and parent allocation.
4. Finally, if a child is receiving one of the Lighthouse services and their worker within that service changes, that could also add an additional allocation to that service.

In light of the above, the service are:

1) Closing cases as soon as an IA is over if the service is then not needed long term
3) Reviewing this in phase two of the Excelicare development during 2020
4) The service have since changed practice and updated the allocations to address this