Joint Targeted Area Neglect Inspection

Post Inspection Action Plan 2018

Final Draft 18/04/18

Stockton-on-Tees
BOROUGH COUNCIL

	Behind schedule
	On track
	Completed

Joint Targeted Area Inspection – Stockton-on-Tees November 2017 – recommendations and actions

Key tasks	How will we know?	Lead(s)	Action to date	Future actions	RAG

Introduction

1. This action plan outlines the actions partners will take in response to the Joint Targeted Area Inspection undertaken in November 2017.

The value of the inspection

2. This inspection has brought considerable value to the work of partners around identifying and responding to neglect.
3. We are encouraged by some of the findings of the inspection around systems, process and quality, and in particular the absolute priority which agencies have in safeguarding children in Stockton-on-Tees.
4. However, we are aware of inconsistencies in our approach, and the extent to which individual agencies are sometimes working in isolation.
5. The action plan attached responds to the specific areas of improvement identified in the report. However, partners have also agreed that we need to respond to the overriding themes of the inspection, and have agreed a number of key principles for how we work together which we intended to ensure are built into the process for designing and agreeing new safeguarding arrangements, which we intend to introduce in September 2018 to replace the Local safeguarding Children's Board.

The key overriding areas where we want to improve:

6. Information sharing between agencies through the assessment and planning process to ensure that all agencies are recognising, understanding and responding to the signs of neglect
7. Ensuring that we are focusing on the lived experiences of children – in some cases we audited as part of the inspection, it was clear that, despite the range of activity underway, we had lost the focus on the actual experience of the child living with neglect.
8. Ensuring that we remain focused on the child's experience of neglect, and not becoming over focused on the symptoms and consequences of that experience, such as challenging or risk taking behaviour.

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Actions across the whole partnership					
A review of the resilience and capacity of staff from each relevant organisation within the hub will be undertaken.	Enhanced capacity Staff resilience within the hub will be strengthened	CHUB implementation group (LA, public health, police, FTs)	Children's Hub Strategic Management Board considered outcomes and issues Review of NHS representation	Strategic review of CHub – June 2018	
Develop a new Joint Strategic Needs Assessment and Children and Young People Plan	New plan in place	SBC - DCS and DPH	Review process underway Young people engagement through Bright Minds Big Futures initiative	CYP Partnership workshop	
Improve the sharing of information across all agencies particularly with children in need so that all agencies are aware of the CIN status.	Evidence of appropriate documentation will be contained in the child's records and read codes/flags will be inserted onto the record to clearly identify status. Evidenced by audit of records demonstrating the sharing of information to inform practice and evidence of flags on records.	All listed agencies (LA,CCG (including primary care), Foundation Trusts, police,	Named GP working with Independent Reviewing Officer manager in Stockton re improving information sharing for conferences.	Review as part of wider review of CIN cases	
All agencies will commence a chronology of significant events when concerns arise in relation to the care of the child or parental behaviour which impacts on the health and well-being of the child	The use of chronologies and the analysis of the information contained within the chronologies will demonstrate the impact of potential abuse on a child, inform next steps to drive forward the work and demonstrate the impact of this work There will be evidence of use of chronologies at any stage of involvement where agencies have concerns about the safety and welfare of a child.	All agencies	Multi agency audit tool refined and used further to identify neglect	Multi-agency Training to be delivered by the joint training group on what is a significant event, how to compile a chronology and how to analyse the information to drive forward a case	

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	There will be evidence of the analysis of the information which will inform next steps. This will be captured in multi-agency and single agency audits				
Case oversight and supervision. All agencies will review their supervision process to ensure the cases being brought consider neglect at the earliest opportunity.	Supervisors and supervisees will be clear that cases brought to supervision will consider Neglect and Neglect will be identified at the earliest opportunity	All agencies		Examine opportunities for group supervision Implement a case study review system to support review of cases involving practitioners	

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Actions for Stockton-on-Tees Borough Council					
Increase attendance or participation of children at child protection conferences	Data collection will indicate increase in attendance It will be evident to conference members what the views of the child are	Service Manager, Review	Refreshed guidance to IROs and social work teams	Continue to monitor and seek engagement through a variety of means	
Develop and implement new CCIF (Children's Continuous Improvement Framework)	New framework in place	DCS	Framework in development and being tested Feedback measures being tested – feedback from service users	Framework to be adopted 1 April 2018 Feedback survey live from 1 May 2018	
Improve the quality of supervision on cases involving neglect	Staff feedback Supervision audit Supervisors and supervisees will be clear that cases brought to supervision will consider Neglect and Neglect will be identified at the earliest opportunity	AD - Safeguarding	Key outcomes emphasised in current supervision approach	Group supervision process being developed	
Continue to embed Signs of safety to improve the quality of plans, especially Child in Need plans with a focus on outcomes based on child's lived experience	Enhanced use of Signs of safety in all plans, reviews and meetings	Service Manager, Review	Task and finish group as part of wider transformation project Enhanced audit, moderation, and training	Review of process and documentation to ensure effective practice led process Review approach to sharing data on children on child in need plans (with Cleveland Police)	

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Actions for Cleveland Police					
Review front line training for neglect to address inconsistencies and lack of consideration of previous history	Enhanced awareness and understanding of child's lived experience	D. Supt. PVP	Refresher 'Through the eyes of the child' training delivered Supervisors briefing	Regular programme of training Attendance at LSCB training	
Review capacity in the PVP and children's hub	New arrangements in place Backlogs managed and cleared	D. Supt. PVP	Swift recruitment process implemented for PVP Supervision approach updated	Prioritisation process to fill vacancies Review of additional temporary resources Review third party material provision Complete CP training for all PVP staff	
Improve the quality of SAFER referrals: application of thresholds, quality of information	QA system in place Improved quality of SAFER	D. Supt. PVP	Chub review of SAFER identified areas for improvement	Supervisors to undertake a review of submissions	
Implement an audit and quality assurance approach	Production of QA reports and improved practice identified	D. Supt. PVP	Enhanced entry system on NICHE developed QA approach being implemented	Trial of audit process	
Review approach to flags on NICHE – moving from current focus on CP to include CIN	Better understanding of child's history and journey	D. Supt. PVP	Child at risk flags for all children on child protection plans	Review use for all children in child in need plans (with SBC)	
Review approach to domestic abuse risk assessments – providing assurance that risks adequately assessed and information shared		D. Supt PVP	Extraction tool has been developed to identify domestic abuse cases to share with partners	Introduce enhanced flagging	

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Actions for Youth Offending Team, National Probation Service and Durham Tees Valley Community Rehabilitation Company					
More effective sharing between NPS, CRC and YOT – in both directions	YOT is able to identify and analyse indicators of harm to children from adults in the family and/or living in the household NPS/CRC more aware of YOT involvement with families	Sheila Whitehead & Sharon Barnett	New information sharing processes have been implemented ensuring information on NPS / CRC database are shared with YOT	Practice Guidance to include transition arrangements for cases managed by YOT	
Provide assurance over effectiveness of links to the Children's Hub, and understanding of respective roles	Local Children's Services Managers & Practitioners understand who DTV CRC are & how to contact the SPOC SPOCs have understanding of CHUB operation	Kay Nicolson Deputy Director Hub manager	Stockton Operational Manager visit arranged to Children's Hub	DD OPS & Operational Managers to link in with / present to Children's Services Managers & Practitioners about DTV CRC	
CRC to review risk assessments	Internal QA audits will show increased quality of risk management & sentence planning	Kay Nicolson Deputy Director	Risk of Serious Harm training undertaken by ALL colleagues Quality & Development Team created Autumn 2017 Internal baseline case management audit of 100 cases undertaken in August 2017 Skills for Effective Engagement, Development & Supervision (SEEDS) approach roll-out has begun	Internal case management audit of 100 cases to be completed by 31/08/18 Case studies to be identified & shared with colleagues by 30/06/18 Lessons learned document to be produced quarterly. First document by 30/06/18	
Improve information sharing from partners to NPS and CRC re sentencing reports	DTV CRC practice guidance documents will indicate correct referral pathways & up to date information regarding information sharing routes for each LSCB	John Graham Director	Instruction to Through the Gate operational colleagues to liaise & share ALL Safeguarding Children information with	Information exchange to be reviewed with LSCB's including use of CPP3	

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	Internal QA audits will show information is shared sufficiently & promptly		community based Responsible Officers	Scoping & recording of current referral pathways & early help offers to be undertaken and incorporated into practice guidance by 30/04/18 Multi-agency audit of Safeguarding referrals.	
Training for NPS and CRC -	DTV CRC colleagues will have attended more LSCB training events in 2018/19 than 2017/18 Feedback and audit will indicate increased understanding of Neglect, 'Toxic Trio', Hidden Harm and whole family approach	Head of People Resources		Head of People Resources to identify suitable training package in conjunction with DD OPS by 30/06/18 Training package to be undertaken by ALL DTV colleagues, including volunteers & peer mentors by 31/12/18	

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Actions for health commissioners and providers					
Examine ways of sharing more information on mental health issues. The children's hub will contact the nominated single point of contact in adult mental health when assessing risks to a child following a referral into the hub.	The HUB will obtain information from the adult mental health SPOC which will inform their assessment of risk. There will be evidence in the recorded risk assessment that adult mental health services has contributed where parental mental health is a factor.	Chub TEWV	When notified TEWV prioritise attendance at child protection conferences. Supervision mandatory when parent / care receiving treatment and children subject to child protection plans.	Roll out same approach to all children on child in need plans	
Develop more effective links with dental practices to understand, identify and share concerns about neglect	There will be clear expectations for dentists as to what information they will share and what information will be shared with them.	NHS England DC	Some additional wording has been added to the Tees procedures to include involving dentists when holding safeguarding meeting		
Where Primary care are informed that a child is in need they will flag the child's record using the child in need read code to inform their delivery of care to the child and contribution to the CIN processes	Audits to be carried out on the flagging of records to maintain accurate status of children.	Primary care Supported by HAST CCG, Named GP and Des Nurse			
Improve work of health visiting to identify and respond to neglect	Health visitors feel confident to identify and respond to neglect. Quality of referrals for early help and to Chub	SBC Public Health HDFT	New 0-19 service commissioned Training and outcomes shared with new provider	Audit quality of responses and referrals	
Review contribution of substance misuse services as part of broader review of strategic approach to substance misuse	Review report and new specification(s) as required	SBC Public Health	Review underway	Revised specification(s) as required	