County Durham

Joint Targeted Area Inspection
“Multi Agency Response to Domestic Abuse”
Improvement Action Plan

DATE OF INSPECTION: 9-13 JULY 2018

DATE OF SUBMISSION TO JOINT INSPECTORATE: 3 DECEMBER 2018

Acronyms:

CDDFT	County Durham & Darlington NHS Foundation Trust
CRC	Community Rehabilitation Company
CWILTED	Condition, Witness, Incident, Location, Time, Escort, Disability (An assessment tool to identify potential abuse)
DASH	Domestic Abuse, Stalking & Honour Based Violence Assessment
DASVEG	Domestic Abuse & Sexual Violence Executive Group
DCC	Durham County Council
ED	Emergency Department
HDFT	Harrogate & District NHS Foundation Trust
ICPC	Initial Child Protection Conference
IRO	Independent Reviewing Officer
LSCB	Local Safeguarding Children's Board
NPS	National Probation Service
NYAS	National Youth Advocacy Service
PIP	Partners in Practice
PPP	Police Protection Powers
SDG	Safeguarding Delivery Group
TAF	Team Around the Family
TEWV	Tees, Esk & Wear Valley NHS Foundation Trust
UCC	Urgent Care Centre

1. AREA FOR PRIORITY ACTION - STRATEGY MEETINGS

Ref.	Area for improvement	Action (intent)	Lead	Timescale	Oversight & Monitoring	Expected Impact	Scrutiny & Audit Programme (Evidence of Impact)
1.1	Strategy meetings are not always being held where the threshold is met due to a lack of effective risk-assessment by all agencies and understanding of thresholds. Where the threshold is recognised, there is significant variation in terms of timeliness and attendance. In some cases, there are delays in strategy meetings, and sometimes weeks between the incidents occurring and the strategy meeting being held. Agencies with critical information fail to attend some strategy meetings or provide relevant background information. Action and minutes are not always shared, and this impedes effective multi-agency decision-making. This means that some children are not adequately safeguarded in a timely way.	Develop and implement a SPOC process and procedure for the notification of strategies so that partners with relevant information receive an invitation to attend or to share this electronically to aid decision making as part of the Strategy and/or S47 enquiries.	SDG	Mar.19	Safeguarding Delivery Group	Improved engagement in Strategy Meetings and S47 enquiries and compliance with Working Together 2018. Improved attendance at strategy meetings leads to more effective information sharing regarding risks to children. Evidence of more consistent application of thresholds across organisations. Improved multi-agency challenge as evidenced through appropriate use of escalation processes. Children in County Durham are safe.	Quarterly exception reports to LSCB Executive of invites to and attendance at Strategy meetings. Safeguarding Delivery Group to carry out observations of practice IRO Report to evidence improved decision making linked to ICPCs. Annual multi-agency thematic audit of Strategies and Section 47 Enquiries to provide assurance of improved application of thresholds and compliance with required procedures and regulations, timeliness of circulation of notes, evidence of multi-agency challenge. LSCB to commission independent evaluation of multi-agency practice improvement
		Delivery of Multi-Agency Workshops and/or briefings outlining roles, responsibilities, procedures and requirements of Working Together 2018					
		All strategy meetings to ensure attendance is compliant with Working Together 2018 through:- - Training for Social Care Team Managers and re-issuing of Working Together 2018 Guidance - Support from PIP North Yorkshire with a focus on direct support to front-line managers to improve practice - Implementation of Signs of Safety	Children's Services	Mar.19			
		Implement dial-in/conference facilities in each Families First team to facilitate partner engagement.	Children's Services	Dec.18			
		Agreed actions to be circulated within 24 hours of strategy meeting.	Children's Services	Dec.18			

		Pilot re GP contribution to strategies to be rolled out across the county	Children's Services/ Primary Care	Dec.18	Safeguarding Delivery Group	See above.	See above.
		All partners when invited to attend strategy meetings to prioritise attendance. All relevant and proportionate information is provided to inform multi-agency decision making. NPS & CRC will ensure they identify caring responsibilities or contact with children of all adult offenders and where involved wil provide information to Strategy Meetings. All relevant staff to be reminded about the essential requirement to attend strategy meetings. Routine multi-agency audit programme to focus on this priority area of practice. Invites and attendance to be monitored.	SDG	Mar.19			

2. FRONT DOOR & MULTI-AGENCY SAFEGUARDING HUB

A review of the Front Door will be undertaken using Partners in Practice expertise. The outcomes of this review will inform developments at the Front Door and in frontline practice.

Ref	Area for improvement	Action (intent)	Lead	Timescale	Oversight & Monitoring	Expected impact	Scrutiny & Audit Programme (Evidence of Impact)
2.1	The MASH and the First Contact are under-resourced. The volume of contacts is high and has increased recently. This is leading to delays in decision-making about suitable interventions to improve children's outcomes. The pressure to make decisions quickly, together with the high volume of work, results in incorrect categorisation of some referrals. Some checks undertaken by social workers in the First Contact service are too superficial, and result in children not receiving the right support at the right time. Examples were seen of referrals incorrectly graded as needing early help when in fact they required statutory intervention such as MASH work or allocation to a social worker.	Review capacity within MASH and take necessary action so that resource is matched to need and new ways of working developed (eg. MAST, Diversion of low level Early Help referrals from front door utilising existing locality information sharing arrangements - eg Team Around School, Primary School Case Clinics etc.). Report outcomes of Review to LSCB with recommendations.	Children's Services	Dec.18	MASH Board	Outcome of review and action ensures resource is sufficient to meet demand appropriate checks are carried out leading to informed, safe decision making	LSCB Executive to receive outcomes of MASH review and agree recommendations and oversees implementation through strengthened governance arrangements and reporting mechanisms. LSCB to commission independent evaluation of multi-agency practice improvement

2.2	There has been a lack of challenge about the operation of the MASH, which has not ensured effective timely multi-agency decision-making.	Review governance arrangements for MASH and report directly to LSCB Executive/Safeguarding Partners Board	Children's Services	Dec.18	MASH Board	Practice development within the MASH reflects key areas for improvement identified through audits and SCRs and leads to improved practice and outcomes for children.	LSCB Executive/Safeguarding Partners Board to receive regular reports on MASH performance, providing the opportunity for challenge and improved effectiveness.
		Programme of reports on MASH performance and issues to be agreed by LSCB Executive/Safeguarding Partners Board	Children's Services	Dec.18			
2.3	Referrals are not always sent through to children's social care in a timely manner in order to ensure that the risk to children is responded to effectively. This is due to a number of reasons, including a lack of understanding of thresholds.	Introduce multi agency screening team (MAST) at the Front Door so that all DA incidents can be screened within 24 hours.	Children's Services	Dec.18		Greater knowledge of thresholds within organisations. Escalation process utilised appropriately. Improved quality of assessments	Desktop dip-sample of referrals within Children's Services to test timeliness. .Multi Agency Audit Programme to test knowledge and application of thresholds. Deficits to be reported to LSCB Executive.
		Individual agencies to ensure their workforce have a well developed understanding of thresholds and how to apply these to concerns about children and families, Learn at Lunch/Breakfast Club sessions to be developed to support improved understanding of thresholds and how to apply these.	SDG	Jun.19			
2.4	Police risk-assessment processes focus on the victim and perpetrator and place insufficient focus on the long-term impact on children.	Implement a safeguarding training programme to all front line staff which will incorporate awareness around risk assessment, cumulative impact of DA on children, police protection powers and through the eyes of the child.	Police	Sept. 19		Risks to children living with domestic abuse are well understood and responded to appropriately by frontline officers	Quarterly performance reports on numbers of Police staff trained to LSCB Executive;

2.5	Some cases are incorrectly graded by the police as standard risk when they should be graded as medium risk and are therefore not shared with children's social care. This means that there are missed opportunities to assess risk and reduce risk to children living with domestic abuse. In other cases, domestic abuse referrals graded by the police as medium too often require an urgent response once they are reviewed against the multi-agency threshold of need, and taking into account information held by children's services. These children experience additional delay in having their needs, including their need for protection, assessed.	Conduct a lean process review of the Central Referral Unit to ensure more timely sharing of information is achieved. Pilot commenced on 1/10/18. Police medium risk DA incidents where children are linked to the incident are jointly assessed by a police decision maker and social worker on a daily basis. Results so far (Nov.2011) suggest more timely, appropriate referrals and risk identified jointly much sooner	Police	Jan.19	MASH Board	Referrals are progressed in a timely manner and actions to safeguard children are implemented quickly where required	Conduct thematic audit of risk grading and timeliness of DA incidents being referred to include assurance of consideration of children within risk assessment. Outcomes reported to LSCB Executive.
		Review DASH risk assessment on Red Sigma to ensure that the child is properly considered as part of any DA incident by moving the Through The Eyes of The Child field in Red Sigma to the top of the DASH risk assessment to reinforce that the impact on the children should be considered first.	Police	Mar.19		All assessments evidence consideration of impact on child of any DA incident.	
2.6	Decision-making within the MASH about next steps, once all known information has been collated, is not undertaken jointly with other agencies. This has inherent weaknesses, for example in non-health staff interpreting health information, levels of risk not being agreed on a multi-agency basis, and partners not being part of discussions about levels of risk and suitable interventions.	Pilot a Multi Agency Safeguarding Team (MAST) daily dynamic screening and information and risk sharing process between Police, Children's Services and the 0-19 Service so that joint decisions are taken on all Domestic Abuse incidents within 24 hours.	Children's Services	Apr.19		Multi-agency decision making leads to improved assessment of risk and informs required actions to keep children safe	Single and multi-agency audit to test the quality of information sharing, multi-agency challenge and decision making. Outcome together with required actions reported to LSCB Executive.
		Review pilot and implement appropriate changes.		Jun.19			

2.7	Information gathering and sharing in the MASH is hampered by some specialisms not being represented. This includes adult and youth criminal justice services (CRCs, NPS, the YOT), and some health services available to children and families in Durham. This means key information about risks to children and their families is missed.	CRC, NPS and YOS to develop SPOC roles so that information sharing and participation in MASH decision making takes place in all relevant cases.	CRC, NPS & YOS	Dec.18	MASH Board	Improved information sharing leading to improved understanding of risks to children and more informed decision making.	Single and multi-agency audit to test the quality of information sharing, multi-agency challenge and decision making. Outcome together with required actions reported to LSCB Executive.
		Provide access to YOS Database within the MASH.	YOS	Mar.19			
2.8	The safeguarding practices in the Urgent Care Centres and the Emergency Department (ED) at County Durham and Darlington NHS Foundation Trust (CDDFT) are significantly under-developed. These shortfalls in both the effectiveness of safeguarding screening processes and the knowledge and understanding of staff have not been identified by the trust, either through supervision or audit activity. This means that risks to vulnerable children and young people who visit the service, or children who are associated with adults who present with risky behaviours, are not identified	Briefing sessions to be held between safeguarding team and ED and UCC staff both on a 1:1 and in groups to support improving the quality of Safeguarding children referrals.	CDDFT	Sept.18		Improved skill and knowledge of health practitioners within Urgent Care Centrs and Emergency Departments leads to more effective assessment of risk to children	Weekly meeting to be held with emergency department and urgent care lead to monitor progress. Report to LSCB Executive on the outcome of the briefing sessions, including numbers attended. Quarterly report on the outcome of weekly dip-sample activity to be provided to LSCB Executive together with actions to be taken where practice issues have been identified.
		The child assessment tool will be completed on all children age 0-18 attending ED and UCC.	CDDFT	Sept.18			
		Safeguarding team will deliver briefing sessions on improving the quality of CWILTED and the use of HEADSSS and CWILTED or HEADSSS will be completed on all children 0-18 attending ED and UCC.	CDDFT	Sept.18			

2.9	The backlog of medium-risk domestic abuse referrals from the police in the MASH means that there is a delay in taking action to safeguard children who are living with domestic abuse. Children are not being included on safeguarding referral forms, which means there are missed opportunities to safeguard them.	Conduct a LEAN process review of the Central Referral Unit and take necessary action to address backlog and reduce delay. Outcome of review to also inform the wider MASH review. (See also 2.5 - review of DASH Risk Assessment)	Police	Sept.18	MASH Board	Process improvements and efficiencies within CRU resulting in more timely sharing of information	Outcome of LEAN review to be reported to LSCB Executive together with actions taken. Outcome of MASH review together with actions to be reported to LSCB Executive
2.10	Only referrers receive information about the decisions made on referrals. Other partner agencies who have significant involvement with the child and family do not receive feedback, which means that they cannot challenge decisions made.	Development of MASH Module within Liquid Logic so that key strategic partners (Police, Health, Education) are able to see outcomes and share information within their agencies.	Children's Services	Mar.19		There is evidence of improved multi-agency challenge where required.	Single and multi-agency audit of Front Door/MASH to test the quality of information sharing, multi-agency challenge and decision making
2.11	There is a missed opportunity to utilise information gathered by the NPS, which is adult-orientated and has safeguarding concerns because the systems rely on knowing the specific details of children or adults close to the child.	Ascertain the possibility of running reports on Liquid Logic to determine the following information:- - Adults in the Household – date of birth and address - Other connected adults – date of birth, address, relationship to child Run a test to provide outcome and assurance so that when requesting information from NPS relevant identifying data can be provided.	Children's Services	Dec.18		Improved information sharing, regarding connected adults in relation to children experiencing Domestic Abuse.	Single and multi-agency audit to test the quality of information sharing, multi-agency challenge and decision making. Outcome together with required actions reported to LSCB Executive.
2.12	The MASH does not have access to the NPS or the CRC databases, and all referrals from these two services to the front door are categorised as 'probation'. It is therefore difficult to monitor the numbers and quality of referrals from each organisation.	NPS Lead Safeguarding Manager and CRC SPOC will work with the MASH to facilitate improved information sharing.	NPS & CRC	Mar.19		Improved awareness within MASH of of NPS & CRC which leads to improved contact and information sharing and risk assessment.	Quarterly reports to MASH Board and LSCB Executive on breakdown of referrals from CRC & NPS.
		Electronic recording system in MASH (SSID) to provide separate category for NPS and CRC referrals and information.	Children's Services	Dec.18			

2.13	A lack of understanding from partners about the distinct roles and statutory responsibilities of the NPS and CRC leads to a lack of effective information-sharing, which impacts on agencies' ability to monitor and manage risks to victims of domestic abuse and on the management of risk posed by perpetrators to adult and child victims.	NPS & CRC to develop "7 minute briefings" to be delivered to staff within the MASH and shared with partner agencies for dissemination in staff team meetings.	DASVEG	Mar.19	DASVEG	Improved understanding about the roles of CRC and NPS leads to improved information sharing and joint working with known perpetrators	Single and multi-agency audit to test the quality of information sharing, multi-agency challenge and decision making. Outcome together with required actions reported to LSCB Executive.
2.14	Information relating to adult offenders is not consistently directed to the right organisation by the MASH. This means that information is not effectively shared, which leads to missed opportunities to manage the risk of perpetrators effectively. This includes delays in information-sharing when perpetrators attend court.	DASVEG to raise the profile of the role of NPS and CRC within multi-agency representative organisations and ensure the workforce has knowledge of Domestic Abuse Pathways.	DASVEG	Mar.19			
2.15	The current threshold to access the Multi-agency Risk Assessment Conference (MARAC) is inconsistently applied, meaning that cases that meet nationally agreed high-risk criteria are not benefiting from the multi-agency information sharing and action planning that MARAC provides. Agencies are not referring significant high risk domestic abuse cases to MARAC appropriately.	Multi-agency briefings to raise awareness of MARAC criteria and agency responsibility to refer to MARAC in relation to potential high risk domestic cases	LSCB Business Unit	Mar.19		Improved awareness of MARAC criteria and referral processes leads to improved information sharing and access to MARAC arrangements for victims	Quarterly performance reports to LSCB Executive on no's of staff attending briefings; Conduct a review of MARAC provide assurance of improved application of thresholds, multi-agency referrals and quality of decision-making.
		DASVEG to review MARAC process to consider and address capacity from a multi-agency perspective in order to ensure appropriate cases are referred and considered to the detail required	DASVEG	Mar.19		Improved application of threshold	
	GPs are not currently asked for information to contribute to MARAC and this means that decisions are made without the benefit of this information.	Named GP to work with MARAC Co-ordinator in police to develop process to facilitate GP information being included into MARAC process.	Primary Care	Dec.19		Improved awareness of MARAC criteria and referral processes	
	There is insufficient quality assurance of the decisions.	Review decision making and quality assurance process around MARAC referrals to ensure consistent application of thresholds	Police	Jul.18		Consistent application of thresholds around decision making	

<table>
<tr><td rowspan="2">2.16</td><td rowspan="2">Operation Encompass is not yet fully effective because there are too many children living with domestic abuse for whom no information on incidents is shared with the school. In addition to standard-risk cases not being shared, medium-risk cases are not shared in cases where there is a delay. This also means that some children are not being identified as needing access to available support services to meet their emotional needs within the school or elsewhere, and it also restricts the school's ability to effectively contribute to multi-agency planning and decision making.</td><td>Operation Encompass to be extended to include standard risk DA cases. Commissioning arrangements to extend Operation Encompass agreed by at Domestic Abuse Sexual Violence Executive Group (DASVEG) on the 12th November 2018. Evaluation of Operation Encompass led by Teeside University expected January 2019. (See also 3.12)</td><td rowspan="2">DASVEG</td><td>Apr.19</td><td rowspan="2">DASVEG</td><td rowspan="2">Improved information sharing with schools ensures children subject to the experience of DA are supported within their school community.</td><td rowspan="2">Quarterly reports to MASH Board and LSCB Executive on the number and timeliness of Operation Encompass referrals to schools.</td></tr>
<tr><td>Review Pilot, seeking feedback from schools, and implement appropriate changes to current process.</td><td>Mar.19</td></tr>
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3. SAFEGUARDING PRACTICE & WORKFORCE DEVELOPMENT

Ref.	Area for improvement	Action (intent)	Lead	Timescale	Oversight & Monitoring	Expected impact	Scrutiny & Audit Programme (Evidence of Impact)
3.1	When professionals make decisions on thresholds, children's history and cumulative risk are not fully considered. A number of children have a history of a significant number of re-referrals and numerous assessments because of a repeated pattern of abuse. Coercive control and disguised compliance is not as well understood by social workers and managers as other aspects of domestic abuse.	Where Domestic Abuse is a factor, all Multi-Agency meetings (eg Team Around the Family, Core Groups, Child Protection Meetings) should ensure the following are clearly articulated, accurate and have been used to inform analysis of the risks to and impact upon children: - Chronologies are well developed and used to analyse risk, particularly in relation to repeat incidence of DA - Disguised Compliance is specifically addressed through assessment; - Coercive Control is specifically addressed through assessment; - A clear analysis of risk to the child is specifically addressed through assessment	SDG & DASVEG	Mar.19	Safeguarding Delivery Group	Improved use of chronologies to inform assessment and analysis of risk to children from repeat experiences of domestic abuse is well articulated throughout assessments, including specifically addressing disguised compliance and co-ercive control.	Multi-Agency Audit to test improved use of chronologies to inform analysis and decision making. LSCB to commission a "One Year On" independent evaluation of multi-agency practice improvement in Autumn 2019.
3.2	There is often an over-optimism of all agencies in relation to the assessment of the future risk of domestic abuse, and this includes a lack of professional challenge.	Multi Agency Safeguarding Delivery Group to work together to improve the culture whereby multi-agency challenge is encouraged and takes place at the earliest opportunity leading to improved safeguarding practice by developing a Develop a Multi Agency "Pledge" which sets out clear expectations regarding how challenge should be made and how to escalate concerns if nothing changes.	SDG	Mar.19		Improved information sharing processes that support front line staff in considering the cumulative impact of DA on children and which enable partners to challenge decisions if they feel risks have not been fully or have been inaccurately assessed.	Single and multi-agency audit to test the quality of information sharing, multi-agency challenge and decision making. Outcome together with required actions reported to LSCB Executive.

		Introduce a "group supervision" approach into Team Around the Family and Core Groups that are "stuck" or where outcomes are not being achieved to support review and reflection, use of scaling questions, danger statements, safety goals.	Children's Services	Mar.19	Safeguarding Delivery Group	See above.	See above.
3.3	Children's social care services fail to progress referrals appropriately.	Ensure standards and timescales for referrals to Families First are monitored for compliance across the service through monthly and quarterly monitoring through the use of Team Profiles and Scorecards. Exceptions to be reported to Senior Management Team.	Children's Services	Dec.18		Timely progression of referrals to Children's Social Care	Quarterly performance report to LSCB Executive on timeliness of referrals to Children's Social Care.
3.4	While flags are visible in systems to alert frontline staff across agencies to changing risk, these are not always being used to aid decision-making and knowledge about the extent and severity of risk to children. Flags did not inform the full extent of risk to those involved.	Multi-agency procedures to be developed and implemented to provide clear guidance about the use of Flags on systems, to include guidance on information to be recorded and how it should be used by practitioners to junderstand and assess risk to children.	LSCB Business Unit	Mar.19		All available information in relation to known risk of adults towards children is stored within appropriate areas within systems and accessed by staff to inform risk analysis and decision making in relation to keeping children safe.	Single and multi-agency audits on use and application of information in Flags in systems to provide assurance of practice improvement relating to risk assessment and analysis leading to informed decision making. Single agency outcomes reported to relevant senior management teams and multi-agency to LSCB Executive.
		Case audit to commence during August 2018 to assess quality of risk registrations applied to cases.	CRC	Sept.19			
		All OMs to ensure additional notes about specific risks to children are included in risk registration flags.	NPS	Sept.19			
		Safeguarding induction policy to be pilotted for all GP practices which will include flags for domestic abuse and other risk factors	Named GPs	Dec.19			
		Review arrangements for storage of MARAC minutes and ICPC minutes to ensure they are accessible to all front line staff if required	Police	Mar.19			

3.5	Children's social care assessments vary in quality and a consistent deficit is that they do not summarise children's history effectively in order to inform analysis of risk.	Ensure all staff consistently complete chronologies on children's case files which draw on partner and historical information gathered through MASH process. Quarterly Collaborative Review to ensure focus with individual practitioners and drive practice improvement individual and service-wide.	Children's Services	Mar.19	Safeguarding Delivery Group	Improved use of chronologies to inform assessments and plans for children leading to improved plans and interventions to improve their safety and wellbeing leading to better outcomes.	Collaborative Review and compliance audits on use of chronologies, outcomes reported to Children's Social Care Management Team and improvement actions taken where required.
		Ensure information contained within Chronologies is systematically used to inform assessments and analysis of risk and leads to improved quality of assessment.	Children's Services	Mar.19			
3.6	Cases sampled highlighted a lack of professional challenge and escalation when health staff disagreed with decisions being made about children and their families.	Establish a Multi-Agency group for Senior Managers to raise issues regarding safeguarding practice and encourage challenge. See also 3.2 above.	SDG	Dec.18		Improved evidence of multi-agency challenge where there is disagreement regarding decisions in relation to keeping children safe.	Single and multi-agency audit to test the quality of information sharing, multi-agency challenge and decision making. Outcome together with required actions reported to LSCB Executive.
		Develop a briefing on Escalation Policy within LSCB procedures	LSCB Business Unit	Mar.19			
		Review of the roles and responsibilities level 3 safeguarding training to ensure staff feel equipped to make appropriate challenges.	HDFT	Dec.18			
		Review of Supervision process Increased supervision of supervisors by named nurses to ensure supervisors report concerns for children so this can be addressed by safeguarding team.	HDFT	Dec.18			
		Professional Challenge training has been rolled out across NTHFT following a local learning lessons review	NTHFT	Sept.18			
		To review training to ensure this encompasses the requirement for challenge when staff disagrees with the decisions made. Ensure that staff are made aware of the escalation process for when there is no resolution to challenges made.	TEWV	Dec.18			

3.7	Across agencies, case planning is not effective. Children's multi-agency plans are not well shared and do not identify key actions and activities against their plans. The majority of child protection plans are of poor quality and are not always sent to partner agencies. The result of this is reduced effectiveness in ensuring that agencies and families are clear about what the risks are to children and what needs to happen to keep them safe. Outcomes and goals do not sufficiently identify what needs to change to protect children from experiencing domestic abuse. Some do not mention domestic abuse and others are adult-focused.	Multi-agency audit and single-agency dip--sampling of care plans to be carried out by all partners to ensure plans are focussed on outcomes and that they have been shared with appropriate partners and children and families. The results of audit and dip-sample activity to be shared with partners and used to inform multi-agency workforce development activity. 7-minute briefing to be developed and disseminated across the partnership providing clear expectations regarding plans.	SDG	Jun. 19	Safeguarding Delivery Group	Improved plans are in place for all children which are well understood by them and their families. TAF/Core Groups are clearly focussed on delivering the plan leading to improved outcomes for children. Partners involved in TAF/Core Groups have copies of plans.	Monitor quality improvement through Collaborative Review and Multi-Agency Review process and ensure improvement actions are taken and reviewed. Quarterly report on outcomes to LSCB Executive.
		Implement multi-agency case audit programme and ensure agencies are identifying and addressing practice improvements	SDG	Dec.18			
		Training has been delivered to practitioners on the use of the Family Plan to ensure actions and required outcomes are clearly described and reflect the key risks to the child. This included ensuring the plans are driving discussion and review at TAF/Core Groups as part of progress monitoring arrangement and ensuring agreed actions have impact on outcomes for children.	Children's Services	Dec.18			
		Above training to be delivered to IROs	Children's Services	Dec.18			
3.8	Improvements in safeguarding practice in maternity services have not been effective in one of the localities. There are still some poor approaches to safeguarding the unborn, adults and linked older children. Routine enquiry of domestic abuse is not embedded or well	Ensure awareness of current deficits in documentation. Named Midwife, Named Nurse and Senior Midwife for Safeguarding to provide support to frontline staff to improve practice.	CDDFT	Sept.18		Improved awareness raising amongst key frontline health staff leads to improved information sharing across departments.	Single agency audits to be carried out and outcomes reported to relevant health senior management team.

	considered, even when there are known risks. Assessments lack professional curiosity, which impedes the timely identification of, and effective response to, risks.				Safeguarding Delivery Group		
3.9	Work to assess and respond to domestic abuse within the CRC is variable, ranging from good assessment and appropriate planning to delay information sharing and planning. There is not a sufficient focus on risks to children.	Quality of assessments and work with domestic abuse will be enhanced via a number of measures:- - Training – case study delivered to all teams; - Updated policies and guidance; - Focused supervision and thematic work in teams; - Annual training and development on domestic abuse;	CRC	Dec.18		Raised awareness and profile of domestic abuse and impact on children via measures identified	Single agency audits to be carried out and outcomes reported to relevant health senior management team.
3.10	For some children, there is an over-reliance by agencies on adult victims of domestic abuse, to keep their children safe. Written agreements are ineffective because they place unrealistic expectations on the mother, such as expecting her (the adult victim) to prevent the perpetrator from attending the home. These agreements do not take into account the power relationship or focus sufficiently on the perpetrator who needs to change their behaviour.	Re-issue guidance on the use of written agreements and ensure Family Plans are robust and clear in relation to risk management and improve awareness of and referrals to perpetrator programmes to minimise the need for the use of written agreements.	Children's Services	Dec.18		Families are supported to implement change leading to reduced violence and improved safety for children.	Collaborative Review to review to include use of Written Agreements in cases of DA, outcomes reported to Children's Social Care Management Team and improvement actions taken where required.
		Introduce new model of working - Signs of Safety - across the Service.	Children's Services	Sept.19			

3.11	Think family' is not fully embedded across health services. The impact of the adults' behaviour on children is not identified and, therefore, children do not receive the support they need. For example, in the adult mental health service, the adult substance misuse service and in some GP practices, assessments focus too much on the adult, which does not enable the effective or timely identification of the impact of adults' behaviour on children. Cases sampled in the ED highlighted significant concerns that ED staff are not recognising risks to children. Therefore, the trust cannot assure itself that children and adults leaving the ED are safe.	Embed the 'think family' approach with professionals in ED and UCC, GPs, 0-19 Service and TEWV. Develop a briefing on what "Think Family" means include examples of the use of system one "Tasking" facility to alert HV and School nursing to issues.	Primary Care	Dec.18	**Safeguarding Delivery Group**	Improved understanding of Think Family leading to the impact of adults behaviour on children being more systematically embedded into practice across the Health landscape.	Improved referrals to the Stronger Family Programmes from Health agencies and commissioned services - performance reported to and monitored by the Think Family Partnership
		Raise awareness of Think Family across all health agencies through training and supervision	All Health Partners				
		Ensuring Vulnerable Parent Pathway Lead Practitioner raises awareness of "Think Family" in training, supervision and performance management	HDFT	Dec.18			
		A section on Think Family is now included in all adult health care records in NTHFT	NTHFT	Sept.18			
		Staff training for all recovery workers within Humankind to ensure a Think family approach is implemented across both adults and C&YP pathways	Humankind	Dec.18		A full think family approach will be formally embedded into the adult pathways of the Drug & Alcohol service	
		DASVEG Partnership to ensure all partners are working to the Think Family strategy	DASVEG	Dec.18	**DASVEG**	Improved understanding of Think Family across the DASVEG partnership	Improved referrals to Stronger Family Programme

3.12	In some cases, children were removed from homes and placed with other individuals without recourse to police protection powers (PPP). This means that checks were not always carried out and the processes afforded to support PPP, such as a strategy meeting and joint plan for the children, did not take place.	Implement a safeguarding training programme to all front line staff which will incorporate awareness around risk assessment, cumulative impact of DA on children, police protection powers, and Through the Eyes of a Child	Police	Dec.18	Safeguarding Delivery Group	Staff are skilled and knowledgeable about the legal framework around Strategies and S47 enquiries and practice improves leading to children being safe	Quarterly performance updates on numbers of Police staff trained to LSCB Executive to provide assurance of progress.
		Provide clear briefing to all staff on expectations and procedures in relation to strategies and section 47 enquiries	Children's Services	Dec.18			Audits to be carried out bi-monthly to ensure compliance with procedures.
3.13	There are delays in police attendance at domestic abuse incidents. This leads to a delay in the submission of safeguarding referrals, which means that these medium-risk cases are not being shared via Operation Encompass and there are delays in sharing them with the MASH.	Changes have immediately been implemented within the Communications Department. This includes a new question set for Comms staff to ensure that children's details are obtained at the point of call, even if the incident is to be made subject of a diary appointment. This will ensure that all domestic abuse incidents are shared in a timely fashion with schools via Operation Encompass. See also 2.16.	DASVEG	Dec.18	DASVEG	The child's needs immediately following a domestic abuse incident can be met by teachers who have an understanding of what has happened to them and can provide support to the child so that the long term impact is minimised	Quarterly reports to MASH Board and LSCB Executive on the number and timeliness of Operation Encompass referrals to schools
3.14	At the time of the inspection, domestic violence call-out information from the police was only provided to NPS if the index offence was domestic abuse-related. People appearing at court with other types of charges did not have a routine domestic violence call-out check with the police. Court staff could only use the self-reported information from the offender in order to identify	NPS will facilitate the placement of Police Computers into NPS buildings These to be accessed by Probation Staff.	NPS	Oct.18		Perpetrators risks, better assessed with information passed to Prisons & CRC	Single agency audits to be carried out and outcomes reported to relevant health senior management team.
		Compliance with OMS and relevant checks associated with domestic abuse perpetrators					
		CRC Through the Gate Team to ensure that Safeguarding Children concerns are identified, checked and information is appropriately shared in all custody cases.	CRC	Dec.18		Safeguarding processes can commence/continue whilst offender in custody.	

	whether there were risks to children or risks of domestic abuse. Therefore, limited information was passed on to prisons and the CRC, and this hampered efforts to manage risk.	On case allocation to DTV CRC from NPS, case admin staff to add safeguarding registrations.	CRC/NPS	Oct.18	**DASVEG**	Responsible Officers alerted to safeguarding information at the point of sentence. Regular and ongoing checks are enabled throughout sentence as a risk management strategy.	
		CRC to reach protocol agreement with Durham Constabulary in relation to the routine sharing of domestic abuse (call-out) information via an electronic request in order that risk assessments can be fully informed and robust risk management plans developed.	CRC	Mar.19		Full information is available to inform risk assessment and management plan to take into account domestic abuse and risks to children.	
3.15	NPS at court need to have access to risk information in domestic abuse cases so that it can be shared with prisons immediately post-sentence. This then enables prisons to take steps to manage the risk in order to protect the victim.	Police and NPS to work together to develop an understanding of NPS requirements and then develop working arrangements to ensure that information is shared with NPS in domestic abuse cases	NPS & Police	Mar.19	**NPS/Police**	Perpetrators risks, better assessed with information passed to Prisons & CRC	Single agency audits to be carried out and outcomes reported to relevant health senior management team.
3.16	The YOS manages some children who pose a significant risk to others. There are evident difficulties in assessing and managing these risks when children are working on a voluntary basis with the YOS. In one case, there was a missed opportunity to respond to a serious assault as restorative disposal, which did not support the YOT in working with the young person.	Review decision making between Police and YOS in relation to the gravity of offences and outcomes proposed. YOS Police Officers to review / challenge low level community-based restorative justice interventions where domestic violence is a feature in offending by the young person.	YOS	Mar.19	**YOS**	Appropriate response in accordance with gravity of offences.	Single agency audits to be carried out and outcomes reported to relevant health senior management team.

3.17	While the Police have developed some additional training, which is positive, inspectors found that some of the cases tracked and sampled show that inconsistencies remain in the quality of decision-making at the front line. Incidents are often dealt with in isolation rather than consideration being given to the previous history of incidents and the wider context of risk and vulnerability.	Implement a safeguarding training programme to all front line staff which will incorporate awareness around risk assessment, cumulative impact of DA on children, police protection powers, and Through the Eyes of a Child	Police	Dec.18	**Police**	Staff are skilled and knowledgeable about the legal framework around Strategies and S47 enquiries and practice improves leading to children being safe	Quarterly performance updates on numbers of Police staff trained to LSCB Executive to provide assurance of progress.

4. LEADERSHIP & MANAGEMENT

Ref.	Area for improvement	Action (intent)	Lead	Timescale	Oversight & Monitoring	Expected impact	Scrutiny & Audit Programme (Evidence of Impact)
4.1	The quality of auditing and monitoring of work has not been sufficiently robust. This has been recognised, and a new model of auditing has now been developed. The monitoring across the partnership of decision-making about next steps for children in need of help and protection has not been robust and therefore deficits in practice have not been sufficiently identified.	Develop and implement an agreed process for the delivery of a quarterly multi-agency audit programme based on themes from inspection, SCR.	LSCB Business Unit	Dec.18	**LSCB**	Practice development reflects key areas for improvement identified through audits and SCRs and leads to improved practice and outcomes for children	Implement Multi-Agency Audit Programme and report quarterly to LSCB Executive.
4.2	Audit activity is under-developed in all health providers, which is not supporting consistency of practice or learning from domestic abuse-related safeguarding casework.	Rolling monthly audit of 0-19 records by Named Nurse and 0-19 management team to include practitioner and address: - Depth of analysis; - Evidence of Risk; - Evidence of Escalation; - Voice of the Child; - Impact of Interventions; - Evidence of handover.	HDFT	Dec.18	**HDFT**	Named Nurses will share the themes from audits in regular meetings with Designated Nurses	Single agency audit to test the quality of information sharing, multi-agency challenge and decision making. Outcome together with required actions reported to relevant health senior managers.
		All relevant health agencies to be part of LSCB Multi Agency Audit Programme	All Health Partners	Dec.18	**All Health**	Improved understanding of practice improvement and development of learning	

4.3	Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) has not undertaken audit activity to support learning from domestic abuse-related safeguarding casework. The leadership focus on domestic abuse is not evident in case recording, and there is limited monitoring of domestic abuse interventions or their outcome.	To review documentation around domestic abuse in place, develop aide memoires to support practitioners to consider the impact of domestic abuse upon children and action required to be taken.	TEWV	Mar.19	TEWV	Improved practice in relation to domestic abuse across the Trust	Single agency audit to test the quality of information sharing, multi-agency challenge and decision making. Outcome together with required actions reported to relevant health senior managers.
		To review current audit work and plan how domestic abuse can be integrated into the current audit programme.		Mar.19			
4.4	Management oversight of safeguarding caseloads in all health services is underdeveloped. Some cases sampled showed drift and delay, and there was no supervision or tracking of these cases. Supervision arrangements need further consideration to ensure that they are fit for purpose, easy to access and meet the specific needs of the local teams in Durham.	The safeguarding team will ensure that ED and UCC practice is compliant with trust policy and safeguarding concerns are appropriately identified and acted upon. Safeguarding practice will be subject to effective operational management governance and monitoring.	CDDFT	Sept.18	CDDFT	The safeguarding team will adhere with safeguarding SOP for hospital nurses; Improved safeguarding supervision across Health leading to improved effectiveness of safeguarding practice	Single agency audit to test the quality of safeguarding practice. Outcome together with required actions reported to relevant health senior managers.
		TEWV to recirculate the managers tool kit to remind staff and managers the requirement of safeguarding supervision	TEWV	Dec.18	TEWV		
		Improve impact of safeguarding link personnel in ED and UCC to support promoting the culture of safeguarding and the ‘think family’ approach.	CDDFT	Sept.18	CDDFT		
		Review of Supervision process, increased supervision by named nurses and audit the quality of safeguarding supervision.	HDFT	Dec.18	HDFT		

		A rolling program of safeguarding supervision for SALT has now commenced with 4 mandated sessions per year. These sessions will include the identification of vulnerability flags and how these should inform assessments	NTHFT	Sept.18	NTHFT		
4.5	Seniors managers are clear about the priorities for children's social care to: improve recruitment and retention of social workers; ensure that caseloads are manageable; reduce delay; and improve the quality of practice. Actions taken have yet to have sufficient impact, and there remains significant deficits in practice and multi-agency working. In addition to this, children experience too many changes of social workers.	Continue with recruitment and retention strategies to achieve stability and fill vacancies.	Children's Services	Dec.18	Children's Services	Recruitment and Retention Payments to continue until teams reach optimum size and achieve stability	Monitoring of all actions to be carried out by Children's Social Care Senior Managers and reported through to the Quality Improvement Board. Updates to be provided to the LSCB Executive.
		Commission additional capacity to support the service achieve optimum caseload sizes		Dec.18		Social Workers have manageable caseloads and the qulaity of frontline practice improves as evidenced through audit activity.	
		Children's Social Care Senior Management Team to maintain focus on monitoring changes in SW for children to ensure this is kept to a minimum and where it is necessary, ensure change is managed robustly with agreed handover processes which engage and involve children and their families.		Jun.19		Improved stability leads to reduced changes for Children. Children's Satisfaction Survey to be delivered ongoing across the service	
		Revise and implement induction programme and ensure all newly recruited SW are supported to ensure knowledge of systems, process, procedures.		Dec.18		Newly recruited SW have a solid grounding into their role within Durham Children's Services. Survey all newly recruited SW within 2 months	

		Identify and address aspects of service-wide culture which delivers inconsistent and poor quality practice, by implementing the following: • Management Oversight Programme. • Signs of Safety/Group Supervision/Reflective supervision. • Liquid Logic. • Compliance audits to test consistency of practice against required standards and procedures. • Collaborative audit. • Review DRP process to ensure it is achieving maximum impact on quality of practice improvements.	Children's Services	Sept.19	Children's Services	Practice improvement leading to improved outcomes for children	Monitoring of all actions to be carried out by Children's Social Care Senior Managers and reported through to the Quality Improvement Board. Updates to be provided to the LSCB Executive.
4.6	Some social workers' caseloads are higher than the local authority's preferred maximum, making it difficult to allocate incoming work. The 'duty inbox' system results in some children experiencing additional changes of social worker.	Recruitment and Retention strategies continue to be delivered to manage vacancies and ensure workforce is at optimum capacity; Ongoing work by Operations and Team Managers to ensure improved focus on workflow management.	Children's Services	Mar.19		Stable workforce and effective management of workflow secures improved capacity to support children to achieve good outcomes.	
4.7	There are capacity pressures in the safeguarding specialist support function in the substance misuse service provided by Humankind. As a result of some recent support staff absence, the safeguarding database used by the lead practitioner has not been updated since May 2018 and so the monitoring of recent safeguarding activity is not taking place.	The database has been updated. Management capacity has been reviewed and additional capacity identified.	Humankind	Dec.18	Humankind	Effective management and oversight of safeguarding risks.	Contract review to monitor compliance with commissioned activity.

4.8	There is insufficient challenge and scrutiny from the LSCB in relation to monitoring and challenge of children living with domestic abuse and the response to children at the front door. Partners are not consistently held to account for their safeguarding responsibilities.	Maintain strong links between Domestic Abuse Sexual Violence Executive Group (DASVEG) and the LSCB to ensure issues requiring multi-agency and individual partner response are identified and addressed.	DASVEG/ LSCB	Sept.19	**DASVEG/ LSCB**	Improved challenge and scrutiny leading to improved practice at the frontline which keeps children safe.	Cross cutting issues between DASVEG and LSCB Executive in relation to Domestic Abuse are identified and jointly addressed through joint ownership and action.
		See action 4.1 above and action 3.2 in section "Safe Practice & Workforce Development" on Multi Agency Challenge and Multi Agency Audit Programme.		Dec.18			
4.9	Schools are not routinely putting individual risk assessments in place for children, when staff become aware of domestic abuse and the risks that perpetrators and other family members may pose to children. Instead, they are relying on existing security arrangements at the school.	Produce detailed guidance, including Health and Safety and risk management advice, to be produced and disseminated to all schools.	DCC Education Service	Mar.19	**DCC Education Service**	Improved risk assessments in place for children keeping them safe at school.	Education Service to check compliance with schools.

5. VOICE OF THE CHILD

Ref	Area for improvement	Action (intent)	Lead	Timescale	Oversight & Monitoring	Expected impact	Scrutiny & Audit Programme (Evidence of Impact)
5.1	Children's voices are rarely recorded in cases where the police attend a domestic incident. There are instances of reports being made by children who have been assaulted and neglected not resulting in a criminal investigation. This means that the opportunities to protect children and help them feel safe are missed.	Implement a safeguarding training programme to all front line staff which will incorporate awareness around risk assessment, cumulative impact of DA on children, police protection powers, and Through the Eyes of a Child	Police	Sept.19	Safeguarding Delivery Group	Children are routinely spoken to and provided with opportunities to have their views heard and taken into account in all casework. Decision making evidences consideration has been given to the experiences of children.	Single agency audits reported to relevant Senior Management Teams within agencies. Outcomes reported to LSCB Executive on request.
5.2	Unborn children in families with known risk factors are not considered at a sufficiently early stage on a multi-agency basis.	Ensure Birth Plans are timely and robust. Ensure all partners know and understand pre-birth procedures and how to challenge if required through clearly stated escalation procedures within each agency.	SDG	Dec.18		Early identification of the needs of vulnerable unborn children; Improved referrals	Thematic Audit of pre-birth procedures, reported to LSCB Executive.
		Reinforce through our midwifery leads the need for early referral and promote a joint approach. Named Nurse to deliver 7 minute briefing on timeliness of referrals	CDDFT				
		All partners to ensure frontline Practitioners within County Durham understand their responsibilities to refer unborn children as soon as they are aware there is a pregnancy and where there are	SDG				

		safeguarding concerns at the earliest opportunity and not wait until 20 weeks stage	SDG	Dec.18	Safeguarding Delivery Group		
		All partners to ensure frontline practitioners are aware of and follow LSCB pre-birth procedures.					
5.3	Some cases seen show that children's views have not been taken into account by professionals across all agencies when assessing their vulnerability and risks. Where children have a consistent social worker, the child is well engaged and their voice is heard. However, the voice of the child is rarely visible in most cases seen and their views are not routinely sought to influence practice.	All partners to ensure they speak to children and young people and capture their views in recordings and review through single service and multi-agency audit programmes.	SDG	Dec.18		Children are routinely spoken to and provided with opportunities to have their views heard and taken into account. This is evidenced in case files. Decision making evidences consideration has been given to the experiences of children.	Multi and Single Agency Audit Programmes evidence the voice of the child is strong there is evidence ov management oversight through supervision and records show children's voices inform decisions and actions and lead to improved practice. Implement Service User Survey in Children's Services and report outcomes to Senior Management Team. Monitor use of NYAS and review effectiveness with children and young people through survey activity.
		Improve the use of tools to support children and young people to express their views and experiences. All partners to ensure supervision of staff explores how the child's voice is sought and used to inform understanding and decision making.					
		Collaborative audit to continue to identify whether Voice of the Child is strong in all cases and identify and implement actions to secure improvement at individual case and service- wide level.	Children's Services				
		Improve the use of NYAS Advocates for children and young people involved in Child Protection Conferences to ensure their views are represented.	Children's Services				