Response Statement from Northumberland Safeguarding Children Board (NSCB) on Baby Eve

Addendum -
Sample of Actions Taken Against Recommendations

Children's Services recommendations

- Children's Social Care (CSC) has reviewed and implemented revised policy, procedure and practice guidance regarding the completion of assessments and risk assessments and is to commission additional training to further embed best practice.

- CSC has reviewed and implemented revised policy, procedure and practice guidance in relation to multi-agency Child Protection Core Group meetings which now includes direct observation and feed-back on a selection of Core Group meetings by Senior Managers.

- CSC has reviewed and implemented revised policy, procedure, practice guidance regarding the Public Law Outline (PLO) and training has been provided. This is strengthened further with the establishment of the PLO/legal panel which has Senior Management oversight.

- CSC reviewed management arrangements and promptly revised the team structure and increased team manager capacity.

- CSC has reviewed the social work teams and increased social work capacity within the statutory social care teams.

- CSC will continue to regularly undertake and report on audits to ensure that the Serious Case Review (SCR) recommendations are firmly embedded and evidenced in practice.

Legal Services recommendations

- Working protocols between the Council's Legal Services and CSC have been reviewed and strengthened, including increasing clarity around the role of the legal advisors and escalation of issues where disagreements are emerge.

Education recommendations

- The Council and the Local Safeguarding Children's Board (LSCB) have developed a safeguarding audit under Section 11 tool which is undertaken with all schools to identify, support and address any safeguarding concerns in schools. Outcomes are reported to the LSCB.

.

Northumbria Healthcare NHS Foundation Trust recommendations

- The multi-agency substance misuse pathway of care for mothers and babies has been reviewed and strengthened to improve early detection of risk and management of cases, with clear prescribing responsibilities to improve patient care and safety for babies. Audits have, and continue to demonstrate significantly improved practice in this area.

- Comprehensive training has been provided to ensure competency and skill in neonatal abstinence syndrome

- An improved communication pathway between healthcare professionals including dentists, health visitors, school nurses and GPs, ensures that where children access dental services with clear signs of neglect the appropriate information is shared and actions are taken in a timely way to address their needs.

- The Trust's safeguarding policy and processes have been reviewed, updated and implemented, reflecting the learning from this Serious Case Review (SCR), providing clearer operational procedures to safeguard children, as well as the appointment of a named midwife and new 'high risk' midwife role.

Northumberland, Tyne and Wear (NTW) NHS Foundation Trust recommendations

- NTW together with CSC have developed a centralised process of identifying NTW staff that are working with families who are under Section 47 enquiries, to better enable their contribution at the assessment and planning stages of the investigation by providing a written report and attendance at the initial conference, core groups and reviews.

- NTW have developed and implemented a local Practice Guidance Note (PGN) to clarify the role of NTW Substance Misuse Services in working with women who are pregnant whilst receiving substance misuse support, based on the common principles agreed within a whole system approach. The PGN introduces a pregnancy coordinator to monitor cases alongside clarifying minimum standards of intervention, frequency of contact and review, all within an audit framework and supporting the wider pathway for review with obstetric services.

Primary Care recommendations

- The Named GP has been involved with the development of the substance misuse pathway to ensure GPs are aware of the process to follow and a 'family template' has

been produced. The local GP toolkit resource pack has been updated (which includes a report writing template and information sharing guidance), distributed widely and is referenced in all GP training. Work is on-going setting up electronic systems to ensure GPs receive information from Child Protection Case Conferences (including invitations) in a timely manner.

- The Designated Nurse has circulated a newsletter to all GP practices which includes an up-to-date list of safeguarding contacts within health.

North East Ambulance Service (NEAS) recommendations

- A review has been completed at the Clinical Advisory Group (CAG) on paediatric Advance Life Support (ALS) as opposed to Basic Life Support (BLS). Medical staff agreed the decision on using ALS and not BLS will be a clinical decision made by the paramedic at each incident.

- Safeguarding procedures have been strengthened and training for staff in respect of leaving vulnerable children and adults at home when the main carer is taken to hospital was included in the Essential Annual Training programme 2014/15.

Local Safeguarding Children Board (LSCB) recommendations

- Specific training (*Sand Stories*) on working with hostile and un-cooperative parents was commissioned by the LSCB and delivered in 2014 and was evaluated positively. The LSCB has issued and since re-issued the specific guidance and is setting out an assurance process to affirm all partners have sent the guidance to all staff.

- It has been agreed that the Principal Children's Social Worker and Designated Nurse Safeguarding Children will observe and audit Child Protection Case Conferences and the Designated Nurse will develop a template to be completed by safeguarding nurses following their attendance at conference to ensure their independent role is demonstrated and auditable.

- The LSCB section 11 template has been revised and now includes a specific requirement for agencies to state how they have identified and met the learning outcomes noted in this SCR and other learning reviews commissioned by LSCB. Challenge and scrutiny of individual agency's section 11 audits has been undertaken by the LSCB business sub group

- The Escalation and Resolution of Professional Disagreements protocol has been re-issued to all LSCB partner agencies.

- The LSCB has ensured that the Northumberland birth plan protocol is in its procedures

- LSCB has agreed and issued Child Protection Case Conference standards that state the expectation on all partners regarding the authorship, attendance, and production of child protection conference documentation. The Chair Person reports compliance to the standard following each conference. Overall compliance with these standards is now monitored by the LSCB. The LSCB receives bi-annual reports which highlight any practice issues identified by the Chair Persons.