Northumberland Safeguarding Children Board

# Business Plan 2018 - 2019 Safeguarding Children in Northumberland

http://www.northumberland.gov.uk/Children/Safeguarding.aspx

# Contents



Version Control

| Version | Date | Author | Changes |
|---|---|---|---|
| V1 | 20/08/2018 | RHC | Draft for consultation |
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## Introduction

Welcome to Northumberland Safeguarding Children Board (NSCB) Business Plan for 2018-19. The plan builds on the work of the Board undertaken since its inception in 2006 and you can find a detailed account of the progress and learning achieved in the 2016-17 Annual Report.

Unusually this plan only covers a one-year period due to the NSCB being abolished in the Children and Social Work Act 2017, however it is important there is continuity and a planned transition into the new safeguarding arrangements lead by the three safeguarding partners the Northumberland Clinical Commissioning Group, Northumbria Police and Northumberland County Council.

The Safeguarding Board has representatives from a wide range of organisations which are directly involved in providing services to children and young people and their families. Board members seek to provide a leadership and challenge in all matters relating to the safety and protection of children and young people in Northumberland. We want to make sure that the safeguarding of children and young people in Northumberland is and remains a priority, whether as a volunteer in a youth group, a teacher in a school, a social worker, nurse, doctor, police officer or in other positions. It will also provide a framework for those who are responsible for making decisions about the future of services in the county.

The Annual Report for 2017-18 sets out progress and learning over the past year and also serves as a review of the previous priorities.

We anticipate further changes to safeguarding services over the year of this plan in the light of national and local drivers and budget restraints affecting all the key NSCB partners. In setting its priorities, Board members have sought to ensure that the Board will be able to lead, influence, support and respond to how this may impact upon keeping children and young people safe, in a way that is realistic, builds on the solid work of the past, and maintain confidence in the arrangements for how people work together across Northumberland.

Paula Mead
NSCB Independent Chair

## Business Plan

The NSCB has a number of statutory functions which are set out in Working Together 2015. LSCBs have been abolished in The Children and Social Work Act 2017 and Working Together 2018, however until the Safeguarding Partners publish their arrangements, the NSCB will continue to be governed using the 2015 statutory guidance.

Whilst not defined within the NSCB Business Plan, there are other key priorities and functions that the NSCB will receive reports, data and information on from statutory partners and local agencies in accordance with their own obligations to assure effectiveness of safeguarding children in specific circumstances (this includes data categories collated for the CIN Census and information from the joint strategic needs assessment (JSNA) for Northumberland).

This NSCB Business Plan, in addition to the core functions, has set out a number of key priorities that have been defined locally. The Plan builds on the priorities and progress made since the Ofsted inspection (January 2016). The NSCB business plan is aligned to the recommendations and desired outcomes defined by the Safer Northumberland Partnership Board, Youth Offender Partnership Board, Health and Well-being Board and the Multi-Agency Looked after Partnership (MALAP). The priorities will also be shaped by the North and South of Tyne Safeguarding Forum at a regional level, which is establishing the future of regional safeguarding arrangements and this Business Plan may adapt during the year to consider regional shared priorities.

At the heart of the plan is ensuring that children and young people of Northumberland are safeguarded and that services designed to support them are coordinated well and are effective in preventing harm and in keeping them safe.

As an overarching Business Objective for 2018-19, the NSCB will continue to update its performance management and quality assurance systems/framework to strengthen data and information gathered and the reporting arrangements to its Quality Improvement and Performance (QIP) and the NSCB with the development of a core regional performance framework. There is an imperative to strengthen the analysis of data across the region to ensure the partnership can demonstrate effectiveness of safeguarding and improving outcomes for children.

## NSCB Strategic Priorities for Improvement and Development 2018/19

The NSCB has agreed five priorities to improve outcomes through the partnership arrangement. The NSCB strategic priorities are detailed below; they are not listed in any particular order and should be considered as having equal status within all work to progress the multi-agency safeguarding response to children young people and their families.

1. **Further promoting preventative and early help approaches**
2. **Neglect**
3. **Working with fathers**
4. **Improving focus on the child's experience of services and better embedding it in practice**
5. **Impact of DV on children**

## How will we know that we are making a difference to Children, Young People and Families?

1. **There is an effective Safeguarding Children Board in Northumberland that meets its statutory obligations and ensures that safeguarding arrangements are robust and protect children**
2. **The NSCB has a work programme in place that provides effective scrutiny and challenge to partners so that safeguarding practice is improving and there is evidence that it impacts on improving the outcomes for children and young people.**
3. **Feedback from children, young people and their families.**
4. **Feedback from Frontline Practitioners** – There is connectivity between Frontline Practitioners and the work of the NSCB.
5. **From our Partners** – Through the JSNA and partner agencies data/assurance/audit activity and the NSCB Performance Management Framework.

| | **What does making a difference look like?** |
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| **Children and their families** | Children are safer and will be helped earlier. Children will have their voice heard. We will continue to conduct multi-agency audits to check that this is happening. The NSCB will have a clearer understanding on the lived experiences of children and this will inform how we shape safeguarding services. We will monitor engagement of children and young people in their assessments, their participation in reviews and the timeliness in which then are seen by statutory services and within early help. |
| **The NSCB and Partners** | All professionals and voluntary agencies in the County will know how they contribute to services for children and young people, particularly in relation to prevention and early help. We will review how we will organise ourselves to achieve improved outcomes in each of our priority areas, how we will be able to tell if we are making a difference, and how we will learn through working together so that children and young people in Northumberland are kept safe and protected. |
| **Children's Workforce** | All professionals working with children will be well trained and supported to achieve the best possible outcomes for children and young people. They will receive regular and effective supervision and we will monitor this through surveys and audit. All workers in the Children's Workforce will be supported to work effectively with children and young people and families. |

## Reporting Framework

The NSCB's Business Plan will be progressed through the sub-committees of the NSCB and report to the NSCB Business Group. This review will be presented to the NSCB on a six monthly basis highlighting exceptions. Each sub-group will have a specific remit and delivery plan which is aligned to the overarching NSCB Business Plan.

The NSCB will receive regular updates on outcomes for children and progress as indicated by performance information and reports on audit findings and case reviews. The Board will also receive a NSCB performance report from partners for the Quality Improvement and Performance sub-committee along with a programme to track progress, and this will add to the wider picture of multi-agency performance information and analysis.

## 1. Further promoting preventative and early help approaches

The NSCB is committed to providing help and support to as many families as possible at the level of need. Currently too many families are having to be referred through children's social care in order to access early help services, The Council and partners are working to improve preventative approaches and access to early help through increasing the number of early help assessments, team around the family and early help plans. The NSCB has an Early Help and Early Intervention sub-committee which is providing a steer to this work and promoting the links between early help and safeguarding services.

**Outcome for children: Emerging problems and potential unmet needs are identified so that families and children receive the right support at the right time. Thus improving outcomes for children and young people and making it more likely that families thrive and become self-sustaining.**

### Action Plan from the Early Help and Early Intervention Sub Committee

| No | Objective (what) | Action required to achieve objective (how) | Lead (s) (who) | Timescale (when) | Anticipated impact on Safeguarding children (why) | Success measures (how we know it's worked) | Quarterly Update/comment and RAG rated Progress rating 1 (poor) - 4 (strong) |
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| 1.1 | Ensure there is a clear communications strategy to disseminate key changes, updates, user feedback to ensure client voices are heard | Develop a culture where both parents are engaged in the early help process and ensures that fathers are present within assessment and that voices of children and families are regularly captured<br><br>Adopt standardised template for agency use and ensure multi-agency monitoring takes place<br><br>Ensure feedback acted on and change is transparent. | Kay Vincent, & Voices nominated<br><br>Kay Vincent | | For all partners to share good practice amongst workforce<br><br>To give assurance the needs of families are being met<br><br>Children receive support in areas where they live with | All agencies to engage in the feedback process<br><br>We will receive positive feedback from families | |

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| | | To deliver more early help services in partnership with communities at a locality level<br><br>To further develop the early help newsletter to contain impact case studies and performance information<br><br>Use of the family satisfaction tool during the exit planning process to gain the views of service users, children and young people | Emma Richardson<br><br>Jackie McCormick | | communities empowered to support themselves<br><br>Professionals working with children can see benefit of early help in safeguarding children and use more regularly<br><br>Use of the family satisfaction tool to enable service users, children and young people's views to have an impact of service development and front line practice | We will receive positive feedback from professionals<br><br>Feedback from communities<br><br>Increased number of early help assessments and referrals to the Hubs<br><br>Satisfaction data will be visible in service development plans and training events | |

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| 1.2 | Explicitly link this strategy to other key working documents e.g. Emotional Health & Wellbeing Strategy -inc resilience programme, HV Parent Partnership Plus, Neglect, SEND & CSE Strategies, Domestic Abuse and Sexual Violence Strategy, Young carers section of Carers Strategy, ?Poverty Strategy | Ensure Early Help Strategy is referred to and updates are linked to relevant workplans<br>Ensure multi-agency integrated working meets collaborative objectives/outcomes ie 2½ year check, transition points<br><br>Ensure system wide adoption of training programme and toolkits ( ie Neglect Toolkit) | Karen Herne & Robin Harper-Coulson | | To ensure all relevant strategies link to each other and address wider determinants that impact on child safety<br><br>Increased awareness amongst workers across council and health providers will result in more children being identified and early help offer triggered | Feedback from individual Strategy leads/placeholder | |
| 1.3 | Reinvigorate the training offer for Early Help Lead Professionals and local outcome plan | Refresh programmes based on feedback, SCR findings and audit recommendations.<br><br>Fully launch the early help workforce offer which includes Early Help Module<br><br>Report twice per year that reflects assessment/evaluation post training sessions are acted upon | Jackie McCormick<br><br>Training sub group<br><br>EH Coordination staff | | There is a trained workforce who understand the importance and role of EHA processes in supporting and safeguarding children | Numbers of staff undertaking the training on offer.<br>Number of staff feeding back that they are confident in undertaking early help processes. | |
| 1.4 | Monitor and improve engagement between professionals in | Produce and disseminate meaningful regular performance updates from all agencies. | Local Authority performance team. | | Raised awareness of the early help hubs and SPA across all services to increase and maintain | Positive impact demonstrated and agencies feel | |

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| | adopting Early Help as a key component of day to day working | Continue to streamline pathways for EHAs, step downs, hub referrals as systems continue to develop and publish in a timely way.<br><br>Ensure thematic audit and ACE factors are relevant to multi-agency workforce.<br><br>Monitor use of Northumberland app for 27 month integrated check uptake | EH coordination staff and First Contact managers<br><br>MC<br><br>KW | 3 monthly cycle | referrals across the county and promote the welfare of vulnerable children.<br><br>Recognition of needs met through early help, barriers or unmet needs which require further multi-agency input or discussion<br><br>All 2-year-old entitled children will have additional health needs identified. Early help / learning and development put in place as required | work is worthwhile<br><br>Quarterly review and evaluation of outcomes<br><br>Quarterly review and supported by recommendations | |
| 1.5 | Ensure all tools are promoted and accessed across partnership agencies | Develop Early Help Module Cascade to external partners<br><br>Embed use of outcomes plan in EHA action planning with practitioners (is this multiagency?) | Mary Connor<br><br>Helen Lancaster | | To ensure that practitioners and families are clear about the outcomes they are seeking to achieve for children and how they will measure success | Numbers of families being claimed for under Supporting Families continue to rise<br><br>Ensure training for | |

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| | | | | | | supporting parents' health is disseminated wider than 'health workforce' | |
| 1.6 | Identify and address organisational barriers to undertaking and participating in EHAs/Hubs across all agencies in Northumberland | To ensure that the strategic sign up to early help is being replicated at an operational level across agencies<br><br>Quarterly strategic meetings continue to identify, challenge and support providers | Mary Connor | | Children requiring support receive it at the earliest opportunity possible from the full range of services they may be involved with. | Numbers of EHAs and Hub referrals being undertaken / registered | |

## 2. Neglect

The impact of neglect on children and young people is enormous. Neglect causes great distress to children, leading to poor health, educational and social outcomes and is potentially fatal. Lives can be ruined, children's abilities to make secure attachments are affected and their ability to attend and attain at school is reduced. Their emotional health and well-being is often compromised and this impacts on their success in adulthood and their ability to parent in the future.

**Outcome for children: Improved outcomes for children and young people, ensuring the offer for early help is identified at the earliest stage and the child is able to achieve their potential and families become self-sustaining, at statutory level children and families are given the help support and guidance they require post social care involvement, to enable parents to sustain the change in the care given to children.**

### Action Plan from the Neglect Strategy 2018-2020

Strategic Aim 1: To secure collective commitment to addressing neglect across all partner agencies and to demonstrate effective leadership in driving the appropriate system, culture and process changes required forward.

| No | Objective/Outcome | Milestone (by Dec 2017) | Milestone (by Dec 2018) | Lead/NSCB Sub-Committee | Final Timescale | Risks | Mitigations | RAG Progress rating 1 (poor) - 4 (strong) |
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| 2.1 | NSCB partners engage fully with the Neglect Strategy to deliver strategic objectives. | The baseline data for neglect is Apr 17 - Dec 17 referrals with Neglect 601/2477 referrals equates to 24% | Milestone (10% reduction based on 2017 baseline of 24%, ie 21.6% or below). *On track?* a)619/1118 (Jan-18/Mar-18) - 55% b)941/2817 (Jul-17/Mar-18) - 33% | Business Group | March 2019 | Early identification of children with Neglect leads to increase in referrals to CS | Strong and effective Early Help offer. Effective application and monitoring of MA Thresholds document | 3 Reduction of referrals set out in Milestone column |

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| | | The numbers of hub referrals are Apr 17 - Dec 17 - 1888 | Target: 1375 in 6 months ending Dec 18<br><br>*On track?*<br>a)574 (Jan-18/Mar-18)<br>b)1781 (Jul-17/Mar-18) | Early Help and Early Intervention Sub Committee | March 2019 | Early identification of children with Neglect leads to increase in referrals to CS | Strong and effective Early Help offer. Effective application and monitoring of MA Thresholds document | 2 Hub referrals showing a reduction during this time period will continue to be monitored and MA engagement promoted |
| | | 2017 Sec 11 Deep Dive Review completed which will provide assurance from all partners about the strategic objectives of the strategy | None | Business Group | Novemb er 2018 | Response rate to deep dive review maybe less than 100% | Assurance will be collected via email regarding neglect review via email | 3 report very nearly complete, awaiting updates to actions plans from partner organisations |
| | Narrative evidence | The 2017 Sec 11 deep Dive review will provide evidence of how the strategic objectives are being delivered in partner organisations.<br>The data from CSC data team will track numbers of referrals to First Contact and Early Help Hubs. | | | | | | |

| Strategic Aim 2: To improve awareness and understanding of neglect across the whole partnership. This includes a common understanding of neglect and the thresholds for intervention. | | | | | | | | |
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| No | Objective/Outcome | Milestone (by Dec 2017) | Milestone (by Dec 2018) | Lead/NSCB Sub-Committee | Final Timescale | Risks | Mitigations | RAG Progress rating 1 (poor) - 4 (strong) |
| 2.2 | Practitioners and their managers across all services and partner agencies provides awareness raising training in neglect to improve recognition of neglect | NSCB Thresholds Document agreed by all partner agencies by July 2017<br><br>Communications undertaken with all partner organisations. | Audit undertaken into the use of the Threshold document by May 2018 as part of the MASH audit | Policies, Procedures and training Sub Committee and NSCB Business Manager | March 2019 | Introduction of revised thresholds document and increased awareness of professionals through training may increase referrals to CSC and early help hubs. | Effective application and monitoring of MA Thresholds document | 2 on track MASH audit to be undertaken in June 2018, Feedback from Focussed Visit by Ofsted saw the threshold document in use and commended CSC in its use. |

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| 2.3 | Training provided for front-line practitioners and managers (including adult focused services) enables access to contemporary research and best practice in working with neglect. | Training reviewed by NSCB Training Sub-Committee to include disguised compliance and working with resistant families By July 2017.<br><br>Incorporate messages from new thresholds document into multi agency training by July 2017 | Training reviewed and kept up to date with the incorporation of finding from audit and SCR | Policies, Procedures and training Sub Committee and NSCB | March 2019 | Due to service contraction training numbers may reduce. | Bi-annual training reports and data will report on the number of frontline practitioners undertaking neglect training from specialist services | 4 Training and development officer and PPT sub committee, has embedded disguised compliance and resistant families into all NSCB training programmes |

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| | Narrative evidence | Training offer adjusted by the Policies, Procedures and Training Sub Committee, with basic child protection training and specialist focusing on non-compliance and disguised compliance.<br>All NSCB training offered includes the use of the threshold document.<br>Training provided for front-line practitioners and managers (including adult focused services) enables access to contemporary research and best practice in working with neglect.<br>A communication strategy and the development of seven minutes guides into neglect have been undertaken across all services and partner organisations, GPs via their monthly update and Schools via termly newsletters. | | | | | | |
| Strategic aim 3: To improve the recognition, assessment and response to children and young people living in neglectful situations before statutory intervention is required, including the appropriate use of assessment tools. | | | | | | | | |
| No | Objective/Outcome | Milestone (by Dec 2017) | Milestone (by Dec 2018) | Lead/NSCB Sub-Committee | Final Timescale | Risks | Mitigations | RAG Progress rating 1 (poor) - 4 (strong) |
| 2.4 | NSCB understands the numbers of children for whom neglect is a feature, the prevalence of parental factors and the effectiveness of the safeguarding system in reducing the impact of neglect. | Introduction of Action for Children Neglect Toolkit in practice following training in March 2017, programme of training for trainers introduced in March 290018 for Early help and health Visitors | Toolkit used in practice across early help and within Health Visiting | Adele Wright/Mary Connor | March 2019 | CSC may not be able to identify families where the use of the toolkit is helpful. | Audit undertaken to understand impact of the toolkit | 3 - On track Toolkit being embedded within HV and with School Health Advisors Early help Training pathway offers Neglect Toolkit training for all partners |

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| | | Milestone: key agencies (CSC, education, PH, NTW, NHFT & Police) share their data on neglect proxy indicators September 2017 | Periodic audits of early help to establish if recognition, assessment and response prior to statutory intervention are improving. March 2018 then six monthly<br><br>*On track?*<br>CSC audit of assessments that led to NFA in May found that two thirds should not have led to a C&F assessment. The action plans is to review eligibility criteria, the processes used around triage at the Front Door, and the | Alan Hartwell and QIP Sub -Committee | March 2019 | As audits are inevitably based on a sample, there is a risk of skewed results | We will not solely use the audit results but will ask senior practice experts such as the PSW and Designated nurse to triangulate the findings with their experience of practice. | |

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| | | | application of thresholds. | | | | | |
| | | Update JSNA section on prevalence of parental factors in Social work cases by August 2017 | CSC single agency Audit and LSCB neglect audit will identify further milestones | Alan Hartwell and QIP Sub -Committee | March 2019 | Under recording on information systems and / or lack of a place to record such information per se | Run exception reports to ensure relevant fields are completed when appropriate | 4 complete Data now in place regarding prevalence factors in social work case s by ward |
| | | Periodic audits of early help to establish if recognition, assessment and response prior to statutory interventio n are improving. October 2017. | The focused visit will identify further milestones | Alan Hartwell and QIP Sub -Committee | March 2019 | As audits are inevitably based on a sample, there is a risk of skewed results | We will not solely use the audit results but will ask senior practice experts such as the PSW and Designated nurse to triangulate the findings with their experience of practice. | 3 - Focussed Visit undertaken by Ofsted gave some insight into the Early help Offer and highlighted satisfaction that assessment and response was in place |

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| | | Audit of neglect April 17 to set baseline: % cases answering positively re use of a) research; b) Analysis; c) tools<br><br>**a)** 3%<br>**b)** n/a<br>**c)** 10% | Re-Audit of neglect April 18 to set baseline: % cases answering positively re use of a) research; b) Analysis; c) tools | Alan Hartwell and QIP Sub -Committee | March 2019 | As audits are inevitably based on a sample, there is a risk of skewed results | We will not solely use the audit results but will ask senior practice experts such as the PSW and Designated nurse to triangulate the findings with their experience of practice. | 2. re-audit changed to focus on the following<br><br>1. Chronologies<br>2. Role of fathers, male carers and male partners, (living at the child's home or not)<br>3. Strategy meetings, attendance, chairing, minutes, invites, decision making.<br>4. Children being seen alone<br>5. Drifting cases and cases closed without multi-agency oversight<br>6. Listening to children and recording their replies accurately within all records especially where their ability to express |

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| | | | | | | | | themselves is compromised through age or disability.<br>7. Case transfer from another authority; all reasonable efforts have been made to obtain all relevant information in order to make accurate risk assessments.<br>8. Medical opinions or Police NFA should be seen as part of a wider, holistic risk assessment as opposed to being seen as expert opinions in their own right, out-weighing other information.<br>9. Retraction of allegations by children |

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| | | MASH fully operational by Dec 17. | x % reduction in referrals resulting in no further action<br><br>*On track?*<br>a) 2.3% (Apr-17/Dec-17)<br>b) 2.3% (Jul-17/Mar-18)<br>c) 1.9% (Jan-18/Mar-18) | Alan Hartwell and QIP Sub-Committee | March 2019 | | | |
| | Narrative evidence | Specialist services undertaking Action for Children Neglect Toolkit training, to establish if the model could be widely used across Northumberland. | | | | | | |
| Strategic aim 4: To ensure the effectiveness of service provision. | | | | | | | | |
| No | Objective/Outcome | Milestone (by Dec 2017) | Milestone (by Dec 2018) | Lead/NSCB Sub-Committee | Final Timescale | Risks | Mitigations | RAG Progress rating 1 (poor) - 4 (strong) |
| 2.5 | NSCB scrutinises the level of understanding of the effectiveness of interventions in reducing the impact of neglect on individual children; and to identify and | Multi-agency case audit to be undertaken to identify if multi-agency support, at all levels of the continuum of need, | Multi agency audit repeated and findings reported to the Health and Wellbeing Board / Family and Children's Trust Board on the effectiveness of services and | NSCB / Business Group /<br><br>Early Help and Early Intervention Sub Committee | March 2019 | Availability of multi agency audit group may be difficult to sustain | investigation other methods to duplicate the audit | 2 Original audit undertaken re-audit to focus on these key areas<br><br>1. Chronologies<br><br>2. Role of fathers, male carers and male partners, (living |

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| | support further areas for development | lead to a reduction in risk/ need associated with neglect.<br>Sept 2017 | interventions on reducing the impact of neglect on children's lives. | | | | | at the child's home or not)<br><br>3. Strategy meetings, attendance, chairing, minutes, invites, decision making.<br><br>4. Children being seen alone<br><br>5. Drifting cases and cases closed without multi-agency oversight<br><br>6. Listening to children and recording their replies accurately within all records especially where their ability to express themselves is compromised through age or disability.<br><br>7. Case |

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| | | | | | | | | transfer from another authority; all reasonable efforts have been made to obtain all relevant information in order to make accurate risk assessments.<br><br>8. Medical opinions or Police NFA should be seen as part of a wider, holistic risk assessment as opposed to being seen as expert opinions in their own right, out-weighing other information.<br><br>9. Retraction of allegations by children |

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| | | Report analysis of s11 audit and multi agency neglect audits to NSCB November 2017. | Reported action plan followed up and actions for all organisations complete | Alan Hartwell Quality Improvement and Performance | Novemb er 2018 | Actions not completed in line with targets | Report 6 monthly to NSCB to ensure completion | 3 S11 audit to be completed by June 2018 all agencies have now completed their audits. |
| | | Each agency member of QIP to produce a report on developme nt of proxy neglect indicators every 6 months starting November 2017 | Number of EHAs increase in line with CSC service statement target by March 2018<br>(Target was average of 130 EHAs per month over the past 12 months)<br><br>*On track?*<br>a) 95 EHAs completed as at March 18, high 90s in the previous | Alan Hartwell Quality Improvement and Performance | March 2019 | Under recording of EHAs | Include data on EHA by agency in performanc e reports to EH sub group | 2. the proxy indicators include<br><br>How many previous cases that were CIN with neglect that were Step down to early help vs how many have NFAd - shouldn't sit with SW, needs to go to the Family Worker<br><br>how many CIN cases have been neglect and open for 6 months or more - monthly trend |

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| | | | months, so target not met to date. Escalated to NSCB in March 18. | | | | | If a previous CIN case is closed and it had been tagged as neglect, how many of those were referred back in for a SW input for neglect within a 3 month period.<br><br>MASH audit - add a question about how many answered 'Yes' and the cases held by the Early Help team? HOLD<br><br>Do a themed audit around neglect around early help to get a baseline from 36 approx cases in January<br><br>How could we identify the cases on the EH module - Do a keyword search on cases, |

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| | | | | | | | | eg parenting out of the total number |
| | | Partnership working across Adult / Children safeguarding boards supports more effective outcomes for families. | Numbers of referrals to the Hubs that are tagged as 'neglect' to increase by x% compared to Nov 15 (baseline) | Alan Hartwell Quality Improvement and Performance | March 2019 | Lack of facility to record referrals to the hubs as 'neglect' | Ensure that such a facility is in place to record referrals as 'neglect' | |
| | | NSCB contributes to the development and scrutiny of services that support families to reduce the impact of neglect upon children's lives. | NSCB reports to CTB and HWBB by January 2018 on effectiveness of service provision and the hubs in particular<br>CTB and HWBB produce responses by April 2018 | NSCB provides ongoing reports to CTB and HWWB on an annual basis | March 2019 | Conflicting LA priorities for the NCC Data team may impact on time scales for providing data to the CTB and HWWB | QIP group to provide these reports. | 2 - Report to be submitted once milestones are researched |

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| | | NSCB to continue to monitor and scrutinise the developme nt of the MASH and progress of early help hubs | CTB and HWBB receive monitoring reports to evidence reduction of impact of neglect every 6 months starting January 2018<br>Report on development of the MASH to NSCB and HWBB and their assurance that they assess it as operating effectively | Alan Hartwell Quality Improvement and Performance/NSCB | March 2019 | MASH development delayed | Multi Agency MASH team to report progress to LSCB six monthly | 4 - Met, MASH has reported to the NSCB on a six monthly cycle since the onset of the planning stage. Senior manager for Early Help also reports to the NSCB on the same basis. |
| | Narrative evidence | | | | | | | |

## 3. Working with Fathers

In Northumberland since 2009 there have been a number of cases where the role of father or significant males has not been clearly understood. There have been a number of cases reviewed by the Serious Case Review Committee where parents had different GPs with mother and children at one GP practice and the father or significant male at another, sometimes in another Local Authority area. In one case, Child Concern Notifications regarding domestic violence in a previous relationship had been historically supplied to another Local Authority by the Police and was not known to Northumberland. During Serious Case Review investigations evidence of engagement with fathers and significant males are often missing from records.

**Andrew 2009 Management Review identified:**

'Fathers and other significant family members should always be considered as part of the assessment process.'

**John 2013 Management Review:**

'During the pregnancy, mother began a relationship with a new partner. At the time that John's injuries were sustained, John and his mother were living at the home of maternal grandmother. It is unclear whether mother's partner was also resident there, as he had an alternative address in a neighbouring authority.'

**Molly 2017 Serious Case Review:**

'The lack of an accurate record of the status of mother's partner by both GP practices is an important oversight; he was variously referred to as "father", "husband", "boyfriend" and "partner". The first practice also assumed that he was Molly's birth father. If accurate baseline information is not collected at the point when patients register, then inaccuracies can assume the status of facts.'

**Outcome for children: Learning from NSCB reviews is known, understood and influences the training, development and practice of staff across the partnership and learning and improvement is informed by feedback from those who access and deliver safeguarding and child protection services in Northumberland.**

| No. | Objective and Action | Responsible Lead/s | Completion by | Progress update | Impact RAG |
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| **Training, Learning and Development** | | | | | |
| 3.1 | Safeguarding training to include Engaging with Fathers, Male Partners or Carers.<br><br>Review of training including safeguarding awareness through to bespoke training to include learning from local SCRs and audit. | Anne Lambert Policies, Procedures and training (PPT) Sub -Committee | September 2018 | Training adapted to include role of fathers, now available to all partner agencies and influence being seen in single agency training<br>The role of fathers and assessment clearly being presented in training | 4 - Complete |
| 3.2 | Early Help training programme to include Engaging with Fathers, Male Partners or Carers<br><br>Training to be reviewed highlighting the role of fathers in assessment and ongoing work. | Anne Lambert PPT Sub - Committee | September 2018 | Training adapted to include role of fathers, now available to all partner agencies and influence being seen in single agency training<br><br>The role of fathers and assessment clearly being presented in training | 4 - Complete |
| 3.3 | Roadshows to be developed highlighting learning from SCRs in particular the role of fathers in these cases and learning identified through the process.<br><br>Roadshows to be developed and facilitated by PPT sub Committee | Roadshow development team, lead Anne Lambert | September 2018 | Learning from SCR and audit communicated to front line staff and learning embedded in their work.<br><br>The role of fathers and assessment clearly being observed in single agency audits | 4 - Complete |
| 3.4 | Ensure that training is available for staff at every level of the organisation/s in father-inclusive practice.<br><br>Training to be developed or training to be reviewed highlighting the role of fathers | Tracey Horseman PPT Sub - Committee | September 2018 | Training adapted to include role of fathers, now available to all partner agencies and influence being seen in single agency training<br><br>The role of fathers and assessment clearly being presented in training | 4 - Complete |

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| **Policies and procedures** | | | | | |
| 3.5 | NSCB should formulate guidance on the importance of engaging with fathers. This should include:<br><br>• The importance of gathering background information<br>• Assessment of needs<br>• Ensuring unmet needs are supported with appropriate offer of services and/or referrals<br><br>Development of guidance undertaken through task and finish group | Robin Harper-Coulson | April 2018 | It is widely recognised as problematic that there are generally low levels of engagement by professionals with fathers and males. Evidence suggests that there is relatively little known about what works. Within Northumberland's audits and SCRs this has been a consistent theme of a failure to engage with fathers. If engagement improves the level of understanding of the fathers role within the family will be better understood and any risk or protective factors identified<br><br>Single agency and multi-agency audit demonstrate improved recording regarding the role of fathers. | Complete |
| **Intervention** | | | | | |
| 3.6 | Ensure that all organisations refine their existing assessment process and accompanying paperwork to ensure that fathers' data is collected explicitly, systematically and accurately. | Margaret Tench Safeguarding Practice Review Group | March 2019 | | |
| 3.7 | All assessments of families where children are at risk should consider historical information about the background of both parents and carers. Wherever possible, this information should be corroborated and self-reported information should be treated with a degree of caution. | Adele Wright, Su Kaur | March 2019 | | |
| 3.8 | Assessments must contain a multi-agency chronology and parenting assessment of all | Adele Wright, Su Kaur | March 2019 | | |

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| | main carers or partners | | | | |
| 3.9 | Ensuring if fathers views, expressed needs and assessment of parenting capacity are not present within reports present for conference there is a challenge from the Independent chair to all agencies. | Jan Tilson, IRO Service<br><br>Paula Mead Independent Chair | March 2019 | | |
| 3.10 | Ensure appropriate focused and gender specific information is available to give fathers antenatally and subsequently. This information, publicity and communication should state "mother, fathers and other carers. | Jayne Smyth | March 2019 | | |
| **Links to other Priorities and Board responsibilities** | | | | | |
| 3.11 | Ensure that the role of fathers and the need to engage with them and better understand their role in their families, either as a person present in the family or as an absent father is understood and recorded on file, including if the person has parental responsibility | NSCB Business Group | March 2019 | | |
| **Data and Performance** | | | | | |
| 3.12 | Use data collection system/s to regularly assess patterns of use in services, and identify areas where fathers are not being included to focus communication and services.<br><br>Identify a set of basic expectations and targets in social work practice that will become a set of Key Performance Indicators (KPIs). example:<br><br>• Altering the case file audit document to include questions of father engagement.<br>• Father engagement to become a strategic aim for all services. (The aim to | Alan Hartwell QIP sub committee | March 2019 | | |

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| | include fathers in practice in all social workers' and other professionals' appraisals for two consecutive years. | | | | |

## 4. Improving focus on the child's experience of services and better embedding it in practice

In ensuring that children and young people are protected and kept safe, we need to be able to understand how they see and experience the things that happen to them and to consider the world from their perspective.

**Outcome for children: The 'voice of the child' is the golden thread running through the work of the board and all sub-committees and is therefore not owned by any one subgroup or individual, but it is explicit that the challenge on this area is led by the lay members.**

| No. | Objective and Action | Responsible Lead/s | Completion by | Progress update | Impact RAG |
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| | **Governance** | | | | |
| 4.1 | The NSCB should create the opportunities to use existing groups, partnerships and research to listen to and engage with children, young people and their families in order that we might better be able to see things from their point of view. | NSCB Members | March 2019 | | |
| 4.2 | The NSCB should recognise and address issues that impact on children's lives such as poverty and acting as young carers. | NSCB Members, supported by Emma Richardson | March 2019 | | |
| 4.3 | The NSCB should develop a culture of participation, to embed the participation of children and young people in organisations, processes and services. They should evaluate the effectiveness of different aspects of the child's journey into help and services. | NSCB Members supported by NAS | March 2019 | | |
| 4.4 | Promote working together arrangements to ensure that when children need help, the help they receive is joined up, has clear purpose and direction and that children, young people and their families are partners in this journey. | NSCB Business Group and Members | March 2019 | | |

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| 4.5 | Making sure that care planning for the child is robust, timely and sensitive to their needs and that they understand what decisions are being made about them and the reasons why. | Jan Tilson, IRO Service | March 2019 | | |
| 4.6 | The NSCB should request data from Children's Services and partner agencies about if the child was seen and spoken to frequently enough by the professionals involved, and was asked about their views and feelings. | Alan Hartwell QIP Sub Committee | March 2019 | | |
| 4.7 | The NSCB should embed that agencies should listen to adults who tried to speak on behalf of the child and who had important information to contribute. | NSCB Members | March 2019 | | |
| 4.8 | The NSCB should consider how children who are home educated can receive the same safeguards as their peers. | Jane Walker Education Reference Group | March 2019 | | |
| 4.9 | The NSCB should consider how they can better engage the general public in safeguarding children. | NSCB Members | March 2019 | | |
| 4.10 | Create opportunities for children, young people and their families to engage with and contribute to what the Board seeks to achieve. | NSCB Members supported by NAS | March 2019 | | |
| Practice implications | | | | | |
| 4.11 | NSCB should seek assurance that all practitioners are:<br>• using direct observation of babies and young children by a range of people and make sense of these observations in relation to risk factors<br>• seeing children and young people in places that meet their needs – for example, in places that are familiar to them<br>• seeing children and young people away | NSCB Member organisations | March 2019 | | |

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| | from their carers<br>• ensuring that the assessment of the needs of disabled children identifies and includes needs relating to protection. | | | | |

## 5. Children living with domestic violence

To develop recognition, knowledge and assessment of the impact of domestic abuse, and interventions for children, young people and families at all levels of need (early help to statutory), living with, or recovering from, domestic abuse. This includes where young people may be displaying abusive behaviours and where young people are experiencing abuse in their own relationships.

**Outcome for children: The NSCB will work with all partners to promote safe outcomes for children living with domestic violence.**

| No. | Objective and Action | Responsible Lead/s | Completion by | Progress update | Impact RAG |
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| 5.1 | All staff will be able to recognise domestic abuse to ensure victims and their children receive the right level of support at the earliest opportunity. | Learning and Development<br><br>DA & SV Business Group | March 2019 | Professionals have raised awareness of domestic abuse and support available.<br>Circulation of DA service leaflets, referral forms and guidance.<br>Numbers attending training sessions and positive evaluations, including e-learning<br>Referrals to DA services, including referrals to the perpetrator programmes. (increased/decreased/quality of referrals improved)<br>Sample feedback 6 months following attendance at training to capture impact on practice | |
| 5.2 | Ensure there are DA & SV Champions in all areas. | DA & SV Coordinator<br><br>DA & SV Business Group | March 2019 | Members review list of champions and recruit new champions for any identified gaps<br>Staff report feeling confident to support colleagues<br>The dissemination of up to date information<br>Staff report DA and SV information is easy to access | |

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| | | | | Staff report feeling confident to make appropriate referrals | |
| 5.3 | All schools and APs in Northumberland deliver high quality RSE in line with national guidance and are prepared to<br>deliver the statutory curriculum from September 2020 | Public Health & Education and Skills Service | July 2020 | All schools and APs indicate in their safeguarding audit that they<br>1. are delivering PSHE in line with national guidance<br>2. feel confident to implement the statutory changes for implementation in September 2019<br><br>All secondary schools deliver the Healthy Relationships package developed in Northumberland | |
| 5.4 | Awareness raising work and support for young people. | NDAS<br>Grace<br>Cygnus<br><br>DA & SV Business Group | March 2019 | Young people receive the right help - data sources Police and DA service providers.<br>Implementation of the KS4 programme<br>Number of sessions and numbers attending, positive evaluations<br>Gaps in provision identified and funding opportunities explored. | |
| 5.5 | All professionals working with young people are able to recognise the signs of domestic abuse in teenage relationships and know where to refer. | Public Health & Education and Skills Service<br><br>NDAS, Cygnus, Grace | March 2019 | Resources reviewed and easily accessible, and promoted widely.<br>Professionals have raised awareness of Teen DA and the young person's version of the RIC and where to sign post and refer.<br>An increase in appropriate referrals for young people at risk of, or experiencing DA | |
| 5.6 | All professionals working with young people and families are able to recognise the signs of APVA and know where to refer. | APVA task and finish group<br><br>MASH | March 2019 | 6 staff identified and trained by RESPECT to deliver the RYPP<br>Referral pathway agreed<br>Briefing sessions and 7 minute APVA guide for managers and staff<br>Referrals and outcomes reviewed<br>Case audits and reviews of resources and pathways | |

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| 5.7 | Operation Encompass embedded as a process in Northumberland. | LA (children's Services and Education and Skills) | March 2019 | School staff aware of the impact of DA on children and young people.<br><br>Through the school's safeguarding audit ascertain that<br>● all school staff aware of the impact of DA on children and young people having received an Operation Encompass briefing, including this being included in their induction packages<br>● designated safeguarding leads in schools understand the referral processes when they are made aware of domestic violence (either following on from an Encompass referral or when in receipt of local intelligence)<br>● staff in schools are aware of the support services which can be accessed for adult victims and children | |
| 5.8 | Counselling, psychotherapy and education services delivered to people who have experienced domestic abuse and / or sexual violence. | Cygnus Support Service | March 2019 | Number of referrals and number of sessions delivered across the county:<br>● from the Cygnus base in Ashington<br>● from venues including; Hexham, Alnwick, Blyth and Berwick.<br><br>Number of Recovery Toolkit groups and numbers attending (one will be targeted at young people and two will be targeted at adults) and positive evaluations | |

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| 5.9 | Review of the MARAC process as part of the development of the MASH. | NCC MASH Strategic & Design groups<br><br>Northumbria Police<br><br>MARAC Steering group | March 2019 | MARAC pilot<br>Referral, including repeat referrals, numbers<br>Timely research and actions<br>Improved and coordinated approach to risk assessment evidenced in case audits | |
| 5.10 | Early intervention with families | Early Help teams<br><br>PSCOs | | A timetable of groups available and clear referral processes<br><br>Number of Freedom Programme and Recovery Toolkit groups, numbers attending and completing, positive evaluations.<br><br>CiN and CP plans<br>Case audits | |
| 5.11 | Challenging perpetrators and provide support | Barnardo's<br><br>MATAC | March 2019 | Increase in referrals to the non-mandatory perpetrator programme<br>Numbers assessed as appropriate to attend the group programme<br>Number of successful completions<br>Monthly MATAC meeting minutes - multi agency attendance and actions and outcomes<br>Police data, including MATAC scores<br>Long term reduction in offending/ domestic abuse incidents | |

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| 5.12 | Northumberland business group to undertake a DA & SV needs assessment to inform a strategy and action plan. | DA & SV Coordinator | May 2018 | DA and SV needs assessment | |
| 5.13 | Northumbria police to undertake a problem profile of DA across the force. | Northumbria Police | May 2018 | Police DA problem profile | |
| 5.14 | The three North of Tyne Local Authorities to arrange a North of Tyne Awareness week to raise awareness of domestic abuse and the support available. | DA & SV Coordinator<br><br>DA week task & finish | November 2018 | DA and SV information up to date on websites<br>Articles in the local press<br>Leaflets, posters, white ribbons and resources distributed<br>Events<br>Increased awareness among employers, staff and the community of DA and SV and its impact and what support is available.<br>Number of referrals and source of referral | |
| 5.15 | Effective use of CP processes, risk assessments and safety planning to ensure children are safeguarded. | CSC | March 2019 | CSC data<br>Case audits | |
| 5.16 | All staff accessing MARAC awareness sessions to ensure they are aware of the process and how to refer. | Learning and Development | March 2019 | Numbers attending MARAC awareness session and positive evaluations<br>Multi-agency referrals to MARAC<br><br>MARAC self-assessment<br>Case audits | |

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| 5.17 | All staff accessing appropriate training to ensure robust risk assessments are being undertaken. | Learning and Development | March 2019 | Staff supervision - evidence that quality risk assessments are being routinely being completed, and appropriate referrals and actions being taken.<br>Case audits - evidence of robust knowledge of risk<br>Appropriate referrals | |
| 5.18 | Local and national learning and recommendations from DHR's and SCR's implemented. | Safer Northumberland<br><br>DA & SV Coordinator<br><br>NCC Commissioning | March 2019 | DHR action plans<br>Training updated following any lessons learnt<br>Staff briefing sessions and feedback<br>Protocol reviews and updates<br>DA and SV service delivery reviews<br><br>Case audits<br><br>Findings from the Rape Scrutiny Panel | |

## Managing Risk

It is essential to identify, analyse and prioritise risks as part of the Business Plan to ensure that these risks are managed effectively.
A risk register will be maintained by the Independent Chair and reported to the NSCB and, where appropriate, risks will be escalated to the relevant agency's corporate risk registers.