Olivia and Yasmine SCR Action Plan September 2017

Finding 1: There is an insufficient understanding of adolescent neglect across the multi-agency network and the link with complex adolescent behaviour leaving young people at risk of harm

Finding 2: Professionals working within the multi-agency safeguarding system struggle to provide an effective service to vulnerable adolescents who display a range of complex behaviours and needs leaving them with a fragmented and reactive response to different aspects of their behaviour.

Finding 3: Parents blaming young people is not sufficient recognised as a potential critical indicator of concern in the context of complex adolescent difficulties, and there is a professional tendency to sympathise with parents, leaving emotional abuse unidentified and children vulnerable to continued abuse.

Finding 4: Services are appropriately focused on providing extensive support to ensure that young people can remain living in their families, but they do not take sufficient account of parental/caregivers engagement in those services, which may lead to a breakdown in family relationships and culminates in a parental request for children to be taken into care; this leaves children and young people feeling abandoned and blamed.

Finding 5: There is a disjoint between both children's and adults safeguarding processes and community safety services, leaving community safety insufficiently informed of vulnerable children and adults and welfare agencies insufficiently informed by community intelligence.

Finding 6: Effective single agency and multi-agency supervision and effective processes to promote multi-agency reflection are necessary to pick up fixed thinking in a particular case. Although there has been action in a number of agencies to promote this approach to complex work it can be further strengthened, including by developing arrangements which enable multi-agency groups to come together

Success Criteria for whole action plan:

- Increased numbers of children/ young people identified at Early (through and Early Help assessment) suffering from neglect
- Increased number of children/ young people who are taking part in risky behaviours with holistic plans dealing with “troubled” and “troublesome”
- Reduced number of children/ young people taking part in risky behaviours
- Reduced number of children becoming subject to CP plans for neglect
- Reduced number of children becoming looked after for neglect

Please note: In relation to this action plan Hartlepool Safeguarding Children Board (HSCB)member organisational leads predominantly involves, Assistant Director of Children’s Services (HBC), Deputy Director North Tees & Hartlepool Foundation Trust (NTHFT), Associate Director Tees Esk & Wear Valley (TEWV), D/Supt Head of Specialist Crime, Assistant Director, Education, Learning & Skills, Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCG) and other members where they are required to implement an action.

During the compilation of this action plan, consultation took place with the Safeguarding Adult Review sub-group and Teeswide Safeguarding Adult Board (TSAB). This was in relation to finding 5, which resulted in a joint recommendation for both HSCB and TSAB. The actions from both reviews encompasses integrated working across children’s and adult’s safeguarding processes, whilst allowing for targeted work within the individual services.

OBJECTIVE	ACTION		TIMESCALE	LEAD	SUCCESS CRITERIA	PROGRESS
1. The Board will be assured that adolescent neglect is recognised and addressed effectively by all agencies (Finding 1)	1.1). Educational conference to be held for all relevant agencies to attend to explore adolescent brain development and the impact of neglect on development		November 2017	Hartlepool Borough Council (HBC)	Attendance of multi-agency staff and impact assessment to demonstrate improvement in knowledge base and link to practice See below points.	Conference booked
	1.2). Provide support to the multi-agency workforce, promoting early help, to enable them to identify neglect at the earliest opportunity and effectively address this by:	1.2.1). Reviewing assessment tools to identify a multi-agency neglect tool for all workforce to use	October 2017	HSCB member organisation leads	Tools identified and will be piloted and evaluated	Tools reviewed and Swindon LSCB tool identified which compliments the Neglect Statement of Intent
		1.2.2). Multi-agency workforce to pilot and evaluate identified neglect tool	March 2018		Audit will demonstrate utilisation of neglect tool	

		1.2.3). Launch Neglect statement of intent	October 2017	Assistant Director of children's services (HBC)	HSCB sign off Neglect Statement of intent October 2017	
		1.2.4). Deliver multi-agency workforce sessions that will enable practitioners to walk the daily journey of a child, understand and improve practice "troubled" versus "troublesome" adolescents	March 2018	Joint training group	Impact assessment of training and audit	
		1.2.5). Deliver training to promote improving the relationships agencies have with families	March 2018	HBC Changing futures North East	Impact assessment of training and audit	
		1.2.6). Promote awareness of HSCB "Rough Guides" (best practice) with all partner agency practitioners	September 2017	HSCB member organisation leads	Evidence of use of rough guides in practice, monitored through supervision and audit	
	1.3). Review and implement evidenced based interventions with families where children/ young people are suffering neglect		March 2018	Assistant Director of children's services (HBC)	Improved confidence in the workforce to identify neglect and provide interventions	

				which result in successful outcomes for children and young people	
	1.4). Each agency to review their internal supervision to ensure that supervision processes are effective in supporting the workforce to identify neglect	November 2017	HSCB member organisation leads/Learning Improving Practice Sub Group (LIPSG)	Single and multi-agency audit processes	
	1.5). Multi-agency audits to be carried out on Child protection cases which will include Adolescent Neglect (16 cases over 1 year) to understand if plans are supporting children's outcomes to improve	September 2017 - September 2018	Head of Safeguarding & Review/HSCB business manager	Findings from audits and subsequent action plans	
	1.6). Findings from the audits to be shared at Learning Improvement Practice sub group (LIPSG) and:	September 2017- 2018	Head of Safeguarding & Review, LIPSG Chair, Chair of training group	Findings from audit will inform future practice and improve service delivery and inform future training programme	
	1.6.1). Workforce session to be arranged to ensure that learning from audits is shared	September 2017- 2018	Head of Safeguarding & Review, LIPSG Chair, Chair of training group	Findings from audit will inform future practice and improve service delivery and inform future training programme	

	1.6.2). Inform training group of additional identified training needs	September 2017- 2018	Head of Safeguarding & Review, LIPSG Chair, Chair of training group	Findings from audit will inform future practice and improve service delivery and inform future training programme	
2. The Board will support its partner agencies to develop the multi-agency workforce to respond to the holistic needs of adolescents rather than relying on presenting problems in decision making forums? (Finding 2)	2.1) Audit the effectiveness of the Child Protection conference system for adolescents, which will include whether plans evaluate the needs of adolescents acknowledging the role of parents.	September 2017-2018	Head of Safeguarding & Review (Partner agencies involved in multi- agency audit)	Findings from audit will inform future practice and improve service delivery and inform future training programme	
	2.2) Workforce sessions to be held to share best practice in developing holistic plans	September 2017-2018	Head of Safeguarding & Review (Partner agencies involved in multi- agency audit)	Findings from audit will inform future practice and improve service delivery and inform future training programme	

3. All Board agencies will have processes in place to support staff to recognise and challenge inappropriate parental blaming of children and the subsequent emotional impact of this behaviour? (Finding 3)	3.1) Embed Signs of Safety Framework (SoS) paying particular attention to multi agency group supervision (as per the action in Finding 2). This will be demonstrated by:	3.1.1). Local Authority SoS implementation plan to be shared with HSCB	September 2017	AD Children's Services (HBC)/Head of Service South Locality	Implementation plan progressed	Implementation in place and being regularly reviewed
		3.1.2). Multi-agency partners to add their organisational commitments as appropriate to inform SoS implementation plan	November 2017	HSCB member organisation leads	Multi-agency contribution to SoS is clear and implemented	
		3.1.3). Multi agency training to take place – (5 day local training for LA staff)	November 2017	Principle Social Worker, Adults & Children	Numbers of workforce attended and impact Evaluations of training	
		3.1.4). Workforce sessions delivered to support workforce to hold "difficult conversations with families"	To Commence March 2018	Chair of joint training group	Number of practice leads that has taken place	

		3.1.5). Continue to hold practice leads sessions	March 2018	Head of Service South Locality	Number of cases that have used SoS approach end to end	
4. Board agencies will ensure that designed interventions which enable children and young people to remain in their families are child centred, planned, implemented and monitored to provide the best outcomes for those children and young people. (Finding 4)	4.1). Review LA rehabilitation policy taking into account best practice		July 2017	Assistant Director of children's services	Rehabilitation policy in place and is implemented	
	4.2). Trial use of rehabilitation policy with existing cases where appropriate		November 2017	Assistant Director of children's services	Existing cases that have used the rehab policy will demonstrate successful outcomes of children rehabilitated home through audit of cases	
	4.3). Review the effectiveness of the rehabilitation policy		November 2017	Assistant Director of children's services	As above	
	4.4). Implement training for all relevant staff in partner agencies		January 2018	Joint training group	Staff will have the knowledge and skills to effectively utilise the rehab policy	

5. HSCB will work in partnership with Tees Safeguarding Adult Board and the Community Safety Partnership to strengthen links between adult and children's services (Finding 5)	5.1). Development of Community Protection Team in Hartlepool to improve information sharing/ flow of community intelligence	March 2018	Director of Regeneration and Neighbour-hoods	Integrated Community Protection teams will be established.	
	5.2). Audit of case studies to be undertaken to demonstrate impact of new community protection teams	September 2018	Director of Regeneration and Neighbour-hoods	Case studies will demonstrate successful outcomes for children, young people and vulnerable adults.	
	5.3). Explore use of eCINS in relation to risk management group and VEMT to decide whether this is an effective method for sharing intelligence	November 2017	Assistant Director of children's services (HBC)	Evaluation of the system will evidence what the impact of using this method will be for the cohort involved.	

	5.4). Further develop locality meetings to ensure that intelligence is shared and actions are clear for all agencies.	July 2018	Assistant Director of children's services (HBC)	Locality meetings will be developed to allow for the sharing of information/intelligence where vulnerable adults and children are considered, to assess and manage any identified risk	
	5.5). Explore the possibility of the addition of adult workers into the already existing children's hub	July 2018	Multi-agency, eg. Police, adult and children's social care and health providers, (TEWV, Public Health, NTHFT)	Explorative exercise will identify benefits and challenges to have a children and adults hub and will determine the feasibility of this as a viable option	
6. All Board agencies will understand the impact of "fixed thinking" and "unconscious bias", and ensure there	6.1). Embed Signs of Safety Framework with multi agency group as set out in 3.1	March 2018	Assistant Director of children's services (HBC) and partner agencies	See 3.1	

are effective arrangements in place via reflective supervision to challenge these? (Finding 6)	6.2). Align HSCB escalation and professional challenge processes with Tees Procedures to ensure that all workers feel confident to be able to raise concerns	January 2018	Chair of Tees Procedures	HSCB will reflect the Tees procedures escalation and professional challenge processes Staff will feel confident and utilise the process. This will be evidenced in both single agency and multi -agency case file audits	
	6.3). HSCB to support the exploration of a more integrated approach to be promoted to support children and young people, building on the effectiveness of group supervision within SoS framework, E.g. consideration of integrated teams within specialist services.	January 2018	HSCB	More integrated approach to plans will be more appropriate to meet the holistic needs of Children and Young People and avoid any unnecessary delay.	
	6.4). Review risk management group remit to facilitate the triangulation of high risk cases discussed in supervision and further inform front line practice	April 2018	Membership of risk management group	Cases reviewed at risk management meeting will be followed through in supervision and frontline practice and will demonstrate positive management and reduction of risk	