Derbyshire
Safeguarding Children
Board

ADS14 Action Plan

Published August 2017

Reviewed January 2018

Rag Ratings

- Limited / No Progress
- On Track / on-going as planned
- Completed

	Recommendation & Question for the Board (as suggested by the Overview writer)	Action taken	Further action and/or completion date	Impact	RAG
1.	The impact of hypothesised personality disorder, or other parental mental health issues, should always be assessed as part of a child protection plan, any drug use and past history should be taken into account when assessing future risks. Further appropriate assessments should be considered where a parent's mental health presentation is identified during assessments by other professionals as being of significant concern or having the potential to have significant impact on the care of the child.	Derbyshire Children's Services have embedded in practice the requirement for assessments in relation to parents who present with parental mental health issues and/or drugs misuse issues to be considered at child protection case conferences and at all appropriate case discussions. The local authority has revised guidance regarding parental drug testing to ensure that drug testing takes place within clear parameters and within the context of a clear plan. This is incorporated into the practice matters guidance entitled 'Parental Substance Use – Guidance in Assessing and Testing Drug and Alcohol Abuse'. 'Practice Matters' is a key briefing document to ensure key legislative and practice changes are communicated across all front line services. This guidance forms part of the Derbyshire Safeguarding Children Board policy and procedure 'Working with Substance Misusing Parents'. The policy has further been reviewed and updated throughout to incorporate specific learning points from the serious case review.	Completed October 2016 July 2017	Expert assessments and testing can provide valuable information to support the progress of a parent or highlight where damaging behaviours still exist. The use of clear guidelines support workers in being consistent in their approach and parents are clear as to the consequences of not agreeing to such tests. The ongoing impact will continue to be reviewed through the quality and assurance process.	
		The Derbyshire Healthcare NHS Foundation Trust had a Continuous Quality Improvement Network in place from October 2014 until May 2017 to progress the 'Think Family' agenda. DHCFT implemented a mandatory 'Think Family' training in January 2015 for all the Trust's clinical staff. This was in order to change the culture of an adult mental health organisation and to train staff on the principles of considering carefully not only the subject adult but also any other person (either child or adult) with whom a patient was closely connected. This training encourages and supports staff in sharing information as necessary and in understanding the potential impact of parental mental health, substance misuse and adult learning disability for children. It supports risk assessments and consideration of how to safely support a family as a whole. The DHCFT specialist safeguarding children's team promotes the use of the Think Family policy, attending team meetings to demonstrate the use of the policy through practice example and to ensure it is embedded in practice.	January 2015	The sharing of information and the consideration of all members of a family are key elements to ensuring children are safeguarded.	
		Derbyshire Community Health Services NHS Foundation Trust 0-19 service have a practice whereby discussions are held regarding children, about whom there are safeguarding concerns, and their families at GP safeguarding liaison meetings, consideration would be given in relation to parental mental health, historical and or present substance misuse and the impact that this may have on the child(ren).	Procedure confirmed to DSCB July 2017		
		Derby Teaching Hospital Foundation Trust have updated safeguarding training and disseminated the learning from this SCR.	Confirmed to the DSCB July 2017		
		Chesterfield Royal Hospital Foundation Trust have ensured that midwives are fully aware of how to refer to maternal health services for assessment.	Confirmed to the DSCB July 2017		

	Recommendation & Question for the Board (as suggested by the Overview writer)	Action taken	Further action and/or completion date	Impact	RAG
		The Metropolitan Housing Trust Ltd have amended the risk assessment training and assessment tools utilised by frontline support staff. Whilst practitioners already consider appropriate responses to significant events, and to non-engagement, this is incorporated into IT systems which support practitioners. This ensures that key information from risk assessments should always be carried through into support plans.	Confirmed to the DSCB 2017		
		CAFCASS have introduced a new training package to support the work of its Family Court Advisors in the identification and assessment of parental mental health and substance misuse and the impact on children subject to family proceedings. Cafcass have introduced a new operating model highlighting the needs to keep a focus on the child's daily lived experience and ensuring there is a clear evidence base for decision making.	August 2017		
2.	Agencies must review their professional supervision/training/models of practice to ensure that they adequately address the need for authoritative/relationship-based practice and challenge the use of the term non-engagement	Derbyshire Children's Services have launched and embedded a new operating model across Early Help and Safeguarding called Stronger Family, Safer Children. The operating model includes a Safety and Wellbeing Grid which is utilised as part of the Supervision process. Derbyshire Children's Services introduced a comprehensive practice review to develop the use of reflective supervision to support analysis of cases and identify issues of disguised compliance and to ensure authoritative practice. A Practice Matters briefing document was issued in October 2014 and was dedicated to management oversight. By April 2015 Senior Practitioners had provided training in each area and the Principal Social Worker had embedded the practice of reflective supervision. Team Managers attended 8 days of systemic managers' training to embed the practice further.	August 2015	The new operating model enables practitioners to identify what level of intervention is required; to respond quickly and effectively to the needs identified by children and their families and to provide practitioners with guiding principles and tools to enable them to work in an efficient, effective and respectful manner with children, young people and families with clear, measured outcomes. Reflective supervision supports workers in dealing with confirmation bias and seeing patterns in behaviours. Results from the monthly case file auditing programme show that 82% of cases audited during the period February 2016 to January 2017 were judged good or better in relation to decision-making and management oversight. 76.3% of social care monthly case file audits were rated good or better for the voice of the child for the 12 month period ending January 2017. A Derbyshire Children's Services staff survey was completed in November 2016 which indicated that 83 % of staff considered that their Manager has and uses the skills and knowledge to assess the quality of their work and to improve the quality of the work being supervised. 74% of Derbyshire Social Care staff considered that their Manager provided them with effective and appropriate supervision. 77% of DCS staff considered that managers do all they can to support staff.	

	Recommendation & Question for the Board (as suggested by the Overview writer)	Action taken	Further action and/or completion date	Impact	RAG
		Derbyshire Children's Services have reviewed the guidance for the use of written agreements and incorporated this into their child protection procedure to ensure that there is consistent and safe use of these in appropriate circumstances	October 2016	Clarity regarding the use of written agreements will support workers in being clear with parents about expectations and the consequences for them when agreements are broken. This will provide clearer timely evidence to escalate cases where appropriate to safeguard children.	
		Derbyshire Children's Services have established a protocol for circumstances where it is proposed to depart from legal advice which has been provided, to ensure there is clear management rationale for such a departure and that the child/ren are appropriately safeguarded.	June 2017	The ongoing impact will continue to be reviewed through the quality and assurance process.	
		Burton Hospital NHS Foundation Trust introduced Safeguarding Supervision Policy in April 2015. Supervisors follow a reflective framework incorporating learning from serious case reviews and local learning reviews, including issues of disguised compliance, non- engagement and resistant parent/carer behaviour. Supervision is monitored and reported by the Safeguarding Children Matron to the Trust Board, Steering group and South Staffordshire CCGs. The supervision protocol for Staffordshire and Stoke-On-Trent Partnership Trust has recently been revised in accordance with governance timescales. This protocol gives a formal framework for supervision to enable front line practitioners to assess risks and to plan and evaluate interventions in complex clinical situations. The policy records that supervision is a fundamental requirement in order to ensure that the safety and welfare of the most vulnerable children are subject to continuing assessment, monitoring and review.	April 2015 March 2017	Key areas of improvement and impact have been safeguarding children supervision becoming embedded into key paediatric areas for nursing and medical staff, the child protection training programme quality and compliance, enhanced assessment at the front door (initial contact) and continuous investigation and checking of social information, electronic safeguarding alerts, missed appointment follow up and improved documentation. These areas of improved safeguarding practice are evident from completed audits, an increase in number and quality of child protection lateral checks and referrals, training impact analysis questionnaires and observation of practice during time spent in the clinical areas.	
		Derbyshire Healthcare Foundation Trust have raised awareness of this recommendation amongst all children's service line managers and operational managers and have included this within safeguarding supervision.	Confirmed July 2017		

	Recommendation & Question for the Board (as suggested by the Overview writer)	Action taken	Further action and/or completion date	Impact	RAG
		Derbyshire Community Health Services NHS Foundation Trust have one to one safeguarding children supervision between the named nurses and 0-19 Children's service, and this is audited. Group supervision is provided by the named nurses for staff working in minor injuries units and sexual health. The safeguarding service offers an on call service to all DCHS staff that may require any advice or supervision on a specific case. Feedback from safeguarding children's training is sought, analysed and changes implemented as appropriate. DCHS Safeguarding Children training at all levels includes safeguarding scenarios. (The scenarios involve the information being given piecemeal to reflect the nature of working with vulnerable children and their families where not all the information will initially be known.) Named nurses have regular one to one supervision with the designated nurse, appraisals and one to one with line manager so as to ensure they are supported, have appropriate training and supervision to undertake the role.	Confirmed July 2017	The Models of supervision used, both in groups and individually with Health Staff in the hospital setting, provide better opportunities to challenge parental behaviours which might perpetuate difficulties or hinder change. This style of training encourages a holistic way of thinking about a child and encourages critical thinking of what information is known and how this may impact on the child(ren).	
		Derby Teaching Hospital Foundation Trust reviewed their supervision policy in 2016 to ensure that all midwives have one to one supervision on all cases of concern at least every 8 weeks.	Reviewed 2016		
		Chesterfield Royal Hospital Foundation Trust – The Named Nurse Safeguarding Children and The Named Midwife for Safeguarding undertook advanced Safeguarding Supervision Training in May 2017. Level III Safeguarding Training incorporates group work with case studies where 'non-engagement' and disguised compliance are explored.	May 2017		
		The DSCB training programme reflects local and national learning from serious case reviews. The practitioners briefing which has been prepared as a consequence of this serious case review is to be shared in every DSCB training event.		Training evaluations record that participants have increased skills and have utilised these skills in the work place as a result of attending DSCB training. 71% of attendees recorded that they had put the learning into practice.	
3.	Any child who is **returning** to a carer where there have been safeguarding concerns should have a Child Protection Plan rather than Child in Need Plan, running parallel to the Supervision order for at least the first six months.	Derbyshire Children's Services have implemented a notification system within the Child Change of Circumstance Form to alert agencies and other local authorities when a child subject to a supervision order moves into their area. Derbyshire Children's Services have amended their procedures in respect of a child, subject to a supervision order who is returning to carers in whose care the significant harm originally occurred. Guidance confirms that a strategy meeting should always be convened to consider the need for an ICPC to be held and the development of a Child Protection Plan The Derbyshire Children's Services policy as regards the recording of supervision orders on electronic files once made by the Court has been amended to promote and ensure multi agency awareness and involvement. Supervision Orders are reviewed by managers quarterly.	Completed January 2017 Confirmed July 2017 Confirmed July 2017	This ensures that if an issue did arise that the local services would be aware of the child's legal status and care plan. A verification audit will be undertaken to ensure that this process is continuing effectively.	
		Derbyshire Healthcare Foundation Trust have ensured all children's service line managers and operational managers have been made aware of this recommendation.	Confirmed July 2017	The child protection plan provides statutory input to the safeguarding arrangements in respect of a child/children in accordance with 'Working Together to	

	Recommendation & Question for the Board (as suggested by the Overview writer)	Action taken	Further action and/or completion date	Impact	RAG
		Derbyshire Community Health Services NHS Foundation Trust are notified by Derbyshire Social care about any child's change in circumstances and the visiting patterns for children subject to supervision orders is as below – - Children under 5 years of age will be seen at least monthly. - Children aged over 5 years will have a School Health Assessment and the level of contact/support required is decided as part of this assessment. (enhanced level of visiting as would be expected for a child subject to a child protection plan)	Confirmed July 2017	Safeguard Children 2015'	
		Derby Teaching Hospital Foundation Trust have ensured all safeguarding supervisors are aware of the change of practice.	Confirmed July 2017		
4.	Derbyshire Safeguarding Children Board should undertake a multi-agency audit of children subject to a Supervision order, to assure themselves that there is good evidence that care plans made post Supervision orders are robust and outcome focused.	Derbyshire Children's Services undertook an audit of all children who were subject to supervision orders in April 2016 to ensure that appropriate safeguards for children and young people were in place.	April 2016	Outcome focused plans with clear tasks and timelines make it easier for progress to be monitored and the audit ensured safeguards were in place as appropriate.	
		The Assistant Director, Early Help and Safeguarding, Derbyshire Children's Services receives and reviews, in conjunction with the Locality Heads of Service, a monthly report concerning children who are subject to Supervision Orders in the circumstances outlined in recommendation three.	January 2018	This ensures that the recommendation at point three is appropriately embedded.	
		Derbyshire Children's Services introduced new policies and pathways for both the recording of supervision orders and the use of child protection plans in conjunction with supervision orders.	Completion January 2017	This enables supervision orders to be identified and audited by all agencies.	
		The DSCB continue to dip-sample on a Multi-agency basis individual records where children are subject to supervision orders. The DSCB will continue dip-sampling to evaluate the impact of the revised recording processes for supervision orders and the revised guidance for child protection plans and supervision orders.	February 2017 & January 2018 October 2017 & January 2018	This provides assurance that child protection plans made in appropriate circumstances are robust and outcome focused.	
		The DSCB held a large scale multi agency learning event to ensure that the learning from this and national serious case reviews were fully disseminated. The DSCB arranged the Local Family Justice Board Development Day on 29th September 2017 when over 100 delegates from across the local family justice arena received training related to the lessons derived from ADS14.	June 2017 September 2017	Participants from all DSCB agencies attended and confirmed the dissemination of learning. The feedback forms indicated that participants would be utilising the learning from this serious case review in their practice.	
		A research project is currently being undertaken by academics at Lancaster and Brunel Universities funded by the Nuffield Foundation. ADS14 has been incorporated into this research project with researchers having spoken to the author of the report, Jenny Myers. The remit of the research project is as follows:- 'Supervision orders have an important role to play in supporting family reunification and kinship care. Yet there is a dearth of evidence on the contribution they are making in practice to child outcomes and family justice,	Completion of the DSCB contribution December 2017 (report from the Nuffield Foundation anticipated Summer	Ensures that the key learning points from ADS14 will inform research and future guidance. The view of the members of the Childrens	

	Recommendation & Question for the Board (as suggested by the Overview writer)	Action taken	Further action and/or completion date	Impact	RAG
		despite persistent long-standing concerns by some that they are ineffective and lack teeth. The way in which the local authority carries out its duty to "advise, assist and befriend" the supervised child is also poorly understood, as are the review mechanisms, and the voice of the child and parent goes largely unheard. The learning from the serious case review has also been shared with the Law Society Childrens Law Sub Committee.	2018)	Law Sub Committee may be sought in relation to any potential changes in legislation concerning supervision orders.	
		The author of ADS14, Jenny Myers and Chris Cook, DSCB Chair, have met with Isabelle Trowler, Chief Social Worker to consider the recommendations in the report and she has supported the work which is being undertaken in relation to supervision orders and the inclusion of the SCR in the Nuffield study.	September 2017	To ensure the learning from this serious case review has been brought to the attention of professionals who are in a position to influence social work practice.	
5.	Where there are safeguarding concerns for children, fathers/male partners must be adequately consulted, supported and assessed in the care of children, even if they are not the primary carer.	DSCB has developed and provides training regarding fathers and "Hidden Men" in children's lives.	Completed November 2014.	This training has raised awareness around significant persons in a child's life and the need to actively engage them in assessment processes and planning to ensure that any plan for a child takes into account the impact, both positive and negative, such relationships have on a child's life	
		Derbyshire Children's Services have circulated Hidden Men research widely across all localities and shared this at team meetings. It continues to be a focus of multi-agency audits that all people known in the household are assessed as appropriate.	DSCB multi-agency rolling audit programme		
		Burton Hospital NHS Foundation Trust introduced a Paediatric Social Assessment for all children and young people up to the age of 18 years in November 2014. Staff have been trained to identify risk and vulnerability in the Emergency Department, Minor Injuries Units and Paediatric Ward setting. A request for the parental held record (red book) is part of the assessment. In March 2016 a sophisticated electronic recording system was introduced to BHFT enabling enhanced recording of this information. The identity of the father/male carer/ significant others are recorded on admission and staff are aware of the significance of '*hidden men'* in children's lives as this is incorporated into mandatory child protection training at all levels and included into supervision sessions. Child Protection training is compliant with the Intercollegiate Document: Safeguarding Children and Young People, Roles and Competences for Health Care Staff (2014) and UK Core Skills Training Framework (2014).	March 2016	Fathers are regularly included in the care and treatment planning of their children and contacted when a situation arises if parents are not living together. This ensures that appropriate decisions can be made with the fullest possible information.	
		Derbyshire Healthcare Foundation Trust have ensured that policies are in place to ensure that fathers/male partners are adequately consulted, supported and assessed in the care of children, even if they are not the primary carer.	Confirmed July 2017		
		Derby Teaching Hospitals NHS Foundation Trust (DTHFT) is reviewing and regularly auditing performance in enquiry relating to fathers / partners to ensure they are known and included in care issues.	Confirmed		
		Derbyshire Community Health Services NHS Foundation Trust - Health Visitors register birth Fathers on electronic health records SystmOne. Partners of parents and significant others are also recorded on electronic records (SystmOne). The Health Visitor Service offers health support to Fathers/partners; this may include an assessment of the home environment.	Confirmed July 2017		
		Chesterfield Royal Hospital Foundation Trust - Staff are encouraged to ensure that all Fathers and male partners are consulted and included in the planning around their child's medical care and interventions.	Confirmed July 2017		

	Recommendation & Question for the Board (as suggested by the Overview writer)	Action taken	Further action and/or completion date	Impact	RAG
6.	Emergency Departments and paediatric staff must ensure that they always consider abuse or neglect within their differential diagnosis [1]when considering the reasons for a child's presentation. Where this remains a possibility, this should be recorded and appropriately risk assessed, considering all available information. This is particularly important for young children who present with a seizure, febrile convulsion or ALTE. Consideration should also be given to obtaining an examination of the child's eyes by a paediatric ophthalmologist. This may provide additional clues to the cause of the event, including retinal haemorrhages in the case of shaking.	The Paediatric Social Assessment in the Emergency Department and Paediatric assessment unit (Queens Hospital, Burton) provides the opportunity to identify risk and vulnerability as a frontline action of information collecting about areas of concern. The Paediatric History Sheet now includes additional prompts related to social history context, including ED visits, historical / current social care involvement (for the child and any siblings), smoking, drug and alcohol use, domestic abuse and mental ill health issues for the child and the parent / carer. Medical staff are trained to complete this record and to consider the possibility and impact of hidden harm.	Confirmed July 2017	There has been significant improvement in this area of safeguarding practice. There is evidence from record keeping audits and Paediatric Social Assessment audits that Emergency Department and Paediatric staff regularly consider child maltreatment and risk indicators of abuse and neglect during the Triage process. This is further supported by lateral checks completed with multi-agency partners, including Children's Social Care, Community Health and Education as a matter of routine when identifying potential vulnerability.	
		Child protection training and supervision is delivered and facilitated in the practice areas highlighted in the recommendation. All staff working directly with the unborn, children and their families are required to complete level 3 child protection training which is monitored and reported by the Safeguarding Children Lead. Role level 3 is defined by the safeguarding board as those with particular and specialised responsibility for safeguarding children though core safeguarding processes: assessments, child protection conferences, gore groups, plans and responses. This is further monitored by the Safeguarding Steering Group and Quality Committee. Learning from this case is included in Trust child protection training programmes. This includes the significance and importance of completing lateral checks and documenting fully in the patient's record all communications as well as treatment, considering the holistic picture of the child, family, siblings. Emergency Department Paediatric study day took place on 10th August 2016 and is to be a quarterly event throughout the year and factors associated with Staffordshire Safeguarding Children Board Hidden Harm agenda and other relevant Local Safeguarding Children Board work stream topics to be included.	Confirmed July 2017		
		Seizures, febrile convulsion and ALTE (Apparent Life-Threatening Event) is included as a regular element of Paediatric and Emergency Staff clinical training and this will be monitored by the Named Doctor and Medical Director to ensure compliance.	Confirmed July 2017		
		DTHFT has appropriate guidelines in place and included in training	Confirmed	The consideration of the fullest possible information and the consideration of all possible explanations will ensure the child/children are most effectively safeguarded.	
		Derbyshire Healthcare Foundation Trust - Professional curiosity and challenge encouraged and covered in training and supervision.	Confirmed July 2017		
		Derbyshire Community Health Services does not have an Emergency Department, however it does have Minor Injuries Units (MIU). The presenting injury/explanation/signs/symptoms/presentation and/or interactions between parent/carer and child/young person would be part of the MIU assessment and this would lead to child abuse or neglect also being considered. MIU staff have access to NICE guidelines built into the electronic health SystmOne MIU modules so that once a clinician is in a patient record they will be able to access the most up to date evidenced clinical care.	Confirmed July 2017		

[1] The process of differentiating between two or more conditions which share similar signs or symptoms.

	Recommendation & Question for the Board (as suggested by the Overview writer)	Action taken	Further action and/or completion date	Impact	RAG
		Chesterfield Royal Hospital Foundation Trust have a new ALTE guideline being developed which will state non-accidental injury needs to be considered and ophthalmology examination needs to be considered. There is an ongoing programme of education with Emergency Department staff and paediatric staff addressing this issue.	Confirmed July 2017		
7.	Both Derbyshire and Staffordshire Social Care and Healthcare Partners should ensure that Child Protection – Information Sharing (CP-IS) is implemented.	Derbyshire Social Care and healthcare partners are currently committed to the installation of CP- IS in 2018. This forms part of a national roll-out program, the timing of which is determined at a local level. Derbyshire has a CP-IS Implementation Group attended by representatives from local authorities, Health Care Trusts, Ambulance Services and the NHS digital. The local authority's ability to adapt their case management systems to connect to the NHS spine will determine the timescales for implementation locally. This is expected to be around September 2017. Following this, the plan to bring Trusts on-line will begin. A CP-IS fact sheet for practitioners has been distributed across Children's Services confirming that the CP-IS service will provide unscheduled care setting healthcare workers with the capability of viewing a child's current CPP or LAC status. The child protection information will be provided by all local authorities nationally. Staff briefings are to be undertaken in January/February 2018 to aide implementation.		The Child Protection – Information Sharing (CP-IS) project is an NHS England sponsored work programme dedicated to developing an information sharing solution that will deliver a higher level of protection to children who visit NHS unscheduled care settings. It proposes to do so by connecting local authorities' child protection social care IT systems with those used by staff in NHS unscheduled care settings. It is anticipated that the impact of CP-IS will be as follows: - Improve the assessment of children presenting in unscheduled care settings through access to better supporting information - Make information about children who the local authority have responsibility for available for other local authorities when placed in their area - Deliver more focused communication between social care and health concerning these groups of children - Improve intervention to prevent the ongoing abuse or neglect of a child - Save time (health and local authority teams will no longer have to produce lists or enter data manually)	
		Burton Hospitals Foundation Trust signed up to CP-IS in 2015 and has been working alongside the Local Authority to enable implementation by January 2018. This remains on target.	February 2018		
		Staffordshire and Stoke-On-Trent Partnership Trust are working with Staffordshire County Council to introduce CP-IS. Staffordshire is noted to be a local authority live with CP-IS with data sharing with healthcare settings.			
		DTHFT, Derbyshire Healthcare Foundation Trust and Derbyshire Community Health Services Foundation Trust are also fully committed to the introduction of the CP-IS process.			

	Recommendation & Question for the Board (as suggested by the Overview writer)	Action taken	Further action and/or completion date	Impact	RAG
		The DSCB are seeking to raise awareness that the CP-IS system would not record children and young people who were the subject of supervision orders, unless they were also the subject of a child protection plan**.** The DSCB is to pursue this with NHS Digital and continue to raise awareness amongst partner agencies. This was highlighted across all agencies at a multi-agency event on 20th June 2017. Cathy Sheehan, Clinical Lead CP-IS NHS England have responded to confirm they have noted this point and that consideration will be given as to whether the system nationally has capacity to include supervision orders in the next phase of implementation.	August 2017	To ensure there is full awareness and understanding of those children who are included in the CP-IS project.	
8.	Missed medical appointments for children on a child protection or children in need plan should no longer be recorded as DNA (did not attend) but always seen in the context of '*was not brought*', to ensure that parental neglect is considered as a factor. Risk assessments should be considered and appropriate action taken as a result of this classification	This key learning has been disseminated to all Derbyshire Children's Services Managers and Practitioners through training, awareness events and supervision. The use and promotion of materials produced and shared by Nottingham Safeguarding Children Board, 'Rethinking Did Not Attend'*, has formed part of this process. This has involved both large scale training events and the continuous promotion of this message by the DSCB training team. This animation is shown at every DSCB training event. It has been shown at the large scale learning events detailed above which took place on 20th June and 29th September 2017. *http://www.nottinghamcity.gov.uk/children-and-families/safeguarding-children-board/ Burton Hospitals NHS Foundation Trust had in place a *Management of Children and Young People Who Do Not Attend Planned Appointments (DNA's) Policy* which was ratified in December 2014. This policy was amended in March 2017 to utilise the term 'Was Not Brought'. The emphasis of the child not being brought to their appointments is clear throughout the training programmes and this context is also used throughout supervision sessions. This is a significant indicator for an acute NHS Trust and therefore Neglect is one of the key level 3 training programmes available internally to staff to access. The Safeguarding Team monitor the non-attendance data and report quarterly to Steering group as a process of identifying themes, seasonal or age related behaviour. This also provides a safety net for children who are not brought to their appointment on two occasions or more and require escalation to multi agencies.	July 2017	The completed feedback forms obtained three months after the June training event and immediately following the September event have confirmed that practitioners have changed their practice to use the term 'Was Not Brought'. This change assists in enabling medical neglect to be identified promptly and safeguarding action to be taken. The animation encourages practitioners to consider the impact of not being brought on the child's treatment and potential safeguarding risks.	
		Staffordshire and Stoke-On-Trent Partnership have updated policies to reflect this classification and is reviewing the systemic changes in terminology across services to ensure this is consistently utilised.	Confirmed July 2017		
		Derbyshire Healthcare Foundation Trust have adopted this policy and the utilisation of the term 'Was Not Brought'.	Confirmed July 2017		
		DTHFT have reviewed their DNA policy and adopted the was not brought terminology	Confirmed		
		Derbyshire Community Health Services NHS Foundation Trust have introduced guidelines within 0-19 services to support this recommendation. These will ensure defaulted appointments, no access visits and withdrawal from services are recorded as 'Was Not Brought'. Other services in DCHS are reviewing their guidelines and policy to reflect the recommendation. 'Was Not Brought' is part of the Level 3 and Level3a training for DCHS staff April 2017 – March 2018.	Confirmed July 2017		

	Recommendation & Question for the Board (as suggested by the Overview writer)	Action taken	Further action and/or completion date	Impact	RAG
		The Derbyshire CCG's have confirmed that the 'Was Not Brought' animation has been shown widely in training and computerized codes developed to reflect the new terminology.	Confirmed July 2017		
		Chesterfield Royal Hospital Foundation Trust - 'Was Not Brought' Policy being introduced. Training is already being provided on the Full Day Level 3 Safeguarding Training regarding this new terminology and the importance of its utilisation to identify medical neglect	Confirmed July 2017		
		Derbyshire Health United – New computerized codes have been developed, the child's GP is always notified of non-attendance for Out of Hours appointments.	Confirmed July 2017		
9	DSCB Partner Agencies should consider how more robust assessments are undertaken when vulnerable parents with children, where there are safeguarding concerns, are housed. These assessments should consider the risks associated with housing being offered and its suitability in relation to the age of child/ren.	Derbyshire Children's Services have ensured that a child's housing situation is fully considered as part of any child protection assessment. A child's accommodation needs and the extent to which these needs are met will be factored into decision making for children and reviewed in supervision.	Confirmed July 2017	The ongoing impact will continue to be reviewed through the quality and assurance process.	
		DTHFT have adopted the Graded Care Profile; it is included in safeguarding training and supervision sessions			
		The Metropolitan Housing Trust Ltd have amended the risk assessment training and assessment tools utilised by frontline support staff. Whilst practitioners already consider appropriate responses to significant events and to non-engagement, this has now been incorporated into IT systems which support these Practitioners. This will ensure that key information from risk assessments should always be carried through into support plans.	Confirmed July 2017	This will ensure key information will be captured and shared.	
		Derbyshire Community Health Services NHS Foundation Trust - The 0-19 Children's service completes home visits as part of the Universal and enhanced service (children subject to plans/Early Help) offer. Professional judgements are made as to whether health reviews are completed in a clinical setting or at the home, to get the best response from the child.	Confirmed July 2017	This enables key safeguarding information to be collated as part of the home visit.	
		The District Council Member of the Derbyshire Safeguarding Children Board disseminates safeguarding learning and information through a safeguarding sub group of the District Safeguarding Leads (The District Councils Safeguarding Lead Sub Group). The DSCB to present on this issue at the September 2017 meeting. There have been two meetings of the District Council Safeguarding Leads Group in September and November 2017. At the meeting in September 2017 assurance was given regarding the implementation of the recommendations contained in ADS14.	Arrangements for the sub group completed July 2017 District Safeguarding Leads sub group Autumn 2017	This will ensure that their housing function benefits from a full awareness of the key learning arising from serious case reviews. This will be evaluated through the Section 11 audit process. Local housing providers confirmed a change in practice had already been implemented in relation to risk assessments as a result of the serious case review.	

	Recommendation & Question for the Board (as suggested by the Overview writer)	Action taken	Further action and/or completion date	Impact	RAG
				This learning will also be disseminated through the National Housing Federation.	
		Chesterfield Royal Hospital Foundation Trust - a policy is in place whereby midwives undertake home visits as routine and would refer families who are living unsuitable accommodation as appropriate.	Confirmed July 2017	This will ensure key information will be captured and shared.	