Joint targeted area inspection of the multi-agency response to abuse and neglect in Bristol

Statement of Proposed Actions

Bristol City Council and safeguarding partners have developed this joint action plan in response to findings from the joint targeted area inspection of the multi-agency response to abuse and neglect in Bristol, which took place in October 2017.

The early identification and response to neglect is a priority for Bristol and robust governance arrangements are in place to ensure that all agencies fulfil their roles and responsibilities with regard to neglect. Delivery of the action plan is overseen by a multi-agency working group that reports to Bristol Children's Safeguarding Board.

The appended plan describes actions taken by all partners against the inspection findings. Progress made to date is also described. This includes:

- A Multi-agency Neglect Strategy for Bristol has been developed and will be launched in early April 2018. This will ensure that neglect is explicitly recognised and that all agencies involved in the care of children in Bristol have a consistent, timely and appropriate response to physical, emotional neglect or abuse.
- Use of the NSPCC Graded Care Profile 2 Neglect Tool is being funded by the Bristol Children Safeguarding Board. An implementation plan is in place and training of practitioners commences in April 2018.
- Implementation of joint procedures have enabled timely joint visiting and streamlined Strategy Discussion arrangements
- Local authority investment has been secured to commence the Strengthening Families Transformation Programme. The programme is changing the way we organise our resources to deliver the most effective and timely response to families and includes the establishment Adverse Childhood Experiences (ACE) Teams

Quality assurance and performance monitoring underpins all actions to help us understand the impact of changes on practice and children's outcomes.

Dr Jacqui Jensen
Director of Children's Services, Acting Executive Director and Head of Paid Service

Bristol Joint Targeted Area Inspection Action Plan

Ref.	Finding	Action	Lead Agency(ies)	Due	Progress Update
1.1	Strategy discussions are taking place, but there are examples of significant delay in children being seen when a joint visit involving children's social care and the police is required. Action was taken to address this during the inspection.	1. Issue joint protocol detailing expectations in respect of visits undertaken jointly between Avon & Somerset & Police and Bristol Children's Social Services. 2. Ensure staff are aware of expectations in respect of joint visits.	Police LA	Oct-17	Clear process now developed for officers and frontline staff to attend to a prompt and timely S.47 activity. Now part of standard procedures.
1.2		Audit and monitor timeliness of visits	Police	Jul-18	Audit has been assigned to SCU Sgt. Framework being developed in order to ensure that joint protocol has embedded. This will be completed by July 2018.
1.3		Develop performance reports to allow monitoring of timeliness of visits to children following strategy discussions. Address any concerns identified.	LA	Feb-18	Performance reporting now available to monitor timelines of visits following contact and start of s47 enquiries. This will now be a focus of service performance clinics.
2.1	Strategy discussions do not always include professionals involved with the child other than children's social care, police and community paediatricians. While community paediatricians are routinely involved, they are not always the health professional best placed to make the most effective contribution. Consequently, the most appropriate health professional does not consistently participate in, and receive information from, strategy discussions. Recording of strategy discussions is not consistently clear or complete; this includes the rationale for decisions and agreed actions.	Review implementation of 2017 BSCB guidance on strategy discussions and support learning and development of workforce regarding this.	BSCB LA	Apr-18	The Strategy Guidance has been launched and reviewed by the Board. Challenge has been made of agencies where there isn't good compliance. Interactive HYDRA multi-agency training on strategy meetings being held in May 2018. Children's Hospital Safeguarding Team members attend all strategy discussions on site. The Strategy Guidance has been re issued to children's social work in December 2017. An internal thematic audit on strategy discussions to be undertaken March 2018.

Ref.	Finding	Action	Lead Agency(ies)	Due	Progress Update
3.1	The quality of referrals to children's social care from partner agencies is variable. This is a result of the majority of police referrals lacking focus on concerns regarding children and some health referrals having insufficient detail and analysis of concerns. This impacts on the partnership's ability to make timely decisions and leads to barriers for FRT to assess and prioritise responses based on clear, assessed risk and need, and is particularly pertinent to neglect, where individual incidents are considered rather than the pattern of neglect.	LA to continue work to challenge when referrals are not good quality by giving referrer clear feedback. Monitor this via audit and review performance data in relation to the number of contacts that become referrals and assessments.	LA	Mar-18	Audit of referrals to be completed March 2018, to understand impact of feedback loop to referrers around quality. Percentage of contacts that led to no further action has reduced over the year to February 2018. This was 35% in February 2018 compared with 50% in August 2018.
3.2		1. Introduce BRAG system to more accurately define concern and what activity is required to resolve. 2. Design new referral document to support partners to understand concerns and risks. 3. Introduce new quality assurance framework, which will highlight good and poor practice.	Police	May-18	1. BRAG is scheduled to go live across the Force by May 2018, although a soft launch has been implemented where training has been delivered. As of 28.2.18, Neighbourhood & Partnership colleagues have been trained, FRO's and some of Response. A briefing video has been recorded and is due to be delivered to all Response officers, via their mandatory briefings, followed up by face to face training throughout 2018. Training dates have been set for Investigations staff. A communications package is being designed and will be ready for launch, via the force intranet. This will accompany all briefings and will provide supplementary information. 2. The referral document has been designed and will go live from July 2018. An interim referral document is being tested through use in DA referrals to CSC across A&S. Feedback from partners is being collated in order to inform the final design and information pull of the new referral form.

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3.3		1. Update existing staff on how to make a good referral, using BSCB guidance. 2. Ensure all new starters receive training on how to make a good referral. 3. Review returned referrals from First Response via quality assurance processes and feedback to staff.	Health	Feb-18	GP training now includes how to make a good referral and practitioners have been directed to the BSCB training. A single agency audit of health referrals will be undertaken by the Health sub-group to be completed in July.
3.4		1. The BSCB to publish and launch a new Threshold Document to increase professional understanding of levels of intervention 2. All Board partners to undertake single agency audit of referral quality in their agency using a BSCB audit tool and provide it to the Board with an action plan of how they will seek to improve them 3. BSCB Training Sub Group to ensure dissemination and use of the BSCB referral training pack	BSCB	Apr-18	New threshold document has been agreed at the February Board. Due to be launched by the end of March 2018. All agencies are undertaking single agency audit of referrals and providing the Board with a tailored quality improvement action plans.
4.1	FRT does not consistently provide a clear response to referrers about actions taken following a referral. There have been recent improvements in some responses to referrers but this is still not consistent.	Remind all decision-makers in First Response to ensure that referrers get written feedback. Monitor compliance through audit.	LA	Jan-18	Audits have provided assurance this is happening. This will continue to be monitored, and included in the audit described under 3.1.
5.1	The purpose of the MASH meeting is not clearly understood by all workers as a result of a lack of clarity about when a	Update MASH process and guidance so that Strategy Discussion can take place within MASH Discussions.	LA Health Police	Oct-17	Guidance updated - when appropriate Strategy Discussions are now taking place in MASH.

Ref.	Finding	Action	Lead Agency(ies)	Due	Progress Update
5.2	MASH meeting should be a strategy discussion, and this leads to delay. Guidance was issued during the inspection to address this.	1. BSCB to undertake an audit of the MASH process 2. MASH Steering group to develop multi-agency guidance on the criteria and use of a MASH and provide to the BSCB 3. BSCB to update all multi-agency training delivered to include the new MASH guidance	BSCB	Feb-18	Threshold Document updated to include details of the MASH process and pathway.
6.1	Overall, there is insufficient focus on neglect across the partnership and BSCB, particularly for children in need. The impact of this can be seen in the lack of practice tools, lack of data and inconsistent recognition of and response to neglect issues. Professionals do not consistently identify the underlying causes of neglect. This is improving in relation to child protection plans, where a focus on neglect has led to a significant increase in the proportion of children subject to child protection plans.	1. BSCB to launch a Neglect Strategy 2. BSCB to agree and implement the use of a multi-agency practice tool which supports professionals to identify neglect and assess its impact on children 3. BSCB to review all their policies to ensure the links with neglect are clear identified and named in all forms of child abuse and neglect 4. BSCB Multi-Agency Briefing on Neglect to be disseminated throughout partners and professionals 5. BSCB Training team to offer increased number of multi-agency Neglect Training courses in 2018-19	BSCB	Mar-18	Multi-agency Neglect Strategy was agreed at the February 2018 Board. Due to be launched in early April 2018. Use of the Graded Care Profile 2 Tool agreed as part of the Neglect Strategy. Implementation plan in place and first training is starting in April 2018.
6.2		Briefing for staff to include: recognising neglect; its underlying causes and its consequences using Asset Plus and a neglect tool as advised by BSCB; recording neglect on ChildView to enable data to be extracted	YOT	Apr-18	Briefings are scheduled to take place on 13th March and 12th April and will be delivered to all YOT practitioners and team leaders.

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7.1	Thresholds are not consistently well understood across the partnership, which is particularly apparent for neglect cases. BSCB has recognised this and is using the opportunity to review the threshold document to enable more consistent understanding and application of thresholds, particularly in relation to neglect.	BSCB to publish and launch a new Threshold document in consultation with the Board Partners	BSCB	Feb-18	New threshold document has been agreed at the February Board. Due to be launched by the end of March 2018.

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8.1	Lack of effective design of the 'front door' combined with ineffective performance information have led to insufficient priority being given to seeing children at the front door in a timely way. Decisions about responding to referrals are not consistently being made within 24 hours, which is the statutory timescale. Referrals are left open while 'further enquiries' are being made, but are not allocated at the point of referral by the priority decision team. Some of these referrals were received up to two weeks before the inspection. Different workers gather further information and the case is not allocated until a visit to the family has been arranged. There needs to be greater clarity about when information is being gathered and an assessment is being undertaken. Some children experience significant delays in being seen and being assessed. In some cases this leads to further delay in action being taken to reduce risk. Senior leaders have identified this and are taking action to improve the effectiveness of the 'front door'.	1. Review design of 'front door' processes, take any remedial action required, and ensure that workforce and partners understand how pathway works. 2. Develop performance reports to allow monitoring of timeliness of visits to children. Produce data report showing length of open referral by team and respond to drift and delay. 3. Practice Direction to be issued in relation to manager decisions in PDT to include when child should be seen on all directions - timescale and clarity of task	LA	Jan-18	The Management team in First Assessment have reviewed and clarified business processes and improved the timeliness of decision-making. 80% of contacts to First Response have a decision made on next action within 24 hours. Those that don't are lower need requests where enquiries have not yet provided the information to determine the right pathway. All child protection contacts progress to referral and assessment on the same day. A workflow diagram has been developed to share with partners. An end to end review of performance and data effectiveness has taken place; additional resources have been committed to the data insight team, including data analyst post; a new live data product has been procured and will go live end March 18. The intention is to improve the 3 strands of Performance and Data activity; predictive data to enable resolution prior to target point; real time data for team management; triangulated data to enable governance scrutiny and challenge. All decisions in PDT now include direction on what needs to be done, including how soon a child needs to be seen. This will be the subject of an audit in April 2018.

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9.1	Agencies effectively identify acute and immediate risks to children and refer these cases to FRT in a timely manner. However, there is less consistency in identifying the risks to children that arise from chronic neglect. Schools, however, do effectively identify indicators of neglect for older children. When children who are suffering the impact of chronic neglect are referred to FRT, the child's experience of neglect is not always identified as quickly or effectively as it could be and in some cases repeat referrals over a considerable period of time are made in relation to the same issue.	1. Managers to ensure that all children who are the subject of an assessment by children's services have a chronology of significant life events and service interventions and this informs decisions made about subsequent concerns. 2. Managers to ensure that all assessments clearly reflect the child's experience and evidence of this is reflected in audits. Review performance on re-referral rates quarterly	LA	Apr-18	Chronologies will be part of a service-wide improvement focus for March 2018 and part of the refreshed improvement plan. Performance reporting on chronologies now in place to understand compliance, which will be reinforced through thematic quality assurance. Recording the child's voice is now mandatory on LCS forms.
10.1	Older children's involvement in child protection conferences and other meetings about them is very limited. Advocacy is not routinely considered and where it is in place, it is not always used to good effect. This is not effectively challenged by child protection chairs.	1. Service improvement work as part of EIP 2 to include focus on the voice of the child in assessment and planning. 2. Child Protection service to liaise with advocacy service to ensure all children have access to advocacy service within the CP conference. 3. Practice Direction to be produced regarding advocacy service.	LA	Feb-18	Meetings have now been held with commissioned advocacy provider to clarify referral routes. New practice in place that when CP chair is advised of initial conference they will have a discussion with the social worker about the best way the child's views can be represented within the meeting and plan is put in place. A new dialogue box requiring the child's views has been added to the CPC record to ensure this is evidenced.

Ref.	Finding	Action	Lead Agency(ies)	Due	Progress Update
11.1	Consideration of diversity is not strong, and while inspectors did see examples of better practice overall, issues of diversity are not well reflected in assessments and do not inform planning and interventions sufficiently.	1. Managers to identify any learning and development needs of the workforce in relation to diversity, an address them. 2. Managers to ensure that the diversity needs of children are recorded and reflected in assessments and care planning. 3. Quality assurance activity to include evaluation of this	LA	Mar-18	Findings disseminated to social work staff and being audited within the QAF, to ensure that our understanding of diversity issues are evidenced and clearly influence the child's assessment and plan. Development of Signs of Safety template (under complicating factors) will ensure that this is more visible.
11.2		1. BSCB to have a focus on diversity and equality within the 2018 Section 11 Audit	BSCB	Nov-17	All multi-agency audits now undertaken include consideration of ethnicity and diversity.
12.1	Families and professionals wait too long to receive minutes and plans from strategy discussions, conferences and other meetings about older children experiencing neglect. Families and professionals are not always clear about what is expected of them, and this can cause delay and a lack of clarity about how to protect and meet the needs of these children.	1. Review with ABS service the dissemination of minutes from Child Protection Conferences and Unit Coordinator manual to specify role of Unit Coordinator in disseminating minutes. 2. EIP 2 to support whole workforce to confidently map and draw up plans with families.	LA	Apr-18	A piece of lean process work has been undertaken with the Child Protection Conference note takers and Child Protection chairs to improve timeliness of minutes being disseminated. All minutes will be sent out within 5 days of the Child Protection Conference and this will be monitored on an ongoing basis.

Ref.	Finding	Action	Lead Agency(ies)	Due	Progress Update
13.1	Child in need and child protection plans and health needs assessments generally detail relevant actions but are not consistently specific, with clear timescales for completion, and are not well used as a tool to drive and monitor progress. Health needs assessments were delayed in some cases. The lack of goals, outcomes and timeframes in plans result in some cases drifting and a focus on incidents, rather than the overall impact for children living with neglect	Managers and CP Conference Chairs to ensure that all plans are time specific and that this ensures required actions progress. Audits to monitor this.	LA	Apr-18	Improvements being undertaken to better evidence the outcomes and plans from CPC's. This will be a service-wide focus for August 2018 and part of the refreshed Improvement Plan and then re audited.
13.2		There will be an audit in quarter 4 (2017-18) of the FHNA document.	BCH/CCHP	Mar-18	
14.1	There was limited evidence of constructive challenge between partners to either inform or improve decision-making or where the child's situation was not improving quickly enough, with schools being the exception. Escalation procedures are not consistently used when there is a disagreement between agencies. This leads to delays in taking action to improve the child's lived experience.	1. BSCB to review the escalation policy 2. BSCB will hold and report via a challenge log to the Board.	BSCB	May-18	Planned review of the Escalation Policy. This is being drafted to be agreed at the May 2018 Board. Evidence from last 4 months on the Challenge Log is that there has been increase challenge and escalation since the JTAI findings.
15.1	Evidence-based tools to support practitioners to identify neglect and to support intervention and monitor progress in a family are not consistently in place. Although such tools are used with some children who are receiving early help, they	1. BSCB to agree and implement the use of a multi-agency practice tool which supports professionals to identify neglect and assess its impact on children 2. BSCB to provide multi-agency training for professionals in using the tools	BSCB	Feb-18	Use of the Graded Care Profile 2 Tool agreed as part of the Neglect Strategy. Implementation plan in place and first training is starting in April 2018.

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15.2	are not routinely used to support referrals or in work with children who are in need or at risk of significant harm as a result of neglect. Inspectors did not see any use of evidence-based tools to identify neglect and underpin assessments or the consistent completion and use of chronologies to help understand patterns of neglect.	Monitor use of BRAG in order to understand impact on identifying neglect issues within family environment	Police	May-18	BRAG will feed into Qliksense, providing qualitative information on which to easily identify patterns of behaviour which are endemic in cases where neglect applies. As new working processes are developed within the LSU during 2018, this will provide opportunities for increased scrutiny of information, and the ability for earlier intervention to take place.
16.1	The local authority's preferred model of practice is not being used in a consistent way within assessments to develop plans and focus on outcomes. Assessments are of variable quality. Some contain clear historical information, the wishes and feelings of children and use the model to highlight key concerns, but some do not achieve this standard. There is limited evidence that children or parents are included in scaling exercises, which does not support them in understanding the multi-agency concerns. Chronic risks and the cumulative impact of harm on children are not consistently recognised. The voices of older children who experience neglect are not consistently heard in assessments or meetings about them, and are not reflected in their plans.	EIP 2 to focus on embedding Signs of Safety. Develop LCS forms to better evidence Signs of Safety methodology and support practitioners in using the methodology.	LA	Sep-18	Second Phase England Innovation Programme project now underway and will respond directly to JTAI findings, supporting us with embedding Signs of Safety across the workforce. This is part of LA Strengthening Families Transformation Programme.

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17.1	The model of practice is, in a number of cases, used in a confusing or overly mechanistic way, which means that past and present worries and the key areas for concern and action are not always clear. This does not help in the production of robust plans. When plans are not used as an objective measure of progress, partners at core groups and children in need meetings often discuss the immediate presenting issues at that point in time and can lose focus on what overall progress is being made. In situations of chronic neglect, this can lead to drift and delay in taking different or more decisive action to protect children.	EIP 2 to focus on embedding Signs of Safety. Develop LCS forms to better evidence Signs of Safety methodology and support practitioners in using the methodology.	LA	Sep-18	See 16.1
18.1	Action to reduce some social work caseloads is starting to be effective, although some social workers' caseloads are too high. This impacts on the effectiveness of their work with children experiencing neglect.	Strengthening Families transformation programme includes caseload reduction plan - this comprises refreshed structure of area services and focussed caseload review.	LA	Mar-18	As at end February 2018, there has been a 12% reduction in area social work caseload. This will be further reduced on completion of new structure and caseload review. Activity has been commissioned to undertake case closure work on 150 cases currently open to social workers.

Ref.	Finding	Action	Lead Agency(ies)	Due	Progress Update
19.1	Although social workers receive regular supervision, only in a minority of cases is effective case direction, monitoring and reflection evidenced in children's case records. In most children's cases, management oversight and supervision is not consistently driving case progression, monitoring action completion or providing guidance to social workers.	1. Review the form/template for recording management directions in LCS and then support managers to use this. 2. Monitor quality via audit	LA	Apr-18	Peer challenge of neighbouring LA has identified the LCS solution for recording management oversight and reflection. Further audit of supervision files is currently being undertaken which includes supervision provided by service managers. Findings from this audit will influence the provision of a new template to ensure reflective supervision is evidenced within a child's records. The refreshed Area Unit model will see an increase in senior management capacity and an additional social worker to each unit, delivering increased capacity for improved management oversight. Increased social worker capacity will release consultant social worker capacity to drive case progression.

Ref.	Finding	Action	Lead Agency(ies)	Due	Progress Update
20.1	Insufficient capacity in the CRC has an impact on the quality of practice. CRC caseloads are high, therefore management oversight is limited. For example, one frontline manager told inspectors that they were responsible for nearly 1000 low and medium risk offenders. Consequently, there is a wide variation in practice. Some inter-agency work is strong, although at times the CRC is not engaged in joint work to protect children despite having a court order on a significant adult in a child's life.	1. Increase the management resources in Bristol so that the maximum number of cases managed by staff overseen by one manager totals 750 medium and low risk case. 2. Deliver BGSW safeguarding improvement action plan, which includes re-issuing the up to date safeguarding policies and introducing eLearning 3. Roll out standardised instructions on how to make enquiries through First Response are being rolled out in Bristol team meetings in January and February. 4. Review and publish BGSW CRC Child Safeguarding Policy alongside eLearning. 5. Establish process with the MASH to ensure that where BGSW CRC is working with an adult involved with a child being considered, the probation member of staff provides relevant information regarding a referral within 24 hours of notification.	BGSW CRC	Mar-18	Manager caseloads are now at 750, enabling more consistent management oversight. New MASH process in place.
20.2		Social Workers to be reminded to consider the involvement of probation in all cases and to include relevant probation staff in joint work to protect children.	LA	Feb-18	NPS and CRC have been added to the invitees template for CPC's to prompt social workers to consider CRC and NPS involvement and subsequently ensure invites are sent out.

Ref.	Finding	Action	Lead Agency(ies)	Due	Progress Update
21.1	Inconsistent engagement of the CRC at a strategic and practice level does not support effective multi-agency working to protect children living with neglect. CRC and BSCB are still devising an approach to enable the most effective engagement and participation by CRC in the work of BSCB.	1. BSCB to work with CRC to identify suitably senior representative to the Board 2. Role of CRC to be reviewed within the BSCB transformation process as part of the Child and Social Work Act implementation	BGSW CRC BSCB	Nov-17	New representation agreed for the CRC at the Board. CRC supporting the work of the quality sub group through ongoing multi-agency case audit programme.
22.1	The police have developed some additional training for officers and staff, although inconsistencies remain in the quality of decision-making at the frontline. Incidents are often dealt with in isolation instead of consideration being given to the previous history of incidents and the wider context of risk and vulnerability faced by those affected. The understanding of neglect, the BSCB and the need to make referrals was not clear among non-specialist officers and staff.	1. SCU staff will have an increased ability to review CP/VA cases, enabling a full review of risks, including patterns of behaviour and risk. 2. Mandatory training will continue to be rolled out to all staff in relation to vulnerability. 3. The use of technology at the scene, and more agile working, will enable frontline staff to understand risks faced, previous calls to the address and agencies already involved. 4. Use of BRAG will be mandatory, and monitored via Qliksense and supervisory reviews	Police	Jul-18	1. All staff will undertake streamlined and focused background checks to inform decision on activity required and onward referrals needed. 2. BRAG Masterclass training on wider vulnerability issues has been delivered as above (3.2). All LSU staff have received DA training for the transfer of referral process and a similar approach will be rolled out for SCU staff through our process alignment work. Role expectations and training requirements, including 6 month induction plans are being developed as part of the LSU redesign work due to go live summer 2018. 3. See above 3.2. The BRAG QA work will tie in with the quality and value of recording at the scene. 4. See above 3.2. Mandatory use of BRAG will be built into performance framework.

Ref.	Finding	Action	Lead Agency(ies)	Due	Progress Update
23.1	In a number of cases, referrals were not made to children's social care or there were delays due to the police viewing an incident in isolation, being too adult focused and not gathering the views of children or considering their day-to-day lived experience.	1. SCU staff will have an increased ability to review CP/VA cases, enabling a full review of risks, including patterns of behaviour and risk. 2. BRAG will focus attending officer on vulnerability visible at scene, and will provide evidence required in order to base decisions on whether to share with partners. This includes the lived in experience of children and adults.	Police	May-18	1. See above 22.12. There will be increased scrutiny by LSU staff to recognise and understand patterns of behaviour. 2. See above 3.2. Monitoring of BRAG will ensure that referrals are made correctly, and within agreed timescales, as BRAG will support officer identification where concerns reach threshold.
24.1	The development of quality assurance processes and a reflective supervision approach within the lighthouse team is positive. However, the cases reviewed highlighted inconsistencies that could have been addressed if the force was better able to test the quality of decision-making at every stage of the team's interaction with a child through similar assurance processes. The absence of this routine scrutiny means that the force is missing opportunities to provide more effective interventions at an earlier stage and results in the possibility that children may be left exposed to unmanaged and/or unidentified risk.	1. Rollout supervisory framework SCU staff to increase scrutiny and oversight of cases, including dip-sampling to ensure consistency in decision-making and process. 2. Thematic reviews and audits will be driven via the Constabulary Management Board, which will dovetail with work completed within Safeguarding Board Quality & Performance Sub-Groups. 3. The use of Qliksense will provide an assurance framework, which will highlight inconsistences in supervisory oversight across the force. 4. Mandatory use of BRAG will enable scrutiny around decision making at the scene, and provide opportunities for intervention at an earlier stage, as risks/concerns will be clearly highlighted.	Police	Jun-18	The use of robust quality assurance processes will be developed in line with the introduction of the LSU. This will begin and develop from June 2018 onwards. Issues identified via single-agency audits will be assessed and recommendations given to the CMB and the Safeguarding Boards where appropriate.

Ref.	Finding	Action	Lead Agency(ies)	Due	Progress Update
25.1	In the police incident and investigation logs examined, there was very little evidence of a supervisory footprint. Individual officers appear to use their professional judgement about whether a safeguarding referral is appropriate when dealing with an incident, with little evidence of supervisors having oversight or of quality assuring decision-making. Furthermore, incidents reviewed in the SCU did not provide evidence of professional challenge or escalation of issues.	1. See above re BRAG/Qliksense 2. Audits required to ascertain quality assurance of supervisory reviews, across the force. 3. Monitor use of Escalation policy, as above 4. Performance framework to be introduced within SCU environment	Police	May-18	BRAG is scheduled to go live across the Force by May 2018, although a soft launch has been implemented where training has been delivered.

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26.1	Information sharing is not robust between health services or with partner agencies where information is not stored within connecting care or if professionals do not have access. For example, the paper-based records systems in use in the community children's health teams do not lead to effective information being shared. School nurses and health visitors do not currently have access to the connecting care system and information held by this service is not accessible to other health professionals or agencies. Furthermore, safeguarding records and documents held by health visitors are not routinely shared with school nurses when a child transitions between the services due the size and bulkiness of the paper record. This means that school nurses do not have a complete record of a child's safeguarding history and some information may be overlooked.	1. Ensure all relevant Health Staff and providers of front line services have a plan for their staff to have access to Connecting Care. 2. Pursue funding for electronic record system for Health Visitors and School Nurses. 3. Develop interim process to ensure Health Visitors are sharing relevant records with School Nurse colleagues.	Health	Apr-18	1. Health Visitors and School Nurses all now have access to Connecting care. 2. A bid for partial funding has been submitted to NHSE (£389k). This is on the CCG risk register.

Ref.	Finding	Action	Lead Agency(ies)	Due	Progress Update
27.1	Information sharing between the Bristol Recovery Orientated Alcohol and Drugs Service (ROADS) and GPs is good. This is not consistent with all health services that are supporting the child, as the details of treatment are not always shared. This means that key professionals may not be fully aware of the current risk a parent may pose to a child, or be fully informed of the impact of their substance misuse on their ability to meet the child's needs. In addition, hard copy safeguarding records, such as child protection conference notes and written records of referrals, are held in a hard copy folder separate from the electronic client record system used by the substance misuse service. Actions and outcomes from supervision are not recorded on the system and in some cases we sampled, safeguarding alerts did not contain up-to-date information. This is a fragmented approach to safeguarding record-keeping systems and limits practitioners' access to important information about risk and harm.	1. Ensure all relevant Health Staff and providers of front line services have a plan for their staff to have access to Connecting Care. 2. Pursue funding for electronic record system for Health Visitors and School Nurses. 3. Develop interim process to ensure Health Visitors are sharing relevant records with School Nurse colleagues.	Health	Apr-18	1. Health Visitors and School Nurses all now have access to Connecting care. 2. A bid for partial funding has been submitted to NHSE (£389k). This is on the CCG risk register.

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28.1	Some health visitors have very high caseloads and have not been able to achieve all mandatory healthy child programme contacts. The capacity of the frontline management of the service is also stretched and so routine clinical supervision is not offered to staff. This has been recognised, a new management structure has been created and the posts have been recruited to. However, the benefits of this have not yet been realised and this delays opportunities to identify families in which neglect is a feature.	1. Monitor effectiveness of new management structure against delivery of mandated checks.	Public Health BCH	Feb-18	The quarter 3 data on the progress towards achieving the required performance in delivering the 5 mandated reviews has seen improvement in all reviews ranging from 4.2% to 11.9%. Actions continue to be delivered to ensure continuing improvement. This includes work with Performance Specialist to provide monthly reports / data validation to improve recording of 5 mandated contacts. Ongoing review with teams of how mandated contacts are being offered to improve performance.
29.1	The capacity of school nurses affects their ability to effectively prioritise their work. School nurses are not commissioned to complete universal health needs assessments on school-aged children that could aid the identification of unmet health needs. In the cases seen by inspectors, there is a lack of direct work with children and young people. Links between GPs and school nurses are underdeveloped, and this hinders any proactive work to identify and respond to neglect.	1. School Nurse Core Offer developed and agreed with partner agencies. This will include clarity on School Nurse Responsibilities, including links with GPS and undertaking universal Health Assessments. 2. Consider how new neglect tool can be implemented.	Public Health BCH	Jul-18	The school nurse core offer draft is written and out for consultation. The neglect tool has been agreed at the safeguarding board and its implementation by the school nurse team will be discussed as part of the core offer consultation.

Ref.	Finding	Action	Lead Agency(ies)	Due	Progress Update
30.1	Health and developmental checks completed by health visitors and school nurses are not always timely. These delays may prevent the early identification of unmet health needs and possible neglect, thus hindering children's access to an effective early response.	1. Monitor effectiveness of new management structure against delivery of mandated checks.	Public Health BCH	Feb-18	See 28.1 for progress in Health Visiting. See 29.1 for progress in school nursing.
31.1	Dentists in Bristol do not have a lead practitioner for safeguarding with whom they can consult for advice and guidance on safeguarding issues. Furthermore, there are no formal arrangements for sharing information with dentists, which was evident in our visits to dental practices and our review of cases. These visits showed a generally variable understanding among dentists of safeguarding processes, a lack of awareness of the need or means for sharing information, and little or no knowledge of children on child protection or child in need plans they may have on their patient lists.	1. Establish a lead practitioner for safeguarding for dentists. 2. Establish systems whereby information sharing with and from dentists is embedded, including guidance on how to check whether children are CIN or subject of a Child Protection Plan.	NHS England	Apr-18	1. A proposal for a Safeguarding Lead across practices in Bristol has been put forward to NHS England. NHSE will seek to engage the Dental Advisor network into promoting the safeguarding agenda as specialists, trained to Level 3 in order to be a conduit for safeguarding knowledge for dental practitioners. 2. Both local and national developments in safeguarding will be circulated at least quarterly via the Dental Bulletin. This will include a link to the BDA website which contains good safeguarding information. Dentists can also contact the designated professionals for advice on an ad hoc basis. Safeguarding newsletter has been prepared and will go out with the Dental Practitioner bulletin to all practices in the South West.

Ref.	Finding	Action	Lead Agency(ies)	Due	Progress Update
32.1	Bristol ROADS follows a protocol to ensure that storage facilities for clients who are accessing opioid substitution treatments are viable and enable medicines to be safely kept away from children. The protocol in relation to clients with children under the age of five relies on a visit and visual check being carried out by associated professionals who report this to the Bristol ROADS shared care worker. However, the service does not monitor whether this check is complied with and so managers cannot be assured that the protocol is met.	ROADS to provide assurance that they are following their safeguarding guidance on safety of medicines, via monitoring and audit	ROADS	Apr-18	New contract in place - audit to be carried out in April 2018.
33.1	In families in which there are significant histories of parental mental ill health or drug use, multi-agency plans lack sufficient focus on these factors. Children in need and child protection plans do not fully consider the impact of this on parenting and consequently lack actions designed to address these concerns. In most cases where there has been involvement of adult services, the involvement has been limited, and there is little evidence of professionals promoting parents' full engagement in the interventions available.	1. BSCB to introduce new guidance about working across children and adult services	BSCB	May-18	New Joint Working protocol for working across children and adults services drafted. Due to be agreed at the May Board.

Ref.	Finding	Action	Lead Agency(ies)	Due	Progress Update
34.1	When neglect of children is a result of parents' mental ill health, agencies do not always make referrals to adult mental health services. The lack of involvement and information sharing with adult mental health services does not support effective multi-agency working.	1. BSCB Parental Mental Health multi-agency training offer to be increase to professionals in 2018-19 2. BSCB to seek assurance from the Children and Families Partnership Board about the focus and effectiveness of work in this area.	BSCB	May-18	New Joint Working protocol for working across children and adults services drafted. Due to be agreed at the May Board. Training on Parental Mental Health increased in the Training Offer from April 2018.