

Meeting: Children, Education and Skills Sub-committee
Date: 16 November 2015
Title: North Tyneside Safeguarding Children Board's Annual Report 2014/15

Author: Elizabeth Kerr, Democratic Services Officer Tel: 643 5322
Service: Law and Governance
Wards affected: All

1. Purpose of Report

To provide the Sub-committee with an introduction to the Annual Report of the North Tyneside Safeguarding Children Board (NTSCB).

2. Recommendation(s)

The Sub-committee is recommended to consider, make comment upon and note the NTSCB's Annual Report.

3. Details

- 3.1 The Sub-committee had established a sub group to examine arrangements in place in North Tyneside to protect young people in the borough from child sexual exploitation. As part of its work it had met with the Independent Chair of the NTSCB to discuss the Board's work.
- 3.2 During discussions with the Independent Chair, Mr Richard Burrows, it became apparent to the members that the Annual Report was a document which should be examined by the Sub-committee. One of the recommendations of the Child Sexual Exploitation Sub Group is that the Children, Education and Skills Sub-committee should be receiving the NTSCB's Annual Report every year.
- 3.3 Whilst the Sub-committee has yet to endorse the recommendations from the Sub Group, the Chair of the Committee agreed that the Annual Report for 2014-15 should be submitted to the meeting closest to its publication.
- 3.4 The NTSCB Annual report was finalised in October 2015 and is enclosed for the Sub-committee's attention.
- 3.5 Mr Burrows has accepted an invitation to attend the meeting.

4. Appendices

- North Tyneside Safeguarding Children Board's Annual Report 2014-15

North Tyneside Safeguarding Children Board

Annual Report 2014/15



Contents of this report

- | | |
|---|-------|
| 1. Introduction | pg 3 |
| 2. Independent chair's Executive summary | pg 5 |
| 3. Local Safeguarding Children Boards – some background information | pg 9 |
| 4. The Local Context – some information about children and services in North Tyneside | pg 10 |
| 5. The National Safeguarding Context | pg 11 |
| 6. North Tyneside Safeguarding Children Board (NTSCB) – information about how the Board is organized | pg 15 |
| 7. Review of 2014 – 15 –what we achieved, including a review of joint working arrangements to protect children and promote their welfare | pg 20 |
| - Policies, procedures and protocols | |
| - Working together standards | |
| - Performance Management | |
| - Training | |
| - Use of learning to improve practice | |
| - Safe recruitment and allegations management | |
| - Private fostering | |
| - Partnership working | |
| 8. Summary and the Sufficiency question - Looking at the report as a whole what view has the Board formed as to the “sufficiency” of joint working arrangements to protect children and the effectiveness of the Board. | Pg 41 |

1. Introduction

Welcome to our Annual Report for 2014 -15 which provides an account of what the Board and its members have achieved during the year. It is an assessment both of the impact of these efforts and the overall position of joint working arrangements to safeguard children and young people in North Tyneside.

We hope that you will find that the report helps you to better understand how organisations and people work together, the contribution the Safeguarding Board has made to this. It sets out how these arrangements can continue to improve on the basis of the Safeguarding Board and partners being able to objectively and critically learn from what works well and act to improve what may not work as well as was intended.

The report is organised in 2 main sections. The first considers the context, the role of the Safeguarding Board and forms a view of the overall position regarding the effectiveness of joint working arrangements to protect children and young people in North Tyneside. The second section looks in more detail at how the Board has fulfilled its statutory responsibilities and forms a view as to how effective this has been. Seen together this contributes to the forming of a wider view of and judgement about how well children and young people are protected in borough.

We have tried to make this report as easy to use and understand as possible, but as safeguarding is a complex area involving literally thousands of people from many different organisations and professions, it may not fully succeed in this. The report will therefore seek to summarise, and provide some examples as well as links to further information and evidence.

The report is intended to provide you with enough information improve your understanding of joint working arrangements to protect children and young people in North Tyneside, and to assist you in forming your own view as to the effectiveness of these arrangements on the basis that “safeguarding children, young people and adults is everyone’s business”.

As a public record the report provides the opportunity for dialogue and also seeks to provide a challenge to all concerned, and invites challenge to the Board and its members, as to how we each can play a full and improving role in ensuring that children and young people do not suffer harm, neglect or abuse.

About this report and how to get the best from it

[Working Together 2015](#) sets out that the Annual Report should provide a rigorous and transparent assessment of the performance and effectiveness of local services. This report identifies areas of strength and weakness, the causes of those weaknesses and the action being taken to address them. The report includes lessons from serious case reviews undertaken within the reporting period.

It is also an assessment of the effectiveness of the Board and the partnership it represents and this judgment is made on the basis of providing an account of and an account for how the Board fulfilled its statutory functions and responsibilities.

The report was formally commissioned by the Board in March 2015 and was signed of by Board members ready for publication on 28th September 2015. Once Board members have had time to consider the learning and implications of the report, an Executive Summary will be published in Autumn 2015 and this will reflect the actions we have agreed to take to amend our current priorities and business plan.

We have included a glossary of terms used and wherever possible we have sought to avoid the use of acronyms, overtly technical language or jargon. If we have fallen short in this respect or you have any other questions or queries then please contact

In order that the report is as concise and focused as possible we have used hyperlinks to take you to fuller information and/or supporting evidence. If you are not able to utilise these then please contact us and we can arrange for this information to be made available.

If you require a version of this report in a form or language that would assist in accessing the report contact us.

This report was written by the Independent Chair and the Board Business Manager drawing on contributions from chairs of the sub groups and board members

The report is formally sent to;

- The Chief Executive of the Local Authority
- The Chair Person of the Health and Wellbeing Board
- The Police and Crime Commissioner for Northumbria
- The Chief Executives and/or senior leadership of all organisations who constitute the LSCB. (For membership see appendix 1)
- The report is published on the LSCB website
- The report is formally tabled at the Health and Wellbeing Board, The Children, Young People and Learning Executive, North Tyneside Council Scrutiny Committee, Safeguarding Adult Board (SAB), North Tyneside Community Safety Partnership and North Tyneside Domestic Abuse Partnership.

Board members assume responsibility for ensuring the report is considered within their own organisations.

2. Independent Chairs Executive Summary

In our last annual report we signalled that we knew there were changes we needed to make and the reasons for this, and we hoped that we had laid a set of sound foundations. This report confirms that we did and we have continued to have a full and active contribution by board members. Who increasingly have demonstrated their willingness to look at things in new and sometimes difficult ways, so as to be sure that children and young people are being safeguarded in the most effective way as possible.

Members have also maintained a commitment to developing the capacity to achieve an improved “line of sight” and the requirements this has for the work of the sub groups.

It is too the credit of members and a confirmation of the vision and principles identified at the review day, that as a board we were more alert to and prepared to address when things were not going as we planned.

In addition to some significant changes of personnel within the Board going forward, a number of partner agencies continued to experience major organisational transitions. So that when seen alongside the increasing demand and complexity of the LSCB role, it was perhaps with hindsight inevitable that there were some areas of shortfall.

I am satisfied as the Independent Chair that these were recognised by the Board and owned, and that as a result of appropriate and proportionate challenge actions were either taken or promised. The dilemma such situations present board members with is to assess the significance of such shortfalls even if these are temporary, most importantly as to whether this might mean that children are not safe and/or that this impacts on the LSCB capacity to determine this.

Rightly as a Board we are able to draw on a wide range of assurance sources, and although at times in the year progress and our own performance were slower than we had hoped for, we were assured that the quality of scrutiny and the openness of relationships enabled the board to fully consider the risk and implications.

The challenge, which has already been embraced by partners, is to learn from this, and be in a position to provide the LSCB with the resources and information that it has been

agreed it needs. In order that it can continue to progress its robust and innovative approach to PMQA and setting standards through Section 11 assurance.

The above remarks are to not diminish or obscure the wider range of thorough, careful and considered monitoring, reviewing and learning that have taken place during the year. This supports and evidences the view that the Board meets its statutory responsibilities. Such reports often fail to capture the informal and discrete learning and challenge that takes place. This is an important dimension of successful joint working and the evidence from the various learning events and multi agency training confirms and assures that at the front line there are strong models of and examples of, informed, directed and purposeful joint working. This was further evidenced by the response to multi agency audits, where the board was impressed by the feel it gave them of issues for those in the front line of services. This enabled members to either be assured or to make further enquiries leading to requirements being placed on partners.

The annual report is now required to comment on and assess the effectiveness of the strategic and partnership response to Child Sexual Exploitation, and details of this can be found in the report. As Independent Chair I would observe that I saw during the year a significant series of steps taken by partners to better understand and ensure that a joined up response was in place. The Board and the Council were swift to respond to the learning from the Jay Report, and a regional master class was helpful in ordering priorities. Over the year the Board has moved into its leadership role in respect of a strategic and an effective operational response to CSE. Northumbria Police have been proactive in sharing their learning from operational experience, and this has ensured a high level of focus on the front line. However this has for a number of reasons, the level of local strategic focus and accountability that had been looked for by the Board fell short of what had been hoped for. As a Board we were quick to raise this and the force has been responsive to this, and in the current year we are hoping to see improved information sharing and reporting, alongside a risk assessed assessment of progress against the action plan. As a Board we have also recognised that the learning from the response to CSE has direct lessons for the wider approach to safeguarding and we are committed to developing this further.

It is important however to note that despite the above developmental issues which have been quickly addressed and to date the improved level of reporting and scrutiny has not indicated that previous assessments of progress and response were inaccurate. There has also been a strengthening on the wider scrutiny and assurance processes across the

Council and other partners have directly reported into the board their position and response on a regular basis.

This report, therefore supports a view that the whole system has demonstrated high levels of commitment across the partnership and the child's journey. Both the CCG and the Health Trusts demonstrated and evidenced a proactive and a learning approach to safeguarding in the context of joint working practice and their contribution to the LSCB. The CCG in particular has maintained and improved its contribution to and leadership role in respect of CDOP and this ensures that the Board is assured that we are learning from child deaths and have an insight into the complex arrangements around health provision. As a Board we have earmarked the desire to make further progress in responding to this complexity and the changing nature of the health economy. We have welcomed the active contribution of Public Health colleagues and are in a position to look for further evidence of their contribution to the safeguarding agenda.

I would also want to comment that this report confirms that the Council despite the many pressures it faces has demonstrated not only its commitment to safeguarding, but its willingness to respond to and be influenced by the voice of the LSCB partnership. As a Council it has an inclusive and an integrated approach to its leadership role in identifying local needs and setting priorities and the CYPP Plan has laid out an innovative framework for taking this forward. Partnerships have jointly acknowledged the learning potential this represents and are committed to giving this further shape and substance in the coming year. This has been replicated in terms of the relationships between the LSCB and the HWBB and the SAB.

Although the LSCB's capacity to present an as yet fully formed PMQA impact, largely as a result of practical and resource based challenges, ground has certainly not been lost and there has been some progress. Not least of which have been some consistent examples of both quantitative and qualitative driven reporting of performance and quality of practice that have enabled the Board to be assured or given ground for further enquiry and challenge. Arrangements around Early Help are one example of this where as a result of scrutiny and challenge partners are looking at how they can improve the evidence base for the effectiveness of arrangements. In order that the strategy and arrangements can more effectively evidence how they meet needs and manage risk at an earlier point. So as to lessen the need for children and their families to become involved with statutory services. The year has seen both the Board and partners arrive at a clearer position as what needs to be done to further develop the strategy and the board will support this throughout the

revision of the Thresholds documentation and guidance, the adoption of specific measures for monitoring performance in addition to those already in place and development of training and learning opportunities.

Schools and front line professionals as well as colleagues from the voluntary sector have contributed to the work of the LSCB in the year, and there has been a growing recognition that as early help develops their role in ensuring that children are protected and in being a part of the LSCB will change. One of the key steps in this has been to include schools in the Section 11 self-assessment and to look at how we strengthen their role as Board members and system leadership.

For some partners it is becoming harder for them to justify limited or diminishing resources and contribute to the work of the LSCB. It is a mark of the strength of the LSCB partnership that for partners such as CAFCASS and to some extent NHS England there has been an open debate about how contribution and participation can be maintained and this is to the credit of their organisations and the board members concerned.

The report rightly highlights the continuing dilemma of how to respond to an increasingly complex agenda to higher standards from an inclusive basis and a limited resource base. It was not necessary in the year to find solutions to this dilemma, though it was looked at by the Board through its risk management arrangements, but with hindsight this report does perhaps illustrate that in the present year it may not be possible to postpone finding a solution, if the Board is able to raise its standards and meet expectations.

One of our continuing priorities is to better understand and engage with how children, young people, their families and communities understand safeguarding. We have maintained our progress in this area, and in the year decided to invest in both a stand-alone website and a new approach to engagement and awareness raising. This is still in its early stages but when seen alongside our approach to Section 11 represents a clear direction albeit presently as a principle, to looking at how we with the other strategic partnerships further engage the public role and responsibilities in terms of safeguarding.

There are of course many more challenges and opportunities and the report draws your attention to these in the context of the statutory responsibilities we hold. This report invites partners and all who read it to form a view based on the evidence of not just the “sufficiency” of joint working arrangements to protect children and young people and the promotion of their welfare, but also of what is required to ensure that everyone whoever they are is “sighted” on the risks and dangers that children and young people face. This

produces the further and essential challenge that at every point when there is a concern or a danger, that action can be taken that is proportionate, child focused and effective. This is the primary concern of the LSCB partnership to ensure that there are clear standards that people know how to recognise neglect or abuse and know how to respond and who else to involve.

It is the view of the Board that this report provides a level of assurance and a level of challenge on the basis of strong and effective partnership working that is undertaking both significant transitions and improvements to further ensure that children and young people are protected, that as far as is possible the factors that can contribute to neglect and abuse are addressed and that the joint working culture is focused, aware and able to learn so as to improve.

Richard Burrows – Independent Chair

3. Local Safeguarding Children Boards

Local Authorities are required to establish a Local Safeguarding Children Board (LSCB) under Section 13 of the Children Act 2004. The Children Act identifies specific organisations and individuals who should be represented on the LSCB which includes (but is not limited to):

- the Local Authority
- the police
- Probation
- Youth Justice
- Health organisations
- CAFCASS

In North Tyneside membership reflects the breadth of the safeguarding agenda and is compliant with working Together 2015 (see appendix 1).

LSCB's have a range of roles and statutory functions including developing local safeguarding policy and scrutinising whether agencies who work with children are doing what they said they would. An LSCB is not directly responsible for the provision and delivery of services but does seek to make sure that protecting children is a shared priority amongst agencies who work with children and their families. The statutory objectives and

functions of LSCB's are set out under Section 14 of the Children Act 2004. These functions are:

- a) To coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
- b) To ensure the effectiveness of what is done by each such person or body for those purposes.

Further clarification of the function of LSCB's can be found at:

www.legislation.gov.uk/ukxi/2006/90/regulation/5/made

4. The local context

North Tyneside has a resident population of around 201,400 (Office of National Statistics 2012) greater than at any other period since 1981. The population continues to grow and 2010 based projections show, that if current trends continue, the population would rise to 224,900 in 2035, an increase of 13.4% from 2010. The future population is expected to include increasing numbers of people aged 65 and over, largely because people are living longer. As of 2010 the number of 0-18 year olds in North Tyneside was 35,000. Challenges to partners in relation to population changes across North Tyneside are in relation to being able to prepare for the likely rising demand for services for children and vulnerable older people

The 2011 Census suggested the black and minority ethnic population (BME) of North Tyneside was 4.6% (which equates to 9,269 residents), almost doubling since 2001.

The main ethnic groups within this were 'Asian/Asian British' at 1.9%, 'white other' (e.g. from elsewhere in Europe) at 1.2%, 'mixed/multiple ethnic groups' at 0.9% and 'Black/African/Caribbean/Black British' at 0.4%.

For religion, the 2011 Census suggested 63.8% of North Tyneside residents were Christian, with 0.7% Muslim, 0.3% Hindu, 0.3% other religion, 0.2% Buddhist and 0.2% Sikh. The proportion of people in North Tyneside with no religion was 28.1%, with 6.4% not stating a religion.

North Tyneside is now one of the least deprived areas in the North East of England. However, some areas in North Tyneside continue to experience relatively high levels of deprivation. 30% of these areas in North Tyneside are ranked as being in the most

deprived 25% of all in England. Most of these deprived areas are in the South and North West of the borough and this has been a persistent issue for a number of years. Currently one in five children in North Tyneside live in poverty.

North Tyneside has a track record of high attainment amongst school age pupils that has continued. This year's provisional GCSE results showed that North Tyneside's overall performance for five or more grades A* - C, including English and Maths, was 64%. This was 2% higher than last year and it continues an improving trend.

Improvement has been made at Key Stage 2 for children eligible for free school meals, while results for Looked After Children at key stage 4 (5+GCSEs A*-C including English and maths) were among the top quartile nationally in 2012.

The attainment of our pupils is supported by a high quality educational infrastructure, in which 84% of the borough's schools are now rated as 'good' or 'outstanding' by OFSTED.

The borough's NEET (Not in Education, Employment or Training) rate amongst 16 - 18 year olds is at its lowest recorded level of 5% (2013). North Tyneside had low levels of young people achieving higher-level qualifications at 19 years of age but expanding vocational pathways and building up high quality apprenticeship opportunities has meant that the proportion of young people achieving a level 2 qualifications at 19 is above the national average for the first time.

The North East region has the greatest rate of Looked After Children and Children subject to Child Protection plans across the country. North Tyneside is no exception with the number of Looked After Children 29% higher than that in 2008 and Child Protection Plans 19% higher over the same period.

5. The National Safeguarding context

Partner agencies continued to face the dual pressures of meeting changing and in many case rising patterns of demand and the need to contend with static or reducing budgets. At the same time expectations in term of performance, effectiveness and accountability developed in part as a result of the understandable reaction to the lessons highlighted as a result of CSE and the continuing convictions of high profile public figures for child abuse, which in turn has highlighted the very real challenges organisations and institutions face in achieving transparency in terms of the past and ensuring that present safeguarding arrangements are effective.

It is not possible to assess the impact of this in terms of public awareness or importantly in respect of safeguarding their level of trust and confidence in the “system”, organisations and professionals.

This has in part served to increase the expectations placed on LSCB's and their partners.

During the year we have also continued to see further change and developments in terms of how and where 'governance and accountability' responsibilities are located for example with the extension of Academies and Free Schools in the education sector. Also in the year we saw continued changes to the ways in which and from where services were commissioned and continued developments in the structure, operation and governance of health services.

The impact of historical abuse allegations, prosecutions and reviews gained further significance in the year with a number of high profile 'celebrities' being convicted, and the working through of reviews and reports across a number of sectors as a result of past convictions impacting on partners and LSCBs. The welcome and increasing focus on listening to and acting on the experience of victims has created an additional dynamic that has further challenged us, and we saw the first difficult steps being taken to commission a national enquiry.

Perhaps the most significant influence and development in the year was the important response to and understanding of Child Sexual Exploitation. The Jay Report re CSE in Rotherham and the subsequent Ofsted Thematic CSE inspection served to heighten and focus the agenda. This dominated both the public and the policy agenda, bringing out the best and the worst of how as a society we respond to such learning.

The year also saw the recognition and better understanding of the range of issues around Female Genital Mutilation (FGM) which further challenged us to be able to understand and engage with cultural and religious based practices and beliefs in the context of the law and the need to ensure that children and young people are protected irrespective of particular cultural and religious justifications for illegal acts.

Issues relating to public safety in the light of the perceived threat to national security by terrorism and the risk of radicalisation of children and young people were also a significant influence in the year, and demonstrated the need for the various strategic partnerships to work more closely together. As with all public and media informed debate there was

challenge in the year to ensure that responses were proportionate especially in relation to safeguarding, radicalisation and the balance between rights and responsibilities.

These and other developments have placed further pressure on the various sectors and areas including the “third and community” sector, which has had a number of impacts on safeguarding nationally and therefore locally;

- An increasingly complex policy and provision landscape.
- Challenges about how best to maintain priorities and match resources to meet existing and new statutory obligations and responsibilities.
- A continuing challenge of how to find the right balance between national and local approaches and priorities, the emphasis placed on responding to acute or crisis factors set against the capacity to invest in longer term preventative and development programmes to meeting need across a social policy, economic, health, law and order, and education landscape.
- In terms of safeguarding, this has raised two challenges; how best to ensure that safeguarding remained a priority in real time and current commitments, and to what extent can “safeguarding” be seen as an integral part of the broader response to the wider challenges and pressures.
- The year also saw significant proposals and developments to clarify and change the expectations of and legal requirements placed on groups of professionals.
- For partners in the education and health sectors there continued to be changes to the ways in which provision and safeguarding were organised and overseen.

In safeguarding terms the year saw the following;

- The continued impact of changes made to Working Together in 2013 as a result of the Munro review of child protection and consultation regarding further changes and developments resulting in further revisions to Working Together in March 2015.
- A growing understanding of the expectations and implications of changes regarding Serious Case Reviews (SCR) from the National Panel of Experts through the publication of its first annual report. Although there was some evidence in the year that SCR models and methodologies were starting to bed in, this remains a difficult and challenging area for all concerned.

- The publication of some 61 SCRs nationally served on most occasions to raise awareness and understanding but remained in some instances a point for questions to be asked about the effectiveness of joint working to protect children.
- Ofsted and its inspection programme and the publication of its Annual Report continued to be influential. Some steps were made in respect of moving towards a different approach to inspection on the basis of joint inspectorate led inspections, especially relevant in respect of LSCBs, so it was disappointing when this was subject to further delay. However other inspectorates were able to evidence how they incorporated a common approach to the assessment of safeguarding. The current approach to inspection which in the year included the inclusion of LSCBs as a separate focus for review, remained an area of debate, especially in respect to the quality and consistency of judgements and the extent to which these fully take into account the fragile nature and importance of public confidence in safeguarding.
- Nationally the Association of LSCB Chairs was able to evidence impact and influence and has provided Chairs and LSCBs with access to support, information that has enabled steps to be taken toward promoting more effective LSCBs and improved sharing and consistency.
- LSCBs had placed on them additional expectations in respect of both Child Sexual Exploitation (CSE) and Female Genital Mutilation (FGM), to provide leadership and accountability for the effectiveness of partner responses.
- As the year progressed there were encouraging indications that government was seeking to promote a Ministerial and cross-departmental focus on issues relating to safeguarding with the announcement of a Ministerial task force in March.

Summary

Safeguarding in the national context has in the year been subject to high profile and often-volatile attention at all levels of the system and across society. This had produced a further challenge on local partnerships including the LSCB to respond and manage the implications of this attention so that this results in changes that further demonstrate the effectiveness of partnerships and local joint working arrangements.

Whilst this has served to produce a focus, it has also demonstrated the increasing difficulty for partnerships to be able to do more with less as well as doing it differently and to

continue to attend to the other key areas that ensure children and young people are protected.

6. North Tyneside Safeguarding Children Board (NTSCB)

North Tyneside Safeguarding Children Board brings together key agencies to coordinate safeguarding and joint working arrangements to protect children and young people in the borough. We ensure partners are held accountable for the effectiveness of their safeguarding practice.

We also have to demonstrate and ensure that the Board is effective in how it does this (NB the report needs to highlight what people do in terms of partnership working and how as a Board we set the standard for this, how we measure this and how we know it has an impact). This report is part of a continuous process of review and evaluation and after its publication the Board will use the learning from the report to review its business plan.

What we do

The Board's main responsibilities comprise:

- Case reviews, including the Serious Case Review function;
- review of all child deaths in North Tyneside;
- support for joint working to protect children, through the provision of policies, procedures, protocols and best practice guidance;
- effective multi agency safeguarding training, including direct provision;
- arrangements for managing allegations regarding an individual working with children; and
- advice on safe recruitment.
- the evaluation of the effectiveness of Early Help arrangements

The Board believes that the responsibility for children's safety is shared by the whole community. The Board want everybody to know:

- how to recognise when a child may be at risk of being harmed, abused or neglected
- what we should do about this and who we should speak to

- what is expected of us and what to expect from the professionals who protect children.

The Local Safeguarding Context

Partners in North Tyneside were not immune to the pressures and learning resulting from the national context, and have maintained a consistent and strong focus on safeguarding in the year. The year also saw in part as a response to the learning from CSE and the Jay Report and the challenge produced by the LSCB a number of important steps to ensure improved monitoring, sharing of learning and clarity re strategic roles and priorities.

The Safeguarding Adult Board proactively responded to pending changes as a result of the Care Act, and there was regular liaison between the 2 chairs to ensure that there was effective communication and collaboration, with the intention of agreeing a protocol for how the Boards will work together in the coming year.

The Children and Young Peoples plan was driven forwards informed and advised by local strategic forums and close links with the LSCB chair. This plan seeks to put in place the optimum conditions and services to ensure that children and young people at key points in their “journey” have access to the right services and support to ensure they achieve highly.

The contribution made by partner agencies to the LSCB

All LSCB member organisations have an obligation to provide LSCB's with reliable resources that enable the LSCB to be strong and effective (Working Together to Safeguard Children 2015). This includes consideration on how the resources for training, including joint training, should be made available with responsibility equally shared among statutory partners. Some partner agencies contribute financially to the Board (appendix 3) and others provide staff, venues and services.

Board membership

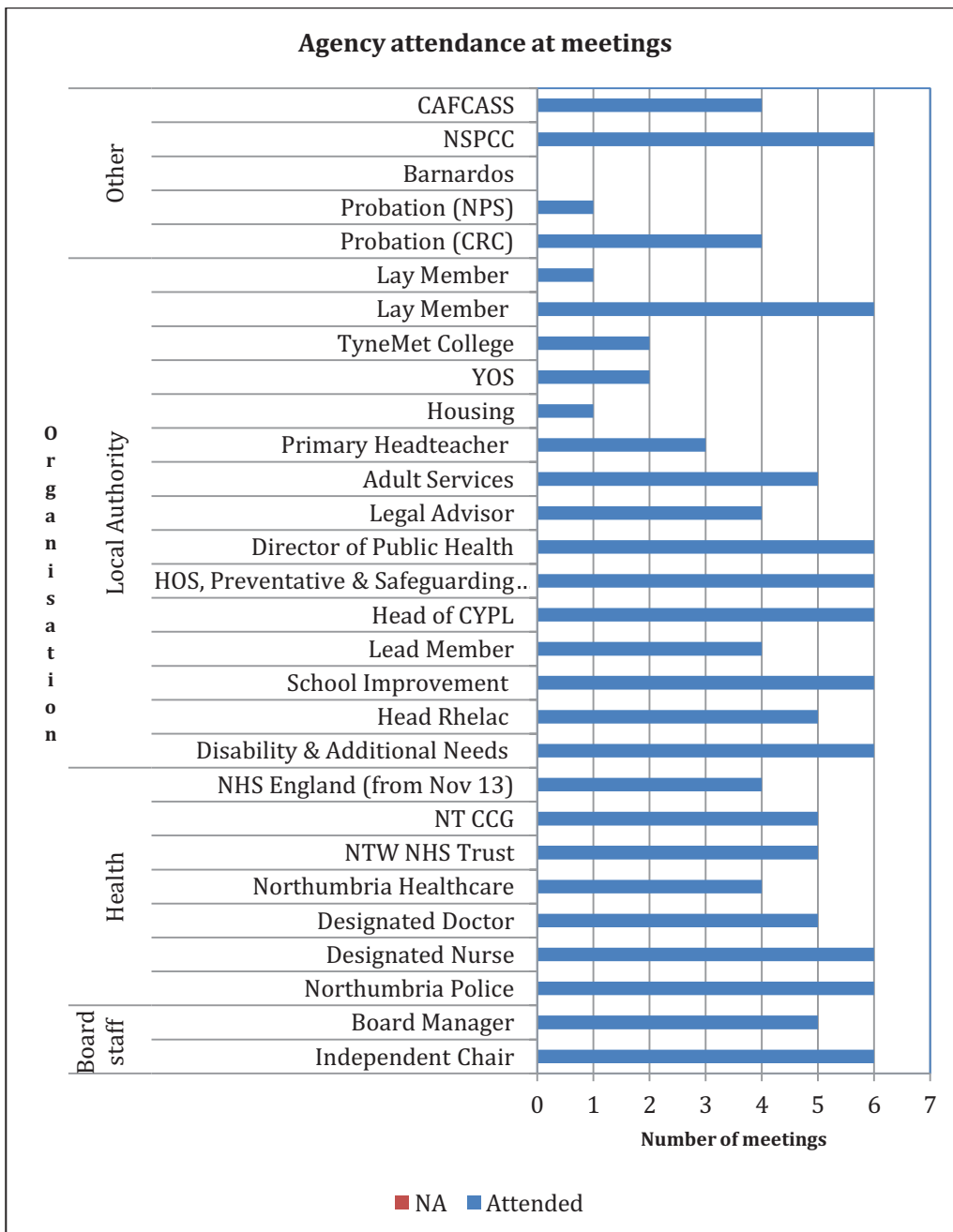
In appendix 1 you will find a full list of the organisations that are represented by Board members. These have to be senior people in their own organisations who are able to influence how their organisations prioritise the safeguarding of children. They also have to be able to speak for their organisations and make sure that the decisions and recommendations the Board makes are followed through.

We have 2 lay members who are recruited from the community and play an important role in helping the Independent Chair and other members make sure the Board has an independent voice and considers things from all points of view.

The Lead Member for Children and Young People also sits on the Board as a “participant advisor” this means that he or she can contribute to discussion but does not have the same responsibilities as other members.

In addition to the members the Board also benefits from the advice provided by its advisors and these are also listed in the appendix. The Board met bi monthly during 2014/15 and held one development session for members. The table below shows attendance by member agency or individual during this period.

In addition to the members the Board also benefits from the advice provided by its advisors and these are also listed in the appendix. The Board met bi monthly during 2014/15 and held one development session for members. The table below shows attendance by member agency or individual.



Attendance at Board meetings is one important measure of the contribution that partners make. Overall, attendance by members was generally good. During the year there were some changes in agency representatives with new members joining from NTW NHS Trust, Barnardos, Adult Social Care and Housing. Additionally;

- Lesley Young Murphy, Executive Director of Transformation and Nursing was appointed to the role of Vice chair
- one of our lay members left to focus on other commitments and Jill Prendergast was welcomed as our second lay person in May 2015.

- Probation services moved to a new service delivery model which means the 35 probation trusts were replaced by 21 Community Rehabilitation Companies (CRC's) who supervise low and medium risk offenders and a new public sector organisation, known as the National Probation Service (NPS) who supervise high risk offenders. Both organisations are now represented on NTSCB

There have been some significant changes to membership going forward as several key members left in March 2015. These were the Designated Nurse, Safeguarding Operations Manager (Children's Social Care), School Improvement Lead, Director of Public Health and the Safeguarding Lead, Tyne Met College. All of the new appointee's to these posts have become Board members.

In relation to police involvement, organizational changes are planned for 2015/16 as Northumbria police move from six area commands to three. North Tyneside and Northumberland will be one area command. It is anticipated the planned changes will increase capacity for involvement in Safeguarding Board activity across the region.

The different changes have also impacted on the chairing of the sub groups and new Chairs have been appointed as follows;

- Business Group, previously chaired by the Safeguarding Operations Manager, Children's Social Care and now chaired by Russell Pilling, her predecessor
- QILP, previously chaired by the Designated Nurse and now by Jane Abbott, Safeguarding Lead Northumbria Healthcare
- CDOP previously chaired by the Chair of Newcastle SCB and now independently chaired by Sheila Moore.
- Case Review sub group previously chaired by the Director of Public Health now chaired by the Designated Nurse.
- Training sub group, currently vacant as the previous Chair, the Workforce Development Manager, NTC, left following a restructure.
- Vulnerable Adolescent sub group is chaired by Northumbria police and has experienced several changes of chair due to competing demands on police resources.

Sub Groups

You will see the sub groups that operated during the year by looking at appendix 2.

The Safeguarding Management Group, the Executive Group who is responsible for progressing the Business plan and monitoring the work of the sub groups is now known as the Business Group, which better reflects its role. Representation and attendance at the sub groups by the Police has been problematic and has been formally raised with Northumbria Police by the NTSCB Chair. As previously mentioned it is anticipated that the proposed changes to the structure of the Protecting Vulnerable People Units who are responsible for safeguarding, will increase capacity and consistency of attendance.

NTSCB Independent Chair

In accordance with Working Together 2015, NTSCB has an Independent Chair who works closely with all NTSCB partners and particularly with the Head of Children, Young People and Learning, North Tyneside Council. The Independent Chair is appointed by the Chief Executive of the Council.

Richard Burrows joined NTSCB in April 2014 and his role includes overseeing the work and strategic direction of NTSCB and providing leadership, scrutiny and challenge. He also promotes and champions safeguarding as a key priority for partner agencies and wider stakeholders and provides leadership to the work of serious case reviews and child death reviews.

7. Review of 2014/15

The Annual Report for 2013-14 posed some key messages and challenges for the present year and these were addressed through the planned review of our business plan and a review of our priorities so that we could be sure we implemented and acted on the learning from last year. The Board and its partners have made steady progress in delivering against their shared priorities and some of these areas of work have been carried forward into 2015 onwards. Below are some of the key achievements;

Early identification and assessment particularly where neglect may be an issue

- ✓ A review of the multi agency training materials in relation to neglect which reflect current research and good practice
- ✓ Additional resources available to practitioners undertaking assessments where neglect is a feature
- ✓ Introduction of the NSPCC 'Thriving Families' in North Tyneside who work collaboratively with families and professionals to tackle child neglect. The aim is

to improve parenting capacity and improve the lives of children by a thorough assessment of the level of neglect, to identify the most appropriate interventions.

Next steps

- ✓ Work continues on developing performance measures in relation to the early help agenda which will inform our understanding of how effectively neglect is identified and addressed at an early stage
- ✓ A review of the NTSCB Thresholds Guidance to reflect service delivery changes

Vulnerable Adolescents

The main focus of the work has been in relation to child sexual exploitation (CSE) which remains a priority area for NTSCB and its partners.

- ✓ Following the publication of the Jay Report a briefing session was held for senior managers from all partner agencies with the aim of sharing the learning specifically in relation to the role of senior management
- ✓ Guidance for professionals has been revised in line with the 'See Me Hear Me' framework
- ✓ CSE briefing sessions have been held for school staff and all schools, except 2 sent a representative. Resource materials were shared for use with pupils.
- ✓ Criteria to meet the 'Healthy schools' standard now requests evidence of how CSE is included in the PSHE agenda.
- ✓ CSE is included in all school safeguarding training
- ✓ A child sexual exploitation training – school survey has been sent to all schools to establish how they are disseminating key messages in relation to CSE and any training needs they may have
- ✓ The Section 11 self assessment tool includes asking respondents to comment on their strategy to raise awareness in relation to CSE. This will assist the NTSCB in strengthening their assurance that single agencies are meeting this responsibility in relation to the CSE agenda
- ✓ The missing Children joint protocol between the police and the local authority has been reviewed, updated and endorsed by NTSCB.

Next steps

- ✓ Revised data collation methods to be implemented in relation to the number of concerns in relation to CSE and/or missing children episodes to inform our understanding of prevalence
- ✓ The appointment of a specialist worker from SCARPA by Children's services will provide the opportunity for advice and guidance to staff and will provide a to undertake work with identified young people at risk of, or involved in CSE
- ✓ It is acknowledged that progress needs to be made in relation to raising awareness work with licensed premises, hotels and taxi companies
- ✓ Explore joint working approaches with the Safeguarding Adults board and the Community Safety Partnership
- ✓ Improved monitoring and assessment of the progress and impact made in relation to the CSE Strategy and Action Plan in order that the Board can fulfil its responsibility to publish regular assessments.

The vulnerable Adolescent sub group who have responsibility for progressing the CSE agenda have struggled to obtain data in relation to the number of concerns/referrals to assist them in understanding the extent of the issues and any emerging themes. This would extend to performance in relation to return interviews. It appeared there was no robust system to record interviews and the low numbers of return interviews recorded did not necessarily reflect the work and communication with young people and their families/carers. The Board was assured as a result of challenge of Children's Services that from 1 April 2015 that system changes would improve recording and collation of performance and subsequent data would confirm this.

Northumbria Police are also working with their IT departments to ensure that the force is able to accurately capture CSE data in 2015/16 and going forward. The data can then be used to provide detailed problem profiles of CSE, which can be shared with partner agencies and support multi agency working to tackle CSE more effectively.

The police are also in the process of establishing Team Sanctuary, which will build on the work of Operation Sanctuary, which investigates allegations of a sexual nature against vulnerable young people and adults. This involves the team tackling the wider issues of sexual exploitation, vulnerability and modern day slavery. It is the intention that two multi agency teams will be established north and south of the Tyne, and work from community

based hubs. These hubs will bring together the police and a broad range of partners including from the voluntary and community sector. A social worker from North Tyneside will be seconded in to the team for a 2-year period. The hubs will support joint working to support victims and ensure access to specialist services.

North Tyneside Council have recently established a missing, Sexual Exploitation and Trafficking (MSET) group, a broad multi agency group that reviews high risk cases and offers support and challenge to social workers working with cases of CSE. It specifically considers the most prolific children in terms of missing episodes, important given the links between missing and risk of CSE. The Vulnerable Adolescent sub group will maintain links with MSET to understand the issues and themes arising from actual cases.

Listening to children, young people and their families

- ✓ The views of children and young people will be incorporated into all audit work
- ✓ NTSCB Annual Family fun Day attracted over 1,000 people and helped to engage children and families in discussion about the Board's work (see below)

Next steps

- ✓ The LSCB to work with the SAB to ensure Child's Voice/Focus on the child is embedded within the Think Family shared safeguarding arrangements.
- ✓ Further embed "child focus and voice of the child" across all areas of the Boards responsibilities and Performance Management and Quality Assurance arrangements.
- ✓ Design and implement a consultation process with a range of children through existing forums to inform the Boards decision as to the next steps in its strategy as a part of the 15/16 Annual Report and Business Plan review.
- ✓ Design and implement a more effective public face and awareness raising programme in response to feedback (below)

NTSCB held its annual Family fun Day in July 2014 at the Rising Sun Country Park. It is facilitated by the Council's Participation and Advocacy Team and involves a wide range of services including Northumbria police, Community Health and Acorns (domestic violence project). The aim of the day is to raise awareness about the role and work of the Board and provide a broad range of accessible information for families on issues relating to

keeping children safe and healthy. This included a NTSCB newsletter to raise awareness about its role and work and included topics such as private fostering, Internet safety and the role of the NSPCC. As the date followed on Child Accident Prevention week there was also information and demonstrations in relation to child safety and accident prevention. The event was well attended with over 1,000 people taking part.

The Participation and Advocacy team, on behalf of NTSCB used the event to consult with families in relation to their understanding of safeguarding and what they would do if they had concerns about a child. Although more than two thirds of those who took part in the survey were not aware of the role of the LSCB, 95% of respondents felt they knew what to do if they had concerns for a child and would contact the police, social services or another professional such as a teacher or health visitor. Two thirds of respondents (66%) knew where and how to access support.

NTSCB agreed to set up an independent website in 2015 and work is ongoing with Northern Grid to finalise the site. The current website sits in North Tyneside Council which restricts layout and makes it more difficult to 'brand' NTSCB and increase its visibility.

Performance Management and Quality Assurance Framework (PMQA)

The QILP sub group (Quality, Improvement, Learning and Performance) has continued to develop the Performance data set and integrate the data with other performance measures, for example, data indicated a rise in the number of children subject to child protection plans under the category of emotional harm. To better understand whether the category of harm was being applied appropriately the sub group undertook an audit of cp plans under this category. This indicated that emotional harm reflected the nature of the concerns and assured the Board that the threshold criteria in relation to emotional harm was being appropriately applied.

As part of its audit programme the sub group undertook an audit of the quality of child protection plans, which linked to learning from a Case Review completed in 2014. The Review raised an issue in relation to the importance of a robust contingency plan as part of a child protection plan, particularly when there is an issue of parental non-compliance. An audit of plans indicated there were clear contingencies which outlined thresholds for further action in the event the plan could not be progressed.

The sub group monitored participation at child protection conferences because this is judged by the Board to be one of the cornerstones of good multi agency working. Quarterly performance reports are included in the QILP report to the LSCB to support members in their scrutiny and challenge role. This identified poor performance from G.P's and North Tyneside Recovery Partnership (NTRP), as well as variable performance across a number of agencies whose professionals were required or invited to attend. In respect of NTRP, staff were not attending or providing reports at all meetings, particularly relevant in cases where the primary concern is parental substance misuse. Senior management within NTW who manage the service have addressed the issue and a training session was facilitated with the staff team to outline their responsibilities. This has resulted in increased participation by the service. This was encouraging evidence that the QILP model was supporting the Board to fulfill their responsibilities and objectives in respect of PMQA.

In relation to GP involvement in conferences, the Named GP and Designated Nurse have worked with G.P's across North Tyneside to increase participation. A report template has been agreed and processes to ensure electronic invites to meetings, which give adequate notice, are in place. QILP are monitoring the impact of this but in the period covered by the report it was felt to be too early identify sustainable improvements

Development of the multi agency dataset was slower than hoped for in part due to supply problems in terms of the additional specialist support the Local Authority committed to. Nevertheless Board members were able to maintain a "direct line of sight" over key parts of the child's journey for example being able to monitor and scrutinise numbers of children made subject to child protection plans, Looked after children so as to seek further dialogue with the Local Authority and to inform additional lines of scrutiny around the role of the IRO service, corporate parent arrangements and consideration of the proposals to implement a "Single Assessment" process. Examples of performance in some of the key indicators that QILP have monitored are included in Appendix 4.

Next steps

- Further review of PMQA and QILP approach in light of slower than hoped for progress
- Having established and worked through different forms of challenge to consider how to mainstream this, to improve recording of challenge and impact and to formalise escalation procedures

- To identify ways of increasing capacity to deliver the PMQA functions so as to allow the Board to have a broader view and a more “direct line of sight” across joint working and the “child’s journey”

Policies, Procedures and Protocols

The Board’s inter-agency procedures and policies set out the safeguarding expectations of adults working with children. The suite of policies and procedures were refreshed in January 2014 following a review by an independent consultant. Following the publication of Working Together 2015 a further review will be undertaken to ensure compliance with current Working Together guidance. Our multi agency training programme ensures frontline professionals understand and know how to access the integrated policies, procedures and protocols. Board members are also responsible for ensuring;

- All of their organisation’s staff are aware of and comply with the inter-agency policies and procedures.
- Their organisation’s procedures and policies are consistent with the inter agency policy framework.
- Identifying the need for new policies, protocols or procedures.

In addition, when we look at performance and quality, when we undertake case reviews and review child deaths the effectiveness of policies and procedures is considered.

Next Steps

- Our policies and procedures will be revised to reflect the changes outlined in Working Together 2015. There is a need to make sure that our policies and procedures continue to be updated and that they reflect the learning we identify from our more effective scrutiny of performance and quality.
- Some LSCB’s commission an external company to regularly update their procedures, there is one company who dominate this market and there is a large financial cost for the service. We intend to explore with regional colleagues the possibility of a more local consortium that would be able to provide a similar service with lower overheads.

- During the year we recognised that as our PMQA approach developed we needed to look at how we integrated the testing of compliance and the impact policies and procedures were having on joint working practice

Section 11 self-assessment

NTSCB is committed to undertaking Section 11 audits as an effective mechanism by which it can assure itself that organisations have in place safe systems and processes as well as allowing agencies to identify gaps and subsequent areas for development. In 2014 the Board committed to a significant re framing and extension of the self-assessment and audit process. In relation to the continuing development of the process, the Section 11 audit tool has been reviewed in collaboration with Northumberland Safeguarding Children Board.

Initial analysis of the responses would indicate that there are no areas that indicate a cause for concern and there appears to be a good level of awareness and arrangements for safeguarding set against the standards.

As part of its 3 year strategy to ensure all organisations engage in the self assessment, assurance and development process, all schools have been asked to complete the self assessment audit, previously the School Improvement Service undertook this task on behalf of schools. The schools training officer and LSCB Business Manager revised the current tool to link to Keeping Children Safe in Education 2015, statutory guidance for schools and colleges. Learning has indicated we need to better plan the timing of the Section 11 process to enable schools to complete earlier in the summer term.

Consideration is being given as to how a large number of responses from schools can be collated and analysed.

The Board intend to hold a challenge event in autumn 2015 to consider the completed audits.

Next steps

- The third stage of the strategy is to involve the non commissioned voluntary and community sector partners in the process. The Safeguarding Adults board (SAB) set up a Voluntary Sector Task and finish Group to look at strengthening the role of the voluntary sector in the safeguarding agenda. The NTSCB Business Manager joined the group to represent the children's safeguarding perspective.
- The task group have developed a joint children's/adults safeguarding self assessment tool for use by voluntary and community groups based on the standards of the Section 11 audit tool. The tool can be promoted by VODA, However to develop a process to measure take up and collate and analyse the

responses from a large number of groups presents a resource issue that the Business Group will need to consider. One possible solution is to explore the use of purchasing an electronic system whereby audits are completed on line and the responses are collated, such as the Virtual college system.

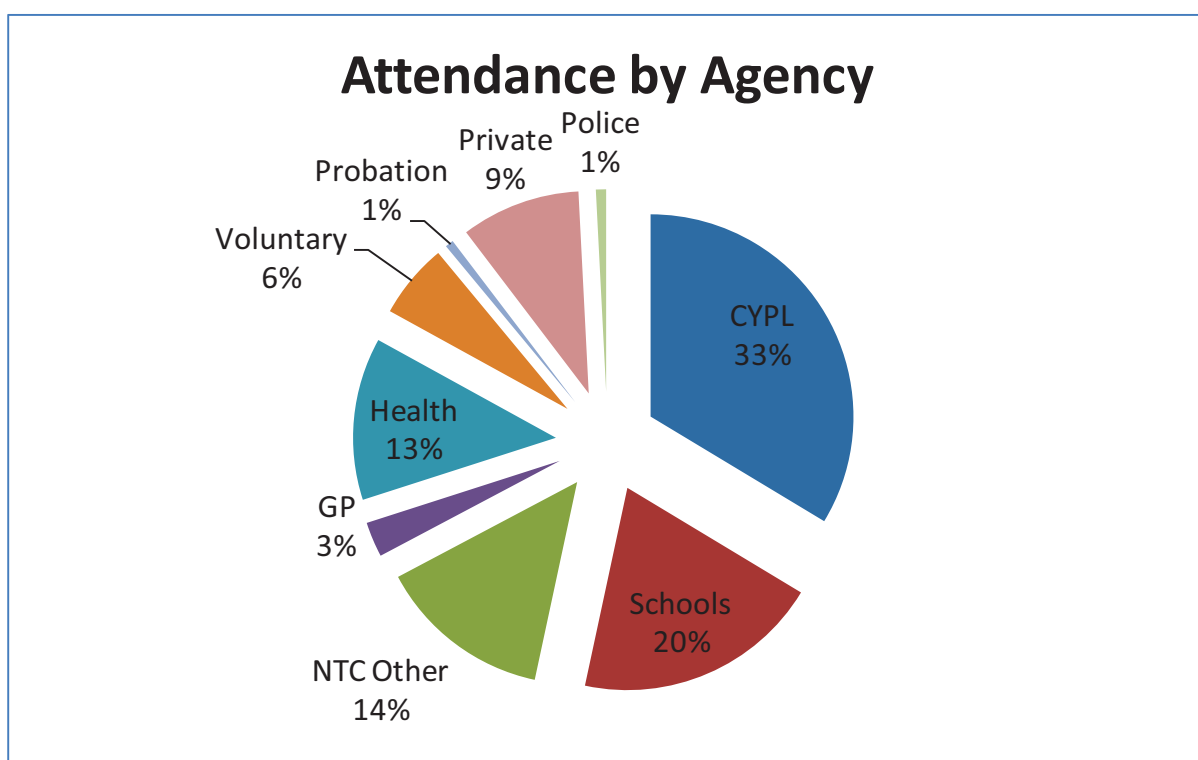
Training

Our Training Sub Group oversees a developed and mature multi agency training and development programme that is strengthening safeguarding practice. The programme is underpinned by a robust analysis of partners' training needs and incorporates learning from case reviews, audits and emerging joint working arrangements.

In total **1,680** learners accessed LSCB safeguarding children training, made up of;

- **1,355** learners at face-to-face multi-agency training
- **210** completers of e-learning
- **115** attendees at the Safeguarding Conference

The chart below shows the percentage of attendance at face-to-face multi-agency training by agency, including the conference. Multi-agency training had an appropriate balance of learners from different agencies, which helped to maximise opportunities for learning and working together effectively.



The Training and Development Officer for Schools, with some support from the Children's Workforce Development Team, delivered and coordinated training to **1,626 school staff** through their Service Level Agreements. This included child protection, designated person and school governor training. A separate report on training for school staff is available from lisa.wardingham@northtyneside.gov.uk

Annual Conference

The subject of this year's joint NTSCB and Safeguarding Adult Board (SAB) Annual conference was Learning From Reviews. The aim of the conference was to share the learning from reviews where there are issues for practitioners who work with children and/or adults at risk, and to improve joint working between services.

Two case studies were played out by a theatre company, to include issues about; vulnerable babies, substance misusing parents, parental mental health problems, child sexual exploitation and multi-agency working.

A total of **115** delegates attended the conference from a range of agencies providing services for children and/or adults.

Delegates were presented with an interactive performance from the Geese Company, followed by group discussions, which helped explore the key issues and formulate actions for improvement.



Members of the Theatre company

Feedback from the event was excellent. *"[The] dramatic presentation was excellent at giving an insight into the key themes, promoting discussion and raising complex issues"*

Quality, evaluation and impact of the training

The quality and effectiveness of the training is monitored through:

- Evaluation sheets completed immediately following training.
- Observations of the trainer's practice monitored against agreed standards.
- Follow up electronic 'SNAP' surveys requesting the perceived impact of training on practice, completed by the learner and their manager.

Evaluations of the training continue to be very positive, with 100% of learners stating the training met their expectations, this result was taken from a sample (n336) for child protection and refresher training courses.

Longer term impact of training on practice

Longer-term impact of training is monitored through electronic SNAP surveys, which are sent to learners who attended training, and their managers, 4 weeks following the training event. The following is a sample from learners in relation to the positive impact of training on their practice/organisation and the changes they have made since the training. Due to the poor response from managers in the past, the SNAP survey has been reviewed and amended to make it more efficient for managers to complete and will be implemented in the coming year.

Sample of how learners put their learning from training into practice

Being more aware of the children's perspective within situations of domestic abuse.	Referred a client to North Tyneside Recovery Partnership for support regarding alcohol use after discussing her intake
Thinking more about the parents we see and how they are with the children we are supporting	I have updated my records to include the new North Tyneside Recovery Partnership and can now signpost people to this service.
Follow up a case involving a child on a school residential and ensuring correct sequence of communication with relevant agencies.	Being more understanding with partners of prisoners - being able to explain prison processes to them
I am involved in many core groups and care teams and the information I received is assisting me to work on these appropriately	knowledge when working with families is better- services available to families-
Referred two children to Young Carers Project	in my recording, more conscious of what I am putting in my recording is factual
Supporting early years providers with current procedures	As evidence in reports and assessments.
Raising the issue of D.A. generally and thinking of this possible issue when considering cases. Even though I have been aware of DA and attended training in the past, this was an important refresher for me	Contact information/Tel numbers given to a parent who is a victim of domestic abuse

Passing relevant information to community staff within their supervision	used the CAADA -DASH ID checklist
Initiating safeguarding procedures for the child of one of my clients.	Yes, when liaising with agencies and sharing information.
Currently in training post but I am applying knowledge learned to my practice	contacted the LADO re a difficult case involving a teacher
being aware of encouraging young people to protect themselves more and to spot possible exploitation	The training provided further confirmation to concerns we had about a family and has enabled us to look more carefully at the family, providing appropriate advice to agencies involved.
updating staff training/school procedures	I am having to write policies and procedures for my childminding business.

Next steps

- Link with the SAB to deliver a range of activities aimed at promoting adult and children's safeguarding agenda's among the public and professionals.
- Review quality assurance process which considers content, methods, impact on learning and application to practice (using Kirkpatrick as a framework).
- A more strategic approach re children's safeguarding workforce.
- The LSCB Training Officer is responsible for the coordination and delivery of the training programme. She is employed by North Tyneside Council and NTSCB make a contribution of £15,000 towards the cost of the post. Due to restructuring within the council her role has expanded to include that of Workforce Development Lead. Whilst this is an opportunity to consider how the learning from the delivery of multi agency safeguarding training can inform the wider workforce planning opportunities across and within partnerships, it raises a potential capacity issue. Following a period of time for the new post to become embedded, the Business group will request as part of the quarterly reports from the Training sub group, an assessment of the impact of the changes. This will ensure any capacity issues that impact upon the delivery of the multi agency training programme can be addressed.

More information on the achievements of the Training sub group are available in the Annual Training Report on the NTSCB website.

Case Review and the use of learning to improve practice

A key function of the Board is to highlight effective safeguarding practice and to identify areas for improvement. No serious case reviews were commenced during the past year. A Learning Review was completed in 2014 in relation to the death of a young baby who was subject to a child protection plan at the time. The death was felt to have been the result of mother falling asleep on the settee with her baby causing him to suffocate. It was felt the criteria for a SCR was not met, a decision the National Panel accepted.

The Review, which was completed by an independent reviewer, included an event with those practitioners involved in the case, to explore their perspectives of the case and to identify good practice and areas for development. Feedback from those who attended was positive and practitioners felt it has strengthened their individual learning which would influence their future practice. The sub group are keen to utilise this methodology in future Reviews.

The wider review identified several learning points, which have been progressed via an action plan;

- The need to explore technology to ensure the timely distribution of invites to child protection conferences to facilitate practitioner participation.
- Child protection plans to include clear contingency plans when non-compliance arises.
- Reinforce safe sleeping messages including consideration of a public health campaign.

In line with the aim of learning from cases more generally, Northumberland Healthcare Foundation Trust shared the learning from a Significant Learning Event with the Case Review sub group. The issues were in relation to a young baby who was not making the expected developmental progress and whether parenting capacity had been identified as a factor. It was felt that it would be useful to share the learning on a wider basis and a workshop is being organised with Children's Social Care to enable this.

Sharing learning from national and local serious case reviews is facilitated as part of the NTSCB multi agency training programme. The case review sub group have also considered the learning with a view to identifying learning for practice in North Tyneside. Following the learning from a SCR in a neighbouring area, the sub group reviewed the

procedure in relation to 'Bruising in Immobile Babies' following work by the designated Doctor. Changes were made to reflect the learning from the SCR and the revised procedure was endorsed by NTSCB.

To take forward the focus on creating opportunities for practitioners to creatively engage in learning the LSCB has set up learning forums, known as 'espresso sessions' in collaboration with the Safeguarding Adults Board. Lunchtime events are held on a quarterly basis to consider learning from case reviews, identifying opportunities to draw on what works, and to share and promote good practice. Topics are chosen on the basis of learning from local reviews – safe sleeping, domestic homicide reviews or as a response to current issues, e.g. the PREVENT agenda.

As Case reviews often focus on learning from what could have gone better, we have a view that sharing what works well is equally valuable for continuous learning and improvement. Services are asked to provide good practice examples which are collated and published with the aim of helping professionals and organisations working with children, young people, families and/or adults at risk, to share and replicate the learning. In the two publications to date there are a variety of examples provided by a number of partner agencies.

The sub group also tasked health colleagues in the group to complete a follow up audit in relation to an action from a previous Learning Review. Child J was removed from his parents care, age 6 weeks when child protections concerns were raised in relation to mother's older child who, as a consequence, was no longer in her mother's care. The case raised issues in relation to poor information sharing, in and between agencies when mother became pregnant with Child J and whether the lack of pre birth assessment and plan to protect him had placed him at risk of harm.

Following the Learning Review a number of recommendations were made which included the following for Northumberland Healthcare Foundation Trust (NHCFT):

“to assure the LSCB that relevant information from the records of previous pregnancies is accessed and considered as part of the antenatal assessment process”

NHCFT considered the recommendation and to achieve it auctioned the following:

“Community midwives as part of the booking process access previous GP records”

Subsequently this action was challenged by the LSCB with a suggestion made that midwives should also access the mother's hospital notes and any previous pregnancy antenatal booking forms and patient held records (PHR). Accessing this information was felt by NHCT to be impractical within the workload of the midwives and a view put forward that it would yield little or no further information.

The Designated Doctor and Designated Nurse undertook an audit of cases comparing the maternity records with the GP and PHR records. The conclusion was, in the majority of cases, all information could be accessed via the GP and PHR records and where there was an extensive history the maternity notes can be accessed. As a result of the audit NTSCB were confident that accessing GP records satisfies the recommendation arising from the Learning Review.

Next steps

- Planned review of the Learning & Improvement framework sections relating to case review
- Review and reset notifiable incidents arrangements

Child Death Overview Panel (CDOP)

The Board are responsible for reviewing child deaths and we carry out part of this function in partnership with our counterparts in Newcastle and Northumberland, through a North of Tyne Child Death Overview Panel. North Tyneside Clinical Commissioning Group has played a central part in supporting and providing a significant element of funding, alongside contributions from the three Boards, to ensure the panel was well resourced and independently chaired.

The CDOP met 8 times from April 2014 to March 2015. 52 cases were reviewed and 13 of these were North Tyneside children.

Of the 13 cases, 4 were reviewed on time (within six months of the death). 9 were not reviewed on time. The final part of the review process is the review of the death by the Panel and cases may have been completed but can wait up to 6-7 weeks to be heard by the Panel who meet on a 2 monthly basis.

Of the 13 cases, 2 were considered to have modifiable factors that may have contributed to the death. These are factors that the panel considered might have made a difference and if these were addressed might make a difference in the future. These factors related to

co-sleeping which reinforces the importance of raising awareness and providing advice, that if followed, could reduce the number of deaths where co sleeping was a factor.

Learning from these reviews is disseminated on a local basis to the individual Safeguarding Boards and nationally, through the collation of data from across the country. In North Tyneside the panel reports directly to the Board and the Case Review sub group via Quarterly reports.

More information about the Child Death Overview Panel and a copy of the annual report, which reflects the learning during this period and sets out the priorities for 2015/16 is available on the website at www.northtyneside.gov.uk

Safe Recruitment and Investigation of Allegations Against Adults Working With Children

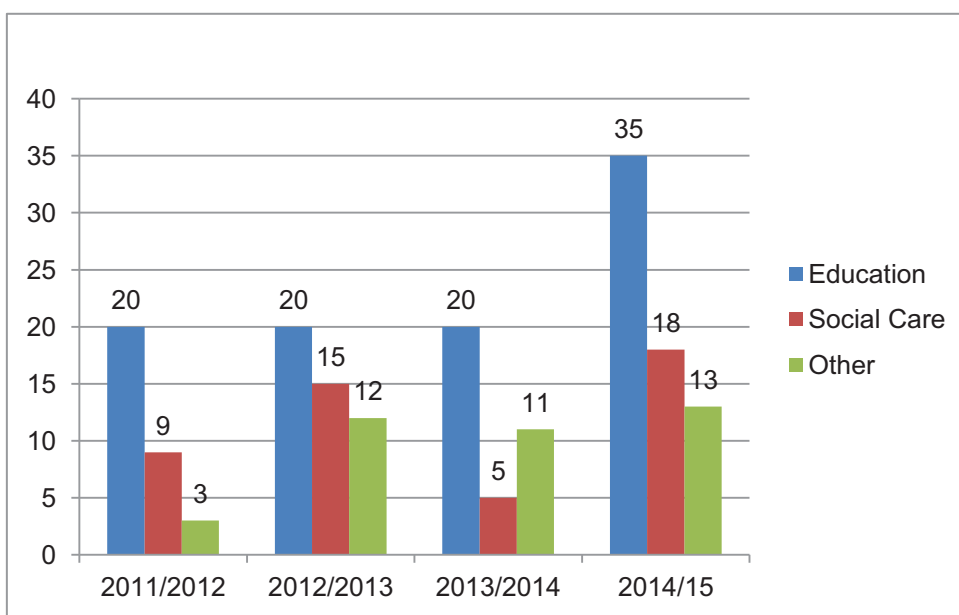
North Tyneside has a widely recognised procedure that ensures referrals to the Local Authority Designated Officer (LADO) are made appropriately and that advice and guidance is sought when necessary from professionals and voluntary organisations. This forms the basis for formal scrutiny by the Board in the form of an Annual Report from the LADO. This referral process applies equally to when an allegation is made either in their personal or professional life and consideration is given to the potential risks in both areas. All organisations are required to make sure that they meet standards in terms of safe recruitment (this is something that the annual Section 11 audit helps organisations to check out), and to cooperate with the procedures that the Local Authority puts in place, which in turn are scrutinised by the Board. The Board in turn then seeks to ensure that learning and or any issues around compliance are addressed.

Angela Glenn, LADO has retained the role following her move to the post of Service Manager, Front Door in April 2015. Working Together 2015 states that allegations against people who work with children are not dealt with in isolation and any action necessary to address corresponding welfare concerns in relation to any children should be taken without delay and in a co-ordinated manner. There has been a suggestion that the Local Authority Designated Officer (LADO) role causes confusion amongst some professionals about what to refer and to whom.

By locating the role within the Front Door Service, the local Authority feels it will simplify referral routes by creating a single entry point. The LADO will be supported by a triage

system to ensure that all calls are signposted to the appropriate services. A large amount of the calls to the LADO are safeguarding enquires or professionals seeking advice and guidance. All LADO referrals will be directed to the Senior Duty Officer who will then advise accordingly or consult with the LADO and HR advisors. We expect that the impact of this change will be to reduce the risk that allegations against those who work with children are managed in isolation from any action necessary to address welfare concerns relating to the child or children concerned.

There has been an increase in referrals to the LADO in 2014/15 as evidenced below and further detail in relation to the breakdown of referring agencies and the nature of the concern is available in the **LADO Annual Report**



The annual report acknowledges the need to embed a new recording system, which will allow better tracking of outcomes and reporting and the Business Group will monitor progress. The LADO meets with regional colleagues as part of a support/ development forum. Plans for the group to develop a 'LADO Handbook' which would bring together a shared level of understanding and consistency to the role is welcomed.

Private Fostering

One of the functions of the LSCB is to ensure there are policies and procedures in place that promote the safety and welfare of children who are privately fostered. The local authority has a Private fostering Lead and the Board receives the Annual Report she completes. Additionally a progress report is provided mid year. The number of private

fostering arrangements in North Tyneside remains low (4 as at 31 March 2015), which appears to reflect the North East position.

Once the local authority is informed of a private fostering arrangement, NTSCB were provided with assurance that a single assessment is completed; that all children have an allocated social worker and the arrangement is reviewed by an Independent Reviewing Officer. Good practice was highlighted in a recent case whereby a 12-year-old girl who was privately fostered became very distressed when her parent threatened to remove her. She was settled in the placement and clearly able to articulate her concern about a possible return home. It was agreed the local authority would instigate legal proceedings with a view to being able to maintain the placement and promote her sense of permanence and stability.

North Tyneside Council are represented on the Northern Consortium of Private fostering Group facilitated by BAAF (British Agency for Adoption and fostering), which promotes a support network and good practice across the region.

Next steps

Work will continue to raise awareness in respect of private fostering with a more specific plan to target;

- a) schools who are in a strong position to know when a child may meet the criteria
- b) Port of Tyne with regard to children arriving in to the area from abroad and confirmation they are accompanied by a parent or close relative
- c) Improved specification to be supplied by the Board for future reports

Partnership Working, Governance Relationships and Accountability)

The agenda for the local safeguarding context forms one important element that should be of common concern across the other strategic partnerships and arrangements that respond to local needs and priorities; these are

- The Health and Wellbeing Board (HWB)
- The Children and Young People's Learning Executive)
- The Safeguarding Adult Board (SAB)
- The Community Safety Partnership (CSP)

- The Family Justice Board
- The Domestic Abuse Partnership
- North Tyneside Council Children and Young People's Scrutiny Committee

There is no national or consistent approach to how these arrangements take form and effect in practice, so it is a question of how at a local level these are addressed. This was a priority last year and has remained one during this year and the following progress was achieved;

The Board reviewed its governance arrangements in 2014/15 and were able to take some key next steps. The document sets out the formal agreement between the Board and all partner agencies. It outlines the accountability arrangements, key purpose, function and tasks of the LSCB; membership and agreed standards. The document sets out the arrangements for the LSCB to link with key strategic groups and provides better clarity on the board's role within the wider strategic framework.

Health and Well Being Board

A protocol was agreed to enhance the effective co-ordination and coherence in the work of the Health and Well Being Board and both the Children's and Adults Safeguarding Boards.

Specifically, formal interfaces between the three boards were agreed at key points including:

- The needs analyses that drive the formulation of the annual Health and Well-Being Strategy and the Safeguarding Boards' Business Plans. This needs to be reciprocal in nature ensuring both that safeguarding boards' needs analyses are fed into the JSNA and that the outcomes of the JSNA are fed back into safeguarding boards' planning;
- Ensuring each Board is regularly updated on progress made in the implementation of the Health and Well Being Strategy and the individual Board Business Plans in a context of mutual scrutiny and challenge;

Annually reporting evaluations of performance on plans again to provide the opportunity for reciprocal scrutiny and challenge and to enable Boards to feed any improvement and development needs into the planning process for future years

strategies and plans. NTSCB achieve this by sharing their annual Report at the respective Boards.

During the year Board members recognised that the opportunities presented by a formal working relationship between the North Tyneside Health and Well-Being Board and the NTSCB and NTSAB and the CYPPL were at the point where further work was needed to negotiate inter board relationships in order to:

- Secure an integrated approach to the JSNA, ensuring comprehensive safeguarding data analysis in the JSNA, in line with the *Working Together* guidance
- Align the work of the LSCB business plan and SAB Strategic Plan with the HWB Strategy and related priority setting.
- Ensure safeguarding is **everyone's business**, reflected in the public health agenda and related determinant of health PDGs and strategies.
- Evaluate the impact of the H&WB Strategy on safeguarding outcomes, and of safeguarding on wider determinants of health outcomes
- Identify coordinated approach to performance management, transformational change and commissioning
- Scrutinise and challenge and "hold to account": the Wellbeing Board for embedding safeguarding, and the Safeguarding Boards for overall performance and contribution to the H&WB Strategy.

Practically, it was agreed:

1. Between September and November each year the Independent Chair of the two Safeguarding Boards would present to the North Tyneside Health and Well-Being Board their Annual Reports outlining performance against Business Plan objectives in the previous financial year. This would be supplemented by a position statement on the Boards' performance in the current financial year. This would provide the opportunity for the Health and Well-Being Board to scrutinise and challenge the performance of the Boards, to draw across data to be included in the JSNA and to reflect on key issues that may need to be incorporated in the refresh of the Sustainable Community Strategy and the Health and Well-Being Strategy.

2. Between October and February the North Tyneside Health and Well-Being Board to present to the Safeguarding Boards the review of the Health and Well-Being Strategy, the refreshed JSNA and the proposed priorities and objectives for the refreshed Health and Well-Being Strategy to enable the Safeguarding Boards to scrutinise and challenge performance of the North Tyneside Health and Well-Being Board and to ensure that their refreshed Business Plans appropriately reflect relevant priorities set in the refreshed Health and Well-Being Commissioning Strategy.
3. In April/May the Boards will share their refreshed Plans for the coming financial year to ensure co-ordination and coherence.

During the year the Independent Chair met regularly with the deputy Chief Executive of the Council in order to identify ways of developing strategic partnership relationships, and the year saw some significant developments.

Independent Chairs of LSCB and SAB met regularly and attended each other's boards

Next steps

- Further responses across all strategic partnerships as understanding of respective roles and interfaces develop.
- LSCB PMQA function to develop to the point whereby the LSCB can deliver formal reporting in addition to annual report on an agreed basis re challenge/assurance and or exception reporting.
- Further integration of planning cycle and plans around common functionality re PMQA – Awareness raising and promotion and “Think Family”.
- Identify next steps for targeted scrutiny of and by the LSCB re Local Authority arrangements and responsibilities.
- Further integration of standard setting and Section 11 assessment and challenge into partnership reporting and scrutiny

8. Summary

This report sets out the context, aims and objectives and priorities the Board worked to during the year. These reflected the learning from past years and a response to new areas of need and the challenges partners and partnerships have faced.

In January 2015 Board members met to formally review progress against the business plan and agree future priorities. It was agreed that the business plan will be more focused on the specific role and remit of the LSCB in ensuring that the welfare of children and young people is safeguarded and protected as set out in Working Together 2015. It focuses on maintaining core functions (case review and quality of practice, policies and procedures, high quality multi agency training, engagement of children and young people, as well as ensuring that priorities agreed locally and nationally are progressing (for example child sexual exploitation, private fostering). It will move to a way of working which emphasises the collective leadership role of the LSCB membership rather than the individual roles of each organization.

This resulted in a move in a 3-year business plan to align with the North Tyneside Children and Young People's Plan 2014 – 18. and the measures and steps outlined in this report.

The report demonstrates that partners have maintained and developed their commitment, resulting in increased focus on the need to progress the ways in which as a Board we set and agree standards, how we monitor these and the different ways we evaluate the quality, effectiveness and impact of joint working arrangement to protect children. In turn the report evidences how Board members and their representatives who make up the sub groups have maintained progress, responded to learning and developed ways of facing and responding to challenge.

For the first time the Board has adopted a new approach to how it integrates the learning from ongoing self assessment and review, as summarized in this report, and will publish an executive summary of this report that will articulate changes and revisions to priorities, objectives, how we do things and how we will respond to the challenges we face.

This will mean that whilst the Annual Report continues to represent an important review and statement of the overall effectiveness of joint working arrangements to protect children and promote their welfare, it will also further integrate how as a Board we maintain a clear and current line of sight of practice and how this impacts on children, young people and their families. As the objectives reported on develop the Board will work more closely providing feedback and challenge with other strategic partnerships, draw in a wider range of partners and stakeholders through the Section 11 audit around a clearer view of and understanding of the key standards the Board views as essential to effectiveness of safeguarding.

The Board has a strong track record of ensuring that relationships between partners at a strategic and a practice level are informed by both a factual analysis of performance and an

understanding of the qualitative characteristics of effective joint working. The steps taken in the year and the learning from this have served to clarify for the partnership the choices it will need to consider in finding capacity and resources to further develop its “its line of sight” in order to support and encourage partners, practitioners, children, young people, families and the community to ensure that “safeguarding is everyone’s business” and that standards are maintained and responses continue to improve.

NTSCB Membership

Richard Burrows, Independent Chair

Angela Yilmaz, Head Teacher, North Tyneside Council

Russell Pilling, Head of Safeguarding and Placements, North Tyneside Council

Rajesh Nadkarni, Group Medical Director, NTW

Dave Bowditch, Lay member

Jill Prendergast, Lay member

Ian Grayson, Lead Member for Children and Young People, North Tyneside Council

Jacqui Old, Head of Adult Social Care, North Tyneside Council

Jane Pickthall, Head of Vulnerable Learners, North Tyneside Council

Jean Griffiths, Head of Children, Young People and Learning, North Tyneside Council

Jackie Coleman, DCI, Northumbria Police

Moira Banks, School Improvement Service, North Tyneside Council

Julie McVeigh, Service Manager, Barnardo's

Kath Robinson, Principal Manager, Disability and Additional Needs Service, North Tyneside Council

Lesley Young Murphy, Executive Director of Nursing and Transformation, North Tyneside CCG

Liz Kelly, Head of Service, CRC, Probation Service

Maureen Gavin, Head of Service, National Probation Service

Lucy Topping, Assistant Director, Patient Experience, NHS England

Wendy Burke, Interim Director of Public Health, North Tyneside Council

Michael Vincent, Designated Doctor, Northumbria Healthcare Foundation Trust

Pat Buckley, Service Manager, NSPCC

Peter Xeros, Service Manager, Youth Offending Service, North Tyneside Council

Rosemary Stephenson, Director of Nursing, Northumbria Healthcare Foundation Trust

Pamela Robertson, Head of Safeguarding, Tyne Met College

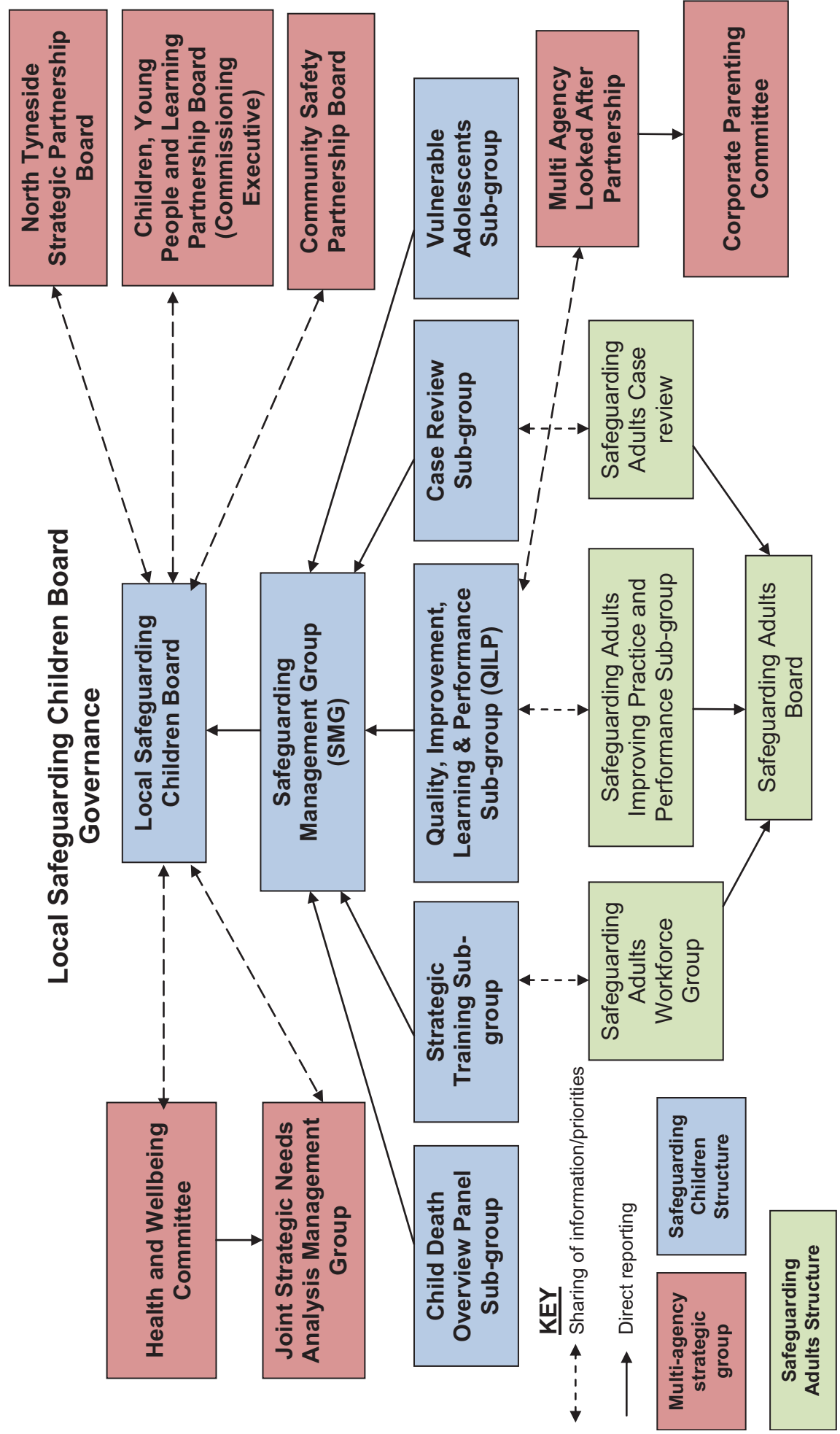
Jan Hemingway, Designated Nurse, North Tyneside CCG

Sue Burns, LSCB Business Manager

Suzanne Armstrong, Service Manager, CAF/CASS

Louise Watson, Legal Advisor, North Tyneside Council

Local Safeguarding Children Board Governance



Financial arrangements

To function effectively the LSCB needs to be supported by member organisations with adequate and reliable resources. Board partners continue to contribute to the NTSCB budget in addition to providing a variety of other resources. This income ensured that the overall cost of running NTSCB was met. Total income for 2014 – 15 was as follows

North Tyneside CCG	£31,823
Northumbria Police	£ 5,000
Y.O.S.	£ 2,000
CAFCASS	£ 550
Probation	£ 300
Under spend from 2013/14	£18,788
Revenue from LSCB charging policy	£11,611
Total	£70,272

Council contribution	
LSCB Business Manager	£28,745
LSCB Training Officer (part cost)	£22,627
Admin support	£10,330
Total	£61,702

Expenditure 2014-15

Training	£16,360
Venues, catering	£ 278
Learning Review	£ 5,113
Independent Chairs	£28,173
Child death review	£ 9,008
LSCB website	£ 2,500
LSCB Family fun Day	£ 500
Total	£61,932
Under spend to carry forward	£ 8,340

Expenditure

Child Death Review process

Expenditure in relation to the child death review process would usually include £12,000 per annum as NTSCB's contribution to the cost of the Child Death Coordinator post. The cost of the post is shared between Northumberland, Newcastle and North Tyneside LSCB's.

As the post was vacant until July 2014 the expenditure for North Tyneside in 2014/15 will be £7,800.

Training

The final sum includes a contribution of £15,000 to the costs of the LSCB Training Officer

Financial Revenue 2015/16

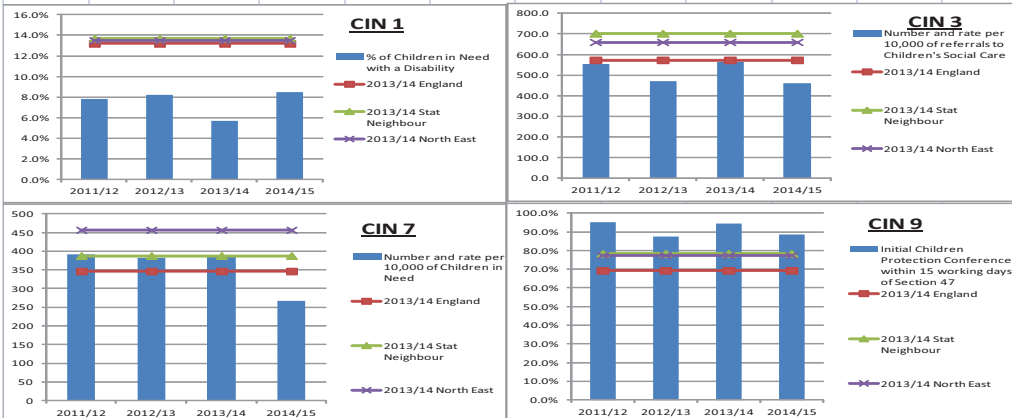
In relation to the financial year 2015/16, financial contributions have been agreed with Board members on behalf of their agency (amounts as below) Additionally the NTSCB Charging policy in relation to non attendance at LSCB training courses has generated the sum of £which will be carried forward into 2015/16 .

North Tyneside Clinical Commissioning Group (CCG)	£31,823
Northumbria Police	£ 5,000
Youth Offending Service	£ 2,000
CAFCASS	£ 550
Probation CRC	£ 500
Under spend from 2014/15	£ 8,340
Revenue, charging policy	£11,670
Total	£59,883

Quarterly budget reports will be provided to the Board to ensure members receive regular oversight of the financial position.

Key Performance Indicators : Children In Need (CIN) (1)

The following statistics are examples drawn from the management information provided to the LSCB in order to help the Board consider how effective it has been in co-ordinating safeguarding and joint working arrangements to protect children and young people in the borough. The information is drawn from a range of sources of which some key examples are provided below, together with a brief explanation. Comparisons are sometimes made to other areas or to previous years performance, but care should be taken when considering this information as in practice it is considered within the context of other activity from the Boards multi agency partners.



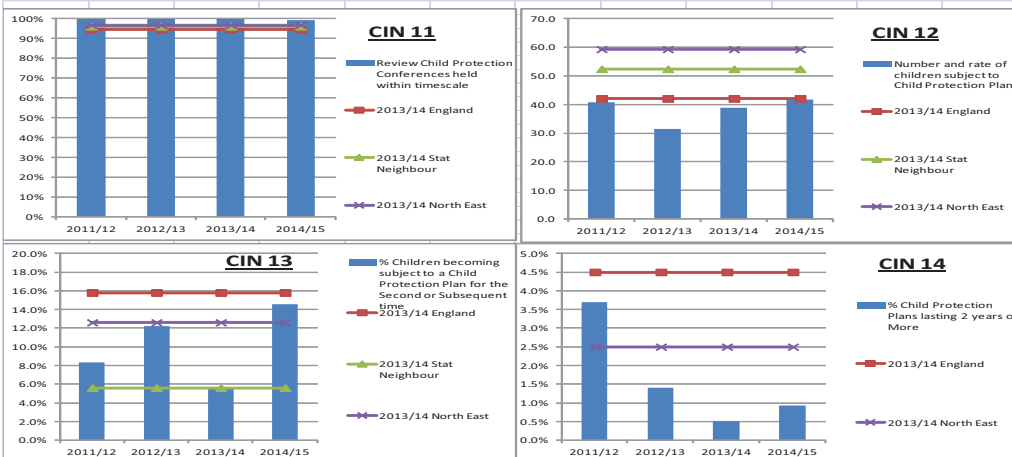
The above information is collected in order to assist in monitoring children referred to local authority social care.

This includes:

- Children in local authority care (e.g children in placements in a residential home, or with a foster family)
- Children who are receiving support from their local authority's social care services
- Children who are the subject of a child protection plan

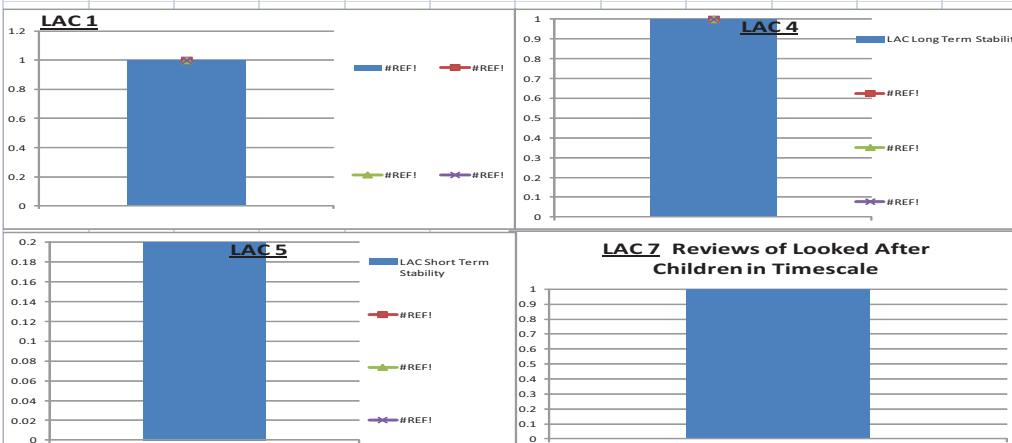
- CIN 1** : Identifies those children identified as Children in Need who have a disability, to consider if they have additional support requirements
- CIN 3** : Shows the rate of referrals to Children's Social Care, this is analysed per 10,000 children and young people in the borough, to allow for some comparison between different local authority areas. There were 1,863 referrals in 2014/15, an average of 155 per month. When adjusted for the number of young people in the borough (40,474), the rate of 460 can be calculated.
- CIN 7** : This figure shows the number of Children In Need, identified following referrals.
- CIN 9** : This indicator considers whether Initial Child Protection Conferences are held within a set timescale. In 2014/15 in North Tyneside this was achieved in 88.6% of cases

Key Performance Indicators : Children In Need (CIN) (2)



- CIN 11** : Following on from CIN 9, this information considers whether review conferences are held within agreed timescales, in North Tyneside this was achieved in 99.2% cases
- CIN 12** : This indicator identifies where a Child Protection Plan was considered necessary, again calculated per 10,000 children and young people. The rate of 41.8% is under the Regionla and National average and represents 169 cases in 2014/15
- CIN 13** : This shows the % of cases where it was necessary to put in place a second or subsequent plan in order to protect a child. This was necessary in 14.5% or 33 cases during 2014/15
- CIN 14** : In a very low number of cases child protection plans are in place for more than two years, as identified in this indicator.

Key Performance Indicators : Looked After Children (LAC)



These indicators deal specifically with the children in the care of the Local Authority, identified as Looked After Children (LAC)

- LAC 1** : Considers the number of children being looked after at the end of the year, the rate of 74.6 equates to 302 LAC as at the end of March 2015
- LAC 4** : In relation to Looked After Children, it is a general principle that a stable placement is best for the child, therefore we measure which % of longer term cases have remained in the same placement for more than 2 years.
- LAC 5** : In conjunction with LAC 4, the number of cases where a Child is moved 3 or more times in 12 months is also considered. In this case a lower % is generally considered a better outcome though the specific needs of the child will be the key deciding factor.
- LAC 7** : A Child's review is an important part of social work practice and this identifies the % of cases where reviews are carried out within agreed timescales. This was for 98.7% of cases in North Tyneside in 2014/15.