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North Tyneside Council

This matter is being dealt with by:
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13 October 2017

To: All Members of Children, Education and Skills Sub-committee

Dear Councillor

Children, Education and Skills Sub-committee – 16 October 2017

I refer to the agenda for the meeting of the Children, Education and Skills Sub-committee to be held on Monday 16 October 2017 and enclose the following item:

Item 5 – North Tyneside Safeguarding Children Board Annual Report 2016-17.

Please bring these papers with you to the meeting.

Yours sincerely

Elizabeth Kerr

Elizabeth Kerr
Democratic Services Officer
On behalf of
Vivienne Geary
Head of Law and Governance

Circulation overleaf

Circulated to:

To all Members of the Children, Education and Skills Sub-committee

Councillor Alison Austin
Councillor Pamela Brooks
Councillor Joanne Cassidy
Councillor Karen Clark
Councillor Muriel Green
Councillor Karen Lee
Councillor Andy Newman
Councillor Pat Oliver (Deputy Chair)
Councillor Margaret Reynolds
Councillor Matthew Thirlaway (Chair)
Councillor Alison Waggott-Fairley
Councillor Frances Weetman

Parent Governor Representatives
Mrs Michelle Ord

Churches Representatives
Rev. Michael Vine, Church of England
Mr Gerry O'Hanlon, Roman Catholic Church

Meeting:	Children, Education and Skills Sub-committee
Date:	16 October 2017
Title:	North Tyneside Safeguarding Children Board's Annual Report 2016/17

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 In 2015 the sub-committee established a sub group to examine child sexual exploitation in the borough. One of the recommendations of the sub group was that the Children, Education and Skills Sub-committee should receive the NTSCB's Annual Report every year.

3.2 The NTSCB Annual report will be published in October 2017 and is enclosed for the sub-committee's attention.

3.3 Mr Burrows, the Independent Chair of the NTSCB, has accepted an invitation to attend the meeting.

4. Appendices

- North Tyneside Safeguarding Children Board's Annual Report 2016/17.

North Tyneside
SAFEGUARDING
CHILDREN BOARD

NTSCB

North Tyneside Safeguarding Children Board

Annual Report 2016/17

Contents of this report

1. Introduction

Welcome to our annual report for 2016-17. Each Local Safeguarding Children Board (LSCB) is required to publish an annual report to show how the partnership met its responsibilities and statutory functions. These are to support partners in their efforts to coordinate the services they provide so as to ensure that children are protected and their welfare is promoted.

The partnership is also expected to be able to have a view as to how effective these joint working arrangements are in order to support learning and improvement.

The annual report sets out the key developments in the year and the difference the LSCB made as a partnership. It also identifies the things that the partnership and partners need to continue to work on as well as any new actions that may be required.

Although the responsibility for services and the outcomes these result in for children and young people, rests with each partner, it is important that as a partnership we are able to demonstrate that we are objective, independent, transparent and fair in the support, scrutiny, challenge and encouragement we provide.

We hope that you will find that the report helps you to better understand how organisations and people work together and 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.

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 the Boards' work in 2016/17 and provide some examples as well as links to further information and evidence.

The report is intended to provide you with enough information to 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".

The report was formally commissioned by the Board in March 2017 and will be published in October 2017.

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 us.

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

If you require a version of this report in a different format or language please contact us.
Email: lscb@northtyneside.gov.uk
Tel: 0191 643 7373

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 Partnership Board, North Tyneside Council Scrutiny Committee, Safeguarding Adult Board (SAB), Community Safety Partnership and Domestic Abuse Partnership.

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

2. Independent Chair's Executive Summary

Over the past three years the LSCB has steadily developed and improved its influence and impact through its highly regarded multi agency training and learning programme; the provision of policies and procedures for joint working and the promotion of what to do when there is a concern for a child's safety. It has also ensured that partners are committed to and clear about how they will cooperate in responding to such concerns.

In setting standards for how people work together to create better outcomes for children, the LSCB has been able to develop its capacity to independently scrutinise these efforts through monitoring of performance and a better understanding of quality. The formal review of practice by looking in detail at cases has also seen consistent improvement. This has meant that partners have continued to need to adjust and develop their work and how they relate to and contribute to the partnership. This has strengthened how partners are able to check out, challenge and be assured that what they do separately and together is making a difference.

This means that whilst this report focuses on concrete and measurable activity and achievements it also has to consider the elements of partnership and joint working that are harder to measure and describe.

As the independent chair I am very aware that those who provide leadership have a wide range of responsibilities and competing priorities, so I am appreciative of the fact that partners continue to invest in the work of the board, even though this is sometimes difficult for them. We continue as a partnership to develop the way we address our role, balancing the challenges of brokering and bringing together different perspectives with the capacity to form an objective overview of how joint working arrangements are working across North Tyneside, and most importantly what this means for vulnerable children, young people and their families. The fact that we are able to have a range of conversations at the board and outside of the board, focused on and informed by evidence means that we continue to listen to each other and to act differently as a result. This also means that we have to sometimes hear about things that are difficult and during the year we have continued to improve the way we address challenge, and this is to the credit and integrity of those at all levels across the many organisations who we rely on to play their part in protecting children.

The different roles, scope and purposes of the organisations who contribute to the partnership can mean that achieving clarity, a common understanding and purpose is an

ongoing challenge. For those outside of these arrangements and perhaps for some front line practitioners it can sometimes appear less than clear, so as a result we have to continue to make sure that the way it all works and how we work together is as clear as possible.

We also know as we have improved our dialogue with children and young people that they can struggle to understand what to expect and what is expected from them. To this end we welcome as a partnership the significant investment being made by the Local Authority in "Signs of Safety" which provides all of those involved with a ways of involving each other in a safer and more inclusive approach to helping families and making decisions that are best for children. As a partnership we embrace this approach and will in the coming year firm up how we can support this across the partnership and be assured that it is making a difference.

During the year we considered, scrutinised and provided advice in respect of the important changes taking place in the ways in which partners organise and provide early help on the basis of multi agency locality based teams. We have seen the vision for this as well as the practice develop over the year and continue to support these developments as well as making sure that the most appropriate measures are in place so that we can be assured that this new approach is fitting in with the approach to how we protect children.

We have also seen as a result of a strong lead from the police and the Local Authority the transfer of learning as a result of how partners have engaged with Child Sexual Exploitation (CSE) and this is leading to some significant changes in how partners work together to share information and use this information to make decisions as to how best to become involved with children and their families.

The Ofsted inspection of the Local Authority and the LSCB took place within the year, and was affirming of arrangements partners have and that the Local Authority provides child, family and community focused leadership and services. This also reminded us that successful outcomes for children and those who care for them is not only about organisational and process issues, but about principles, culture and how we create the right conditions for people working together. In the coming year the partnership will further reflect on how it can continue to influence and model working relationships at all levels that promote collaboration, cooperation and the capacity to work out differences. In this respect we feel there is a strong parallel with what happens when practitioners engage with children and their families.

During the year the partnership made good steps to close some of the gaps and complications that exist as a result of the different bodies and responsibilities that are a necessary factor in providing public services at a national, regional and a local level. Our aims will remain simple: to improve clarity and understanding about the importance of joint working arrangements to protect children and the means by which we are assured these are good; to support the recognition, that how the protection of harm to children and therefore prevention of circumstances that can contribute to this, comes together at the highest level of determining local and regional priorities. To help make sure that the many different approaches to prevent children being harmed are as integrated as possible to reduce duplication of effort and to promote shared learning. We will need to continue this work in the coming year especially as many things continue to change.

During the year the government commissioned a review of LSCB's, Serious Case Reviews and Child Death reviews as a part of its agenda to support the improvement of social work and provide Local Authorities with greater freedoms to innovate and achieve improved results. Whilst the legislation that resulted in the Children and Social Work Act, April 2017 did not include many of the measures intended to help Local Authorities, it did result in some changes for the social work profession and those responsible for the delivery of social work led services for children. It also adopted the outcomes from the Wood Review which means that in the coming years the Local Authority, the Clinical Commissioning Group (CCG) and the Police will be designated Statutory Safeguarding Partners (SSP) and will be required to identify revised arrangements to replace the current LSCB. At the time of writing it is anticipated that the Department for Education will enter into consultation about the revised Working Together statutory guidance in the autumn/winter of 2017/18. This is likely to provide more detail as to what will be required. Until there are any changes to the present arrangements, which it is anticipated will need to be in place by April 2019, it has been made clear that the partnership will need to maintain its current statutory responsibilities and functions. As a Board we have been proactive in monitoring and responding to this, and have identified a number of opportunities and risks that will be reflected in our revised plan and programme.

In conclusion, the year as with previous years has seen continued changes and uncertainties and we remain a committed and resilient partnership who discharge our responsibilities and functions in an efficient, effective and increasingly proportionate way. Our continued development based on our vision of what's important for protecting children and promoting their welfare, is built on open and informed relationships, a willingness to

look at things that can be difficult and a confidence that we can arrive at a point where we are assured that this is making a difference for children. We have identified some of the key risks and opportunities that may influence our capacity to build on where we are now, and there will continue to be challenges that arise from complexity and competing agendas. We will need to be satisfied as partners embark on further changes as a result of necessity and learning, that they have been able to do this on the basis of how this will improve the joint working response. Therefore as a partnership and with other partnerships we will need to continue to strive for an increasingly mature and sophisticated understanding of what makes for an effective and integrated response to the risks children face and how we can be assured that the outcomes are the best possible.

Richard Burrows
Independent Chair

3. Local Safeguarding Children Boards

The Children Act 2004 requires each local authority to establish a LSCB for their area and specifies the organisations and individuals including the local authority that should be represented. The LSCB's statutory functions are to:

- 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
- To ensure the effectiveness of what is done by each such person or body for those purposes.

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. A 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.

What we do

The Board's main responsibilities comprise:

- Case Reviews - including the Serious Case Review (SCR) 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

Further clarification of the function of LSCB's can be found **here**

North Tyneside Safeguarding Children Board (NTSCB) has:

- Membership which reflects the breadth of the safeguarding agenda and is compliant with of Working Together 2015 (see appendix 1).

- arrangements in place to enable its statutory functions to be met and priorities to be effectively progressed
- groups which sit under the LSCB have up to date Terms of Reference that outline their responsibilities and accountability
- clarity of role and function described in the Constitution and Governance Arrangements which is signed up to by NTSCB members

4. Going Forward - the National Safeguarding Context

Going forward there is a period of significant change to the role of LSCBs. Both the 'Wood Report: Review of the role and functions of LSCBs' March 2016, and the response from the Government were published in 2016. The reports indicated changes to the strategic and statutory arrangements for the organisation and delivery of multi agency arrangements to protect and safeguard children in their area. The Government's response pointed to the introduction of a stronger and more flexible statutory framework.

In April 2017, ***The Children and Social Work Act (2017)*** received Royal Assent. Chapter 2 of the Act, entitled 'Safeguarding of Children' will affect the Board in three ways:

- The establishment of a Child Safeguarding Practice Review Panel. This panel will replace the existing national panel that looks at serious case reviews and in an essence abolishes serious case reviews as they currently work;
- Abolition of Local Safeguarding Children Boards;
- Changes to Child Death Overview Panels.

The Act abolishes the statutory requirement for an LSCB and deals with safeguarding arrangements under section 16: *"Local arrangements for safeguarding and promoting welfare of children"*

This section states that: *"The safeguarding partners for a local authority area in England* ***must make arrangements*** *for:* (a) *the safeguarding partners, and (b) any relevant agencies that they consider appropriate, to work together in exercising their functions, so far as the functions are exercised for the purpose of safeguarding and promoting the welfare of the children in the area."*

The safeguarding partners are clearly identified as:

- *the local authority;*
- *a clinical commissioning group for an area any part of which falls within the local authority area;*
- *the chief officer of police for a police area any part of which falls within the local authority area."*

It states that local safeguarding partners must publish these arrangements and in terms of what the arrangements might look like, the only statutory requirements are:

- there must be arrangements for scrutiny by an independent person of the effectiveness of the arrangements;
- a requirement that all safeguarding partners and relevant agencies for the local authority area act in accordance with the arrangements;
- and at least once in every 12 month period, the safeguarding partners must prepare and publish a report on what the safeguarding partners and relevant agencies for the local authority area have done as a result of the arrangements, and how effective the arrangements have been in practice.

The next step will be for the key partners to meet and agree how this will move forward in line with the proposed new legislation.

5. The Local Context

The needs of families in North Tyneside our informed by the Joint Strategic Needs Analysis (JSNA), and this was refreshed in 2015. Although North Tyneside is one of the least deprived boroughs in the region, and generally there is an improving picture of health and wellbeing, some areas, communities and vulnerable groups continue to face significant challenges.

- One fifth of children are living in poverty which increases to nearly half in the most deprived parts of the borough
- The infant mortality rate is similar to the England average and the child mortality rate is similar to the England average
- Breastfeeding is lower than the England average and more mothers continue to smoke during pregnancy compared to the England average
- Teenage conception rates are continuing to fall
- Childhood immunisation rates are above the England average.
- There are 148 children and young people who are subject to a child protection plan (as at 31/3/17)
- There are 296 children looked after (as at 31/3/17)
- It is estimated that around 7,900 children and young people in the borough have a long standing illness or disability
- There are over 3,000 children and young people with mental health and behavioural disorders
- There has been an increase in the number of children with special educational needs over the last five years
- Hospital admissions for under 18's are significantly higher in North Tyneside compared with the England average including admissions due to injury, substance misuse and as a result of self harm
- The rate of obese children doubles between Reception and Year 6. One in 10 children are obese in Reception, and 1 in 5 by Year 6
- There is a clear relationship between deprivation and obesity
- There is a persistent gap in educational attainment between disadvantaged children and other children in the borough
- Rates of young people not in education, employment or training (NEET) at 18 are similar to England, but North Tyneside has higher rates of under 25s who are unemployed

As a safeguarding board we work within the following plans and strategies;

- The North Tyneside Health and Wellbeing Strategy 2013 -2023

- The Children and Young Peoples Plan 2014 -18 (this is also the Poverty Strategy)

We therefore understand the needs of children, young people and their families on the basis of the following:

- North Tyneside's population is projected to grow from a population of 200,800 in 2011 up to 220,478 by 2030.
- The Black and Minority Ethnic (BME) population is currently estimated at nearly 6% and has almost doubled since 2001.
- North Tyneside is becoming increasingly diverse; the largest BME group is the Asian and Asian British group and the BME population is likely to grow over the next 15 years as are minority faith groups, with Islam remaining the largest minority faith in the borough.
- Population projections indicate an ageing population. The number of persons aged 65 years and over is projected to increase significantly by 2025. The number of people aged 85 and over is projected to increase in North Tyneside by 46% by the year 2030 creating additional demand for social care, housing, support, and health services.
- The percentage of the population in North Tyneside with a limiting long term illness is significantly higher than the average for England.
- By 2030 the population aged 5-19 will increase by 12%.
- Approximately 24% of people currently have some kind of disability; this figure is expected to increase with an increasingly aging population.
- Around 6% of people identify themselves as lesbian, gay, bisexual or transsexual (LGBT)
- 23.3% of the population in North Tyneside lives in the most deprived national quintile whilst 21.3% of the population lives in the least deprived quintile
- The proportion of the population aged 16-64 years estimated to be economically active in North Tyneside between April 2011 and March 2012 was 79% which higher than the figure for both the North East and Britain

6. 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 contribute in other ways.

Financial contributions remain a reflection of a formula and local arrangement agreed some time ago, and there continues to be a reliance on the Local Authority and the CCG. This was clearly hampering pace on improving capacity and impact. As a result, the local authority increased its contribution for 2016/17 in recognition that the LSCB needs additional capacity to meet targets. This additional funding has allowed the Board to employ a part time administrator who commenced in November 2016. This has developed our capacity in a key area - basic administrative and organisational support for the Board and its members around meetings, agendas, reports, minutes and associated processes such as consultations, feedback and the Section 11 audit process.

Partners also contribute in other ways by attending meetings, releasing staff to sit on sub groups, sharing information, responding to local and national consultations, supporting the implementation of decisions and agreements within their own organisations, and being accountable for the performance and quality of joint working arrangements collectively and on behalf of the organisations or sectors they represent.

Board membership

Appendix 1 shows the 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.

During the year there have been a number of changes to our membership. We said goodbye to:

- One of our Lay Members who resigned after three years and whose input was specifically valuable in the QILP sub group
- Principal Manager, Disability and Additional Needs Service, North Tyneside Council following a restructure of the disability service
- Head of Service, Community Rehabilitation Company following retirement.

We welcomed:

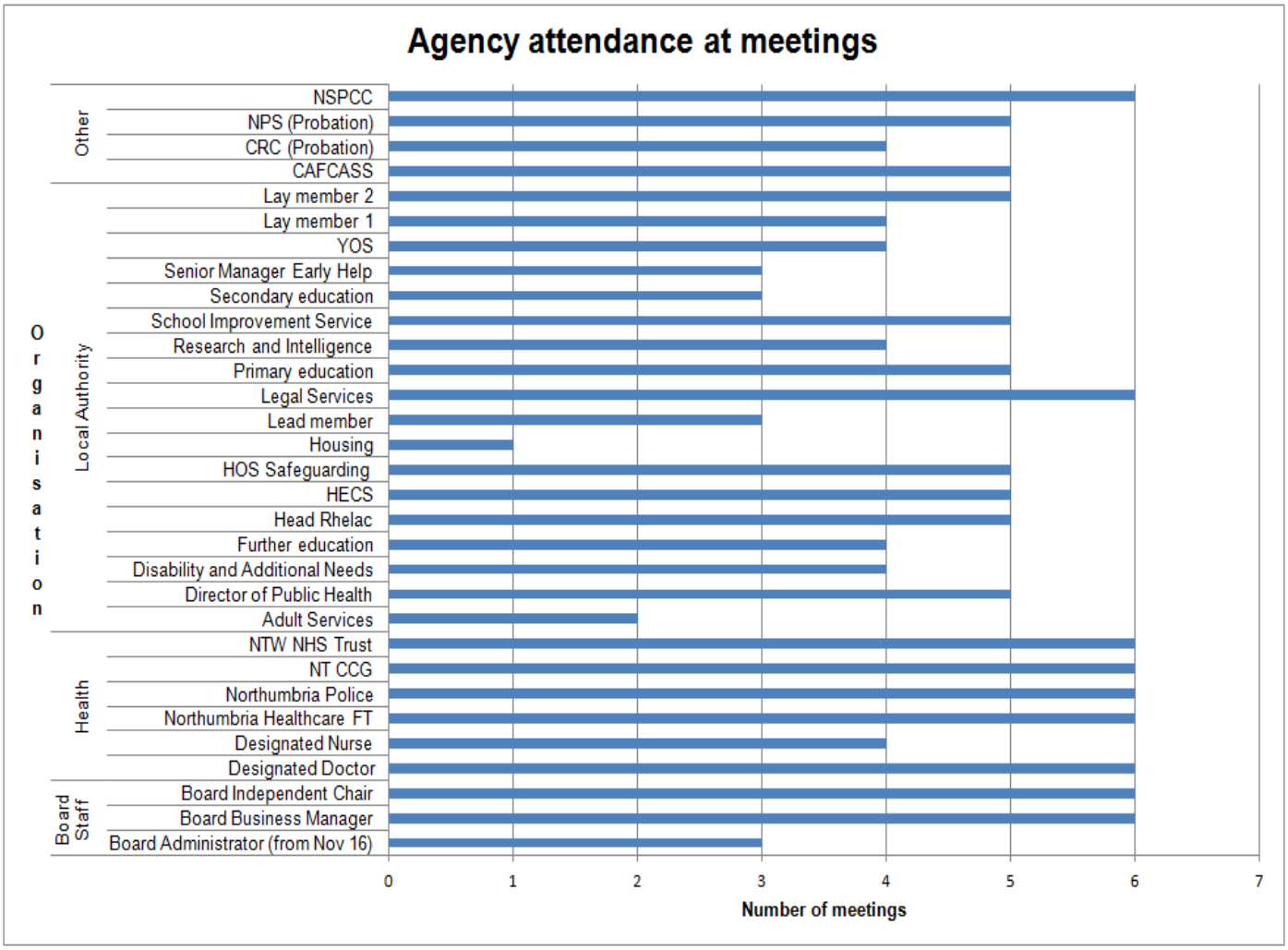
- A secondary school Head Teacher representative

- New representation from Northumbria Police, Children's Social Care and the Community Rehabilitation Company

We have recruited a further two lay members who will join us in September 2017 and who will 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 they can contribute to discussion but they do not have the same responsibilities as other members.

The Board met bi-monthly during 2016/17 and held one development session for members. The table below shows attendance by members or a nominated deputy during this period.



Sub Groups

The following sub groups operated during the year;

- Business Group, chaired by Sue Burns, LSCB Business Manager
- Quality Improvement Learning Performance (QILP), chaired by Trish Grant, Named Nurse, Northumbria Healthcare
- Child Death Overview Panel (CDOP) chaired by Sheila Moore, Independent Chair
- Case Review Sub group chaired by Jan Hemingway, Designated Nurse.
- Training Subgroup, chaired by Louise Robson, Workforce Development Manager, North Tyneside Council
- Sexual Exploitation Subgroup, chaired by Ellie Anderson, Assistant Director Business and Quality Assurance, North Tyneside Council

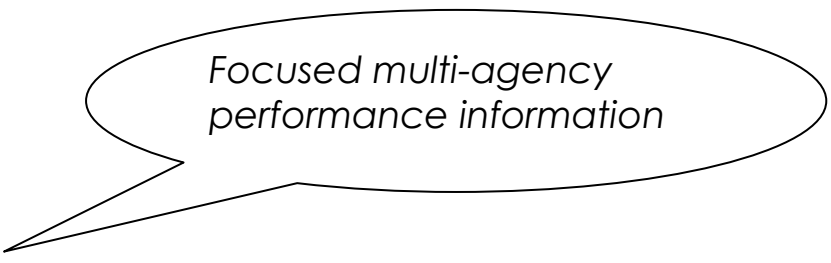
NTSCB Independent Chair

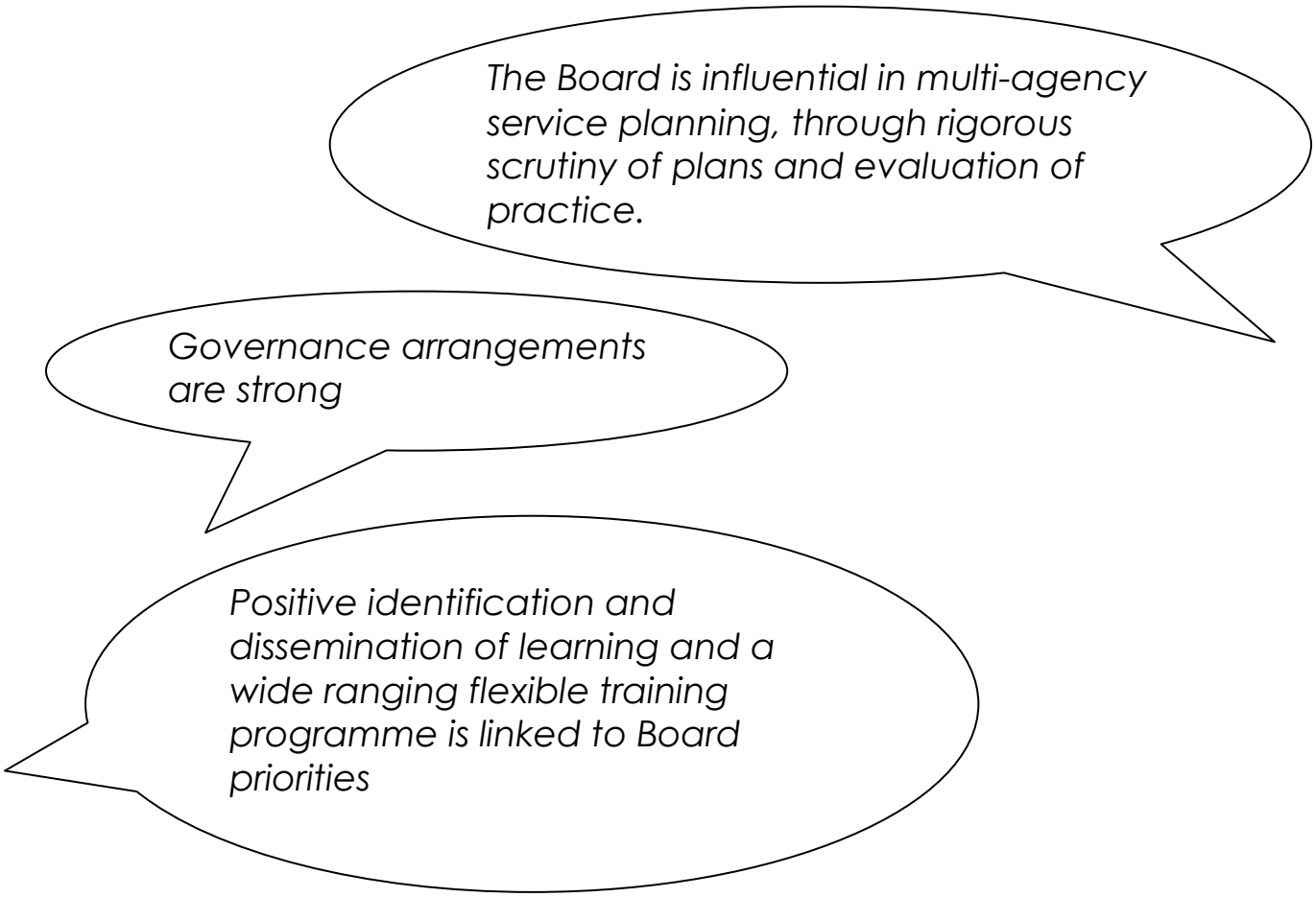
In accordance with Working Together 2015, NTSCB has an Independent Chair who works closely with all NTSCB partners and particularly with the Director of Children and Adult Services, North Tyneside Council. The Independent Chair is appointed by the Chief Executive of the Council. Richard Burrows joined 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. The Independent Chair was subject to a satisfactory appraisal undertaken by the Director of Children and Adult Services in July 2017.

7. Ofsted Review

An Ofsted review took place from 6 – 24 March 2017 and the subsequent report published on 13 June 2017 judged the effectiveness of NTSCB as good. The local authority inspection of services for children in need of help and protection, children looked after and care leavers during the same period was also judged to be good. NTSCB is described as;

‘an efficient, reflective Board, meeting its statutory requirements and effectively co-ordinating and assuring itself of the quality of multi-agency safeguarding work’.





There were three recommendations from the review:

1. Ensure that the outcomes of all learning activities are supported by clear actions with timescales, including ways in which the impact of the activity will be evaluated

2. Ensure that the voice of children and young people effectively informs wider board activity and developments

3. Ensure that the annual report rigorously and succinctly reflects the evaluation and effectiveness of safeguarding services in North Tyneside.

We have developed an action plan to progress the three areas which will be monitored by the Business sub-group.

8. Review of 2016/17

The NTSCB agreed 4 priority areas and actions are progressed via the Business Plan 2015-18. Some of these areas of work are carried forward in to 2017/18. Below is some of the progress made against the priorities;

Priority 1 - Improve accountability, challenge and communication to develop the effectiveness of the Board

√ We have continued to make improvements to our web site to strengthen the visibility of NTSCB and its role as an independent partnership

√ We published a series of posters highlighting some of the thematic learning from local and national Serious Case Reviews

√ Within the LSCB there exists a culture of challenge evidenced through comprehensive minutes and a challenge log. Some key areas of challenge have been:

Resourcing

Our 2015/16 Annual Report highlighted to the local authority and partners a clear overall risk that whilst we were a "lean" board ,if we were to continue to meet our development targets, further resourcing would be needed. The local authority identified additional funding to pay for dedicated administration and support and to allow the buying in of specialist services to assist with an analysis of the Section 11 responses.

Development of the 0-19 agenda

Challenge was made to commissioners in respect of sharing proposals with the Board at an early stage with a focus on possible implications for joint working arrangements.
The Board has been briefed on a regular basis in relation to the changes to 0-19 arrangements and the development of early help.

G.P participation at child protection conferences

It was identified that participation by this professional group was poor, viewed as important as Conferences are an integral part of multi agency working to safeguard children and robust information sharing is key. Learning from reviews also tells us GP's may hold key information. It is not realistic to expect G.P's to attend all Conferences and therefore reports are key to sharing information at meetings. A revised template for Section 47 enquiries/Conference Reports has been developed and a 3 month pilot will assess whether this has improved participation.

Local Authority Designated Officer (LADO) arrangements

The robustness of the Local Authority LADO arrangements was raised following consideration of the LADO Annual Report 2015/16 and a board judgement that there was little evidence of improvement from the previous years reports and resulting advice. A review of the arrangements was requested by the board and this has led to a proposed change to how the LADO arrangements will be delivered.

Priority 2 - Prevent harm and the protection of vulnerable groups

√ We formed the sexual Exploitation sub group with colleagues from Safeguarding Adults Board (SAB) to develop a shared approach across adults and children's services. This has led to a revised and refreshed strategy

√ We have maintained oversight of early help and the 0-19 agenda

√ We completed our first 'Safe Week' in collaboration with the Safeguarding Adults Board. Various activities were arranged to raise community awareness of safeguarding including information on topics such as neglect, mental health and domestic abuse

√ We supported the introduction of Operation Encompass across North Tyneside's schools, a Northumbria Police led initiative to make sure that school staff are made aware of an incident of domestic abuse in a child's home early enough to support the child or young person. For more information, please visit www.operationencompass.org

Priority 3 - The views of children and young people are contributing to learning and best practice

√ We conducted an audit of how partners listen to the voice of the child and were assured that agencies have processes in place to listen to the child's point of view and these views feed in to service delivery

√ We invited young people to our Annual Conference and their presentation about what is important to them when professionals become involved in their lives, was both challenging and thought provoking.

Priority 4 - Learning and Improvement positively influences multi agency practice

√ Continued with the Espresso Learning Events to disseminate learning from local and national reviews – the outcome from these has confirmed that developing proportionate ways of sharing lessons means that we reach more practitioners across the partnership and that this will inform our learning and improvement strategy.

√ Implemented a new electronic evaluation and impact strategy which measures the effectiveness of training and provides evidence to the board of the impact on practice.

What do we need to do ?

A development session was held for members in June 2017 and although numbers were low there was attendance by all the key partners and there was some useful discussion in relation to identifying key actions going forward. It is recognized that we need to firm up our approach of putting children at the centre of all we do and we will explore talking to young people already engaged with our partners to see how they can contribute to our work.

We need to continue our commitment to early help so increasing numbers of families are supported at the earliest stage to build capacity and solve their own issues so they do not require a statutory social work service. Early help is the first point of safeguarding and we need to continue to support, train and quality assure practice in this area to continually strengthen the effectiveness of support that children and their families receive

In relation to Priority 2, vulnerable groups identified as a priority were;

- Neglect, significantly high numbers of children are the subject of child protection plans under the neglect category, learning from Case Reviews which identify learning around the recognition of neglect
- Disability, monitoring of progress against the Whole Life Disability agenda
- Domestic Abuse, progressing the learning from our JTAI self assessment (Joint Targeted Area Inspections are ‘deep dive’ inspections on specific themes completed by Officers from The Care Quality Commission (CQC) Ofsted, HM Inspectorate of Constabulary and HM Inspectorate of Probation. In preparation for the domestic abuse theme, the LSCB completed a self assessment of practice)

Whilst it was felt that children missing from school, home and care and the links between this and child sexual exploitation remain a priority as this group of children represented a vulnerable group, the differentiating factor was that, although not yet complete, the data reporting and analysis for

this group meant that the board was able to monitor and measure progress of the partner response. Whereas in terms of the other identified vulnerable groups identified a better level of analysis and understanding was required.

Sexual Exploitation

The LSCB has worked closely with partners over the past three years to ensure there is an effective multi-agency response to child sexual exploitation (CSE) As a result of this regular review it became clear that further focus and challenge was required in order to maintain momentum and to be able to exercise more effective scrutiny of key parts of joint working arrangements. In response to a joint conference run the LSCB and the Safeguarding Adults Board (SAB). It was also agreed that there should be a wider focus on sexual exploitation and that this complimented existing approaches to work across age boundaries. In March 2016 a Joint sub group across three Boards - LSCB, SAB and the Community Safety Partnership was implemented.

A revised Strategic Action Plan has been agreed across the three partnerships. This reflects the progress made in terms of the coordination of operational arrangements and the learning from review and self-assessments including Section 11.

Updates are provided to all three boards on a regular basis. In the case of the LSCB the sub group and chair are aware of the particular responsibility the LSCB has in terms of evidencing the level of assurance the partnership can agree in relation to joint working arrangements in relation to CSE and children missing from home, care and education. As such the sub group works closely with the QILP and the business group to ensure this key responsibility is addressed.

The current Strategic Plan reflects and builds on the following key learning:

1. The Police provide a strong lead focused on operational delivery and effective information sharing across the key aspects of the strategy e.g. disruption and prosecution. The operational focus and learning provided from Operation Sanctuary has enabled local changes in terms of commissioned services, specialist posts and the adoption of an effective model to share information and manage risk at the point of referral.
2. The Local Authority at the highest level provided a strong response to the Jay report, which has ensured members are clear, and that all arms of the Councils activities are focused on recognition, response and information sharing. Their work on ensuring taxi and night time economy providers/personnel is aware and the focus on sharing information around “addresses of concern” has strengthened the position in North Tyneside.

3. Schools and health partners have been able to evidence as a result of direct scrutiny and assurance through Section 11 that they have acted on the strategy and ensured that their training and safeguarding arrangements treat CSE as a priority.
4. The sub group along with the QILP recognise that key partners will need to be supported to provide enhanced information and analysis that further demonstrates the effectiveness of the multi agency response to CSE and in particular children missing from home, care and education.
5. Newcastle LSCB will shortly be publishing an extensive SCR involving the work of Operation Sanctuary and the respective chairs have liaised so as to ensure that this key learning informs both the front line and the strategic response. Ongoing work within the Children's Social Care transformation agenda and work being led by the Police in developing more effective hubs, have been supported by the Board as being a positive next step.

Key achievements to date

- A review of MSET(Missing, Sexual Exploitation and Trafficked) arrangements has been undertaken with actions agreed. (This has included challenge re the delay in partners fulfilling this request from the Board). The MSET Panel is an operational multi agency arrangement to manage risk in relation to individual cases. The sub group has responsibility for monitoring the action plan with a view to the Board considering whether further assurance is required
- Performance Data set in relation to sexual exploitation has been agreed to commence April 2017
- Communication task and finish group is in place to build on the success of past campaigns and to ensure that new messages reflect the current arrangements and expectations
- Schools audit information has been provided to progress concerns as how best to achieve a more consistent response across the education landscape
- Assurance re early help arrangements has been provided regarding the process for identification and referrals and this has informed the emerging Board priority to be assured and to support the coordination and integration of information and management of risk across the early help and statutory threshold and MASH arrangements.
- Mapping exercise to identify new hot spots and improve understanding of those already known is underway. This now needs to look at refining risk e.g. the times of day when risk is higher. This has been taken to the Local Authority's "addresses causing concern", group re

sharing and utilising the intelligence. (NB This is an innovative task as it seeks to adopt some of the potential benefits of a shared sub group and ensure that the problem profile and response has a “public safety” approach).

- Training report has been received highlighting the training provision provided through the LSCB/SAB/Community Safety Partnership in order to identify future objectives and targeting of multi agency and single agency training.

Next steps

- Performance Data and analysis provided by partners to be provided on a more regular basis and to demonstrate lines of enquiry identified by the Sub Group and action plan.
- SCARPA Squad to advise on hearing the voice of the child and engagement work, especially in respect to the learning and challenges raised from recent audit activity re missing interviews
- Focus on Hard to reach groups including BME, young males and children with a disability
- To support the continued development of the Business Group in integrating the work of the sub groups especially in relation to the QILP led performance and quality framework.

Performance Management and Quality Assurance Framework (PMQA)

Since early 2016 the Board has benefited from the dedicated specialist support and advice from a member of the Council’s Performance Team. This support is highly valued and has enabled the continued strengthening of the multi agency dataset with the sub group requesting additional information as areas of interest or concern are identified. QILP uses data to follow the child’s journey across early help and into statutory intervention, and can also measure against and alongside specific indicators from partner agencies. We can measure performance against statistical neighbours and assure ourselves of any trends. We have successfully linked the focus and outcome of our audits to our analysis of what performance information is telling us. For example, the number of second or subsequent child protection plans increased to 19% from the 2015/16 rate of 13.8% and is now higher than the North East, national and statistical neighbour comparators. The indicator can be an indication of the effectiveness of the original child protection plan. The sub group wish to better understand the increase and have added an audit of second and subsequent plans to the 2017/18 audit programme. Below are some further examples of the types of performance data that QILP consider;

- The timeliness of child protection processes is routinely monitored and shows good performance.

- The monitoring of professional participation at child protection conferences raised an issue in relation to the involvement of G.P's in the process. This has been addressed via an agreed template which will increase information sharing in the process by this professional group.

- This year has seen the development of an MSET (Missing, sexually exploited and trafficked) dataset which was requested both from QILP and the SE sub group in order that members could better understand the performance information in relation to children missing and/or exploited within North Tyneside. Members wanted more detail about the numbers of young people affected and whether or not they were subject to Child protection plans or were Looked After Children.

- The local prevalence of reported incidents of female genital mutilation (FGM) remains low leading to the view that the LSCB's continued raising awareness and e learning training continues to be a proportionate response.(3 incidents reported to Children's Social Care)

- Following on from the board seeking assurance about the safeguarding arrangements in relation to children with a disability, the sub group developed some performance indicators to better understand performance in this area which will be reported on a quarterly basis.

As previously mentioned the QILP sub group also manage the multi agency audit programme and this is linked to data and other key areas of activity such as learning from reviews, previous audit findings and the Boards response to reports. One of the audits looked at Single Assessments and the application of thresholds. The data indicated the number of cases referred to Children's Social Care which were assessed but did not meet the threshold for intervention, was high. The outcome of the audit was that in some cases early help may have more promptly met the families needs reducing the need for duplication of assessment and potentially unnecessary social care interventions. This has supported the wider Local Authority transformation agenda of a new and wider approach to early intervention.

Early Help Assessment's (EHA) have been on the QILP agenda throughout the last year and the group has been regularly reviewing the number of EHA undertaken by Maternity services, as an audit conducted in 2015 reported a very low number undertaken. Northumbria Healthcare

Midwifery and Safeguarding departments undertook extensive EHA training with Midwives in an attempt to improve the number completed. A re audit was requested by QILP and this was completed in December 2016. The results were equally disappointing with Maternity having completed no EHA's. The audit found that one of the reasons may be the use of an unborn thresholds document which was written in 2014 and does not reflect some of the changes made within LSCB thresholds and the new early help pathways. As a result the LSCB has endorsed a revised document to take into account the Early help offer and the standards expected.

Policies, Procedures and Protocols

The Board has a comprehensive suite of policies, procedures and protocols that are available on the NTSCB website. A number of the procedures are due for review and previously this has been managed by the Business Manager. The majority of LSCBs use an external organisation to provide on-line procedures which include regular updates. There is a significant financial cost to this and we are exploring with regional colleagues, the appetite for negotiating a shared local arrangement with lower overheads.

Members are also expected to ensure:

- 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.

Section 11 & 175 self-assessment

Section 11 is the LSCB's primary audit to examine safeguarding arrangements within agencies and provide the Board with assurance that agencies are doing what they can to safeguard children and young people.

The Section 11 Audit provided evidence of good practice from all agencies who all reported full compliance with:

• A named person with sufficient seniority identified to champion safeguarding.
• Clear policies and procedures in place to show how to report welfare and safety concerns.
• Staff are encouraged and required to attend safeguarding and child protection training.
• Safer recruitment training to all staff involved with recruitment.

• Children are made aware of their right to be safe from abuse.

For a second year all schools were asked to complete a self assessment and we were pleased with the response from schools which showed an increase in participation from the previous year. The collated findings indicate that overall compliance with the standards is high: on average 90% of schools assessed themselves as Green against the eight standards. The next page outlines some common themes from the collation of responses from schools.

Common Themes

	Key issues / improvements	Good practice
Safeguarding training	This needs arranging, updating or refreshing for staff, volunteers and Governors in some schools, and training logs need to be created or updated.	Regular training updates for all staff. Training is included in staff inductions.
Information and communication	Policies and documents not up-to-date / accessible (e.g. for different languages) in both hard copy and online. Contact information and details are not available / clear enough. Child-friendly versions of policies need to be created.	Regular communication between Designated Safeguarding Leads (DSLs), staff and Governors. Keeping policies, documentations and contact details readily available and easily accessible online and in hard copy.
Policies, systems and procedures	Require review or update. Parents and pupils need to be consulted and involved more in service development. Curriculum requires review to ensure all elements of safeguarding for children and education are addressed.	Policies are reviewed on an annual basis and any legislative updates or changes are added. Electronic systems improve lines of communication and monitoring. Active School Councils help children feel listened to and school respond to issues. Brightly / uniquely coloured 'Cause for Concern' forms. Pro forma available to record all communications.

Recommendations

1. Further training and guidance for those completing audits may improve the quality, length and accuracy of self-assessment.
2. The use of an online survey or Excel form may help standardise answers and improve the analysis process.
3. Including 'Actions' alongside ratings and description for each criteria may help create a direct link and encourage schools to give specific and clear actions for any criteria they are not yet exceeding.

Multi Agency 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 1,282 learners accessed face to face NTSCB safeguarding children training, made up of;

- **1,179** learners at face-to-face multi-agency training
- **103** attendees at the Annual Safeguarding Conference: Working together to safeguard children who are missing, exploited or trafficked

Below is a comparison of attendance and non-attendance over the past six years. This does not include an analysis of e-learning as there is a growing number of e-learning modules, which are available through external websites, such as FGM which it is not possible to monitor internally. However, the NTSB will continue to promote relevant e-learning modules.

Comparison of attendance, non-attendance over past six years

	Face to face attendance	**Non-attendance**	**% of Non-attendance**
2011-2012	**1370**	**186**	**14%**
2012-2013	**1051**	**105**	**10%**
2013–2014	**1309**	**66**	**5%**
2014-2015	**1355**	**108**	**8%**
2015-2016	**1182**	**86**	**7%**
2016 - 2017	**1282**	**155**	**12%**

Non-attendance. Although attendance at face-to-face training this year is slightly above average, there has been an increase in non-attendance to 12% from its lowest of 5%, despite the charging policy being implemented.

It would appear that the most popular methods of learning are short briefings, conferences and espresso events (short informative sessions with space for reflective discussion). Feedback shows this to be an efficient use of practitioners' time, and that they are more likely to be released from the workplace. It is recommended that these methods are maximised in the future along with

other forms of continuing professional development, for example shadowing or e-learning. These complimentary forms of learning are reflected in the training strategy.

The Training and Development Officer for Schools, with some support from the Children's Workforce Development Team, delivered child protection training to **1596 school staff** in 2016-2017 through their Service Level Agreements. In addition 284 Designated Safeguarding Leads in school received training in their roles and responsibilities and 25 school Governors received safeguarding training for Governors.

The NTSCB safeguarding training pathway for schools, was introduced in July 2016. The pathway outlines how schools safeguarding training can be compliant with the new Keeping Children Safe in Education (September 2016). As well as outlining the pathway for general school staff, it outlines the specific requirement that designated safeguarding leads (DSLs) should,

- attend NTSCB multi-agency training every two years and;
- keep their safeguarding skills and knowledge up to date *regularly but at least annually* (this can be done by accessing half-termly briefing sessions)

A separate report on training for school staff is available from lisa.wardingham@northtyneside.gov.uk

Quality, evaluation and impact of the training

The quality and effectiveness of the training is monitored through:

- Electronic evaluations sent four weeks after the training event
- Observations of the trainer's practice monitored against agreed standards

Evaluations of the training continue to be very positive with the vast majority showing learners are satisfied that the training met their expectations and was of high quality.

Despite the resource pressures that partners are facing we have maintained a pool of experienced trainers and greatly value the contribution from all agencies and the expertise and commitment that individual trainers bring to the programme. Observations of the trainer's training practice were carried out last year and will resume in 2017 – 2018 in line with the quality assurance process of bi-annual observations.

Annual NTSCB Conference

Working Together to Safeguard Children and Young People who are, or have been, missing, sexually exploited, or trafficked
8 February 2017

Our Annual conference was attended by **103** delegates and had the aim of considering best practice in our approach to working with children and young people who are, or have been, missing, sexually exploited, or trafficked, by exploring:

- Vulnerability of young people and the impact of exploitation
- Perpetrator profiles – identifying risks
- The local picture of sexual exploitation, missing and trafficked children
- Our approaches and processes when working with victims including; early help and support, return interviews and interventions
- Young people's experiences and what has helped them

The key Speaker was Zoe Lodrick, who has a highly regarded profile working in the field of sexual exploitation. Key messages that delegates were asked to consider included:

- Confidence protects young people against abuse, it does not invite perpetrators. Therefore young people who lack confidence are less likely to be able to defend themselves.
- Perpetrators are mostly socially skilled people, they use these techniques to groom, not just the young person but those around them.
- Perpetrators are not stereotypical 'creepy' people, they can't be identified easily. Research is often based upon those who get caught, and potentially this misinforms our perceptions of what a perpetrator looks like, therefore young people have no chance to identify offenders.
- Perpetrators don't necessarily see the 'C' in CSE – it is not the 'child' they are attracted to, it is the vulnerability. This could equally apply to adults who are vulnerable.

The involvement of young people

SCARPA's work is designed to help young people make better choices, develop resilience, reduce missing episodes and reduce risks. The SCARPA Squad (a group of young people who have benefited from the services of services of SCARPA) now work together to improve the lives of other young people.

The squad addressed the confidence with great confidence, explaining what worked well for them when they were in need of support and gave their 'Top tips' for hearing the child's voice. For more information about the Children's Society and the SCARPA Squad, visit https://www.childrenssociety.org.uk/users/scarpa-squad

The following delegate feedback assists in summing up this positive and well received event;

"*I just wanted to say how fantastic the conference was. I think it did exactly what it set out to do and ran really smoothly. Zoe's session was brilliant and the social workers also did a fab job. The case study was a great way to work together and generate discussion. The SCARPA Squad were inspirational and added*

"just wanted to say well done for yesterday it was a brilliant day and really beneficial. Really enjoyed it, again thanks"

More information on the achievements of the Training sub-group is 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 (SCR) were commissioned by NTSCB in the past year

although one case was considered to meet the criteria and agreement reached that a Scottish Child Protection Committee (comparable to the LSCB role) would undertake a SCR with a contribution from North Tyneside. Kevin was a young child who was placed with a relative in North Tyneside by the Scottish local authority. He sustained significant injuries which were assessed as non accidental and initial enquiries seemed to indicate the learning would be relevant to the placing authority. The draft report is awaited.

There have been two Learning Reviews completed.

Jake

Jake was a young child who lived with his parents. An incident occurred when parents had been arguing which led to physical violence and Jake sustained an injury during the incident.

A Learning Review was held in October 2016 facilitated by an Independent reviewer. Both managers and front line staff who had worked with the family participated in the learning review and were enabled to explore their practice and in particular, interagency working.

Several key themes emerged from the review which were:

- Sharing information meetings that take place between staff in primary care need to be documented.
- The importance of staff challenging decisions when they disagree with a plan.
- The importance of early intervention by with families regarding unborn children.
- Escalation of professional concerns and disagreements.

An action plan has been developed with regard to the recommendations and monitoring of the implementation and impact of those actions is being undertaken by the Case Review sub-group.

Daisy and Erica

Two girls aged 13 and 14 years abducted a two-year old child from her mother.

The police later located the two year old child who was apparently unharmed. In the recent months prior to the incident there was an increase and escalation in the concerning behaviours of both girls. A Learning Review was held in January 2017 facilitated by an Independent Reviewer. Both managers and front line staff who had worked with the family participated in the learning review and were enabled to explore their practice and in particular, interagency working. One of the learning points was that agencies awareness of the possible indicators of sexual exploitation is

varied and consideration needs to be given to how awareness raising activity is targeted. This will ensure practitioners are given every opportunity to increase their knowledge and understanding of CSE and the way in which children and young people may behave or respond to being groomed. The subsequent action plan from the review recommendations is currently being progressed by the Case Review sub group.

David and Martin – Learning Review from previous year.

There was a learning review held the previous year and the issues were in relation to the long term neglect of two siblings.
Several key themes emerged from the review which are:

- Assessing the impact of neglect over time
- Lack of engagement
- Consideration of the child's world
- Escalation of professional disagreements
- Role and views of the extended family

Two multi-agency training sessions known as 'espresso events' have been facilitated by NTSCB Business Manager and the Designated Nurse Safeguarding Children (Chair of the Case Review sub group) to share the learning from the Review.
The action plan developed in response to the recommendations from the formal independent learning review has been completed and a number of actions have been taken;

- Raising awareness sessions were held on both a single and multi-agency basis.
- A 'Process for Resolving Professional Concerns and Disagreements' and 'An Early Help Pathway/ Professional Conversations Framework for Locality Teams' have been written and ratified by the Board. A briefing paper outlining the key learning points has been written and circulated to staff in partner agencies.
- The NTSCB neglect strategy has been revised

Next steps

- Audit of the impact of recommendations and actions from learning reviews.
- Continue to disseminate the learning from case reviews
- Formalise communication and links with training-sub group and QILP

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 is well resourced and independently chaired.

The indicative timescale referred to in Working Together 2015 is that cases should be reviewed by the CDOP within six months. The figures for the last four years are outlined below and show a continuing improvement over the last 3 years. Although the timeliness of cases is important, it is recognised that other factors, e.g. serious case reviews, learning reviews and post mortem reports can have an impact on when a case is brought to panel.

Timeliness of reviews

Year	lumber of cases eviewed at panel	% of cases reviewed within timescale
2012/2013	43	30%
2013/2014	45	24%
2014/2015	52	40%
2015/2016	36	56%
2016/2017	37	62%

Total number of child deaths reviewed

The panel met six times between 1 April 2016 and 31 March 201 to review a total of 37 cases.

	2012/13	2013/14	2014/15	2015/16	2016/17	5 year average
Northumberland	15	12	15	19	12	15
North Tyneside	7	8	13	4	12	9
Newcastle	20	25	24	13	13	19
Out of Area	1	0	0	0	0	0
North of Tyne Total	43	45	52	36	37	45

Of the 37 cases reviewed in 2016/17 modifiable factors were identified in 15 cases. A modifiable factor is identified as something which: "may have contributed to the death of the child and which, by means of locally and nationally achievable interventions, could be modified to reduce the risk of future child deaths".

It is worth noting that the child death process also creates an opportunity at the meetings held before the panel review (Rapid Response, Morbidity and Mortality and Local Case Discussions) for services to identify other smaller, micro changes to practice, for example, a need for workplace training or amendments to internal policies and procedures.

In the 15 cases, some of the factors identified were:

- Co-sleeping and parental use of alcohol
- Co-sleeping and parental smoking
- Two cases related to consanguinity – First cousin marriages
- Maternal smoking and obesity
- Not immunised against influenza as there is no routine immunisation programme for under 2yr olds
- Young person did not receive the meningococcal ACWY immunisation
- Alcohol intake by the young person influencing behaviour

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 CDOP Annual Report, which reflects the learning during this period and sets out the priorities for 2017/18 will be available on the website at http://www.northtynesidelscb.org.uk/

Safe Recruitment and Investigation of Allegations Against Adults Working Children

Following the Ofsted Inspection of services for children in need of help and protection, children looked after and care leavers in February 2017, one of the recommendations concerned the role of the Local Authority Designated Officer (LADO):

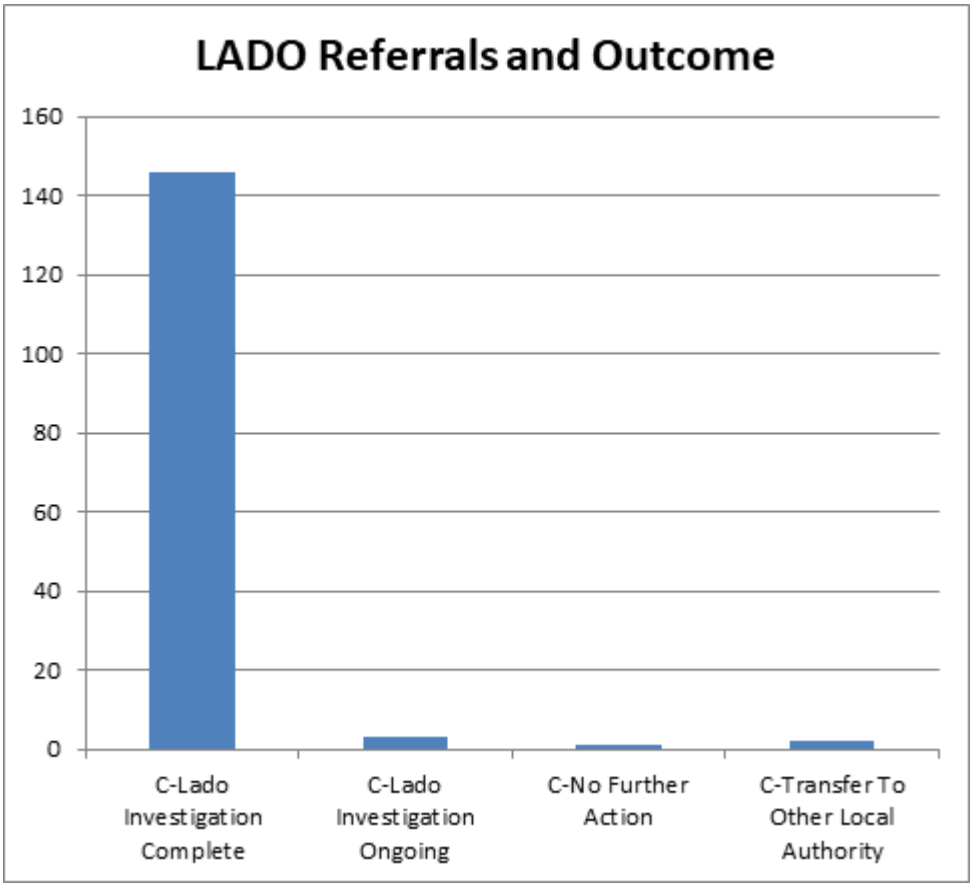
- Improve the timeliness with which designated officers complete investigations.

This highlighted an issue with that was already known to the local authority that the current arrangements needed to improve. Following the presentation of the 2015/16 LADO Annual Report

in September 2016, members expressed their concern about the robustness of the LADO arrangements. It was agreed that the LADO would review the arrangements and her subsequent report identified a fragmented approach which safeguarded children and young people but lacked resilience. Also the current system for recording allegations did not allow for effective monitoring of investigations. Since this time there has been a review of the service and the following proposal agreed;

The Local authority have been in the process of developing a Multi-Agency Safeguarding Hub and this became the opportune point to integrate the role within the Front Door service and transfer the role to a team manager where this would be a primary function.

The MASH goes live in September 2017 and there will be 2 MASH managers (children's) who will share the role of MASH manager and LADO so that someone always has responsibility to undertake the management of all allegations. Within this revised process the LADO will undertake all aspects of any allegation made, including chairing strategy meetings thus taking the allegation from referral to conclusion. This should ensure a more seamless service and improve the timeliness of investigations.



Reporting on LADO allegations is difficult and laborious due to the limitations of the current database therefore a bespoke module has been commissioned when the Local Authority moves to

a new electronic recording system in February/ March 2018. This will enable the reporting of LADO allegations in a more sophisticated manner and allow for greater analysis of data to target areas for improvement, development and raising awareness.

The LADO's will become part of the regional network in order to share knowledge and build on their skills. They will also undertake a developmental role with other agencies which has been identified as a gap when the role was part of a senior manager's responsibilities.

Private Fostering

Is when a child under the age of 16 (under 18 if disabled) is cared for by someone who is not their parent or a 'close relative'. This is a private arrangement made between a parent and a carer, for 28 days or more, and the local authority must be informed so that it can assess that the arrangement is suitable for the child.

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 that is completed. The number of private fostering arrangements in North Tyneside remains low and this has been the position for some time. In 2016/17, a total of 6 private fostering arrangements were notified to the Council. This is down 3 from the previous year. At the end of March 2017 there were four ongoing private fostering arrangements.

Year	Number of arrangements
March 2017	4
March 2016	2
March 2015	4

These low numbers appear to reflect the North East position.

Given concerns about the level of 'hidden' private fostering, local authorities are required to raise public awareness of the requirement to notify the local authority of private fostering arrangements and therefore to reduce the number of 'unknown' private fostering arrangements. In 2016 the board challenged the local authority in relation to the robustness of this awareness raising. The Lead Officer has raised the profile of private fostering within the social work teams and has revised the procedure for staff. Work has started to engage external promotion, for example with black and ethnic minority groups, the Port of Tyne and a local language school.

It was also recognised that the assessment of children and young people in private fostering arrangements needed to be more timely. In some cases good practice was identified and there was a proactive approach in supporting permanence. In recognition of the need to ensure the all notifications receive prompt high quality assessments, the Local Authority intend to locate the management of private fostering within the MASH and Social Work Assessment Teams.

8. Strategic Summary and What We Have Learned and Need as a Partnership to work on

In previous years we have noted the strengths of effective joint working and advised of potential weaknesses and partners have acted on this. As a result and alongside our improving capacity as a board we have been able to be assured that services are coordinated and effective. Importantly we have also been assured that as a result of the way in which partners cooperate with scrutiny, any challenge and evidence their responses joint working is transparent and responsive to learning. This means that there continues to be grounds for assurance and a collective recognition of challenges and risk. In respect of the recent Ofsted SIF inspection this confirms that the Local Authority and its partners provide good leadership and a good response to the needs children have and any risks they face.

As a result of the Children and Social Work Act 2017 the ways in which joint working to protect children and promote their welfare will be subject to change. Partners will continue to face multiple pressures and changes which can place a strain on effective joint working. Therefore as our understanding, and therefore our expectations continue to develop, an ever more sophisticated response will be needed. Going forward we therefore think, that the following will be important:

- That as a partnership pending the changes we remain focused on what we know works and continue to improve how we deliver on our statutory responsibilities
- That early help will be important in the coming year as it represents an opportunity to improve outcomes for children and ensure they are better protected especially in respect of neglect, radicalisation, bullying and exploitation
- We will continue to support and hold partners to account for the ways in which they prioritize and demonstrate the protection of children and expect them to continue to act on learning and advice
- We will support and seek evidence of positive impact of the Local Authority and partner transformation agenda and the introduction of Signs of safety which we feel provides an opportunity to refresh and update how we all work together to make timely interventions and judgments to protect children.
- We will continue to develop our scrutiny and review functions alongside improved and child centred engagement and communication, together with other partnerships, recognising the need to engage a wide constituency in making sure safeguarding children is everyone's business

Appendix 1

NTSCB Membership

Richard Burrows, Independent Chair
Angela Yilmaz, Head Teacher, North Tyneside Council
Nik Flavell, Interim Safeguarding Service Manager, Children's Services, North Tyneside Council
Dr Jane Carlisle, Group Medical Director, NTW
Jill Prendergast, Lay member
Ian Grayson, Lead Member for Children and Young People, North Tyneside Council
Jacqui Old, Head of Health, Education, Care and Safeguarding, North Tyneside Council
Jane Pickthall, Head of Vulnerable Learners, North Tyneside Council
Jill Baker, Senior Manager, Early Help and Vulnerable Families, North Tyneside Council
Peter Storey, DCI, Northumbria Police
Moira Banks, School Improvement Service, North Tyneside Council
Lesley Young Murphy, Executive Director of Nursing and Transformation, North Tyneside CCG
Lindsay Blackmore, Head of Service, CRC, Probation Service
Carina Carey, Head of North of Tyne, National Probation Service
Wendy Burke, Director of Public Health, North Tyneside Council
Dr Michael Vincent, Designated Doctor. Northumbria Healthcare Foundation Trust
Pat Buckley, Service Manager. NSPCC
Peter Xeros, Service Manager, Youth Offending Service, North Tyneside Council
Debbie Reape, Interim 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, CAFCASS
Louise Watson, Legal Advisor, North Tyneside Council
Ellie Anderson, Adult Social Care, North Tyneside Council
Martin Bewicke, Housing, North Tyneside Council

Appendix 2

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 2016 – 17 was as follows

Financial contributions 2016/17

North Tyneside Council	£ 87, 178	
North Tyneside CCG	£ 31, 823	
Northumbria Police	£ 5, 000	
CAFCASS	£ 550	
National Probation Service	£ 863	
Community Rehabilitation Company	£ 250	
Under spend from 2015/16	£ 2,169	
Total	£127,833	

Expenditure 2016/17

Staffing	£ 61,702
Venues, catering	£ 2,079
LSCB website, set up costs	£ 1,512
Section 11 analysis and report	£ 5,300
Learning Review	£ 5,643
Conference Guest speaker	£ 1,121
Membership, Assoc of Independent Chairs.	£ 1,500
Membership of NWG	£ 500
Independent Chair	£ 28,844
CDOP Co-ordinator post - contribution	£ 9,227
Total	£117,428
Carry forward to 2017/18	£ 10,405

Expenditure

Child Death Review process

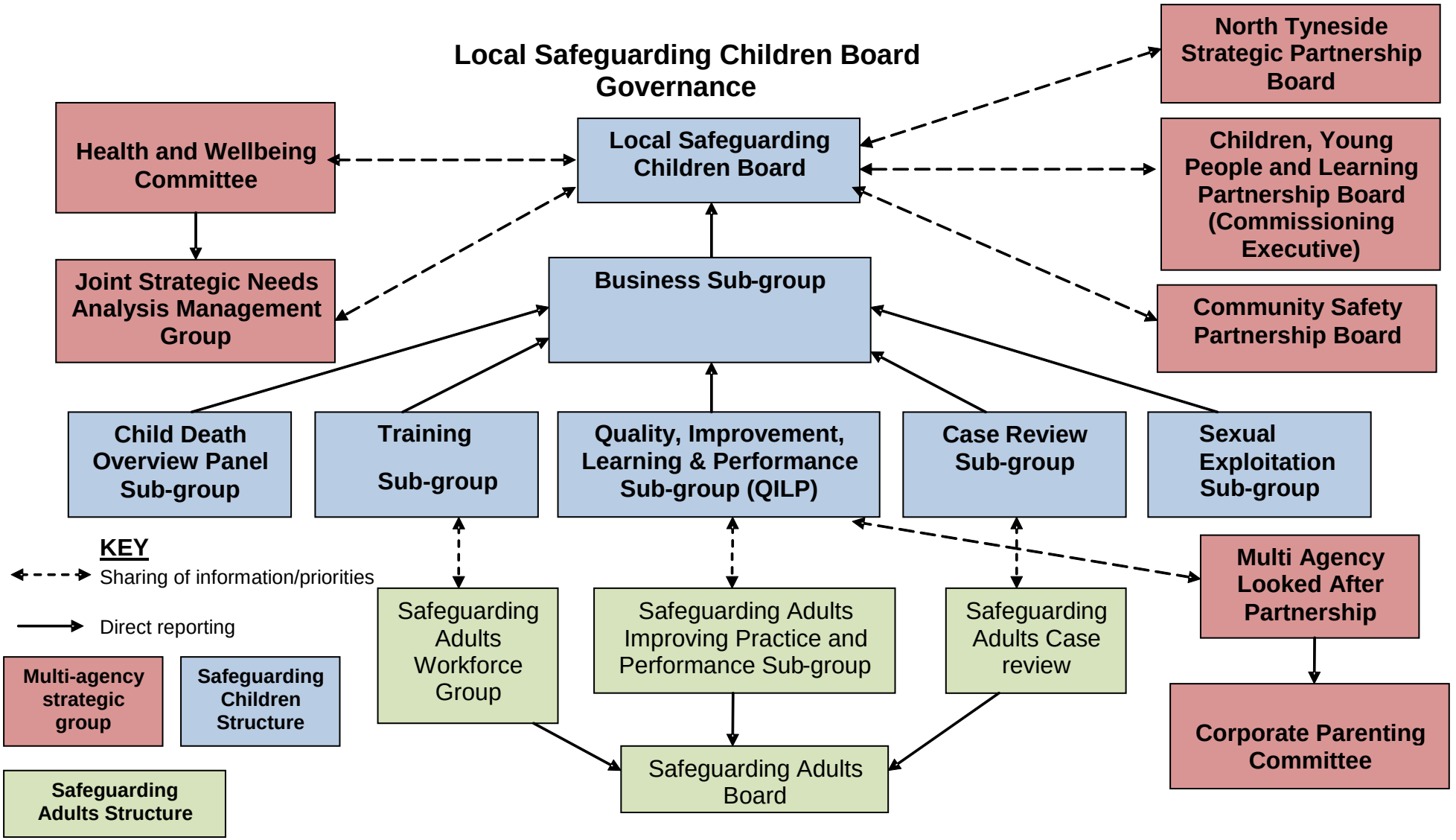
Expenditure in relation to the child death review process includes £9, 227 per annum as NTSCB's contribution to the cost of the Child Death Coordinator post. The cost of the post is shared between Northumberland, Newcastle and North Tyneside LSCB's.

Financial Revenue 2017/18

North Tyneside Council		£87,178
North Tyneside Clinical Commissioning Group (CCG)		£31,823
Northumbria Police		£ 5,000
CAFCASS		£ 550
NPS		£ 863
Probation CRC		£ 250
Under spend from2016/17		£ 5,646
	Total	£131, 310

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

Local Safeguarding Children Board Governance

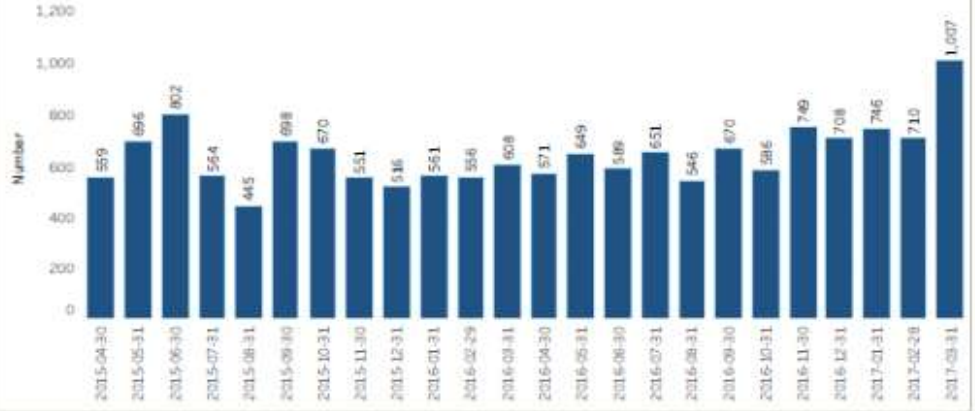


North Tyneside Safeguarding Children's Board Performance Report Quarter 4 2016/17

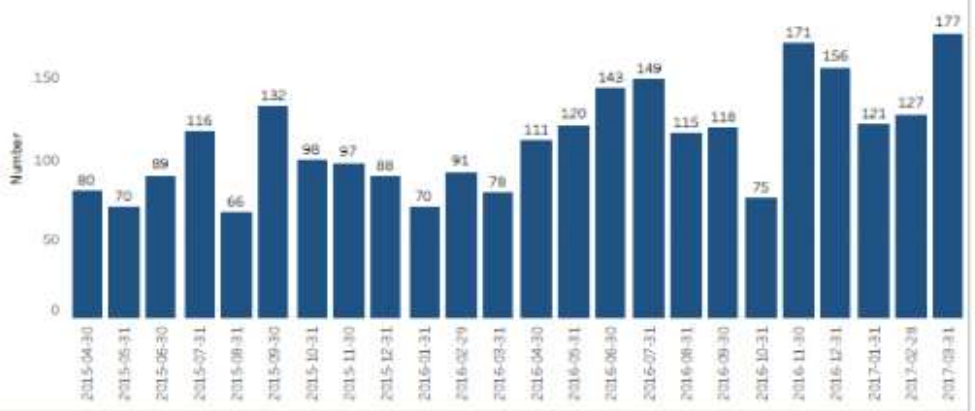
Author: Policy, Performance and Research, North Tyneside Council

Contact and Referral Dashboard

Contacts per Month



Contacts with a Stated Issue of Domestic Abuse



Police contacts remain exceptionally high particularly given the conversion rate is 17.8%. Discussions have taken place with the Police around this including time spent at the Front Door on how to reduce the number that lead to no further action. There is a ongoing improvement strategy which will be further explored as part of the MASH development.

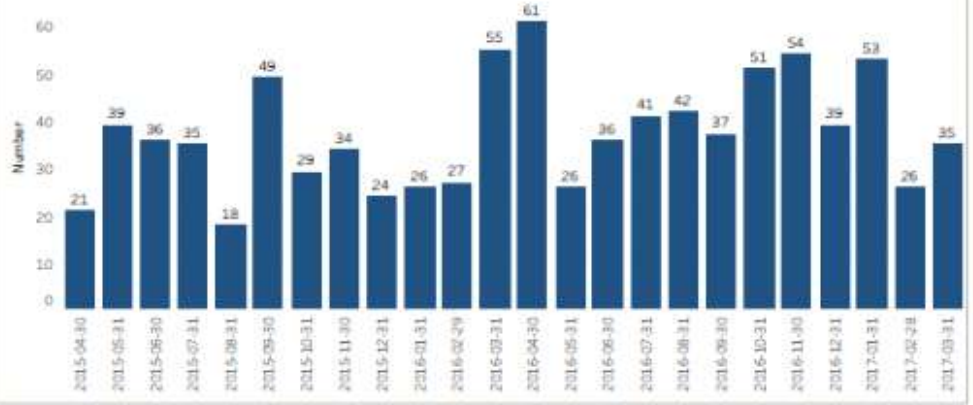
The Front Door continues to use the daily report to monitor contacts and ensure timeliness of action.

Work is being undertaken on thresholds with early help in order to reduce the number of contacts that do not progress to referral from partner agencies.

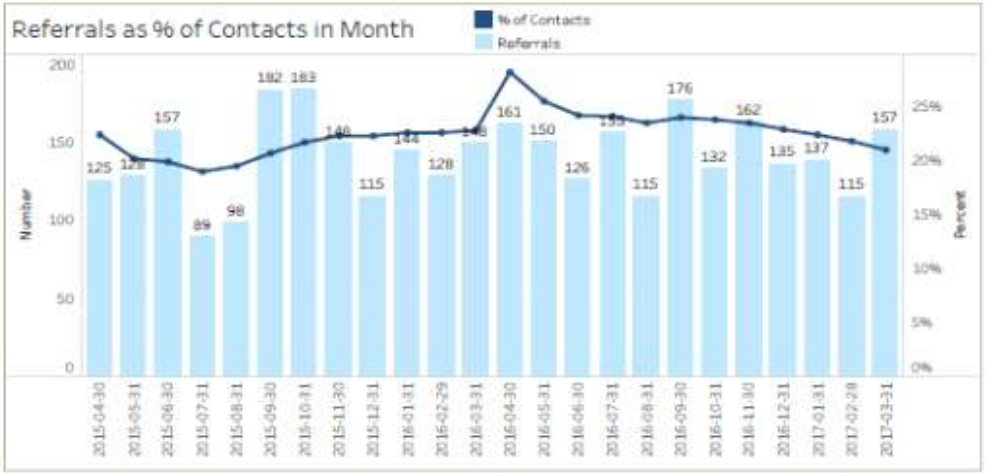
Re-referrals remain an area focus and development. Audits are undertaken to understand patterns, trends and areas of development. Two key themes arising are:

- The handover between early help and the Front Door.
- Understanding the history and impact on the child.

Section 47 Enquiries Initiated



Referrals as % of Contacts in Month

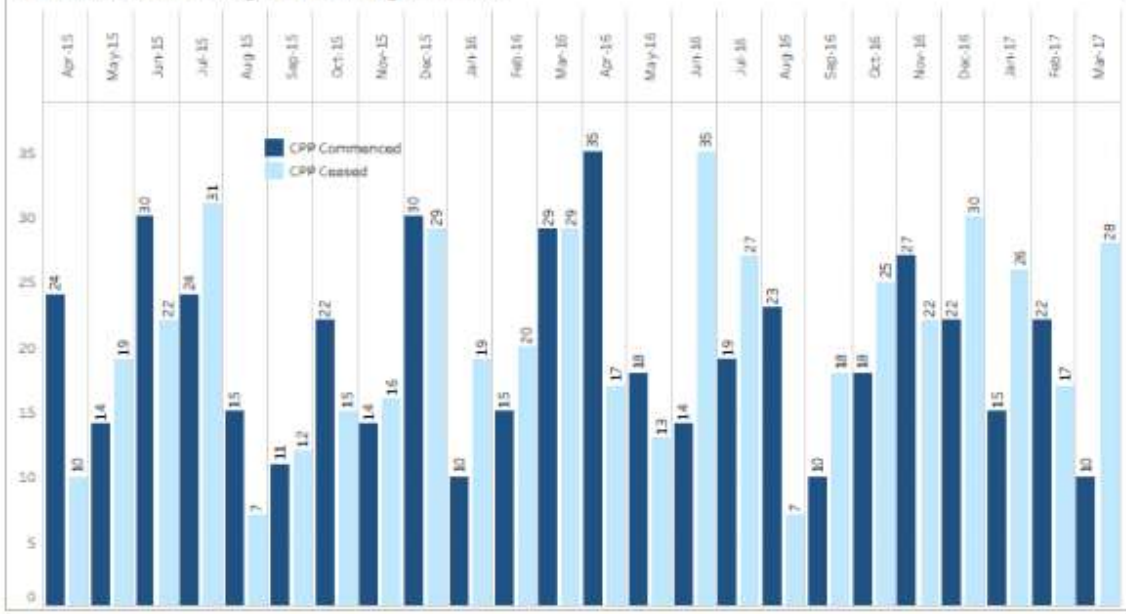


North Tyneside Safeguarding Children's Board Performance Report Quarter 4 2016/17

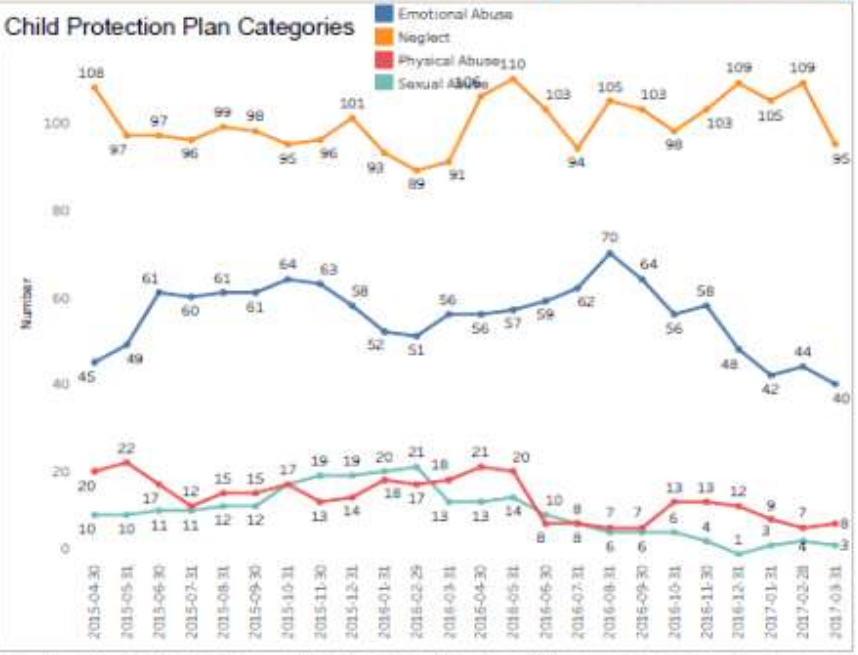
Author: Policy, Performance and Research, North Tyneside Council

Child Protection Dashboard

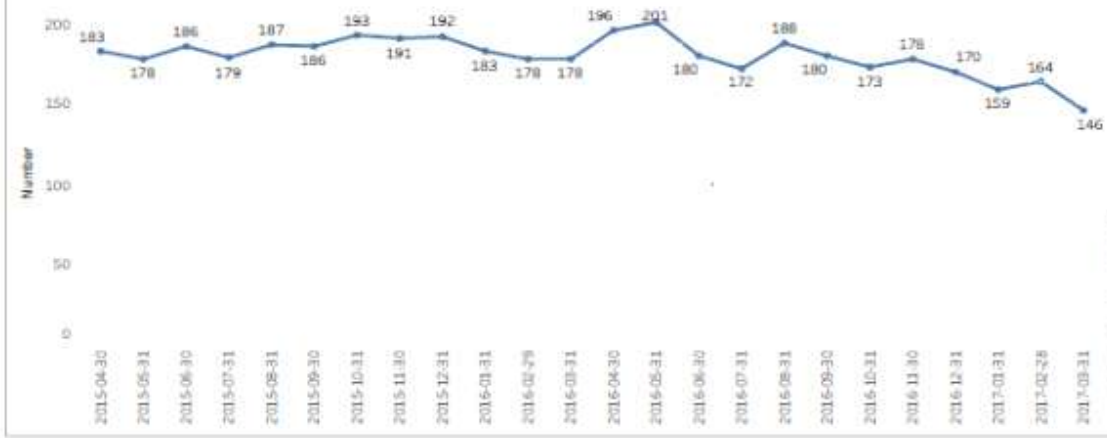
Children Commecning and Ceasing CP Plans



Child Protection Plan Categories



Child Protection Plans at Month End



More than 9 in 10 ICPCs (90.9%) were held within 15 working days of the start of the S47 enquiry / Strategy Discussion, in line with 2015/16 despite the increase in activity and above comparator groups which range between 77% and 82%.

While the number of plans commencing during the year in 2015/16 (238) and 2016/17 (233) was broadly comparable, it is the number of case closed during 2016/17 that has had the impact on the year end number of open cases. 264 cases were closed in 2016/17, compared to 229 in 2015/16 .

44 CP Plans (18.9%) commenced for the second time, this proportion is an increase on the 2015/16 rate of 13.9% and now is higher than the respective 2015/16 national, North East and stat neighbour rates. 12 of these commenced a second plan within two years (5.2%).

Safeguarding team are to review the use of advocacy services in terms of ensuring the voice of the child within child protection processes. This is to ensure that every child is offered the opportunity of an advocate who can express their views and wishes.

There has been a full review of the Legal Panel including discussion with Senior Manager Quality Assurance and the Safeguarding and Litigation Team Manager. As a result the Terms of Reference have been updated alongside the relevant paperwork required to present at the meeting. This will ensure the process is rigorous and robust allowing appropriate challenge of planning and responses to risk management. Legal Panel will be called Legal Gateway Meeting.

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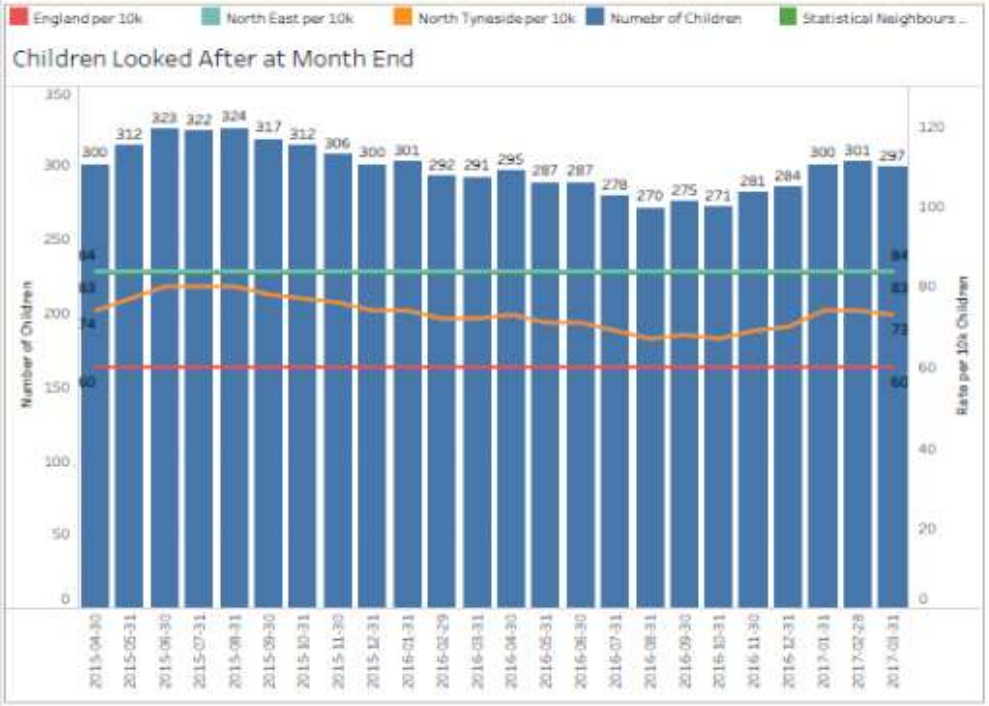
Looked After Children Dashboard



The looked after population are distributed across safeguarding and permanency team. All children with plans of permanency agreed at the second review transfer to permanency. Within the permanency team plans are continually reviewed to determine the appropriateness of looked after status. The plans within safeguarding are time limited as part of the safeguarding process and will either secure the child within the family or through plan of permanence.

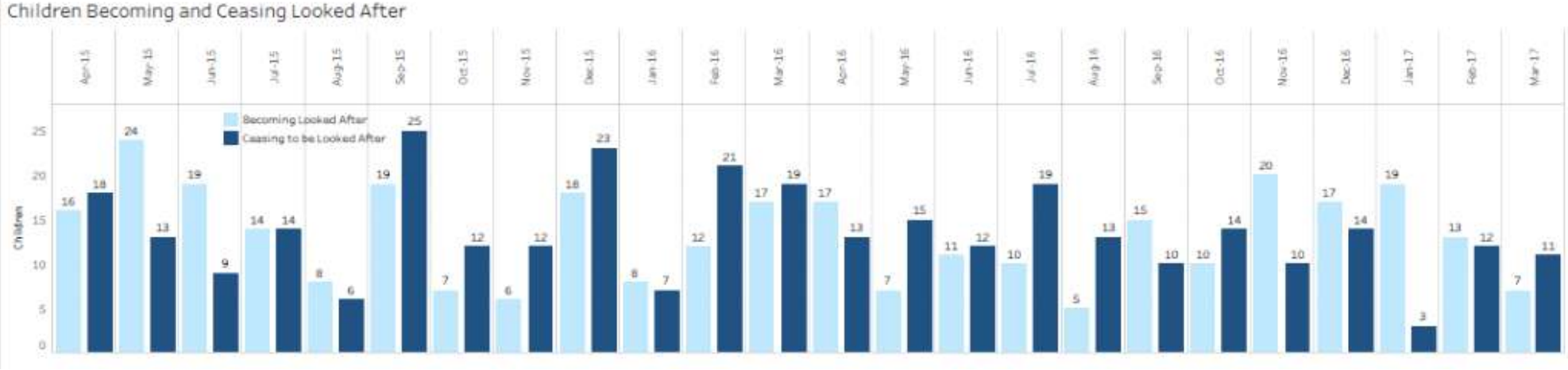
We are aware that across services we have in recent months accommodated children from large families and this has upwardly skewed our figures accordingly.

Most children and young people are placed with in house foster carers within the borough. A smaller number of young people with specific needs are placed with in house residential services. The use of in house residential assessment services allows planning for young people with particular needs to be placed in appropriate services outside of the borough.

During 2017 there is a plan to increase the number of in house fostering households, including specialist carers, and reduce the use of independent placements.

Children and young people are visited in a timely way in line with their care plans. During visits children are routinely seen alone and their views are gathered. In addition children and young people have access to advocacy services and their IRO. Plans are reviewed within timescales.

We are strengthening our offer around the Edge of Care and this will include flexible use of in house residential staff to provide targeted support within the family home. We are already piloting this approach with a small number of families.



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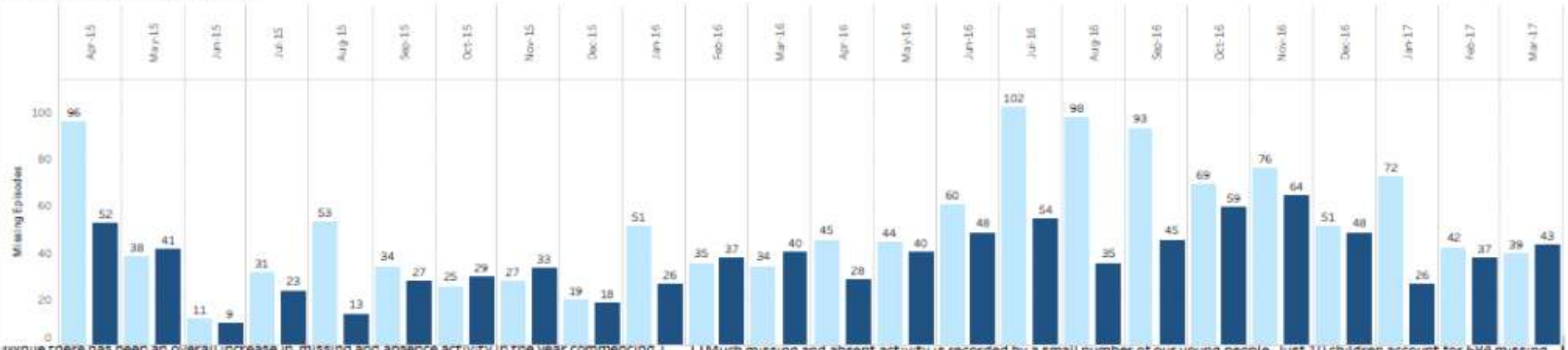
Missing Dashboard

Missing Episodes for Children in NTC Care Missing Episodes for Children Not in Care

Missing Episodes per Month



While there has been an overall increase in missing and absence activity in the year commencing 1 April 2016, the overall figures do not show the in year variations since 1 April 2016, nor the changes in the placement types from which children are going missing.

Missing and Absence activity peaked in Q2 July to September 2016, and has since declined, as demonstrated by both the monthly and the 3 month rolling average figures.

Overall approximately 60% of Missing & Absent episodes involve Children in Care.

Much missing and absent activity is recorded by a small number of our young people. Just 10 children account for 684 missing and absent episodes, or 28% of all activity going back to April 2015. However there has been a reduction over the last quarter in the number of episodes recorded by this group. In the 3 months to end Feb 2017 108 episodes, a 37% reduction compared to the 171 episodes in the 3 months to 30 Nov 2016. This is the result of targeted activity.

We are seeing change in the type of placements from which our children and young people are going missing, with reductions in LA residential accommodation, and increases in Foster Care and Supported Residence.

% Return Interviews Completed % Return Interviews Offered

Return Interviews Offered and Held