North Tyneside
SAFEGUARDING
CHILDREN BOARD

NTSCB

North Tyneside Safeguarding Children Board

Annual Report 2015/16

Contents of this report

1. Introduction

Welcome to our Annual Report for 2015 -16 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 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.

The report is organised in two main sections. The first considers the context, the role of the Safeguarding Board and forms a view on 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 these contribute 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 the Boards work in 2015/16 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”.

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 how the Board fulfilled its statutory functions and responsibilities.

The report was formally commissioned by the Board in March 2016 and was signed off by Board members ready for publication on 25 August 2016. Once Board members have had time to consider the learning and implications of the report, an Executive Summary will be published in Autumn 2016 and this will reflect the actions we have agreed to take to amend our current priorities and business plan.

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 form or language please 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 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

This is the third annual report to be published since I have had the pleasure of chairing NTSCB. I hope that the report will help inform and contribute to the continued improvements in how partners work together to protect children and promote their welfare in North Tyneside.

As with any such report it looks back to identify important learning so that as a partnership we are able to continue to look forwards. It seeks to demonstrate how as a partnership we are able to be child and outcome focused, in delivering the responsibilities we hold and being able to do this in a way that supports "relationships with a purpose".

Increasingly the Board is able to hold a mirror up to reflect a view of front line working arrangements and relationships. Critically in the past year we have been able look at practice in some detail and this has resulted in high levels of challenge across partners and for some partners in particular. This has been responded to positively and in ways that have further helped to inform how we all find new ways of addressing old issues.

The following key points reflect how as a safeguarding partnership we have addressed challenges, responded to opportunities and continued to build our capacity and capability to focus on ensuring that we can be assured children and young people in North Tyneside are safe as a result of joint working arrangements.

- All partners have maintained their commitment, and there has been a continued focus on making sure that each partner and Board member understands and takes their role and the responsibilities of the Board seriously.
- The relationship between the Local Authority and partners, and therefore with the Board is a central one. This report illustrates a continued step change in the ways in which the Local Authority has been able to provide leadership and develop this in the light of feedback from partners and the partnership. This has resulted in a stronger and more confident Board.

- The establishment of a Corporate Assurance Group that brings together Chief Executives and the chairs of the safeguarding partnerships on a regular basis has resulted in more strategic focus and priority as to how we are assured children and vulnerable adults are safe. This has been an important and welcome development.
- The Board has been able to actively contribute to the steady progress in redefining and resetting the wider strategic partnership arrangements for understanding local needs and ensuring clear leadership. As a result there is a stronger focus on safeguarding and child protection. This has enabled the safeguarding partnership to more actively engage with and influence key areas such as mental health and early help developments. Improving the interface and influence between partnerships and strategic priorities will continue to be a priority.
- As a result, NTSCB has been able to scrutinise and challenge significant commissioning developments and intends to formalise the learning from this for the benefit of commissioners and the partnership, to ensure that standards and expectations for protecting children are clear.
- Changes in the leadership of Children's Social Care and the important role social work led interventions play, has resulted in an open and constructive dialogue and the capacity of the Board to scrutinise and hold services more to account has supported the changes and improvements in the social work response.
- Despite "lean" resourcing the partnership has been able to significantly develop its capacity to further develop the ways it monitors partner joint working performance and the quality of this. This has resulted in targeted and significant analysis, feedback and challenge across some of the key points in the "child's journey" through early help and statutory interventions.
- As a result the Board has re affirmed its commitment to making sure there is a "clear line of sight" into practice so as to be able to scrutinise, learn, and challenge in order to be assured. The report recognises that child protection practice is always vulnerable, in part due to the nature and level of demands, capacity as well as the fact that this is a complex undertaking involving critical judgments and information sharing. Pace of scrutiny has improved during the year, which reflects the effectiveness of the Board to act, and whilst the volume

and breadth of safeguarding remains a concern, this has been mitigated by considered judgements as where to target scrutiny effort.

- Partners and the Board have focused attention of the arrangements for responding to children missing from home, care and education and therefore the risks they may face such as child sexual exploitation (CSE). It is fair to say that these arrangements have helped to identify the strengths and weaknesses of joint working at a strategic and an operational level generally. These have been embraced by all concerned with the Local Authority and the Police taking direct steps to address some of the learning and challenges highlighted by the Board. This has helped to inform other developments such as an increased focus on the "front door" arrangements, information sharing, risk assessment and management on a multi agency basis. It is significant and notable that lead partners have been able to approach this with transparency and have welcomed the opportunity to examine how they work together and how they provide evidence of this.
- This has provided NTSCB with a clear indication of how it can continue to develop how its supports joint working arrangements that can demonstrate evidence based impact and improvement. The Board will continue to support all partners in demonstrating how what they do is effective and is focused on improved outcomes for children, young people and their families.
- NTSCB has continued to build on and implement its long term strategy to embed core safeguarding standards as a basis for organisations to self assess and share how they meet and are able to learn from these standards. Resource limitations resulted in a missed opportunity to share these results as widely as hoped. This was recognised and has been mitigated through partners identifying further resources for the Board and by revising the programme. As a result of this learning the approach will be strengthened in the coming years. It is clear from the evidence and feedback, that this is supporting improved awareness, understanding, sharing and accountability across sectors and the Board. It has also informed the recognition that as a Board we need to find different ways of including education providers, especially as the role they play in protecting children becomes more significant. Representation on the Board will change in

the coming year to reflect this and to ensure a more effective way to learn from and contribute to this important area of provision.

- During the year it has become clear and has been recognised that some “whole system” developments would add “value” to joint working arrangements, especially around prevention and early help. NTSCB has been able to provide a “sounding Board” for some of the issues and options, as well as providing some key areas of challenge to ensure partners have had the opportunity to understand and work out the implications of changes. The Board remains concerned at some aspects of the approach and pace adopted in relation to the “tranformation” of early help arrangements, but has thus far been able to identify assurances and has started to put in place the monitoring and feedback arrangements. This will allow the partnership to make the necessary adjustments to joint working standards and expectations. This is further evidence that the Board is increasingly positioned to support partners by alerting them to potential risk. As a result the partnership will position and target a significant part of its efforts to support the effective protection of children at a time of significant change.
- Case review and dissemination of learning has continued to improve through the year, with the continued development of the notification, consideration and decision making process. During the year NTSCB commissioned a Learning Review as an alternative to a Serious Case Review and promoted learning from other regional and national reviews. Policies, procedures, protocols and pathways were updated and widely disseminated and all audits and review take these into account in order to test them.
- Through structured and regular review the Board has continued to work on some other key areas in relation to developing a more strategic approach to and understanding of workforce development needs, the launch of a new website and the need to improve communications and engagement with young people, families, and communities. Further progress in these areas remains a priority and whilst these are judged to be adequate, they have yet to fully reflect the wider shift and development in the role and impact of the Board that has been achieved in other areas.
- The year has continued to see an improved focus on risk, particularly those that can impact on an effective response to children who may not be safe or for whom

there are concerns. This has meant more focused lines of scrutiny, more open challenge between partners and an improved capacity to revisit areas where commitments were made in respect of key areas of joint working practice such as the quality of assessments, and information sharing. It has meant that as a Board we were for example able to negotiate and agree a strategic response to Female Genital Mutilation (FGM) and look at how the safeguarding needs of Children Looked After are being met. As a result the partnership is able to adopt a more strategic approach and balance priorities in the light of a clear view of risks and timely feedback and scrutiny of information.

One of the key questions a report like this has to seek to answer is whether in the view of NTSCB and on the basis of the evidence they have seen, is whether joint working arrangements are “sufficient” and meet the needs of children and young people?.

It is the conclusion of this report and the Board, that increasingly there is a more robust view of and testing out of joint working arrangements, as well as a better understanding of “what good looks like” and what is expected. That in terms of quantitative analysis and the audits and reviews of practice it has undertaken, that joint working relationships and arrangements are responsive to learning, reflect a focus on acting in the best interests of children and their protection. It is also possible to observe that statutory partners have demonstrated initiatives that indicate a desire to do better, not just in response to external pressures, but also in line with the clear vision the Council and its partners have for North Tyneside.

This leaves NTSCB with the need to continue its improvement trajectory and provide further constructive and proportionate challenge in the light of the significant risks posed by change at all levels. This means a need to remain focused on child protection, across early intervention and the statutory threshold, and with other partnerships develop a more integrated approach to the wider elements of safeguarding. The coming year will see the partnership focus more on children, their voices, being able to see more clearly how interventions produce positive outcomes and especially children who are missing from home, school, care and consequently from sight.

The risks and threats children face are not always obvious or easy to spot, and effective joint working on the basis of simple, clear and understandable arrangements helps to minimise the risk of these signs not being seen and acted on.

This will require the Board to give further consideration to how it addresses its key responsibilities, but also promotes dialogue and relationships that do not become deflected by the many and often legitimate points of view and perspectives. In this way the partnership will focus in the years ahead on strategic developments that will build capacity to improve the ways in which people work together, so that they, children, their families and the Board can have improved confidence that all will do their best.

Alongside this NTSCB will further define and share “what good looks like” and therefore what’s expected, and will measure this in order to promote partnership and joint working that reflects and respects each other strengths and seeks to support without compromising what’s important when there may be cause for concern.

You will find on the key learning and recommendations for what the next steps are on page 58.

Finally I want to note the genuine commitment and transparency of partners on being focused in making sure children are protected. Reports such as these necessarily have to list and itemise the complexities and broad scope of the issues and responsibilities. This report of course does that, but it also seeks to demonstrate how as partners and a partnership we engage with the difficult judgements that front line practitioners make on a daily basis, and seek to reflect an approach that supports them but also helps all to meet high standards and reflect what is important for children.

Richard Burrows

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
- National Probation Service (NPS) and Community Rehabilitation Company (CRC)
- 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. 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. The statutory objectives and functions of LSCB's are set out under Section 14 of the Children Act 2004. These functions are:

- 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.

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.

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

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.

Further clarification of the function of LSCB's can be found at:
www.legislation.gov.uk/uksi/2006/90/regulation/5/made

5. The National Safeguarding Context

Ensuring children and young people are protected from harm, abuse and exploitation has continued to be influenced by the national response to Child Sexual Exploitation and missing children. At central government level there has been a focus on coordinating approaches across government and in December 2015 the Prime Minister signaled reforms for child protection arrangements and the role of Local Authorities. This has resulted in new draft legislation and a review of LSCB's, SCR's and CDOP, which was published in March 2016.

The year also saw the continued impact of and learning from the Ofsted Single Inspection Framework (SIF) which includes a review of the LSCB. Outcomes from this process continued to be mixed with significant numbers of LSCB's and Local Authorities "requiring improvement". The year also saw the introduction of a multi inspectorate inspection programme, Joint Targeted Area Inspections (JTAI) the first round and theme was CSE and children missing, and these were undertaken by Ofsted, Her Majesties inspectorates for the police and probation (HMIC/HMIP) as well as the Care Quality Commission (CQC).

Inspection of partners and joint working arrangements continued to offer clarity re standards and benchmarks, but also placed additional pressures on the systems especially when outcomes were disappointing.

NHS England during the year further progressed its focus in safeguarding by publishing in 2015 its revised policy and arrangements(Safeguarding Accountability and Assurance framework) and this was a welcome focus in a sector that continued to be subject to change. Locally, Clinical Commissioning Groups (CCG) provided the interface between this framework and how services maintained a focus on safeguarding.

During the year the revised arrangements for probation services, NPS and CRC, continued to develop, creating opportunities to clarify revised joint working arrangements for safeguarding.

Nationally arrangements for education continued to develop with the continued growth of academies and free schools. In the year the “Keeping Children Safe in Education” guidance was rolled out and also subject to further consultation.

The introduction of new legislation around counter terrorism placed new duties on a number of partners and professionals, and as these bedded in the links between these arrangements and safeguarding have developed.

The response to FGM has maintained a high profile during the year with the introduction of “mandatory reporting” and the publication of coordinated information about prevalence.

Arrangements for children subject to private law proceedings have been led by CAFCASS who saw a 14% rise in applications over the year. Developments and judgments in the private law arena continued to focus attention on areas of formal joint working arrangements especially when children are placed with family members.

There was continued central government attention given to adoption and residential homes for children. There continued to be a concern that children who would benefit from adoption should do so with minimal delay and during the year there were various developments to support improvement, with proposals in January 2016 for changes in the law. The Secretary of State for Education commissioned Sir Martin Narey to undertake a review of children’s residential care in October 2015.

The year also saw the continued fall in the numbers of children and young people held in custody, but it also saw a number of reports and inspections that raised concerns about the capacity of the provision as well as the quality especially in respect of self harm and violence.

Domestic violence and abuse continued to have a high profile, with high levels of reported incidence and an improved understanding of when this should be seen as a child protection issue. There was a wider debate as to the need to re configure arrangements to address more effective early intervention and the recidivism rates.

During the year the needs of children and young people with mental health needs were given prominence with the publication of Future in Mind (Promoting, protecting and improving children and young people's mental health and wellbeing). This resulted in a number of key developments in the year.

Child poverty and neglect have continued to be the subject of concern and attention with reports of increasing numbers of children living in poverty. Childhood neglect remained the most common reason for taking child protection action during the year.

Many areas of public services and the voluntary sector continued to experience changes to funding, resulting in some areas in the need to change priorities and re allocate reduced levels of funding.

In England the year also saw significant developments around "devolution" resulting in increased freedoms to configure local government arrangements.

Summary

Making sure that children and young people are protected and safeguarded has remained a significant challenge in part because of the complex interrelationships between how economic and social policy priorities interface and work through the wide range of national, regional and local arrangements for how services are developed and delivered. The Local Authority, despite the significant changes to the resources they have available has retained the leadership role in respect of how partners (local and national) work together to deliver services that reflect local needs and priorities as well as making sure that the most vulnerable groups are protected.

4. 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
- 52 children aged 0 to 4 years and 251 aged 5- 17 were Looked After by the Authority
- 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
- There are increasing numbers of young people with special educational needs

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

Issues in relation to children and families:

- 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.
- We have so far identified 140 families who are experiencing long-standing problems and disadvantage
- There are currently over 400 children and young people who are subject to a child protection plan and /or looked after

- 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
- 1 in 5 children and young people live in poverty in North Tyneside
- 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

NTSCB also support and share the following vision and principles:

Vision

North Tyneside is a place where; Children and young people are respected, valued and listened to. Childhood is nurtured. Children and young people are happy, healthy, confident and safe.

Principles

- Children and Young People come first.
- Have a right to be recognised as people with views and interests.
- Have a right to be protected from harm and discrimination.
- Have a right to develop as curious, enthusiastic and autonomous learners.
- Have a right to the best health possible and to appropriate medical care.
- Have a right to live and play in a safe healthy environment.
- Have a right to an identity.
- Should grow up in a family and community with equality of access and opportunities.
- Parents, carers and communities should be supported in promoting the interests and welfare of their children and children in their communities.
- No child should be seen as a lost cause.

As a safeguarding Board we focus on the most vulnerable groups of children in North Tyneside with a primary focus on being assured that through effective joint working they are being protected and that early help arrangements ensure this occurs at the earliest point.

This means that we focus on a wide range of multi agency indicators which are most likely to tell us when there is a need for further consideration and scrutiny so as to better understand and be assured that the response is effective. From this we can also identify factors or questions that might suggest that partners and other partnerships may need to consider their working practices and priorities.

In the year our focus has been on some of the key points in what we call the “child’s journey” and this will be explained later on in the report.

We also draw on and share learning and evidence from other sources such as national research, learning from case reviews and inspections. We also ensure that partners have the opportunity to be involved in consultations that inform changes to the law and policy, for example the national review of LSCB’s.

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.

During the year a number of statutory partners such as NHS England, CAFCASS, NPS, CRC and Barnardo's, have all had cause to examine in light of their changed role and/or national brief how they maintain their local commitment to the Board. This has by and larger been a transparent process involving other partners at each stage of the process. The Board took and maintained a view that especially in the context of "statutory" membership any consideration of changes should be undertaken through the Board in order that any implications could be considered for their impact on the effectiveness of joint working. This has to date resulted in agreed clarifications as to the ways in which these partners maintain their commitment.

Financial contributions remain a reflection of a formula and local arrangement agreed some 10 or so years ago, and although Board members have continued to take ownership of setting the Board budget and managing any risks, there has been little progress in resolving the historical imbalances and reaching a more equitable and fully funded position.

In last years report we identified that the nature of the present budgetary arrangements and a reliance on two partners (the Local Authority and the CCG) posed a potential risk and was clearly acting as a brake on pace and improving capacity and impact. As a result, the local authority has increased its contribution for this financial year in recognition that the LSCB needs additional capacity to meet targets. This additional funding will allow the Board to develop its capacity to improve the quality and impact of core activities required to meet statutory responsibilities

and to better evidence the effectiveness and improvement of joint working arrangements to protect children and promote their welfare in North Tyneside.

The priority area where capacity and improved pace is required is basic administrative and organisational support for the Board and its members including meetings, agendas, reports, minutes and associated processes such as consultations, annual report, feedback and appraisals. The impact would include the release of Board manager time to “manage”, and improved efficiency in relation to core processes. These key areas are; performance management arrangements, awareness raising and promotion and Section 11 and 157 audits. It is therefore proposed to identify the optimum arrangements for these with a view to bringing forward further proposals, which may include investment in technology to support present objectives and increase efficiency.

Partners also contribute in other ways by attending meetings, releasing staff to sit on sub groups, sharing information, 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.

Attendance is a headline indicator i.e. it only tells a part of the story and Board minutes more fully reflect how members exercise their responsibilities. At various points in the year the Board has had to recognise and challenge some aspects of attendance and contribution, particularly in ensuring that subgroups are chaired, have sufficient and appropriate representation and are working to agreed targets. The Independent Chair has had occasion to raise challenges and to work with some partners to address these issues. These remain, reflecting as they, do the pressures on partners and ongoing areas of concern. This is especially the case when partners are subject to review and or reorganisations and this has been the case for both Children’s Social Care and Northumbria Police. The Independent Chair has met regularly with senior leaders from each of the above organisations to monitor and address how their representation can be more consistent and effective. In relation to Northumbria Police, they increased resources to enable this more consistent and appropriate involvement.

Also during the year, the Board recognised that there was scope for further improvement in how the Board had a more direct relationship with schools and education providers. This has resulted in a renegotiation with the Local Authority in the light of their changing role and plans are now being implemented to strengthen relationships and reporting.

The Board has benefited from the contribution of the NSPCC who have provided valuable challenge and support. This has highlighted the need to find ways of securing Board representation in respect of the local community and voluntary sector and this is work in progress.

A key part of the revised arrangements for helping the Board to focus on core business and responsibilities with greater effect within its limited resource base that was identified in previous reports was the role of the Business Group. This brings the chairs of the sub groups together on a regular basis with a view to coordinating, integrating developments and the work of the sub groups, so as to ensure that Board meetings are well prepared for and as focused as possible.

The Business Group has had an impact but the full potential of this has not been fully exploited due to a high number of cancelled meetings and changing representation. Challenge and change in the later part of the year will hopefully see an improvement and the group is now chaired by the Business Manager. Additionally some key changes of personnel have taken place but there are now chairs in place who are positioned to exercise stronger leadership roles.

The designated health professionals have provided consistent and high levels of support to the partnership as have health partners, who have provided strategic support and challenge.

The lead member has had problems with attendance due to a conflict with other council meetings but has maintained and exercised his influence and positive contributions. Lay members continue to support the Board and are active members

in two of the sub groups. The capacity for supporting meetings and the future timings is currently being addressed.

During the year the deputy Chief Executive of the Council attended a meeting as did the Chair and members of the scrutiny committee.

A development session was held for members and those that were able to attend were able to focus on the early help agenda, progressing the child's voice agenda and taking stock in terms of key risks and challenges in the light of learning from the last annual report. It was agreed to maintain the current plan and objectives but look to align these with available resources and re prioritise the focus on performance management and quality assurance arrangements (PMQA) as providing the lead for how as a Board we are able to scrutinise, challenge and be assured.

Key learning and next steps

- Full and active participation and attendance by Board members has on the whole been of a good level, but there remains scope for improvement, especially as some of the statutory partners stabilise their own internal arrangements.
- It has been recognised that with the additional resources available to the Board induction and Board member evaluation arrangements can be progressed, this will help support the Board member role
- The new leadership arrangements for the sub groups have started to impact on pace and quality but have also highlighted the need for members to consider the importance of and priority they place on the role of the business group. This is now chaired by the business manager and this role will be enhanced by the introduction of dedicated support and administrative arrangements.
- The formation of a shared sub group to address sexual exploitation (including CSE) has highlighted the opportunity to review the numbers of and role of sub groups, as well as the consideration of more time limited and task focused groups to scope or progress specific issues, and this is being progressed. It does highlight the challenge for members to be able to recognise the key role these groups play and to make sure these are supported by appropriately skilled and experienced representatives.

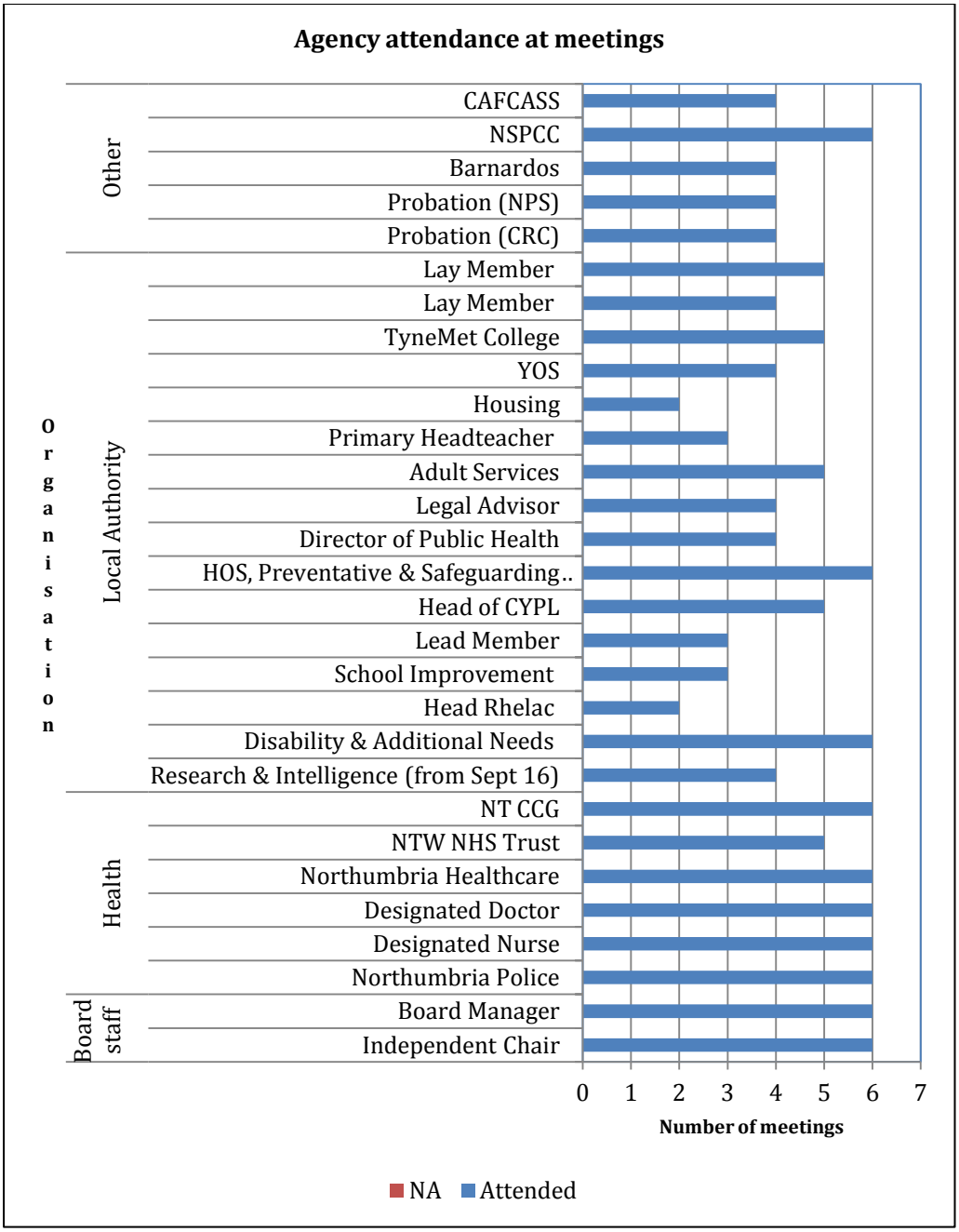
Board membership

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.

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.

The Board met bi monthly during 2015/16 and held one development session for members. The table below shows attendance by members or a nominated deputy during this period.



The start of April 2015 saw several changes to membership as a result of members leaving. New appointments included the Head of Safeguarding, Childrens Social Care, Interim Director of Public Health, the Designated Nurse and Northumbria Police representative, These changes impacted on the chairing of sub groups as new Chairs needed to be appointed as follows:

- Business Group, chaired by Russell Pilling Safeguarding Operations Manager, Children's Social Care

- QILP, initially chaired by the Safeguarding Lead, Northumbria Healthcare until September 2015 when Trish Grant, Named Nurse, Northumbria Healthcare took over
- CDOP chaired by Sheila Moore, Independent Chair
- Case Review sub group chaired by Jan Hemingway, Designated Nurse.
- Training sub group, following a vacancy is chaired by Louise Robson, Workforce Development Manager, NTC
- Vulnerable Adolescent sub group, chaired by D/I Jackie Coleman, Northumbria police

The Board also welcomed new member Jill Baker, Senior Manager, Early Help and Vulnerable Families, North Tyneside Council.

Sub Groups

Appendix 2 shows the sub groups that operated during the year. Please note that as from March 2016 we have stood down the Vulnerable Adolescents Sub Group as NTSCB formed a joined up sub group with the Safeguarding Adult Board to address Sexual Exploitation/CSE and children who are missing.

We are currently, in the light of the learning from the annual report looking at a range of options for the sub group structure and more use of task and finish groups to look at specific issues in order that the board can determine a more strategic impact.

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 2016.

7. Review of 2014/15

The Annual Report for 2014 -15 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 2016 onwards. Importantly our awareness of what is not being kept on top of and why, is improved and this supports Board members in their leadership role.

Below is some of the progress:

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

- ✓ Launched the independent NTSCB website to increase the 'brand' and visibility of the Board – this has helped strengthen the identity and role of the Board as an independent partnership and learning has highlighted further improvements and opportunities that are being progressed

- ✓ Developed a Communication strategy to strengthen the dissemination of key messages – this is helping to target information and messages to the right people in the right place at the right time, it has highlighted the need to adopt possibly with other partnerships an approach that raises awareness at a more general level across the communities of North Tyneside

- ✓ Linked with the SAB to deliver a range of learning events aimed at promoting adult and children's safeguarding agenda's among the public and professionals –

This has a resulted in a greater level of understanding and dialogue between the 2 partnerships and discussions are taking place to scope further potential for cooperation, not withstanding the forming of a joint adult Board with Northumberland.

- ✓ As a Responsible Authority, the Business Manager on behalf of NTSCB, has objected to two licensing applications where there were concerns in relation to the under age sale of alcohol

- ✓ We continued to improve the way as a Board we engaged with key issues, priorities, risks and outcomes. This has meant higher degrees of agreement, debate and challenge.

Priority 2 - Prevent harm and the protection of vulnerable groups

- ✓ The NTSCB Thresholds document was revised in 2015 and disseminated across organisations across North Tyneside and embedded within NTSCB procedures and training. The document provides a framework for practitioners, managers and volunteers who work with children, young people and families to help identify when a child may need additional support to achieve their full potential. An evaluation of its effectiveness will be undertaken in 2016 to inform how best to improve on how it is understood and applied in practice – this has served to raise awareness across all partners and across the front line of the importance of their being guidance for and understanding of the circumstances when people need to work with others and when to escalate. The Board has also been able to routinely reflect on any potential impact for thresholds of matters considered. The PMQA framework is being developed to better reflect thresholds and challenges to practice and service planning have been achieved as a result.

- ✓ Ensured a focus in multi agency training on the importance of Whole Family and the early help approaches, including Early Help Assessment in the NTSCB programme.

- ✓ Coordinated, delivered and promoted training on harmful practices in partnership with the local authority (CSE, legal highs, Prevent, mental health issues) - as a result core local authority staff and staff from partners have been able to acquire and increase the knowledge base of parts of their workforce.

- ✓ Identified key learning from research and best practice in working with neglect which informed the update of neglect training – this has helped to highlight the need for the Board to consider in the coming year a more strategic approach to neglect and how as a partnership we can be assured that practice is effective.

- ✓ NTSCB have supported Childrens Social Care and the NSPCC to implement the Thriving Families project. The project offers an integrated approach to neglect with the aim of enhancing local partnership working by filling critical gaps in neglect assessments, plans and support services. This activity and learning has helped to inform the view that we need as a partnership to be assured that neglect is sufficiently recognised, understood and responded to. We have also learnt from this that because of our narrow resource base we need to plan more clearly as to how activity we support informs our overall assurance remit.

- ✓ A procedure and multi agency pathway has been developed for responding to cases of FGM. This is intended to raise awareness among practitioners so they know how best to respond if they have concerns. As a result we have recognised that this clarifies one area of our future PMQA agenda and as a result we will look to lead partners to provide key information and to support the Board formally reviewing progress and learning.

- ✓ Work has been undertaken by the Named GP and Designated Nurse to raise awareness of FGM amongst all clinicians in Primary Care. This included e.learning training and face to face training.

- ✓ Child sexual exploitation has continued to be a high priority and we have successfully co-ordinated the review and implementation of a joint Sexual Exploitation Strategy and supporting action plan with the Safeguarding Adults

Board and Community Safety Partnership – outcomes and learning are addressed in the section below.

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

- ✓ NTSCB has supported the integration of feedback from children who have experienced the care system and promoted systems for capturing feedback from children about their engagement and participation in meetings, through training. For example promoting tools to capture the voice of the child in child protection conference training – This learning has highlighted the need to take further feedback and reports from the service that oversees child protection meetings, it has also enabled us to more fully consider the performance information that is looked at in relation to CP meetings and the outcomes we have tested through analysis and case file audit.

- ✓ Provided support for the North Tyneside Councils Engagement and Participation Team to gather the views of young people in relation to their awareness of sexual exploitation which fed into Healthy Relationship sessions in schools. – This has served to support the ongoing Board agenda of developing a more strategic approach to the child's voice and how the Board draws on what groups of children are doing and telling us.

- ✓ As the report acknowledges elsewhere pace in this area was flagged up in the year as a concern and was subsequently addressed at the Board development session in March 2016 and this has resulted in the recommendation to re set the priorities and approach in the coming year

Priority 4 - Learning and Improvement positively influences multi agency practice

- ✓ Provided challenge and support to partners including the Local Authority to review and revise notification procedures including the Significant Incident Notification process. As a result the case review function of the Board and the

Learning Improvement Framework are up to date and focused on maintaining the Boards capacity to consider all notifiable incidents for case review. This means that the Board has improved its capacity and performance in this area.

- ✓ 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.

- ✓ Collated and published examples of good practice by practitioners working in North Tyneside

In addition to the impact in relation to our headline priorities during the year we also fulfilled our statutory responsibilities and developed our base line capacity, experience and competency in respect of the following.

Child Sexual Exploitation /Children and young people who go missing in North Tyneside

During the year the partner arrangements for responding to and managing reported concerns and known incidents of CSE have continued to develop. The Local Authority with Northumbria Police and other partners have continued to exercise leadership.

The Boards challenge for partners continued to be improvement in the reporting of how information is shared, used and what impact this is having on children and young people at risk or subject to sexual exploitation. (This report evidences elsewhere the steps the partnership took to raise awareness, support training and hold partners to the commitments they made in respect of the Strategy and action plan).

During the year there has as a result been an increased focus on children who go missing, as this can often be one of the indicators of sexual exploitation, and children

are likely to be vulnerable if they are either not where they are supposed to be or they have run away.

The partnership response to missing children and sexual exploitation is serving to help us set new standards and find new solutions to old problems.

There were 985 reported Missing Episodes in the year April 15 to March 16, for 283 individual children. 117 children had repeat episodes, while 166 children only had a single missing episode during the year. 547 missing episodes were for children who were Looked After by North Tyneside in 2015/16, 55.5% of the total figure.
Children are mainly reported as missing to the police, who work as a part of the Local Authority Children's Services Front Door arrangements, where all contacts, information and referrals are considered and coordinated. In the year Northumbria Police brought to the Board, proposals to change the way in which they respond and manage reports of children who are missing. They proposed the introduction of an "absent" category to respond to incidents when children go missing for very short periods of time. This was in line with national police practice. The partnership supported this change after some robust challenge and was assured that there were safeguards in place to reduce the risk of missing reports being downgraded or overlooked. The police agreed to report back to the Board on progress. (NB Subsequently the All Party Parliamentary Group produced a report raising some concerns as to the advisability of this practice, so the partnership will revisit this).

Children who go missing have a right to what is called a "return interview" which means they should be seen by an independent and appropriate person, who will explore why the child went missing, what he or she was doing and who they were with and try to identify any other important information that may indicate the need to make further enquiries or take further action to protect the child or other children.

During the year partner performance in making sure these interviews take place has improved substantially and there is now regular reporting and some evidence that the learning and intelligence gained is being put to strategic and operational use in an improved way. 94% of children who went missing were offered an interview and 19% of them turned this down. There are dedicated workers who support this

process and engage with families at this point. The partner protocol has continued to bed in especially in relation to children looked after with designated points of contact across all accommodation.

The recruitment (May 2015) of a designated missing persons worker in partnership with the Children's Society and SCARPA (Safeguarding Children at Risk Prevention and Action) has improved monitoring of children who are missing and strengthened the links with other vulnerabilities such as CSE.

Key learning and next steps

- Sharing information and intelligence about children who go missing as well as responding to all reports within a consistent and systematic multi agency approach remains central to an effective operational and strategic response. It is the view of the Board that these arrangements and the outcomes they have resulted in have improved during the year.
- The Board continues to offer support and challenge for partners to ensure that this information and intelligence is used to further improve the operational response and to develop a more comprehensive understanding of and approach to children who go missing and who are reported missing or as being absent.
- This means a need to consider in more detail why children go missing and where they go missing from. Understandably as they are often the most vulnerable children, children who are looked after have been an important focus in the past year, and considerable improvements have been noted in performance and in putting in place trained people at key points across the care system. This means that when a looked after child is reported missing there is now a high probability that there will be a consistent and high quality response. It is also encouraging that the Local Authority have self assessed their response and identified clear areas for further improvement in terms of improving the quality of engagement with missing children and their families/carers and strengthening the links with more focused care plans and planning.
- However it is the view of NTSCB that this approach needs to be broadened to develop a focus on and a better understanding of children who go missing from home (who on the basis of available national statistics are a significant number) and children who are missing from education. In this way in the coming year, if

significant progress is achieved by partners, the Board can be more assured that there is a comprehensive response to and understanding of where children go missing from, why they do this and therefore how they can be better protected.

- The availability and integration of information and data from across partners and sectors continues to be a challenge, which if not addressed in the view of the partnership is likely to constrain progress. It is therefore reasonable for the partnership to be made aware of on a regular basis an analysis of when, why and where children are missing from home, education and care. This then allows partners operationally and strategically to better assess their performance in working together and to demonstrate how this has resulted in improved outcomes for children.
- The Board will therefore prioritise supporting this approach through scrutiny and agreeing with the relevant partners an approach that ensures that this next key step is achieved.
- The Board has been assured that the Council in respect of its responsibilities has afforded priority and appropriate levels of scrutiny and that the outcomes from this have been made available to us. Likewise other partners have been able to demonstrate through their Section 11 and directly in Board discussions their position.

Child Sexual Exploitation

LSCB's are required to formally assess the effectiveness and impact of the partner response to CSE. During the year there has been continued development and improvements in the response to CSE and how this has been reported to the Board.

There has also been consistent challenge provided by the partnership focused on its own effectiveness in progressing actions agreed and to some partners, (re their leadership role and more generally in issues around sharing information and analysis). This has resulted in improvements so that there is more evidence and understanding of how joint working arrangements are ensuring a effective response to children who are or who are at risk of being sexually exploited.

Arrangements are clustered around the Front Door so as to ensure that all information and reports are effectively considered on a multi agency basis. There is

an established Missing, Sexually Exploited and Trafficked (MSET) multi-agency panel arrangement to identify and monitor the support and protection available to children who go missing and who are at risk of CSE. The MSET Panel meets monthly, is chaired by the Police, and summary data regarding missing children is presented including the consideration of the most frequent and persistent 'missing' children episodes. Care plans are reviewed at MSET as is intelligence regarding hot spots and other 'push and pull' factors influencing children's behaviour.
The identification of dedicated and specialist staff and roles across partners has had a positive impact in ensuring that there is a focus on the child and that additional support in the form of training is provided.

There is also evidence of a detailed approach to improving capacity and capability within the Front Door and MSET arrangements involving regular audit of cases, revised vulnerability checklist and tools and improved reporting and analysis of performance information and outcomes for children within the Social Care led parts of the system. NTSCB have requested a review of the MSET arrangements, terms of reference were agreed and the final report is awaited.

Since April 2015, 45 children and young people have been identified as being at risk of sexual exploitation. By June 2016, 32 of these children and young people were no longer assessed to be at risk of CSE, with a remaining 13 children and young people currently classed as being at risk. During the first 3 quarters of 2015/16 an average of 12 children per quarter were identified as being at risk of CSE, 5 children were identified as being at risk during quarter 4 2015/16.
Two children under 10 year old (4%) were identified as being at risk during the period from April 2015; 10-14 year olds made up 35% of those identified whilst those aged 15+ accounted for 61% of concerns.

Listening to and understanding the experiences of children and young people, especially victims of CSE is important to ensure response at all points of intervention is victim led. The present partner strategy places an emphasis on making sure that how partners work together achieves a balance between recognizing when children are at risk of, or being exploited with an effective operational response that also support prevention, disruption and prosecution.

A NTSCB conference held in February 2016 involved getting the views and perspectives of children and this will support the development of strategy as well as operational responses.

One key area of learning has been the need to recognise that sexual exploitation is not just a significant issue and threat for young people, but that vulnerable adults can also be subject to sexual exploitation. Equally there is a responsibility to better understand and respond to those adults who exploit either vulnerable adults or children. As a result the 3 partnerships (NTSCB, Adult Safeguarding, and Community Safety) agree to work together to provide clear leadership, review and develop the strategic response in North Tyneside aswell as providing each partnership with evidence that the response was effective, improving and supporting the strategic objectives. This group will oversee the continued improvements in how partners provide and explain their performance, test the impact of this strategically and from the perspective of victims. It will ensure that there is an improved local understanding of and therefore a more targeted and proportionate approach to prevention, intervention to protect children and vulnerable adults and disruption to ensure that they are better protected in the future.

This will include building on important steps that have made in the year to find a more proportionate and balanced response. In part because much of the regional learning has been focused on a large scale operation that has not directly impacted on North Tyneside, though there is evidence that learning from this has been applied. It is therefore likely that achieving a better understanding of local prevalence although a challenge, will be the key to further strategic impact. There is evidence that sufficient information and experience is now available to achieve this, and some key elements are in place such as the arrangements for sharing “addresses of concern” and the approach to regulating the night time economy and taxi driver licensing.

Key learning and next steps

- Partners and the Board have recognised the learning that places a greater emphasis on the reliability, capacity and capability invested in the Front Door

arrangements as being key to an effective and improving response to CSE and missing children. There is evidence that the lead partners (Children's Social Care and the Police) are better able to evidence how these arrangements are working to produce positive outcomes for children.

- The Local Authority has continued to provide a strong local lead and there have been significant steps and tests made of arrangements within the year that have complimented and supported those undertaken by the Board.
- NTSCB has recognised that there is a need to continue to support and challenge partners to report and evidence how learning continues to be applied. The development of an approach that is driven by understanding of local prevalence and is focused upon children at risk as well as responding to children who are or have been sexually exploited is an important benchmark to be achieved in the present year.
- There is a recognition that whilst we need to be assured that there is an effective response in respect of CSE, this needs to align with the need to be assured that the response to all other forms of abuse and harm is effective. This has two direct implications, firstly it supports the view that there should be an increased focus upon and support for the way in which information is shared and managed by partners and how this results in more targeted operational arrangements and multi faceted strategic impacts which may present a wider opportunity. There is therefore a need for the safeguarding partnership to focus on the points at which people report and share concerns. Secondly, it necessarily raises some additional challenges and places a spotlight on the partners who lead these arrangements, and in this respect the evidence suggests that they need to continue to improve how they share and report learning and progress to the Board

Performance Management and Quality Assurance Framework (PMQA)

In line with developments across the region and in other LSCB's nationally we continued to focus on developing our set of high level indicators that enable us to monitor across the child's journey and from a joint working perspective. Developing these indicators as well as checking we have the right ones is a significant challenge and many partnerships have designated specialists to support this. The Local Authority recognised this in 2014/15 and provided access to their specialist resource,

but for a number of reasons this did not prove to be successful. As a result the Independent Chair raised with partners and the LA the possible implications and risks this situation may result in, both in terms of maintaining pace and also in respect of key areas of joint working practice. The LA was able to re assign specialist support in October 2015 and this has made a substantive and significant difference in terms of pace, development of capacity and implementation of the approach. It does remain in part because of the need to “catch up” as well as “keep up” and that it is a complex undertaking, and an area that requires continued support by the Board.

High level indicators and also the further scrutiny and analysis, these can trigger is necessarily complex as it requires a number of partners to supply data and analysis, and in some instances this data/analysis from different sources needs correlation and coordination.

Over the year we have been able to complete and test some of the indicators and this has either resulted in an outcome that requires planned and regular high level monitoring i.e. the information does not suggest an immediate cause for concern as to joint working performance or significant trends in the child’s journey. Or it has resulted in the need for further information sharing and analysis to determine either assurance on the basis of what this produces or the need for escalation either in terms of requiring assurance from partners and or reporting into the Board .

To some extent the development of this arrangement has offered challenge to partners in itself, in that there has been a need to understand why information is important and also that it is helpful to provide analysis. In this way the partnership can act as a “mirror”.

The Board and the Independent Chair have had to formally challenge a number of partners in respect of them making available data and analysis on a number of occasions and this has resulted in some progress being made.

Some years ago the Board decided that its approach to PMQA would be taken forward by the Quality, Improvement Learning and Performance (QILP) sub group this was felt to be a proportionate and innovative response, seeking to combine

quantitative and qualitative scrutiny that focused on practice. Previous assessments and annual reports have highlighted the potential risk that this arrangement may not produce sufficient pace and breadth of scrutiny. Despite the set backs identified above and subject to continued investment in the model, method and application it is felt that during the year we have been able to progress our overall monitoring of the "child's journey" and for this to trigger further scrutiny and analysis. As an example of the impact of regular monitoring QILP identified that domestic abuse was cited as a referral reason in a lower percentage of contacts to Children's Social Care (and subsequently referrals, and assessments) compared to statistical neighbours and national averages. The figure was also not felt to be reflective of our understanding of the wider prevalence of domestic abuse in North Tyneside. This was fed back to Children's Social Care who undertook some work with practitioners to ensure accurate recording representative of the details of the case. This has resulted in a significant increase in the number of cases where domestic violence is recorded as a reason for a contact – from an average of 35 per month during the first half of 2015/16 to 50 per month from Sept 2015 to March 2016.

Reflecting on another part of the child's journey, the number of children subject to a child protection plan is part of the QILP's regular monitoring. Whilst the quantitive data does not reflect any significant trends the sub group agreed to supplement their understanding of performance in this important area of joint working and include an audit in relation to the quality of child protection plans in the 2016/17 audit programme.

We have also identified that we need to improve rigor, recording and how we present learning and challenge to the Board, so as to support them in scrutiny, challenge and assurance.

During the year QILP have been able to commission and complete multi agency audits. As part of this 2015/16 programme, an audit in relation to the quality of return interviews that are completed following a missing episode was undertaken.

A total of 10 completed return interviews were included in the audit which it is acknowledged is a very small sample. Generally, the interviews were completed within timescales and appropriately identified risks/behaviours including CSE. The

process of embedding the completion of return interviews into practice has been recently prioritised by the local authority and the recording of their completion has improved evidenced by quarterly performance data provided to QILP. It was felt the interview template was lengthy which resulted in repeat information and may have felt, to practitioners, cumbersome to complete. Children's Social Care have subsequently reviewed the documentation to promote the analysis aspect of the process.

Strategically this has been a significant step forward in that we have tested out early help and arrangements for missing children, and this has resulted in challenge and outcomes that have and will contribute to improved joint working arrangements, management of change and increased understanding of our own processes.

Key learning and next steps

- The evidence suggests that the continued focus on what we call PMQA as a priority is non negotiable, although the challenges and concerns re pace and breadth as well as the need to have access to specialist support, and the need for partners to recognise that sharing information and analysis is important, may continue to test this resolve.
- Important steps have been taken in giving an evidence based process and form to scrutiny and assurance, which in turn has highlighted the need for Board members to be fully committed and involved in this. It also requires us to communicate and convey in direct terms the implications of scrutiny and analysis as it is focused on practice, outcomes for children and what this also tells us about our strategic capabilities as aBoard.
- The QILP approach remains innovative but may need to explore additional ways of meeting demand and the growing sophistication of the model.
- The evidence considered during the year confirms the need to pay particular attention to the key points in the child's journey around assessment of needs and risks, decision making and response of the system to contacts and referrals where there is concern at the points of early help, child protection, when children go missing and in response to sexual abuse and neglect.
- The learning and the evidence also suggests that there may be a need to map and integrate partners own arrangements for auditing practice alongside the

delivery of multi agency audits, which in themselves will benefit from being subject to a clearer rationale, terms of reference, outcome measures and more structured analysis of results.

- We also have to continue to find better ways of presenting and involving Board members in the monitoring and oversight of the child's journey, so that they can follow lines of enquiry and when asked to consider recommendations be able to scrutinise not only the recommendation but their awareness of their own agencies position.

Policies, Procedures and Protocols

The Board's inter-agency procedures and policies set out the safeguarding expectations of adults working with children. Following the publication of Working Together 2015 a review of our procedures was undertaken to reflect the changes and ensure compliance with the guidance. In 2015 in collaboration with the Safeguarding Adults Board in North Tyneside and both Adults and Children Boards in Northumberland, we have produced FGM guidance for practitioners. The aim is to raise awareness and provide a clear consistent pathway (which will be monitored and reviewed) Additionally our procedures in relation to the CDOP process and domestic abuse have been revised, the latter to reflect the fact that the Serious Crime Act 2015 creates a new offence of controlling or coercive behaviour in intimate or familial relationships. Our multi agency training programme ensures frontline professionals understand and know how to access the integrated policies, procedures and protocols. All policies are available via the website. 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.

Some LSCB's commission an external company to provide and regularly update their procedures electronically for which there is a substantial financial cost. We continue to explore with regional colleagues the appetite for a more local consortium that would be able to provide a similar service with lower overheads.

Key learning and next steps

- Providing partners and practitioners with policies, procedures, protocols, pathways and guidance (sometimes supported by recommended tool kits) remain a core activity for the Board. Despite not being able to resource the use of an externally provided solution or achieve agreement with other local Boards for a consortia type arrangement, the Board has been able to maintain, review and introduce procedures where needed.
- One of the ways of mitigating risk has to been to remind Board members of their accountability and responsibility for ensuring that these are used and that they compliment their own policies etc
- We will need to consider in the coming year whether the current arrangements are sufficiently tested and are appropriate possibly through some form of external review, whilst continuing to explore opportunities for more joined up approaches regionally. The continued development of the website and communications strategy will also serve to support this and mitigate any risks.

Section 11 & 175 self-assessment

NTSCB has a long term commitment and strategy for re defining and re setting the delivery of the statutory responsibility for Section 11 and 175 audits.

This in effect seeks to put in place across the totality of provision there is for children and young people in North Tyneside a standards led arrangement that supports each partner to assess their own progress and commit to ongoing learning and improvement, against the 8 standards and the other benchmarks that may apply in their setting and context. In this way the partnership can support and draw on the assurances, learning and evidence partners produce to test the quality and to help meet the requirement to form an overall view of the sufficiency of joint working arrangements to protect children.

Partner agencies all completed audits in 2015 although there was a delay in the final analysis of responses due to a capacity issue. This meant the planned challenge event did not go ahead. The CCG agreed to undertake the task and 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. There has been a robust response from GP practices, facilitated by the Named GP and resulting in all 29 practices in North Tyneside submitting a return.

All schools in North Tyneside were also asked to complete the self assessment in 2015. The schools Training Officer and LSCB Business Manager revised the current tool to better reflect school structures and links to Keeping Children Safe in Education 2015, statutory guidance for schools and colleges. 37 responses out of a possible 78 were received the results were also collated and analysed by a CCG Performance Lead. Again, responses indicate positive responses to the standards being met.

Feedback from schools included changing the timing of the request for completion as the self assessment was received 6 weeks before the end of the summer term, a particularly busy time for schools. It has been agreed the request for this years self

assessment will move to the autumn term. Plans are underway to raise awareness with schools to increase the participation rate.

Key learning and next steps

- The third stage of the strategy is to involve the non commissioned voluntary and community sector partners in the process. 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.
- Whilst progress has been maintained in terms of Board partners and also involving schools, the failure to undertake the challenge and learning events is a significant lost opportunity. This is therefore a priority for the coming year as evidence from other Boards indicates that this kind of sharing not only adds value but promotes take up and development.
- We have also identified the following areas where further negotiation and details are required in order develop potential and maintain the strategic objectives; further discussion with commissioners re their role, how to prevent “mission creep” i.e keeping the self assessment relevant and manageable, development of more sophisticated benchmarks for assessing high level analysis of completed assessments, improving guidance, timeliness and support, further focus upon evidence accessibility within on going assessment cycle i.e how you can strengthen the internal and therefore external assurance, exploration of joined up approach with SAB.
- The ongoing challenge for the Board and partners remains the delivery of this ambitious objective which seeks to strategically re set how as a partnership and a system we can be led by clear standards supported by internal monitoring, regulation and improvement.

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 1,523 learners accessed LSCB safeguarding children training, made up of;

- 1,100 learners at face-to-face multi-agency training
- 341 completers of e-learning
- 82 attendees at the Safeguarding Vulnerable Adolescents Conference

Below is a comparison of attendance, non-attendance and e-learning over the past five years. This shows a fairly static number of attendees over time. Dips in attendance can most often be attributed to periods of change in services, when training needs are not always clear, or other training takes priority over LSCB such as induction into new service areas, or other organisational priorities. Rises in e-learning tends to happen when new e-learning packages are introduced and/or made mandatory. The non-attendance charges introduced in 2011 took a little while to embed, but the benefits were seen by the beginning of 2013.

Comparison of attendance, non-attendance and e-learning over five years.

	Face to face attendance	E-learning	Non-attendance	% of Non-attendance
2011-2012	1370	908	186	14%
2012-2013	1051	315	105	10%
2013–2014	1309	185	66	5%
2014-2015	1355	210	108	8%
2015-2016	1182	341	86	7%

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.

In April 2015 as part of a Council restructuring, Barbara Morris, the LSCB Training Officer post successfully applied for the newly created post of Children's Workforce Development Lead. The Business sub group on behalf of NTSCB requested a report on the impact of the merger with a view to seeking assurance that it did not impact on the delivery of the Board training offer. A report was considered in November 2015 and Barbara reported that over time and with the support of the wider team, it has quickly been possible to maximise the use of resources, integrate and streamline processes and systems and increase capacity from within the team to ensure the continued delivery of the NTSCB training programme. The post holder will focus upon; the strategic development of a NTSCB training programme which is fit for purpose; quality assurance and measuring the impact of training; monitoring and reporting on the effectiveness of the programme and supporting the trainers to enable them to deliver a high quality programme, and developing effective working relationships between NTSCB partners.

The Training and Development Officer for Schools, with some support from the Children's Workforce Development Team, delivered child protection training to 2,286 school staff in 2015-2016 through their Service Level Agreements. In addition 86 Designated Persons in school received training in their roles and responsibilities and 12 school Governors received safeguarding training for Governors. 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:

- 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 the vast majority showing learners are satisfied that the training met their expectations and was of high quality.

In relation to SNAP surveys, which are sent to learners who attended training, and their managers, 4 weeks following the training event, the return percentage is poor. A sample of the comments captured from SNAP surveys is shown below. It is recommended that a more robust mechanism be developed for capturing the longer term impact of training in the future, including maximising the potential of the councils new Learning Management System.

Sample of SNAP survey responses when asked how they have put their learning into practice following training

- Ensured all safeguarding information is up to date
- During assessments on Children and Young Peoples mental health needs
- We work with vulnerable adults with substance issues we need to embed EHA as an option for those with children in their care
- Used issues seen in sick party DVD to inform young persons awareness of CSE risks
- Greater awareness when working in problem areas, applying knowledge gained to enhance assessment of situations
- To support a year 9 student in school
- I have a greater understanding of the dangers of what our most vulnerable young people are exposed to when they go missing; the video particularly confirmed this. I have also shared this knowledge in specific situations with schools.
- Shared information with colleagues / informed discussions
- Informed my decision making re individual cases where CSE is a risk factor.
- Printed off and shared with other GPs 'thresholds' document- now in Practice's child safeguarding folder. Completed introductory e-learning on FGM.
- I've filled an EHA with a family
- Discussed New thresholds for EHA's with my team at our weekly referrals allocation meeting today
- knowledge used that a child should have had a risk assessment in place
- being more aware of processes and asking questions at new practice
- Frequently when considering adoptions, the concept of emotional closeness of birth family is to be considered

- Checking whether absent parent has contact with child when referral may not necessarily indicate there are concerns regarding this.
- More aware of contact details for support organisations
- Regularly refer back to thresholds during calls to identify the tier of need and relate information back to referrers about establishing which tier the concern is at.

Annual NTSCB Conference

The subject of this year's annual conference, in partnership with Tyne Metropolitan College, was Safeguarding and Vulnerable Adolescents, in line with one of our priorities. The aim of the conference, held in February 2016 was to enable practitioners to identify vulnerability in children and young people, and develop their knowledge to improve practice. As well as guest speakers there were 4 workshops covering radicalisation, substance misuse, understanding adolescent development and promoting positive emotional health and well being.

Feedback from delegates was positive and comments from the evaluation included;

- Use the resources, tools, websites and reference links given out and share with the team
- An awareness of how to engage and work more closely with young people, more training of this type would be much appreciated
- Prevent training was excellent, will cascade, I'm now more aware of the issues within my current practice
- Use information with apprentices in health and social care

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

Key learning and next steps

- NTSCB is not required to deliver multi agency training, but is required to ensure that the training provided by partners ensures that joint working arrangements are appropriately supported. Like other LSCB's the delivery of multi agency training is a highly valued activity and forms an important link with and potential to influence how people work together to protect children.

- The evidence suggests that delivery has been well received, has contributed to not only our priorities but also our learning, and has been responsive. Efforts to assess impact on practice as opposed to the quality of delivery continue.
- The Board has assumed a leadership role in the year taking regular reports as to progress, impact and quality. As with some other aspects of the Boards activity it can sometimes be difficult to differentiate between the wider local authority led responsibilities and the Boards role. During the year the Board demonstrated its independence in challenging the change in Local Authority arrangements, this resulted in a risk assessment and the interesting conclusion that commitments could be maintained with less direct investment and the drawing on of alternative models of delivery.
- This helped along with the appointment of a new chair for the sub group to support the need for the Board to take a more strategic approach in terms of vision and objectives for how we are assured that those who work with children have the right knowledge and skills for high quality interventions and joint working.
- This means in the coming year that we will need to pay more attention to how we are assured of the quality and effectiveness of training that partners provide, being able to be sure that our delivery is balanced across the different types of delivery, is multi agency and does not unduly reflect the needs of anyone partner, takes into account the significant transitions taking place re early help and supports likely Board initiatives around supporting challenge and supervision principles.

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 however the following learning review was undertaken:

David and Martin (pseudonyms)

A formal independent learning review was commissioned and undertaken using the Significant Incident Learning process (SILP). The issues were in relation to the long term neglect of the siblings. Both managers and front line staff involved who had worked with the family were involved in the learning review and enabled to explore their practice and in particular, interagency working. The feedback from staff those who were involved in the review was extremely positive and the practitioners felt the learning would impact on their future practice.

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 subsequent recommendations are being implemented by the Case Review sub group and include a revision of the NTSCB Neglect Strategy and the development of a procedure for raising and resolving professional disagreements in relation to the safeguarding of children and young people.

Baby Eve (pseudonym)

This was a Serious Case Review undertaken by a neighboring LSCB involving the death of a baby aged 3 weeks. Both she and her two elder siblings were subject to child protection plans under the category of neglect at the time of her death. As a result of the complex needs within the family, a range of services were involved and the review found that there could have been more effective inter-agency working and indicated a number of barriers to effective working.

The Case Review sub group decided that there was some significant and important learning for North Tyneside practitioners from this case review, particularly as many of the organisations also provide services within North Tyneside. To share this learning two 'espresso events' were facilitated by the Designated Nurse Safeguarding Children (chair of NTCRG) and the Named GP Safeguarding Children. A separate training session was also held for the GP safeguarding leads for the GP practices in North Tyneside.

Other Achievements:

- The Learning and Improvement framework has been updated.
- A Notifiable Incident, Serious Case Review and Learning Review procedure has been developed.

Recommendations from Child K Independent Learning Review

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. The need to raise awareness of safe sleeping messages was a recommendation from the review and subsequent actions included:

- Appropriate multi- agency training now incorporates the risks posed by co-sleeping and the evidence based guidance so that practitioners can inform the parents and clients they are working with.
- An audit of the case records of health visitors by NHCFT, to assess whether or not advice and leaflets in relation to co-sleeping were being given to parents by health visitors. The findings confirmed that overwhelmingly health visitors were providing advice and leaflets.
- An audit of whether or not midwives are providing advice and leaflets in relation to co-sleeping to parents will be undertaken in 2016/17
- Child protection plans for unborn and young babies include an action that all staff working with the family would regularly enquire about the sleeping arrangements for the baby and remind parents of the evidence based guidance in relation to co-sleeping.

- The Director of Public Health emailed health providers information and a briefing paper to disseminate amongst staff with regard to the risks in relation to co-sleeping

North of Tyne Child Death Overview Panel (CDOP) has also raised concerns in relation to the risks associated with co-sleeping and it remains an important issue to continue to address.

Next steps

- Complete the development of the Escalation policy.

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 panel met 6 times between 1 April 2015 and 31 March 2016 to review a total of 36 cases.

Number of cases reviewed at each panel meeting within 2015/2016

May	July	Sept	Nov	Jan	March	Total
8	7	7	2	6	6	36

The average number of child deaths that have been reviewed per year across the North of Tyne over the past 5 years is 39.

	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016	Average
Newcastle	12	21	27	24	13	19
Northumberland	11	15	12	15	19	12
North Tyneside	10	7	7	13	4	8
Total	33	43	46	52	36	39

Age of Child at time of death across the North of Tyne

	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016
0-27 days	12	24	22	20	11
28-364 days	8	7	13	12	8
1-4 years	5	7	7	9	5
5-9 years	4	0	1	4	3
10-14 years	2	2	2	4	6
15-17 years	2	3	1	3	3
Total	33	43	46	52	36

Out of the 36 cases reviewed in 2015/16, 10 showed modifiable factors:

- Co sleeping – 3 cases
- Consanguinity
- Importance of the influenza vaccination for children
- Importance of early booking in pregnancy and good ante-natal care
- The importance of early recognition of meningitis: a range of awareness-raising was undertaken with the agencies involved and the case details were shared with the health group looking at sepsis.
- Maternal smoking
- The importance of effective communication between the various health agencies: this case generated a great deal of discussion by the agencies involved in the child's care resulting in awareness raising of the issues and a review of protocols. The case details were also shared with a health group looking at sepsis.

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 2016/17 is available on the website at http://www.northtynesidelscb.org.uk/

Safe Recruitment and Investigation of Allegations Against Adults Working Children

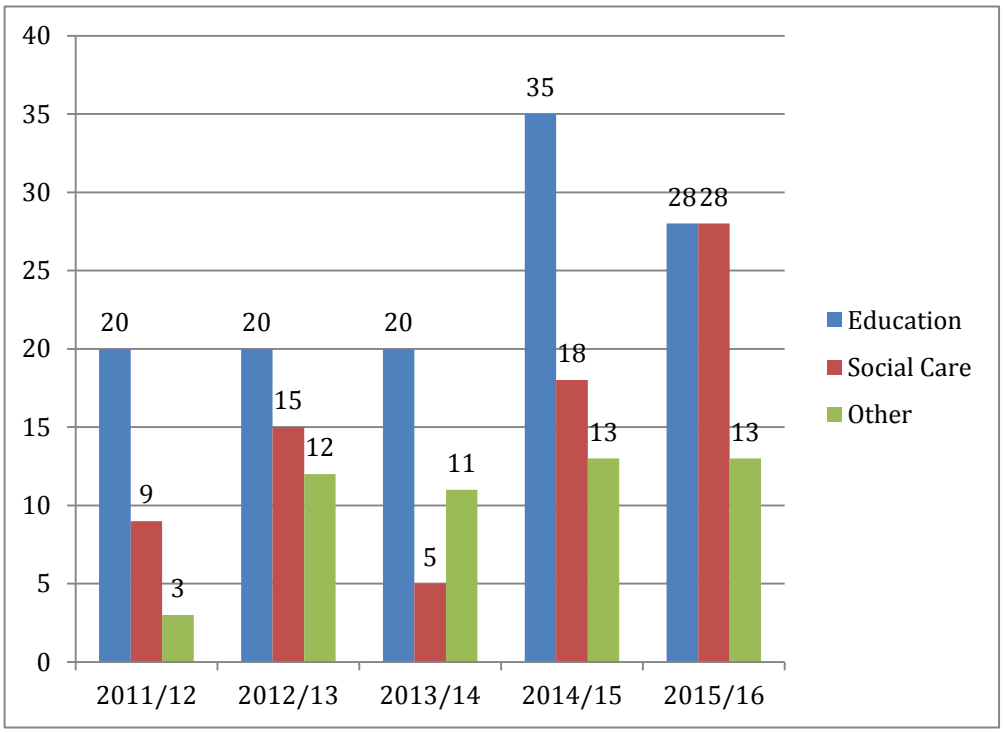
North Tyneside has a widely recognised procedure that ensures referrals to the Local Authority Designated Officer (LADO) are made appropriately and that advice and guidance is sought when necessary from professionals and voluntary organisations. This forms the basis for formal scrutiny by the Board in 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.

To ensure a single point of entry for all enquiries and referrals to the LADO they are directed to the Senior Duty Officer within the Front Door arrangements. A large number of the calls to the LADO are safeguarding enquiries or professionals seeking advice and guidance. The Duty Office is able to consult with the LADO and HR advisors as appropriate. Using this process reduces 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.

In April 2015, to align further with the delivery of services from the Front Door, the Service Manager, Front Door took over the LADO role. When the post holder left in April 2016 the role reverted to Angela Glenn, Service Manager.

Figures below reflect the number of referrals to the LADO in 2015/16 and further detail in relation to the breakdown of referring agencies and the nature of the concern is available in the LADO Annual Report which will be considered by the Board.

Referrals to the LADO



The annual report indicates a rise in the number of allegations against foster carers/connected persons, a total of 21 during the year. These were not all reported to the LADO. A subsequent audit by the LADO evidenced management oversight of the allegations and all cases had been appropriately investigated. Raising awareness sessions across the Fostering Service and social work teams is planned by the LADO.

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 (3, as at 31 March 2016, a decrease from 4 in March 2015) These low numbers appear to reflect the North East position.

There were 9 notifications received by North Tyneside Council during the year April 2015 – March 2016. These were assessed although six of these arrangements have

ended. The reasons the arrangements ended vary and include two children returning home, one child moving into a foster care placement and three children being made subject to a legal order.

The annual report indicated that case file audits were undertaken to quality assure the work with children who are privately fostered against national standards. The audit identified areas of good practice as well as some governance issues and in response to this the Local Authority have developed an action plan to ensure consistency of practice and this will be monitored by the Business Group and a progress report submitted to the Board in September 2016.

Key learning and next steps

- The Business Group will monitor the action plan and a progress report will be submitted to the Board in September 2016.
- All Board partners have been challenged to evidence the focus they place on private fostering and how they promote this and this will be tested out through Section 11/157 and audit activity as necessary.

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

- We need to ensure that our understanding of children's needs and how these relate to safeguarding is better reflected in future JSNA's
- We need to continue to support partners to provide information with analysis relating to key points in the child's journey where joint working is critical in order to continue to support our capacity to monitor and scrutinise this.
- This means we need to ensure that the child's journey is actively promoted and as widely understood as possible.
- We need to continue to consider whether as a partnership we are able to develop and balance limited resources between our analysis and scrutiny of partner's joint working performance and quality, with our need to ensure that standards are set, clear and current (policies, procedures, protocols, thresholds, guidance and pathways) to support further improvement.
- We need to develop how we ensure that commissioners are drawing on the learning from the partnership to ensure that services and specifications fully reflect joint working requirements and support the key responsibilities of the safeguarding partnership.
- We need to continue to develop our capacity to challenge each other, support challenge as a key part of joint working practice so as to ensure and support improvements across joint working arrangements and within partner organisations.
- We need to take to the next level how, across the Safeguarding Adult Board and the Community Safety Partnership, each is able to provide a clear lead on key issues and themes, in order that respective plans and impact reflects a more joined up approach focused on improving safeguarding outcomes.
- We need to ensure that the revised arrangements for Early Help in the Borough provide timely and proportionate protection of children on the basis of effective partnership working and clearly understood "front door" arrangements.
- Whilst the joint working response to children who are sexually exploited or who are at risk of sexual exploitation continues to improve, we will maintain our

challenge and support for improved reporting of this that evidences high quality and effective outcomes.

- This also means we will prioritise our focus in joint working arrangements that respond to children who are reported as missing or absent in order that a comprehensive borough wide approach can be further evidenced.
- We also recognise that there is an opportunity to take this learning and apply it to other aspects of joint working arrangements especially in relation to social work led interventions and early intervention.
- We know that for many children domestic violence and neglect are too often a feature of their lives, so we will work more closely those who provide leadership on domestic abuse to ensure that along with a revised approach for the joint working response to neglect we can be further assured that these needs and risks are recognised and acted on.
- We need to hold the Local Authority to a higher level of account especially in respect of its oversight of private fostering, allegations management, multi agency partnership and corporate parenting of Children Looked After, in order to support their own improvement goals.
- We need to bring partners together to share how they listen to and act on what children and young people tell them, in order that we can a) be assured that the voice of the child is being heard and b) draw on this experience to engage children and young people in the safeguarding partnership.
- We need to continue to influence how priorities are understood especially in respect of the work of the CYPL Partnership Board and the Health and Wellbeing Board to ensure that these reflect and support the focus on making sure children and young people are protected as well as supporting the preventative agenda.
- We need to continue to respond to the challenges and changes that arise as a result of the complexity and breadth of the partnership and safeguarding remit, to ensure that Board members are able to lead and act with maximum impact.
- We need to further develop a more strategic approach to the things that we feel will have the maximum impact on front line joint working arrangements, by asking partners to work towards a more integrated and strategic approach to work force development, to support the introduction of initiatives such as shared supervision

principles, more effective ways of raising concerns and improved promotion of thresholds and guidance.

- We need to work with partners and as a partnership to implement the wider learning from how we have changed the way we respond to children at risk of CSE, by ensuring that arrangements for sharing information, risk assessment and decision making and a focus on an approach that is victim led is considered for wider implementation.

Appendix 1

NTSCB Membership

Richard Burrows, Independent Chair
Angela Yilmaz, Head Teacher, North Tyneside Council
Kevin Buck, Interim Safeguarding Service Manager, Children's Services, North Tyneside Council
Dr Jane Carlisle, 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 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
Paul Woods, DCI, Northumbria Police
Moira Banks, School Improvement Service, North Tyneside Council
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
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
Alison Tombs, 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 2015 – 16 was as follows

Financial contributions 2015/16

North Tyneside Council	£73, 702
North Tyneside CCG	£31,823
Northumbria Police	£ 5,000
Y.O.S.	£ 2,000
CAFCASS	£ 550
National Probation Service	£ 250
Community Rehabilitation Company	£ 250
Revenue from LSCB training charging policy	£14, 670
Under spend from 2014/15	£ 4, 177
Total	£132, 422

Expenditure - 2015/16

Staffing	£ 61, 702
Training – contribution to the training officer post	£ 15, 000
Venues, catering	£ 2, 079
LSCB website, set up costs	£ 1, 512
Learning review	£ 7, 867
Membership, Assoc of Independent Chairs.	£ 1, 500
Membership of NWG	£ 500
Independent Chair	£ 23, 286
CDOP Co-ordinator post - contribution	£ 12, 000
Analysis of CDOP data (CCG)	£ 1, 330
Total	£126, 776

Carry forward to 2016/17	£ 5, 646

Expenditure

Child Death Review process

Expenditure in relation to the child death review process includes £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.

Training

The final sum includes a contribution of £15,000 to the costs of the Children's Workforce Development Lead within North Tyneside Council who has responsibility for the LSCB training programme.

Financial Revenue 2016/17

The following sums have been agreed by partners. The local authority has increased its contribution for this financial year in recognition that the LSCB needs additional capacity to meet targets. This additional funding will allow NTSCB to develop capacity and recruit a dedicated part time business administrator.

North Tyneside Council	£87,178
North Tyneside Clinical Commissioning Group (CCG)	£31,823
Northumbria Police	£ 5,000
CAFCASS	£ 550
NPS	£ 863
Probation CRC	£ 250
LSCB charging policy	£11,040
Under spend from 2015/16	£ 5,646
Total	£142, 350

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

Appendix 3

What the data tells us

Introduction and overview

NTSCB has developed its performance information during 2015/16. The Quality, Improvement, Learning and Performance (QILP) sub group has had the scrutiny and challenge of performance information as a key objective during the year and a comprehensive quarterly scorecard has been developed augmented by a series of other reports. Areas identified by NTSCB as a priority such as the number of Children subject to a Child Protection Plan(CPP), or data in performance in relation to missing episodes remain under ongoing scrutiny supplemented with other routine data/ information including children considered to be at risk of sexual exploitation or domestic abuse. Key areas of interest are then reported to NTSCB and feedback informs subsequent areas of scrutiny. It has been pleasing that the multi agency nature of the QILP has developed with key performance data being received from the Local Authority, the Police and Health.

In November 2015 the QILP considered the Department for Education Children's Safeguarding Performance Information Framework (published January 2015) and this was used to review the local indicator set.

Further information has also been included such as in relation to CSE, Female Genital Mutilation (FGM), and in relation to Child and Adolescent Mental Health Services.

Taking the example of CSE, while this was a key focus for the multi agency Missing Sexual Exploitation and Trafficking (MSET) group, and that related indicators featured in social care and police performance information, QILP felt that they were not sufficiently cited in relation to performance and activity in the area. An indicator was therefore introduced into the dataset that measured the number of children felt to be a risk of CSE at the end of each quarter, as below. Wider MSET data will feed in to QILP going forward.

						2015/16				
		2011/12	2012/13	2013/14	2014/15	Q1	Q2	Q3	Q4	No of children in Year
3.14	Number of Open "At Risk of CSE" Cases at the end of the quarter [s]	n/a	n/a	n/a	n/a	17	17	21	18	49

Similarly the area of missing episodes was an area that was subject to scrutiny via the QILP and NTSCB. The return Interview is an important part of this process but it was evident that this was being inconsistently recorded during the first quarter of 2015/16. Processes and recording were clarified and recording improved subsequently from quarter 2 onwards as is shown in the graphic featuring in figure 8 of the summary Performance Report produced for NTSCB on a quarterly basis.
To supplement the data in relation to return interviews and to further understand the process, QILP completed an audit in relation to the quality of return interviews which also evidenced improving performance. An action in relation to reviewing the report form template to make it more streamlined was progressed by Children's Social Care

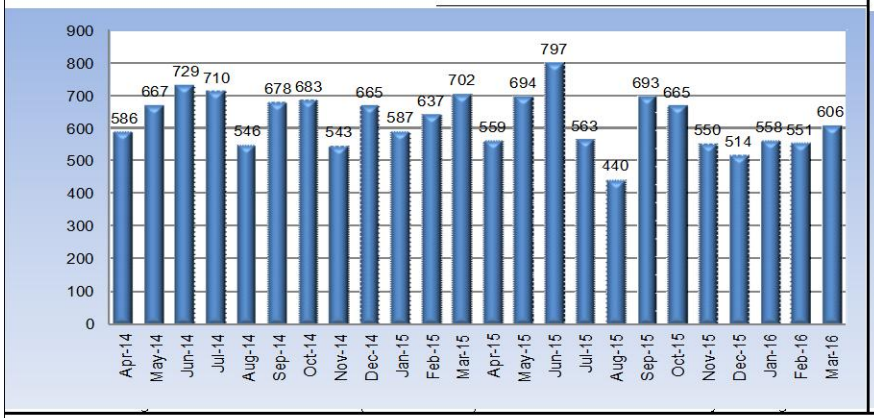
A sample of this graphic is attached on the following pages together with an extract of the more detailed information that is scrutinised by the QILP. It should be remembered that while information for North Tyneside has been included for the year ending 31 March 2016 , this latest information is not yet available for our comparator groups at a national, regional or a "statistical neighbour" level. North Tyneside's statistical neighbours are selected by the National Foundation for Educational Research, on behalf of the DfE to provide 10 local authorities who best match North Tyneside, i.e. it's closest statistical neighbours. This is done by reference to Census and other similar data. While these authorities can and do change over time as data is reviewed, our current statistical neighbours are:

Darlington	Stockton	Durham	Gateshead	Northumberland
St Helens	Sefton	Wirral	Wigan	Calderdale

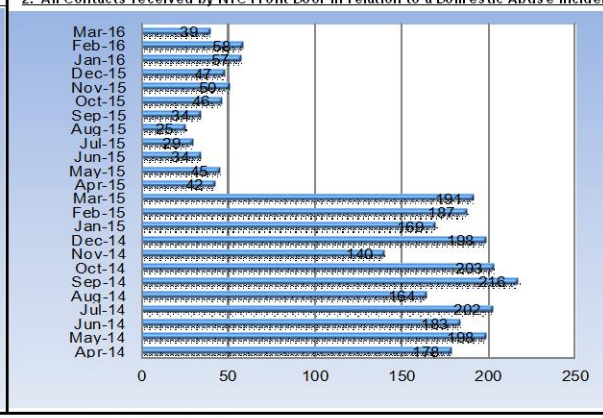
Quarter 4 2015/16 - North Tyneside Safeguarding Children Board Performance Report

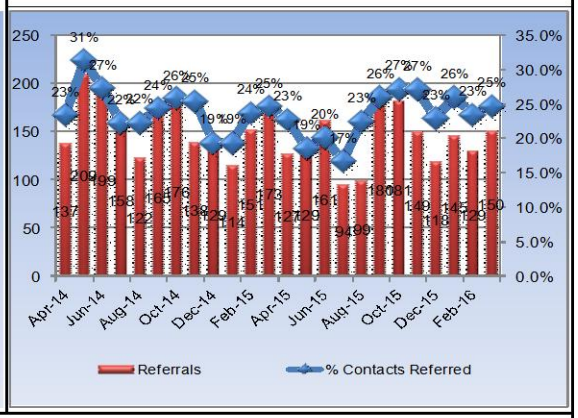
Appendix C

Safeguarding Contacts and Referrals



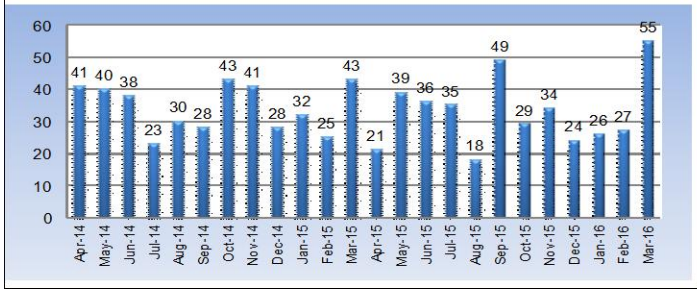
2. All Contacts received by NTC Front Door in relation to a Domestic Abuse Incident



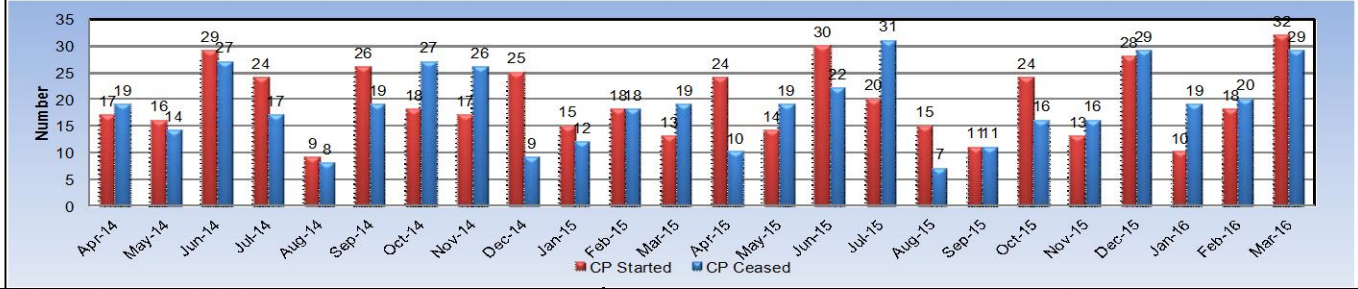


Child Protection

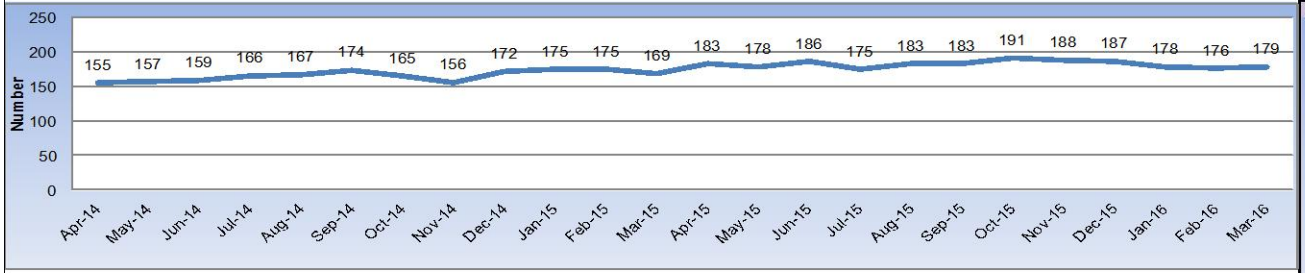
4. Section 47 Enquiries Initiated for Children at Risk of Serious Harm or Neglect per Month



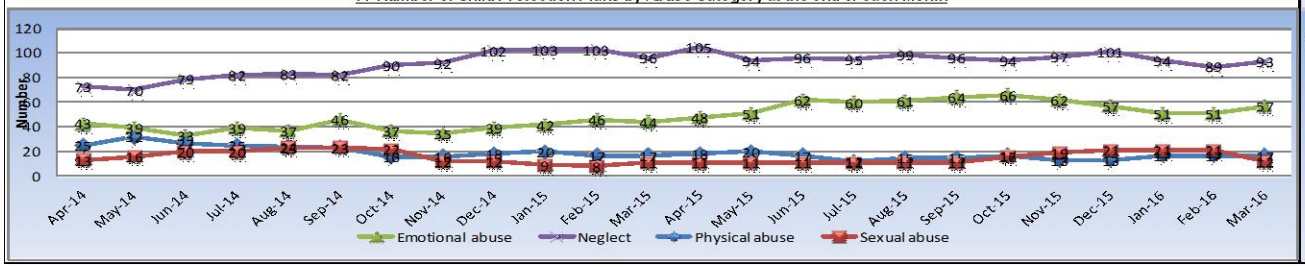
5. Number of Children Becoming Subject and Ceasing to be Subject to a Child Protection Plan per Month



6. Number of Children Subject to a Child Protection Plan at the end of each Month

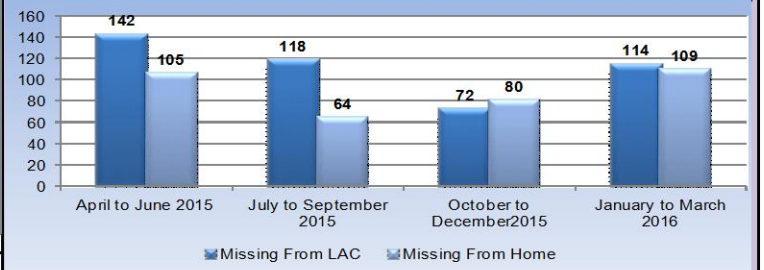


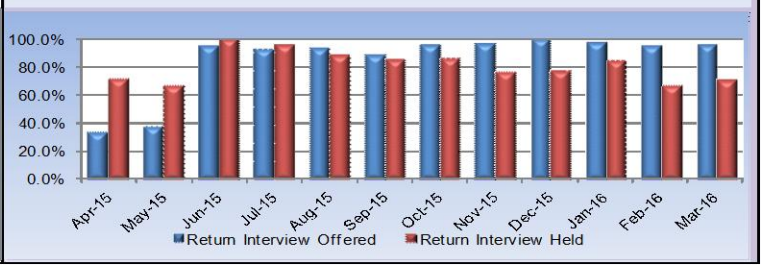
7. Number of Child Protection Plans by Abuse Category at the end of each Month



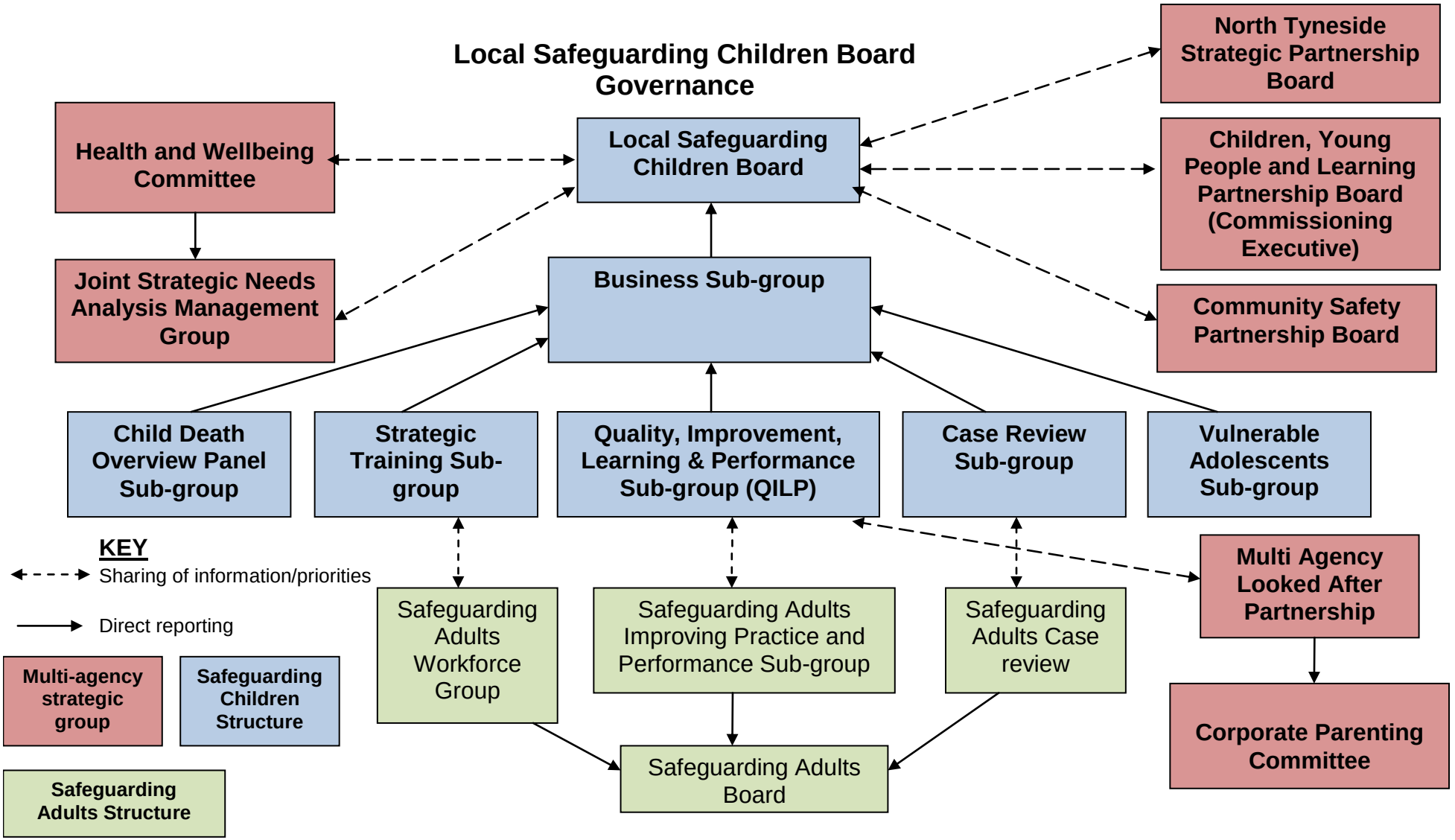
8. Missing Children

This section looks at Missing Children Episodes as recorded on the NTC Social Care Database





North Tyneside Local Safeguarding Children Board Dataset EXTRACT			Position at Year End / Quarter 4, 2015/16									APPENDIX A		
												Comparators (Source: DfE Sfr)		
							2015/16						Stat	
	Ref	Definition	2011/12	2012/13	2013/14	2014/15	Q1	Q2	Q3	Q4	Number of Children	England	Neighbour	North East
Thresholds are clear and appropriate, planning and decision making is effective	5.2	% of referrals to Children's Social Care which are repeat referrals within 12 months [C]	25.9%	24.2%	24.8%	25.1%	21.3%	19.4%	18.3%	18.1%	301/1662	**24.00**	**24.21**	**22.30**
	5.3	% of referrals to Children's Social Care leading to Assessment [C]	79.0%	82.4%	92.8%	85.2%	95.2%	99.6%	98.5%	98.7%	1640/1662	**85.9%**	**96.0%**	**94.4%**
	5.4	Number and % of Single Assessments which are completed within threshold timescales [C]	-	-	-	84.7%	85.6%	87.0%	85.3%	85.5%	1403/1640	**-**	**-**	**-**
	5.5	Number and rate per 10,000 of Children in Need [S] (does not include children undergoing assessment)	391.8	382.1	388.0	267.1	341.0	348.1	345.4	330.6	1338	**337.30**	**399.79**	**451.00**
	6.1	Rate of accident and emergency attendance caused by unintentional and deliberate injuries to children and young people 0-14	173.9%	132.8	144.9	-	Annual Measure				-	**112.2**	**N/A**	**158.6**
We are safeguarding and supporting children who are in need of protection	6.2	Number and Rate per 10,000 of Section 47 enquiries [P]	67.90	67.90	87.80	101.79	94.88	97.84	93.89	97.10	393	**138.20**	**160.17**	**137.30**
	6.3	Initial Children Protection Conferences within 15 working days of Section 47 [C]	95.0%	87.3%	94.4%	88.6%	86.8%	90.6%	91.5%	88.9%	232/261	**74.70**	**82.27**	**81.70**
	6.4	Review Child Protection Conferences held within timescale [S]	100%	100%	100%	99.2%	100%	100%	100%	100%	-	**94.0%**	**95.1%**	**94.6%**
	6.5	Number and rate of children subject to Child Protection Plans [S]	40.7	31.4	38.9	41.8	46.0	45.2	46.2	44.2	179	**42.9**	**53.1**	**59.5**
	6.6	% Children becoming subject to a Child Protection Plan for the Second or Subsequent time [C]	8.3%	12.2%	5.7%	14.5%	7.4%	12.3%	13.4%	13.8%	33/239	**16.60%**	**17.2%**	**14.0%**
	6.7	% Child Protection Plans lasting 2 years or More	3.7%	1.4%	0.5%	0.9%	0.0%	2.0%	1.2%	0.9%	2/229	**2.30%**	**1.64%**	**2.00%**
The Local Authority fulfils it's corporate parenting role and looked after children and care leavers have good outcomes	7.1	Number of Looked After Children per 10,000 who are the responsibility of the Local Authority	74	73	75.6	75.1	79.8	78.8	74.4	71.9	291	**60.0**	**82.8**	**81.0**
	7.2	Number of Children Becoming Looked After [C]	141	138	136	138	60	101	132	170	-	**30430**		**1980**
	7.3	Number of Children Ceasing to be Looked After [C]	124	141	128	134	40	85	134	181	-	**30430**		**1990**
	7.4	Reviews of Looked After Children in Timescale [S]	99%	95%	100%	99%	91.1%	99.2%	99.3%	98.9%	271/274	**N/A**		
	7.5	Care leavers in Suitable Accommodation *[C]	100%	95%	91.2%	96%	95.7%	95.6%	94.7%	94.2%	98/104	**81.0%**	**86.7%**	**82.0%**
	7.6	Care leavers in Education, Employment or Training *[C]	12%	24%	46.2%	50%	65.2%	71.1%	71.1%	71.2%	74/104	**48.0%**	**47.4%**	**46.0%**
	7.7	Looked after children with their Health Assessment carried out within timescale guidelines	-	-	100%	100%	Annual Measure				-	**-**	**-**	
	7.8	Average Strengths and Difficulties Questionnaire Score for Children Looked after for 12 months or	14.7	16.4	13.8	13.7	13.50	13.70	13.80	14.3	70	**13.90**	**13.88**	**14.00**


Local Safeguarding Children Board Governance
North Tyneside Strategic Partnership Board
Health and Wellbeing Committee
Local Safeguarding Children Board
Children, Young People and Learning Partnership Board (Commissioning Executive)
Joint Strategic Needs Analysis Management Group
Business Sub-group
Community Safety Partnership Board
Child Death Overview Panel Sub-group
Strategic Training Sub-group
Quality, Improvement, Learning & Performance Sub-group (QILP)
Case Review Sub-group
Vulnerable Adolescents Sub-group
KEY
Sharing of information/priorities
Direct reporting
Multi-agency strategic group
Safeguarding Children Structure
Safeguarding Adults Structure
Safeguarding Adults Workforce Group
Safeguarding Adults Improving Practice and Performance Sub-group
Safeguarding Adults Case review
Multi Agency Looked After Partnership
Corporate Parenting Committee
Safeguarding Adults Board