Agenda item 11 i)

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 25 January 2017

Title and Author of Paper: Local Safeguarding Children's Board Update Report
Jan Grey, Head of Safeguarding and Public Protection

Executive Lead: Gary O'Hare, Executive Director of Nursing and Operations

Paper for Debate, Decision or Information: Information

Key Points to Note:

Regular update report for information.

Risks Highlighted to Board : None

Does this affect any Board Assurance Framework/Corporate Risks? No
Please state Yes or No
If Yes please outline

Equal Opportunities, Legal and Other Implications:

Outcome Required: The Board of Directors are asked to note the content of the report.

Link to Policies and Strategies: Working Together to Safeguard Children 2015 Children's Act 2004

This paper provides a brief update on issues raised at each of the Local Safeguarding Children Boards in the area covered by the Trust.

Northumberland Children: Vida Morris Group Nurse Director, Trust Representative

The Northumberland Safeguarding Children's Board met on 29th November 2016.

Absent and Missing Update
Board members received a presentation by the DI of the use of the absent category since adopted by Northumbria Police in April 2016. Highlighted was the large amount of work that has been done recently by the Inspector from the Programme of Change staff and Police Liaison NTW.

The Herbert Protocol specifically deals with persons reported missing or AWOL from Northumberland, Tyne & Wear NHS Foundation Trust (NTW) dedicated Mental Health wards. This new protocol offers guidance to NTW staff on their responsibilities and the actions that should be taken in relation to missing people prior to contacting Police. This has improved the way the police respond to missing individuals suffering from mental health issues.

Development of Modern Slavery Guidance
Members received an overview of the Modern Slavery Guidance that has been developed over the last four months led by Northumbria Police with the 6 LSCBs to develop a regional approach and pathway regarding Modern Slavery and Trafficking. This guidance ensures professionals working across social care, education, health, immigration and law enforcement develop an awareness of this activity and an ability to identify trafficked children.

Self Assessment SEND
The county has a population of 316,000 with 60,000 aged 18 or under. The under 18 population is declining. 98% of the population is White British.

18% of children and young people live in child poverty. 14.5% of primary aged pupils and 13.2% of secondary aged pupils are eligible for free school meals.

Northumberland's population density of 63 residents per square kilometre is lower than any other local authority in the North East region and is the lowest top tier local authority in England.

50% of the population lives in 3% of the land area in south-east Northumberland.

SEND pupils
Northumberland has a marginally higher than average proportion of pupils in primary or secondary education with SEND (15.6% compared to 14.9%).

The most prevalent areas of need identified in Northumberland are Speech, Language and Communication (SLCN), moderate learning difficulties (MLD) and social, emotional and mental health needs (SEMH).

Key priorities
Improve the progress made by pupils with SEND between KS1 and 2 and between KS2 and KS4 to ensure that the attainment gap narrows when compared to pupils without special educational needs.

Improve the proportion of young people with SEND in education, paid employment and training at post-16 and the proportion of SEN support learners achieving level 2 and 3 qualifications by age 19.

Reduce the proportion of SEN support pupils who are persistently absent from school.

Newcastle: Dr Jonathon Richardson, Group Medical Director, Trust Representative

The Newcastle Safeguarding Children's Board met on 16th November 2016.

MSET Update
The Missing/Sexual Exploitation and Trafficking Group, known as the M-SET Group, is a sub working group of Newcastle Safeguarding Children Board (NSCB).

Progress on objectives and actions since last report:

- Sexual Exploitation document to be added to the website
- Survey monkey sent to all professionals re SE questionnaire
- Police IT sexual exploitation screens are now live, which will ensure current data capture. Training on the new screens have been provided force wide and will be used with the missing episodes and return home interviews at each meeting to inform operational activity.
- Risk Management Group uses data from the previous 12 months to shape the response.
- Reassurance has been provided regarding the success of partners submitting intelligence
- Missing protocol to be updated in NSCB procedures to include changes in missing category
- Children's Social Care risk assessment tool to be finalised and will be used by all staff.
- Number of operations carried out to reduce absent episodes and deter activity in hotspots and during key times.

Child Death Annual Report

Child Death Overview Panels (CDOPs) have been in place since April 2008. Their role, outlined in Working Together 2015 is to review all deaths of children up to the age of 18 years, excluding stillbirths and planned terminations. CDOPs are made up of people with professional expertise from a range of organisations.

We are pleased to report that the timeliness of reviews of child deaths continues to improve in the North of Tyne area.

We found an association between high levels of deprivation and high rates of child deaths.

No patterns of note were found in either trends or national comparisons of the categories of deaths or the percentage where modifiable factors were identified. In all, ten deaths were identified as having modifiable risk factors, and the lessons learnt from these will be widely disseminated to try to reduce risks in the future.

Priority actions as a result of this review include:

- An in-depth look at the data on death by disability
- The development of performance dashboards for the 3 LSCBs to commence April 2017
- To continue to monitor the timeliness of reviews against a target
- To ensure that local needs assessments and health strategies are informed by the variation in child death rates by deprivation decile.
- An in-depth review of child deaths in the Asian community, including approaching other
- areas where similar patterns may exist
- To exchange information and intelligence with the South of Tyne CDOP area in order to
- maximise learning and improve outcomes

North Tyneside: Dr Jane Carlisle Group Medical Director, Trust Representative

The Safeguarding Children's Board met on 21st November 2016.

"Now I know it was wrong", a summary report of the Parliamentary Inquiry into support for children who display harmful sexual behaviour (HSB)

Board members received a presentation regarding the parliamentary inquiry into HSB. A Parliamentary Inquiry was set up in partnership with Barnardo's, to examine how we respond to children who display harmful sexual behaviour (HSB) and to investigate whether policy and practice are fit for purpose. The report, published in 2016 is based on the analysis of written evidence received and evidence from three oral sessions. The three sessions covered:

- Understanding harmful sexual behaviour;
- Responses to harmful sexual behaviour and prevention of further harm;
- Hearing directly from young people.

The report made a number of key recommendations. The Inquiry heard that harmful sexual behaviour has become much more prominent in recent years, with specialist services reporting increasing numbers of referrals. One of the outstanding questions is whether harmful sexual behaviour is not just more visible, but also more prevalent?

The recommendations include:

- children who display HSB should be treated as children first and foremost
- the Government should work with relevant partners to develop a national strategy for preventing and responding to harmful sexual behaviour in children
- the Government should work closely with schools, local government and the voluntary sector to improve support for parents, increase children's knowledge of relationships and restrict access to inappropriate content.

Cafcass CE Strategy

Cafcass has a Child Exploitation Strategy, (CE) which includes: child sexual exploitation; trafficking; and radicalisation. The strategy aims to equip practitioners with the knowledge and skills they need to identify and respond to CE. It includes:

- Training staff;
- Raising awareness;
- Collating and analysing data;
- Completing research;
- Reviewing and developing guidance, resources and policies relating to exploitation.

The strategy has been informed principally by: submissions to Serious Case Reviews; operational experience; expert input from a forensic psychologist, the police and the third sector; and by the work of Ambassadors and Champions

The strategy is developed and overseen by a steering group formed of senior managers and benefitting from dedicated management input.

NTSCB Annual Report

NTSCB continues to meet its statutory role and requirements including the production of an annual report. The report provides an account of the impact of the board and its partners and a view of the overall sufficiency of joint working arrangements to protect children in North Tyneside. The report demonstrates continued progress and impact in all areas of its activities. It also highlights how, year on year, the board is responding to ongoing self assessment to build on strengths and address identified weaknesses.

In the year 2015 – 16 this process of continuous improvement was strengthened by drawing on local and national learning in respect of inspection (single and multi-inspectorate) and this has served to refine improvement goals and performance measures.

As a result the board has improved its focus on whole system impact including a new website, further implementation of Section 11 self-assessment and the development of its Performance Management and Quality Assurance (PMQA) framework and approach.

In the reporting year the board has recognised and acted on the need to accelerate the development of its monitoring and scrutiny arrangements. There have been measurable improvements across all aspects of this complex and challenging activity. However resource and capacity limitations have slowed the pace of progress. Nevertheless whilst this may not yet be as comprehensive as it needs to be, there is evidence of a well-targeted approach resulting in challenge and assurance, as well as a proactive management of the risk. This will remain a key priority and risk in the coming year(s).

South Tyneside: Ann Marshall Group Nurse Director, Trust Representative

The Safeguarding Board met on the 17th November 2016.

Children and Young People's Awards 2016
The LSCB have been shortlisted under the safeguarding category for a Children and Young People's Award. The application focused heavily on the partnership approach to CSE.

Bright Futures Personal Safety App
South Tyneside young women's charity Bright Futures and Northumbria Police have developed an App called 'Bright Futures Personal Safety App'. The purpose of the App is to provide a range of information, advice and sources of support for children, young people and parents around a range of issues.

The App contains information around: substance misuse and former legal highs, confidence and self-esteem, mental health and self-harm, healthy relationships, grooming, online and e-safety, consent and exploitation.

The App also provides information on how to access further information and support locally (across Tyne and Wear) and nationally.

Primary CSE Production
South Tyneside in partnership with Rochdale, Oldham, Calderdale and Oxfordshire Council and the GW Theatre Company are part of a project that has developed a drama production and resources for teachers to raise the awareness of CSE with children aged 10-12 yrs. The called drama production is called Mr Shapeshifter.

Further performances have recently taken place with other primary schools from across the borough. The initial feedback is that the drama production was very good, delivered the key messages to the children effectively and more importantly the children were fully engaged.

Gateshead: Dr Steve Moorhead, Group Medical Director, Trust Representative:

The Gateshead Safeguarding Children Board met on the 12th December 2016.

LSCB Review
The newly appointed Chair provided members with a LSCB review paper and recommendations were agreed in principal to go ahead with a quarterly pattern of Board meetings, and to change the BPG into an Executive group, a further set of proposals was agreed to be brought to the next Board meeting in January.

In Care, Out of Trouble report
This document is written following the Lord Laming review of children in care and involvement in the criminal justice system. .

The report recommends that new statutory guidance should be published. This will cover a number of areas including LA leadership, multi-agency meetings, peer mentors and data.

Concerns were raised about the possible gap in services as the current Designated Doctor for LAC retires soon and a replacement has not been identified and may not be in post until next summer.

Proposals from Police report on sex offences
Members received a report written by Northumbria Police Chief Superintendent regarding the increase in children being accused of offences.

It was noted that there has been a change in the way that police forces have to record and “crime” things now and this is largely responsible for the perceived increase. It was noted that Gateshead was the first area in Northumbria to introduce Operation Encompass (reporting to schools by Police the following day when a child has been in the household were a Domestic Abuse incident has occurred)

Sunderland: Anne Moore, Group Nurse Director, Trust Representative

The Sunderland Safeguarding Children Board met on the 11th October 2016.

Business Plan
Members were presented with the revised Business Plan after a full review was undertaken. Actions that were not the core business of the SSCB have been

removed and the outstanding actions of the SSCB Ofsted Improvement Plan have been added to the plan. Timescales have been amended to allow for the work to be undertaken. Members agreed the new business plan.

An overview of the DfE "Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014

This study is the 5th in a series of consecutive analyses of Serious Case Reviews (SCRs); covering 11 years from 2003. This 'long view' utilised systems methodology and has allowed the research team to build a picture of the nature and circumstances of serious and fatal maltreatment and provides essential reading and learning for all practitioners and their managers who work with children and their families or carers. It is also a significant resource for Local Safeguarding Children Boards (LSCBs) and should complement and reinforce local learning from reviews and influence our business plans around training, audit, performance and strategy/policy development.

The report also notes examples of effective and creative safeguarding children practice and clearly highlights that for many of the children involved the harms they suffered occurred despite the support and protection being extended to them by professionals.

The research concludes that in most SCRS, even when the author specifically commented that a child's death could not have been predicted or prevented, learning could still be identified. The authors suggest that SCRs should therefore not focus on predictability or prevention, and instead acknowledge that there is always room for learning and improvement in our systems. Such an approach embraces the model of pathways to harm and protection adopted in this research; recognising that children are harmed within contexts of risk and vulnerability and that there are often many opportunities for professional intervention. This would acknowledge the positive work being done by professionals and acknowledges the need for an authoritative approach which combines authority, empathy and humility. Importantly it should challenge the culture of blame and failure and move to narrative of "progress and hope"

In 2016-17 there are likely to be fundamental changes to the way in which multi-agency safeguarding is coordinated and SCRs are conducted, informed by the Wood review of LSCBs and Government's response and the passage of the Children and Social Work Bill. Whatever the structural arrangements in future, the significant body of learning contained in this Triennial Analysis and the previous reports will remain an essential resource for everyone concerned to prevent and protect against the maltreatment of infants, children and young people.

Gary O'Hare
Executive Director of Nursing and Operations