Gateshead
local safeguarding
children board

Gateshead LSCB Annual Report

2017-2018

LSCB ANNUAL REPORT 2017-2018

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APPENDICES

1. INTRODUCTION AND WELCOME

Foreword – Sir Paul Ennals, LSCB Independent Chair

It has been a privilege to chair the Gateshead LSCB for a second year. The Board brings together all partners who are working across Gateshead to keep children safe; the partnership has the confidence to challenge each other, whilst all seeking to support each other – "high support, high challenge". I have been pleased to see the strong relationships which have been forged across the services, at the front line as well as amongst senior partners.

This year we have welcomed a new business Manager, Saira Park, who has had a great impact on all aspects of our work. Supported by Gemma Crawley, she has driven the work of the board with great energy, enthusiasm and commitment.

This year we have done more to work in collaboration with colleagues in other boards across the region. The issues facing each Board are broadly similar, and there is much to be gained from working together. We now work especially closely with the areas South of Tyne, and during this coming year we plan to strengthen our links North of Tyne. Next year we will respond to the new Government legislation by changing our structure fundamentally; partners have been working closely to ensure that our new arrangements will be just as effective as our current ones.

The children of Gateshead can be grateful for the commitment of the many partner agencies who work hard an effectively to keep them safe.

2. SUMMARY OF PROGRESS

2.1 Purpose of report

As set out in *Working Together to Safeguard Children* (2015), every Local Safeguarding Children Board (LSCB) is required to produce and publish an annual report on the effectiveness of safeguarding in the local area. This report sets out the arrangements to safeguard and promote the welfare of children in Gateshead and provides an assessment of those arrangements. The report also sets out how we discharge our statutory functions.

2.2 Overall LSCB progress

Once again, 2017-2018 has been a busy year for us. Although we did not undertake any statutory Serious Case Reviews (SCRs), our "business as usual" and a number of new emerging issues nationally and locally have meant that our meetings have been busier than ever. Considerable work has also been undertaken between meetings by our sub groups, task and finish groups and highly committed members.

2.3 Progress against last year's objectives

Our Business Plan was monitored at every meeting of the LSCB Executive. By year end most of our priorities were signed off or due to be signed off imminently. The only exceptions are as follows: The redesign of Early Help is ongoing to enable active involvement of partner agencies; the review of "Thresholds/Indicators of Need" document from Children's Social Care in ongoing and updates will be completed once the Early Help offer is finalised; and the work around the national Child Protection – Information System has now been completed.

In terms of **Leadership** we strengthened our links with our local communities and other partnerships to improve the visibility of the LSCB and ensure that safeguarding children was still a priority for groups with an adult or community focus. We also continued with work to engage children and young people with the work of the Board.

We **challenged** our partner agencies to provide us with details of their own internal single-agency scrutiny and audit. We were not asking agencies to do additional audit work but wanted to make sure that we knew what audits were already taking place, what they were showing and whether they made a difference, in order to reassure the Board that there were no significant issues picked up in term of practice, and to ensure that agencies were robust in their own arrangements for identifying any issues. Overall, the findings identified no specific concerns about single agency practice and indeed some high quality single agency and joint working was demonstrated. In terms of areas for development, Children's Social Care identified that in 53% of the cases audited "visits" were not in timescale (this was across all cases including Child Protection, Child in Need and Looked After Children). This figure improved to 80% as a result of the actions undertaken following the audit. The voice of the child is heard and acted upon; however this is not always evidenced as well as it could be through recording. Inconsistencies were noted in the planning process and areas for improvement identified. Some very good work was noted in all of the Children's Social Care audits however. Gateshead Health NHS Foundation Trust identified that there was limited evidence in hospital records of paediatric engagement with child protection conferences. Invitations were only received a few days before the meeting, making paediatric attendance more difficult due to clinical commitments. Processes were introduced to address this and plans put in place to re-audit and determine if improvements had been made. The LSCB Executive will continue to monitor single agency audits on behalf of the Board in 2018-2019.

2.4 Board effectiveness

We challenged ourselves as a Board through our new Effectiveness Framework. Our benchmarking exercise showed us that there were no significant areas of concern but we needed to evidence further the impact of our work. Work in this particular area will continue into 2018-2019 as we review our arrangements in light of the Government's review of LSCBs and new legislation. We also reviewed our mini peer review proposal from previous years and looked at more effective ways of challenging each other.

We continue to collaborate with LSCBs across the region regarding future safeguarding arrangements. The final shape of arrangements across all 6 areas will be determined by how much agreement can be reached on integrating the safeguarding processes and how we can coordinate delivery around some specific safeguarding issues

The LSCB Business Managers across the 6 areas have produced a workplan for developing integrated tools and further integration of processes – performance datasets, QA frameworks, policies & procedures, training, practice review arrangements, and CDOP arrangements are being considered, in light of new statutory guidance.

In terms of **Learning**, we considered the national review of LSCBs and proposed changes to legislation and statutory guidance. We also reviewed cases in a multi-agency setting where there were lessons to be learned and took this learning forward.

We are satisfied that we have highly effective partnership arrangements in Gateshead which are built on trust and honesty. Agencies have the confidence to challenge each other due to robust working relationships.

The LSCB Business Manager's role is crucial to the work of the Board to ensure compliance with statutory requirements and drive delivery of the Board's Business Plan. The Business Manager provides a link between the Board, sub groups and other partnerships. The LSCB Chair also chairs the SAB and this further strengthens joint working and the transition agenda.

As a Board, we are confident that we have effective training that responds well to LSCB priorities. Despite increasing pressures on partner agency staff we have a skilled pool of trainers who deliver a lot of our sessions "in house", but we also have the resources to commission specialist sessions when appropriate. We continue to carry out work to ensure that our training has an impact on frontline staff to ensure that the sessions lead to improved outcomes and provide the Board with best value for money.

We acknowledge that we need to do more to hear the voice of the child as a Board. Our partner agencies undertake a lot of work to listen to and act on the voice of children accessing their services and there is some work for us to do to join this up better across the partnership and to see more meaningful outcomes from this. We also need to carry out more work to capture the voice of children who aren't part of groups such as school councils, the Youth Assembly, One Voice, Police Cadets etc. We will take this work forward into 2018-2019.

2.5 Summary of sub group progress

At year end we had seven sub groups, one of which is shared with the Safeguarding Adults Board (SAB). They are:

- Gateshead Local Child Death Review Group

- Joint LSCB & SAB Strategic Exploitation Group
- Learning & Improvement Sub Group
- Licensing Sub Group
- Performance Management Sub Group
- Policy & Procedures Sub Group
- Training Sub Group

The LSCB Missing, Sexually Exploited and Trafficked Sub Group (MSET) also reports into the Strategic Exploitation Group having previously reported directly to the Board.

An **Education Reference Group** has been established to strengthen the engagement of schools in the work of the LSCB.

The group includes wide representation from primary and secondary schools, and from all parts of the borough; feedback has been positive, and several key issues such as CSE, early help and training have been discussed. The reference group provides a means whereby school concerns can be brought to the board, issues discussed within the Board can be brought to the attention of schools, and schools can increase the level and quality of their multi-agency working.

Some successful workshops have been held in several schools, to examine the impact of the development of early help on thresholds, and there is evidence of some excellent work amongst many senior leadership teams in schools. Head teachers endorsed the positive feedback from these workshops. As all agencies respond to the continued budget challenges, it becomes ever more important that our responses to vulnerable children are jointly planned and delivered, and the early evidence of the Education Reference Group suggests real progress is being achieved.

Throughout the year our sub groups continued to work towards their own work plans and towards one or more of our priorities of **Leadership, Challenge** and **Learning** and specific details of this are found in the sub group reports in Appendix 4**.**

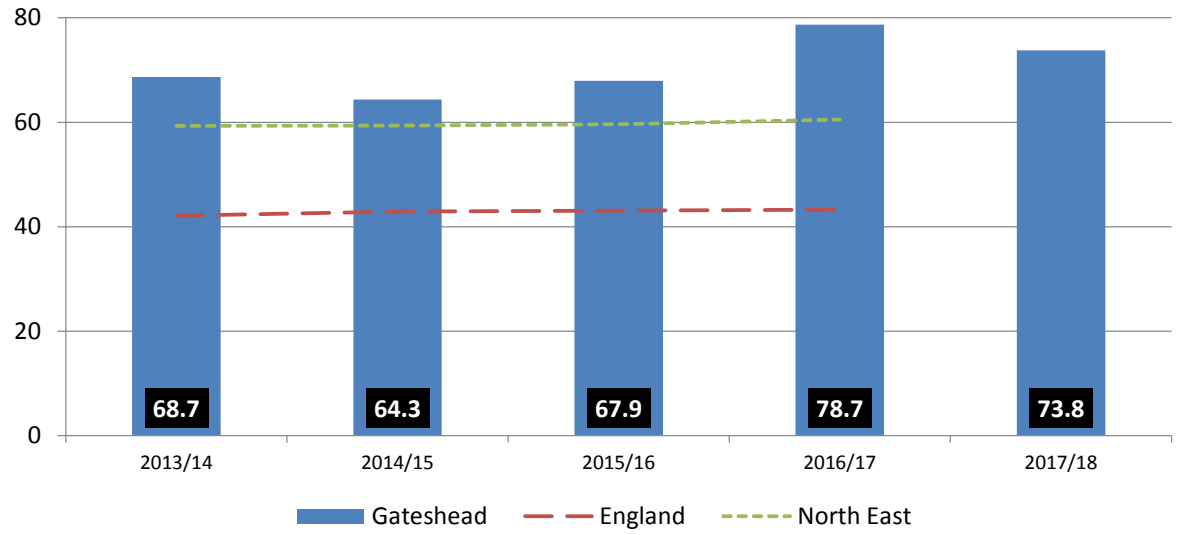
3. PERFORMANCE DATA AND INFORMATION

3.1 Performance Data

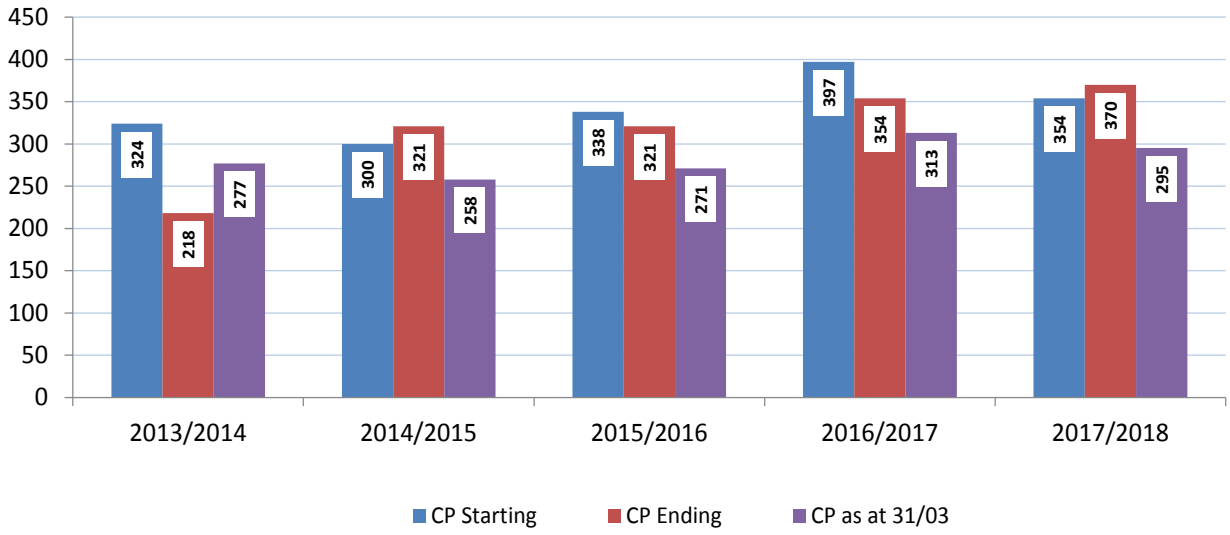
The LSCB Performance Management Sub Group monitors performance information on behalf of the LSCB and reports regularly to the Board against an agreed data set/performance dash board linked to priority areas.

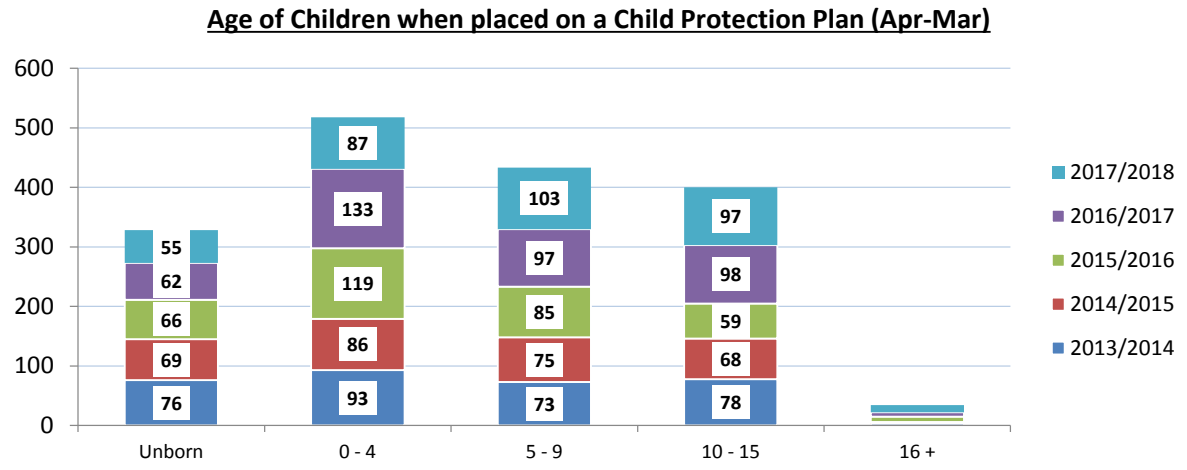
At year end there were **295** children from Gateshead subject to a Child Protection Plan, which is a rate of 73.8 per 10,000, and higher than the England rate of 43.3 per 10,000 reported in 2016-2017. It is also 18% higher than the North East rate of 60.5 but a decrease of 4.9 per 10,000 on the previous year in Gateshead.

Child Protection Plan numbers per 10,000

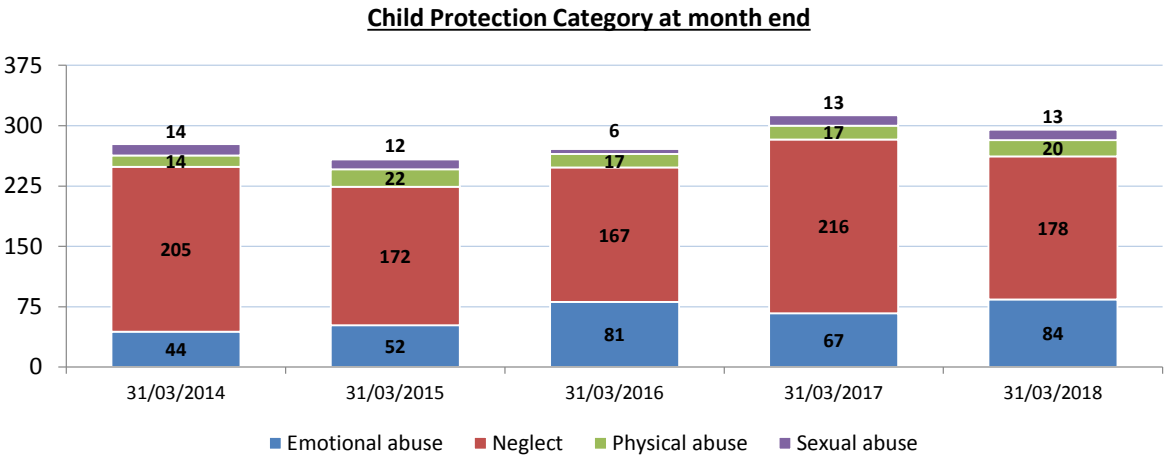


Child Protection Numbers

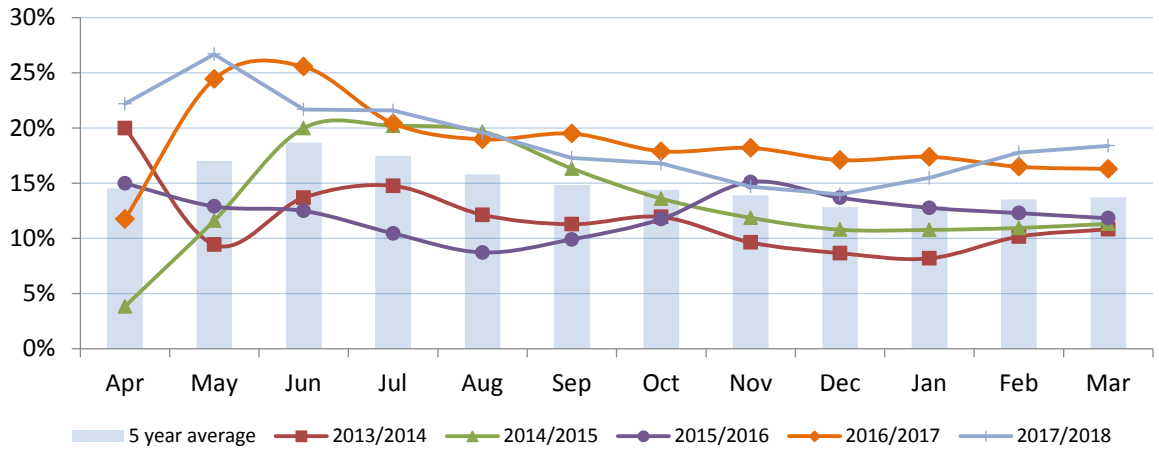




The category of neglect remains the highest at 60.3% of all plans. The numbers of plans lasting over 2 years remains low.



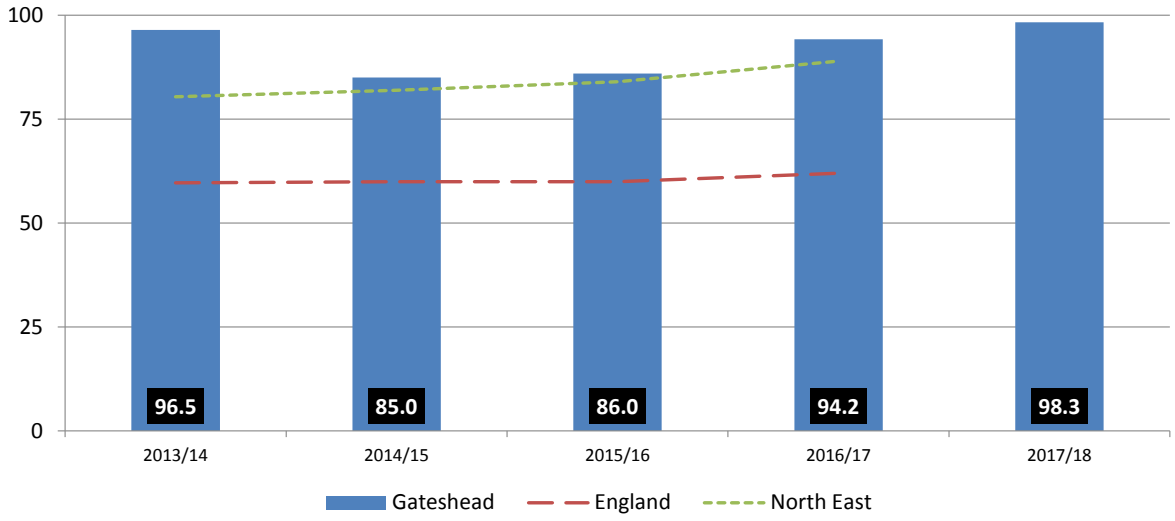
Performance Indicator: Percentage of children becoming the subject of Child Protection Plan for a 2nd or subsequent time



There was an increase noted in the numbers of children who became subject to a plan for a second or subsequent time (65 of 354 plans that started in 2017-2018 or 18.4%) and work is underway to understand this. The figure has increased in the first quarter of 2017-2018 and there are currently 23 children subject to a second or subsequent plan (27.7%). This indicator will continue to be monitored closely, although the 23 children involved does include two sibling groups of 4 and one sibling group of 3, which may help to account for the higher figure.

This reporting period also saw an increase in the number of children who are Looked After by Gateshead Council. At year end the rate showed a 4.4% increase from the previous year end and is 36.9% higher than the latest England rate and 9.5% higher than the North East rate. The Looked After Children performance information indicates good placement stability and timely performance planning. This data and information on outcomes is monitored regularly by Gateshead Council Children's Social Care Performance Clinic, the Corporate Parenting Partnership, the Looked After Children Overview and Scrutiny Committee and a number of other partner agency forums. The LSCB established a task & finish group to examine ways of safely reducing this figure.

Looked After Children numbers per 10,000



Other data to note included:

- Child Concern Notifications and contacts to Children's Social Care decreased from previous years by less than 1%; the number of referrals also decreased by around 3.5%.

- A high number of assessments undertaken by Children's Social Care identified mental health (37.7%) and domestic abuse (37.1%) as a factor. Other common factors included alcohol or drug misuse, socially unacceptable behaviour, neglect and emotional abuse. Whilst the numbers of cases where domestic abuse is a factor is high it is much lower than the England average of 2016-2017 (48.2%) whereas the socially unacceptable behaviour rate (19%) is much higher (7.1%).

- There was a 2.5% increase in Child In Need (CIN) Assessments being completed in 2017-2018 compared to 2016-2017, and there was also an increase in CIN assessments being authorised within timescales. The % of CIN assessments completed in timescales (88.3%) is higher than the latest reported national average (82.9%) and regional average (83.1%). There was a 14.3% decrease in Section 47 investigations but a higher percentage of these progressed to Initial Child Protection Conference (ICPC). Of those cases going to ICPC, 84.8% went on to require a Child Protection Plan, which indicates multi-agency agreement on the way to progress these cases

- 96.4% of ICPCs were held within the 15 day timescale (well above the regional average of 86.3% and national average of 78.3%). Attendance and contribution to CP conferences is monitored and remains strong overall, particularly for some partners e.g. Police. Work is ongoing to improve the contribution of some agencies to the process e.g. GPs. and also ensure sustained improvement against timescales for distribution of minutes

3.2 Summary of thematic information

3.2.1 Missing children

The LSCB Missing, Sexually Exploited and Trafficked Sub Group (MSET) monitors and coordinates multi-agency activity for children who are reported missing from home or care.

In total, there were **841 episodes** in 2017-2018 where a young person from Gateshead was reported missing or absent to police. **493 (58.6%) of these episodes were children/young people looked after by Gateshead Council**. These figures differ slightly from those presented by Northumbria Police – they state that there were 439 "missing" episodes involving under 18s in Gateshead and 331 "absent" episodes. This equates to 770 episodes in total, 417 of which were Looked After Children. However these figures only include young people reported missing from a Gateshead address and do not include Gateshead looked after children placed elsewhere in the Northumbria area or further afield whereas the LSCB data for MSET does. There are also a small number of young people placed into private children's homes in Gateshead by other local authorities who are included in the police figures (e.g. Fairways, Caxton House and Church Rise). There were 862 missing/absent episodes in 2016-2017 (of which 541 or 63% related to Looked After Children) therefore this represents a **2.4% decrease year on year** on the total episodes and an **8.9% decrease in missing from care episodes.**

All children who are missing or absent on two or more occasions in a six month period or for a single episode lasting more than 24 hours are offered an Independent Return Home Interview. This differs from a police Safe and Well Check (which all missing people receive on return) and is carried out by skilled and experienced youth workers to determine underlying

reasons for the missing episode and wider risks and vulnerability factors. The interviews are also used to identify broader trends, including "CSE hotspots" and there are clear links into MSET meetings and intelligence sharing with police.

In total there were **280** requests for a return interview in 2017-2018 (as the 841 missing episodes relate to a smaller number of individuals as a small cohort of young people were reported missing more than once). 154 interviews were carried out (55%), 86 young people refused (31%) and 40 interviews were no longer required or not appropriate (14%).

This 60% completion rate is significantly higher than in other LSCB areas where external services are commissioned to provide the service and reflects the specialist skills and local knowledge that the youth workers have whilst also retaining independence from the case. The youth workers also have links in to other services which means that appropriate support can then be put in place for young people when required.

3.2.1 Child Sexual Exploitation (CSE)

The MSET sub group of the LSCB also has oversight of cases where there are concerns about sexual exploitation. There were **79 cases** discussed at MSET due to concerns about them in 2017-2018, 20 of which were discussed on more than one occasion. This is a **68% increase** from 2016-2017 when there were 47 cases discussed (27 of those were discussed more than once).

It is not possible to separate how many of those cases were discussed due to missing episodes and how many due to CSE due to the overlap between the two, but a CSE risk assessment was carried out for each case that was discussed and disruption plans put in place. It is thought that this increase represents improved awareness rather than increased incidence of sexual exploitation. More detail on the work of the MSET is set out in Appendix 4. It is not possible to provide case studies on how the work of the group improved outcomes as they may lead to young people being identified.

The LSCB Business Manager is reviewing how CSE is recorded on the Social Care System and is working with the management information team to improve the way CSE is recorded to ensure data is accurate and up-to-date. This review is also looking at the way risk assessments are recorded, how we can improve the quality of risk assessments and how they inform care planning.

3.2.2 Private Fostering

Gateshead LSCB receives an annual report on Private Fostering from Children's Social Care to update members on the number of arrangements in the borough and to raise local and national issues. The 2017 report set out that at the time of the report there were no children subject to private fostering arrangements in Gateshead. Reporting rates are likely to be an under-estimate. Professionals have a legal duty to report possible cases of private fostering to the local authority. A recent Ofsted thematic inspection noted the national under-reporting, and recommended that authorities focus on awareness amongst relevant professionals rather than seeking to increase public awareness. An action plan was put in place to raise awareness and encourage professionals to report private fostering arrangements, this included sending information to all schools and a webpage on the new website.

3.2.3 Child Deaths

The Gateshead LSCB Child Death Review Sub Group reviews the death of every child in the borough and reports into the sub regional Child Death Overview Panel (CDOP) which is shared with Sunderland and South Tyneside LSCBs. More information on the work of the sub group and CDOP is set out in Appendix 4.

In 2017-2018 the LSCB was notified of the deaths of **11** children from Gateshead. There were no significant safeguarding issues in any of the deaths. Detailed information is not presented in this report so that the young people cannot be identified but it should be noted that the majority of deaths were premature babies or babies born with life limiting conditions who died within a short period of their birth.

3.2.5 Allegations against those working with children

There are clear statutory processes in place for responding to allegations made against those working with children. The Local Authority Designated Officer (LADO) is a key role in this process.

From 1 April 2017 to 31 March 2018 there were a total of 340 contacts and enquiries to the LADO, and 67 referrals, making a total of 407 LADO enquiries where there were concerns about someone working with children. 57 of the 67 referrals were progressed. Referrals to the LADO were received from statutory and non-statutory organisations. Police, education and social care remain the main source of referrals in addition to Ofsted and other local authorities.

The most common category of abuse recorded for those cases which went to strategy meeting/discussion was physical abuse (38.6%). A number of the allegations were found to be false or malicious (14%); the remainder were recorded as “unfounded” (22.8%), “substantiated” (24.6%) and unsubstantiated (26.3%). The remainder of the cases are currently ongoing. An outcome is defined as substantiated where on the balance of probability abuse or harm is confirmed and unsubstantiated where there is insufficient identifiable evidence to prove or disprove the allegation. Employees subject to investigations that concluded either substantiated or unsubstantiated predominately received management advice with additional training. 0 employees were issued with written warnings and 0 received final written warnings. 7 employees were dismissed, 6 employees had referrals to the Disclosure and Barring Service for consideration, 2 employees had professional organisational referrals and 2 employees had a standard of care meeting. Please note that some employees could have multiple ‘outcomes’.

The LADO will continue to provide advice and guidance to employers and voluntary organisations in 2018-2019 and continue to liaise with the police and other relevant agencies and professional bodies in responding to allegations or complaints.

3.2.6 Pupil Exclusions

The increasing numbers of pupils being excluded from schools is a national issue. However, within Gateshead the rates of exclusions would appear to be even greater than the national average over recent years. This issue was identified by the Local Safeguarding Children Board (LSCB) and officers were asked to carry out research to identify why exclusions were increasing at such a rate and more importantly how could this be halted and reversed. This work was led by Service Manager for Education Support Service and a report presented to LSCB in the spring 2017. The report identified a number of factors were likely to be driving up exclusions. A key outcome was that a range of children’s services, health and school professionals would need to try to address the issue by working more closely together. As a

consequence, a conference was organised to bring services together to discuss the issue and agree a way forward. The conference was led by the LSCB chair.

Following the LSCB "Reducing Permanent Exclusions" conference in the summer of 2017, a joint action plan was devised and agreed with partners. Actions started to be implemented from September 2017 and are being monitored and evaluated by a group consisting of partners from the original LSCB conference. In addition to the LSCB receiving regular updates, The Council's Families OSC has asked for a regular update on the impact of the action plan.

Although it is relatively early days in regard to the plan, there are some promising figures to date.

	Numbers of Permanent Exclusions		
	16/17	17/18	% change
Autumn Term	34	29	-15%
Spring Term	19	15	-11%

Compared to last year, by the end of the Spring Term 2018 there has been nine fewer permanent exclusions.

4. SUMMARY OF LEARNING FROM INSPECTIONS AND REVIEWS

Gateshead LSCB was not subject to a Joint Targeted Inspection in 2017-2018 by Ofsted, the Care Quality Commission (CQC), Her Majesty's Inspector of Constabulary (HMIC) and Her Majesty's Inspector of Prisons (HMIP).

4.1 Inspections of partner agencies in 2017-2018

A number of Board partner agencies were inspected or had recent inspections published in 2017-2018:

Northumbria Police – PEEL
Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) visited Northumbria Police between the 8th and 9th January in order to undertake an inspection of the organisation's child protection arrangements. The inspection, part of a national programme of thematic inspections of all forces in England and Wales, sought to examine all aspects of response of all the organisation, including leadership, governance, partnerships, initial contact, investigations, decision making, management of those who pose a risk to children and the detention of children and young persons.

HMICFRS found a clear commitment to protecting children and recognised examples of good work across the organisation, with good engagement with partner agencies across the six local authorities.

Inspectors also identified areas for improvement to ensure the service provided to children in need of help and protection is of a consistently high quality. Seven recommendations have been made. HMICFRS found positive professional relationships and collaboration with external partners at both strategic and practitioner levels.

Gateshead Council: Ofsted Focused Visit – Care Leavers

Ofsted undertook a focused visit of Gateshead's Children's Services in March 2018, looking at the Council's arrangements for care leavers. The inspectors considered a range of

evidence, including discussions with care leavers, social workers, personal advisers and senior managers. They also looked at performance management and quality assurance information and children's case records. No areas of serious safeguarding concern were identified. An action plan has been developed, progress against which is monitored by the Council's Corporate Parenting Overview and Scrutiny Sub Committee, with updates to the LSCB.

Clinical Commissioning Group

NHS England has a statutory duty to undertake an annual assessment of CCGs. This is done under the auspices of the Improvement and Assessment Framework (IAF), with the overall assessment derived from CCGs' performance against the IAF indicators, including an assessment of CCG leadership and financial management.

Newcastle Gateshead CCG received a rating of Outstanding for 2017/18.

During 2017/18 a total of **7 GP practices** have been inspected by CQC – all received a rating of **Good**.

Newcastle Gateshead CCG also had their annual internal assurance audit - a risk based audit of safeguarding arrangements; for which they received Substantial Assurance which is the highest grade of assurance.

Northumberland, Tyne and Wear NHS Foundation Trust

A team of inspectors visited Northumberland Tyne and Wear NHS Foundation Trust in April (and May). It was rated Good for safety, and Outstanding for caring, effectiveness, responsiveness and well-led. Overall, the trust rating has remained Outstanding - the same rating that it achieved when it was last inspected, in June 2016.

For safety, inspectors rated 14 of the 15 core services as Good and one as Requires Improvement. The rating of safety had improved from requires improvement to good in child and adolescent mental health wards, but the rating had gone down in the safe domain from good to requires improvement in acute wards for adults of working age and psychiatric intensive care units.

The organisation improved its rating for caring, moving from Good to Outstanding. The trust ratings for being responsiveness and effective remained at Outstanding. Patients had access to a range of activities, including during evenings and weekends – and with child and adolescent mental health wards, patients had good access to education provision. The trust was working with commissioners and staff to design specialist community-based services to ensure the right care and treatment could be provided in the community and to prevent hospital admissions.

During the inspection, it was noted that the trust had carried out a significant organisational restructure in October 2017, and engaged extensively with staff during this time, introducing cohesive new structures and governance arrangements.

The quality of performance data was outstanding. Staff at all levels had access to a wide range of data which was used to actively inform and shape how services were delivered and how care was provided. Inspectors noted that there was evidence of significant positive impact on patients as a result. CQC found some areas of outstanding practice.

Schools

A number of our **schools** were inspected by Ofsted in 2017-2018 and, once again, no safeguarding concerns were identified. Overall 38.3% of our schools are outstanding, which is higher than the national average of 19%.

Of 70 primary, junior, infant and nursery schools (including primary special schools), 40% are outstanding, 57% are good and 7% require improvement. Of 10 secondary schools and academies 30% are outstanding, 10% are good, 30% require improvement and 30% are inadequate. 50% of the total number of special schools are outstanding and the others are good. The PRU has recently academized and has not yet been inspected.

4.2 Learning from reviews in 2017-2018

The LSCB Learning and Improvement Sub Group manages learning from Serious Case Reviews (SCRs) and other reviews on behalf of the Board. There have been no SCRs initiated or published by Gateshead LSCB in the past 12 months. In 2017-2018, two Serious Incident Notifications were submitted to Ofsted/Department for Education.

It was agreed that the criteria for a SCR was met for one of the cases and the National Panel agreed with this decision. The SCR will be carried out during 2018-2019. Although the criteria for SCR for the other case was not met, it was agreed that there was additional learning and work should be carried out to learn lessons from this case and apply them to future practice – see appendix 2 for a summary.

Durham LSCB will be carrying out a SCR of a case that was previously open to Gateshead. Durham initially felt that the case did not meet the criteria for SCR, however the national panel requested the decision to be reviewed and a SCR is now being commissioned. The review should be completed by October 2018.

Despite the fact that no formal reviews were required in 2017-2018 the sub group worked within the Board's Learning & Improvement Framework to drive forward multi-agency learning and changes to practice.

The sub group carried out detailed reviews of the cases of 6 children and young people where potential lessons were identified.

The group also continued to build on the learning from a case first discussed in 2016-2017 and received a single agency management report on the learning. These reviews have led to a number of changes in practice including an increased emphasis on challenge/escalation and changes to procedures when children are returned home from care, and holding Initial Child Protection Conferences for a small number of complex cases where the child is Looked After under section 20. The learning from these cases has also led to the delivery of additional training on disguised compliance and working with hostile families. All of the reviews identified numerous examples of good practice as well as areas where things could have been done differently.

The sub group also considered a diverse range of SCRs from other areas to ensure that any relevant learning is disseminated and applied to practice in Gateshead. More detail on the work of the Learning and Improvement Sub Group is set out in Appendix 2 and 4 of this report.

5. HOW SAFE ARE CHILDREN IN GATESHEAD?

It is never possible to say categorically that all children are safe. However, external scrutiny of our services within Gateshead suggests that our services are at least as good as most other areas, and in many cases better. This is no mean achievement, since the authority scores highly on most deprivation indices, and all the public services have faced very severe reductions in funding.

We know that Gateshead **schools** are more likely than most to be rated outstanding, and that no schools in the area have been identified by Ofsted as having weaknesses relating to safeguarding. However, several schools have been rated inadequate or requires improvement during the course of this year. Good schools are normally safe schools, and schools play a vital role in helping children learn how to keep themselves safe, as well as providing us with a great opportunity to check on how children are doing.

We know too that many of the **child health** indicators in Gateshead are worrying; our rates of child poverty, smoking in children, under 16 conceptions, smoking amongst expectant mothers, obesity, and hospital admissions for injuries and for self-harm, all remain high.

The **safeguarding data** presents a mixed picture. We saw a small decrease in contacts and referrals, though the overall rates are still higher than we should be receiving; there is more work to be done in further improving our multi-agency front door. Numbers of children on child protection plans have also decreased slightly, from the previous record numbers of last year. Numbers of children in care have increases slightly. The timeliness of assessments and conferences remains high. We have been analysing these data changes with some care; as we strengthen our early help services, we must hope to see a reduction in the numbers of children that require child protection plans or being looked after.

External inspections paint a broadly positive picture of the quality of services operating across Gateshead; the hospital trusts, the CCG, the mental health trust and the police have all been subject to inspection with broadly positive outcomes. Just as importantly, where issues have been presented, partners have responded vigorously to the challenges presented to them, and the partnership itself has been strengthened through the process.

In the year ahead all LSCBs will be facing change, as the government's new legislation comes into force. Partners across Gateshead have been discussing the options, and we are confident we will have a robust and effective set of processes in place to respond to the new changes.

All partners are facing changes – reorganisations, budget reductions, changes of focus. Change brings the risk that the eye might veer off the ball of child protection. Gateshead LSCB is committed to ensuring that all partners stay focussed, and that we continue to work effectively together to keep the children of Gateshead safe.

APPENDIX 1 – SUMMARY OF STATUTORY ARRANGEMENTS

Legal duties and general summary

Chapter 3 of *Working Together to Safeguard Children* (2015) and *Regulation 4 of the Local Safeguarding Children Board Regulations* (2006) set out the statutory objectives and functions of LSCBs. Gateshead LSCB was judged to meet statutory requirements in the 2015-2016 Ofsted inspection and compliance is monitored by both the Board and LSCB Executive as well as the Independent Chair and Business Manager.

Policies and Procedures – the LSCB has web-based multi-agency child protection procedures which set out actions to take where there are concerns about a child, thresholds for intervention, guidance on recruitment and supervision, investigation of allegations, management of private fostering arrangements and cross border working (in line with 1(a) of Regulation 5). This is managed by the Policy and Procedures Sub Group on behalf of the Board and joint work is carried out with Sunderland and South Tyneside LSCBs.

Communicating the need to safeguard and promote the welfare of children – A number of methods are used in Gateshead to communicate the need to safeguard and promote the welfare of children depending on the audience and subject matter. For example, the LSCB has a website which contains detailed information for professionals on the work of the Board, Serious Case Reviews, Child Death Reviews, sexual exploitation and missing children and links to key documents such as *Working Together to Safeguard Children*, the LSCB Annual Report and the referral form for safeguarding concerns. There are also links to the online LSCB Inter-agency Child Protection Procedures for professionals to access. There is also a page called “what to do if you’re worried about a child” and this explains to members of the public, professionals and young people themselves how to respond to concerns.

For the last few years a summary version of the LSCB’s annual report has been produced with the assistance of Gateshead Council’s Communications Team and this has been shared with groups of young people including all school councils. This sets out what key issues have been noted in the past year and also how to raise concerns about a young person at risk.

The LSCB has a full training programme of face-to-face and e-learning modules to raise awareness of the need to safeguard and promote the welfare of children. Professionals are encouraged to attend the sessions and some sessions are mandatory for some practitioners.

All LSCB members are aware of their roles and responsibilities as Board members and partner agency representatives. This includes a requirement to promote the role of the Board and promote safeguarding in their own organisation/service. The LSCB’s lay member is also aware of his responsibilities and his unique role in linking the Board to the community which it serves.

Training – A full LSCB, Safeguarding Adults Board and Community Safety Board Training Programme is in place. This is managed by the Training Sub Group on behalf of the Board. See Appendix 3.

Monitoring and evaluating effectiveness – Gateshead LSCB operates under the principles of high support and high challenge with and between partners. The theme of challenge is a key business priority for the Board and this is monitored at each meeting. Effectiveness is also monitored via single agency audit reports, the LSCB Development Day (and in previous years the section 11 audits) and areas of the Learning & Improvement Framework

Serious Case Reviews – There were no Serious Case Reviews (SCRs) initiated or published in 2017-2018. A framework is in place to ensure that SCRs are carried out when the criteria are met and published as appropriate. See Appendix 2 for more information.

Budget

Section 15 of the Children Act 2004 sets out that statutory Board partners may:

- Make payments towards expenditure incurred by, or for the purposes conducted with, a LSCB directly, or by contributing towards a fund out of which payments may be made
- Provide staff, goods, services, accommodation or other resources for purposes connected with a LSCB.

Cafcass, Gateshead Council, National Probation Service, Newcastle Gateshead CCG, Northumbria Police and Northumbria CRC all made contributions to the LSCB in 2017-2018.

Income 2017-2018 (£)	
Gateshead Council	73,083*
Newcastle Gateshead CCG	44,023
Northumbria Police	5,000
National Probation Service	932
Cafcass	550
Northumbria CRC	250
TOTAL	**123,155**

*The contribution from Gateshead Council includes the £11,430 budget for the LSCB Multi-Agency Training Programme which was previously reported separately.

In 2017-2018:

- **£74,131** was spent by the LSCB in salaries and on-costs for the LSCB Business Manager and business support post.
- **£15,453** was spent by the LSCB on fees which included £3,600 on the maintenance of the online LSCB Inter-Agency Child Protection Procedures, £500 to the National Working Group (for CSE) and the remainder was payment to the LSCB Independent Chair
- **£11,430** was spent on the LSCB multi-agency child protection training programme and **£4,905** was spent on other training

The budget for Child Death Reviews is shared with Sunderland and South Tyneside LSCBs and is not reported here.

Agencies have confirmed that they will match their contributions in 2018-2019.

APPENDIX 2 – FULLER LEARNING FROM LEARNING REVIEWS AND CHILD DEATH REVIEWS

The LSCB Learning & Improvement Sub Group take the lead on the LSCB Learning & Improvement Framework on behalf of the Board. Appendix 4 sets out progress made by the sub group in 2017-2018.

There were no Serious Case Reviews initiated or published in 2017-2018.

The Gateshead Local Child Death Review Sub Group and South of Tyne and Wearside Child Death Overview Panel (CDOP) review the death of every child resident in Gateshead on behalf of the LSCB. Appendix 4 details work undertaken by the sub group in 2017-2018 and the CDOP Annual Report details the learning from cases in the sub region.

LEARNING FROM CASE REVIEW – POLLY

BACKGROUND

Polly's case was reviewed by the LSCB's Learning & Improvement Sub Group following an allegation of rape made by Polly. It was agreed that the criteria for a Serious Case Review was not met and this recommendation was subsequently endorsed by the LSCB Independent Chair and National Panel of Independent Experts. However, it was agreed that there was additional learning and work should be carried out to learn lessons from Polly's case and apply them to future practice.

LEARNING EVENT

A learning event was held and was facilitated by the Service Manager for Safeguarding and Care Planning, who is an accredited Significant Incident Learning Process (SILP) reviewer. The event used a systems-based methodology and focussed on areas of significant practice.

The purpose of the learning event was to establish what lessons could be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children.

The learning event included professionals from:

- Gateshead Council Children's Social Care
- Gateshead Council Legal Services
- Gateshead Council Safeguarding Children Unit
- Gateshead Youth Offending Team
- Newcastle Gateshead CCG (including links to GPs)
- Newcastle Hospitals NHS FT
- Northumbria Police
- Northumberland, Tyne and Wear NHS FT
- Schools and education agencies
- South Tyneside NHS FT

The session focussed on **key decision points** and **key learning events** in a five year period in Polly's life. It also covered some key events historically.

The session ended with a discussion on what the next steps should be and how any learning could be used to impact on future practice. This information is being used to inform recommendations and develop an action plan.

The action plan will be monitored by the L&I Sub Group on behalf of the LSCB and the chair will update the Board as part of regular sub group updates.

KEY LEARNING

- **Practice implications:**
  - Recognition must be given to the vulnerabilities in the system of handover between teams – information gets lost/diluted and focus is changed.
  - Allegations concerning mother and fathers physical abuse appeared to be true. Polly would make disclosures but would then withdraw, possibly due to parent manipulation. She would also make allegations about every placement she had which meant disclosures lost their impact.
  - CAF/TAF relies on parents cooperation – if no progress or significant change is being made, consider escalation to Child in Need or Child Protection.
  - CAF/TAF process is not always robust in terms of gathering and analysing information from other sources.
  - Concerns about children should always be followed up – do not assume another agency will make a referral into Children's Services.
  - Care review and planning meetings should involve all agencies who work directly with the child or their family.
  - Volatile family relationships – Cycles of familial reconciliation and rejection have a significant impact on young people's wellbeing and mental health.
  - Complex abuse strategy meetings should be recorded on each child's file.
  - Importance of multi-agency chronologies to share information and inform decision making and care planning.

- **Sexual activity and the issue of consent**
  - The fact that young people are engaged in what they view as consensual sexual activity does not mean that they are not being exploited or abused.
  - Victims of sexual exploitation or abuse may be coerced into sexual activity. They may feel unable to say no.
  - Some young people may not recognise they are being sexually exploited, believing they are behaving as they wish.
  - 16 and 17 year olds are often viewed as being more in control of their own choices and so less vulnerable to exploitation.
  - Sexual activity between young people of the same age is often perceived as being consensual, but exploitation may still be occurring.

Sexual activity is illegal under any circumstances for under-13 year olds. Those aged under 13 cannot give consent. Doing anything sexual with someone under 13 is automatically and offence, whatever the young person says.

- **ADHD – help or hindrance?**
  - Too much focus was put on ADHD. Parents had financial motivation for diagnosis. Parents used ADHD label to remove responsibility from themselves and deflect blame onto Polly.

- **Child abuse and neglect can cause.. (off set by good quality care-givers)**
  - Attachment and inter-personal relationship problems

- Mental health problems
- Alcohol and drug use
- Behaviour problems
- Child sexual abuse causes sexualised behaviour/anti-social behaviour and difficulties in relationships
- The earlier the abuse, the more likely the impact in adolescence.

- **Important to consider impact of adverse childhood experiences –** Using Trauma Informed Model changes everyone's mindset from **"What's wrong with you?"** to **"What happened to you?"** - impacting on how we assess & respond to need as well as build and maintain relational interventions and treatments. It also increases the likelihood that's the child's account will be believed.

MOVING FORWARD

- Robust Procedure for children returning home – Decision Making Meeting attended by multi-agency partners and IRO. The meeting should agree a detailed support package, monitoring arrangements and contingency plan
- Recognising the vulnerabilities in the system at the point of handover between social work teams. Adherence to previous plans made on the basis of assessment is crucial
- Awareness and understanding of escalation processes with regard to Child Protection Conferences.
- New practice guidance - Working with and recognising families who behave in a hostile, aggressive way or display behaviours indicative of disguised compliance.
- Multi-agency training available regarding uncooperative families and disguised compliance.
- Understanding CSE and role of MSET.
- Over reliance on medical diagnosis as a 'quick fix'.
- Trauma-led (ACE) focus needs to be more at the forefront of the minds of professionals.
- The importance of sharing information and working together to safeguard children

NEXT STEPS

Key learning from the event will be shared across agencies. Multi-agency workshops have begun and are scheduled until the autumn.

The purpose of the workshops is to explore the key events and disseminate the learning from the case. The workshops include facilitated discussion and some group work. We are also asking attendees to further explore:

- Are there any lessons for the system as a whole?
- Are there any lessons for your organisation?
- What do we need to do to change as a result of what we've learned today?
- How can any learning be disseminated?

Feedback from the workshops will also inform recommendations and the action plan.

APPENDIX 3 – TRAINING REPORT

The LSCB Training Sub Group aims to ensure that LSCB priority areas are supported with appropriate learning and development opportunities that have a positive impact on frontline practice. The work of the group links directly to the LSCB priority of **Learning.**

The 2017-2018 LSCB training programme saw the delivery of 60 training events with 1166 professionals attending classroom-based training and 304 professionals completing e-learning modules. The table below provides a comparison.

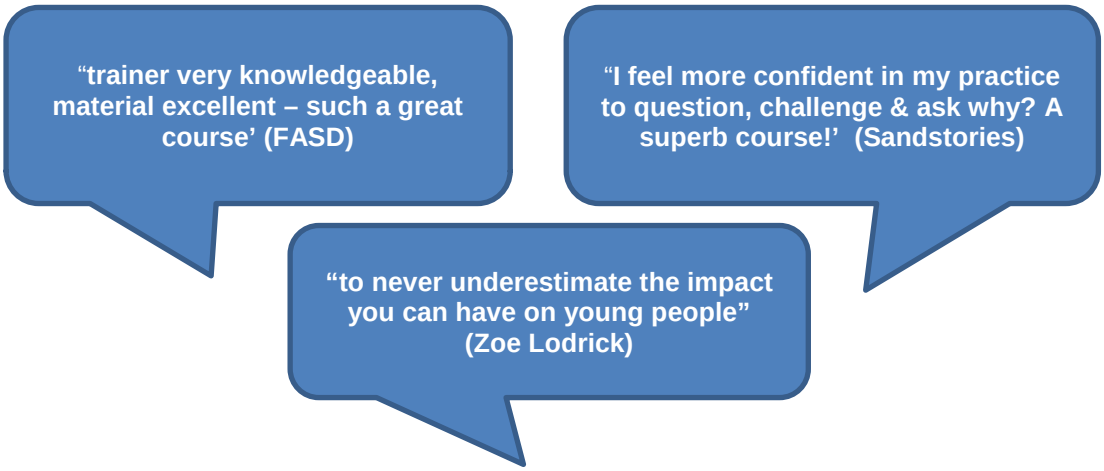
	Number of learning events	Face-to-face attendees	E-learning modules completed
2016-2017	59	1109	473
2017-2018	60	1166	304

The following sessions were delivered in the reporting period:

Event	Number of sessions	Number of Attendees
Boys and Young Men at Risk of Sexual Exploitation (LSCB)	1	17
Child Protection Awareness (LSCB)	8	153
Common Assessment Framework (LSCB)	3	40
Effective Child Protection Conferences and Core Groups (LSCB)	2	26
Female Genital Mutilation (LSCB)	1	15
Foetal Alcohol Syndrome (LSCB)	1	28
Introduction to Child and Adolescent Mental Health (iCAMH) (LSCB)	3	53
LGBT Young People at Risk of Sexual Exploitation (LSCB)	1	12
Multi-agency Working to Safeguard and Protect Children (LSCB)	2	40
Neglect (LSCB)	7	154
Safeguarding Babies from Abuse & Neglect (LSCB)	1	14
Safeguarding Children and Young People in the Digital Age (LSCB)	6	90
Safeguarding Children for Health and Social Care Professionals (LSCB)	2	53
Safeguarding Children with Disabilities (LSCB)	1	17
Sandstories (LSCB)	9	165
Serious Case Reviews - National and Local Picture (LSCB)	1	17
The Impact of Drug Use on Young People (LSCB)	1	10
The Impact of Parental Mental Health (LSCB)	2	45
Understanding Eating Disorders (LSCB)	2	18
Unveiling the Psychology of Sexual Exploitation and Domestic Abuse (LSCB)	1	86
Working with Disguised Compliance (LSCB)	3	67
Working with Hostile or Uncooperative Families (LSCB)	1	21
Young People Who Self Harm (LSCB)	1	25

Work continued in 2017-2018 to try and reduce the number of professionals who booked a place on a session and failed to attend and we updated our charging policy. From November 2017 to date cancellation & non-attendance charges have been applied generating an income of £2,050. Work also took place to better understand the impact of training on practice and ensure that the training programme was responsive to local need.

Once again, most of our training sessions were delivered "in house" by Gateshead LSCB multi-agency partners. The committed pool of trainers continues to deliver training which receives excellent feedback. We were also fortunate to be in a position to be able to commission external training sessions delivered in a unique style; for example Zoe Lodrick, a highly regarded psychotherapist delivered "Unveiling the psychology of sexual exploitation and domestic abuse" and Sue Woolmore, a renowned safeguarding expert with over 30 years' experience, delivered "Sandstories" which brought insight and wisdom to the impact of neglect and maltreatment on infants and children. Responses from impact evaluation questionnaires highlighted the positive impact that the training had on people's thinking and practice.

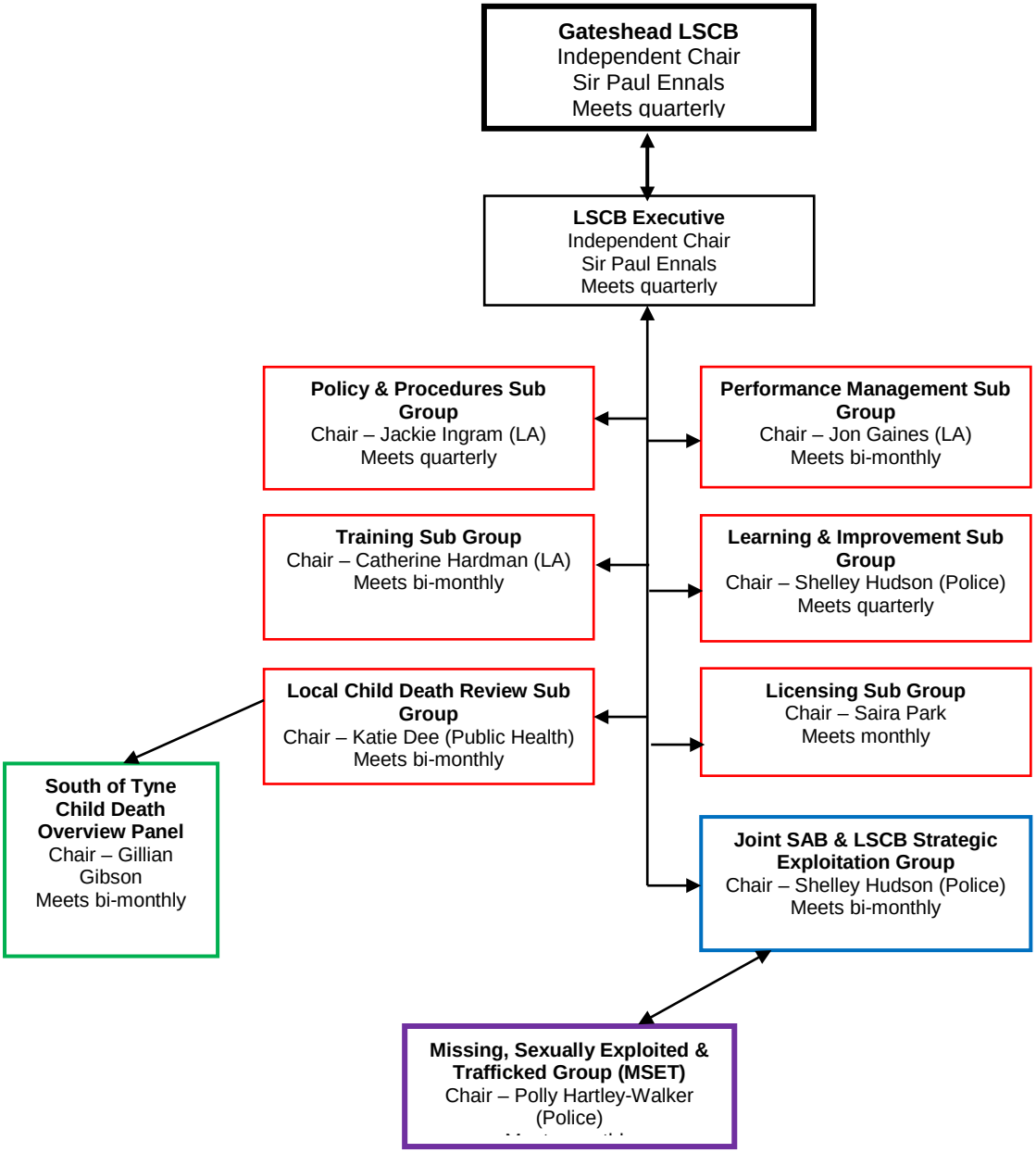


The LSCB Training Sub Group will continue to facilitate a live training programme receptive to and supporting the LSCB priorities for 2018-2019. The group will work to effectively communicate the training programme to encourage attendance from partner agencies as multi-agency training is important in supporting effective working together to safeguard children and young people. Specifically, the group will develop the skills and knowledge of those working to safeguard children and young people with mental health problems and disabilities and work with representatives from Gateshead Council's Community Safety Board & Safeguarding Adults Board to ensure that training across the three areas, including Domestic Abuse training supports the needs of partner agencies.

Gateshead LSCB are working with neighbouring LSCBs to develop a package of learning with regional themes from SCR's. We are also currently working with Newcastle Council on two packages of classroom based training. Gateshead LSCB continues to be represented at the NESCT regional trainers group.

APPENDIX 4 – SUB GROUP ACTIVITY

At 31 March 2018 Gateshead LSCB had seven sub groups, one of which was shared with the Safeguarding Adults Board and operated the following structure.



All sub group chairs are expected to provide an update at each meeting of the LSCB Executive Group, reporting on progress and plans for the future.

Joint SAB & LSCB Strategic Exploitation Group (SEG) – chaired by Detective Chief Inspector Shelley Hudson, Northumbria Police in 2017-2018.

The Strategic Exploitation Group is a sub-group of both the Safeguarding Adults Board and the Local Safeguarding Children's Board. The group is responsible for overseeing all work with respect to sexual exploitation, modern slavery, trafficking and female genital mutilation in Gateshead.

The **Missing, Sexually Exploited and Trafficked Group** (MSET) is a sub group of the SEG. In 2017-2018 there were 79 cases discussed at MSET, 20 of them more than once and this is an increase from the previous year. MSET members are also clear that after each meeting they must share current intelligence (e.g. hot spots, new social media apps of concern etc.) with all members of frontline staff in their team/service/agency.

During 2017-2018 a refresh of the CSE framework/MSET assessment was carried out to ensure that all agencies are focused on CSE and understand local processes. The revised risk assessment allows for a more thorough, corporate risk assessment to ensure that the right children are being discussed at MSET. The framework will be used by all LSCBs in the South of Tyne sub-region to ensure a more corporate and consistent approach and improve referrals into Team Sanctuary South.

Team Sanctuary South was formally established in April 2016 and the Detective Inspector from the team took over the chairing of MSET to ensure that there were clear links between Gateshead MSET and Team Sanctuary. The Gateshead embedded social worker also attends MSET to ensure that there is early effective sharing of information and an efficient referral and allocation into the team and partners.

There has been a significant amount of work conducted to improve the sharing of intelligence between agencies with the Team Sanctuary South Intelligence Cell being the central point of collection. This has allowed hot spot areas to be identified and disrupted. A number of disruption packages were produced from MSET intelligence in relation to vehicles, potential perpetrators and potential victims.

It is not possible to share specific case studies to demonstrate how the work of the MSET has helped reduce risks to young people and improve outcomes as this may lead to young people being identified in this report. Disruption plans have included specific actions to reduce missing episodes, disrupt relationships with inappropriate adults and work to promote self-esteem and improve individual young people's awareness of risk.

A series of "MSET road shows" took place in 2017-2018 to refresh professional with regard to processes for CSE, trafficking and missing children and young people. The multi-agency workshops were for professionals to highlight and discuss the new MSET referral process and risk assessment framework.

The LSCB Business Manager and Social Worker for Sanctuary South have also visited schools and attended team meetings to provide training and support use of the screening tool. This offer has been extended across all agencies and a number of workshops are planned for 2018-2019.

Work will also continue with regard to continued intelligence sharing between agencies to ensure that as many preventative and disruption tactics can be introduced and considered. This will ensure that all agencies are working together (coordinated by Team Sanctuary Intelligence) to keep children and young people safe from CSE and human trafficking. Through robust challenge by MSET panel members appropriate and effective individual safeguarding plans will be devised to reduce the risk presented in relation to CSE and missing and trafficked children. Gateshead Council will also continue to support Team Sanctuary South by funding the embedded social worker and there is a strong commitment from Northumbria Police to maintain the model.

Learning & Improvement Sub Group – Chaired by Shelley Hudson, Detective Chief Inspector, Northumbria Police in 2017-2018.

The Learning & Improvement Sub Group has been developed to further promote the role of the Board in providing scrutiny of safeguarding practices and ensuring that multi-agency learning from practice is effectively disseminated and drives improvement in safeguarding and the promotion of children's welfare in Gateshead. The Learning & Improvement Framework approved by the Board sets out the approach and time frame for activity. The framework is consistent with the requirements in *Working Together* (2015) and includes learning from:

- Local and regional Serious Case Reviews (SCRs)
- Child Death Reviews
- Reviews of child protection/child in need cases that fall below the threshold for a SCR
- Review or audit of practice in one or more agencies

The sub group reviewed 6 cases over the last year (and continued the work from some reviews initiated in the previous year), none of these cases met the criteria for a SCR. However, it was agreed that further learning could be gained from carrying out a learning review for one of the cases, using systems methodology.

The sub group considered a diverse range of SCRs from other LSCBs and cases across partner agencies. Some cases have been subject to deep dive management reviews where all relevant agencies across the LSCB have actively taken part to consider the learning for their agency. Learning from these cases has been identified across multi-agency services to improve practice in Gateshead.

Partners within the sub group have worked effectively to scrutinise and challenge practice, systems and frameworks taking actions back to their own agencies in order to continuously improve service delivery.

Licensing Sub Group – Chaired by Saira Park, LSCB Business Manager from September 2017 (previously chaired by Louise Gill, LSCB Business Manager)

The purpose of the Licensing Sub Group is to ensure that the LSCB fulfils its responsibilities as the "Responsible Authority" with regard to the "protection of children from harm", which is one of the licensing objectives of the Licensing Act 2003.

The workload of the group is largely dependent on licensing applications. The group meets on a monthly basis and considers all applications submitted to Gateshead Council under the Licensing Act 2003 for premises licences, club premises certificates) and also review applications on existing licenses submitted by other parties.

The group considers each application individually and determines whether there are any implications from a child protection or safeguarding point of view. Other aspects of the licensing process, such as anti-social behaviour, are considered by other responsible authorities. If there are any concerns then the applicant may be asked to provide further information and this could lead to a representation being made to Gateshead Council's Licensing Committee. This could then lead to a licence not being granted, or being granted with conditions in the case of a new application, or a licence being revoked in the case of a review application.

The sub group reviewed **37** applications in 2017-2018, an increase from 2017-2018 when there were 28 applications. There were no safeguarding issues identified in the majority of applications – most of these were from individuals or businesses for premises licences, for example new restaurants/pubs/supermarkets opening and due regard had been given to protecting children e.g. "Challenge 25" procedures for the sale of alcohol.

The LSCB had cause to submit representations against two premises who had applied for review of their licence due to concerns regarding the sale of alcohol to children under 18. The Council's Licensing sub-committee made the decision to revoke the licence of both premises.

In relation to **Leadership, Challenge** and **Improvement** the sub group chair has continued to lead on the delivery of CSE training to taxi drivers licenced by Gateshead Council. The chair of the sub group has also challenged other responsible authorities on a number of occasions following intelligence sharing in MSET meetings e.g. around premises where young people stated that they could easily purchase alcohol or premises where it was easy to shoplift alcohol before congregating locally to get drunk and possibly have sex.

In 2018-2019 the group will continue to respond to applications for new licences or reviews of existing licenses and challenge any issues that impact on the protection of children.

The work of the sub group has previously been identified as good practice locally, regionally and nationally and the chair will make representations to ensure that it continues to feature in the new arrangements being developed as a consequence of the national review of LSCBs and changes in legislation. The LSCB Business Manager will continue to act as a link between this group and other related groups such as MSET and the Strategic Exploitation Sub Group to ensure robust links between safeguarding and licensing.

Local Child Death Review Sub Group (CDRG) – Chaired by Lynn Wilson and Katie Dee, Public Health in 2017-2018

The purpose of the CDRG is to undertake multi-disciplinary reviews of the deaths of all children who were resident in Gateshead at the time of their death to better understand how and why children die. These findings are used to take action to prevent other deaths, where relevant/appropriate and improve the health and safety of Gateshead's children. The sub group's remit is determined by the statutory functions of the LSCB as set out in Regulation 6 of the LSCB Regulations 2006, made under section 14(2) of the Children Act 2004 and Chapter 5 of *Working Together* (2015).

The work of the CDRG feeds in to the South of Tyne and Wearside Child Death Overview Panel (CDOP). The group collects and collates an agreed minimum data set of information on all child deaths in Gateshead, Sunderland and South Tyneside. This data set reflects the national requirements. CDOP produces a separate annual report and this is published on the LSCB website.

The sub group identified a number of areas of good professional practice, particularly with some of the more complex cases. There was evidence of good partnership working and good communication between professionals and with families.

The CDRG and surrounding processes continue to identify challenges around the availability of neonatal beds and this has been raised with the regional Neonatal Network.

CDRG members were also part of some regional work to learn from each other's processes in light of the Government review of LSCBs and CDOPs. A mapping exercise was undertaken and discussions carried on into 2017-2018

Sub group members continued to deliver training to clinicians and other professionals involved in child deaths as outlined in the LSCB training programme and specific to individual cases.

The LSCB was notified of the deaths of 11 children who were resident in Gateshead in 2017-2018. The majority of these deaths were neonatal cases, particularly premature babies or babies born with life limiting conditions. There were also a small number of Sudden

Unexpected Deaths in Infancy (SUDI) (numbers not listed to ensure anonymity). There were no significant safeguarding issues identified with any of the cases.

Due to the timescales involved in the Child Death Review process, the group also reviewed the cases of some children who died in previous years. Again, the majority of cases were neonatal deaths.

There has also been some national learning which has been discussed by the CDRG. For example there were a number of deaths where premature/small babies died after prolonged periods in car seats. Awareness raising work was carried out with professionals to advise that babies should only be in seats for 30 minutes at a time and always be visible so that parents can regularly check them.

It has been agreed that Gateshead CDRG will be part of a wider piece of work in 2018-2019 as the CDOP South of Tyne links CDOP North of Tyne CDOPs to hold a regional event and explore current child death themes. There is also consideration being given to future arrangements and how learning is shared, both regionally and nationally.

The workload of the group is determined by regional and national events and the group will continue to respond as appropriate in 2018-2019. Changes to legislation and statutory guidance may impact on the work and governance of the sub group but arrangements will continue as they are until this is clearer.

Performance Management Sub Group – Chaired by Jon Gaines, Service Manager Gateshead Council from November 2017

The purpose of the Performance Management Sub Group is to support the LSCB in fulfilling its statutory duty to monitor and evaluate the effectiveness of what is done by the local authority and Board partners, individually and collectively, to safeguard and promote the welfare of children, and advise them on ways to improve.

Continuous performance management is at the core of ensuring the effectiveness and impact of inter-agency safeguarding activity. The sub group supports the LSCB in the monitoring, promotion and planning of high quality practice in line with the inter-agency Performance Management Framework. The framework is used to monitor and analyse a range of quantitative and qualitative information, both via ongoing and set pieces of work. The sub group reports regularly to the Board highlighting any areas of practice that need to be addressed, and identifying areas of good practice.

Due to staffing changes within Gateshead Council the sub group did not meet until May 2017. The work of the group and dataset were reviewed when a new chair was appointed in August following the Council's recruitment of Service Manager for Quality Assurance.

Work was then carried out to refine and develop the set of performance indicators and produce a dashboard. Discussions are also under way with neighbouring boards with a view to moving towards common elements of the data in order to simplify the task of those partners who operate across many LSCB boundaries.

The LSCB continued to receive performance and data reports on the previously agreed set of indicators (this was coordinated by Gateshead Council on behalf of the Board). A summary of this is provided in Section 3 of this report.

Policy & Procedures Sub Group – Chaired by Jackie Ingram, Senior IRO, in 2017-2018

The Policy & Procedures Sub Group works on behalf of the LSCB to ensure that statutory functions in relation to policies and procedures are carried out. The LSCB commissions TriX, an external provider, to produce and host the online LSCB Inter-Agency Child Protection Manual as part of a sub-regional agreement with Sunderland and South Tyneside LSCBs.

In 2017-2018 the sub group was able to manage the online LSCB Inter-Agency Child Protection Procedures on behalf of the Board.

Review of LSCB Thresholds
A key piece of work undertaken in 2017-2018 was the review of thresholds document, as part of the wider review of procedures. Significant progress has been made in reviewing the document, which the Board has responsibility for endorsing. A task and finish group has been working on details and a draft document has been agreed. The group felt that a more detailed document would be beneficial, to help inform decision making and also support early help.

The draft document describes levels of concern for children, young people and their families and should support consistent application of definitions and promotion and maintenance of good practice. The document is due to be ratified by LSCB in May and once finalised it will be available on the website in a format that is accessible.

The LSCB Business Manager will continue to lead on the sub regional work with TriX in 2018-2019.

Training Sub Group – Chaired by Naju Khanom, Workforce Development Officer, Gateshead Council until September 2017 and then Saira Park, LSCB Business Manager.

The purpose of the group is to develop and promote, through training, a shared understanding amongst safeguarding partners around the tasks, processes, principles, roles and responsibilities for safeguarding children and promoting better outcomes. For more information on the work of the sub group and the LSCB training programme see Appendix 3 of this report.

APPENDIX 5 – LSCB PRIORITIES FOR 2018-2019

Vision

"Our vision is that every child should grow up feeling safe and in a loving, secure environment, free from abuse, neglect and crime, enabling them to enjoy a happy and healthy childhood in which they can fulfil their social and economic potential

Role of the Business Plan

The Gateshead LSCB Business Plan sets the strategic direction for the LSCB. The Business Plan also reinforces the specific role of the LSCB to **lead, challenge** and support **learning.** The plan identifies specific priorities for action and is clear about roles and accountability.

The Gateshead approach

Due to the expected changes to statutory guidance, the LSCB agreed that the business plan for 2017-2018 should cover only one year, unlike the previous three year plan. There have been considerable delays in finalising the new statutory guidance so it was agreed the LSCB would continue with the same approach for 2018-2019.

This document provides a focus for 2018-2019 to build on the progress made in the previous year and to drive forward work to prepare Gateshead for the new safeguarding arrangements which will be established in 2019 in line with new legislation. This document will enable the Board to continue to focus on the specific role and remit of LSCBs in ensuring that the welfare of children is safeguarded and protected, as set out in *Working Together* (2015) and the Children Act 2004.

This Business Plan emphasises the role of Gateshead LSCB in **leading** the safeguarding agenda, in **challenging** the work of partner organisations, and in committing to an approach which **learns** lessons, embeds good practice and which is continually influenced by the views of children and young people.

2018-2019 Action Plan

In 2018-2019 the focus will continue to be on the three strategic business priorities:

- **Leadership**
- **Challenge**
- **Learning**

There will also be a focus on five thematic priority areas:

- **Voice of the child**
- **Communication & engagement with the frontline (including schools)**
- **Early Help & Early Intervention**
- **Mental health & Emotional Wellbeing**
- **Child Sexual Exploitation & Missing**

In addition, we will continue to work to prepare for the implementation of new legislation and guidance around statutory strategic arrangements for safeguarding.

We will do the following to deliver our priorities:

In relation to **Voice of the child** we will improve the way we capture the voice of the child and how its is heard by services and the LSCB so that we can learn from what young people are telling us and our partner agencies. We will evaluate the effectiveness of different aspects of the child's journey into help and services, the quality of the decisions made by individual agencies and the quality of multi-agency processes.

In relation to **Communication & engagement with the frontline (including schools)** we will

In relation to **Early Help** we will continue to challenge progress of the Early Help Strategy and receive assurance about the impact on safeguarding children. LSCB will monitor how early help arrangements are working and if this is reducing the need for escalation.

In relation to **Mental health & Emotional Wellbeing** we will continue to receive assurances on the implementation on the new model for delivering Child and Adolescent Mental Health Services (known as EMIL) and receive assurances that mental health services commissioned for children in Gateshead are adequate in terms of safeguarding and services for adults operate with a "think family" approach. We will ensure we liaise with Health & Wellbeing Board and any other groups to ensure work is joined up and reduce risk of duplication.

In relation to **Child Sexual Exploitation & Missing** we will seek to ensure that those children and young people who are likely to be exploited or go missing can be identified and supported appropriately and to ensure the workforce understand the particular vulnerabilities of these children and young people.

In addition, we will do the following to maintain a focus on our strategic priorities linked to our specific role to **lead**, **challenge** and **learn:**

In relation to **leadership** we will work to ensure that our future arrangements are fit for purpose and enable the new body which will be established to oversee strategic safeguarding arrangements in Gateshead to build on the work of the LSCB and strengthen the position in Gateshead further.

In relation to **challenge** we will continue to strengthen on our links with other partnerships (e.g. the Safeguarding Adults Board, Health and Wellbeing Board and Community Safety Board) and influence their agenda via our own work plan and membership.

In relation to **learning** we will continue to review cases where there are lessons to be learned through the Learning and Improvement Sub Group (and Serious Case Review Panel when necessary). We will also implement and embed the findings of any relevant inspections of the Board and partner agencies and cascade the learning across partner agencies.

APPENDIX 6 - GLOSSARY

CAF -	Common Assessment Framework
Cafcass -	Child and Family Court Advisory Support Service
CCG -	(NHS) Clinical Commissioning Group
CDOP -	Child Death Overview Panel
CIN Assessment -	Child In Need Assessment
CP Plan -	Child Protection Plan
CQC -	Care Quality Commission
CRC -	Community Rehabilitation Company (Probation)
CSE -	Child Sexual Exploitation
FT -	(NHS) Foundation Trust
HMIC –	Her Majesty's Inspector of Constabulary
HMIP -	Her Majesty's Inspector of Prisons
ICPC -	Initial Child Protection Conference
IRO -	Independent Reviewing Officer
LAC -	Looked After Child
LGBT -	Lesbian, Gay, Bisexual, Transgender
LSCB -	Local Safeguarding Children Board
MASH -	Multi-agency Safeguarding Hub
MOMO -	Mind of My Own (mobile app)
MSET -	Missing, Sexually Exploited and Trafficked Sub Group
SAB -	Safeguarding Adults Board
SCR -	Serious Case Review
SUDI -	Sudden Unexpected Death in Infancy