FAMILIES
OVERVIEW AND SCRUTINY COMMITTEE

22 October 2015

PRESENT: Councillor Malcolm Brain

Councillors: Caffrey, J Graham, McCartney, Adams, Hawkins, Ronchetti, Clelland, Turnbull, Robson

CO-OPTED MEMBERS: Malcolm Brown and Jill Steer

F16 Apologies for Absence

Apologies for absence were received from Councillors S Craig, McHatton, Simcox, Oliphant, McMaster, Thompson, McNally and co-opted members, Sasha Ban, John Wilkinson and Ray Tolley.

F17 Minutes

RESOLVED - The minutes of the meeting held on 10 September 2015 be agreed as a correct record subject to the following clarification;

Minute F15 'OSC Review – Evidence Gathering' – paragraph 9 be amended to read:

"A breakdown of child protection figures was provided, it was noted that figures were high at 2013/14 however the 2014/15 ***national comparator figures*** *are not yet available."*

Matters Arising
The Chair confirmed that he has met with officers regarding the REALAC team and in particular around LAC achievement in education results. Further information will be brought back to a future meeting.

Following the query raised at the last meeting around what work is being done in schools to raise awareness that 'sexting' is Illegal, it was confirmed that this is delivered through the Chelsea's Choice Workshop. It was also noted that this is picked up through the Healthy Schools Programme, which has 100% take up. In addition the Emotional Health and Wellbeing Team will also pick up on such issues.

In relation to the Child Health Profile (minute F13) it was confirmed that LAC immunisation rates are currently at 96.1%. It was noted that the Child Health Profile looks only at the number of LAC continuously looked after for 12 months, there is a limitation on data in that the child can refuse a health assessment so there may be under reporting.

F18 Performance Improvement Update – Children Presenting at Hospital as a result of Self Harm

The Committee received a presentation around the work achieved, in relation to self-harm in 10-24 year olds, over the last 12 months.

It was noted that the term self-harm describes a range of things, it can be hidden and is defined as self-poisoning or injury. It was acknowledged that regionally and nationally this is a real problem with most self-harm hospital admissions as a result of self-poisoning. It was confirmed that self poisoning includes overdosing with a medicine or a poisonous substance, self-harm also includes; cutting, burning, scalding, hair pulling and strangulation.

It was reported that for Gateshead there are high hospital admission rates and the numbers of young people being admitted as a result of self-harm have increased. It was noted that the reasons for this are complex and are not isolated incidents; this can be linked to Child Sexual Exploitation and vulnerability factors. A recent Peer Review looked at sector led improvement and self-harm was flagged. Self-harm is also a focal point of the LSCB for 2014-2017.

It was noted that in 2014/15 there was a significant number of hospital admissions as a result of self-harm, however A&E admission have reduced, although this is not a full data set as data is one year behind. It was also reported that Gateshead is towards the higher end of the scale in terms of hospital admissions and is above the North East aggregate line. The wards with the highest rates currently are; Pelaw and Heworth, Dunston and Teams and Winlaton and High Spen. It was acknowledged that there are a lot of young people who may be self-harming but who are not presenting at hospital, therefore there will be some under reporting.

The Committee was advised that during 2014/15, 353 children and young people were seen by the Tier 2 CAMHS service, of this number 23 were coded as self-harm, this equates to 6%. From this 6%, five were referred on to specialist CAMHS provision. Referrals for these 23 young people were through GP's, schools, health professionals and self-referrals from parents. It was confirmed that, during 2013/14, 77 young people under the age of 18 were admitted to the QE Hospital as a result of self-harm.

In order to tackle this problem a Self-Harm Protocol for Gateshead has been developed by a multi-agency sub-group. This is based on good practice examples and looks at pathways to identify risk and harm minimisation. It is aimed at ensuring consistency across agencies. From the protocol an action plan is being developed, which will be endorsed by partners. Training for frontline staff will be developed around self-harm, in particular embedding in schools. Trends will continue to be monitored in relation to self-harm and new ways of working will be explored. It was noted that the Action Plan would be circulated once there was wider sign up.

It was questioned why there was a low take up of schools in relation to the Health Related Behaviour Survey. It was confirmed that this was done electronically to make it more flexible for schools to sign up, however no secondary schools signed up. Headteachers and pastoral support were contacted and this will be repeated. It was suggested that the Safeguarding Governor should be contacted in addition to the Headteachers. It was also suggested that completion of the survey should be a requirement of the Healthy Schools status.

The point was made that in certain groups of young people, self-harm is a fashionable status and therefore what could be done to separate that group. It was noted that in terms of the protocol's action plan there will be support for schools to do basic questioning to differentiate those young people who are at risk. It was acknowledged that cases will need to be filtered where additional support is required.

It was suggested that there is not enough awareness made of the issue, for example in terms of the risks of over the counter medicines. It was acknowledged that the severity and complexity of cases are increasing and work is ongoing to look at early prevention through the Healthy Schools Programme. The point was made that schools can be a stressful situation for young people and therefore it was questioned whether school was the best setting for such support. It was confirmed that the support is wider than schools and a training directory of services is available and it is hoped will be built into all areas not just schools.

The pressures in terms of waiting times for CAMHS services and GP's was acknowledged and it was questioned whether anything was being done to bring this time down. It was noted that work is ongoing to bring waiting times down but that 18 weeks is quite typical, however that also depends on priority and where there is a risk the young person is seen earlier.

It was pointed out that information around the re-design of the CAMHS service will be reported to the Health and Wellbeing Board and any gaps in data will be flagged up during that process.

RESOLVED - (i) That the Committee noted the content of the report and its comments on the information provided and suggested areas for development be noted.

(ii) That the Committee agreed to receive an update in 12 months following the implementation of the protocol and to share the findings of the Health related behaviour questionnaire.

F19 OSC Review – Child Protection in Gateshead – Evidence Gathering

The Committee took part in the second evidence gathering session of the review into how the child protection system operates in Gateshead. The

session looked at how referrals are made, the thresholds for whether a child and family should be assessed and how the level of support is determined.

The presentation focused on the work of the Referral and Assessment Team (R&A), which is the 'front door', the team filters all contact and assesses the circumstances of each referral. The service structure underneath the R&A Team consists of the Safeguarding and Care Planning Team, Disabled Children Team and the Children and Families Support. Depending on the level of support required, as assessed by R&A, families can be referred to any of these teams. The R&A team provides the initial point of contact for all new referrals into Children's Social Care.

It was reported that the R&A team is a very busy team, consisting of 23 Social Workers, a Domestic Violence Worker, two Family Support Workers and a Homeless Prevention Support Worker. The core business of the team is to ensure the statutory duties and responsibilities of the Council are discharged in respect of safeguarding children. The R&A team provides advice and support to signpost families to appropriate services. The team begins the initial planning process by providing timely assessments such as; Child in Need Assessments, Domestic Violence Assessments, Private Fostering Assessments, Prison Visit Assessments and Children in Hospital Assessments.

In terms of thresholds it was noted that these must be right as there cannot be an open door for all. It was noted that a multi-agency threshold document provides guidance for professionals as to whether to recommend an assessment and at what level. This is divided into three tiers; level 1: baseline – universal services, level 2: moderate – targeted services and level 3: high – specialist Social Care services. It was noted that the list of indicators is not exhaustive and in many cases multiple factors are likely to be present and it is for professional judgement as to whether the criteria are met. It was also acknowledged that the needs of a child are often found in a number of different pieces of evident, for example a number of indicators being met in tier 2 may indicate the need for a tier 3 assessment. Similarly, it was recognised that a single indicator can sometimes be so significant that it will deem assessment at a high level even in the absence of any other indicator.

In terms of the referral process, if the threshold is met and there is no immediate risk of harm, a case will be allocated within 24 hours. If a referral does not meet the threshold criteria no further action is needed but the contact will be recorded. If the referral does not meet the threshold criteria but low level needs are identified, referrers will be advised and signposted to other more appropriate services. If the threshold is met the case will be allocated for assessment.

It was noted that the assessment framework is a regionally agreed document, this ensures more collaborative work to guarantee consistent assessments. The assessment framework focuses on four domains; child development,

family and environment, parenting capacity and risk. It was noted that the assessment is a diagnostic process and must be completed within 45 days. It looks at whether parents can make changes, the child's social integration and family parenting capacity. The assessment looks at whether the child's current environment is safe, what works well and the anticipated impact if nothing changes. The Social Worker must analyse all the information available and in particular looking at risk factor; whether there is a probability of a negative occurrence that may be avoided through pre-emptive action. The Social Worker must deal with uncertainty and ambiguity and develop an evidence base and demonstrate professional judgement to establish the severity and likelihood of risk.

It was noted that key principles have been identified which have come from a number of Serious Case Reviews;

- professional curiosity
- family history and cumulative risk
- partnership cooperation between agencies
- checks and balances – use supervision as an opportunity for error correction, during assessments there are 10, 25 and 40 day checkpoints
- bias – need to be challenged
- keeping the child in focus

In relation to the work of the team it was confirmed that between April and September 2015, the R&A team completed 772 Children in Need Assessments, 97.4% of which were completed within timescales. A breakdown of factors applicable during assessment was provided, this showed that the factor present in the most cases was domestic violence, mental health was also applicable in a lot of cases. It was noted that Child Sexual Exploitation was only a factor in a small number of cases, however it is expected that this will increase as awareness on this issue is raised.

The Committee was provided with a case study and a discussion was held about how a decision was made in relation to that case. In terms of decision making the Social Worker will do a history check and gather information, there will also be consultation with the Duty Manager which ensures there is management oversight. Threshold criteria is used at all times when making decisions and the immediate safety of the child must always be considered. It was noted that referrals can vary, they can be written referrals or through a telephone call or from walk in's at the Civic Centre.

Once a Child in Need Assessment begins a Social Worker is allocated on the second day. The assigned Social Worker will spend time speaking to the child in a variety of environments. Following completion of the assessment a number of outcomes can be reached;

- no further action
- signpost to Universal Services
- refer to TAF/CAF (early support services)
- refer to Family Intervention Team

- transfer to another Local Authority
- transfer to Safeguarding Care Planning on a Child in Need Plan or a Child Protection Plan

The Committee was invited to ask questions and make comments about the information presented.

It was questioned whether there is challenge at all points throughout the assessment. It was confirmed that there is and at the end of the process in particular. In addition, on a weekly basis managers check a random selection of cases and during inspection Gateshead was judged as outstanding in its quality assurance processes. It was noted that quality assurance starts at the beginning and is also checked at the end, Social Workers have ready access to management at all times. When a referral is made it cannot be closed until there is agreement from a manager.

The point was made that previously there was a high level of sickness within the team and it was queried whether this impacted on the service in terms of completing assessments within 45 days. It was confirmed that at present the sickness rate is good, Social Workers are supported and regular supervisions are held to ensure they are fit and well and there is cover for anyone that is on long term sick. It was also noted that the team is very stable and if a Social Worker had to go off in the middle of an assessment this would be passed to a manager.

It was noted that the majority of referrals are through the police, probation and court, and concerns were raised that this is when a family or child is at crisis point. It was confirmed that every time the police attend an address in Gateshead where a child is present a referral will be received, therefore the severity of the cases can vary. It was noted however that there is a police wide referral process but they are able to use some discretion and they will decipher whether the situation requires a referral or just a contact. It was confirmed that Gateshead has done well in ensuring people and professionals understand thresholds and they are encouraged to call for advice before making a referral. It was also recognised that Operation Encompass, where domestic violence cases are reported to schools, is working very well.

RESOLVED - (i) That the Committee's comments on the second evidence gathering session be noted.

(ii) That the Committee agreed the proposals for the next evidence gathering session.

F20 Collaborative Commissioning of CAMHS Service

The Committee received a report outlining the work currently ongoing to redesign children and young people's mental health services across Gateshead and Newcastle, the project is called 'Expanding Minds, Improving Lives'.

It was reported that there is national recognition that CAMHS is not meeting the needs to children and young people. Work is being carried out jointly with Newcastle Council and the CCG to set up different ways of designing services. The timescales for the project were set out and it was confirmed that multi agency events are being held during November and December.

An Advisory Group has been established to share early thinking with key stakeholders, and Youth Focus has also been commissioned to develop a group of young people aged 13-19 to become co-commissioners. It is hoped that this group can help shape future mental health services.

The consultation is currently ongoing until 13 November, a new model will be co-produced from November to January with formal consultation on the proposed new system starting in February 2016. It is hoped that the new system will be in place from May 2016.

The Committee welcomed the change to the service.

RESOLVED - That the Committee noted the progress of the project to date.

F21 Monitoring Report – OSC Review – Role of the Council in Supporting Educational Outcomes

The Committee received the first monitoring report following its review into the role of the Council in supporting educational outcomes. The main recommendations from the review were around information and transparency, the strategic delivery of education services and work with Special Schools.

Since completion of the review it was confirmed that 2014/15 examination data analysis is ongoing. An annual assessment of the impact of the secondary 'narrowing the gap' project is now on senior officer's performance management targets. Work is also underway to review the Governors' development programme to enable them to challenge school leaders. Special School Headteachers will undertake annual discussions with the committee in the future. It was noted that there has been a response to the increasing numbers of SEN statements with Eslington School currently being expanded and also additional provision at Gibside.

The Committee was happy with the progress so far and agreed to receive a further monitoring report in six months time.

RESOLVED - That the Committee was satisfied with the progress against actions to date.

F22 Any Other Business

The Chair, on behalf of the Committee, thanked Martin Gray for his work on the Committee over the last several years and wished him well for the future.