Learning from practice

Annual Report

1 April 2016 – 31 March 2017

Newcastle Safeguarding Children Board

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1. Purpose of this Report

1.1 The purpose of this report is to provide an overview of the work of the NSCB in relation to learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice. This includes a full range of reviews and audits which are aimed at driving improvement. Whilst this will include any reviews required under legislation such as Serious Case Reviews, in Newcastle, reviews and audits are conducted regularly on cases which can provide useful insights into the way organisations are working together which includes highlighting good practice. This annual report is received by the NSCB outlining the work undertaken over the year. The reporting period for this report is 1 April 2016 up to 31 March 2017 which should be read in conjunction with the NSCB Annual Report 2017/18 and Section 5 and the Learning and Improvement Framework. **http://newcastlescb.proceduresonline.com/chapters/p_learn_fw.html**

1.2 In addition, this year's learning from Practice annual report also includes some thematic audits completed by Children's Social Care (CSC) include learning for partners where relevant. In future reports we will be aiming to incorporate more learning from single agency audits across agencies.

1.3 The purpose of all the quality assurance and audit activity taking place, is to ensure all work is carried out to the highest quality. It aims to evidence and improve our understanding of whether we are supporting the right children, in the right way, at the right time and whether we are making a difference.

2. Introduction

2.1 Regulation 5 of the Local Safeguarding Children Board (LSCB) Regulations 2006 requires LSCBs to undertake reviews of serious cases. They should be undertaken in accordance with processes set out in chapter 4, Working Together to Safeguard Children 2015, which includes a clear criteria for when a Serious Case Review (SCR) should be undertaken.

2.2 The prime purpose of a SCR is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children. Working Together states that in some cases it may be valuable to conduct a single Individual Management Review rather than a full SCR, for example where there are lessons to be

learned about the way in which staff worked with one agency rather than about how agencies worked together, or a smaller scale audit of an individual case that gives rise to concern, but does not meet the criteria for a SCR.

2.3 Research shows that learning from what works and safeguarding incidents ('near misses') can prevent more serious incidents in the future (Cooperider 2003; SCIE 2005). Any learning model used must be consistent with the principles in Working Together 2015. The DfE report published May 2016 Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, found that the widespread adoption of systems approaches to reviews appears to have led to a greater focus on learning lessons. Newcastle has adopted strength/system based models which includes Appreciative Inquiry, an innovative approach to creating an achieving positive change and have also used the strength/system based approach Critical Incident Collaborate Inquiry (CICI).

3. Serious Case Reviews

3.1 Since the last annual report there has been one SCR instigated, one ongoing and SCR Child J from 2015/16 published.

3.2 **SCR Child J** was published in June 2016. The review considered the circumstances of the unexpected death of J when she was 15 weeks old. She had been subject to a Child Protection Plans as an unborn for neglect. An initial post-mortem concluded that her death was caused by a head injury. Further tests confirmed that this was likely to have been as a result of shaking, by either her mother or mother's partner. The learning from this SCR was included in the Learning from Practice Annual Report 2015/16. A supporting SCR Action Plan was developed and implemented until its sign off by NSCB in November 2016. An Impact Assessment has been used to demonstrate the impact of learning and actions on practice, systems and outcomes for children and young people.

3.3 The review identified 12 Findings with 33 associated actions covering aspects of practice, systems, procedures and resources. Whilst the findings did relate to partner agencies the majority were for Children's Social Care. A significant amount of action has been taken to embed the learning from the review, the impact of which is being tested out by audit activity with evidence of some improvements in practice.

3.4 The onset of numerous innovations and projects to strengthen practice e.g. Systemic Practice, Signs of Safety, Parents under Pressure; MST CAN; Thriving Families, will all take time to demonstrate long term impact, and therefore the NSCB will continue to maintain an oversight of the work as it develops.

3.5 Additional areas identified for improvement through the audits have been embedded within individual agencies service improvement plans for all partners where relevant and overseen by the individual agencies NSCB is confident that services will continue to improve as a result of the Child J Serious Case Review.

As part of its scrutiny function and for assurance purposes the NSCB will undertake a multi-agency sample audit in July 2017. The audit will cover the practice components identified in the SCR to establish whether learning has been embedded and what difference this has made.

3.6 **A Joint SCR (JSCR) into Sexual Exploitation** between Newcastle Safeguarding Children's Board and Newcastle Safeguarding Adults Board commenced in October 2015 and is on-going. The JSCR adopted a thematic approach to reviewing Sexual Exploitation of both children and adults, however, learning has been identified from a number of carefully selected cases which include both children and adults. The cases identified fully reflect, insofar as is relevant, the different characteristics of the individuals (for example age, ethnicity, gender, health/care needs, contact with services/agencies) and types of abuse, setting, model of sexual exploitation) 16 events have been held involving front line practitioners and managers in order to learn lessons and improve future practice. The purpose of Learning Events was to bring together key staff to reflect and learn from what has happened in order to improve practice in the future. Using a strength/systems approach, the emphasis has been on understanding what happened, considering why some assessments and decisions were made, and how and what can be learned for the future.

3.7 Reporting restrictions are in place until the criminal trial have concluded, therefore specific details of the individuals involved and the circumstances cannot be provided in this report.

3.8 Learning from the JSCR so far, together with learning from a large scale police investigation into sexual exploitation which precipitated the JSCR, has led to a significant amount of learning. To date this learning includes:

- The importance of a multi-agency victim team and victim strategy
- Having prosecution strategies in place which are designed to incorporate multiple rather than single victims are essential
- Third party material disclosure has emerged as a significant resourcing and trial issue
- The vocabulary and language used by professionals is very impactful and often undermines victims
- Social care professionals and other partners are key in developing sexual exploitation intelligence
- Covert policing techniques and multi-agency disruption techniques are essential to combatting sexual exploitation
- Emphasis on vulnerability
- The range of procedures/legislation e.g. Court of Protection, Mental Capacity Act
- Risk indicators, models of exploitation – importance of not being blinkered towards specific models of sexual exploitation
- Sexual Exploitation and the impact on victims is better understood
- Not always about money, drugs or material possessions, often more basic i.e. food, accommodation
- Victim support – needs to be dedicated, persistent, flexible and committed
- Better understanding of safeguarding systems across children's and adults services
- Increased knowledge and awareness of how to mitigate risk and increase resilience
- Links between victim and facilitator are better understood

3.9 The impact of learning so far:

- Learning has been incorporated into existing training programmes, enhancing social work skills and practice
- Briefings to CSC practitioners to influence practice
- Joint NSCB and NSAB M-SET Group, strengthening safeguarding arrangements across the life course in
- Joint children's and adults sexual exploitation strategy, monitored and overseen by M-SET strengthening arrangements for children and vulnerable adults
- Development and implementation of a multi-agency team, which provides support to victims of sexual exploitation
- Input from a Sexualised Trauma Specialist to support staff to be able to work effectively with victims of sexual exploitation
- Adult services representation at Risk Management Group (RMG)

- Raised awareness of risk indicators leading to improved outcomes
- Actively engaging in multi-agency frameworks to develop robust and where necessary, innovative protection plans
- Focus moved to SE not just CSE
- New SE Tool devised and implemented across Children's and Adults Social Care
- Identifying need – increase in numbers particularly adults
- Robust transition protocol and process
- Joint training on sexual exploitation
- Risk Management Group terms of reference has been reviewed to bring together those young people who are at risk from their own behavior, those who go missing from home and those at risk of sexual exploitation

3.10 Other work undertaken by both the children's and adults' board includes:

- Update of SE practice guidance and referral pathway
- Annual review of the joint Sexual Exploitation Strategy 2015/18 supported by annual action plan overseen by MSET
- Chelsea's Choice drama production shown in 10 schools in Newcastle
- RMG Data Group in place to share information, inform practitioner to minimise risk, support disruption activity and target resources

3.11 The JSCR is ongoing with a focus on learning and identifying improvements. Once the criminal proceeding are complete and reporting restrictions lifted there will be time needed to capture learning from victims and perpetrators, prior to publication.

3.12 **SCR Child K** a 3 month old baby who died as a result of an inflicted and traumatic non-accidental injury which is subject to police investigation. An Independent Reviewer has been commissioned and the review is now underway. The final report will not be published until the criminal proceedings are finalised the date of which is unknown at this point.

4. Serious Incident Notifications to Department of Education (DfE)

4.1 During 2016/17 NSCB submitted one serious incident notification to Ofsted. These are submitted when a child has died or is seriously injured and abuse or neglect are suspected. This notification relates to Child K as outlined in section

3 above, who was considered by the Case Review Committee which then led to the decision to undertake a SCR.

4.2 A case considered in December 2015, reported in the last Learning from Practice Annual Report concerned a 14 year old who committed suicide. The recommendation of the CRC and the decision by the Independent Chair was that the criteria were not met for a SCR, which was then agreed by the National Panel. A full multi-agency review was planned, however, the Coroner has requested that this is held after the inquest. The inquest is planned to be held in June 2017.

5. Learning Reviews

5.1 There has been one review undertaken during this period which was not a Serious Case Review in respect of Child S (see below) and also 16 learning events held in relation to the Joint Serious Case Review outlined in Section 3.

5.2 Child S – Serious Injury June 2016

5.2.1 S (aged 7 months) was admitted to hospital with subdural haemorrhages and some abnormalities of the retina and abnormality of one of his vertebra, highly suggestive of non-accidental injury. The injuries were consistent with inflicted traumatic injuries such as violent shaking.

5.2.2 S was subject to a Child Protection Plan at the time of the injuries under the category of neglect and there had been involvement by Children's Social Care and other agencies pre-birth. Concerns included criminal activity, a history of domestic abuse and vulnerabilities of both parents. The plan had been removal at birth however parents declined Section 20 and therefore, the matter was put before the court at which point an Interim Care Order was made. The court made the decision for S to remain in the care of mother as she agreed to separate from the father. A significant amount of support was provided to mother including Community Fostering, however, once things started to improve this support was reduced. The court proceedings concluded with the making of a 12 month Supervision Order, a 12 month Non-Molestation Order and a No Contact Order for father.

5.2.3 Following proceedings concerns were felt to be increasing and in response additional visits were put in place by the Social Worker and Community Fostering. Not long after this S was admitted to hospital with injuries as outlined above.

5.2.4 The case was considered by the Case Review Committee and whilst S had clearly suffered significant injuries as a result of suspected abuse, there was no evidence that there was concern regarding the way agencies had worked together to safeguard S. The recommendation that the criteria were not met for an SCR was agreed by the chair of the NSCB and by the National Panel. It was agreed however that there should be a multi-agency Learning Review.

5.2.5 The review was undertaken using CICI (Critical Incident Collaborate Inquiry) a strength-based, appreciative inquiry approach to learning and improving safeguarding practice.

5.3 Learning from the case

- The heightened vulnerability of babies aged between 0-2 years
- The importance of timely completion of parenting assessments to inform effective decision making
- Formal and recorded case transfers/handovers between social workers ensure that concerns, plans and actions are clearly articulated between workers
- Analysis of the risk presented by both parents/carers needs to be integral to a thorough assessment
- The role and accountability of Service Managers in ensuring Team Mangers have robust cover arrangements in place during periods of staff sickness and vacancies is important to maintaining safe practice

5.4 Areas to strengthen

- NSCB to consider how it can support/develop strengthening safeguarding arrangements for babies
- NSCB/Children's Social Care (CSC) to review procedure and practice on the timeliness and completion of parenting assessments
- CSC to review its case transfer processes
- Promotion of NSCB Conflict Resolution Policy
- Exploration of the quality and timeliness of response to unborn baby cases

5.5 Impact/action

- Safeguarding babies is a priority in the NSCB delivery plan
- The Conflict Resolution Process has been promoted across agencies

- Procedures for responses to unborn babies has been reviewed and revised in response to learning
- The case transfer process within CSC has been revised alongside the restructure of Long Term Social Work Teams, following the Family Insights Programme. This will be subject to review to ensure cases transfer without delay

5.6 Key comments on learning and the review process from a participant perspective, from those involved in the review

- *'Looking back and learning where the gaps are and how to improve current practice was really helpful'*
- *'Visual representation of cases made it easy to establish where opportunities were missed to challenge how the case progressed'*
- *'How important transfer process and reallocation is and how it can be improved'*
- *'Importance of history, use of chronologies and sharing with other agencies. Importance of how we counter fixed thinking and work with disguised compliance'*
- *'This was a positive way of approaching a difficult subject. It didn't feel 'blaming' at all – a positive way of looking at how to do better'*
- *'This has reinforced the value of challenge through supervision'*
- *'I am motivated to act on lessons to be learnt and key points raised by all professionals of things to improve in the future'*

6. Section 11 and Challenge

6.1 The NSCB has a role to ensure that those key people and organisations that have a duty under Section 11 of the Children Act 2004 are fulfilling their statutory obligations about safeguarding and promoting the welfare of children. The NSCB developed Core Standards for Safeguarding and Promoting the Welfare of Children and Young People in Newcastle which were previously used as the self-assessment and benchmarking tool under Section 11, which included a total of 68 individual criteria within 10 specific standards. The Section 11 audit is completed every two years by individual agencies completing a self-assessment. Responses are then collated, followed by a partnership learning event chaired by the NSCB Chair, with the intention to undertake deep dive audits during the intervening year.

6.2 Areas of improvement during 2016/17 have included:

- A review undertaken of the S11/175 process which resulted in the procurement of the Virtual College online S11 audit tool, to enable a consistent and effective approach to the process and reporting
- Training was provided by the Virtual College to audit administrators and auditors in October 2016
- The online tool was set up in Jan 2017 and rolled out across partner organisations in March 2017
- The scope of the S11 audit has been widened to include more services for example, Your Homes Newcastle, culture and leisure services, early years and childcare together with commissioned voluntary sector services
- Findings will be collated and a partner learning event is to be held in July 2017
- Similarly, a Schools specific tool is being developed using the Virtual College on line tool which will be rolled out and completed before the end of summer term 2017

7. Multi-agency and Thematic Audits including those by Children's Social Care

7.1 Audits are a key feature of the work of the NSCB and are critical to understanding practice and identifying improvements. Over the period covered in this report there have been a number of multi-agency audits/thematic audits. The audits scheduled for the year have been with the aim of following the child's journey from referral, including being LAC. In addition, there have been themed audits including Child Sexual Exploitation, Children Subject to Child Protection Plans for two years or more, Thresholds for ICPC, Section 47s with outcome NFA and Outcome Focused Plans.

7.2 All multi-agency audit activity is overseen by the Standards Effectiveness Management Group (SEMG) and reported to the NSCB. The design of the audits are intended to improve practice and ultimately improve outcomes for children. Full reports are available for each piece of work undertaken, however a brief overview is provided below.

7.3 <u>Section 47s</u> – Multi-agency Audit April 16

7.3.1 A multi-agency audit was undertaken of Section 47s, the purpose of which was to consider quality, timeliness, involvement of key partner agencies,

involvement of children, young people and their families. The intended outcome of the audit was to demonstrate not only the factors outlined above but also:

- Whether a S.47 was appropriate in the circumstances
- Was the S.47 completed in a timely manner
- The appropriateness of the outcome of the Section 47

7.3.2 A random sample of 10 case were selected to reflect a range of factors including gender, age, ethnicity, service area and outcome.

7.3.3 Learning from the audit included:

- In all cases audited the Section 47 was felt to be an appropriate response and had been held in a timely manner in accordance with procedure, with some completed significantly quicker, reflecting the level of concerns in those cases
- The voice of the child was evident in all of the cases, although it was not always clear where they had been spoken to or if they had been spoken to alone
- In all but one case, the outcome of the Sec 47 was found to be appropriate. For the one case where the audit group concluded the outcome of the S.47 was inappropriate, the young person was subject a CPP at the time of the S.47 and the outcome recorded as *'provision of services'*. The audit group concluded that while the child was being safeguarded through the CPP, this was a third period of CPP and risks in the case remained high and therefore the Team Manager was advised that if it had not already been done, legal advice should be sought. The TM advised legal advice had been sought which concluded there was no threshold to intervene in the living arrangement as was, and so the plan agreed was to monitor the situation and initiate proceedings if safeguarding issues are identified / concerns re quality of care. It was however recommended that the case be considered at Legal Panel where a decision was made to put the matter before the court and a Forced marriage Order was obtained

7.3.4 Examples of good practice identified included:

- Examples were seen of multi-agency partners (e.g. a Staff Nurse) engaging with Young People (YP) when they would not engage with their SWs, in order to obtain information to help in the S.47 to assess the risks and concerns

- The S.47 sample clearly demonstrated good engagement with a range of multi-agency partners as part of the information sharing and gathering process, with all agencies engaging and providing detailed information when requested
- Where it was clear GPs had been contacted as part of a strategy and S.47 process, they had provided detailed written information in a timely manner and were found to have engaged well with the process

7.3.5 Areas to strengthen include:

- Revision of Integrated Children's System (ICS) document to improve recording of information gathered, outcomes and use of Signs of Safety to support analysis
- Ensure where appropriate carers views are captured
- Ensure expectations and standards are clear for completion of S.47 documentation i.e. dates when agencies are contacted, what information has been provided and by whom
- Importance of consistency of management oversight
- Involvement of Adults Safeguarding where appropriate
- Ensuring School Health Advisors in Private Schools are involved in the process

7.3.6 Outcome/action

7.3.7 The learning from the audit was shared with SEMG and an action planned developed.

7.3.8 Learning has been shared with Children's Social Care staff to improve practice in the areas identified, as well as to share good practice with the aim of improving consistency

7.3.9 The ICS document has been revised to reflect the issues identified and through supervision SHAs in private schools are aware of their responsibility in relation to Section 47s

7.4 <u>CSE</u> – Multi-agency audit July 2016

7.4.1 A multi-agency audit of 10 cases where Child Sexual Exploitation (CSE) was identified as a factor, was undertaken with partners including Children's Social

Care, Adult Social Care, Northumbria Police, Newcastle Hospitals NHS Foundation Trust (NUTH),Newcastle Gateshead Clinical Commissioning Group (CCG) and Northumberland, Tyne and Wear NHS Foundation Trust (NTW). The audit considered key practice areas regarding how risks around CSE had been identified, prioritised and responded to, the involvement of the case with the Risk Management Group, a view of the plans that had been put in place and how effectively agencies were viewed to have been working together.

7.4.2 Cases for audit were identified from cases open to Children's Social Care who had an open CSE classification. he cases chosen ad a range of characteristics resulting in a mixture of males and females, some assessed as low, medium or high using a CSE risk assessment tool, different case types including LAC, Child Protection and Child in Needs and some who had been recently reported missing to the police and some who had not.

7.4.3 Learning from the audit includes good practice examples of:

- Northumbria police providing support for a YP out of area following an issue being identified relating to CSE
- Complex Abuse meeting was held following concerns raised by in house residential unit concerning Novel Psychoactive Substances (NPS), which resulted in training being arranged by North East Ambulance Service (NEAS) for response to medical emergencies and drugs overdoses
- Complex abuse meetings identifying concerns and risks around CSE effectively in cases and actioning referrals to RMG as a result
- 'Hotspots' of activity concerning CSE were identified through effective multi-agency working arrangements
- Partners in NUTH using risk assessment tools to effectively identify risks, leading to swift and appropriate action
- The use of victim safety plans by the police to protect vulnerable young people and a case where a Forced Marriage Prevention Order (FMPO) had been used effectively in a case of Honour Based Violence (HBV)
- Return interviews undertaken by CSC where CSE was identified, resulted in a more in depth assessment using the CSE Integrated Children's System (ICS) toolkit and arrangement of strategy meetings in a timely manner
- Cases where YPs chose to not engage, evidence of a range of multi-agency professionals including CSC, Police and Health having been

tenacious in their efforts to engage the YP and had not given up in attempts to reduce risks
- For the one transition case there was a referral made to adult services in a timely manner meaning plans could be put in place to continue to protect a vulnerable young person into Adulthood

7.4.4 Key themes emerging from the audit:

- Difficulty in engaging with YP who do not recognise the risks associated with CSE or indeed other vulnerabilities (such as missing episodes)
- The use of 'legal highs' (NPS) in a number of cases and its impact on increased risks
- Correlation between links to potential CSE victims and YP who may lack capacity or have a learning difficulty, and the associated potential to increase vulnerability in these cases
- Occasions where parents are seen as protective factors to the young person, without full consideration being given to their ability to protect
- Lack of clarity as to how the range of risk assessment tools are shared and correlated (e.g. under 18s health pro-forma, CSE risk tool kits, Voluntary Young People (VYP) checklists)
- Ensuring consistent use of the Integrated Children's System (ICS) CSE risk assessment tool by Social Workers and updates as per the procedure
- CSE procedures need to specify clear timescales for how long a CSE toolkit should take to complete ensuring risks are assessed in a timely manner
- Some cases observed to have been repeatedly reviewed by RMG over a period, with risks continuing, therefore question raised regarding the impact of the RMG process and how RMG escalation procedure is used
- The language used by a professional in one case was inappropriate and needed to be addressed
- Delays in GP practices receiving the child's information when they move
- Inconsistent involvement and information sharing with GPs (not just around CSE)

7.4.5 Impact/action

7.4.6 The audit identified a number of areas of good practice but also areas of development to consider further. The full report was considered by SEMG and an action plan developed.

- Training was provided to Social Workers on direct work with children where CSE is a factor
- Specific training with residential staff, strengthening skills and knowledge
- Mental Health Capacity (MHC) training now mandatory for CSC and ASC staff
- PACE (Parents Against Sexual Exploitation) has agreed to be commissioned via MSET, through a train the trainers course to ensure practitioners are skilled to support parents where CSE is a concern
- CSE Measurement Tool has been revised and implemented, including briefings to staff, which includes a timescale for completion
- An audit is underway to establish level of information sharing with GPs at various points of the safeguarding and LAC processes

7.5 Signs of Safety and Outcome Focused Plans– Audit by Principal Social Worker (PSW) - August 2016

7.5.1 The Serious Case Review, Child J published in June 2016, outlined in section 3 found the child protection plan for J and her siblings was not outcome focused, therefore limiting its effectiveness. The plan contained no indicators through which success of the task might be measured and no contingency in the event that it was not proving effective. Whilst the review did not undertake a sample audit of other plans, they did find through consultation with practitioners that neither the format nor content of Child J's plan was unusual; therefore, it was deemed to be an underlying issue, not unique to the case.

7.5.2 This is not just something peculiar to Newcastle but is widespread in child protection practice. Professor Jan Horwath, writing about child protection planning in her book 'Child Neglect, Planning & Intervention', says:

"*The outline plan can become a 'to do list' for both parents and professionals. When this occurs, little time is spent ensuring that parents understand why these actions will be of benefit, how the actions complement each other and the priority that should be given to each action. A further issue with the production of a list of actions is that they do not take into account that some changes will be easier for parents to make than others.*"

7.5.3 It was therefore felt to be timely to review the current effectiveness of plans given the work undertaken to date, together with the need to consider the areas identified in the SCR.

7.5.4 Whilst the SCR focuses on child protection plans it was felt important to consider the wider system and therefore the audit examined the quality and effectiveness of plans for children subject to child protection plans, but also those Looked After.

A sample of 10 cases were chosen, 5 CP and 5 LAC, however, to test out consistency the same IRO was not selected more than once.

7.5.5 Learning from the audit included:

- In a number of plans the Risk Statement/Reason for the plan was not clear or specific enough and did not define what the impact would be on the children of the risk
- Some of the outcomes identified in the plans (defined as safety goals in the SoS framework) were not measurable, do not relate to the specific issues and could in fact relate to any child, for example *'C will be safe from harm and not exposed to risk'*
- There were however some plans which did have examples of outcome focused safety goals, however where this was seen, it was not consistent across the whole plan
- The actions do not always relate to the relevant issues specific to the case i.e. the concerns/child's needs, therefore given the finding regarding outcomes outlined above it would appear that practitioners need to strengthen what they describe and articulate as outcomes more clearly
- The majority of actions do have timescales, however there is a tendency for some to refer to the timescale as 'ongoing' with no specified date, leaving a feeling of open-endedness, which could potentially lead to drift and delay. In addition, some actions would benefit from more detail to avoid any misunderstanding
- The majority of the plans identified how actions were to be achieved i.e. by whom, but some had just the name, others just had the role and/or the service. It is important that names and roles are clearly stated to avoid any confusion, especially in situations where professionals change over time

- Children's views were not always evident in the section of the conference minutes 'children's views' and were often embedded in the content of the minutes, which minimised their importance

7.5.6 Examples of good practice included:

- Good examples of positive engagement with children
- Good evidence of the IRO engaging with children before and during their meeting and requesting direct work with children where evidence of the children's views were limited
- Examples of plans which were outcome focused and SMART
- Evidence of Signs of Safety Goals supporting more outcome focused planning

7.5.7 Areas to strengthen included:

- Findings and learning from this audit to be fed back to the IROs and embedded in all related training and to the wider children's workforce through single agency internal briefings and the NSCB Learning from Practice events
- Strengthen the plan template to support the formulation of outcomes
- All recommendations must have a timescale i.e. a date rather than 'ongoing', with named individuals (full name and role)
- Ensure all plans reflect consideration to contingencies in the event of a plan not working well or quickly enough
- Provide bite sized training events on the use of Signs of Safety as a risk assessment tool
- Development of training, whether this be face to face and/or an e-learning package, to support outcome focused planning with a specific focus on gaining children's views to influence planning
- Develop practice guidance to support planning
- Develop practice standards with expectations for preparation prior to conference including a draft risk statement/reason for plan, genogram, and evidence of direct work with children (signs of safety tools)
- All practitioners to be reminded of the NSCB Resolution Policy.http://newcastlescb.proceduresonline.com/chapters/p_conflict_res.html?zoom_highlight=resolution

7.5.8 Outcome/action

7.5.9 Overall this audit identified some areas of good practice, however, it has also highlighted areas to strengthen and improve.

7.5.10 There is evidence that suggests that the introduction of Signs of Safety has had a positive impact on the quality of planning and as such actions are more focused on the issues of concern and with what needs to improve, rather than a 'to do list' for families and professionals which in the past often related to referrals to other services.

7.5.11 There is also evidence of some good practice where children's views have been sought and reflected, together with an overall understanding of the importance of the experience of children and this is seen particularly in minutes and/or covering documents, however it is not always evident that their views have been used to influencing planning or used as a measure of parenting capacity, this is therefore an area for further consideration.

7.5.12 Use of the signs model shows better assessment and planning in some cases. Overall however, the audit identifies a lack of consistency in practice and particularly a difficulty in articulating outcomes, this may well be linked to the limitations of the child protection conference process to provide time and space to facilitate the reflection needed to do this well and therefore preparation is a critical part of the process, particularly where the conference is considering a large amount of information on what may be a complex case, with a large sibling group of children with varying needs.

7.6 Initial Child Protection Conference Thresholds Audit by CSC November 2016

7.6.1 This audit was undertaken as part of the audit scheduled for the year following the child's journey. 20 cases who had been subject to an ICPC in August/September 2016 were chosen at random.

7.6.2 Learning from the audit included:

- Auditors in all cases (100%) judged the correct thresholds had been applied and that the case did meet the thresholds for an ICPC

In most cases:

- The strategy meeting involved the correct people and shared all the relevant information available

- The right people were judged as in attendance and the right information was available at the ICPC
- The child's views had been gathered and taken into account as part of decision making

7.6.3 Less consistent practice was observed as follows:

- Life events chronology having been used to inform the decision making
- Evidence of alternatives to progressing the case through to ICPC having been considered at the point of S.47 or children and family assessment
- Evidence of the IRO challenging the decision to proceed to ICPC, and evidence that alternatives were considered

7.6.4 Examples of good practice included:

- In majority of cases, appropriate and timely action had been taken to asses risks and protect the child
- Child and Family assessments undertaken alongside s.47s supports more informed decision making
- The use of genograms which help identify clearly other family members who might have been at risk
- In one case a child at risk of honour based violence was identified at an early stage, and action taken to protect the child
- Evidence of cohesive working between all relevant professionals, with a range of agencies contributing to the overall decision making in cases
- A range of examples of good quality strategy and Section 47s being produced, which provided good consideration of all relevant information
- Childrens views being gathered and used to inform decision making in the majority of cases (including the use of three houses in some cases)

7.6.5 Areas to strengthen included:

- Ensuring s.47 & strategy are not undertaken concurrently as this negates the role of the s.47 and means often deciding to progress too early to ICPC, reducing opportunities for other avenues to be explored
- Ensuring ALL necessary checks are completed in all cases when undertaking S.47s (e.g. probation, hospitals, GPs)
- Ensuring life events chronologies are up to date in all cases and used to inform decision making In the CP process
- Child and Family Assessment and analysis of historic information – i.e. not summarised and not analysed
- Ensuring decisions making recorded by managers as part of key documents is clear, detailed and analytical in all instances

- Discussion around direction on unborn baby conferences – when they are held and how they are case managed during the intervening period
- Clarifying timescales for the completion of parenting assessments

7.6.6 Outcome/action

- The audit gave assurances that thresholds to ICPC are consistent and appropriate
- Pre-proceedings Panel now in place chaired by Assistant Director (AD) ensuring robust oversight and identify early drift or delay
- Revision of templates for Strategy meetings and Sec 47 and a new child protection assessment to provide more clarity and a defined pathway to ICPC where the threshold is met

7.7 IRS weekly and monthly multi agency audits thresholds

7.7.1 In order to test that thresholds are correctly applied and decision making appropriate, audits were set up from September 2016. A group of representatives from the Local Authority meet on a weekly basis membership includes:

- Dorothy Chambers – Service Manager IRS
- Jayne Forsdike – Principal Social Worker
- Sue Kirkley – NSCB Co-ordinator
- Jon Gaines – Quality Standards Officer, CSSU
- Grainne Fegan – Lead Specialist Early Help

7.7.2 The group review a sample of contacts that did not progress to referral, received by IRS from a range of professionals. In the main, cases are selected randomly however, some weeks have had a focus on certain factors for example Domestic Violence, CSE and Children going missing, contacts received from GPs, contacts received from Schools.

7.7.3 In addition, on a monthly basis the group is joined by partners from the following areas:

- Police
- NUTH
- Education Service
- Designated Nurse Safeguarding Children, CCG

- Northumbria Police
- Other agencies depending on specific cases identified e.g. IDVA

7.7.4 Since this audit process was implemented in August 2016 up to 31 March 2017 the group have examined 100 cases in total.

7.7.5 learning from the audits have included:

Where any immediate action is identified these are progressed immediately. The audits have identified thematic findings, but have also provided a process in which to examine cases where an Early Help Plan is recommended (previously CAF) and for the Lead Specialist for Early Help to bring cases where there may be some disagreement between Early Help and CSC, therefore strengthening the relationship between Early Help and CSC and increased the understanding of each other's role and responsibilities.

7.7.6 Thematic findings include:

Overall the thresholds have been found to be appropriate in 86% of the cases audited, with 14% where the audit group viewed that the thresholds were not applied appropriately which in the main led to an immediate action or further consideration for those cases.

7.7.7 Examples of good practice included:

- Examples of good quality written referrals by Health Visitors, Schools and GPs
- Identification of risk of CSE following a missing return interview by SCARPA which was escalated via formal referral
- Good evidence of multi-agency information sharing and gathering
- Evidence of FGM pathway being followed resulting in appropriate assessment of risk and actions where required
- Evidence of timely decision making based on perceived levels of risk

7.7.8 Areas to strengthen included:

- Ensure that CSC always inform referrer of the outcome of the contact
- Inconsistent use of the DASH assessment by partner agencies as part of referral

- The need to continue to improve practitioner understanding of risk factors associated with DV particularly where victims may minimise or retract incidents of abuse
- Contacts being provided to CSC for information only with no expectation of any action from CSC
- Ensuring where recommendation is Early Help that a discussion is held with the Early Help Team in advance and ensuring consent is requested prior to the outcome/referral
- The importance of practitioners keeping up to date with the latest developments/research and current practice in relation to CSE to ensure appropriate decision making
- The purpose and intended outcome of letters of support sent to family's needs to be reviewed; where CSC have decided to take no further action as thresholds have not been met following a contact

7.7.9 Outcome/action

- Early indications of improvements in CSC informing referrers of the outcome of the contacts in writing
- An increase in schools providing referrals in writing
- Briefing in February 2017 to IRS staff from Steve Barron Detective Superintendent with a lead for CSE providing an update on developments, practice and the profile of CSE in the city, including learning from operations and work with victims
- More recent developments have included the tracking of cases by the audit group to oversee outcomes

7.8 Long term CP (2 years or more) – CSC Monthly audit from August 2016

7.8.1 Across the course of the 2015/16 the number of children open on Child Protection Plans (CPP) for two years or more at the month end slowly increased compared to previous years. This led to a recommendation from NSCB for SEMG to investigate this trend, look at aggregated data and case examples to improve understanding of the story behind the data through an audit undertaken in February 2016. Following the audit, a number of actions were agreed which included a review of the Designated Conference Process which then led to revising and strengthening the process. A further outcome of this audit was to establish a process to routinely identify and review cases in which CPPs are approaching two years in length therefore providing a mechanism for measuring the impact of this work.

7.8.2 This process was put in place from August 2016 and 12 cases have been audited to date.

7.8.3 The cases audited are presented to Children's Social Care Senior Management Team on a monthly basis and findings collated quarterly.

7.8.4 Good practice

- Evidence of improved use of the Designated Conference Process
- Evidence of challenge by the IRO in the Child Protection Conferences
- No children were found to be at immediate risk
- Risk factors were being identified

7.8.5 Areas to strengthen included

- Examples of drift and delay, including lack of progress with the plan and the pace of the assessment
- Lack of outcome focused plans
- Where drift and delay was apparent, whilst in the main, the IRO provided appropriate challenge the Dispute Resolution Process had not been used
- Importance of keeping a focus on progressing the plan when new issues/concerns came to light

7.8.6 Outcome/action

- Referral back to the IRO to ensure Designated Review takes place
- Dispute Resolution Process requested on one case
- Referral to Legal Panel for one case
- Ensure all agency safeguarding training reflects the importance of keeping a focus on progressing the plan even when new issues come to light

7.8.7 The main focus going forward will be to ensure that IROs address challenge formally through the Dispute Resolution Process and address any performance issues where non-compliance to the process is an issue.

7.9 Chronologies – CSC Audit March 2017

7.9.1 The importance of chronologies has been identified through previous audits, learning reviews and the Serious Case Review Child J.

In response to the SCR a new recording system was implemented within CSC capturing life events in a chronology. All staff across CSC were trained in the new system and compliance and quality has been monitored through management oversight and reports to CSC Senior Management Team.

A follow up audit was undertaken in March 2017 to measure any improvement in the quality of chronologies since the introduction of the new system.

7.9.2 The audit considered 20 open cases which had Life Events Chronologies recorded chosen at random. The sample included at least one case from each of the teams/units across the service.

7.9.3 Learning from the audit included:

In most cases life events chronologies were being used, but quality was variable and some needed updating.

7.9.4 Examples of good practice included:

- An example of a chronology being strengthened through the inclusion of information regarding mother's history which demonstrated risk indicators regarding the unborn child
- An example of a chronology effectively showing a pattern of issues emerging regarding potential sexual abuse resulting in action being taken
- Clear reference to the impact on children, and subsequent actions taken as a result
- An example of a chronology which was well-considered and thorough, however auditors view it could have benefitted from further detail regarding the outcome of SGO and the positive impact on the case

7.9.5 Areas to strengthen included:

- Out of the 20 cases,16 were identified as needing further work
- Improved understanding among staff is required so that they are clear what to record
- Evidence of impact of events on children and families must be included in life events chronologies
- Re-visit what a 'good' chronology looks like with practitioners.
- Outcome of assessments and reasons for plans should consistently be incorporated into life events chronologies

- Ensure court chronologies where they exist are consistently referenced and used to inform the Life Events Chronologies (LEC)
- Life Events chronologies must be updated regularly
- Managers/supervisors and IROs need to continuously remind staff to update LECs and should refer to them in supervision, conferences and LAC reviews in order to help ensure compliance.
- Quality of LECs should be tested to identify any improvements in practice through monthly CSC audits and any further themed audits
- Ensure where the chronology does not start at the beginning of CSC involvement a summary of historical involvement must be available on file
- Team Manager to check in supervision that chronologies are updated and record relevant information
- Case recording policy to be circulated on a regular basis reinforcing that chronologies are required on all cases and need to be up to date
- Circulate One Minute Guide / Briefing and practice guidance on use of chronologies to all staff

7.9.6 Outcome/action

7.9.7 Learning from the audit has been shared with to CSC SMT. Many actions have already been implemented including the following:

- Life Events E-learning package developed and implemented
- Briefing in a minute outlying the process and expectations circulated
- Life Events Chronologies made a standing agenda item at conferences, LAC reviews and supervision
- Monthly and thematic audits to consider quality of Life Events Chronologies and report to CSC SMT (see Section 47 Audits 7.10)

7.10 <u>Section 47 – outcome NFA</u> – CSC Audit - April 2017

7.10.1 Data provided to the NSCB in January 2017 via the NSCB scorecard identified that 13% of Section 47s are recorded as resulting in No Further Action (NFA) which then lead to an audit of these cases to examine whether the outcome was appropriate and to understand the rational for NFA. In addition, the audit examined a number of key areas of practice such as whether the correct agencies were involved/provided information, evidence of children's views and evidence of a life events chronology and the appropriateness and timeliness of the Section 47 itself.

7.10.2 The audit examined a random sample of 20 cases who had been subject to Section 47 where the outcome was recorded as NFA, completed between January and March 2017. The sample included 7 females and 13 males. The

ages of the children ranged between 0 and 17. 9 of the cases were from a BME background. 15 of the cases were from IRS, 4 from Long Term Social Work and one from the Children with Disability Team. Thematic results have been collated into this report.

7.10.3 Learning from the audit included:

- Having considered all of the information, auditors in all cases (100%) judged that the Section 47 was appropriate in the circumstances.
- In all but one case auditors found that the outcome of the S.47 was appropriate. In respect of the one case further information was requested and the Service Manager ensured that the plan was robust.
- Using the outcome of 'NFA' does not fully reflect the actual activity on the case, for example in the majority of cases the Section 47 led to other actions/intervention such as assessment, or updating of plans etc.

7.10.4 Examples of good practice included:

- A range of examples of good quality strategy meetings and Section 47s being produced, which provided good consideration of all relevant information, with the exception of one case in which the notes for the strategy minutes were handwritten
- Childrens views being gathered and used to inform decision making in the majority of cases, with some good evidence and some excellent recording
- Good example of a Family Meeting held which supported planning in the case
- Good example of one case which involved the Police PREVENT Team at initial referral stage, which then supported evidence that the child was not being exploited or radicalised

7.10.5 Areas to strengthen included:

- Ensuring that partner agencies comply with procedures in relation to providing information for Sec. 47s (Delays from Probation and Schools were noted in this audit)
- Ensuring life events chronologies are up to date and include impact in all cases and are used to inform decision making
- Children's views must always be evidenced within the S.47 even if recorded in other documents/parts of the record
- The importance of including views of all family members, improvement required in relation to fathers
- The outcome options recorded in Care First should be reviewed to ensure they capture more appropriate and relevant outcomes of S.47s

7.10.6 Outcome/action

The audit identified a number of areas of good practice but also areas of development to consider further. This audit has just been completed at the point of writing this report. An action plan has been implemented which will be shared, together with the findings, with SEMG in August 2017.

7.11 Safeguarding Children with Disabilities- CSC Audit – April 2017

7.11.1 National research has found that disabled children are three to four more times to be abused and neglected than non – disabled children (Jones et al 2012, Sullivan and Knutson 200). However they are less likely than other children to become subject to child protection plans. Additionally the thematic Ofsted report protecting disabled children: thematic inspection (August 2012) also found evidence that low level risks were managed effectively through timely multi agency early support but that children who were in receipt of child in need services too often had child protection needs. Ofsted found a mixed picture especially regarding how well the views, wishes and feelings of disabled children were captured and found that advocacy services were rarely used.

7.11.2 In light of national research, Newcastle Children's Social Care has been keen to ensure children with disabilities are a high priority and included in the ongoing case file audit process. An audit has therefore undertaken of 10 children to look at the quality and impact of work with disable children (including CiN, CP and LAC).

Strengths:

- Team Management oversight evident in all cases
- Good compliance in terms of recording of basic information and demographics
- The majority of cases had up to date supervision and management oversight
- All children had been visited and seen within statutory timescales
- The child's learning needs had been identified in all cases
- The majority of the cases had clearly recorded the disability/special needs of the child
- A clear focus on missing and CSE in 2 of the cases where these were factors
- Information from education colleagues regarding nature of the disability / special need, was of good quality
- All cases, except one had a genogram

Areas of practice to strengthen include:

- All cases to more clearly evidence the views and voice of the child

- The disabled child's preferred communication method for understanding and expressing themselves needs to be given priority (including those with non-verbal means of communication and deaf children)
- Need to clearly outline the disability, special need or impairment
- Ensure all cases have up to date Life Events Chronologies
- Advocacy to be considered for all children in need and subject to child protection plans
- All plans to be SMART

Outcome/action

The audit identified a number of areas of good practice but also areas of development to consider further. This audit has just been completed at the point of writing this report. An action plan has been implemented which will be shared, together with the findings, with SEMG in August 2017.

8 Learning from Research

8.1 The Voice of the Child in the Child Protection Conference – Doctoral Research Study Northumbria University – March 2017

8.1.1 This research study was conducted by Justine Stewart, Senior Lecturer at Northumbria University.

8.1.2 The theme for research study originated from Munro's (2011) recommendations for promoting the participation of children and young people in the child protection process. The study aimed to explore how children and young people experienced their involvement in one aspect of this process: the child protection conference and from this to explore the extent to which participation rights as defined in the Children Act 1989 and Article 12 of the UNCRC were upheld in contemporary child protection practice.

8.1.3 The study was informed by the following data sources:

- Interviews with young people, some of whom had attended initial and review conferences. One participant had taken part in preparatory work but had been unable to attend in person on the day of the conference.
- An analysis of reports associated with twenty-seven conference events from April 2014 - June 2015. A random sample was extracted based on age, gender, ethnicity and type of conference and conference bundles were made available for analysis
- A focus group discussion with Independent Reviewing Officers held in May 2016

- A focus group discussion with Social Workers held in June 2016

8.1.4 Key findings

- Social workers did not routinely explore the possibility of attendance with children and young people
- There was divergence over degrees of participation, with the Independent Reviewing Officers being more open to attendance at a split conference. This correlates with views expressed by the young people who were interviewed, they understood and accepted why some information (in particular police records) might not be considered appropriate for sharing
- Signs of Safety framework was viewed to be a positive practice development, creating a stronger practice culture for ascertaining the child's views, although some tools were considered to have age related application
- The tools were only as effective as the social worker's application of them and practice was considered to be variable
- A significant theme was the absence of voice, expressed in the child's or young person's own words across the age ranges, the information provided was predominately a professional interpretation of the child's views, expressed in adult language
- Without exception, none of the school reports (primary and secondary) indicated that the report had been completed with the child or young person or the report content shared
- Loss of unique identity occurred across the age ranges for children and young people who were part of a sibling group. There was no consistent approach towards referring to the child or young person by their first name. For example, "Child/ young person's view" in conference report by: *"The children are both happy and well cared for"*
- There were good examples of recording which clearly conveyed the views, wishes and feelings of the child which demonstrated evidence of skilled practice in communication to ascertain the child's views and wishes
- Despite some good examples there was a tendency towards professional filtering and interpretation of the voice and this dismissed the capacity for the child to be heard in their own words

8.1.5 Impact/action

The research provides a number of recommendations which are intended to strengthen the participation of children and young people in the conference process.

The research study has provided a solid foundation on which to build on. All of the issues outlined above have been shared with CSC Senior Management Team, the NSCB and the IROs, together with the Social Work Forum lead by

the Principal Social Worker, who have been given responsibility for taking forward the areas identified. At the point of writing this report the SW Forum has developed a robust action plan taking on board all of the recommendations, the implementation of which will be monitored monthly through CSC SMT and as part of the IRO monthly report shared with the AD for Children's Social Care.

8. Learning from Practice

9.1 A recommendation from 2014/15 Learning from Practice Report was to strengthen the process of sharing learning from reviews and audits with the wider children's workforce through regular Learning from Practice events, which would also provide an opportunity for the NSCB to 'hear' from the front line. It was therefore agreed that these would be held twice a year with a different focus each year. There has been two events held in this reporting period June and November 2016.

9.2 The practice events ask staff specific questions about the area covered:

- What stands out for you as the critical lessons?
- How will you take these back into your own service area/organisation and how will they impact upon your own practice and the practice of others?
- Is there anything from your own experience you can add to this area?

9.3 And then more general questions relating to safeguarding practice:

- What do you think works well?
- What do you think we should do differently?
- What do you think we need to change or improve? Three best ideas…
- Is there anything else you would like to tell us?

9.4 The events were evaluated and received a positive response, the full evaluation together with key learning are available in separate reports, however for the purpose of this report an overview is provided below.

9.5 Learning from Practice events June and November 2016 – with a focus on Child Neglect

9.5.1 These events focused on Child Neglect by sharing information and learning from a range of sources including the Neglect Strategy, NSPCC Research and Thematic Review, NSCB Audits and the Serious Case Review Child J. There was also input from the Family Insights Programme, Parents under Pressure and MST CAN.

9.5.2 The feedback from practitioners included a number of areas that were working well, including increased awareness, more opportunities for reflective practice, stronger multi-agency working leading to improved practice.

9.5.3 There were also areas where practitioners felt there needed to be improvements/changes which included being more aware of what services were available where neglect is a factor, however, they felt that the event had provided this a lot of this information. There were frustrations in relation to different IT systems across agencies and also concerns raised that neglect as a category does not become a catch all and therefore lose focus on danger where physical risk is present.

9.5.4 Key comments on the process/experience form a participant perspective:

- *'Excellent event – thank you'*
- *'Getting a forum like this works'*
- *'More professionals realise they don't know as much as they would like – so this has helped'*
- *We would like more information on systemic practice*

9.6 Impact/action

9.6.1 The impact of these events has not only ensured that practitioners are up to date with local and national learning on key issues with the aim of improving practice, but also provides an opportunity for the NSCB to hear from the front line. It was evident from the evaluations that practitioners found the events informative and provided evidence as to how the learning would impact positively on their practice.

9.6.2 It is also important that the NSCB not only actively listen to those directly working with children and families, but also fully considers and acts on areas where practitioners have suggested changes/improvements. The following provides some examples of what has been done in response:

- A number of areas had already been identified as part of the SCR therefore are already being implemented, however it is positive that these are areas that practitioners were also aware and fully supportive of
- Specific Neglect Training is now available through the NSCB with a focus on risk and assessment
- A two day workshop has been arranged in April and July 2017 by the NSCB covering a specific aspect of systemic practice 'Unpacking Safe Uncertainty and Putting ideas into practice' facilitated by Dr Barry Mason, from The Institute of Family Therapy, London

10. Summary

10.1 The primary purpose of undertaking reviews and audits as outlined in government guidance is to learn lessons about how those involved worked together and to identify what needs to be done as a result, with the aim of improving local inter-agency working and better safeguarding and promotion of the welfare of children. They should not be seen as ends in themselves but to identify improvements and to consolidate good practice. Findings should be translated into action which leads to sustainable improvements.

10.2 In assessing the impact of the work outlined in this report consideration needs to be given firstly to whether improvements were identified and translated into actions/recommendations, which have then been achieved. Secondly to assess what impact the actions/recommendations have had on practice.

10.3 All SCR/Learning reviews/audits in Newcastle identify learning and where appropriate make recommendations for action to improve practice by agencies. The actions/recommendations demonstrate a clear link between learning lessons in individual cases and identifying what needs to change and then doing it. Any action plans/recommendations are monitored by the Case Review Committee and/or SEMG. Some actions/recommendations may be delegated to another NSCB Committee, a task and finish group, or single agency. Any areas of delay or drift are reported to the NSCB.

10.4 Whilst the role of action plans is helpful in methodically navigating agencies through a series of improvement activities designed to effect change, it can be somewhat mechanistic and the challenge is to ensure that a clear focus is maintained on the desired positive outcomes. Further challenge for the NSCB is in achieving assurances that the change or improvement can stand up to medium or longer-term scrutiny and establishing how this will be measured to guarantee lasting change, but also understanding that learning also happens alongside implementation and the importance of having mechanisms in place to capture and address this, which SEMG in its scrutiny role provides.

10.5 Measuring impact on practice is complex, particularly in relation to identifying a clear correlation between a specific action and an improvement in practice. For the purpose of this report the outcome and subsequent impact has been identified as far as possible in respect of each piece of work throughout.

10.6 Having clear processes in place to consider practice such as regular audits, reviews, which include identifying areas of good practice, is a strength and has supported a move away from a compliance culture to a learning organisation. Professionals have become more used to learning from effective safeguarding practice as well as where there are concerns, with an emphasis on creating a reflective and supportive environment conducive to learning. This is evident in the feedback from practitioners provided through the evaluations.

10.7 Whilst identifying areas for improvement there are clear examples in this report demonstrating good practice which have provided assurance to the NSCB as to the effectiveness of safeguarding arrangements in Newcastle. Other work undertaken has provided information to help partner agencies come together to understand the story behind some of the data. This has then informed areas to target or specific pieces of work to take forward.

10.8 This report has clearly demonstrated the importance the NSCB places on learning and development to understand the strengths and weaknesses of multi-agency practice and to continuously identify areas for improvement.