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Steve Ashman, Chief Constable of Northumbria police force
Pam Vedhara MBE, Youth Justice Service
Nick Hall, CEO, Community Rehabilitation Company
Linda Marginson , Deputy Director , National Probation Service
Sir Paul Ennals, Chair of South Tyneside LSCB

Dear local partnership

Joint targeted area inspection of the multi-agency response to abuse and neglect in South Tyneside Metropolitan Borough

Between 22 and 26 February 2016, Ofsted, the Care Quality Commission (CQC), HMI Constabulary (HMIC) and HMI Probation (HMIP) undertook a joint inspection of the multi-agency response to abuse and neglect in South Tyneside Metropolitan Borough.[1] This inspection included a 'deep dive' focus on the response to child sexual exploitation and those missing from home, care or education.

This letter to all the service leaders in the area outlines our findings about the effectiveness of partnership working and of the work of individual agencies in South Tyneside.

The inspection identified a number of strengths across the partnership in relation to raising awareness in the community about the risks of child sexual exploitation. This is leading to increasing identification of those at risk and effective responses to children when risks are first identified. The partnership is aware of many of the areas that need further development, both in respect of the effectiveness of multi-agency practice at the front door and in the quality of practice in supporting children at risk of child sexual exploitation. This inspection has also identified those areas for improvement which the partnership was unaware of, such as the lack of robust management oversight of the quality of safeguarding practice in South Tyneside Foundation Trust.

[1] This joint inspection was conducted under section 20 of the Children Act 2004.

Key strengths

- There is a clear commitment from leaders across the partnership and from the council to improve outcomes for vulnerable children. The local partnership has a clear determination and ambition to prevent child sexual exploitation. A 'whole council' approach to tackling child sexual exploitation in South Tyneside is developing and this is promoted through the Local Safeguarding Children Board (LSCB). The Chief Executive of South Tyneside Council has a good understanding of the needs of children and young people in South Tyneside. Together with the Lead Member Children, Young People and Families has been instrumental in ensuring that members understand their responsibilities in terms of safeguarding, including their responses to child sexual exploitation. All members have now had training on the awareness and prevention of child sexual exploitation.

- The approach of the partnership, coordinated by the LSCB, has been to focus on preventative work and awareness rising, which has resulted in a comprehensive range of awareness raising activity across local communities and businesses. This is improving understanding of the risks of child sexual exploitation and has resulted in increased notifications to the police from the community, in particular from those working in the night-time economy. For example, 94% of taxi drivers in South Tyneside have undertaken training on child sexual exploitation, and this is now a condition of their receiving a licence. As a result, between 2014 and 2015, there was a 53% increase in calls related to child sexual exploitation from taxi drivers to the police.

- Analysis of the cohort of victims of child sexual exploitation is informing the partnership's approach to promoting understanding of child sexual exploitation. For example, the inclusion of licensed premises, security staff, social landlords, fast food outlets and hotels in training and awareness raising demonstrates a real understanding of the mechanisms that are used by perpetrators to engage in exploitative behaviour and the ways in which children may be exposed to risk.

- Effective work is in place to engage with young people and local communities to raise awareness and develop bespoke materials to highlight the risk of child sexual exploitation. All schools include child sexual exploitation as part of the Personal, Social, Health and Economic curriculum and all secondary schools have hosted a production of 'Chelsea's Choice', which has been adapted to reflect local issues. The 'Junior LSCB' has been involved in the development and dissemination of materials for promoting understanding of child sexual exploitation. The LSCB manager has worked closely with some Black and Minority ethnic communities to produce bespoke posters and leaflets to reach local communities.

- This comprehensive approach to raising awareness, together with mandatory training on child sexual exploitation for all front line staff, is leading to increasing numbers of children being identified as at risk of child sexual exploitation. The figure has risen from 12 in 2014/15 to 38 in 2015/16.

- The Missing and Sexual Exploitation and Trafficked multi-agency meeting is very effective in ensuring that overarching strategic information is shared. This is resulting in significant and timely disruption activity by the police, which is reducing risk.

- Young people who are at risk of sexual exploitation and of going missing have day-to-day risk effectively managed and contained by staff from a range of agencies who work with them. Some good examples were seen of using creative ways of engaging young people, such as involving them in the development of materials to support others at risk of child sexual exploitation. This is enabling them to begin to discuss and understand the risks that they face.

- It is clear that police leaders are committed to the partnership and to using their experience across the borough to promote improvements in practice. The force has prioritised child protection and there is a clear determination to reduce the risks to those identified as being vulnerable. Immediate significant concerns for children, such as when they are missing from home, have strategic oversight by the police through daily management meetings, which means that responses are well managed. There is a clear commitment to safeguard children which is manifest in police responses to risk, for example child protection investigations are well managed.

- There is evidence of police leaders driving a culture of continual improvement to enhance decision making and ensure delivery of appropriate protective responses to victims. For example, the police work closely with partners to review and develop their approach to tackling child sexual exploitation.

- A successful Home Office Innovation Fund bid that secured in excess of £3million has led to the development of an expanded Operation Sanctuary (a police led operation investigating sexual crimes against vulnerable women and girls). Sanctuary South is a multi-agency project which builds on learning from Operation Sanctuary in providing support to vulnerable victims of sexual crimes and in the investigation, prosecution and disruption of criminal behaviour. This has resulted in improved opportunities for engagement with vulnerable child victims, leading to increased trust and confidence and disclosures that more accurately reflect the experiences of the victim. For example, in one case seen the victim-focused approach of the investigating officer resulted in a young person who had previously withdrawn her statement deciding to reengage with

the police and provide clear evidence. The effective engagement has developed prevention and disruption planning across the Borough.

- Redesign of the children's social care 'front door' has resulted in improved performance within this service with timely and appropriate responses to children when harm and risk are first identified. Risks to children from domestic abuse are effectively identified by police and where risk requires a social care response, this is timely. There is prompt notification to schools about incidents of domestic abuse, and in cases seen this means that children's needs and behaviours were understood and responded to well by schools.

- The vast majority of assessments undertaken within the contact and referral team are thorough and capture the voice and experiences of the child. Multi-agency liaison is evident, and analysis appropriately underpins proposed plans. There is evidence of services being provided while assessments are being undertaken, as well as examples seen of good direct social work with children.

- When young people present at the emergency department of South Tyneside District Hospital with alcohol misuse problems and/or issues of self-harm, there is appropriate support provided through effective partnership working between health, the Matrix team (Young People's substance misuse service) and children's social care.

- The Youth Justice Service (YJS) has a good understanding of the importance of identifying specific risks to young people at an early stage, including the risk of child sexual exploitation. This enables practitioners to understand and respond to a range of risks that young people face and contribute effectively to multi-agency responses to children and their families. For example, the involvement of YJS is leading to some insightful and sensitive decisions about sequencing of interventions to protect children and reduce offending.

- The probation services have a strong focus and good understanding of child protection, which has been maintained during a period of significant change. The ability of staff in the National Probation Service (NPS) and the Community Rehabilitation Company (CRC) to remain focused on the needs of children has enabled them to manage cases in a way that both supports the management of risk of harm to others and promotes the safety of children.

Case study: highly effective practice

Staff in the Community Rehabilitation Company (CRC) and the National Probation Service (NPS) are effective in identifying and taking action to address risks to children that arise from the behaviour of the people who are supervised by these agencies. The staff manage risks well and work closely with partners to alert them to concerns and offer support to address offending and behaviours that might harm children. For example, the NPS are effective in identifying children who are linked to offenders who have committed violent offences. Offenders appearing at court are asked to provide details of all children and pregnant women with whom they have contact. This information is then shared with children's social care to ensure that risks can be assessed. There is appropriate sharing of further information once the case has been allocated to the NPS, or the CRC in case of any changes. Appropriate questions are also asked to identify whether there are unborn babies. This enables the probation services to quickly identify children linked to people who commit violence offences, and supports joint planning and multi-agency work to reduce risk.

Areas for improvement

Leadership and management

- There is a lack of effective management oversight within health services to ensure that all health professionals effectively and routinely assess risks to children. Health Local Authority and CCG commissioners and senior managers in South Tyneside Foundation Trust do not have a sufficiently robust understanding of what is happening to assess and manage risk in those frontline services inspected. There is a lack of regular safeguarding audit activity by safeguarding leads in the South Tyneside Foundation Trust in both the community and acute services inspected. As a result, commissioners and managers cannot be assured of the quality of safeguarding practice undertaken by clinicians in these services. Risk assessment by clinicians was found in this inspection to be dependent on individual staff knowledge, confidence and professional curiosity, rather than a consistent and clearly defined approach to the identification of risk.

- The absence of effective frontline operational governance of risk assessment practice in the Emergency Department (ED) and sexual health services means that the South Tyneside Foundation Trust, Local Authority Commissioning, Clinical

Commissioning Group and the partnership cannot be assured that young people accessing these services have all risks identified effectively. This is exacerbated by the absence of standardised risk assessments in sexual health, school nursing and ED teams, leading to an over reliance on a medically focused model. This means that vulnerabilities, for example to child sexual exploitation are not always fully considered. In two cases seen, sexual health services failed to share relevant information with children's social care despite the involvement of this agency with both young people. All issues of concern identified in health services during this inspection have been made subject to an immediate action plan.

- Evidence of sustained change as a result of performance management and audit is limited across the partnership. Performance information is available for frontline staff and managers to manage their day-to day-work, for example in the front door of children's social care, but not in enough detail to inform strategic planning.

Identification and managing risk of harm at the 'front door'

- The majority of contacts from partner agencies are timely, but the quality is variable and, in too many cases, risk and need are not adequately identified. This was seen to be an issue across agencies, including health, police and schools. This means that too much social work time is spent in gathering key information to inform judgements about the appropriate level of service response.

- It is not clearly and consistently recorded that, where parental consent is required for a referral to children's social care, it has been sought by the agencies making the referral, such as health, schools and voluntary agencies. When children are referred for early help, it is not recorded by children's social care whether parental views and agreement for early help interventions have been provided. Parental consent, where this is required, needs to be more clearly identified at the point of initial contact by the referring agency and needs to be confirmed by social care if the information is passed on to the Multi-agency Allocation Team.

- Work has been undertaken by the partnership to reduce the high number of contacts to children's social care. This includes partner engagement in reviewing the threshold document, the newly established Multi-agency Allocation Team (MAAT) to enhance the take up of early help, and meetings with the police to review the high number of police notifications. This work is beginning to have an impact, for example a reduction in the number of police notifications passed to children's social care. Further work is needed to ensure that all agencies, including health and schools, understand the pathways for early help referrals and consistently apply appropriate thresholds for referral.

- There is no joint agency decision-making between the police, health and children's social care at the front door. This leads to potential delays in service provision. For example, one case was seen where the social worker took several hours to establish that the family did not live in the local area, whereas had there been joint health and social care screening at the point of contact, this would have been immediately evident.

- Referrals where the primary reason is support for a disabled child are transferred directly to the local authority Child and Adult disability service. Robust management oversight of assessments is not evident in this service, and at the point of allocation, managers do not agree appropriate timescales for assessments to meet the needs of the child. As a result, in a small number of cases seen, the initial response to complete an assessment was delayed. The local authority immediately implemented an action plan when this was brought to their attention during this inspection.

Responses to children missing and at risk of child sexual exploitation

- Until January 2016, the police had not distinguished between children missing and those who are absent, therefore all children have been categorised as missing, including those who are late returning home. This means that the partnership has not previously had a coherent list of those children most at risk in order to analyse systematically the needs of children who go missing. For example, children's social care is not able to report on how many children who need a return home interview receive such an interview. This limits their ability to respond at a strategic level, to understand the risks that children face and to forward plan to ensure that services are routinely providing support to children who go missing. While the police have now introduced the categories of missing and absent, children's social care are still not ensuring that all children who require a return interview have one. This means that the needs of children who go missing are not always understood and that findings from return interviews are not systematically informing plans.

- Although the police force has prioritised child sexual exploitation and undertaken some analysis of the profile of victims, it has more to do to understand the extent and nature of child sexual exploitation across South Tyneside. More sophisticated information gathering and profiling is evolving. However, at present this is underdeveloped.

- Child sexual exploitation vulnerability checklists are completed on all children identified as at risk of exploitation. However, across the partnership, and in particular in children's social care, there is an inconsistent approach to completing the child sexual exploitation checklist. This means that the scoring of risk and the

understanding of how key vulnerabilities might impact on the risk of child sexual exploitation is too variable. This is limiting the partnership's understanding of specific vulnerabilities of children at risk of child sexual exploitation in the local area. The partnership have recognised this and a new toolkit with accompanying training is about to be introduced.

- While children on plans have their progress reviewed, there is no system within children's social care to regularly review the child sexual exploitation checklist. A sharper focus on reviewing the checklist would provide a clearer understanding of risks associated with child sexual exploitation and of the efficacy of multi-agency responses to reduce risk. This, in turn, would impact on the strategic understanding of how well risk is managed across the partnership.

- Planning within children's social care and the youth justice service does not always capture all the areas of need identified in the assessment, and not all plans adhere to statutory guidance on children who run away or go missing from home or care. For example, in one case the care plan did not address strategies to reduce the risk of missing episodes and there was no risk management plan. Risk management planning by children's social care, health, and the youth justice service is not always specific about exactly what actions are needed when and by whom to ensure that risk does not escalate, and these plans are not always sufficiently well integrated into an overarching multi-agency plan.

- Response to child sexual exploitation by partners, including children's social care, the youth justice service, and health is characterised by a reactive approach to risk and need, which means that some young people are not being fully supported to sustain changes and improve outcomes in the longer term. In many cases seen, supervision across the partnership did not support a proactive planning approach. Practice needs to develop to ensure appropriate persistence when young people fail to engage. Staff need to have the appropriate support, training, supervision and management oversight, to provide challenge when practice is not bringing about change quickly enough.

The LSCB

- There is a lack of clarity amongst social workers and health practitioners about the role of the Missing and Sexual Exploitation and Trafficked (MSET) group and inconsistent practice to ensure that outcomes from the MSET meetings are shared across all agencies. The lack of understanding of the remit of MSET has led to delays. For example, in one case, a worker had not completed a risk management plan as she thought this was the role of MSET. Despite clear terms of reference, more work is needed across the partnership to clarify the role of

MSET and ensure consistent and regular feedback to practitioners and managers when cases are reviewed in this meeting.

- The LSCB dataset is not yet fully robust or comprehensive. For example, assessment outcomes are not captured and reported, and there is no information on early help. There is very limited analysis in performance reports to explain performance outcomes, for example the reason for relatively high levels of repeat referrals is not understood by the partnership and there is limited use of target setting to improve performance. The limited quality and scope of performance information impedes the strategic partners' ability to have a comprehensive understanding of those areas of practice that require improvement, both at the front door and in response to children at risk of child sexual exploitation and who are missing.

Case study: area for improvement

South Tyneside agencies are working together to contain and manage risk on a day-to-day basis, but it is not clear in all cases that they are proactively planning to reduce long-term risk for children in the future.

Josh is a young person looked after living in local authority care. He was recently arrested for a serious offence and is currently under an electronic curfew. Josh is at a high risk of child sexual exploitation. He is associating with older men known by the police to potentially present a risk of child sexual exploitation, and is using drugs. Josh has a history of going missing, although due to the electronic curfew this is now reducing. He is engaging with the youth justice service, but is struggling to cope with the high number of professionals involved with him and has withdrawn from, or refused to engage with, several services.

There is a well coordinated multi-agency group involved with Josh that understands the risks he faces. So far, however, the group has been unable to engage him consistently in a way that would help stabilise his risky behaviour and work with him to support sustained changes to reduce risk. This means that although risk is currently contained on a daily basis, longer term risk is not being reduced. There are an overwhelming number of professionals from different agencies attempting to interact with him. Josh is not able to form relationships with all those trying to support him. A more measured, less reactive approach would ensure that the key professionals who have a relationship with him would lead the provision of services. More consistent and supportive challenge from managers across the partnership would allow for a more flexible approach. This would

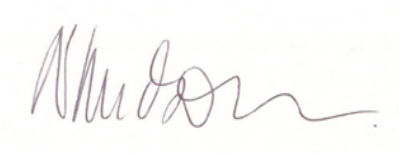
enable the group to look beyond the immediate and forward plan to address longer term risk.

Next steps

The local authority should coordinate the preparation of a written statement of proposed action responding to the findings outlined in this letter. This should be a multi-agency response involving LSCB partnership and specifically health, the police, children's social care, and the Youth Offending Service. The response should set out the actions for the partnership and, where appropriate, individual agencies.[2]

The local authority should send the written statement of action to protectionofchildren@ofsted.gov.uk by 14 July 2016. This statement will inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

Yours sincerely

Ofsted	**Care Quality Commission**
 Nick Hudson Regional Director	 Sue McMillan Deputy Chief Inspector
HMI Constabulary	**HMI Probation**
 Wendy Williams Her Majesty's Inspector of Constabulary	 Helen Davies Assistant Chief Inspector

[2] The Children Act 2004 (Joint Area Reviews) Regulations 2015 www.legislation.gov.uk/uksi/2015/1792/contents/made enable Ofsted's chief inspector to determine which agency should make the written statement and which other agencies should cooperate in its writing.