The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	26 November 2020						
Title	Consultant Appointments						
Report of	Andy Welch, Medical Director						
Prepared by	Colin Sakhe, HR Advisor (Medical & Dental)						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	The content of this report outlines recent Consultant Appointments.						
Recommendation	The Board of Directors is asked to review the decisions of the Appointments Committee.						
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. People – Supported by Flourish, our cornerstone programme, we will ensure that each member of staff is able to liberate their potential.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☐	☐	☐	☒	☐	☐	☐
Impact detail	Ensuring the Trust is sufficiently staffed to meet the demands of the organisation.						
Reports previously considered by	Consultant Appointments are submitted for information in the month following the Appointments Panel.						

CONSULTANT APPOINTMENTS

1. APPOINTMENTS COMMMITTEE – CONSULTANT APPOINTMENTS

1.1 An Appointments Committee was held on 17 September 2020 and interviewed 1 candidate for 1 Consultant Anaesthetist post.

By unanimous resolution the Committee was in favour of appointing Dr Jane Danby.

Dr Danby holds MBBS (University of Newcastle Upon Tyne) 2007 and FRCA (UK) 2016. Dr Danby is currently employed as a Specialty Trainee based at the Royal Victoria Infirmary.

Dr Danby is expected to take up the post of Consultant Anaesthetist in November 2020.

1.2 An Appointments Committee was held on 23 September 2020 and interviewed 2 candidates for 2 Consultant in Neonatal Paediatrics posts.

By unanimous resolution the Committee was in favour of appointing Dr Jenna Gillone and Dr Elda Dermyshi.

Dr Gillone holds MBChB (University of Edinburgh) 2006 and MRCPCH (UK) 2010.Dr Gillone is currently employed as a Specialty Trainee based at the Royal Victoria Infirmary.

Dr Dermyshi holds Surgical and Medical degree (University Universita degli Studi di Bari) 2008. Dr Dermyshi is currently employed as a Locum Consultant in Neonatal Paediatrics based at the Royal Victoria Infirmary.

Dr Gillone is expected to take up the post of Consultant in Neonatal Paediatrics in February 2021.

Dr Dermyshi took up the post of Consultant in Neonatal Paediatrics in October 2020.

1.3 An Appointments Committee was held on 14 October 2020 and interviewed 2 candidates for 1 Consultant in Paediatric Dentistry post.

By unanimous resolution the Committee was in favour of appointing Dr Virginia Hind.

Dr Hind holds BChD (Leeds University) 1987 and FDS(Paeds)(UK) 2016. Dr Hind is currently employed as a Speciality Doctor based at the Newcastle Dental Hospital.

Dr Hind is expected to take up the post of Consultant in Paediatric Dentistry in December 2020.

1.4 An Appointments Committee was held on 14 October 2020 and interviewed 1 candidate for 1 Consultant Physician post.

By unanimous resolution the Committee was in favour of appointing Dr Stephen Wiltshire.

Dr Wiltshire holds BM (University of Southampton) 2007 and MRCP (UK) 2011 Dr Wiltshire is currently employed as a Locum Consultant Physician based at the Royal Victoria Infirmary.

Dr Wiltshire took up the post of Consultant Physician in October 2020.

1.5 An Appointments Committee was held on 16 October 2020 and interviewed 1 candidate for 1 Consultant Neurologist post.

By unanimous resolution the Committee was in favour of appointing Dr Anais Thouin.

Dr Thouin holds MBBS (University of Newcastle) 2005 and PhD (University of Newcastle) 2017. Dr Thouin is currently employed as a Specialty Trainee based at the Royal Victoria Infirmary.

Dr Thouin is expected to take up the post of Consultant Neurologist in January 2021.

1.6 An Appointments Committee was held on 22 October 2020 and interviewed 1 candidate for 1 Consultant in Emergency Medicine post.

By unanimous resolution the Committee was in favour of appointing Dr Amlan Borah.

Dr Borah holds MBBS (Gauhati University) 2000 and FRCEM (UK) 2019. Dr Borah is currently employed as a Locum Consultant in Emergency Medicine based at the Royal Victoria Infirmary.

Dr Borah is expected to take up the post of Consultant in Emergency Medicine in November 2020.

1.7 An Appointments Committee was held on 28 October 2020 and interviewed 2 candidates for 1 Consultant Ophthalmologist post.

By unanimous resolution the Committee was in favour of appointing Mr Jaswant Sandhu.

Mr Sandhu holds MBChB (University of Manchester) 2008 and FRCOphth (UK) 2017. Mr Sandhu is currently employed as a Consultant Ophthalmologist by County Durham and Darlington NHS Foundation Trust.

Mr Sandhu is expected to take up the post of Consultant Ophthalmologist in January 2021.

1.8 An Appointments Committee was held on 04 November 2020 and interviewed 1 candidate for 1 Consultant Respiratory Physician post.

By unanimous resolution the Committee was in favour of appointing Dr Wendy Funston.

Dr Funston holds MBBS (University of Newcastle) 2009 and MRCP (UK) 2012. Dr Funston is currently employed as a Locum Consultant Respiratory Physician based at the Royal Victoria Infirmary.

Dr Funston is expected to take up the post of Consultant Respiratory Physician in November 2020.

1.9 An Appointments Committee was held on 06 November 2020 and interviewed 1 candidate for 1 Consultant Urological Surgeon post.

By unanimous resolution the Committee was in favour of appointing Mr Arjun Konath Nambiar.

Mr Nambiar holds MBBS (Tribhuvan University) 2009 and MRCS (UK) 2011.Mr Nambiar is currently employed as a Specialty Trainee based at the Royal Victoria Infirmary.

Mr Nambiar is expected to take up the post of Consultant Urological Surgeon in September 2021.

2. RECOMMENDATION

1.1 – 1.9 – For the Board to receive the above report.

Report of Andy Welch
Medical Director
13 November 2020

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	26 November 2020						
Title	NHS Emergency Preparedness, Resilience and Response (EPRR) Assurance						
Report of	Andy Welch, Medical Director/ Deputy Chief Executive Officer						
Prepared by	Michael Clark, Head of Business Continuity & Preparedness						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☒		☐		
Summary	NHS England requires NHS organisation and providers of NHS funded care, to provide annual assurance of Emergency Preparedness Resilience & Response (EPRR) readiness against the NHS core standards assurance process. The content of this report outlines the Trust's position regarding EPRR NHS Core Standards Self-Assessment for 2020-21						
Recommendation	The Board of Directors is asked to note the contents of the report.						
Links to Strategic Objectives	Putting patients at the heart of everything we do and providing care of the highest standard focusing on safety and quality.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☐	☐	☐	☐	☐
Impact detail	The Trust is required to meet legislative duties set out in the Civil Contingencies Act 2004.						
Reports previously considered by	The EPRR Core Standards Self-Assessment Board Report is submitted annually to the Trust Board.						

NHS EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) ASSURANCE 2020-21

1. INTRODUCTION

The NHS is required to plan for, and respond to, a wide range of incidents, emergencies, threats and hazards that could impact upon the provision of healthcare. Examples include external incidents such as extreme weather conditions, a major transport accident or a major outbreak of an infectious disease such as a pandemic. The Civil Contingencies Act (2004) and NHS England, via a set of national core standards, requires NHS organisations, and providers of NHS-funded care, to provide assurance that they can deal with such incidents while maintaining essential services.

2. ASSURANCE REQUIREMENTS

Despite the challenges of 2020, our statutory requirement to formally assure ourselves of EPRR readiness in our own organisation and the wider NHS remains. It is recognised by NHS England and NHS Improvement that the detailed and granular process of previous years would be excessive while we prepare for a potential further wave of COVID-19, as well as upcoming seasonal pressures and the operational demands of restoring services. In acknowledgement of this, the National Director of EPRR has mandated that the assurance process for 2020-21 will ask all NHS organisations to submit a statement of assurance to the relevant NHS England and NHS Improvement regional head of EPRR by 31 October 2020.

This statement should include:

- The updated assurance position of any organisations that were rated partially or non-compliant in 2019/20.
- Assurance that all providers of NHS-funded care have undertaken a thorough and systematic review of their response to the first wave of the COVID-19 pandemic, and a plan is in place to embed learning into practice.
- Confirmation that any key learning identified as part of this process is actively informing wider winter preparedness activities for your system.

NHS regions will submit their statement of assurance to the director of EPRR (national) by 31 December 2020.

3. TRUST POSITION ON COMPLIANCE STATEMENT

The response to the questions below formulates the Trust's statement of compliance for 2020-21.

i) Where relevant, have your EPRR assurance action plans have been reviewed in order to improve your level of compliance against the 2019/2020 EPRR Assurance

Core Standards, and where you have previously reported partial or non-compliance as your overall assurance rating that you provide an updated assurance level following review and delivery of your ongoing action plans?

NUTH Response:

In September 2019 the Trust reported its status as Substantially Compliant against the 2019/20 EPRR Core Standards. The only area within these standards against which the Trust did not report full compliance was Business Continuity, this was due to being unable to evidence alignment to the NHS Digital Data Security & Protection Toolkit for 2019/20. An exercise was held in March 2020 with IM&T to evaluate the response to a cyber security event. This exercise allowed IM&T to evidence compliance with the NHS Digital Toolkit, which subsequently means that the Trust can now also evidence full compliance with the 2019-20 EPRR Core Standards as outlined in the table below.

STANDARD	COMPLIANCE POSITION IN SEPTEMBER 2019	WORK PLAN REQUIRED TO ACHIEVE COMPLIANCE	COMPLIANCE POSITION IN SEPTEMBER 2020
General			
Governance	Fully compliant	N/A	Fully compliant
Duty to Assess Risk	Fully compliant	N/A	Fully compliant
Duty to Maintain Plans	Fully compliant	N/A	Fully compliant
Command & Control	Fully compliant	N/A	Fully compliant
Training & Exercising	Fully compliant	N/A	Fully compliant
Response	Fully compliant	N/A	Fully compliant
Warning & Informing	Fully compliant	N/A	Fully compliant
Co-operation	Fully compliant	N/A	Fully compliant
Business Continuity	Partially compliant	Data protection and security toolkit not fully met – plan agreed for completion by June 2020.	Fully compliant
Chemical, Biological, Radiological, Nuclear (CBRN) & Hazardous Material (HAZMAT)	Fully compliant	N/A	Fully compliant

ii) Have you undertaken, or do you plan to undertake, a formal review process on your response to the COVID-19 pandemic to date, and have associated plans to ensure that the lessons and recommendations from that review are embedded as part of your ongoing EPRR work programme?

NUTH Response:

A formal review of the Trust response to the COVID-19 pandemic began in June 2020. This began with an online questionnaire sent to all colleagues with a role in the operational, tactical and strategic management of the incident, including senior medical and nursing staff. Information gathered in this exercise was used to inform in-depth discussions during hot debrief session that were held in July 2020 with Silver (tactical) and Gold (strategic) command teams. Finally, the outcome of the discussions at these two hot debrief sessions has informed an internal report with recommendations for improvement and action plan for implementation.

Ownership of this action plan is the responsibility of the EPRR Strategy Group, chaired by the Trust Accountable Emergency Officer. The Trust Head of Business Continuity & Emergency Planning is responsible for embedding the recommendations by incorporating the action plan into the departmental work programme. A quarterly report will be submitted to the EPRR Strategy Group for monitoring the implementation of the agreed actions.

iii) Have you have reviewed your response to the COVID-19 pandemic and taken steps to embed key lessons and actions in your planning for winter and associated system response arrangements?

NUTH Response:

The development of the Trust Winter Plan has been informed by the lessons learned in the first phase of the pandemic as established in the hot debrief sessions mentioned in the response to question two. Some of the key measures implemented as part of the Winter Plan include:

- Enhancing social distancing measures in ward environments by reducing the number of beds in bays from 6 to 4 to reduce the risk of infection. This will have a positive impact on reducing the spread of infection, such as COVID and Flu, leading to a reduction in lost bed days.
- Securing capital investment for creation of a dedicated High-Level Respiratory Support Unit (RSU) at the RVI. This will increase capacity by 17 beds and act as a dedicated unit for the isolation and care for COVID-19 patients.
- Capital investment into the refurbishment of ward 17 at the Freeman Hospital to act as a winter surge ward, increasing capacity by 18 beds.
- Starting the Flu vaccination campaign earlier in the year and extending access for staff through training more peer vaccinators, providing more clinics and running clinics for longer hours. This will ensure that more staff are vaccinated against Flu to reduce the risk of outbreaks across the Trust.

A R Welch FRCS
Medical Director
17 November 2020

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	26 November 2020						
Title	Guardian of Safe Working Quarterly Report (Q2 2020)						
Report of	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours						
Prepared by	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	The terms and conditions of service of the new junior doctor contract (2016) require the Guardian of Safe Working Hours to provide a quarterly report to the Trust Board to give assurance to the Board that the junior doctors' hours are safe and compliant. The content of this report outlines the number and main causes of exception reports for the period 27 June 2020 to 26 September 2020 which was considered by the Trust People Committee at their October meeting.						
Recommendation	The Trust Board is asked to note the contents of this report.						
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☐	☐	☐	☐	☐
Impact detail	In order to maintain quality and safety, we must have a junior doctor workforce who can work within safe hours and receive excellent training.						
Reports previously considered by	Quarterly report of the Guardian of Safe Working Hours.						

GUARDIAN OF SAFE WORKING QUARTERLY REPORT

1. EXECUTIVE SUMMARY

This quarterly report covers the period 27 June 2020 to 26 September 2020.

There are now 816 trainees on the New Junior Doctor Contract and a total of 1,016 junior doctors in the Trust.

There were 26 exception reports in this period. This compares to 9 exception reports in the previous quarter, and 69 exception reports in the same quarter of 2019. The marked reduction compared to 2019 reflects the lack of exception reporting in the early part of the quarter when elective clinical activity was reduced to respond to the COVID-19 pandemic.

The main area of exception reports is general medicine (RVI) and general surgery (FH).

The main cause of exception reports is when there is excessive workload which was not appropriate to hand over to on call teams, and time taken for mandatory training which could not be completed in working hours due to clinical commitments.

2. INTRODUCTION / BACKGROUND

The 2016 New Junior Doctor Contract came into effect on 3 August 2016. All Lead Employer Trust (LET) employed trainees transitioned to the New Contract Terms and Condition of Service (TCS) in February 2020. The 2016 Contract has recently been reviewed. The changes are to be implemented in a staggered approach from August 2019 to October 2020.

The TCS on the new 2016 contract allows for exception reporting to raise reports on breaches of working hours and educational opportunities. These are ratified or rejected as appropriate by clinical supervisors and the process is overseen by the Guardian of Safe Working Hours.

The TCS require the Guardian of Safe Working Hours to provide a quarterly report to the Trust Board to give assurance to the Board that the junior doctors' hours are safe and compliant.

3. HIGH LEVEL DATA

		(previous quarter data for comparison)
Number of Junior Doctors on New Contract	816	(909)
Number of Exception reports	26	(9)
Number of Exception reports for Hours Breaches	25	(9)
Number of Exception reports for Educational Breaches	6	(0)
Fines	1	(0)

Admin Support for Role	Good
Job Planned time for supervisors	Variable

4. EXCEPTION REPORTS

4.1 Exception Report by Speciality (Top 3)

General Surgery	11
General Medicine	10
Orthopaedics	4

4.2 Exception Report by Rota (Top5)

General Surgery FH F1	8
General Medicine RVI F1	7
Orthopaedics RVI F1	4
General Medicine FH F1	2
General Surgery RVI F1	2

4.3 Exception Report by Grade

Foundation Year 1	23
F2	2
SpR	1

4.4 Example Themes from Exception Reports

General Surgery FH F1/ Orthopaedics RVI F1

Trainees staying late to complete routine jobs within their normal working day. This is exacerbated when other problems add to the workload (e.g. problems with phlebotomy.)

General Medicine RVI F1

Trainees staying late to complete routine jobs. Mandatory training is expected to be completed within hours. On busy wards this is not always achievable.

5. EXCEPTION REPORT OUTCOMES

5.1 Work Schedule Reviews

There have been no work schedule reviews carried out due to exception reports. All work schedules have been reviewed to ensure compliance with the changes to the Junior Doctor Contract.

5.2 Fines

1 fine has been issued:
General Surgery F1 FH: £138.16. Working in excess of maximum 13 hour shift length on 2 occasions.

6. ISSUES ARISING

6.1 Workforce and workload

The majority of exception reports (22/26) for this quarter have been submitted in the last 5 weeks. This reflects the increase in activity within the Trust. The pattern of exception reporting is similar to previous, with trainees required to stay late to complete routine tasks on busy wards.

6.2 Supervisor Engagement

Supervisor engagement is variable, with some supervisors requiring multiple prompts to complete exception reports.

6.3 Administrative Support

Administrative support is currently excellent.

7. ROTA GAPS

Specialties and rotas with gaps as of September 2020 are outlined below. A full breakdown of gaps has been circulated privately for the People Committee.

Site	Specialty/Sub Specialty	Grade	No. required on rota (at full complement)	September 2020
	Cancer Services			
FH	Oncology	ST3+	14	0.2
FH	Palliative Medicine	ST1+	13	3.5
FH	Haematology	ST3+	11	1
	Cardiothoracic Services			
FH	Cardiology	F2/ST1-2	4	1
FH	Cardiothoracic Anaesthesia	ST3+	9	3
FH	Cardiothoracic Surgery	F2/ST1-2	3	1
FH	Cardiothoracic Surgery	ST3+	10	1
FH	Cardiothoracic Transplant	ST3+	3	1
FH	Paediatric Cardiology 1st	F2/ST1/ST2	8	0.4

FH	Paediatric Cardiology 2nd	ST3+	11	4.2
FH	Respiratory Medicine	CMT/ST1-2	4	0.4
FH	Respiratory Medicine	ST3+	10 (rotate with RVI)	3
	Children's Services			
RVI	Paediatric Surgery 2nd	ST3+	9	1
RVI	Paediatrics 1st - ST1/ST2 (now inc Paeds Surgery)	F2/ST1/ST2	31	1.2
RVI	General Paediatrics	ST3+	21	2.4
RVI	Paediatric ICU (PICU)	ST3+	9	1.6
	EPOD			
FH	ENT	ST3+	9	1
RVI	Ophthalmology	F2/ST1/ST2	5	0.2
RVI	Ophthalmology	ST3+	25	2.24
RVI	Dermatology	F2	1	0.2
RVI	Dermatology	ST3+	11	2
	Integrated Lab Medicine			
RVI	Histopathology	ST3+	12	2
RVI	Histopathology	ST3+	8	3
C4L	Genetics	ST3+	4	1.7
RVI	MM rota integrated with ID and MV and GIM	ST3+	14	1.4
	Medicine			
FH	General Internal Medicine	F2/GPVTS/CMT/TF	20	1
RVI	CMT BOH and FOH Combined (August 2019)	CMT	10	1
RVI	General Internal Medicine	ST3+	18	2.4
FH	Care of the Elderly	ST3+	6	2.4
RVI	Accident & Emergency 1st	ACCS/ST1-2/CT1-2	19	0.6
RVI	Accident & Emergency 2nd	ST3+	15	2
	Musculoskeletal			
FH	Orthopaedics	F2/ST1/ST2	6	1
RVI	Spinal Surgery	ST3+	2	1
	Neurosciences			
RVI	Neurosurgery	F2/ST1/ST2	7	2
RVI	Neurosurgery	ST3+	14	2
RVI	Neurology	ST3+	13	1.2
RVI	Neurophysiology	All grades	2	1.4
	Peri-operative FH			
FH	Critical Care	F2 ST1-7	11	2.2
FH	Anaesthetics General	ST1-7 CT1-2	30	0.6
	Peri-operative RVI			
RVI	Critical Care	ST3+	21	0.2
RVI	Anaesthetics	ST1-2 / ST3 +	43	1.6

	Radiology			
RVI / FH	Radiology On Call	ST2 / ST3+	33	0.8
	Surgical Services			
FH	Vascular	ST3+	10	3.26
FH	Hpb / Transplant	ST3+	11	1
RVI	General Surgery	F2/ST1/ST2	7	1
RVI	General Surgery	ST3+	14	0.6
	Urology & Renal			
FH	Renal Medicine	F2/ST1/ST2	6	1
FH	Renal Medicine	ST3+	9	0.2
	Women's' Services			
RVI	Obstetrics & Gynaecology	F2/ST1/ST2	14	0.6
RVI	Obstetrics & Gynaecology	ST3+	22	2.2
	Foundation Year 1			
FH	Cardiology	F1	1 (post removed, replaced with Trust Doctor)	1

7.1 Locum Spend

The total amount of internal locum spend was £603,447. There was no external agency locum spend during the period.

8. REVISION TO 2016 JUNIOR DOCTOR CONTRACT

The 2016 Junior Doctor Contract has been revised. All work schedules are now compliant, although there remain 5 rotas where the weekend frequency exceeds 1 in 3. It is a recommendation of the contract that no rotas have a frequency of more than 1 in 3 weekends.

9. RISKS AND MITIGATION

The main risk remains medical workforce coverage across a number of rotas.

10. JUNIOR DOCTOR FORUM

The new junior doctors' mess at Freeman has been well received and is well used. The main concerns of the junior doctors at the junior doctor forum were around the ability to take breaks whilst maintaining social distancing and the lack of suitable facilities. Some QI projects were presented, including improving paperless referral pathways and a survey of rota release dates.

11. RECOMMENDATIONS

I recommend that we continue to be proactive at assessing the workforce/workload balance, and continue to find local solutions to ensure that patient safety and excellent training are maintained.

Report of Henrietta Dawson
Consultant Anaesthetist
Trust Guardian of Safe Working Hours
6 October 2020

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NEWCASTLE SAFEGUARDING ADULTS BOARD

newcastle safeguarding adults board

Annual Report 2019-20

CONTENTS

Case studies are used throughout this annual report to highlight multi-agency working. Names and details have been changed to protect identities.

I AM DELIGHTED TO INTRODUCE THE NEWCASTLE SAFEGUARDING ADULTS BOARD'S ANNUAL REPORT FOR 2019-20.

This is my seventh year as Chair and I continue to be impressed by the commitment to safeguarding adults in Newcastle, both from partner organisations and individuals.

CHAIR'S INTRODUCTION

Newcastle continues to have some of the highest rates of safeguarding concerns and Section 42 enquiries in the country. The interpretation of the Care Act 2014 and how the key areas of safeguarding adults activity are counted has been well considered by the Board over the years. The NSAB were reassured this year when national guidance on Section 42 enquiries was published which reflected the approach that Newcastle had taken since the advent of the Care Act. As this guidance is implemented by other areas, it is hoped that it will make it possible to accurately compare rates of concerns and enquiries with local and statistical neighbours.

The Board is still prioritising a person-centred approach to safeguarding, as outlined in "Making Safeguarding Personal"- undertaking ongoing, detailed analysis of key performance indicators to try and understand where we should focus efforts to embed this key area of work.

This year has also seen the NSAB focus on practitioner development particularly through spreading good practice learnt from experiences and cases.

We held a successful safeguarding "carousel-style" event in December, allowing multiple services and professionals to showcase their knowledge of safeguarding adults. The event was fully booked within 24 hours, demonstrating the desire of people to learn more about safeguarding adults. We know that there continues to be opportunities for us to learn and improve.

This report covers April 2019-March 2020 and therefore only briefly touches on the impact of Covid-19 on safeguarding adults. The passion, hard work and priority afforded to keeping our most vulnerable safe in Newcastle cannot be underestimated. It goes without saying that Covid-19 will have a lasting legacy on our communities, services and individuals.

I would like to acknowledge, on behalf of the NSAB, Andrea Semple, Board Adminstrator, who very sadly died suddenly in December 2019. Andrea was a crucial part of the Board's achievements this year and those previous. She was well respected by all those who worked with her and she will be sadly missed by all those involved in safeguarding in Newcastle.

NEWCASTLE IS A CITY OF SANCTUARY AND OF DEEPLY HELD VALUES OF JUSTICE AND FAIRNESS.

This is evident in the NSAB's Annual Report for 2019-20, with many agencies and people working together to protect our most vulnerable residents from abuse and neglect.

FOREWORD: COUNCILLOR KAREN KILGOUR

The work of the NSAB links to Newcastle City Council's ambition for a healthy and caring city. We know that the people of Newcastle are renowned for their warm and generous spirit and I've been particularly keen to ensure that messages about safeguarding adults are promoted more widely to our communities. It is important that everyone understands how they can report abuse and neglect of adults, not only those who work directly with adults with care and support needs.

As a Council, we are committed to help people to keep in touch with their family and friends and be a part of their communities. The NSAB acknowledges that social isolation and loneliness can be an increasing risk factor for abuse and neglect, so it is important that we continue with initiatives such as "Dementia Friendly Newcastle" to help people with dementia and their carers feel safe and well.

Despite the unrelenting, unfair and disproportionate budget cuts Newcastle has faced for the last decade, the work of the NSAB continues to demonstrate that those working in this field are committed, innovative and dedicated to ensuring Newcastle is safer city for adults at risk of abuse and neglect.

Thank you to all the organisations represented on the Board for your continued hard work.

WHO WE ARE & WHAT WE DO

The Newcastle Safeguarding Adults Board (NSAB) is a statutory multi-agency partnership responsible for safeguarding adults from abuse and neglect. There are a number of agencies represented on the Board, including the Council, Health Services and the Police (see page 32 for membership).

OUR VISION

"To ensure Newcastle is a safer city for adults at risk of abuse and neglect"

OUR PURPOSE

To help and protect adults with care and support needs.

Empowerment
Proportionality
Protection

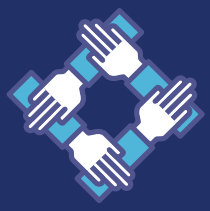
Partnership
Prevention
Accountability

To do this, we have to make sure that:

Local safeguarding arrangements are in place.

Our safeguarding practice is person centred and outcome focused

We work together to prevent abuse and neglect



Agencies and individuals give timely and proportionate responses when abuse or neglect have occured

Our safeguarding practice is continuously improving and enhancing the quality of life for adults in our area.

The NSAB is supported by a number of sub committees, one of which is jointly overseen by the Newcastle Safeguarding Children Partnership (NSCP).

NSAB

NSCP

- Learning and Development Committee
- Improving Practice Committee
- Safeguarding Adults Review Committee
- Missing, Sexually Exploited, Trafficked (M-SET)

2019-20 OUR HIGHLIGHTS

June 2019
Week of safeguarding adults action at the Grainger Market including the Launch of the Herbert Protocol

July 2019
Reviewed NSAB Communications Strategy

September 2019
Criminal Exploitation Conference, Discovery Museum

September 2019
ADASS & LGA guidance on the conduct of Section 42 enquiries released

October 2019
Falls guidance produced - when is a slip, trip or fall a safeguarding adults issue?

December 2019
Practitioner Event held at City Library

January 2020
Making Safeguarding Personal scorecard developed to enable detailed analysis of performance

March 2020
Response to Covid-19 begins

Consultation on our Strategic Annual Plan

Each year we use a variety of methods to consult with members of the public, people who use our services and professionals on what the NSAB should focus on in the forthcoming year. Feedback from this consultation activity directly influences the NSAB's priorities.

Some of the themes and issues that were raised included:

- Training and awareness raising;
- Abuse and neglect of older people;
- Homelessness and substance misuse;
- Online safety;
- Liberty Protection Safeguards.

We also use analysis of our key performance indicators, the results of partner agency self-assessments and multi-agency audits to inform what we do.

LOOKING AHEAD TO 2020-21

Our Strategic Annual Plan 2020-21 includes the following action areas:

- Ensuring people who are at risk of harm are involved in safeguarding adults enquiries that are about them.
- Responding to national guidance on safeguarding adults and homelessness.
- Contributing to cross-partnership work around criminal exploitation and serious violence - building on best practice approaches from our response to sexual exploitation.
- Continue to implement the NSAB's Communication Strategy to increase awareness of safeguarding adults.
- Receive assurance on the support vulnerable victims of crime receive.
- Contribute and respond to national work around "safeguarding concerns".
- Ensure practitioners are confident in the application of the Mental Capacity Act 2005. Respond to changes around the Deprivation of Liberty Safeguards.
- Ensure the workforce in Newcastle is accessing high quality learning and development, whether that is on a single or multi-agency basis.
- Host learning events, considering findings from Safeguarding Adults Reviews.
- Review how and when feedback is given to referrers.
- Continue to increase partner agency participation in the Multi-Agency Safeguarding Hub (MASH)

CASE STUDY: SELF-NEGLECT

Complaints were received by YHN, Police and Tyne & Wear Fire Rescue Service (TWFRS), that a single male had set fire to his home and placed immediate neighbours at risk. Neighbours were worried about what they had observed to be a deterioration in the man's wellbeing. The man looked unkempt and was acting erratically.

Initial discussions took place with the Adult MASH which established there was no statutory involvement or known vulnerabilities. His mental health had been assessed on arrest by mental health triage. This assessment confirmed he was suffering from mental health problems but was deemed at that stage to have capacity for his actions.

Through discussion with the MASH we were able to confirm that he was also being supervised by the Probation service and that his property was in poor internal condition. This swift discussion alleviated the need for a safeguarding concern to be raised on the grounds of self-neglect and helped develop a partnership approach towards helping the man. He was subsequently jointly visited by a Housing Officer and TWFRS to carry out a fire safety assessment and provide fire prevention advice. Smoke alarms were replaced, and new ones fitted.

Contact was made with their Probation Officer to highlight the behavioural issues and it was established that Probation had written to the man's GP regarding low mood and anxiety. Approximately a week later neighbours again called the Police and TWFRS after windows were smashed from inside the property.

As the incident had so quickly followed the fire at the property several neighbours asked to be urgently rehoused as community tensions were extremely high.

At this stage agencies had more recorded information about the man and concern for his mental health wellbeing. A thorough mental health assessment was carried out and the man was sectioned and detained under the Mental Health Act.

Police and Housing Officers visited neighbours. Although they could not provide specific details, they gave reassurance that agencies were working together to address their concerns and that where appropriate further information would be shared over the next few weeks.

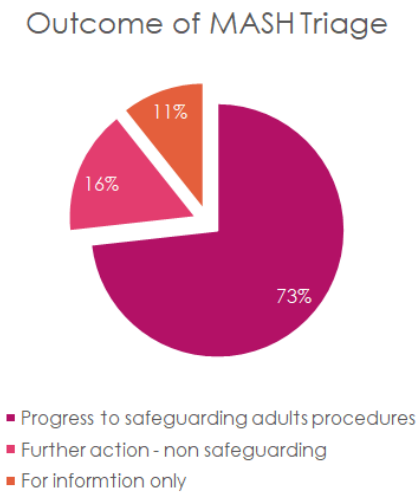
Housing Officers then contacted the hospital where the man was being treated to arrange a multi-disciplinary team meeting to discuss his housing situation prior to discharge. This meeting considered it was not safe for him to return to his property in terms of both his wellbeing and possible tensions with neighbours.

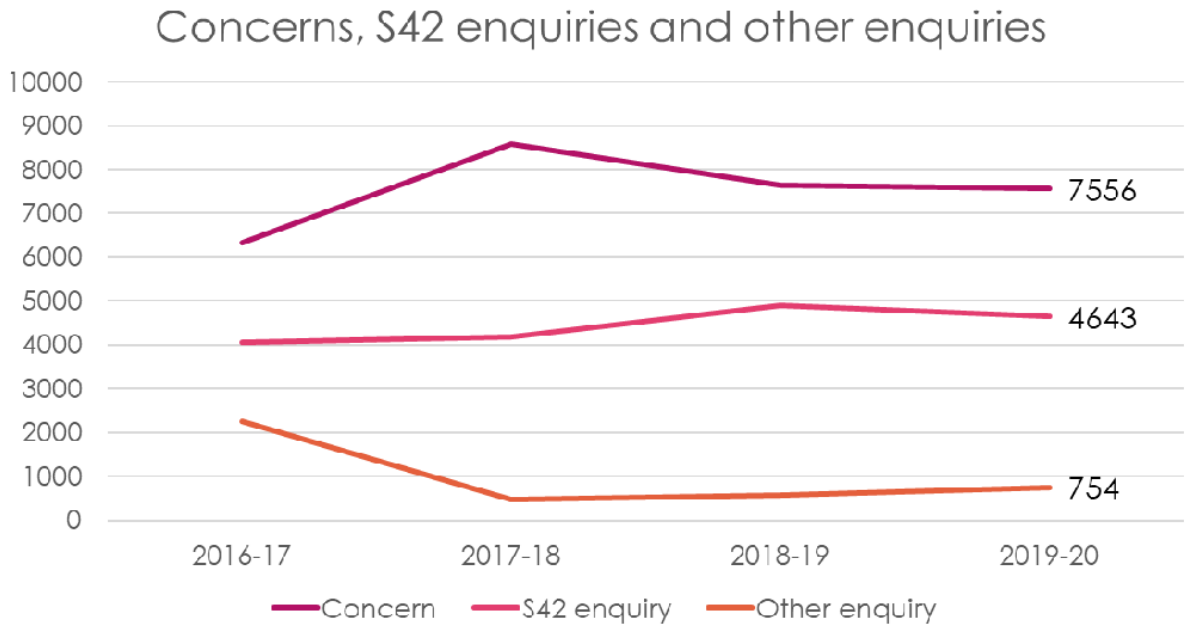
A temporary accommodation option was identified. Whilst in temporary accommodation he was provided with floating support to help him sustain a tenancy and manage his mental health wellbeing.

This case demonstrates the level of multi-agency working that goes in to keeping people safe in Newcastle and a focus on prevention of risks escalating. The NSAB have **self-neglect guidance** which promotes multi-agency working outside of safeguarding adults procedures where appropriate.

WHAT OUR LOCAL DATA TELLS US

- This is the first full year that Adult Multi-Agency Safeguarding Hub (MASH) data is included in the NSAB Annual Report. The MASH triaged **7,693** referrals which equates to 75% of all safeguarding adults referrals made in Newcastle. The other 25% are made directly to allocated Social Workers or Hospital Social Work Teams.
- **97.7%** of all concerns reported via the MASH are **triaged within 24 hours**. The remaining are those referrals made out of hours and are triaged the following day.

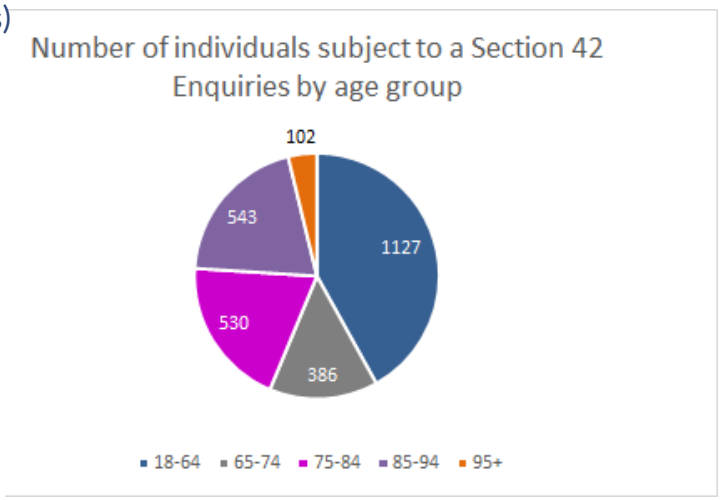


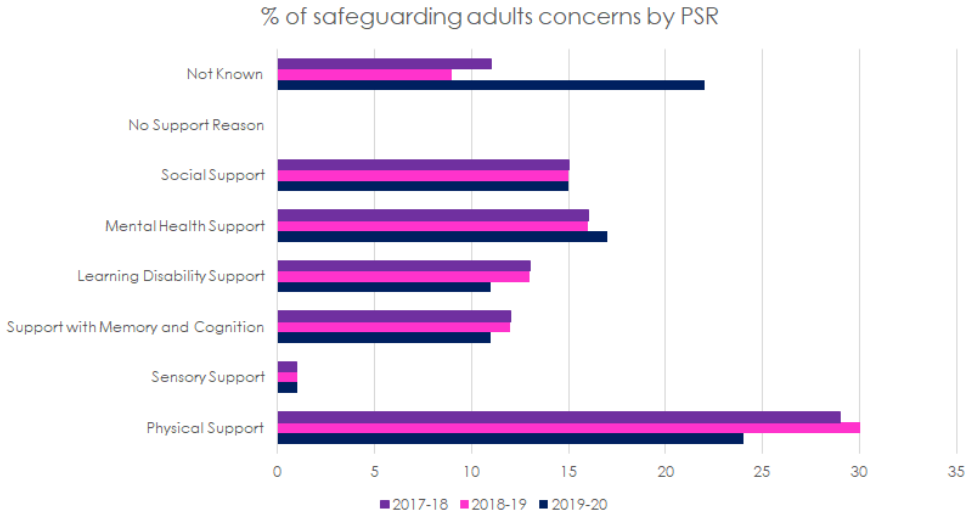


- **"Concern"** relates to all reports to the local authority of suspected abuse or neglect in relation to an adult.
- **"Section 42 enquiry"** refers to statutory enquiries made by the local authority when it is confirmed that the "concern" meets the criteria under the Care Act, 2014.
- **"Other Safeguarding Enquiries"** refers to enquiries where the "concern" related to abuse or neglect but the adult did not have care and support needs.
- There have been consistent levels of concerns, Section 42 enquiries and other enquiries over the past three years.
- Newcastle remains in the upper 10th percentile for the number of concerns raised and Section 42 enquiries per 100,000.
- The Local Government Association and the Association of Directors of Adult Social Services produced guidance on how Section 42 enquiries should be counted which reflected the Newcastle approach since the advent of the Care Act. As the guidance takes effect it is hoped that there will be a greater ability to make accurate comparisons with nearest statistical neighbours.

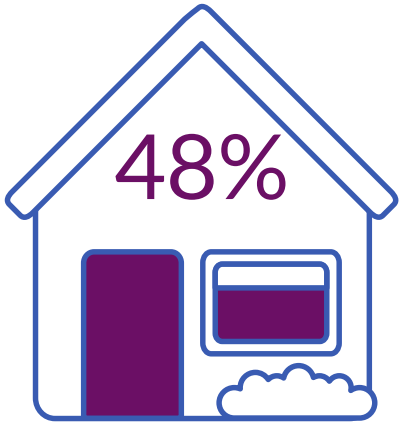
WHAT OUR LOCAL DATA TELLS US

- The data suggests that women (53% of all concerns) are slightly more likely to have a safeguarding adults concern raised about them.
- Whilst the highest volume of enquiries relate to people aged 18-64, the prevalence of abuse increases with age, when compared to the overall population totals for age groups.
- The proportion of concerns relating to people of Black, Asian, Minority Ethnic (BAME) background has remained static over the course of the last three years. 6% of all concerns related to people from a BAME group, in 14% of cases ethnicity was undeclared or unknown.

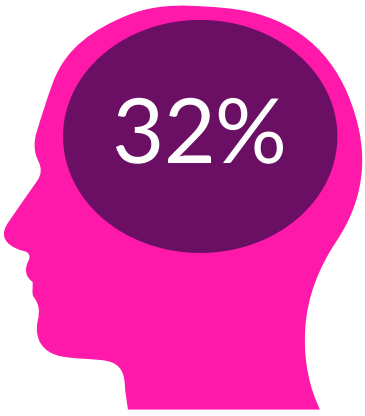




- The Primary Support Reason (PSR) describes what type of support it is believed that the Adult at Risk requires.
  The most common PSR overall is Physical Support (24%). Physical support includes age related frailty.
  There has been a large increase in concerns where the primary support reason is not known. This suggests more people are being referred into adult safeguarding procedures who are not previously known to Adult Social Care. A person does not have to be eligible or receiving social care services to be considered under safeguarding adults procedures.



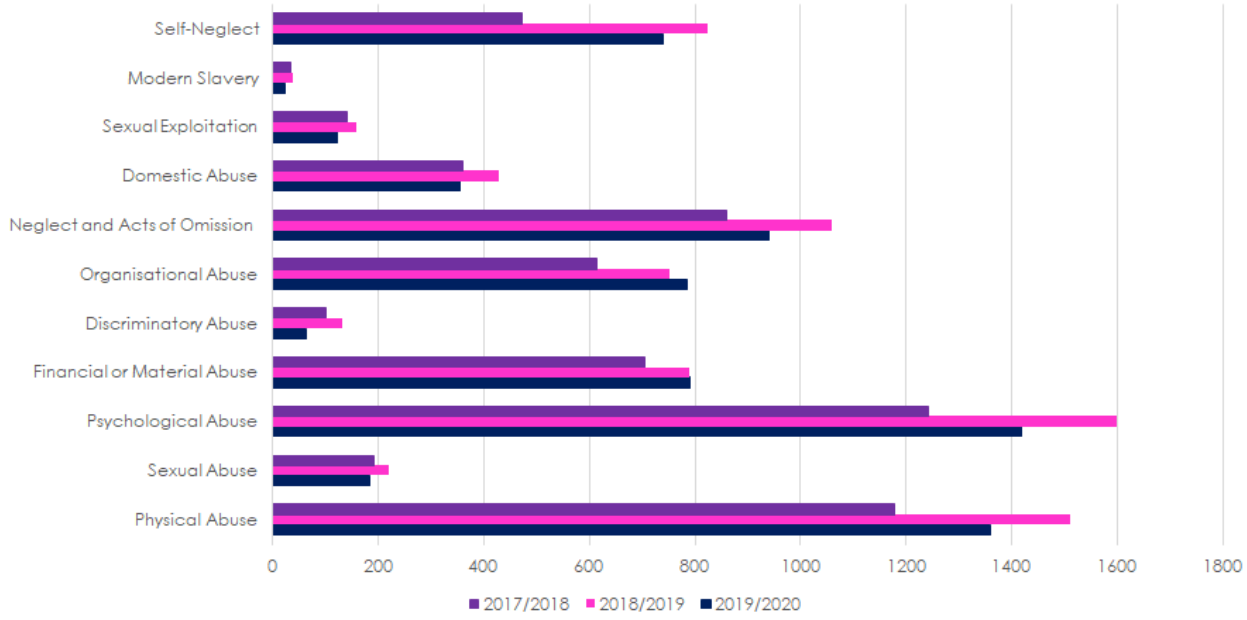
The proportion of safeguarding adults enquiries where the location of abuse was the person's own home.



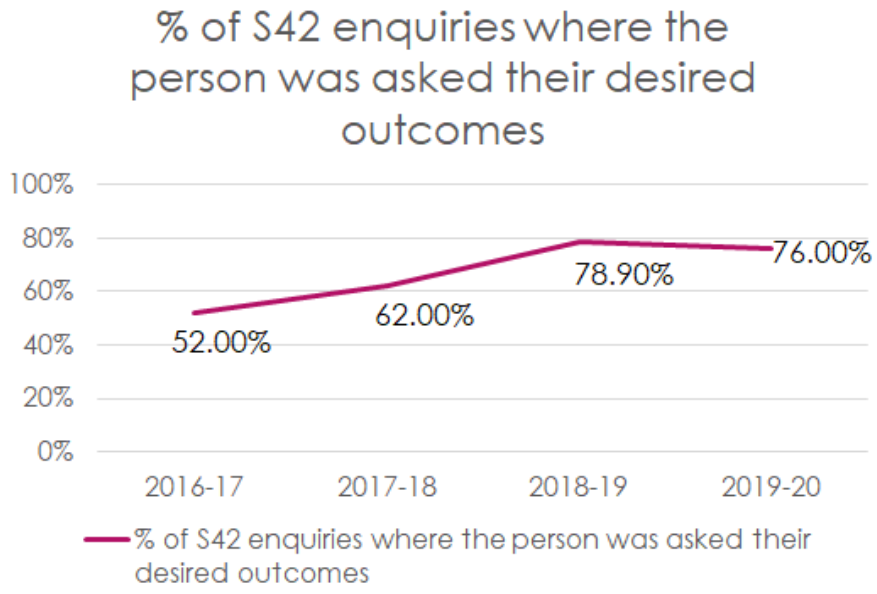
The proportion of safeguarding adults enquiries where the victim lacked mental capacity in relation to the concern

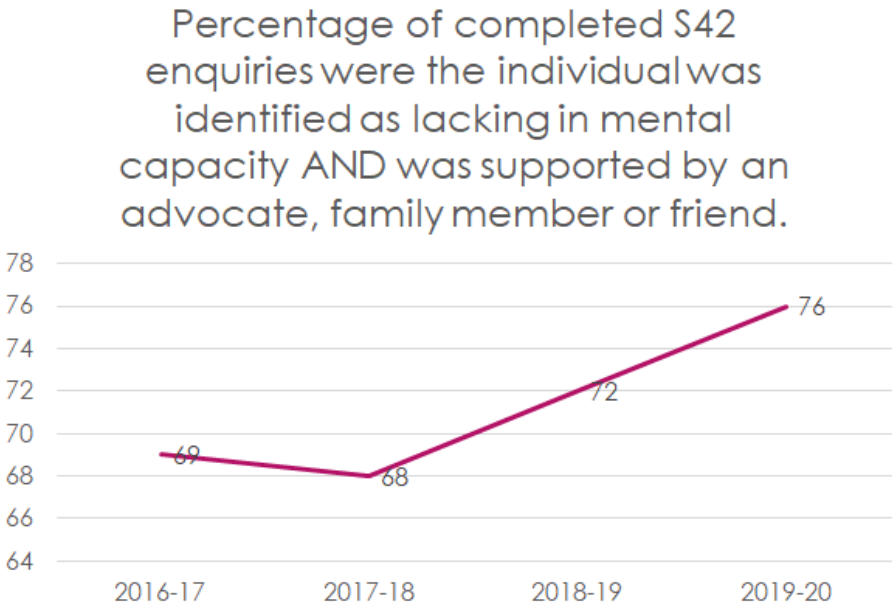
The number of safeguarding adults enquiries where a referral was made for an independent advocate

WHAT OUR LOCAL DATA TELLS US



- Multiple abuse types can be recorded for each safeguarding adults enquiry. There has been a reduction in 2019-20 of the number of abuse types recorded in each enquiry which is why most categories of abuse have reduced.
- There has been an increase in organisational abuse concerns in 2019-20, with psychological abuse being the most commonly reported.



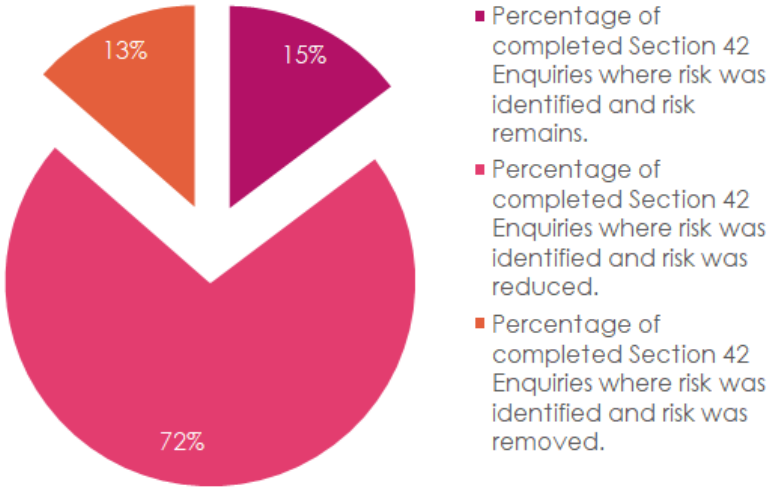


- The performance indicators above and to the left are a key focus for the NSAB's Improving Practice Committee in 2020-21 as part of their Making Safeguarding Personal Scorecard.
- They are analysed in detail to see where improvement action may need to be targeted.
- Action in 2020-21 will include work to increase confidence with referrers about the Making Safeguarding Personal approach.

WHAT OUR LOCAL DATA TELLS US

In 85% of cases where risk is identified, action is taken

- It is not always possible to take action to reduce or remove risk even if it has been identified. The person might not consent to action being taken and there might not be a legal basis to override this.



UNDERSTANDING DEMAND & RAISING AWARENESS - NORTHUMBRIA POLICE

Mental Health Demand

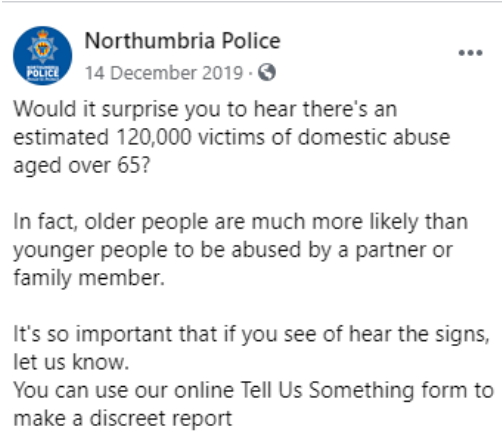
Northumbria Police took part in the 24 hour national mental health demand snapshot on 12th November 2019. This 24 hour data capture showed that Northumbria Police dealt with 1105 incidents in the 24 hour period, with 77 being assessed as a Mental Health Related Incident. This was 7% of our overall policing incident demand.

In addition Northumbria Police dealt with 33 Missing Person reports of which 10 had a mental health flag. There were also 68 arrests that day of which 40 had a mental health flag. It can be seen from these figures that Mental Health is a cross-cutting issue across all areas of policing.

Mental health issues create complex demand across a range of partner services with a wide variety of causative factors requiring a multi-agency partnership response.

Raising awareness of vulnerable adults

In December 2019 a successful media campaign was launched by Northumbria Police with the objective of education in relation to elder abuse. The campaign reached **136,000** people on social media channels alone. This campaign was supported by face to face inputs by our Community Engagement Teams. Feedback indicated that the campaign was positively received.



CASE STUDY- MISSING ADULT

Sam was a frequent missing person with a history of family and relationship problems, substance misuse issues and a diagnosed learning disability. Sam had not been engaging with support services. Sam was assessed as being at risk of exploitation and had several risk factors.

Sam was the subject of several adult concern notifications from the Police. This enabled assessment of her case at multi-agency safeguarding meetings and led to a multi-agency response involving: Adult Social Care; Children's Social Care; Northumbria Police Missing from Home Coordinator; the Sexual Exploitation Hub; Mental Health services; Drug and Alcohol Services; Your Homes Newcastle Multiple Exclusion Team; Probation; Department for Work and Pensions; and Sexual Health Services

This resulted in a safeguarding adults plan being put in place to help Sam who is now in residential care with therapeutic services in place. Sam has also had cognitive assessments undertaken and there is a better understanding of her mental capacity.

Police trigger plans are in place to support Sam should she be reported missing in future and support is in place for her ongoing management and welfare.

Trigger plans assist the Police (and other agencies) to respond quickly when someone goes missing. They are usually made when someone is a known risk of going missing.

In 2019-20, the NSAB has been involved in a number of pieces of work involving missing adults.

Herbert Protocol

The NSAB supported the Police-led launch of the Herbert Protocol. The protocol encourages carers to record useful information which could be used in the event of a vulnerable person going missing.

The Herbert Protocol form includes all vital details, such as medication required, mobile numbers, places previously located, a photograph etc.

In the event of a person going missing, the form can be easily handed to the police to reduce the time taken in gathering this information and ultimately reduce the amount of time a vulnerable person is missing.

All Party Parliamentary Group Inquiry into Runaway and Missing Children and Adults

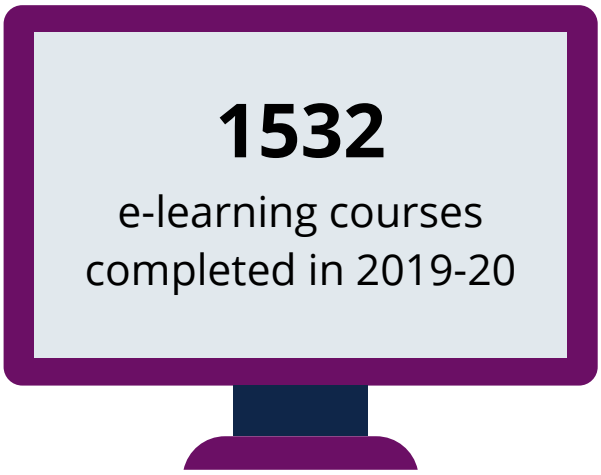
The NSAB's Improving Practice Committee considered the findings from the above inquiry. One of the key recommendations was around better multi-agency working in response to a missing adult.

Regional Missing Adults Protocol

The NSAB is working alongside other Safeguarding Adults Boards in the region to produce a clear protocol on how missing adults should be responded to. Adults go missing for many reasons and a safeguarding response is not always appropriate. Newcastle have shared experiences and learning from the Joint Serious Case Review into sexual exploitation.

LEARNING AND DEVELOPMENT COMMITTEE

2899 people participated in multi-agency safeguarding adults training in 2019-20



The most popular e-learning course was the basic awareness course, with 773 completions.

The biggest user group of the multi-agency training programme in 2019-20 was the voluntary and community sector - 747 individuals.

Achievements 2019-2020

The committee has focussed on several key areas. The first of these has been to ensure that all training supports the Making Safeguarding Personal Agenda, whereby the views and wishes of those in need protection from abuse are given priority.

Alongside this several events have been undertaken with community groups and in public locations to help raise community awareness of adult abuse and neglect and how to respond to it by raising an alert.

It is of the highest importance that the multi-agency safeguarding adults training is contemporary and up to date. As such we have been monitoring the situation about the impending changes to the Deprivation of Liberty Safeguards and the training needed for the new Liberty Protection Safeguards that will replace them.

A further task the committee have is to ensure the multi agency training plan corresponds with advice given to agencies about training. This year we have therefore scrutinised the Royal College of Nursing's Intercollegiate Document - Adult Safeguarding: Roles and Competencies for Health Care Staff. Our role has been to ensure the advice in this guidance is integrated into our multi-agency training programme so that staff do not become confused about what level of training they need to undertake.

The Committee also had the opportunity to explore local and national Safeguarding Adults Reviews (SARs). Members were tasked with completing a self-assessment to understand if employees had access to training in relation to autism. The results were fed into NSAB and SAR Committee.

LEARNING AND DEVELOPMENT COMMITTEE (CONT)

Looking ahead to 2020-21

In the immediate future our attention will focus on restarting the multi-agency training programme by being innovative, developing and adapting our training by using online technology i.e. webinars, virtual groups, e-learning, and workbooks, with a view to face to face sessions recommencing in line with public health guidance.

The Committee will need to continue its role in updating training, monitoring uptake of training across the programme and supporting agencies to ensure any other safeguarding training they provide meets the Minimum Standards & Capability Framework.

Areas of development in the training programme, will this year include an additional focus on the Mental Capacity Act with reference to the York Judgement and changes to the Deprivation of Liberty Safeguards. We will also be exploring the training implications of factors which increase vulnerability such as substance misuse; social isolation, loneliness, unstable accommodation and homelessness and how they may increase a person's risk of being abused.

There will be a task and finish group established to ensure there is development of training around criminal exploitation and serious violence. T

The NSAB Learning & Development Committee will continue to work in conjunction with the Newcastle Safeguarding Children Partnership''s Learning & Improvement Group to identify areas of joint training and working together.

As one annual cycle of planning and delivery of training concludes, and another commences the opportunity is provided to reflect upon developments throughout the year.

New policy initiatives, organisational developments such as the evolving role of the Multi Agency Safeguarding Hub and concerns that have arisen following both national and local case reviews, have been reflected in safeguarding adults training.

Unfortunately, multi-agency training has a high level of face to face training and once the COVID–19 pandemic emerged and the country went into lock down in mid-March, many of the courses on the multi-agency training programme were suspended. However, this has given the Learning and Development Committee the opportunity to look at new and innovative ways of delivering training in the medium term. This will enhance our Training Programme for 2020/2021 as the committee continues to coordinate an extensive range of training at different levels to meet the needs of agencies and staff who undertake a wide spectrum of roles and responsibilities.

IMPROVING PRACTICE COMMITTEE

Much has been achieved this year due to the dedication and commitment of the committee and their willingness to try out new ideas. One such highlight was the best practice 'café' style event held in December. This brought together people from different sectors and organisations across the city, to learn about the wide range of services and support available, all of which contribute to safeguarding vulnerable adults.

New members bring diversity and renewed enthusiasm to our work. This year we have welcomed two new members from the Independent Sector.

At the beginning of the year we set up a task and finish group with representatives from across the health and social care sector, to develop Falls Guidance – when is a slip, trip or a fall a safeguarding adults issue? This was identified as a gap in Newcastle and an area where staff would value additional guidance. The group felt that a visual prompt would be most helpful for front-line practitioners and so an interactive flowchart was developed which sits alongside the guidance published in November 2019.

The Committee discusses a wide-range of issues and hears about services which keep people safe in different ways. With the aim of sharing this with a wider audience, we planned and held a practitioner event in December 2019 at the city library. We approached a number of people and organisations who had been guests at our meetings and asked them to talk about their service or best practice in a "café" style event.

Over 50 participants attended, circulating around different tables to learn about topics including hoarding, sexual violence against older people, making safeguarding personal, social prescribing, Search Newcastle and Friends Action North East.

A number of committee members are part of a subgroup that audits safeguarding referrals related to different themes. The important work of this audit group is both responsive to concerns and questions raised by the Improving Practice Committee, and also identifies recommendations for wider safeguarding practice improvement.

During 2019-20 audits have focused on cases where adults have gone missing, those involving a medication error / incident and cases where the alleged perpetrator of the abuse was a service user. Findings have led to changes in guidance and processes. In order to ensure that recommendations are acted upon, a log comprising recommendations from all previous audits is now kept and will be reviewed regularly by the committee.

IMPROVING PRACTICE COMMITTEE (CONT)

The importance of getting messages out to the public about safeguarding adults is vital in keeping people in Newcastle safe. A day of action at the Grainger Market in June 2019, linked to Newcastle being a Dementia Friendly City saw 100s of leaflets handed out and the launch of the Herbert Protocol by Northumbria Police.

The Herbert Protocol is a tool designed to help reduce risks for people with dementia who may go missing. The protocol can be used by professionals or family members to record key information that would assist in finding the person, should they go missing. The Herbert Protocol forms part of wider work around adults who go missing.

Towards the end of 2019/20 the importance of getting messages out to the public become particularly apparent as we entered lockdown due to Covid-19 and needed to communicate key messages to the wider population about what to look out for and how to report abuse and neglect of adults. The use of technology has played an important part in this and will continue to do so going forward.

Looking ahead to 2020-21

Making Safeguarding Personal will remain a priority for the Committee. We will focus on two important elements: increasing the proportion of enquiries where a person is asked their desired outcomes and increasing representation for those people who would have a substantial difficulty in participating in the safeguarding adults process.

We will continue to focus on implementing new policy and legislation, focussing on what this will mean for front-line practitioners. In 2020-21 we anticipate doing work around the Mental Capacity Act and the Liberty Protection Safeguards and new national guidance on homelessness and adult safeguarding.

Practitioners have identified a need to explore financial abuse further. In particular, the role of the Office of the Public Guardian in safeguarding adults enquiries. The Committee will decide if any tools or resources are needed to support practitioners in responding to financial abuse.

We will build on the success of the best practice event held in December 2019. We hope to run a similar event this year, adhering to the necessary restrictions related to Covid-19, by holding it virtually/remotely.

What difference has the work of the Improving Practice Committee made to adults with care and support needs at risk of abuse and neglect?

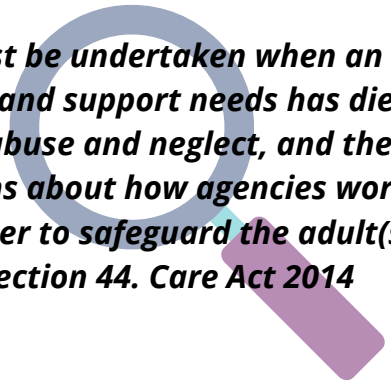
- Public and practitioner awareness increased, especially of the wide range of services and support that is available in Newcastle to keep people safe.
- Ensuring safeguarding adults procedures are used appropriately, for example when a vulnerable person has a fall
- Reducing risks around adults who go missing.

SAFEGUARDING ADULTS REVIEW COMMITTEE

The Safeguarding Adults Review (SAR) Committee received two referrals in 2019-20 for consideration for a SAR. In both cases, the Committee felt that the criteria for a SAR had not been met. One case related to a delay in medication getting to a resident in a care home, the other related to a drug-related death.

Even when the criteria for a SAR is not met, the Committee still want to make sure that any learning is identified and shared. This might involve asking individual agencies to undertake reviews, referring into other review processes (such as the drug-related death review process) or tasking another sub-committee of the NSAB with action in relation to a case.

In November 2019, the NSAB formally signed off the Joint Serious Case Review action plan. It was agreed that all actions had been completed as far as could be, and to the extent that was in the control of the NSAB or partner agencies. The NSAB plan to continue receive updates on the multi-agency review of the Sexual Exploitation Hubs and also to lobby national government about guidance around the sexual exploitation of adults. The NSAB will also ensure that developments around criminal exploitation in Newcastle will build on the learning from the Joint Serious Case Review, in particular that adults can be victims.



SARs must be undertaken when an adult with care and support needs has died as a result of abuse and neglect, and there are concerns about how agencies worked together to safeguard the adult(s). Section 44. Care Act 2014

The Committee have continued to oversee an action plan in relation to findings from an Appreciative Inquiry. This has included assessing the availability of autism training for staff from across all agencies. All NSAB agencies confirmed that training was available to their staff or that training would be available in the near future. The Appreciative Inquiry looked at a case of a person who had been diagnosed with an Autism Spectrum Disorder but practitioners involved felt they had a limited understanding of autism, the impact of living with autism and how best to engage with people who have autism. A number of actions within the SAR Committee's action plan have been included in the draft Criminal Exploitation and Serious Violence Strategy to ensure that learning informs local practice and policy developments.

LEARNING FROM REVIEWS IN OTHER AREAS

In January 2020, the SAR Committee arranged a multi-agency Learning Event to consider a SAR undertaken by Portsmouth Safeguarding Adults Board. The Learning Event considered the case details and recommendations and asked participants to consider what might have happened if the individual lived in Newcastle and the same circumstances were happening.

This resulted in healthy, reflective discussion about what might have been done differently here and equally what might have been done in the same way.

One of the issues that arose from participants was an ongoing confusion around the use of learning difficulty and learning disability. A recent report by Newcastle Gateshead CCG, produced following the Joint Serious Case Review, had addressed this.

MISSING, SEXUALLY EXPLOITED TRAFFICKED (MSET) SUB COMMITTEE

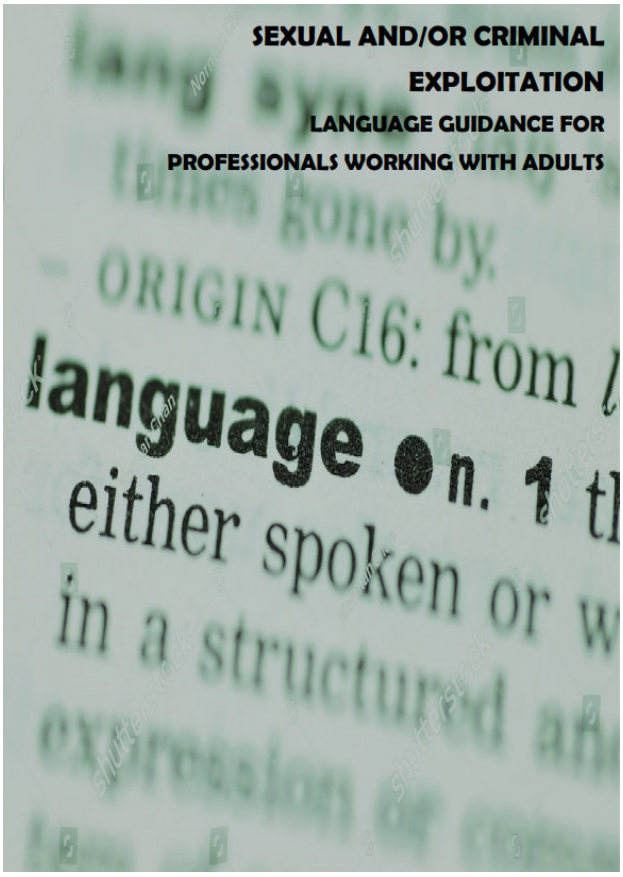
Achievements

- The joint MSET strategy was reviewed to strengthen work around criminal exploitation, children and adults missing from home or care and practitioners' understanding of current emerging themes and risk. This forms the basis of what we do to continuously improve.
- Children's return home interviews and partner data and intelligence is regularly used to strengthen disruption activity, inform partners of local 'hotspot' areas where young people are most at risk of exploitation and to inform licensing activity for certain premises e.g. review of licenses where there are concerns or visiting premises to provide advice, support and training opportunities.
- Implemented an MSET Operational Group to consider those young people assessed as being at medium to high risk of exploitation and to ensure robust multi-agency safety plans are in place to help to minimise the risks.
- Supported the implementation of national toolkits on intelligence gathering and the appropriate use of language when working with young people and adults.

Looking ahead to 2020-21

Plans for 2020/2021 will include:

- Continuing to support multi-agency, cross partnership working to safeguard children and adults from exploitation
- An evaluation of the effectiveness of the MSET Operational Group
- Work with partners across the region to develop a regional missing protocol for adults.
- Bench mark our current position and effectiveness on providing support and scrutiny to missing young people
- Contribute to the development and implementation of local webinars on issues relating to criminal exploitation to continuously improve practitioners' understanding of emerging themes and issues



"It is imperative that appropriate terminology is used when discussing adults who have been exploited, or are at risk of exploitation. Language implying that the adult is complicit or responsible for the abuse or exploitation that has happened or may happen to them, must be avoided."

Extract from the Sexual and/or Criminal Exploitation Language Guidance for Professionals Working with Adults

CRIMINAL EXPLOITATION CONFERENCE, SEP 2019

Nationally there has been an increased focus on violent crime, including serious and organised crime, knife crime (or weapon carriage) and criminal exploitation. In February 2019, the NSAB joined the Newcastle Safeguarding Children Partnership (NSCP), Safe Newcastle and the Youth Justice Partnership to collectively assess levels of criminal exploitation in Newcastle.

The partnership coordinators and strategic leads (of the partnerships above) organised an event at the Discovery Museum on 26 September 2019 to assist in developing a public health approach to tackle the issue, including learning from other areas, to support the development of a local criminal exploitation and serious violence (CESV) strategy and delivery plan.

Over 140 practitioners, specialists and strategic leads attended this event. The Police and Crime Commissioner, Safe Newcastle Chair, Director of Public Health, Chair of NSAB Safeguarding Adults Review Committee and Police Superintendent were joined by key national speakers from Glasgow Violence Reduction Unit and the Home Office Violence and Vulnerability Unit.

At the event, participants were asked to contribute ideas to a city-wide strategy to address criminal exploitation. Attendees were asked to identify actions themed around:

- Understanding the problem;
- Prevention, engagement and diversion;
- Education and awareness;
- Safeguarding vulnerable people;
- Disruption of criminal activity.

Some of the key points raised by participants were:

- A desire for safe and open channels of communication between professionals and with the public and people at risk to enhance understanding of the problem of CESV.
- A common language and understanding of risks factors and norms in CESV.
- Person-centred and trauma-informed engagement and intervention.
- Appreciation of the value of lived experience of victims, perpetrators and frontline staff in informing effective action.
- Enhanced awareness of the nature of the problem of CESV across the city.
- An understanding of accountability and responsibility across agencies and communities.
- Enhanced support for those affected by CESV including frontline staff.
- Collaborative working across agencies, particularly with schools.
- Use of existing powers to disrupt the criminal ecosystem.

Delivering on the Criminal Exploitation Strategy will be a key priority for the NSAB in 2020-21.

CASE STUDY: CRIMINAL EXPLOITATION & SERIOUS VIOLENCE

Northumbria Community Rehabiliation Company (CRC) service user "Lillie" was sentenced to probation supervision for possession of a weapon.

As a teenager Lillie disclosed that she was raped by an older person when she attended a party at his house. At the age of 16 she began a relationship with her current partner, who is significantly older than her. Her partner's mother financially, verbally and physically abused her. This led to the couple becoming street homeless. Lillie began to use drugs heavily at this time and described the time as being very frightening.

Lillie has disclosed that she was coerced into offending by her partner. The CRC responsible officer (RO) has worked closely with Adult Social Care and Lillie's housing provider around the safeguarding adults enquiry.

Work has been done with Lillie on developing safety plans, where and who to go to for help. Lillie has shown more confidence in speaking out about her partner. Healthy relationships, exploitation, and grooming, have been discussed with Lillie to allow her to understand and process the abuse she has faced. Lillie has also engaged well with support networks and stopped using drugs and alcohol.

Lillie remains in a relationship with her partner and all professionals are conscious of the changing risk dynamics. Lillie is considered still to be within a coercive controlling relationship. Concerns are still active for possible domestic violence and exploitation (financially and sexually). Whilst Lillie's supervision by the CRC will end later this year, her supervising officer has ensured that all other agencies and support networks are in place so Lillie still receives continued support.

This case highlights a trauma-informed approach to adult safeguarding. Professionals involved are aware of Lillie's background and the impact that has on her as she moves into adulthood.

The case also demonstrates the complexity of criminal exploitation and serious violence. Victims of criminal exploitation and serious violence might be offenders. It might be easy to miss vulnerabilities or not recognise them as victims of abuse or neglect. Professional curiosity in this case highlighted that Lillie was likely to have been coerced into offending.

"Brave" graffiti art by victims and survivors of sexual exploitation in Newcastle

PARTNER AGENCY PERSPECTIVES

Northumbria Community Rehabiliation Company (CRC)

Northumbria CRC's clear vision and priorities for safeguarding adults are outlined in our recently reviewed and updated Safeguarding Adults Policy Statement and Safeguarding Adults Staff guidance.

A series of '7 Minute Briefings' have been made available to all CRC practitioners. Teams are encouraged to view these together to allow the opportunity for reflection and practice discussion. A wide range of topics relevant to adult safeguarding have been made available to date, including Self Neglect, Online Radicalisation, County Lines and Professional Curiosity. The briefing on Risk Review and Evaluation, for example, focuses on the following key messages:

- reviewing risk should acknowledge what has been achieved and what needs to be reconsidered and delivered
- review and evaluations must incorporate evidence from other organisations e.g. police, safeguarding, mental health agencies
- the views of the service user must be considered
- focus on strengths, not just risks
- information sharing is critical; don't assume other agencies know about changing circumstances

A new 'Stalking and Harassment' Rehabilitation Activity Requirement (RAR) was designed and introduced across the CRC in September 2019. The RAR was developed in line with research and information on behaviours associated with stalking and harassment; namely, unwanted and repeated contact or other communication, which causes others to experience fear or concern.

The RAR is suitable for those who have offending related history or evidence of activity linked to unwanted and repeated stalking or harassment type behaviours. This can be towards an ex-partner, parent or other family member, or a stranger.

Staff awareness around Hate crime, Mate crime, the Prevent Duty, FGM, and Modern Slavery has increased over the last 12 months and is ongoing. The CRC has a hate crime SPOC in each local area team and a manager whose role it is to promote understanding, awareness and the delivery of targeted interventions to address the issues evident in this type of offending. We have also established Prevent Duty SPOCs in each CRC team and we liaise with counterparts in police and probation counter-terrorism to monitor and address emerging themes.

Our strategic priorities include "enabling service users to live better lives" and "promoting positive client relationships." Assessment of each service user takes place early on in the sentence. Consideration is given to individual need, and referral or signposting to relevant support services throughout the sentence.

Northumbria CRC is subject to a high level of external scrutiny by the Ministry of Justice, HMPPS and internal Contract Management functions. The work of our practitioners is under regular scrutiny via monthly case audits which quality assure risk assessment, risk management and case management.

PARTNER AGENCY PERSPECTIVES

Northumbria Police

Our partnership work with CNTW in support of people with mental health issues has been celebrated as best practice by the National Police Chiefs Council National Lead, having a strong focus on lessons learnt and continuous improvement in all areas of mental health. Our capability has been improved with the recruitment of a Mental Health Sergeant into a newly developed post and she will assist in driving forward our response to mental health with a focus on training and partnership working.

We have taken part in national discussions around missing adults and are working with partners to develop a joint protocol in respect of vulnerable missing adults.

We have recruited a further four missing from home coordinators in 2020, three of which will be working in Newcastle – which is great news for police and partners as it means we can concentrate on multi agency problem solving for repeat missing persons, including vulnerable adults, with a focus on prevention and safeguarding.

We are a key partner to the multi-agency Northumbria Violence Reduction Unit, with a Police Chief Inspector embedded within the project as project manager and the chair of the multi-agency Northumbria Serious Violence Reduction Board being the Police and Crime Commissioner. Established in 2019, this is a public health approach to tackling serious violence and identifying key drivers which cause people to become victims or perpetrators of serious violence. We hope this will have a positive effect on tackling knife crime and domestic homicides.

We ensure victim focused investigations are delivered and take the views of victims to the heart of our decision making. Our policy and procedures incorporate Making Safeguarding Personal and we adhere to the Victims Code of Practice to ensure that the views of victims are taken in to account when decisions are made regarding safeguarding and investigation. Victim personal impact statements presented at Court ensures victims' views are known to Courts prior to any offender being sentenced.

We support the National Vulnerability Action Plan and we are reviewing how the plan may be implemented to develop coordinated, effective and evidence-based responses to protect vulnerable people. Representatives from Northumbria Police and the Crown Prosecution Service attended the inaugural regional learning event hosted by the Vulnerability Knowledge and Practice Programme in March 2020 in Newcastle.

In 2019 Northumbria Police formed Harm Reduction units led by a Chief Inspector, enabling a problem solving approach to supporting victims including vulnerable adults, working closely with adult safeguarding and mental health services.

22% INCREASE IN ADULT CONCERN NOTIFICATIONS

This increase is attributed to the internal training delivered by Northumbria Police which has raised awareness and understanding of vulnerable adults and also mental health issues. Officers are now more likely to recognise signs of vulnerability and risk of abuse.

PARTNER AGENCY PERSPECTIVES

Northumbria Police (cont)

Our continued support to resource and work within Multi Agency Safeguarding Hubs (MASH) ensures that problems are identified at an early stage following submission of an adult concern notice. An additional six staff have been recruited in to the MASH. Referrals are subject to multi-agency triage within the MASH arrangements for adults which enables partners to come together and work collaboratively to safeguard adults experiencing abuse or neglect as well as adopt a wider early help and information sharing approach to prevention.

Multi-agency discussion during triage in the MASH ensures a coordinated, proportionate and least intrusive approach to adult safeguarding concerns is taken.

We actively engage with the NSAB to ensure our policies and service delivery are open to scrutiny and that we uphold our statutory responsibility with representation on the Board to hold all agencies involved in safeguarding adults to account.

Our engagement in Safeguarding Adults Review meetings ensures any issues around standards of service are fully addressed and learning is taken from cases.

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW)

The Patient Safety trust Clinical Police Liaison Lead nurse is now embedded as part of the Safeguarding and Public Protection (SAPP) team, which further enhancing multi-agency working with police colleagues/partners.

Northumbria Police Harm Reduction team is working closely with our community services regarding those individuals who have complex risk issues who do not meet the threshold of statutory processes. These individuals may be adults at risk of harm or pose a risk of harm. The Clinical Police Liaison Lead is supporting this work.

The SAPP team now has a dedicated Case Review Officer to support the Trust in it's commitment attendance at statutory meetings as panel members and write Individual Management Reviews in respect of:

- Safeguarding Adult Reviews – Adults
- Domestic Homicide Reviews (adults)
- Appreciative Inquiries / local Learning events

There is a dedicated SAPP Practitioner for PREVENT related concerns. The SAPP Lead provides an additional level of safeguarding and mental health input to those individuals who have been referred due to concerns and may have mental health problems and/or learning difficulties and who are at risk of radicalisation. The role also incorporates and promotes best practice from other CNTW established mental health services.

PARTNER AGENCY PERSPECTIVES

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (cont)

The appointment of a Case Review Officer has provided a dedicated role to participate in the Safeguarding Adults Case Review Group and provide consistency of attendance to the group.

The SAPP team PREVENT lead is a member of the Newcastle Prevent Delivery Group and was involved in of Lord Carlisle's Home Office Prevent Peer Review of Newcastle (December 2019). The Lead also presented an overview of the role to the North East Contest board which Newcastle are partners. The lead also attend Channel Panel meetings.

The Role of the Clinical Police Liaison Lead along with working with the Harm reduction Team is integral to the prevention of escalation of risk and multi-agency accountability.

Newcastle City Council

Our medium-term plan for 2019-2020 through to 2020-2021 entitled "Shaping Our Future Together" outlines our intention for Newcastle to be a healthy and caring city and our commitment to supporting and protecting vulnerable adults. A key principle of this work is how we identify opportunities for early intervention, reduce and where possible prevent the risk of abuse or neglect from escalating. An important element of this work is our Information Now service which is a web-based resource which connects people to local services and provides advice on a variety of topics including areas such loneliness and social isolation.

IN 2019-2020 THE INFORMATION NOW WEBSITE WAS VISITED IN EXCESS OF 438,000 TIMES.

As the lead agency for co-ordinating safeguarding enquiries we take pride in the way we respond to concerns of abuse and neglect but we are also ambitious when identifying how our safeguarding service can develop and enhance the way in which we support people at risk. Newcastle City Council provide the largest proportion of staff for the Multi-Agency Safeguarding Hub (MASH) and take a lead role in it's development.

The Safeguarding Adults Unit support staff from across all sectors in responding to abuse and neglect in Newcastle. In particular, supporting responses to complex safeguarding adults cases. The Advice Line received 2,874 contacts last year.

In 2020-2021 we will move to a new recording system for safeguarding adults. This will provide an opportunity for us to build upon the ways in which we ensure that the voice of the person at risk is at the centre of a safeguarding adults enquiry. By adding extra checks and balances into our recording pathways we aim to enhance our approach to embedding the best practice principle of making safeguarding personal.

Our Corporate Safeguarding Training Group have continued to meet to ensure that our workforce across the Council are confident in their role in protecting adults at risk of abuse and neglect and have the skills and knowledge to raise any concerns. The work of the Corporate Safeguarding Group builds upon the principle that safeguarding is a core element of all job roles and recognises the valuable role that staff from across our directorates can play in identifying and responding to safeguarding concerns. In 2020-2021 the Corporate Safeguarding Group will launch a new "Keeping Everyone Safe" programme for all Newcastle City Council staff.

PARTNER AGENCY PERSPECTIVES

Newcastle City Council (cont)

The Council continues to contribute staffing and resource to the Sexual Exploitation Hub and are active participants in the multi-agency review of the Hub, led by Northumbria Police.

In providing both the operational lead for safeguarding adult enquiries and the staffing resource for co-ordinating strategic multi-agency service improvements for safeguarding adults, Newcastle City Council play a pivotal role in progressing the NSAB priorities.

In 2019-2020 this included:

- Developing a targeted safeguarding adults awareness training course for family members, friends and carers.
- Continued expansion of the MASH.
- Development of the Making Safeguarding Personal Performance Scorecard.

Newcastle upon Tyne Hospitals NHS Foundation Trust (NuTH)

The Safeguarding Adult team has continued to experience complex and challenging work, with multi-agency partnership working a critical element in ensuring safety of individuals and families.

Overall, there has been an incremental increase in referrals compared to 2018-2019 with the nurse specialist contributing to 2630 cases. The key area of concern remains self-neglect, which can often include young individuals who may be street homeless or living in temporary accommodation, who use substances and as a consequence are vulnerable to exploitation from others.

A number of cases continue to require legal input, particularly where there are levels of exploitation and abuse that can be significant. With recent initiatives to explore criminal exploitation and violence reduction, safeguarding is also increasingly playing a role in issues of public health and for the prevention of harm, abuse or self-neglect.

Key Achievements 2019 - 2020

- Continuing to improving recognition of when a Deprivation of Liberty Safeguards (DoLS) needs to be applied.
- The establishment of Level 3 Adult Safeguarding, which commenced for identified staff in July 2019 in line with Intercollegiate Guidance for Safeguarding Adults that defines the skills and competencies for health care staff.
- Continuing to respond to high risk domestic abuse through referrals and contribution at MARAC meetings within Newcastle. The team have also increased staff awareness of domestic abuse through internal learning opportunities including 'Schwarz Rounds'.
- Evidence that self-neglect is a high level concern within adult safeguarding as defined by the Care Act (2014) regardless of age or disability and working with legal and multi-agency partners to reduce risk.

...the proportion of NuTH staff completing Prevent training

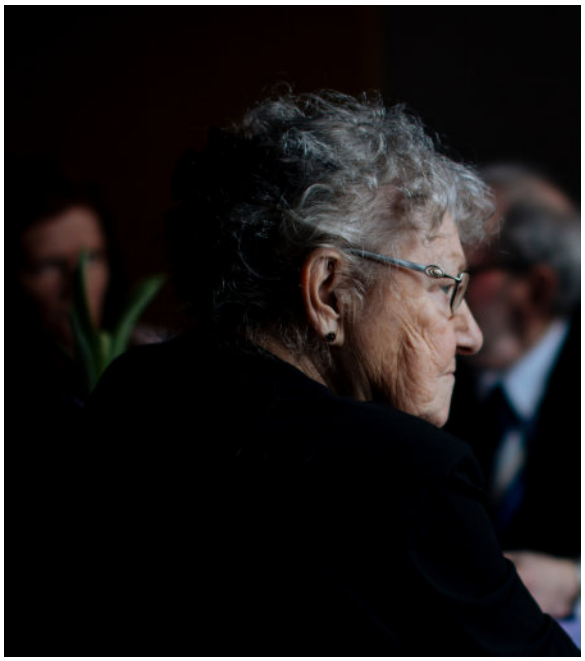
PARTNER AGENCY PERSPECTIVES

Newcastle upon Tyne Hospitals NHS Foundation Trust (cont)

The Trust continues to contribute to NSAB priorities both at Board and sub-committee level, through multi-agency work and also through contributing to multi-agency training. Training included a workshop that shared learning from a Portsmouth Safeguarding Adults Review (Adult D) that explored areas such as Mental Capacity and the Making Safeguarding Personal agenda.

Work has also commenced to interface the Making Safeguarding Personal Agenda, a key NSAB priority, with the Trust's Equality and Diversity group, with one aim to ensure greater visibility for patients, families and visitors of safeguarding.

The introduction of electronic records within the acute hospital has provided further opportunities to integrate and raise the visibility of safeguarding practice. This work has supported mechanisms to develop where possible a standardised framework to shape practice.



CASE STUDY - MENTAL CAPACITY

Mrs R has significant health and treatment needs, with support from district nurses for diabetes and frequent attendances at the Trust for dialysis. Mrs R has difficulty reading and writing, she lives at home with her partner and there are concerns about self neglect. Mrs R's home is described as cluttered where there is a risk of falls, the visiting teams suspected there may be domestic abuse, exacerbated by carer stress. Mrs R does not always attend dialysis, which can then result in hospital admission.

Mrs R's risk are several including risk of significant harm if her health deteriorates and increased complications and morbidity should her diabetes worsen.

Staff have worked flexibly to offer appointments for treatment, consider reasonable adjustments and continued visits from District Nursing team. There has been safeguarding meetings and most importantly mental capacity assessments. Teams have all worked to understand and hear Mrs R's voice and opinion. Although safeguarding procedures closed with a risk management plan in place, the need to reconvene multi-agency discussions has been essential. When risks have increased, as Mrs R condition changes and potentially deteriorates, it has proved vital to further consider support, and to consider if best interest decisions may be needed, without losing sight of Mrs R's wishes. Legal services from both health and social care have had involvement as teams have navigated through a complicated picture for Mrs R and her husband.

PARTNER AGENCY PERSPECTIVES

Your Homes Newcastle (YHN)

During 2019 /20 YHN has recruited three dedicated Safeguarding Partners to enable us to effectively contribute and enhance our approach to tackling safeguarding and domestic abuse.

Safeguarding Partners provide a specialist service to colleagues throughout the organisation. Where possible, Safeguarding Partners have been co-located into safeguarding hubs to help carryout research, develop links and promote the role social housing can play in supporting victims.

We have re-launched our employee safeguarding forum which includes all our safeguarding trainers in order to:

- Raise the profile of child and adult safeguarding across YHN.
- Monitor and analyse safeguarding performance and make recommendations based on the findings.
- Monitor and evaluate training needs to help ensure training content and materials are 'fit for purpose'.
- Provide peer support.
- Consider feedback and learning from Safeguarding Hubs.

We have developed a range of performance indicators which are reported on within our governance structures.

We recognise that reporting abuse and ultimately sustaining a tenancy can be challenging for some victims. As a result, we have introduced a procedure to ensure that all applicants who declare domestic abuse, harassment or safeguarding on their housing application to YHN will be immediately referred by the Housing Solutions team so their application can be processed swiftly. These applicants are now checked daily and where statutory safeguarding criteria is met concerns are raised.

Within our dedicated Support & Progression Service we have trained specific support workers to offer support to all new customers who have experienced domestic abuse. We recognise that issues can still continue after a person has moved into their new home and that some people may need ongoing support to help them sustain their tenancy.

We have trained our repairs operatives to identify and report domestic abuse and safeguarding concerns they see within tenant's homes and whilst based on estates. To support this training all operatives are issued with air fresheners for their works vehicles. The air fresheners carry the message **'think if I'm right, not if I'm wrong"** and have contact details on how to report safeguarding concerns. This acts as a constant visual reminder to encourage reporting without delay.

PARTNER AGENCY PERSPECTIVES

North of Tyne National Probation Service (NPS)

In North of Tyne NPS Cluster, we have a keen interest in working with perpetrators and victims of domestic abuse and the associated harm caused by domestic abuse.

We participate in a number of local forums – MARAC, MATAC etc – and through MAPPA we ensure that the most complex and risky offenders are successfully managed via a well-established multi agency approach for the benefit of victims and their families.
We have also this year successfully piloted a toolkit for Offender Managers – the Skills for Relationships Toolkit (SRT) – working with perpetrators not suitable for groupwork interventions and following a successful evaluation the Toolkit will be rolled out nationally.

We are also leading a national pilot of polygraph for high risk domestic abuse perpetrators that will commence as soon as the Domestic Abuse Bill has passed through Parliament. This is an innovative piece of work that will represent a significant addition to our ability to successfully manage perpetrators.

We were also particularly proud of a multi-agency domestic abuse learning event that took place at our Newcastle office bringing together practitioners, academics and survivors in an attempt to better increase our understanding of the issues and controversies surrounding the assessment and treatment of perpetrators as well as the perspectives and experiences of survivors.

The NPS North of Tyne LDU Cluster has a long-standing commitment to working with its service users to empower them to manage their own risk by providing practical help and support within the statutory frameworks within which we work. Safeguarding is at the heart of what we do and our policies and procedures as well as the training and support that we provide for staff working in our organisation are evidence of that commitment.

As an organisation we recognise that we cannot achieve what we want to achieve by working in isolation and our commitment to working in partnership – either on a day to day basis in case management or in more specialist functions such as MAPPA – is well established and evidenced throughout all of the work that we do to help reduce re-offending and protect the public.

NSAB Members at the Self-Assessment Session in December 2019. Agencies presented their areas of good practice and areas for improvement

PARTNER AGENCY PERSPECTIVES

Tyne and Wear Fire and Rescue Service (TWFRS)

As a service we are very pleased to have rolled out further safeguarding awareness training for operational firefighters in 2019. This focused on the types and signs of abuse they may encounter, as well as our internal processes for notifying local authorities. This is now an essential part of our internal training programme for current operational firefighters, with refreshers every two years.

Trainee firefighters have this input as part of their initial 14 week training course too.
Also in 2019, safeguarding awareness has been included into the induction process for new corporate staff, who may not be frontline, but are trusted people within the community in their role as TWFRS staff.

Self-Neglect and hoarding will be our priorities in 2019-20. This type of vulnerability was an issue in all safeguarding adults referrals made in Newcastle this year.

TWFRS will continue with our Covid-19 response work in the community, and engage with the vulnerable members of Tyne and Wear, where other services might have to withdraw.

We will develop a structured feedback procedure with Newcastle and other local authority partners to ensure we can better understand the impact of our safeguarding actions in the community and improve our response.

Voluntary and Community Sector

The voluntary and community sector (VCS) is broad and diverse in Newcastle. The sector is represented on the NSAB by Search Newcastle, Changing Lives and Connected Voice Advocacy. Some examples of the work done around safeguarding adults in 2019-20 includes:

- Increasing promotion of criteria and eligibility of Care Act Advocacy in Safeguarding.
- More advocates qualified in Care Act Advocacy to meet needs of increase in demand in referrals
- Supporting individuals and organisations through the Whorlton Hall scandal
- Increased training for the VCS around safeguarding awareness with Connected Voice training programme
- Auditing protected characteristic (Equality Act) safeguarding activity and subsequent targeted response (via training and service delivery) to address cultural issues.

The training provided by Connected Voice has been part of a national package of resources and support to the VCS around safeguarding. 2019 saw the launch of a government portal on safeguarding and updated resources on the National Council of Voluntary Organisation's Knowledge Bank around safeguarding.

As the Covid-19 pandemic hit, the community and voluntary sector came into their own in Newcastle. They provided a key support to many vulnerable residents, particularly in the first few weeks of lockdown, both preventing the escalation of risk and identifying and reporting abuse and neglect.

PARTNER AGENCY PERSPECTIVES

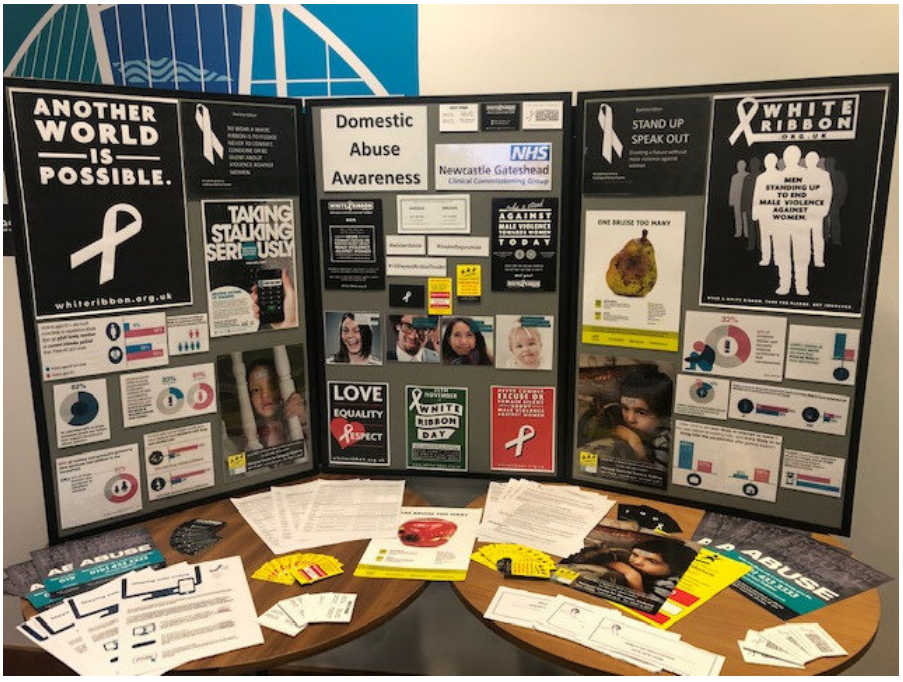
NHS Newcastle Gateshead Clinical Commissioning Group (CCG)

During 2019-20 Newcastle Gateshead CCG has continued to lead a number of key developments these have included:

- Supporting Multi-Agency Task and Co-ordination process (MATAC) meetings aimed at tackling serial perpetrators of domestic abuse through a multi-agency approach. The CCG has ensured that General Practice is effectively linked into the process to highlight any aspects of the patients health and treatment that may increase or decrease risk in relation to their alleged offending behaviour.
- The CCG has effectively supported the delivery of a Domestic Abuse Advocate in Primary Care pilot which was co funded between the CCG and Police and Crime Commissioner.
- Publication in June 2019 of a toolkit to support general practice staff in relation to safeguarding adults and public protection. The toolkit supports consistent and effective safeguarding practice.
- Implementation of an extended CCG Safeguarding Supervision Policy and delivery of safeguarding supervision to CCG staff working in Continuing Healthcare, Section 117 and Transforming Care.
- The CCG has delivered a range of training to primary care staff including safeguarding adults, Prevent, MCA/DoLS and domestic abuse which ensured that staff maintained their core safeguarding competencies and continued to practice safely.

In response to the Covid -19 pandemic the CCG quickly established home working and remote access for staff which has enabled the CCG safeguarding team to continue to deliver the CCG's statutory responsibilities for safeguarding during lockdown.

During lockdown the CCG has supported partners and staff to link with other parts of the system by supporting the implementation of additional multi agency information sharing meetings and forums which have enabled safeguarding practitioners across the system to identify and manage key themes and risks related to safeguarding adults in Newcastle.



Domestic abuse awareness at Newcastle Gateshead CCG, supporting White Ribbon Day 25 November 2019

BOARD MEMBERS

In 2019-20, the NSAB was chaired by Vida Morris. The following people were members:

Changing Lives (representing the community and voluntary sector)	Neil Baird
Connected Voice Advocacy (representing the community and voluntary sector)	Jacqui Jobson
Cumbria, Northumberland, Tyne and Wear NHS Trust	David Muir
	Karen Whorton
National Probation Service	Paul Weatherstone
Newcastle City Council	Ewen Weir
	Alison McDowell
	Jonathan Jamison
	Linda Gray
	Samantha Keith
	James Steward
	Councillor Kilgour
NHS Newcastle Gateshead Clinical Commissioning Group	Chris Piercy
	Howard Stanley
Northumbria Police	Scott Hall
	Sav Patsalos
	Alan Cairns
Northumbria Community Rehabilitation Company	Martyn Strike
Newcastle upon Tyne Hospitals NHS Foundation Trust	Maurya Cushlow
Public Health	Michelle Stamp
Search (representing the community and voluntary sector)	Simon Luddington
Tyne and Wear Fire and Rescue Service	Peter Iveson
Your Homes Newcastle	Helen Neal
Newcastle Safeguarding Children Partnership	Sue Kirkley
Chair of Improving Practice Committee	Clare Abley
Chair of Learning and Development Committee	Dr Carole Southall
Legal Advisor to the NSAB	Peter Larkham
NSAB Coordinator	Claire Nixon

No excuse for adult abuse.

Report it.

For more information search online for "Safeguarding Adults Newcastle"

newcastle safeguarding adults board

How to report abuse

To report abuse please contact;

Community Health and Social Care Direct
Telephone: 0191 278 8377
Textphone: 0191 278 8359
Email: scd@newcastle.gov.uk

Outside of office hours please call the Emergency Duty Team
Telephone: 0191 278 7878

In an emergency always call 999

All agencies in Newcastle work together to protect adults from abuse. If you want to tell somebody else that you trust, like a GP, nurse, police officer or care worker then they will pass on your concerns.

Newcastle Safeguarding Children Partnership

Annual Report 2019/2020

GLOSSARY

CPP	Child Protection Plan
CCN	Child Concern Notification
CME	Children Missing Education
CSC	Children's Social Care
SE	Sexual Exploitation
EHE	Elective Home Education
FGM	Female Genital Mutilation
ICPC	Initial Child Protection Conference
IRS	Initial Response Service
CiC	Children in Care
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference
MASH	Multi-agency Safeguarding Hub
MSET	Missing, Slavery, Exploitation and Trafficking
NSCP	Newcastle Safeguarding Children Partnership
NSAB	Newcastle Safeguarding Adults Board
CNTW	Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
NuTH	The Newcastle upon Tyne Hospitals NHS Foundation Trust
RHIs	Return Home Interviews
SCR	Serious Case Review
SNB	Safe Newcastle Board
YHN	Your Homes Newcastle

CONTENTS PAGE

SAFEGUARDING PARTNERS' FOREWORD

This is the first Annual Report of the three Newcastle Safeguarding Partners since the implementation of the new safeguarding arrangements in Newcastle in June 2019.

Publication of the new arrangements signalled our ambition to develop an equitable and robust partnership and re-affirmed our local commitment to improve outcomes for all children in Newcastle.

As the three key statutory safeguarding partners we are committed to working with, and providing leadership to, all partners in order to continue to improve how we safeguard children in the City.

During 2019/20 we have continued to embed our new safeguarding arrangements in Newcastle, whilst at the same time ensuring business continuity.

The Annual Report evidences that much has been achieved by the Partnership and partners to progress work on our strategic priorities and demonstrates the continued commitment of a wide range of local partners, and reflects the challenging and dynamic nature of safeguarding practice.

During 2020 we will continue to review our local safeguarding arrangements to ensure they continue to be fit for purpose and will work with regional partners to align key safeguarding responsibilities and activity.

Finally, we would like to thank everyone for their commitment and hard work over the last year, which puts us in a strong position moving forward over the next 12 months and beyond.

Pat Ritchie, Newcastle City Council Chief Executive Officer

Chris Piercy,
Executive Director of Nursing, Patient Safety and Quality Newcastle Gateshead Clinical Commissioning Group

Sav Patsalos, Detective Chief Superintendent, Safeguarding, Northumbria Police

INDEPENDENT CHAIR'S COMMENTARY

The year 2019/2020 introduced the new Safeguarding Children arrangements and established the Newcastle Safeguarding Children Partnership. These changes also required that statutory responsibility for Children's Safeguarding shifted from the Local Authority alone, to that of a shared partnership with Northumbria Police, and the Newcastle Gateshead Clinical Commissioning Group.

It was agreed that this first year of operation would be a "transition period", with a full and formal review being undertaken by September 2020, to ensure that the new arrangements were effective and to provide assurance about the work of the new Partnership. Who would have ever imagined the additional challenges produced by the Coronavirus outbreak, and the response needed by all partners to ensure that children and young people in the city remained safe?

Partners had to very quickly adapt, and find new ways of working, that allowed them to maintain contact, whilst "social distancing". Their response has been a credit to the staff on the frontline, and their leaders and managers who have demonstrated creativity and commitment in their work. It has also demonstrated the strength of the partnership in Newcastle, with clear co-operation between partners being apparent at many levels. This continues as we move towards our "new normal", and different ways of working continue to be needed as we start to understand the new challenges emerging from the recent lockdown.

Throughout this time there has also been the need to continue many aspects of "business as usual", to deal with the many challenges that existed before Coronavirus was recognised. The Newcastle Safeguarding Children Partnership continues to forge stronger alliances with others in the City, i.e. Safe Newcastle, and the Newcastle Safeguarding Adults' Board, through the Cross Partnerships Steering Group, and work with the local Violence Reduction Unit, to ensure a co-ordinated approach and maximum effectiveness.

I commend this report to you, and thank all the staff, young people, and others in the City who have contributed to the achievements described, during an unusual and challenging year.

Helen Lamont

Independent Chairperson

WHO WE ARE AND WHAT WE DO

In June 2019 Newcastle Safeguarding Children Partnership (NSCP) replaced the previous Local Safeguarding Children Board in accordance with statutory guidance Working Together (2018). Full membership is out on set on page 34.

Our Vision

Is to ensure that Newcastle is an increasingly safer city for children and young people at risk of abuse

Our Purpose

Is to help to protect children and young people at risk of abuse, neglect and exploitation

The NSCP is supported by a number of sub groups and task and finish groups, one of which is joint with the Newcastle Safeguarding Adults Board to provide a joined up approach to the business as shown above

Our Principle

Safeguarding is everyone's responsibility and has a co-ordinated approach

What is children's safeguarding?

Safeguarding and promoting the welfare of children is defined in Working Together 2018 as: protecting children from maltreatment; preventing impairment of children's health or development; ensuring the children are growing up in circumstances consistent with the provision of safe and effective care; taking action to enable all children to have the best outcomes.

Child protection is a part of safeguarding activity that is undertaken to protect specific children who are suffering, or likely to suffer, significant harm.

Who is a child at risk?

Working Together 2018 defines a child as anyone who has not yet reached their 18th birthday. The fact that a child may have reached 16 years of age, is living independently, is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate, does not change their status or entitlements to services or protection.

As well as the threats to the welfare of children from within their families, children may be vulnerable to abuse or exploitation from outside their families. These extra-familial threats might arise at school and other educational establishments, from within peer groups, or more widely from within the community or online.

What is abuse or neglect?

Abuse is a form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others. Abuse can take place wholly online, or technology may be used to facilitate offline abuse. Children may be abused by an adult or adults or another child or children.

Statutory Guidance

Working Together 2018

Physical abuse—a form of abuse which may involve hitting, shaking, throwing, poisoning, burning, scalding, drowning, suffocating or otherwise causing physical harm to a child.

Sexual abuse—involves forcing or enticing a child or young person to take part in sexual activities whether or not the child is aware of what is happening. Sexual abuse can also occur online.

Sexual exploitation—- is a form of sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a young person into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. It can also occur using technology.

Emotional abuse—the persistent emotional maltreatment of a child such as to cause severed and persistent adverse effects on the child's normal development.

Neglect—the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development.

Criminal exploitation - occurs where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a young person. The victim may have been criminally exploited even if the activity appears consensual. Criminal exploitation does not always involve physical contact; it can also occur using technology. Criminal exploitation is broader than just county lines and includes for instance people being forced to work on cannabis farms or to commit theft.

Modern slavery - is a serious and often hidden crime in which people are exploited for criminal gain. The common factors are that a victim is, or is intended to be, used or exploited for someone else's (usually financial) gain, without respect for their human rights. The perpetrators seeking to take advantage of them could be private individuals, running small businesses or part of a wider organised crime network.

HIGHLIGHTS AT A GLANCE 2019/2020

Our Priorities	Highlights
Protecting Vulnerable Children and Young People	• Implementation of the MSET Operational Group (December 2019) to scrutinise those young people who have been assessed as medium or high risk of criminal exploitation • Project group set up to implement the NSPCC Neglect Graded Care Profile assessment tool across universal and targeted services • Development of a local criminal exploitation and serious violence strategy and action plan (page 10) • Private fostering practitioner survey undertaken to better understand practitioners' understanding of Private Fostering arrangements (page 13)
Leadership	♦ Peer Review commissioned to look at the effectiveness of the local Multi-agency Safeguarding Arrangements for Children and Young People ♦ Development of the Newcastle Partnerships Group to consider cross cutting issues and joint areas of work e.g. criminal exploitation, domestic abuse ♦ Fortnightly Partnership meetings during the COVID-19 lockdown period to ensure that statutory responsibilities and arrangements for safeguarding children and young people in Newcastle were robust during the pandemic ♦ Regional work strengthened through contribution to the North and South Strategic Safeguarding Forum
Learning and Improving	• Annual young person's themed event on gangs, knife crime, culture and self identity held October 2020 (page 12) • Delivery of the NSCP annual training programme (separate annual report) • Partner safeguarding audits undertaken to assure the NSCP that partner's safeguarding arrangements are in place and robust • Baby A, Baby C and Laura case reviews published (pages 14-16) • Twice a year scrutiny of the NSCP Scorecard performance data (pages 17-18)

LOOKING AHEAD TO 2020/2021

In June 2019 the Newcastle Safeguarding Partners published their new local safeguarding arrangements for children and young people in Newcastle **https://www.nscb.org.uk/newcastle-multi-agency-safeguarding-arrangements-children-and-young-people**
The new arrangements reflected a transitional process with some streamlining of the previous Safeguarding Children Board arrangements. However, much of the previous functions were retained to enable a smooth transition and to allow time to consider those areas of activity and functions that work best and where things could be strengthened, improved and done differently.

To assist in the process the NSCP commissioned a Peer Review to take an in depth look at the effectiveness of the new safeguarding arrangements, including governance, accountability and leadership. The outcome of this will help us to shape how we move forward in 2020 and beyond.

Further strengthening how we engage children and young people in the work of the Partnership is a priority area for us to think about during 2020; building upon the already positive relationships we have with a number of children and young people groups and networks. We will of course continue to have our annual young people's event; the theme for 2020 being 'young people and alcohol' and how this impacts upon life chances.

Cross partnership work with the Newcastle Safeguarding Adults Board, Safe Newcastle Board and the Youth Justice Partnership Board will continue during 2020/2021 to continue to strengthen collaboration on cross cutting issues and partnership working; including work with regional partners.

However, it must be acknowledged that the NSCP new business year for 2020 has been affected by the COVID-19 pandemic lockdown and social distancing measures from March 2020, although the Partnership has endeavored to maintain business continuity as best it can. This has been achieved through adopting other ways in which to deliver and manage its business, particularly through the use of virtual online meetings and discussions. This will continue during 2020 and will change and adapt as and when required.

Safeguarding Partners' Strategic Priorities 2019/2022

SPOTLIGHT ON SAFEGUARDING YOUNG PEOPLE FROM CRIMINAL EXPLOITATION AND SEXUAL VIOLENCE

Last year we highlighted how the four strategic partnerships, Newcastle Safeguarding Children Partnership, Newcastle Safeguarding Adults Board, Safe Newcastle Board and the Youth Justice Partnership Board, had joined up to collaborate on cross partnership working to safeguard children and adults from criminal exploitation. During 2019 (and 2020) this work has continued to progress.

The four Partnership business managers and strategic leads organised an event at the Discovery Museum in September 2019 to support the development of a public health approach to tackling criminal exploitation in Newcastle, and included a keynote introduction from the Northumbria Police and Crime Commissioner, national speakers and learning from other areas.

140 practitioners, specialists and strategic leads attended, who were encouraged to contribute to a city-wide strategy and action plan for tackling criminal exploitation themed around:

- Understanding the scale of the problem in Newcastle
- Prevention, engagement and diversion
- Education and awareness

  Safeguarding vulnerable people
- Disruption of criminal activity

Since then a cross partnership steering group, including Northumbria Police and the Police and Crime Commissioner Violence Reduction Unit (VRU), has been set up to oversee the development and implementation of a local strategy and action plan; and the VRU has produced local and regional 'Insight' reports looking at the scale of the problem. This work continues to be a priority for the NSCP in 2020/21.

Plans for 2020/2021 include

- Partner consultation on the local strategy and action plan and subsequent implementation
- Continued leadership of the work by the four strategic partnership chairs, Northumbria Police, and the VRU
- Partner/practitioner follow up event
- The VRU awareness in schools programme to be supported by the NSCP
- NSCP to be involved in the regional **Tackling Child Exploitation (TCE) Support Programme**

SPOT LIGHT ON VULNERABLE YOUNG PEOPLE

(Centrepoint (2020) centrepoint.org.uk)

In March 2020, the NSCP commenced a multi-agency thematic audit of vulnerable young people and looked at a number of cases that were active at that time under the NSCP MSET Operational Group risk management arrangements. Progress of the audit was initially impeded due to the COVID-19 pandemic, although concluded and was published in August 2020 during the course of writing the Annual Report. The NSCP considered the learning too important to wait to be included in its 2020/2021 Annual Report.

What did we learn?

Nationally despite its high-profile practitioners are still thought to be slow to recognise and respond to vulnerability of exploitation and can feel unprepared for working with young people when it comes to relatively new challenges such as knife crime and criminal exploitation.

In Newcastle, whilst there were a couple of isolated incidents identified where the recognition of vulnerability and the timeliness of response to concerns or service intervention was questioned, in most cases the recognition and response to young people's needs and experiences were timely e.g. referral to MST, escalation to child protection enquiries and child protection processes and referral to the educational psychology service. This is a good indication that multi-agency frontline practice is being responsive and effective.

Where key workers are persistent in trying to engage with young people this does make a difference to how they respond.

Inappropriate language and terminology when discussing young people who are being exploited or at risk of exploitation can prevent them from engaging and disclosing their abuse.

Where parents are engaged and involved in discussions and planning the most positive outcomes for young people are achieved.

Regardless of their circumstances, all children and young people are entitled to an efficient, full time education which is suitable to their age, ability, aptitude and any special educational needs they may have. Exclusion from mainstream school is a trigger point for risk of serious harm. It is essential that all services work together to identify and re-engage these young people back into appropriate education provision as quickly as possible.

What have we done?

The NSCP has set up a task and finish group to consider the learning and areas identified for further exploration or improvement to further strengthen what it does to safeguard vulnerable young people. This group will link with the work being developed around criminal exploitation and sexual violence.

ANNUAL YOUNG PEOPLE'S EVENT: KNIFE CRIME, GANG CULTURE, AND SELF IDENTITY OCTOBER 2019

This is the third NSCP's annual young people's event, which brings together young people who live, learn and socialise in Newcastle to hear their views and suggestions for improving practice and service provision. Members of the Safeguarding Children Partnership also attend the events to respond to young people's key questions and issues as they arise.

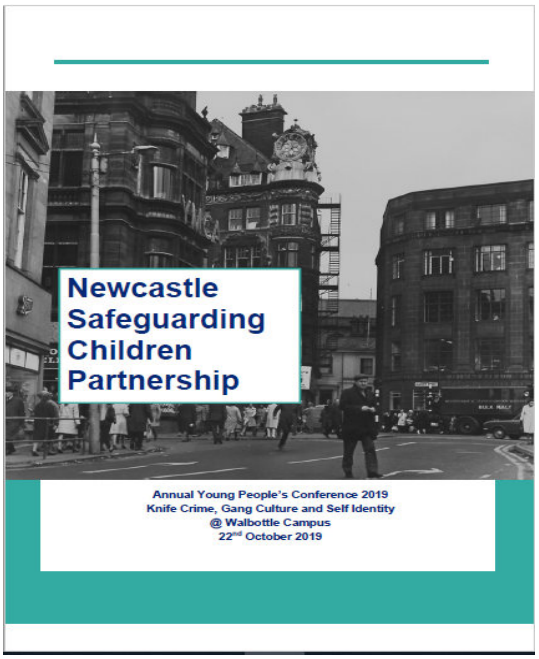
The theme for the 2019 event was '*knife crime, gang culture and self identity'*. The key speakers included Elysia Balsdon, a youth leader from

Newcastle Youth Democracy Group the Newcastle Safeguarding Children Partnership Independent Chairperson, Helen Lamont and Northumbria Police Superintendent Karl Wilson, who set the scene.

The Saltmine Trust where invited to present an extremely thought provoking drama production and workshop called 'Switch Up'.

Video interview of two young people

https://www.youtube.com/watch?v=fkUvzKz1_Q8&feature=youtu.be



What did we learn from the young people?

"We don't feel safe anymore"

"Develop school/police relationships"

"Change of attitude by young people towards the police."

What have we done?

- The young people's views, comments and suggestions from the event have been shared with the safeguarding partners with responsibility for tackling criminal exploitation and serious violence
- The event report was widely shared
- The 2020/2021 event will have the theme 'young people and alcohol'

SPOT LIGHT ON PRIVATE FOSTERING

Private Fostering arrangements relate to some of the most vulnerable children and young people within our communities. It is important to ask questions about care arrangements and parental responsibility for children and young people as part of your role in ensuring that children and young people are safe.

A Private Fostering arrangement is when a child or young person under 16 (under 18 years if disabled), is cared for and provided with accommodation for more than 28 days, by an adult who is not a close relative. A close relative is defined as a grandparent, sister, brother, uncle and aunt. A step parent if married to the birth parent is also included.

Parental responsibility does not shift to the private foster carer under a Private Fostering arrangement, and as such there are implications in terms of consent for medical treatment.

The number of reported Private Fostering arrangements in Newcastle is very low, although not out of step with regional and national partners. This prompted the NSCP to question how well practitioners understand what a Private Fostering arrangement is and their responsibility for notifying the local authority when they become aware of such an arrangement. A practitioner survey was undertaken by the NSCP in February/ March 2020, to gain a better understanding, which received 147 responses.

What did we learn?

Most people who completed the survey understood what a Private Fostering arrangement was and their legal duty to report an arrangement to Children's Social Care should they become aware. Training and where to get information on Private Fostering was identified as the greatest learning need within the survey.

The Newcastle Safeguarding Children Partnership refers to Private Fostering at all levels of its training.

Guidance on Private Fostering is contained within the NSCP procedures: Section 4 Children Living Away from Home and is available to all practitioners and managers. https://www.proceduresonline.com/nesubregion/p_ch_living_away.html

What have we done?

- Re-issued a practitioner brief across Newcastle
- Requested partners to ensure Private Fostering is embedded in their internal training and staff inductions
- Continue to monitor the numbers of Private Fostering arrangements as part of the NSCP performance scorecard

LEARNING FROM PRACTICE: BABY A SERIOUS CASE REVIEW PUBLISHED NOVEMBER 2019

Baby A (3 month old baby) tragically died as a result of parental overlay. At the time of the baby's death the parent was under the influence of illegal drugs and alcohol.

What did we learn from this case review?

Similar to other cases that the NSCP has audited or reviewed relating to babies, this case re-emphasises the intrinsic vulnerability of all babies who are dependent on their parents for care and survival, even when they are only known to universal services.

Substance misuse by a parent is widely recognised as one of the factors that puts children more at risk of harm, the biggest risk posed to them is that parents, when under the influence of drugs or alcohol, are unable to keep their child safe, including overlay through co-sleeping. Current advice recommends not sharing a bed with a baby, particularly if parents/carers have been drinking or have taken drugs.

In this case whilst details of the level of the parent's drug and alcohol consumption became more apparent after the death of Baby A, unless it is disclosed by the parents themselves, or is having an obvious impact on parenting ability or becomes known to the police, routine testing of drugs or alcohol consumption (during pregnancy) is not national routine practice.

Co-sleeping whilst under the influence of drugs and alcohol has been a theme in the learning from the North of Tyne Child Death Overview Panel review of cases. The Panel has considered this issue and is assured by health partners that robust systems and processes are in place to ensure that parents are provided with the information and advice they require in a timely way.

Reassuringly the review did not identify any action by any professional or system that was a critical factor in what happened to Baby A. In fact the review acknowledged that knowledge and learning is well understood and translated into practice in Newcastle by midwives and health visitors.

What have we done?

The review recommended that the NSCP use the learning to inform the development of the local safeguarding vulnerable babies' strategy; and that partners should use the learning to inform local safeguarding training opportunities to raise awareness of the intrinsic vulnerability of all babies.

The NSCP acknowledges the intrinsic vulnerability of all babies and has included this in its 2020/2021 annual delivery plan and will also follow up what partner agencies have done and what difference this had made.

The NSCP also intends to undertake an audit of cases open to Early Help and Children's Social Care to scrutinise the quality of assessment, planning and decision making for those babies aged one year and under already recognised as being vulnerable.

The full report has been published on the NSCP website.

NSPCC (2013). *Parents who misuse substances: learning from case reviews - Summary of risk factors and learning for improved practice around parents with substance misuse problems*.

Carpenter R, McGarvey C, Mitchell EA, et al (2013). *Bed sharing when parents do not smoke: is there a risk of SIDS? An individual level analysis of five major case–control studies* BMJ. Published online

LEARNING FROM PRACTICE: BABY C LEARNING REVIEW PUBLISHED FEBRUARY 2020

Baby C (8 month old baby) was admitted to hospital with a traumatic head injury that occurred at home. The original explanation was that the child had rolled off the sofa and banged his head on the floor, suffering a fractured skull and possible life changing brain damage.

During a Court hearing mother admitted to picking Baby C up and throwing him to the ground causing him to bang his head on a concrete step.

What did we learn from this case review?

Similar to findings from previous local and national case reviews, learning tell us that babies and very young children are intrinsically vulnerable and dependent on their carers for the care and survival, and that some factors over and above the demands of caring for a baby make them especially fragile and place them at higher risk of abuse and neglect. These issues potentially pose challenges to their parents and in this case the additional vulnerabilities arose from the pressures of being new parents, Baby C suffering from the reflux and the impact of this on the parent's emotional and physical wellbeing, the parental relationship and mother's own mental health diagnosis of a borderline personality disorder.

The quality of assessment is very important as inadequate assessments are likely to be associated with worse outcomes. Comprehensive assessment involves more than just information gathering; it needs the professional to draw upon research evidence, be able to analyse and make sense of all available information, understood in the context of trauma, ensure that all relevant professionals involved with the family are involved and the assessment is shared with all relevant parties on completion.

Assessments should be informed by evidence and reflect the latest research on the impact of abuse and neglect and relevant findings from serious case and practice reviews when analysing the level of need and risk faced by the child. The use of evidence stimulates thinking, triggers conversations and increases options, although it is acknowledged that getting the messages from academic study into social care work is not easy.

It is important that practitioners have a good understanding of each other's roles and responsibilities: in Newcastle for example the 4-5-6 approach for health visiting; and during assessment, planning and review practices, triangulate self-reported information to ensure its reliability and validity for safeguarding children.

The NSCP recognises that the learning from this case review is very similar to previous reviews undertaken and whilst the family and social circumstances may vary, sadly the intrinsic vulnerability of all babies cannot be underestimated.

What have we done?

- The local Early Help Plan has been revised to have more emphasis on holistic assessment
- The Newcastle upon Tyne Hospitals Foundation Trust are piloting a Vulnerable Parents Pathway , which offers a greater opportunity for continuity of care for the most vulnerable parents and their children
- The NSCP will undertake an audit of the quality of assessment and planning in Early Help Assessments and Child and Family Assessments for unborn babies and babies under I year old during 2020

Sidebotham et al. (2016), Triennial analysis of serious case reviews (2011-2014). Triennial analysis of serious case reviews (2011-2014): practice briefing for health practitioners

Turney et al (2011), Social Work Assessment of Children in Need: What Do We know? Messages from Research.

Laulik, S. et al. (2016), *Maternal Borderline Personality Disorder and Risk of Child Mal-*

LEARNING FROM PRACTICE: LAURA SERIOUS CASE REVIEW PUBLISHED MAY 2020

Laura was diagnosed with ADHD and a learning disability in early childhood. She lived with her mother and her older half sibling. Unknown to the family or any of the professionals working with Laura and her mother at the time was the fact that her mother's boyfriend was a registered sex offender, regularly visited by police in his home town. He repeatedly reported to officers that he had no contact with children and was not in a relationship with anyone. In late 2017 Police intelligence led to him admitting that he had been in a relationship with Laura's mother for seven years and that she had a daughter who at that time was 19 years old. Mother was informed by the police about her partner's background and when asked Laura disclosed a history of sexual abuse spanning several years. It appears that the relationship had begun some years previous.

What did we learn?

Laura's learning difficulties were well understood, but not all professionals demonstrated an awareness that Laura was at heightened risk of sexual abuse in her family. A lack of awareness about sexual abuse of children with disabilities among professionals contributes to their vulnerability.

Professionals coping with multiple demands in stressful work environments need access to support and regular reflective supervision. Without this, errors are more likely to occur this can leave children vulnerable.

Professional understanding about the lives and experiences of children with disabilities can impact on all aspects of a child's life. Unchecked assumptions can inhibit professionals from focusing on the child and family and this limits communication and exploration about what may be happening for a child in their family.

There are risks of professionals making assumptions and taking things at face value without enquiring more deeply into what might be happening in the home environment. Professionals who are questioning and curious create opportunities for opening up conversations with people to explore vulnerabilities, seek their views, and understand their needs, but without access to supervision and opportunities for reflection professionals with busy workloads may be less likely to be curious about those children about whom they have no significant concerns.

If professionals in contact with children do not regularly update their records about family members and purposefully and intentionally seek out information about significant males in a child's life, the risks posed by some men are more likely to go unrecognised.

Unless there is a disclosure or the presence of easily recognisable signs and symptoms, professionals may not always consider the possibility of child sexual abuse as often as they should do, and this can leave some children vulnerable.

Some of the key opportunities presented to professionals working with disabled children and their families lie in their recognition and understanding of the heightened vulnerability of these children and the potential interaction with risks and harms. The learning emerging from this review highlights the importance of professionals being continually mindful that risks to all children and especially those with additional vulnerabilities, are ever- present requiring them to be ever- vigilant and ever-curious.

What have we done?

- The NSCP has accepted all of the Findings and recommendations in full
- The full report was approved and published on the NSCP website during the COVID-19 lockdown
- A task and finish group is considering the learning and recommendations and will develop the NSCP action plan and response to these

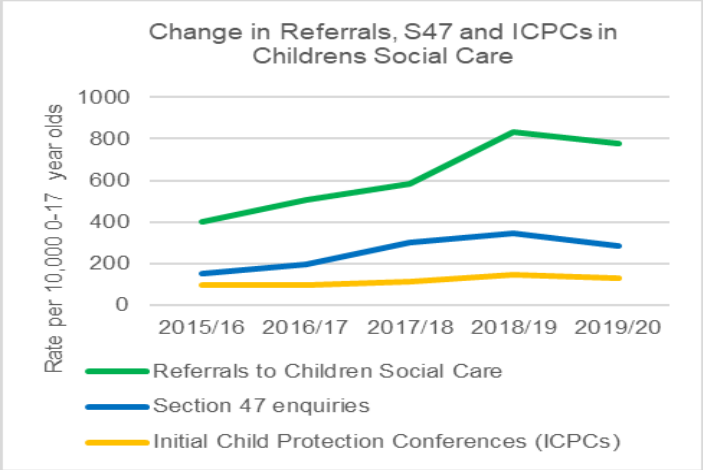
Intra-familial child sexual abuse: Risk factors, indicators and protective factors Research in Practice (2018)

We have the right to be safe' Protecting disabled children from abuse. NSPCC: Miller and Jon Brown (2014)

WHAT THE LOCAL DATA TELLS US

The NSCP performance scorecard enables the NSCP to identify areas of safeguarding activity that require further investigation. The NSCP performance scorecard contains a variety of data from multiple partners relating to the safety and wellbeing of children and young people. Scrutiny of this data enables the partnership to identify trends in safeguarding and understand the picture for the city as a whole. Some of the finding and trends for the year are included below.

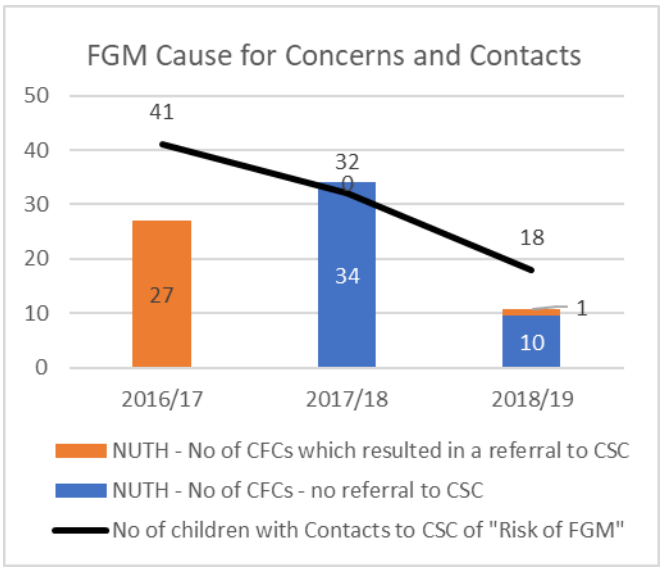
During 2019/2020 extensive work has been done within Children's Social Care and with partners to manage demand and ensure referrals and escalations are appropriate. Consequently, we have seen a reversing of the upward trend in numbers of referrals, assessments and S47 enquiries, along with number and rates of children in need. Regular audits ensure that these reductions are being made safely.



The number of Police Child Concern Notifications increased force wide in the first 9 months of the year, most likely influenced by an internal drive within the Police in ensuring officers submit a CCN at every Domestic Abuse incident when a child is present as well as for all children who are reported missing. Despite this, referrals from the police to CSC fell in 2019/20. The police remain the largest referral group to CSC, but triage and joint working between Police and CSC helped to identify the most relevant CCNs and reduced the number in Newcastle which were converted into contacts to CSC. In addition, the offences against children are reducing, reversing the trend seen in the last 4 years.

A further indicator of improving trends in safeguarding children is that there were no new Serious Case Reviews initiated in 2019/20, where there has been at least one in each of the last four years.

2019/20 has seen reduction of more than 40% in the number of contacts received to Children's Social Care about Female Genital Mutilation. There was only one cause for concern for FGM which resulted in a CSC referral from NUTH in this period and there were no offences of FGM from the police. This is despite a programme of training in health services in summer 2018, including guidance on when to refer to CSC. The NSCP has decided to undertake a review of local arrangements to better understand the prevalence of FGM in light of the falling numbers.



There has been an implementation of new documentation and processes between partners around those young people considered to be at medium to high risk of exploitation.

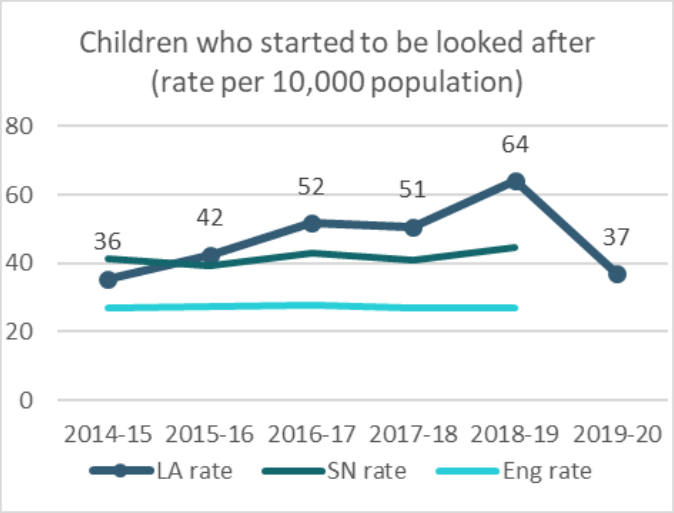
The number of assessments of risk remains high, although down slightly from last year and in the number of children considered to be at medium or high risk has also fallen slightly to 44.

Continuing this trend, the number of complex abuse meetings has decreased this year by 23%, from an exceptionally high year in 2018/19. The average number of children and young people involved in each meeting has stayed high implying that the increased complexity that we saw in 2018/19 has remained.

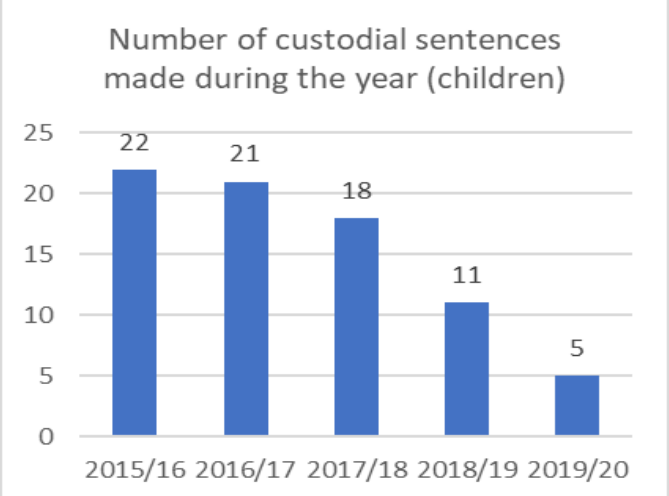
WHAT THE LOCAL DATA TELLS US

At the 1st April 2020, there were 662 children in care, down by 19 from 683 last year. This is down from the largest number we have ever seen in Newcastle but still puts us above all comparators from last year.

The main driver for change was an a reduction in entries to care, which was achieved through an initiative called Right Child Right Care. This programme, led by Children's Social Care, worked as a result of social workers, partners and families finding safe alternatives to care and find ways to intervene differently, to reduce the large increase in entrances to care we had seen in the previous year. One side effect of this initiative has been that there has been a slight decrease in the measure of stability of placements for children.



In relation to youth justice, the use of custodial sentences for children and young people continue to reduce, with only one young person serving the custodial element of their sentences at the end of March 2020.



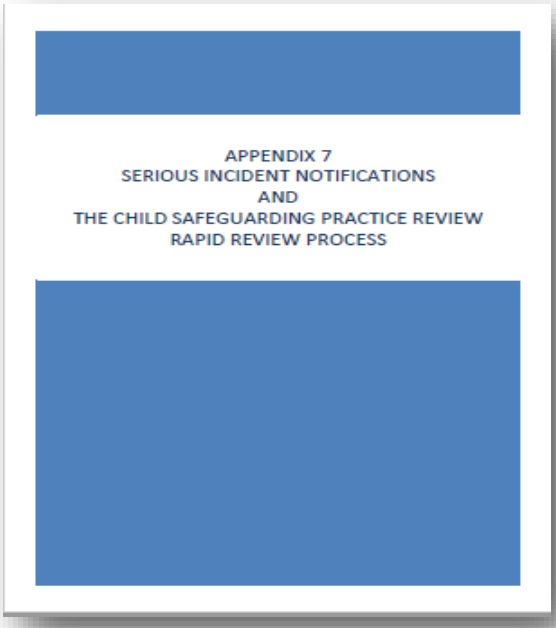
To conclude, despite many improvements over the year – reduction in offences and markers of risk, fewer CP plans starting and more CP plans ending, levels of child protection in the city remain high with 587 children on a plan at year end. This is much higher than in other similar authorities. (101 per 10 000 children in Newcastle, compared to 62 for statistical neighbours).

Whilst some of the high level of child protection can be attributed to the reducing number of children in care, it is still a cause for concern in Newcastle, and will be an area of focus for the NSCP during 2020.

Case Review Group

The Case Review Group is a sub group of the NSCP and is responsible for:

- Considering cases to establish whether the criteria for Local Child Safeguarding Practice Reviews is met
- Commissioning of Local Child Safeguarding Practice Reviews and overseeing the process and quality assurance
- Maintaining an overview of all out of area case reviews where Newcastle partners have been asked to provide information
- Undertake learning reviews on cases that do not meet the criteria for a Local Child Safeguarding Practice Reviews
- Consider learning from local and national reviews and the Child Death Overview Panel
- Ensure learning from all case reviews is widely disseminated and embedded within practice, systems policy, procedures and training
- Contribute to other reviews as required e.g. safeguarding adults' reviews, domestic homicide reviews, drug related death reviews



Progress report

- The Case Review Group replaced the previous Committee in June 2019 as part of the new safeguarding arrangements
- Serious Case Reviews were replaced with Local Child Safeguarding Practice Reviews
- The Case Review Group published its Serious Incident Notifications and Child Safeguarding Practice Review Rapid Review Process in June 2019
- During 2019/2020 the Case Review Group published one Learning Review and two Serious Case Reviews, which are described in more detail in pages 14-16

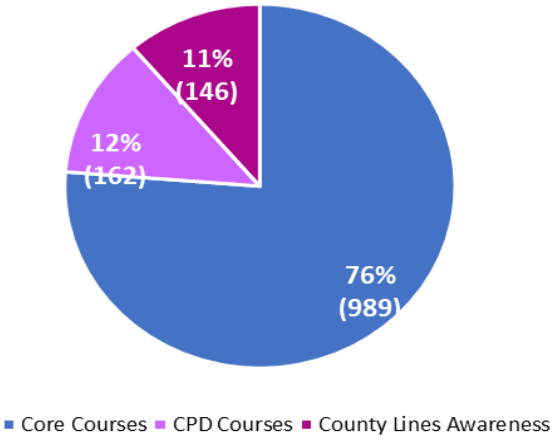
Plans for 2020/21

- At the time of writing the Annual Report the Case Review Group has one Serious Case Review to ready to publish under the old safeguarding arrangements, which involves the issue of a concealed pregnancy; and one ongoing Learning Review involving a young person involved in a stabbing incident
- The Case Review Group will review its Serious Incident Notifications and The Child Safeguarding Practice Review Rapid Review Process to ensure the new arrangements are working and effective

Learning and Improvement Group

The Learning and Development Group is a sub group of the NSCP and is responsible for:

- Developing and reviewing policies and procedures for safeguarding and promoting the welfare of children in Newcastle upon Tyne
- Considering the implications for training and procedure from new policy, legislation, research, Local and National Child Safeguarding Practice Reviews
- Identifying multi-agency training and learning priorities for safeguarding children
- Evaluating the effectiveness of training and learning outcomes on practice
- Overseeing the work of the Trainers Group



Progress report

- The NSCP has a joint training programme with the Safeguarding Adults Board
- 1,297 people attended Safeguarding children training and 2,322 e-learning courses were completed
- All courses evaluated as excellent' or 'good' and 99% rated the sessions as having met their stated objectives
- Safeguarding procedures were updated twice during the
- The Training Annual Report published https://www.nscb.org.uk/about-us/nscb-annual-reportshttps://www.nscb.org.uk/about-us/NBCs-annual-reports
- Partners' biennial safeguarding audits undertaken to assure the NSCP that agency's safeguarding arrangements are in place and robust (all relevant partners; GPs and schools in Newcastle)
- Private fostering survey undertaken March 2020 (page 13)
- Vulnerable Young People audit published (page 11)
- NSCP performance scorecard scrutinised twice per year (pages 17-18)

Plans for 2020/2021

- Practitioner procedural update briefings twice per year
- Development of practitioner webinars on key themes e.g. criminal exploitation, intrafamilial sexual abuse
- Vulnerable Young People task and finish group to be set up
- Random sample and follow up on partners' safeguarding audits to provide assurance to the NSCP that arrangements are robust
- Development of a scrutiny framework for the NSCP
- Training to be provided to practitioners to be able to undertake a case review on behalf of the NSCP
- Pilot of a multi-agency conference report format
- Partner 'practitioner week' to be explored

Newcastle Education Safeguarding Partnership Report

Newcastle Education Safeguarding (NESP) Partnership provides the mechanism for the Safeguarding Partners to fulfil the requirements of Working Together (2018) and enables representatives from all schools, colleges and other education providers in Newcastle, to engage with the work of the Safeguarding Partners by:

- Helping to shape procedure and guidance
- Feeding back to the Safeguarding Partners on implications of decisions and practice relating to safeguarding in schools
- Feeding back on areas of safeguarding activity identified and undertaken by the partnership
- Identifying strengths and gaps
- Reviewing impact of policy and practice
- Providing an opportunity for schools to identify and share best safeguarding practice
- Contribute to inspections on issues related to education as and when required
- Ensure that all schools are represented within the wider partnership Improving practice across all Newcastle schools

Progress report

- Considered and discussed the learning from the 2019/2020 S175 schools safeguarding audit
- Thresholds of service intervention is a standing agenda item at meetings
- Flowchart provided by the LADO to easily reflect how allegations against staff are managed
- Operation Endeavour, a system for informing schools about those children who go missing from home or care, rolled out
- Reviewed the purpose and function of the NESP
- New exploitation checklist shared with schools

Plans for 2020/2021

- NESP to contribute to the development of a single conference review report
- Links to be made with the Violence Reduction Unit education officer
- Consideration of conference calls for strategy meetings

I have found it really useful to share ideas at the meetings. (Newcastle 6th Form College)

***Operation Encompass** is a police and education early information sharing partnership enabling schools to offer immediate support for children and young people experiencing domestic abuse

Joint Missing, Slavery, Exploitation and Trafficked Group

The Missing, Slavery, Exploitation and Trafficking (MSET) Group is a sub group of the Newcastle Safeguarding Children Partnership and the Newcastle Safeguarding Adults Board. Its purpose is to:

- Implement and monitor the joint MSET strategy and plan
- Improve outcomes for children, young people and adults who go missing from home and care
- Be assured that arrangements for safeguarding children and adults from criminal exploitation, including trafficking, sexual exploitation and modern slavery are robust and effective and there are effective links with other strategic and service plans to prevent duplication
- Ensure that recommendations and learning from new policy, legislation, research and guidance are acted upon
- Influence and contribute to the commissioning of services for children, young people and adults
- Consider performance data and partner intelligence to influence practice and service provision and development
- Develop and maintain links with other relevant local and regional partnerships tackling associated issues
- Contribute to regional collaboration and working

Progress report

- The joint MSET strategy was reviewed to strengthen work around criminal exploitation, children and adults missing from home or care and practitioners' understanding of current emerging themes and risk. This forms the basis of what we do to continuously improve
- Children's return home interviews and partner data and intelligence is regularly used to strengthen disruption activity, inform partner's of local 'hotspot' areas where young people are most at risk of exploitation and to inform licensing activity for certain premises e.g. review of licenses where there are concerns or visiting premises to provide advice, support and training opportunities
- Implemented an MSET Operational Group to consider those young people assessed as being at medium to high risk of exploitation to ensure robust multi-agency safety plans are in place to help to minimise the risks
- Supported the implementation of national toolkits on intelligence gathering and the appropriate use of language when working with young people and adults

Plans for 2020/2021

- Continue to support multi-agency, cross partnership working to safeguard children and adults from exploitation
- An evaluation of the effectiveness of MSET Operational Group
- Work with partners across the region to develop a regional missing protocol for adults
- Bench mark our current position and effectiveness on providing support and scrutiny to missing young people
- Contribute to the development and implementation of local webinars on issues relating to criminal exploitation to continuously improve practitioners' understanding of emerging themes and issues

Partner agency updates - partners are asked to provide a summary of their safe-guarding activity during 2019/2020

The Newcastle upon Tyne Hospitals NHS Foundation Trust

The Children's Safeguarding Team are constantly striving to ensure the protection of the children and young people the Trust comes into contact with. This means we not only have a responsibility to our own Trust staff but as a tertiary centre we interface with many services that are out of area sharing information with and from Trust areas.

This year we have implemented clinical pathways for both 'Childhood Obesity' and 'Self harm/ Overdose' these have been embedded into practice and the effectiveness of these will be audited in 2020/21.

We have had a review of our Child Protection and Safeguarding Children Policy and procedures and updated to make it more 'user friendly'. As a Trust we have implemented an electronic record keeping system in the acute setting which has required working closely with our IT colleagues to ensure we have a robust safeguarding system. Final work streams are being completed and the safeguarding team will provide training and support around this for all wards/departments. We are currently negotiating a strategy for implementation of system one (electronic record keeping for community) which when complete will enhance the flow of information between us and community practitioners. The end goal is that the Children's Safeguarding Team will be virtually paperless going forward.

We have completed audits across both Acute and Community services, including both Hospital/ Community record keeping, Sexual health practice and following the implementation of 'Was not Brought' Policy. We have shared findings with practitioners and managers and completed and reviewed action plans as required

We continue to provide a health perspective and supporting information to ensure robust multi-agency decision making in the MASH and the normal MDT meetings for Strategy/Discharge planning have continued virtually between Safeguarding team and NSCP partners during COVID restrictions. We have continued to contribute to multi-agency audit for referrals into CSC.

There has been significant change within the Children's Safeguarding Team in the Trust over the last 12 months with the appointment of a new Named Nurse and two new Safeguarding Advisers into post. The way that support is given to Services/ Wards and departments has changed radically with the introduction of bespoke support given to each area from a named Safeguarding advisor and there has been a significant extension of supervision offered to different groups of staff. We continue this support through virtual platforms during the current pandemic.

Relationships with Paediatric Matrons, Sisters and Specialist Nurses have been strengthened. Supervision has been maintained with departments such as Emergency Department (Adults and Children's), Sexual Health and Children's Community Nurses and also included this year have been bespoke sessions for Dental, Ophthalmology and the Freeman Children's Wards/ PICU which we hope to continue going forward.

The visibility and support with community teams has been significantly increased to include group supervision for the 0-19 senior team and supervision introduced for all walk-in centre staff.

The Children's Safeguarding Team have supported the Safeguarding trainer in both reviewing and delivering a new package for in house Children's Level 3 training, which is now being delivered using video conference, feedback from which has been positive.

Covid-19 restrictions has limited the amount of support we have provided for the NSCP multi-agency training but some sessions were delivered and evaluated positively; as a team we reflect the value of multi-agency training in all supervision and will continue to support this as a priority in the future.

The Safeguarding Children's Team have been involved in a number of Serious Case Reviews and learning events over the past 12 months both internally and acting as Trust single point of contact for cases from other areas and has maintained a presence as part of the Trust Child Death Overview Panel, liaising with teams/practitioners and giving tailored support where there have been practice issues. We have held several safeguarding forums to disseminate the learning and provide an opportunity for staff to share their experiences and opinions. We have contributed information to several inspection processes as required and have included learning/changes from these in NUTH internal action plans.

We constantly strive to improve our support and to Trust staff to incorporate learning from case reviews, 2019/20 was particularly focussed on reviewing all our systems and processes and having a solution focussed approach.

Newcastle Gateshead CCG has continued to work closely with the NSCP and relevant agencies to address the safeguarding children priorities. This has included attendance at the various sub group meetings, to drive forward the work of the partnership, provide respectful challenge where required and support partners to protect and improve the lives of children and young people. The CCG has continued to disseminate any learning and key messages to primary care and developed a bespoke audit tool for primary care fulfilling the requirements of the section 11 audit. The CCG as a statutory agency has continued to embed the new safeguarding children arrangements and has worked on the revised child death review process to combine the North of Tyne and South of Tyne Child Death Overview Panels. This will allow for increased thematic learning across a wider geographical footprint through the identification of contributory factors, any modifiable factors (those which can be changed through national or local interventions) and make recommendations to prevent future similar deaths, or improve the safety and welfare of children in the local area and further afield.

The CCG Executive Director of Nursing, Quality and Patient Safety and the Designated Nurse Safeguarding Children continue to attend partnership meetings, providing and seeking assurance in relation to safeguarding responsibilities, whilst conveying information back to relevant colleagues in various agencies. The Designated Nurse chairs the revised Learning Improvement Group which now combines three previously separate meetings into one. The CCG safeguarding team has significant involvement in learning reviews, contributing to the reporting of such reviews whilst supporting primary care to fulfil their role. In addition, the safeguarding team participate in multi-agency audits and delivery of training.

The CCG through the learning and improvement processes identifies and disseminates learning to colleagues across the health economy. Learning from serious case reviews and learning lessons reviews is shared with primary care and 7-minute briefings produced which are shared with partner organisations and also with NHS England on a regional basis.

Throughout the reporting period we have highlighted the intrinsic vulnerabilities of babies, the importance of sharing information during assessments and continue to highlight the increased risk of abuse for children with learning disabilities.

The completion of the bespoke section 11 audit for primary care which produced a positive response will be undertaken on an annual basis with the review of any associated actions.

Children's Social Care

Children's Social Care support children, young people and families in Newcastle to stay safe. We work with families to understand what support a child or young person may need from us or other organisations to be happy, healthy and safe.

In 2020, the Children, Education and Skills Directorate was formed, bringing together Children's Social Care, Early Help, Education and Skills, and the Children and Families Strategy Unit. Our new Directorate with its shared priorities has strengthened our collaborative approach to improving outcomes for children, young people and families in the city.

We are now in the second year of our Right Child, Right Care transformation plan and have successfully delivered on a number of initiatives to support great social work to flourish in Newcastle. We launched our Centre of Excellence which focuses on the development of social workers and managers across our service, starting with our ASYEs (newly qualified social workers). Our CoE Practice Lead delivers bespoke training and development workshops for ASYEs which build upon our learning from audit, Practice Weeks and compliments and complaints received by our service.

In collaboration with staff and children and young people we also launched 6 Working Principles which support and guide our interventions and decision making.

Child Centred
We are all about supporting children and young people. They are our priority.

Working Together
We work with children, young people and their families to achieve positive change.

Family Solutions
We value a family's ability to solve their own problems. We help families to do this and only intervene when needed.

Safely at Home
Our aim is to keep children safely at home. Where this is not possible, we will find somewhere safe for them to live for as long is needed.

Balanced Response
We manage risk by working together. We are evidence based and balanced.

Challenge and Support
We challenge ourselves and support each other. We welcome challenge and support from others.

We have reduced agency staffing within the service and successfully recruited practitioners to permanent posts who benefit from a revised and robust induction offer giving all staff that join us a formal and warm welcome to our service.

We have increased our inhouse fostering households with more than 15 new foster family placements and opened two new, smaller children's homes, which support us to care for some of our most vulnerable and complex young people.

In March 2020, we held our third practice week. Practice Weeks have become a valued part of our Quality Assurance activity and are enjoyed by managers and staff across the service as a chance to focus on practice and the experiences of children, young people and their families. We have begun to theme the weeks and March saw us deliver our 'We Care About Care' Practice week, considering the experiences of children in our care. We are now preparing for our Practice Week in October 2020 which will consider the quality of assessments and plans for children and young people.

Corporate safeguarding

Corporately our Corporate Safeguarding Training Group have continued to meet to ensure that our workforce across the Council are confident in their role in protecting adults at risk of abuse and neglect and have the skills and knowledge to raise any concerns.

The work of the Corporate Safeguarding Group builds upon the principle that safeguarding is a core element of all job roles and recognises the valuable role that staff from across our directorates can play in identifying and responding to safeguarding concerns. In 2020/2021 the Corporate Safeguarding Group will launch a new "Keeping Everyone Safe" programme for all Newcastle City Council staff.

Early Help

As a multi-disciplinary system approach to supporting families in Newcastle, Early Help supports and protects vulnerable children and young people from conception, through birth and the earliest years of a child's life, through key transition times into primary and secondary school until 18, and by providing whole family support when difficulties first arise and when they require a more coordinated, targeted response. Early Help is the responsibility of all agencies in the city.

The majority of a child or family's needs are met by universal services in the city. Early Help is when a child or family need more support than universal services routinely provide. Early Help can be a single agency, enhanced response, such as midwifery additional support during pregnancy, health visitor additional support e.g. for a mother with post-natal depression or a school response to an attendance issue. Where families require more targeted additional support from more than one agency, then they are supported by a whole family assessment and plan. The Local Authority's framework for this is the Early Help Assessment and Plan but other whole family assessment documents such as the Health Needs Assessment and the Youth Justice Service assessment can be used.

Families access Early Help support in a number of ways;

- by speaking to a universal service who offers support, signposts to services or undertakes an assessment of need;
- by accessing a Community Family Hub building or other community building managed and staffed by council, or commissioned services who offer support, signpost or assess need and offer targeted support;
- by contacting the Early Help Access Point managed by the Local Authority who signpost to relevant services and / or undertake an assessment of need;

following a referral to Children's Social Care that does not meet threshold, but ongoing support needs are identified, Early Help is "recommended" and;

following the end of a Children's Social Care intervention in which the family are "stepped down" to Early Help.

The Early Help system has a Partnership governance structure in place led by the Early Help Board. The purpose of the Early Help Board is to ensure there is a single accountable Board with a remit across all Early Help Services to establish the direction of work being undertaken and ensuring system level outcomes are met. The board comprises of senior managers and decision makers from multi-disciplinary services across the city.

The Local Authority also has a leadership role in ensuring those families requiring targeted support via a whole family assessment of need are supported by a quality assessment. Assessments are regularly reviewed to avoid case drift and to ensure relevant paperwork collating outcomes is submitted.

Early Help has an audit framework which ensures that cases logged as an Early Help Assessment and Plan by any service in the city, including families supported by commissioned or targeted services within the Community Family Hub are reviewed in each locality with feedback provided to the Service Improvement Lead for collation and dissemination in quarterly reports.

Multi-agency audits of Early Help Assessments led by health, school, housing etc will be completed in the future.

There are joint Early Help and Children's Social Care audits of; Early Help Recommended cases, Step downs and cases that have been open to targeted Early Help support for over 9 months. Reviewing decision making, quality of assessments and referrals made, and support offered, ensures feedback is shared with practitioners and managers within both Early Help and Children's Social Care.

Some key themes from audits of 2019/2020 Q4 cases;

- there is a wealth of interventions delivered to families evidenced in assessments and case recordings
- there is clear evidence of children's and parents' involvement in assessments although more could be done to ensure the child's lived experience is referenced in some assessments and case recordings
- there are some issues with case recording which has led to training being commissioned
- there is more to be done to monitor and understand why families disengage from Early Help services

"Things feel nicer at home and he has been having nice times with mam and dad. He talked about how he hasn't been nasty to gran or mam - he has just gone to his bedroom to calm down".

Safeguarding in schools

Newcastle City Council Education and Skills works closely with NSCP to ensure that the safety and wellbeing of children in the city is paramount. The division provides a number of services that aim to maximise the achievement and promote the welfare of children in education for example, by supporting effective teaching via the schools effectiveness service and liaising closely with schools alongside statutory processes, such as admissions, attendance and SEND assessments to ensure that education is accessible to all. The MASH education post based in the Multi-Agency Safeguarding Hub (MASH) continues to facilitate information from schools, allowing education information to be shared in multi-agency discussions in a timely way.

Children Missing Education (CME)

CME are “children of compulsory school age who are not registered pupils at a school and are not receiving suitable education otherwise than at a school. Children missing education are at significant risk of underachieving, being victims of harm, exploitation or radicalisation, and becoming NEET (not in education, employment or training) later in life” (Department for Education, 2016). This area therefore is a continued priority for the Local Authority (LA).

99 online children missing education referrals were made to the local authority from Newcastle schools in 2019/20 – a reduction of 10% compared to 2018/19 referrals.
There was a significant peak during the first academic term following the summer break which is consistent with previous years. Checking and reporting systems have been developed, including linking into the national census data to enable the local authority to search to see if a child missing education is attending a school anywhere else in the UK.

Close multi agency links developed including robust working with the Police. Staff specialising this area have developed their knowledge by attending a national CME workshop in February 2020 and with this added learning we hope to make this process even more effective and ultimately reduce the numbers in this highly vulnerable group.

Not in Education, Employment or Training (NEET)

In March 2020, 90.9% of young people aged 16 and 17 years of age known to Newcastle Upon Tyne were recorded as meeting the duty to participate in education, employment or training, compared to a national figure of 92.7%. The Connexions service provides support, advice and guidance to young people between 13 and 19 years old, and up to 25 years old for learners with a learning disability or difficulty. This service helps to improve outcomes as learners approach adulthood, particularly those who are NEET or at risk of becoming NEET.

Permanent Exclusion

Between April 2019 to March 2020, there were 134 permanent exclusions. The Access and Inclusion Service have been working with families and schools around permanent exclusions and this has resulted in 14 permanent exclusions being withdrawn. Reducing the overall number of permanent exclusion remains a key priority for the LA Education and Skills service and this is being achieved by supporting and challenging schools and parents in this area to ensure that the process is carried out fairly and with as little disruption to the child’s education as possible.

Elective Home Education (EHE)

The number of children who are EHE continues to increase- LAs nationally reported an average 20% year-on-year increase (Elective Home Education Survey 2019, ACDS) in the number of children and young people known to be home schooled over the previous 5 years. This reflects what is happening in Newcastle and neighbouring authorities. 0.5% of the school population in Newcastle are registered as being home educated, this is comparative to our statistical neighbours. Therefore, this is an area where sustained support, intervention and multi-agency working is being carried out to ensure that these children are safe, well and receiving a suitable education while in a home learning environment.

Section 175

The Section 175 safeguarding audit was carried out among nurseries, FE colleges and first, primary, secondary, special, free and independent school for the academic year 2020.

100% of schools and settings responded to the audit questionnaire. The thorough and detailed responses confirm that all schools and settings carry out their functions to safeguard and promote the welfare of children. The audit was also successful in highlighting some areas of good practice as well as aspects that can be improved, which will be used as a source to support schools and settings further.

OFSTED

There have been 24 Ofsted visits between April 2019 to March 2020, with 10 of these being Section 5 inspections. A Section 5 inspection is a two-day full inspection of an education provider by Ofsted. 100% of schools/settings have had positive feedback around safeguarding arrangements.

As an organisation we ensure that all our training is up to date and have robust monitoring systems in place for this, and have an effective triage and web-based reporting system.

As all organisations, we have delivered care and treatment under Covid-19 restrictions.

When the pandemic first began, we went through all caseloads and RAG rated them, and ensured that delivery of care and treatment was completed as required. Those who required face to face contact received it with all precautions in place, and for others virtual platforms were used.

Whilst working under Covid-19 restrictions, each safeguarding board and CCG has requested bespoke data and narratives with regards assurances that we have continued to deliver our service to a high standard.

The Named Nurse for Children's safeguarding has contributed to these calls, and also cascaded back into the organisation any learning or concerns raised.

Our report writer attends the NSCP Learning and Improvement Group and any learning and improvement of our services is brought back via that method.

We also have one of our practitioners who completes all our PREVENT work and attends the CHANNEL panels.

The trust collects all feedback via our points of view system, and reports upon these to our commissioners.

Case study

Counter Terrorism Police charged a 16 year old boy from Newcastle for offences of Inviting Support for a proscribed organisation (Contrary to Section 12 Terrorism Act 2000), Encouraging Terrorism (Contrary to Section 1 Terrorism Act 2006) and offences relating to the incitement of racial hatred (Contrary to Public Order Act 1986).

The offences came to light following a review of social media postings believed to have been made by him.

The individual is known to be on the autism spectrum and receiving support from Mental Health services for this.

There is material that tends to support the view that the individual possess right wing white supremacist extremist views and as he lives with younger siblings and vulnerable adults there are genuine concerns that other family members / associates may have been exposed to extremist material and developed or be developing similar views.

CNTW involvement:

- SAPP PREVENT lead acted as appropriate adult throughout a 24hr period when the individual was originally arrested and quested in October 2019
- SAPP PREVENT lead has also liaised extensively with counter terrorism Police throughout the period

Clinical involvement

- Newcastle/Gateshead Children and Young People Services
  - Forensic Children Adolescent Mental Health Service

Our continued support to resource and work within Multi Agency Safeguarding Hubs (MASH) ensures that problems are identified at an early stage following submission of a child concern notice. Referrals are subject to multi-agency triage within the MASH arrangements for children which enables partners to come together and work collaboratively to safeguard children.

An additional Police Staff Investigator at Newcastle MASH has been recruited which will improve our capacity to attend Initial Child Protection Conferences, quality assure Child Concern Notifications and process Child Sex Offender Disclosure applications (Sarah's Law). In the first half of 2020 we have processed 44 Sarah's Law applications, an increase of 37.5% over the same period last year.

We have recruited a further 4 missing from home coordinators in 2020, three of which will be working in Newcastle – which is great news for police and partners as it means we can concentrate on multi agency problem solving for repeat missing children with a focus on prevention and safeguarding. Our MFH coordinators work closely with Children's Social Care to coordinate our response to vulnerable missing persons.

Our operational response to Safeguarding Children and investigating offences against Children is managed by a Detective Chief Inspector and a Detective Inspector within Northumbria Police's Child and Adult Protection team in Safeguarding Department.

Both the DCI and DI engage in NSCP meetings providing Police input on leadership and operational issues. The Strategic MSET meeting is chaired by a DCI from Northumbria Police and reports to the NSCP board, whilst the operational MSET meeting is chaired by a DI.

Northumbria Police are leading the Violence, Vulnerability & Exploitation Coordination Group (VVECG) pilot project which will start in 2020. The VVECG is a multi-agency pilot project designed to tackle and disrupt criminal exploitation of children and young people. The key focus is delivering effective early intervention partnership working to safeguard higher risk victims and divert, deter or pursue high harm offenders.

Northumbria Police fully engage with the learning and improving framework established under NSCP governance. A DCI sits on the Case Review Group and Child Death Overview Panel to identify any areas for learning from cases and from learning reports. A DI sits on the Learning and Improvement Group to provide operational input from the Police.

We are a key partner to the multi-agency Northumbria Violence Reduction Unit (VRU), with a Police Chief Inspector embedded within the project as project manager and the chair of the multi-agency Northumbria Serious Violence Reduction Board being the Police and Crime Commissioner.

Established in 2019, this is a public health approach to tackling serious violence and identifying key drivers which cause people to become victims or perpetrators of serious violence. We hope this will have a positive effect on tackling knife crime and domestic homicides. The focus of the VRU is about education and preventing young people and children from being involved in crime, giving them the best opportunities to succeed.

Case study

K was a frequent missing child who became involved in drug use and subsequently had problems with drug debts. K had been in foster care for several years and over a three month period was reported missing on 17 occasions. During one episode K was missing for 8 days. Due to K's drug use and debt, K even stole from their mother to pay debts.

K was managed at MSET and was subject of several strategy meetings.

Police were able to intervene in the criminal activity and during one missing episode at Christmas the Police missing from home coordinator and missing Social Worker worked together to find K, who was with their father who was homeless.

Working together, Police, Social Care and Housing services were able to secure a property, help with benefits and financial management, and involve drug and alcohol services to help K and their father.

K was able to spend their first Christmas with their father.

SCARPA (Safeguarding Children at Risk Prevention and Action) provide support to children and young people at risk of, or affected by exploitation, as well as young people who go missing from home or care. We strive to develop meaningful engagement, ensuring we tailor support around the needs of the individual and persevere to ensure that children and young people are given the opportunity to fulfil their potential by making positive informed decisions and safer choices.
We support the exploration and development of strategies to promote emotional wellbeing, whilst providing a platform that ensures the voice of the young person is heard and acted upon.
Our services provide a pathway of support, include one-to-one targeted youth support, Return Home Interviews (RHI) for young people who have had a missing episode, training to professionals around raising awareness of exploitation, mentoring and group work via SCARPA Squad; a group of young people who help raise awareness around issues of missing and exploitation who have previously received one to one support from a SCARPA Project Worker. SCARPA work closely with statutory services such as Children's Social Care and Police and are part of both the strategic and operational MSET, ensuring the most vulnerable children have access to support tailored to their needs. During this period The Children's Society in Newcastle made 30 safeguarding referrals to Children's Social Care, undertook over 400 RHI's with vulnerable, missing children 'at risk'. Of those 400 RHI's, we identified 30 young people who required additional support. 15 young people were referred for continued mentoring support. We also delivered awareness raising sessions to over 40 local frontline practitioners throughout the year.

Our Children in Need Boys and Young Men's project has continued to deliver tailored one-to one targeted youth support to over a dozen boys and young men that have experienced exploitation. Our programmes of support ensure young people experiencing or at risk of Child Criminal Exploitation are provided with an environment that enables them to explore issues that affect them, such as mental and emotional wellbeing, peer influence and family relationships with the aim of developing coping mechanisms and support young people to identify unhealthy influences.
The Project has from the outset sought to raise awareness of Child Criminal Exploitation and bring system change to the way that young men and boys are viewed by statutory agencies, to ensure that they are "safeguarded" and not criminalised.

Through our engagement with young people, we have been able to map out patterns of exploitation resulting from gang activity and have shared these findings with the Local Authority and Police. We are extremely keen to extend this aspect of the work, with young men who are already actively involved in gang culture. We want to understand why it is that these young men are seeking our support, and develop new ways of working to identify the sort of interventions and ways of working that are likely to engage these young men and help them exit the gang lifestyle.

Our 'My Voice' emotional health, well-being and resilience programme has delivered anti-knife crime programmes to over 200 vulnerable young people in local schools and colleges across the region and has worked with students in 4 Newcastle schools.

The Good Childhood Report 2019 is the eighth in our annual series and alongside the latest trends in children's well-being, also focused on family dynamics, financial circumstance, multiple disadvantage and children and young people's perspectives about their future. We hosted a well-attended event at the Sage Gateshead, to launch the report locally and we are calling on the Government to introduce national measurement of well-being for all children aged 11-18 to be undertaken through schools and colleges once a year. This would enable the experiences of young people to be recorded and issues acted upon for future generations. Based on the latest figures we estimate a quarter of a million children are unhappy with their lives, with factors like friends, school and appearance all playing a role.

Northumbria Community Rehabilitation Company PROBATION

Northumbria Community Rehabilitation Company's (CRC) clear vision and priorities for safeguarding children are outlined in our Safeguarding Children Policy Statement and Safeguarding Children Staff guidance. Both documents were substantially revised in 2019/2020 to reflect changes in legislation and recent practice developments and challenges. Both documents are now on the staff intranet and have been focused on in team briefings.

Northumbria CRC remains committed to contributing to learning opportunities that may help us further develop and improve frontline practice. We have shared with staff throughout the year key messages from local and national safeguarding practice reviews.

Northumbria CRC requires all staff to attend refresher safeguarding training every 3 years, preferably in a multi-agency context to enhance the learning experience. In the last 12 months we have enabled a substantial proportion of the workforce to attend internal or external safeguarding training events. In internal staff briefings we have covered safeguarding to raise awareness of issues such as child criminal and sexual exploitation (including county lines activity) and to further develop the professional curiosity and persistence of our staff group. We have also issued to staff a series of '7 Minute Briefings' on a variety of topics related to safeguarding (Risk Review and Evaluation, Online Radicalisation, County Lines and Professional Curiosity) and we encouraged them to view these with colleagues to allow the opportunity for reflection and practice discussion. Each of our local management centre teams now has a safeguarding SPOC who can support colleagues in their day-to-day practice and raise issues at our Practice Advisory Group for discussion and the development of CPD materials.

Good quality risk assessment and risk management practice are imperative to our work with service users, to best protect the public and reduce harm in our local communities. Our recent inspection by HMIP and Operational Assurance Audits demonstrated that Northumbria CRC is committed to ensuring our staff continue to prioritise safeguarding activity in their day-to-day practice.

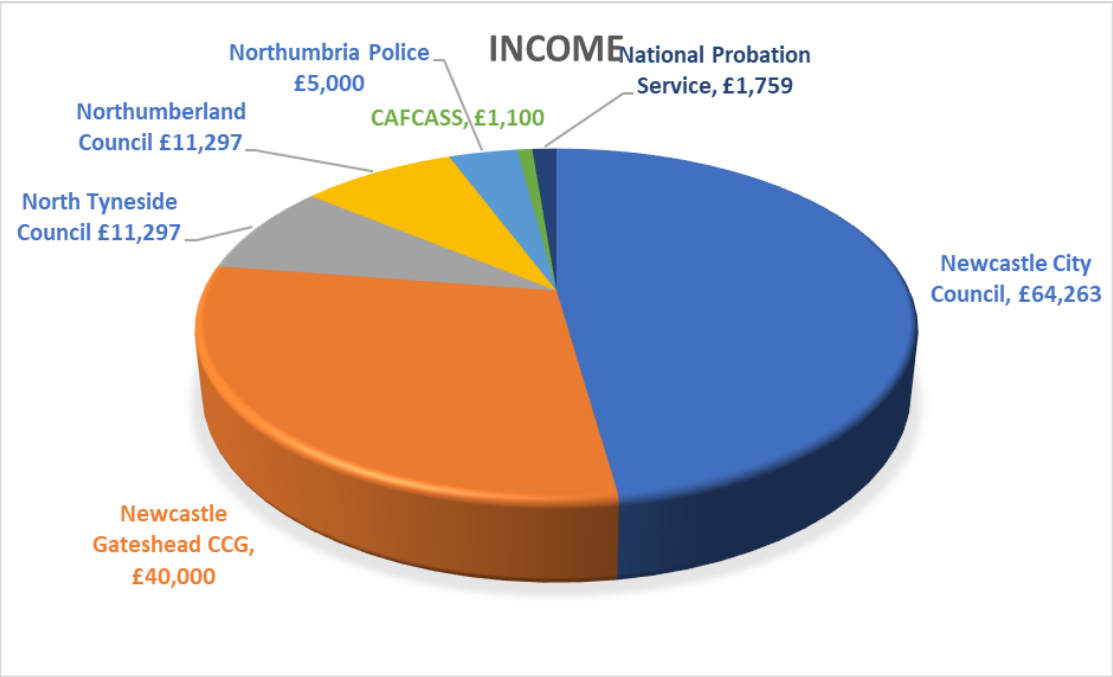
MEMBERSHIP

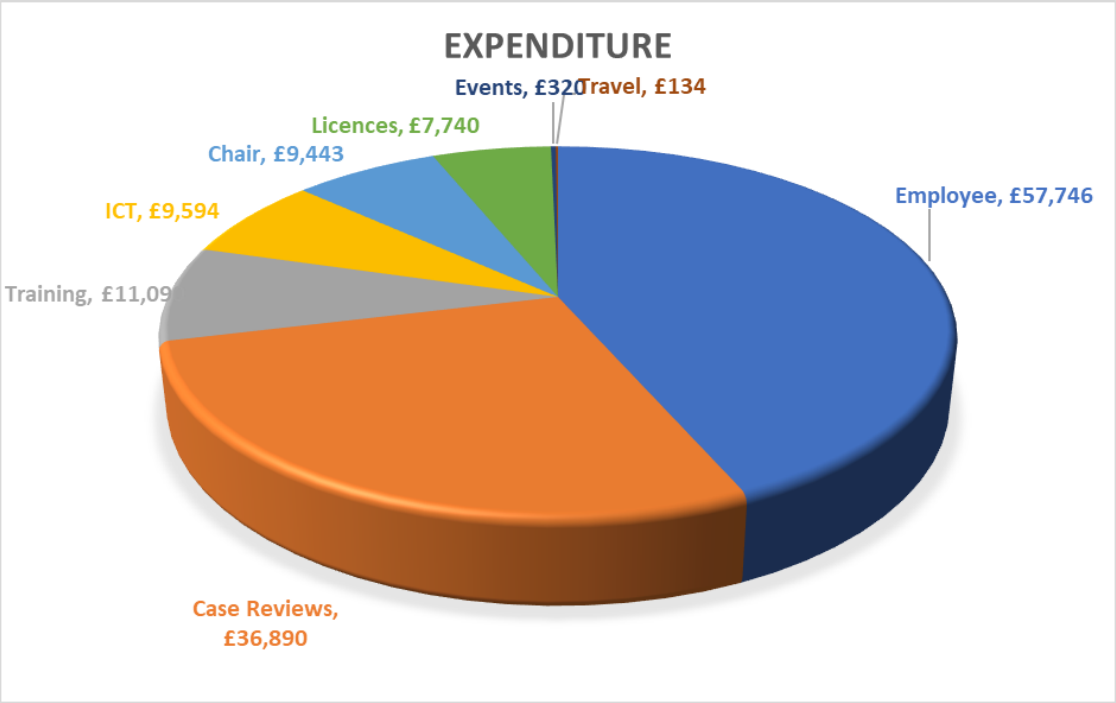
Agency	Title
Independent	Chairperson
Newcastle City Council	Director of Children, Education and Skills Assistant Director of Children Assistant Director of Education and Skills Cabinet Member for Children, Education and Skills Senior Legal Advisor
Northumberland Tyne and Wear NHS Foundation Trust	Group Nurse Director
NHS Newcastle Gateshead Clinical Commissioning Group	Executive Director of Nursing, Patient Safety and Quality
The Newcastle upon Tyne Hospitals NHS Foundation Trust	Executive Chief Nurse Designated Dr Child Protection
Northumbria Police	Detective Chief Superintendent, Safeguarding
Northumbria Community Rehabilitation Company	Deputy Director (North of Tyne)
National Probation Service, North of Tyne	Head of North of Tyne Cluster
Tyne and Wear Fire Service	Group Manager, Service Delivery North
Newburn Manor Primary School	Head Teacher
Public Health	Director of Public Health
Your Homes Newcastle	Customer Services Director Assistant Director Support Services
NSPCC	Service Manager
The Children's Society	Area Manager North East
Angelou Centre	Deputy Director & VAWG Services Manager
CAFCASS	Service Manager

The NSCP is supported by a Co-ordinator, Senior Business Support Officer, Training and Development Officer and a Legal Advisor, Performance Analyst and Press Officer from Newcastle City Council.

Budget

The NSCP acknowledges, in addition to financial contributions, the significant amount of 'in kind' contributions that partners provide through attending and chairing meetings, leading on task and finish groups and other pieces of priority work and delivery of training.





“Safeguarding children and young people is everyone’s responsibility”

If you are worried or have a concern about a child or young person contact:

Northumbria Police on 101

If there is immediate danger contact

999

For advice or to make a referral about a concern for a child or young person contact:

Children’s Social Care Initial Response Service

0191 277 2500

Anonymous referrals can be made by members of the public

Practitioners should use the online referral form

https://www.nscb.org.uk/have-concerns-about-child

Emergency Duty Team

0191 278 7878

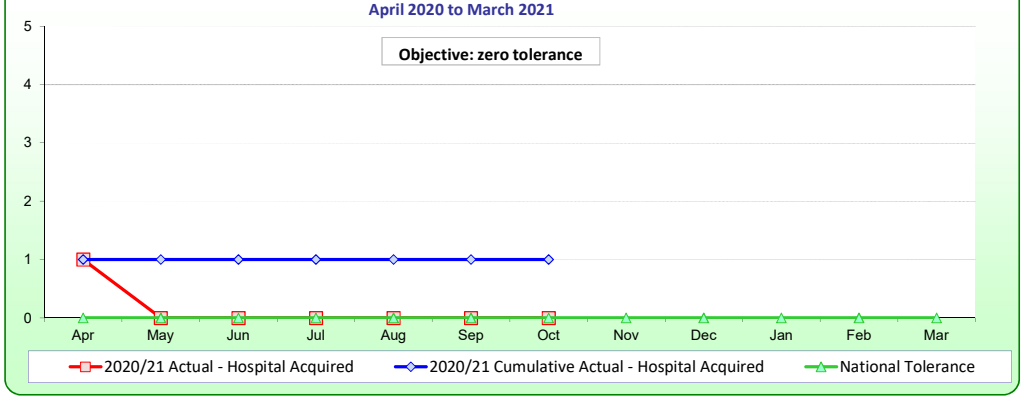
https://www.nscb.org.uk/

Appendix ii

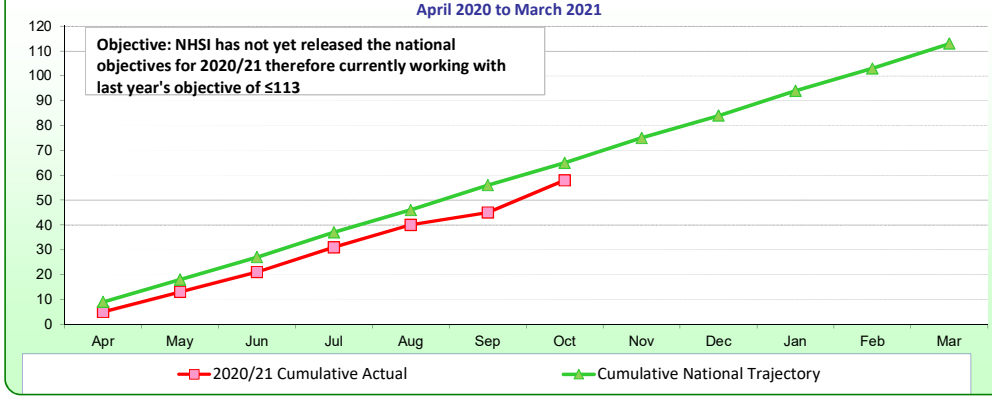
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Healthcare-Associated Infections Report
October 2020

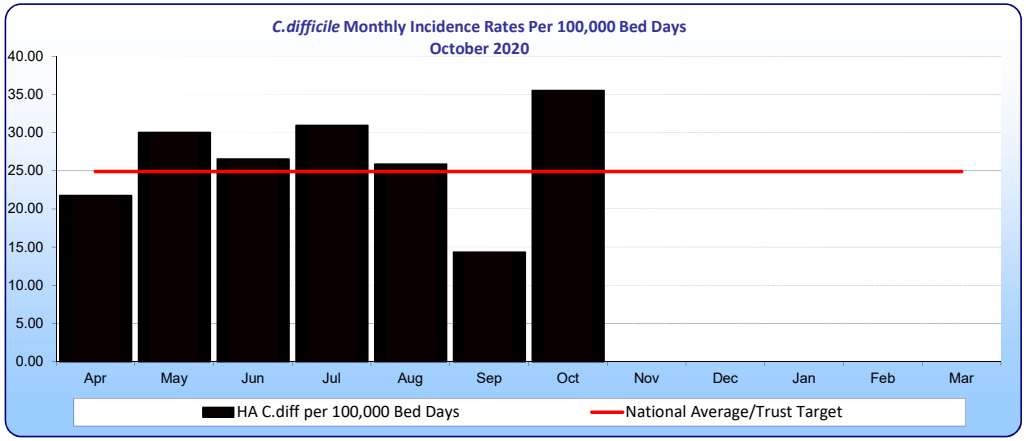
MRSA Bacteraemia - Cumulative Performance
April 2020 to March 2021



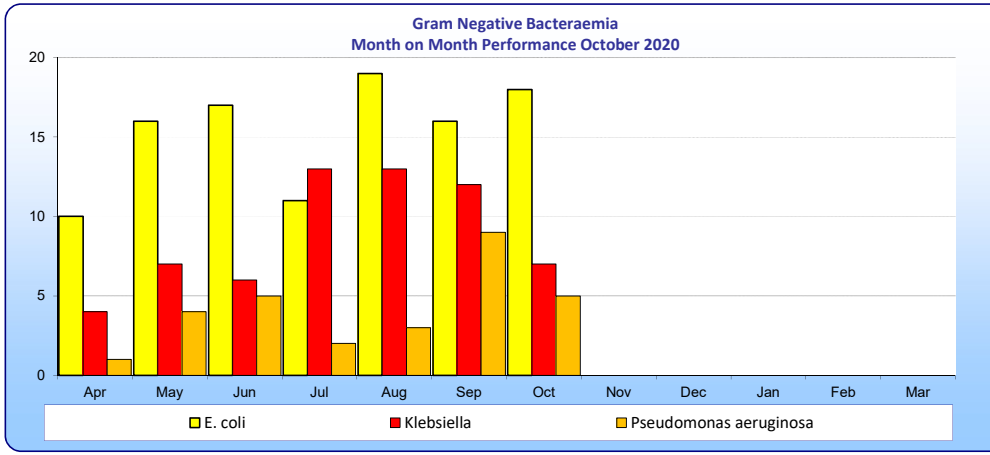
C. difficile - Cumulative Performance
April 2020 to March 2021



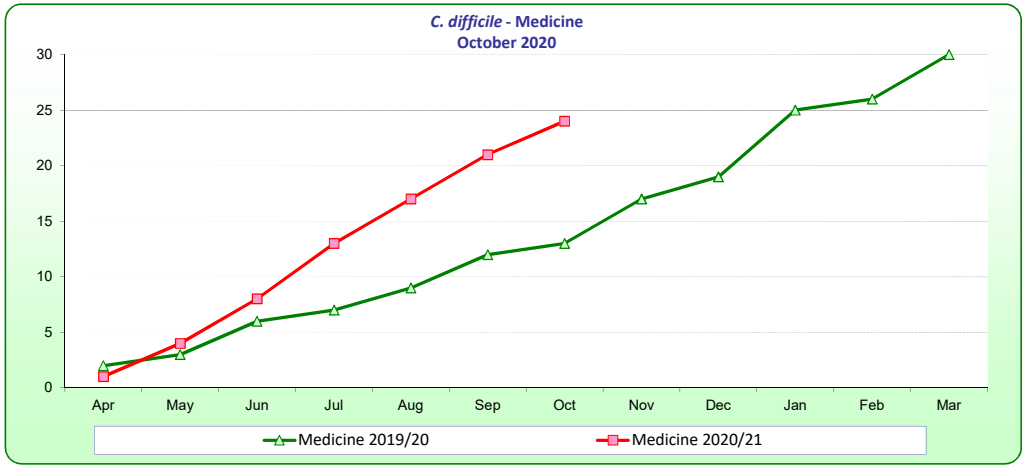
C.difficile Monthly Incidence Rates Per 100,000 Bed Days
October 2020



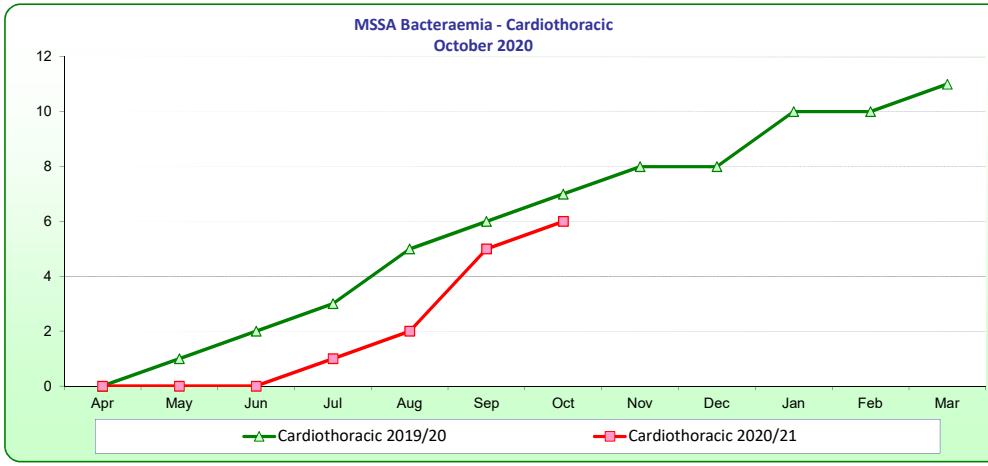
Gram Negative Bacteraemia
Month on Month Performance October 2020

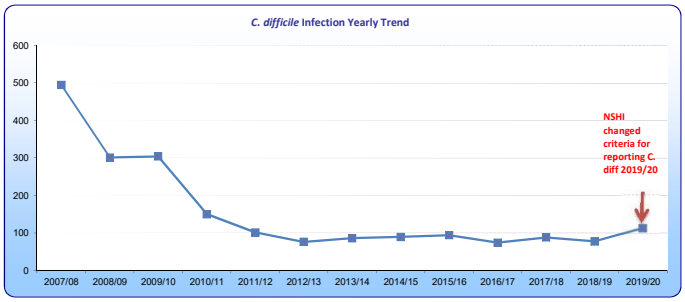


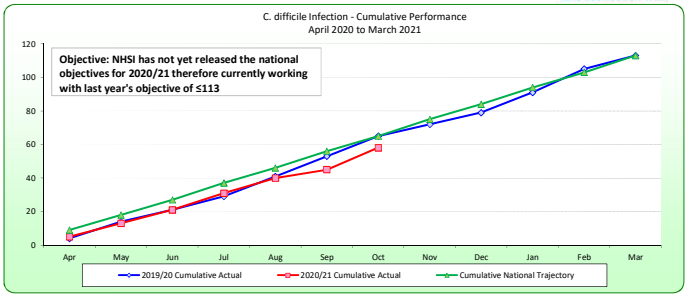
C. difficile - Medicine
October 2020

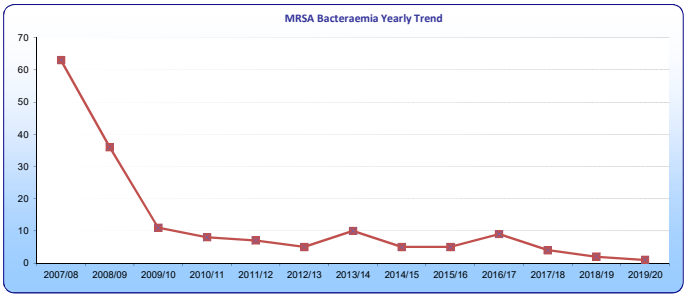


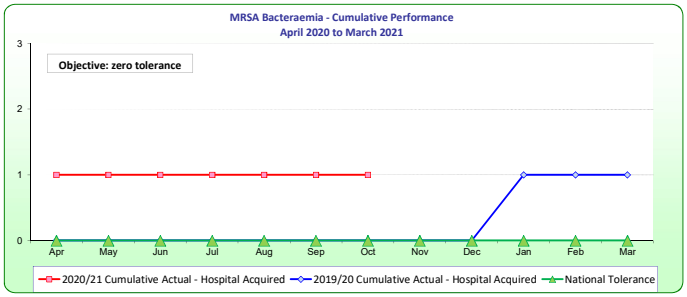
MSSA Bacteraemia - Cardiothoracic
October 2020

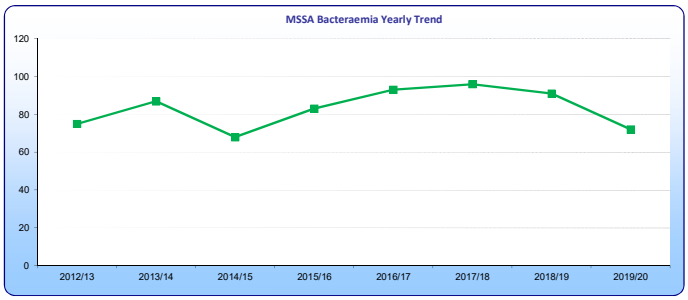


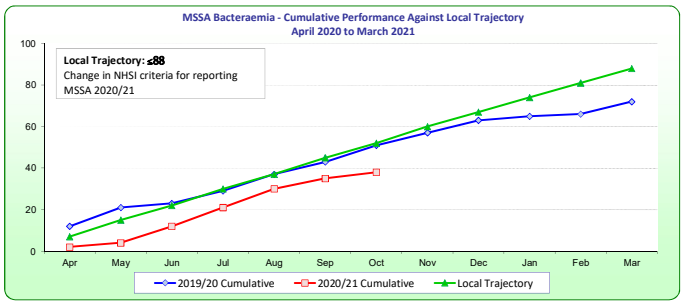

C. difficile Infection Yearly Trend
NSHI changed criteria for reporting C. diff 2019/20
2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
2019/20

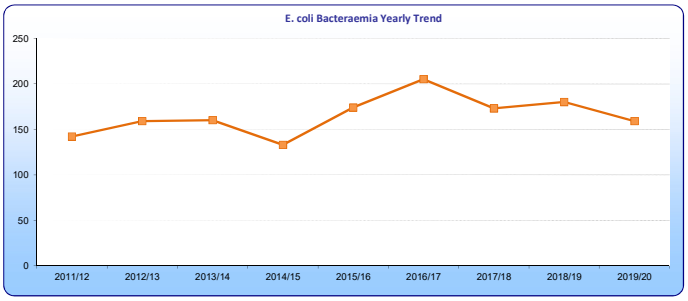

C. difficile Infection - Cumulative Performance
April 2020 to March 2021
Objective: NHSI has not yet released the national objectives for 2020/21 therefore currently working with last year's objective of ≤113
2019/20 Cumulative Actual
2020/21 Cumulative Actual
Cumulative National Trajectory

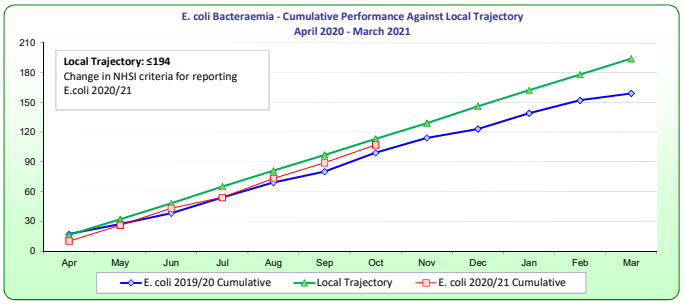

MRSA Bacteraemia Yearly Trend
2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
2019/20

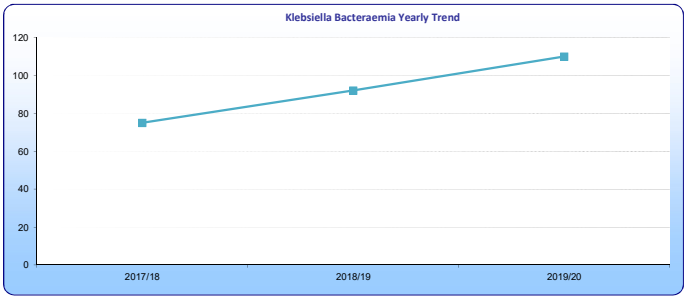

MRSA Bacteraemia - Cumulative Performance
April 2020 to March 2021
Objective: zero tolerance
2020/21 Cumulative Actual - Hospital Acquired
2019/20 Cumulative Actual - Hospital Acquired
National Tolerance

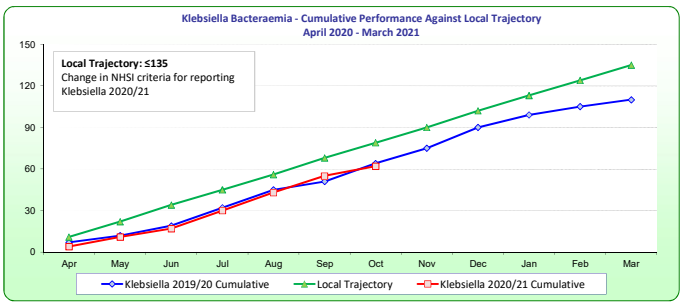

MSSA Bacteraemia Yearly Trend
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
2019/20

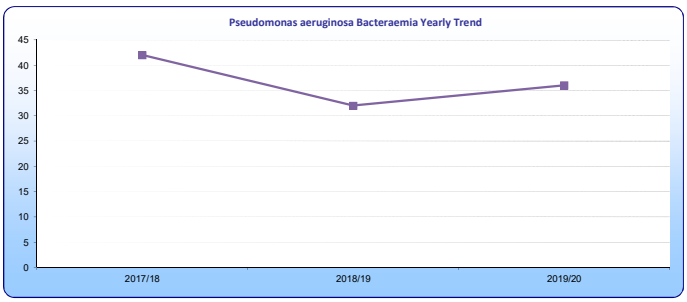

MSSA Bacteraemia - Cumulative Performance Against Local Trajectory
April 2020 to March 2021
Local Trajectory: ≤88
Change in NHSI criteria for reporting MSSA 2020/21
2019/20 Cumulative
2020/21 Cumulative
Local Trajectory

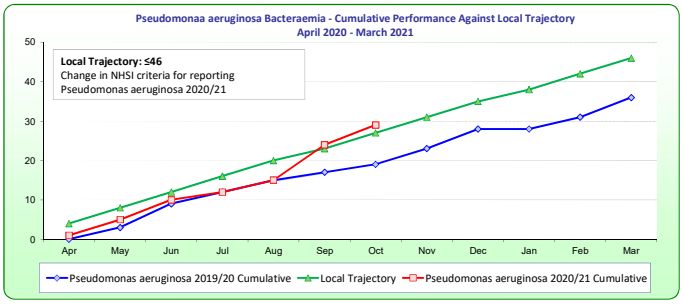

E. coli Bacteraemia Yearly Trend
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
2019/20


E. coli Bacteraemia - Cumulative Performance Against Local Trajectory
April 2020 - March 2021
Local Trajectory: ≤194
Change in NHSI criteria for reporting E.coli 2020/21
E. coli 2019/20 Cumulative
Local Trajectory
E. coli 2020/21 Cumulative


Klebsiella Bacteraemia Yearly Trend
2017/18
2018/19
2019/20


Klebsiella Bacteraemia - Cumulative Performance Against Local Trajectory
April 2020 - March 2021
Local Trajectory: ≤135
Change in NHSI criteria for reporting Klebsiella 2020/21
Klebsiella 2019/20 Cumulative
Local Trajectory
Klebsiella 2020/21 Cumulative


Pseudomonas aeruginosa Bacteraemia Yearly Trend
2017/18
2018/19
2019/20


Pseudomonaa aeruginosa Bacteraemia - Cumulative Performance Against Local Trajectory
April 2020 - March 2021
Local Trajectory: ≤46
Change in NHSI criteria for reporting Pseudomonas aeruginosa 2020/21
Pseudomonas aeruginosa 2019/20 Cumulative
Local Trajectory
Pseudomonas aeruginosa 2020/21 Cumulative

The Newcastle upon Tyne Hospitals NHS Foundation Trust

IPC indicators (reported to DH)	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
MRSA Bacteraemia - non-Trust	-	-	-	-	-	-	-						0
MRSA Bacteraemia - Trust-assigned (objective 0)	1	0	0	0	0	0	0						1
MRSA HA acquisitions	1	1	4	1	1	5	1						14
MSSA Bacteraemia - post-48 Hours Admission (local objective ≤65)	2	2	8	9	9	5	3						38
E coli Bacteraemia - post-48 Hours Admission (local objective ≤144)	10	16	17	11	19	16	18						107
Klebsiella Bacteraemia - post-48 Hours Admission (local objective ≤99)	4	7	6	13	13	12	7						62
Pseudomonas aeruginosa Bacteraemia - post-48 Hours Admission (local objective ≤33)	1	4	5	2	3	9	5						29
C.diff - Hospital Acquired (objective ≤113)	5	8	8	10	9	5	13						58
C.diff related death certificates	-	-	-	2	1	0	0						3
Part 1	-	-	-	-	1	0	0						1
Part 2	-	-	-	2	0	0	0						2

Periods of Increased Incidence (PIIs)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
MRSA HA acquisitions	-	-	-	-	-	-	-						0
Patients affected	-	-	-	-	-	-	-						0
C.diff - Hospital Acquired	-	-	-	1	0	1	2						4
Patients affected	-	-	-	2	0	2	4						8

Outbreaks	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Norovirus Outbreaks	-	-	-	-	-	-	-						0
Patients affected (total)	-	-	-	-	-	-	-						0
Staff affected (total)	-	-	-	-	-	-	-						0
Bed days losts (total)	-	-	-	-	-	-	-						0
Other Outbreaks	-	-	-	-	2	2	-						4
Patients affected (total)	-	-	-	-	7	17	-						24
Staff affected (total)	-	-	-	-	16	0	-						16
Bed days losts (total)	-	-	-	-	59	23	-						82
COVID Outbreaks	-	-	-	-	-	3	8						11
Patients affected (total)	-	-	-	-	-	2	17						19
Staff affected (total)	-	-	-	-	-	10	58						68
Bed days losts (total)	-	-	-	-	-	119	398						517

C.diff Transit and Testing Times Target <18hrs	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
Trust Specimen Transit Time	10:30	11:13	12:01	12:23	10:32	13:34	10:50						11:34
Laboratory Turnaround Time	02:27	02:08	03:18	03:25	03:00	03:18	03:00						02:56
Total to Result Availability	0.53958	13:21	15:19	15:48	13:32	16:52	13:50						14:31

Hygiene Indicators/Audits (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
CAT Trust Total	CAT currently suspended due to COVID-19 pandemic												#DIV/0!
Hand Hygiene Opportunity													#DIV/0!
Hand Hygiene Technique													#DIV/0!
Environmental Cleanliness													#DIV/0!

Infection Control Mandatory Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
Infection Control	85%	85%	85%	86%	86%	87%	87%						86%

Aseptic Non Touch Technique Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
ANTT (M&D staff only)	61%	61%	61%	61%	60%	59%	58%						60%

COVID-19 Outbreaks - 01/09/2020 to 31/10/2020

The Newcastle upon Tyne Hospitals NHS Foundation Trust

AREA	DATE OUTBREAK DECLARED	EXPECTED DATE OF OUTBREAK CLOSURE	PATIENTS		STAFF		NUMBER OF BED DAYS LOST TO DATE (ROLLING)
			NUMBER OF POSITIVE	NUMBER OF CONTACTS	NUMBER OF POSITIVE	NUMBER OF CONTACTS	
RVI Plastics Admin Team	14/09/2020	12/10/2020	0	0	3	1	0
RVI Car Parking Team	14/09/2020	12/10/2020	0	0	2	2	0
FH18	19/09/2020	02/11/2020	2	3	6	4	119
FH15	07/10/2020	04/11/2020	2	3	0	0	11
Ophthalmology Waiting List Office	07/10/2020	17/11/2020	0	0	13	8	0
RVI Porters	09/10/2020	06/11/2020	0	0	5	11	0
RV15	16/10/2020	12/11/2020	4	0	3	0	164
RV22	22/10/2020	27/11/2020	5	0	16	3	211
RVI Theatres	26/10/2020	24/11/2020	0	0	5	16	0
FH L6 Medical Secretaries	29/10/2020	27/11/2020	0	0	9	2	0
FH09	31/10/2020	28/11/2020	6	2	7	0	12

Appendix 1

By 2024 We will ensure....	Patients	People	Partnerships	Pioneers	Performance
	We deliver the best possible health outcomes for our patients	We are the recognised employer and educator of choice in the NE	Our partnerships provide added value in all that we do	We lead the way in delivering world class, cutting-edge diagnostics, treatment and care, research, education, innovation and management	We are recognised as a national exemplar in all that we do
	We focus on prevention and population health	We enable all staff to liberate their potential			
	Learning and continuous improvement is embedded across the organisation	We create an environment where all staff and volunteers feel welcome and valued	Patient pathways are streamlined through integration and collaboration	We maximise the benefits from the use of technology	We maintain financial strength and stability

On track

Progress delayed

Risk to delivery / roadblock

Appendix 2: Supporting Strategies

Our vision	Achieving local excellence and global reach through compassionate and innovative health care, education and research				
Our strategic priorities (5 P's) Supporting strategies top priorities:	<u>Patients</u> Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality	<u>People</u> Supported by Flourish, our cornerstone programme, we will ensure that each member of staff is able to liberate their potential	<u>Partnerships</u> We will be an effective partner, developing and delivering integrated care and playing our part local, national and international programmes	<u>Pioneers</u> Ensuring that we are at the forefront of health innovation and research	<u>Performance</u> Being outstanding, now and in the future
Quality Strategy (2018-2021)	**Patient safety** • Reducing avoidable harm and deterioration • Increasing incident reporting and learning from error • Reducing healthcare acquired infections • Safe staffing levels **Clinical Effectiveness** • Ensuring mortality rates are at least within expected limits • Participating in national and local audits • Effective discharge **Patient experience** • Acting on what patients tells us and co-creating solutions to challenges they • Involving patients in their care and embracing the 'nothing about me without me' philosophy				
Clinical Strategy (2015-2019)	• Delivery of core quality objectives • To improve the management of non-elective admissions • To deliver safe & sustainable 7 day and out of hours care		• To deliver whole system, integrated care so that patients are treated in the right place, at the right time, by the right person	• To deliver a comprehensive portfolio of Specialised Services as well as high quality secondary care for the people of Newcastle	• To improve the management of non-elective admissions
Public Health Strategy (2018-2022)	• Primary prevention – reducing smoking prevalence, reducing alcohol related harm, giving every child the best start in life and reducing the prevalence of obesity. • Secondary prevention – reducing premature mortality from CVD, Cancer, COPD and Diabetes • Increasing Flu immunisation • Health and Work • Making Every contact Count (MECC)	• Health and Work	• Making Every contact Count (MECC) • Scaling opportunities for social marketing, communications and public health messages across the NHS		

Appendix 2: Supporting Strategies

Food and Drink Strategy (2016-2021)	• Patient Nutrition and Hydration	• Healthier Food and Drink for Staff and Visitors			• Sustainable Food and Drink
Nursing and Midwifery Strategy (2016-2019)	• Quality of Care and Patient Experience • Nursing and Midwifery Excellence • Working in Partnership	• Nursing and Midwifery Excellence • Working in Partnership	• Working in Partnership		
Dementia Strategy (2015-2020)	• Care and Partnership	• Care and Partnership • Support and Development for Staff	• Care and Partnership • Assessment and Pathways of Care		
Patient, Carer and Public Involvement Strategy (expired 2017) Action Plan in place 2018	• To strengthen patient experience and engagement • Listening and acting on feedback • Information provision • Feedback on Trust services • Influencing planning and decisions about services				
Workforce Strategy (2018)		• Professional and leadership development, including talent management and succession planning • Centre of excellence providing high quality education, training and development • Workforce strategy and planning informed by robust data; aligned to service demands, financial sustainability and use of technology (Right staff; right skills; right place and time) • Facilitate workforce transformation and change • Workforce engagement and wellbeing	• Facilitate workforce transformation and change	• Centre of excellence providing high quality education, training and development	
Leadership Development and Talent Management Strategy (2018-2021) - DRAFT		• Attract more people into leadership positions with a focus on medical and clinical leadership • Attracting and developing more staff currently under represented in leadership roles, in particular, staff that identify as BME. • Adopting a more systematic and consistent approach to succession planning and talent management.			• Supporting and improving the wellbeing of staff. Responding to the on-going leadership challenge of delivering stretching performance targets and financial balance, working within and across the system, leading continuous quality improvement, and being more (publicly) accountable.

Appendix 2: Supporting Strategies

		• Supporting and improving the wellbeing of staff. Responding to the on-going leadership challenge of delivering stretching performance targets and financial balance, working within and across the system, leading continuous quality improvement, and being more (publicly) accountable.			
Integration Strategy (2018 - 2023)	• Focus on frailty		• Intermediate Care • Integrated Health & Social Care • Urgent Care • Integrated Workforce		
IM&T – EPR Strategy (2016-2020)	• More informed, and safer decisions about patient care. • Improving the Patient Experience • Patient Engagement.		• Collaboration across health and social care	• More informed, and safer decisions about patient care. • Improving the Patient Experience • Patient Engagement.	
Research and Innovation Strategy (2018) - DRAFT				• Achieving Nursing Excellence and improving research delivery • Digital solutions from patient to payment • Effective trial set up and oversight	• Recovering and attributing the costs of Research and Innovation • Broadening our Research capacity

Newcastle Specials Growth Strategy (2018 -2023)				• Invest in capital equipment required to exploit commercial opportunities
				  ○ Moxifloxacin Product Development
				  ○ Flucloxacillin Product / OPAT Service Development
				  ○ Continued Investment in Infrastructure Supporting Clinical Trials Manufacture
				• Explore options for secondary production unit	

Surgical Training Centre Strategy (2016-2020)			• Building effective partnerships with other educational bodies to improve the delivery of education material and enhance training programmes • Working with the Human Tissue Authority through Collaboration and Teamwork, working together to achieve the best outcomes	• Education, Development performing to and upholding high standards • Building effective partnerships with other educational bodies to improve the delivery of education material and enhance training programmes • Promote Surgical innovation and research • Positioning for the Future	
Climate Emergency					• Reduce carbon emissions from

Appendix 2: Supporting Strategies

Strategy (2020-25)					building energy use by at least 28% by 2020 (compared to 2013) • Reducing energy demand • Renewables and resilience- identify renewable and other technology opportunities • Trust Culture – promote energy best practice • Information and Data – to identify energy saving opportunities and report performance • Procurement and financial management – to deliver best value • Compliance – manage the Trust's legal obligations and mandatory reporting requirements
Nursing, Midwifery, AHP Research Strategy (2015-2020)	• To provide care to patients and families that is consistent with the best available evidence	• To contribute to the development of research conducted by NMAHPs in the Trust both internally and externally • To increase research capability in the Trust through raising research awareness and promoting a culture of enquiry and critical thinking • To build an infrastructure that will support a research active environment through strong leadership • To create an environment that supports and values the development and maintenance of research skills and experience through improving access to research training and other opportunities.	• To contribute to the development of research conducted by NMAHPs in the Trust both internally and externally • To promote research collaborations that engages with local universities at all stages of the research process.	• To contribute to the development of research conducted by NMAHPs in the Trust both internally and externally • To ensure research that is conducted adheres to principals of good research governance	• To increase research capacity, through increasing the number of research projects and the amount of funding gained for research
Estates Strategy (2018-2023)	• Provide quality environments that foster and facilitate the healing and the well-being of patients, staff and visitors • Premises that are fit for purpose			• Premises that are responsive to changes in medical technology and clinical practice	• Premises that are free from defects and backlog maintenance • Premises that are flexible for alternative uses. • Premises that are responsive to commissioning priorities , demographic trends and changes in service configuration. • Premises that are compliant with all statutory, regulatory and professional standards • Premises that are cost effective in

					operation. • Premises that minimise their energy consumption and carbon footprint.

ACHIEVEMENT OF TRUST STRATEGY - 2020 /21

The Newcastle upon Tyne Hospitals NHS Foundation Trust

By 2024 We will ensure….

PATIENTS Putting patients at the heart of everything we do. Providing care of the highest standard focussing on quality and safety	We will do this by ….	What have we done so far
We deliver the best possible health outcomes for our patients	Developing our quality faculty to build improvement capability in our organisation	Newcastle Improvement has been set up and is working closely with IHI
We focus on prevention and population health	Continuing to develop and deliver the highest number of specialised services	The Trust has recently been awarded contracts for Vaginal Mesh Removal Surgery, Abnormally Invasive Placenta and Termination of Pregnancy services
Learning and continuous improvement is embedded across the organisation	Maximising the use of digital solutions	Use of Attend Anywhere and digital diagnosis

LEAD : Mauyra Cushlow, Andy Welch and Angela O'Brien

By 2024 We will ensure….

PEOPLE Supported by Flourish, our cornerstone programme, we will ensure that each member of staff is able to liberate their potential	We will do this by ….	What have we done so far
We are the recognised employer and educator of choice in the NE	Delivering our people strategy	The Trust is reviewing its People Plan, with involvement from union and staff representatives, including staff networks, along with an action plan to underpin this.
We enable all staff to liberate their potential	Supporting leadership development across the city-wide system to develop strength in integrated working	The successful completion of our first Joint System Leadership programme and a further two joint system leadership development programmes for 48 senior clinicians, managers and social care professionals from the Trust, Council, primary care, CCG, NTW and voluntary sector will be commencing in the New Year.
We create an environment where all staff and volunteers feel welcome and valued		

LEAD : Dee Fawcett and Caroline Docking

By 2024 We will ensure….

PARTNERSHIPS We will be an effective partner, developing and delivering integrated care and playing our part in local, regional, national and international programmes	We will do this by ….	What have we done so far
Our partnerships provide added value in all that we do	Working with our local partners on wider economic strategies	The Integrated Covid Hub North East involves working with local partners including Newcastle City Council and will provide numerous job opportunities for the region
Patient pathways are streamlined through integration and collaboration	Delivering our integration strategy, integrating and streamlining services to patients	The Newcastle Collaborative continues to bring together our 'place' partners to work towards integration of services and has played a large role in managing the Covid response in care homes in the City.

LEAD : Vicky McFarlane-Reid and Martin Wilson

By 2024 We will ensure….

PIONEERS Ensuring that we are at the forefront of health innovation and research	We will do this by ….	What have we done so far
We lead the way in delivering world class, cutting-edge diagnostics, treatment and care, research, education, innovation and management	Achieve our target of being carbon neutral by 2040	Published a Climate Strategy which details how we will achieve our target
We maximise the benefits from the use of technology	Develop & Promote our innovation and commercial strategies	The Commercial Enterprise Unit has started work within the Trust and is working closely with Directorates to fulfil commercial opportunities which are in line with the overall Trust Strategy

LEAD : Vicky McFarlane-Reid, Graham King and Rob Smith

By 2024 We will ensure….

PERFORMANCE Being outstanding now and in the future	We will do this by ….	What have we done so far
We are recognised as a national exemplar in all that we do	Having strong operational performance, meeting targets and standards where appropriate	The Trust has restarted activity in all areas follwing the initial Covid interruprion and continues to work towards returning to previous levels of activity
We maintain financial strength and stability	Having a clear finance and investment strategy which includes securing our finances for the future which requires significant capital investment	Work is continuing on large Capital projects such as the Richardson Wing development.

Angela Dragone and Martin Wilson