Sheffield Safeguarding Children Board

ANNUAL REPORT
2012 – 2013

www.safeguardingsheffieldchildren.org.uk

DP14402

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Introduction from the Independent Chair

Dear Colleagues

The last year has seen the move towards establishing the Safeguarding Children Board as a Learning Board, building on the previous good standards of review, audit and training.

Our well established training programme has been further enhanced this year by linking it to the findings from the Thematic Review of Serious Case Reviews and Case Reviews and has led to a high volume of multi-agency events and seminars. The increased use of the seminar approach has been welcomed by practitioners and managers alike in terms of delivering on focus and time efficiency.

The SSCB launched its Threshold of Need guidance this year and delivered multi-agency seminars to 1000 practitioners across the city building a firm foundation for consistency and clarity.

There has been significant work over the last year on emerging safeguarding issues, which have included tackling the impact of New Psychoactive Substances ('legal highs'), training with the taxi and hospitality trade to raise awareness of safeguarding issues and work within schools on e-safety issues.

The Board has continued to contribute to the national safeguarding agenda through representation on the National Working Group for Child Sexual Exploitation, Child Exploitation and Online Protection (CEOP), and the national Parenting Alcohol Misuse Working Group.

We recognise the importance of participation of young people in the work we do and last year young people undertook a survey on safeguarding and what it means for them to help inform our work. In addition the previous annual report was placed under scrutiny by a Young Advisors panel which was both thoughtful and challenging.

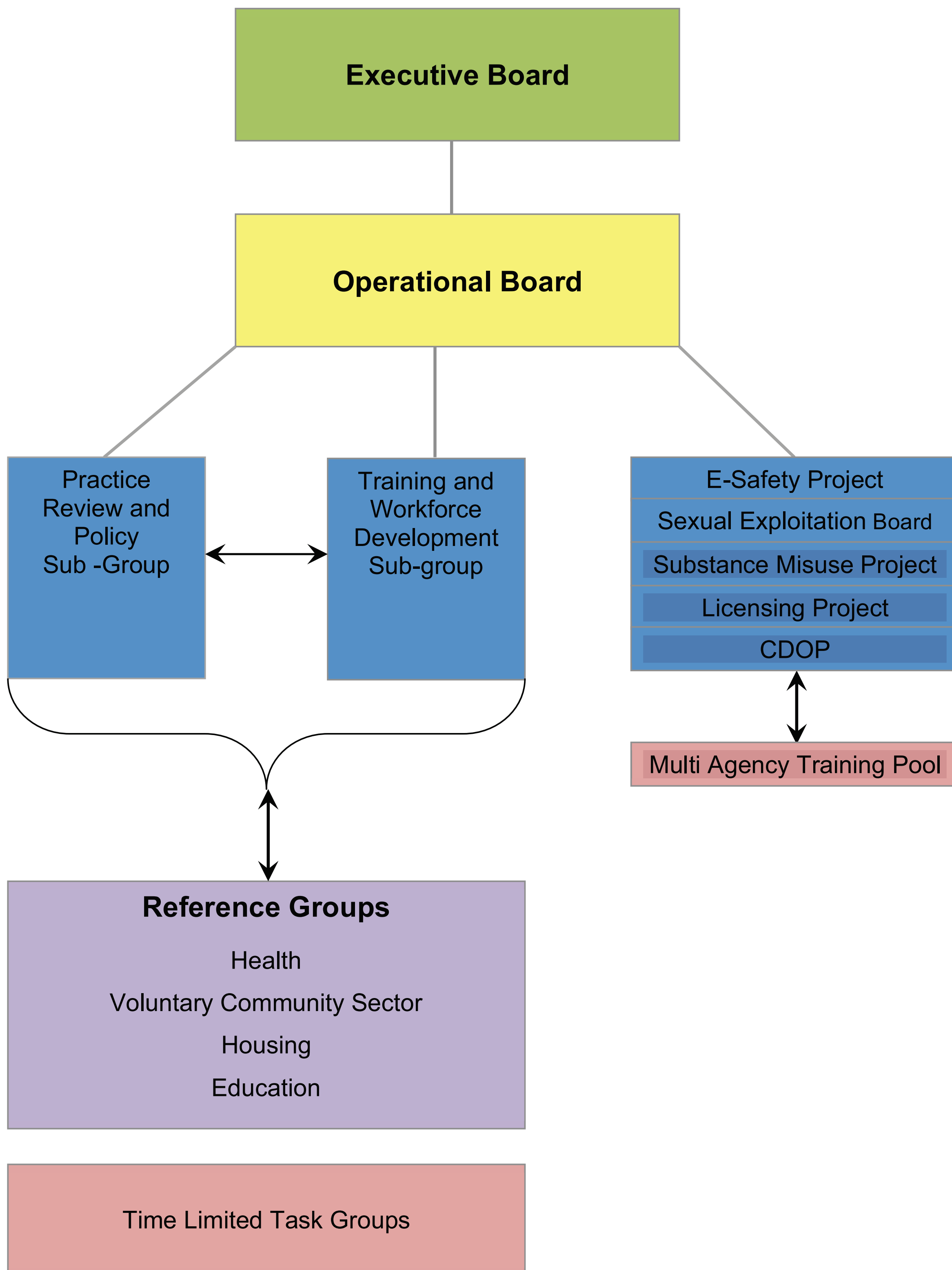
The above shows a focus on quality and learning during a time of financial difficulty for all partner agencies. Safeguarding remains a key priority for Sheffield partners and the Board is determined to see development achieve more for investment.

Finally, I would like to thank workers across the city for the good work over the year of this report and congratulate agencies on open governance and willingness to test leadership and practice.

Sue Fiennes

Independent Chair

Sheffield Safeguarding Children Board Structure



Section One – How Sheffield Agencies Work Together

Engagement, Participation and the Effectiveness of the Board

An effective LSCB is one where all partner agencies feel able to fully participate and engage in the business of the Board. In Sheffield we continue to achieve a high level of attendance at our meetings from the Executive Board through to the sub-groups and reference groups. There is now a clear communication pathway between all the groups which provides a greater understanding of the different roles and responsibilities within the structure and has led to an increased and shared ownership. One of this year's priorities was to develop a Business Plan that identified the key safeguarding priorities for the city and could be delivered by all partner agencies and to achieve this we held a facilitated workshop to agree specific, shared priorities. Regular updates of the Business Plan are provided for all members. The introduction of the bi-monthly Board Officers' report has ensured that all members are regularly updated on current projects and the quarterly newsletter provides a quick dissemination of key information. The data dashboard that provides quarterly updates on Serious Case Reviews (SCR) action plans, the SSCB Business Plan, s.11 action plans and child protection statistics has provided members with the data to enable effective challenge to take place.

One of Sheffield's strengths, which has been recognised by outside facilitators, has been the open and honest engagement of partner agencies in reviews of practice. The move this year to try new methods for undertaking reviews, including the participation of front line practitioners in the process, has been equally embraced and participants have been willing to share their experience to enable us to develop a methodology that best meets the requirements of Sheffield. Partner agencies continue to implement actions from reviews in a timely manner and there has been a continued willingness to engage, learn and embed recommendations into practice. Agencies are required to support the SSCB in the dissemination of key messages and are equipped to do so through resources provided by board officers. For example, following the workshops and seminars for the Threshold of Need guidance and the Thematic Review of Serious Case Reviews, training packages were provided via the website to enable this process to continue. Workers across all agencies are encouraged by their managers to attend training, seminars and conferences provided by the SSCB and they provide valuable resources to the board in particular for the multi-agency training pool and the newly created multi-agency audit group.

Sheffield Safeguarding Children Board encourages independent oversight of our work and this is enhanced by the inclusion of two Lay Members, who sit on the Executive Board. The lay members provide a valuable contribution by being active participants who provide thoughtful contribution, effective challenge and an objective viewpoint. In addition the Child Death Overview Panel is also enhanced by the contribution of two lay members.

Involving Children and Young People in Our Work

Definition

Children's participation is about listening to children's views and giving them a say in decisions that affect that lives.

Participation with children and young people is vital and should permeate all aspects of the board's work. Our aim is to promote and develop a culture where children and young people's participation in safeguarding is central to professional practice, organisational systems and how safeguarding is developed and provided.

To keep children safe we must hear, see and act on what children tell us

During 2012-13 Board projects have facilitated, supported, and enabled work to be undertaken with children and young people to gain an understanding from their perspective about their experiences with services and their concerns regarding the safeguarding issues affecting them. This has included the following:

The Licensing Project has involved Sheffield Young Advisors in developing a flyer for the Fake ID awareness workshops that will be distributed via social media networks. In addition they have contributed towards the scripting and acting of a docu-drama that will be used as an educational resource for schools.

Consultation has been undertaken with young people in schools regarding the production of body modification educational resources

The SSCB along with partner agencies has devised and delivered multi-agency training to assist licensed traders to develop their awareness and skills so that they understand what makes children and young people feel safe in their environment. All training delivered illustrates the impact that underage drinking, or irresponsible drinking by adults, can have on children and young people by using quotes and information provided by children and young people who were involved in local surveys. The training includes the use of a DVD that was produced by the SSCB which gives the views of young people about what makes them feel safe/unsafe at licensed premises.

The E-Safety Project has worked closely with young people and children consulting with them about e- safety issues. This includes encouraging primary and secondary aged children to complete a comprehensive e-safety survey which provided the city with an overview of the e-safety issues facing young people. Focus groups have been organised with children and young people to continue to build a picture of the issues facing them to help inform future training.

A peer mentoring scheme has been developed so that young people can be equipped and trained to offer support to other students, run assemblies, deliver lessons to younger children and develop and participate in parental workshops through schools to raise awareness of the issues to parents of school aged children in how they may be able to support their children in keeping safe when on line.

The SSCB has worked closely with SOVA who ran a group with young people who have been involved with social care/youth justice. They looked at the issues arising from the Munro review and supported the board in developing an understanding of what

safeguarding means to young people, what the primary safeguarding concerns are for young people in Sheffield, how their experiences and views could help shape the work of the Board and service development, and how to gather feedback from children and young people who have had experience of working with Social Workers.

We have also worked with the Sheffield Young Advisors who have developed an on line questionnaire around safeguarding, and have looked at the SSCB workplan and identified what they felt were priorities. A young person's scrutiny panel comprising of a number of Young Advisors was convened whose remit was to read the SSCB annual report and meet with the SSCB Independent Chair and senior managers to scrutinise the report introducing a level of accountability but also to participate in the shaping of the Boards safeguarding priorities.

Young advisors were also commissioned to undertake some 'youth proofing' for the principles of best practice for transition from children's to adult services.

The Substance Misuse Project is part of a national working group listening to children and young people living with parents who misuse alcohol (Silent Voices 2012). The Hidden Harm Strategy is currently being revised across the city. User Consultation is a vital part of the process of revision. Specifically the views/voices of children and young people attending WAM (a group for children whose parents misuse drugs and alcohol) and The Corner are being sought regarding services / resources / processes and what they feel help improve their family situation but also what needs developing further. The SSCB along with partner services devise and deliver a range of multi-agency training to assist practitioners develop their awareness and skills in working with children and families where there are substance misuse issues. All training delivered illustrates the impact of parental drug and alcohol misuse by using quotes and information provided by children and young people attending WAM. The training also utilises DVD's produced by the Children's Society that tell the stories of children living in households with parental / carer drug and alcohol misuse.

Budget Information

Income and Expenditure 2012-13

Income		Expenditure	
c/f 2011-12	£151,344	c/f	£123,119
Contributions:		Employees	£308,304
Sheffield City Council	£101,000	Multi Agency Training	£ 9,084
Health	£101,000	*Practice Review & Standards:*	
South Yorkshire Police	£ 40,500	} Document Production	£ 17,550
Probation	£ 6,500	} Tri-X (Procedures)	£ 3,135
Cafcass	£ 550	Board running costs	£ 13,340
		SCR's	£ 0
Munro Grant (c/f)	£ 41,133	Independent Chair	£ 5,500
		Mosque Advisor	£ 24,300
Child Death Overview (CDOP)	£ 76,000	Sexual Exploitation Service	£ 13,695
TOTAL	**£518,027**	**TOTAL**	**£518,027**

Projected Expenditure 2013-14

Activity	Cost
Independent Chair	£ 6,000
Board Manager	£ 59,000
Secretariat	£ 18,000
Operating Costs	£ 25,000
Multi-Agency Training	£72,000
Manager + Business Support / Training Strategy & Programme	
Practice Review & Standards	
Coordinator + Research & Audit Officer (Safeguarding Evaluation)	£ 64,000
Business Support	£ 23,000
SCR's / Publicity / Campaigns	£ 30,000
Policy & Procedure	£ 5,000
Tri X / Sheffield Procedures & Policies	(2 years)
E Safety Project / Manager (50% traded services)	£ 28,000
Community Adviser	£ 10,000
SUBTOTAL (CORE BUDGET)	**£340,000**
Child Death Overview arrangements (grant funded EIG)	£ 76,000
TOTAL (OVERALL COSTS)	**£416,000**

Indicative Agency Contributions

Agency	Formula	2012 - 13	2013 - 14 (-5%)
SCC (CYPS)	40%	£101,000	£ 96,000
Health (PCT)	40%	£101,000	£ 96,000
SY Police	16%	£ 40,500	£ 38,500
Probation	4%	£ 10,000	£ 9,500
		(£6,500 actual)	(£6,500 actual)
Sub Total	**100%**	**£253,000**	**£240,000**
c/f		£ 94,000	£100,000
			(estimated)
TOTAL		**£347,000**	**£340,000**

Sexual Exploitation Service – New model

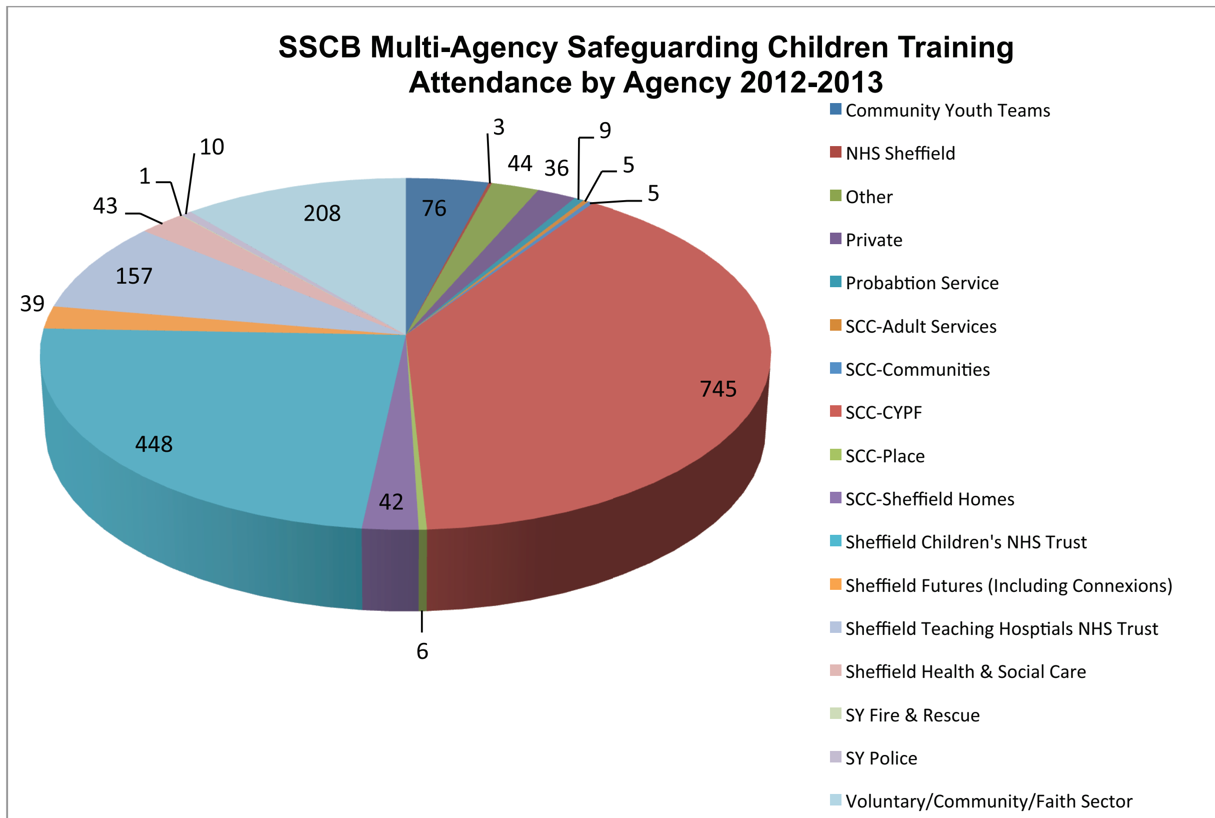
Agency	Sexual Exploitation 2012-13	New Service Sexual Exploitation 2013-14	Variation
SCC (CYPF)	£ 27,000	£ 28,700	+ £1,700
	(35%)		
Health (PCT)	£ 22,000	£ 24,600	+ £2,600
	(30%)		
SY Police	£ 27,000	£ 28,700	+ £1,700
	(35%)		
TOTAL	**£ 76,000**	**£ 82,000**	**+ £6,000**

Training for Professionals and Volunteers

Local Safeguarding Children Boards are responsible for safeguarding and promoting the welfare of children; this includes ensuring that there are appropriate training and learning opportunities for people who work with children and families.

Training covering a wide variety of safeguarding issues is delivered by a range of projects and services, in line with the SSCB training strategy. Information regarding all the training offered during the year has been collated below. For more details on courses available, please see www.safeguardingsheffieldchildren.org.uk.

SSCB Multi Agency Training	***Numbers Trained***
The SSCB provides a comprehensive programme of high quality multi-agency training covering a range of issues including working with uncooperative and hostile families and engaging fathers and father figures among others. The *key aims* are enabling participants to achieve: • A shared understanding of the tasks, processes, principles, roles and responsibilities for safeguarding children and promoting their welfare. • More effective and integrated services at both the strategic and individual case level. • Improved communication and information sharing between professionals including a common understanding of key terms, definitions and thresholds for action. • Effective working relationships, including an ability to work in multi-disciplinary groups or teams. • Sound and child focused assessments and decision-making. • Learning from Serious Case Reviews (SCRs) and reviews of child deaths.	*848*
The programme of training supports the SSCB Business Plan and is responsive to local need and emerging priorities. Courses are open to any practitioner in Sheffield working with children, including the voluntary and community sector.	
New course introduced this year: ▪ Threshold Guidance Workshops	
A common understanding of thresholds of need is essential for effective multi-agency working in order to safeguard children at an early stage. These seminars provide guidance to help practitioners assess need and identify and involve the right service at the right time to support children, young people and their families.	*1029*



SSCB E-learning

Seven on line courses are now offered allowing staff to study at a time and place that is most convenient to them. The courses are:

- Basic Awareness of Child Abuse and Neglect - an introductory level course.
- Hidden Harm – the effects of parental problem substance misuse on children.
- Safer Recruitment.
- Runaways.
- Safeguarding in leadership.
- Child trafficking.
- Safe sleeping for babies.

. SSCB One Day Conferences

- *Confronting Difficulties & Improving Practice*
  This included sessions on professional challenge and engaging fathers/father figures.
- *Meeting the Safeguarding Needs of Children & Young People age 13-18*
  The focus of the sessions were on sexual exploitation, E-safety, legal highs (NPS) and the launch of the Transitions Best Practice guidance.

	Numbers Trained
SSCB E-learning (seven on line courses)	*2405 courses allocated*
Confronting Difficulties & Improving Practice	*154*
Meeting the Safeguarding Needs of Children & Young People age 13-18	*229*

Numbers Trained

SSCB Lunchtime Seminars

This year lunchtime seminars were offered covering various subjects including:

202

- Thematic Review of Sheffield Serious Case Reviews & Case Reviews.
- Domestic Homicide Reviews & Domestic Abuse Risk Assessment.
- The work of the UK Border Agency & safeguarding.
- Safeguarding children and young people who have caring responsibilities.
- The Mental Capacity Act and deprivation of liberty safeguards.
- The importance of attunement and regulation for children's development.
- Female Genital Mutilation.

Education Safeguarding Training

The Education Advisors offer a range of training for education staff including basic, advanced and refresher safeguarding courses.

3473

Other training includes:

- School governors. *87*
- Sessions for volunteers/support staff supporting those students with English as a second or other language/ home school volunteers. *98*

Licensing Project Training

The core training delivered by the licensing project is 'Safeguarding Children at Licensed Premises'. This training is delivered on a multi-agency basis to licensees, with contributions from the youth service, police and trading standards. In house training for licensed traders is also provided.

108

In addition, safeguarding / licensing awareness training has been offered to, Children's Social Care, Hoteliers, South Yorkshire Police, Head shop traders (new psychoactive substances) & Taxi/private hire traders.

373

Safeguarding and tattoo and body modification has been provided to teaching staff.

8

A presentation was given regarding the Sheffield Events Guidance to Sheffield Hallam University events management students.

15

	Numbers Trained
Early Years Safeguarding Training	
The Early Years Advisors offer introductory and advanced safeguarding and child protection training.	*975*
In addition there have been joint early years and health focused training regarding the importance of engaging fathers and father figures and the learning from Serious Case Reviews.	*32*
Substance Misuse Service	
The core training delivered by the service is the 'Substance Misuse and Safeguarding Children Multi Agency Training'.	*49*
In addition there were: • Half day refresher – working with hostile and uncooperative parents where there is drug and alcohol misuse. • Workshops at the local Evidence Informed Practice conference. • Single agency update sessions on substance misuse and safeguarding children. • Volunteer training. • Introduction to the Sheffield Alcohol Screening Tool.	*529*
Social Care Practice Seminars:	
• Understanding the effects of drugs and alcohol on the unborn baby: top tips for multi-agency working.	*88*
• Safeguarding children and substance misuse for social workers.	*15*
E Safety Project	
The SSCB E-safety project has delivered training and e safety awareness sessions to a wide range of organisations, including:	
• School staff training (in schools or on courses).	*425*
• Governors of schools/colleges.	*70*
• Other professionals.	*40*
LADO (Local Authority Designated Officer)	
Training provided regarding the procedure for managing an allegation against people who have contact with children (professionals and volunteers). Two groups trained:	
• Managers & HR professionals at Sheffield Teaching Hospitals.	*20*
• Community Football Coaches, Sheffield Wednesday.	*40*

	Numbers Trained
Child Death Overview Panel	
Sheffield Infant Mortality Stakeholder Event: *Reducing Sudden Infant Death; A review of Initiatives from around the Country*. To raise the profile of the Sudden Infant Death agenda and gather learning from nationwide initiatives aimed at reducing Sudden Infant Deaths. There was a focus on the successes and challenges of implementing initiatives and also on the impact on Sudden Infant Death rates.	*105*
Health Safeguarding Training	
This training includes 'Safeguarding and promoting the welfare of the child for health practitioners', GP training, which also involves other clinical and non-clinical staff (seminars, PLI (Protected Learning Initiative) event and in house training), training aimed at CAMHS, Health Visitors and Pharmacists.	*1014*
Safeguarding Children's Service	
Understanding Fractures; Protecting Children Conference There are times when groups of professionals from different agencies are required to meet together to determine whether injuries presented in young children should be subject to child protection procedures. This often includes crucial decisions as to whether such children can be safely discharged to the care of their parents. The aim of the day was to: • Describe the local context. • Provide up to date expert information about fractures and bone disorders that is accessible to a range of professionals. • Consider the evidential requirements of the criminal justice and family court systems. • Discuss joint decision making.	*70*
Serious Case Reviews	
• *IMR Training Day*; Multi-agency training for those that complete individual management reviews for Serious Case Reviews and Domestic Homicide Reviews.	*68*
• *Thematic Review of Sheffield Serious Case & Learning Lessons Reviews*; The findings of this analysis have been shared with various professionals through presentations at the EIP (Evidence Informed practice), to MAST and Children's Social Care.	*122*

Total number of training contacts in the year = 12,691 [1]

[1] This is the number of attendees at training, briefings, workshops and seminars. Some professionals will have attended more than one event.

Feedback from Training

"This will be a great reference tool when assessing families and planning interventions – will focus the decision making and help reduce silo working"

Thresholds of Need Guidance – Jan '13

'*It was great to learn alongside people from such a wide range of agencies - helped me understand roles and appreciate how we are all working towards the same ends*!'

Working Together – Nov'12

'This was the best training I have attended and would definitely recommend the course to others'

Substance Misuse – Sept '12

'Another excellent training session from the SSCB, many thanks'

Lunchtime seminar – March '13

Conferences (Regional & National)

In addition members of the SSCB were asked to speak at a number of regional and national conferences. These included:

	Number of attendees
BLAST conference, Leeds. April 2012. E-safety workshops.	*30*
National Working Group. Child Sexual Exploitation. Licensing presentation on CSE at licensed premises.	*75*
SSCB Licensing presentation at CSE safeguarding regional event, Leeds.	*180*
Doncaster safety advisory group. Licensing presentation regarding Sheffield events guidance.	*10*
Whole Family Support for Drug & Alcohol Misusers. Community Care Conference, London, September 2012.	*60*

Total number of conference contacts = 355

Raising Awareness – Seminars and Workshops for Parents and Young People

	Number of attendees
Although the majority of training delivered is for professionals and volunteers working with children, some seminars and awareness raising sessions have been provided for parents and young people. These include:	
E safety	
• Parent workshops	146
• Bespoke E-safety training for Y5 & 6th form pupils	300
In addition, the E-Safety project had an e-safety stall within the Disney Store, Meadowhall, to meet parents and promote knowledge of e-safety.	
Licensing	
• False ID (legal consequences & the risk of using false ID) for young people	10
• Tattoo & body modification – young people	45

Total number of training contacts with parents & young people = 501

Evaluation and the Impact of Training

The amount, and range, of safeguarding training delivered by the SSCB and partner agencies demonstrates the robust arrangements that are in place to ensure that all staff have access to appropriate learning opportunities. Whilst many courses are part of a repeating 'rolling' programme there is also a clear commitment to respond to emerging issues and changing priorities.

The introduction of Lunchtime seminars, new from June 2012, have provided a valuable forum for responding to training needs in a timely and convenient manner;

"I really like these short sessions, I find it difficult to attend full day training and these are a really good way of keeping up to date and improving my practice"
(Learning from Serious Case Reviews seminar Nov '12).

In response to an identified need across partner agencies, an extensive programme of Thresholds of Need Guidance seminars were also introduced in 2012/13. These seminars were both very well attended, attracting over 1000 staff, and very effective, with a practitioner self- assessment of confidence and knowledge both before and after the seminar indicating an overall improvement rate of 70%.

All courses and events are subject to an end of session evaluation and all consistently evaluate highly. The evaluation process indicates that training makes a difference to the practice of attendees in a number of ways, including:

- Increased knowledge and awareness of safeguarding issues.
- Improved understanding of the safeguarding roles and responsibilities of other practitioners and agencies and acknowledgment of the importance of working together to safeguard children.
- Increased understanding of thresholds, levels of concern and making referrals to Children's Social Care.
- Increased confidence in own role, leading to more confident practice and feeling better able to challenge decision making of others.

The evaluation also provides an opportunity for practitioners to identify other professional development needs to which we respond where possible. For example, a new 1 day course 'Working with Uncooperative and Hostile Families' has been developed in response to requests from a number of practitioners.

Training Priorities for 2013-14

Whilst the key priority for training in 2013-14 will be to ensure that there continues to be a wide range of high quality training and learning opportunities available to all staff working with children and families, a number of specific priorities have been identified;

- To develop and coordinate the delivery of a city wide awareness raising programme that addresses the issue of Child Sexual Exploitation.
- To ensure that the voice of the child is reflected in all training programmes.
- To review and revise all programmes to take account of the new Working Together to Safeguard Children statutory guidance (April 2013), and the significant changes taking place in the way that SSCB partner agencies operate.
- To encourage managers to support their staff pre and post training to ensure messages from training are embedded in practice, thus contributing to improved outcomes for children and families. This will be included in a conference for Managers planned for Autumn 2013.

Local Authority Designated Officer (LADO)

Managing Allegations against Staff and Volunteers who work with children and young people

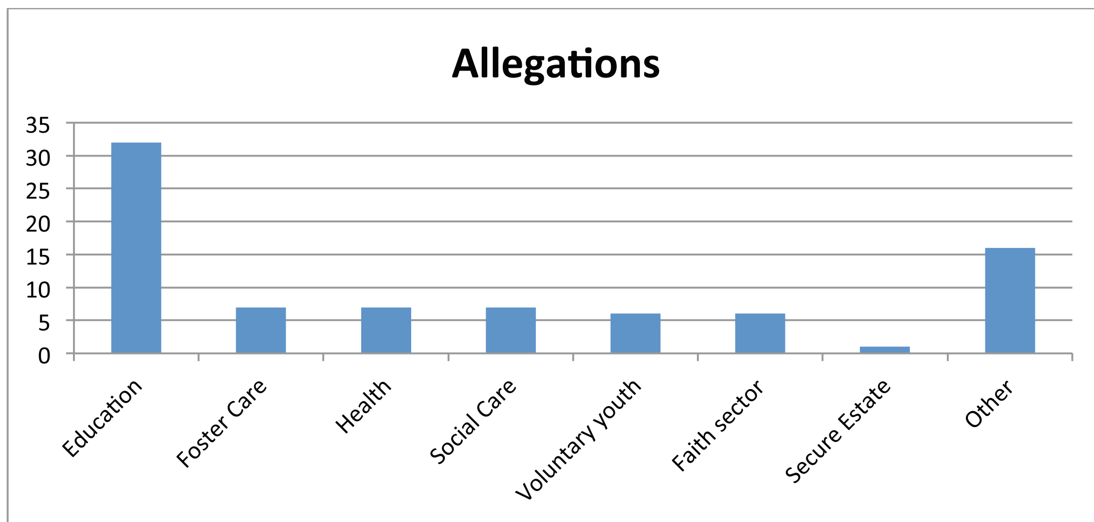
The role of the LADO and the guidance contained in *Working Together to Safeguard Children* (2013) enables services, the police and social care, to work together, as required, to assist employers in deciding whether a complaint or allegation is true or not. The guidance seeks to provide a standard for enquiries to take place in a fair manner, to ensure that there is a speedy resolution of allegations. It also provides a process to remove those unsuitable people from working within the children's workforce.

The key achievements of the last year have been:

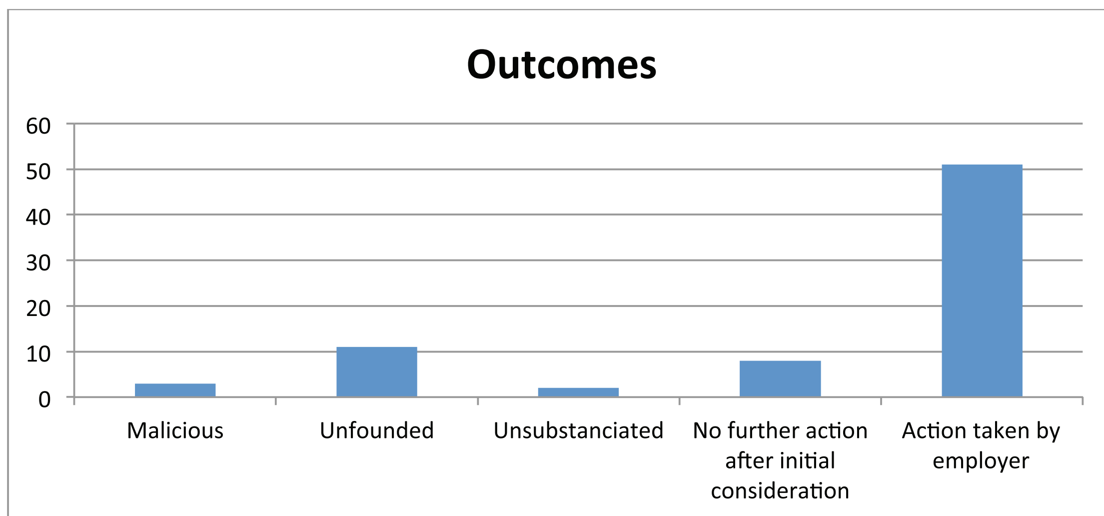
- Meeting with over 20 NHS personnel and managers to explain the role of the LADO and why it is relevant to the majority of NHS staff who have patient contact.
- Meeting with the Detective Inspector within South Yorkshire Police who has responsibility for standards and discipline and leads the team that investigates complaints regarding police officers.
- Ensuring that an explanation of the outcome of an allegation is given to the child or young person themselves through the agencies involved (in response to a suggestion by the Young Advisors to last years SSCB Annual Report).
- Working closely with a Community Advisor for Mosques and Madrasah's, a protocol has been developed to support employers investigating allegations in situations where there is no role for the police or social care (for example, the Community Advisor works directly with the employer to, interview witnesses, establish facts and reach a conclusion on the balance of probabilities regarding the allegation).

Notifications of Allegations 2012-13

79 notifications were referred to the LADO during 2012-13 (as compared to 86 in the previous year) regarding named individuals. There were 6 further notifications made regarding unnamed persons (entirely from within madrasahs).



Once again the education sector continues to be the area where most allegations are made and once again our figures are consistent on a year on year basis that between 40 and 50 % of all allegations are made regarding employees from this sector. They are also consistent with figures nationally collated by York University.



In terms of outcomes there have been no criminal convictions as a result of an allegation, and at the time of writing there have been no dismissals but there are matters still outstanding in a number of cases where dismissal remains an option. In the vast majority of cases where employers find there is substance to the allegation the matter is dealt with by additional support or training or through a disciplinary process falling short of dismissal.

Priorities for 2013-14

- In the forthcoming year the LADO intends to provide information and training across the sector regarding the management of allegations in the light of the Government's publication of "Working Together to Safeguarding Children" – 2013.
- The LADO plans to offer Safeguarding refresher sessions to the Madrasah Child Protection Officers and establish basic safeguarding training for all teachers in Madrasah's and supplementary schools.

Learning Lessons from Reviews

Serious Case Reviews & Case Reviews

Sheffield Safeguarding Children Board is keen to learn from practice and this year we commissioned and completed one Learning Lessons Review. This was on a case that fell below the threshold for a Serious Case Review but where the Board felt learning across agencies would result from an in depth review. To enhance the learning process we commissioned a review using the Serious Incident Learning Process (SILP), which included front line practitioners who had worked with the family in the review process. The review was well supported by the partner agencies in Sheffield who provided an honest and open analysis of their agency's engagement.

Several areas of good practice were identified within the review and it was clear that many professionals showed a commitment and a level of persistence in working with the parents in the best interests of the child.

The issues arising from the review included:

- Recognising Vulnerability >the parents had experienced difficult, abusive childhoods and were known to Children's Social Care in other local authorities. Parental risk and vulnerability is a common theme which often emerges in both national and local reviews. Practitioners were not able to recognise all of the relevant parental vulnerabilities due to a failure to access relevant historical information held by organisations within other local authorities.
- Safeguarding Information Gathering >Information gathering at the start of an assessment is crucial to enable effective risk analysis and appropriate decision making. It is essential that the relevant information is efficiently and speedily collated and that all practitioners should be encouraged to robustly pursue information held by other local authorities and within other local organisations in a timely manner with the support of their managers.
- Early Prevention and Intervention Services >Early interventions were not provided to the family in a timely way. It is anticipated that the introduction of the integrated front door will assist in the removal of delay and resolve communication issues lost in the current system of referral and consideration prior to allocation.
- Assessments >the pre-birth assessments of universal services and children's social care were not fully informed and the analysis of risk was flawed. The result was that the work identified did not take place before the child was discharged from hospital.
- Child Protection Plans >the plans produced at the Child Protection Conference lacked focus and were unrealistic and remained unchallenged by partner agencies.
- Hospital Discharge >the decision was taken to discharge the child from hospital without the planned parenting assessments having been concluded and without multi-agency consideration at a discharge planning meeting. It is recommended that the SSCB should review the work completed thus far regarding discharge planning meetings, establishing a wider group to develop it and progress it to sign off by relevant agencies.

The primary purpose for conducting reviews is to embed the lessons learnt into the daily practice of frontline workers. The SSCB is keen to ensure this happens through rigorous monitoring of action plans arising from reviews. Agencies are expected to update action plans on a regular basis and once completed provide evidence to the SSCB to support the implementation. Where progress is delayed or evidence does not sufficiently address the recommendation, the agency is supported to make the required changes. Where this fails to result in action, the SSCB Independent Chair challenges the agency at a senior level to ensure action is taken. Three action plans were agreed as completed by the Board this year. The Learning Lesson Review detailed above is currently being monitored for progress.

The dissemination of key messages from reviews is central and agencies are expected to share the findings with their workers. In addition, the SSCB provides learning briefs for use in training or supervision and shares the learning through presentations at key safeguarding events.

A Serious Case Review was commissioned in February 2013 and will be reported on following the conclusion of the criminal proceedings.

Thematic Analysis of Sheffield Cases of Concern

One of the key priorities during 2012-13 was to undertake a thematic review of the Serious Case Reviews completed in Sheffield. This analysis focused on Serious Case Reviews & Learning Lessons Reviews that were completed between December 2005 – April 2012 with the aim of identifying themes that have occurred across cases and/or over significant time periods. The results of this have been used to inform both training and practice.

The analysis[2] resulted in 6 overall themes, each containing a number of ‘sub themes’.

1. Public Involvement

Apathy v’s Public concern: Two reviews raised the issue that ‘*neither the extended family nor the community felt able to play their part in safeguarding the children*’ (2005). This led to the start of an ongoing campaign ‘making safeguarding everybody’s business.’ In the more recent reviews there was evidence of relatives and members of the public reporting concerns to professionals or becoming involved in situations. However, the response from professionals wasn’t always what they expected. This issue has been recognised nationally, ‘*A recurring message in these serious case reviews is the important role of adults who are in a position to speak on behalf of the child……..but their views were not always taken seriously enough’* (Ofsted, 2011).

2. Everything is ok

There were examples of how professionals didn’t always recognise safeguarding issues or the vulnerability factors in the families. This was for two main reasons:

- *Normal for community*: In two reviews professionals accepted that the children were ‘*one of a number of children like this’ (2005)*. In response professionals lowered their expectations of parenting and childcare and developed thresholds that were too high.

[2] *The stages of thematic analysis were adapted from those suggested by Braun & Clarke (2006).*

- *Misplaced optimism*: Evidence was found of professionals working with an overoptimistic view of the situation. The most commonly occurring reason for this was when professionals didn't recognise, know, or collate the full family history or the vulnerabilities that exist. '*Assessments failed to consider the historical information regarding this couple. Agencies failed to consider the multiple risk factors…..would result in them struggling to parent' (2011).*

3. Assessment, Assessment, Assessment

There were 5 main issues regarding assessment identified:

- *Holding an 'assessment mindset'* is seeing every encounter with a family as an opportunity to re-evaluate the situation. This was lacking when professionals worked with the 'start again approach', got 'stuck' (reaching a conclusion from which they didn't move from even when new information contradicted this) or assessments lacked rigour.
- There was evidence of professionals working in 'narrow silos', dealing with situations in isolation and not looking beyond this: '*there is a picture painted of services that focus on an individual task or issue rather than taking a holistic approach' (2010).*
- *Downgrading of risk*: Professionals closed cases when there was no evidence of any information to inform this decision.
- *Recognition of risk: Universal Services*. Reviews highlighted that although many agencies within universal services were in contact with the family, they didn't recognise the circumstances the children were living in, '*there was adequate information to alert practitioners to potential risk and with an effective risk assessment tool coupled with professional judgement within universal services an earlier identification of potential risks could have occurred' (2011).*
- *Communication*: The results locally are in line with the national findings as this was an issue in 83% of reviews.

4. Protection

This occurred where professionals failed to keep their focus on the child, failed to see things from the child's perspective, didn't see and speak to the child on their own or failed to hold the child's safety and wellbeing as the most important aspect of their work. This has also been found repeatedly in national analysis (Ofsted, 2010).

Some of the reviews involved children that were 2 years or younger and these highlighted the *vulnerability of the very young*.

5. Challenge and responsibilities

- *Challenging parents* >Professionals have a responsibility to challenge parents when necessary, but this didn't happen in some cases *'statements made by the parents were too quickly accepted without professionals feeling the need to check the information out'(2011).*

- *Evasive/manipulative parents* >The main issues were working hard to keeping parents ‘on side’; parents pressurising professionals to alter reports or refusing access to the child and/or property; parents giving professionals incorrect information and the challenges for universal services. The difficulties of working with manipulative parents were highlighted by Lord Laming (Victoria Climbie inquiry, 2003) and again in the Baby Peter SCR, Haringey (2009).
- *Fathers/male carers are ‘not important’* >In some reviews the fathers/partners were not known or their role was not fully considered by the professionals involved.
- *Professional responsibility >T*o challenge other professionals when necessary. There were situations in some of the reviews where this did not happen.
- Professionals made *assumptions of responsibility*, that others were monitoring the situation or they had made a referral and their responsibility had ended ‘T*hey assumed that action or monitoring was being undertaken by others. This assumption was sometimes unfounded*’ (2011)

6. Professional knowledge and support
   - *Knowing your client - what is important?* There were 2 reviews that required specific knowledge, without this, professionals lacked the confidence in intervening and were not able to support parents.
   - *Where were the good practice guidelines?* There were examples of professionals’ not following the practice guidelines that were in place. This has been reported as an issue nationally, ‘*there had been a failure to implement and ensure good practice rather than an absence of the required framework and procedures’* (Ofsted, 2010).

Conclusion

The analysis has highlighted a number of interconnecting themes relevant to Sheffield. These are similar to those found in the national summaries but the analysis has been able to provide clear evidence of those that are specific to the local area. Although it may seem surprising that there are themes that are still arising, even when recommendations have been made and action plans have been completed, this is not just an issue seen in Sheffield but has been identified nationally. Sheffield agencies have completed the action plans from reviews in a timely and robust manner but the issues identified through this thematic analysis show us that there are safeguarding challenges that cannot be resolved simply through making SMART recommendations but require a cultural change in the way that professionals work and are thus more difficult to achieve.

Report from the Child Death Overview Panel

Sheffield Safeguarding Children Board has specific procedures in place when a child who is under the age of 18 dies. The key requirements are that we;

- Have a rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating the unexpected death of a child
- Have an overview panel of key professionals who come together to review the deaths of all children under the age of 18 who are resident in Sheffield.

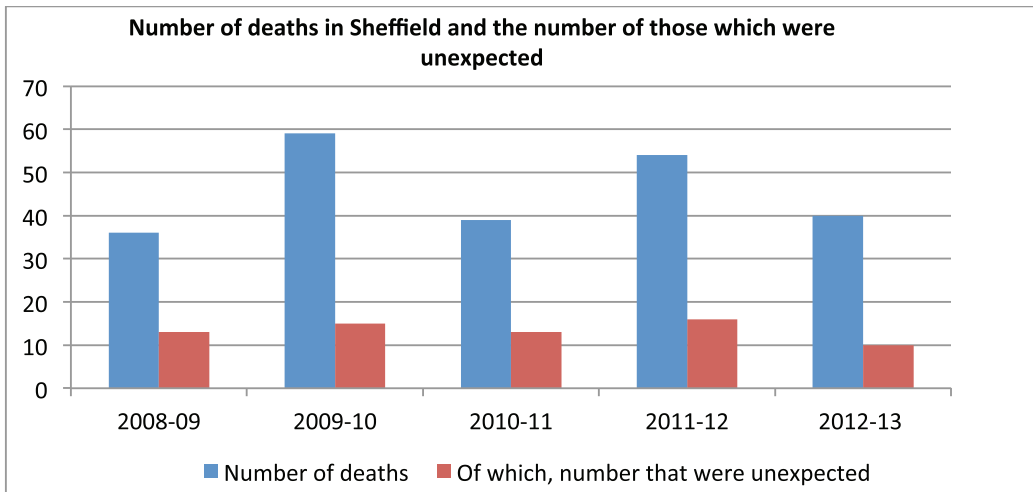
In September 2012 Sheffield held a Safe Sleep Conference, where professionals were invited from across the country to present their regional work. Professor Ed Mitchell was the Key Note Speaker, talking about the success that New Zealand has had with their preventative programs for Safe Sleep. Professionals reported back that they found the day beneficial and it raised awareness of campaigns in other areas to prevent Sudden Infant Death.

Representatives from the four South Yorkshire Child Death Overview Panels met for a special meeting to review child deaths in South Yorkshire since the start of the CDOP process, where death by hanging or suicide by hanging was deemed to be the cause of death. 12 deaths were discussed from across the four panel's, with the children aged between 8 and 17. Deaths by hanging in children are rare events in each locality and the purpose of the session was to understand if there were any potentially modifiable themes emerging amongst these deaths. Key areas for work identified were;

- Children need to be offered support following bereavement.
- Risks posed by rope swings or home-made swings.
- Prescribed drugs with side effects of known psychiatric disturbance/ suicidal ideation.
- Review support offered to vulnerable homeless young people.
- Interventions for young people with a history of suicide attempts or self-harm.

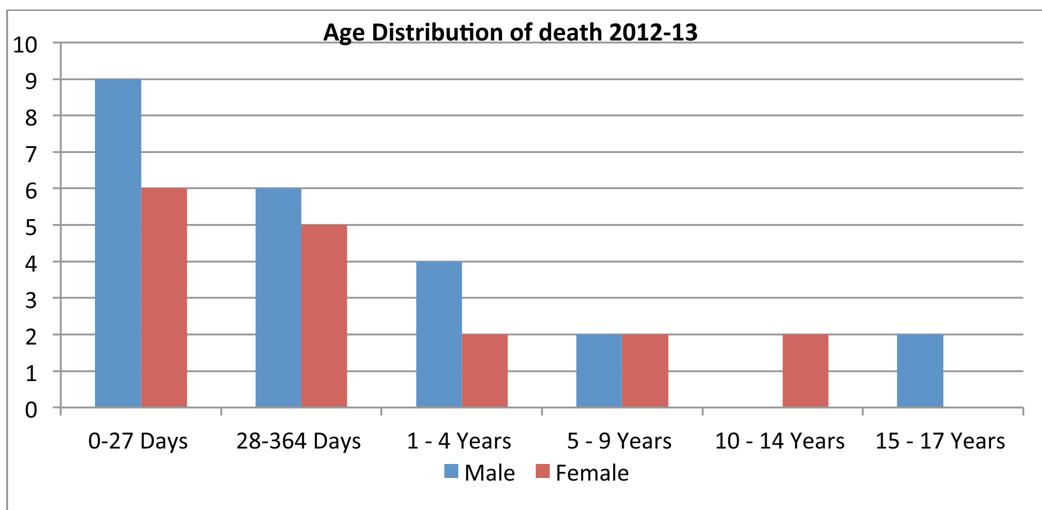
Cases

In 2012-13, there were 40 deaths of Sheffield children reported – 22 male and 18 female. 10 of these (25%) were unexpected. Unexpected deaths require follow up by a multi-agency Rapid Response Team (RRT), to ascertain the exact circumstances surrounding a child's death to assist the Child Death processes.



Age Distribution

A child that shows any signs of life at birth is classified as a live birth and therefore is reviewed by CDOP. This accounts for the relatively high numbers of neonatal deaths (babies dying between 0-27 days) some babies being born so prematurely that they are not viable. Children remain more vulnerable in the early years of life. The rates of child deaths decrease after the first year and then are likely to be due to accidents or life limiting conditions.



Panel findings and recommendations

The Panel reviewed 39 deaths through the year. Members identified modifiable factors in 6 (15%) cases. This means that in the deaths of 6 children there were one or more factors which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths.

The Panel made a number of recommendations that are now being acted upon. These are:

- Where a child has multiple disabilities, families can find it hard to navigate the system of care and support. The Panel recommended that where a number of professionals are involved in the care of the child, there should be a lead care co-ordinator identified for the child.
- Parents need to be able to support their teenage children if they are taking drugs. In order that parents know where and how to access this support a leaflet has been produced to inform them of the early intervention services that are available in Sheffield.
- Slovakian children receive routine vaccinations in their home country that are not included in the standard UK vaccination schedule. The Panel recommended that Slovakian children entering the UK part way through their vaccination programme should receive the same immunisations that they would receive at home in order to promote their general health. This is due to be implemented by Public Health in the next couple of months. Slovakian children are also receiving Hepatitis B vaccinations.
- It is essential that young people comply with treatment and medication provided to them, and they may require additional support to achieve this. Sheffield Children's Hospital are working to ensure that this support is provided when needed by identifying an individual who can work with the young person.
- A Sudden Infant Death highlighted the particularly transient lifestyles of the Traveller community, and the impact this can have on the child's sleeping arrangements. This was highlighted with the Health Visitors serving this community so that they can ensure safe sleep practices are discussed regularly with families.

Priorities for 2013/14

- To review the current Rapid Response provision in Sheffield and consider options for extending the availability of health staff for this.
- Develop a Work Plan based on the information that was collated at the South Yorkshire CDOP that discussed deaths by hanging.
- Implement any changes required by the new Working Together, published April 2013.

Sheffield Infant Mortality Strategy

Sudden Infant Death Work Stream of Sheffield Infant Mortality Strategy

The Sudden Infant Death (SID) work stream is a multi-agency group of professionals that aim to reduce the SID rate in Sheffield from 0.77 per 1000 live births to 0.40 per 1000 births by 2020. The current national average SID rate is 0.42 per 1000 live births. The group works effectively to progress the SID section of the delivery plan for the Infant Mortality Strategy and is led by the Safeguarding Children Service and Public Health.

Main achievements

National Conference on Safe Sleep practice
This took place on 17th September 2012 and was very well attended by people from all over the country. Ed Mitchell, Professor of Child Health in Auckland, New Zealand, was the guest speaker. Other presentations were given from professionals locally and nationally on good and innovative practice on safe sleep in their area. Good feedback was received from attendees and the knowledge gained has helped inform practice in Sheffield.

E-learning
An e-learning package has been developed for professionals working across all sectors, to promote the messages of safe sleep. This was in conjunction with the virtual college and several other areas were involved, which helped keep the costs down. The package became available in the autumn 2012 and at the end of April 213 number of workers had completed it and 531 have applied to do the course. Positive comments have been received about the usefulness and relevance of the course.

The e-learning can be applied for at:
www.safeguardingsheffieldchildren.org.uk/welcome/safeguarding-children-training.html.
Workers in all sectors are encouraged to complete the e-learning, especially if they visit families in their own homes.

Work Stream Membership
During this year the membership of the group has been widened to include more agencies. Prior to this, it was felt that the safe sleep messages were not reaching a wide enough range of workers. Membership now includes representatives from Social Care, South Yorkshire Fire and Rescue Service, the Private, Voluntary and Independent Sector, MAST, Bereavement Services at Sheffield Children's Hospital, Paediatric Liaison, Substance Misuse Services, Housing and others.

Multi-agency Working
The meetings are well attended and there is good cooperation from participants to promote safe sleep in their agencies. A multi-agency policy on safe sleep was ratified by the Operational Board of SSCB, thereby supporting work in all agencies in this area.

Publicity
Leaflets and posters on safe sleep were revised and circulated to partner agencies. Leaflets are to be distributed routinely by Midwives and Health Visitors to deliver Safe Sleep messages. A press release was circulated in December to promote Safe Sleep using photos of a high profile local celebrity. Audit and research is being used to identify gaps in knowledge and further publicity initiatives are likely to ensue as a result.

Main challenges

Safeguarding Concerns
A research project is currently being undertaken, by Health Visitors, with parents of small babies that asks questions about "Where did your baby sleep last night?" The rationale for this is to determine whether parents are putting Safe Sleep in to practice and if not, what is preventing them from doing so. A recent case review undertaken by the Sheffield Safeguarding Children Board (SSCB) on a very young baby that had a "near miss" sudden infant death, evidenced that the parents had been given advice and information on safe sleep, but at the time of the incident, the baby was found lying on his front. The outcome of the research may indicate that more work needs to be completed to address issues where parents and carers do not adopt safe sleep practice.

Working with parents and carers
The work stream for SID aims to ensure that the safe sleep messages are received by parents and carers by raising awareness amongst workers who see babies and families in their own homes.
In addition to the work highlighted above, the Young People's Scrutiny Panel met in February, as part of the on-going drive to involve young people in the work of SSCB. They suggested that the e-learning safe sleep course should be available for parents. In view of this, consideration is being given to whether it is possible to produce something for parents and carers.

Impact and outcomes of the work undertaken
From the 1st April 2012 until the 31st March, there were two sudden infant deaths recorded in Sheffield. This is less than in previous years, but rates do fluctuate over time. The hope is that workers and parents are becoming more aware of the importance of adopting safe sleep practice and that the overall rate of SID is decreasing in Sheffield. Due to the small numbers, SIDs rates are monitored as a 5 year rolling rate. There appears to be a downward trend, but it will take a few years to determine whether this represents a true reduction in the number of SIDs in Sheffield.

Plans for 2013 to 2014

The work stream on Sudden Infant Death for the Sheffield Infant Mortality Strategy has developed a delivery plan for 2013 to 2015, so this will form the basis for the work in the forthcoming year. This includes;

- Repeating an audit of professionals to identify resources used and knowledge of SID. A report will be circulated and training needs will be identified and action taken to address these
- Considering development of a training package for parents and carers.
- Ensuring that promotion of Safe Sleep and the Care of Next Infant (CONI scheme that supports parents who have had a previous SID) are included in service specifications for Health Visiting and Care Pathways for Midwives
- Continuing to promote Safe Sleep messages to the general public and the work force
- Reviewing barriers to Safe Sleep on an on-going basis
- Developing and implementing a system to identify babies at higher risk of SID and devise an intervention package for these families to reduce risk

SECTION TWO – THE CHILD'S JOURNEY

Demographic Information

There are 113 200 children and young people aged 0-18 living in Sheffield[3].

The city's population is becoming increasingly diverse; the most recently available data for school age children shows that 29.6% of children and young people are from BME backgrounds; this figure is increasing year on year (it was 26.9% in 2011 and 28.4% in 2012.)

1 in 4 Sheffield children live in poverty, with great disparity across the city. For example, just 3.4% of children and young people in the Fulwood Ward live in poverty, compared to 45.0% in the Manor Castle Ward.

22.1% of Sheffield children have special educational needs; although this figure has been falling since 2010 - when it was 26.1% - it remains higher than the national figure of 18.7%.

25% of adults who accessed drug treatment during the year reported having at least one child living with them.

In 2012/13, 109 young people in the city accessed treatment for drug or alcohol misuse.

Every year a number of primary, secondary and special schools across Sheffield take part in the Every Child Matters consultation run by Sheffield City Council. The consultation has been taking place since 2006, and seeks to find out the issues affecting children and young people living in the city. Key findings from this year include[4] ;

- In Year 2 (Yr2), 83% of children who took part said they always feel safe at school, but by Year 10 (Y10) this figure drops to 55%. The most common reasons given for not feeling safe at school were bullying and teasing.
- In Y10, less than 45% of young people said they were happy with the way they look 'most of the time'.
- Over a third of Year 5 (Y5) pupils reported that they help to care for a parent or someone else in their family. The main caring tasks carried out by young people were housework, listening and providing company.
- Over 20% of pupils in Y10 said they had given out personal information on line to someone they had not met.

[3] Source: Department for Education, Statistical First Release *Characteristics of Children in Need in England 2011/12* (31 October 2012)

[4] For more information on the ECM Survey go to: https://www.sheffield.gov.uk/education/about-us/plans-partnerships/every-child-matters-survey.html

Safeguarding Activity
Early Intervention and Prevention

Research evidence is clear that preventative services which work with children and families as soon as problems emerge can do far more to reduce abuse and neglect than reactive services. Early help and early intervention cover interventions which occur early in the life of a child and those which are provided early after the emergence of a problem.

In Sheffield, Multi Agency Support Teams (MAST) provide early intervention and prevention services to families across the city. There are 3 MAST area teams (East, North & West) that work with the whole family to provide information and support on a range of issues including parenting skills, being healthy and happy and help with learning, behaviour and attending school.

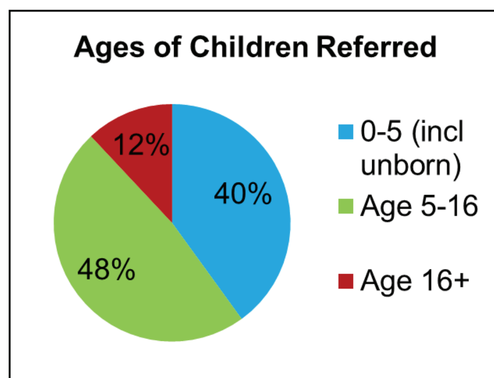
During 2012-13, MAST teams in Sheffield received **10520** requests for a service, an increase of 15% on the number received during 2011-12 (an average of 877 requests per month). Of the requests, 8381 (80%) resulted in support being provided to vulnerable children and families.

A total of **3021** CAFs (Common Assessments) were received by the MAST teams during 2012-13. CAFs are completed with families who are vulnerable or have complex needs and need additional support.

Requests for Service by MAST Area

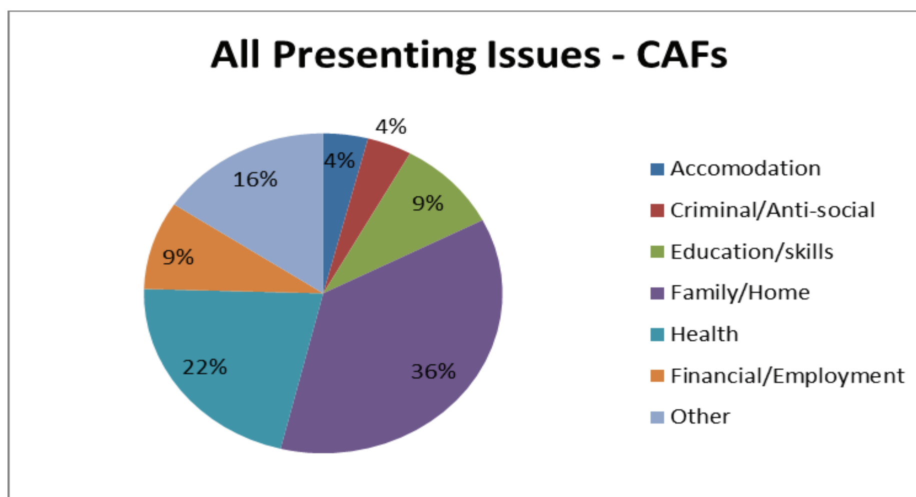
Area	Number	Percentage
East	3249	31%
North	4233	40%
West	3038	29%

MAST Requests for Service by Age of Child



Reason for Referral to MAST

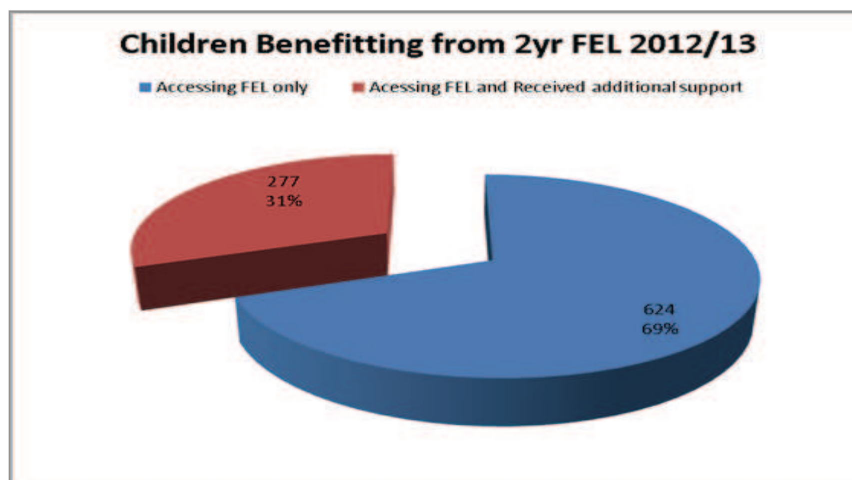
When a referral is received the reason for this is recorded (these are called presenting issues, up to 2 are recorded). These are shown below:



Free Early Learning

Nationally, children aged between 3-4 years are eligible for 15 hours of free early learning (FEL). The aim of FEL is to give young children the best possible start in life by helping them develop reading and writing skills, encouraging play and exploration and providing other positive activities.

In 2007, Sheffield became one of the first authorities to trial the provision of FEL for 2 years from disadvantaged families. During **2012/13**, **901** children benefitted from a FEL place; almost a third of these children also accessed additional support services.



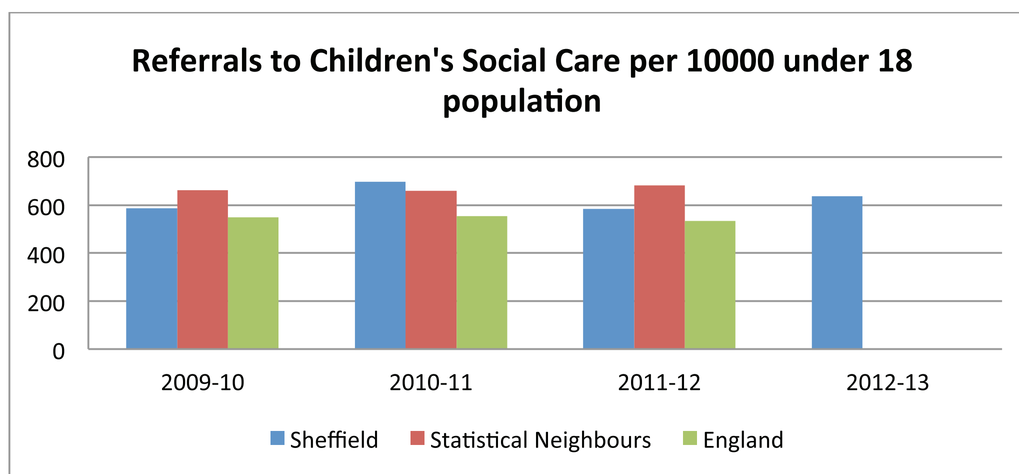
From April 2013, the criteria for accessing the 2 year FEL has been widened meaning that any children who would be eligible for free school meals will be entitled to 15 hours of learning. The additional funding provided will enable another **1400** children to access learning and thereby improve their speech and communication skills.

Children’s Social Care – Children In Need

Where concerns about a child or young person are more serious, a referral should be made to Children’s Social Care. When a referral is received, the local authority has 24 hours to decide whether or not to accept the referral. Once a referral is accepted, a social worker will start an assessment to gather information on the child and their circumstances. The outcome of this assessment will inform the plan which is put in place to support the child or young person.

Referrals to Children’s Social Care

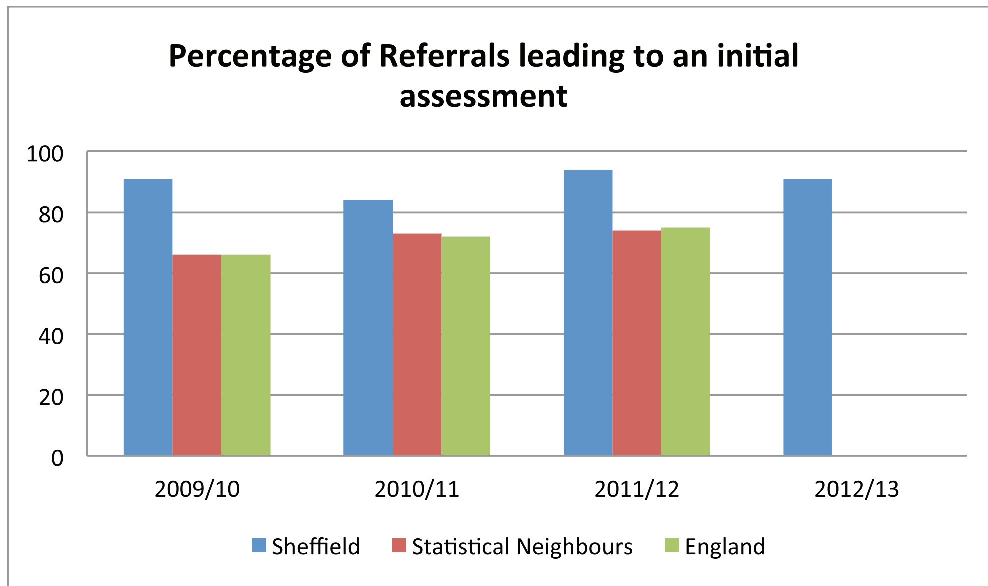
In 2012-13, children’s social care received **7180** referrals, an increase of 8% from the previous year.



Referrals Leading to Initial Assessment

91% of referrals received during the year led to an initial assessment. Sheffield has a much higher proportion of referrals leading to initial assessment than similar (comparator) authorities.

Social workers completed **6511** Initial Assessments during the year. The high conversion rate between the number of referrals received and the number of initial assessments undertaken suggests that professionals across the city have a good understanding of thresholds for interventions, and are referring appropriate cases to children’s social care.

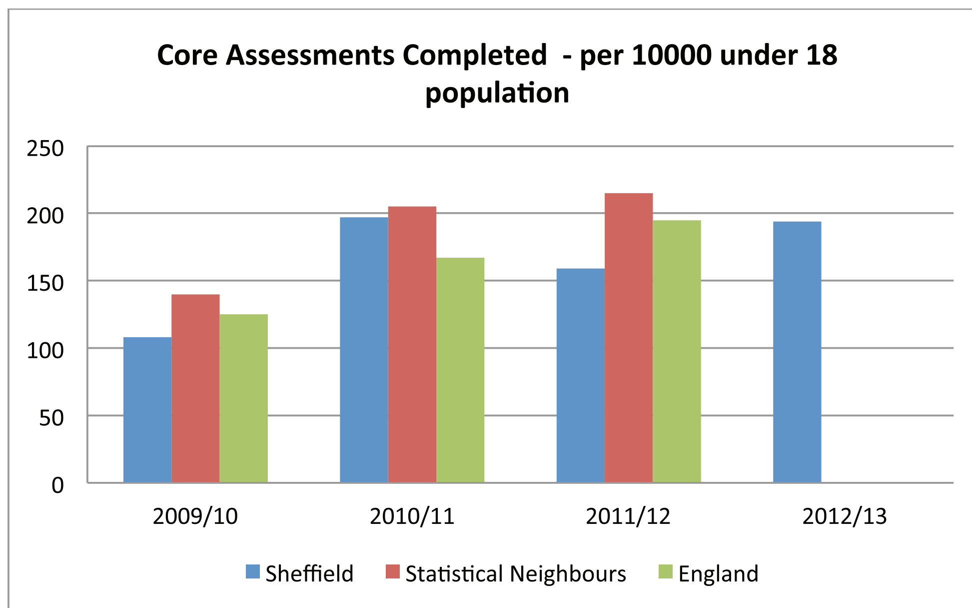


Initial Assessments in Timescale

Working Together to Safeguard Children (2010) required initial assessments to be completed within a maximum of 10 working days from the date of referral. This timescale attracted widespread criticism and was removed when the revised Working Together was published in April 2013. During 2012-13, 64% of Initial Assessments were completed within 10 working days.

Core Assessments

During 2012-13, Children's Social Care completed **2190** core assessments, up 21% on the number completed during the previous year.



SSCB/Children's Social Care Child In Need/Child Protection (CIN/CP) Threshold Audit 2012

This audit was jointly commissioned by Sheffield Safeguarding Children Board and Sheffield Children's Social Care. It was undertaken as a 'follow on' audit after a similar piece of work was completed in 2010/11. The audit focused on a sample of 36 children where a referral had been received by Children's Social Care between January 12 – June 12 and a strategy discussion/meeting had been held. Although cases were randomly selected consideration was given to ensure balance based on demographic area, gender, ethnicity and age.

The aim of the audit was to see if cases were being referred onto Child Protection at the correct time (ie. not too early/too late). The main findings were:

- The audit evidenced that the CIN/CP threshold is being used appropriately.
- There was a significant improvement in the quality and consistency of recording (in comparison with the previous audit).
- There was an improvement in the overall quality of assessments with 88% of all assessments being seen as satisfactory or above.
- There was better evidence of appropriate and clearer decision making.
- There was greater evidence of good management oversight in cases.
- There was evidence of more CIN plans on the system than in the 2010/11 audit.
- Excellent assessments were those that provided clear evidence of the 'child's voice'.

Further work is now being undertaken on the following areas:

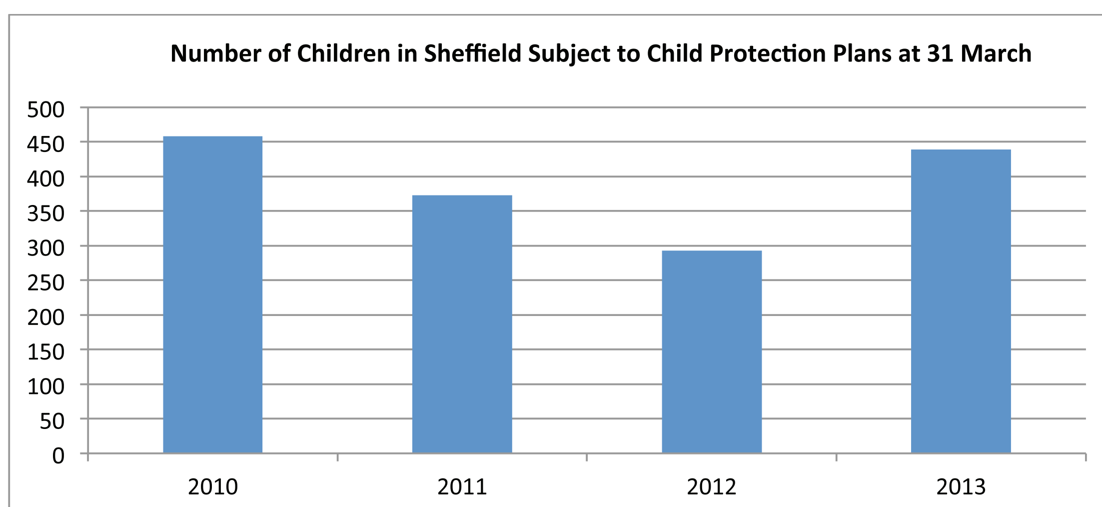
a) S47 processes – there were a number of cases where an Initial assessment was used to complete a S47 investigation. Although this did not always lead to an unsatisfactory assessment it is not compliant with Working Together 2010.
b) There was a lack of consistent use of the S47 outcome forms.
c) Auditors felt that there needed to be an increase in the feedback provided to key professionals throughout the process.
d) Further work is required to ensure consistent, relevant and child focussed CIN plans that are regularly reviewed and updated.

Children Subject to Child Protection Plans

Where an enquiry made by Children's Social Care (under s.47 Children Act 1989) indicates that a child is suffering or likely to suffer significant harm, then a Child Protection (CP) conference should be arranged. At the initial CP conference, if professionals agree that the child is at continuing risk of significant harm, then they will be made the subject of a CP plan. The plan will set out the steps which need to be taken to ensure the child remains safe. A conference is arranged after 3 months, were the CP plan is reviewed, and then further conferences continue at 6 monthly intervals as needed.

Number of Children & Young People subject to a Child Protection Plan at 31 March 2013

The total number of children subject to a child protection plan at 31st March 2013 was **439**. This represents an increase of **49.8%** since 31 March 2012 when the number was 293.

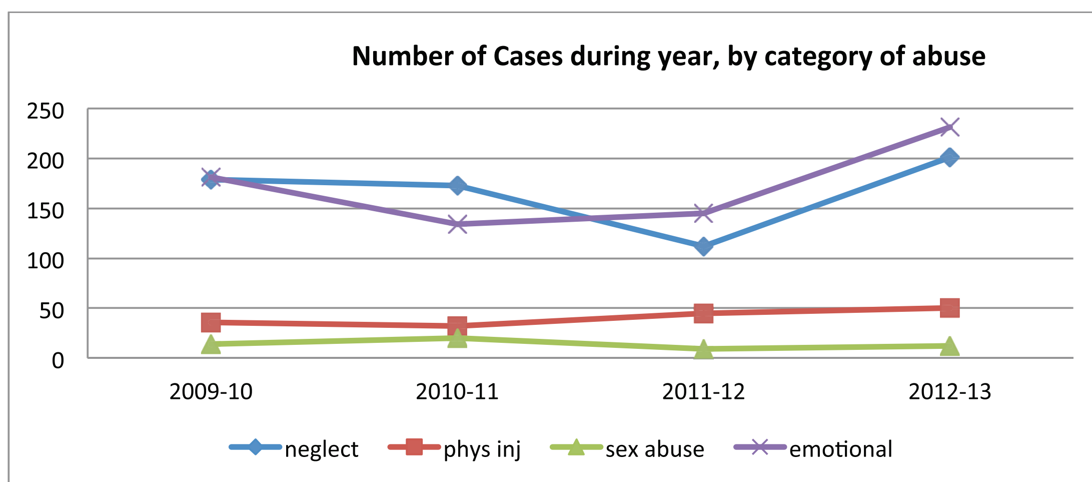


The number of children subject to a child protection plan, measured as a rate per 10,000 of the population under 18, gives a rate for Sheffield of **38.8** (439 children subject to a CPP and an estimated population of 113,200). The Sheffield rate is higher than the rate for England (37.8) but lower than the average rate for both our statistical neighbours (51.4) and the core cities (52.5)[5].

In England there were 42,900 children who were subject to a child protection plan at 31 March 2012, compared with 42,330 at the same point in 2011. This represents an increase of 1.3% over 12 months. The number of plans being made nationally has slowed considerably since 2010/11, when there was an 18.6% increase on the previous 12 months.

[5] **NB** All comparative figures are taken from Department for Education, Statistical First Release *Characteristics of Children in Need in England 2011/12* (Published 31 October 2012) Data for some local authorities was missing and therefore excluded from any analysis.

Category of Abuse: Reasons for CP Plans during Year



For the second year running, emotional abuse was the most common reason for plans being made (n = 231, **46.8%** of all plans made.) Neglect accounted for **40.7%** of all plans made (n=201), physical injury **10.1%** (n=50) and sexual abuse **2.4%** (n=12).

When considering the total number of children subject to CP plans as at 31 March 2013, as opposed to plans made over the year, the proportions were: emotional abuse 50.6%, neglect 38.5%, physical injury 9.1% and sexual abuse 1.8%.

Nationally during 2011/12, neglect was the most common reason for children requiring CP plans, with 42% of all plans being made in this category. 28% of plans nationally are as a result of emotional abuse, 12% due to physical abuse and 5% concern sexual abuse. A further 12% of children subject to plans nationally cite multiple reasons. In Sheffield we do not use multiple categories; this may account for some of the difference between the proportion of plans made locally for emotional abuse and the proportion nationally.

Children Subject to a Child Protection Plan who are also Looked After

At 31 March 2013, **4** looked after children were subject to child protection plans; this is less than 1% of all children subject to CP plans. The number at 31 March 2012 was 17 (5.8%).

SSCB Safeguarding and Child Protection Procedures contain clear guidance on managing cases where children subject to CP plans become looked after. There must be a clear justification for a child who is looked after to also be subject to a CP plan and this decision must be taken jointly by the conference chair and the child's Independent Reviewing Officer.

Children who became the subject of a Child Protection Plan during the Year

In Sheffield **494** children became the subject to a Child Protection Plan during 2012-13 (compared with 311 in 2011-12) – this is an increase of 58.9 % on the previous year.

This gives Sheffield a rate per 10000 of **43.6** (previously 27.5) which is lower than the rate for all England authorities (45.9), core cities (65.7) and statistical neighbours (65.3).

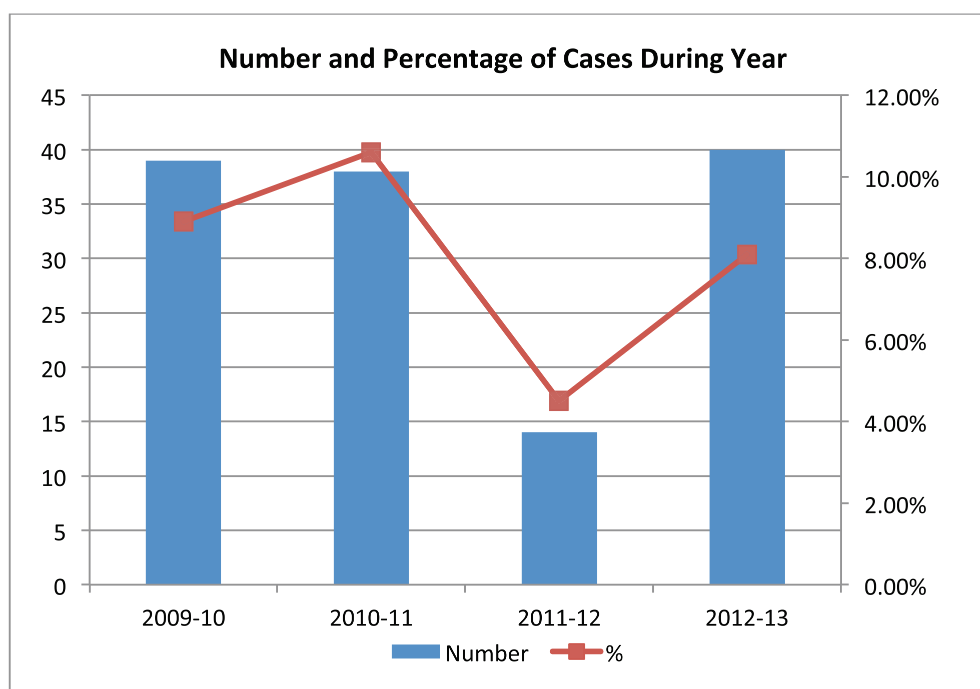
Locally the gender split was 238 boys (48.2%), 217 girls (43.9%) and 39 unborn babies (7.9%).

There was a fairly even distribution between age groups:

- babies under a year accounted for 17%
- 1-4yrs: 31.6%
- 5-9yrs: 30.2%
- 10-15yrs: 19.8%
- Young people over 16yrs who were made subject of a CP Plan represented 1.4% of the total.

SSSB and Sheffield Adult Safeguarding Partnership (SASP) have developed best practice guidance to ensure that staff in all agencies are aware of their responsibilities to safeguard young people transferring from children's to adult's services. The guidance requires all agencies to have robust protocols in place to enable safe and effective transition from young people focused to adult oriented services. In addition, agencies must demonstrate that key staff understand their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Standards, so that young people are assessed and properly safeguarded during periods of transition.

Children Becoming the Subject of a Child Protection Plan for a Second or Subsequent Time



During 2012-13, **40** children were made subject to a Child Protection Plan for a second or subsequent time.

That represents 8.10% of all Child Protection plans made during the year. During 2011-12, 14 (4.5% of the total) children were made the subject of a second or subsequent plan.

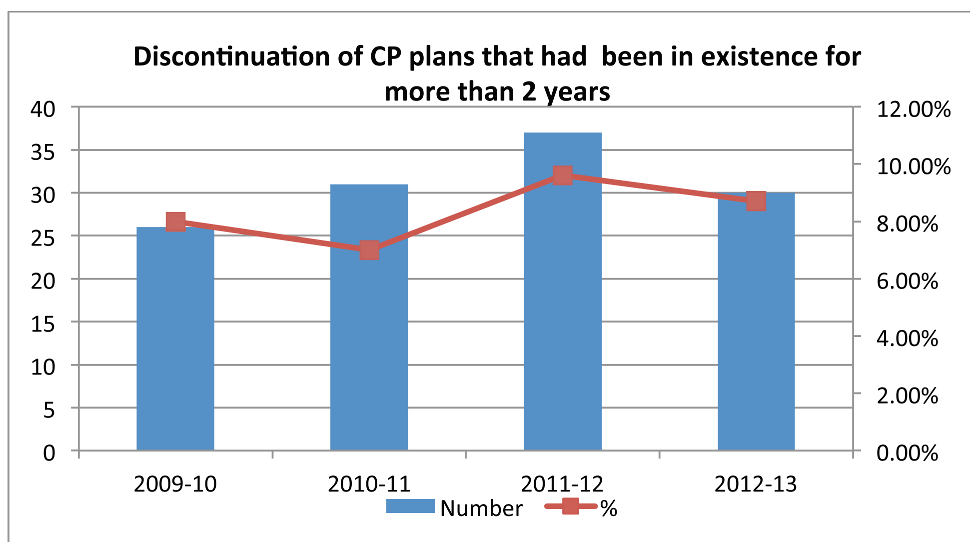
The proportion of children becoming subject to second or subsequent Child Protection Plans in Sheffield is lower than the national average for all authorities (13.8%), statistical neighbours (13.9%) and Core City comparators (16.3%).

NB Second/Subsequent Child Protection Plans + Length of Time a Plan is in place are separate but inter-related indicators in the national performance set - they have to be considered together as one can influence the other. A low rate for the making of Second/Subsequent Plans might be achieved by keeping a higher proportion of children subject to their original Plan for longer, or vice versa.

Discontinuation of Child Protection Plans

During 2012-13, **345** Sheffield children had their Child Protection Plans discontinued. This is a 10.8% decrease on 2011-12 when 387 children had their Child Protection plans discontinued, represents a rate per 10000 of **30.5**.
The national average for England = 45.5; the average for statistical neighbours = 64.1; and core cities = 70.0.

Child Protection Plans Lasting More Than 2 Years



During 2012-13, **30** children (8.7% of all discontinued plans) had a Child Protection Plan discontinued that had been in place for more than 2 years. This figure is lower than the number in the previous year (37, 9.6%).

The national average for all authorities is 5.58%, our statistical neighbours 4.44% and core city comparators 5.29%. Core city comparators range from 2.8%–7.7%) While Sheffield had a higher percentage of plans lasting 2 years or more than any of the core city comparators, the percentage of children being placed on second or subsequent Child Protection plans locally was lower than any of the core cities**.**

To help avoid drift in a case, a new process has been introduced whereby at the 12 month point Child Protection Co-ordinators based within the Safeguarding Children Service, review progress being made towards implementing the Child Protection plan. This review will ensure there is rigorous challenge and that alternatives are considered if parents have not demonstrated a willingness to change within a year.

There can be an issue if it appears children's Child Protection Plans are being discontinued too quickly. If that was happening, it would tend to show in an increased frequency of Second/Subsequent Plans needing to be made. Equally, the need for Second/Subsequent Plans can be reduced if children remain the subject of a Plan for longer – the two indicators are inter-dependent. However, in Sheffield there remains a reasonable balance between these measures.

Child Protection Plans Discontinued in Under 6 months

During 2012-13, of those children who had Child Protection plans discontinued, **25%** (n=87) had been in existence for less than 6 months.

40.3% of plans ended between 6m to one year. **25.8%** ended 1-2 years from their start and **8%** had been in place for longer than 2 years. Most children locally remain the subject of a plan for more than 6m, but action to make sure they are safe enables those Plans to cease usually within 2 years.

Child Protection Reviews in Timescale

During 2012/2013, **98.9%** of Review Child Protection Conferences were held within timescales set out in *Working Together to Safeguard Children*.

In England, 96.7% of all Review Child Protection Conferences were held within timescale; for core city comparators the figure was 91.2% and for statistical neighbours it was 94.2%.

Ethnicity Information

Over recent years, the possible over and under representation of different ethnic groups within the population of children subject to Child Protection Plans has been a recurring source of concern.

Ethnicity of Children Subject to CP plans at 31 March

2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
% of children subject to a child protection plan who are White British									
81.7	81.2	82.8	79.9	79	74.8	71.4	71.8	64.2	62.6
% of children subject to a child protection plan who are of Mixed ethnic origin									
7.3	10.7	9.8	11.7	15	17.4	15.3	10.7	12.6	16.2
% of children subject to a child protection plan who are Asian or Asian British									
6.3	4.0	4.0	5.5	1.5	2.6	5.9	5.1	9.2	7.9
% of children subject to a child protection plan who are Black or Black British									
4.7	4	2.9	1.7	3.1	3.4	4.6	3.8	6.5	3.9
% of children subject to a child protection plan who are of Other ethnic origin									
0.0	0.0	0.0	1.5	1.4	0.9	1.5	8.0	4.8	7.9

Since 2003/04, the percentage of children subject to Child Protection Plans who are White British has fallen from 81.7% to 62.6%.

Over the last twelve months the percentage of children who are of mixed ethnic origin and subject Child Protection Plans has increased, and are over represented among children subject to Child Protection plans.

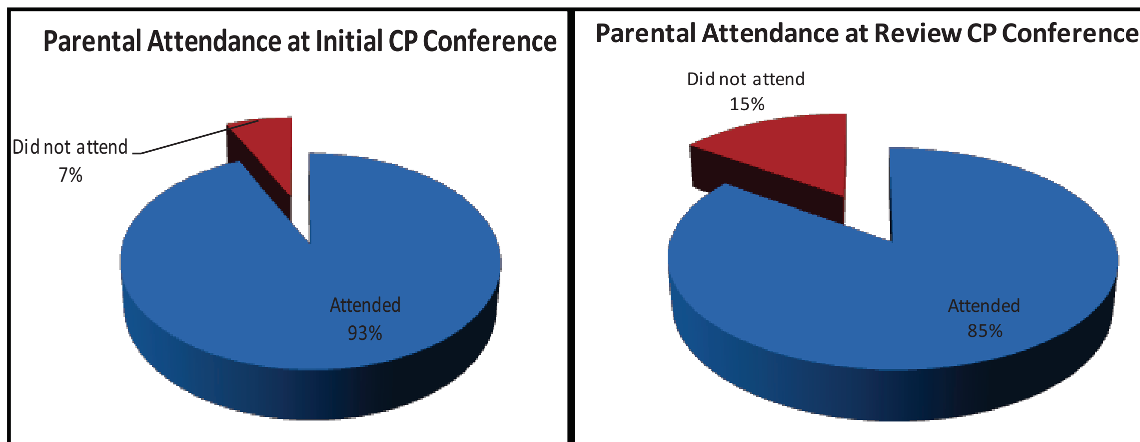
Disproportionality: Analysis has been carried out comparing the ethnicity of children subject to Child Protection Plans with the ethnicity of young people aged 0-17 from the 2011 census. We compared differences with the percentage of children from different ethnic backgrounds across the city with the percentage of children from the same group who were subject to Child Protection Plans. This technique looks at disproportionality which is whether children from different ethnic groups are subject to Child Protection Plans in proportion to their presence in the local area.

A disproportionality index of 1 would mean the ethnic group was represented on Child Protection Plans at the same rate as they are represented in the population.

Ethnic Group	Disproportionality Index – Sheffield
White British	0.89
White and Black Caribbean	2.51
White and Black African	1.53
White and Asian	3.37
Other Mixed Background	2.37
Pakistani	0.40
Bangladeshi	2.88
Chinese	1.12
Other Asian	1.35
Black African	0.68
Caribbean	1.39
Other Black	0.40

Parental Involvement: Attendance at Initial and Review Conferences

During 2012-13, parents / carers attended 93% of initial child protection conference, and 85% of review child protection conferences.



Involvement of Parent/Carers & Children in Child Protection Conferences

During 2012-13 Sheffield Safeguarding Children Board undertook two evaluations that looked at both parental and children's involvement in the child protection processes.

1. Parent/ Carer Feedback from Child Protection Conferences

Direct feedback from parents and carers is an important part of service development and quality assurance. Two previous parent evaluations have been completed (January 2010 and 2009) and can be found on the research and evaluation pages of the website. There have been specific changes in response to the results of these including; changing professional leaflets and report proformas to highlight the importance of sharing reports with parents prior to conference and giving parents more information about what to expect at the conference.

Between Monday 2nd – Tuesday 31st July 2012 parents/carers attending all Child Protection Conferences were asked if they would complete a short feedback questionnaire.

Results

Forty seven questionnaires were completed and these were from parents and/or other relatives at 40 conferences. Below is a list of questions asked and the parents' response as well as comparisons with the results from previous parent feedback questionnaires.

Involvement of professionals and parent experience

- ***Do you feel professionals who work with you and your children listen to and consider your views?***
  - 85% of parents felt professionals who work with them 'completely' or 'mostly' listen to and consider their views (39% 'completely' & 46% 'mostly').

- ***Do you understand why the social worker became involved with your child(ren)?***
  - 96% of parents reported that they understood.

It is the first year that these questions have been used. It is encouraging that the majority of parents understood why the social worker became involved with their children. In addition to this a large majority of parents felt that professionals listened to and consider their views.

Conference reports and understanding the reason for a conference

- ***Do you understand why this meeting has been arranged?***
  - 96% reported that they understood.

- ***Did you see a copy of the report from the social worker before today's meeting?***
  - At 67.5% of conferences at least 1 parent had seen a copy of the social workers report before the meeting. Of these 41% saw it 2 days (or more) before the conference and 55% saw it 1 day before. The social worker went through the report, with at least one parent in 74% of cases.

The SSCB Child Protection and Safeguarding Procedures state that the social worker should provide the report to parents at least 2 working days in advance of the conference. It is positive that at 67.5% of conferences at least one parent had seen a copy of this

report prior to the meeting. This question was asked in 2010 and at that time 44% of parents had seen a copy of the social worker report prior to the conference.

- ***Did the social work report include your views?***
  - 55% of parents felt the social work report included their views, 13% were unsure.

- ***Did the report include your child's views?***
  - 69% of parents felt the report included their child's views (of those that felt their child was old enough to express this).

- ***Did other professionals go through their report with you before today's meeting?***
  - 52% reported that all or some of the other professionals involved with their family went through their reports with them prior to the meeting.

The parents experience of the conference

- ***In the meeting, do you feel that you were given the chance to get your point of view across?***
  - 89% felt that they were 'completely' or 'mostly' given the chance to get their point of view across in the conference. (72% completely, 17% mostly).

This question has been asked in all the parent feedback questionnaires (2012, 2010 & 2009). The proportion of parents who feel that they are 'completely' able to get their point of view across has increased over time, from 61% in 2009 – 72% in 2012.

- ***Did you feel that your views were listened to during the meeting?***
  - 93% felt their views were 'completely' or 'mostly' listened to during the meeting (67% 'completely', 26% 'mostly').

- ***Did you understand what was happening in the meeting?***
  - 77% reported that they understood all of what was happening in the meeting and 19% understood some of it.

- ***Does your child have a child protection plan?***
  - 80% of parents reported that their child was subject to a child protection plan (CPP) at the end of the conference, 2% were unsure. Of these, 84% reported that they understood what needs to happen in order for their child to no longer need the plan, 5% were unsure and 11% did not know.

The proportion of parents (of children who were subject to a Child Protection Plan at the end of the conference) who understood what needed to happen in order for their child(ren) to no longer need a plan, has increased since 2010 (73% in 2010, 84% in 2012).

Conclusions

The feedback demonstrated many positive areas as the majority of parents understood why the social worker became involved with their children and the reason the conference were called. Parents felt that their views were listened to and considered by the professionals that work with them.

The results from this questionnaire were compared with results from previous years and this also demonstrated some improvements. For example, two thirds of parents had seen a copy of the social work report prior to conference (up 23% since 2010) which is very positive, although, there is still work to do to meet the requirements of the SSCB procedures (this states that the social worker should provide the report 'to parents and older children …… at least 2 working days in advance of the initial child protection conference').

Of the parents whose child(ren) had a child protection plan in place at the end of the meeting, there was an increase, in comparison with 2010, in the proportion that understood what needed to happen in order for their child(ren) to no longer need a plan. However, there were still 16% of parents that were not clear of what action was required and professionals need to be aware of this.

2. Children's Wishes and Feelings within Child Protection Conferences

Recent research (Cossar, Brandon & Jordan, 2011) with children who had a Child Protection Plan concluded that '*Professionals need to think carefully about what it is like for the young person to be at the (child protection) meeting, the likely emotional impact and how the young person's involvement is best managed to make it a positive experience.'* In Sheffield, Children's Wishes and Feelings (CW&F) forms were introduced in 2011. They are to be completed by the social worker, with the child prior to their Child Protection Conference and submitted alongside the social work report. The aim of this piece of work was to:

- Investigate whether children/young people's voice is being heard within the child protection conferences.
- Assess whether the CW&F forms have strengthened the children's voice.
- Identify ways to strengthen the voice of the child/ young people within the conference in the future.

Method

A comparison was undertaken of those conferences where CW&F forms were brought to conference with those that hadn't, using July 2012 as focus. A 'matched pair' technique was used, where each child (aged 3 – 17 years) with a CW&F form or who attended the conference (Group 1) was matched for age and reason subject to a plan with another child that had not completed a CW&F form (Group 2) who had also been the subject of a conference in the same month.

Result

Summary of the group's experiences;

Group 1(CW&F forms or had attended a conference)

- 92% had CW&F forms and/or wishes and feelings within the social work report submitted to the conference. Some CW&F demonstrated the child had a level of understanding of the role of the social worker and insight into their situation.
- 85% conferences discussed the child/young person's wishes and feelings.

Group 2 (No CW&F forms or attendance at conference)

- 31% of the social work reports contained the child/young person's wishes and feelings.
- 15% of the conferences discussed the child/young person's wishes and feelings,
- For 85% of children there were no wishes and feelings discussed.

Discussion

The analysis undertaken demonstrated that 61.5% of children had written wishes and feelings provided to the conference (either through a CW&F form or social work report).

Those within Group 1 (CW&F forms/young people attended) were much more likely to have their wishes and feelings submitted to the conference (92%) in comparison to those in group 2 (31%, no CW&F form). It appears that the majority of social worker's that discussed wishes and feelings with the child or young person choose to use the CW&F forms, sometimes in conjunction with further discussion (summarised in the social work report). Although the sample size in this analysis was small, it has been able to evidence that even very young children can demonstrate some insight into their situation and offer relevant views. It is therefore important that social workers understand that using resources can help children express views relevant to the conference, even if these views are not a direct comment on the child protection plan or conference itself.

Core group questionnaire

A Core group is meeting involving the professionals and parent/carers of a child who is subject to a CP plan. They meet regularly in between child protection conferences to work with the family on the child's CP plan.

To gain a more in-depth understanding of core groups, the SSCB agreed to undertake a small scale audit looking at attendance, quality and outcomes. During a two week period in September 2012 and again in January 2013 each attendee (including both professionals and family members) coming to a Review Child Protection Conference was asked to complete a short questionnaire regarding their experiences of core group meetings. In total this related to 48 conferences with 227 responses received.

The main findings were that

- 98% of family members stated they had attended a core group meeting with 85% saying they had attended all core group meetings since the last review child protection conference.
- 90% of professionals had attended a core group meeting with 60% attending all core groups since the last conference (some of the difference in this figure related to workers who had only recently been allocated the case).73% of all those reported that core group meetings had taken place on a monthly basis.
- 57% reported that the core group meeting focussed on the child protection plan but only 34% stated that changes were made to the plan to reflect those discussions.
- Professionals stated that they found the meetings useful but a criticism was that minutes were either not received (51% of respondents stated they had received minutes following the core group meeting) or there was a lengthy delay.

The SSCB recommended that social workers be provided with the tools and resources to enable them to effectively chair core group meetings.

Looked After Children

On 31 March 2013, **577** children from Sheffield were looked after by the Local Authority; this is a reduction of 5% on the same time in 2012.

Demographic information

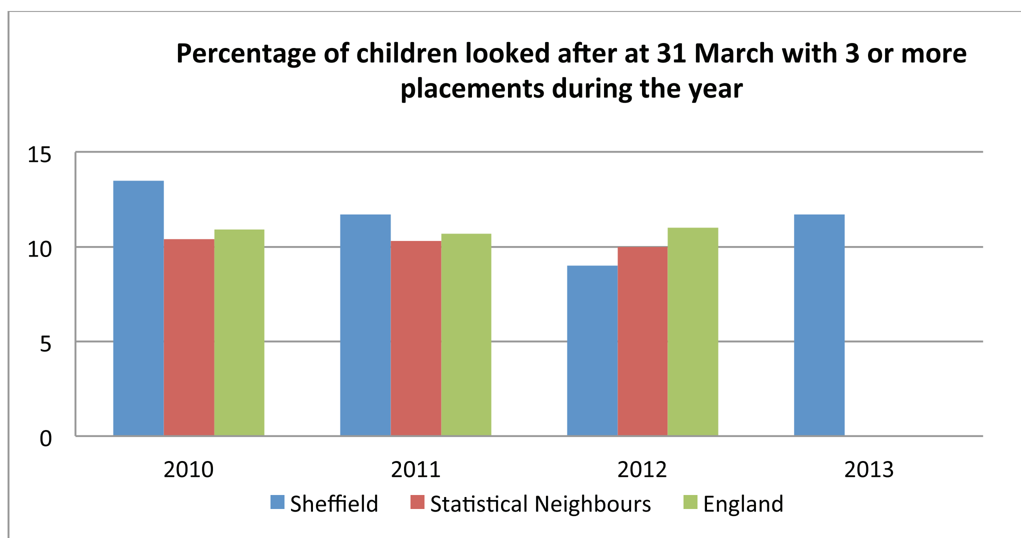
Age	Boys		Girls	
Under 1	30	6%	16	3%
1-4 years	54	10%	42	8%
5-9 years	55	10%	29	5%
10-15 years	111	21%	88	16%
16-17 years	67	12%	45	8%
TOTAL	**317**	**59%**	**220**	**41%**

Ethnicity		
White	434	81%
Mixed	46	8%
Asian or Asian British	17	3%
Black or Black British	22	4%
Other Ethnic Groups	18	3%
TOTAL	**537**	**99%**

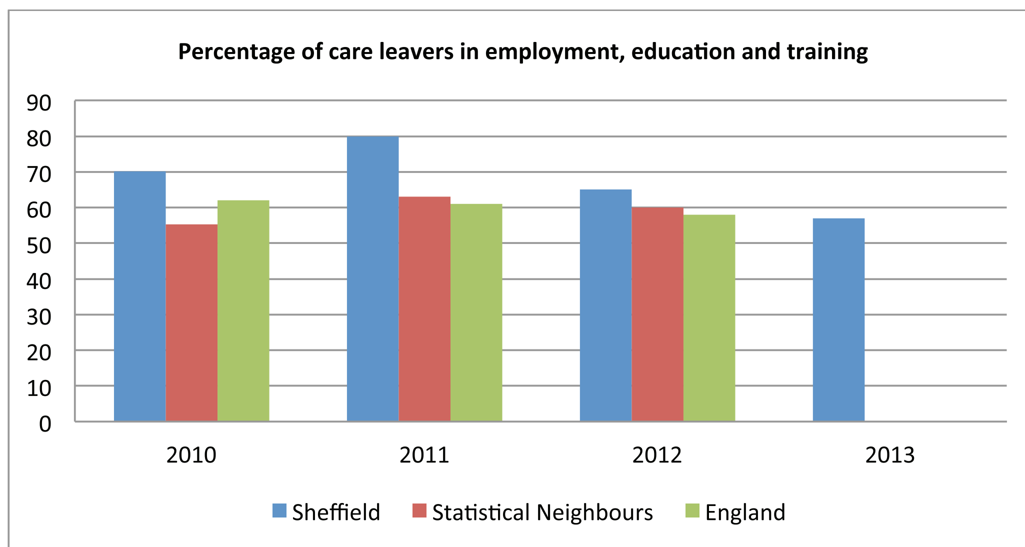
The ethnicity of looked after children is quite different to that of children subject to Child Protection Plans, with a higher proportion of looked after children being from White British families and a lower proportion of children from mixed ethnicity.

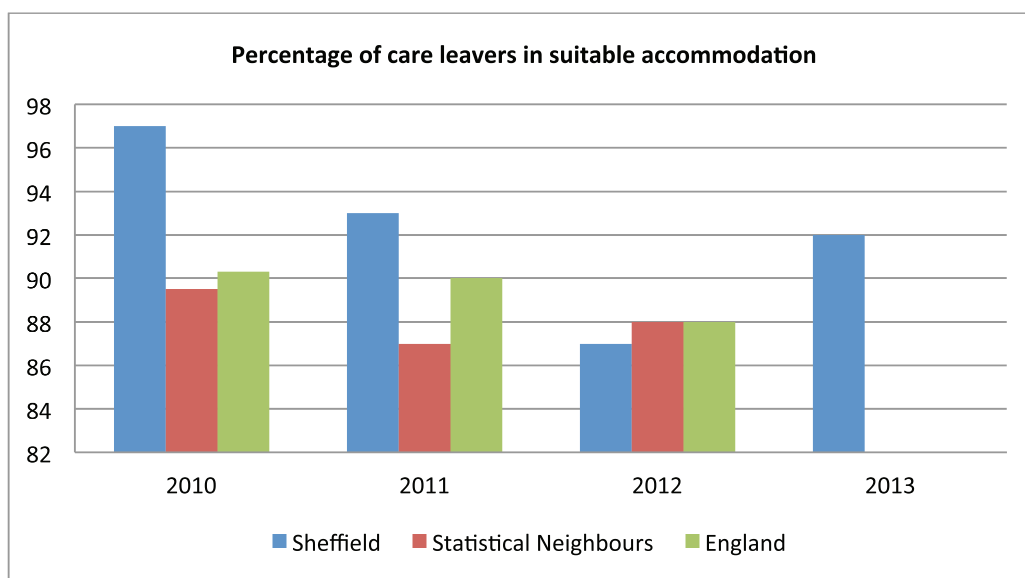
Placement Type	Number	%
Foster Placement with Relative or Friend (inside Local Authority)	8	1.5
Foster Placement with Relative or Friend (outside local authority)	5	1
Placement with other foster carer (inside local authority)	242	45
Placement with other foster carer (outside local authority)	127	24
Secure Unit	3	0.5
Homes and hostels	59	11
Hostels and other supportive residential placements	4	0.7
Residential Schools	11	2
Other Residential Settings	7	1.3
Placed for Adoption	38	7
Placed with own parents	18	3
In lodgings, residential employment or living independently	15	2.7

Placement Stability



Care Leavers





Adoption

Locally, during 2012-13, 74% of looked after children were placed for adoption within 12 months of the decision that they should be placed for adoption.

Year	Percentage Children placed for adoption within 12 months of decision being made
2012 / 2013	74.0%
2011 / 2012	58.7%
2010 / 2011	66.7%
2009 / 2010	61.9%

Over the last 3 years (2009 – 2013) an average of 17% of looked after children locally have been adopted. Nationally this figure is 12%.

SECTION THREE – ACHIEVEMENTS AND PROGRESS IN OUR PRIORITY AREAS

Private Fostering

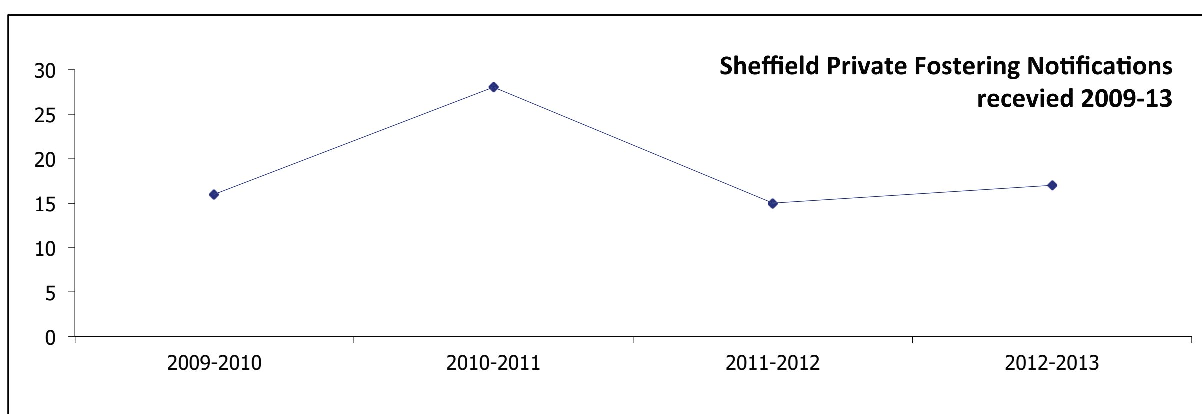
Under the Children Act 2004, Private Fostering is defined as a child under 16 (or under 18 if they are disabled) who is looked after for at least 28 consecutive days, by someone other than a close relative. Under the Act there is a legal requirement for the Local Authority to satisfy themselves that such a child is being safeguarded and their welfare promoted. This is undertaken by offering support and guidance, undertaking assessments and checks, and regular visits to the child and their carer.

Private notifications in Sheffield

The number of new notifications has dropped from 2010-11 and as of 31st March 2013 there were **17** private fostering arrangements being monitored (NB: this figure is continually changing as private fostering arrangements are often transitory) however this figure represents a small increase on last year's figures.

As reported in 2011-12 the Local Authority embarked on a substantial campaign of raising awareness of Private Fostering throughout the city using posters and advertising in a variety of placements (including on local transport, local news-letters/papers etc.) This was in addition to sending out leaflets and posters to every council office, GP and dentist in the city. However despite this "advertising" campaign the increase in referrals has been relatively minor. The Local Authority will continue to undertake the provision of leaflets and posters in offices and other relevant establishments and will continue to raise awareness with practitioners.

The majority of referrals being made come from professionals working within Children Young People and Families, however there have been three referrals directly from families (two who are hosting children from abroad).



Protocols

The most frequent way a referral is taken is through early discussions with the duty staff or the team manager (in Children's Social Care) about potential Private Fostering arrangements. It is apparent when discussing potential Private Fostering arrangements

that understanding among professionals of what constitutes Private Fostering has resulted in clearer identification of arrangements at an early juncture. Inappropriate referrals are identified at an early stage and where it is required a suitable service is signposted to. This helps to explain why there are few notifications recorded that have not progressed to private fostering arrangements.

Families Adopters and Carers Team (FACT) perspective

- FACT continue to identify one worker who is mainly responsible for the initial private fostering assessment however the team have a general expertise in this area and all four social work qualified staff have responsibility for some Private Fostering cases.
- The variety of Private Fostering arrangements continues and FACT have been involved with children who have been subject to Special Guardianship Orders (SGO) and have left the guardian's home to live with another distant relative. FACT has liaised closely with other relevant agencies including Child and Adolescent Mental Health Service, Education, Multi-Agency Support Team (MAST) to ensure adequate services and support is provided.
- FACT have also worked with the carers of Private Fostered children to assist them in applying for court orders to secure a child legally and negate the need for private fostering visits
- The majority of the children being Privately Fostered are teenagers and consequently there has also been a development of knowledge and better links with the MAST service in identifying what support is available for this age group.
- It is important to note that FACT has achieved a very high percentage, (approximately 95%), of the statutory requirements within specified timescales.

Future Plans

- FACT will need to continue its efforts in alerting the public, professionals and the voluntary sector as to their responsibilities in relation to Private Fostering notifications
- Continue of information giving and presentations to official bodies.
- Continued development of relationships with adjacent authorities to develop best practice and perhaps look at consistency between authorities
- Consider developing a group or at least an event for Private Fostered children and their carers.
- There needs to be a discussion regarding resources allocated to Private Fostering particularly given that there has been no increase in notifications.
- The links FACT has with the MAST has been helpful in securing support and resources for children who are privately fostered in the local community. This should continue
- FACT will monitor the advertising to establish its effectiveness

FACT will continue to strive to keep all Private Fostering arrangements serviced according to the statutory timescales.

Sexual Exploitation

Achievements

- Due to a climate of tight and increasingly difficult budgetary conditions, it became clear that the Service needed to adapt, change and refocus its energies to deliver on strategic and operational priorities. The development of a new Model of Delivery for the Sheffield Sexual Exploitation Service commenced in 2012.
- Since October 2012 the newly configured Child Sexual Exploitation (CSE) Service is not just co-located, but genuinely integrated, with a new Service Manager driving the work, setting priorities, and establishing a team identity and approach. The expansion of the CSE co-located team now includes an Education Worker, Social Workers and a Family Support Worker. New and different opportunities will be pursued to continue to build and broaden the skills base and capacity within the Service.
- Securing another three years funding from Comic Relief to further develop work with boys and young men.
- The Taking Stock team were asked to speak at the Community Care Conference in London for the second year running demonstrating the value of the Service from a national perspective.
- CSE training was successfully delivered to over 200 police and professional staff by the team at a West Yorkshire Police training event in September 2012 with very positive evaluation feedback.
- CSE training was delivered as part of the Open Doors Sexual Health annual training day in July 2012.

Challenges

- Working with Children's Social Care to ensure cases are joint worked where there are specific vulnerabilities that require the input of a qualified Social Worker.
- Working on the transition agenda to ensure the needs of young people identified as vulnerable adults are provided with suitable support at exit from the CSE service.
- In early 2012 there was a waiting list for referrals to be placed on a caseload with Taking Stock, as the year came to an end in March 2013 historical referrals were reviewed and this situation was resolved. However, closer monitoring and reporting of capacity issues should have taken place to prevent this from happening.

Evidence of Multi-agency working and participation

The service works closely with professionals from a wide variety of agencies including the Youth Justice Service (who are already co-located in the same building as the Sexual Exploitation Service), and the Permanence and Through Care Service for Looked After Children and Care Leavers. This will improve in 2013-14 when they also co-locate to the same building as the Sexual Exploitation Service.

The service has implemented a new risk assessment model; ensuring young people receive the appropriate level of support. Young people who are deemed to be at less significant risk of exploitation are now supported by the Community Youth Teams, who have officers trained by the service to work with those at risk of sexual exploitation. This new model of working continues to be developed, but has already ensured that young people do not have to wait for a service.

The voice of young people is very important to the way the CSE team develop the Service. There was a young people's panel as part of the recruitment processes to select the Manager post. In 2013-14 we are planning the introduction of a 'service user' group as part of service evaluation and development. Boys and young men were involved in the development of posters and leaflets, funded by Comic Relief and included in a national campaign alongside resources (these have been distributed to all Sheffield Secondary Schools and Colleges and youth centres). On the 20th March High Storrs School hosted a South West schools event, organised by Julia Codman, focusing e-safety and CSE for approximately 100 parents and young people. The evening was a carousel style workshop, with 5 different workshops which all parents attended for 20 minutes.

Evidence of impact

- The good working relationship and trust developed between workers and young people have achieved a number of positive outcomes for young people. These are sometimes small steps and milestone targets but significant in the lives of these young people.
- Young people were supported to produce a DVD, posters and leaflets.
- A variety of outcomes have been achieved with different young people on caseloads such as
  > Improved attendance in education
  > Reduced number of missing episodes
  > Reduction in self harm
  > Reduction in substance misuse (drugs or alcohol)
  > Improved relationship with parents
  > Improved awareness of risk

Priorities for 2013-14

- The new Child Sexual Exploitation Service will have a re-launch as soon as the new Manager is established in post and will promote the new model based on 4 core principles which influence how the service is configured to deliver these aims and objectives: Prevent ; Protect; Pursue and Prosecute.
- The Service will contribute to a city wide workforce development programme to ensure everyone working with children and young people can identify the warning signs and behaviours which may indicate sexual exploitation and the nationally recognised typical vulnerabilities in children and young people prior to being sexually exploited.
- The Service is about to produce an updated new version of 'Friend or Foe' to include a new section for use with young people with language, literacy or mild disability issues.
- The team would like to raise funds to finance a video interview room within the Service to provide a more effective and supportive process.
- Successful prosecutions.

Domestic Abuse

Performance

The community based domestic abuse services supported **3442** individuals during the year:

Independent Domestic Violence Advocates	715 clients
Outreach Service	321 clients
Helpline	2406 calls and referrals

In the first three quarters of 2012-13 (full year data not yet available), the adults supported had **3608** dependent children.

Review of Domestic Abuse Structures and Services

The Sheffield Domestic Abuse Partnership Co-located Team was launched in spring 2010; 34 units of refuge accommodation are also commissioned in Sheffield from 3 providers. While there has been good progress made in relation to better partnership working, some elements of the structure were less robust than others and the lack of clarity between the roles of commissioners and providers in particular was raised as an issue by a number of partners involved in the Domestic Abuse Partnership. This concern along with new legislation, research and guidance, together with the serious economic difficulties facing commissioners and providers alike led partners to conclude that the time was right to 'take stock' of current services and arrangements, review progress to date, and ensure that the partnership is achieving good value for money.

The Director of Substance Misuse Strategies was asked to undertake a review of the Domestic Abuse structure and services and a report has subsequently been produced and agreed by elected members. The Review contains 17 recommendations designed to improve both the services and governance structure. As part of this work the Sheffield DAAT has been given responsibility for Domestic Abuse in the city and this major and important area of work is currently being embedded across the DAAT which has now changed its name to Drug and Alcohol / Domestic Abuse Coordination Team or DACT; the city's Domestic Abuse Strategy Manager and Administrator has joined the DACT.

Commissioning

As part of the Strategic Review a Joint Commissioning Group was established in the summer of 2012 involving key partners, and a supporting document was developed primarily in 2012-13. This is currently out for consultation and includes an analysis of need in relation to domestic abuse in the city based on information currently available. This will be signed off in the autumn and will inform future service design. This document includes an initial estimate of the numbers of children and young people living with adults experiencing domestic abuse as follows:

Children Prevalence data – living in a household where the victim is the parent
There is no specific calculation to estimate the number of children affected by domestic abuse in Sheffield. However efforts have been made (using the 'ready reckoner' and Modus data) to provide an estimation of the number of children living with a female victim of domestic abuse.

Prevalence (over 12 month period)	Estimation	Based on
Total female victims (16-59 years old)	10,584	Ready Reckoner
Proportion of clients in support with a child/ children	58%	Modus Q2 data
Number of victims with a child	6,138	Based on 58% of those in support had a child
Average number of children per victim	2	Modus Q2 data indicating that victims with children have on average two children
Total number of children with a parent suffering domestic abuse	12,276	

An estimated **12,300** children (aged 0 to 17) are potentially living with a female victim of domestic abuse in Sheffield.

Note - This figure should be used with caution, and only as an indication.

The Joint Commissioning Group has also begun considering commissioned provision for children affected by domestic abuse in the city, funded by internal and external funding streams. A mapping project is under way with the aim of considering gaps and possible duplication with Council or other services.

A post, specialising in children and young people affected by domestic abuse, to be based within the Multi Agency Support Teams, is currently in development. The aim is that this post will link with the commissioned domestic abuse services in order to ensure children and young people are accessing support as necessary and also, where adults (parents or carers) experiencing domestic abuse are identified that they are risk assessed and referred or signposted appropriately to specialist domestic abuse services.

The Joint Commissioning Group will continue to work with the Housing Independence Service (HIS) to deliver a high quality refuge service for the city – the new building has already been designed. HIS will also progress plans to move to a situation of one provider of refuge services in the city.

The Joint Commissioning Group reports to the Domestic Abuse Strategic Group. Pooled budgets have been established where possible and the reconfiguration of community based services, aligning them on the basis of risk as recommended by the Review, is nearly completed.

As part of this process a review of unit costs has been undertaken in order to ensure effective use of public funds. Service Level Agreements (SLA) and contracts are being designed so that they are consistent with other local commissioning frameworks. Issues of capacity (under or over) have been considered as part of the redesign of service specifications following the work done in relation to initial estimates of need.

Pathway development

A clear pathway has been developed (to fit with the new Supported Accommodation Pathway when it is implemented – projected date 2014) that will be promoted to all agencies that may identify domestic abuse. The pathway will be aligned in accordance with identified risk levels of clients. Work still needs to be taken forward in relation to clarifying the pathway for people affected by domestic abuse with No Recourse to Public Funds.

The Domestic Abuse Strategy Manager has participated in the development of the Family CAF by submitting suggestions for the guidance document and requesting that explicit links are made, both in the guidance and the form itself, to the ACPO DASH risk assessment tool so that people experiencing domestic abuse are identified (whether these are young people experiencing domestic abuse in their own relationships or parents/carers) that their risk level is determined and they are referred on appropriately e.g. to MARAC (Multi-Agency Risk Assessment Conference) if necessary .

Governance

As well as the new Joint Commissioning Group, a new Provider Consultation Group has been established in order to keep the Joint Commissioning Group and Strategic Board up to date with developments in the sector and among the client group; a Service User Reference Group will also be established in order to ensure customer focus.

The Domestic Abuse Strategic Board was established in February 2013. Its key area of work is overseeing the implementation of the DA Review recommendations. Two sub groups of the Domestic Abuse Strategic Board have been established: one to oversee the implementation of Action Plans in relation to Domestic Homicide and Serious Incident Reviews, and one to oversee the multi-agency work in relation to civil and criminal justice including the MARAC.

Multi Agency Working

The definition of domestic abuse changed in March 2013 to include 16 and 17 year olds both as victims and perpetrators. A pilot project was undertaken in October – January 2013 which reduced the age limit of cases referred to MARAC in anticipation of this change. As a result, Community Youth Teams and Youth Justice Service now have representatives attending MARAC and bringing relevant information regarding cases.

The process for triaging safeguarding issues in relation to domestic abuse incidents reported to the police will continue at Snig Hill police station led by the Joint Investigation Team following the service reconfigurations e.g. appropriate and relevant information will be shared by the commissioned domestic abuse services to inform this process.

Domestic Homicide and Serious Incident Reviews

The city's second Domestic Homicide Review Overview Report was submitted to the Home Office in December 2012 and is still awaiting quality assurance. Also in December, a decision was taken to develop a process for Domestic Abuse Serious Incident Reviews in relation to near misses and / or attempted murder, especially in situations where the case had been considered by MARAC. Such a review is now nearing completion and this will result in an action plan that will encompass learning relating to situations where a parent has been assessed as at high risk of serious harm or homicide and how agencies should apply a whole household approach in such cases.

Challenges

Challenges remain relating to ensuring agencies are confident using the ACPO DASH risk assessment tool hence the importance of ensuring the tool is referenced in the new Family CAF and the new pathway relates to the Integrated Front Door development.

Some challenges remain in relation to information sharing e.g. setting up systems to ensure that information regarding the fact that an individual has been assessed as high risk of serious harm or homicide and has been referred to MARAC is communicated to GPs and Magistrates.

Main safeguarding concerns in the area of Domestic Abuse

As a result of the Serious Incident Review conducted last year the issue of separation as a risk factor has been highlighted as a safeguarding concern.

The following is from the Co-ordinated Action Against Domestic Abuse (CAADA) Practice Guidance regarding the Association of Chief Police Officers Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment; 'Attempts to end a relationship are strongly linked to intimate partner homicide… It is therefore important that work is carried out to ensure that the victim can leave as safely as possible… This reinforces the importance of offering your client support beyond the point of separation as this is when victims are particularly at risk of further violence/homicide.' It is notable in several of the reports in this case that agencies identified the separation of the parents as a factor that lessened risk of harm to the adult victim and child, however, this is not usually the case and as such, agencies should increase awareness of this fact and use it as a risk indicator. This is a specific tension for children's services that often see the child as being protected by parental separation in domestic abuse cases.

Priorities for 2013/14

The coming 12 months will see the joint commissioning embedded with a cycle in place of analysis, planning, reviewing and delivery. Reconfigured community based services will be operating with, it is intended, improved responsiveness. Work will be continuing on the development of a new refuge with a single provider. The issue of children's provision in refuges will also be discussed during the year in the Joint Commissioning Group. The intention is to move to a joint commissioning model whereby all elements of the service (e.g. support for adults and children) are commissioned together.

The new governance structure will become embedded and an additional task to be progressed during the year is the development of a citywide strategic plan for the response to domestic and sexual abuse. An area that still needs to be progressed during these twelve months is the development of a Service User Reference Group to ensure the voice of the user informs service design going forward.

Multi agency processes such as the MARAC are well established in Sheffield however due to issues of capacity both in terms of case numbers and the resources to support MARAC, it has been agreed that the Sheffield MARAC process should be reviewed this year.

E-Safety

During 2012-13 the E-safety Project has worked with many children, young people, parents and carers, professionals and staff within Sheffield. This year there has been engagement on a wider scale specifically across the Yorkshire and Humberside region and nationally in an advisory role for the Child Exploitation and Online Protection Centre Education Advisory Board.

Children, Young People & Parents/Carers
Consultation with children and young people has significantly increased this year. From September 2012 schools have been offered the opportunity for their pupils to complete an e-safety online questionnaire and to undertake pupil focus groups. Currently 20 primary schools and 5 secondary schools have participated. This level of consultation gives the school an overview of what their children like doing online, what their concerns are and to what level they are supported in school and at home. From this data we have been able to identify any gaps in support and target areas of concern which can be addressed at school level. The combined information from schools provides data to obtain an overview for Sheffield which will impact on our e-safety strategy in planning support and activities to meet the current specific needs of our young people in the city.

Support for parents has continued with e-safety workshops delivered in schools across the city. For the first time a parents event was held in collaboration with 3 south west schools. The event offered workshops for parents to give them information to help support their children around specific issues such as digital parenting, security and parental controls, identifying and dealing with sexual exploitation and digital footprints. The event also gave young people from the schools the opportunity to take part by running workshops to provide information and guidance relating to setting parental controls on digital devices and mobile phones. The event was very well received by parents with 89% of attendees stating that the evening covered all aspects of E-safety parents need to be aware of. One parent commented, "Everybody should come to this - after all, don't we all want to do whatever we can to protect our children.

In collaboration with 'Disney' and the Child Exploitation and Online Protect Centre we were based in the 'Disney' Store in Meadowhall for Safer Internet Day. We ran activities for children and gave e-safety advice to parents from across the South Yorkshire region.

Training
This year we have had success in providing e-safety training and awareness for early years and childcare providers in the city. A consultation group was created which included the E-safety Project Manager, Safeguarding Service Early Years Consultant and early years / childcare providers to create a model e-safeguarding policy and supporting documents to enable them to implement sound policies and good e-safeguarding practice. The policies were launched in March 2013.

The training programme for schools has been extremely well attended by staff from all sectors of education including nursery, primary, secondary, academies, independent and special schools. This provides schools with an overview of e-safeguarding and the tools to implement a whole school approach to support children, staff and the whole school community. We have also provided an opportunity for a school to take part in a national pilot scheme for the Information Commissioner's Office.From the feedback we have received, the training and support we have provided has had a significant impact for schools.

“This year saw a reduction in the number of e-safety incidents involving students in KS3 due the impact of the help, support and ongoing guidance provided by The E-safety Project Manager and the amazing opportunities our partnership has provided to the School, our students, staff and parents. It has enabled us to move all aspects of e-safeguarding forward for the benefit of our students, parents and staff”.

“…Students in Y7-Y11 completed an online E-Safety questionnaire to identify the current issues relevant to E-safety across our school to inform our e-safeguarding action plan.”

“…The impact being that students are aware of how to protect themselves through using e-communications responsibly as a powerful resource for learning.”

C. Gott
Assistant Headteacher, High Storrs School

“The support has been instrumental in the school moving forward at a considerable rate and improving its practice with the inclusion of some innovative approaches”.

“The school is now in a position where it is very clear about the online practice of children in each year group through pupil interviews and questionnaires and is adjusting the curriculum to meet children's needs. Systems are now in place to gather the views of parents and pupils in order to ensure the provision of E-safety is most effective”.

“In conclusion, the support given by the E-safety Project Manager has enabled the E-safety co-ordinator to pinpoint areas of development and rapidly improve the provision of E-safety. It has been an extremely successful and effective partnership that is having a striking and impressive impact”.

J. Chadbourne
Deputy Headteacher, Nook Lane Junior School

School Governors have had an e-safety training programme for the first time this year. Five sessions have been delivered across the city which have been well attended and have had a very positive impact in enabling Governors to understand their responsibilities in relation to e-safeguarding.

One of the main challenges this year has been to encourage more parents to attend awareness and support sessions. However, despite the opportunities we have provided some of the numbers attending have still not been high in some areas. Although this continues to be a challenge, we have seen an increase in the last few months

Priorities for 2013/14

The e-safeguarding landscape rapidly changes and the past year has been very challenging in keeping abreast with advances in technology, the emergence of new environments and risks to children and young people. There is concern around the creation and distribution of self-generated indecent images which is being addressed in our schools by educating young people of the possible consequences. The increase use of Apps and mobile technologies to access the internet has also heightened concerns as supervision becomes more difficult for parents.

The risk of children being sexually exploited online is part of all our e-safeguarding training to raise awareness with professionals, parents and young people. Training is delivered in collaboration with the Sexual Exploitation Service and support and advice is given to parents and young people who are involved with this service.

Over the next year there will be further consultation with children and young people and also projects to involve parents in the development of e-safety within their schools.

A new e-safety section of the Safeguarding website is to be created with advice for schools, parents and young people.

Licensing Project

Main achievements

Over 2012-13 the Licensing Project has developed existing work and established new initiatives, including:

- Promotion of the Code of Good Safeguarding Practice in relation to families living at licensed premises, so that corporate licensees are aware of their social responsibilities and how to support families living at their premises.

- Undertaking an advisory role to the National Working Group for the Prevention of Child Sexual Exploitation in relation to engaging local businesses and it has contributed to the development of a national awareness campaign with the hospitality trade.

- Expansion of the False ID awareness campaign. Materials (a short film and factsheet) have been developed in consultation with young people, for inclusion in the Substances And You (S.A.Y.) educational resource pack. The resources will be used in schools and the factsheet is for young people to access via social media networks. This aspect of the campaign is a preventive measure, to discourage young people from using false identification to access age restricted products or venues.

- Further developing the training previously piloted with the taxi/private hire vehicle trade in regional consultation with drivers, Licensing Authorities, Local Safeguarding Children Boards and Adult Safeguarding Services. The training is well received by trainees and relevant bodies and continues to be delivered as part of the BTec training at Sheffield College.

- The project has seen improved engagement with health and social care workers following a number of worksite presentations throughout the year.

- The Licensing Project received recognition for its partnership work with the 'Leaders in Action' award (South Yorkshire Police, June 2012), the Purple Flag award (July 2012, Sheffield City Council City Centre Team) and in February 2013 the project received the South Yorkshire Police Partnership Award.

Our challenges

As work expands, the project continues to be faced with competing priorities. This has resulted in some tasks being deferred (for example the review and accreditation of the training for licensees and the move towards a paper-free E-Systems).

As the effects of the economy increasingly impact on local businesses, events and public sector partners, it has been vital to keep safeguarding high on partners' agendas to ensure that standards are not affected by budget considerations. This has involved negotiating with licensing partners about prospective changes to the way premises/events operate, so that safeguarding remains a priority.

The main safeguarding concerns

This year saw an escalation of concerns relating to the availability and misuse of 'new psychoactive substances' ('legal highs'). In response to reports from schools and a local young people's substance misuse treatment agency, the Licensing Project developed a multi-agency strategy to raise awareness of the issue. The strategy includes educating staff working in 'head shops' about the risks to young people who misuse this type of substance and requires them to operate a voluntary policy restricting the sale of risk-related products to children and young people. It also educates traders about the legal consequences of breaching Trading Standards regulations. This work has become the foundation for a broader local campaign including adult services and will be further developed over 2013–14.

Working in partnership with other organisations

The Licensing Project Manager works in partnership with statutory agencies, local businesses and other organisations in the following ways;

- Contributing at multi agency 'Safety Advisory Group' meetings. These are attended by statutory, private and voluntary sector agencies to plan large scale public events. The Licensing Project Manager advises on risk management procedures in relation to children and young people.
- Chairing the 'Tackling Underage Sales Group' meetings. This group comprises officers of the police, trading standards and licensing authority and shares information/strategy in relation to problem premises, develops and delivers new initiatives and reviews/evaluates the training that is provided by this partnership group to the licensed trade to promote safeguarding children at licensed premises.
- Representing the SSCB on the DACT's Alcohol Sub Group within various SNAs. This comprises representatives from local services to specifically address issues raised by the local community in relation to alcohol. The partnership is attended by the Licensing Project Manager, Community Youth Teams, DACT, trading standards, local residents, schools and police.
- The Licensing Project works proactively with its private sector partners by advising event organisers, promoters and local retailers including large corporate organisations; also by attending Licencewatch Committee and Pubwatch meetings and consulting with the trade when producing best practice guidance, tools and guidance.

The project has received recognition for its partnership work as outlined above.

How the project works with families, children and young people

The project routinely engages with parents/carers who live at licensed premises in relation to their lifestyle and the environmental issues that may present at this type of household. This takes place during advice visits to licensed premises. We also assist families who may have issues if they live in proximity to licensed premises, for example if children are exposed to irresponsible behaviour or noise. This type of engagement is usually by written correspondence when we respond to their complaints.

We also engage with young people when undertaking face to face work, delivering awareness workshops (as part of the local police restorative justice response when they

are found using false ID) and we routinely consult with young people when producing educational or publicity materials, as outlined above, by going into schools.

How our work impacts

By delivering a significant amount of training and awareness to local businesses and partner agencies we are proactively challenging perceptions about social responsibility towards children in the broader community, embedding the concept that *'safeguarding children is everyone's business'*. We know this by:

- Assessing the feedback and evaluations from training events and the positive responses/comments we receive from other local safeguarding children boards/statutory agencies and other organisations
- The increase in the number of enquiries/referrals/complaints we receive year on year.

Comments from this year's training include:

"*I found this course very beneficial, thank you*" (licensee)
"*Covered a lot but we ran out of time, the course could maybe be a bit longer, it was good that people could give their input"* (licensee)
"*Excellent event"* (BTec trainee, taxi/private hire vehicle driver)
"Need to share all this information with rest of taxi drivers" (BTec trainee, taxi/private hire vehicle driver)

We also measure impact by quantifying the number of licensed premises/events that operate (either by choice or under licence conditions) the safeguarding measures we ask for, so that places are safer for children and young people and the number of advice visits and complaints investigated (36 complaints were investigated and a further 27 premises received advice visits).

Our work also impacts by contributing towards licence reviews to address problems at licensed premises which can result in better measures being established to manage risk, or the risk being eradicated, depending on the determination of the Licensing Authority. We contributed towards 8 licence reviews this year.

A number of other local authorities have requested guidance about the way the Sheffield Safeguarding Children Board has approached licensing and have adapted our materials, suggesting a broader impact of this local work.

Over the next year the Licensing Project aims to;

- Deliver a training session for Events Managers to embed the revised good practice guidance for safeguarding children and young people at events.
- Develop the local NPS/legal highs campaign to include staff training for people working in schools and social care residential homes.
- Transfer business support paper systems to E-systems.

Safeguarding Children Who Live in Households with Substance Misuse

During the period 2012 – 2013 the service has primarily focused on the following areas of work:

Safeguarding Children Substance Misuse refresher events

This year the main focus was "working with hostile and uncooperative families who misuse drugs and alcohol", but the seminars also covered an introduction and update on the Sheffield Alcohol Screening Tool and joint working between drug and alcohol workers and health visitors. To ensure a multi-agency response to these challenging areas of work, health visitors, specialist midwives, Family Intervention and Prevention workers and social care workers attended alongside drug and alcohol practitioners (269 people participated in the 6 events).

The feedback was extremely positive;
"Presentations were excellent! Packed a real punch!"
"Engaging, insightful and evidence based"
"Really enjoyed doing the case study with workers from different services!"
"Now I know what to do and who to do it with! Thank you!"

Parenting groups and resources for parents who misuse drugs and alcohol

Sheffield now has 4 drug and alcohol workers that have been trained and accredited to deliver Triple P parenting groups. The parenting groups will be organised in partnership with MAST but will specifically engage drug and alcohol misusing parents and will be run in the drug and alcohol services.

The first course has been completed and initial feedback from parents and workers involved with the families has been very positive. A service user consultation is now being undertaken with the participants.

Parenting worksheets have also been developed and are available through the Safeguarding Children Substance Misuse Service web pages for use with parents who misuse drugs and alcohol.

Contributions to the National Substance Misuse and Safeguarding Children Agenda

The Safeguarding Children Substance Misuse Service was invited to speak at a recent Community Care Conference: "Whole Family Support for Drug and Alcohol Misusers" following a recommendation by the National Treatment Agency (NTA) who visited Sheffield in January 2012. The NTA felt that the Sheffield model of multi-agency working regarding safeguarding children who live in households where substance misuse features was one that should be showcased. The presentation was well received and has been followed by a marked increase in interest from other local authorities regarding the work undertaken in Sheffield.

The Safeguarding Children Substance Misuse Service also represents Sheffield on a National Expert Group "Parental Alcohol Misuse: Uncovering and Responding to Children's Needs at a Local Level"

MAPLAG (Multi-Agency Pregnancy Liaison and Assessment Group)
Local screening / risk assessment system for all pregnant women who disclose drug and alcohol misuse

129 pregnant women were referred into the MAPLAG system of assessment. **103** babies were born of which **78%** discharged home with their mothers with appropriate care plans in place.

Improved information gathering pathways due to newly established links with key agencies (e.g. Probation and open access substance misuse agencies) resulted in earlier and more informed risk assessments being undertaken.

The MAPLAG user consultation undertaken in 2012 received positive feedback with the general theme being that women felt happy about the process and supported by the professionals they saw during their pregnancy. They said they would recommend women in similar situations to engage in the appointments and the process in order to achieve the best outcomes for them and their family. However the majority of women who disclosed cannabis or alcohol use in pregnancy refused onward referral to a drug agency and it was evident that they viewed themselves as pregnant women that occasionally smoked cannabis or drank alcohol rather than women with substance misuse issues that are pregnant. Further discussion is required with them about where they feel the most appropriate environment would be to receive education, support and advice.

Advice and Consultation regarding substance misuse and safeguarding children

The Safeguarding Children Substance Misuse provided **723** consultations relating to improving outcomes for children whose parents misuse drugs and alcohol.

This year the Service also attended monthly case discussion meetings at each of the drug and alcohol treatment services to discuss cases and help identify early intervention pathways, as well as receiving increased numbers of calls from services involved with children and families regarding identifying parental drug and alcohol misuse and accessing drug and alcohol treatment services.

Together these have helped promote better multi-agency working and information sharing, and developed a greater understanding of the issues affecting families where there is drug and alcohol misuse, enhancing the prospects of a positive outcome for the family at an earlier stage.

Launching the Sheffield Alcohol Screening Tool into services working with children and families

The Sheffield Alcohol Screening Tool is part of a citywide campaign to raise awareness and provide information around alcohol use. Health & Social Care services (including GP's, dentists, pharmacists, housing officers, social care workers, health visitors) across Sheffield are asking **ALL** adults they have contact with evidence based questions relating to drinking alcohol. Its purpose is to ensure **ALL** adults living in Sheffield are informed about their current drinking and the affect this could have on their health and family life. Where it is appropriate, an offer for further assessment, information or support by an alcohol worker can be offered.

The Sheffield Alcohol Screening Tool is easy to use and enables personalised brief advice to be produced which can then be sent or emailed to the parent.

It is now part of Children's Social Care Initial Assessment and between February 4th 2013 and June 11th 2013 **620** parents have been screened with 31 accepting onward referral to alcohol services (In 2011 – 12, prior to the introduction of the alcohol screening tool only 8 parents were referred into drug and alcohol services).

Refreshing the Hidden Harm Strategy and Implementation Plan (together with the DACT and other partner agencies)

The development of the Hidden Harm Strategy (2013) was informed by the findings of a review into the previous Hidden Harm Strategy (2010 – 2013) which included recognising drug and alcohol treatment and recovery as a protective factor for families; documenting the current practice in Sheffield; identifying new insights and understandings as well as considering both national and local research, evidence based practice and case reviews.

The Hidden Harm Strategy (2013) and Implementation Plan was endorsed by SSCB on June 20th 2013.

Challenges this year

The main challenges the Safeguarding Children Substance Misuse Service has faced this year have related to;

- The increase in both the volume of advice and consultation calls as well as the variety of information and advice being requested. However this has resulted in improved multi-agency working and information sharing.
- Ensuring the Sheffield Alcohol Screening Tool was embedded into Sheffield's children and family systems and processes e.g. Family CAF, social care's assessment process has involved attending a large number of meetings and delivering a considerable number of training sessions and briefings.

Main safeguarding children concerns this year

Parents not recognising the impact that cannabis and alcohol misuse can have on their parenting and their children and therefore are unwilling to make changes or access services that will help them address it. The Safeguarding Children Substance Misuse service will work with parents and drug treatment services to produce information leaflets regarding cannabis misuse and how it impacts on parenting.

The impact of the work undertaken this year

Through the work undertaken by the Safeguarding Children Substance Misuse service this year we can evidence;

- Improved communication and understanding of referral pathways between adult services and those working with children and families resulting in;
    - increased referrals into drug and alcohol services from children and family services
    - increased joint working between Family Intervention and Prevention services and Drug and Alcohol services
      improved attendance at child protection meetings by drug and alcohol workers

- Increased understanding, by drug and alcohol workers, of the different affects parental drug and alcohol misuse can have on children in the household resulting in;
    - Improved information and advice provided to parents to support them in making informed choices (evidenced through feedback from Triple P group and MAPLAG user consultation)

Objectives for 2013-2014

- Evaluate and develop the parenting programmes, tools and resources currently utilised within the substance misuse services with the aim of ensuring all parents accessing drug and alcohol treatment services receive additional support with their parenting and thus benefit their children and family.
- Undertake "good practice case reviews" to identify the children's journey when the parent accesses drug and alcohol treatment services with the aim of highlighting and expanding on good practice and identifying areas for improvement.
- Embed the Hidden Harm Strategy into the daily working of services in Sheffield focusing on the 7 strategic priority areas: Commissioning and governance; early identification of drug and alcohol misuse; whole household approach; addressing intergenerational drug and alcohol misuse; drug and alcohol treatment and recovery, workforce and data collection.

Safeguarding in our Faith Communities

The Safeguarding Children Service works closely with the Anglican, Catholic and Muslim faith communities in Sheffield.

The Diocese of Hallam Catholic Safeguarding Commission has an advisory, supportive and monitoring function in matters relating to safeguarding children, young people and vulnerable adults in the Diocese Congregations. The Commission has an independent (lay) Chair, the Head of the Safeguarding Children Service attends alongside other members with safeguarding experience/expertise. The Commission co-operates with statutory bodies which have particular responsibilities in these areas.

The Safeguarding Management Group of the Anglican Diocese meets quarterly to discuss issues in the Anglican Churches in the Sheffield area. The meetings are chaired by an Archdeacon and a Safeguarding Service Manager attends these. In the last year the meetings have focused on:

- Training for clergy and other church personnel on raising awareness on safeguarding children.
- Managing allegations against staff and management of cases where people may pose a risk and wish to attend church.
- Keeping the meeting up to date on changes in Safeguarding both locally and nationally (including Working Together to Safeguard Children 2013).
- Case work – updates the members of the meeting on issues that are on-going in regard to clergy and other staff who are being investigated for allegations or convictions of abuse. Changes to Disclosure and Barring Services.
- The Interim Chichester Report and action plan (a report that addressed the issues of child abuse that had occurred in the Chichester area, where the convicted perpetrators were clergy and other staff in the Church).

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The Sheffield Safeguarding Children Service has worked closely with the Mosques and Madrasahs in the City, with the assistance of a Community Adviser (a respected Muslim scholar and cleric who lives in the city). In the last year the focus of the work has been;

- A programme of Safeguarding training for Imams and teachers.
- Identifying Child Protection Officers at the majority of Madrasahs (these take the safeguarding lead for their establishment if concerns are raised about the safety or wellbeing of children who attend for religious or supplementary studies).
- Working closely with the Mosques and Madrassahs and the Local Authority Designated Officer (LADO) to seek to prevent the use of physical chastisement.
- Working with schools to improve community cohesion and understanding for the benefit of pupils (e.g. the Community Advisor has played a significant role in assisting with a community /school relationship as well as working with a number of schools to improve their understanding of cultural issues).

Transitions

Main achievements

Best Practice Guidance for transition of young people focused to adult oriented services
A multi-agency task and finish group, with members from children's and adult services, developed this document for all agencies to use as a basis for their single agency protocols. A group of young people considered the document and made suggestions so that it is more appropriate to the needs of young people. The document has been approved by the Operational Board of Sheffield Safeguarding Children Board (SSCB). It was launched at the (SSCB) half day conference in April 2013. The document is available on the SSCB website.

Awareness raising in relation to The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS)
MCA applies to all young people and adults over the age of 16 and DoLS to all over 18 years old, although there has been a test case where a 17 year old young man was found to have been deprived of his liberty. It is essential that awareness is raised amongst all workers, both in Children's and Adult Services, on the implications and responsibilities of MCA and DoLS. Various initiatives are on-going to achieve this, including: a session on MCA and DoLS at the SSCB half day conference in April, training for fieldwork Social Workers receiving a session on MCA and DoLS (consideration is given to MCA and DoLS, along with transfer to adult services), and training of Child Protection Co-ordinators in respect of young people aged 14 and over. Audits are being undertaken to assess knowledge, uptake of training and presentation of information to plan the way forward on MCA and DoLS.

Improved Working Together between Children's and Adult Services
This work has been commissioned by SSCB and Sheffield Adult Safeguarding Partnership (SASP). This has given the opportunity for colleagues to work on initiatives that encompass both children's and adult services. Examples of this are; the work on the Best Practice Guidance mentioned above, audit work, the Planning Table for transitions (reported to SCCB and SASP Operational Boards), and awareness raising on MCA and DoLS.

Main Challenges

On occasions it has been challenging to get agencies engaged in responding to requests for assurance or audit. However, both the Operational Boards of SSCB and SASP have been supportive and have encouraged agencies to respond. Consequently work is now moving forward on these issues.

Main Safeguarding concerns

Child Protection Conferences
There are very few young people subject of child protection plans who are aged 14 and over, but it is essential that the needs of these young people are met and they are adequately safeguarded. A session was held with the Child Protection Co-ordinators in September 2012 to raise awareness on MCA and DoLS and to encourage inclusion in child protection plans of early planning for transfer to adult services for those young people who will need them. An audit is to be undertaken to identify any gaps on this issue and to help plan services accordingly.

Young People involved in Sexual Exploitation

Young people who are at risk of, or are involved in Sexual Exploitation, do not stop being vulnerable on their 18th birthday. In some circumstances the Child Sexual Exploitation Services may continue working with a young person until they are 19, but it is necessary to ensure that services continue for these vulnerable young adults. This is currently being considered at a strategic level.

Evidence of Multi-Agency Working

The majority of this work is multi-agency based in view of it being commissioned by SSCB and SASP. Improved working across children's and adult services is starting to be reflected too. Examples of multi-agency working include;

- Development of 'Best Practice Guidance in Transitions from Young People Focussed to Adult Oriented Services.'
- Collation of agency information available for young people, their parents and carers on transfer from children's to adult Services.
- Multi-Agency training on MCA and DoLS.
- Regular updates provided to both SSCB and SASP.

Evidence of Working with Young People

A group of young people were involved with the development of the Key Principles on Best Practice document. A draft of the document was taken to a meeting of the young people, where a facilitated discussion took place. Most of their comments were in relation to the language used; on their advice the title of the document was changed. The suggestions made by the young people were taken on board and included in the document.

Impact of work undertaken

There has been a gradual improvement in the knowledge base of staff in all agencies on MCA and DoLS. This will improve the outcomes for young people.

Plans for the next 12 months

- Complete all the actions on the planning table by December 2013, demonstrating that that the "Measures of Success" have been achieved. Work on improving transition from young people focussed services to adult services will then be the responsibility of partner agencies. SSCB and SASP may decide to audit agencies from time to time to be assured that improvement is maintained.
- Promote training on MCA and DoLS across all agencies in both Children's and Adult services.

SECTION FOUR – SSCB PRIORITIES FOR 2013/14

Sheffield Safeguarding Children Board Business Plan 2013/14

This Business Plan takes place during a time of significant change both nationally and locally with major reforms to health services, reductions in public sector funding, the launch of the new Working Together to Safeguard Children 2013 and the implementation of the Munro Review into Child Protection.

Sheffield has an effective Safeguarding Board with strong partnership working and arrangements and this will continue to be built on and strengthened during this period of change.

All of these changes have been taken into consideration in the development of this year's business plan. This plan will run for one year and will be updated quarterly using the SSCB dashboard. This allows both progress to be monitored and also enables us to quickly identify any delays or risks to implementation.

An effective Board demonstrates good practice by;

- Identifying and agreeing a small number of priorities and concentrating on doing those well.
- Undertaking regular reviews and updates of the Business Plan.

Vision Statement

The SSCB vision is that;

- Every child and young person in Sheffield should be able to grow up free from the fear of abuse or neglect.
- We are committed to improving the safety of all children and young people in Sheffield. If children are not safe, they cannot be healthy, happy, achieve or reach their full potential. We recognise and promote the concept that keeping children safe is everybody's responsibility.

Objectives

The objectives of the LSCB are set out in s.14 of the Children Act 2004 as;

- Coordinate what is done by each person or body represented on the board for the purpose of safeguarding and promoting the welfare of children in the area.
- To ensure the effectiveness of what is done by each such person or body for those purposes.

Core Business and Functions

- Develop local procedures and policies.

- Communicate the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encourage them to do so.
- Participate in local planning of services for children.
- Undertake reviews of serious cases and advise the authority and board partners on lessons to be learnt.
- Monitor and evaluate the effectiveness of what is done by partners individually and collectively to safeguard and promote the welfare of children and advise them on ways to improve.
- Assess whether board partners are fulfilling their statutory obligations under s.11 of the Children Act 2004.
- Monitor and evaluate the effectiveness of training.
- Produce and publish an Annual Report on the effectiveness of safeguarding in the local area.

Sheffield Safeguarding Children Board

Through the Board structure the SSCB provides the strategic and operational direction of safeguarding and continuous monitoring of performance in Sheffield. The Board produces the Annual Business Plan and the Annual Report. The Board provides funding for an Independent Safeguarding Children Board Chair who provides leadership to the Board via effective chairing of meetings and representation of the SSCB in the public domain. The Board receives reports on an annual basis from priority safeguarding areas, including LADO, private fostering, missing children, and Child Sexual Exploitation.

Objective 1: Challenge A key function of the SSCB is the need to monitor and evaluate the effectiveness of what is done by its partner agencies individually and collectively to safeguard and promote the welfare of children and advise them on ways to improve. This will be achieved through supportive challenge.		
Key activity	**Completion Date**	**Lead Board Officer**
A s.11 audit will be undertaken. This will be a joint audit with Sheffield Safeguarding Adults Partnership and will focus on the essential requirements. In addition it will look at how agencies address early help and issues of data security. The s.11 will be underpinned by a challenge event where a senior representative will assure the Board that their agency is compliant with s.11.and where gaps have been identified they have an action plan in place to address this.	March 2014	Research & Performance Officer
s.11 audits will be conducted on a rolling 3 year programme but in the intervening years a single agency audit will take place with those organisations that are more disparate; in 2013-14 this will be the education sector.	December 2013	Research & Performance Officer
A multi-agency audit and evaluation sub-group will be developed with partners that will provide oversight of single agency audit activity which is taking place in the city. Part of the remit of that group will be to identify areas for more in depth independent audit led by the SSCB.	October 2013	Research & Performance Officer
Regular follow up and monitoring of actions arising out of the review and audit process will ensure that improvements are sustained and making a real impact on improving outcomes for children.	March 2014	Practice Review & Standards Coordinator

Objective 2: Responding to Change

There are a number of key changes that will take place in the public sector during the coming year. These will include significant changes in the way our partner agencies operate in the health, social care, education, police and probation sectors. In addition consideration needs to be given to the likely impact of social policy reforms and the changes in the demographics of the city.

Key activity	Completion Date	Lead Board Officer
The revised Working Together to Safeguard Children statutory guidance will be launched in the next year which will require the board to; • Quality assure and evaluate the effectiveness of local performance, procedure and practice. • Revise the SSCB safeguarding policies and procedures. • Revise training programmes. • Develop new processes for learning from practice, including Serious Case Reviews.	March 2014	SSCB Board Manager SSCB Training and Development Manager Practice Review & Standards Coordinator
Ensure that there are appropriate links with other key strategic partnerships in the city, for example the Children's Trust, and the Health and Well-Being Board.	March 2014	Professional Adviser to the Board
Produce and analyse data in respect of the demographics of the city and ensure this is incorporated into the work the SSCB undertakes.	March 2014	Research & Performance Officer
Raise awareness of the safeguarding responsibilities of those organisations that are under private or third sector control.	March 2014	SSCB Board Manager

Objective 3: The Child's Journey The Munro review of child protection re-emphasised the need for effective safeguarding systems to be child centred and that the focus should be on the child at every stage of the child protection process, from the beginning, through the middle to the end. It is important that Sheffield provides the right help at the right time to the right child. As Sheffield develops the FCAF and PAT models this will be the focus of the SSCB during 2013-14.		
Key activity	**Completion Date**	**Lead Board Officer**
The SSCB will establish a base line report of the early help provided to children and families in the city and identify any gaps in provision.	June 2013	SSCB Board Manager
The SSCB will receive and consider any internal audits and performance monitoring reports conducted on the PAT and FCAF but in addition will undertake a targeted independent audit to assure itself of the effectiveness of the new systems in meeting the needs of children, young people and families.	March 2014	SSCB Board Manager
The SSCB will seek assurance of how well agencies and front line practitioners have embedded the thresholds of need guidance and that these are being consistently applied throughout the city.	September 2014	Practice Review & Standards Coordinator
A small audit team will be developed that links into the Audit and Evaluation sub-group which will routinely undertake sample audits of targeted groups. These will include, pre-birth assessments, children with disabilities, children who sexually offend, BME children subject to CP Plans.	March 2014	Research & Performance Officer
The transitions action plan to be implemented and monitored via the Operational Board.	March 2014	Service Manager – Safeguarding Service

Objective 4: Child Sexual Exploitation A number of significant reports have been published in the last year, including the Interim Report of the Children's Commissioner; 'I thought I was the only one', and the ACPO Child Sexual Exploitation Action Plan which have been considered by the SSCB. In light of recent research both nationally and locally, Sheffield is developing a new delivery model based on the 4 key principles of prevention, protection, pursue and prosecution and the SSCB will seek assurance that this model provides effective intervention.		
Key activity	**Completion Date**	**Lead Board Officer**
The SSCB will request and receive regular reports on the effectiveness of the new service delivery model focusing on the key principles of prevention, protection, pursue and prosecution.	March 2014	SSCB Board Manager
The SSCB will lead a task and finish sub-group which will report on the current awareness raising and training provided on CSE throughout the city and develop an action plan for the delivery of a coordinated, rolling programme that ensures all key practitioners have received input on CSE.	September 2013	SSCB Training and Development Manager
The SSCB will ensure that CSE is linked in with other key developments in the city, for example missing children, gangs, building successful families.	September 2013	Practice Review & Standards Coordinator