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Essential Information

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Introduction from the Independent Chair



Dear Colleagues

Keeping our children and young people safe is at the heart of our work in the Safeguarding Board. It requires the effort and commitment of a wide range of partners and their colleagues to deliver the systems and services we need. In 2016/17 we have worked hard to continue to deliver for our children and young people and I am grateful to all those partners and colleagues across all sectors that have supported us.

I am particularly grateful to the young people who reviewed our previous year's activity and helped us to develop the business plan for 2017/18. Their input has helped us to develop our

thinking on neglect and bring a stronger focus on the impact of our work. They are involved in our work as we move forward in 2017/18 particularly in our training and development programmes.

This report sets out in detail the range of our work this year in particular:

- Our continued focus on child sexual exploitation which is also supported by the work on licensing across Sheffield;
- The development of Future In Mind to support mental health in our young people;
- Our comprehensive audits involving all our partners which allow us to ensure that we are doing the best we can for our children and young people;
- Our key strategies around neglect, female genital mutilation and the suicide prevention pathway; and
- Our wide ranging multi-agency training which is so important in supporting our workforce to be the best they can be in safeguarding children and young people.

This work continues in 2017/18 with a strong emphasis on the transition of young people into adulthood and ensuring that our services, as they develop and change, continue to keep our children and young people safe.

I hope that this annual report helps you understand the detail of our work and helps you to deliver our vision that every child in Sheffield can grow up free from the fear of abuse and neglect.

Jane Haywood, MBE

Independent Chair SSCB

Jare Haywood

An Outline of Sheffield

- 575,400 Total population of Sheffield
- 117,211 Total number of children and young people living in Sheffield, which is 20.4% of the Sheffield population
 - $40,626 \quad 0 5 \text{ year olds}$
 - 40,265 6 11 year olds
 - 36,320 12 17 year olds
- 71,486 children and young people attend primary, secondary or special schools within the city
- 95.1% Attendance for years 1 11 (Sept 2016 February 2017) at Sheffield primary and secondary schools



- 24.7% of children live in poverty in Sheffield (2014, 19.9% in England), with large disparities across the city.
- 21.8% of children are entitled to and claiming free school meals (13.9% nationally)
- 33.5% of children attending primary, secondary and special schools are from minority ethnic groups (30.7% nationally).
- 20.6% of school aged children have English as an additional language (18.5% nationally)
- 1999 2 year olds were receiving 15 hours a week of Free Early Learning in the autumn term, 68% of those eligible
- 12997 of 3 and 4 year olds received free early learning or an early education place, 94% of the eligible population.

Children and Young Peoples Involvement

Sheffield Young Advisers participating in the SSCB Development Day December 2016

A development day involving members from both the Operational and Executive Board was well attended. Two young advisers joined us for a question and answer session which member's found thought provoking. Young Advisers provided the Board with what they considered to be key issues for young people in the city and what they feel the Board should consider as their priorities for the coming year. These included the voice of young people further influencing the direction and priorities of the Sheffield Safeguarding Children Board



SSCB Participation framework

In response to the Development Day a Participation Framework was developed and signed off by the Board in March. This sets out how the Board will work with children and young people so that they are able to influence the Board's work over the year. The framework sets out how the Board wants children and young people to be part of their:

- Project work and delivery
- Policy development
- Evaluation programme

The Board recognises that involving children and young people can be achieved through 1:

- Supporting professionals in understanding and enabling the shared decision making for children and young people (CYP)
- Ensuring reports, projects and training are shaped by what children/young people have said or by their experiences
- Children/young people being actively involved in training and learning events or projects

What we will do next

- Ensure that reports submitted to the Board meetings will consider how the views/opinions of children and young people have influenced this work/proposal
- Outline children/young people's current involvement
- Ensure the Board holds an effective partnership with children and young people so that the voice of young people influences the strategic direction of the Board

¹ Information adapted from www.commonroom.uk.com

SSCB seminar: Talking to Young People About Difficult Topics

The SSCB Workforce Development Manager worked alongside Sheffield Futures Young Advisers to develop this seminar. Three Young Advisers delivered this session with a focus on talking to young people about difficult topics. In addition to the presentation there was also time for discussion around this topic between the young advisers and the professionals attending. There were 27 frontline professionals in attendance, including those from health, education, social care, Community Youth Teams and the voluntary sector.

Impact

The evaluation demonstrated the significant impact of this with 100% reporting that the seminar had increased their knowledge, 92.5% feeling more confident to support children and young people following the session and 85% said they would make a change in their practice as a result of the seminar. In addition, the Young Advisers were approached after the session to ask if they could be involved in further discussion sessions with some partner agencies, as they valued the opportunity to talk to young people directly about raising difficult topics.

Children's Involvement Team, Sheffield City Council

The Children's Involvement Team (CIT) is commissioned by Sheffield Children's Social Care. The team's primary focus is to seek the views and opinions of children and young people on what matters to them, to ensure that their views are listened to and taken into account by decision-makers.

During the financial year 2016–17, the Children's Involvement Team delivered the following:

- 259 Children were advocated for at their Initial Child Protection Conference (see page 36)
- Looked after children and care leavers received an advocacy service

 Advocacy support is offered to all children in care, care leavers up to the age of 25 years, and disabled children. Once a referral is received, an advocate is allocated within five working days and the allocated advocate works with the child until the child decides that the issue has been resolved or that they no longer need an advocate.
- 17 Children were involved in Children in Care Council activities (see page 41)
- 11 Young people were involved in Care Leaver Union activities (capturing the voices of care leavers in Sheffield). This year there has been 11 members actively participating with the majority involved in a programme leading to a leadership qualification. The members have been involved in various local and area projects, SCC recruitment opportunities and have received training in public speaking, presenting and interviewing.



Independent Visitors (IV) were recruited and 34 matches supported between a child in care and an Independent Visitor

All children who are cared for by Sheffield Local Authority are eligible to be matched with a volunteer who takes them out to do fun activities once a month

Section 1

How Sheffield Agencies Work Together

The SSCB: Who we are and what we do

Sheffield Safeguarding Children Board (SSCB) is the key statutory body overseeing multi-agency child safeguarding arrangements in Sheffield. Governed by the statutory guidance in Working Together to Safeguard Children 2015 and the Local Safeguarding Children Board (LSCB) Regulations 2006, the SSCB comprises of senior leaders from a range of different organisations. It has two basic objectives defined within the Children Act 2004;

- to co-ordinate the safeguarding work of agencies, and
- to ensure that this work is effective.

This annual report provides a transparent assessment on the effectiveness of safeguarding and the promotion of child welfare in Sheffield.

Our Vision

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



Key roles and relationships

The Independent Chair

During 2016/17 our Independent Chair was Jane Haywood. Jane was supported in her role by a Senior Professional Advisor and a dedicated team of Board Officers. The Chair is tasked with ensuring the Board fulfils its statutory objectives and functions. Key to this is the facilitation of a working culture of transparency, challenge and improvement across all partners with regards to their safeguarding arrangements.

Partner agencies

All partner agencies in the city are committed to ensuring the effective operation of the SSCB. This is supported by a Constitution that defines the fundamental principles through which the

SSCB is governed. Members of the Executive Board hold a strategic role within their organisation and are able to speak with authority, commit to matters of policy and hold their organisation to account.

Safeguarding leads/designated professionals

The safeguarding leads and designated professionals in the city provide a valuable source of professional advice and support for practitioners across their agencies and have continued to demonstrate their value during this year.

Relationship with other Boards

There is an expectation that LSCBs are highly influential in strategic arrangements that directly influence and improve performance in the care and protection of children and that this is achieved through strong arrangements with key strategic bodies across the partnership. During 2016/17, engagement continued with Sheffield Safeguarding Adults Partnership (SAP), the Health and Wellbeing Board and the Safer and Sustainable Communities Partnership. The SSCB also met with elected members through the scrutiny functions operating in Sheffield.

The connection between the children and adults Boards is strengthened by having the same independent chair, Jane Haywood. The professional adviser to the Board also maintains a key partnership role by membership of the Domestic Abuse Strategic Group, the Vulnerable Young Peoples Risk Panel, The Youth Justice Partnership, the Sexual Exploitation Strategic Board and the Harmful Sexual Behaviour Strategic Group. All of this enables clear communication and a good flow of information.

Lay Members

The SSCB encourages independent oversight 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 effective challenge and an objective viewpoint.

Children and Social Work Act 2017

Over the last year Sheffield Safeguarding Children Board have carefully considered the proposals for Local Safeguarding Children Boards contained in the Children and Social Work Bill (given Royal Assent in April 2017) and work to implement these are contained in the Business Plan for 2017/18.

Board Performance

The Board monitors progress against its objectives and ensures self-challenge against its responsibilities through a variety of methods:

- The Business Plan which indicates that all tasks were completed or proceeding on time
- The quarterly data dashboard that provides information on progress against section 11 compliance, SCR/Learning Lesson Review action plans and inspection reports
- The quarterly data suite which provides information on partner compliance with safeguarding requirements, the continued re-balancing of the children's safeguarding system and assurance on the quality of multi-agency interventions with children and young people
- Oversight of work plans and action plans for the board sub-groups to ensure progress is being made.



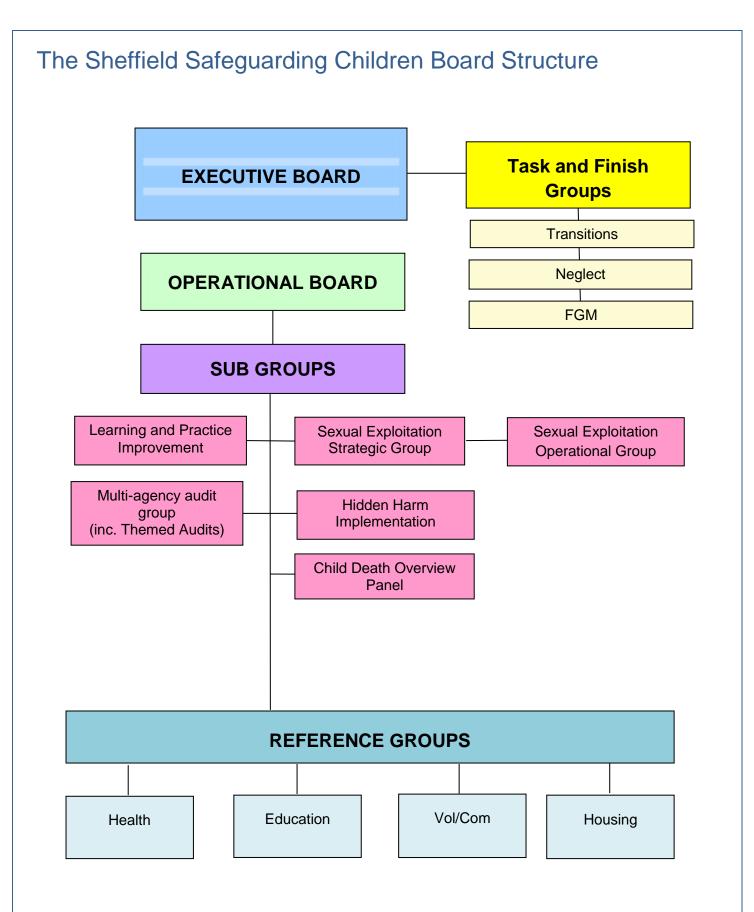
Achievements in 2016/17

- The SSCB Neglect strategy and associated resources were launched. Training the Trainer sessions took place with single agency representatives. Single agency training commenced.
- Young people were engaged in the work of the Board with specific projects. A participation framework was developed and further work planned.
- The Data Suite (performance data) was reviewed and updated to focus around 5 priority areas. It now feeds into both the Operational and Executive Boards.
- The Suicide Prevention Pathway was developed and there was a successful launch event.
- As a result of the implementation of a new training and licensing regime for Chaperones,
 which was initiated by the SSCB in partnership with the Child Permits & Licensing team, there
 was an improvement in the number of Chaperones who received Safeguarding training.
- A joint Transitions group was established which developed a terms of reference, scope and action plan. In addition, a transitions worker was based within the Sexual Exploitation Service for 6 months to develop this area of work.
- At the New Psychoactive Substances Strategic Meeting, it was reported by The Corner children and young people's substance misuse treatment service that they have seen a "significant reduction" in the number of children and young people reporting use of NPS.
- An FGM strategy was developed and launched.
- All statutory partners completed a Section 11 Self-assessment. These will be quality assured and scrutinised during 2017/18.
- Two successful conferences were delivered. One focused on Sexual Abuse Spotting the Signs, Intervening Early and Supporting Children and Families. The second was the Domestic Abuse – A Whole Family Approach Conference. A total of 485 professionals attended these and reported a positive impact on their knowledge and confidence.

The Sheffield Safeguarding Children Board Business Plan

Details the priority areas for 2017/18

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Funding of the SSCB

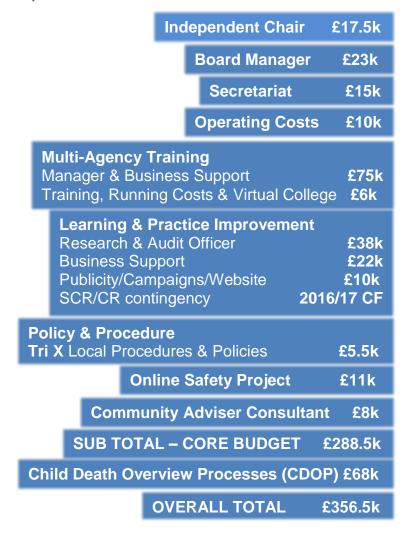
The Partners that make up the SSCB have continued to demonstrate their commitment to safeguarding by providing the resources required to ensure an effective LSCB. Resourcing this programme of work relies to a significant extent on input of staff time from partners who supplement a core base budget.

| Income 2016/17 | | |
|--|----------------------|--|
| Carried Forward £ | £81k | |
| Contributions (% of funding): | £91.2k | |
| Sheffield City Council Health: CCG | £91.2k | |
| SY Police: PCC Probation* | £36.6k £2.7k | |
| | 20.51 | |
| Income Generation | £9.5k | |
| Child Death Overview Total | £68k £380k | |
| (* £10k was requested from Probation: NPS/CRC) | | |

| Expenditure 2016/17 | |
|-----------------------------|--------|
| Employees | £235k |
| Multi Agency Training | £2.7k |
| Practice, Review & Standard | ds: |
| Case Reviews | £3.4k |
| Document production | £2.6k |
| Signis (Procedures) | £5.9k |
| Independent Chair | £13.5k |
| Advocacy | £36k |
| Community Advisor | £10.8k |
| Board Running Costs | £2k |
| Carried Forward | £68k |
| Total | £380k |

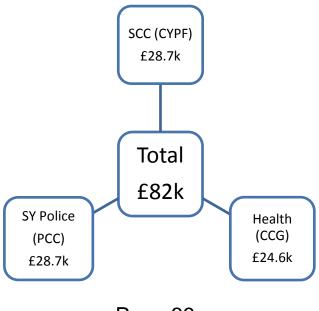
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Projected Expenditure 2017 – 2018



SSCB Funding of the Sheffield Exploitation Service 2016/17

The SSCB provides additional partnership funding to the Sexual Exploitation Service to cover the costs of the Manager and Business Support. The amount provided by each Board partner agency has remained the same since 2013 (consistent with the rest of the SSCB budget).



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Section 2

How we learn from what we do

Quality Assurance, Learning & Improvement Framework

Sheffield's Quality Assurance, Learning and Improvement Framework outlines the Board's routine activity in learning through practice, quality assurance, performance management and case reviews. The Board is committed to recognising, reflecting and learning from good practice and seeks to continually assess effectiveness, understand impact, inform professionals of the learning and drive improvements.



The Board has worked to increase the number of projects that involve multiagency partners, frontline professionals (including education settings), parents/carers and young people and this is now a strong and very positive aspect of the quality assurance programme. The child centred approach (Munro, 2011) remains at the heart of the Boards work. The Board's Learning, Practice and Improvement Group (LPIG) has a key role in reviewing this work, identifying the key themes and responding to these. This chapter sets out some of the learning from practice this year.

Multi-Agency Themed Audit Days

Three Themed Audit Days (TADs) are undertaken each year. These review the work of multi-agency partners with 5 children/young people in relation to an identified theme. Every TAD uses the same process and aims to identify and learn from what has worked well. This review process involves professionals, parents/carers and young people.

This year the TAD process has been developed to ensure the multi-agency review team has additional time to reflect and identify the learning from the review. The findings have been reported to and discussed by the Learning, Practice and Improvement Group. This group has also been key in responding to the findings. The themes this year have been:

- 1. IntraFamilial Sexual Abuse (IFSA)
- 2. Sexual Exploitation (CSE)

3. Neglect

Research has shown that significant numbers of victims of CSE had experienced child sexual abuse, often intrafamilial. ² In 2015/16 the SSCB workforce questionnaire highlighted that a quarter of responents reported a lack of confidence in recognising child sexual abuse. Two of this years TAD focused on these areas. The main learning from these were that:

- All practitioners need to consider the risk of CSE, be alert to the signs of this and be aware of the process for referral.
- Close multiagency working is key to successful intervention. This can lead to the early identification of issues, ensure consistency between workers and identify disguised compliance.
- Professionals that focused on the child, demonstrated a clear understanding of their issues and were motivated to get what the child needed had the greatest impact. This was evidenced through:
 - Children that had experienced IFSA can experience feelings of guilt as they see the impact of the allegations on their family situation. They can be scared, unhappy and want the family back to how it was. Where professionals worked closely, focused on the child/young person, monitored the child's behaviour, addressed any misconceptions and talked with them about their concerns then these fears could be addressed. Where professionals reinforced their belief of the child this had a positive impact on their confidence.
 - Discussions and work relating to the CSE risk helped young people to feel more in control, have a better understanding of the risks and begin to make positive choices.
 - Cases where professionals demonstrated a focus on, and a commitment to the young person helped them feel valued and in some cases led to increased engagement and in the disclosure of further information.



² Berelowitz, S., Clifton, J., Firmin, C., Gulyurthlu, S. & Edwards, G. (2013). 'If only someone had listened' The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups Final Report. London: Office of the Children's Commissioner.

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- The review evidenced how it is critical to keep the child at the focus, even when parents have their own, complex needs. When issues arise, these need to be addressed with the parents, again keeping the focus on how these impact on the child. The TADs evidenced where professionals worked to keep parents/carers focused on their child and provided further information regarding the situation this could have a positive impact. Some examples are:
 - In situations where the parents/carer(s) did not believe the allegations of IFSA, where professionals reinforced their belief of the child, challenged if parents attempted to minimise concerns and undertook work with the parents relating to the allegations this could change parent's views and understanding.
 - In some situations, CSE work with the parents increased their confidence in knowing how to respond to the concerns and it also equipped them with the skills to do so.
 - In many cases, schools already held a positive working relationship with the child and their family. Their role was significant as they: undertook work with the child relating to the concern; introduced other professionals to the family; provided information to the mulitagency team and provided support to the family.
 - There were examples of how assessments and legal processes can take time and can have a distressing impact on the family. In these cases the professional team had an important role in supporting them. However, it was also recognised that avoidable delays must be challenged.
 - As some of the young people were heading towards adulthood professionals were working to ensure that services would be in place for them. However, it was identified that further work is required to ensure transition is a smooth process.

Impact

The findings of the IFSA Themed Audit Day were fed back to 207 professionals attending the SSCB Sexual Abuse Conference this year. The evaluations from those attending the conference highlighted the positive impact of this (further information is provided on page 26). The CSE findings, including the information relating to transitions has been fed back to the CSE Operational Board and has fed into their work around transitions. Further information relating to their work on this area can be found on page 49.

The results of each Themed Audit Day are summarised with a one page Learning Brief: http://www.safeguardingsheffieldchildren.org/sscb/learning-from-practice/learning-briefs

What we will do next

 Child Sexual Abuse and CSE will be the focus of a joint SSCB/NSPCC 12 month campaign, 'It's not ok' commencing in May 2017

A third TAD was undertaken this year and this focused on Neglect and further information relating to this is provided in the Neglect Strategy section of this report (page 45)

Family B Learning Lessons Review - Neglect



What happened?

Ben was taken by ambulance from a relative's home after being located by a social worker who found him looking unwell and weak. Ben was said to have been suffering from diarrhoea and sickness for 2 weeks and was found to have a weak pulse and high temperature. He was admitted to hospital and found to be suffering from chronic neglect. He had not been attending nursery and it took some time to track his whereabouts as his parents had provided false addresses and contacts. Bethany was also examined at the hospital. Both children were removed from their parents care and placed with local authority foster carers.

What did this tell us?

Parents and services failed these children. The children had been well known to services in the city and both universal and specialist services had been involved with them since before they were born. There had been ongoing input from Children's Social Care, Early Intervention and Prevention Services, the Children's Hospital, Health Visiting, Substance Misuse Services, GPs, and Midwifery. Despite the number of agencies involved and the intensive support provided, including Child Protection Plans being in place for nearly three years, their medical, physical and emotional care was severely neglected.

Professionals tell us that they are aware of the signs and indicators of neglect but this case shows us that identification and intervention is more complex. Workers failed to recognise the long term impact on the children's health and development as a result of the parent's failure to ensure medical appointments and follow up treatments were kept. Assumptions were made that as the children looked well fed and well clothed they were not being neglected. Other workers felt assured by the Child Protection Plan being in place believing that any issues of neglect were now being dealt with despite often holding information that contradicted that assurance.

Workers told us that the parents were likeable with their own emotional and medical needs. This led to an overly supportive approach being adopted to ensure the family engaged. Interventions were adult focussed; addressing the adult's needs and failing to place the children at the centre. The parents were skilled at saying the right thing, by looking like they would comply, by sometimes just doing enough. They were good at keeping the professional network on side. This is disguised compliance and practitioners should be able to recognise this and address it in the same way they would address issues of open hostility. Workers applied an overly optimistic stance about the parent's ability to provide good care for their children.

Child protection and legal processes lacked rigour and challenge and were passive in their approach and failed to consider the impact on the children.

What can we do now?

Child Protection Conferences are important meetings and make important decisions.

Make sure you come prepared with the right information and prepared to contribute to the decision making

Ensure all workers in Sheffield are aware of the Sheffield Neglect Strategy and have access to neglect training to equip them with the skills and resources to identify and intervene in cases of neglect

Think about what a 'day in the life of' is like for the child you are working with – use the guidance provided

Chronologies can be a useful tool in cases of neglect

If you are not happy with the response you receive from a professional or an agency it is your responsibility to challenge. Seek support from your line manager or safeguarding lead and ensure you are aware of the escalation processes available.

If in doubt ask for advice from your manager or safeguarding lead

Child H Serious Case Review (2014) Audit of the Recommendations



What happened?

A 3 year old child was taken by ambulance from the family home to the hospital emergency department. On examination she was found to have subdural haemorrhages, retinal haemorrhages and bruising. Her injuries were incompatible with life and she died after intensive care was withdrawn. Mother's partner who had been a member of the household for approximately 18 months was convicted of her murder and sentenced to life imprisonment.

Serious Case Review Recommendations

There were single agency recommendations in addition to those for the LSCB. This audit has focussed on 2 recommendations:

• Frontline staff in universal services that come into contact with children and families must establish who are the key figures in a child's network and record these.

Agencies responding to incidents and concerns about domestic abuse should use a consistent model of risk assessment (e.g. consistent application of the DASH).

D Findings

agency self-audits were reviewed relating to the records of 19 children/young people (15 cases from the 2015/16 year of Themed Audit Days and 4 from MAAG). The majority of audits were completed by Children's Social Care/MAST (28), health (24) and nursery/education (9). Of the 19 cases, there were 17 that were open to Children's Social Care at the point of the review.

The main findings are:

87.7% had a record of all adults living in the house

The 9 audits that reported no record of this were across a variety of agencies (schools, housing, health (community, hospital, Adult Mental Health) and social care).

 71.2% had asked the family about others that are in close contact with the family e.g. new partner, other relatives, friends

The 21 that did not record this represented a range of agencies, but the majority were health (7: including both community and hospital bases services) and social care (8).

83.6% recorded that domestic abuse has been discussed/considered

Of those 12 that didn't record this, the majority were from health (6: community and hospital based services), MAST (2) or social care (2).

Aim of the Audit

The audit used completed agency self – audits from 3 Themed Audit Days and the Multi-Agency Audit Group to assess if:

- All services are recording the key figures in a child's life (names of adults living in the child's home and those having close contact).
- All services are routinely asking parents about domestic abuse and recording this.

Recommendations

Where a child is receiving additional support, all agencies must:

- Record all adults living in the home and significant others in close contact with the family.
- 2. Consider the issue of domestic abuse and record this.

Multi-Agency Audit Group

The aim of the multi-agency audit subgroup is to monitor and evaluate local practice in delivering services to children and families, determining the quality of practice, level of agency involvement, partnership working and related outcomes. The audit is focused on the child's journey and highlights areas of good practice, areas for development and those that require improvement. It has a clear focus on impact and outcomes and promotes a culture of continuous learning and improvement.

The audit group meets bi-monthly and is made up of safeguarding leads in key partner organisations. A case is randomly selected and each agency is asked to self-audit using the audit tool.

As well as good engagement by agencies, in an open and honest way, the audit process has also highlighted **evidence of good practice**, including:

- Continued evidence that universal services are providing excellent levels of support to children and families, for example, through pastoral support at schools.
- Evidence of good communication between agencies on some cases that enabled a consistent message to families and reduced the risk of disguised compliance
- Good and early identification of domestic abuse
- Evidence of effective challenge on cases that led to better outcomes for the child/young person

Impact

- The SSCB have provided the 'day in the life of' tool to multi-agency partners and included it as part of the neglect resources
- The SSCB have publicised and encouraged the use of 'Was not Brought' instead of Did Not Attend (DNA) to ensure there is a clear focus on the child's needs
- The SSCB have highlighted the benefits of using the Alcohol Screening Tool to all agencies as audits have demonstrated better outcomes for children as a result
- Safeguarding supervision masterclasses have been developed and are being rolled out

Learning

- The right people need to be in attendance at meetings to ensure the right information is provided to inform decision making. Requirement on all agencies to ensure their workers prioritise attendance at key meetings (e.g strategy meetings, core groups, Child Protection Conferences, Looked after Children reviews)
- Parental mental health featured in a number of the cases audited over the last 12 months.
 The vast majority of these did not however hit the threshold for intervention from adult
 services but were having a detrimental impact on the family circumstances. Parents were
 often not engaged or did not have the provision of services to meet their needs
- Social isolation was a feature in a number of cases and this was particularly so for single parents with pre-school children. Considering the point above, the support needs for this cohort requires further exploration

What we will do next

 In light of the learning from the Family B Learning Lessons Review the Multi-Agency Audit Group will review all cases of children and young people subject to a Child Protection Plan for over 2 years.

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The SSCB Multi-Agency Data Suite

The Data Suite has developed the Boards understanding of safeguarding performance across the city and provided evidence of impact of the Boards work.

Following a review of the data suite and its process, this year the data suite changed and was extended to focus around 5 priority areas:

- Neglect
- Sexual Exploitation (CSE)
- Transitions
- Thresholds and Timescales
- Substance and Alcohol Misuse (Hidden Harm)

Since the start of this year the data suite has been presented to and scrutinised by the Operational Board. In addition, the CSE data set began to be considered by the CSE Operational Board and the Substance and Alcohol Misuse data set by the Hidden Harm Strategy Implementation Group. The themes highlighted through this review process are included in the performance dashboard reported to each Executive Board.

Impact

The impact of the data suite can be evidenced in a number of ways.

- 1. Demonstrating the provision of a service: In January 2015 CAMHS (Children and Adolescent Mental Health Service) agreed to accept referrals for 16/17 year olds (supported by the SSCB). Numbers referred to CAMHS and those receiving a service have been increasing since this time demonstrating the importance of this. Figures demonstrate that this older group has represented the majority of the increased numbers. The Board are continuing to monitor this.
- 2. Monitor the recommendations from previous audit work: In 2015 a Themed Audit Day reviewed the work with children under 5 years subject to a Child Protection Plan where there was parental alcohol misuse. This demonstrated the positive benefits of using the alcohol screening tool and there was a recommendation to increase its use as this had been reducing (supporting the Hidden Harm Strategy 2016 2020). The Board has continued to monitor this and this year and has renewed its commitment to this.
- 3. Monitoring issues that have been highlighted nationally: Following from the draft concordat on children in custody³, this year the Board has included the numbers of children that are charged with an offence and are unable to be released on bail and require accommodating (the child should be transferred to local authority accommodation unless this transfer is impracticable). The concordat highlighted that this transfer was not happening (nationally) and the SSCB are now monitoring this within Sheffield.

What we will do next

To enable further scrutiny of the data prior to its presentation at Operational Board a Data Review Group will be developed. The group will identify the main themes for discussion at Operational Board (alongside those identified by the CSE Operational Board and the Hidden Harm Implementation Group).

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³ Home Office. 2016. Draft Concordat of Children in Cust Plage 47

The Child Death Overview Panel (CDOP)

The Child Death Overview Panel reviews the death of any Sheffield child, including those that occurred in another area. The Board is responsible for collecting and analysing information about each death to identify any case that should be subject to a Serious Case Review; consider any matters of concern that affect the safety and welfare of children in the area or any wider public health or safety concerns arising from a particular death or pattern of deaths in the area⁴.

There were 42 child deaths of Sheffield residents this year which is a 20.1% reduction from 2015 -16 (53). The vast majority were under 1 year olds (73.8%) and over half were girls (57%). There were 11 classified as unexpected. In response to any unexpected death there is a 'rapid response' procedure. This year, the rapid response multiagency meetings have now been added to the commissioning arrangements and these are now held within 5 days of the child's death.

During the year there were 6 CDOP meetings. The Director of Public Health became the Chair of CDOP and a Neonatologist began attending every meeting. There were 51 deaths reviewed. Not all deaths can be reviewed in the same year. However, the panel has worked hard this year to address the number of cases waiting for discussion. At the Panel the meeting considers how each child's death compares to others (reviewed previously) and whether any common themes or trends emerge. As part of the process they will identify any factors which could be prevented or avoided in future and recommend any changes that need to be made to achieve this. These are referred to as modifiable factors. This year 45% of deaths reviewed had an identified modifiable factor.

Impact

The work done by the Safer Sleep Steering Group has shown significant success in reducing the number of infant deaths. Sheffield now has a rate of Sudden Unexpected Deaths in Infancy below the national average and the lowest rate in the region. However, a significant proportion of unexpected deaths continue to include unsafe sleeping practices. The Safer Sleep Steering Group has continued to promote consistent messages including the expansion of Safer Sleep Champions and working to ensure consistent messages are being reinforced with other adults who may be involved in the care of children.

Over the past few years CDOP has reviewed a number of deaths of young people from suicide. One of the recommendations from these reviews was that Sheffield should develop a Suicide Prevention Strategy and this was launched in March 2017 (see page 44).

A recommendation from CDOP highlighted the need to raise awareness with practitioners on the impact of sexual abuse on family members and increased understanding of the pathways available to support families. In response, the SSCB held a multi-agency conference on sexual abuse in November 2016. The significant impact of this conference is detailed on page 26. A new Suicide Prevention Pathway has also been developed (see page 44 for further details).

What we will do next?

- Implement changes required following the Children and Social Work Act 2017.
- Conduct an independent review of the CDOP functions in Sheffield.
- Aim to review all deaths within 12 months where appropriate

The CDOP Annual Report is available on the SSCB website.

⁴ Working Together to Safeguard Children 2015 Page 48

Section 11

Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure that when they go about their day to day business (and any services that they contract out to others) they do so in a way that takes account of the need to safeguard and promote the welfare of children.

Local Safeguarding Children Boards have a responsibility to ensure that Board partner agencies are meeting all the requirements of Section 11. This outlines the safe systems and safe processes that need to be in place; for example, by ensuring safe recruitment of staff, providing appropriate training, ensuring safeguarding leads are in place and having up to date policies which all staff know how to access. This year Board partner agencies completed the section 11 self-assessment.

Impact

Ensuring that agencies have safe systems and processes in place helps to safeguard Sheffield children and young people.

The agencies self-assessments have highlighted that the following areas are strengths:

- Agencies have a Board level lead for safeguarding that takes overall responsibility for safeguarding children
- Safeguarding children is routinely discussed at internal meetings for the vast majority of agencies
- Agencies have safer recruitment practices in place
- Agencies have safe storage of records and have clear processes in place to ensure that records are retained as required
- Professionals understand the importance of intervening early to prevent problems escalating.

Areas of development (for some agencies) have been highlighted. These are now within the action plans monitored by the Board. These include ensuring that:

- Training pathways/individual training plans are in place for those staff members who have more in-depth contact with children.
- Training records are maintained and can be audited
- Ensuring there are identified processes for disseminating safeguarding updates (national and local) through the organisation

What we will do next

- The Board will monitor the actions that agencies have identified.
- A programme of challenge and quality assurance interviews will take place, in the autumn, with each of the agencies that submitted an agency self-assessment. This will allow closer scrutiny of the section 11 responses, alongside other relevant agency scrutiny (in relation to SSCB action plans that the agencies are progressing) and the identification of any further actions.

Children's Workforce Questionnaire

In 2015/16 the SSCB developed an online Children's Workforce Questionnaire. The questions related to section 11 requirements, the Performance Information Framework (2015 DFE⁵) and Board priority areas.

There were 1033 frontline professionals that answered the questionnaire. The results were analysed and single agency feedback was also provided with areas for further action highlighted.

This year the Board has been monitoring agency's progress against their action plans. In addition, the Board has also responded to the findings. Some examples are:

- There were 26% of respondents that reported to be 'not very' or 'not at all' confident in recognising sexual abuse. In response, the Board ran a Sexual Abuse Spotting the Signs, Intervening Early and Supporting Children & Families Conference. The evaluation demonstrated this had a significant impact on those attending (see page 26).
- There were 42% of professionals that were not aware of the Threshold of Need Guidance. The Threshold document is under review and will be relaunched in 2017/18.
- There were a minority of professionals that felt that the supervision they received was 'not very good' or 'inadequate'. This year the SSCB developed training on reflective safeguarding supervision which will be delivered in 2017/18.
- There were approximately 20% of professionals that did not understand the role of the SSCB and a significant proportion that did not know where to find some of the resources the SSCB provides.

There will be further work in relation to each of these areas next year and this is detailed below.

What we will do next

- There will be the launch of the new SSCB website which will provide improved access to the Boards resources.
- CSE and Sexual Abuse will be part of a joint 'Its not Okay' campaign with the NSPCC
- The new Threshold of Need guidance will be launched
- Deliver training on reflective safeguarding supervision and agree city-wide safeguarding supervision standards with all partners.



⁵ DFE Reference DFE-00016-2015

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Multi-Agency Safeguarding Training

The SSCB Training and Development Team has developed and delivered a wide range of multi-agency safeguarding training and learning events over the year, which were available to the Sheffield children's workforce. They include conferences, seminars, courses and e-learning. Topics are identified through the Learning and Practice Improvement Framework.

This year alongside the programme of lunchtime seminars there has been the development and roll out of the Training the Trainers course on Neglect (following on from the launch of the Neglect Strategy, for further information see page 45) and the development and delivery of 2 city wide conferences. These focused on:

- Sexual Abuse Spotting the Signs, Intervening Early and Supporting Children & Families.
 This was developed in response to the findings of the SSCB Workforce Questionnaire and a
 recommendation from CDOP that highlighted the need for training in relation to recognising
 the signs of sexual abuse and an understanding of the emotional impact on family members.
- Domestic Abuse A Whole Family Approach Conference. This encouraged thinking and working together differently with families experiencing domestic abuse. The Conference provided an opportunity to share learning from a regional DfE Innovations Fund project and considered how new approaches can build resilience in families and improve outcomes.

Impact

This year there have been **10,341** professionals that have attended training sessions provided by the SSCB. The impact of the training has been clearly demonstrated through the evaluations:

- Lunchtime seminars have continued to address current and emerging issues including teen on parent abuse, Female Genital Mutilation (FGM), information sharing, sexually harmful behaviour and licensing. The evaluations of these demonstrated that 95% felt that the seminars increased their knowledge of the subject area and 89% reported that they would make a change to their practice as a result of the seminar.
- 207 professionals attended the Sexual Abuse Conference. The impact was clearly
 demonstrated as 86% of participants felt they had learned new information that will help
 them recognise and respond to signs of sexual abuse, 80% reported their confidence in
 being able to spot the signs of sexual abuse at an early stage had improved and 89% said
 they felt more able to respond to concerns of child sexual abuse if needed

'Thank you for putting on a conference like this – reaffirming, refocussing and refreshing'

 The Domestic Abuse conference also had a significant impact on the 278 professionals attending. 98% of professionals reported they had learnt new information that would help them to recognise and respond to signs of domestic abuse, 97% felt their confidence in being able to identify this issue at an early stage had improved and 95% said they felt more able to respond to concerns of domestic abuse.

What we will do next year

- Develop and deliver a conference focusing on Emotional Health and Wellbeing of Children and Young People
- Continue to work with Sheffield Young Advisers to ensure that young people's views are taken into account when developing training
- Develop 'Masterclasses' to extend practitioner knowledge of key safeguarding areas.

Section 3

Safeguarding Children in Sheffield

| She | ffield Safeguarding Overview |
|--------|--|
| 6 | Under 18 year olds required a homeless investigation this year |
| 127 | Young people were placed in supported accommodation |
| 1,110 | Family CAFs (assessment) were received by early intervention services, focusing on 2495 Children |
| 633 | Young People were supported by Community Youth Teams on a 1:1 basis |
| 570 | Cases were heard at MARAC (high risk domestic abuse cases), involving 1,210 children |
| 28 | Young people (16/17 year olds) were referred to MARAC as victims of domestic abuse |
| 57 | Complaints relating to licensed premises were investigated, 9 licence reviews undertaken & 21advice visits made to licensed premises |
| 233 | Young people accessed substance misuse services |
| 7,103 | Referrals were made to Children's Social Care |
| 5,330 | Sheffield Social Care Assessments were completed |
| 608 | Children became subject to a Child Protection Plan over the year with 40.6% of all plans made were for neglect |
| 13,748 | 3 Core groups met in the year |
| 259 | Children at Initial Child Protection Conferences were represented by an advocate |
| 200 | Young people received one or more criminal justice outcomes |
| 10 | New secure remands to custody and 6 custodial sentences |
| 586 | Children were looked after by the Local Authority at the end of the year |
| 51 | Children were placed for adoption |
| 6 | New private fostering referrals were received |
| 61 | New referrals to the sexual exploitation service were assessed as medium/high risk and allocated a specialist worker from the sexual exploitation team |

Child Abduction warning notices (relating to child sexual exploitation) were served in the

23

second half of the year

Early Intervention

Early help services provide support for whole families after the emergence of a problem with the focus of intervening at the earliest opportunity. The focussed support is on health and wellbeing, life skills, and family and relationships. A family can receive help from a number of agencies working together. It is hoped that once they have received this families can 'step down' to universal services

This year the early help services moved towards providing services within local areas (locality model). In partnership with a wide range of agencies an early help framework was developed which set out how these can work together to better identify, assess and support families with unmet needs.

The Family Common Assessment Framework (FCAF) is the assessment tool used by professionals across the city to help them review and assess the needs of whole families. This year 1110 FCAFs were received by Early Intervention and Prevention Services (previous year 1183)

Impact

The proportion of eligible 2 year old children accessing 15 hours a week of Free Early Learning (FEL) has increased (to 68.8%, 62.3% last year). The take up of 3 and 4 year old FEL has also increased (to 93.8% from 93.6% last year). This is a total of 14,996 children receiving this provision in the year. Free early learning and childcare helps to give children a great start to their education. It encourages them to learn through play with other children and promotes the development of language and social skills in a safe environment. It also helps them to prepare for school and close the attainment gap for those children from disadvantaged backgrounds.

Sheffield has introduced a new parenting model that aims to further meet the needs of the family. Discussion groups have been introduced with each session covering a commonly encountered problem such as coping with teenager's emotions, fighting and aggression in under 12s, managing situations such as shopping with children and bedtime. Parents can flexibly access the necessary sessions to meet their family's needs. 609 places have been accepted by parents for seminars, discussion groups and parenting programmes in a 7 month period this year.

248 professionals attended multi-agency training this year including 100 people on the FCAF training and 22 practitioners attended Voice of the Child training. This gives practitioners the opportunity to use tools to gain the wishes and feelings of the child and includes sessions on engaging children in difficult conversations.

The Building Successful Families programme continues to work with families across Sheffield and this year there has been significant success with 1036 families. 77% of this year's target has been achieved, comparing favourably with the national picture.

What we will do next

- Continue to deliver locality based services and further develop this model
- Introduce the Early Help Gateway Meetings and Multi-agency complex case panels, which will support the working within localities.
- Review and revise the FCAF to produce an Early Help Assessment.
- Continue to roll out the Extended Free Entitlement of child care for 3&4 year olds from September 2017.

Page 54

Community Youth Teams (CYT)

Multi-agency targeted young people's service, providing support for vulnerable young people aged 10-18 involved in risk-taking behaviour.



633 young people were referred for prevention work, including Community Resolution referrals. This is a slight fall in numbers compared to the previous year (731). However, the number of referrals being allocated for an assessment has increased to 91% (575 cases) compared to 84% in the previous year. This year CYT revised the referral criteria and this may have led to an increase in the proportion of appropriate referrals, and a decrease in the overall number. The service has become more targeted, referral thresholds have been made clearer and the service has introduced an enhanced offer for Looked after Children.

In September 2015 in partnership with South Yorkshire Police, CYTs developed the Community Resolution Pathway Pilot in the North and North East of Sheffield. The pilot has seen a positive impact on the First Time Entrants (FTE) into the criminal justice system with a reduction in 2016/17 across the pilot area of 11% from the previous year, despite a slight increase in overall FTE figures of 4% city wide. The pilot focussed on partnership work with secondary schools, putting packages of support in place for young people where their behaviours had become problematic and they were at risk of being involved with criminal activities. This pilot will be rolled out to East and West CYTs as part of a wider Out of Court Disposal model, in partnership with the Youth Justice Service and South Yorkshire Police which aims to reduce FTE's by ensuring decisions are needs led and young person focused and avoid criminalisation where possible. The number of Looked after Children who were FTE in 2016/17 reduced by 50% from the previous year.

Impact

CYT received 90% positive feedback from young people who received individual support and 96% from their parents/ carers.

'Helped me realise some of the dangers I was putting myself in' Young Person

'We have not had x get in any trouble in the community or had x have any involvement with the police since we have had CYT involved' Parent/Carer

In December 2016, due to the emerging case complexity, CYT developed a Complex Case Review Panel. This aims to manage risk and vulnerability to achieve the best outcomes for young people. The panel meets monthly and can include representatives from CYT police, health (substance misuse, speech and language, primary mental health), sexual exploitation, YJS and any other relevant service. The panel has seen many positive outcomes including signposting parents to the Advice and Conciliation Service when they are struggling to liaise with school, referrals into health services and social care to escalate increased risk, or step down into community based youth provision where the intervention plan outcomes have been met.

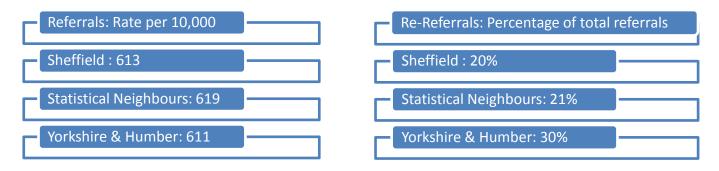
What we will do next

- Develop processes that work alongside the new Sheffield Safeguarding Hub and Locality Working Model to ensure that vulnerable young people are supported.
- Develop pathways with Youth Information Advice Guidance and Counselling service (YIACS)
 based at Star House to improve young people's mental health and wellbeing
- Roll out the Community Resolution pilot (Out of Court Disposal) to reduce the number of First Time Entrants into the Criminal Justice System
- Focus on supporting specific groups of young people into education, employment and training
- Continue to support the Sexual Exploitation Service ensuring that young people at risk of CSE receive early help to keep them safe and are supported to make positive choices

Children in Need

Children's social care receives referrals for children and young people where there are significant concerns. The Sheffield Social Care Assessment (SSCA) is used by social workers to assess if a child is 'in need' or has suffered, or is likely to suffer, significant harm. The social worker uses this to identify what (if any) service is needed, and/or if any specialist assessments are required. Where concerns relate to sexual exploitation (CSE) the CSE screening tool is used to assess risk.

This year there have been 7,103 referrals to children's social care, a 11.9% increase on the previous year. Of these referrals 20% have been re-referrals (i.e. they have been received within 12 months of a previous referral) which is in line with Statistical Neighbours (see below). This suggests that children are receiving an effective service from their social worker and good support from early help and universal services (i.e. services for all children) once the work with social care has ended. The largest number of referrals continues to come from education, health and the police.

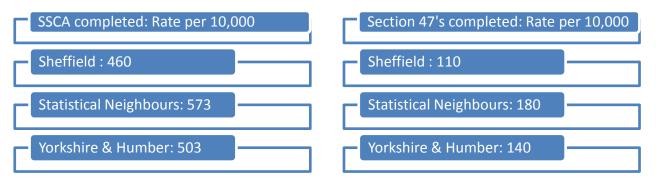


At the end of the year there were 4,312 Children In Need, an increase on the previous year. The



rate per 10,000 for Sheffield is at 372, above that for Yorkshire and Humber (333), Statistical neighbours (343) and England (338).

There were 5330 Sheffield Social Care Assessments (SSCA) completed in the year, which equates to a rate below the rate for Statistical neighbours and Yorkshire and Humber.



Where there is concern that a child is suffering, or likely to suffer significant harm a multiagency strategy discussion is held, which may lead to section 47 enquiries. There were 1,278 Section Page 56

31

47's undertaken in the year (a rate of 110 per 10,000) which is below that for Yorkshire and Humber and Statistical Neighbours.

Where concerns of significant harm are substantiated and the child is assessed to be suffering or likely to suffer significant harm (Working Together 2015) then a Child Protection Conference will be convened. This year 54% of Section 47 enquiries led to an Initial Child Protection Conference.

What we will do next

In October 2016 Sheffield City Council (SCC) in consultation with other agencies took the decision to create an Integrated Safeguarding Screening Service in Sheffield. The scope of this new service was confirmed by the SSCB Executive Board in December 2016. SCC had identified the need to further develop the way concerns about the welfare and safeguarding of children are considered and then progressed within the City, in order to improve compliance with existing regulation and inspection.

The Sheffield Safeguarding Hub (SSH) will be implemented in April 2017 and will consist of an integrated team of professionals from a range of agencies who will work together to safeguard vulnerable children. The SSH will facilitate the collection and analysis of all available and relevant information and intelligence in order to ensure that safeguarding responses are timely, proportionate and effective.

The overarching principles agreed by the Partnership Board, provide a framework which has been utilised to inform the structure of the SSH:

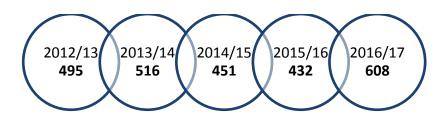
- Evidence based It should be compliant with regulation and inspection requirements.
- Improving the quality of decision making by ensuring screening decisions are based on a broader understanding of initial concerns, which relies on better and timely access to relevant information from a range of services, people and organisations.
- Lead to an improved journey for the child with greater emphasis on earlier identification and informed services at the right time.
- Closer partnership working, with clearer accountability and less duplication of effort, supporting the ability of Information being shared in a timely and appropriate manner.
- Be linked to wider system redesigns in Sheffield (Adults, Health and Police services) as well
 as early help in children and young people services. These have a shared focus to integrated
 working in localities to provide early help and prevention services which meet need and
 prevent demand from escalating unnecessarily.
- Support a cultural change in the approach to integrated working which creates a more
 efficient and effective way of utilising diminishing resources to safeguard vulnerable children,
 young people, adults and families.
- Be delivered in three separate phases to consolidate each phase of work as subsequent phases are developed.
- Face to Face strategy discussions should include the relevant agencies and statutory partners as a matter of routine and records of strategy discussions are recorded.
- Clear outcomes will be recorded.
- Appropriate consent obtained and defined within the process (when required).
- Contact information is appropriate to be screened and a Multi-Agency Confirmation Form (MACF) will be used across agencies to support consistency.

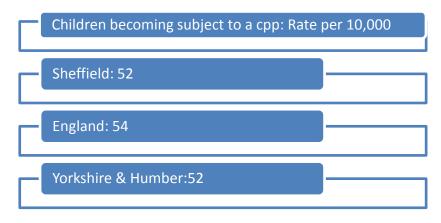


Children Subject To Child Protection Plans

An Initial Child Protection Conference is organised when there are concerns that a child is at risk of significant harm due to neglect, emotional, physical or sexual abuse. The conference brings together family members and professionals. If the conference decides that there is a risk of significant harm to the child then they will become subject to a Child Protection Plan. This plan sets out what professionals and family members must do to keep the child safe and well. Once a child has a Child Protection Plan, this is reviewed regularly.

There were 608 children that became subject to a Child Protection Plan over the year. Although this has increased (when compared to previous years, see below), Sheffield sits in line with the rate for England and that for Yorkshire and Humber.





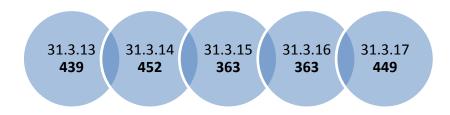
The most common reason for a plan being made was emotional abuse (49.9%), followed by neglect (40.6%). Nationally the most common reason was neglect (44.8%), followed by emotional abuse (35.4%).

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Of all the Child Protection Plans starting this year, 59 children became subject to a Child Protection Plan for a second (or subsequent) time (10% of all plans made). This remains lower than the figure for England (18%) and statistical neighbours.

There were 519 Child Protection Plans that ended during the year, of these 19 (3.6%) had been subject to a Child Protection Plan for over 2 years.

At the end of the year, there were 449 children that were subject to a Child Protection Plan (50%



male), an increase of 23.7% on the previous year. However, even with this increase Sheffield's rate of 39 per 10,000 remains significantly lower than that for England (43) or statistical neighbours (49).

Of those subject to a Child Protection Plan at the end of the year, 12% were under 1 year old, 29% between 1-4 years, 30% from 5-9 years and 29% that were 10 years and above.

The ethnicity of those subject to a Child Protection Plan are 67% White, 10% Dual/Multiple heritage, 8% Asian/Asian British, 4% Black/Black British, 2% Other ethnicity, 9% not known. At 31st March 2017 there were 6 children that had been subject to a Child Protection Plan for over 2 years.

Review of the Strengths Based Approach for Child Protection Conferences

In June 2015 the Strengths Based Approach (SBA) was introduced to Child Protection Conferences. As this was a significant change the SSCB undertook an independent multiagency evaluation of this in 2015/16. This year a re-evaluation was undertaken, following the same process, involving professionals and parents/carers. The main findings were that the:

- Focus on, and involvement of the parents in the Child Protection Conferences is positive
- Role of the advocates is valued. The information they bring on behalf of the child/young person has a significant impact
 Page 59

Use of the safety scale is well embedded and is now being used in some core groups

There remained concerns in relation to agencies providing (and sharing) reports and in professionals attendance at conferences. Therefore, one of the recommendations focuses on monitoring and improving this. All the recommendations from this evaluation are being monitored by the Learning, Practice and Improvement Group.

What we will do next

- Monitor attendance and report submissions for Child Protection Conferences
- Ensure the completion of the action plans

Independent Advocacy for Children in Child Protection Conferences

The Children's Involvement Team provide independent advocacy for children aged 5 to 17 at their Child Protection Conference. Once parental consent has been given, the advocate meets with each child on their own before the conference. In the majority of cases the advocate attends the conference alone to represent the child's views, ask questions on their behalf and ensure that the child's views are incorporated in the Plan where appropriate. However, the advocate can also accompany a child to the conference. After the conference they meet with the child to feed back to them about the outcome of the conference and the Plan.

During 2016-17 there were 402 referrals received and 259 (64%) children and young people were advocated for, an increase of 41.5% on the previous year. The main reasons for a child not using the advocate were due to parents refusing to give consent or a child opting out. As well as providing advocacy for children at their Initial Child Protection Conference, in September 2016, the commission was extended to first Review Child Protection Conferences. From 1st September 2016 until 31st March 2017, 37 children were advocated for at this first review.

Impact

Children complete an evaluation of the advocacy service and these clearly demonstrate the impact:

'They have helped us a lot and showed me I could say the truth. Now I can tell people what has happened and I get the results I want. They have helped me so much that I can't explain'

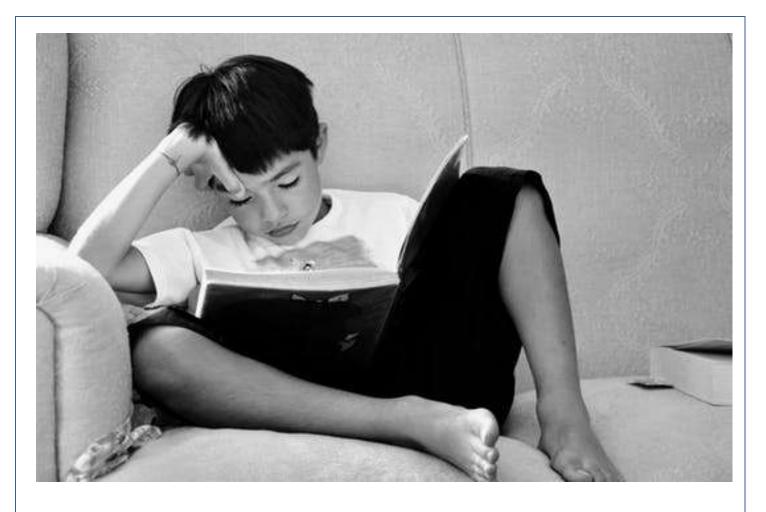
'It has been helpful towards me and my family because in the conference I don't think I would have had the confidence to stand up to all the people there. It's good because he spoke for me when I couldn't and then people knew what I felt like'

Professionals also recognise how advocacy has improved the focus on the child:

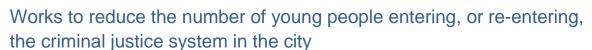
'As part of the conference I have always found the child advocate role vital and the information they bring to conference key'

What we will do next

We will continue to offer advocacy support at initial and some first Review Child Protection Conferences.



The Youth Justice Service (YJS)





There were 200 young people receiving one or more criminal justice outcomes in the year, which is a 41% reduction from the previous year (341). There were 10 new secure remands to custody (6 in 2015/16) and 6 custodial sentences (down from 11).

In response to a concern of the disproportionate number of young people from Black and Minority Ethnic (BME) background involved with the service, we have worked with the Police and Court service to review the services and outcomes received by these young people. The conclusion was that there was consistency in assessment and practice and the outcomes were the same (for those from BME and those not). Overall this year there has been a reduction of BME First Time Entrants. However, those of dual/multiple heritage have continued to increase.

The Support for Children in Care, Preventing Offending and Anti-Social Behaviour Protocol (between the Police, CPS, Sheffield City Council and YJS) has been reviewed. Training has now been provided to staff and managers of Children's homes in preparation for the implementation of this next year. The service has also facilitated training in implementing the new procedures in response to young people that go missing from children's homes.

Impact

Staff received training to undertake assessments in the new Youth Justice Boards assessment tool, Asset Plus. This is a holistic end-to-end assessment and intervention plan, allowing one record to follow a child or young person throughout their time in the youth justice system and

incorporates speech, language and communication needs; serious youth violence; gang affiliation; child sexual exploitation, and; restorative justice. Asset Plus is now fully implemented.

This year the YJS Management Board approved the plan to develop a Children in Care (CIC) Police Officer role within the YJS. The aim is for them to: develop positive relationships with the carers and young people in children's homes; be the single point of contact for carers, young people and professionals in relation to policing matters; liaise with Crown Prosecution Service (CPS) with regard to their decision making processes for CIC; and promote the delivery of restorative approaches and interventions within children's homes through training the staff. The aim is identify every opportunity to reduce the criminalisation of young people in care.

A new Intensive Family Support Team (IFST) has been set up to support families where teens are displaying risky and problematic behaviours which are putting families under stress. The IFST works with the whole family to get an understanding of where and why the problems are occurring; developing skills that will help families develop their own solutions. This year a programme was developed to tackle conflict from a young person towards their parents, with the aim of helping families manage and reduce violence and improve communication.

What we will do next

- 1. To prevent young people getting involved in crime through reducing the number of First Time Entrants by implementing a new Out Of Court Disposal Process.
- 2. The next step in reducing ethnic disproportionality will be an audit to consider the factors that influence offending and ascertain whether opportunities for intervention are being missed.
- 3. Publicise and implement the new 'support for children in care, preventing offending and antisocial behaviour' protocol.



Use of Restraint in the Secure Estate

Aldine House is a Secure Children's Home, licensed by the Department of Education (DfE) to provide care, education and treatment to 8 young people who display significant behavioural problems, are awaiting trial, or are sentenced by the courts for criminal offences. Aldine House has gained credibility by accepting young people who are nationally difficult to place. The DfE are aware of this and are supportive of what this means for Aldine House and the number of restraints.

The method of restraint used is the "Management of Actual or Potential Aggression" (MAPA). MAPA is accredited by the British Institute of Learning Disabilities (BILD) and approved by the Royal College of Nursing Institute (RCNI). MAPA remains a crucial behaviour management tool at Aldine House. Aldine's Service Manager and Assistant Manager completed training this year and are Certified MAPA Instructors by CPI (Crisis Prevention Institute). They are able to deliver MAPA training to all employees within the service to Advanced and Emergency level. Though there was a significant financial and time impact to achieving this, we believe that this approach will greatly benefit both young people and staff.

The Home has two comprehensive policy and practice guidelines, 'Restraint Minimisation' and 'The Use of Physical Restraint and Control within Aldine House', which outline how the home works to reduce the use of restraint. Both documents have been reviewed this year.

All incidents that involve a restraint are reviewed on CCTV by a Certified MAPA Instructor. Next year we will introduce a Daily Safeguarding Meeting where all incidents will be reviewed by senior managers and fed-back to staff prior to the end of the shift, so that good practice can be recognised and areas for development addressed. The Safeguarding Service link person visits Aldine House regularly to review practice. They are also MAPA trained.

'Staff's use of physical restraint is monitored and reviewed by both internal managers and a representative from the Local Safeguarding Children Board (LSCB). The representative has been trained in the method of restraint used in the home, so has the knowledge to review and assess incidents. This promotes transparency and independence assessment of practice' **Ofsted 2016**

There has been an average of 62 restraints a month. The Home remains extremely confident in the staff using restrictive physical intervention as a last resort to keep young people and staff safe. An important part of the restraint minimisation strategy is to ensure that these are kept as short as possible to keep young people and staff safe.

Aldine House implements a number of systems for data recording, allowing for detailed analysis of restraints. This enables us to provide detailed and up-to-date information about incidents and restraints to partners and stake-holders. Young people are actively involved in their own behaviour management plans and are consulted about how they would like staff to work with them. We implement specific, bespoke strategies for young people to ensure that their individual needs are met throughout their care within the home.

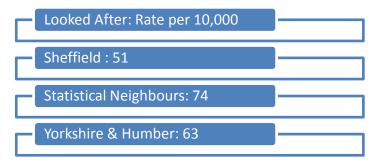
Aldine House is proud of the work it does with young people who present challenging behaviour and we continue to see improvements in the outcomes for young people, improving their life chances and opportunities once they return to the community.

At the most recent full Ofsted inspection, Aldine House received "Good" with "Outstanding" features and "Improved Effectiveness" at the last Interim Inspection.



Looked After Children and Adoption

This year there were 318 children and young people that became looked after and 286 that ceased to be. At the end of the year there were 587 children that were Looked After by the Local Authority, which is higher than the previous year (530). As a rate per 10,000, Sheffield remains lower than comparator groups.



Sheffield has historically had lower numbers of Looked after Children per 10,000 than both its Statistical Neighbours, and Core Cities. Since 2007 Sheffield has had a general decline in the numbers of children becoming Looked After although there has been a steady increase in these since 2015/16.

At the end of March, 46% of children admitted to care were taken into care (i.e. not accommodated under s20).

When children are Looked After for more than 20 days they have regular review meetings. There were 534 reviews, of which 87% were in timescale (95% the previous year). There were 91% of children aged 4 or over that were able to contribute to their review either through a consultation booklet or by attending the meeting. The involvement of children within their reviews is a priority for Sheffield and has consistently remained over 90% (for over 5 years).

Of those that were Looked After at the end of the year 11% had had 3 or more placements during the year. This is less than the previous year (17%) and now in line with comparator groups. There were 70% of children remaining in the same placement for 2 years or more (previous year, 71%). These figures demonstrate that there has been more stability for more children over the year.

There were 51 children placed for adoption in the year and 80% of these were placed within 12 months of the decision that they should be placed. This is higher than the proportion for the

previous year. There were 19 children that left care due to a special guardianship order (7%) and 38% leaving care due to permanence (a reduction on last year of 42%).



Children in Care Council (CiCC)

The CiCC are a group of enthusiastic 13–18 year-olds who meet every fortnight to work on projects to improve the care experiences of children in the care of Sheffield Local Authority





The group have developed a film 'Our Messages for Social Workers' which has been a success in Sheffield and nationally, including winning a Diana Award in July 2016 for 'Services to the local community'. The film was made by members of the care council to talk about their experiences of being in care, specifically focusing on their relationships with social workers. This included messages to social workers about how they would like them to work with young people. In addition, the group have designed a booklet for social workers to use when they are meeting a child in care for the first time. The idea for the booklet came from the group seeing the results of 2015 Looked After Children's Survey in

Sheffield and noting that a proportion of children in care did not know their social worker's name. The booklet includes details such as the social worker's name, working hours, contact details and other information the CiCC felt would break down barriers between a social worker and the child they are working with. These are now being used across the city.

Private Fostering

Private fostering is when a child under 16 years (or under 18 years if they have disabilities) is looked after for at least 28 consecutive days by someone other than a close relative. There is a legal requirement for the Local Authority to satisfy themselves that these children are 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.

There were 6 new private fostering referrals in the year and 17 children were in private foster arrangements in Sheffield at the end of the year. Private fostering arrangements are often very transitory and over the past year the Local Authority has sought to ensure that where appropriate a secure legal basis for the placement is pursued.

The Local Authority continues to provide leaflets and posters to offices, schools and language schools to ensure that professionals are aware of their responsibility to notify the Local Authority. New leaflets have been published for private foster carers, professionals, parents and young people and sent out to local GP practices and schools. Other work has included providing information to the two football teams in Sheffield on how to contact the Local Authority if they have a young person under 16 coming to live in a Private Fostering Arrangement, presentations to staff attending adoption training and handing out leaflets at adoption recruitment events.

The majority of referrals continue to come from professionals working within children and families. This is similar to many Local Authorities (http://cfab.org.uk/). However, the work with schools has led to referrals being made which is positive as it is ensures these children receive the assessment and visits required.

What we will do next

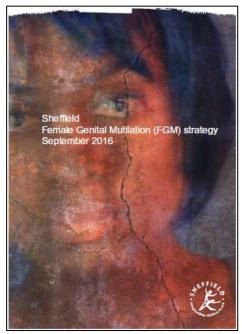
Impact

- Continue to alert the public, voluntary and faith sectors to their responsibilities in relation to private fostering notifications
- Ensure that the requirements are highlighted within police and housing.
- Ensure information is provided in the training for newly qualified social workers.



Section 4 Safeguarding Strategies

Female Genital Mutilation (FGM) Strategy



The Sheffield FGM Strategy and Pathway was developed by a multi-agency professional group including representatives from the local Hospital Trusts, GPs, Social Care, Safeguarding Children, Adult Safeguarding Partnership, Early Help Services, Police, Domestic Abuse Partnership Board and the Voluntary Sector. The Pathway was launched in May 2016 and the Strategy in March 2017.

Alongside training, mandatory reporting and monitoring of data, it is hoped that this strategy will enable statutory and voluntary organisations to work in partnership to:

- Protect those at risk of FGM or who have suffered FGM
- Identify the provision of resources and support, and prevent incidents of Female Genital Mutilation (FGM)

including the requirement to pursue and prosecute those who inflict FGM.

Impact

The Sheffield Strategy has 3 key objectives:

Protection - To safeguard the physical and emotional health of girls and women who have undergone FGM by ensuring professionals in all agencies are able to identify and assess their needs and to investigate individual cases of abuse. In addition to protect girls suspected to be at high risk of FGM.

Provision - To ensure women and girls who have undergone FGM can access specialist services for information, advice, support and any necessary psychological or physical health interventions. In addition to ensure all agencies are clear of the services available.

Prevention - To improve education and awareness of FGM with agencies, professionals, community groups, education and youth services; to inform and help address attitudes and myths about FGM; to eradicate acceptance of FGM in Sheffield; to support professionals and community groups to share their knowledge of what works in reducing the risk of FGM to girls and to support and educate pregnant women and new mothers to improve their understanding of FGM (including legal position), children's safeguarding issues and access to help and advice.

Providers have given assurance that FGM is now included in safeguarding training. Policies and procedures have been updated to reflect the pathway. What we will do next

The Health Reference Group will monitor the ongoing impact of the Strategy and Pathway.

http://www.safeguardingsheffieldchildren.org/assets/1/sheffield_fgm_strategy.pdf

Why it is important to prevent FGM:

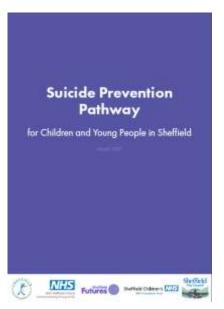
FGM is "an illegal, extremely harmful practice and a form of child abuse and violence against women and girls" (DH, 2016, page 1).

FGM is recognised internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women. It is nearly always carried out on minors and is a violation of the rights of children. The practice also violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death (WHO 2016).

FGM is a form of violence against women and girls which is, in itself, both a cause and consequence of gender inequality. Whilst FGM may be an isolated incident of abuse within a family, it can be associated with other behaviours that discriminate against, limit or harm women and girls. These may include other forms of honour-based violence (e.g. forced marriage) and domestic abuse. (HM GOV - Multi-agency statutory guidance on female genital mutilation 2016)

Suicide Prevention Pathway for Children & Young People in Sheffield

The number of young people under the age of 18 who die by suicide is fortunately low both nationally and in Sheffield. However, when it does occur, it has a devastating impact on the family, friends and communities and questions are always asked as to whether the suicide could have been prevented. At the same time, the number of young people reporting mental health and emotional well-being difficulties is on the rise nationally and locally. Investing in the development of the Suicide Prevention Pathway, and supporting the workforce to recognise and respond appropriately to young people at risk of suicide was identified as a priority for the SSCB. In response, the Suicide Prevention Pathway for Children & Young People in Sheffield was developed and launched this year. The development and implementation of the Suicide Prevention Pathway is a key element of the Sheffield *Future in Mind*



Transformation Plan (a national initiative) and was identified as a priority following the completion of a local Mental Health Needs Assessment for Children and Young People. This pathway was developed through a multiagency group and included consultation with specialist voluntary, community and faith organisations as well as with parents and with young people affected by mental health and emotional well-being issues.

Impact

The Suicide Prevention Pathway provides a welcomed resource for front line services working with vulnerable children and young people. It provides checklists, thresholds, referral pathways and sources of support and information for children and young people at risk of suicide, their families and workers.

What we will do next

- The strategy will be reviewed by the All Age Suicide Prevention Strategy Group
- Further awareness raising will be undertaken. For example, GP training events and awareness raising amongst universal health services
- There will be comprehensive programme of training regarding children and young people's
 mental health for the children's workforce, to embed a culture that responds positively to the
 mental health needs of all children/young people in the city. The SSCB will be offering 2 half
 day conferences on this issue to further support professionals.
- Suicide prevention and early intervention and prevention for young people experiencing mental health difficulties will be provided by the new city-wide Youth Information, Advice and Counselling Services (YIACS) and Well-being café resource based in Star house (city centre).
- A practitioner network will be developed by the YIACS service to ensure that frontline
 practitioners are able to be informed of regular updates and developments; share good
 practice; and access peer support.

http://www.safeguardingsheffieldchildren.org/assets/1/suicide_prevention_pathway_final_version.pdf

Neglect Strategy

The SSCB developed a new Neglect Strategy and Training Pathway for the city, setting out Sheffield's approach to tackling this issue. The aim of the strategy is to ensure the early recognition of neglect and improved responses to it by all agencies, so that the life chances of children are promptly improved and the risk of harm reduced.



The strategy was launched this year alongside the Neglect Training Pathway, which outlines the training available to support practitioners and improve the recognition, assessment and intervention for children and young people living in neglectful situations. The training pathway includes the development of single agency neglect training, which has been rolled out through a training the trainers approach (equipping trainers to provide this within their own agency). The neglect

webpage includes resources for professionals and this will continue to be developed.

To ensure the SSCB has a good understanding of how professionals are currently working with neglect one of the SSCB Themed Audit Days (TAD) focused on this issue. Three years ago, the first Themed Audit Day focused on neglect and this year's TAD replicated this process. Some of the main findings were that:

- In both reviews there were concerns that historical information was not used and not all risks were being addressed. This led to concerns regarding the effectiveness of plans for children.
- Professional challenge had been required in some situations. In some cases this had occurred but this had not affected change and no further challenge had been undertaken.
- Professionals had a better focus on the child in this TAD (in comparison to the first neglect Themed Audit Day). However not all professionals had the child central to their focus.

Impact

This year 1634 professionals have completed the Awareness of Child Abuse and Neglect Elearning package providing them with a good basic understanding of this issue. There were 69 professionals that attended a Neglect Training the Trainers session, providing them with the information and skills needed in order to roll out this training within their own agency.

'Excellent session and great to have a comprehensive training resource to use with my team'

What we will do next

- Review progress and consider the findings of the Neglect TAD.
- Develop Masterclasses on managing neglect cases, targeted at managers.
- Develop a culture of challenge to ensure all workers have the skills, confidence and support to challenge others in the best interest of children and young people
- Track the numbers of professionals attending single agency neglect training

http://www.safeguardingsheffieldchildren.org/assets/1/sheffield_neglect_strategy.pdf

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Sexual Exploitation Strategy



This strategy sets out the commitment of the SSCB and its partners to do everything possible to prevent sexual exploitation and support victims of abuse. It is only with a proactive, co-ordinated, multi-agency approach that we will be effective in protecting children and young people from sexual exploitation and disrupting and prosecuting offenders. This strategy is aimed at all organisations and practitioners across the city. Due to the need to address the issue of Sexual Exploitation (CSE) holistically, this strategy addresses our role to tackle exploitation of vulnerable young adults up to the age of 25.

It is our collective responsibility to;

- Prevent children and young people from becoming sexually exploited through effective leadership, governance and a co-ordinated, multi-agency response in our organisations and communities to enable them to recognise the signs and indicators and do everything at their disposal to prevent and tackle child sexual exploitation
- Protect children and young people who are at risk of sexual exploitation as well as those who are already victims and survivors
- Pursue relentlessly perpetrators of child sexual exploitation
- Prosecute those responsible and ensure there is effective risk management of perpetrators in the community
- Provide support for survivors of child sexual exploitation, ensuring their needs are met
- Ensure participation of all children and young people at risk of or experiencing child sexual exploitation

What children, young people and carers are telling us

'We are a group of young people who have different experiences of Child Sexual Exploitation. We have come together to share our experiences with you, to tell you what helped us in the hope that it will prevent other young people from going through what we did and to help workers understand what they can do to help and support someone who finds themselves in similar situations.

We feel that it is important for young people experiencing CSE to have a safe place where they can come and talk about their life with someone who they feel they can trust and who won't judge them. We also feel that the one thing that helped us most was having that one person who was there for us no matter what. That person should be willing to listen to our perspective of what as happening for us and not just push their own idea of what was going on. Someone who remained accessible and consistent and who really cared about what we were going through. Someone who didn't blame us or make us feel like what was happening was our fault.

Many young people who are affected by CSE don't really understand that this is what is happening to them until it's too late. If we had known what the intentions were of the people we met, we may not have got involved. Young people need to learn about grooming, what to look for and to understand that not everyone who is nice to you has your best interests at heart. This knowledge could save them from a life of heartache and pain. Nevertheless, you need to know that for some young people, even knowing this will not make a difference, because what they are being offered is better than what they have. What you have to do is understand this and help them see an alternative. Help them to understand that they deserve more and should expect better for themselves.'

http://www.safeguardingsheffieldchildren.org/assets/1/sheffield_child_sexual_exploitation_strate

qv_2016_pdf

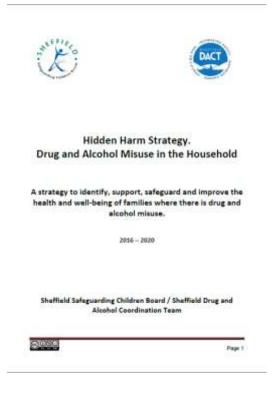
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Hidden Harm strategy 2016 – 2020

Drug and Alcohol Misuse in the Household

This strategy commits Sheffield's agencies to improving outcomes for whole households where drug and/or alcohol misuse is a feature. The review into The Hidden Harm Strategy (2013-2016), alongside the findings from the current evidence base and the 'new insights and understanding', identified that further work was needed to ensure that good practice and the progress made is embedded into routine work by all services. The Hidden Harm Strategy 2016-20 will:

- Encompass a Whole Household Approach, including fathers, mothers, significant others as well as children, young people and their siblings;
- Pay greater attention to households where there are issues relating to alcohol misuse, and the use of cannabis, image and performance enhancing drugs (IPEDS), new psychoactive substances (NPS), and prescribed and over the counter preparations, as well as opiate and cocaine use;



- Have a greater focus on prevention in addition to early intervention work with families;
- Have a greater focus on intergenerational use;
- Include primary (universal) and secondary (targeted) prevention services as well as specialist services.

It is therefore relevant to all services coming into contact with children, young people, adults and families.

The core of the Strategy centres on improving the ability of frontline staff in universal services to identify those that are misusing alcohol and or drugs (including new psychoactive substances and prescribed and over the counter preparations) at the stage when the evidence base for early brief interventions is strongest. Supporting and enabling front line staff to intervene, especially in relation to drug and alcohol misuse and parenting, at an early stage will reduce the need for more intensive interventions at a later stage.

Effective delivery of interventions requires a competent workforce with the awareness, tools and confidence to identify and take action to support families where there are issues relating to drug and alcohol misuse. Organisations must ensure they have a competent and well-trained workforce. The issues relating to drug and alcohol misuse in the household (including routine screening for drug and alcohol of whole household) must be addressed in all the organisations policies and procedures; the workforce must have attended appropriate training and Hidden Harm tools and resources must be available to and appropriately utilised by the workforce.

The Hidden Harm Strategy 2016-20 will work in conjunction with the Sheffield Alcohol Strategy 2016-2020 and the Sheffield New Psychoactive Substances Strategy 2016-2018.

http://www.safeguardingsheffieldchildren.org/sscb/drug-and-alcohol-misuse/hidden-harm

Section 5 Safeguarding Priorities

Sexual Exploitation

The service is responsible for tackling Sexual Exploitation (CSE) in Sheffield. It is multi-agency and works to address sexual exploitation on five key principals; prevention, protection, pursuit, prosecution and participation.

Sheffield Sexual Exploitation Service (SSES) comprises of professionals from Sheffield Futures, South Yorkshire Police, Sheffield City Council and the NHS. This year the service received 141 referrals, a slight increase on last year of just below 4%. Of these, the SSES worked directly with 61 young people (assessed as medium/high risk). A further 51 were assessed as low/medium risk (in regard to CSE) and were referred on to the Community Youth Team (CYT) to complete the intervention work. 29 cases were supported by other agencies. The majority of referrals were female. Over 63% of the referrals were aged 14-16 years.

Impact

The Multi-agency focus continues to expand with the appointment of a Specialist CSE Nurse this year. The impact is that all young people referred into the service now receive a full health assessment. The assessment is young person centred, and works with other agencies that hold key relationships with the young person to address any unmet health need. This can include Social Care, CAMHS, Sexual Health and School Nursing. This service is providing an essential bridge and communication into health settings, ensuring young people are able to access and engage with their treatment and care.

An advanced practitioner from Adult Social Care Services has been based in the service this year. They have undertaken research into transitions for young people who have experienced CSE and are turning 18 and entering adult services. This is nearing completion and recommendations have been based on case studies and consultation with young adults. The findings will be available next year.

The Friend or Foe document has been updated. This resource has been produced by the service, with the help of the young people who have been supported in Sheffield. This latest edition has been re-written to address new trends in exploitative behaviour and vulnerability of victims including online exploitation, peer-on peer abuse and more work specifically targeted at boys and young men. The training is planned for next year.

Sheffield Futures is the Hub for the South Yorkshire Alexi Project, part of a national CSE practice sharing initiative (University of Bedfordshire). Through this, Barnsley and Doncaster are offered direct case work, participation expertise and workforce training to develop their local capacity.

The 'Introduction to CSE' training for professionals has been updated. This has been delivered to 967 Professionals across South Yorkshire (878 in Sheffield, 23 in Barnsley, 50 in Doncaster and 16 in Rotherham) as well as a reaching a further 116 professionals through national conferences sharing the learning from the Alexi Project.

What we will do next

- Embed new assessment tools and processes to support the Sheffield Safeguarding Hub development
- Consider the findings of the transitions review and use this to inform service developments.
- Develop an integrated CSE and missing service.
- Expand the Alexi project to Kirklees.

The **Sexual Exploitation** Annual Report can be found on the SSCB Website

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Children Who Live in Households with Substance Misuse

Impact

This year the Hidden Harm Strategy and action plan have been reviewed and updated to reflect the rapidly changing trends within the drug and alcohol field and the impact on Sheffield children and families. The review identified significant progress that has been made to date including an increase in referrals into drug and alcohol services by children services; greater use of the alcohol screening tool by children's services (used with 86% of the parents where an Initial Child Protection Conference was held); health visitors now being automatically notified if parent / carer with children under the age of 5 enters substance misuse treatment and a notification system established for when a controlled drug is ingested by a child, young person or adult.

Professionals' awareness of the importance of safeguarding children who live in households where there is substance misuse has continued to increase. This year, the service has responded to 1071 requests (a 6% increase on 2015/16) for checks and advice from professionals within drug and alcohol treatment, support services and children services. From these 820 had children living with them, many of them had had no previous contact with children's social care. This illustrates that substance misuse support is being offered to parents at an earlier stage. Evidence shows this early intervention leads to better outcomes for children and their families.

This year the service has established safeguarding children case file supervision for all substance misuse practitioners to support them in identifying and effectively managing safeguarding children issues within the families on their caseload.

A questionnaire of the training needs of the substance misuse workforce was undertaken. The results of this led to the refresher events focusing on Neglect. This was attended by 111 workers from the Sheffield's drug and alcohol services, 20 from the domestic abuse services as well as 30 health visitors, 10 housing workers and 26 early help and social care workers.

What we will do next

Training

- Review and update the SSCB substance misuse course
- Facilitate masterclasses on significant topics such as WAM (What About Me: service to support children affected by someone else's substance misuse) and substance misuse in pregnancy
- Ensure safeguarding children training includes information to help identify and address 'Hidden Harm'.
- Continue to promote and monitor the use of the alcohol and drug screening tool.

Developments

- Establish reliable drug and alcohol testing to support workers monitoring drug and alcohol misuse in child protection
- Help increase the understanding of substance misusing parents on the impact their drug / alcohol misuse has on their parenting and children through the substance misuse parenting programme.
- Parents and children on a Child Protection Plan will be offered an intensive package of parenting support alongside psychosocial interventions to help address their substance misuse and parenting.

Domestic Abuse

The Domestic Abuse Coordination Team (DACT) is based within the Local Authority. It has responsibility for domestic abuse services in Sheffield and works to reduce domestic abuse and raise awareness.



A new Domestic and Sexual Abuse needs assessment has been undertaken and this concluded:

- An estimated 17,292 children have a female parent who is a victim of domestic abuse in Sheffield.
- 4,450 children affected by domestic abuse have had a parent in specialist domestic abuse support in the last year.
- 1,219 children affected by high risk domestic abuse were discussed in cases at MARAC (Multi-Agency Risk Assessment Conference) in the year.
- Domestic abuse is a key factor cases referred to Children's Services

Young people have a higher domestic abuse prevalence rate than adults:

- 12.6% females and 6.6% males aged 16 to 19 years have experienced domestic abuse in the last year (compared with 8.2% all female adults and 4% male adults).
- An estimated 3,500 aged 16 and 17 years old (2,300 of these are female) in Sheffield have been a victim of domestic abuse in the year.

Impact

The Domestic Abuse, A Whole Family Approach SSCB conference ensured the sharing of learning and good practice across the city around the need to take a holistic approach to the impact of abuse on parenting, reject victim blaming and work together to hold perpetrators to account. A training programme focusing on domestic abuse and substance misuse is now being delivered as part of the multiagency training.

The 'You and Me Mum' parenting programme for women who have experienced domestic abuse is evaluating positively and complements the Power To Change programme for survivors.

A county wide exploration of teenage domestic abuse was led by the Local Criminal Justice Board during the year. There is now ongoing work led by the Domestic Abuse Children and Young People's Strategy Group to improve our understanding of the prevalence of abusive relationships among young people. The Community Youth Team (CYT) secured funding, to work closely with the Independent Domestic Violence Advocacy Service (IDVAS) to provide one to one support to young people as a step down from the IDVAs service or where young people need a youth work approach. This is for young victims and for young people causing harm.

What we will do next

The needs of children living with domestic abuse in their families have been a central consideration in the development of the Sheffield Safeguarding Hub (SSH). Next year, as the Hub goes live, IDVAS staff will be co-located in this service.

The findings of the domestic abuse needs assessment will be used to develop the new Domestic Abuse strategy.

A web based resource will be launched this autumn providing information about best practice on the full range of issues which impact on young people or cause young people to be vulnerable relating to healthy relationships, including promotion of local resources and provision

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Children Who Go Missing

The Missing Young People Operational Group (MYPOG) brings together key agencies to maintain an oversight of children and young people that are missing, and to ensure that all relevant agencies are working effectively to implement the Sheffield and South Yorkshire missing young people policy.

There has been significant policy change towards the end of this year with the abolishing of the 'absent' category (from February) and new police risk categories being created. Sheffield had already recognised the flaws with the 'absent' category and had strategies in place to mitigate risks for this group. Those previously recorded as 'absent' are now recorded as:

Missing: anyone whose whereabouts cannot be established and where the circumstances are out of character, or the context suggests the person may be subject of crime or at risk of harm to themselves or another, or

Away from placement without authorisation: a looked after child whose whereabouts is known but who is not at their placement or place they are expected to be and the carer has concerns or the incident has been notified to the local authority or the police.

| April 2016 – March 2017 | Missing Children – Monthly Average | | Absent Children** - Monthly Average | |
|-------------------------|---------------------------------------|-------------|--|-------------|
| | All Sheffield | Children In | All Sheffield | Children In |
| | Children | Care | Children | Care |
| Number of incidents* | 164 | 78 | 51 | 39 |
| Number of individuals* | 100 | 34 | 26 | 15 |

^{*} Includes young people placed in Sheffield from another local authority ** The 'absent' category ceased from 02/17

This year the initial response forms have been reviewed. These are completed by the lead professional (e.g. Social Care, Early Help, CYT, YJS or the Sexual Exploitation Service) where a young person is currently missing to help the police and partner agencies to locate the young person. The Return Interview process has also been reviewed to encourage safeguarding concerns (shared immediately) and other relevant information to be highlighted and shared within 4 working days of the interview.

Impact

- New Sheffield Missing from Home Procedures have been finalised alongside a revised and updated South Yorkshire protocol.
- All Return Interview Forms are quality assured by YJS managers, after the interview. This
 ensures that appropriate and consistent follow-up and that support has been put in place.
 Missing episodes are checked where a young person has declined an interview.
- MYPOG is responsible for oversight of all missing cases, including reviewing and quality
 assuring of cases. There is a multi-agency approach which ensures agencies working with
 young people in Sheffield are jointly responsible for the oversight of missing young people.
 Analysis of missing episodes is ongoing.

What we will do next:

- Develop co-location of the Missing Young People team and Sexual Exploitation Service to improve joint working.
- From 1 April 2017 all return home interviews will be carried out by the Youth Justice Service. Training has been delivered to those staff undertaking them, and the consistency and quality of the interviews is expected to improve.

Online Safety

The focus of the **Online Safety** work is to teach children and young people how to safely enjoy and make the most of being online (when using social media, the internet, games, apps etc.) This is achieved through teaching professionals how to approach this subject with parents or children; training online safety leads in schools to feel confident in teaching other school staff or through direct work with children and young people. The online safety training for schools is provided by Sheffield City Council eLearning Service (SCC ELS) on behalf of SSCB with schools commissioning additional bespoke services.

Impact

The September 2016 DfE publication: Keeping children safe in education: for schools and colleges clearly sets out the requirements to all schools, academies and colleges around Safeguarding children online particularly the need for all settings to provide a progressive online safety curriculum for children and young people between 4 and 18 years. The SSCB have ensured that schools in the city are well placed to respond to this expectation as they all have access to the SSCB's Online Safety Curriculum which was produced and revised after extensive and ongoing consultation with young people from Foundation Stage 2 to year 13. The Sheffield model fits directly with the approach advocated in the Children's Commissioner's Report of January 2017 "Growing Up Digital", which recommends a PHSE based online safety curriculum from ages 4 to 14 and a complimentary computing curriculum.

There have been 67 professionals attending e-safety training in the year and 25 parents attending sessions. Student voice activities are at the heart of establishing both the efficacy of delivery and the changing patterns of online use and concerns of children and young people and there has been direct work with 450 pupils in the year.

Nationally, online safety education now incorporates a broader range of issues than previously, including cybersecurity, fake news and the risk of radicalisation. Across all age groups, young people in Sheffield have cited a fear of the news as one of their major online safety concerns. Additionally the children have spoken of the pressure that they feel always to be online, concerns about violent and sexual content, the mental health of their peers and also concerns about how to respond to the sharing of politically extreme or racist content.

What we will do next

A major area of development in this area next year will be collaborative work with leaders in 'Prevent' duty to combine delivery in the two areas. Funding secured from the Safer and Sustainable Communities Partnerships will be used to deliver online safety messages to non-school settings e.g. Foster Carers, Sheffield Futures, Libraries and Community groups as well as providing a body of work so that external funding sources can be explored to expand this work in Sheffield in the future

Service continuity has been ensured by SCC ELS continuing to represent Sheffield at national level and by closer contact with Safeguarding Service Education Advisors. The two teams plan to deliver joint training in this financial year to ensure that all Designated Safeguarding Leads (in schools) are aware of Online Safety provision and expectations, as there is still a tendency amongst some schools to view this as a computing rather than a safeguarding responsibility.

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Safeguarding and Licensing

The SSCB works with the licensed trade and other businesses, to make places safer for children and young people who live, work, perform, entertain, socialise, or otherwise access premises. We do this so that the opportunities offered to children are in a safe and suitable environment.

Impact

Following the success of the 'Say Something If You See Something' pilot in 2013/14, (an awareness campaign for people working in the hotel trade) a number of hotels were revisited in Sheffield this year, to see if the scheme had been effective and was still in operation. This resulted in some establishments requesting more training due to staff turnover. Following on from this, in March all Sheffield hotels tested by the Police, passed the test purchase assuring them that staff were being vigilant when customers behaved suspiciously when using the hotels.

There has been a 'Safer Takeaways' campaign (CSE and child employment awareness) which included visits with takeaway owners and the training of City Council enforcement officers (including trading standards, licensing, environmental health, food hygiene officers)

This year we have raised safeguarding/CSE awareness of 1,373 workers (885 people in the taxi/private hire trade and 488 other sectors). Evaluations consistently demonstrate the positive impact of this with comments such as "Very informative and understood very clearly what to do in all situations" and "Overall it was very important as a taxi driver".

We deliver a visible and accessible service during trade operating hours and make places safer for children and young people using licensing legislation including conditions, and reviews. This year participating in 57 complaints; 9 licence reviews and 21 advice requests. We have regular input to the Council's Safety Advisory Group to promote safeguarding at events.

This year saw the expansion of safeguarding children and vulnerable adults training for the taxi/private hire trade. An 'Advanced Safeguarding Vulnerable Passengers' taxi training resource was developed and training for passengers assistants reviewed.

The Licensing Project continues to hold beacon status for developing and sharing good practice in relation to working with licensed and other businesses and sexual exploitation. This year, in addition to training over 1,370 individuals across the trades, we supported the National Working Group (NWG) for Tackling CSE, National Association of Licensing Enforcement Officers, the Institute of Licensing; the University of Bedfordshire/Alexi Project; and met with the Children's Commissioner and Home Office (Safeguarding).

The Safeguarding in Sport guidance leaflets were relaunched this year (a leaflet for the hosting premises and one for the junior sports club). They promote good safeguarding practice when junior sports clubs organise events. The materials were produced in partnership with the Yorkshire Sport Foundation and the Sheffield and Hallamshire County Football Association (and are available from their websites). In addition, there has been consultation with SWFC and SUFC to develop a safeguarding scheme to protect children and vulnerable spectators at football or similar events and safeguarding training provided to stewards at sports venues.

What we will do next

- Pilot the Risual NIMOS mobile phone application to improve reporting of safeguarding concerns with the taxi/private hire trade
- Develop a safeguarding scheme for children and vulnerable spectators in sport age 79

Appendix 1 Board Partner Agencies

Executive Board Members

| Designation | Organisation |
|--|--|
| Independent Chair – Jane Haywood | SSCB |
| Assistant Director for Safeguarding and | Children, Young People and Families, |
| Quality Assurance / Professional Advisor | Sheffield City Council |
| to the SSCB | |
| Chief Executive | Sheffield City Council |
| Executive Director | Children, Young People and Families, |
| | Sheffield City Council |
| Director of Children's Services | Children, Young People and Families, |
| | Sheffield City Council |
| Chief Nurse | Sheffield Clinical Commissioning Group |
| Director of Nursing | Sheffield Children's NHS Foundation |
| | Trust |
| Head of Service | Community Rehabilitation Company |
| Director of Public Health | Public Health |
| Executive Director of Nursing and | Sheffield Health and Social Care NHS |
| Quality | Foundation Trust |
| Chief Nurse | Sheffield Teaching Hospitals NHS |
| | Foundation Trust |
| Superintendent | South Yorkshire Police |
| Chief Executive | Sheffield Futures |
| Head of Probation (Sheffield) | National Probation Service |
| Lead Member (Participant Observer) | Sheffield City Council |
| Lay Member | |
| Lay Member | |
| Chair of the Education Safeguarding | Sheffield Schools |
| Reference Group | |
| Chair of the Housing Safeguarding | Housing Solutions |
| Reference Group | |
| Senior Nurse | NHS England |

Operational Board Members

| Designation | Organisation | |
|--|--|--|
| Independent Chair | SSCB | |
| Assistant Director for Safeguarding and | Children, Young People and Families, | |
| Quality Assurance / Professional Advisor | Sheffield City Council | |
| to the SSCB | , | |
| Voluntary Sector Representative | Supporting Tenants Manager, | |
| | Roundabout Ltd | |
| Chief Inspector | South Yorkshire Police | |
| Head of Service | Community Youth Teams | |
| Safeguarding Lead | South Yorkshire Fire and Rescue | |
| Designated Doctor for Safeguarding | Clinical Commissioning Group | |
| Assistant Director, Legal Services (Legal Adviser) | Sheffield City Council | |
| Safeguarding Lead | Sheffield Health and Social Care NHS Foundation Trust | |
| Vice Chair | Housing Safeguarding Reference Group | |
| Service Manager | Youth Justice Service | |
| Vice Chair | Education Safeguarding Reference Group | |
| Domestic Abuse Strategy Manager | Sheffield Drug and Alcohol / Domestic Abuse Co-ordination Team | |
| Named Nurse for Safeguarding (Acute) | Sheffield Children's NHS Foundation Trust | |
| Named Nurse for Safeguarding (CAMHS) | Sheffield Children's NHS Foundation Trust | |
| Service Manager | NSPCC | |
| Operations Manager | Sheffield Futures | |
| Named Nurse for Safeguarding | Sheffield Children's NHS Foundation | |
| (Community) | Trust | |
| Assistant Director Fieldwork Services | Children, Young People and Families, Sheffield City Council | |
| Head of Place Strategy Team | Place, Sheffield City Council | |
| Lead Nurse | Sheffield Teaching Hospitals NHS Foundation Trust | |
| Designated Nurse | Clinical Commissioning Group | |
| Service Manager | CAFCASS | |
| Assistant Director Prevention & Early | Children, Young People and Families, | |
| Intervention | Sheffield City Council | |
| Team Manager | National Probation Office | |
| Team Manager | Community Rehabilitation Company | |

For an up to date list of Board representatives and agencies, please see:

 $\underline{\text{http://www.safeguardingsheffieldchildren.org/sscb/safeguarding-board-information/sscb-executive}$

