



**SHEFFIELD SAFEGUARDING  
CHILDREN BOARD  
ANNUAL REPORT 2014-2015**



## Essential Information

Author: Victoria Horsefield, SSCB Board Manager

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### Contact details

Independent Chair	Sue Fiennes sscb@sheffield.gov.uk
Safeguarding Children Board Manager	Victoria Horsefield Victoria.Horsefield@sheffield.gov.uk
Research and Performance Officer	Sarah Adams Sarah.Adams2@sheffield.gov.uk
Training and Development Managers	Jayne Kerr Jayne.Kerr@sheffield.gov.uk Rachel Reynolds Rachel.Reynolds@sheffield.gov.uk
Vice-Chair Child Death Overview Panel	Karen Bennett Karen.Bennett@sheffield.gov.uk
SSCB Administrator	Deborah Pinder Deborah.Pinder3@sheffield.gov.uk
SSCB Postal Address	Floor 3 South Howden House Union Street Sheffield S1 2SH
SSCB Phone Number	0114 273 4450

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## Introduction from the Independent Chair



I am pleased to present the Annual Report of the Sheffield Safeguarding Children Board (SSCB). This report outlines the progress that has been made during the year and the key challenges ahead for Sheffield to ensure that our children are safe from harm, abuse and neglect. My role as chair is to bring independent scrutiny and challenge to the work of the Board and our partner agencies, a role I hope I have fulfilled to the best of my ability.

2014-15 has been a challenging and busy year for the Board as we take forward the recommendations following our Ofsted inspection and respond to new and emerging challenges in the field of safeguarding. A strong Board with support from dedicated Board officers has enabled us to continue to deliver high quality, effective safeguarding and agencies and practitioners in Sheffield continue to prioritise their safeguarding responsibilities in this ever complex and challenging area.

This year we commissioned a review of Sheffield's response to Sexual Exploitation following the publication of the Jay Report in Rotherham. Sheffield has shown both best practice and resilience in this area and has engaged directly with young people to enable their voices to influence this important area of work. However, there is no room for complacency and we will continue to drive forward improvements in practice and service delivery.

We have continued to ensure that participation of young people strongly influences our work. Our e-safety project launched a model e-safety curriculum for schools which was informed by young people and children's focus groups providing valuable insight into their digital lives. Our Licensing Project, working with our partners and the Sheffield Young Advisers, developed a z-card and poster highlighting the dangers of scratchers (illegal tattoo and body modification). Thank you to all the young people who have assisted us in our work.

To strive to be a 'learning Board' we have further enhanced our Learning and Improvement Framework by ensuring that all workforce development is clearly influenced by our learning from reviews of practice and we have established a comprehensive data suite. Going forward this will help to set the Board direction and priorities.

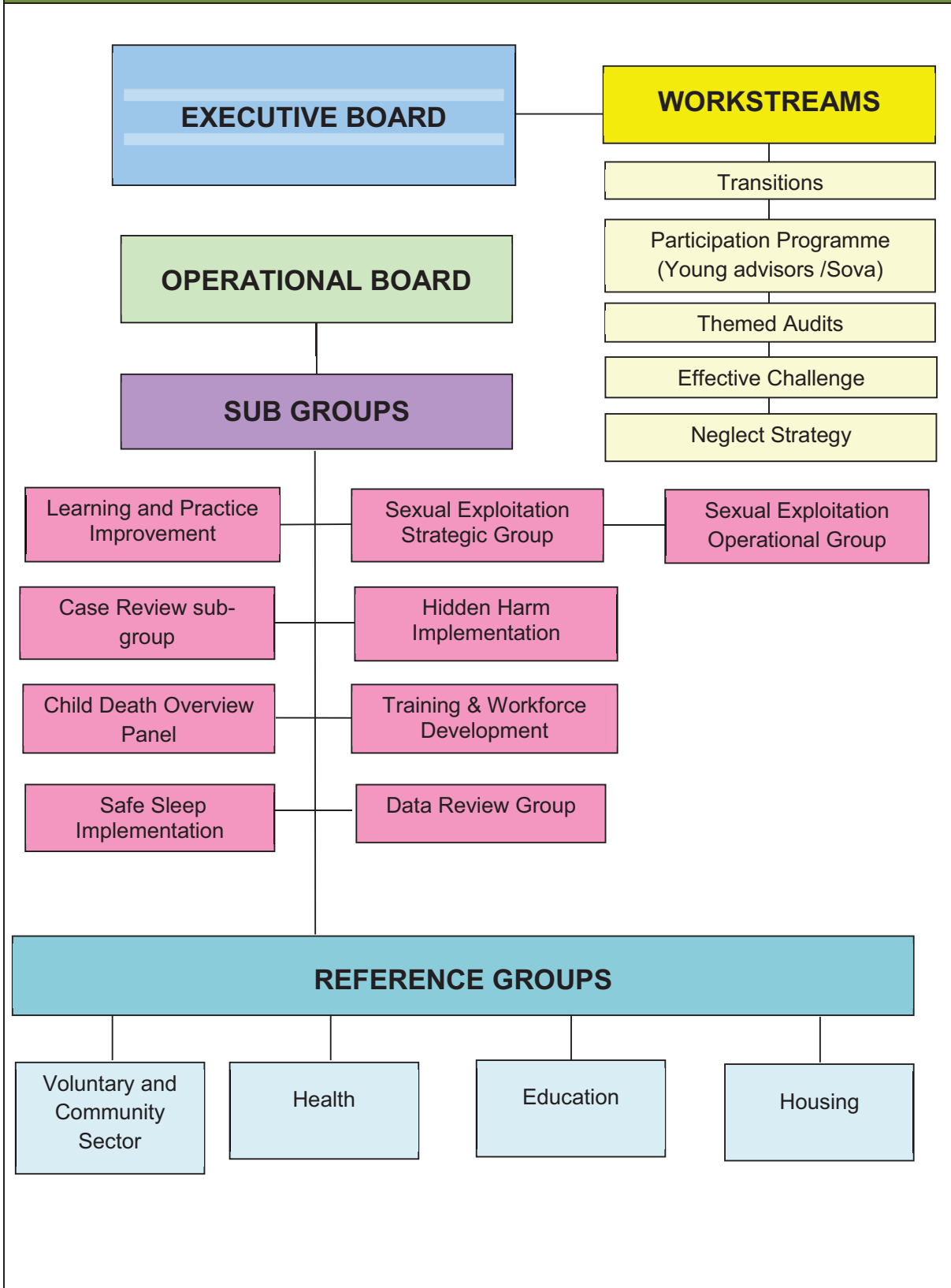
Two significant challenges for 2015-16 will be to ensure young people have easy access to the support and counselling they require and that there is effective transition.

Finally, I would like to thank you all for your hard work, commitment and engagement that ensure keeping children safe remains a key priority for our city.

*Sue Fiennes*

Sue Fiennes - Independent Chair SSCB

Sheffield Safeguarding Children Board Structure





## The SSCB: Who we are and what we do

Sheffield Safeguarding Children Board (SSCB) is a statutory body established under the Children Act 2004. It is independently chaired and consists of senior representatives of all the principle stakeholders working together to safeguard children and young people in the city. Sheffield Safeguarding Children Board 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.

The statutory objectives of the SSCB, as defined in Working Together 2015, are to:

- Co-ordinate local work to safeguard and promote the welfare of children and young people
- To ensure the effectiveness of that work.

### 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.***

### We will achieve this by:

- Monitoring and evaluating the effectiveness of what is done by partner agencies individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve
- Undertaking reviews of serious cases and advising partner agencies on lessons to be learned
- Collecting and analysing information about all child deaths in the city
- Participating in the planning of services for children in the city
- Developing effective and accessible policies and procedures
- Communicating the need to safeguard and promote the welfare of children, raising awareness of how this can best be done and encouraging it to happen
- Acting as the 'responsible authority' in connection with safeguarding children under the terms of the Licensing Act 2003
- Publishing an Annual Report on the effectiveness of arrangements in Sheffield

### Organisation

The SSCB comprises of an Executive Board and an Operational Board with a number of important sub-groups. An effective SSCB is one where partner agencies feel able to fully participate and engage in the business of the Board and in Sheffield we continue to achieve a high level of attendance and contribution at all our meetings. One of Sheffield's strengths continues to be the open and honest engagement of partner agencies and their willingness to participate and learn from practice audits and reviews to bring about effective changes in practice.

The Independent Chair meets on a regular basis with the Director of Children's Services and the Lead Member for Children. The Chief Executive of Sheffield City Council is an active member of the Executive Board. There are effective links between the SSCB and key strategic bodies in the city, including the 0-19 Partnership (the Children's Trust) and the Health & Well-being Board.

## Budget Information

INCOME		EXPENDITURE	
c/f 2013-2014	£144,553	<b>Employees</b>	£295,489
<b>Contributions:</b>		<b>Multi Agency Training</b>	£ 5,250
Sheffield City Council	£ 91,200		
Health (CCG)	£ 91,200	<b>Practice Review &amp; Standards:</b>	
S.Y Police (PCC)	£ 36,600	Serious Case Reviews	£ 4,502
Probation	£ 6500	Document Production	£ 2,377
Cafcass	£ 550	Tri-X (Procedures)	£ 5,000
<b>Management Charges / Income Generation</b>	£ 14000		
<b>Child Death Overview – CDOP</b>	£ 66,000	<b>Independent Chair</b>	£ 5,793
		<b>Community Advisor</b>	£ 9,600
		<b>Board Running Costs</b>	£ 7,622
		<b>Phone App</b>	£ 5,000
		c/f	£109,970
<b>TOTAL</b>	<b>£450,603</b>		<b>£450,603</b>

### PROJECTED EXPENDITURE 2014-2015

<b>Independent Chair</b>	<b>£8k</b>
<b>Board Manager</b>	<b>£57k</b>
<b>Secretariat</b>	<b>£18k</b>
<b>Operating Costs</b>	<b>£25k</b>
<b>1. Multi-Agency Training</b>	
Manager + Business Support	<b>£74k</b>
Training, Running costs +Virtual College	<b>£13k</b>
<b>2. Learning &amp; Practice Improvement</b>	
Research & Audit Officer	<b>£38k</b>
Business Support	<b>£23k</b>
Publicity/Campaigns/Safe Sleep	<b>£15k</b>
SCR/CR contingency	<b>2014-5 C/F</b>
<b>3. Policy &amp; Procedure</b>	
Tri X Local & S.Y. Procedures & Policies	<b>£5k</b>
<b>4. E Safety Project / Manager</b>	<b>£52k</b>
<b>5. Community Adviser Consultant</b>	<b>£7k</b>
<b>SUB TOTAL – CORE BUDGET</b>	<b>£335k</b>
<b>6. Child Death Overview Processes (CDOP)</b>	<b>£66k</b>
<b>OVERALL TOTAL</b>	<b>£401k</b>

**INDICATIVE AGENCY CONTRIBUTIONS 2014-15**

AGENCY	Formula %	2014-15	2015-16	Variation
SCC (CYPF)	40%	£91.2k	£91.2k	↔
HEALTH (CCG)	40%	£91.2k	£91.2k	↔
S.Y.POLICE (PCC)	16%	£36.6k	£36.6k	↔
PROBATION	4%	£6.5k (9.5k requested)	£6.5k (9.5k requested)	↔
Sub Total	100%	£225.5k	£225.5k	↔
C/F		£148k (est)	£110k (est)	↓ £38k
<b>TOTAL</b>		<b>£373.5k</b>	<b>£335.5k</b>	<b>-10% = £38k</b>

**SEXUAL EXPLOITATION SERVICE - SSCB FUNDING ELEMENT**

AGENCY	New CSE Service 2013-14	Standstill 2014-15	Standstill 2015-16
SCC (35%) (CYPF)	£28.7k	£28.7k	£28.7k
HEALTH (30%) (CCG)	£24.6k	£24.6k	£24.6k
S.Y.POLICE (35%) (PCC)	£28.7k	£28.7k	£28.7k
<b>TOTAL</b>	<b>£82k</b>	<b>£82k</b>	<b>£82k</b>



Learning Lessons From Reviews

**A Review of the Transition Process**



**What happened?**

This review focussed on the lack of transition planning for a young person with complex needs which delayed their move from a children's provision to adult services. This young person, who has complex needs relating to ADHD, Autistic Spectrum Disorder and learning difficulties, was detained under Section 3 of the Mental Health Act 2007. Regular meetings took place through the dual processes of mental health and Looked after Children planning which raised the issue of transition (planning for the move to an adult provision). The Dispute Resolution Process (DRP) was used to escalate concerns about the lack of progress and these meetings were attended by a number of senior practitioners and commissioners. Plans were made for joint assessments between children and adult mental health services which would feed into placement plans but the assessments were never actioned and placements not secured. Despite a number of professionals from both health and social care being involved it appears that no professional or agency was willing or able to accept the responsibility for ensuring the transition to adult services. There was a collective failure to put in place the necessary and agreed arrangements leading to this young person remaining in a young person's unit until after their 18th birthday.

**What did this tell us?**

The review identified that the gap in the commissioned provision between CAMHs and adult services for those aged between 16 and 18 years was a significant factor impacting on the delay in planning for this young person which was compounded by the lack of a formally identified lead professional within health. This was not addressed until NHS England reinstated the Case Manager system and a worker with case management responsibility was allocated and progressed the planning.

Adult services failure to undertake an assessment prior to the 18<sup>th</sup> birthday was due to an 'overly strict adherence to the threshold age' for adult provision and out of line with best practice. The nature of the young person's complex needs meant that no provision in Sheffield could meet them. Services therefore needed to work together to ensure timely assessments and planning, and to ensure that all options were fully explored.

It was acknowledged that there is a lack of understanding of the Mental Capacity Act (MCA) in the children's workforce and this was not considered in the planning process

All agencies and workers should feel able to effectively escalate their concerns and equally act on the recommendations of escalation processes like DRP.

**What are we doing now**

CAMHs services in Sheffield will be provided up to 18 years with the exception of early psychosis and eating disorders.

The SSCB will ensure that workers in all partner agencies including those in adult services who may be expected to assess young people as part of the transition planning understand the purpose and function of the Dispute Resolution Process for Looked after Children

All young people who are placed in a provision outside of the area will have an identified lead health clinician in Sheffield with this being a requirement of contracts.

Workers will be fully briefed and understand the requirements of the Mental Health Act and the Mental Capacity Act during a young person's transition from children to adult services.

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

## Multi-Agency Themed Audit Days

There are 3 Themed Audit Days each year (TADs), each reviewing 5 cases chosen to fit in with the theme. Every TAD uses the same process of questionnaires, agency self-audits, focus groups and interviews with parents/carers and young people (where appropriate), but each is adapted slightly to ensure the theme is at the focus.

Professionals are involved in the process in two ways; those directly working with the cases complete a questionnaire and attend a focus group (and their line manager completes an agency self-audit). In addition, 10 – 15 professionals working for one of the Board partner agencies (all managers with safeguarding experience) attend on the Themed Audit Day to participate as one of the multi-agency team members to review the cases on behalf of the Board. The TADs use 'Appreciative Inquiry'. This new way of learning involves identifying and learning from what has worked well. The main learning points are drawn from the positive work identified in each review.

### Key Achievements

Undertaken 3 Audit Days, each with a different theme at the focus. The themes were:

- Children who are subject to a child protection plan (CPP) or are 'Looked After' (e.g. in foster care) and are of dual heritage
- Transitions – preparing young people for adult life and the transfer to adult services (where appropriate)
- Children who are Looked After for less than 28 days (20 working days)

### Main Learning Points

The TADs demonstrated many positive working practices and the impact of this on the case work. The positive learning points below are those seen across all themes and the SSCB would encourage professionals to reflect on these in their own work:

- Good multi-agency working and communication led to the professionals having clear roles, enabled progression of the cases, provided support to parents/carers and children and enabled the professionals to manage parents when they were aggressive or manipulative.
- There was evidence of professional challenge regarding a variety of situations. Some challenge led to change (and the progression of the case), others did not, but did ensure all were clear of the views of the team and/ or family therefore keeping communication channels open.
- Professionals focused on the children/young people in the majority of cases. This enabled them to understand the child's wishes and feelings, knew how to work with them to involve them in meetings and in some cases, led to a strong bond providing the child with trusted adults that they knew they could rely on.

There were also findings linked to specifically to the themes at the focus of the TADs and further information can be found in the Learning Briefs:

<https://www.safeguardingsheffieldchildren.org.uk/welcome/sheffield-safeguarding-children-board/sscb-information/themed-audit-days.html>

In the previous year one of the Themed Audit Days focused on neglect. From this a Neglect strategy has been developed.

### What we will do next

- To undertake 3 Themed Audit Days
- Undertake a case audit of children who are subject to a CPP or are Looked After and are of dual heritage – using the findings of the TAD3 to guide this
- Appreciative Inquiry – To develop this aspect of the TAD further whilst continuing to review this process in relation to the learning from the TADs.

## Multi-Agency Case Review Sub Group

The SSCB multi-agency case review sub-group meets regularly and has a 'standing panel' from SSCB partner agencies. Auditors have sufficient seniority in their organisation to effect the required changes that emerge from the audits. The group monitors and evaluates local practice in delivering services to children and their families by determining the quality of practice, the level of agency involvement, partnership working and related outcomes. The audits focus on the child's journey and highlight areas of good practice, areas for development and areas that require improvement. The process provides a culture of continuous learning and improvement, with a clear focus on impact and outcomes. This complements the Themed Audit Days.

We regularly see examples of good practice within the audits and there is clear evidence from the audits that Sheffield practitioners know each other well and regularly communicate and share information. There is also evidence of child focussed practice with practitioners from all agencies demonstrating a good understanding and awareness of the children and young people they are working with.

A theme tracker has been developed that enables us to identify common themes which inform the Learning and Improvement Framework. Themes emerging this year have included the:

- The positive use of professional challenge to improve outcomes
- The need for the child's voice to be documented in records
- The need to consider a child's ethnicity within assessment and planning
- The need for services to be flexible to meet the needs of young people
- That separation in domestic abuse cases does not automatically mean the end of risk
- The impact of the trilogy of risk (domestic abuse, substance misuse and mental health) and the need to consider all three elements in all assessments

## Ofsted: SSCB Area for Improvement 1

*'Further develop the mechanism to combine learning from case reviews and case file audits to ensure practice is informed and improved by regular review and feedback.'*  
Ofsted, 2014

### Key Achievements

Following the Ofsted inspection the SSCB recognised the need to ensure that the audit and evaluation work was influencing and changing practice and that the SSCB could evidence change. A tracker has been developed to collate the themes emerging from practice audits and reviews and this informs the Learning and Improvement Framework to ensure that all areas of workforce development reflect the learning coming from practice review. The training strategy has been revised to take on board these messages and dip sampling evaluation now takes place following training to ensure changes are being made to practice. Future case reviews and audits will review whether previous concerns are still present. A workforce survey has been developed and will be rolled out in 2015/16 and will inform practice.

Case Reviews, Themed Audit Days and specific CDOP themes are now summarised in Learning Briefs; a one page summary that includes issues for professionals to reflect on.

These are distributed widely, including to professionals that have participated in the work, and are available to download from the website. Learning from reviews and themed audit days has been presented at 3 multi-agency lunchtime seminars highlighting the themes seen across cases

#### **What we will do next**

- To review the Learning & Improvement Framework to further consider how the learning from all the Boards work feeds into training and /or out to single agencies.
- Further develop the connection between the Learning Practice and Improvement Group and the Training and Workforce Development Group in order to ensure that practice is informed and improved through the Boards work.

## **Ofsted: SSCB Area for Improvement 2**

*'Develop a comprehensive data report to enable Board partners to understand performance across services, and to identify and challenge areas where improvements in practice are required'*  
Ofsted, 2014

#### **Key Achievements**

A multi-agency data suite has been developed and has been in place since the start of this year. This includes a number of data points that sit within 6 priority areas:

1. Early help and prevention
2. Identification of risk
3. Children subject to child protection processes
4. Children who are 'Looked After'/in alternative care
5. A safe and secure place for our children to live
6. A skilled children's workforce

This data is collected quarterly from Board partner agencies and is reviewed by a multi-agency team. They highlight a number of pertinent points from the data suite that are included in the summary report, which is one element of the Data Dashboard reported to the Executive Board. These have included:

- The number of under 18 year olds referred to CAMHS has increased in quarter 4 and the number of 16/17 year olds referred to adult mental health services has dropped. This is in line with a recent agreement that 16/17 year olds will be accepted by CAMHS.
- The proportions of Children's Social Care single assessments completed in timescale (45 days) have been low. The agency has recognised that this is an issue and has been working to address this. The Board are monitoring the progress of this.

#### **What we will do next**

Further develop the Data Dashboard (of which the Data Suite is one element) to establish an SSCB Performance Framework which incorporates learning from single and multi-agency audits, inspections, data and SSCB work-streams.

## Report From the Child Death Overview Panel (CDOP)

The Child Death Overview Panel reviews the death of any Sheffield child. There were 49 deaths reported to CDOP this year and 38 deaths were reviewed by the Panel in the year (not all deaths can be reviewed in the same year).

### Key achievements

- Completed an audit of the Rapid Response to unexpected child deaths, over a 12 month period. The rapid response is led by a paediatrician or nurse together with the police and aims to understand, as fully as possible, the cause of the death and circumstances leading up to or contributing to it.



- Adopted resources from The Lullaby Trust giving safer sleep messages to parents.

- Completed an in-depth review of all suicides reported since April 2008. This included a focus on the recent suicide of a vulnerable young person living in homeless accommodation.

A learning brief (a one page summary) from this review can be found at

[www.safeguardingsheffieldchildren.org.uk/welcome/sheffield-safeguarding-children-board/child-death-processes/Thematic-Review-of-Suicides.html](http://www.safeguardingsheffieldchildren.org.uk/welcome/sheffield-safeguarding-children-board/child-death-processes/Thematic-Review-of-Suicides.html)

Key recommendations included:

- No young person will be placed in B&B accommodation.
  - Any young person presenting as homeless will be treated as a Child In Need with a holistic assessment.
  - Work is on-going to improve access to mental health services.
  - A Suicide Pathway is to be developed for Sheffield
- Pertussis (Whooping cough)  
CDOP identified that although expectant mothers are informed of the whooping cough vaccination by midwives, they have to attend a GP surgery to receive this. The issue of streamlining this process is being taken forward by the Health & Wellbeing Board.

### What we will do next year

- Agree sharing of data with the Medical Examiner (the person that independently reviews deaths prior to a death certificate being issued). This may highlight additional areas for improvement in care of the child/or family which CDOP can discuss or address.
- Implement recommendations from the Rapid Response audit: One of the key recommendations is to hold an information sharing meeting or discussion shortly after each death occurs to develop an early picture of the child. The CDOP will be looking at how to put this in place.
- Identify how the Safe Sleep message could be highlighted through routine appointments that 'new' parents have with GPs.

A more detailed Annual Report for the Child Death Overview Panel can be found at:

[www.safeguardingsheffieldchildren.org.uk/welcome/sheffield-safeguarding-children-board/child-death-processes.html](http://www.safeguardingsheffieldchildren.org.uk/welcome/sheffield-safeguarding-children-board/child-death-processes.html)



## Review of Sheffield's Response to Sexual Exploitation

Professor Jay's Independent Inquiry into Child Sexual Exploitation in Rotherham, published in August 2014, highlighted the need to scrutinise all aspects of governance and practice in relation to Child Sexual Exploitation (CSE). A full meeting of Sheffield City Council elected to conduct an assessment and overview of services across Sheffield.

The SSCB was commissioned to undertake the independent review, which was overseen by Kathryn Houghton (Independent Consultant) to focus on how effective Sheffield agencies were in achieving the city's strategic aims in tackling CSE (including the operation of the multi-agency Sheffield Sexual Exploitation Service (SSES)) and benchmarking their current practice against the Jay recommendations to ensure agencies are providing the most responsive best practice.

The CSE assessment looked at many aspects including: leadership and governance; multi-agency CSE safeguarding self-assessment; compliance with Ofsted CSE thematic inspection Annex A requirements; evaluation of processes, procedures and tools; evaluation of the CSE training programme; staff survey on training and support; evaluation of ten cases managed via the SSES service; audit of 32 cases of children and young people who received input from SSES and a young people's panel. The findings were reported back to the SSCB Executive Board and full council in January 2015.

*"It is clear from this multi-agency assessment that Sheffield's partnership approach to Child Sexual Exploitation is meeting standards to deliver effective services, and in many instances is at the forefront of best practice. This work has taken a thorough look at how services designed to respond to Child Sexual Exploitation are currently delivered across Sheffield and we have found that practice already incorporates the recommendations from the Jay report, and has done so for some time.*

Kathryn Houghton, Independent Consultant, 2014

### Summary of Areas of Strength

44 areas of strength were identified, including;

1. SSCB and partner agencies strongly comply with the Jay recommendations and many of the requirements have been embedded in Sheffield for many years, given the early and proactive response to CSE.
2. Sheffield has a history and evidence of being willing to tackle and confront difficult issues, regardless of any gender or ethnicity implications.
3. SSCB and partners operate in a learning environment evaluating and adapting services to children and young people.
4. There is a culture of openness; questioning and professional challenge supported by robust policies and procedures.
5. Operation Alphabet was recognised by the judge as a model of its kind, due to diligent work including partnership working and support provided to victims.
6. Robust action has been taken to deal with CSE in all areas of licensing regulatory requirements.
7. CSE training and awareness programmes have reached over 1700 practitioners, is recognised as best practice by Ofsted and been adopted nationally.
8. Practitioners and managers are able to recognise the indicators of risk and vulnerability of CSE and when to refer children and young people to SSES.
9. Case evaluations and audits demonstrated innovative and effective means of engaging with children and young people who have been subject to CSE



10. All children and young people referred to SSES had received a CSE assessment
11. Sheffield has a recognised Community Youth Model of working with the children and young people.
12. Sheffield builds trusting and supporting relationships with children and young people, ensuring the most appropriate professionals deliver direct work.

### Summary of Areas for Development

There were 16 areas for development, including:

1. SSCB need to continue to provide those who serve on scrutiny and licensing panels with sufficient CSE awareness and knowledge to enable effective independent challenge and decision making.
2. Clearer pathway to, and greater availability of, health services for those children and young people who are impacted by CSE.
3. Continuation of development of the CSE assessment tool, in particular looking at alternatives to scoring systems.
4. Education advisors to provide a specific CSE policy for all schools and other groups such as MAST, faith sector and voluntary agencies
5. SSCB and SSES, together with partners, to further develop CSE awareness in schools and all communities within Sheffield including ethnic minority communities, leveraging on available networks and resources.

### Action plan

Following the review an action plan was developed and is being implemented through the CSE Strategic group with governance through the SSCB Executive Board.

The full report and the executive summary can be found at:

<https://www.safeguardingsheffieldchildren.org.uk/welcome/sheffield-safeguarding-children-board/sexual-exploitation.html>

## Section 11

*'Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others..... safeguard and promote the welfare of children.'*

Working Together to Safeguard Children, 2015

Local Safeguarding Children Boards have a responsibility to assess whether Board partner agencies are meeting all the requirements. In Sheffield this is undertaken through an agency self-assessment, which is completed every 3 years. In addition to this, in the intervening years a specific piece of work is undertaken that relates to Section 11.

### What we have achieved

- Monitoring the remaining outstanding agency Section 11 action plans from the last self-assessment.
- Identified a self-assessment tool for use by the voluntary and community agencies.

### What we will do next

- To ensure that all partner agencies have training pathways and recording processes in place for their organisation.

## Children & Young People's Involvement

The SSCB are continually seeking new ways to involve young people in the work of the Board. This has had a positive impact in raising awareness of various safeguarding issues.

### Licensing

The SSCB Licensing Project Manager in partnership with the Health Protection Service has met regularly with our Young Advisors Group to get their views about how to deliver safeguarding messages to young people who are thinking about having an illegal tattoo or other kind of body modification. The young people drafted the artwork and wrote the content of a z-card and poster in a format and style that would appeal to the SSCB's target audience. They did a great job and their work was endorsed by the Lead Member for Children, Young People and Families at a launch event in February 2015 which saw 20,000 cards and posters being distributed across the city.



Well done to our young advisors!

### Sexual Exploitation

Following the involvement of young people in Dr Kathryn Houghton's independent review of Sheffield's response to Sexual Exploitation, the Sexual Exploitation Service has enhanced its participation work with young people, this includes:

- Development of a youth consultation group to consider campaign work and peer education
- The publication of a second edition of the 'Pieces of Me' booklet, a collection of creative writing by young people affected by child sexual exploitation. This was funded by Office of the Police and Crime Commissioner
- The re-launch of the Friend or Foe Pack
- Engagement with the National Working Group for Sexual Exploitation

### E-Safety

The E-safety Project Manager has worked with groups of children in primary, secondary and higher education to involve them in delivering key e-safety messages across our school communities:

- A group of E-safety Ambassadors at Nook Lane Junior School took part in delivering a parents event.
- A group of 'A' level drama students at High Storrs School created a performance called 'Selfie' which has been delivered to Year 5 and Year 6 pupils in local primary schools.
- A group of students from Sheffield Hallam University delivered a parents workshop with the E-safety Manager at Lydgate Junior School.

*High Storrs students in costume for their performance "Selfie"*



These projects have provided an opportunity for young people to work together to present important e-safety messages and guidance to parents and their peers.

Further examples of how children and young people have been involved and influenced the work of the Board can be found in other sections of this annual report

## Multi-Agency Safeguarding Training

### Key Achievements

- Development of training for professionals on the new Strengths Based Approach to child protection conferences
- Development of 'Young People and Intimate Partner Abuse' course
- Development of a Child Sexual Exploitation (CSE) 'Training for Trainers' programme for secondary schools to enable schools to both deliver in-house CSE training for staff, and develop effective CSE programmes for pupils.
- Development and hosting of the Yorkshire and Humberside Multi-Agency Safeguarding Trainers Regional Conference on Serious Case Reviews.
- Delivered an event for parents 'Child Sexual Exploitation – Keeping Your Child Safe: What Parents/ Carers Need to Know '
- A programme of seminars on Gangs and Youth Violence developed and delivered.
- An evaluation of the impact on practice of the SSCB CSE training programme.
- The development and on-going delivery of Sexually Harmful Behaviour training, incorporating the Sheffield multi-agency strategy.
- Delivery of a comprehensive programme of lunchtime seminars addressing current and emerging issues.

An extensive programme of multi-agency and single agency training and events were attended by a total of **11,951** practitioners from across partner agencies. This included training in relation to e-safety and substance misuse, training for schools, sessions for the licensed trade, taxi transport trade and Sheffield City council drivers and escorts, the Regional Conference hosted by Sheffield on Serious Case Reviews and e-learning sessions.

In addition there were **888** young people and parents/carers that attended e-safety and sexual exploitation related training.

### Responding to safeguarding concerns

- CSE has remained a priority in 2014/15 with lunchtime seminars (each term) addressing different aspects of CSE, including work with boys and young men, 'training the trainers' to use resources in schools and learning from a recent South Yorkshire Police CSE investigation, Operation Alphabet.
- Lunchtime seminars included those addressing mental health issues for children and young people, e.g. self-harm, bereavement and loss, novel psychoactive substances, impact of domestic abuse.
- Responding to the training needs of practitioners identified through evaluations following courses as well as the revision of courses in line with policy/national changes.

### Main Challenges

- Ensuring training keeps up-to-date with national changes and local restructuring of services and new processes
- Reaching all staff that require training on an ever increasing number of safeguarding issues.

### What we will do next year:

- Delivery of a conference on neglect and revise the neglect multi-agency training programme.
- Training on 'refreshed' Thresholds of Need document.
- 'Training the trainers' on Strengths Based Approach to Child Protection, Conferences, ensuring the children's workforce are prepared for this change.
- Continue to offer a full programme of lunchtime seminars on emerging issues

## Report From the LADO – Allegations Against Professionals

The Local Authority Designated Officer (LADO) provides advice, guidance and management in cases where an allegation has been made against a person who works with children. The document, *Working Together to Safeguard Children (2015)* sets out the types of allegations that the LADO should consider. The LADOs role is to work closely with the police and other agencies to consider whether an allegation is true or not. They ensure that any allegation is dealt with as quickly as possible.

In the year 2014/15 there were 56 allegations against staff and volunteers and on average a further 10 discussions each month where the matter did not fit the scope of the LADOs role (the data of those beyond the scope of the LADO has been collected from June 2014 – March 2015)

Of the 56 allegations, 36% were in relation to Physical abuse, 29% were for sexual abuse and 29% were in relation to behaviour to a child suggesting that a risk is posed to children in employment. The remainder were for other reasons.

As in previous years the largest proportion of referrals are made against those who work in schools (34%) followed by those that work in health (18%).

In 32% of cases no action was taken against the employee as these were unsubstantiated or proven to be false. There have been 7 people that have been dismissed from their post and a number of cases are awaiting criminal proceedings and/or disciplinary investigations. A number of matters are still outstanding.

### What we will do next

- A referral form has been devised and will be sent to employers or referrers to ensure consistency of information.
- A review of how the LADO function is operated within the Safeguarding Children and Independent Reviewing Service will be undertaken.

## Demographic Information and Background

- There are approximately 115,160 children and young people living in Sheffield with approximately 24% of children living in poverty, with great disparity across the city<sup>1</sup>.
- The city's child population is becoming gradually more diverse with 34.5% of primary and 28.4% of secondary pupils from minority ethnic groups.
- The proportion of children with English is an additional language in primary schools is 22.1% and for secondary pupils is 16.8%
- Of the school age population, there are 19.5% of infant children (reception – year 2) and 17.5% of upper secondary pupils that are eligible for free school meals<sup>2</sup>.
- There were 179 young people that accessed drug and alcohol services in the year.
- There were 31, 16 & 17 year olds that required a homeless investigation this year

## Early Intervention

Early intervention services in Sheffield are delivered through Multi Agency Support Teams (MAST). Early intervention services are those that are provided to families early after the emergence of a problem. The aim is to provide support for families and ideally once families have received early intervention services, it is hoped that they can then 'step down' back to universal services (i.e. services that all families receive). Early intervention includes a variety of services e.g. help with learning, behaviour, school attendance and parenting skills. A family may receive help from one agency or a number of them working together. In the last year, early intervention services have been expanded to include the Best Start Strategy (services for early years).

### Main achievements

- The Building Successful Families (BSF) programme has seen significant success. Phase 1 of the national Troubled Families programme (known locally as BSF) has been completed and Sheffield has "turned around" 100% of its target. Sheffield was invited to become an early starter for the expanded programme, which began in September 2014. This requires success with 5540 families over the next 5 years.
- Free Early Learning (FEL) places for 2 year olds is the provision of 15 hours a week of a free early learning place (e.g. a nursery) for those meeting a criteria. This year the number of children eligible increased. There were approximately 3263 children that benefited from a Free Early Learning place (up 59% from the previous year).
- Worked with the Early Years Safeguarding Advisors to improve the recording of safeguarding incidents in centres and updated safeguarding policies and procedures.

<sup>1</sup> <http://webarchive.nationalarchives.gov.uk/+/http://www.hmrc.gov.uk/statistics/child-poverty-stats.htm>

<sup>2</sup> For January – March 2015

- MAST received 1112 FCAFs (Family CAF) this year. The CAF is an assessment that reviews the needs of the family. The CAFs focused on approximately 2606 children. Work has focused on ensuring that the quality of assessments continues to improve.
- In September 2013 – August 2014, 59 parenting programmes were run, reaching over 600 people. 75% of parents/carers attending complete the programmes. Assessments indicate that 75% of the parents/carers completing the programmes see an improvement (reduction) in the overall stress of parenting their child.
- A Family Action Plan Tool has been developed to assess effectiveness of the interventions; indicating that 82% of the actions identified are achieved.

### What we will do next year

- The challenges of the new BSF target, the broader criteria and the expanded data requirements will require more resources from across services.
- It is likely that the number of free early learning hours will continue to increase. It will be a key challenge going forward for services to ensure there is enough capacity to support this increase in demand over the coming year.
- To continue to work with schools and GP's to identify ways of joined up working.
- Begin a new audit process to ensure the effectiveness of the FCAF.
- To ensure the new Family Action Plan Tool can further support outcome focussed working and the expanded needs of the BSF programme.



### Youth Services: Community Youth Teams

Community Youth Teams (CYT) are a multi-agency targeted young people's service, providing support for vulnerable young people aged 8-19 involved in risk-taking behaviour. CYTs work with young people in need of extra support, to improve their lives and make better choices, in order to make a successful transition to adulthood.

### Key achievements

- Provided tailored, individual support to 692 young people referred for anti-social behaviour and low level offending. Levels of complexity have increased: total referrals for aggressive violent behaviour equate to 29.8% of the total referrals; in the previous year (2013/14) it was 20% of the total.
- Provided support to 411 young people at risk of becoming NEET (Not in Education, Employment or Training) and 1453 young people aged 16-18 who are NEET. Sheffield's percentage for 16-19 year olds NEET (for November – January) was 5.9% of all CYT referrals, compared to 6.6% the previous year. The Not Known figure was 5.8%, compared to 6.3% the previous year.
- In partnership with Sexual Exploitation service, increased support for young people assessed as low-medium risk of sexual exploitation. 63 young people have been supported by CYTs, equating to 9% of the total CYT referrals; in 2013/14 it was 6.8%. This includes a mixture of one to one and group-work with a focus on healthy relationships, building self-esteem and confidence and staying safe.



- In partnership with The Corner, increased support for young people requiring access to substance misuse service. The percentage of total referrals for substance misuse (for CYT) increased from 7% in 2013/14 to 9.4% in 2014/15.
- Delivered 3442 youth work sessions in priority areas of Sheffield. This includes a mix of centre-based and assertive outreach in communities and is an average of 69 sessions per week.
- In partnership with CAMHS, introduced Primary Mental Health workers to CYT, ensuring access to specialist consultation for staff supporting young people with increasing emotional and mental health needs.

### **What we will do next**

Maintain young people's engagement in school & post-16 education, employment & training through:

- On-going monitoring and review of new delivery model for NEET young people
- Implement a model for young people pre-16 risk of NEET alongside 'Futureshapers' programme (3 year Government programme to support long term participation)

Steer young people away from crime, through:

- Implementing a pilot Community Resolution Pathway to support performance with First Time Entrants to the Youth Justice System
- Developing appropriate links with regional Liaison and Diversion work in partnership with YJS

Steer young people away from anti-social behaviour (ASB) by

- Leading on the delivery of effective support to young people involved in ASB as part of agreed partnership processes

## **Children In Need**

Children's social care receives referrals for children and young people where there are significant concerns. This year the Sheffield Social Care Assessment (SSCA) tool was introduced to replace two separate assessments (initial and core assessments). The SSCA is used by social workers when they are assessing if a child is 'In need' or has suffered, or is likely to suffer, significant harm. The social worker uses this assessment to identify what (if any) service is needed, as well as identify whether any specialist assessments are required. Social care work closely with the early intervention services and families can receive services from both in order to address their needs.

This year there have been 10,706 referrals to children's social care. The largest number of referrals came from education (19%). There were 18% from health services and 17.9% from the police. The numbers of referrals were 12.9% higher than the previous year. There were 5,249 SSCA completed.

## **Children Subject To Child Protection Plans**

A 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. It brings together family members and professionals. If it is felt 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, these are reviewed regularly (considering the progress and reviewing the risks to the child).

As at 31<sup>st</sup> March 2015 there were 363 children subject to a child protection plan, a drop of 19.7% on the previous year. The most common reason for a plan being made was for emotional abuse (60.5% of all plans made). Since 2011/12 this has been the most common reason for plans being made in Sheffield. Nationally, the most common reason for a plan starting is for neglect<sup>3</sup>.

There were 451 children that became subject to a child protection plan over the year. Of these, 56 children became subject to a child protection plan for a second (or subsequent) time (12.4% of all plans made). This remains lower than the figure for England.

There were 541 child protection plans that ended during the year, of these there were 6.5% that had been subject to a Child protection Plan for over 2 years. This is higher than last year, higher than for England and 'Core cities', but in line with Sheffield's 'statistical neighbours'.

## Youth Services: The Youth Justice Service (YJS)

The YJS works to reduce the number of young people entering or re-entering the criminal justice system in the city.



### Key Achievements

- Stronger, Safer Families programme has been developed in collaboration with Multi Agency Support Teams and Community Youth Teams with a focus on families experiencing aggression and/or violence from their teenager. In this model, parents/carers have; an opportunity to meet with other people in their situation in a non-judgemental environment; learn techniques to help them manage and reduce violence in their home; learn the importance of warning signs and how to respond when their child is violent as well as other positive parenting techniques. The young people learn that abuse isn't acceptable and they are accountable for their behaviour.
- The Sheffield YJS are the second to have achieved the Trinity College Gold Standard Artsmark Award for work and programmes delivered to young people centred around the Arts. Young people have performed at the National Youth Justice Convention, the annual 'Youth Word Up' performance (part of the Sheffield 'Off the Shelf' programme) and engaged in YJS summer Art College to gain Arts awards.
- The YJS has continued to work collaboratively with other agencies to promote effective joint working with children and young people who display or are likely to develop, Sexually Harmful Behaviour (SHB), providing them with help and intervention at the earliest opportunity.

TRINITY  
COLLEGE LONDON

LOTTERY FUNDED

ARTS COUNCIL  
ENGLAND

Artsmark is Arts Council England's flagship programme which enables schools and other organisations to evaluate, strengthen and enhance their arts and cultural provision. It is delivered by Trinity College London and supported by sub-regional bridge organisations.

### Number of referrals:

In 2014/15 the number of young people in the criminal justice system was 450 (10% rise on the previous year), there were 22 new remands to custody (37% decrease) and 21 custodial sentences (50% increase, though this was a historic low).

### What we will do next:

1. Preventing young people getting involved in crime: working alongside other services to reduce the number of first time entrants and contribute to the new all-age Liaison and Diversion Service introduced into police custody suites. This aims to identify

<sup>3</sup> All comparative figures are taken from Department for Education, Statistical First Release. *Characteristics of Children in Need in England, 2013 – 2014.*

- people with health needs and refer them out of the criminal justice system.
2. Reducing the use of custody: promoting alternative placements (out of custody and police cells) and developing a protocol to offer spare capacity across South Yorkshire.
  3. Reducing reoffending through the use of information on arrests and/or charges for crimes.
  4. Engagement and participation: re-establishing a pool of trained young advisors who have experience of the criminal justice system, to act as a reference group for us and for partners including the Police and Crime Commissioner.

## Looked After Children & Adoption

The number of children who were Looked After by the Local Authority at the end of the year was 531, similar to the previous year (537). There were 279 who became Looked After in the year and nearly the same amount (278) that ceased to be Looked After. There were 9% of children who were Looked After that had 3 or more placements during the year, lower than the last two previous years (between 12% – 13.2%)

There were 42 children that were placed for adoption in the year, with 71% being placed for adoption within 12 months of the decision that they should be placed. This is comparable with the previous two years (at 74%).

## Private Fostering

*'A private fostering arrangement is essentially one that is made privately (that is to say without the involvement of a local authority) for the care of a child under the age of 16 (under 18, if disabled) by someone other than a parent or close relative with the intention that it should last for 28 days or more ... it is the duty of local authorities to satisfy themselves that the welfare of children who are, or will be, privately fostered within their area is being, or will be, satisfactorily safeguarded and promoted'*

Replacement Children Act 1989 Guidance on Private Fostering.

### Key Achievements

- The Local Authority has continued to raise awareness of their responsibility in relation to children who are privately fostered by:
  - Sending electronic versions of posters and leaflets to council offices and schools (including language schools).
  - Giving presentations to social workers and to the psychological services.
  - Colleagues in the safeguarding team have worked with school leadership teams to ensure that they are aware of the council's website information and aware of their duties toward privately fostered children.
- The local Authority has established protocols for the provision of support through the MAST services where appropriate. All new private fostering cases are first assessed by social workers to ensure that any immediate issues or risks are addressed expeditiously.
- This year the Local Authority have sought and gained financial support for some private foster carers to enable them to make application to the court for a Child Arrangement Order (CAO) or Special Guardianship Order (SGO) so as to establish legal basis for the placement and thus negate the need for private fostering regulation, but ensuring continuing support is available where required.

As at 31<sup>st</sup> March 2015 there were 14 privately fostered children in Sheffield. The majority of these are teenagers.

## Sexual Exploitation

### Sexual Exploitation Service

The service is responsible for tackling child sexual exploitation (CSE) in the city. It is a multi-agency service and works to address sexual exploitation on four key principals; prevention, protection, pursuit and prosecution.

#### What we have achieved

During 2014-15 the service risk assessed 255 cases in the year, a 21% increase on the previous year. Of these, 70 were assessed as medium/high risk and have been allocated a dedicated support worker from the CSE team and 63 of the cases were referred to the Community Youth Teams for preventative work. The high profile nature of child sexual exploitation and the on-going efforts to ensure the children's workforce and other professionals are trained to spot the signs of CSE has contributed to a continued rise in the number of referrals to the service.

Successful prosecutions have been achieved with the involvement of the sexual exploitation service through Operation Keg with guilty verdicts for all five defendants who were sentenced to a total of 28 years.



The service has continued to be recognised for its innovative work to engage the business community in regard of child sexual exploitation, receiving an award for community engagement in South Yorkshire.

Further work has been carried out in this field in partnership with the Sheffield Safeguarding Children Board and South Yorkshire Police to secure the support of the Federation of Small Businesses for the 'Say Something If You See Something' campaign.

[www.nwgnetwork.org/](http://www.nwgnetwork.org/)

The service successfully applied for funding to deliver the Hub & Spoke programme, after a request from the University of Bedfordshire to develop the programme, which aims to share best practice locally. Alongside this the service is pivotal in the MsUnderstood Programme, which addresses peer-on-peer abuse.

The service has supported the local authority's successful social care innovation bid to develop specialist foster care for those at risk of child sexual exploitation.

The learning from Operation Alphabet witness care has been shared nationally at Project Blast's national conference in Bradford and Link to Change's annual conference in Cambridgeshire.

#### What we will do next:

- Continue to increase community engagement and awareness of CSE
- Develop further the participation of young people in service development
- Development and sharing of good practice through the Hub & Spoke Project

## Domestic Abuse

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



### Key Achievements

The community based domestic abuse services supported 5377 individuals during the year; an increase from 4893 the previous year.

The Multi-Agency Risk Assessment Conference (MARAC) is a meeting which focuses on the safety of high risk domestic abuse (including any children). This year 923 cases were heard at MARAC (up 6.5% on the previous year), involving 893 dependent children. There were 20 individuals discussed at MARAC that were aged 16 or 17 and 8 cases that involved young people causing harm.

The Domestic and Sexual Abuse Strategy for Sheffield 2014-17 was published and can be found <http://sheffielddact.org.uk/domestic-abuse/resources/local-strategies/>.

Worked with other professionals and the Children and Young People's Domestic Abuse Strategy Group on the MsUnderstood Project, to:

- Develop a 'pathway' for children and young people affected by domestic abuse in their own relationships.
- Incorporate key elements of the training and guidance offered by the national charity CAADA (now Safe Lives) into a local training programme hosted by the SSCB on working with young people affected by domestic abuse.

Sheffield DACT has again procured the High Risk Domestic Abuse service so that the Independent Domestic Violence Advocacy Service (IDVAs) and the specialist training is in one contract, enabling practitioners to better understand how and when to complete the DASH risk assessment. New investment from the Office of the Police and Crime Commissioner has enabled the IDVA service to expand by 2.5 posts.

The Domestic and Sexual Abuse Needs Assessment for Sheffield was updated and can be found at: <http://sheffielddact.org.uk/domestic-abuse/domestic-abuse-needs-analysis/>

### Domestic Homicide Reviews (DHRs)

Sheffield has published 4 reviews with 3 more progressing. The key learning points are:

- More awareness is needed of domestic abuse in young people's relationships
- The importance of exercising professional curiosity – in particular if a young person retracts an allegation
- To ensure connections with the other professionals working with young people
- If a staff member is on leave/off sick then another professional should be allocated the case.

### What we will do next:

- Continue to implement the Domestic and Sexual Abuse Strategy in relation to:
  - Finalising and embedding in practice the 'young people's pathway'
  - Developing a framework for education and prevention work in the city and promoting key messages
  - Female Genital Mutilation – working with partners to ensure preventative measures are in place.
- Continuing to work with colleagues on the MsUnderstood Programme to ensure a 'joined up' approach to Peer on Peer abuse and sexual violence
- Continue to disseminate the findings of domestic homicide reviews and promote learning around good practice.



## Children Who Go Missing

The Sheffield Runaway Action Group (SRAG) brings together key agencies to maintain an oversight of all children and young people that are missing to ensure that all relevant agencies are working effectively on robust action plans to address any identified problems.

A child or young person can be 'Missing' or 'Absent':

- **Missing<sup>4</sup>:** Anyone whose whereabouts cannot be established and where the circumstances are out of character or the context suggests the person may be the subject of crime or at risk of harm to themselves or another.
- **Absent:** A person not at a place where they are expected or required to be.

### Key achievements:

- Worked with South Yorkshire Police (SYP) to develop how missing and absent children are reported.
- Created a missing / absent report to monitor the overall numbers of children who are missing or absent as well as missing / absent episodes for specific individuals.
- SRAG created a detailed monthly 'data pack' which reports and summarises trends in missing and absent young people in Sheffield.
- Monitored those children who are 'looked after' that go missing. This includes those children who are living outside of South Yorkshire as well as those who are living in Sheffield, but are from other authorities.
- The four South Yorkshire Local Authority areas have worked with SYP to develop the Regional Missing from Home or Care and Runaways Protocol, which states the key overarching principles to which all areas will work, underpinned by local guidance and procedures.

The monthly average number of children missing or absent each month are:

	<b>Missing Children</b> <i>Monthly Average</i>		<b>Absent Children</b> <i>Monthly Average</i>	
	All Sheffield Children	Children in Care	All Sheffield Children	Children In Care
Number of incidents	150	48	66	51
Number of individuals	90	23	31	19

### What we will do next:

- Improve the timeliness of Initial Response Form completion (a form completed after any episode of missing)
- Ensure there is regular auditing of missing/absent cases
- Review the independent return interview processes (return interviews are undertaken with children and young people on their return from missing episodes)

<sup>4</sup> Interim guidance on the 'Management, Recording and Investigation of Missing Persons', ACPO / College of Policing, 2013)



## E-Safety

### Key achievements

The voice of children and young people in Sheffield continues to be central to our e-Safety strategy. Building on the work of the previous year (see the *Sheffield E-Safety Survey Report 2014*), this year the consultation was expanded to include face to face focus groups in a number of schools, across the City. **The Curriculum Focus Group Consultation Report** gives a fascinating insight into the current digital lives of some of our children in Key Stage 2 to Key Stage 4. Their views on what an e-safety curriculum should provide and at what age have been taken into consideration when producing our new model curriculum.

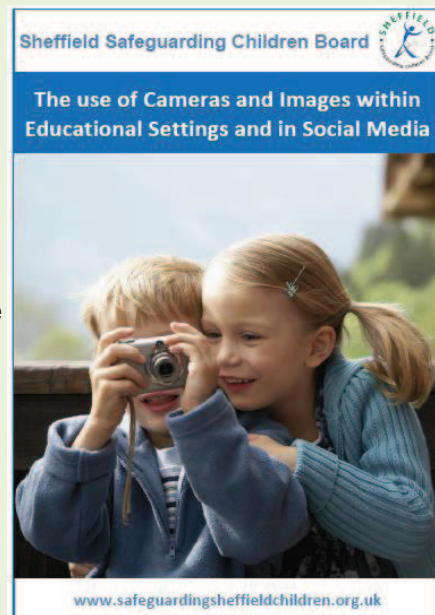
**E-Safety Curriculum Project:** A model curriculum for Key Stage 1 - 4 has been developed and has been designed to help identify opportunities where elements of e-safety, security and digital literacy can be taught at each Key Stage enabling schools to design their own flexible and progressive E-safety curriculum.

The views of children and young people, teachers and professionals all underpin the model curriculum. As a result changes have been made relating to the age when particular online risks and behaviours are introduced. From the children we established current trends in online behaviour, including the most popular websites and Apps used at Key Stages 2 to 4. They also told us:

- What they considered to be the being the most important issues and topics that needed to be included in an e-safety curriculum
- At what age they thought these should be introduced
- How these should be taught
- What support they needed and in what format.

All schools were invited to attend the events to launch the new curriculum which gave an update from the findings and access to the key documents.

**Model policy templates and guidance documents** are made available to support educational settings develop their e-safeguarding policies. This year guidance around the use of cameras and images within educational settings and in social media was produced to help them understand their safeguarding responsibilities and to ensure they comply with the Data Protection Act 1998.



### What we will do next

- Support schools to integrate e-safety in their curriculum
- Undertake e-safety consultations with children with special educational needs and their parents – to consider the current trends in the children/young person's use of social networks and media, identifying any concerns and associated risks and to consult with them regarding any education and support they require
- Extend the model e-safety curriculum to special schools

## Children Who Live in Households with Substance Misuse

The Hidden Harm Implementation group reports changing trends in substance misuse in Sheffield with fewer new opiate and crack users presenting at services in Sheffield. However we have seen increasing numbers of alcohol and non-opiate users coming into contact with children's services but few were accessing drug and alcohol treatment services. A key aim of the strategy is to increase identification and engagement with parents and carers who use alcohol and non-opiate drugs problematically (e.g. cannabis, powder cocaine, Steroids, NPS's and over the counter preparations) and assertively refer them to drug and alcohol treatment services

### **The key achievements**

- The Hidden Harm Implementation group is well represented by key Sheffield agencies.
- The Sheffield Alcohol Screening Tool has received National recognition and is seen as an example of best practice. Locally it is used by a number of different services including; social workers, family intervention workers, health visitors, GPs, pharmacists, probation workers and has resulted in a significant increase in referrals from children's services into the alcohol service.
- Drug and alcohol workers are now trained to deliver parenting programmes within both the adult and young people's drug and alcohol services. 7 programmes have been run and have evaluated well by parents. In addition a bespoke course has been developed for parents of young people who misuse substances.
- To address intergenerational drug and alcohol misuse a Transitions Protocol has been produced illustrating the need for services to be flexible to meet the needs of the young person. The WAM service has also been re-commissioned. Discussions with clients in both the adult and young people's drug and alcohol services are now identifying cases where referrals for family members should be made between services.
- Safeguarding children protocols and processes within drug and alcohol treatment services have been reviewed and updated and an annual case file review has been undertaken.

As new issues emerge they are incorporated into the Implementation Plan ensuring that actions are identified to address them, for example the increase in use of NPS by young people and adults, the recognition of links between substance misuse and domestic abuse, and the need for a whole household dual diagnosis protocol.

### **Challenges going forward include**

- Rapidly changing trends in drug and alcohol misuse.
- Organisational change in Sheffield has affected the length of time services are involved with families yet where drug and alcohol misuse is involved facilitating change can take time.
- Services are better at identifying drug and alcohol misuse within families, and now routinely ask questions about drug and alcohol misuse. However this needs to correspond into an increase in referrals into substance misuse services.

## Safeguarding and Licensing

### Key achievements

- Extended the target audience for taxi driver training to include providers of Sheffield City Council driver and escort services and provided four training sessions to existing drivers
- Developed and launched an educational resource and awareness campaign around body modification/'scratchers'
- Received an award from the Police & Crime Commissioner in recognition of partnership work in tackling child sexual exploitation. In partnership with the National Working Group for Tackling Child Sexual Exploitation, we developed and implemented the 'Participation Scheme' for local businesses (see photo from launch of the scheme). At the NWG National Annual Conference we also co-delivered a training workshop about engagement with local business communities
- Developed positive working relationships with operators in the Gambling trade in order to raise awareness of children and vulnerable people
- Completed an audit of safeguarding systems at saunas and massage parlours



### How our work impacts

We know that we have raised safeguarding awareness of people working in local businesses from the training evaluations and the consistency of complaints/enquiries that we receive. We know that we are making places safer for children and young people by improving the regulation of licensed premises in relation to safeguarding, by the number of licence conditions we achieve and the number of licence reviews in cases of problem premises. This year we investigated 91 complaints; made 45 advice visits; participated in 5 licence reviews.

### What we will do next

- Review training materials and explore accreditation.
- Work with the Licensing Authority to review the safeguarding content of its policies in relation to taxi drivers, gambling and other licensed premises
- Work with the children's workforce to improve awareness and reporting of businesses where children and young people are at risk

## Work with our Faith Communities

### Sheffield Diocesan Safeguarding Children Group

The Diocesan Safeguarding Children Officer (DSCO) has delivered a wide range of training during the last year, including:

- Safeguarding for pastoral workers courses
- Safeguarding children training sessions in parishes to 300 children's workers
- Training for Clergy on allegations management and on agreements with those who pose a risk
- Training for police and probation staff that work with high risk people and sex offenders on working with church organisations to minimise risk.

The Safeguarding Children policy and guidelines for Parishes in the Sheffield Diocese have been updated.

The DSCO, working alongside independent assessors, has examined all the files of deceased clergy for any evidence of mishandling of safeguarding issues. No issues were identified that hadn't been addressed at the time.

A Service Manager from the Safeguarding and Independent Reviewing Service continues to attend the Diocesan Safeguarding Children Group to provide advice and support on safeguarding children issues.

### Sheffield Mosques and Madrassas Safeguarding Children Project

This year the project aimed to offer safeguarding training to harder to reach community groups. Three training events were organised in different locations, with nearly 60 teachers and committee members attending. The training included safeguarding children, raising awareness about Female Genital Mutilation (FGM), forced marriage, Child Sexual Exploitation (CSE) and extremist grooming.

During this year a number of safeguarding concerns, including some 'Prevent issues' were dealt with. As part of this, meetings were held with police, parents and organisations.

To raise awareness regarding safeguarding, extremism, CSE and FGM, numerous community events and meetings were attended.

Communications were maintained with independent Muslim schools and monthly schools' community cohesion meetings were attended.

In the coming year the focus will be to offer refresher training for CPLO's from Madrassas with particular emphasis on the 'Prevent agenda'.

### The Diocese of Hallam Catholic Safeguarding Commission

The manager of the Safeguarding Service continues to attend the Catholic Safeguarding Commission. This has an independent chair and has responsibility for safeguarding children and vulnerable adults. Some of the work undertaken this year has been:

- Ensuring that there are safeguarding representatives in place across the diocese areas.
- 'Common Sense Training' in safeguarding, with the DSCO (Diocesan safeguarding colleague), to 120 children's workers
- Annual safeguarding event, with attendance by clergy, educations and parishioners.
- The SSCB Board Manager also now sits on the Sisters of Mercy safeguarding Group

## MsUnderstood Programme

MsUnderstood is a partnership between the University of Bedfordshire, Imkaan, and the Girls against Gangs project. It is a three year programme of work addressing peer-on-peer abuse, including teenage relationship violence, peer-on-peer exploitation and serious youth violence. Sheffield, one of three chosen sites across the country, is now in the second year of the programme delivery.



The programme involves:

- A local area audit of the response to peer-on-peer abuse
- A work programme of support, devised from the evidence generated by the audit process
- Quarterly monitoring updates, an annual report and a final report for the site
- Engagement of young people within the site about their experiences of, and views about, local service provision and contact with professionals

Findings from the first year are that:

*'In auditing Sheffield's response to peer-on-peer abuse it is evident that from practitioners to managers, professionals are committed to safeguarding young people. This commitment provides essential building blocks for further developing Sheffield's response over the forthcoming two years'*

A delivery model has been developed for the next two years to work with local multi-agency panels concerned with peer-on-peer abuse to link their problem profiles, identifying any trends, duplication or areas of difference.

## Use of Restraint in the Secure Estate

Aldine House is a Secure Children's Home, licensed by the Department of Education 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 works closely with its link in the Safeguarding Service.

The Home has two policy and practice guidelines which outline how the centre works to reduce the use of restraint. The method of restraint used is the "Management of Actual or Potential Aggression" (MAPA). Restraint is considered only as a last resort. Minimisation of restraint begins with a thorough recruitment and vetting process for staff, followed up with training and development. The home has the use of the Forensic Child and Adolescent Mental Health Service, which can be instrumental in providing support and advice for strategies in managing difficult cases.

When the Home accepts a referral there is a pre-admission risk assessment completed. As soon as the young person arrives on site the pre risk assessment is updated. This assessment is reviewed and revised as necessary after any incident or once a month. The risk assessment contains a section where staff can record previously used strategies, both successful and unsuccessful, in order for the Centre to be able to monitor risk behaviours for clear trends and patterns. The use of risk assessment along with the Centre's Individual Behaviour Management Programme, which uses positive praise and rewards to promote positive behaviour, an experienced staff team and the relationship ethos plays a big part in the minimisation of the use of restraint.



The number of restraints can fluctuate widely due to the residents in place at the time. In 2013 the monthly average number of restraints was 9. This year it was 20.

The restraints are always viewed by the centre manager/team (always two managers present to ensure a measured view is given). Where appropriate for lessons learned or to debrief from significant incidents a manager may choose to take the staff through the CCTV footage of a restraint and this can be seen logged in the review records. The number of restraints are monitored closely by the Youth Justice Board and reported to Ofsted. Monthly figures are also sent to the Safeguarding Service link professional, who also visits the House on a regular basis (observing CCTV images of restraint) and has been involved in staff training on restraint. The Service Manager regularly meets with the providers of the MAPA training and discusses emerging trends that can then be adapted to form part of the training. To date there have been no significant injuries.

After a restraint, the young person participates in a debriefing, which are effective in promoting the positive relationship with the young person. The Centre also discusses restraint during community meetings with the young people in order to promote discussion and transparency around restraint and to promote the resolution aspect of the de-brief. All young people are offered the opportunity to speak with the visiting children's advocate and the home automatically informs the visiting advocate that a restraint has taken place.

In the most recent Ofsted inspection, Aldine House received "Good" in all areas of the service provided for young people.

*"Restraint is only used when absolutely necessary. The home uses a method of physical intervention which does not use pain compliance techniques."* **Ofsted, July 2014**