

Sheffield Safeguarding Children Board
ANNUAL REPORT
2015 – 2016

www.safeguardingsheffieldchildren.org.uk



Essential Information

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Introduction from the Independent Chair

Dear Colleagues

This is my last introduction to the Sheffield Safeguarding Children Board Annual Report. Throughout my time as the Independent Chair I have been consistently impressed with the determination of both members of the Board and front line professionals in Sheffield to ensure best practice in safeguarding. This has been well supported by the Safeguarding Board officers and partner safeguarding leads who have contributed effectively to Board activity, driving forward Board priorities and contributing through training, development and audit.



During 2015/16 the Board has delivered on a range of projects and achievements, including:

- The changes in the child protection conference process by the introduction of the Strengths Based Approach which has been well received and in particular has strengthened the voice of the child and the family.
- The accreditation of the taxi driver safeguarding training to enable sustainability in the future and the national recognition for the work Sheffield has undertaken with the licensed trade.
- The multi-agency Themed Audit Days continue to both promote best practice and highlight where improvements and developments are needed
- One such development is the Neglect Strategy, which will create the right climate for focussed work in this area.
- The data suite for the Board enables a sharper focus on achievement and need for changes. The result of **No** young people being in B&B accommodation following a review recommendation shows efforts to take seriously the concerns from routine work.
- The child sexual exploitation participation group has been established formally and I would add my admiration of the young people who have experienced such abuse coming forward to give voice to that reality and contribute to changes in the future.

In an ever changing and challenging environment, I am confident that Sheffield Safeguarding Children Board will continue the positive work into the future.

Sue Fiennes

Sue Fiennes - Independent Chair SSCB

Introduction from the Independent Chair



I took over as Chair of the Board in April 2016 and I want to thank Sue Fiennes for her leadership in Sheffield. I have been impressed with the strength of the partnership and the strong commitment to safeguarding in Sheffield. The partners in Sheffield have demonstrated a commitment to keeping our children and young people safe and they bring a high level of leadership, skill and compassion to their work.

This annual report shows what has been achieved in the last year but there is always more to do against the back drop of challenging resources and changing structures across all partners and an increasingly complex world for our young people.

This year we will continue to give a strong focus to child sexual exploitation and female genital mutilation. We will also continue our work on improving practice and simplifying our work so that all our resource is used to meet the needs of our children and young people. We will also ensure that our work is shaped by the views and needs of children, young people and families.

Over the next two years there will be changes to the operation of Safeguarding Boards. We will ensure that this change does not impact on the quality of the service we provide in Sheffield. We will do all we can to ensure that the change helps us to improve and develop our ways of working together.

I am honoured to be asked to lead the Board at such an important time. My promise to you is that I and the Board will continue to do all that we can to ensure that children and young people in Sheffield grow up free from the fear of abuse and neglect and have happy and fulfilling lives.

A handwritten signature in black ink that reads "Jane Haywood". The signature is written in a cursive style.

Jane Haywood, MBE

Independent Chair SSCB

Section 1

How Sheffield Agencies Work Together

The SSCB: Who we are and what we do

The 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 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 is 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 2015/16 the Independent Chair was Sue Fiennes. Sue was supported in her role by a Senior Professional Advisor, a Board Manager 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 organisations 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 the 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 2015/16, 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.

➤ 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.

Achievements in 2015/2016

- The SSCB undertook a **multi-agency evaluation following the introduction of Strengths Based Approach (SBA) for child protection conferences** in June 2015. This found;
 - That conferences have a strong emphasis on parent participation and this was popular with parents/carers and professionals.
 - An interactive white board is used to record the discussion (in a grid layout) and parents/carers and professionals found this useful:

'I think it (the grid) was good and clearly explained by the (chair) before the meeting' Parent

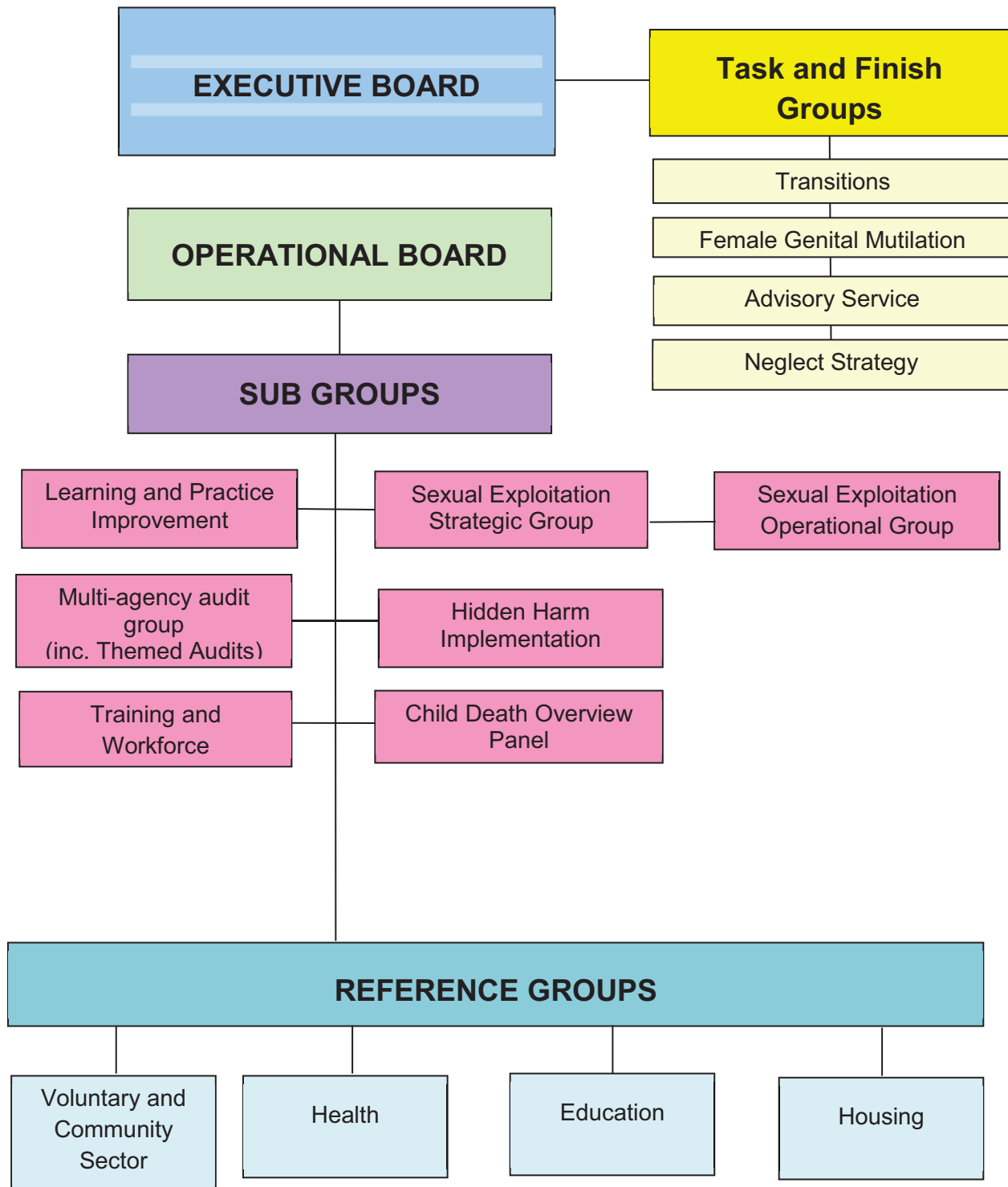
- The child's voice was evident/clear in the majority of conferences and professionals were positive of the role of the advocates.

As a result the decision was made **to expand the role of advocates** for children subject to a Review child protection conference

- Following on from the Themed Audits 2014-15, focusing on neglect, the SSCB produced a **Neglect strategy** for the city and this included:
 - Neglect strategy, poster, leaflet developed and ready to be launched in 2016/17
 - Training competency pathway developed and ready to be launched in 2016/17. This includes a 'training the trainers' single agency training pack, an e-learning module, 3 hour basic and 3 hour advanced face to face training.
 - Lunchtime seminars were held to address specific areas, including obesity and neglect, dental decay and neglect.
 - A neglect data set was developed and will report during 2016/17
- The establishment of a **young people's Child Sexual Exploitation (CSE) advisory group** that will inform delivery of the CSE Action Plan and CSE Innovation Model. The CSE Participation Group:
 - Developed and undertook peer accreditation. They will be running a lunchtime seminar on having difficult conversations with young people.
 - Published 'Pieces of Me2'.
 - Have influenced the national agenda with links to the Home Office and NWG (consultation of definition of CSE).
- The SSCB **acted on the recommendations of the Houghton report** during 2015/16 (a Review of Sheffield's Response to Sexual Exploitation, published in 2014). This was formally signed off by the Board.
- The Board was instrumental in ensuring that **CAMHS (Child and Adolescent Mental Health Services) provision was extended to age 18**. The Data Suite provided evidence that this was being actioned by services.

- **Accreditation of the taxi driver training by People First** to ensure sustainability going forward and development of an advanced taxi driver course to include safeguarding. Work with the child permits team to **formalise arrangements for child chaperones**.
- The SSCB and the Sexual Exploitation Service have **shared knowledge and experience of working with the night time economy with the Home Office and NWG**.

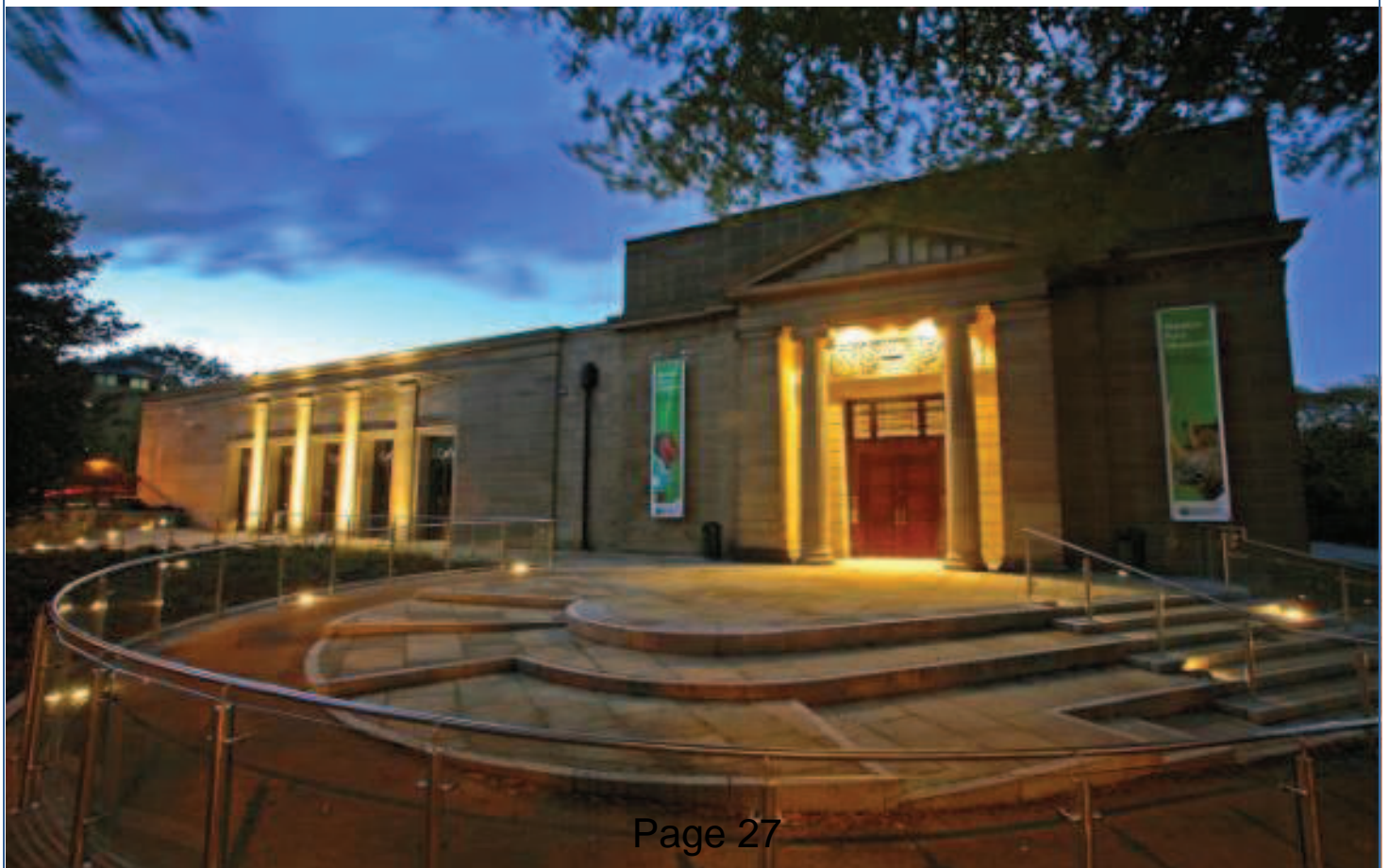
The Sheffield Safeguarding Children Board Structure



Funding of the SSCB

The Board partner agencies continue to provide the majority of funding for the SSCB. The level of funding has remained the same since 2014 (prior to this there had been a 25% reduction over 3 years). This has led to the Board using some of its reserve (carry forward) each year.

Income		Expenditure	
Carried Forward £109970		Employees	£283800
Contributions (% of funding):		Multi Agency Training	£19330
Sheffield City Council (40%)	£91200	Practice, Review & Standards:	
Health: CCG (40%)	£91200	Case Reviews	£6348
SY Police: PCC (16%)	£36600	Document production	£2480
Probation (4%)	£6500*	Signis (Procedures)	£5200
Cafcass	£500	Independent Chair	£3550
Management Charges / Income Generation	£14000	Community Advisor	£7500
Child Death Overview	£68101	Board Running Costs	£9300
Total	£418071	Carried Forward	£80563
	(* £9.5k was requested from Probation)	Total	£418071

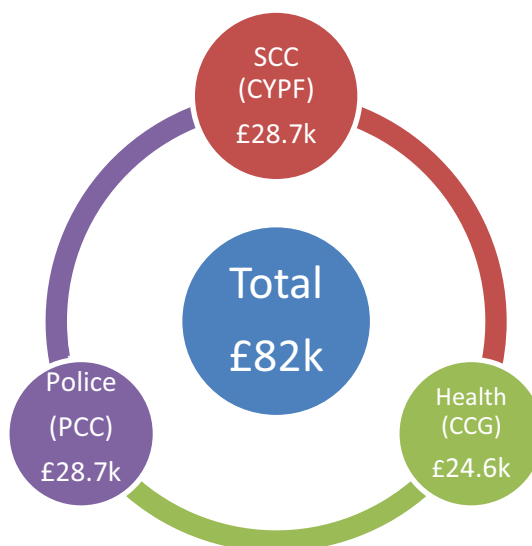


Projected Expenditure 2016-2017

Independent Chair	£17.5k
Board Manager	£57.5k
Secretariat	£15k
Operating Costs	£10k
Multi-Agency Training	
Manager & Business Support	£75k
Training, Running Costs & Virtual College	£6k
Learning & Practice Improvement	
Research & Audit Officer	£38k
Business Support	£22k
Publicity/Campaigns/Safe Sleep	£10k
SCR/CR contingency	2015/16 CF
Policy & Procedure	
Signis Local & S.Y. Procedures & Policies	£5k
E Safety Project/Manager	£52k
Community Adviser Consultant	£7k
SUB TOTAL – CORE BUDGET	£315k
Child Death Overview Processes (CDOP)	£68k
OVERALL TOTAL	£383k

SSCB Funding of the Sheffield Exploitation Service

The new Sheffield Exploitation Service was created in 2013. The amount provided by each Board partner agency has remained the same since this time.



Section 2

How we learn from what we do

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 and involves professionals, parents/carers and young people. The TADs use 'Appreciative Inquiry', which involves identifying and learning from what has worked well. There are 3 TADs each year. This year these focused on:

1. Missing Young People
2. Children and young people subject to a child protection plan where there is parental alcohol misuse
3. Neglect – where there are concerns regarding a child's weight

The results of each TAD are summarised in a Learning Brief. These are a summary of the findings and include key messages for professional practice and are available on the SSCB website.

'Thanks for these interesting and helpful learning guides. Having been part of the Themed Audit Day process recently, I just wanted to feed back what an excellent approach to multi-agency learning and improvement I think this is' A professional

This year one of the key messages from professional good practice was identifying the multiple benefits of good multiagency working, communication and information sharing. These benefits were:

- Enabling the team to build up a clear picture of historical and current concerns and risks.
- Identifying if any professional already had a pre-existing positive relationship with the child, young person, parents or carers, which other professionals could link into.
- Agreeing the best way for the team to communicate and ensuring everyone was kept up to date with any changes.
- Identifying if all key professionals had been identified and if there should be referrals to any other agency.
- Agreeing a consistent approach, with clear direction.
- Identifying when parents were not engaging (and challenging this) or where there was disguised compliance.



Impact

In January 2014 the first Themed Audit Day (TAD) focused on neglect. The information collated demonstrated evidence of good practice with positive outcomes for children. However, issues were identified that related strongly with the identified themes in the Ofsted Thematic Review of neglect published in March 2014¹, which found:

- 'Drift and delay featured in a third of all long-term cases and derived from inadequate assessments; poor planning; parents failing to engage; lack of professional challenge; and limited understanding by professionals of the cumulative impact of neglect on children's well-being and development'
- Almost half of assessments did not take sufficient account of the family history or did not sufficiently convey or consider the impact of neglect on the child. Some assessments focused almost exclusively on the parents' needs.
- The quality of child in need and child protection plans was highly variable and one third of parents interviewed did not know what would happen if the plan was not successful.
- Non-compliance and disguised compliance by parents were common features.

In response the SSCB have developed a **neglect strategy**. The purpose of this is to set out the strategic objectives of Sheffield's approach to tackling neglect. It also identifies the key principles of the work that will be undertaken. This will be

rolled out in 2016/17 and the impact monitored. Copies of the strategy, posters and leaflets can be found at:

www.safeguardingsheffieldchildren.org.uk/welcome/sheffield-safeguarding-children-board/sheffieldneglectstrategy.html

What we will do next

- Evaluate and develop the TAD process
- Involve the TAD multiagency review team and the Learning, Practice and Improvement (sub)Group in identifying the learning and recommendations from each Themed Audit



¹ Ofsted. 2014. In the child's time: professionals responses to neglect. Reference no: 140059

Why we need to prevent neglect in Sheffield

Neglect impacts on all children irrespective of their age, gender, and ethnicity and irrespective of where they live. Neglect may occur before the child is born as a result of maternal substance misuse.

Tackling neglect will make a difference and help prevent the serious long term consequences of neglect which includes;

- Poor growth and physical development/delayed learning
- Poor attachment
- Poor language development
- Untreated dental decay
- Poor ability to play, socialise and learn
- Behavioural problems in later childhood
- Adolescent violence and anti-social behaviour
- Increased likelihood of suicidal thoughts and attempts in adolescence
- Mental health problems in adulthood
- Difficulties parenting their own children
- Severe neglect can result in the death (including as a result of suicide) of a child or young person



Multi-Agency Case Review Sub Group

The aim of the multiagency case review subgroup (CRSG) 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. Agencies involved over the last year have included – schools, health, children's social care, early intervention and prevention services, youth justice, and domestic abuse services.

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

- Clear evidence that universal services are providing excellent levels of support to children and families, for example, through pastoral support at schools.
- Domestic violence is being recognised and responded to by frontline practitioners

Impact

In one case the audit team identified a high number of health contacts for a child that raised concerns – in response to this a chronology of health contacts was undertaken and the significant learning from this has been shared with health providers.

In response to the case review audit, children's social care has included a section focusing on 'day in the life of the child' within the single social care assessment. This is supported by an information sheet that provides prompts and asks the worker to include; comment of what

happens in each part of the day (ie. routines); what food is provided/available; what resources/toys/activities are available to the child etc. The impact of this is to focus social workers assessment very clearly around the child, which will inform the assessment and focus any intervention more clearly as a response to this.

Neglect featured in the majority of the cases. However, in approximately 61% of these professionals focused on the emotional abuse. In response, the group has recommended that in Child Protection Conferences all practitioners, under the guidance of the Child Protection Chair, re-focus on the categories of abuse to more accurately reflect the risk of harm and the impact on the child of parental behaviour. The impact of this has been noted through the SSCB Data Suite with the proportion of cases of child protection for neglect increasing, thereby refocusing professionals onto the neglect concerns in order for these to be addressed at the earliest opportunity.

Learning from the audits

The findings from this group feed into the Learning Practice Improvement Sub-Group and the Training and Workforce Sub group.

- There is a need to focus on the performance of timeliness of Child Protection Conferences, including
 - Timeliness of a case being considered to have met the threshold for a Child Protection Conference
 - Timeliness of the convening of an Initial Child Protection ConferenceThis is being taken forward by the Safeguarding Service
- The majority of cases showed some element of resistance to engage. The multi-agency audit group noted that a degree of resistance is acceptable and expected but that the workforce needs to recognise when this becomes a concern and is having an impact on the outcomes for the child. This area will be addressed within the Neglect training to run during 2016/17.
- The audit group noted the need for front line practitioners across all organisations to be equipped to have the confidence to make evidenced based professional judgements. There was a recognition of the need for good, consistent, reflective supervision to be provided. In response multiagency supervision training is being developed by the SSCB.

What we will do next

- From the audit of case files it was difficult to evidence the influence and impact of the child's voice in the planning and decision making. However, when professionals attended (that worked with the child and family) it was clear that they knew the child well and understood their views and wishes. This has also been noted within the Themed Audit Day process. There is a need to work with front line practitioners to capture the child's voice and how it influences the direction of their work.

The SSCB Multi-Agency Data Suite

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

An extensive multiagency data suite has been collected quarterly for 2 years. This focused on:

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

Each quarter a multiagency review team has considered the data. The outcome of this discussion has fed into a report that is included in the Executive Board Data Dashboard.

Through this, the Board has gained a broader understanding of safeguarding areas, for example, the number of cases reviewed at MARAC (Multi-Agency Risk Assessment Conference) where information is shared about high risk domestic abuse cases is in line with, or just above, the number expected for the population size. However, the number involving children, each quarter, has increased since the start of the data collection. This demonstrates professionals' recognition and response to this issue and the significant numbers of children this involves.



Impact

Housing services provide support to young people. Following a CDOP (Child Death Overview Panel) Case Review in 2014, one recommendation was that young people were not housed in B&B accommodation. This was considered as part of the data suite and this evidences that no young people have been given this type of accommodation.

The proportion of children's social care single assessments completed in timescale was low and had been highlighted within the data suite in the previous year. Children's Social Care were aware of the issue and by the end of this year it had increased by 16%.

What we will do next

- Change the focus of the data suite onto 5 Board priority areas (expanding the data collection in order to ensure an in depth analysis of each):
 1. Child Sexual Exploitation
 2. Neglect
 3. Transitions
 4. Thresholds and Timescales
 5. Substance and Alcohol Misuse
- Change in process, to enable both Boards to gain more of an understanding of safeguarding performance across the city, from 2016/17 the data suite will be tabled at the Operational Board and a short report of pertinent points will be included within the Executive Data Dashboard.

The Child Death Overview Panel (CDOP)

The Child Death Overview Panel reviews the death of any Sheffield child. There were 53 child deaths (Sheffield residents) from 1st April 2015 until 31st March 2016, which is a slight increase from the previous year (49 child deaths). During the year there were 8 CDOP meetings and a total of 55 child deaths were reviewed (not all deaths can be reviewed in the same year).

Impact

- **Reducing the Incidence of Sudden Infant Deaths (SIDs, formerly known as cot deaths):** This work began in 2012 with the aim of reducing Sheffield's incidence of SIDs to below the national average by 2020. This year the work has focused on disseminating the safer sleep message through information sharing with specific community groups and training professionals. A Safer Sleep event (attended by over 60 professionals) demonstrated that the majority of attendees felt this led to them feeling better informed and more confident to deliver the safer sleep message. In addition there was a presentation to GPs focusing on reinforcing the Safer Sleep messages when babies are seen with minor illnesses. An audit of MAST (Multi-Agency Support Teams) professionals demonstrated the need for further training in this area and in response to this 'Safer Sleep Champions' have been appointed and training is being developed to improve staff awareness.
- **Rapid Response:** the focus of this work has been to improve the systems in place to ensure a smooth response to any unexpected death. This has been achieved through:
 - the sharing of the initial post-mortem results to inform early multiagency meetings.
 - to ensure the easy identification of the Senior Investigating Officer to enable improved communication between the police and health staff.
 - the training of police and hospital staff to improve their knowledge and compliance with the procedure.
 - a two way information sharing process being agreed with the Medical Examiner. The information received can be used to identify how and when a home visit should be undertaken.
- **CDOP recommendations:** have led to the development of a step down process to ensure that children and young people being discharged from CAMHS would receive an automatic referral to early intervention services. This ensures that these children and young people continue to receive support and a smooth transition back to universal services.

What we will do next

- Early Multi-Agency meetings following an unexpected child death will become embedded in practice
- The numbers of child deaths being reviewed within a timely manner will be improved
- CDOP will work with Sheffield Safeguarding Children Board (SSCB) to implement the recommendations of the Wood review of LSCBs, including CDOPs
- To review infant mortality cases and preventability, in order to continue to reduce infant mortality.

Review of Sheffield's Response to Sexual Exploitation

Following the publication of the Jay Report in August 2014 the SSCB was commissioned by Sheffield City Council and its partners to undertake an independent review focussing on how effective Sheffield agencies were in achieving the city's strategic aims in tackling CSE (including the operation of the multi-agency SSES) and benchmarking practice against the Jay recommendations to ensure agencies were providing the most responsive best practice. This was overseen by an independent consultant, and reported in 2014 (the Houghton report).



This review looked at many aspects including leadership and governance, multi-agency CSE self-assessment, compliance with Ofsted Annex A requirements, evaluation of processes, procedures and tools, evaluation of the CSE training programme, staff survey on training and support, an audit of cases and a young people's panel. The review identified 44 areas of strength and 16 areas for development.

Following the review an action plan was developed focussing on the areas for development and was implemented through the CSE Strategic Group with governance through the SSCB Executive Board. The action plan was finalised in December 2015.

Significant developments included:

- A Sheffield CSE strategy was agreed by all partners:
<https://www.safeguardingsheffieldchildren.org.uk/Safe-Home/welcome/sheffield-safeguarding-children-board/Sexual-Exploitation-Service>
- A new referral pathway was developed between Children's Social Care and the Sexual Exploitation Service to ensure all concerns regarding CSE are screened through Children's Social Care to ensure a holistic assessment is undertaken
- A comprehensive data set was produced to provide greater information about CSE activity and partner responses and enable robust scrutiny
- Practitioners and elected members in the city have access to the National Working Group website which provides information, guidance and training
- A specific CSE policy was developed for schools and all schools have a CSE lead
- A young people's participation group was formed that has contributed to the national CSE agenda and informed local practice
- Friend or Foe (a resource pack for practitioners) was re-published to ensure it remained relevant and current

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 are discharged having regard to the need to safeguard and promote the welfare of children. Working Together to Safeguard Children, 2015

Local Safeguarding Children Boards have a responsibility to ensure that Board partner agencies are meeting all the requirements of Section 11. In Sheffield this is undertaken every 3 years. In the intervening years specific work is undertaken that relates to Section 11. This year the focus was on ensuring that all partner agencies have training pathways and recording processes in place for their organisation.

Impact

The impact of ensuring that training pathways and recording processes (of attendance) are in place ensures that the workforce are receiving relevant safeguarding training and the agencies are able to respond if they realise there is an issue in relation to attendance. Where specific additional training is developed agencies are ensuring these opportunities are communicated with staff and uptake monitored.

What we will do next

- Undertake the full section 11 self-assessment



Children's Workforce Questionnaire

The Children's Safeguarding Performance Information Framework (2015, DFE)² describes 'The key nationally collected data that can help those involved in child protection at both the local and national levels understand the health of the child protection system. It also describes recommended questions that can be asked of children, families, professionals and providers at a local level. Taken together they give a richer view of the effectiveness and impact of child protection including early help services'

In response to the Performance Information Framework, the SSCB developed an online Children's Workforce Questionnaire. This included relevant questions from the recommended 'locally collected information' as well as those relating to Section 11 requirements (Section 11 of the Children's Act, 2004) and other Board priority areas.

² DFE Reference: DFE-00016-2015

This online questionnaire was distributed widely across the children's workforce and the **SSCB received 1033 responses**.

The results highlighted a number of strengths, including that:

- 97.3% of professionals knew who to go to in their organisation if they have any safeguarding children concerns.
- 98.7% were quite/very clear about their professional role/ responsibilities in relation to safeguarding children and young people

It also identified issues that need to be addressed. For example, although policies or procedures maybe in place (a requirement of section 11), in some agencies there was a significant minority of staff that have not seen or read these. Agencies have been informed and are actively addressing issues identified through action plans, which are being monitored by the Board.

The questionnaire results have also highlighted some training needs as professionals have indicated that they do not feel confident in responding to specific safeguarding issues. These are being addressed through a single and/or multiagency response.

What we will do next

- Monitor agency action plans
- Develop the Board's response to the areas identified

Review of Health Services for Children Looked After and Safeguarding in Sheffield (Care Quality Commission)

The Care Quality Commission is required to review children looked after and safeguarding (CLAS) services commissioned and provided across England.

In October a team of 4 inspectors came to Sheffield to carry out the CLAS review. They tracked 10 specific cases and dip sampled other cases in each of the healthcare settings they visited. In total the records of 97 children were reviewed.

The inspectors visited a wide variety of settings across all 3 provider trusts and primary care. These included adult mental health services, CAMHS, drug and alcohol services, midwifery, health visiting, school nursing, adult and children's emergency departments, looked after children services, GP practices and sexual health services.

The inspectors focussed on 6 key areas which were: early help, children in need, child protection, looked after children, leadership/ management and training/ supervision.

The CQC reported on many areas of good practice in Sheffield. They made 29 recommendations, none of these required immediate action. The recommendations focussed on strengthening information sharing, multi-agency working, pathways and supervision.

All actions are being monitored by the Clinical Commissioning Group with regular updates provided to the SSCB

Multi-Agency Safeguarding Training

The Training and Development team develop and deliver a range of multi-agency safeguarding training events available to all practitioners working with children and young people in Sheffield. A range of training methods is used including conferences, seminars and e-learning. Topics can be offered in response to safeguarding concerns, as a result of audit activity or to address emerging issues.

New courses this year included:

- Hidden Sentence: understanding the support needs of children of prisoners
- Young People and Intimate Partner Abuse
- Working with resistant families and 'disguised compliance' to agencies offering 'early help'

Regionally there was also an involvement in the Yorkshire and Humberside Safeguarding Training Regional Conference in Doncaster on: 'That Difficult Age: The Journey Through Adolescence' and nationally, safeguarding support was given to the 'Let's Get Cooking' scheme.

Impact

Through the comprehensive training offer, **11,924** practitioners and **1,250** parents/carers and young people have gained a deeper understanding of safeguarding issues. The impact of this training can be evidenced through:

- The preparation of professionals for the change in the way that child protection conferences were run as the Strengths Based Approach was introduced in June 2015. This was through a mixture of direct training and a 'training the trainer' approach (these trainers went on to deliver in house single agency training to conference attendees) and reached 364 professionals. This changeover was successful and professionals reported many positives of the new system.
- 200 professionals attended the 'Keeping children safe: understanding, recognising and responding to child neglect' conference. At the end of this conference professionals reported:
 - an increased understanding of neglect, and
 - an increase in how confident they felt in recognising the signs of neglect in children and young people.
- Relating to the Houghton Report (2014), 132 schools attended 'Training for Trainers' CSE events. These sessions prepared each attendee to offer training to other school staff and also to develop programmes to increase pupil awareness. In addition, parents/carers that attended the awareness raising 'Keeping Your Child Safe: What Parents/Carers Need To Know' reported the value of the information, particularly around e-safety with 100% reporting they found the event useful.

'Attending today raised my awareness of the real impact of neglect on children and the need to share information with other agencies in order to intervene and support families quickly'

What we will do next

- Delivery of a series of briefings aimed at managers around thresholds of need, information sharing, challenge and supervision.
- Current threshold guidance will be reviewed and revised and accompanied by a programme of training for a multi-agency audience and a training package developed for single-agency use (following the training roll-out model).
- In relation to the Neglect Strategy, to develop specific 'Training the Trainer' and targeted Neglect training.

Allegations against Professionals Report from the Designated Officer

The Designated Officer 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 Designated Officer should consider.

This year a referral form has been developed and is sent out to those to ensure a consistency of information is collected on all referrals in.

Impact

Out of over 200 enquiries, there were 47 cases that have met the scope as set out in *Working Together to Safeguard Children (2015)*. The majority (24) of these were from schools or other education based establishments with the most common query in relation to the use of force by school based staff.

Section 93 of the Education and Inspection Act 2006 states that reasonable force can be used to prevent a child harming self or others, prevent damage to property or maintain the good order and discipline of the school.

Of the allegations within scope the majority refer to concerns relating to physical harm (53%), sexual abuse (26%) or inappropriate behaviour towards a child (15%).

In 18 cases no further action was taken. In 17 cases the person received a response from their employer (dismissed, written warning or employer ceased using them) or the person has resigned. The remaining cases are ongoing.

What we will do next

- Develop a dedicated Designated Officer/Prevent Coordinator post within the Safeguarding Service

Children and Young Peoples Involvement

Recruitment of the new SSCB Independent Chair

Sheffield Young Advisors assisted in the recruitment of the new Independent Chair. To prepare for this they met and discussed what they felt were the safeguarding issues that should be addressed, read the annual report, the job description and person specification. They met with the Professional Advisor to the Board to prepare their questions and they used these in the interview with the candidates. After this they provided valuable feedback to the interview panel. Candidates remarked on the intelligent, challenging and robust questions they asked:

'It was very helpful to meet the young people and answer their questions about my experiences and views. They were well prepared and thoughtful and showed me the issues that are of importance to young people in Sheffield. I will continue my discussions with them during my role as Chair' Jane Haywood, New SSCB Independent Chair



Online Safety

This year a model online safety curriculum for Sheffield primary and secondary schools was launched. Over 130 people attended the events which were held jointly with the Sheffield E-Learning Team. Teachers from two schools were able to demonstrate how they have successfully adapted the new model curriculum in their schools. Consultation with children, parents, teachers and other professionals has been a key element of producing the guidance. The online safety curriculum provides guidance to schools to enable them to integrate online safety education within their existing Personal, Social, Health and Economic (PSHE) and computing programmes of study. It has been designed to help identify opportunities where

elements of online safety, security and digital literacy can be taught at each Key Stage so schools can design their own flexible and progressive online safety curriculum.

This year work began on developing a curriculum that can be accessed by children and young people with special educational needs. Alongside representatives from special schools and schools with integrated resources, online safety and how it can apply to the three main areas of Personal, Social and Health Education (PSHE) were considered. The project also included the views of the young people and their parents through focus groups to ensure there is an understanding of their online presence and usage. The impact of this will be that conversations around online safety and other related topics will be accessible to all children and young people.

Article in Optimus Education, Special Children. Meeting Children's Additional Education Needs. March 2016

Staying Safe Online

'Special school children

There was considerable overlap between the two groups, with the same age-inappropriate games being played, and the same issues being raised. One significant difference lay in the fact that while some children made regular use of the internet, others were denied access by their parents in the interests of safety. While that is very understandable, the day will come when these children will want to do the same things as their peers, or they will find a way of getting access for themselves. So we need to start teaching e-safety at a basic level and build their knowledge up'

Sexual Exploitation

There are a number of extremely articulate and brave young people whose risk of exploitation has reduced but they continue to work with the service. This year they became Sheffield's first CSE Participation Group and have enrolled to become accredited CSE Young Advisors. They have been involved in the National Working Group's participation group, helping to youth-proof the #Saysomething campaign, aimed at increasing awareness and reporting of CSE. They also met with Karen Bradley MP, Minister for Prevention of Abuse and Exploitation to help understand the needs of young people at risk of being exploited. In addition they have supported work on the NICE guidelines for violence in teenage relationships

Section 3

Safeguarding Children in Sheffield

Sheffield Safeguarding Overview

115,841 children live in Sheffield, 20.3% of the Sheffield population

22.7% of 0 – 16 year olds live in poverty in Sheffield (2012/13, 18% in England), with large disparities across the city.

19.2% of primary children are entitled to and claiming free school meals and 17.2% for secondary (England: 14.5%: 13.2%)

34% of children within local authority schools are from minority ethnic groups.

19.9% of school aged children have English as an additional language

14 under 18 year olds required a homeless investigation this year

14,854, 2 – 4 year olds were receiving 15 hours a week of Free Early Learning

1183 Family CAFs (assessment) were received by early intervention services, focusing on 2793 children

650 Young People were supported by Community Youth Teams on a 1:1 basis

941 cases were heard at MARAC (high risk domestic abuse cases), involving 1123 children

26 young people (16/17 year olds) were referred to MARAC as victims of domestic abuse

92 Sheffield children went missing, with a total of 139 missing incidents

76 complaints relating to licensed premises were investigated, 5 licence reviews undertaken & 22 advice visits made to licensed premises

6348 Referrals were made to Children's Social Care

4839 Sheffield Social Care Assessments were completed

432 children became subject to a child protection plan over the year with 50% of all plans made for neglect

183 children at initial child protection conferences were represented by an advocate

341 young people received one or more criminal justice outcomes

6 new remands to custody and 11 custodial sentences

531 children were looked after by the Local Authority at the end of the year

65 children were placed for adoption in the year

15 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 protection team

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

Early Intervention

Early intervention services are provided through Multi Agency Support Teams (MAST) and provide support for whole families, early after the emergence of a problem. Once they have received this, it is hoped that families can 'step down' back to universal services (i.e. those that all families receive). Early intervention can include help with learning, behaviour, school attendance or parenting skills. A family may receive help from a number of agencies working together.

Impact

Phase 2 of the Building Successful Families (BSF) requires success with over 5000 families over the next 5 years. All families identified have at least two of the following concerns; crime and anti-social behaviour; education; child who needs help; financial exclusion & homelessness; domestic violence and health issues. 92 have achieved success to date, which requires families to maintain their progress without continued intervention, (31 have sustained employment).

The proportion of eligible 2 year old children accessing 15 hours a week of Free Early Learning (FEL) (e.g. a nursery) has increased to 62.3% this year (60.6%, Spring 2015). The provision of 3&4 year old FEL has also increased to 93.6% in Spring 2016 (90.9%, 2015). Overall the number of children accessing FEL has risen from 14,444 (spring 2015) to 14,854.

The Prevention and Early Intervention service works with schools to develop early help to families in schools. MAST have delivered drop-in advice sessions for parents, workshops, meetings across families (groups) of schools to discuss cases and to provide support and train school staff to ensure that children and their families get good quality early advice and support at the earliest opportunity. The impact of this is that more children and families are being supported (through early advice sessions or workshops) and there have been fewer requests from GPs for children attending these schools.

The FCAF (Family CAF) is an assessment that reviews the needs of the family. MAST received 1183 FCAFs this year focusing on approximately 2793 children (2606 children 2014/15). Work continues to improve the quality of assessments, for example, schools that have successfully used the FCAF are helping to facilitate wider use and better quality FCAFs, enabling services to provide more effective support at an earlier stage.

A new Family Action Plan Tool has been rolled out to assess the effectiveness of early interventions with families. The Intervention Worker and the family agree outcome focussed actions, the types of intervention and the success of that work. The results indicated that 79% of the actions identified have been achieved.

What we will do next

- The broader criteria of the BSF programme and the expanded data requirements will require more resources to ensure targets are met.
- Launch the locality (local area based) services across the city, through a number of facilitated events to share experiences.
- Launch a new model of delivering parenting intervention that will enable parents to attend appropriate groups to their needs.

Community Youth Teams



Multi-agency targeted young people's service, providing support for vulnerable young people aged 8-19 involved in risk-taking behaviour.

CYT have supported over 650 young people on an individual 1:1 basis offering support on a range of issues including offending and anti-social behaviour; gangs; sexual exploitation; domestic abuse; community cohesion issues.

There has been an increase in referrals for young people around sexual harmful behaviour (SHB) which includes behaviours such as sexting, sending sexual images, inappropriate sexual language. The CYT staff completed SHB training and it will now support low-level SHB cases.

Impact

The service provided support to 152 young people at risk of becoming NEET (Not in Education, Employment or Training) and 1335 young people aged 16-18 who are NEET. Sheffield's NEET figure is now at an all-time low of 5.4%.

Community Youth Teams supported 28 young people that were subject to an Anti-Social Behaviour Contract (ABC), the impact of this work was that 86% did not go on to offend, compared with a reoffending rate of 51% for those without this support.

Community Resolution Pilot is a new scheme worked in partnership with South Yorkshire Police, which ran in the North East area of the city. This area was chosen as it has the highest First Time Entrants (into the criminal justice system). The work targeted young people, generally in school, for low level offences and negative behaviours, issuing them with a Community Resolution as an alternative to a 1st Youth Caution or as a route to engage with CYT. This commenced as a 3 month pilot but was reviewed and extended to the end of the school year (2016). 165 young people were supported through this scheme.

CYT worked with young people that have been assessed as at low- medium level of risk of sexual exploitation. This year 56 young people were supported and interventions focused on healthy relationships, online safety, staying safe and building self-esteem and confidence.

Over the year 68 open access youth work sessions were provided across the city. This includes youth centre based provision, detached street based sessions and a 'rapid response' service where detached youth workers are deployed to a 'hot spot' area where ASB concerns are raised by SY Police/SY Fire and Rescue/Council. 6558 young people accessed open access centre based and detached youth work sessions in 15/16.

A Liaison and Diversion practitioner offers support to young people within CYT who have had contact with the police, to identify and respond to unmet health need which may be an underlying factor in relation to offending behaviours.

In the **Partnership Working Award** category, our multi-agency project, led by the Community Youth Teams (CYT) with the Accident and Emergency Department at the Northern General Hospital, was highly commended after becoming a national finalist in the Children and Young People Now Awards, 2015. The '*Pathway for Vulnerable Young People*' project aims to ensure that all 16 - 19 year olds who visit Accident and Emergency with additional needs are offered

appropriate individual support that reduces their risk-taking behaviour. This has been effective and is now planned to be introduced at the Sheffield Children's NHS Foundation Trust.

What we will do next

Steer young people away from crime through:

- Implementing the new Asset Plus assessment process to ensure young people's needs are fully understood, and intervention plans to reduce risk are robust and jointly developed with young people and their families.
- Develop group interventions which work with peer groups to reduce risk and promote resilience
- Implement new referral and support systems for Looked After Children



Children in Need

Children's social care receives referrals for children and young people where there are significant concerns. Where concerns relate to child sexual exploitation (CSE) the CSE screening tool is used to assess risk (as recommended by the Houghton Review, 2014)

Children's social care are co-located with the multi-agency support teams which ensures that, on contact, families and professionals are signposted to the most appropriate support. Children's fieldwork services have increased the number of experienced social workers in the fieldwork screening teams. At the contact stage information is gathered to ensure that risk is identified, assessed and managed. The Sheffield Social Care Assessment (SSCA) tool 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, as well as identify whether any specialist assessments are required. The SSCA includes the 'Day in the life of the child' section, included in response to the work of the Case Review Sub Group.

This year there have been 6348 referrals to children's social care. The largest number of referrals came from education (19%), health (19%) and the police (17%). The numbers of referrals were 41% lower than the previous year (10,706).

In the last year there were 4839 SSCA completed (76% of referrals leading to a SSCA) and of these, there were 1485 that were Child In Need.



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.

As at 31st March 2016 there were 363 children subject to a child protection plan (an increase of 0.8% on the previous year). The most common reason for a plan being made was for neglect (50% of all plans made). This in line with national findings (42% of those made in England³). There were 432 children that became subject to a child protection plan over the year. Of these, 49 children became subject to a child protection plan for a second (or subsequent) time (11.3% of all plans made). The numbers of subsequent plans made remains lower than the figure for 'statistical neighbours', 'core cities' and for England.

There were 428 child protection plans that ended during the year, of these 40 (9.35%) had been subject to a Child Protection Plan for over 2 years. This is higher than for England (3.7%) and Core cities (3.7%). The total number of children on plans for over 2 years has been gradually decreasing, with 8 subject to a child protection plan at the end of year (there were 24 as at 31st March 2015).

Introduction of the Strengths Based Approach (SBA) to Child Protection Conferences

This year saw the successful introduction of Strength Based Approach to child protection conferences. The key elements of this are that:

- Parent and child involvement is key
- Families and communities are seen as key resources in protecting children
- All reports are shared with parents in advance
- Strengths and risks are identified with families
- Child protection conferences concentrate on creating an outline plan and this is solution focussed and outcomes led
- The outline plans are developed using a whiteboard and simple grid system. Detailed plans are created in the Core Group meetings that follow

SSCB Review of SBA conferences

As this was a significant change to the way child protection conferences were undertaken, the SSCB undertook an independent multiagency review of this. This involved professional and parent feedback questionnaires, 5 single agency focus groups, observations of conferences and an audit. The results demonstrated that the new conference process was very popular, in particular the increased involvement of parents/carers, the use of the interactive white board and the 'grid' (a table on the whiteboard in which the conversation is recorded within different sections). The evaluation also raised some areas that require further development and as the evaluation took place when the new SBA conferences had only just been implemented, the plan is to repeat this again in one years' time.

Independent Advocacy for Children in Child Protection Conferences

The Children's Involvement Team provide independent advocacy for children aged 5 to 17 at their initial child protection conference. The advocate meets with each child on their own, as many times as necessary, before the conference. The advocate can accompany a child into a conference, though in the majority of cases the advocate attends 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. After the conference they meet with the child to feed back to them about the outcome of the conference and the Plan.

³ All comparator figures are from 31st March 2015 <https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2014-to-2015>

During 2015-16 there were 295 referrals received and 62% (183) were advocated for:

- 37% between 5 – 8 years
- 35% between 9 – 12 years
- 28% 13- 17 years

The main reasons for a child not being advocated for include parents refusing to give consent or a child opting out.

Impact

During each feedback visit, advocates ask each child to complete an evaluation form and the positive impact of having advocacy has clearly been explained by the children:

'I think it's been great having an advocate because she helps me and talks about what is going to happen and I feel safe talking with her'

'It has been helpful because everything I want people to know but I don't have to tell them and feel uncomfortable'

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

Children's advocate discussed wishes and feelings of the children. This had a real impact and brought the children into the room, making it real. Advocate was excellent at keeping the children at the centre of the process' Observer, SSCB Review of SBA conferences, 2015

What we will do next

To extend advocacy in order to offer this service to children and young people at 50% of first review conferences. A triage system has been developed to identify cases to receive this extended service.



The Youth Justice Service (YJS)



Works to reduce the number of young people entering, or re-entering, the criminal justice system in the city.

There were 341 young people receiving one or more criminal justice outcomes this year, a decrease of 24% the previous year (nationally there has been a 23% decrease). There were 6 new remands to custody (a 73% decrease) and 11 custodial sentences (48% decrease; nationally there has been a 14% decrease).

The young people that the service works with can have significant and complex needs, many with attachment, trauma and developmental problems. To respond to this the service has received training in acquired brain injury and its effects on behaviour and also the Desistance and the Good lives model, which promotes a strengths-based approach to assessment and interventions which supports the development of capabilities in young people to reduce their risk of reoffending.

Impact

The service contributed to the formation of a new youth Liaison and Diversion service, now established within a new custody suite in the youth crown courts. It provides assessment and support for young people at the point of entry into the criminal justice system. The impact of this is to ensure that those with mental health, learning disability, substance misuse and other vulnerabilities are identified as soon as possible and are provided with and supported in accessing appropriate services. Community Youth Teams can also provide interventions. Information is also shared with relevant agencies to inform decisions on diversion, charging, case management and sentencing which reduces first time entrants or re-offending.

Within the YJS premises, an Engagement Team has been developed and has worked to reduce restless, abusive and negative behaviours within the building. This has resulted in a significant drop in the number of serious incidents which has provided a better environment and service for the young people, staff and visitors.

The YJS has also led on the development of a South Yorkshire protocol for the use of PACE (Police and Criminal Evidence Act 1984) accommodation. The impact of this is to reduce the time that a young person spends in police detention and ensures that whilst the police complete their essential process they take account of their vulnerability. All four local authorities/children's trusts, all four youth offending services and South Yorkshire Police have signed up to the protocol

What we will do next

1. Preventing young people getting involved in crime by reaching a target of 194 individuals a year.
2. The proportion of youth justice disposals going to young people of BME backgrounds continues to rise and this group are over-represented. To undertake 'journey mapping' to identify if opportunities for earlier intervention are being missed, or if these young people are being dealt with differently.
3. The development of a new Systemic Family Intervention Team will provide case management, supervision and intervention for families. A primary function will be to ensure

that young people with sexually harmful behaviour are supported where possible to safely remain in their families.

4. To review the 'Support for children in care, preventing offending and anti-social behaviour' protocol between the Police, CPS, Sheffield City Council and YJS.
5. Introduction of the new Youth Justice assessment and planning tool, Assetplus, (linking in with the findings of the MsUnderstood programme).

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 House has gained credibility by accepting young people who are nationally difficult to place. The Department for Education are aware of this and are supportive of what this means for Aldine House and the number of restraints.

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.), which are BILD accredited techniques. Restraint is considered only as a last resort.

All incidents at Aldine House are scrutinised internally, viewed by the Duty Manager and Service Manager with a view to providing feedback regarding the incident. As part of the therapeutic rapport with young people, following a restraint, the young person will be supported to participate in a debriefing, which are effective in promoting positive relationships with them. All incidents are monitored closely by the Youth Justice Board and reported to Ofsted. In addition, monthly figures are sent to the Safeguarding Service link professional, who visits the Home on a regular basis and has been involved in staff training on restraint. To date, there have been no significant injuries.

One of the main achievements this year has been the implementation of a renewed data management system, which sends electronic emails to notify stakeholders about incidents automatically and allows us to manage data so that trends can be identified.

The number of restraints can fluctuate widely due to the residents in place at the time. This year, the monthly average number of restraints (over 11 months) is 49, with 90% of these lasting less than 3 minutes.

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.

In the most recent Ofsted inspection, Aldine House received "Good" with "outstanding and excellent" features and our management of restraints was mentioned within the final report:

"Restraints are well managed and only occur in line with the individual behaviour management plans and regulations. Events are swiftly examined through the CCTV system, assessing both safety and effectiveness of the restraint." Ofsted, October 2015

Looked After Children & Adoption

The number of children who were Looked After by the Local Authority at the end of the year was 532, which is similar with the previous year and is lower than all comparator groups, (to be in line with other Core Cities Sheffield would need to have in excess of 1,000 Looked After children). There were 255 children and young people who became Looked After in the year and a similar amount (269) that ceased to be Looked After. At the end of March 2016, 45% of children admitted to care were taken into care (i.e. not accommodated under section 20 Children Act 1989), higher than all comparator groups.

There were 17% of children who were Looked After that had 3 or more placements during the year (9% in the previous year). Children remaining in the same placement, for 2 years or more, remains at 71% (better than comparator groups). During this year we have seen a steady rise in the demand for placements alongside a change in the profile of young people who are becoming looked after at an older age. This trend is being experienced nationally along with a national pressure on placement availability and consequently a higher percentage of young people have experienced placements moves. Efforts are focussing on placement providers and corporate parenting partners to ensure we provide stable placements that meet young peoples' needs and prevent disruption wherever possible.

There were 75 children that were placed for adoption in the year (compared to 42 in the previous year) and 70% of these were placed for adoption within 12 months of the decision that they should be placed, which is comparable with the previous year (71%). There were 8 children that left care as a result of a special guardianship order and a further 30 as a result of a child arrangement order. Overall there has been an increase in children leaving care due to permanence from 33% in 2014-15 to 42% in 2015-16. 28% of young people who left care remained with their previous Foster Carers under staying put arrangements.

Independent Reviewing Officers undertook 1426 reviews of which 95% were in timescale (96% in 2014-15). For children over the age of 4 years, contributions were made by children directly, via an Advocate or through the completion of a consultation booklet in 98% of reviews. 76% of children attended at least one of their reviews during the previous year (82% in 2014-15).

Private Fostering

Under the Children Act 2004, private fostering is defined as a child under 16 years (or under 18 years if they have disabilities) who is looked after for at least 28 consecutive days by someone other than a close relative. Under the Act there is a legal requirement for the Local Authority to satisfy themselves that such a child is being safeguarded and their welfare promoted. This is undertaken by offering support and guidance, undertaking assessments and checks and regular visits to the child and their carer (every 6 weeks in the first year).

There were 15 new referrals in the year and at 31st March 2016 there were 11 privately fostered children in Sheffield. The majority of these are teenagers.

To raise the profile of private fostering the Local Authority has:

- Continued to provide leaflets and posters to offices, schools and other relevant establishments, including language schools to ensure that professionals are aware of their responsibility to notify the Local Authority of private fostering arrangements.
- Given presentations to social work teams and to professionals attending adoption training
- Distributed information through Child Protection Liaison Teachers training

Impact

The majority of referrals continue to mainly come from professionals working within children, young people and families service (Local Authority), which is in line with other authority areas⁴. However, due to the continued awareness raising with professionals, Sheffield private schools are also recognising and referring private fostering arrangements, ensuring the children receive the assessment and visits required.

FACT continued to successfully advocate for funding to support court applications for appropriate private fostering placements. The team have worked with carers to assist them in applying to secure a child legally and negate the need for private fostering.

What we will do next

- Develop new leaflets for foster carers, professionals, parents and young people.
- Initiate a renewed campaign of publicity, with a focus on schools, GP surgeries, council services, faith groups



⁴ <http://cfab.org.uk/>

Section 4

Safeguarding Priorities

Sexual Exploitation

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

The service received 136 referrals. Of these, 61 were assessed as medium/high risk in regard of CSE and allocated a specialist from the 'protection team', 58 were referred to the CYT for CSE preventative intervention work, 7 cases were supported by other agencies and 10 required no further intervention (moved away, refused a service or no issues identified).

Sheffield Hub & Spoke Project, Alexi: is one of 15 national Hubs, based within voluntary services (funded by CSE Funders Alliance; evaluated by the University of Bedfordshire). Over 3 years the remit is to explore the contribution of the Third Sector in sharing good practice and building capacity across geographical neighbours.

Impact

Prevention: We have increased professional's awareness of CSE through providing introductory training for 862 professionals and advanced training for 187. CSE awareness courses have been developed and delivered to 590 Sheffield young people.

Protection: To improve the protection offered, young people at risk have their profiles raised on the district's 'risk and vulnerability' pages to highlight them to area staff. Trigger plans are completed by CSE detectives to provide local policing teams with a structured approach. In addition, weekly meetings with the police's Intelligence Unit are held, where individual risk is reviewed. A Partnership Information Record has been developed to facilitate information sharing with SYP. CSE victims that are fully disengaged with the perpetrator can be supplied with TecSOS alarms, which are GPS tracking devices that can be used when threatened, intimidated or in fear of attack.

Pursuit: We know that the awareness raising with the hotel trade has been effective as there has been 50 calls to the police from staff, resulting in 8 arrests. Using powers under the Child Abduction Act 2004, SYP have served 20 child abduction warning notices (relating to CSE). Nominals of note/ perpetrators are also highlighted on SYP's 'risk and vulnerability' page. Some of these individuals are raised at the weekly Offender Management meeting and managed using the SYP's CSE Disruption Toolkit.

Prosecution: the work has led to a number of CSE related operations with successful court outcomes (with the convictions of perpetrators). The service has supported a number of victims involved in court cases and is planning and delivering support for victims and witnesses in anticipation of future trials.

Participation: There are a number of extremely articulate and brave young people whose risk of exploitation has reduced but they continue to work with the service. Their work has been highlighted in the children/young person's involvement section (page 24).

What we will do next

- To develop Trigger Plans by incorporating additional detail from professionals working with the young people
- Roll out the updated Friend or Foe? Group work programme with a one day "Training for Trainers" across South Yorkshire.

Children Who Live in Households with Substance Misuse

Impact

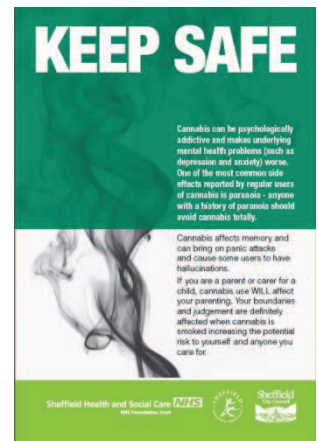
Professionals' awareness of the importance of safeguarding children who live in households where there is substance misuse has been evidenced through an increase in requests by professionals (from drug and alcohol treatment support services and children service) for checks and advice. This year there were requests in relation to 1011 clients, of which 640 had children living with them.

An analysis to understand the issues relating to unborn babies and children involved in the child protection process in terms of Trilogy of Risk (drug and alcohol misuse; mental health and domestic abuse) was undertaken. Working with the domestic abuse service, the findings were delivered to 209 practitioners from the drug and alcohol and the domestic abuse services at an annual Safeguarding Children Refresher Event. This provided professionals with a better understanding of the inter-relationship of the 3 predominant risks and their impact on parenting and children. It facilitated closer working relationships and addressed issues to joint working.

In response to requests from universal services a "Keep Safe – Cannabis" leaflet was developed. The impact of this is to help inform parents/carers of the potential impact of using cannabis on pregnancy, parenting and childcare.

An ingestion notification process was developed and implemented. This is to be used by children and adult's A&E hospitals to notify prescribers (SHSC Opiate Service) when a child, young person or adult attends hospital following ingesting / overdosing on a controlled drug (methadone; buprenorphine; suboxone; diamorphine). This is to ensure a timely response to families where there are issues with drug misuse.

Universal services were supported in the implementation and use of the Alcohol Screening Tool to ensure that alcohol issues in families are identified as early as possible and appropriate support is accessed.



What we will do next

- Develop safeguarding children case supervision for all substance misuse practitioners to support them in identifying and effectively managing safeguarding children issues within the families they are working with.
- Design and distribute a workforce questionnaire regarding safeguarding children for substance misuse practitioners to guide future training needs.
- Establish a referral pathway between SCH Children Hospital and The Corner – (Young Person's Drug and Alcohol Service for young people), for young people admitted to hospital following ingesting alcohol or drugs including New Psychoactive Substances (NPS).
- Update the Hidden Harm Strategy (2013 – 2016) to reflect the rapidly changing trends within the drug and alcohol field and the impact on children and families within of Sheffield

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.



Community based domestic abuse services received a total of 6,026 referrals of which 17.9% of these were high risk cases (includes repeat referrals). Of these, 3,637 individual contacts were made with an (estimated) total of 4,442 children. An estimated 218 individuals aged 16-19 contacted services in the year.

There were 941 cases heard at MARAC (Multi-Agency Risk Assessment Conferences focusing on high risk domestic abuse cases), which was similar to the number of cases reviewed the previous year, (932 cases). These cases involved 1,123 children (higher than the previous year: 893) with an average of 147 cases each quarter this year (117 cases in 2014/15). In addition, there were 26 young people (16-17 years) referred to MARAC that were victims of high risk domestic abuse and 7 cases had a perpetrator aged 16 - 18 years. Sheffield's rate of domestic homicide is low in comparison with other core cities.

You and Me Mum is a new 10 week programme delivered by early intervention services for mothers with experiences of domestic and sexual abuse. It aims to empower and support survivors in understanding their role as mothers addressing the needs of children and young people who have lived with domestic abuse.

Impact

There has been a training programme to ensure the Sheffield workforce can identify and refer those experiencing domestic and sexual violence and abuse, understand the role of MARAC and to share the learning from Domestic Homicide reviews. There are domestic abuse specialists now embedded in early intervention services. The impact of this has been noted through an increase in the identification and reporting of domestic abuse.

There has been an increased focus on work with young people from 16 years up in relation to domestic and sexual abuse. A pathway to support young people affected by domestic abuse and a traffic light tool to aid the risk assessment to young people affected by abuse have been developed. Increased capacity in the High Risk IDVA service (Independent Domestic Violence Advocacy) has allowed for greater focus on referrals of this age group.

What we will do next

- To complete the domestic and sexual abuse needs assessment.
- To ensure the young person's traffic light tool is embedded in practice.
- Review the results from the Every Child Matters survey regarding controlling and coercive behaviour in young people's relationships
- Improving the reach of preventative programmes in schools and colleges
- To continue to work with the substance misuse service to develop a training programme on domestic abuse and substance misuse that includes guidance on asking about both issues in such a way as to encourage disclosure

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 identified problems.

A child or young person can be 'Missing' or 'Absent'⁵

- **Missing:** 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 and there is no apparent risk.

This year the Missing and Absent Team was relocated within the Youth Justice Service. On returning from a missing episode a child or young person is then referred to the Return Home Interview Service for a return Interview. This year, the process of return home interviews was returned to children and families (Sheffield City Council). The Return Interview Co-ordinator provides training and guidance to a range of services to support these interviews.

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

	Missing Children <i>Monthly Average</i>		Absent Children <i>Monthly Average</i>	
	All Sheffield Children	Children in Care	All Sheffield Children	Children In Care
Number of incidents	139	45	51	38
Number of individuals	92	24	26	17

The number of missing incidents is lower than the previous year (there were a total of 150 missing incidents in 2014/15).

Impact

- A SSCB Themed Audit Day found evidence of strong multi-agency working and a good focus on the young person.
- Monitoring children in care 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.
- Developed and agreed a Missing from Home or Care and Runaways Protocol for Sheffield, expanding on the South Yorkshire protocol with local processes and procedures.

What we will do next

- Review how information is shared during and immediately after a missing episode to ensure it is of most use
- Review the return interview processes to ensure they are timely and consistent
- Develop contextualised and thematic analysis of missing episodes
- Develop regular auditing and quality assurance of missing/absent cases

⁵ Interim guidance on the 'Management, Recording and Investigation of Missing Persons', ACPO / College of Policing, 2013), amended by ACPO letter 11th March 2015.



Online Safety

The Online Safety Project Manager has worked with two 'families of schools' (these include Nursery/ Infants, Primary and Junior schools), to support online safety work across the schools including consultations with the children, staff training and a joint parent event.

Online safety training sessions have been delivered to professionals working with vulnerable groups including the hearing impaired service, CAMHS, Children's Hospital and a children's home. In addition there have been various parent events that have taken place to highlight safety issues that parents/carers should be aware of.

Work has been undertaken in reaching specific professionals including presentations to newly Qualified Teachers and computing undergraduates in relation to online professionalism, reputation and legislation. The computing students went on to deliver a joint online safety event for parents at a local primary school to raise parents knowledge and understanding.

Female Genital Mutilation (FGM)

Since October 2015, there has been a mandatory responsibility on registered professionals in Health, Social Care and Teaching to report girls under 18 who have been victims of FGM to the Police using the non-urgent number; 101. Acute NHS Trusts, Mental Health Trusts and GP practices are required to report newly identified incidences of FGM to the Health and Social Care Information Centre (HSCIC). For the year ending 31st March 2016, there had been 165 newly identified cases of FGM in Sheffield. These are all women and girls who have been cut in other countries before they came to Britain. There is no evidence that any girl or woman has been cut in Sheffield. The SSCB FGM Task and Finish Group has worked on a draft pathway on

FGM. The plan is to develop a strategy on FGM for Sheffield, that will ensure that workers in Sheffield are aware of the impact of FGM on girls and women's physical and mental health, how to support girls and women who have been victims of FGM and how to prevent FGM happening.

Safeguarding and Licensing

Impact

This year saw the launch of the nationally recognised and accredited taxi training resource 'Safeguarding Vulnerable Passengers'. Sheffield is the first city to achieve trade accreditation through a partnership between the trade, the LSCB and the local authority. This ensures all private hire and taxi drivers receive training that includes safeguarding and child sexual exploitation awareness. The impact is to increase driver knowledge, protect children, young people and businesses. This is also reflected in council tendering contracts for children and young people receiving council transport.



The Licensing project, South Yorkshire Police and Sheffield Futures have worked in partnership with the NWG to provide all types of businesses with posters, leaflets, risk assessments, refusal logs, information sharing reports and training materials, to support business communities to safeguard children from the risk of Child Sexual Exploitation. This work increases awareness and this has been evidenced through referrals received.

This year Sheffield received 3 national awards (Best Bar None and Purple Flag), through the involvement of a multiagency team (including Licensing). This recognises that Sheffield is a safer destination venue and has good multi agency strategies to make the city safe for all.

A new training resource and partnership approach for safeguarding children in employment or entertainment was developed. This is aimed at chaperones and applicants (producers and directors in the performing arts, professional and amateur) to ensure they are safeguarding aware. The impact is that children will be safer in these settings due to raised safer awareness and protocols being in place.

The licensing project has also been involved in the 'Night Time Economy Expert Panel' to share information about working with the licensed trade and views of ways to go forward.

This year we have raised the safeguarding awareness of 842 people working in the taxi trade, including transport providers to children's social care and 220 people working in other places (local businesses, night time economy operators, voluntary/statutory agencies). This includes awareness of child sexual abuse/exploitation. We evaluate impact through delegate feedback:

'It was very informative and gave an insight into some aspects of the job that may have been taken for granted before'

'Very good. Gained a good understanding of safeguarding awareness'

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 76 complaints; participated in 5 licence reviews and in addition to advising event operators, made 22 advice visits.

What we will do next

- Pilot and launch a training resource and regulatory regime for children in employment or entertainment
- Develop and deliver practical training materials for the late night refreshment industry
- Continue to work regionally and nationally to promote the safeguarding agenda in a corporate way across the licensed trade



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. Sheffield, was one of three chosen sites across the country. It has now completed the final year of the programme delivery.



Since January 2014 the MsUnderstood Partnership (MSU), has been working with practitioners in Sheffield to develop contextual and holistic responses to peer-on-peer abuse (peer-on-peer CSE, serious youth violence, harmful sexual behaviour and teenage relationship abuse). Following a six month audit of work in Sheffield (which resulted in an audit report presented to the SSCB in November 2014) the partnership has worked to deliver against an agreed set of actions to develop local practice

Through discussion with the SSCB and MSU Steering Group in Sheffield the following areas of activity were agreed upon.

1. The first was a need to understand the extent to which peer-on-peer abuse was contextual (reflecting some of the national research into this issue) and how this was being managed at present. While this matter was being addressed there was agreement amongst the steering group that MSU should identify ways in which different groups concerned with peer-on-peer abuse cases (MARAC, HSB group, gang's panel etc) coordinate and connect.
2. The steering group wanted to establish appropriate governance arrangements for the MSU agenda and progress towards a strategic structure for safeguarding adolescents in Sheffield to ensure that the learning from the programme was sustained.
3. There was a need to conduct a data linkage exercise to compare peer-on-peer abuse profiles across multi-agency groups, alongside journey mapping: identify young people's

routes through Sheffield services to identify referral pathways and points of intervention/assessment duplication, considering young people's direct experiences of this process

4. And finally by utilising the findings from the data linkage and journey mapping exercises, develop and pilot a linked assessment tool for vulnerable young people in Sheffield

Impact

The overarching aim during the project was to ensure Sheffield was well placed to provide holistic training on peer-on-peer abuse, engage with analytical support, develop an overarching strategic document to enable this work to progress and provide a consistent response to young people affected by peer-on-peer abuse, particularly those suspected of abusing their peers. A strategic group with representation from key senior managers across partner organisations agreed to the development of a strategic adolescent delivery plan and the establishment of a Sheffield strategic group on Vulnerable Adolescents / Safeguarding Adolescents.

'This is a very progressive step for Sheffield and provides a unique opportunity to sustain the learning from the MSU' (Carlene Firmin)

Journey mapping was completed in 4 cases using a contextual case template to gain a sense of each young person's contact with education, youth service provision, youth justice, children's social care and policing. The analyses provided insight into both the nature of the behaviour in each case and the nature of the professional response.

The findings of this process have been fed back and case studies have been created of each case to be used in training and facilitate developments in local practice beyond the life of the MSU programme.

The journey mapping identified that existing assessment tools were identifying concerns associated with peer on peer abuse however; it was not the focus of the assessment which were based on traditional child protection concerns within familial contexts and not designed to look at the extra-familial challenges of street-based victimisation, peer pressure, bullying or harmful cultures.

The introduction of Assetplus during this programme was an ideal opportunity to link the findings of MSU into the training programme for workers in the CYT and YJS.

'The message I took from the session was to be more aware of peer on peer abuse and how it inter links with other aspects of their lives'.

'with the older young people I work with the family sometimes is not as involved, I need to try to keep track of young people's peer groups more effectively'

What we will do next

Although the MSU programme has concluded in Sheffield the strategic group continues to meet to ensure the recommendations and work already underway is sustained into the future.



Appendix 1 Board Partner Agencies

Executive Board Members

Designation	Organisation
Independent Chair	SSCB
Assistant Director for Safeguarding and Quality Assurance / Professional Advisor to the SSCB	Children, Young People and Families, Sheffield City Council
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
Director of Public Health	Public Health
Executive Director of Nursing and Quality	Sheffield Health and Social Care NHS 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
Deputy Director	Community Rehabilitation Company
Lead Member (Participant Observer)	Sheffield City Council
Voluntary Sector Representative	Chair of the Voluntary Sector Safeguarding Reference Group.
Lay Member	
Lay Member	
Chair of the Education Safeguarding Reference Group	Sheffield Schools
Chair of the Housing Safeguarding Reference Group	Housing
Assistant Director of Nursing Quality and Patient Safety	NHS England

Operational Board Members

Designation	Organisation
Independent Chair	SSCB
Assistant Director for Safeguarding and Quality Assurance / Professional Advisor to the SSCB	Children, Young People and Families, Sheffield City Council
Voluntary Sector Representative	Vice Chair of the Voluntary Sector Safeguarding Reference Group
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
Service Manager	NSPCC
Operations Manager	Sheffield Futures
Named Nurse for Safeguarding (Community)	Sheffield Children's NHS Foundation 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 Intervention	Children, Young People and Families, Sheffield City Council

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

<https://www.safeguardingsheffieldchildren.org.uk/welcome/sheffield-safeguarding-children-board/sscb-information/sscb-structure-and-membership.html>

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