



Leeds  
Safeguarding  
Children Board

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**Report of Jane Held, Independent Chair**

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**LSCB Annual Report 2012/13**

This draft of the report to be received by the LSCB at its Annual Review Meeting on 19 July 2013.

The LSCB Executive will receive the final draft at its meeting on 16.08.13.

An introduction from the LSCB Chair will be added to the final version.

The final version will be published on the LSCB website at the end of August 2013.

**1.0 Executive Summary**

This Annual Report of the Leeds Safeguarding Children Board (LSCB) evaluates the effectiveness of safeguarding arrangements for children and young people in Leeds in 2012/13 and sets out how the Board's work will be developed and strengthened in 2013/14. It is drawn from a wide range of sources from across the children's partnership and reflects the continuation of an 'improvement journey' that has involved a high degree of multi-agency co-operation and collaboration.

We are seeking to improve outcomes for vulnerable children and young people in Leeds by ensuring that they receive 'the right services at the right time' in order to address emerging issues and problems quickly and effectively. This has required a commitment by the children's partnership to develop preventative early help family support services that will, over time reduce the number of children and young people whose problems have developed to the point where statutory intervention (through a child protection plan or becoming 'looked after' by the Local Authority) has become necessary.

### **Context**

The report notes the considerable impact of policy developments from Central Government and sets the work of the partnership and individual agencies within the Leeds context.

### **The Effectiveness of Safeguarding Arrangements in Leeds**

A comprehensive review of performance, quality assurance and audit findings clearly outlines the breadth and depth of work being undertaken to safeguard and promote the wellbeing of children and young people in Leeds. Engaging children and young people about safeguarding matters and their own care is being progressed and good use is being made of external expertise to shape the planning and development of services. Significant service restructuring has and is taking place to respond to the changing circumstances of the public sector and to promote more effective ways of working with children, young people and their families. More quantitative and qualitative information is being collated to help analyse:

- Where progress is being made
- What outcomes are being achieved
- What difference this is making
- Where more improvement is required
- What requires further investigation and understanding.

There are positive indications that the improvement journey has sound foundations:

- There is a clear, coherent strategic direction which is focused on increasing the availability and effectiveness of Early Help preventative services and reducing the need for statutory intervention. This is formalised in the Children and Young People's Plan and supported through the challenges from the LSCB to 'rebalance the safeguarding system'.
- A shared partnership culture is developing underpinned by a restorative approach to working with children, young people and

their families that seeks to 'never do nothing' and to provide the right service at the right time with 'high support and high challenge'.

There is evidence of good progress being made in the aims and objectives set by the partnership:

- The reduction in the number of children and young people who need to be looked after
- The quality of services being provided for children and young people in the care of the Local Authority
- The establishment of revised Children's Services 'Front Door' arrangements which have supported:
  - An increase in conversations between partners about how best to respond to children and young people about whom concerns have been raised
  - A reduction in the number of referrals accepted by Children's Social Work Service
  - An improved understanding of the nature and scale of patterns of domestic violence across the city
- Continuing the investment in and co-ordination of Early Help services.

Emerging challenges are identified which have contributed to those set for the LSCB and Children's Trust Board in 2013/14:

- A greater understanding is required of:
  - The trends and composition of the number of children and young people who are subject to child protection plans
  - The full nature and extent of multi-agency Early Help and preventative activity being undertaken
  - How the development of a single assessment framework across the partnership and the continuum of 'risk' and 'need' can enhance the planning of Early Help interventions
- Areas identified for improvement include:
  - The timeliness of child protection processes
  - The effectiveness of child protection plans
  - The provision of services for children and young people at risk of or suffering sexual exploitation
- Areas identified for development include:
  - The agreement to a single assessment framework and process which is robust and straightforward to use
  - The updating of the Leeds 'Think family Protocol' to improve multi-agency responses to children and young people living in the context of 'compromised parenting'.

- The exploration of a partnership approach to establishing a Young People's Service (16 – 25 yrs) that would cater for vulnerable young people, including care leavers.

During a period of 'whole system re-orientation' it is particularly important that the Board has that risk in individual cases is being managed appropriately and safely. The report provides the following information to inform that judgment:

- The reduction in the number of looked after children and young people is gradual and is being actively managed. The reduction is due to a combination of fewer receptions into care (with alternative, more appropriate, options being rigorously explored) and improved permanency planning.
- Although the number and make-up of the cohort of children and young people who are subject to child protection plans requires further investigation and improvements are required in the effectiveness of plans, it is notable that the LSCB audit confirmed the Ofsted findings of 2011 that children and young people are not being left in unsafe situations.
- Concerns remain about the high rate of re-referral to Children's Social Work Services with the implication that some children and young people may not be receiving a timely and effective response. Nevertheless, the introduction of the new Duty and Advice Team has impacted positively on these figures and the trend is expected to continue in 2013/14 as the new arrangements bed in.
- Considerable audit and review activity is being undertaken to better understand the working of the safeguarding system as a whole and the performance of its component parts.

### **The Effectiveness of the LSCB**

Through its annual review process the LSCB evaluates the work it has undertaken through the previous year, identifying progress made, emerging challenges and the impact it has had on the work to improve safeguarding services and outcomes for children and young people.

Good progress was made on all the tasks set in the Business plan for 2012/13 and outstanding actions have been included in the Business Plan for 2013/14.

Within the framework of the Strategic Plan progress has been made in the following areas:

- Lead, Listen and Advise
  - The production of an Annual Report evaluating the effectiveness of safeguarding in Leeds and identifying challenges for the coming year

- Improved dissemination of safeguarding messages across the partnership
- Establishing Lay Member and children and young people's input to the Board
- Know the Story; Challenge the Practice
  - The development and expansion of the LSCB Performance Management System
  - Learning lessons from Local and Single Agency Reviews
  - Undertaking safeguarding seminars with cluster leaders
- Learn and Improve
  - The establishment of a Framework for Learning and Improvement to promote a culture of continuous improvement
  - Improved dissemination of lessons from Reviews
  - Continued co-ordination and development of the LSCB Training programme

More progress needs to be made in:

- Increasing community engagement through the development of the LSCB website, the role of the Lay Members and input from the Voice and Influence sub group
- Receiving performance and audit information from across the partnership
- Increasing our understanding of the quality of practice delivered at the front-line and contributing to its improvement.

Challenges for the LSCB to address in 2013/14 have been identified:

- To maintain and increase the momentum of the current work programme to support continuing improvement in services for children and young people
- To continue to monitor the management of risk within the safeguarding system
- To lead the partnership in addressing issues posed by children and young people living in the context of 'compromised parenting'
- To build on progress being made to collaborate more effectively with other strategic bodies
- To further implement the LSCB Communications strategy using the new website
- To encourage all partners to more fully engage in the work of the LSCB through its sub group structure.

The LSCB is having an impact on the work of the wider partnership through:

- The development and revision of policies and procedures which impact directly on how frontline work is undertaken. In 2012/13 this has supported work with children and young people who are missing / at risk of sexual exploitation / exhibiting self harm

and suicidal behaviours.

- Raising awareness across the partnership of key safeguarding issues, lessons from Reviews and findings from audits
- Participants on training courses subsequently indicating that there had been an impact on their practice
- Findings from multi-agency audits being used to inform partners' in house audit programmes and the development of action plans to implement improvements in services
- Regular Performance reporting has identified issues that need further investigation (eg the child protection system) and have contributed to decisions made to undertake specific audits.
- Lessons from Serious Case Reviews and Local Learning Lessons Reviews informing the development of new initiatives (eg exploration of a Young People's Service) and the updating of existing arrangements (eg the Leeds Think Family Protocol).
- Improved understanding of the circumstances of child deaths has resulted in support for a number of public health campaigns (eg the dangers of co-sleeping)

## **Conclusions**

The report concludes that considerable progress that is being made to make the necessary changes to improve multi-agency working, services and outcomes for children and young people. It identifies where more progress needs to be made and where we need to better understand problems and issues faced by children and young people in Leeds.

Challenges are set for the LSCB and the Children's Trust Board to address in 2013/14 which promote a direction of travel which encompasses an increasing focus on:

- The quality of services rather than on the timeliness of processes
- The LSCB operating more like an 'Improvement Board'
- The frontline and community engagement
- The voice of children and young people
- The use of research and evidence based practice.

## 2.0 **Introduction**

This report reflects work undertaken in 2012/13 by organisations and agencies in Leeds to safeguard and promote the welfare of children and young people and sets out how this will be developed and strengthened in 2013/14. It is the continuation of an 'improvement journey' that was begun in 2009 and has involved a high degree of multi-agency co-operation and collaboration

(partnership working) in order to:

- Identify problems in the way the safeguarding system was operating
- Develop a coherent and sustainable strategic plan to address the issues identified
- Restructure key services to meet new aims and objectives
- Implement changes in how services are delivered and how agencies work together and with children, young people and their families.

The underlying driver in this work has been to improve outcomes for vulnerable children and young people in Leeds by ensuring that they receive 'the right services at the right time' in order to address emerging issues and problems quickly and effectively. This has required a commitment by the children's partnership to develop preventative early help family support services that will, over time reduce the number of children and young people whose problems have developed to the point where statutory intervention (through a child protection plan or becoming 'looked after' by the Local Authority) has become necessary.

This report charts the considerable progress that is being made to make the necessary changes to improve multi-agency working, services and outcomes for children and young people. It identifies where more progress needs to be made and where we need to better understand problems and issues faced by children and young people in Leeds. It sets out how plans are being taken forward to ensure that the gains of the improvement journey are consolidated and embedded and that the pace of change is maintained and enhanced.

In producing this report the LSCB is asking three main questions:

- How effectively are children and young people being safeguarded in Leeds?
- How well is the LSCB and the Children's Trust Board undertaking their roles?
- What plans are in place for 2013/14 to ensure that the improvement journey continues?

The report also includes information about the context in which safeguarding work is undertaken and the work of the LSCB and of the Children's Trust Board, which is the strategic partnership body leading the development of services for children and young people in Leeds.

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### 4.0 The LSCB and its Statutory Responsibilities

Leeds Safeguarding Children Board (LSCB) is a statutory body established under the Children Act 2004. It is independently chaired and consists of senior representatives of all the principle stakeholders working together to safeguard children and young people in the City. The Board's membership for 2012/13 is set out in Appendix 1.

Its statutory objectives are to:

- Co-ordinate local work to safeguard and promote the welfare of children



- To ensure the effectiveness of that work

The full Board currently meets bi-monthly and an Executive Group meets on the alternate months in order to maintain the momentum that completion of the Board's significant workload requires. The Board has a series of sub-groups, each with its own business plan, focused on key elements of the Board's work. The Board Manager is supported by a Business Unit which supports the varied elements of the Board's work. (See Appendix 2, Structure of the LSCB)

Working Together (2013) requires each Local Safeguarding Children Board to produce and publish an Annual Report evaluating the effectiveness of safeguarding in the local area. The report should be submitted to the Chief Executive and Leader of the Local Authority, reflecting that accountability for the safety and welfare of children and young people must be led by them. It should also be sent to the local Police and Crime Commissioner and the Chair of the Health and Well Being Board. There is also a local agreement to submit it to Leeds City Council Scrutiny Board for Children and Families and to the governance bodies of all partner organisations to support their governance of safeguarding practice in Leeds.

The guidance states that the Annual Report 'should provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action'. The Report should:

- Recognise achievements and progress made as well as identifying challenges
- Demonstrate the extent to which the functions of the LSCB are being effectively discharged
- Include an account of progress made in implementing actions from Serious Case Reviews
- Provide robust challenge to the work of the Children's Trust Board (CTB).

The LSCB works closely with the Children's Trust Board which is specifically accountable in Leeds for overseeing the development and delivery of the Children & Young People's Plan (CYPP). This Report identifies challenges for both the LSCB and the Children's Trust Board. The Children's Trust Board considers the report in preparing and refreshing the Children & Young People's Plan. The Health and Well-being Board considers the report in completing the Joint Strategic Needs Assessment.

## 5.0 LSCB Vision, Values and Principles

Children, their welfare, protection and the promotion of their best interests are at the heart of everything the LSCB does. The existence and continued prominence of what the Board stands for and the commitment to how it carries out its work remains crucial and Leeds, as a Child Friendly City, values the Board's work and supports it strongly.

The following was agreed by the LSCB members working together at development sessions as part of the creation of the LSCB Strategic Plan 2011-15 and is refreshed annually.

### **Our Vision**

*Is for Leeds to be a child friendly city in which children and young people are safe from harm in their families, their communities and their neighbourhoods.*

### **Our Values**

*We will promote these values in order to influence our behaviours jointly with the Children's Trust Board*

- *Celebrating diversity*
- *Engaging citizens locally*
- *Being open and honest*
- *Working as a team for Leeds*
- *Spending money wisely*

### **Our principles**

*We are as a Board:*

- **Committed** to putting the child / young person at the centre of all that we do
- **Focused** on getting safeguarding right for children, young people and their families
- **Clear** about what we expect of safeguarding services
- **Informed** about how well protected children and young people are in Leeds
- **Open** about what we do and why
- **Co-operative and collaborative** with each other
- **Challenging** of each other and of the safeguarding services each partner provides
- **Effective** and providing value for money
- **Accountable** to the people of Leeds for how we invest our resources
- **Accessible** to and informed by children, young people and their families, the communities they live in, the staff in our organisations that serve them, and the priorities of the Children's Trust

- **Learning** from everything we do and changing as a result
- **Improving practice and outcomes for children and young people**

All our work is underpinned by an agreed set of approaches, shared with the Children's Trust Board, so that we all work together to deliver improved outcomes for children and young people –

- *The child IS the client*
- *Talking a common language*
- *Using 'outcomes based accountability' to improve outcomes in each locality across Leeds*
- *Doing things WITH children and families, not TO or FOR them*
- *Doing the simple things better – never doing nothing*
- *Supporting strong schools, settings, families and communities*
- *Involving everyone who has a part to play – a whole city approach*
- *Improving assessment and intervention*
- *Targeting resources to make the biggest impact on our priorities*

The vision of the LSCB is translated into action through the Strategic Plan (2011 – 15) and a more detailed business plan, both of which are also refreshed annually. The Strategic Plan is based on three priorities:

Strategic Priority 1: Lead, Listen, Advise

- Exercise strategic leadership across all stakeholders: to support a child friendly city
- Support the professional community to keep children and young people safe
- Engage with and influence the wider community to keep children and young people safe
- Ensure transparency and public accountability

Strategic Priority 2: Know the Story; Challenge the Practice

- How do we know how efficient and effective the local safeguarding system is?
- How do we know the quality of interventions with children and young people?
- How are we learning and implementing lessons from child deaths, serious child care incidents and examples of good practice?

Strategic Priority 3: Learn and Improve; using what we learn to change practice

- Develop a culture of continuous learning and improvement
- Promote effective multi-agency working and professional practice.

Each year's business plan sets out objectives and tasks within the three strategic priorities, identifying which sub groups will take the lead and timescales for completion. The business plan is reviewed regularly to ensure that emerging issues and themes can be included and to monitor the progress being made. See appendix 3 for the completed plan for 2012/13.

#### 4.0 The National Safeguarding Context

Agencies working together in Leeds to safeguard and promote the welfare of children do so in the context of national legislation, guidance and reviews of emerging issues and concerns. These need to be taken account of when evaluating local services and arrangements and planning changes and improvements. The LSCB is responding to a number of national developments from 2012/13.

In November 2012 the interim report of The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups was published, identifying this organized abuse as a significant national problem. A number of high profile court appearances and convictions have occurred across the country alongside reviews of the multi-agency responses to the needs of children and young people at risk or suffering sexual exploitation. The report highlighted the need to raise professional awareness about the issues and challenges to be addressed to ensure a better understanding of the scale and nature of the abuse in all areas and to improve the identification responses to victims and those at risk. In June 2013 the House of Commons Home Affairs Committee published its second report on Child sexual exploitation and the response to localised grooming. This area of work has received significant attention in Leeds in the last year and is a priority area for sustained activity.

A review of services and outcomes for children living in the context of parental mental health and / or substance mis-use problems was published by Ofsted in March 2013 ('What about the Children?'). It requires LSCBs to audit the quality of joint working between Adult and Children's Services and put in place structures for joint training and supervision in order to drive improvements in services and outcomes for this vulnerable group. The LSCB has identified as a priority for 2013/14 the need to review and revise the Leeds 'Think Family Protocol' in conjunction with the Leeds Adult Safeguarding Board and the Community Safety Partnership to respond to children and young people living in the context of compromised parenting.

- 4.1 Central Government had long made it clear that it intended to simplify the guidance to professionals working with vulnerable children and young people and held a consultation exercise on its outline proposals during 2012/13. In March 2013 new guidance was issued; Working Together to Safeguard Children which introduces a much less prescriptive approach to multi-agency working with vulnerable children and young people. Its philosophy promotes the 'child's voice and experience' as central to working to improve outcomes for children and young people and challenges professionals to ask themselves whether 'this action or work is going to have a positive

impact on the life of this child ... and what is going to happen if nothing changes.’ The changes incorporate a new definition of safeguarding and promoting the welfare of children and young people which makes it clear action needs to be taken to ensure **all** children have the best outcomes across the whole system; thus underlining the importance of effective Early Help Services as well as Family Support, Child in Needs and Child Protection services. As well as the specific implications for Local Safeguarding Children Boards, the consideration and implementation of this guidance will be central to the work of the LSCB in 2013/14 and beyond as it leads the development of a new professional culture and new systems and protocols on behalf of the partnership.

4.2 At the same time the Government published the Accountability and Assurance Framework for the NHS which provides clear guidance on the responsibilities of each of the key players for safeguarding in the new NHS arrangements. It is complementary to the Working Together guidance and re-iterates the requirement to work in partnership to safeguard children and young people at risk of abuse at both strategic and operational levels. It requires each NHS organization to have appropriate governance and assurance systems in place.

4.5 Earlier in the year (August 2012) Local Safeguarding Children Boards developed a national profile through the establishment of the Association of Independent LSCB Chairs, with a remit of improving the effectiveness of Local Safeguarding Children Boards in England through:

- Shared learning
- Professional development
- Responding to consultations and policy proposals
- Working in partnership with other bodies committed to safeguarding children and young people
- Securing and strengthening the identity of Local Safeguarding Children Boards
- Enhancing the contribution of independence in the Chairing of Local safeguarding Children Boards.

An immediate benefit of the Association has been the setting up of a peer review process for decision making by chairs as to whether the circumstances surrounding serious child care incidents meet the criteria for undertaking Serious Case Reviews. This will support more consistent decision making about the types of reviews that are undertaken at a time when national guidance has changed significantly in this area.

## 5.0 The Local Safeguarding Context

The most immediate context for work to safeguard and promote the welfare of children and young people in Leeds is to be found in the city itself (the makeup of its population, the degree of deprivation experienced, levels of crime etc) and the strategic response to the

issues and themes identified. This section provides a brief overview of the circumstances in which children and young people live in Leeds, the response of the partnership through the Children and Young People's Plan and the particular challenges and developments for the individual agencies which collectively make up the children's partnership.

## 5.1 **The City of Leeds**

Leeds is the second largest city council in England. The population of the city has increased rapidly in recent years. The latest population estimate is 798,800 representing a 12% increase over the last 10 years, which is higher than the average regionally and nationally. The population of children and young people aged 0-19 is just over 180,000. Within this, the number of very young children (0-4 year olds) has increased faster with over 10,000 children born in Leeds in 2009/10. Leeds has a significantly higher proportion of 15–25 year olds compared to both the regional and national averages, with a total population of 289,000 0-25 year olds living in the city.

Leeds is a very diverse city, with over 130 nationalities included in a minority ethnic population of just less than 17.4%. The proportion of pupils in Leeds schools that are of minority ethnic heritage has increased by more than six percentage points since 2005 to 22.5% of pupils in 2011. A higher proportion of primary than secondary pupils are of minority ethnic heritage. Some 14% of pupils have English as an additional language and over 170 languages are recorded as spoken in Leeds schools. The largest minority ethnic groups in the city are the Indian and Pakistani communities but more recently there has also been a significant increase in economic migration, mainly from Eastern Europe.

The local authority area includes some rural communities, as well as densely populated inner city areas where people can face multiple challenges. The Indices of Multiple Deprivation indicate that 19%, or over 150,000 people in Leeds, live in areas that are ranked amongst the most deprived 10% nationally. Around 30,000 children and young people, 23% of all those aged 0-16, live in poverty.

Leeds is a large, urban city with many features associated with traditionally high levels of crime. Whilst the re-offending rate for children and young people in Leeds is higher than that in England and Wales as a whole, two of the core cities have substantially higher rates. The number of young people re-offending in Leeds has reduced by 61% over the last five years compared with 49% nationally.

## 5.2 **The Children and Young People's Plan**

In consultation with stakeholders (including the LSCB) the Children's Trust Board has developed The Children and Young People's Plan (2011-15) which is designed to provide an over-arching strategic direction to the development of services across the city. This is made up of five outcomes, one of which is co-sponsored by the LSCB Chair:

- That Children and Young People are safe from harm, which involves
  - Helping children and young people to live in safe and supportive families
  - Ensuring that the most vulnerable are protected.

In order to provide a focus on key issues three 'obsessions' have been agreed. One is to reduce the number of children and young people who need to be 'looked after', which reflects the partnership commitment to reducing the need for statutory intervention by providing children and young people with 'the right service at the right time' through the development of effective Early Help preventative services. This approach has been supported by the LSCB, through its Annual Reports in 2011 and 2012, challenging the Children's Trust Board to 'rebalance the safeguarding system' accordingly.

### 5.3 **Issues and developments for Partner Agencies**

The scale and pace of change in, and re-organisation of, public sector services are factors that are increasingly having to be taken into account when planning services for children and young people and in ensuring that they are effective and safe. In their contributions to this annual report partner agencies have identified the key challenges and changes that they are facing and the steps that they are taking to respond.

Children's Services:

During 2011/12 a new Directorate within Leeds City Council was created for services to children and young people. This created a structure based on two service areas; Learning, Skills and Universal Services and Safeguarding, Specialist and Targeted Services; complemented by Partnership Development and Business Support; and Strategy, Performance and Commissioning.

During 2012/13 changes to the way in which services for children and young people are delivered have been progressed and embedded based on a move to locality working on a 'cluster model' and the creation of a specialist approach to children and young people who are 'looked after' and 'care leavers.' The implementation of revised Children's Services 'Front Door' arrangements is having a significant impact on patterns of requests for services and referrals accepted.

The Learning Skills and Universal Services Directorate faces continuing challenge to maintain its commitment to support all Leeds children and young people in learning in the context of schools receiving an increasing budget share and being made responsible for functions and activities which were previously the remit of the local authority. Maintaining a focus on safeguarding is a priority in this period of change.

Children and Family Court Advisory and Support Service:

Cafcass is a non-departmental public body accountable to the Secretary of State for Education and operates in the region on a West Yorkshire basis. In line with the changing focus of Local Authorities in the region it experienced a reduction in public law applications over 2012/13 (in comparison with an increasing trend nationally) but an increase in private law applications (against a reducing rate nationally). A key challenge for 2013/14 is implementation of the revised Public Law Outline and delivery against the key recommendations of the Family Justice Review.

NHS:

The national restructuring of the NHS has culminated in the establishment of three Clinical Commissioning Groups in Leeds at the beginning of 2013/14. Using the NHS Accountability and Assurance Framework work is ongoing to draw up a memorandum of understanding between the groups and the LSCB and to ensure that appropriate measures are in place to oversee safeguarding activity across the whole of the NHS structure in Leeds.

Leeds Community Healthcare has raised the profile and priority given to safeguarding during the year. It has integrated its Safeguarding Children and Looked After Children Teams resulting in pooled knowledge and experiences, the streamlining of systems and processes and more efficient use of resources. The introduction of a new electronic recording system has improved awareness within the unit when a child or young person is subject to a child protection plan. The Looked After Children Health Team achieved the GP Clinical Team of the Year Award in 2012 for their innovative approach to practice.

In February 2012 Leeds Partnership NHS Foundation Trust merged with mental health and learning disability services from NHS North Yorkshire and York, becoming Leeds and York Partnership NHS Foundation Trust. The Trust has direct involvement with Children and young people through the Leeds perinatal / mother and baby unit, the Leeds Addiction Unit pregnancy and parenting team and the Child and adolescent mental health service in York.

Leeds Teaching Hospital Trust:

In addition to the normal business of the Trust, there have been a number of issues that have required an additional focus, namely the Savile Inquiry, the National Safe and Sustainable Review of Paediatric Cardiac Services and the Francis Report.

Savile Inquiry :

Following the allegations of abuse committed by the late Sir Jimmy Savile, the Secretary of State for Health launched an investigation involving the NHS sites where abuse by the celebrity had been cited, Leeds Teaching Hospitals was one of those.



An independent investigation team led by Professor Sue Proctor, Diocesan Secretary for the Diocese of Ripon and Leeds (former SHA Chief Nurse), was established and investigations commenced under the oversight of Kate Lampard, appointed by the Secretary of State for Health to oversee the 3 NHS investigations.

In addition to the historical investigation, the work has focussed on ensuring that similar incidences could not happen today; therefore audits have been conducted of a number of Trust policies including the Safeguarding and Human Resources policies, these are being strengthened where required.

A "Speaking Out" month facilitated by the investigation team was run in February 2013 to encourage staff and patients to come forward.

The independent investigation team are expected to report their findings during 2013.

Paediatric Cardiac Service :

The Secretary of State for Health had launched a review into Paediatric Cardiac Surgery with a view to reducing the number of centres that provided this service nationally. The aim being to ensure there were sufficient numbers of surgeons in each centre with enough children being treated in each to enable the surgeons to treat the wide variety of complex defects in numbers that would maintain their competence.

This review reported in 2012 and suggested that Leeds was one of the centres to close. This decision was challenged in a number of arenas and the outcome judged unlawful. Therefore NHS England have been asked by the Secretary of State for Health to develop a fair mechanism for achieving the desired outcome.

During the period of the challenge Leeds Teaching Hospitals temporarily suspended Paediatric Cardiac Surgery amid allegations that the mortality data was showing higher death rates than its' peer hospitals. This was found not to be the case and surgery resumed after a week and continues to provide a full service to the population of Yorkshire and the Humber.

The service underwent a thorough review from independent teams and a number of recommendations relating to governance and the handling of complaints have been made.

The Francis Report :

The public inquiry, chaired by Sir Robert Francis into the failings in care that occurred in the Mid Staffordshire NHS Trust reported in February 2013 with a long list of recommendations for a number of national organisations, health professions and Hospital Trusts.

The Leeds Teaching Hospitals is developing a plan to address the themes of the report. This will be implemented through 2013.

#### Public Health:

Following the publication of “Healthy Lives, Healthy People”, the Government’s Strategy for Public Health (Nov 2011), a new national public health system has been established. At national level, Public Health England has been established, whilst at local level, public health responsibilities transferred to Local Authorities on 1<sup>st</sup> April 2013. Local Authorities have now taken on a leadership role in: tackling the causes of ill health and reducing health inequalities; promoting and protecting health; and promoting social justice and safer communities. Under the Health and Social Care Act 2012, Health and Wellbeing Boards were established as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. The Leeds Health and Wellbeing Board, chaired by the Lead Executive Member for Health and Wellbeing, has been meeting formally since April 2013. Under the Act, a range of mandatory services (which must be commissioned or provided), may be prescribed by the Secretary of State. In 2013-14, these mandatory services are:

- appropriate access to sexual health services;
- a duty to ensure that there are plans in place to protect the health of the population;
- provision of public health advice to NHS commissioners;
- delivery of the National Child Measurement Programme;
- and delivery of the NHS Health Check.

In addition, a range of commissioning responsibilities have transferred to Local Authorities from 1<sup>st</sup> April 2013, funded through the Public Health grant. These responsibilities included the commissioning of the School Nursing Service, a core universal health service contributing to the safeguarding of children and young people. Responsibility for the commissioning of Health Visiting Services and the Family Nurse Partnership transferred to NHS England for a period of 2 years, pending transfer of these commissioning responsibilities to Local Authorities in April 2015.

West Yorkshire Police:

In April 2012, West Yorkshire police combined the Leeds Child and Public Protection Unit with the three area based Safeguarding Teams in the City. The creation of one District Safeguarding Unit co-located resources under one management structure, bringing all victim centred non investigative functions together with an enhanced ability to investigate all child abuse, sexual exploitation, domestic abuse, forced marriage and honour based violence allegations.

At the same time a regional safeguarding Governance Unit was established to ensure local compliance with national and West Yorkshire safeguarding policies.

Leeds Youth Offending Service:

The significant reduction in the rate of re-offending in Leeds means that the service now works with young people who are more likely to re-offend. The change in legislation that gave young people who were remanded in custody the status of 'looked after' children has resulted in a joint protocol with Children's Social work Service to ensure that this results in the appropriate entitlements for this vulnerable group. The introduction of a new case management system will enable performance data to be used to monitor compliance with national standards.

The Service is working with the newly elected Police and Crime Commissioner to remodel and improve services in alignment with the Police and Crime Plan for West Yorkshire and to provide more targeted support to young people at risk of involvement in crime, substance mis-use and poor educational outcomes. This remodeling will be taking place in the context of changing national policy agendas and reduced income from partners over the coming years.

Leeds City College:

The College, which delivers courses to around 10,000 young people (16 – 18 yr old) has appointed a Governor who champions safeguarding and chairs a safeguarding strategy group once a term. Around 50 child protection / designated officers are available across the campuses to respond to safeguarding concerns from staff or students. Communication between the College and schools has improved following a request to Head Teachers (supported by the LSCB chair) to share safeguarding information when students transfer from school to college.

HMP & Young Offender Institution Wetherby:

A new safeguarding team with a wider monitoring remit has been established and will be developing its role during 2013/14.

In 2012/13 the catchment area of the Institution increased following the closure of Carstington in the North East. Two of Wetherby's wings are national resources and thus accept young people from across the country. The identified challenge for 2013/14 will be to maintain current standards in the light of a national benchmarking process and proposed financial cuts to the service.

The Third Sector:

There are currently 903 Third Sector agencies in Leeds who are registered with the Charities Commission (which estimates that this represents approximately a quarter of all agencies). Around 400 are linked into Young Lives Leeds and 31 engaged directly with the LSCB in 2012/13 in order to complete their audit of compliance with statutory safeguarding requirements. Fuller engagement across the sector remains a priority for the LSCB and will be supported by the new website which will be introduced in 2013/14.

## 8.0 Effectiveness of Safeguarding Arrangements

This section addresses one of the key questions posed in the introduction to this report: 'How effectively are children and young people being safeguarded in Leeds?' It provides an overall picture of the progress being made to improve services and outcomes for children and young people across the whole safeguarding system (from universal services through early help to statutory intervention) and identifies where more needs to be done.

In order to evaluate the effectiveness of safeguarding and promoting the welfare of children and young people in Leeds evidence is drawn from a wide range of sources and is arranged in the following format:

- Engagement with and involvement of children and young people
  - The views and experience of children and young people
  - Listening to children and young people
- Monitoring and Reviewing
  - Inspections and Reviews

- Serious case reviews and Local Learning Lessons Reviews
- Allegations against professionals
- Private Fostering provision
- Safeguarding in secure settings
- Performance Management and Quality Assurance of safeguarding services
  - Partner compliance with required safeguarding arrangements
  - Performance data
  - Quality Assurance and Audit
- External input to the development of services
- Summary and Whole System analysis

## 8.1 **The Engagement and Involvement of Children and Young People**

### 8.1.1\* **The Views of and Experience of Children and Young People**

One of the key commitments made by the LSCB and the Children's Trust Board is to put the 'voice of the child' at the centre of all we do; an aspiration which is underlined in the new Working Together (2013) guidance. Engaging with children and young people is well established in Leeds and has been given further impetus in recent years by the establishment of the Child Friendly City initiative. The LSCB is seeking to particularly understand the views of children and young people in relation to safeguarding issues. This section summarises feedback received and ongoing initiatives to work with children and young people.

#### Growing in up in Leeds survey 2011-12

The survey, based on the Every Child Matters outcomes, was presented to the Children' Trust Board in May 2013 and is drawn from responses from a sample of primary and secondary pupils. Findings in the 'Stay Safe' section include:

The extent to which children and young people feel safe:

- The vast majority felt safest at home, followed by at school during lessons
- 39% did not feel safe where they live after dark

- 21% did not feel safe in their local park

Experiences of bullying:

- 35% thought that bullying was a problem in their school and 60% felt that their school was good at dealing with it.
- 28% said they had been bullied a few times during the year
- 6% said they were bullied most days or every day.

These figures for bullying are similar to those presented for the previous year.

#### Partner engagement with children and young people

The Youth and Skills Service in liaison with the Youth Council uses a range of evaluation, questionnaires and direct feedback from users to inform programme development. Youth Engagement and Peer Inspection groups are being developed in the cluster localities. Schools and Leeds City College promote 'pupil voice' as a vital component of their own quality assurance processes (and contribution to inspection preparation). There are student representatives on Leeds City College committees and involvement in staff recruitment.

In Wetherby Young Offender Institution, systems are well embedded for young people to voice complaints and receive feedback. These contribute to improvements in practice and the development of services.

Through a partnership with User Voice, the Leeds Youth Offending Service regularly engages in consultation exercises with service users to ensure that young people are engaged in shaping services for their local communities.

The Cafcass Family Justice Children & Young People's Board has been involved locally in open days, recruitment and selection, the development of focus groups and office inspections.

#### LSCB Voice & Influence Group

The LSCB, in conjunction with Leeds City College, has identified and is working with a group of young people to implement the LSCB Voice and Influence Strategy. To date the group have been involved in supporting the LSCB Annual Conference 'Let me speak – will you Listen?' and in interviewing for the post of the LSCB chair. The group is developing proposals for how it links into the main Board and progresses its status as a formal reference group.

Work planned for 2013/14 includes contributing to the development of the new LSCB website and providing consultation to partners who are working to engage children and young people in the planning and development of their services as part of their s(11) action plan.

### 8.1.2 Listening to Children and how their Views are Influencing Practice

Alongside incorporating the views of children and young people in the design and planning of services is the need to take more account of their views and experiences when working with them to improve outcomes; a point that is emphatically made in the revised Working Together (2013) guidance. There is evidence of good progress being made in Leeds in the context of a partnership commitment to a restorative approach to working *with* children, young people and their families, rather than providing services *for* them or *to* them.

More than 80% of children and young people who are looked after participate in their statutory reviews and a toolkit is being developed to improve the quality of this input. The Care Planning, Placement and Case Review Regulations 2010 introduced a new requirement for Independent Reviewing Officers to speak with children and young people separately as part of the reviewing process and this has resulted in an increasing number of such consultations and observations completed (65% in 2011/12, 79% in 2012/13).

A survey has been commissioned from the Barnardo's Children's Rights Service to consider the impact of these pre review visits and the extent to which they facilitate the building of a relationship that enables children and young people to participate more fully in their reviews.

The adoption of the Strengthening Families Framework is intended to increase family member and children and young people's participation in child protection conferences, which has been historically low in Leeds. Whilst being clear that 'attendance' does not necessarily equal 'participation', all children over the age of 10 are invited to conferences where this is felt to be appropriate. On average children and young people attend 10% of conferences and the response from professionals has been positive. Recording of children and young people's views has improved, both within conferences and in the minutes.

A multi-agency audit of the effectiveness of child protection processes co-ordinated by the LSCB (see below) reiterated that the voice of the child needs to be more clearly included and evidenced in conferences and core group meetings..

A pilot project was undertaken between December 2012 and April 2013 looking specifically at the efficacy of child protection conference chairs having contact with children and young people prior to a conference. This is being evaluated by the Children's Service Voice and Influence Team and the outcome and recommendations will be reported in 2013/14.

The Leeds Children's Rights and Advocacy Service is being re-commissioned with the intention that the current service being provided

for looked after children and young people and care leavers will be broadened to include those within child protection processes, family group conferencing, child in need meetings and complaints. Funding has been agreed to provide a pilot advocacy service for children aged 10 years and older who are the subject of initial child protection conferences. This service will be initially offered to 15 families.

## 8.2 **Monitoring and Reviewing**

Many key processes and specific services are subject to independent monitoring and reviewing which provides a useful external measure of how well safeguarding is being carried out in Leeds.. This section considers the evidence provided from a number of sources.

### 8.2.1 **External Inspection**

External inspections and reviews give a crucial objective view of the quality of services being provided, the impact on children and young people, and where improvements need to be made. Although there was no 'whole system' inspection in 2012/13, the findings of previous Ofsted inspections of multi-agency safeguarding arrangements have proved crucial in (i) initiating the current Leeds Improvement Journey, and (ii) providing assurance that progress is being made.

#### Ofsted Inspections of multi-agency arrangements

In 2009 an announced Ofsted inspection judged safeguarding services in Leeds to be 'inadequate' and the authority was subsequently made the subject of a statutory improvement notice. Since this point the partnership has viewed itself as being on an 'improvement journey' based on political and professional co-operation and generating a coherent and sustainable strategic plan to improve multi-agency working and services and to improve outcomes for children and young people.

In October 2011 Ofsted published its report of the outcome of their announced re-inspection of Safeguarding in Leeds. The Report recognised significant improvements made across the city. Overall, five of the nine categories that Ofsted assessed were rated as 'good' and four were rated as 'adequate' - there were no categories rated as inadequate. The key judgments of 'overall effectiveness' of Safeguarding in the City were rated as 'adequate' and the 'capacity to improve' was rated as 'good'. Taken together with their unannounced inspection of contact, referral and assessment arrangements in January 2011 - when Ofsted noted 'remarkable and impressive improvements' - this provided strong endorsement of the progress being made in Leeds.

The report supported the view that developments in Safeguarding were making a significant difference to the well-being and safety of children in Leeds. The inspection found that 'arrangements to ensure children are safeguarded are now secure' and highlighted 'significant progress in improving outcomes'. The inspectors did not identify any children left at potential risk of harm, and none of the



cases reviewed were deemed to be inadequate.

Amongst the other areas that the inspectors highlighted were:

- The development of more child centred approaches, for example through the way that children are increasingly involved in child protection conferences so that their wishes and views are fully taken into account.
- Improvements in the way partnership between different services to safeguard children works, especially in terms of shared responsibility, vision and priorities, and the overall understanding that in Leeds, 'safeguarding is everyone's business'.
- That the Leeds Safeguarding Children Board is much improved.

The Report noted areas in which further development needs to take place:

- To improve the electronic social care record system (ESCR) – used by the Children's Social Work Service.
- To continue to improve the timescales for initial children protection conferences.
- To improve the quality of assessments to help achieve a consistent standard across the service.
- To support information sharing between partner agencies in relation to domestic violence.

As a result of the significant amount of progress made the Government removed the Improvement Notice.

### Inspections of Partners

Many partners have been the subject of inspections by their regulatory bodies in 2012/13 which either focused on safeguarding or included it in a wider remit. The findings highlight much that is positive in the development of services and provide a further degree of assurance that good progress is being made.

Children's services:

Three inspections have taken place in relation to Looked After Children's Services:

- An Ofsted thematic inspection of Independent Reviewing Officer services in January 2013 provided very positive feedback including that:
  - The service is independent of the Children's Social Work Service but has a strong link
  - Dispute resolution and quality assurance processes are well understood

- The service is child focused and engages well with young people
  - Independent reviewing Officers are involved in quality assurance and case auditing, which is used to inform practice development
  - There was evidence of good communication between Reviewing Officers and Social Workers
  - There were good links with Cafcass.
  - The approach to peer and management observation of practice was an example of good practice.
- In February 2013 Ofsted tested their proposed methodology for the inspection of Looked After Children's services. Headline messages were that:
    - No cases were found where a child was unsafe or where there were concerns about practice
    - Services for looked after children and care leavers were improving
    - Front line practitioners knew and understood the strategic direction and objectives of the service
    - There was a clear emphasis on supporting children to achieve permanence
    - Leeds demonstrated high ambitions for looked after children and care leavers and for services to support them
    - Areas identified for improvement included:
      - § Care Plans were not always Specific, Measurable, Achievable, Realistic and Timely
      - § Many Pathway Plans and Personal Education Plans did not evidence involvement of children and young people
      - § Not all plans had a contingency plan
      - § Some inconsistencies evident in the way supervision was used challenge practice and drive care planning
  - Also in February a LILAC inspection took place (Leading Improvements for Looked After Children), undertaken by young people with experience of being in care. Leeds was felt to have met all seven standards of the inspection and comments from the team were very positive about the commitment to involve children and young people in improving their care and lives. Specific comments included:
    - 'I was happy to see the council realizing their role as the parent, often something forgotten about in other Local Authorities'.
    - 'Overall I was confident Leeds was moving in the correct direction with a lot of progress made'.
    - 'We feel that Leeds were deserving of all 7 Standards with some very enthusiastic members of staff which was encouraging'.
  - Inspections carried out by Ofsted over the year of Local Authority Children's Homes revealed that no Leeds children's home is rated as 'inadequate'. Five of the twelve (42%) are rated 'good' or better, with the remaining seven (58%) rated 'satisfactory / adequate'. Recent interim inspection reports suggest that eight homes (67%) are currently making good or better progress.

#### Early Start Service:

No Ofsted inspection judgments of Children's Centres in 2012/13 questioned safeguarding practice and the vast majority make very positive reference to the effectiveness of policy and practice. Of 57 Children's Centres across the city Ofsted judged 82% to be 'good' or 'outstanding'.

#### NHS:

In February 2013 Leeds Community Healthcare took part in a pilot with Ofsted and CQC inspectors to test their methodology for implementing proposed Looked After and Care Leavers inspection standards. Whilst no judgment was given, positive feedback from the inspectors indicated that the health needs of looked after children and young people are viewed as a priority and that individual Health Needs assessments are of a very high standard.

Ofsted inspections of Eastmoor Secure Children's Centre highlighted health delivery as a strength, with the appointment of a Nurse Manager as being instrumental in key quality improvements.

Leeds and York Partnership Foundation Trust were judged by Ofsted as being 'satisfactory with good capacity to improve.'

#### West Yorkshire Police:

In July 2012 Her Majesty's Inspectorate of Constabulary conducted a review of the Force's recording of serious sexual offences, identifying. Some inconsistencies were identified in the rationales provided for deciding whether a crime should be recorded, which resulted in a streamlining of processes and the introduction of additional supervisory checks.,

#### The Secure Estate:

Although Wetherby Young Offender Institution was not formally inspected in 2012/13 it was reviewed and received IMB and Advocacy Annual Reports which highlighted areas of good practice and good interaction between staff and young people. Scrutiny visits by the Youth Justice Board and Young People's Group highlighted themes that are currently being addressed, including: violence reduction, searches at reception and responding to young people shouting out of cell windows.

### 8.2.3 Serious Case Reviews and Learning Lessons Reviews

One of the key functions of the LSCB is to ensure that lessons are learnt from the circumstances of serious child care incidents that will improve future practice and reduce the risk of such incidents re-occurring.

The LSCB is responsible for initiating a Serious Case Review (SCR) in circumstances where there has been a death of a child and abuse or neglect is known or suspected, or where there has been a serious injury and there are concerns about interagency working. The purpose of such a review is to:

- Establish whether there are any lessons to be learnt from the case and from the way in which local professionals and organisations worked together to safeguard and promote the welfare of children.
- Identify clearly what those lessons are, how they will be acted on, what is expected to change as a result and within what timescale *and*
- as a consequence, improve inter-agency working to better safeguard and promote the welfare of children

During 2012/13 the standing SCR sub-committee received 3 completed Local Learning Lessons Reviews (LLLRs) and 2 Single Agency Reviews. These generated 12 recommendations for action by the LSCB, 5 of which have been completely implemented and the remainder are on-going and being monitored. Key learning themes from these Reviews include:

- The importance of early intervention and preventative service provision underpinned by use of the Common Assessment Framework
- Keeping the child at the centre of practice;
- The need for effective intra-agency and interagency communication
- To improve professional recognition and response to disguised compliance
- Adult mental health assessments to consider the safeguarding implications for children
- The need for health visitors to be aware of safeguarding issues through good record keeping and its transfer when children change areas
- Greater rigour required around analysis of 'risk' and 'need' within a more child focused approach.
- There should be less reliance on adult self-reporting and the adoption of a 'respectful uncertainty' approach to assessment.
- Greater management oversight and scrutiny of assessments.

- The need for robust and consistent system of quality assurance of assessments
- To ensure the continued safety and well-being of children who are 'de-escalated' from a Child Protection Plan and made the subject of a Child in Need Plan.
- To ensure that CSWS staff are aware of their statutory obligations in relation to housing and safeguarding when working with 16 to 17 year old young people.
- The LCC Environment and Neighbourhoods Directorate to ensure the timely completion of the comprehensive review of services for sixteen to twenty two year old young people "Children and Young Person's Housing Plan".

As well as generating recommendations for the LSCB these themes reflect recommendations for action for the individual agencies involved and have been incorporated into business planning for 2013/14 (eg the review and revision of the Think Family Protocol' to underpin multi-agency working with children and young people living in the context of compromised parenting and the developing proposals for a Young Person's Service (16 – 25 yr old).

No Serious Case Reviews were initiated in 2012/13 but 2 Local Learning Lessons Reviews were commissioned and are on-going.

In addition, the Leeds Youth Offending Service undertook and shared with the LSCB a review of 6 serious incidents in 2012/13 identifying and progressing the following lessons:

- Learning together with partners, particularly regarding information sharing and professional challenge
- Learning about best practice regarding domestic violence
- Learning about the needs of looked after children and young people in out of area placements
- Learning about managing vulnerability
- Recognising excellent practice.

#### 8.2.4 **Managing Allegations Against Professionals**

One of the LSCB's functions is to ensure that there are appropriate policies and procedures in place to investigate and respond to allegations of abusive behavior made by children and young people against professionals. The Board receives an annual report from the Local Authority Designated officer summarising the allegations that have been made over the year and how they have been managed.

Dealing with allegations made against professionals is the role of an employing agency. However, the Local Authority is required to

provide a coordinating role through the provision of a Local Authority Designated Officer, or 'LADO'. Individual agencies are required to notify the LADO of any allegations made. The role of the LADO is to provide advice and guidance to employers, to liaise with the police and other agencies and to monitor the progress of cases to ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process.

An annual report has been provided to the LSCB on activity by the LADO during 2012/13. This report provides statistical information for the period, development work this year and plans for future development for the year 2013/14.

There were 267 referrals to the LADO in 2012/13 (179 about specific children and young people and 87 about concerns about professionals arising out of the work place eg within their families). Since a full time officer has been in post the average annual referral rate is around 300. A breakdown of these referrals indicates a similar pattern to previous years:

- 33% from Education
- 20% about foster carers
- A small but significant number from the Secure Estate (Regional Secure Children's Centre and Wetherby Young Offender Institution)

The largest group of allegations involved physical abuse, although a significant number involved emotional abuse by professionals (bullying or derogatory comments). Half of all referrals resulted in holding inter-agency allegations management strategy meetings, which alongside considering the risk posed by the professional also considers the impact on the child or young person. 37% of allegations about specific children involved those who were 'looked after' and 13% of allegations resulted in Police investigations.

With the recent appointment of a second full time LADO it will be possible in 2013/14 to develop the service further:

- To provide a more consistently timely response to allegations and effect the quicker completion of processes.
- To develop information leaflets and feedback forms for children and young people
- To better understand the pattern of referrals and to test out whether all agencies are dealing with allegations appropriately
- To deliver a one day national conference exploring the links between the LADO role and the Secure Estate
- To provide in the annual report for 2013/14 information about outcomes of investigations and a consideration of the wellbeing of all involved when allegations are made.

### 8.2.5 Private Fostering

Children and young people who go to live with adults outside of their immediate family are 'privately fostered' and are viewed as being potentially vulnerable. Working Together to Safeguard Children 2010 set out a policy and procedural function for the LSCB in relation to private fostering. The LSCB role includes monitoring and quality assurance, and to ensure that public awareness is raised about private fostering.

It is the duty of local authorities to promote public awareness of the requirement for those considering undertaking private fostering arrangements to notify the local authority. The local authority has a duty to satisfy itself that the welfare of children or young people who may be privately fostered within their area will be satisfactorily safeguarded and promoted. It is a requirement of the Private Fostering Regulations, 2005 that an annual report is presented to the LSCB.

Private fostering arrangements in Leeds were inspected in September 2008 and were judged to be inadequate. In January 2011, the service was independently reviewed and a further action plan developed. Some progress was made in all aspects of the plan. However, further internal auditing of the service indicated a significant lack of compliance with requirements. There was also a continuation of a low rate of reporting of private fostering arrangements albeit with year on year increase.

Following the Annual Report to the LSCB in June 2012 privately fostered children and young people were identified as an LSCB priority vulnerable group for 2012/13. A Leeds City Council Scrutiny Board Inquiry also took place in 2012/13 and has asked for an update on progress in July 2013.

The LSCB received the Annual Private Fostering Report in June 2013 which indicated:

- There has been a modest increase over the past 3 years in the number of children and young people known to be privately fostered in Leeds (12 at the end of 2012/13). The number of children and young people who have moved out of such arrangements or reached their 16<sup>th</sup> birthday (32) has been offset by a significant increase in notifications received (28 in 2012/13). This indicates that efforts over the past 3 years to increase professional awareness about the need to identify and respond to private fostering arrangements are bearing fruit.
- The Private Fostering Communications Strategy has been revised and updated for 2013/14.
- An internal audit of files in January 2013 indicated that progress was being made in ensuring that statutory visits to privately fostered children and young people were taking place, although improvements were still required in the completion of assessments within the required timescales and the timely obtaining of police checks.
- Since January 2013 changes to staffing arrangements have been consolidated, with temporary posts made permanent and the appointment of a worker with considerable knowledge and experience of the requirements of private fostering.

- The next audit of files is to take place in November 2013.

### 8.2.6 **Safeguarding in Secure Settings**

Another group of children and young people who are particularly vulnerable are those who have been remanded or sentenced to a secure residential setting for criminal activity.

Leeds has two secure establishments for children and young people; Wetherby Young Offender Institution (16 – 17 yrs) and East Moor Secure Children's Centre (10 – 17 yrs, with an average age of 15). With the exception of a small number of 'welfare beds' at East Moor, the population is made up of those remanded or sentenced for criminal matters.

The LSCB is required to report annually to the Youth Justice Board on the use of 'restraint' in secure units its area and has chosen to commission an independent specialist in youth justice and looked after children to undertake this task. Findings from the 2012/13 report are:

- That both units are to be commended for a continuing trend of less use of restraint. Whilst it is acknowledged that this is in the context of reduced occupancy rates, there is a consensus that the complexity of the needs and challenging behaviour of the children and young people in their care has increased.
- That changes in policy, practice and data recording of restraint in both parts of the secure estate in recent years have made it difficult to progress recommendations from reports in previous years; which proposed that common definitions about restraint, injuries, length of incidents etc be developed so as to provide a basis for comparison and a common approach to minimization.
- Wetherby is currently in the process of undertaking an extensive programme to train staff in a new package 'Minimising and Managing Physical Restraint'.
- Eastmoor's scheduled external review of its Restraint Minimization Strategy has been delayed and will now take place later in 2013/14.

The report concludes that with the changes to the methodologies of restraint due to be completed this year it should be possible to generate a consistent shared data base to monitor incidents, their duration and their impact in 2014/15.

### 8.2.7 **Safeguarding in Education Establishments**

Schools and colleges have contact with the vast majority of children and young people in the city and provide support for many who are vulnerable. Education establishments play a key role in safeguarding and promoting the welfare of children and young people and are closely monitored and regulated.



There was a 98% response rate from Education establishments to the annual self audit of safeguarding arrangements (s175 /157 Education Act 2002). This involved 211 schools and the Leeds City College. In response to the findings the following actions have been taken by the Integrated Safeguarding Unit:

- Where gaps have been identified the Chair of Governors for each establishment has been notified.
- All designated staff that are due to undertake 2 yearly refresher training have been sent a letter reminding them
- All schools that are due to undertake whole staff refresher training have been contacted and reminded.

Ofsted inspections undertaken between September 2011 – March 2012 found 17% of Leeds schools to be 'Outstanding' and 64% to be 'Good' for safeguarding standards, which compares well with the national average. No school received an inadequate judgment for safeguarding standards.

Leeds City College was inspected in May 2012 and received Grade 1 (Outstanding) across all campuses and sites in the City for:

- How well the college promotes and ensures safeguarding arrangements
- How safe students feel

Managing and responding to school non attendance is now predominantly the responsibility of locality clusters. This has resulted in a 50% increase in referrals for children and young people missing education and prompted the development of revised procedures for schools and training for staff responsible for attendance and child protection matters.

Performance monitoring in 2010/11 had identified that a significant number of Initial Child Protection Conferences were delayed during school holiday periods due to the lack of availability of education staff. This issue was raised with the Head Teacher's Forum and more consistent arrangements were put in place with the LCC Integrated Safeguarding Unit. This has resulted in a significant improvement in the increase of education staff representation to 78% during the 2012 summer holiday period, with no conferences being cancelled due to lack of education representation.

The LSCB will be increasing its engagement with education establishments in 2013/14 through the newly formed Education Safeguarding Forum. This LSCB reference group will facilitate two way communication between the Board and the sector, ensuring that key safeguarding messages are disseminated and that feedback about issues and concerns is received.

## 8.3 Performance Management and Quality Assurance of Safeguarding Services

Ensuring the effectiveness of multi-agency working to safeguard and promote the welfare of C&YP is the second of the LSCB core functions. This requires the LSCB to develop its own comprehensive overview of the quality, timeliness and effectiveness of multi-agency practice which is facilitated through the LSCB Performance Management System and is made up of three components:

- 1) Monitoring partner compliance with the statutory requirement to have effective safeguarding arrangements in place
- 2) A Performance Management Framework based on the strategic priorities of the Board and including measures from the national Children's Safeguarding Performance Information Framework.
- 3) A multi-agency Quality Assurance and Audit Programme

This system complements and feeds into the Leeds Framework for Learning and Improvement which helps to promote a culture of continuous improvement across the partnership.

### 8.3.1 'Section 11 Duty to Safeguard' Compliance

The Annual Partner Audit of compliance with the statutory requirements of s(11) of the Children Act 2004 indicates that safeguarding arrangements remain strong across the nine standards. The main areas identified as requiring review or improvement by organisations include:

- A clear statement of the organisations responsibilities towards children is available for staff and volunteers
- A clear line of accountability within the organisation for work on the safeguarding of children
- Developments within the organization to take account of the need to safeguard children and to be informed, where appropriate, by the views of children and families
- Training on the safeguarding of children for staff and volunteers working with or, depending on the organisation's responsibilities, in contact with children and families
- Staff are aware of the information sharing procedure for their organisation
- Ensuring that children are made aware of their right to be safe from abuse.

Progress on action plans by partners to address the improvements required will be monitored in 2013/14 along with the introduction of a range of audit and peer challenge processes to cross check standards. Information about the extent of partnership engagement in the process is provided in 10.2.6 (below).

In 2013/14 the LSCB programme to ensure compliance with s(11) responsibilities will take account of the extended scope to include all

private, voluntary and independent sector agencies as set out in Working together 2013.

### 8.3.2 **The LSCB Performance Management Framework**

A key component of the LSCB Performance Management System is the 'Performance Management Framework' which collates data from across the partnership about safeguarding activity. Established in 2011 and refreshed to include measures from the national Children's Safeguarding Information Performance Framework, it is based on an 'Outcomes Based Accountability' approach, asking three questions: How much did we do?; How well did we do it?; Did it make a difference?

Within the framework are 4 scorecards which collate performance information about operational processes and the safeguarding of priority vulnerable groups of children and young people:

#### The child's journey through the safeguarding system

This reviews information about how the safeguarding system responds when concerns are identified and raised about vulnerable children and young people. It throws light on how children and young people become the subject of statutory intervention and the extent to which Early Help, preventative services are employed to reduce that need.

The restructured Children's Social Work Service Duty and Advice Team has had a significant impact on the nature and patterns of referrals from across the partnership. 2012/13 saw:

- A 6% increase in the number of requests for service (31,000 to 33,000), indicating that more conversations are taking place between agencies about how best to respond to children and young people about whom there are concerns
- Referrals accepted by Children's Social Work Service for consideration of statutory intervention has fallen from 14,000 in 2011/12 to 11,000 in 2012/13 and as a percentage of request for service made (46% to 34%), indicating that the conversations are resulting in improvements in the quality of referrals received and a refocusing on alternative, preventative approaches where appropriate.
- A reduction in the number of children and young people who are re-referred to Children's Social Work Service within a 12 month period (which may reflect the extent to which services were not provided 'at the right time') from 36% at the beginning of the year to 30% at its end. Although this latter figure remains high, and a cause for concern, the trend is clearly positive and expected to improve further in 2013/14. The Duty and Advice Team has demonstrated increasing consistency in decision making through a weekly multi-agency review meeting which considers contacts from partners which did not result in referrals being accepted.

Of the 11,000 referrals accepted by Children's Social Work Service, 1682 resulted in child abuse investigations and, following assessments, 1458 initial child protection conferences were held. Reviewing performance data about the efficiency of the this process

identifies that:

- The timeliness of core assessments within statutory guidance fluctuated throughout the year between 64 – 90%, representing an overall fall in performance compared with 2011/12.
- The timeliness of initial child protection conferences within statutory guidance also fluctuated throughout the year between 34 – 88%, although overall there was a significant improvement compared with 2011/12. A marked dip in performance occurred between December 2012 and January 2013 which coincided with a high level of staff sickness and a focus on the pilot to more fully engage children and young people in the conference process (above).

The number of Common Assessments initiated in 2012/13 (867) remains relatively low, albeit representing an 11% increase on the previous year. Conversations between partners and the Duty and Advice Team include consideration of when a Common Assessment may be appropriate. Between December 2012 and March 2013 advice was given that 471 children and young people (from 246 families) should be considered for a CAF, of which 52% have been progressed.

#### The provision and effectiveness of Early Help

The development of Early Help services is an essential part of the aspiration to reduce the need for statutory intervention by providing the 'right service at the right time and the partnership continues to make a significant investment in this approach. The Children's Services Early Intervention and Prevention Strategy underpins this commitment to tackle emerging problems as soon as possible by working with children, young people and their families in a restorative way that is supportive and empowering.

There are a number of components to the strategy:

- The embedding and further development of locality cluster working
- Maintaining Children's Centres in Leeds
- The establishment of Early Start Teams which bring Health Visitors and Children's Centre staff together (working closely with the Family Nurse Partnership) to provide joined up services for families from pre-birth to 5 years old. It is planned to create 4,500 places for 2 year olds by 2014.
- The implementation of a Top 100 methodology to identify children and families in localities who are vulnerable, have multiple needs and who require additional support from partners. Each family will have a shared assessment, a team with a shared intervention plan and a lead practitioner.
- De-escalation support from specialist intervention to less intensive based cluster care and support is being developed to reduce dependency on specialist services and avoid vulnerable children and young people failing to maintain the gains that such intervention can provide once it is withdrawn.

- The expansion of the Family Group Conferencing Service that allows families to consider the difficulties experienced by vulnerable children and be supported in finding ways to manage and improve the situation in a safe and appropriate manner before statutory intervention is considered.
- Increasing the number of 'conversations' between the Children Social Work Service Duty and Advice Team and professionals who have concerns about children and young people with a view to exploring, where safe and appropriate, preventative early help options.

The Leeds Youth Offending Services provides a good example of collaboration with partners to support Early Help Services:

- Working with young people at risk of offending who are referred from Children's Services, West Yorkshire Police and other partners. Between April and December 2012 the first time entry figure for the Youth Justice System in Leeds was 665 per 10,000 of the 10 – 17 year old population, which represents a 14% reduction on the previous year.
- Working closely with the Families First programme in the city, linking with Targeted service Leaders in each cluster and supporting the use of the Top 100 Methodology. Youth Offending staff operate as lead practitioners for families in a significant number of cases.

It is evident that much preventative multi-agency work is being undertaken through these services but it remains difficult to establish the full scale and scope of such work. Despite assurances given by Dr Mark Peel at the LSCB Annual Review Meeting in July 2012 that Leeds compared favourably with other cities, it is concerning that the number of multi-agency Common Assessments undertaken has not increased significantly over the year, particularly given the simplification of the process undertaken in 2011/12,. In December 2012 the LSCB hosted a series of safeguarding seminars for cluster leaders to consider the use of CAF in the City; which identified a number of factors:

- Barriers to progressing and embedding CAF:
  - Lack of staff confidence / competence across the partnership
  - Capacity in partner agencies
  - Inconsistent agency ownership / cluster engagement
  - Professional / Cultural attitudes which maintain a 'silo' approach
  - Tension between adult / family / child focused approaches
- Opportunities / Areas for Improvement:
  - To more effectively promote the benefits of CAF and the need for professional / cultural change
  - To ensure that strategic sign up by partners results in operational progress at practitioner and 1st line manager levels
  - To ensure that commissioning processes embed the requirement to engage, and lead, CAF processes
  - To provide a more sophisticated analysis of the 'CAF gap' to identify the likely number of CAFs that should be

- undertaken
- For Clusters to develop 'CAF Forums'
- To launch the newly developed 'Family CAF' with appropriate training

A clear challenge for 2013/14 is to capture and evaluate all the multi-agency Early Help activity being undertaken across the City; a task that will be helped by the introduction in the Autumn of a new Children's Services Electronic Recording System. The development and introduction of the single multi-agency assessment framework, protocols and processes across the whole safeguarding system (Working Together 2013) will provide an opportunity to review the continued centrality of CAF in these processes and to explore further the current uneven commitment to it at an operational level across the partnership.

#### Children and young people subject to a child protection plan

Children and young people are made subject to a child protection plan when it is assessed at a child protection conference that they have suffered or are likely to suffer 'significant harm.' Whilst the circumstances of each case is dealt with carefully and comprehensively, the overall number of children subject to a plan and a comparison with statistical neighbours can give an indication of the effectiveness of the safeguarding system as a whole (and in particular the efficacy of Early Help preventative services).

Following the Ofsted inspection in 2009, when concerns were raised that Leeds was not initiating a sufficient number of statutory child protection interventions, the number of children and young people subject to a child protection rose steadily from 511 to a peak in August 2011 of 1171. The introduction of the Strengthening Families approach helped to stabilize this rise and manage a gradual reduction in overall numbers to 870 in April 2012. During 2012/13 the numbers have steadily increased to 993 at the year end. This represents a rate of 59 per 10,000, which is a third higher than for statistical neighbours in 2011/12 (39 / 10,000) but is slightly less than for 'core cities' (64 / 10,000).

Work is being undertaken by the Children's Social Work Service and the Children's Services Integrated Safeguarding Unit to better understand the reasons for these trends. This includes reviewing de-escalation processes ( from child protection plans to children in need plans) and the development of the new assessment process to include a second review point to consider whether safe alternatives to an initial child protection conference could be pursued.

Within the cohort of children and young people subject to plans are two groups requiring further investigation:

- The number who have been subject to plans for more than 2 years. This has fluctuated over the first 7 months of 2012/13 but has then risen from 29 to 56 by the year end and raises questions about the effectiveness of the plans in reducing the risks identified and whether alternative approaches should be considered.

- The number who have become the subject of a plan for a second or subsequent time. This has risen steadily over 2012/13 from 153 in April 2012 to 217 in March 2013, a 42% increase. This raises questions not only about the effectiveness of the previous child protection plan and the sustainability of progress made but also about the decision to remove the child or young person from the previous plan.

The cases identified are being audited by the Integrated Safeguarding Unit to gain a better understanding of the issues involved and the implications for the system as a whole. It is already clear that many of them involve long term 'neglect' and children and young people living in the context of 'compromised parenting' (domestic violence, parental substance mis-use and parental mental health problems).

#### Children and Young People who are Looked After

The number of looked after children in Leeds had been steadily increasing since 2005, with the most significant rise coming between November 2009 and November 2010 when the numbers rose from 1370 to 1434. This placed significant pressure on the budgets of agencies working with looked after children. In addition there is a significant body of research highlighting that looked after children have poorer outcomes than other children and young people in the community and that reducing the numbers of looked after children and improving their outcomes requires a coordinated effort from agencies working with children, young people and families.

For these reasons, safely and appropriately reducing the numbers of children and young people who need to be 'looked after' is a priority for the partnership. Reducing the number of looked after children in Leeds have been accepted as one of the three 'obsessions' by the Children's Trust Board.

There has been a steady reduction in the number of children becoming looked after over the year. In March 2013 there were 1377 looked after which is a reduction of 98 children from the same period last year. This is an encouraging trend, although there is more progress to make as the current rate of 88.9 per 10,000 remains significantly higher than for statutory neighbours (74 / 10,000).

This progress has been made by a combination of:

- A 10% reduction in the number of receptions into care (the result of a more rigorous approach to exploring safe alternative options), with the average age of this group falling significantly (suggesting that for individual children 0 – 5 years old, intervention is being offered in a more timely and potentially effective manner).
- A 16% increase in the number leaving care (the result of improved permanency planning, with more children and young people being returned to their families and an increase in adoption and special guardianship orders).

Alongside these headline figures is evidence of that this group of vulnerable children and young people are being provided with high quality services:

- Improving placement stability. The proportion experiencing 3 or more moves in 2012/13 has reduced from 10% (151) to 7% (103).
- All have statutory reviews, with 98% being within statutory timescales and, on average 85% participate in those reviews.
- All have an allocated social worker.
- 94% have a health needs assessment (85% within statutory timescales) and a health plan
- 96% are up to date with their schedule of immunisations
- 80% under 1yr old and 92% over 1 yr old have had a dental check within the last year

An important area for development in 2013/14 will be to engage with the full range of private and voluntary children's homes and foster care agencies in Leeds to seek assurance that the children and young people in their care are appropriately safeguarded.

#### Children and Young People who go 'Missing' / at risk of Sexual Exploitation

In recent years there has been an increased appreciation of the vulnerability of young people who go missing from home or care and the link between this and the risk of becoming sexually exploited. The LSCB has identified these young people as a priority vulnerable group requiring a concerted and co-ordinated multi-agency response.

The term 'missing' refers to children and young people up to the age of 18 who have run away from their home or care placement or whose whereabouts is unknown. Many of these young people stay with friends or family members, but there are some who do not have access to these networks of support and end up in harmful situations such as sleeping rough or at risk of child sexual exploitation. The LSCB, in conjunction with partners in West Yorkshire has developed a protocol that applies to all children and young people that go absent without permission from their parents, carers, residential carers or foster carers. It defines the roles and responsibilities of the Police, Children's Social Care, and carers and sets out how return home interviews should be conducted.

During 2012/13 there were 1133 missing episodes in Leeds involving 455 children and young people. 54% of these were 11 – 15 yrs old and 40% were 16 – 18 yrs old.

Child sexual exploitation involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender,



intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability.

Ascertaining the prevalence of child sexual exploitation has been identified nationally as a challenge. In Leeds systems are being developed to more accurately capture the scale of the problem locally. The data for the city which is currently available indicates that in 2012/13 103 children and young people were identified as being at risk of sexual exploitation and that this cohort was made up of:

- 14 looked after by the Local Authority
- 83% female, 17% male
- 67% were between the ages of 15 – 16 yrs old , with 12% under 10 years old
- 55% were White British, 13% White Other, 8% Dual Heritage, 5% Asian British.

The LSCB is developing a multi-agency strategy to tackle the issue of CSE in Leeds. A new post was developed through Leeds Children's Services to lead on CSE and Missing children and a lead officer was appointed in January 2013. West Yorkshire Protocols and Guidance for professionals were updated in March 2013. In order to better lead and co-ordinate a strategic approach a new LSCB sub group has been established, with links to various operational groups and partners.

Developments so far include:

- Raising awareness through training amongst professionals to help in the early identification of CSE.
- The development of a practitioner forum.
- Improving understanding by developing a comprehensive data-base to map the scale of the issue within Leeds.
- Piloting a new Risk Assessment Matrix
- Developing closer links with the Safer Leeds Partnership and Third Sector organisations.
- Considering how the victims of exploitation can be appropriately supported.
- Developing a Perpetrator Risk Assessment tool
- Planning the delivery of 'Missing' briefing sessions
- Ensuring all children and young people that go missing will have 'return to home' interview carried out.

### 8.3.3 **Evidence from Single and Multi-agency Auditing Activity.**

Having established a performance framework in 2011 which collates and enables the analysis of quantitative information about safeguarding activity (how many / how much / in what timescale did we complete safeguarding tasks etc) the LSCB initiated a Quality

Assurance and Audit programme in 2012 designed to provide much more information about the quality of the work being undertaken and its impact on outcomes for individual children and young people.

The LSCB multi-agency Quality Assurance and Audit Programme progressed 5 strands of work in 2012/13. Of these one was completed and two reported findings at the yearend:

#### Strand (1): The Effectiveness of Child Protection Plans

25 cases were audited by a pool of multi-agency auditors during 2012/13. From these 1 (4%) case was judged as good, 15 (60%) adequate and 9 (36%) inadequate. No child or young person was judged to be suffering or at risk of suffering immediate significant harm.

Areas of good practice identified include the following:

- Good attendance by agencies at conferences and core groups
- High level of support available
- Good professional communication
- High quality of reports provided for conferences
- Evidence of parents / carers being engaged in the process.

Nevertheless, the audit identified inconsistency in the overall quality in the planning, implementation and reviewing of child protection plans. Areas identified for improvement focus on the operation of multi-agency core groups and include:

- Child Protection Plans need to be SMART (Specific, Measurable, Achievable, Realistic, Timely) in order to reduce the potential for drift and delay.
- Children, young people and families need to know exactly what is expected of them
- Members to be more effective in challenging the work and progress made by core groups
- Core groups to be more responsive to changing circumstances / insufficient progress in addressing identified risks and amend child protection plans accordingly
- The voice of the child to be more clearly included and evidenced.

The findings have been disseminated across the partnership and a process put in place for all core groups to review their practice in the light of them.

In response to emerging findings earlier in the year Leeds Community Healthcare set a target of 100% attendance at child protection

conferences for Health Visitors and School Nurses. In 2012/13 attendance was recorded at 97.5%.

The audit continues in 2013/14.

Strand 2: To receive the views of professionals involved in multi-agency child protection plans

In order to gain a greater understanding of the emerging findings of the Strand (1) audit, a pilot survey was carried out engaging a small number of professionals involved in the core groups audited. Practitioners stated that:

- Sufficient time was given to read and take in written reports provided for conferences
- Decisions and recommendations from the conferences are sent out within timescales
- Core groups meet at least every six weeks, or as agreed if sooner
- Core group minutes were not always recorded and sent out in a timely manner.

This survey will be repeated in 2013/14 following work undertaken by core groups to consider the findings of the Strand (1) audit.

Strand 5: To evaluate the effectiveness of revised care and control policies in Specialist Inclusion Learning Centres

This audit set out to evaluate the implementation of an action in response to a recommendation in a Serious case Review which had been completed in June 2010. The actions had included:

- Reviewing and revising the existing care and control policy
- Issuing a revised model policy (following consultation) to the Specialist Inclusion Learning Centres.

The Audit found that although a revised model policy had been produced and issued it did not meet statutory guidance.

Subsequently the model policy was further revised in order to fully meet statutory guidance and the 5 Specialist Inclusion Learning Centres required to adapt their own procedures accordingly. A follow up audit is to take place in 2013/14 to ensure that procedures are now fully compliant.

Although the circumstances of this case involved one agency, which is no longer in existence, the audit raised more general concerns about the robustness of processes used to ensure that agreed actions from Serious Case Reviews were completely implemented. All Partners were required to review their processes and provide assurance to the LSCB chair that they were fit for purpose and effective.

### LSCB Chair Audit Activity

Over the course of 2012/13 the LSCB Chair has visited six partner agencies in order to review case files and discuss issues with staff.

### **Partner Agency Audits**

The LSCB Quality Assurance and Audit Programme complements extensive auditing by partner agencies. For example:

Cafcass:

A national audit programme of closed cases found 83% to have met the required standards / good and none with any safeguarding concerns.

Early Start Service:

The Service has established an ongoing audit of case files undertaken by managers from different children's centres to provide assurance that recording meets the required standard.

NHS:

Leeds Community Healthcare have undertaken the following safeguarding related audits in 2012/13:

- Analysis of enquiries to the Safeguarding Team
- Quality of child protection supervision (which indicated 94% compliance with standards).
- SUDIC process 2008 – 2012
- Ongoing audit of assessments for statutory looked after reviews (35 per month)

Leeds and York Partnership Foundation Trust have undertaken an audit of cases where service users transfer between services and will be monitoring standards of record keeping in 2013/14.

Leeds Youth Offending Service:

The Service operates to Quality Assurance processes: a sample audit of cases is undertaken by managers on a quarterly basis and a questionnaire is completed on a sample of cases facilitating 360 degree feedback on from all involved, including the young person and their parent / carer.

Through the further development of the Leeds Framework for Learning and Improvement, the LSCB will be requesting partners to provide summaries of their audit findings and actions taken in 2013/14 in order to contribute to the overall understanding of the quality of safeguarding services across the partnership.

## 8.4 **Implementing Learning from Research into Practice**

An important part of the Leeds Improvement Journey is the harnessing of expertise, research findings and external challenge in order to ensure that services are designed and planned on a solid evidence base. There are a number of initiatives currently being facilitated through Children's Services.

In 2011 the LSCB and Children's Services jointly commissioned an updated review of processes and decisions made in response to requests for service and referrals made to the 'front door' duty system for children and young people and their families. Professor Thorpe's research identified a significant increase in investigative and assessment work undertaken by, the then, Children and Young People's Social Care in response to 'requests for service' and referrals from across the partnership. However, this increase in workload was not matched by a proportionate increase in the level of support services provided to children and young people and their families. Moreover, the research identified a number of procedural and professional issues in the operation of the Council's Contact Centre and Children's Services Duty Room.

In April 2012 a restructured Children's Social Work Service Duty and Advice Team was established which, during the course of the year, has already had a significant impact on patterns and quality of referrals. Further research is being commissioned in 2013/14 for Professor Thorpe to review the patterns and outcomes of domestic violence referrals.

In August 2011 a 'Strengthening Family' approach was introduced to child protection conferences with a focus on risk analysis, shared responsibility for the child protection planning process and timely improvement in outcomes for children and young people. Further investigation of aspects of child protection processes is being undertaken in 2013/14 and the approach is being considered for statutory reviews of children and young people who are looked after.

Work has been undertaken with Mark Friedman to embed his Outcomes Based Accountability approach to understanding and using performance data to plan service development and assess its impact on outcomes for children and young people. This has underpinned the production of the Children and Young People's Plan and the LSCB's own Performance Management System.

In May 2012 a more flexible and streamlined Common assessment framework was introduced following work with Dr Mark Peel of the University of Leicester. This allows partner agencies to fit elements of the assessment into their own 'in house' processes.

Professors Mike Stein and Nina Biehal (University of York) are working with the Children's Social Work Service to review the quality of care planning for children and young people who are 'looked after'. From this four ongoing work strands have been identified:

- Quality of assessment
- Kinship care and special guardianship
- Young people leaving care
- Permanence.

Complementing this work is a research project being undertaken by Emily Munro (Institute of Education) which is reviewing practice in regard to care leavers and will report in September 2013. This work links with issues identified through Local Lessons Reviews undertaken by the LSCB and the challenge accepted by the Children's Trust Board 'to develop and co-ordinate improved services for vulnerable 16 – 21 year olds'.

In addition to academic input Children's services have engaged leading practitioners from the UK and abroad to advise, support and challenge the development of the following:

- Family Group Conferencing Service
- Children's Services 'Front Door' arrangements
- Fostering policies and procedures
- Performance management and Quality Assurance functions.

## 8.5 **Summary and Whole System Analysis**

Section (8) of this report clearly outlines the breadth and depth of work and initiatives being undertaken to safeguard and promote the wellbeing of children and young people in Leeds. Engaging children and young people about safeguarding matters and their own care is being progressed and good use is being made of external expertise to shape the planning and development of services. Significant service restructuring has and is taking place to respond to the changing circumstances of the public sector and to promote more effective ways of working with children, young people and their families. More quantitative and qualitative information is being collated to help analyse:

- Where progress is being made
- What outcomes are being achieved
- What difference is this making

- Where more improvement is required
- What requires further investigation and understanding.

For the LSCB, in discharging its responsibility to evaluate the effectiveness of safeguarding activity in the city, a series of questions must be answered:

### **1) Are we doing the right things?**

Whilst the answer to this rests ultimately on whether outcomes for children and young people improve consistently over time, there are positive indications in the development of:

- A clear, coherent strategic direction since 2009 which is focused on increasing the availability and effectiveness of Early Help preventative services and reducing the need for statutory intervention. This is formalized in the Children and Young People's Plan and supported through the challenges from the LSCB to 'rebalance the safeguarding system'.
- A shared partnership culture underpinned by a restorative approach to working with children, young people and their families that seeks to 'never do nothing' and to provide the right service at the right time with 'high support and high challenge'.

### **2) Are we making sufficient progress?**

There is evidence of good progress being made in the aims and objectives we have set ourselves in:

- The reduction in the number of children and young people who need to be looked after
- The quality of services being provided for children and young people in the care of the Local Authority
- The establishment of revised Children's Services 'Front Door' arrangements which have supported:
  - An increase in conversations between partners about how best to respond to children and young people about whom concerns have been raised
  - A reduction in the number of referrals accepted by Children's Social Work Service
  - An improved understanding of the nature and scale of patterns of domestic violence across the city
- Continuing the investment in and co-ordination of Early Help services.

### **3) What are the emerging challenges?**

A greater understanding is required of:

- The trends and composition of the number of children and young people who are subject to child protection plans
- The full nature and extent of multi-agency Early Help and preventative activity being undertaken
- How the development of a single assessment framework across the partnership and the continuum of 'risk' and 'need' can enhance the planning of Early Help interventions

Areas identified for improvement include:

- The timeliness of child protection processes
- The effectiveness of child protection plans
- The provision of services for children and young people at risk of or suffering sexual exploitation

Areas identified for development include:

- The agreement to a single assessment framework and process which is robust and straightforward to use
- The updating of the Leeds 'Think family Protocol' to improve multi-agency responses to children and young people living in the context of 'compromised parenting'.
- The exploration of a partnership approach to establishing a Young People's Service (16 – 25 yrs) that would cater for vulnerable young people, including care leavers.

The issues identified in this sub section have contributed to the development of challenges for the LSCB and Children's Trust Board for 2013/14.

#### **4) Are we managing risk appropriately and safely?**

This is a crucial factor at all times; but particularly so during a period of 'whole system re-orientation' as is currently the circumstances in Leeds. It is important that the LSCB is able to be satisfied that risk is being managed safely and appropriately in individual cases.

The evidence includes:

- The reduction in the number of looked after children and young people is gradual and is being actively managed. The reduction is due to a combination of fewer receptions into care (with alternative, more appropriate, options being rigorously explored) and improved permanency planning enabling more to leave.
- Although the number and make-up of the cohort of children and young people who are subject to child protection plans requires further investigation and improvements are required in the effectiveness of plans, it is notable that the LSCB audit



- confirmed the Ofsted findings of 2011 that children and young people are not being left in unsafe situations.
- Concerns remain about the high rate of re-referral to Children's Social Work Services with the implication that some children and young people may not be receiving a timely and effective response. Nevertheless, the introduction of the new Duty and Advice Team has impacted positively on these figures and the trend is expected to continue in 2013/14 as the new arrangements bed in.
  - Considerable audit and review activity is being undertaken to better understand the working of the safeguarding system as a whole and the performance of its component parts.

## 9.0 Review of Challenges to the Children's Trust Board for 2012/13

In the presentation of the Annual Report in June 2012 the LSCB set a series of challenges to the Children's Trust Board for 2012/13. Progress against these challenges is considered here:

### **(1) To embed changes being implemented to the safeguarding system and be able to evidence the development of a more 'balanced' system (towards earlier intervention) with improving outcomes for vulnerable children and young people.**

The Children's Trust Board wants to ensure that any vulnerable child in Leeds receives the right support at the right time in the right way. The Board has maintained a focus on develop a range of services that enable interventions to take place early in the life of a problem.

The Board has supported the roll out of Targeted Service Leaders in all clusters. As a result more vulnerable children and families are having their needs met through joined up local services. Referrals to social care are reducing. Local services are becoming more confident and able to meet needs locally. Support through the Common Assessment Framework meets the majority of needs. Feedback from parents and carers is very positive.

Children's Centres and health visiting services have merged to create the 'Early Start' service to create a more joined up support for families. The Early Start Centres provide strong support for young children and their families. 82% of Leeds' Children's Centres are rated as good or outstanding.

The Board has continued to support improvements to the Children's Social Work Service 'Front Door'. The development of a dedicated phone line for professionals, which is answered by a qualified and experienced social worker has resulted in a better referral processes and better referrals. As a result the number of 'contacts' that is conversations between professionals about children have increased. However the number of these conversations that require a referral to the Children's Social Work Service has decreased. The number of referrals receiving an initial assessment and the number of children receiving a service following an initial assessment have increased. This indicates that the service is now more focused on those children who require the support of a social work practitioner. All referrals

are quality assured weekly by a multi-agency group of senior officers. External academic researchers and local partners have provided positive feedback on our new arrangements for managing referrals to social work services. Decision-making is improved, supported by clearer referrals, with more referrals progressing to assessments.

**(2) To ensure that high quality services are provided to C&YP within the statutory system (C&YP subject to CP Plans and LAC)**

Looked after children are one of the Children's Trust Boards three obsessions. The Board receives regular reports from the Children's Social Work Service on progress on safely and appropriately reducing the number of looked after children. The report provides an overview of the actions taken by the Children's Social Work Service and key partners to reduce the need for children to become looked after through early intervention and effective safeguarding services and the quality of care provided to children looked after by Leeds City Council.

The Board received the last report in May 2013. This highlighted that all looked after children and children subject to a child protection plan are allocated to a qualified social worker and that robust arrangements are in place through the Integrated Safeguarding Unit to provide robust challenge and support on plans for these children.

The Board receives regular performance reports on safeguarding and looked after children's services. These reports are presented to the Board by the Director and Deputy Director of Children's Services who are questioned about the story behind the figures.

In February Children's Services Independent Reviewing Officer Service was subject to an external review by Ofsted. The feedback from inspectors was positive and no cases were referred back to the service. Positive feedback was also received from inspectors who piloted some of the tools for the new inspection framework for looked after children.

**(3) To ensure that risk is appropriately considered as services delivery is developed in response to the Munro Review of Child Protection, so that children's safety is not jeopardised as a result.**

The Board receives regular reports from the Director of Children's Services. The Board has been informed of the work being undertaken with Professors Mike Stein and Nina Beihal from York University to improve the quality of assessment and care planning. This work will support the implementation of the new social work recording system *frameworki*. The implementation of the system is also being monitored by the Board.

**(4) To lead the development within partner agencies of complementary quality assurance frameworks consistent with the 'The**

### **Children's Safeguarding Performance Information Framework' published by the Government in June 2012.**

The Board receives regular performance information. This has been informed by the The Children's Safeguarding Performance Information Framework'.

#### **(5) To ensure that the potential risks to safe practice, such as changes to how Health Services are provided are implemented, are kept under consideration.**

The CTB has responded to the changes in health services by reviewing the membership of the Boards. A representative from the CCGs has been attending CTB since Nov 2012 and the CTB formally agreed two places for CCG representative at the meeting on 10 May 2013. The representatives are Jane Mischenko and Dr Helen Hayward.

Public Health colleagues are now co-located with Children's Services colleagues in Merrion House. This arrangement will enhance current partnership working relationships and enable new relationships to be developed.

In December 2012 the Health and Wellbeing Board Chair attended the CTB to present the draft H&WB Strategy for information and comment and a report outlining the engagement process. The Strategy was formally adopted by the Health and Wellbeing Board in May 2013. The Chair of the CTB and the Director of Children's Services are members of the Health and Wellbeing Board. We are currently planning a joint event of both Boards to be held in the Autumn 2013.

Partners are willing to make changes together and explore new ways of working. This has been demonstrated by the new 'front door' arrangements at social care offices, where health and police professionals work alongside social care officers and are available to give advice and support to service users and professionals

## 10.0 **Assessment of the Extent to which LSCB Functions are being Effectively Discharged**

This section of the Report reviews the way in which the LSCB has carried out its functions and responsibilities during the year and met its statutory requirements. It begins with a summary of the outcomes from the Annual Review Meeting held in July 2012 before considering:

- How the LSCB has undertaken its work
- How it has promoted a shared culture of continuous improvement
- How effective it has been

## 10.1 LSCB Annual Review July 2012

The Annual Review offers an opportunity for the Board to step outside of its busy schedule of business meetings in order to consider the findings of the Annual Report Evaluating the Effectiveness of Safeguarding in Leeds for the previous year and to reflect on how well it is working to provide strategic leadership for the partnership. The LSCB Annual Review undertaken in July 2012 included:

### A self-assessment exercise

This considered:

- Governance and Mandate, with a consensus that there is clarity in this area through documentation and on-going discussion.
- Infrastructure and Capacity:
  - The Business Support Unit and sub group structure viewed as working effectively.
  - There is a positive attitude to implementation of the implications of the revised 'Working Together' framework
  - Issues raised re admin support to the Child death Overview Panel have been included in current business planning.
  - Concerns were raised about sustaining LSCB budget contributions in the future.
  - Recognition was given of the progress made in further developing the Quality assurance framework, and the importance of continuing to prioritise this.
- Delivery and Outputs:
  - The positive performance of the Training Programme.
  - There are high aspirations for the different components of the communications strategy (includes engagement of children and appointment of lay members).
  - Recognition was given of improved Serious case Review processes.
  - There is an emphasis on the importance of progressing the Audit strategy in order to provide evidence of quality of services
- Outcomes:
  - Acknowledgement was given of major changes in processes but a continuing lack of evidence of the impact on individual children. This needs to be seen as a priority.

#### A 360° Review of the LSCB Chair:

- There was a unanimous view that the Chair carries out the role responsibilities effectively.
- Members appreciate the Chair's experience, her clear leadership and inclusivity.
- Board members are positive about the Chair's style of leadership.
- All felt the Chair is approachable and that 1-1 meetings arranged when she took up her post had been very helpful in securing engagement and there would be value in repeating these at intervals.
- It was suggested that an area for increased attention was the time and focus that the business of the LSCB gets at the CTB and other strategic forums.

#### A review of the functioning of the Board identified:

- Successes:
  - The development of the Performance Management System (processes, structure and framework)
  - The Board is becoming more closely connected to practice, but needs further extending to include the 'front line', children, young people and families.
  - The Business Unit is better resourced
  - The sub group structure is more effective.
- Challenges:
  - The development of the Communications Strategy for a wider variety of audiences.
  - Promoting wider ownership of the CAF process.
  - Ensuring we are focusing on the right 'vulnerable groups' of C&YP.
  - Participation and engagement of C&YP.
  - Promoting a professional culture across the partnership of 'high support and high challenge.'
  - Clarity about our expectations of Lay Members.
  - Ensuring the right balance of quality / quantity of paperwork received by the Board.
  - The adequate representation of all sectors across the partnership.
  - Maintaining timely progress against Business Plan objectives and tasks.
  - Reviewing funding arrangements for 2013/14 and beyond.

10.1.4 Following the LSCB Annual Review in July 2012 the following actions were implemented:

- The LSCB Chair has held an additional round of 1:1 appraisal meetings with Board Members
- A funding and Value for Money Review was undertaken to inform future financial planning, from which the need to review Business Unit admin arrangements was identified
- A programme of reporting to strategic forums has been initiated
- Amendments and additions to the LSCB Business Plan 2012/13 were made
- Planning was undertaken to establish an 'Education Forum' which will be fully operational in 2013/14
- A tracker system has been introduced to ensure the timely progression of actions agreed at Board meetings.

## 10.2 How the LSCB has undertaken its work

The LSCB, in meeting its statutory requirements and progressing an ambitious business plan needs to be well organised and the efforts of its members effectively co-ordinated. This section considers how this has been undertaken in 2012/13.

### 10.2.1 Membership and Meetings

During 2012/13 there have been 6 Board meetings and 6 meetings of the Executive Group. The LSCB Annual Review Meeting took place in July 2012 in order to sign off the Annual Report and review the effectiveness of LSCB structures and ways of working. A workshop was held in December 2012 to consider and develop proposals for the LSCB Voice and Influence Strategy as part of the Board improving its links with the wider community.

Attendance at LSCB Board meetings has averaged at 77% which is an increase from the 2011/12 average of 71%.

New members to the Board have an induction session and all members undergo an annual appraisal session with the LSCB Chair. During 2012/13 a process was undertaken to recruit and select two Lay Members, who subsequently took up post at the Board meeting on 17 May 2013.

The work of the LSCB is largely undertaken through the sub / reference / task group structure. Sub, reference and task groups have met on a regular basis throughout the year to monitor and progress their components of the Business Plan. Summaries of work undertaken and decisions made are provided for each Board meeting. A decision was made in the Autumn 2012 to consolidate the strategic overview of work to address Child Sexual Exploitation by creating a formal sub group of the LSCB.

In order to directly evaluate the effectiveness of the sub / task / reference group structure and the support provided to it from the Business Support Unit, chairs and vice chairs were asked to complete a short questionnaire evaluating the support the groups received. Returns provided a picture across all of the LSCB constituent groups indicating that the support was viewed in very positive light. Overall the Business Unit was viewed as providing value for money.

### 10.2.2 **Supporting the work of the Board**

Progressing the work plan of the LSCB is heavily reliant on the input of staff from all partner agencies through sub groups, the training pool, undertaking Serious Case Reviews and Local Learning Lessons Reviews and engagement in the Quality assurance and Audit programme. The commitment shown by agencies and their staff is testament to the seriousness with which the LSCB is viewed and the shared intent across the partnership to improve multi-agency working, services and outcomes for children and young people.

A Funding and Value for Money Review identified the need to maintain the current level of Base Budget expenditure for the LSCB and requested partners to increase their contributions to ensure 'in year' financial viability and maintain an appropriate level of strategic reserve. A revised funding formula was agreed amongst existing contributing partners to ensure that the agreed expenditure for the Base Budget of £521,000 was fully funded for 2013/14 and that a small commissioning budget would be available to be used to address emerging themes and challenges. Out-turn figures at the end of March 2013 indicated that an in year shortfall in funding of £21,000 was mitigated by an underspend of £32,000. This enabled a strategic reserve of £50,000 to be carried forward into 2013/14 and a commissioning budget to be established of £35,000. A financial statement is provided in appendix 4.

An outline review of Business Unit administration identified the need for increased flexibility within a clearer management structure. A subsequent detailed review has been initiated and will report in 2013/14.

### 10.2.3 **Development of Effective partnership working:**

Progress on the challenges set for 2011/12 and emerging Challenges for 2012/13 from the LSCB Annual Review Process were presented to and accepted by the Children's Trust Board in June 2012, with the final Annual Report being received in September. The LSCB Chair or her representative has attended all CTB meetings in 2012/13, ensuring an input into the monitoring of the progress of the Children and Young People's Plan and the refreshing of the Plan for 2013/14. The Annual Report was presented to:

- The LA Chief Executive through the LA Corporate Leadership Team
- The Children and Families Scrutiny Board.
- The Assistant Chief Constable, West Yorkshire Police.

Liaison during 2012/13 with the Adult Safeguarding Board and the Community Safety Partnership (Safer Leeds) culminated in a joint Board development session in June 2013 from which common work streams have been identified to be progressed in 2013/14.

In addition to work undertaken in Leeds, the Board has been involved with regional initiatives through Regional LSCB Chairs and Managers meetings. A particular focus in 2012/13 has been to ensure consistency in approach to addressing children and young people who are at risk, or suffering, Sexual Exploitation. All five LSCBs in West Yorkshire are supporting a community campaign led by West Yorkshire Police in the summer of 2013 to raise awareness of Child Sexual Exploitation.

Leeds LSCB continues to be an active member of the West Yorkshire Consortium, which ensures a common set of overarching multi-agency safeguarding procedures is available for practitioners and managers across the region. A particular challenge for 2013/14 will be ensuring regional consistency in the response to Working Together 2013.

#### Examples of partnership working between partner agencies

Leeds Community Health Care and Children's Services (Education) have collaborated to develop a supervision pathway for the Early Start Service.

Looked After Children Nurses are collaborating with Children's Rights Workers to establish the health information young people want to receive within their Leaving Care Health Needs Assessment.

Leeds and York Partnership Foundation Trust has delivered briefings to staff on their engagement with revised Common Assessment processes and ratified the MARAC information sharing agreement.

Wetherby Young Offender Institution operates a multi-agency approach to provide interventions for young people to address offending behaviour.

Leeds Youth Offending Service's comprehensive set of safeguarding arrangements is based on working in partnership with other statutory and non-statutory bodies. Central to these are:

- Multi-agency risk management panels to review young people assessed as highly vulnerable or posing a serious risk of harm to others and to ensure appropriate interventions are in place.
- An early intervention project involving the co-location of staff in a single police custody suite at Stainbeck Police Station for young people arrested in Leeds. This allows for joint decision making regarding bail, charge and diversion, liaison with



- appropriate agencies regarding immediate welfare needs and the sharing of information around risk or safeguarding concerns.
- The integration of services at a neighbourhood level to contribute to the Children and Young People's Plan objectives of reducing the number requiring to be 'looked after', those not in education, employment or training and improving attendance at school.
- Collaboration with the Probation Trust to improve the transition process for young people moving from child to adult services.

#### Development of multi-agency Front Door Arrangements.

Representatives from Health and West Yorkshire Police are engaged in a pilot to explore the potential for co-location of staff within the Children's Social Work Service Duty and Advice Team. Representatives are involved in the weekly meetings to review referrals and decisions made about the most appropriate response (Statutory Intervention / Early Help Services).

#### Multi-Agency Looked After Partnership

The Multi-Agency Looked After Partnership was re-established in January 2013 in order to provide a clear strategic overview of services to this vulnerable group to ensure they contribute to reducing vulnerability, improving outcomes and respond flexibly to the changing needs of looked after children and young people and care leavers. Five sub groups are being established:

- Education, Employment and Training
- Children 0 -5 entering care
- Looked after children and young people and offending
- Care Leavers
- Health Commissioning

#### LSCB multi-agency training pool

The LSCB continues to have a substantial and well resourced multi-agency training pool to support the delivery of its safeguarding training programme. At the end of 2012/13 there were 92 regular trainers in the pool.

### **10.2.4 Maintaining focus on the Strategic Plan and Carrying Out the Annual Business Plan**

Progress on the objectives and tasks within the LSCB Business Plan are monitored through Executive Group meetings and reported on a regular basis to the Board. At year end 82% of tasks had been completed or were being progressed within timescale and 18%, whilst subject to delays, were being progressed. A significant contributory factor to delays incurred was the late publication of updated

guidance in Working Together in March 2013. A review of progress against the Business Plan was conducted at the end of 2012/13 with consideration given to which outstanding / on-going tasks should be included in work planning for 2013/14. Work continued on on-going tasks and identified priorities during the first quarter of 2013/14 while the Business Plan for the year was developed to be accepted and signed off at the Annual Review Meeting.

#### 10.2.5 **Development of Effective Inter-Agency Procedures**

An important contribution to the first of the LSCB's objectives; to co-ordinate local work to safeguard and promote the welfare of children and young people, is made through the development of policies and procedures for use by professionals across the partnership. The Policy and Procedures sub group leads this work, in collaboration with the West Yorkshire Consortium, which ensures that a set of consistent regional procedures are maintained. This is particularly important for partners who work across the region and for working with vulnerable children and young people who move from area to area.

The following policies and procedures have been developed during 2012/13:

- Dispute resolution procedure
- Updating procedures for responding to children and young people who go missing / are at risk of sexual exploitation
- Policy for out of hours forensic medical examinations
- Protocol for police attendance at child protection conferences
- Suicide Prevention Strategy – including a Self Harm and Suicide booklet for professionals.

Work has been undertaken with the Children's Trust Board Workforce Reform sub group to develop

- A common set of professional values, attitudes and behaviours to support a restorative approach to working with children, young people and their families
- Common principles for supervision across the partnership

Challenges for 2013/14 include:

- Developing local procedures in the light of Working Together 2013 that are consistent with regional procedures.
- Revising and re-launching the Think Family Protocol.

## 10.2.6 Holding partners to account for safeguarding arrangements and practice

Ensuring the effectiveness of multi-agency working to safeguard and promote the welfare of C&YP is the second of the LSCB core functions. This requires the LSCB to have a comprehensive overview of the quality, timeliness and effectiveness of multi-agency practice. This is provided through the LSCB Performance Management System, which is made up of three components:

- 1) A Performance Management Framework based on the strategic priorities of the Board and including measures from the national Children's Safeguarding Performance Information Framework.
- 2) A Quality Assurance and Audit Programme
- 3) Monitoring partner compliance with the statutory requirement to have effective safeguarding arrangements in place.

The Performance Management sub group receives and collates performance information on a quarterly basis, providing a report to the LSCB which identifies trends, analyses progress and highlights areas that require further investigation. Findings from audits are presented to the LSCB as they are completed, or annually for those which are on-going.

An Annual Performance Report, collating and analysing information from all three components of the Performance Management System is presented to the LSCB and Children's Trust Board in June of each year, forming the basis for the Annual Report and identifying emerging challenges for both boards.

The Performance Management Framework, established in 2011 and refreshed for 2012/13 comprises 8 score cards: 3 LSCB Strategic Priorities, 1 Business priority, 1 tracking the journey of a child through the safeguarding system and 3 monitoring performance and outcomes for 3 priority vulnerable groups (children & young people who are subject to child protection plans / 'looked after' / missing / at risk of sexual exploitation).

The LSCB multi-agency Quality Assurance and Audit programme has 6 strands of work. In 2012/13 five were initiated and 1 has been completed:

- Strand 1- To quality assure and audit the impact and outcomes for children and young people subject to child protection plans
- Strand 2 – To receive the views of professionals involved in child protection plan processes.
- Strand 3 - To quality assure and audit the impact and outcomes of Child Care Plans for Looked After Children, including the quality of participation in LAC Reviews.
- Strand 4 - To audit the effectiveness of the practice against policy on safeguarding outcomes for the children of teenage parents who have been referred to the Leeds Teenage and Pregnancy Pathway.

- Stand 5 - The effectiveness of revised care and control policies in Special Inclusion Learning Centres (SILCs)
- Strand 6 -To audit the extent to which the views of children and families inform agencies' service development regarding the safeguarding and promotion of children and young people's welfare.

A programme of self-assessment audits involving 21 Statutory, 31 Third Sector partners and 211 schools and the Leeds City College has been undertaken to evaluate compliance with s(11) and s(175) safeguarding requirements. A total of 65 agencies were asked to complete s(11) audits. There was a 100% return from statutory agencies and 78% from those in the Third sector. Ensuring that all agencies have appropriate safeguarding arrangements in place is an important requirement of Working Together 2013 and will underline the LSCB's work in this area in 2013/14.

The development and further implementation of the LSCB Performance Management System has provided a more comprehensive and informed overview of multi-agency safeguarding arrangements, processes and practice through 2012/13. This has enabled monitoring of the implementation of the 'Children and Young People are safe from harm outcome of the CYPP and the Children's Trust Board's 'obsession' to reduce the number of C&YP who need to be in care. Overall assurance has been received that effective safeguarding arrangements are in place across the partnership and success is evident in the plan to 'rebalance' the safeguarding system away from a focus on statutory intervention to a more preventative, Early Help approach.

The LSCB has agreed to broaden and increase the pace of its Quality Assurance and Audit Programme in 2013/14, whilst continuing to increase the contributions of data from partners to further enhance the Performance Management Framework.

### 10.3 **Promoting a shared culture of Continuous Improvement**

The Vision, Values and Principles set out in section 5 (above) require the LSCB to actively lead the partnership in identifying areas of safeguarding working and practice that need to be improved and to ensure that action is taken as a result.

Following the consultation exercise for the revision of Working Together, the LSCB developed an outline Framework for Learning and Improvement in November 2012 (see appendix 5). It is designed to underpin and facilitate the development of a culture of continuous improvement involving the whole partnership. Its key elements are:

- A partnership approach to learning and improving
- Transparency and public accountability
- Responsibilities of partners
- Learning methodologies
- Planning and implementing improvements

- Disseminating lessons learnt and changes required
- Monitoring the impact of changes made.

The framework is being used to identify how learning is being used and the impact it is having on improving multi-agency working, services and outcomes for children and young people.

The development of a clear understanding of partner responsibilities will be undertaken at the Annual Review Meeting in July 2013 as part of the strategy for the LSCB to 'step up a gear' in 2013/14.

### 10.3.1 **Responding to Child Deaths**

The death of any child is tragic with far reaching consequences for families and friends. The LSCB has a responsibility to ensure that the circumstances of all deaths are carefully considered in order to identify any lessons that may contribute to reducing similar deaths occurring in the future.

#### The Child Death Overview Panel

The Panel reviews the deaths of all Leeds Children. Its Annual Report (2012/13) is attached as appendix 6.

Since its implementation in April 2008 the Panel has reviewed 228 child deaths (74% of the total number of deaths). This compares favourably with the national rate of 71% for this period.

Themes emerging from 2012/13 include:

- Two thirds of deaths involve babies under 1 year old
- Babies of African and Asian ethnicity are more vulnerable to early deaths (in line with national findings)
- For young babies the majority of deaths relate to complications of pregnancy and child birth and the data highlights known risk factors (eg smoking in pregnancy and the higher risk for twin pregnancies).
- 11 babies died unexpectedly in their sleep, 8 of whom were sharing beds / sofas with an adult. Frequently smoking, alcohol or drugs were also present.
- Among the older age range, children of Pakistani origin are significantly over represented, with the biggest single category being 'chromosomal, genetic and congenital anomalies.' The report highlights the importance of 'cousin marriage' which contributes to around 8% of child deaths in Leeds.
- 13 children and young people died in road traffic accidents.

The Annual Report also reviewed progress against recommendations made in previous years. Of 16 recommendations, 11 have been implemented with significant progress made in the remaining 5. Further recommendations are made in the current report including addressing:

- Co-sleeping
- Support for evolving national policy on minimum alcohol pricing
- Reducing smoking in pregnancy
- Raising awareness of the relationship between cousin marriage and genetic disorders

#### Responding to deaths which are unexpected

Where the death of a child is unexpected (not anticipated as a significant possibility 24 hours earlier) a multi-agency response is co-ordinated by a team in Leeds Community Health to investigate the circumstances of the death and to provide support to the bereaved family. The Sudden Unexpected Death In Childhood Annual Report (June 2011 – May 2012) highlighted that:

- 74% of cases received a home visit from the rapid response team
- 52% of these visits were within 24 hours (the current contract does not cover weekends)
- 31% of the cases were concluded within the 12 week recommended time frame. Delays are often experienced in receiving the final post mortem report.

A number of recommendations for action were made:

- To ensure the team is provided with adequate support through supervision
- To review the protocol and establish a steering group
- To ensure that the final post mortem report is available before the assessment is undertaken at 12 weeks
- To explore the possibility of extending the availability of the team to weekends and Bank Holidays
- To consult with professionals involved in the process to determine their views and to consider a similar piece of work with families.

An Independent Review of Sudden Unexpected Death In Childhood arrangements was undertaken in 2012/13, identifying a number of areas for improvement, including:

- Operational Practice
- Profiling and networking
- Policies, Procedures and Protocols
- Partnership working and LSCB leadership
- Involvement and support of parents (including signposting bereavement services)
- Monitoring performance and effectiveness

Recommendations from the Review have been accepted and actions included in work planning for the LSCB in 2013/4.

### 10.3.2 **Undertaking Serious Case Reviews**

Serious child care incidents where abuse or neglect is known or suspected or where there are concerns about the way in which agencies worked together require careful consideration to ensure accountability for practice and to identify lessons that could help improve services for children and young people in the future.

In 2012/13 the Executive Group, sitting as the standing SCR subcommittee, has considered and made recommendations to the LSCB chair as to whether the circumstances of 6 Serious Child Care Incidents that were notified to Ofsted met the criteria for undertaking a Serious Case Review. In the light of these recommendations the Chair made the following decisions:

- 3 Local Learning Lessons Reviews were initiated
- 1 Single Agency Review was commissioned
- 1 resulted in no further action being taken
- 1 remains outstanding; awaiting further action.

During 2012/13 3 Local Learning Lessons and 2 Single Agency Reviews were monitored to completion, generating recommendations for the agencies involved and the partnership as a whole. The subsequent action plans are being monitored through the Business Support Unit and updates on progress are provided regularly to the subcommittee.

Three previously completed Serious Case Reviews have been published on the LSCB website.

As the revised Working Together was not published until March 2013 it was not possible to amend local Serious Case Review processes and procedures within 2012/13, although piloting different methodologies through Local Learning Lessons Reviews ensured that planning for changes commenced. Revising these processes is a priority in the Business Plan for 2013/14.

The subcommittee has refined its decision making processes to ensure that proportionate responses are made to serious child care incidents which seeks to capture key learning in a timely and effective way. A better 'grip' has been established on monitoring the progress of reviews and on the implementation of action plans. The sub group has requested that the Performance Management sub group follow up its audit of the embedding of action plans from a previous Serious case review with the inclusion of an annual such audit as part of the Quality Assurance and Audit programme.

### 10.3.3 **Communicating and Raising Awareness**

A central part of the leadership role of the LSCB is to ensure that key safeguarding messages and emerging lessons from its activity is disseminated quickly and effectively across the partnership so that front-line staff can act on them and develop their practice accordingly.

The newly established Communications and Engagement task group has implemented and progressed the LSCB Communications Strategy through:

- The publication of 3 Serious case reviews on the LSCB website and the development of a media handling strategy for the partnership for each of them.
- Supporting the LSCB Chair in developing media handling strategies for serious child care incidents.
- The introduction of an e-bulletin as a method of disseminating messages from the LSCB quickly and efficiently across the partnership.
- Progressing the agreement of a Voice and Influence Strategy for the LSCB and then liaising with the Leeds City Council Voice and Influence Team and Leeds City College.
- Providing feedback to West Yorkshire Police in their development of a public campaign for 2013/14 to raise awareness of child sexual exploitation.

There have been unforeseen delays in procuring a new, more interactive website for the LSCB. These have now been resolved and the process is going ahead in 2013/14. The new website is viewed as crucial in enabling the LSCB to be a more effective communicator of



key safeguarding messages across the partnership and the wider community.

Regular Third Sector reference group meetings and the link with the Young Lives Leeds Forum have helped to maintain engagement and support of agencies across the sector around safeguarding issues. The group supports:

- The contribution the sector makes to the LSCB Trainers Pool and the delivery of the multi-agency training programme.
- Agencies undertaking s(11) 'duty to safeguard' audits
- Developing relationships with sports organisations
- Input into the work of other LSCB sub groups (Policy and Procedure sub group and the Front Door Reference Group)

There is a recognition that the reference group only engages with a small fraction of the Third Sector agencies in Leeds and a review of functioning is being undertaken in 2013/14 to address how this can be more effectively undertaken. Factors already identified include:

- The commissioning of the new LSCB website
- Work with a local university to identify umbrella organisations that will facilitate improved access to faith groups.

#### 10.3.4 **Assessment of Single and Multi-Agency Training**

Ensuring that the workforce and volunteers across the partnership are suitably knowledgeable and competent in undertaking safeguarding tasks is a significant contributory factor in children and young people receiving timely, high quality effective services that keep them safe and improve outcomes for them. Learning and Development / training events are central to developing skills, ensuring up to date knowledge of policies, procedures and guidance, and incorporating lessons learnt from reviews and audits into practice.

The Learning and Development sub group presented its Annual Review to the LSCB in May 2013. It highlighted that in 2012/13:

- The LSCB safeguarding training programme had delivered
  - 118 training sessions with 2302 participants
  - A series of city wide and regional events:
    - § Safeguarding seminars for cluster leaders
    - § City wide Conference
    - § Yorkshire and Humberside regional conference
    - § Two West Yorkshire master classes

- Evaluations of the training continued to be positive:
  - 90% of responses received at the end of sessions indicated that the training had been a positive and useful experience
  - Post course impact evaluations (3 months after the event), although with a lower response rate, indicated that 76% felt that there had been a positive impact on their practice.

Alongside evaluations from participants, quality assurance is maintained by reviewing the content of partner agency level 1 safeguarding training and will be augmented in 2013/14 by a pilot of direct observation of the delivery of sessions within the LSCB programme.

#### Examples of safeguarding training delivered by partner agencies

##### Early Start Sector:

An evaluation of 569 responses from the children's centre workforce indicated a significant impact on practice from attending safeguarding training, identifying improved confidence in the recognition of abuse and neglect and highlighting the need for further training on parental substance mis-use and mental health problems.

##### Education:

5,232 education staff from 179 establishments and 415 staff from children's centres accessed safeguarding training from the Education and Early Start Team. Leeds City College uses a matrix to set out mandatory and recommended training for all staff and governors.

##### NHS:

Leeds Community Healthcare has developed a safeguarding training strategy to identify mandatory training for staff in contact with adults / children at risk. Compliance with a requirement for attending multi-agency safeguarding training (Level 1 & 2) is currently 87% (with a target set for 90% in 2013/14).

Leeds and York Partnership Foundation Trust are promoting basic safeguarding training for staff to improve upon the current uptake of 69%.

##### Leeds Youth Offending Service:

The Service currently has Investors in People status and is committed to an in house training programme. It commissions a small

number of specialist courses (in 2012/13 this included Family Group Conferencing, adolescent to parent violence, young women affected by sexual exploitation and gangs).

West Yorkshire Police:

The newly formed Safeguarding Central Governance Unit is responsible for ensuring that there is an adequate number of appropriately trained and accredited personnel in the area of child abuse investigation and management of registered sexual offenders.

All police officers receive basis child safeguarding training aimed at recognizing signs of abuse, vulnerability and awareness of interventions available to support children and young people.

Cafcass:

The Service has a mandatory core training programme supplemented by themed local area workshops. Uptake of LSCB multi-agency training is identified as a priority for 2013/14.

### 10.3.5 **Summary of lessons learnt, actions taken and impact on outcomes**

Lessons that may help to improve the quality of response to, and practice with, children and young people arise from across the whole of the work undertaken by the LSCB. In recent years there has been a recognition that identifying lessons learnt is only the start of a process that should result in improvements to practice and outcomes for children and young people. This typically involves the production of action plans, whose implementation must be monitored, followed by checks to ensure that changes have been embedded into practice and then an evaluation undertaken of the impact on children and young people.

The LSCB is developing its Framework for Learning and Improvement to capture key learning and summarise the impact that this has had on services for children and young people to ensure that a focus is maintained on 'making a difference'. The Summary Framework is attached (as appendix 7) and asks 3 questions:

- What lessons have we learnt?
- What responses / actions did we take?
- What impact did these have on:
  - Practice
  - Multi-agency working
  - Outcomes for children and young people.

Examples lessons identified and progressed in 2012/13 include:

What have we learnt?	What have we done?	What impact did this have?
'Disguised compliance' by parents / carers when engaging with professionals not addressed within procedures	<ul style="list-style-type: none"> <li>○ Leeds policies updated</li> <li>○ Amendments being made to West Yorkshire Procedures</li> </ul>	Training courses updated
Lessons from Serious Case Reviews not being effectively disseminated across the partnership	Format for city wide briefing sessions changed to be more interactive	Feedback from participants is that the approach facilitates dissemination at team meetings.
Restraint policies and procedures in had not been updated in line with national guidance	<ul style="list-style-type: none"> <li>○ Model procedures developed</li> <li>○ Review of implementation set up for 2013/14</li> </ul>	Governing Bodies requested to implement new procedures
An action from a Serious Case review was not fully implemented	<ul style="list-style-type: none"> <li>○ Action taken to fully implement recommendation</li> <li>○ Partners requested to provide assurance that their monitoring of action plans was appropriate.</li> </ul>	<ul style="list-style-type: none"> <li>○ Partners are reviewing the robustness of their governance arrangements re SCR action plans</li> <li>○ LSCB Audit Programme to include a dip sample of implementation in 2013/14</li> </ul>
Child Protection Plans are not consistently effective in reducing risk and improving outcomes	<ul style="list-style-type: none"> <li>○ Disseminated the findings of the audit across the partnership</li> <li>○ Planning a programme that will support core groups discussing the implications for their practice</li> </ul>	Impact to be judged through the continuing child protection plan audit in 2013/14

## 10.4 **Summary: the Effectiveness of the LSCB**

### 10.4.1 **Review of progress against challenges the LSCB set itself for 2012/13**

The LSCB set itself 27 specific challenges within the framework of its Strategic Plan for 2012/13. A full summary of the progress made can be found in appendix 8.

Progress has been made against all the challenges set, with some ongoing work being included in business planning for 2013/14. Notable achievements include:

- The development of the LSCB Voice and Influence Strategy
- The appointment of Lay Members to the Board
- The establishment of new LSCB groups:
  - The Education Forum
  - The Child Sexual Exploitation strategic sub group
  - The Front Door reference group
- The development of the LSCB Quality Assurance and Audit Programme
- The increased input of partners into the Annual Review process
- Holding a successful city wide conference 'Seeing the world through children's lives' in May 2012.

### 10.4.2 **Overall Effectiveness**

Section 10 of this report has detailed the considerable amount of work undertaken by the LSCB, its constituent groups and partners during 2012/13 to lead and support the safeguarding of children and young people in Leeds and to hold agencies to account for their performance and practice.

In order to evaluate its effectiveness in discharging its statutory responsibilities and undertaking its core functions three questions need to be asked:

1) Are we making sufficient progress?

Good progress was made on all the tasks set in the Business plan for 2012/13. Many of the delays were the result of factors outside of the control of the LSCB and all outstanding actions have been included in the Business Plan for 2013/13.

Within the framework of the Strategic Plan progress has been made in the following areas:

- Lead, Listen and Advise
  - The production of an Annual Report evaluating the effectiveness of safeguarding in Leeds and identifying challenges for the coming year
  - Improved dissemination of safeguarding messages across the partnership
  - Establishing Lay Member and children and young people's input
- Know the Story; Challenge the Practice
  - The development and expansion of the LSCB Performance Management System
  - Learning lessons from Local and Single Agency Reviews
  - Undertaking safeguarding seminars with cluster leaders
- Learn and Improve
  - The establishment of a Framework for Learning and Improvement
  - Improved dissemination of lessons from Reviews
  - Continued co-ordination and development of the LSCB Training programme

More progress needs to be made in:

- Increasing community engagement through the development of the LSCB website, the role of the Lay Members and input from the Voice and Influence sub group
- Receiving performance and audit information from across the partnership
- Increasing our understanding of the quality of practice delivered at the front-line and contributing to its improvement.

## 2) What are the emerging challenges?

Challenges for the LSCB have been identified through the annual review process and are formalised in section 11 (below). Key themes identified are:

- To maintain and increase the momentum of the current work programme to support continuing improvement in services for children and young people

- To continue to monitor the management of risk within the safeguarding system
- To lead the partnership in addressing issues posed by children and young people living in the context of 'compromised parenting'
- To build on progress being made to collaborate more effectively with other strategic bodies
- To further implement the LSCB Communications strategy using the new website
- To encourage all partners to more fully engage in the work of the LSCB through its sub group structure.

### 3) What impact is the LSCB having?

Currently, indications of impact can be seen in:

- The development and revision of policies and procedures which impact directly on how frontline work is undertaken. In 2012/13 this has supported work with children and young people who are missing / at risk of sexual exploitation / exhibiting self harm and suicidal behaviours.
- Raising awareness across the partnership of key safeguarding issues, lessons from Reviews and findings from audits
- Participants on training courses subsequently indicating that there had been an impact on their practice
- Findings from multi-agency audits being used to inform partners' in house audit programmes and the development of action plans to implement improvements in services
- Regular Performance reporting has identified issues that need further investigation (eg the child protection system) and have contributed to decisions made to undertake specific audits.
- Lessons from Serious Case Reviews and Local Learning Lessons Reviews informing the development of new initiatives (eg exploration of a Young People's Service) and the updating of existing arrangements (eg the Leeds Think Family Protocol).
- Improved understanding of the circumstances of child deaths has resulted in support for a number of public health campaigns (eg the dangers of co-sleeping)

Now that an established work plan is being delivered which addresses the full range of LSCB strategic priorities it will be important to evaluate the impact that this work is having on the safeguarding system as a whole, the work of partners within it and the drive to improve outcomes for children and young people.

## **11.0** Challenges for 2013/14

From the Annual Review Process and the Annual Performance Report the LSCB has identified a series of challenges for itself and for the Children's Trust Board to be addressed in 2013/14. These are designed to maintain and increase the momentum for positive change in the development and delivery of services to safeguard and promote the wellbeing of children and young people.

## 11.1 Challenges to the CTB for 2013/14

The following challenges for 2013/14 were presented to and accepted by the Children's Trust Board on 27 June 2013:

1. To continue to progress the 'rebalancing' of the safeguarding system in Leeds in order to promote a more preventative approach (C&YP receiving 'the right service at the right time') and reduce the need for statutory intervention. Key components of this approach are:

- To reduce the number of C&YP who need to be 'looked after.'
- To support more effective multi-agency engagement in the oversight and implementation of child protection plans.
- To develop and extend the comprehensive, multi-agency, Early Help offer, supported and facilitated by a common approach to assessment.

2. To ensure that during this period of transition within the system, risk is managed appropriately and safely in individual cases.

3. To ensure that the rebalancing of the system is supported by the development of a partnership approach to shared professional values, attitudes and behaviours and common principles of supervision.

4. To continue to promote a restorative approach to working with C&YP and their families that will more consistently result in 'the voice of the child' being included in all interventions and which promotes the principles established by the CTB:

- The default behaviour of Children's Trust and Local Government partners in all their dealings with local citizens/partners/organisations should be a restorative one - high support with high challenge.
- Children's Trust and Local Government partners should ensure that families, whose children might otherwise be removed from their homes, are supported to meet and develop a safe alternative plan before such action is taken.
- For all other families where a plan or decision needs to be made to help safeguard and promote the welfare of a child or children the family should be supported to help decide what needs to happen. Children's Trust and Local Government partners must create the conditions where families can be helped to help themselves - this would represent a fundamental renegotiation of the relationship between Local Government and local citizens - from doing things to and for families to doing things with them.
- Children's Trust and Local government partners must see all local schools as community assets and have a clear role in holding those institutions - no matter what the governance arrangements - to account for the contribution they make to the well-being of the local population.



5. To work with partners who commission services for C&YP to:
  - Build into their commissioning processes a requirement of compliance with s(11) of the Children Act 2004 / s(175) Education Act 2002
  - Establish a common performance management framework which is compatible with the LSCB framework.
6. To review access and availability of services for families who have suffered a child / young person bereavement.
7. In the light of work being undertaken by the LSCB, LSAB & SL, to review the provision of services to address situations where C&YP are living in the context of compromised parenting (domestic violence, parental substance mis-use, parental mental ill health).
8. As a better understanding of the scale of CSE is established, to review the provision of services to (i) reduce the number of Young People at risk / suffering from sexual exploitation and (ii) respond to young people who have become victims.
9. To develop and co-ordinate improved services for vulnerable 16 – 21 year olds.

## 11.2 **Challenges the LSCB is setting itself for 2013/14**

Emerging challenges for 2013/14 were identified by the LSCB on 28.06.13. for discussion at the Annual Review meeting on 19.07.13.

### OVERALL

To 'step up a gear' in 2013/14; to build on progress made in 2012/13 in order to more fully understand the effectiveness of the safeguarding system in Leeds and better lead the partnership in developing services and multi-agency working in order to improve outcomes for C&YP.

- 1.0 STRATEGIC PRIORITY (1): LEAD, LISTEN & ADVISE
- 1.1 To fully implement the Learning & Improvement Framework to ensure clarity about partner responsibilities in contributing to a culture of continuous improvement.
- 1.2 To co-ordinate a partnership approach to the implementation of Working Together 2013 which is consistent with the overall approach being undertaken across West Yorkshire.

- 1.3 To continue to support the embedding of effective Children's Services 'Front Door' arrangements and monitor the management of risk.
- 1.4 To collaborate with other strategic bodies to revise and relaunch the 'Think Family Protocol' – to support multi-agency working with C&YP who are living in the context of compromised parenting.
- 1.5 To use the redesigned LSCB website to:
  - Engage more fully with:
    - § Faith Groups
    - § Community (and non-commissioned) groups
    - § GPs
  - Increase understanding of compliance across the partnership with s(11) requirements.
- 1.6 To further develop the relationship with the education sector (through the LSCB Education Forum)
- 1.7 To ensure that the LSCB is sufficiently resourced to discharge its statutory responsibilities and progress the agreed Business plan.
  
- 2.0 KNOW THE STORY; CHALLENGE THE PRACTICE
- 2.1 To more fully understand the effectiveness of practice at the 'front line' through the development of a broader range of monitoring methods and the implementation of the enhanced QA & Audit Programme.
- 2.2 To continue to monitor the effectiveness of services provided for priority vulnerable groups; in particular C&YP who are at risk / suffering Sexual Exploitation.
  
- 3.0 LEARN & IMPROVE
- 3.1 To broaden the LSCB Learning & Development / Training offer across the partnership and to monitor the impact of this on practice.

## Appendices

- 1) LSCB Membership 2012/13
- 2) Structure of the LSCB
- 3) Business Plan 2012/13
- 4) Financial Statement
- 5) Framework for Learning & Improvement
- 6) Annual Report of the Child Death Overview Panel
- 7) Learning & Improvement Summary
- 8) Progress against challenges 2012/13