Leeds Safeguarding Children Partnership

ANNUAL REPORT

2021-2023

Contents

Independent Chair's Introduction

This annual report has been informed by safeguarding partners and scrutinised by myself as Independent Chair. This is to ensure independent scrutiny of the report to provide additional assurance in the interest of safeguarding children and families. This report is an opportunity to provide an analysis of the effectiveness of the safeguarding arrangements and sets out what has been achieved because of the arrangements, including on Child Safeguarding Practice Reviews, and how effective these arrangements have been in practice. Therefore, this report considers areas related to priorities, progress, impact, strength of the Partnership and areas that require improvement. I hope you find this report to be open and transparent as this approach enables greater protection for vulnerable children and families, who remain at the heart of the Leeds Safeguarding Children Partnership.

The safeguarding system across Leeds is strong and this report provides identified areas requiring improvement which you would expect within a system constantly challenged. This report highlights many themes, and I would like to highlight four key messages, that are informed by this report, that the partnership should consider as a priority. To meet the needs of children earlier, so to prevent statutory intervention. To ensure schools remain fully engaged across the safeguarding system and consistently informs the partnership. To ensure statutory partners and the Third Sector are fully aware of how to escalate cases of serious concern. To seek assurances related to service provision and the experiences of care leavers who continue to experience poorer outcomes. The LSCP has a strong system of gathering learning, but there is a need to ensure dissemination that clearly monitors and can evidence impact and changes in practice, because of the learning. I am confident that the commitment of all partners and the strong leadership evidenced within the Executive will continue to ensure the areas that require improvement are addressed to ensure the most vulnerable children continue to be safeguarded.

Finally, I would like to take this opportunity to highlight and give credit to the strength of the Leeds safeguarding partnership arrangements. An indicator of this is that partners can and continue to build on having open, transparent, and often challenging conversations. The Executive and Practitioners demonstrate strong leadership and effectively manage differences of opinion between partners. This was clearly evidenced following a case escalated for notification where there were clear differences of opinion. I appreciate difficult conversations are not easy, but they enable greater outcomes in the interest of those we serve. These discussions led to a review of the notification systems and processes that have led to significant local improvements, that include changes in partners understanding and awareness of processes and strengthened how partners work together. The debate in Leeds also influenced national debates and policy, leading to the National Safeguarding Children Review Panel issuing additional guidance in September 2022. Finally, I wish to end by thanking you all for working tirelessly to safeguard children and young people and especially during the period of this report during the unprecedented time of Covid 19.

Jasvinder Sanghera CBE,
Independent Chair LSCP

Summary of the Safeguarding System

Leeds is the second largest city council in England. The latest population figure based on the 2021 census shows a population of 812,000 representing an 8.1% increase over the last 10 years, which is higher than the average increase seen in the Yorkshire and Humber (3.87%) and England (6.6%). In 2021, Leeds ranked second for total population out of 309 local authority areas in England, maintaining the same position it held a decade ago. The population of children and young people aged 1-17 in Leeds is 171,822. The percentage of households including a couple with dependent children rose from 17.7% in 2011 to 18.3% in 2021. During the same period, the regional percentage fell from 19.2% to 18.2%.

The Local Authority area includes some rural communities as well as densely populated inner-city areas where families can face multiple challenges. The Indices of Multiple Deprivation (IMD) indicate that 19%, or over 150,000 people in Leeds, live in areas that are ranked amongst the most deprived 10% nationally. *The social gradient in English child welfare services*, a study by Kingston University academics and Ofsted analysts, said that children from the poorest neighbourhoods in England were almost fourteen times more likely to be referred to social care services than those from the richest areas.

At a more local level, the latest estimates from HM Revenue and Customs and the Department for Work and Pensions estimate that 36,496 children under 16 were in poverty in 2019/20 with 74% of these children living in a household where one person was in work. In response to this challenge, the city is currently reviewing the 'Thriving: The Child Poverty Strategy for Leeds. Within this strategy is a workstream called 'Empowering Families & Safeguarding' led by Head of Service / Principal Social Worker, Children and Families Service. As well as reviewing the strategy a key area that will contribute to this work is seeking the views of children and families who are experiencing poverty.

Covid brought about significant challenges for all services both in terms of maintaining a frontline workforce to support vulnerable children and the significant financial pressures on organisations across the city. Despite this, the LSCP Partnership maintained a relentless focus on protecting vulnerable families in the city. Led by Children Services, specific multi-agency 'Bronze' meetings were developed across the city to ensure that families had their needs met under difficult circumstances. Professionals prioritised visiting the most vulnerable families in PPE equipment and for those less vulnerable families, phone and virtual meetings continued. A benefit of the move to virtual working has been the improvement in important areas of multi-agency work. Attendance at multi-agency child protection conferences increased because professionals were able to attend online; in particular, representation from GPs improved. Virtual meetings continue to be held when it is the preferred option for children, families and professionals consider this safe.

Two inspections from Ofsted over the past five years have highlighted innovative and outstanding practice and leadership. This year's annual report acknowledges the latest OfSTED report in that this continues to be a strong reflection of the effective protection, safety and wellbeing of children and young people by the safeguarding partnership. The Police Effectiveness, Efficiency and Legitimacy (PEEL) inspection undertaken on West Yorkshire Police in 2021 also reflects good standards of protecting vulnerable people eg: those experiencing exploitation and families where domestic abuse is a feature.

Leeds Early Help approach has ensured that the number of children requiring statutory intervention has remained relatively stable over the years despite increases seen across the country. A review of the Local Authority Early Help services is being undertaken by the Children and Families directorate supported by the Safeguarding Partnership.

Child protection systems remain strong despite the challenges of a national pandemic 2020-2022. Effective Front Door arrangements ensure that children's and family's needs are responded to appropriately. Families are encouraged to lead, own and contribute to plans with Family Group Conferences offered to families where safe to do so. The 'doing with' culture in Leeds ensures a strength based relational approach that enables families to remain central to all decision making. Data shows that progress against key statutory performance indicators remains good overall although challenges with recruitment and retention across the multi-agency system has impacted on capacity and in turn timeliness of some statutory requirements. Qualitative assurance is also explored through a range of multi-agency audits which brings together joint learning experiences and improvements.

The city's focus on children experiencing adverse childhood experiences through the development of its Trauma Informed Strategy and the drive to make Leeds a Trauma Informed City is a welcome development. This strategy combines resources from both the Integrated Care Board and the Children and Families Service to reduce the prevalence of adverse childhood experiences as well as respond to trauma that young people may experience. This is a positive step forward in breaking intergenerational cycles of abuse and providing children who have experienced trauma with appropriate support.
There is a consistency of approach in responding to safeguarding or child protection concerns by partners across Leeds. Multi-agency policies and procedures provide professionals with clear guidance on how to protect children and when to report any concerns about their welfare to the appropriate agencies. These policies and procedures are developed and agreed by a range of local professionals which are then adopted and integrated into practice.

The Chairs of the Childrens Safeguarding Partnership, the Adults Safeguarding Partnership and Safer Leeds Executive continue to meet throughout the year to identify opportunities for closer strategic partnership working where cross cutting learning is identified. This has included increased focus of the 'Think Family Work Family' way of working, recognition of neglect and self-neglect and domestic abuse.

Overall, the safeguarding system appears to be strong and senior leaders continue to be fully committed to the multi-agency safeguarding arrangements in the city. Stimulating discussions continue to take place when identifying areas for improvement and a strong culture has been developed whereby partners are open and responsive to challenge within their own agencies as well as offering challenge to partner agencies.

The current priorities have been in place since 2018. The LSCP Executive have agreed the need to review the current priorities to ensure that they are fit for purpose and may wish to consider new priorities for the coming year. The strength of Leeds multi-agency safeguarding arrangements and structures are well placed to ensure a data and intelligence led approach to setting priorities, their implementation and evidence of impact.

Key Learning from this report

Within this report there are learning points for the partnership to consider, and these have been brought forward and listed below.

Poverty

1. Poverty is a re-occurring theme that can significantly impact on children's well-being. The Leeds Children and Young People Partnership (LCYPP) will seek assurance on the city's strategic framework to mitigate the impact of child poverty including progress, opportunities, and challenges.

Children in Care and Care Leavers

2. Care leavers are more at risk of poorer outcomes than their peers. Care leavers are much more likely to be homeless or enter the prison system and may suffer from poorer mental health and higher suicide rates. The Council, as their corporate parent, has a responsibility to ensure that they have the same aspirations and interest as any parent would have for their own child. This should also include those care leavers transitioning into adulthood. This engagement will be monitored and supported by the LSCP Performance Management Subgroup to identify further opportunities for shared learning and improvement.

Early Help Systems

3. For the Early Help Board to present progress and updates of the city's Early Help Strategy to the Children and Young People Partnership including opportunities and challenges for the Partnership.

4. All professionals across Leeds need to ensure that that they are sighted on wider social economic factors that are impacting on parenting alongside any presenting safeguarding issues. This must be considered and addressed in plans for children and families.

5. For the LSCP Performance Management Subgroup to seek more robust multi-agency information regarding the effectiveness of partners early help activity. Leeds Childrens Services are developing data streams to evidence this activity however, partner agencies should contribute by providing their own data and narrative that highlights evidence of change or challenge when leading on early help plans.

Engaging and Supporting the Education Sector

6. That the LSCP Education Reference Group to seek assurance on how those schools/academies who are not part of the cluster arrangements support children and young people in need of help and support.

7. The LSCP Executive does not currently have an education representative at its meetings. This is not an explicit requirement within Working Together to Safeguard Children 2018 however, the National Care Review highlights the importance of involving the education sector at a strategic level.

Children and exploitation

8. Child exploitation is an issue that impacts on the most vulnerable children and young people in the city. The current refresh of the Child Exploitation Strategy and underpinning action plan for Leeds requires partners' continued commitment and focus for the coming year. Close monitoring of its implementation and evidence of improvements and outcomes should continue to be a focus for the city's Multi Agency Child Exploitation (MACE) arrangements

9. Child exploitation goes beyond the traditional understanding of child protection where the risks to young people are generally intra-familial. Developmentally, adolescence is a time of exploration, increasing independence, and risk taking. Young people become more engaged with, and influenced by, peer norms and relationships, and other adults, groups and communities not connected to their families, and may be more at risk of online exploitation. These extra-familial contexts can pose a set of complex risks for children, and these must be considered and addressed in all assessments. Furthermore, there needs to be a continued commitment by the wider partnership to respond to the risks children face in these contexts.

10. The LSCP Risk and Vulnerability Strategic group will promote and encourage organisations to sign up, and feed information into the Police Partnership Intelligence Portal (PIP). This portal is used for professionals to share information about routine criminality through to serious and organised crime that can impact on children in the city.

11. The Risk and Vulnerability Subgroup will review the city's exploitation risk assessment tools acknowledging the work undertaken in the city by Carlene Firmin.

The voice of children, young people, and families

12. The Partnership will seek assurance through a Section 11 audit, that all agencies continue to listen and respond to the lived experiences and views of children and families and ensure that service development takes into account these views.

LSCP Partnership Local Arrangements

Working Together to Safeguard Children 2018 lays out the shared responsibility between organisations and agencies to safeguard and promote the welfare of all children in a local area. Local organisations and agencies that work with children and families play a significant role when it comes to safeguarding children. The responsibility rests with the three safeguarding partners who have a shared and equal duty to make arrangements to work together. Full details of our local partnership arrangements can be found on our website here and are briefly described below.

LSCP Executive Group:

The LSCP Executive Group consists of the three statutory agencies that have equal and joint responsibilities for local safeguarding arrangements and ensuring that responsibilities under Working Together to Safeguard Children 2018 are discharged. They set and lead the strategic safeguarding vision, provide leadership across the city, and identify the LSCP priorities as required.

The three statutory agencies and representatives for the city are:

- Chief Superintendent - Leeds District Commander, West Yorkshire Police
- Director of Children and Families, Leeds City Council
- Director of Nursing and Quality, Leeds office of NHS West Yorkshire Integrated Care Board.

The Executive also includes:

- LSCP Independent Chair
- LSCP Business Manager
- LSCP Legal Advisor

The 2022 Ofsted Inspecting Local Authority Children's Services (ILACS) report identified that the city's strategic partnerships are strong. It recognised that although there have been some professional challenges, these are resolved through the strength of relationships and restorative culture. As is often inevitable in large statutory organisations there are regular changes in senior leaders. The new statutory Executive leadership team is now in place and are resolute in their aim to maintain and maximise the strong relationships currently held.

During 2022 the LSCP Executive took the opportunity to have two dedicated face-to-face facilitation and coaching sessions from the National Multi-Agency Child Safeguarding Reform Facilitators. This time was used to consider the city's current arrangements, reflect on some difficult leadership decisions and reconsider roles and responsibilities with the benefit of examples of good practice and experiences in other regions.

It is three years since the last set of changes were made to the city's Children's Safeguarding Partnership infrastructure and it is recognised how the policy direction is changing. The national facilitators, in their diagnosis of the sessions confirmed the arrangements in Leeds are good and advised against any whole scale change that could destabilise this.

As a result, the LSCP Executive have committed to 'reset' some of the safeguarding arrangements in collaboration with the wider children's partnership.

Independent Chair

The Independent Chair provides important scrutiny of the local multi-agency safeguarding arrangements and the effectiveness of the safeguarding partnership, including providing assurances and recommendations on areas for improvement to the LSCP Executive through a variety of means including auditing, reviews, engaging with front line practice and seeking the voice of children, young people and families. Within the last year a significant part of this work has included:

- Reviewing arrangements where children are living in families where domestic abuse is a feature
- Instigating a review of the notification process of Serious Child Safeguarding Incidents (SCSIs) to the National Panel
- Chairing the Review Advisory Group which reviews cases under the criteria laid out in Working Together to Safeguard Children 2018 where children may have experienced serious harm

Leeds Children and Young People Partnership (LCYPP)

The LCYPP was developed to provide strategic leadership, vision, and drive delivery of the LSCP Annual Report priorities and the Leeds Children and Young People's Plan. It brings together those agencies within the city working with children and families and is responsible for the oversight of both the safeguarding priorities set by the LSCP Executive and ensuring that core and statutory functions laid out in WTSC 2018 are delivered. This may be through its subgroups, standing / task and finish groups or making recommendations, as appropriate, to other strategic partnerships in Leeds.

The LCYPP are also responsible in driving priorities set within the Children and Young People's Plan to ensure an integrated strategic join up between safeguarding and those wider factors which may impact on the lives of parents, carers, children and young people. Progress of the 5 outcomes and 11 priorities of the Leeds Children and Young Peoples Plan are also brought to this meeting for discussion, developing strategic links and scrutiny.

The LCYPP is co-chaired by Executive Board Member for Children, Families and Adult Social Care and the LSCP Independent Chair. Members of this group also include Chairs of the LSCP subgroups which encourages a more joined up organisational accountability and ownership of safeguarding across the work of the Partnership.

Partners are encouraged to bring forward agenda items, current themes across the city, challenges they face within multi-agency working and opportunities for stronger joint working. There is the expectation that when partners bring agenda items to the Leeds CYPP meeting, they submit a cover report outlining the key issues, how the item relates to the priorities of the Leeds Children and Young Peoples Plan, how children's voices are heard and how the Partnership can support the work. Key themes and topics discussed and debated by the LCYPP over the past year have included:

- Domestic Abuse Routine Enquiry Review by Health
- Progress on the Maternity Strategy and Best Start Plan
- City wide Domestic Abuse Review
- Children and Families Covid 19 Transition Plan
- Revised 3As Plan
- Multi-agency Audit – Child in Need Plan
- Progress on the Futures in Mind Strategy

- Ofsted Inspection of Leeds Local Authority - Improvement Plan
- Independent National Review of Children's Social Care
- Serious Child Safeguarding Incident (SCSI) notification review and partner SCSI Referral Form

Assurance has been provided on progress of these key areas along with a solution focussed partnership approach to challenges that are identified and presented.

The LSCP Sub-Groups which drive the work of the partnership are standing agenda items. The Sub-Group Chairs feedback key areas of work, aligned to partnership priorities and any issues that require partnership action. This provides additional scrutiny and challenge by partners on the work being undertaken within the Partnership.

Full membership of this group can be found on our LSCP Website

As a child friendly city, the voice of children and young people is fundamental to how we shape and deliver services and to ensure inclusivity for the communities the Partnership serves. The voice of children is a standing agenda item in the LCYPP meeting to influence local or city-wide priorities and agendas, or where they make recommendations or advise decision makers. The city's Voice and Influence team which is led by Leeds Children and Families Directorate ensure the Partnership hears and supports the represented voices of children and young people across the city. There are further opportunities in the LCYPP meeting to hear how our partners use the voice of children and young people to influence the services they provide, especially in those groups of children who may be unrepresented.

In 2023 the LSCP Performance Management Subgroup (PMSG) will undertake an audit of partner agencies compliance of Section 11 of the Children Act. There is a specific question calling for evidence of a culture of listening to children and taking account of their wishes and feelings. This is an opportunity to assess the effectiveness of how partners engage and listen to children when providing services. Furthermore, to explore how this informs the planning and delivery of those services.

Leeds Children and Young People Partnership Bi-annual Network Meeting

The Network Meetings were established in March 2022 and provide the opportunity for partners to come together to share and discuss safeguarding topics across the Partnership and to hear their views. Meetings are open to frontline practitioners, managers and agency safeguarding leads, and are themed around information identified from either the LCYPP meeting or directly from practitioners.

The first Bi-Annual meeting considered learning from recent LSCP review processes including Rapid Reviews and Child Safeguarding Practice Reviews (CSPRs). Discussions highlighted how the Third Sector often felt there to be a lack of understanding and urgency from some agencies when advocating the presenting risk to a child which often led to escalating concerns. This led to further promotion of the LSCP Concerns Resolution process to ensure practitioners understand how to escalate concerns in relation to the safety of a child.

The most recent Bi-annual meeting discussed the refresh of the Leeds Children and Young People's Plan, considering the key proposed updates. Following on from the previous meeting it also considered the reoccurring theme of Professional Curiosity that has been highlighted from the most serious child safeguarding incidents. This was also another

opportunity to explore the LSCP Concerns Resolution Process including practitioner challenges and barriers to implementing this.
The initial evaluation of the Bi-annual meeting indicated that:

- 80% of participants found the meeting useful, and the approach suitable for their needs as a practitioner.
- 93% of participants stated they would attend future meetings, although some participants indicated a shorter meeting would be preferable (meetings are currently 3 hours in length).

Participants indicated that going forward they would like to consider new policies and procedures, findings from national reviews, trends and responses within Leeds and the sharing of good practice. These will be taken forward through future Bi-annual meetings.

The Role of the Business Support Unit

The LSCP Business unit is commissioned by the LSCP Executive to support the city's multi-agency safeguarding arrangements. This work includes:

- Ensuring that the responsibilities under Working Together to Safeguard Children 2018 are discharged fully across the city.
- Working with Chairs to support the facilitation and preparation of the LSCP Subgroups, LCYPP and Executive meetings and provide additional information, advice, and guidance.
- Supporting Rapid Reviews, CSPRs and child death reviews in line with national guidance and support the implementation of action plans and recommendations.
- Maintaining the LSCP Website, developing bulletins for practitioners, safeguarding campaigns for children and families, and the dissemination of learning across the partnership.
- Providing a comprehensive, responsive, and adaptable safeguarding training and development offer for practitioners across Leeds.
- Developing strong links with other West Yorkshire safeguarding partnerships to identify common themes and link up relevant work.
- Developing and updating multi-agency safeguarding policies and procedures both locally and regionally.
- Undertaking audits and quality assurance work to support learning and improvements.
- Identify any local or national challenges or opportunities for the Partnership and support the implementation of new ways of working.
- Supporting and encouraging a strong culture of child centred safeguarding arrangements for the city
- Working with other strategic partnerships in the city to identify opportunities for collaboration, cross cutting themes and reduce duplication of effort.

In January 2022, the LSCP Executive requested that the Business Unit was reviewed to ensure it continues to support the LSCP safeguarding structure and arrangements in Leeds in the most effective way. The outcome of this review has been presented to the Executive in November 2022 and will be completed by May 2023.

Funding Arrangements

The LSCP Executive have continued their commitment to funding the multi-agency safeguarding arrangements with additional funding from West Yorkshire Probation. This funding provides staffing and resources that are managed through the LSCP Business Unit.

Leeds City Council		£234,675
Leeds Health and Care Partnership		£150,300
West Yorkshire Police		£ 26,102
West Yorkshire Probation		£ 6,000
	Total	£417,077

LSCP Subgroups

The subgroups of the LSCP support the LSCP Learning and Improvement Framework, that provides the opportunity for leadership from the Partnership to engage on the LSCP safeguarding priorities, and explore the effectiveness of the safeguarding system. Each of the LSCP Subgroups have undertaken a review of their work including reviewing terms of reference, membership and the roles and responsibilities of members.

The following section reports on the work of the LSCP Subgroups

Learning and Development Subgroup

The group is chaired by a representative from Leeds and York Partnership Foundation Trust and has met six times since April 2021.

This is a significant sub-group that is responsible for oversight of multi-agency safeguarding training for the partnership. It also takes forward learning and improvements identified in the city resulting from case reviews and auditing.

Key areas of work have included the future model of training delivery following the move to a hybrid (online and face to face) approach to training. The development of a training needs analysis to understand multi-agency safeguarding training requirements of the partnership has been developed and is currently being analysed by the subgroup.

It has also developed a mental health subgroup to consider learning from Rapid Reviews whereby mental health (parental and child's) has been a feature. Areas of learning have been shared with relevant agencies and there has been an offer to pilot an internal training session in relation to parental mental health as a multi-agency session.

The Learning and Development offer and approach established during the pandemic has been retained, with a core training offer of training that included:

- Introduction to Safeguarding Children and Young People,
- Working Together to Safeguarding Children and Young People
- Safeguarding Children and Young People refresher training
- Thematic specific training and a series of topic-based briefings:
    - Mind Your Language – the impact of language when assessing risk
    - Introduction to Domestic Violence and Abuse (joint with Safer Stronger Leeds)
    - Introduction to County Lines
    - Modern Slavery and Human Trafficking
    - Harmful Sexual Behaviour
    - Teenage Interpersonal Violence and Abuse

- Child to Parent Abuse
- Sudden Unexpected Death In Infants (SUDIC)
- Fabricated and Induced Illness
- Safer Recruitment
- Introduction to Child Exploitation
- ReThink Formulation
- Stress in Infants
- Managing Allegations Against Professionals
- Foetal Alcohol Spectrum Disorder (FASD)
- Prevent
- Introduction to Initial Child protection Conferences (ICPCs)
- Safeguarding Children and Young People with a Disability

The training offer has remained online due to the positive evaluations and feedback from practitioner surveys in relation to the LSCP online approach and moving forward a hybrid offer will continue to be available. In addition, learning and development opportunities are also available through a variety of resources available within the Safeguarding Topics page on the LSCP Webpage.

Over the year the offer has grown as partners capacity to offer briefings, and support delivery has grown, along with demand. Joint development of a domestic abuse training session with Safer Stronger Leeds has supported the LSCP Priority "children witnessing and experiencing domestic violence" and ensured the impact of domestic abuse on children and young people is included. All learning and development opportunities are informed and updated in relation to identified learning from the Partnerships review and audit processes.

Training demand data and attendance by agencies identified that in 2021-22 bookings for the Introduction and Working together course increased by 100%, with completion rates for the introduction course increasing by 6%. Completion rates for Working Together were down by almost 50%, however it should be noted that the session is a 2-part course and that at the time of reporting not all participants will have completed part 2.

Partner agency demand is comparable to 2020-21 where the highest demand came from:

- Third Sector organisations,
- Leeds Community Healthcare,
- Private sector organisations and
- Leeds City Council Children's Services (non CSWS)

All sessions are evaluated and used to inform training delivery. These remain positive, with over 85% of participants indicating that the session had met expectations, learned outcomes and increased knowledge and understanding either to a great extent or to some extent in 2020-21. In addition, over 90% participants indicated that their confidence had increased as a result of attending LSCP training. The impact of training remains a difficult area to measure and over the years many methods have been used to try to quantify this. This remains an area for improvement.

During the initial phase of COVID-19, the use of the LSCP Multi-agency Training Pool to deliver training was paused for 10 months due to partner agencies responding to the pandemic. To ensure that opportunities for staff training continued the LSCP developed flexible online training to support professional development

Initial live interactive sessions were delivered by the LSCP Training and Development Officers, with Pool trainers delivering from January 2021. Contact with previous training pool

members to express interest in delivering training in 2021/22 resulted in a significant decrease in numbers within the pool (28 compared to 84 in 2019/20), and of those who expressed an interest in continuing, a significant number identified capacity issues and therefore were not able to deliver sessions.

In 2021/22 a total of 11 trainers delivered (compared to 60 in 2019/20). The need to train existing trainers with regards to the technical elements of the current delivery methods, and recruit and train new trainers remains a priority when the capacity allows. Proposed methods of delivery going forward, and their associated capacity requirement, have been discussed at the LSCP Learning and Development Subgroup. A training Needs Analysis which includes sections in relation to provision of trainer and preferred delivery method is to be sent to all partners in January 2023 and will inform both the training programme and the delivery method (a training pool or via commissioned trainers).

Performance Management Subgroup (PMSG)

This group has been chaired by a policing partner since September 2021 and vice chair represented by Leeds Teaching Hospital Trust. This group has met 7 times since April 2021.

The PMSG undertake audits and monitor safeguarding data to be assured the child protection systems are robust, effective and identifies areas for improvement.

The PMSG have reviewed the safeguarding data it monitors and have identified changes in how it intends to request data. The PMSG has noted an absence in narrative within provided data. Therefore, going forward partners agencies will be requested to present safeguarding data and provide additional narrative to ensure the PMSG is informed to better understand the significance of the presented data.

The PMSG also intends to refocus its efforts to be assured that learning from LSCP reviews have been effectively implemented and can demonstrate impact and better outcomes for children and families.

<u>PMSG Activity</u>

In 2021 the Review Advisory Group (RAG) requested the PMSG undertake an audit seeking assurance that information is being effectively shared between agencies involved in multi-agency plans, namely Child in Need and Child Protection, and that practitioners are confident with what the plan involves and what their role is in ensuring positive outcomes for children. The PMSG recognise that they are not sighted enough on children in care, and this should be a key focus over the coming year.

Child in Need (CIN) Audit
Following the notification of a safeguarding incident, the Review Advisory Group reflected on whether all the agencies involved with the family were aware of the multi-agency plan around the child and when made aware, if there was insufficient notice for the practitioner to attend the meeting or provide information.

An audit of 10 case files was undertaken by the LSCP Business Unit Quality Assurance Officer in January 2022 and was presented to the LCYPP meeting in March 2022. The audit highlighted good information sharing amongst practitioners and a commitment to supporting families and safeguarding children who are subject to CIN plans. Good relationships between social workers, local schools and local services were highlighted by practitioners in being instrumental in being able to effectively share information.

The audit identified the Covid 19 Pandemic has not had a significant detrimental impact on information sharing within CIN plans and may have improved communication and information sharing in some areas. This is a credit to practitioner's commitment to safeguarding children and supporting families as well as a commitment to finding effective ways of communication during a difficult time. CIN plans were reviewed within statutory requirements in 80% of occasions. CIN plans made when the pandemic had started were reviewed more frequently. Practitioners spoke of a high level of information sharing between meetings and there were examples of this evidenced within the case file audits.

Attendance at Meetings was also considered:

- Attendance at Child in Need meetings was good (91%). Virtual meetings aided practitioner attendance.
- Attendance from adult services, when invited, was good. Practitioners attended the CIN meeting in 93% of cases. Attendance at reviews was 79% and at the second review was 83%.
- At the beginning of the pandemic there was an NHS England directive, detailing that staff groups should be redeployed which may have resulted in a change of practitioners within the 0-19 service. Social workers highlighted they did not always know who the allocated health visitor or school nurse was. The Named Nurse for Safeguarding Children acknowledged that initially at the start of the Pandemic there may have been some challenges however, the service returned to usual practice in September 2020,

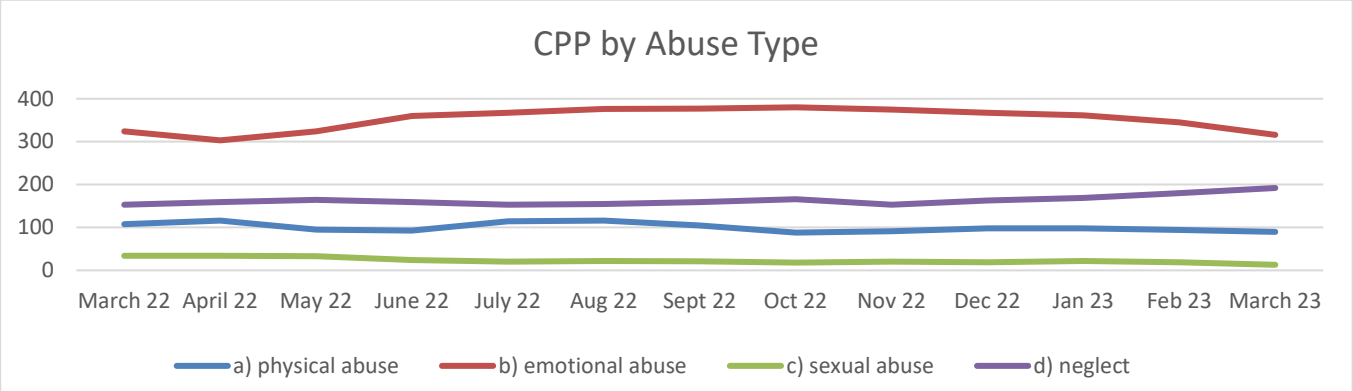
Child Protection Audit
A case file audit of 10 cases where a child was made subject to a Child Protection Plan between September and November 2019 was undertaken to consider the effectiveness of information sharing between agencies involved in multi-agency plans. An aim of this review was to identify practitioner confidence with plans and their role in ensuring safe and positive outcomes for children and young people.

In addition to the case file audit, a questionnaire regarding general experiences of information sharing within a child protection plan was sent to all practitioners who had been involved in the core groups in the 10 cases. Individual interviews also took place with four of the lead social workers for the cases audited.

There was particularly good information sharing between children and family services, children's social work services, education, health visitors, children's centres and family support services. In the sample of cases reviewed, practitioners recognised the need to share relevant information and were committed to plans. Attendance from these practitioners at both Initial Child Protection Conferences (ICPC's) and Review Conferences was very good, and case files suggested they had a shared understanding of their role.

Child Protection Systems
Data on child protection systems are routinely examined through the LSCP PMSG. The purpose of analysing data is that it acts as an early warning system. This enables the partnership to be informed when performance indictors may be falling out of normal parameters. Although data on child protection is provided by children's services, this should not be seen as a performance measure for children services but a performance measure for the Partnership as all agencies have an equal role in contributing to children in need of help and protection.

As of March 2023, there were 611 children on a child protection plan (CPP). This is lower that in March 2022 where 619 children were on a CPP. This equates to rate per ten thousand of 36.8 which is lower than both the national average (41 per 10,000) and statistical neighbours 52 per 10,000.



The number of children experiencing emotional abuse remains the key reason of being on a CPP, reflective of the awareness in the city of the impact of this type of abuse on children. The city continues to recognise this through the strengthening of its Trauma Informed strategy.

The age categories of children requiring a CPP have broadly remained the same over the four years of data in the table below.

Age Categories CPP	2019/20	2020/21	2021/22	22/23
Percentage of cohort under 1	8.80%	6.9%	7.6%	8.5%
Percentage of cohort 1-4	23.40%	25.5%	25.5%	21.4%
Percentage of cohort 5-9	28.10%	29.9%	30.5%	31.3%
Percentage of cohort 10-15	35.80%	31.7%	31.5%	32.6%
Percentage of cohort 16+	3.90%	6.0%	4.8%	6.2%

The PMSG raised questions that in quarter 2, 2021 the number of Initial Child Protection Conferences (ICPC) undertaken on time fell to a significantly low level (11.4% on time in December 2021). Children's services provided a response to the PMSG that this was due to restructure and redeployment of administrative staff across the council. Interim safety plans were presented to the PMSG and assurance that children and young people were being appropriately safeguarded. Data continues to be monitored by the PMSG and ICPC's increased to 87.5% in March 2022. RCPC's were not significantly impacted in the same way dropping to 61% in January 2022 and returning to levels of over 90% March 2022.

For children who have been on a CPP it is essential that the plan achieves both short and long-term outcomes. A measure that is considered in the PMSG is whether a child is re-referred to children's social work service 12-24 months after the plan ends. It is welcome to see that there has been a reduction in children re-referred with 10.7% of children re-referred in 20-21 dropping to 6.4% in 21-22 and further again in March 2023 to 5.9%. Those children who's plan ends continue to be supported to appropriately access local universal services, including those commissioned and in the third sector.

Where families have more complex issues, it is sometimes appropriate to extend the level of support that is usually provided if safe to do so. As of March 2023, there were 8 children on plans for over two years which will include households with more than one child on a plan.

This equates to 1.3%, which is lower than the mean average for all English metropolitan boroughs (4.3%)

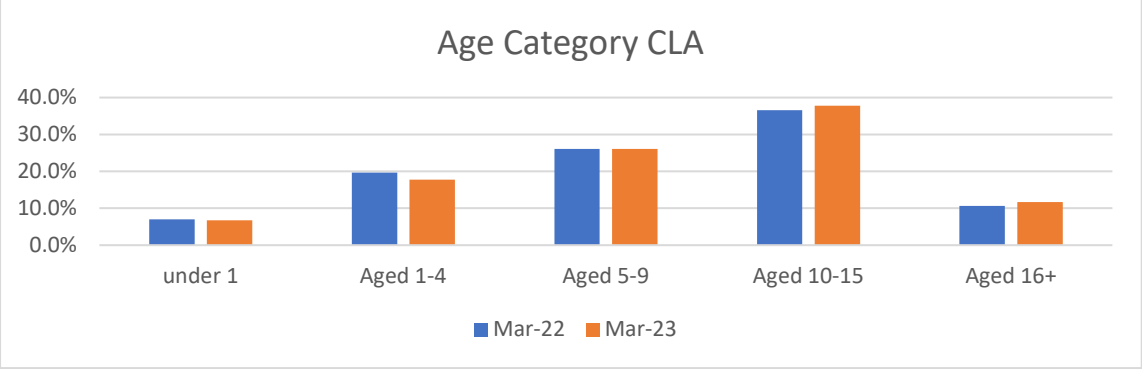
Children Looked After (CLA)
Data pertaining to children and young people who are looked after continues to be monitored by the PMSG. The number of children who are looked after has risen over the year.

In Leeds, as of March 2023 there are 1452 children who are looked after which is a 6% increase since March 2022. The current CLA numbers include 77 unaccompanied asylum seekers which is in line with the city's strategy to increase and support the number coming into the city.

For context, in England, there has been a 26% increase in the number of 13–17-year-olds entering care between 2012/13 and 2018/19. The result is that more than a third of the children who entered care in 2018/19 were teenagers. Compared to younger children in care, teenagers in care are 50% more likely to have an Education, Health and Care Plan, ten times more likely to have attended alternative education, and six times more likely to be living in a residential or secure children's home. It is important that Leeds recognises the significant events that lead to family breakdown much earlier. There are often significant points in a child's life that can impact of their safety and wellbeing such as parental substance use, school exclusion or the death of a significant family member.

The most recent comparative data, from March 2021, demonstrates England average shows a rate per ten thousand of 67, the core cities average at 94, and the Yorkshire and the Humber average at 78. Leeds rate per ten thousand currently sits at 80.

Most children who are looked after, live with extended family members, such as grandparents or aunties and uncles under kinship care arrangements. Leeds recognises the importance of kindship care and continues to explore and encourage these arrangements where it is safe to do so.



The ages of children coming into care have broadly remained the same over two years.

Key data in relation to CLA identified that In December 2022[1]:

- Health needs assessments undertaken on CLA remains high with 89.3% completed

[1] LSCP Score Card 2022-23

- Dental checks undertaken on time reduced to 58.2% reflecting the continued difficulty of identifying a dentist for young people following Covid restrictions. These are now rising to pre pandemic levels
- All children who are looked after have a qualified social worker assigned to them to support them with their needs
- 93% of children have engaged and completed their looked after reviews.

All three areas of Leeds have dedicated looked after children teams within the Children and Families directorate for two different age groups, age 12 and under, and 13 plus. These teams focus on the specific needs of looked after children implementing plans to ensure that more children experience permanence through adoption, special guardianship, return to their family or independence. Further scrutiny of Children's Homes is undertaken through Independent Regulation 44 visits. Reports on the outcomes of these visits are provided to both the local authority, Ofsted and the LSCP and provide assurance that young people are provided with the best possible care.

Leeds Corporate Parenting Board chaired by the Executive Member for Adult and Children's Social Care and Health Partnerships, set out as a three-year strategy delivery from 2021-2024 is supported through a series of live action plans that are driven within specific priority theme groups led by partners / officers and supported by elected member champions. These groups are:

- Strategic Priority 1 - Looking after learning and supporting engagement and achievement in education, training, and employment
- Strategic Priority 2 - Ensuring that our children in care and care leavers have stable homes and secure support
- Strategic Priority 3 - Listening and responding to the voice of our children, young people, and care leavers
- Strategic Priority 4 - Ensuring that our children, young people and care leavers are healthy and are supported in the physical and emotional wellbeing
- Strategic Priority 5 - Developing a highly effective Care Leavers partnership
- Strategic Priority 6 - Support children and young people and care leavers to have fun and new experiences and develop their own interests

Assurance on the progress of the Corporate Parenting Board's strategic priorities and progress are to be presented to the CYPP in 2023.

Areas for Further Assurance for the Partnership

Care Leavers are more at risk of poorer outcomes than their peers. Care leavers are much more likely to be homeless or end up in prison and may suffer from poorer mental health and higher suicide rates. The Council, as their corporate parent, has a responsibility to ensure that they have the same aspirations and interest as any parent would have for their own child. This should also include those care leavers transitioning into adulthood. This engagement should be closely monitored and supported within the PMSG to identify further opportunities for shared learning and improvement.

The LSCP PMSG need to have more assurance on the outcomes of those children that are in the care system. Although children in care data is monitored by the PMSG there needs to be more oversight on the quality of care, transitions, and outcomes. This will be built into the PMSG workplan in 2023.

The PMSG requires more robust information regarding early help activity. Leeds Childrens Services are developing data streams to evidence this activity however, partner agencies should provide their own data and narrative that highlights evidence of change when leading on early help plans. This should include any challenges or opportunity they identify when working with children and families

Poverty remains a significant challenge for the city. All professionals across Leeds need to ensure that that they are sighted on wider social economic factors that are impacting on parenting and children alongside presenting safeguarding issues and ensure this is reflected and addressed in plans for children and families.

Multi-Agency Safeguarding Operational Group (MASOG)

This group is Chaired by a representative from the Leeds Health and Care Partnership and has met five times between 2021 and 2023.

The purpose of this group is to maintain a line of sight of children supported through the child protection (CP) medical process and after care. This group is represented by the Police, Children and Families Service, and the Child Protection Medical Service (CPMS). Mountain Health Care are commissioned to provide sexual abuse medicals throughout West Yorkshire and contribute to this meeting, providing the MASOG with assurance that pathways into their service are effective and the support children receive following their medical is robust.

In January 2021, the MASOG undertook the review of five cases to consider elements of decision making at the Front Door when a child is referred, and a suspected non-accidental injury may have occurred. The following learning points were identified.

- When it is not clear how a child has sustained a suspected physical injury and there is a decision not to refer a child for a CP medical, the rationale for this must be clearly recorded. This decision should never be made in isolation and consultation with all relevant partners involved in the strategy discussion must be undertaken.

- Health practitioners at the Front Door may require further specialist advice from the CPMS on whether a CP medical should be undertaken. When seeking the views from the CPMS, this should be clearly recorded within in the assessment including the name and job role of the professional consulted.

- The review identified challenges for the CPMS in balancing the rights of parents to refuse their child from having a CP medical, and what is in the best interests for the child. If a parent (or child with capacity to make decisions themselves) refuses a CP medical, a further strategy discussion to assess the impact this may have on the child's safety and well-being must be considered. In non-emergency situations, when parental permission is not obtained, the social worker may need to seek legal advice.

The child protection medical guidance has been updated to reflect this learning and can be found here.

Children in Secure Settings Sub Group

The LSCP Secure Settings Subgroup monitors the safeguarding arrangements in three secure settings in Leeds (Wetherby Young Offenders Institute, Adel beck Secure Children's Home and the Police Custody Suite) providing oversight and challenge in relation to safeguarding.

Due to their different cohorts, their different governing bodies, and the different ways in which they operate it is not possible to provide a comparison across the estates, rather a narrative and analysis of each setting.

For all of the secure estates 2021 - 22 continued to be a particularly difficult year with respect to the COVID Pandemic, periods of isolation and everchanging landscapes in relation to government guidance and how that translates within the different estates. However, each estate has adapted practice in relation to the current circumstances and worked hard to ensure the safety of both children and staff, often in a backdrop of reduced staffing capacity due to issues arising because of the pandemic.

It is acknowledged that all children and young people within secure settings remain an extremely vulnerable group. All the establishments have worked hard, creatively and within some ever-changing unknowns to safeguard this group of children and young people. Both Wetherby YOI and Adel Beck have recently been inspected however the LSCP, through its Secure Setting Sub-group monitor and support these secure settings to be assured that children and young people's safety and well-being continue to be of a good standard.

The Sub-Group acts as the link between the secure estates and the wider LSCP in providing assurance in relation to the safeguarding of the children and young people resident in the three estates, and in addition to the three estates the subgroup has the following representation:

- Children and Families Service; Youth Justice
- The South and West Yorkshire Resettlement Service
- Children and Families Service; CSWS
- Leeds Community Healthcare who provides health services for Wetherby YOI and Adel Beck.

The group is chaired by a representative of the West and South Yorkshire Resettlement Consortium They meet quarterly having met seven times since April 2022.

Wetherby Young Offenders Institute (YOI)
Wetherby YOI caters for males aged 15 to 18 years old serving a detention and training order sentence of up to 2 years and those remanded into custody from sentencing courts within the catchment area of Humberside, North Yorkshire, South Yorkshire, West Yorkshire and designated areas of Lancashire and Greater Manchester. It incorporates the Keppel Unit[2] which specialises in providing a safe and supportive environment for some of the most challenging and vulnerable young people in the country, whose needs cannot be met in the mainstream prison system. The establishment is administered by HMPS[3] as part of the Yorkshire and Humberside Prison region and has a capacity of 326 young people, including 48 in the Keppel Unit.

The LSCP were informed in 2022, that following the closure of Rainsbrook Secure Training Centre, girls would be placed at Wetherby YOI. Concerns were raised by Partners within the Secure Setting Subgroup with regards to the appropriateness of the placement of girls at a male YOI, and specifically the anticipated timeframe for this arrangement to be in place,

[2] A national resource looking after some of the most vulnerable children and young people in the YOI estate

[3] Her Majesty's Prison Service.

decision processes in relation to placing girls at Wetherby YOI, the impact in relation to available accommodation in the Keppel Unit and appropriate medical facilities for girls including any pregnant girls and new mothers.

The LSCP Independent Chair also contacted the Executive Director of the Youth Custody Service (YSC) to raise these concerns. A response was provided giving assurance that placing females at Wetherby would be a temporary measure for the next 18-24 months whilst other options are considered. This is an area that will be closely monitored by the Sub-group.

The LSCP has also been assured of ongoing work in relation to the accommodation of females into Wetherby YOI, including identifying a suitable area within the Keppel Unit which has been reconfigured to provide females with a suitable physical and emotional environment. Funding has been secured to allow for the reconfiguration of other parts of the establishment to accommodate the needs of females, for example, medical facilities, and staff have been specifically selected to work with the girls along with the appointment of a Head of Young People's Female Services, who is responsible for coordinating and managing the work with the girls within Wetherby YOI.

The LSCP were also made aware of the challenges of undertaking child protection medicals with children within secure estates. All child protection medicals for children from Wetherby YOI currently take place within community setting, however this requires all children from Wetherby YOI to be transported and escorted to medical appointments, sometimes in handcuffs and accompanied by prison staff throughout the process, although prison staff are separated by a curtain when the medical is taking place. This is resource intensive and impacts on the child's privacy and dignity. However, to hold child protection medicals within Wetherby YOI is also resource intensive requiring a pediatrician to attend Wetherby YOI impacting on their limited time to manage clinics within the hospital. Conversations have been held between NHS England, (the service commissioner) Leeds Community Healthcare NHS Trust (the service provider), and the YCS with regards to identifying the most suitable location for child protection medicals for children within Wetherby YOI. This work has been completed to ensure that child protection medicals currently held within the community setting continue to be undertaken in a way which affords the highest level of dignity and support for those children.

The impact of the introduction of Operation Safeguard (the national response to a surge in the prison population) whereby children are assessed on an individual basis, and where appropriate, their transfer to the adult estate is deferred until their 19th birthday in order to afford capacity within the adult estate, is being monitored by the Secure Settings Subgroup. This will be considered further in the next report LSCP Annual Report.

Adel Beck Secure Children's Home

Adel Beck is a secure children's home (SCH)4 operated by Leeds City Council and is approved by the Department for Education. It accommodates up to 24 children and young people of different genders aged between 10-17 years of age. It provides for up to 14 children and young people placed by the Youth Custody Service and up to 10 children and young people subject to section 25 (welfare) of the Children Act 1989 who are placed by

[4] Secure Childrens Homes provide accommodation for young people aged 10-17yrs who have been remanded into local authority care either as a result of a custodial decision, or on welfare grounds.

Local Authorities. The admission of children under 13 years of age on welfare grounds under section 25 requires the approval of the Secretary of State for Education.

In May 2021 Adel Beck were inspected by Ofsted receiving an overall judgement of outstanding, compared to good in 2020. The elements of the review were judged as follows:

- Children's education and learning: outstanding
- Children's health: good
- How well children and young people are helped and protected: outstanding.

Elland Road Police Custody Suite
Leeds is one of five districts served by West Yorkshire Police and is the largest with regards to the population it serves. The main custody suite in Leeds is located at Elland Road Police Station and has 40 cells available, however if required there is additional capacity at Stainbeck Police Station

There is a dedicated booking in space for children, young people and vulnerable individuals, which is separate to the main booking space. Although all cells are the same, children and young people are placed in cells located on a corridor specifically for vulnerable individuals. This allows closer monitoring, and if required cells with CCTV and larger windows are utilised.

The total number of arrests during 2021 - 22 amounts to 1070, a slight increase from the previous year and represents 34% of arrests made by West Yorkshire Police Service. Additionally, the number of children and young people processed by attending on a voluntary basis rather than going through the custody area is 556, a higher percentage to other districts.

West Yorkshire Police aims to process children and young people through the custody area as quickly as possible (unless being held overnight for Court). There were 608 young people detained and released within 12 hours. However, there has been an increase of those detained for longer periods during this year (38.3% being held over 12hrs compared to 35.2% the previous year.) This is likely to be reflective of the increasing number of serious offences for which those young people are held to enable the investigation to take place and to manage risk.

Youth Custody Service Incident Review
A multi-agency review was undertaken by the Youth Custody Service in response to concerns regarding the transportation of a young person from a secure setting to a hospital environment. Within the course of the transportation the young person was placed within leg restraints, which remained in place for a projected time period including whilst in hospital which no one questioned. There was no ongoing assessment or consideration within regards to the need to retain the use of the restraints.

Relevant partner agencies were involved with the review and policing partners were praised for their openness, transparency and providing open access for the reviewer. This review was also presented to the RAG and below are key areas of learning:

- A lack of professional curiosity, no-one considered if the restraints used on the young person continued to be necessary or questioned if the rationale for the use of restraints that had initially been applied remained applicable.
- A lack of handover between services in relation to the use of the restraints – the reasoning for the use of the restraints was not discussed or questioned. There

was a level of professional respect with regards to decisions made by other practitioners.

This review highlights the consistency of other reviews across the partnership regarding the need to improve professional curiosity and to encourage practitioners to question what may not seem right. This review will now inform the broader plan to ensure this area improves across the partnership.

Restraints
The LSCP has a duty to report on restraints within secure estates and this data is collated annually through the Secure Settings Annual Report.

Restraints[5] within the Wetherby main site have fluctuated between 42 in September 2021 and 105 in February 2022, with the average of the other months being 74. Within the Keppel Unit, numbers were significantly lower (6 to 19) with a similar spike (42) in February 2022.

The table below outline restraints in Wetherby YOI:

	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Main site	72	88	76	78	62	42	58	67	90	65	105	81
Keppel	7	8	11	9	8	29	6	8	10	22	42	28

Unplanned incidents remain higher, and the spikes are attributed to a small number of children. These range from children waiting for hospital places and the behaviour they have displayed, preventing self-harm but also cuffing having to be used to escort them due the risk they have posed to themselves and others.

The reviewing of incidents involving girls is done separately by Wetherby's MMPR manager and the YCS central team.

Wetherby YOI have adopted reflective practise after incidents and open discussions around them, looking for learning outcomes and support for the staff involved. It has been acknowledged that the arrival of the girls increased staff anxiety and extra training has been offered to upskill staff around this.

To support all staff with this learning, Wetherby YOI have adapted their refresher training to reflect the live incidents experienced in planned scenarios.

WYP Custody Suite
Records detail that 915 children and young people had force used on them pre-detention, 739 of these recorded as having soft physical force used. 78 of the children and young people received physical force post detention within the custody area (55 recorded as soft physical). These numbers are reflective of the type of offence an individual was arrested for.

Third Sector Safeguarding Group (TSSG)

The third sector remains a significant partner. Within the LSCP structure there is a Third Sector Reference Group which is a valuable safeguarding resource to the partnership as

[5] all restraints undertaken by Wetherby YOI from low to high level, and planned and unplanned

third sector organisations often respond to safeguarding challenges for children and families that do not reach the level of statutory intervention.

The purpose of this group is to maintain strong relationships with the Third Sector. It acts as a conduit to sharing learning from LSCP Safeguarding Reviews and highlight any challenges or opportunities from the Third Sector into the Safeguarding Partnership. The TSSG is also key to encouraging Third Sector agencies to have appropriate safeguarding governance arrangements compliant with Section 11 of Children Act.

The TSSG is led by Young Lives Leeds Forum, which is a strategic forum for Third Sector organisations working to improve the lives of children, young people, and their families in Leeds. It is important to note that not all third sector organisations are members of the organisation. The TSSG consistently reviews its membership to encourage broader engagement, especially from under-represented groups. The group is Chaired by the CEO of Leeds Survivor Led Crisis Service and has met six times since 2021.

Safeguarding in Faith

In 2021 LSCP secured £32,500 of national funding to commission a part time officer to:

- Foster stronger relationships with the Faith Sector
- Develop self-assessment tools to encourage stronger safeguarding arrangements in faith organisation
- Ambition to deliver a multi-faith safeguarding conference to promote safeguarding and listen to the needs of the faith sector.

There have been some difficulties in recruiting to this post with the advert going out three times with no successful applications received. The LSCP Business Manager has met with the Leeds Faith Forum and a representative from Young Lives Leeds to jointly take this work forward early in 2023 which will include:

- Recruitment of a part time faith worker
- Establish a faith sector safeguarding steering group
- Work with safeguarding faith leads to co-design adapted versions of Safeguarding basics training
- Support safeguarding faith leads to deliver training in their communities
- Hold a multi-faith conference to share best practice and embed learning.
- Develop a ‘safeguarding in faith’ toolkit in different languages highlighting the importance of robust safeguarding governance arrangements within their place of worship

This project will also take into account findings from the Independent Inquiry into Child Sexual Abuse report, Child protection in religious organisations and settings.

LSCP Risk and Vulnerability Subgroup – (RVSG)

This meeting is Chaired by a senior representative from West Yorkshire Police and the Vice Chair is from the Leeds Health and Care Partnership

Leeds have developed strong multi-agency arrangements to respond to child exploitation through its Multi-Agency Child Exploitation (MACE) arrangements, the RVSG is the silver strategic group within these arrangements. The purpose of the RVSG is to ensure that the city’s Child Exploitation Strategy and action plan is delivered and to monitor data and intelligence to better understand the picture of exploitation across the city.

The RVSG strategy outlines a focused approach and a robust multi-agency response towards prevention, early identification and intervention of children and young people, and the proactive targeting, disrupting, and prosecuting of individuals or groups who seek to exploit, abuse and harm children. The RVSG are responsible for ensuring the city's Child Exploitation Strategy and Action plan in Leeds provides leadership and direction in this area and during 2022 acknowledged that the Strategy requires a refresh to reflect the complexity of this work. Progress on the action plan included:

- Review of the Bronze MACE arrangements in 2020 which recommended the Bronze group should be split into two separate meetings 'Child Focused' and 'Contextual' which is now in place.
- Developed online Exploitation training opportunities for professionals during the Pandemic. This course continues to be available however the numbers of professionals accessing this course has reduced during 2022. This course continues to be promoted throughout the partnership.
- Delivered campaigns as a response to emerging themes eg: money laundering

Gold MACE: Gold MACE have strategic leadership and oversight of the city's Child Exploitation Strategy. These meetings take place immediately after the LSCP Executive meeting while the leaders from the three key agencies responsible for safeguarding are in attendance. In response to the Gold Group's request to review the Child Exploitation strategy, the RVSG are currently undertaking a multi-agency review of this strategy and underpinning action plan. There have been four sessions (September-March 2023) with representation from Health, Education, Police, Social Care, Youth Justice Service, Safer Stronger Communities, and the Third Sector reviewing the four strategic objectives:

1: Identify
To establish comprehensive and accurate data profiles and identify early indicators of risk and vulnerability. These are to enable the identification of children at risk and perpetrators (individuals, groups, locations, and patterns, including across borders), to inform partnership understanding and the targeting of professional responses, to enable early identification and effective child safeguarding and to prevent, divert or prosecute those who facilitate and /or seek exploit and abuse.

2: Prevent
To prevent children and young people experiencing or continuing to experience sexual and criminal exploitation. This in relation to preventing children being at risk of harm and abuse from: going missing from home, care or view; experiencing or continuing to experience sexual and / or criminal exploitation; peer on peer abuse, and harmful sexual behaviour. Through responding proactively to information and intelligence shared about individuals and groups in order to divert or prosecute those who seek to abuse and harm.

3: Support and Protect
To intervene early and provide information and services to children, young people, parents, carers, friends and communities through restorative, holistic and multi-agency whole family approaches.

4: Respond appropriately to those who seek to harm children
To successfully disrupt and/or prosecute those who perpetrate the exploitation and abuse of children and young people; ensuring a child focussed approach where perpetrators are children. This in conjunction with the prevention and diversion of crimes against children wherever possible.

The outcome of this review will be presented to the LSCP Gold Group with a view to being embedded into the safeguarding arrangements in the city in May 2023.

Child Exploitation in Leeds

West Yorkshire Police have identified an increasing number of young people being exploited through online money laundering. Criminals resorting to the use of social media to recruit young people by using images of fast cars, piles of cash and messages such as “earn some fast cash”.

Young people responding to these messages are offered money in exchange for their bank details. This led to a campaign, in partnership with West Yorkshire Police, that replicated the messages used by the criminals to inform young people about money laundering. Young people who clicked on the campaign were provided with an explanation of how criminals use social media to recruit young people, a definition of money laundering, what the long-term consequences could be and where to go for support. The **campaign** launched in March 2022 and achieved a total of 25,719 engagements. Young people spent an average of 2min 40 seconds on the page which is the amount of time it takes to read the information.

Headlines of exploitation in Leeds include:

- This is a highly complex area of work involving all partners, statutory services, early help, families, and communities. Significant progress is being made in relation to practice, process, systems, and learning
- A shift in the Leeds profile as systems have been developed to enable data capture and reporting of different forms of exploitation
- Understanding, knowledge and practitioner confidence continues to increase around Child Exploitation
- It is essential that the city maintains continued focus on Child Criminal Exploitation (CCE) to ensure children at risk of this receive the best possible support.
- LSCP social media campaigns around exploitation continue to reach large numbers of young people and enable them to access both information and where to get support
- Preventative work and early identification for younger children and young people identified with emerging risks is crucial. The Bronze Multi-Agency Child Exploitation (MACE) meetings and the Early Help Hubs partnership work are key to this area of work.
- Research highlights children on reduced timetables, who are excluded or who are Not in Education Employment or Training (NEET) are more vulnerable and the link between these issues and child exploitation remain clear

Data demonstrates that children in Leeds who are known to be at risk of/experiencing exploitation have been predominately White British, however further work should be undertaken to better understand the impact of exploitation in other communities in Leeds. This will be explored further through the refreshed Child Exploitation Strategy.

Data on child exploitation in Leeds over the last 12 months demonstrated lower trends to previous years.

Year	High Risk	Medium Risk	Low Open
2021/22			
CCE	91	159	99
CSE	25	73	87
CSE and CCE	17	47	40
Year	High Risk	Medium Risk	Low Open

2022/23			
CCE	78	153	77
CSE	21	70	66
CSE and CCE	21	44	33

The lower numbers of children experiencing exploitation may be a result of many factors. Exploitation awareness training aimed at professionals supports early identification and mitigation of risk factors. Targeted awareness raising to children provide opportunities for education and where to get support. The Bronze MACE allows professional to discuss emerging cases with other professional enabling early responses to divert children away from exploitative relationships.

Areas of improvement

Child exploitation remains an issue that impacts on the most vulnerable children and young people in the city. The current refresh of the Child Exploitation Strategy and underpinning action for Leeds requires partners commitment going forward. Close monitoring of its implementation and evidence of improvements should be a focus for the LCYPP.

Exploitation goes beyond traditional CP processes where the risks to young people are generally intra-familial. This changes in the teenage years. Developmentally, adolescence is a time of exploration, increasing independence, and risk taking. Young people become more engaged with, and influenced by, peer norms and relationships, and other adults, groups and communities not connected to their families, including online. These extra-familial contexts can pose a new set of complex risks for children, and these must be considered and addressed in all exploitation risk assessments. In July 2022, Leeds Childrens Services were successful in a bid for Professor Carlene Firmin to work in Leeds to support the city's plans to strengthen contextual assessments and pathways for children. There were initial trial meetings in the east of the city over January and February 2023. The outcome of this work will be incorporated into the review and refresh of Leeds Child Exploitation Strategy and action plan due for completion in March 2023.

There are often key identifiers which make children more vulnerable to being abused through exploitation and these should be considered in all assessments. Furthermore, Leeds should consider the language used when assessing children e.g., terms such as 'low' risk may minimise the perceived risk for children who may not yet be experiencing exploitation but have multiple indicators that may need addressing immediately to prevent risks escalating in the future. The Risk and Vulnerability Subgroup will review the city's exploitation risk assessment tools acknowledging the work undertaken in the city by Carlene Firmin.

The LSCP Risk and Vulnerability Strategic group will promote and encourage organisations to sign up, and feed information into the Police **Partnership Intelligence Portal.** (PIP). This portal is used for professionals to share information about routine criminality through to serious and organised crime that can impact on children in the city.

Looking forward, the review of the Child Exploitation Strategy and Action Plan originally written in 2019 by the LSCP Silver group will be informed by these findings. This will be presented to the LSCP Gold Group in May 2023

Youth Violence

In April 2021 the Violence and Vulnerability Unit (VVU) were commissioned by Leeds Council to undertake an Extended Learning Review. During the VVU over 60 staff from across the statutory, voluntary and community sectors were spoken to. During these discussions, those involved spoke about the violence and criminal exploitation challenges facing young people and their families across Leeds, the good practice in place to support these families, and what may be required to further develop work in Leeds linked to community harm.

From the information captured a set of recommendations were prepared by the VVU. These recommendations were agreed and accepted by the Safer Leeds Partnership.

Work on the VVU Extended Learning Review recommendations was delayed due to COVID-19 pandemic. In March 2022 work on the recommendations re-commenced. The senior leaders team agreed with the support of the VVU, the development of this work would be progressed through a multi- agency task and finish group. The task and finish group would have joint Chairs from Community Safety, Social Care, and the Police.

The Task and Finish group are now progressing its action plan which includes:

- Build a detailed understanding of the issue of violence, including youth violence, urban street gangs, wider community harm and violence in the city centre to inform the development of any future strategy and associated action plan(s).
- Review existing multi-agency approaches and work arrangements, with a view to streamlining governance and operational delivery alongside national best practice to present recommendations for improvement. This will feature a pan Leeds approach/meeting holding an overview of youth crime in and across Leeds. There will also be a locally based meeting structure in the three main areas of Leeds to support frontline workers with families and young people affected by youth violence and/or exploitation.
- Create a structure that will create a more integrated and streamline structure which will reduce duplication of work with young people and families in this complex landscape.
- Review existing interventions and support arrangements, alongside national best practice to align further with the multi-agency approach.
- Promote the understanding of signs and identification of violence including youth violence, USGs and associated issues across the public, private and community sectors in the city.
- Develop a partnership training and awareness raising programme for the multi-agency approach.

It is essential that the VVU and Risk and Vulnerability Subgroup maintain close working relationships ensuring a joined up approach to both youth violence and exploitation.

Education Reference Group (ERG)

Education engages with children and their families every day and therefore have a significant role in safeguarding children. Early Years providers, school and college staff are key as they can identify concerns early, provide help for children and to prevent concerns from escalating. Early Years providers, schools and colleges and their staff form part of the wider safeguarding system for children where agencies are expected to work together to ensure children are safeguarded and their welfare protected.

The LSCP structure has an Education Reference Group which informs the Partnership and provides an opportunity to drive forward priorities. The purpose of the ERG is to maintain strong relationships and engagement opportunities within the Education Sector across Leeds. It also supports the sector with implementing updates of Keeping Children Safe in Education, being assured that schools are compliant with Section 157/175 of the Educational Act and ensures a central point for disseminating learning from safeguarding reviews. The sub-group will also be an opportunity for schools to share their issues to inform the partnership and support wider educational strategies including the Children and Young People's Plan. This has led to seeking the broader engagement of partners including school nurses, school police officers and designated safeguarding leads and identifying a new chair from the education sector.

In the past the ERG has provided a significant contribution to the work of the LSCP; however, in 2021 There were some difficulties in identifying a Chair to lead on this group which significantly impacted on progressing its workplan. the ERG has met only twice in 2021 and met just once in 2022 limiting opportunities in this area. In December 2022 a new Chair has come forward and will be taking the work of this group forward.

This is a key area for development for the Partnership, to ensure it continues to build on and strengthen partnership working with the education sector. The Independent Review of Childrens Social Care highlights the importance of the education sector having strategic influence in responding to the needs of children.

LSCP Learning from Reviews 2021 – 2022

The LSCP Learning and Improvement Framework aims to ensure that learning from practice, audits, local and national research is disseminated and embedded through improvements to safeguarding systems alongside training and development opportunities for practitioners across Leeds.

The LSCP Review Advisory Group (RAG) is a significant sub-group of the Executive who provides nominated members from their organisations and is chaired by the Independent Chair. It is responsible for identifying learning in relation to the most serious cases, including Serious Child Safeguarding Incidents (SCSIs), identifying good practice and areas of learning and improvement.

The fundamental purpose of reviewing incidents where children who have either died because of abuse or neglect or where children have been seriously harmed is to learn from those cases to help make improvements to systems that protect children and to prevent other children from being harmed.

A central role is to seek assurance related to actions taken following local learning activities, Rapid Reviews, Local Child Safeguarding Practice Reviews (CSPRs) or National Child Safeguarding Practice Reviews. The RAG can request support from LSCP Subgroups to disseminate learning, undertake quality assurance work to measure impact and to seek assurance that partner agencies use their own internal structures to implement recommendations.

Notifications of SCSIs

Working Together to Safeguard Children 2018 states that the duty to notify Serious Child Safeguarding Incidents (SCSIs) to the National Child Safeguarding Practice Review Panel rests with the local authority. Furthermore, that in making that decision it is an integral part

of the decision-making process that they are informed and guided by the views of statutory partners. However, the ultimate responsibility to notify, or not to notify, lies with the local authority, as set out in legislation. There are no provisions within the legislation which permit a local authority to delegate this statutory duty to partners. The local authority remains accountable in law for the decisions made.

The LSCP RAG collectively considers whether an incident meets the criteria for notification as a SCSI, with relevant partner agencies providing information and professional opinions to support the Local Authority decision making. Following the notification of a SCSI by the Local Authority to the National Safeguarding Panel the LSCP through the LSCP RAG will promptly undertake a Rapid Review[6].

A Serious child safeguarding incident is defined as:

- Abuse or neglect of a child is known or suspected; **and**
- The child has died or been seriously harmed.

Cases for consideration are raised to the RAG via partner agencies using the SCSI notification and discussion form developed by the RAG and introduced in May 2022. Prior to that, cases were raised directly with the LSCP Business Unit.

When an agency other than the local authority becomes aware of an incident that appears to meet the criteria for notification, the relevant partners discuss this with their agency's safeguarding lead (or RAG member) and refer this to the LSCP RAG for a discussion in relation to a potential notification.

Review of Notification Processes

In 2021 The Independent Chair informed the LSCP Executive she required assurance of the notification systems in Leeds and whether all partners were equally able to inform the decision of whether to notify the National Panel of a SCSI. This initiated a review of notification process undertaken by representatives from each of the three key statutory partner agencies, led by West Yorkshire Police and independently scrutinised by the Independent Chair. This review acknowledged that the legal duty and decision to notify a SCSI to the National Panel rests with the Local Authority and this cannot be changed.

The outcome of the review has led to improvements that ensures all statutory partners are informed of any consideration of a notification by the Local Authority and are able to provide information and their professional opinions to inform the decision-making process. In addition:

- All cases for potential notification are first reported to the Independent Chair and the LSCP Business Unit
- All relevant statutory partners (RAG members) are informed of any consideration of a notification by the Local Authority and are encouraged to provide information for consideration via the notification referral form
- Partner agencies are encouraged to refer serious childcare incidents into the RAG for partnership discussion

[6] The statutory timescale for a Rapid Review is 15 working days

- Extra-Ordinary RAG meetings are held whereby all statutory partners can share relevant information, their professional opinions and in addition, there is a multi-agency discussion to inform the decision-making process
- Partner agencies are encouraged to invite relevant professionals to discussions to provide additional professional opinion
- the rationale to notify or not, is recorded and shared with all statutory partners in a timely manner.

Since this process has been implemented, all the SCSI cases considered by the RAG resulted in collective discussion and agreement on decisions.

Continuous Improvement and Reflection by Executive and Senior Partners

In the interest of continuous improvement and building on open and transparent discussions, two workshops were facilitated with the LSCP Executive, National Child Safeguarding Practice Review Panel and the three National Safeguarding Reforms Facilitators. This led to further conversations of how differences in opinion can be extremely challenging, recognising that this can be reflective of a strong partnership, mature enough to disagree at times. It also recognised that despite these challenges, a way forward was identified and a mutually agreed set of arrangements were put in place. This is a clear indicator of the Partnership's ability to be open, transparent, and challenging of each other, and of systems and processes in the interest of children and young people.

Rapid Reviews

A Rapid Review is a multi-agency process which considers the circumstances of a SCSI. The purpose of the Rapid Review is to identify and act upon immediate learning and consider if there is additional learning which could be identified through a wider Child Safeguarding Practice Review (CSPR).

The Rapid Review enables safeguarding partners to:

- Gather the facts about the case, as far as they can be readily established at the time.
- Discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately.
- Identify immediate learning and consider the potential for identifying improvements to safeguard and promote the welfare of children
- Decide what steps they should take next, including whether to undertake a local Child Safeguarding Practice Review (CSPR).

At every stage of a rapid review, multi-agency meetings are held to ensure all partners within the RAG have an equal opportunity to share their professional opinion and contribute to any decisions. Minutes of these meetings are used to capture the rationale for any recommendations made and shared with the LSCP Executive and the National Panel.

In Leeds, between 01 September 2019 and 31 March 2023, the LSCP have undertaken 16 Rapid Reviews (including a retrospective notification).

- Police referred 9 cases to RAG
- CSWS referred 9 cases to RAG
- Health referred 3 cases to RAG

Of those referred 15 were notified to the National Child Safeguarding Review Panel resulting in a Rapid Review.

The details of the 15 Rapid Reviews since September 2019 are as follows:

Age	
Under 1 year	4
1-4 years	5
5-11 years	4
12 years or older	2

Gender	
Male	7
Female	8

Incident	
Passed away	7
Serious harm	8

Child Safeguarding Practice Reviews were commissioned following four Rapid Reviews, and a CSPR was initiated in relation to a retrospective notification. A joint review has also been undertaken with the Leeds Community Safety Partnership (Safer Leeds) and the Leeds Safeguarding Adults Board to consider learning from a case which did not meet the criteria of a CSPR, but where it was recognised that there was an opportunity for the consideration of joint learning.

The National Panel provides a response to Rapid Reviews submitted by the LSCP and have the authority to agree or disagree with local decisions on whether a case is considered a CSPR or whether a local review is more appropriate. In all cases, the National Panel have agreed with the LSCP Executive decisions. Feedback from the National Panel on Rapid Reviews has been positive with comments highlighting 'clear recommendations and learning points' 'all appropriate learning identified' and a 'clear and focussed review'

Examples of Cutting Cross Themes from Learning Reviews.

Professional curiosity – This has been a reoccurring theme that has led to much discussion within the RAG whereby it has been identified a consistent theme. The combination of looking, listening, asking direct questions, checking out and reflecting on the information received has led to missed opportunities to fully understand an individual or family's situation and what might be needed to support them.

Partnership discussions have been held in relation to professional curiosity to consider good practice, barriers and support required, along with a partner agency survey in relation to how professional curiosity is promoted and supported including within supervision by partner agencies. The findings have been fed into an ongoing piece of work with Safer Stronger Communities and the Leeds Safeguarding Adults Board to develop consistent city-wide resources around professional curiosity.

A Yorkshire and Humber Masterclass series in Spring 2023 will focus on professional curiosity with the findings of the above work influencing the choice of topics and speakers.

Disguised compliance –Reviews demonstrated how individuals were able to sometimes, divert attention from what was happening within the family through appearing co-operative and providing practitioners and agencies with the information requested, and this was not further pursued regarding assurances in relation to how the family were or undertaking what was asked of them. It was acknowledged that this was closely associated with the need for professional curiosity and not taking everything on face value.

This learning has been fed through to the LSCP learning and Development Officers and the work they are undertaking in relation to professional curiosity due to the links between disguised compliance and professional curiosity.

Escalation processes –Reviews have highlighted how in some cases there is a lack of escalation and / or where professionals have attempted to escalate concern have not always been resolved as expected. This has led to ongoing work to understand barriers to implementing the escalation process, namely related to why it is not effectively being used by all practitioners or recorded when used. Issues of confidence and power differentials were identified, and these issues are being taken forward through both training and specific guidance and messages for practitioners across the partnership.

Death of a significant family member –several reviews noted families has recently experienced the death of a significant family member which understandably had an impact. The reviews identified the need to ensure a sensitive balance between supporting families in relation to the grieving process and the provision of bereavement support, alongside the need to monitor plans and assess risk. The impact of a bereavement needs to be considered in all assessments. This learning will be shared with the partnership as part of the presentation of learning from reviews and be fed into the learning and development subgroup

Domestic abuse – The majority of cases identified domestic abuse either historically or in the present. Reviews have identified a need to improve how risks and / or impact on children is assessed. This should include how historical abuse is considered and assessed in relation to the birth of a first child based on the research in relation to pregnancy being a time of heightened risk in relation to domestic abuse. This learning was shared as part of the LSCP Domestic Abuse Review and provides recommendations for the partnership which require monitoring to be assured of improvements.

Different agencies risk assessment processes – One review identified that practitioners are not always fully aware of / fully understand the risk assessment processes used by different agencies or what the identified risk levels / assessment outcomes mean. This was particularly evident in relation to assessment and management of Registered Sex Offenders. The partnership is now considering broader discussions to develop work in this area including a workshop to consider improved multi-agency oversight and management of Registered Sex Offenders currently being developed by police colleagues.

Impact of Covid Pandemic –Reviews identified the impact of the COVID Pandemic ranging from impact on agency capacity and staffing levels which resulted in a lack of consistency of allocated workers for families; differing ways of working which reduced face to face visits and contact; isolation for children from services, schools, and peers; the cancellation of appointments both by agencies and families resulting in longer periods of time between an agency's contact with a family

Complex health needs – two reviews considered children with complex health needs, identifying the impact for a family of the numerous services and agencies that were involved, along with the co-ordination of numerous medical appointments.. In addition, the need for assurance in relation to access of appropriate medical support when a child is staying out of area was identified, resulting in the LSCP policy for children with complex health needs travelling abroad being updated in November 2022 to include traveling out of area.

Consistent application of safeguarding approaches – Throughout reviews undertaken, the impact of the consistent application of core safeguarding approaches including the Think

Family Work Family approach, Was Not Brought Approach, Early Help Approach and Safeguarding being everybody's responsibility was evident for improving outcomes for children and young people. There have been examples of excellent practice whereby these approaches have been considered and applied, however it was recognised that these approaches were not always consistently applied across the Partnership resulting in the potential for differing responses to situations.
These approaches are continually being promoted across the partnership, and where appropriate reviewed and updated to reflect specific learning.

Taking Learning from Reviews Forward

Following the completion of a review, an action plan is collated and agreed by all the relevant partners. Progress against this is monitored by the LSCP Business Unit with assurance being provided to the LSCP RAG. The oversight of Action Plans is being reviewed and incorporation into the Performance Management Subgroup work plan.

The LSCP Business Unit supports the dissemination of learning through:

- The production of learning sheets which summarise the incident which has been reviewed and the key good practice and learning – this is also provided to partner agency training leads to support them in reflecting lessons within single agency training
- Updating training to reflect learning, including a section in relation to learning from reviews within the LSCP Refresher Training
- Presentation to the LCYPP meeting including requests for partners to disseminate and embed learning internally
- Inclusion in any learning from reviews presentations for example at the LCYPP Bi-Annual Meetings
- Practitioner presentations based on the review and identified learning – consideration is also undertaken with regards to capacity in relation to the number of sessions required to reach the workforce within Leeds.

An annual assurance request of all partners is being considered to seek assurance in relation to how partner agencies are disseminating and embedding learning and identifying the impact and outcomes. This will be introduced in March 2023 and will be overseen by the Performance Management Subgroup, with findings being present to the CYPP on an annual basis.

Child Death Reviews

LSCP Child Death Overview Panel (CDOP)

The LSCP have a statutory responsibility to review the deaths of all children in Leeds.
The Leeds Child Death Overview Panel (CDOP) has been undertaking its role to review the death of every child aged under 18 who were resident in the city since April 2008. The responsibility for this process differs slightly to Working Together to Safeguard Children in that the key agencies responsible for this process are the Local Authority and Health.

To comply with the national guidance, Leeds have employed a Designated Doctor for Child Deaths who has a role to work between the CDOP and the Health Economy. This post continues to add richness to discussions as well as further scrutiny and challenge to the safeguarding system.

The CDOP have also extended its child death review arrangements to include specific focus on neonatal deaths through its Neonatal Death Overview Panel (NDOP). This panel, chaired by the CDOP Chair, has representation from midwifery, neonatologists, obstetrics from Leeds Teaching Hospital Trust, the LSCP Business Manager and the CDOP Designated Doctor for Child Deaths. The Neonatal panel considers information from internal hospital meetings and investigations such as Perinatal Mortality Review meetings, as well as using Coroners Reports, Post-mortem Reports, MBRRACE[7] Forms and Death Discharge Summary's to consider if there were any modifiable factors to learn from. The outcome of these reviews is presented to the CDOP for assurance and transparency purposes.

Leeds CDOP is Chaired by the Chief Officer / Consultant in Public Health. In 2021-22 there were six CDOP meetings where nineteen deaths were reviewed and seven Neonatal CDOP meetings where thirty-six deaths were reviewed.

A significant finding from the CDOP report was that 52% of child deaths occurred in children living in decile 1, the poorest 10% of Leeds. These findings were reflected a national report by the National Child Mortality Database published in 2021. The report Child Mortality and Social Depravation 2021 found that over a fifth of all child deaths in England might be avoided if children living in the most deprived areas had the same mortality risk as those living in the least deprived. This translates to over 700 fewer children dying per year in England.

An overview of the child death review arrangements, the findings from the CDOP Annual Report, recommendations made and progress on the previous year's recommendations can be found here

Sudden Unexpected Death in Childhood Strategic Reference Group (SSRG)

Established in 2014 to implement the findings from a local independent review of the SUDIC process, the group continued to meet to ensure that the city's response to sudden and unexpected child deaths are effective, coordinated and meets the needs of families. Key areas of work undertaken by the SUDIC team have been:

- Developed SUDIC information leaflets for families that comes in a range of different languages and includes contact details for the SUDIC team and information on how to give feedback
- An online event on the "National and Regional Impact of Covid-19 on Child Deaths" was developed and delivered by the SUDIC Consultants, offering an opportunity for ongoing professional development within the team and across the SUDIC network.
- A briefing on Child Death Review Processes in Leeds has been developed for delivery via the Leeds LSCP training programme offering practitioners across the multi-agency partnership an opportunity to gain some basic understanding of the SUDIC process.
- When the SUDIC team undertake a home visit (usually within 48 Hours), families are provided with information for a range of bereavement support groups including the Community Bereavement Service offered by Martin House.

[7] Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries

LSCP Priorities

The Executive in partnership with safeguarding partners set the priorities for the LSCP. The expectation is for sub-groups to drive the agreed priorities to explore and provide assurance of the effectiveness of the safeguarding system. The constant need to ensure they remain relevant and are evaluated to ensure progress against the priorities are a significant role for Executive and sub-groups. This also involves providing assurance of completed actions, evidencing impact for change and identifying areas for improvement.

The current priorities have been in place since 2018 and the Executive Board now wish to revise the priorities with stakeholders to ensure they remain relevant and to seek assurances on their progress. Furthermore, to ensure they are owned and driven by the sub-groups and the LCYPP.

The current priorities:

- Domestic Abuse and the impact on Children
- Vulnerable Learners
- Exploitation

Children and Young People Experiencing Domestic Abuse
The priority was overseen by the Independent Chair who sought assurances across the system for children and young people growing up in a household with domestic abuse. The theme of domestic abuse continues to be a consistent theme across learning from local Rapid Reviews which highlights the devastating consequences for children and young people. This also included witnessing domestic abuse which is identified as one of ten traumatic events or circumstances that research demonstrates increases the risk of adult mental health problems and life-threatening disease before the age of 60. Research repeatedly demonstrates that specialist support services for children reduces the impact of domestic abuse and improves children's safety and health outcomes.

The Domestic Abuse Bill gained Royal Assent on 29th April 2021 and is now signed into law. This Act lays the foundations to reshape how society responds to domestic abuse, following successful campaigns to ensure it recognises children of domestic abuse for what they are, victims. The Act explicitly recognises children as victims if they see, hear, or experience the effects of abuse. For child victims of domestic abuse, the success of this Act will depend on partnerships and leadership in responding to and supporting children so that they recover from the trauma they've experienced.

In response to this new Bill, the LSCP Independent Chair undertook a city-wide review with support from the LSCP and Safer Leeds Executive, exploring how effectively children witnessing and experiencing domestic violence and abuse are supported and protected by agencies across the city of Leeds. The findings from this review were also presented to the Leeds Domestic Violence Programme Board and an example of partnership engagement that had led to strong joint partner working, leading to on-going safer outcomes for children and young people.

The following details the progress against the Children Experiencing Domestic Abuse Priority:

- A Designated Safeguarding Lead Reference Group was established and continues because of this review. The group contributed to the discussion based on their experiences of improvements to the school notification process, which clearly

required improvements. The role of education is central to safeguarding children and young people and this review highlighted the challenges of information sharing and communication between the school and reports to the school of domestic abuse. There is a real challenge of ensuring timely accurate information as it some schools reported children were not recorded in the household when present. West Yorkshire Police responded by issuing guidance on ensuring the recording of children to frontline police officers when attending domestic violence incidents.

- Operation Encompass is a process whereby the police report all domestic abuse incidents directly to the school. It was clear that schools referred to this, however, Leeds does not have the full Operation Encompass model that enables a wealth of information, including a free child psychologist helpline to support both children and practitioners and the reporting of children affected by domestic abuse to go directly to a call centre. This is an area that requires improvement, and all education providers stated the need to have a system whereby all domestic abuse reports of children are directly reported to the school and in good time. This has led to the creation of a task and finish group in April 2022 led by Children's Social Work Services with support from Safer Stronger Communities and partners. The group is exploring opportunities to improve the current school notifications systems and processes, including ensuring notifications during holiday periods, cross border notifications and improving the quality and timeliness of information shared with schools. The majority of Designated Safeguarding Leads (DSL's) stated that they had officers on duty during school holidays and would be available to receive information which would enable them to prepare support for children and young people.

- A Healthy Relationships task and finish group was established to explore current practice and opportunities in relation to RSE/PSHE and responses to the My Health My School Survey (MHMS) focusing on schools and further education settings that have engaged with the review. The survey provides several questions as an opportunity to hear the voice of children. There is currently one question related to domestic abuse, however, there is a need to understand how the Education Sector use this information to inform the delivery of Personal, Social, Health and Economic (PSHE) session you young people. Most of the education settings involved in this review shared how they rarely used this information to inform their practice, and this remains a missed opportunity for the partnership.

- In December 2021 West Yorkshire Police produced guidance and a bulletin to all front-line police officers on the importance of seeing all children present at a domestic violence incident and recording all children living in a household. This was due to officers not recording all children present and not providing detailed information on the presentation of the child. First responders are now given information about repeat domestic abuse incidents. All officers have handheld devices which they can use to research those present at a Domestic Violence and Abuse (DVA) incident including children. Checks are continually being made to make sure that improvements are being seen in the information collected by police officers. This is being monitored through the Operation Encompass Task and Finish Group.

- The Elective Home Education (EHE) Notification form did not have a question related to domestic abuse, this has now been updated and the electronic form now includes a key question for schools "are you aware of any domestic abuse incidents within the family". The form was updated and came into use at the end of March

2022. Work is now being undertaken to ensure that all schools use the electronic form to notify the Local Authority of a child who has become EHE.

- DVA Coordinators are seconded to the Early Help Hubs from Behind Closed Doors to support the facilitation of work with children who are the victims of DVA. Staff in the Early Help Hubs continue to deliver bespoke training sessions where there is a need and coordinators have a focus on mental health, substance use and domestic violence and abuse. In the coming months, the DVA Coordinators will be supporting colleagues to develop specific programmes of work for children affected by domestic violence and abuse. DVA Coordinators are going to prioritise supporting schools to deliver healthy relationship work which is suitable for Key Stage 1-4. This is being trialled within a primary school with a view to rolling out to other schools, clusters, youth service and any other interested partner agencies thereafter.

  It is important to note that the review highlighted that not all 'clusters' are equal when it comes to accessing domestic abuse support for children. This is an area that requires improvement as children and young people should not be disadvantaged due to not being in a Cluster arrangement.

- Child Protection Online Management System (CPOMS) is the electronic monitoring system used by education providers as a way of monitoring safeguarding, wellbeing, and pastoral issues. This system supports schools and further education settings to be automatically notified about domestic abuse incidents and reduces instances where the notification may be missed through the current telephone call system. This priority review identified this to be an area that requires improvement to improve the timeliness of information sharing and access for all. The task group have now undertaken reference meetings with other local authorities who have fully adopted this system to establish the merits of adopting CPOMS across all schools in Leeds. In addition, the local authority has held a workshop with DSLs in schools who access CPOMS daily and the feedback overall for the system has been very positive. The local authority with their I.T department will be presenting an options report for consideration in December 2022. During 2023 assurance will be required to understand the 'take up' of schools using CPOMS.

In addition, during 2020-21 the LSCP part funded a health post to sit in the Front Door Safeguarding Hub (FDSH) with part of the role being to support the daily domestic violence meetings and MARAC[8] process and subsequently funded by the Leeds Health and Care Partnership (LHCP).

In April 2021 the LHCP raised with the Executive that domestic abuse incidents are increasing, therefore this is placing significant demands on the partnership resources within the MARAC. LHCP requested assurance that these demands are investigated and addressed. The Executive invited Safer Leeds to the Executive to highlight work undertaken to mitigate these demands, ensure that the FDSH is appropriately resourced while ensuring that families continue to be protected.

The presentation provided to the Executive describes a new model of triaging cases through a multi-agency approach called Daily Risk Assessment Management Meetings (DRAMM) The DRAMM is a daily meeting consisting of 3 key agencies, Children's Social Care

[8] Multi-Agency Risk Assessment Conference

Services, West Yorkshire Police and Leeds Domestic Violence Service, who triage high risk police incidents and MARAC repeats. Any cases discussed in the DRAMM and assessed as high risk and in need of further discussion will be referred into the MARAC. The impact of this is fewer inappropriate referrals to the FDSH however, this work will require continued monitoring to ensure its effectiveness.

Priority Two: Vulnerable Learners
The LSCP Business Unit, Executive with the support of the Independent Chair, intend to lead on Priority Two during 2023, to seek assurance within the area of vulnerable learners, including areas of improvements and understanding the safeguarding systems partnership response to the most vulnerable learners.

This review will be scoped to seek views in relation to the areas for explorations, however, we aim to consider the following children and young people:

- Those who do not attend mainstream school,
- Children with special educational needs where there are also safeguarding concerns,
- Looked after children and Care Leavers
- Those educated at home who may have additional vulnerabilities
- Children missing from education
- Educational experiences for children from Gypsy and Roma Traveller backgrounds

Priority Three: Exploitation of Children and Young People
The below provides an account of how the LSCP continues to focus on children at risk of / experiencing exploitation. This remains an area that requires on-going work and monitoring with further opportunities to strengthen this work to the Serious Youth Violence Strategy.

The Multi-agency Child Exploitation (MACE) Framework describes Leeds arrangements when responding to the challenge of children vulnerable to exploitation, including child sexual exploitation (CSE), those children who go missing; and other forms of abuse such as child criminal exploitation (CCE). This framework has three specific multi-agency functions:

Bronze MACE-Child Focused: This muti-agency team which includes police, the Safe Project, health and third sector representatives meets every two weeks. Professionals can refer emerging cases of child exploitation and works with them to identify strategies to reduce risk. It will also consider cases where a Child Protection Plan is in place and the risks continue to escalate to identify more intense strategies to reduce risk. It also provides a sharp focus on disrupting perpetrators ensuring that they are managed appropriately. Information, advice, and guidance is provided to professionals bringing cases to this meeting as well as further background checks undertaken to identify possible links to other young people or adults already known to services.

Bronze MACE-Contextual: It was recognised that the Children Act is more aligned to abuse that happens in the family home or related to extended family / friendship circles and not a contextual perspective. This process is built on the idea that safety for a child is achieved through interventions with their families and their capacity to protect their children and not necessarily the contexts in which they have come to harm.

The MACE Contextual Meeting started in Leeds in August 2021 and gathered momentum in 2022 and meetings currently take place twice a month to look at bringing together data, information, and intelligence to support the disruption of exploitation and the protection of children. To date, there have been attendees from over 20 partners from across Leeds from

a range of departments and organisations including CSWS, Police, Health, Education, Probation, Libraries, Youth Justice Service, Licensing, Parks & Countryside, and the Housing and Communities Teams. This group has identified 10 clusters where there are higher rates of known risk and has enabled a coordinated effort to disrupt causes of harm in those clusters. Businesses have been targeted with information on exploitation, police and community awareness have been heightened and a focus on gathering further intelligence in those areas have been encouraged. Furthermore. OfSTED in their 2022 visit observed a contextual meeting and stated in the report *'multi-agency approaches to identifying and disrupting exploitation are effective'.*

External Inspections

Inspections make sure our statutory services meet basic standards of quality and safety ensuring the best possible support for those that require the use of those services. All inspections operate under an inspection framework to ensure a consistent approach. In 2021-22 there were two significant inspections carried out on two of the three key statutory agencies.

The OfSTED inspection of Leeds Local Authority Childrens Cervices, undertaken in 2022, highlighted that children benefit from *'consistently strong and creative social work delivered to an exceptionally high standard.* And that they *'harness effective partnership working'*[9]

OfSTED grade four areas within their inspection process:

- The impact of leaders on social work practice with children and families was rated as **Outstanding**
- The experiences and progress of children who need help and protection was rated as **Good**
- The experiences and progress of children in care and care leavers was rated as **Outstanding**
- Overall effectiveness was rated **Outstanding**

There were 2 recommendations set out in the report:

1. Contingency planning in children's written plans
2. Consistent decision-making for strategy discussions

An action plan has been developed and progress of this is being monitored through the LCYPP meetings. It was noted by the LSCP Executive that in the Ofsted focussed visit inspection 2021 the recommendation highlighting the need for partners to engage more with strategy discussions, However it was noted in Inspection of Leeds local authority children's services in 2022 that multi agency attendance at strategy discussions was good.

The Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) December 2021 Police Effectiveness, Efficiency and Legitimacy (PEEL) inspection assess the performance of all 43 police forces in England and Wales.

[9] Inspection of Leeds local authority children's services

The inspection highlighted that the force has effective governance in place to protect vulnerable people. It highlighted good examples of preventative measures to divert young people from becoming involved in serious and organised crime. Well-established child vulnerable exploitation teams provide support to children and young people at risk of child sexual exploitation and refer them into local multi-agency pathways. It found that the force also plays an active role with partners in intelligence-gathering and disrupting perpetrators of exploitation.

In addition, the Inspectors found officers and staff working together in partnership with other agencies, and evidence of positive working relationships and information-sharing.

To further strengthen multiagency information sharing and decision making, the police will now attend and contribute to weekly Front Door review meetings which considers contacts made to the Front Door and quality assures decision making and information provided by partners.