City of York
Safeguarding Children Board

Working with children, parents and professionals to make our childrens' lives safer.

Annual Report 2012-2013

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CYSCB Chairperson statement

In the revised Government guidelines, 'Working Together to Safeguard Children' published in March 2013, a requirement is given to the Chair of the Local Safeguarding Children Board (LSCB) to publish an annual report on the effectiveness of child safeguarding in the area served by the Board. This is to be a public document. The report will outline details of the Board's activities, but more importantly it will provide an opportunity to provide a statement about the position of safeguarding in York.

There continues to be a strong national and local interest in the children's safeguarding agenda, and the level of public interest remains high. The intention of this annual report therefore is to indicate to a wider audience, the key messages in the safeguarding arrangements for children and young people in the City of York, and to reassure the local public that the commitment to provide the highest levels of service in this crucial area of work is maintained from all agencies in the city that have a responsibility for the welfare of children and young people.

Safeguarding Children Board's have a number of responsibilities, which aim to ensure that there is a multi-agency approach and commitment to the safeguarding of children. They have responsibility for multi-agency training and for ensuring that all agencies provide training to their staff; they are responsible for common practices and procedures; for oversight of the Child Death Overview Panel (This is managed by the North Yorkshire on behalf of the two LSCBs); and for the commissioning as appropriate Serious Case Reviews and Learning Lessons Reviews so as to ensure that any lessons are learned from serious child protection incidents. In addition, the Board is responsible for the management of arrangements for the investigation of safeguarding allegations against professionals and volunteers working in child care; and importantly to the holding of all agencies to account about their standards for the safeguarding of children arrangements.

There can be no complacency in York about the need for continued high vigilance about standards, but it is pleasing to note the outcome of the most recent Ofsted Inspection of safeguarding and looked after children in March 2012. This inspection was wide ranging, and it is pleasing to record that the judgement given by the inspectors to the standards of safeguarding children in York was 'good'. The standards of partnership working and the work of the City of York Safeguarding Board were judged to be 'outstanding'.

The Board continues to carry out its work through regular quarterly meetings, which are well attended by all agencies; an Executive Group; a Serious Cases Panel; and two Lead Officers, who take the lead in respect of Training and Policies and Procedures. In addition there are

now two Groups in respect of Child Sexual Exploitation (CSE), whose work is described elsewhere in this report. Also where required the Board uses 'task and finish' groups to consider specific policy areas. There will be the re-establishment of the Quality Assurance and Performance Group in June 2013.

The Board currently has two outstanding Serious Case Reviews, and a newly commissioned Learning Lessons Review. Details of these cases are described in the report from the Serious Cases Panel.

There have been important new developments which are affecting the work of the CYSCB.

- The revised 'Working Together Guidelines' have now been published. There is a separate section in this annual report outlining the key changes and responsibilities for the CYSCB. The publication of the Guidelines has however given the opportunity to review the work of the Board and the Safeguarding unit which supports it. Necessary work is now in hand to ensure that the requirement of holding all agencies to account is under-pinned by work and information which provides reassurance to the Board. In particular, work is being carried out to develop a revised multi-agency management performance framework; to set up a regular monitoring of cases through a multi-agency audit process; and to seek the views of children and young people on the safeguarding agenda.

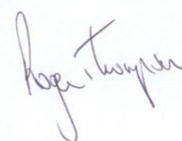
- The Safeguarding Unit is to limit its direct involvement with operational work, and move to the required quality assurance role expected in the revised Guidance. The Unit will still though need to be satisfied about the effectiveness of the standards of work from all agencies working in York. An important way in which this requirement will be carried out, arises from the decision to place the Independent Reviewing Service as part of the Safeguarding Unit and the Board. This important Service has a significant quality assurance role in respect of the monitoring of safeguarding standards.

- The high national profile in respect of CSE needs to be emphasised and the Board has responded to this difficult and challenging area of work. One of the Serious Cases Reviews carried out by the Board relates to CSE, and a task in the immediate period ahead is to ensure that the recommendations arising from this Review are implemented and incorporated into practice.

- The Board hosted a very successful conference in, on the subject of neglect, and this was the opportunity to roll out across York, the Thematic Review of Neglect which had been set up following two serious cases in the City. The conference had as its key speaker Professor Eileen Munro, the author of the National Review into Child Protection and Safeguarding Services. The Board will ensure that the messages from the Thematic Review will continue to be promoted to staff of all agencies.

- The Board has to ensure that high priority is given to children's safeguarding at a difficult time for all agencies, which are facing financial restraint. Organisational changes have also taken place among key agencies, notably the Health Service, with the setting up of local Clinical Commissioning Groups. The Board must ensure that any changes do not affect local safeguarding arrangements.

The City of York Safeguarding Children Board must continue to ensure that the very highest standards of safeguarding are maintained in York among all agencies. It is grateful for the support and commitment of partner agencies to enable this to continue.



Roger Thompson
CYSCB Independent Chair

Membership of the Board

Names in bold represent members of the CYSCB Executive

CYSCB Independent Chair

Roger Thompson

City of York Council

Kevin Hall *(Interim Director Adult, Children and Education)*
Eoin Rush *(Assistant Director, Children's Specialist Services)*
Dot Evans *(Head of Service, Children's Social Care and CYSCB Policy Lead Officer)*
Jill Hodges *(Assistant Director of School Improvement and Staff Development)*
Melanie Perara *(Deputy Head of Legal Services)*
Steve Waddington *(Assistant Director, Housing and Community Safety)*
Nick Sinclair *(Substance Misuse Pathways Office)*
Councillor Janet Looker *(Cabinet Member for Children)*
Simon Page *(Head of Integrated Youth Support Services)*

North Yorkshire Police

Sue Cross *(Acting Assistant Chief Constable)* represented by **DCI Nigel Costello**

North Yorkshire Probation

Joanne Atkins *(Area Manager Public Protection)*

Health

Sue Roughton *(Designated Nurse, Nurse Consultant Safeguarding Children, North Yorkshire & York Clinical Commissioning Groups)*
Carrie Woolerton *(Executive Nurse, Scarborough and Ryedale, and Vale of York Clinical Commissioning Groups)*
Jen Slaughter *(Associate Director Safeguarding & Child Protection York Hospitals NHS Foundation Trust)*
Robin Ball *(Designated Doctor Child Protection)*
Carol Redmond (Mental Health represented by Joanne James, Service Manager CAMHS, NHS North Yorkshire & York Community & Mental Health Services *(Adult & Child)*
Claire Anderton *(GP, North Yorkshire Local Medical Committee)*
Norman McCleland *(Associate Director of Nursing, Leeds & York Partnership NHS Foundation Trust)*

Children and Family Courts Advisory and Support Service

Margaret Harvey *(Service Manager)*

Askham Grange Prison

Philippa Harding *(Women's Service Development Manager)*

NSPCC

Debra Radford *(Service Manager & CYSCB Training Lead Officer)*

Children's Society

Lynda Corker *(Programme Manager, PACT Project)*

Independent Schools

John Owen-Barnett *(Child Protection Lead Officer, St Peter's School)*

Maintained Schools

Lesley Barringer *(Head Teacher, Osbaldwick Primary School)*
Bill Scriven *(Head Teacher, All Saints School)*

York Council for Voluntary Services

Craig Waugh

Laypersons

Emma Langton
Barry Thomas

CYSCB Unit

Joe Cocker *(CYSCB Unit Manager)*
Dee Cooley *(Safeguarding Advisor, Children's Workforce)*
Caroline Williamson *(Safeguarding Advisor, Education)*
Amanda Dickinson *(CYSCB Unit Administrator)*

WORK OF THE EXECUTIVE

The Executive group includes Board representatives from the key statutory and other partner agencies.

During this period there were 4 meetings of this group as follows:

- 12th June 2012
- 26th September 2012
- 10th December 2012
- 12th March 2013

All of the meetings were well attended with the statutory member agencies represented. This is a well-established group charged with supporting and overseeing the Board's progress against its key priorities. It is a forum of lively debate and challenge, which serves as a source of intelligence for the Board on a wide range of local safeguarding children issues and has undoubtedly helped to make progress in key areas.

Throughout this review period the full minutes of each Executive Group meeting have been included for information at each subsequent CYSCB meeting. In these circumstances this report will only highlight some key issues including areas for further development.

Key issues considered by the Executive Group

Governance

The regular attendance of the Board's independent chair at the Executive Group meetings has achieved a sharper focus by this group on the delivery of CYSCB priorities.

A programme of sub group reports to the main Board has been established and is working well.

As part of the overall review of governance the Executive Group recommended to the Board that the CYSCB independent chair should chair the Serious Cases Panel meetings so that this responsibility did not lie with an individual agency.

It was further agreed that the frequency of these meetings should be increased. Early indications are that these arrangements are working well.

Budget review

Through the work of the Executive Group, the Board's partners were able to negotiate a significant uplift in the respective contributions of the statutory agencies to ensure that the work of the Board is adequately funded through to 2015.

These new budget arrangements saw the implementation of a new tripartite funding arrangement for undertaking Serious Care Reviews.

Learning lessons

The Executive Group has maintained a continued focus on the work and findings of Serious Case Reviews and of the Thematic Review of neglect.

Recommendations from several learning lessons reviews, and reinforced by recommendations from the Safeguarding and Looked After Children inspection, the group agreed an approach for the review of assessments with a particular emphasis on pre birth assessments and the need for a more risk / outcome focussed model.

The group considered the outcomes of the Safeguarding and Looked After Children inspection and contributed to the subsequent improvement plan.

The Executive has also ensured the appointment of lay members to the Board. Following the successful appointment of two lay members the Executive also agreed an induction and mentoring approach to support the active involvement of lay members on the Board.

Performance framework

Although still not finally published, the various revised Working Together drafts suggest that the final guidance will greatly strengthen the role of LSCB's in monitoring the performance and effectiveness of local safeguarding arrangements. The Executive group prompted by the independent chair has undertaken an initial review of existing arrangements and a new

proposed framework has been developed.

Sexual Exploitation of Children [CSE]

This issue has been the subject of considerable discussion and work, both nationally and locally, during the review period. Locally there have been considerable developments in information sharing and local intelligence gathering and a new process for dealing with specific cases has been introduced and used.

A Police led action plan has been presented to the Executive Group and discussions are ongoing about how each agency can most effectively engage with this work.

Other issues

During the review period the Executive Group also considered the following issues:

- A review of the Independent Reviewing Service
- The reorganisation of Children's Social Care
- The Impact of Parental Alcohol Misuse
- The multi agency response to the tragic death of a child at a York Nursery
- The Introduction of a new Integrated Family Service for the City
- The effectiveness and quality assurance of CAF activity in York

Looking Forward

The Executive Group will continue to maintain a sharp focus on the delivery of the Board's key priorities. Central drivers for this work will include the implementation of the Munro recommendations especially for social care colleagues. The final publication of a revised Working Together also provides a clear reference point for the group throughout 2013/14

Eoin Rush (Assistant Director, Children's Specialist Services)

Lay Person Report

A relatively recent change to membership of CYSCB has been the appointment of two lay persons of whom I am one. The role of the lay members, though they may have some previous understanding of the requirements concerning the safeguarding of children, is to contribute to the discussions of the Board from the point of view of the non-professional. My first two years in the role have been highly informative. The Board meets four times a year. In addition to these meetings I have attended training programmes for the staff involved in child protection and attended the children's front door's daily meeting, where staff discuss the latest individual cases and decide on a way forward both of which have proved highly informative.

The overall impression is that York is fortunate in the capabilities of the staff dealing with the work covered by the Board. Its latest OFSTED assessment outcome reflects on the high standards achieved by all those involved in safeguarding. There is a risk, after such an OFSTED report, for complacency to set in. That has not been apparent to me. That is not to say that, with hindsight, all decisions are faultless. That will never be so when the best way forward in particular circumstances has often to be based on less than complete information, either because not all facts might be forthcoming or a rapid intervention needs to be made. Nevertheless my impression has been that the discussions between staff before a course of action is decided upon are responsible and balanced.

One difficulty that is apparent is that relevant information on a case may be held outside of the area of the City of York. This can be a particular problem in a small authority especially when the boundaries of other organisations, for instance health authorities, do not coincide with the city's administrative boundaries. The increasing mobility of the general population only exacerbates the difficulties of ensuring that all information is available to those who have to take decisions. Against this background one can

only praise the commitment of the staff involved when they know that there are those outside who are only too ready to criticise if an outcome is subsequently found to be less than ideal. When this is the case lessons must be learnt but we are never going to be able to say that all outcomes all faultless.

Having attended meetings of other bodies which drag on interminably I am impressed by the efficiency of CYSCB meetings. I never feel that discussion is being discouraged yet we seem to get through the business very efficiently. One minor niggle I have: coming to terms with the many acronyms used takes time!

Barry Thomas (CYSCB Layperson)

CYSCB UNIT REPORT

Working Together 2013 places increased emphasis on the quality assurance and performance management role of Local Safeguarding Children Boards (LSCBs). The guidance further stresses the independence of the LSCBs and their role in challenging partner agencies and improving outcomes for children.

Whilst graded as 'outstanding' in the last Ofsted inspection, the CYSCB along with the CYSCB Unit is currently undergoing a review to ensure it maintains its relevance, creativity and challenge in the rapidly changing child safeguarding landscape.

Independent Reviewing Service

One of the key changes to the CYSCB is the transfer of the responsibilities of the Independent Reviewing Service to the CYSCB. Independent Reviewing Officer's (IRO) primary role, both in chairing Looked After Children (LAC) Reviews and Child Protection Conferences is to oversee and assure the quality of practice with the aim of promoting and protecting the human rights of children within the LAC and child protection system.

Incorporating the IRO service within the CYSCB will ensure the independence of IRO who will be better placed to challenge interagency practice. The move is also designed to strengthen the IROs role by providing them the authority in exercising their functions on behalf of the Board.

Quality assurance and performance management

The review of the CYSCB is appropriately placing increased emphasis on the quality assurance function of the Board. CYSCB members have recognised the need to challenge shortfalls in safeguarding practice and to drive up standards.

In future the CYSCB Unit will receive performance data via the Children's Trust Unit from a range of agencies. The Unit role will be to analyse the information with particular focus on those areas prioritised by the Board. Where questions arise, the Unit will be expected to explore the issue is detail and provide regular reports to the CYSCB.

A key aspect of the Unit's quality assurance function will be the case file audit. The Unit has developed an audit tool which focuses on the quality of practice unlike previous approaches which have concentrated more on adherence with a process.

The tool is based around a set of agreed standards dealing with each aspect of effective assessment, 1) problem identification, 2) assessment and analysis, 3) objective setting and 4) outcomes. Consideration is currently being given to using the standards as part of clinical supervision.

CYSCB Constitution

The CYSCB constitution was developed in 2006 following the Board's transition from being an Area Child Protection Committee. Although serving the Board well, the innovative constitution is in need of revision in order to meet the changing demands placed on LSCBs.

Although not yet finalised, the revised constitution will strengthen the independence of the Board and CYSCB Unit. In line with the new requirements in Working Together, the Board Chairperson will ultimately be accountable to the Council's Chief Executive. In turn, the CYSCB Unit Manager will have an increased accountability to

the Chairperson.

Other amendments to the constitution will include changes to terms of reference of the Serious Cases Panel and reconstituting of the performance management arrangements which will include significant changes to the Professional Practice Monitoring Group. The review will also consider the effectiveness of the Lead Officer arrangements.

Child Sexual Exploitation (CSE)

The Board identified CSE as a priority objective for its work over the last year. A multi-agency stakeholder group has been established with the CYSCB Chair and the Lead Council Member for Children.

This area of work has progressed rapidly over the last 3-4 years: successive governments have produced guidance; a number of bodies have published research covering various aspects of the issue; a number of LSCBs have undertaken serious case reviews into CSE cases in their localities; media attention has focussed on many of the high profile cases; raised awareness has led to far more vulnerable individuals being identified and to a rise in referrals to both national and local services.

Serious case reviews into cases of young people harmed by child sexual exploitation in both York and North Yorkshire have given extra impetus to this area of work. Early in 2013, a countywide strategic group was set up, chaired by Detective Superintendent Simon Mason, and reporting directly to the respective LSCBs. A strategic action plan has been developed, with plans for the York stakeholder group to act as a local delivery group for the plan.

CYSCB is now a member of the National Working Group, the recognised lead on the issue, and is being supported by the specialist team in developing plans for the future, including: dissemination of findings form the Child B serious case review, and learning lessons from other reviews, e.g. Torbay; identifying and supporting targeted learning for specific individuals and sectors; raising awareness in professional and local communities to promote prevention and early intervention; and, identifying existing providers and developing capacity to engage in work with young people at risk of child sexual exploitation. Securing funding for a dedicated post to co-ordinate further activity will feature in the action plan for local agencies.

Domestic abuse

Domestic abuse, and its impact on children and young people, has continued to be a priority area of concern for the Board. In the year 2012-13, North Yorkshire police recorded 2476 incidents of domestic abuse (against 2218 for the previous year, a change of 11.6%) Crimes of domestic abuse also increased by 7.1% with the Independent Domestic Abuse Service (IDAS) receiving 642 adult referrals in this period.

Multi Agency Risk Assessment Conferences (MARAC) have continued to increase Year on Year with 142 MARAC cases in 2011/12 and 166 in 2012/13 an increase of 16.9%. The MARAC funding is vulnerable specifically around the framework supporting the Multi-agency Risk Assessment Conference (MARAC) process. Section 9 of the Domestic Violence Crime and Victims Act 2004 was implemented in April 2011 which made Domestic Homicide Reviews (DHR) a statutory requirement. The DHR guidance highlights MARAC as a specific area of interest to the review teams.

Perhaps the biggest change over this year has been the government's decision to reduce the age limit for recognition of domestic abuse from 18 to 16 years old. This reflects the presence of abuse in teen relationships, and offers the opportunity to access risk management and support services for vulnerable young people. The national organisation, Respect, has trained a number of practitioners in York to be able to work with young people who may be using abusive behaviours in their relationships. IDAS, as well as delivering the Respect programme, is continuing its work with young victims of domestic abuse, whether in their own or in parent/carer relationships. A range of campaign materials have been produced which aim to promote healthy relationships, and work is

ongoing to embed key messages in schools and other locations.

The service providing support to victims engaged with court processes, the Independent Domestic Violence Advocate (IDVA) will regrettably cease to be funded by the Home Office at the end of this year. The IDVA service is a crucial role in engaging and supporting victims through an often complicated process. The IDVA has been responsible for significantly reducing attrition rates and increasing guilty pleas. In 2012 the York IDVA was successful in supporting 164 Victims of Domestic Violence.

Domestic abuse continues to feature in relation to concerns for children, whether at early intervention or at child protection levels. The CYSCB and service providers remain committed to providing good quality, appropriate support in a challenging financial environment.

Home Office Safeguarding Project

The Unit Safeguarding Advisors took part in this project funded by the Home Office, which sought to identify and promote innovative, new and good practice in multi-agency working in the light of austerity measures. The project was initiated by ACPO, and commissioned by the policing minister within the Home Office.

Visits took place in 40 locations around all regions of the UK (London and Wales will be dealt with separately), including York. Representatives from both children's and adult's safeguarding in each region, alongside a police officer seconded to the Home Office, interviewed representative in the host area and visited projects.

Emerging practice is scrutinised by research teams from Salford and Manchester universities, prior to being published as a report; additionally, a safeguarding community website has been established to support the development of multi-agency strategy and operations in adult and child safeguarding.

CYSCB Safeguarding Advisor for Education

The Safeguarding Adviser for Education has now been in post for over two years. The post has a key role in promoting safeguarding practice in schools; to advise schools on safeguarding issues; to assist schools with the process of managing allegations against staff; to contribute to anti-bullying work in schools; and to participate in safeguarding training for schools. The Board remains grateful to the Education Community in York for the funding of this post.

In the last year the Safeguarding Advisor has been heavily involved in managing allegations against staff, including a number of high profile / complex cases which have attracted media interest. In this work, there has been excellent engagement and cooperation from schools.

The post will now play a key part in the Board's monitoring role of safeguarding practice in York, by developing work around an audit model for schools and reporting this into the Board.

Other development work is planned with partners to engage schools in the Board's work around vulnerable adolescents and provide advice and support to schools around Child Sexual Exploitation.

Multi Agency Training

During 2012-13, a number of multi-agency training events have been delivered, including:

- 14 full day courses including the core Working Together training, Safeguarding Disabled Children and the Child Sexual Exploitation course;
- 15 half day briefings including those on Neglect (disseminating findings from the thematic review) for multi-agency audiences and specialist teams, e.g. adult mental health services; and,
- Commissioned work including St John University module and targeted early years training generating £2,300 income.

In November 2012, the CYSCB hosted a major conference on Neglect, which included key input from Professor Eileen Munro, and used drama and interactive techniques to involve 150 participants in considering the issues involved in working with chronic neglect. The review of

training (see below) will consider future and ongoing learning and development needs for multi-agency and targeted groups of practitioners.

Post course satisfaction for training, and delegate evaluation of the conference, were extremely good, with practitioners keen to engage in a wide range of learning opportunities. Feedback will be incorporated into the review of learning and development.

Peer Supervision

Integrated working has involved practitioners in the wider children's workforce in managing outcomes for children. This has led to recognition of the need for reflective supervision to support staff in a range of settings. The CYSCB has co-authored and delivered training to two groups of prospective peer supervisors with the intention that they will establish networks. Evaluation and review will inform any further development.

Yorkshire and Humber Multi Agency Safeguarding Trainers (YHMAST)

The CYSCB is a member of the above regional group which brings together trainers from across the region to share practice, ideas, experience and resources. The inaugural conference, on Child Sexual Exploitation, was held in 2012, attracting 200 delegates from the region. Psychotherapist, Zoe Lodrick, a local authority licensing officer and voluntary sector support agencies offered opportunities to learn from practice elsewhere.

Future Plans

A review of review of learning and development was commenced at the beginning of 2013 with a temporary suspension of all but core courses. Drivers for change in terms of the training programme include:

- The influence of the Munro Review;
- The publication of the new Working Together;
- Restructuring of key services; and,
- In late 2012, 3 courses had to be cancelled - 2 due to trainer availability/illness, and 1 due to low delegate numbers suggesting an issue with releasing staff.

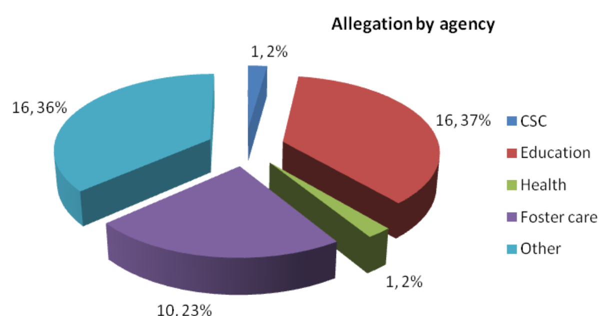
Currently, in addition to the core Working Together course, a number of new events are planned for 2013, including: a briefing to disseminate the lessons learned from the Child B serious case review; a master-class on Creating Safer Organisations to promote the CYSCB Arena of Safety model and safer recruitment processes; and, a briefing on the Toxic Trio of domestic abuse, parental substance misuse and adult mental ill-health. These events will include, where possible, input from national speakers and organisations, and offer larger numbers of participants to access learning which fits current styles and needs.

Future development of learning and development will be informed by:

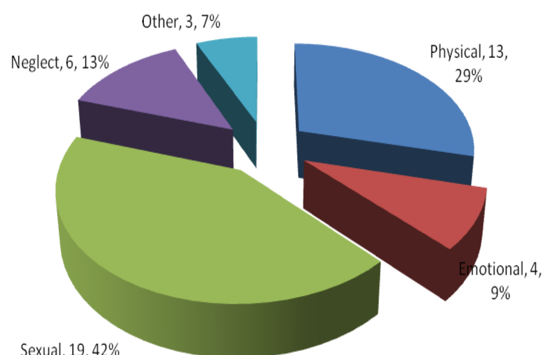
- The CYSCB Business Plan priorities;
- The emerging Performance Management framework;
- A survey of multi-agency safeguarding training needs; and of existing single/joint agency provision and quality assurance information; and,
- Partner involvement in supporting and promoting creative methods of delivering learning and development.

ALLEGATIONS AGAINST CHILDCARE PROFESSIONALS

The allegations against people who work with children process has been operating since 2006 with a yearly average of approximately 45 - 50 cases being referred into the process each year. During the period 2012 to 2013 a total of 45 allegations where received by the Local Authority Designated Officer.

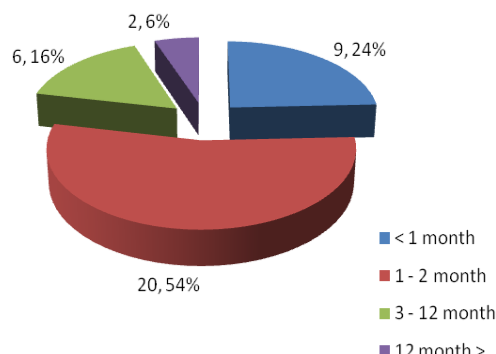


The majority of allegations (37%) were made against school personnel with 23% made against foster carers; figures which are broadly in line with the previous year.

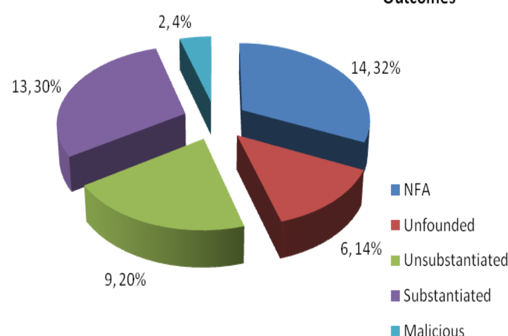


The most significant change over the previous year relates to the nature of the allegations received with a substantial increase in sexual allegations (17% to 42%) and a decrease in physical ill-treatment (70% to 29%). Whilst the reasons for these changes are not understood, there is a possibility that the reduction in physical ill-treatment derives from the positive impact of the process and improved safeguarding practices. This view is supported by the rise in sexual allegations, indicating a continued confidence by schools in the effectiveness of the process.

The reason for the rise in sexual allegations is unclear. However, a number of the cases involve concerns involving inappropriate conduct from teaching personnel towards pupils. Reassuringly, in the majority of the cases the concern was identified early which may correspond with a growing awareness arising from the CYSCBs work around the 'Arena of Safety' along with the impact of high profile media cases. Whilst the rise in such allegations could be viewed as concerning, there is no evidence of a rise in incidence; rather the evidence suggests an increased effectiveness in identification and intervention.



The process aims to conclude with a clear outcome and avoid the category of 'unsubstantiated' due to the uncertainty this leaves. The majority of cases managed within the process result in a clear outcome (80%) with 45% of cases establishing that something happened albeit that in 14% of cases the event was misunderstood or misinterpreted by the child. Reassuringly, the number of malicious allegations is low (4%).



The emotional impact of an allegation both on the alleged person and victim should not be underestimated and therefore it is important to reach an outcome as soon a possible. The majority of cases are resolved within 1 to 2 months (78%) with those cases extending beyond 3 months usually being due to delays in the criminal justice process.

Overall, the figures should be viewed positively as they demonstrate the effectiveness of process along with the confidence partner agencies have in the way allegations are managed. The evidence of the past year, especially in relation to allegations of sexual ill-treatment is that such

conduct is identified at an early stage and that the interventions are effective in preventing more serious harm.

CHANGES TO POLICIES AND PROCEDURES

Procedural changes

The introduction of the revised Working Together represents a radical departure from the trend towards increased prescription and volume. The statutory guidance has been reduced in size from over 350 pages to 97 with a focus on the core child protection process and a relaxation in rigid timescale.

As a result of the introduction of the new statutory guidance, the CYSCB is undertaking a significant revision of the local interagency procedures. To date, the Board has introduced a revised procedure for making a referral and responding to safeguarding concerns. In line with Working Together, this procedure represents the core process for responding to safeguarding concerns with the procedures for dealing with 'specific circumstances' now being regarded as guidance.

A procedure and guidance for dealing with child sexual exploitation was updated in March 2013, building upon extensive work undertaken by the Board Unit. The process has successfully identified a number of children at risk of being sexually exploited and ensured an effective interagency response.

Assessment of a Child under the Children Act 1989: Response to Working Together 2013

Working Together (2013) Guidance sets out the single assessment process (which needs to be completed within 45 working days) that underpins this assessment, replacing initial and core assessments.

In response to the guidance along with responding to lessons emerging from case reviews and the Thematic Review of Neglect, Children's Social Care has developed a multi agency assessment process which, subject to the CYSCB's endorsement, will be introduced from June 2013. At the centre of this process is the voice of the child, with a strong emphasis on multiagency engagement. CSC will seek endorsement for this new process from the LSCB in July 2013.

Work in progress

Work is currently underway revising the interagency procedure dealing with child protection conferences. The revision will reflect the transfer of management of the conference chairs to the CYSCB along with the requirements in Working Together 2013.

Working Together 2013 states that an *LSCB can require a person or body to comply with a request for information*. In order to ensure information is obtained lawfully and expediently, a CYSCB information sharing protocol is currently out for consultation with key partner agencies.

The CYSCB has in place a procedure for dealing with professional disagreement and conflict although it is evident that the procedure is rarely used, at least in terms of the escalation mechanism. This issue was highlighted in a recent Serious Case Review and as a consequence the CYSCB is currently amending and re-launching the process.

RESPONSIVE SERVICES: CHANGES TO PRACTICE AND PROCESSES WITHIN THE 'CHILDREN'S FRONT DOOR'

The context

Working Together 2013 (WT), in addition to the recent restructure in Children's Social Care (CSC), has led to a re-configuration of the Children's Front Door.

WT is clear in its requirement that:

> *'Anyone who has concerns about a child's welfare should make a referral to local authority children's social care. Within local authorities children's social care should act as the principal point of contact for welfare concerns relating to children'*

Additionally, WT places a strong emphasis on

'early help' and on integrated working:

> *'Children are best protected when professionals are clear about what is required of them individually and how they need to work together'*

Over the past two years the Children's Front Door has comprised the Children's Advice Team and the Children's Assessment Team; line-managed through CSC. The restructure takes the Advice Team and its line management out of CSC and into the Early Intervention section of Children's Specialist Services, enabling the service to be more focused on partners and to further strengthen and support integrated working and early intervention across all agencies.

The Assessment Team has been enhanced to become two Child In Need Assessment teams with not only the capacity to work with those children and young people at risk of significant harm (S47), to assess but also to co-ordinate services for children who are in need (S17) and to ensure that ongoing support is provided when CSC intervention ceases.

The changes

Since the 'Children's Front Door' was first launched, all 'first contacts' have been taken by the duty Advice Workers. From August 2013, this will change, and all of these contacts will be received by social workers in the CIN Assessment Teams.

Practitioners and members of the public will be able to talk through their concerns with social workers, who will make a decision about whether the concerns reach the threshold for involvement of CSC. For those (on average, 70%) of contacts and enquiries which do not reach social care thresholds the Advice Team will continue to be on hand to provide advice, support and brokering.

The challenge remains substantial in supporting and enabling all agencies to have confidence in assessing, planning and working together in order to reduce the numbers of children becoming subject to statutory intervention. The Advice Team will rise to this challenge by:

- delivering regular training in assessment and integrated working processes;
- rolling out the new 'Family Assessment'; promoting collaboration between agencies to meet the needs of the whole family;
- providing a link worker to every school and agency to offer advice and support and bespoke packages of training where required;
- co-ordinating networks for practitioners to use as learning forums and to share good practice;
- meeting regularly with partners as a multi-agency forum to ensure the best 'early help' service provision for the more complex cases.
- quality assuring assessment and planning across the workforce in order to further inform learning and build confidence.

The Advice Team will also continue to maintain the information hub (eTrack). The collected data provided from all partners will serve to identify issues and gaps in service provision and inform commissioning.

PERFORMANCE MANAGEMENT

Having Confidence that Children are Safe in York

The CYSCB's primary responsibility is to ensure the quality and effectiveness of York's arrangements to keep children and young people safe and well. The proposed new performance framework will greatly strengthen the Board's ability to discharge this responsibility. At the heart of this framework is one simple question – are children in York safe and how do we know?

The CYSCB's performance management framework was last updated in 2006. However, the policy landscape and knowledge base for safeguarding children has changed considerably since 2006 and some updating of the CYSCB framework is now due.

Helpfully, as part of a wider programme of reforms to the child protection system the Department for Education (DfE) has published a

children's safeguarding performance information framework. The framework was developed in consultation with the sector is expected to be widely adopted throughout the country.

The new outcome focussed approach will improve the Board's ability to understand and learn from the experiences of those delivering and receiving services. The framework places a greater emphasis on qualitative data and will undoubtedly require and drive some new practices and systems in each agency.

Rationale

This new framework is intended to move the focus of the child protection system from processes and indicators towards performance measures that improve professional understanding and drive improvements locally. This new framework describes key nationally collected data and also sets out key questions to be asked at a local level to understand the impact and effectiveness of local arrangements.

The DfE recommend that a combination of this national and local data should be used by LSCB's, Children's Trusts (where they have been retained) and Health and Well-being Boards as part of an overall performance monitoring framework.

The New Framework

The new framework is broken down into 5 themes:

- Outcomes for children, young people and their families
- Child protection activity (including early help)
- The quality and timeliness of decision making
- The quality of child protection plans
- Workforce

For each of these themes there is national performance information available. Perhaps more importantly they provide an approach to local information gathering and analysis.

The DfE recognise that the current suite of national data to support this framework and available for benchmarking is as yet incomplete. A full data set is expected by autumn 2014.

The importance of Local Data

In York, we recognise that national level performance only provides part of the picture. It is essential that we also ask questions about the quality of services and experiences of those who are part of (delivering or receiving) services locally. Finding the right ways to do this is a key challenge for the Board and its partners. The new framework includes questions agreed with the sector that local agencies need to ask users and service providers so that their experiences can help drive local improvement.

A Holistic Approach

Developing the new framework requires that we work closely to the work of the YorOK Children's Trust. The benefits of both Boards working together on this issue are clear and will ensure a shared overview of how well our children in York are served.

Key components

Alongside the collection and analysis of a range of agency data the CYSCB will be developing improved process for ensuring member agencies are compliant with statutory and local expectations through a revised Section 11 (Children Act 2004) audit tool.

Finally, we will be trialling a new 'live' multi agency case file audit approach focussing on the quality of inter-agency practice at key decision making elements within the child protection process. The audits will be based around agreed standards and will differ significantly from the previous process focussed approach.

Child Death Overview Panel

Legislation requires every LSCB to review the death of every child (up to the age of 18 years) in the area via a Child Death Overview Panel

(CDOP). This reflects the need to learn any lessons that may help other children and families in the future.

The CYSCB works in collaboration with our partners in the North Yorkshire LSCB who administer the CDOP on our behalf. The CDOP membership comprises of representatives from North Yorkshire and York Children's Social Care, health visiting and midwifery managers, police, consultant paediatricians and is chaired by an Assistant Director for Public Health.

Over the past 4 years the CDOP has reviewed over 230 child deaths across North Yorkshire of which 76 were children resident in York. In 2012/13, the Panel reviewed 15 cases of children resident in York.

Category of death identified at CDOP	
Deliberately inflicted injury, abuse or neglect	1
Suicide or deliberate self-inflicted harm	0
Trauma and other external factors	3
Malignancy	3
Acute medical or surgical condition	3
Chronic medical condition	2
Chromosomal, genetic and congenital abnormalities	9
Perinatal/neonatal event	16
Infection	1
Sudden unexplained, unexpected death	3
Total	41

In the reporting period, there have been more notifications of deaths in boys (54%) than girls (46%) mirroring data from England and Wales, where nationally 56% of deaths occurring in boys. Boys are more likely to die from all causes. This is particularly evident for sudden and unexpected deaths and trauma.

The majority of children reviewed by CDOP were aged 0 – 27 days at the time of death (61%) with 17% dying between 28 days and a year old. 70% of children died within a hospital setting.

In 2012/13, the majority of deaths resulted from a perinatal/neonatal event, genetic abnormality or other medical condition (82%). However, 4 deaths resulted from abuse or other trauma with 3 of those cases having 'modifiable factors' which may have contributed to the child's death.

One case resulted from what the Panel considered to be deliberate harm which was later to be the subject of a Serious Case Review. Of the 3 cases classified as 'trauma and other external factors' each death resulted from a road traffic collision.

The issue of 'safe-sleeping' of infants continues to be prominent with the findings of the reviews confirm the already acknowledged risk factors of Sudden Unexplained Deaths in Infancy and Childhood (SUDIC).

For further details on the work of CDOP including copies of the annual report please visit: http://www.safeguardingchildren.co.uk/cdop.html

Serious Case Reviews, current and past, and Learning Lessons reviews

The CYSCB Serious Cases Panel is chaired by the Independent Chair, and has members from Police, Health and Children's Social Care. The Panel meets on a bi-monthly cycle both to consider cases of concern, but also to monitor the implementation of the recommendations and action plans from agencies in respect of reviews carried out.

In 2012 one Serious Case Review and two Individual agency Reviews were commissioned. Also one Serious Case Review commissioned in 2011 is still outstanding. The publication of the Review has been delayed due to the protracted Criminal Justice process.

The new Serious Case Review was in respect of a case of child sexual exploitation (CSE. The Panel also considered at its meetings, a number of cases which gave rise to concern.

Whilst for legal reasons the details of the Serious Case Review have not been published, the case identified valuable lessons which have contributed to improving the identification and response to CSE. Whilst the review concluded that *it could not have been predicted ... that [the child] would be the victim of sexual exploitation.... given [their] background and the presenting issues which became evident during [their] adolescence it was predictable that [they] was vulnerable and at greater risk of abuse.*

The review found that the issue of CSE was not sufficiently understood and as a result the child although being seen as being 'in need' was not considered to be in need of protection. In effect the focus was often on the child's behaviour rather than on the possibility that she was being sexually exploited. Positively, the review recognised that awareness of CSE has improved significantly across all the agencies.

The two individual agency reviews were undertaken by Children's Social Care due to concerns raised around the quality of assessment in each case. The first case [Case 1] related to a family with a history of potential sexual abuse and neglect. The second [Case 2] related to a child who was found to have received non-accidental injuries following being returned home after previously been removed from her mother's care.

The individual agency reviews highlighted shortfalls in assessment practice with Case 1 stressing the need for assessments to fully *take full account of past history of the family and the nature of family engagement with professionals.* The case further highlighted the need of practitioners to understand the often complex issues associated with dealing with child sexual abuse.

Case 2 stressed the need for social workers in assessments to *understand what they are observing; using various tools of assessment; how to use the information gathered to inform planning and future intervention; and how to evaluate if that particular intervention/plan is working towards the intended outcome.*

Key lessons

Child sexual exploitation

- When dealing with young people who are engaging in high risk behaviours (drug taking, sexual activity, missing from home and school, in receipt of money or gifts without explanation etc), child sexual exploitation (CSE) should be considered
- Where there are indications that a child is being sexually exploited, the CYSCB CSE procedure must be followed
- Tacking CSE effectively demands the involvement of all the agencies involved with the child including, school, school health, sexual health
- CSE is a serious crime and therefore any response should involve the Police
- The Police must provide an appropriate response to CSE which involves where possible apprehending an offender or where this is not possible employing an approach which disrupts an alleged offenders involvement with a young person

Assessments

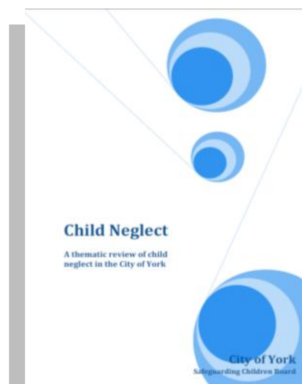
- Assessments must always consider previous involvement and interventions
- Assessments should always involve and draw upon the expertise from the range of professionals involved with the child
- An assessment is more than a completed form or collection of information. Importantly, an effective assessment involves the analysis of the collected information in order to produce clear objectives whose aim are to bring about sustainable, positive change for the child

Miscellaneous

- Where a professional disagrees with another professional or agency or feels that their views have been unreasonably disregarded and where a child is felt to be at risk, the CYSCB procedure for dealing with professional disagreements must be used
- The Police should provide a dedicated

service which deals with all crime committed against children irrespective of whether the alleged person is a family member

THEMATIC REVIEW OF NEGLECT



The thematic review of neglect was launched at the CYSCB's conference in October 2012 Eileen Munro as its key note speaker.

The review, whose key findings were outlined in last year's CYSCB annual report, highlighted the importance of identifying neglect early, ideally within the child's first year of life and in assertive interventions with the aim of addressing the factors underpinning the neglectful parenting.

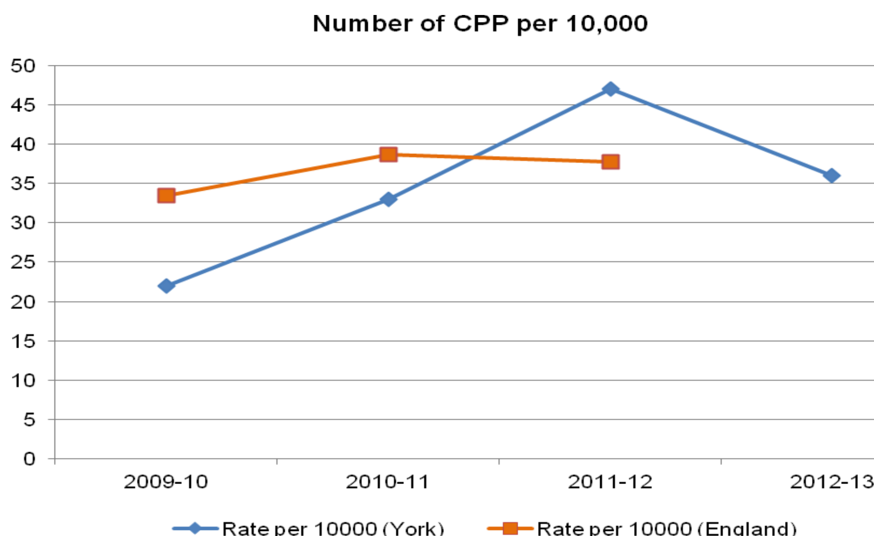
The challenge to all agencies working with children and families is to ensure the review's lessons are implemented. To this end, in addition to the highly successful conference, the CYSCB Unit undertook a range of interagency briefings to disseminate the reviews key lessons.

The CYSCB has incorporated the lessons of the thematic review into its business plan and will act to monitor the effectiveness of interventions. Performance measures are being developed which will look to reducing the number of repeated interventions. Emphasis also needs to be placed on reducing the age at which the intervention is assessed as having a positive impact on the child's wellbeing.

Work is underway with the Police and Children's Social Care exploring the use of warning with parents where there is evidence of neglectful parenting. The warnings are designed to act as a 'marker' to parents with the primary aim of motivating change. However, should the warning not be heeded, the approach will make if easier for the police to pursue a criminal enquiry under the Children and Young Persons Act 1933.

Further information about the thematic review along with a copy of the report can be obtained on the CYSCB website: www.saferchildrenyork.org.uk

TRENDS IN CHILD PROTECTION 2012/13



After a brief period where the numbers of children subject to child protection plans significantly exceeded the national average, the numbers of children subject to plan in York has fallen and is now in line with the national average.

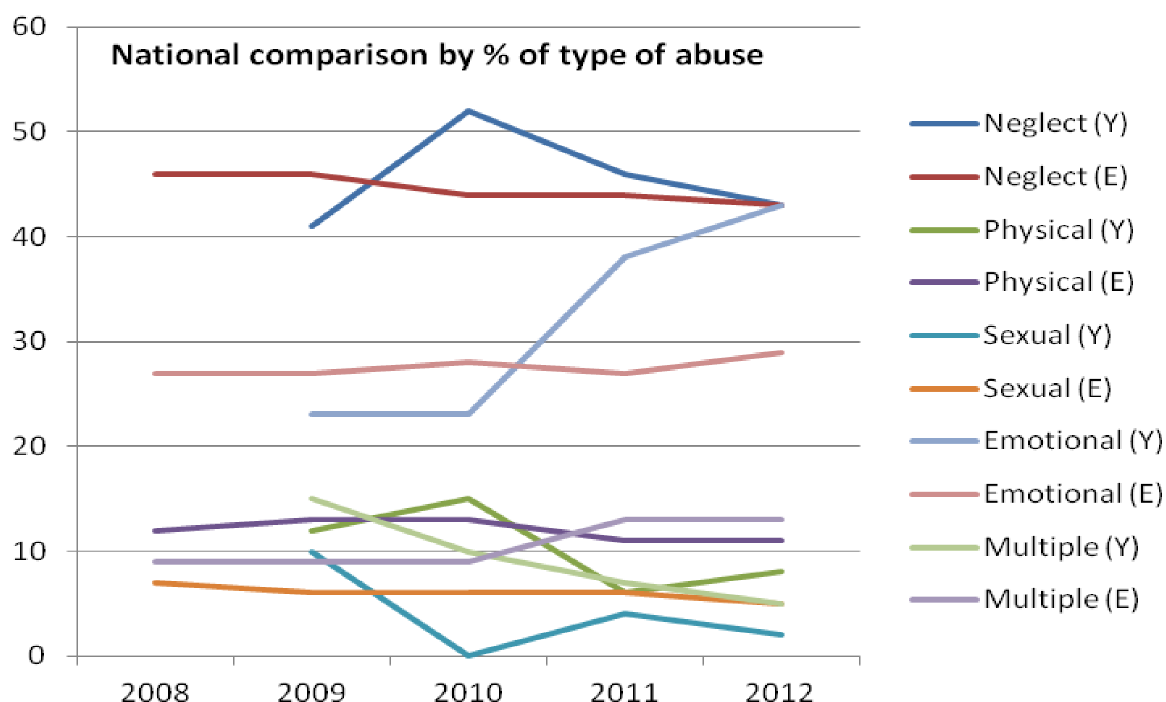
It is noted that the current downward trend possibly results from changes within Children's Social Care whose policy is to reduce the numbers of children subject to plans by the provision of early interventions. However, the impact of such interventions on the number of plans should be monitored to ensure those children most in need of protection are being effectively safeguarded.

	2009-10	2010-11	2011-12	2012-13
Number who had been the subject of a plan for 3 or more months (York)	62	65	110	108
Number who had reviews carried out within the required timescales (York)	58	61	98	101
Percentage who had had reviews carried out within the required timescales (York)	94%	94%	89%	94%

The percentage of children who are subject to plan who have had reviews carried out within the required timescales has increased to 94% representing a significant improvement on last year.

Children who became the subject of a child protection plan, by category of abuse (York)

	2009-10	2010-11	2011-12	2012-13
Emotional Abuse	22%	23%	38%	43%
Neglect	41%	52%	46%	43%
Physical Abuse	12%	15%	6%	8%
Sexual Abuse	10%	0%	4%	2%
Multiple Categories	15%	10%	7%	5%



Note: (Y) = York (E) = England

The number of children who are subject to a child protection plan under the category of emotional abuse has almost doubled over the past two years and is significant higher than the national average (29%). Children registered under the category of neglect have fallen slightly although when taking the last four years the numbers have remained stable. Neglect together with emotional abuse now accounts for 86% of all CP plans.

The numbers of children registered under the category of physical and sexual abuse have both fallen over the past 4 years. Physical abuse now accounts for 8% of all registrations compared to a national average of 11%.

The number of children registered under the category of sexual abuse has seen an 8% drop over the past four years to 2% whilst nationally the number of children registered under the category of sexual abuse has also fallen from 7% to 5%.

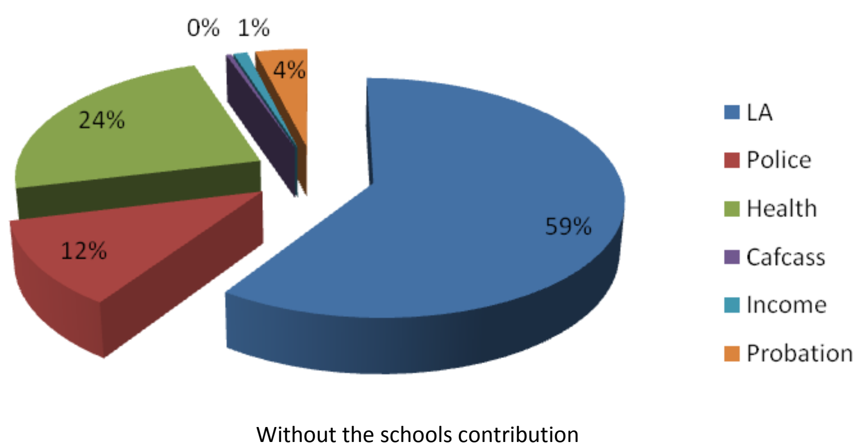
BUDGET

Expenditure	2011/12 Costs	2012/13 Projected Outturn (£)	Income	2011/12 Income	2012/13 Projected Outturn (£)
			Balance B/fwd	**17,069**	**13,313**
CYSCB Manager	65,017	65,651	Children's Services: City of York	62,070	66,430
Admin Assistant	11,002	10,991	Health: PCT	31,951	32,910
Safeguarding Advisor (Children)	36,693	38,896	Police: North Yorkshire Police	15,975	16,454
Safeguarding Advisor (Education)	45,909	47,501	Front Door: City of York	14,900	14,900
Temporary Staff	-	2,500	Probation: NY Probation Service	5,321	5,481
Training Budget	3,170	3,673	Schools Contribution for Safeguarding Advisor	50,000	50,000
Information/Miscellaneous	3,585	6,622			
Chairing	4,346	7,517	CAFCASS	550	550
Website	161	0	YPS Contribution	2,000	2,000
Recharges	18,840	18,840	Others:	2,200	1,450
Child Death Review Grant	12,000	12,000	Munro Report grant		8,000
Serious Case Review	13,500		Child Death Review grant	12,000	12,000
			Serious Case Review	13,500	
	214,223	214,190		210,467	210,175
Balance C/fwd	**13,313**	**9,297**			
	227,536	**223,488**		**227,536**	**223,488**

The CYSCB has stayed within its budget despite continuing to have an underlying shortfall (contributions / expenditure) of approximately £12,000; the year end budget shows a surplus of £9,297.

As can be seen from the budget statement, there have been increased demands placed on the budget. It can be seen that there are growing costs arising from increased expectations of the independent Chair with a 70% increase in the costs of Chairing.

Additional expenditure arose from the cost of the neglect conference, albeit that this was underwritten by national money made available following the Munro review. As such, and following the publication of Working Together 2013, there is a continuing need to review the Board’s funding.



Without the schools contribution

The original funding formula for the Board was based on the local authority (CSC and education) providing 45%, health 30%, police 15%, probation 5%. It is interesting to note how over the years the percentages have changed with the local authority contribution now amounting to 64% (59% if accommodation costs are removed) of the budget (excluding the £50,000 contribution from schools).

Accessibility

This report has been produced online, and is available to download or print at www.saferchildrenyork.org.uk. If you require a ready printed copy, or larger text size version of this report, please contact the City of York Safeguarding Board unit as outlined below.

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BUSINESS PLAN