Annual Report 2011-2012

Introduction by the CYSCB Chairperson

It is a government requirement for a Local Safeguarding Children Board to produce an Annual Report, which will be a public document. The report will outline details of the Board's activities, but also it provides an opportunity for comments to be made both in respect to the state of safeguarding in the area, and the key safeguarding issues in York.

There continues to be significant national and local interest in the children's safeguarding agenda, and the intention of this Annual Report is to indicate to a wider audience, the key messages in the safeguarding arrangements for children and young people, and also to ensure that the strong commitment to provide the highest levels of safeguarding services in York, is maintained from all agencies in the city that have responsibility for the welfare of children and young people.

Safeguarding Children Boards have a number of responsibilities, which ensure that there is a multi-agency approach and commitment to the safeguarding of children. They have responsibility for multi-agency training and practices and procedures; for commissioning if appropriate Serious Case Reviews and Learning Lessons Reviews so as to learn lessons from any serious child protection incidents; for oversight of the Child Death Overview Panel (This is managed by the North Yorkshire, on behalf of the two LSCBs); for the management of arrangements for investigating safeguarding allegations against professionals and volunteers working in child care; and to holding all local agencies to account about their standard of safeguarding children arrangements. Whilst there is always room for improvement, it is important to state that evidence indicates a strong commitment to inter-agency working, as demonstrated by the setting up of the 'Front Door' service, which has the responsibility for responding to all enquiries about the welfare and safeguarding issues relating to children and young people in York. This service now operates on a multi-agency basis, involving children services, health and police. A recent unannounced Ofsted Inspection, was positive about the Front Door service, and a Peer Review from the Local Government Improvement and Development Group of safeguarding children services in 2011, indicated strong performance, leadership and partnership working.

The most recent Ofsted inspection of safeguarding and looked after children in York was carried out in March 2012. This was wide ranging inspection and it is pleasing to record that the judgement given by the inspectors to safeguarding children in York was 'good'. The work of the City of York safeguarding Children

Board and partnership working was judged 'outstanding' and much credit for this position must go to the staff of the Safeguarding Unit and to members of the Board for their commitment.

The Board continues to carry out its work through regular quarterly meetings, which are well attended by all agencies; an Executive group; two groups responsible for Professional Practice and Serious Cases monitoring, and two Lead Officers, who take the lead in Training and Policies and Procedures. In addition, where necessary working groups are established to review and make recommendations to the Board on particular policy areas. A recent initiative has been the set up a group to take forward work on sexual exploitation of children and young people. The work of the above groups is supported and organised by staff from the Safeguarding Children Unit.

During the last year, the Board has commissioned one Serious Case Review. The case is still subject to on-going care proceedings so no comments about the case can be made at this time. Ofsted has however seen and reviewed the report that has been prepared and approved by the Board. In due course a report on the case will be made public.

There have been some important developments in relation to the work of the Board that need to be commented on.

- The Government has confirmed its support for the recommendations arising from the Review of Child Protection Services by Professor Eileen Munro. The Government is now consulting on the proposed changes to services, and a draft new 'Working Together' document has been produced. This envisages an enhanced role for Local Safeguarding Children Boards, particularly in the role of holding agencies to account and in a broader prevention remit.

- In last years Annual Report, comment was made about the Thematic Review of Neglect, which had been set up following two serious cases in York, where neglect had been a key issue. The aim of the Review was look at the way in which neglect is handled in York. Much progress has been made in respect of this Thematic Review, and a progress report is contained in this Annual Report.

- The work of the Safeguarding Adviser for Education has now been in place for over a year. 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 fort he funding of this post.

- The high national profile concerning the sexual exploitation of children and young people has led to the setting up of a group to review local responses to this difficult and challenging policy area. Work has been carried out on procedures and guidance to all staff in this area; training, which has been running for some years in York, has been reviewed and enhanced; and raising awareness of the issue among staff needs to be an on-going process.

- The Board has to ensure high priority is given to children's safeguarding at a difficult time for all agencies, which are facing financial constraints. Also the Board must be vigilant to safeguarding responsibilities arising from changes to the organisation of the Health Service, and the setting up of the local GP Commissioning Group.

The City of York Safeguarding Children Board must ensure that high standards of safeguarding are maintained in York, and is grateful for the support and commitment of all partner agencies to enabling that this to happen.

Roger Thompson
CYSCB Independent Chair

MEMBERSHIP OF THE BOARD

Independent Chair Roger Thompson
North Yorkshire Police Acting Assistant Chief Constable Sue Cross represented by DCI Nigel Costello
North Yorkshire Probation Service Joanne Atkins, Area Manager Public Protection
The City of York Youth Offending Team Simon Page, Head of Integrated Youth Support Services
NHS North Yorkshire & York Sue Roughton, Designated Nurse Child Protection (CYSCB Serious Cases Lead Officer)
NHS North Yorkshire & York Primary Care Trust (Commissioning) Julie Bolus, Interim Director Of Nursing, NYY PCT Cluster
York Hospitals NHS Foundation Trust Jen Slaughter, Associate Director Safeguarding & Child Protection, Robin Ball, Designated Doctor Child Protection
CAFCASS (Children and Family Courts Advisory and Support Service) Margaret Harvey
Askham Grange Prison Carol Burke, Head of Learning and Skills
City of York Council – Adults Children and Education (ACE) Pete Dwyer, Director ACE, Eoin Rush, Assistant Director – Children's Specialist Services, John Roughton, Head of Service (Operations) Children's Social Care (CYSCB Policy Lead Officer), Sarah Olorenshaw, Service Manager Quality Assurance Services for Children's Social Care (CYSCB Quality Assurance Lead Officer), Jill Hodges, Assistant Director of School Improvement and Staff Development,
City of York Council - Legal Services Melanie Perara, Principal Solicitor
City of York Council - Housing Department Steve Waddington, Head of Housing Services
City of York Council – Nick Sinclair, Substance Misuse Pathways Officer
City of York Council - Councillor Janet Looker
NHS North Yorkshire & York Community & Mental Health Services (Adult & Child) Carol Redmond (Mental Health represented by Joanne James, Service Manager CAMHS)
NSPCC (The National Society for the Prevention of Cruelty to Children) Debra Radford, Children's Services 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
Primary Schools Lesley Barringer, Head Teacher, Osbaldwick Primary School
Secondary Schools Bill Scriven, Head Teacher, All Saints School
North Yorkshire Local Medical Committee Claire Anderton
Safer York Partnership Jane Mowat
York Council for Voluntary Services Craig Waugh
Council Cabinet Member Janet Looker
Laypersons Emma Langton & Barry Thomas

WORK OF THE EXECUTIVE

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

Eoin Rush	Assistant Director (Chair)	City of York Council
Debra Radford	Children's Services Manager	NSPCC
Nigel Costello	Detective Chief Inspector	North Yorkshire Police
Dot Evans	Head of Service	City of York Council
Sue Roughton	Des. Nurse Child Protection	NHS North Yorkshire & York
Robin Ball	Des. Doctor Child Protection	NHS North Yorkshire & York
Roger Thompson	Independent Chair	CYSCB
CYSCB Unit officers:		
Joe Cocker	CYSCB Manager	CYSCB
Dee Cooley	Safeguarding Adviser (Children's Workforce)	CYSCB
Caroline Williamson	Safeguarding Adviser (Education)	CYSCB
Amanda Dickinson	Administrator	CYSCB

This group met quarterly throughout the period 11/12 and in advance of the main Board meetings.

The meeting dates for this period were:

16th	March	2011
8th	June	2011
14th	September	2011
12th	December	2011

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.

In this past year some key themes considered by this group included;

- Implementation of the recommendations by the Chair to strengthen the governance and accountability arrangements for the Board.
- A budget review including new tripartite funding arrangements for undertaking Serious Case Reviews.
- The development of a York response to the issue of Sexual Exploitation of Children
- A continued focus on the work and findings of the Thematic Review of Agency Responses to Neglect
- The appointment of lay members to the Board pursuant to guidance and the recommendations of the LGiD Peer Review conducted in 2010.
- Key service developments in Children's Services (including the introduction of a new Children's Advice and Assessment Service).

Outcomes against all of the issues described above are positive. During this year:

Governance

A programme of sub group reports to the main Board has been established and is working well. Minutes of the Executive Group are considered at each Board meeting. The inclusion of the Independent Chair on the Executive Group has worked well and served to strengthen the focus of this group on the Board's overall key priorities.

Budget

During the course of the year 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.

Child Sexual Exploitation

Described in more detail later in this report the Executive ensured a sharp focus on this issue throughout the year. Local arrangements are now in place to ensure an effective and consistent response to all concerns for CSE across the agencies.

Thematic Review

Again an issue discussed in more detail later in this report, the Executive Group maintained an oversight of this work as it progressed. Critically, the Group helped to ensure that early emerging messages were quickly disseminated and learning acted upon. This is a piece of work that will be ongoing but has already been widely recognised as very valuable research which will inform improvements in practice across all children's agencies.

Peer Review Recommendations

Two key areas of progress driven by the executive Group over the past year;

- the successful appointment of two lay members to the Board, and;
- through some of the practice development initiatives (CSE, Professional Practice Monitoring Group and Thematic Review feedback sessions) front line practitioners report that they have a better understanding of the Board and that they feel more engaged in its work.

Overview of Service Developments

The Executive Group has played an important role in commenting on and helping to shape the effective implementation of the new Children's Advice and Assessment Service (The Children's Front Door). This service launched in May 2011 brings together (co-located) social care, Health, Police and early intervention advice workers who through one single point of contact collectively evaluate and plan responses to any concern raised about a child / young person in York.

External Scrutiny

More recently in March 2012 there has been a clear external validation of the work of this group and the Board more widely in the Ofsted Safeguarding and Looked After Children inspection. The outcome of this inspection is described elsewhere in this report.

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 is also anticipated and this guidance will also provide a clear reference point for the group throughout 2012/13.

Eoin Rush (Chair) Assistant Director – Children's Specialist Services

CYSCB UNIT REPORT

The CYSCB Unit comprises of the CYSCB Manager, two Safeguarding Advisors (Education and Workforce) and a Unit Administrator. The Unit is responsible for administering the CYSCB and delivering on the business plan objectives. The Unit also oversees and coordinates the interagency response to allegations made against childcare professionals, child sexual exploitation, children who pose a risk to others; and, delivers safeguarding training across the children's workforce.

Over the past year, the CYSCB Unit has prioritised the emerging issue of children at risk of sexual exploitation (CSE). Although York does not have the same scale of problem as exists in many large metropolitan areas, the CYSCB's spotlighting of CSE has identified a significant number of young people engaging in high risk behaviours which makes them vulnerable to exploitation. In response, the Unit coordinates an inter-agency response to facilitate effective information sharing and ensure that the young person's safety and complex needs are addressed; and, to assist in the disruption and potential prosecution of perpetrators.

The CYSCB Unit has also developed a new approach to dealing with children who pose a risk to others. The need arises from a recognition that, in the past, the response was variable and uncoordinated. As a result, a process has been developed whereby the Unit coordinates the response from a range of agencies to ensure the needs of the victim, public and the offender are addressed.

The year ahead promises many new challenges, notably with the implementation of the lessons arising from the thematic review of neglect along with the implications arising from the significant changes to *Working Together to Safeguard Children*. The CYSCB Unit is also to lead on a review of assessment practice whose aim is bring about changes that ensure assessments are truly multiagency, child focussed, continuous and fit for purpose.

CYSCB SAFEGUARDING ADVISOR FOR EDUCATION

The appointment of the school's funded Safeguarding Advisor (Education) to the CYSCB Unit demonstrated the value and confidence schools placed in the Unit and specifically the allegations process. Arising from the appointment has been an increased demand from schools requesting work with staff on developing a code of conduct strengthening the 'arena of safety' for children by establishing clear boundaries.

Ultimately, the aim is to create an arena of safety which 'is a place of safety for not just for children

but also for adults. It's a place where the staff have appropriate attitudes and life style. Where the behaviours are appropriate and where the regime and cultural practices are safe' (Wyre). In so doing, the aim is to prevent incidents occurring by increasing awareness and establishing clear professional boundaries.

Sessions have been undertaken with schools staff and governors raising awareness of safeguarding issues and demystifying the allegations process in order to promote the message that effective safeguarding equates to good professional practice. The CYSCB also works in cooperation with the University of York providing an interactive session to all new teaching students promoting safe working practices and the arena of safety.

INSPECTIONS

The City's safeguarding and looked after children arrangements were inspected in April 2012 receiving an overall judgement of 'good' with an 'outstanding' capacity to improve. Interagency and partnership working was assessed as 'outstanding' with the inspectors praising many aspects of the work of the CYSCB.

The inspectors observed that... *'effective leaders across all agencies have a clear shared strategic vision. They use collective resources well through very effective joint commissioning of provision.... The impact of this is reflected in strongly cohesive service provision and a very strong commitment by staff to multi-agency working'.*

The report identified a 'culture of respect' which is *'reflected in the work of the highly effective CYSCB'* with the Board providing *'effective leadership, support and challenge'*. The report continued...*partner agencies are highly committed to the work of the board and its sub-groups....*

The thematic review of neglect was commended as *'an example of the partnership's collaborative and robust approach where complexities are firmly and effectively tackled. It is based on a thorough examination of national research and local practice through case audit and testing the thresholds for responding to neglect'.*

Recognition was made by the inspectors of the way in which the Board Unit's practice in overseeing practice in respect dealing with allegations against child care professionals, children who pose a risk and child sexual exploitation. *'The LADO is responsible for overseeing strategy meetings that consider the needs of children and young people who have been or are at risk of being harmed by other children. Therapeutic needs of child perpetrators are also indentified and strategies such as placement changes and exclusion zones are put in place'.*

Perhaps the strongest accolade was with the inspectors assessed on the effectiveness of the CYSCB communication and relevance across agencies and with practitioners... *'key priorities are effectively communicated and as a result the board's priorities are understood and implemented across the partnership. The lessons from serious case reviews have been very effectively disseminated through a series of briefings and presentations. Front-line staff identify with the work of the CYSCB and some staff were able to explain to inspectors how findings from serious case reviews have been used to improve their practice'.*

INTER AGENCY TRAINING

The CYSCB multi-agency courses continue to be well attended and received. Course material is constantly reviewed to incorporate current policy, guidance and good practice, and to successfully support delivery of the Board business plan. A new set of briefings has been introduced, on MARAC and MAPPA Processes (Multi-agency Risk Assessment Conference and Multi-agency Public Protection Arrangements), involving trainers from North Yorkshire Probation and the York Community Safety Partnership, with the purpose of improving the engagement and use of these processes within the children's workforce in order to safeguard children.

Training Report Jan 2011 – Dec 2011

- 21 multi-agency courses (not charged for), which attracted a total of 282

delegates

- 4 commissioned courses (charged) were delivered, raising £2,200 for CYSCB (plus an additional £500 donation to charity in lieu of payment)
- Delegate evaluations again register satisfaction as 60%+ as Excellent, and 30%+ as Good
- A post course evaluation on impact on practice was undertaken with staff and line managers. Feedback was positive in relation to impact on knowledge, awareness and practice; and, 100% of participants said they would access further training and/or recommend it to others. One manager stated,

"I can't speak highly enough of all the training - we have sent a number of staff on a range of courses. We feel it has helped us to expand our organisation's safeguarding knowledge and practice".

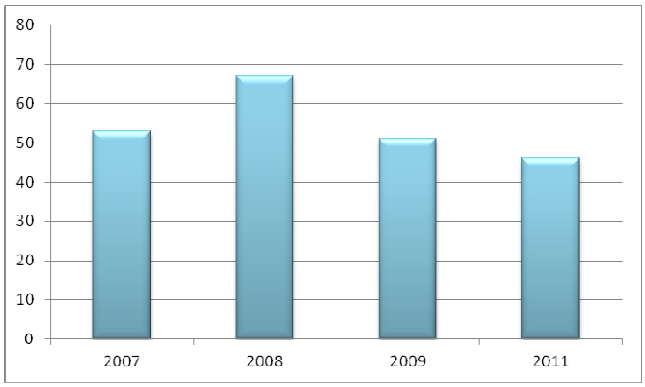
- A range of additional learning events have taken place including Neglect threshold workshops for CYC Children's Social Care, Health and multi-agency groups, involving 150+ practitioners.
- We remain committed to our partnership with York St John University in supporting delivery of the Foundation Degree in Working with Children and Young People and the Governors award.

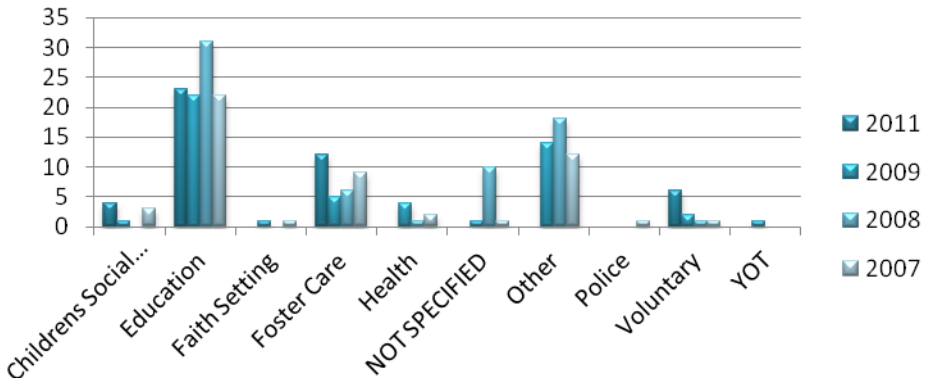
Forward Planning

- The learning from the Neglect threshold testing events has informed the CYSCB Neglect thematic review, and will be incorporated into the suite of learning events to disseminate findings from the review, which commence delivery in 2012.
- All training and development will be reviewed following publication of the new Working Together (planned for 2012), which will incorporate the Munroe recommendations.
- Continue to develop processes to measure long-term impact of training on practice, particularly in relation to the dissemination of the Neglect Thematic Review.
- Maintaining quality and consistency of learning opportunities, and engagement of partners in supporting delivery and attendance at training, in support of the Board business plan and identified priorities.

ALLEGATIONS AGAINST CHILDCARE PROFESSIONALS

The allegations against people who work with children process has been operating since 2006 with a yearly average of approximately 50 cases being referred into the process each year. Whilst the available data does not provide a complete years total it is likely that the number of referrals for 2011 will be between 45 and 50 corresponding to the 2009 total.





As can be seen from the chart below, the highest numbers of allegations are received in respect of education personnel (23), the majority being teachers or teaching assistants followed foster carers (12) and voluntary / private agencies (6). The numbers of education personnel rose slightly

over the 2009 figures. However, the number of allegations against foster carers more than doubled from 5 to 12 with a threefold rise for private / voluntary bodies (2 to 6).

In relation to the rise in allegations against foster carers, over the period October 2011 to March 2012, 5 out of 7 cases where dealt with as an Initial Evaluation Meeting; a process which decides whether the matter should be dealt within the allegations process. Therefore, it could be hypothesised that whilst there is a rise in the number of referrals, the level of concern is lower than for other groups (education personnel 1:5).

The figures for outcomes can only be taken over the period Jan to July 2010. The aim of the process is to achieve a definitive outcome based on the balance of probability. Over this period majority (15:18) had a clear outcome being substantiated (8), unfounded (5) or malicious (2). However, it would be unsafe to project the individual numbers based on the low sample, specifically in respect of the category of malicious allegations which in the past account for between 2-3% of all allegations.

It is difficult to present a definitive breakdown of the nature of the allegations. However, based on the limited information, the majority of the allegations relate to physical mistreatment (70%) with sexual abuse amounting to 17%.

Dealing effectively with allegations against people who work with children demands good interagency working to ensure the child is safeguarded and the alleged person is dealt with sensitively and fairly. A key aspect of the process is ensuring, as far as possible, that there is a definitive outcome in order to ensure a clear outcome. Whilst this is not always possible, it is felt that the CYSCB process achieves good results in this area.

The process recognises that dealing with allegations can have a significant impact of all concerned including the organisation. Consequently, the process places emphasis is placed on ensuring a proportionate response that seeks to resolve issues with minimum disruption to children, employees and the organisation.

Overall, the process is assessed to be effective and working well. Anecdotal feedback from partner agencies is positive in the support and advice received in dealing with often complex employment and management issues. It is planned to undertake routine evaluations of the process to include partner, referring agencies and young people in order to identify both strengths and areas for development.

CHANGES TO POLICIES AND PROCEDURES

Child protection guidance and practice remains in a state of change following the publication of the Munro Review, *A child centred system* in May 2011. The review signalled fundamental changes to the child protection system away from the bureaucratic towards an emphasis on practice. However, unlike previous reviews, Munro promotes an evolutionary approach by creating the environment for change. As such local authorities are to be allowed greater freedom and autonomy in deciding what is needed for their area.

A key recommended in the review was that the statutory guidance, *Working Together to Safeguard Children* should be revised along with the *Framework for Assessment* with the aim of removing 'constraints to local innovation and professional judgment that are created by prescribing or endorsing particular approaches'. Although still waiting for the revised guidance, the CYSCB has already embracing the increased flexibility in developing guidance that is more responsive to the needs of children and over the past year, the CYSCB has developed two new innovative processes for dealing with child sexual exploitation and children who harm others.

Child sexual exploitation is an emerging issue that has been prominent in the national media. However, whilst the media has focussed on organised exploitation, the issue is wider, encompassing children engaged in high risk behaviours which make them vulnerable to being sexually exploited. Despite the real risks involved, in the past the interagency response has tended to be fragmented with little coordination. A similar situation can be seen with children who harm others, where it often the case that no one

agency has a clear responsibility to oversee a coordinated response. As a result the complex needs of children engaging in such behaviours would often go unmet.

The approach adopted by the CYSCB has been to develop a process for dealing with cases with additional complexity which requires a robust, coordinated interagency response. Cases meeting the criteria are referred into the CYSCB Unit who then convenes strategy meetings comprising of all the relevant agencies. The strategy process assesses the issues and risk before setting clear goals with the meetings continuing until a positive outcome is achieved. Although a relatively new development, the process has received positive feedback from professionals and Ofsted.

The year ahead presents many challenges to the CYSCB not least from the publication of *Working Together to Safeguard Children* and from responding to the findings of the thematic review of neglect. However, the freedom and flexibility offered by the changes arising from the Munro Review provide the unique opportunity to develop practice that is responsive and child focussed.

Trends in Child Protection (2011 - 2012)

The number of children subject to child protection plans (187) has seen a 63% increase since 2010/11 (115) and a 140% increase since 2009/10 (78). Comparing these figures against York's 'statistical neighbour' and the regional average as a rate of plans per 10,000, York is currently 54 compared with 32 and 39 respectively.

During 2011/12, 176 children ceased being subject to child protection plans with 31% being on a plan for 3 months. 13% remained on a plan for 6 months, 32% for a year and 21% for 2 years. 3 children remained on a plan for over 2 years (1.7%).

The category of plans reflects previous years with neglect being the highest (45%), followed by emotional abuse (37%), physical abuse (8.6%) and sexual abuse (3.7%).

The number of children looked after has also seen a rise of 8% from 237 to 256 and a 30% increase since 2008/9 (199). As a rate per 10,000, York (73) is significantly higher than its statistical neighbour (54) and the regional average (65).

Despite the increase in child protection plans, the number of referrals dropped slightly from 1,325 in 2010/11 to 1,148 in 2011/12. However, the percentage of referrals relating to child abuse rose from 59% to 73% over the same period showing an increase of 9%. In 2011/12, 278 s.47 enquiries (child abuse enquiries) where initiated compared with 220 the previous year, an increase of 26%.

The unprecedented rise in children subject to child protection plans has occurred despite the significantly smaller increase in the number of child protection referrals. Although the reason for the increase in plans is not known, there has been a similar rise in child protection plans nationally where it is commonly suggested to result from social workers 'playing safe' as a result of the high profile case of Peter Connelly. However, the reason for the rise will be more complex than any single factor.

Any significant rise in children subject to plans or becoming looked after places additional demands and stress on services operating in the current challenging economic conditions. However, caution is needed before introducing mechanisms to reduce the numbers without undertaking an analysis of why the rise has occurred. The CYSCB will therefore prioritise undertaking or commissioning an analysis to inform child protection practice in partner agencies.

Practice Monitoring Group (PPMG)

The PPMG monitors a range of information relating to Child Protection Conference processes and multi agency audit in relation to children receiving services subject to statutory assessment plans (including early intervention services, child protection concerns and children 'looked after' by CYC). The PPMG is also responsible for overseeing the thematic review into child neglect and ensuring the lessons learned are

disseminated, addressed and the impact of service developments monitored.

A key area of work has been the conducting of case file audits which has identified a number of themes and subsequent actions in relation to the effectiveness of the child protection process:

Core Groups

1. Maintain consistently good standards in core group practice and output
2. Frequency of core groups to be clearly specified in protection plan / conference record
3. Core group minutes to be consistently distributed to all core group members
4. Local protocol to be agreed (and endorsed by CYSCB) regarding the multi agency roles and responsibilities re the production, distribution and storage of core group minutes

Written agreements

5. Awareness and adherence to Children's Social Care written agreement procedure to be promoted via serious case review briefing sessions
6. Child protection written agreements to be reviewed as part of child protection plan in core groups and child protection conferences.

Conference reports

7. Revise current practice re distribution of agency reports for conference so that all available reports are shared prior to the conference meeting.
8. Expectations regarding the timely and secure distribution and storage of conference reports and records to be incorporated in CYSCB procedures
9. Maintain robust monitoring and reporting on multi agency compliance re procedural expectation about timeliness and quality of reports to conference
10. Maintain a consistently good level of managerial oversight of reports prepared for conference across all agencies
11. Continue to deliver rolling program of multi agency training to promote and embed procedural and best practice standards

Other work of the PPMG has included;

- Introduction of a refined report to child protection conference that gives more focus to the assessment of risk/ protective factors
- Publication of guidance notes for professionals to assist in compiling the report to conference
- Introduction of more streamlined arrangements for ending protection plans when children become subject to care planning regulations to avoid duplication of planning / process.
- Introduction of a new style core group record, that better captures assessment activity and refinements to the protection plan

The challenge for the year ahead is to ensure that newly developed tools are consistently used, to embed multi agency evaluation of what works well and to ensure the learning arising informs ongoing service development and is effectively disseminated to front line practice.

Child Death Overview Panel

The overall purpose of the child death review processes is to understand how and why children die, put in place interventions to protect other children and to prevent future deaths. It is intended that the processes will:

- Document and accurately establish causation of death in each individual child.
- Identify patterns of death in a community so that preventable factors can be recognised and reduced.
- Contribute to improved multi professional collection of medical, social and forensic evidence in the small proportion of deaths where there has been maltreatment or neglect.

On average there are 48 childhood deaths each year across North Yorkshire and York with an average of 15 in York. Over the past year, the Child Death Overview Panel (CDOP) have been notified of the deaths of 12 children in York.

The majority of childhood deaths occur within

the first year of life (62%) with 12% between the ages of 1 – 4 years, 4% between the ages of 5-9, 11% between the ages on 10 -14 and 11% between the ages on 15 -17 years. Male children accounts for 59% of all deaths.

The CDOP reported that there were 'modifiable factors' present in 10% of cases in 2011-2012, where it was assessed that there were factors which may have contributed to the child's death which 'by means of locally or nationally interventions, could be modified to reduce the risk of future child deaths'.

68% of all child deaths resulted from a medical condition (excluding sudden unexplained, unexpected deaths, 8%). 3% of all deaths in childhood resulted from abuse and neglect (1 case), 6% from suicide and 15% from trauma or other external factors (e.g. accidents).

The CDOP process has highlighted some patterns in childhood deaths, most notably with the issue of parents sleeping with newborns especially after drinking. In 2010/11, the North Yorkshire and York LSCB launched a campaign raising awareness of the issue with new parents. Although longer term data is required to judge the success of the campaign, there are some early indications that the number of deaths from co-sleeping have reduced slightly.

For further information about the work of CDOP and the Rapid response process, please download the CDOP Annual Report from: http://www.safeguardingchildren.co.uk/annual-reports.html

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

The CYSCB Serious Cases Panel is comprised of members from Police, Health, Children's Social Care, CYC Legal Services and NSPCC and also benefits from the attendance of the CYSCB Manager and Chair. In 2011 the Panel met on six occasions; there were no extraordinary meetings (to consider specific and urgent issues) needed within the year.

During 2011, the Panel considered whether the criteria for a Serious Case Review or a Learning Lessons Review had been met in nine separate cases. In one case (that initially came to Panel in 2009) the criteria for Serious Case Review was met and the Executive Summary of the Review has now been published on the CYSCB web site. A further case, which also commenced in 2009, resulted in a Learning Lessons Review, the Executive Summary of which has been circulated to appropriate agencies. The Serious Cases Panel is monitoring the implementation of single agency and CYSCB action plans arising from these cases. Both involved neglect as a very significant theme, resulting in the neglect thematic review that the CYCSB in currently undertaking, and from which the Board expects to learn further lessons that will significantly improve practice.

The other seven significant cases discussed by the Panel prompted actions and increase in knowledge, which have been disseminated to the appropriate agencies. In one particular case, the concerning practice related solely to another local authority, which subsequently decided to undertake its own Learning Lessons Review in relation to the case, and shared the outcome of that Review with the Panel.

In addition to considering referrals the Panel has looked at some Serious Case Reviews and Executive Summaries published by other Local Safeguarding Children Boards (since June 2010 all Serious Case Reviews have to be published in full), to ascertain if there were any implications for CYSCB and partner agencies, and has made recommendations to agencies where appropriate. The Panel has also reviewed the implications of the revised Chapter 8 of Working Together to Safeguard Children 2010 and developed plans for how media interest in high profile York cases will be handled.

The Chair of the Panel remains grateful for the continued commitment to learning and improvement from all agencies, and in particular the commitment of the Panel members.

Thematic review of neglect

In May 2010, following the completion of two reviews dealing with the issue of child neglect,

the CYSCB embarked on an ambitious project with the undertaking of a thematic review into professional responses to neglect. Simply, the review is seeking to understand why professionals find it difficult to identify neglect and respond effectively.

The messages of the review are not new; child neglect must be identified early with interventions based on sound assessment and grounded in the evidence of 'what works'. Early intervention and prevention, addressing maladapted parental behaviour before a cycle of maltreatment is established, is an imperative and must be central in the City's strategy for children.

Whilst there is a need to identify neglect early it should be recognised that there are children of all ages living with neglect. Therefore, the strategy requires two distinct components, 1) a systematic multiagency approach to early identification and intervention at the earliest opportunity; and, 2) robust, targeted intervention for older children and/or those found to be in more entrenched, higher risk situations.

It is clear, from research and from the findings of the review, that high risk families can be identified early. However, effective identification requires a shared professional understanding of neglect along with changes in intra and inter-agency working. Importantly, there needs to be a central coordination and monitoring of activity, including CAFs, as a means of quality assuring assessments, plans and interventions.

Early identification and intervention inevitably requires an enhanced role for the health professional (e.g. midwives and health visitors). Health professionals are ideally placed to identify issues early and have unique skills in assessing child development and attachment. Research identifies that parents, *'respond well to an 'active firm' approach, for example, from an interested, sensitive health visitor or school nurse. Clear directive advice about what they need to do and by when from a "straight-talking" professional is highly effective and appreciated by parents'* (DfE, 2011).

Assessment should be continuous, often beginning with the health professional (in cases of young children) and added to by other professionals who subsequently become involved with the family. Assessments should reflect all aspects of the assessment framework and should include and value the professional expertise of each practitioner involved with the family.

A key aspect of assessing child maltreatment is in the need to identify risk and, once identified, the parent's capacity to change. However, it is acknowledged that the concept of risk when applied to neglect can be problematic. Therefore, consideration should be given to implementing standardised actuarial tools (research based questionnaires used to determine risk), for use by all professionals, to assist in the assessment of risk.

Assessing a parent's capacity to change requires a clear acceptance by parents of the problem along with what is required to change. Such assessments also require an understanding by practitioners of human motivation, models of change and motivational techniques. Assessing parental capacity to change would also benefit from the use of existing standardised tools as a means of measuring progress.

In order to combat the 'stop / start' or 'start again' approach identified by the review, prevention and intervention must be both assertive and tenacious, and must be maintained until a positive outcome is achieved. Importantly, interventions must be based on clear objectives which are informed by an accurate assessment of the underlying factors, attachment and family functioning.

It is essential that objectives are achieved and result in a positive sustainable change in the child's circumstances. Failure to meet objectives, should not result in cases being closed, rather it should act as a trigger to review the effectiveness of the intervention and consider alternative approaches.
Interventions should be perceived by families as supportive. However, parents should be left in no doubt of the concerns of professionals and of the likely consequences, both to the child and to themselves, of not meeting the objectives (including civil and criminal legal interventions). To be effective, practitioners need to have clarity

about the primary focus of their role; to ensure and safeguard the child's welfare as opposed to 'family support'.

Interventions should not be open-ended. Rather, they should be focussed within a clear timescale that takes account of the child's age. Therefore, in view of the neurobiological research on the impact of neglect on the developing brain, consideration should always be given to whether the work can be completed within the child's timescale.

It is recognised that change is a process that takes time rather than something that results from a single intervention. Neglectful families have a range of complex needs and often have limited internal resources on which to draw upon. Consideration should therefore be given to providing long term access to support whereby the parent, recognising indicators of a lapse into problematic behaviours, has somewhere to turn. A potential model on which to base such a service can be found with the 'Circles of Support and Accountability' used with sex offenders which utilises volunteers to provide community support.

Unlike other forms of child maltreatment which would typically lead to either single agency or joint CSC / Police enquiries, child neglect requires a coordinated interagency response. Consequently, there needs to be a review of existing procedures to ensure the involvement of all those professionals involved with the child and its family.

All agencies have a vital contribution to make when dealing with child neglect. All too often cases receive a single agency response, even when other key agencies may be involved. Research identifies that child neglect correlates, or is contributed to, by issues such as mental ill-health, substance misuse, domestic violence or the parent's maladaptive coping strategies when faced with external stressors. It should therefore be routine to work in close partnership with colleagues in adult focussed services, criminal justice or housing providers.

Where it is evident that interventions have been ineffective, civil and criminal legal action should be considered. Whilst the police have typically played a relatively minor role in this area, prosecuting neglect as a crime has a number of potential advantages: 1) reflects the seriousness of the issue; 2) sends a message of intolerance of neglect; and, 3) provides additional motivation for change.

When prosecuting neglect, whether as part of a civil or criminal process, the importance of the professional evidence should not be under-estimated. Consequently, the components of good practice previously identified above (e.g. parents aware of the concerns and consequences, provision of focussed interventions, failure to comply or to deliver outcomes etc.), provides the evidence required for a successful prosecution. Simply, professionals must be mindful of the value of their work as potential evidence within a legal process. Therefore, consistent, good quality practice in recording of assessment, analysis, interventions and outcomes is critical across all agencies.

FINANCIAL STATEMENT

The public sector continues to experience unprecedented pressures on income as a result of the national economic downturn. However, the CYSCB finances have benefited from a strong commitment by each of the funding agencies.

The past year has seen an unplanned rise in expenditure of almost £18,000 due to the commissioning of the Baby A Serious Case Review. However, due to an undertaking by the key funding agencies to underwrite the costs of reviews, the amount has not impacted on overall budget.

It was anticipated that the Child Death Review grant would be with withdrawn by the Coalition Government which would have resulted in LSCBs having to cover the full cost of this statutory duty. Thankfully, the funding has continued albeit with a reduction of £3000.

In order to support the changes recommended in the Munro review, the Children's Workforce Development Council has provided LSCBs with a

grant of £7,000 (note shown in the budget below). The CYSCB plans to use this money to promote the findings of the thematic review of neglect along with any additional expenditure arising from responding to changes in statutory guidance.

Overall, whilst the budget is healthier than reported in the last annual report, 2011/12 saw an underlying shortfall in income of approximately £6000 which has been covered by the CYSCB's reserves.

BUDGET

Expenditure	2010/11 Costs	2011/12 Projected (£)	2011/12 Costs (£)	Income	2010/11 Income	2011/12 Projected (£)	2011/12 Income (£)
		-		Balance B/fwd		17,069	17,069
CYSCB staffing costs	145,484	158,621	158621	Children's Services: City of York	59,270	62,070	62,070
Training Budget	6,501	2,791	2,791	Health: PCT	34,320	31,951	31,951
Information/Miscellaneous	8,632	3,585	3,585	Police: North Yorkshire Police	15,510	15,975	15,975
Chairing/Serious Case Review	7,044	17,846	17,846	Education Dept/Early Years: City of York	14,900	14,900	14,900
Website	1,127	161	161	Probation: NY Probation Service	5,166	5,321	5,321
Recharges	18,840	18,840	0	Schools Contribution for Safeguarding Advisor	50,000	50,000	50,000
Child Death Review Grant	15,020	12,000	12,000	Child Death Review Grant	14,550	12,000	12,000
				CAFCASS	550	550	550
				YPS Contribution	2,000	2,000	
				Others:	5,150	2,200	2,200
				Serious Case Review		13,500	13,500
	202,649	213,844	195,004		201,416	210,467	208,467
Balance C/fwd		13,692	30,531				
		227,536	225,536			227,536	225,536

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

Mission statement	What's been done so far	What needs to be done	Progress 2011-12	Future plans (2012-13)
DEVELOPMENT OBJECTIVES Objectives requiring significant input, including stakeholder engagement, to develop and deliver outcomes				
1. Ensure that children are safeguarded from **sexual exploitation** through the development and implementation of processes that raise professional awareness, develop practical intervention skills, and facilitate effective interagency working. Specific issues may include the vulnerability of children via the Internet, and to commercial sexual exploitation. (key development objective for 2011-12)	• Training developed and ongoing within CYSCB training calendar • Interim procedure now complete • Lessons can be learned from other authorities via membership of the National Working Group	• Convene a stakeholder group to undertake/commission work to understand the nature and risk of sexual exploitation in City of York • Convene a NY & Y working group • Develop York practice guidance • Ensure links to other relevant CYSCB objectives, e.g. E-safety, YP substance misuse	• Stakeholder group convened (York) and working group NY&Y completed tasks • York procedure developed and been used in 3 cases • York practice guidance drafted • CSE info sharing template developed • NY&Y targeted training tendered • Prevention and early intervention strands of CSE work embedded in Risk & Resilience strategy	• Complete and agree practice guidance • Evaluate procedure in light of cases where used • Agree single points of contacts in partner agencies and deliver info sharing training • Agree tender and deliver targeted NY&Y training on working with high risk CSE
2. Ensure that **children whose parents or carers misuse substances or alcohol** are safeguarded from harm through the development and implementation of processes that raise professional awareness, develop practical intervention skills, and facilitate effective interagency working.	• Good links developed with some local services to take forward this work in the future • Interim procedure now complete	• Re-convene multi-agency stakeholder group to inform development of practice guidance and training • Develop training and awareness-raising targeted at key staff	• Key messages about vulnerabilities and additional risk embedded in CYSCB training courses and neglect briefings	• To be embedded in pre-birth assessment work • To be addressed in targeted Neglect training • Further actions to be agreed by CYSCB
3. Ensure that **children whose parents or carers suffer**	• Interim procedure now complete	• Re-convene multi-agency stakeholder group to inform	• Key messages about vulnerabilities and	• To be embedded in pre-birth assessment work

Mission statement	What's been done so far	What needs to be done	Progress 2011-12	Future plans (2012-13)
mental ill health are safeguarded from harm through the development and implementation of processes that raise professional awareness, develop practical intervention skills, and facilitate effective interagency working.		development of practice guidance and training • Develop training and awareness-raising targeted at key staff	additional risk embedded in CYSCB training courses, neglect briefings and learning lessons from SCRs sessions	• To be addressed in targeted Neglect training • Further actions to be agreed by CYSCB
4. Ensure that children are safeguarded from **sexual abuse**, and that appropriate actions are taken when children display sexually harmful behaviours through the development and implementation of processes that raise professional awareness, develop practical intervention skills, and facilitate effective interagency working.	• Interim procedure now complete • Practice based, advanced training on child sexual abuse targeted managers and practitioners • Multi-agency sexual abuse conference Dec 2008 • NY & Y multi-agency working group convened to look at processes and gaps where a child is displaying sexually harmful behaviours	• Further work on targeting training at key staff • Briefings and awareness raising on new procedures and particular reference to children who display sexually harmful behaviours • Explore means of providing services for children who harm	• NY&Y task group convened: shared procedures, practice guidance and AIM 2 training re: children who harm • Applying York procedures and processes (incl. m-a strategy and working) in children who harm cases • AIM 2 training delivered	• Evaluate York procedure in light of children who harm cases where used • Further AIM 2 training • Establish AIM 2 practitioner network
5. Ensure that children are safeguarded from the impact of **Neglect** through the development and implementation of processes that raise professional awareness, develop practical intervention skills, and facilitate effective interagency working.	• Thematic review into Neglect initiated using threshold testing vignettes • Report overseen by PPMG • Involvement of interagency practitioners and managers in key elements of the thematic process • Emerging lessons disseminated across interagency groups CSC, health, FIPS, problem family strategy group	• Continue thematic review - interviews and threshold analysis • Identify barriers and levers to good practice • Develop practice guidance re: Neglect • Develop and deliver training and briefings to identified staff re: Neglect • Develop QA processes to monitor progress re: responding to neglect • Further establish and	• Bulk of thematic review complete • Neglect briefings developed and in process of delivery • Dental health training delivered to NY&Y dentists • Audit of LAC / CP cases re dental health	• Develop m-a procedure, practice guidance and tools to support delivery against thematic review recommendations • Develop and deliver targeted training on assessment, risk and outcome focused interventions

Mission statement	What's been done so far	What needs to be done	Progress 2011-12	Future plans (2012-13)
		develop links to promote enhanced awareness of dental health as an indicator of neglect with dental and other practitioners • Conference focussing on neglect autumn 2012 • Integrate key findings into citywide strategy on problem and resistant families		
6. Ensure that **schools are well placed to play their unique role in contributing to the safeguarding of children** from abuse and neglect through the development and implementation of processes that raise professional awareness, develop practical intervention skills, and facilitate effective interagency working; and in meeting the Safeguarding requirements outlined by Ofsted	• Safeguarding Advisor (Education) funded and appointed	• Establish post to meet needs identified by schools	• Links established with designated CP leads in schools • Briefings for Heads • Input in school governor training • School briefings • Education LADO work • Co-ordinating other complex cases involving schools, e.g. children who harm, complex child sexual exploitation	• Further actions to be agreed by schools and CYSCB
MAINTENANCE OBJECTIVES Objectives where significant work has been undertaken, but which remain Board priorities and, therefore, require input to maintain				
7. Ensure children are safeguarded from the harm arising from **domestic abuse** through the development and implementation of processes that raise professional and public awareness and facilitate effective interagency	• Interim procedure now complete • Guidance on domestic abuse in Allegations process • CYSCB is represented on the NY&Y JCG and the York DATG • Domestic abuse	• Ensure that current activity is maintained • Keep CYSCB informed of relevant issues • Monitor developments and review activity as appropriate (e.g. partner engagement in MARAC)	• Input in NY&Y strategy, services and training reviews • Regular reports to CYSCB and actions identified, e.g. CYSCB scrutiny of partner agency representation at MARAC • Awareness raising of violence in teen	• Evaluate use of York procedure on children who harm cases where used • Develop and deliver targeted training on working with perpetrators • Further actions to be agreed by CYSCB

Mission statement	What's been done so far	What needs to be done	Progress 2011-12	Future plans (2012-13)
working.	developments and stats reported to each Board meeting • Training has been developed and is ongoing in CYSCB training calendar		relationships • Modification of children who harm and complex abuse procedures and processes in serious cases of violence in teen relationships and test	
8. Ensure that **disabled children and children with additional needs** are safeguarded from harm through the development and implementation of processes that raise professional awareness, develop practical intervention skills, and facilitate effective interagency working.	• Interim procedure now complete • Multi-agency stakeholder group convened to inform policy and training development • Training reviewed in line with WT 2010 and Safeguarding Disabled Children Guidance and delivered 2010 • Children's Society representative on CYSCB to ensure the issues re: disabled children are a continuing priority	• Ensure that current activity is maintained • Work with local and national agencies (e.g. Children's Society, National Deaf CAMHS) to ensure the safeguarding needs of disabled children are understood and promoted • Keep CYSCB informed of relevant issues • Monitor developments and review activity as appropriate	• Co-developed I'll Go First toolkit "safeguarding boards" alongside Children's Society, in consultation with CS PACT (yp's) project • Briefings delivered to CANDI forum and Children's Society • Additional risk related re: disability embedded in core CYSCB training • Safeguarding Disabled Children training delivered regularly	• Conducting audit of safeguarding services to deaf children in line with NDCS guidance • Incorporate chapter on Neglect and Disability in thematic review • Deliver safeguarding session to The Glen • Further actions to be agreed by CYSCB
9. Ensure that **children and young people who misuse substances or alcohol** are safeguarded from harm through the development and implementation of processes that raise professional awareness, develop practical intervention skills, and facilitate effective interagency working.	• Membership of Young People's Substance Misuse Steering Group • Working group identified to develop training for targeted staff	• Convene multi-agency stakeholder group to inform development of procedure, practice guidance and training	• Representation on the Risk & Resilience network • Input into training re: yp substance misuse	• Further actions to be agreed by CYSCB

Mission statement	What's been done so far	What needs to be done	Progress 2011-12	Future plans (2012-13)
CORE OBJECTIVES Objectives required to ensure the ongoing functioning of the Board				
10. Ensure that the Board develops and delivers **training** that complies with national guidance and effectively promotes the CYSCB objectives to the wider professional community. This includes specialist training to school communities to support safeguarding and Ofsted requirements	• Core training has been reviewed in line with WT 2010 • The training calendar for 2011 has been agreed and published on the website • Evaluation of training for 2010 has been completed • Head teachers briefings developed and delivered • Governor training (for YSJ school improvement module) developed and delivered • Child protection designated teachers identified and surveyed re: training needs	• Develop and deliver, or commission (cost permitting) additional specialist, targeted training to meet Board priorities for 2011, including dissemination of Neglect findings • Develop and implement post training processes to monitor the impact of training on practice • Develop and deliver rolling programme of updates for child protection designated leads within schools • Ensure that current activity is maintained	• Neglect briefings developed and currently being delivered • Targeted training on CSE and AIM 2 commissioned NY&Y • The SA(ED) delivering schools updates • Training constantly reviewed in line with current policy and good practice • Post training evaluation conducted Jan – Jun 2011. Currently undertaking Jul-Dec 2011 evaluation	• Further targeted training, e.g. Neglect (as outlined above) • Conference (poss NY&Y) to roll out Neglect work, and recommendations from Munro • Further actions to be agreed by CYSCB in support of delivery of business plan • Ensure messages from SCRs/CDOP locally, regionally and nationally are embedded in training and other learning
11. Ensuring the Board has an **understanding of unexpected child deaths** in the City of York by providing a rapid response by key professionals for the purpose of evaluating all unexpected child deaths via the development and implementation of a Child Death Overview Panel, jointly with North Yorkshire Safeguarding Children Board.	• The joint CYSCB/NYSCB panel established and has produced first annual report • Safe sleeping campaign launched and materials distributed in response to CDOP findings re: co-sleeping risk to young babies • Better Beginnings seminar organised for targeted practitioners re: sudden infant deaths & sleeping	• Improve accountability between CYSCB and CDOP by having the CDOP Chair sit on the Board • Improved reporting of lessons / recommendations to CYSCB	• CDOP well established with excellent cooperation with the NYSCB	• Respond to issues identified at CDOP
12. Ensure that children are safeguarded from abuse perpetrated by childcare	• Procedure well established • Safeguarding Advisor (Education) funded and	• Monitor Government plans re: the allegations process, and respond appropriately	• Allegations process well embedded across agencies • Role of Safeguarding Advisor	• Further actions to be agreed by CYSCB in support of delivery of business plan

Mission statement	What's been done so far	What needs to be done	Progress 2011-12	Future plans (2012-13)
workers, foster carers and volunteers through the development and implementation of processes that ensure safe working environments and effective interventions and which facilitate interagency working.	appointed to increase capacity to respond effectively to Education allegations • Safer Recruitment training delivered 2010		(Education) well utilised across the education community • Messages about professional behaviours and allegations processes delivered in key training.	
13. Review and where necessary amend **interagency guidance and procedures** to reflect changes contained within national guidance and legislation. Specifically to: a. Lead to a clear separation between procedure and guidance b. Seek to work in cooperation with North Yorkshire SCB to ensure cross boundary consistency c. Develop quality assurance standards to facilitate the measurement of compliance	• Interim procedures now complete • Added procedure for child sexual exploitation (trial) and children who sexually harm • Added interim guidance for pre-birth assessment	• Identify, develop and implement any additional procedures, policy and practice guidance to meet Board objectives and identified local need	• Procedures for child sexual exploitation and children who sexually harm being successfully used	• Review procedures in light of the revision to Working Together and Munro review • Ensure that procedures reflect learning from SCRs/CDOP locally, regionally and nationally
14. Review and agree the **CYSCB financing** arrangements to reflect the additional requirements and responsibilities of the Board and to provide continuity of resources.	• Additional funding secured to appoint Safeguarding Advisor (Education) • Additional income generation of £7k raised in 2011 • Agreement by funding agencies to increase budget in 2012/13			• Increase budget in 2012/13 to meet projected shortfall

Mission statement	What's been done so far	What needs to be done	Progress 2011-12	Future plans (2012-13)
	• National CDOP funding secured albeit at a reduced level • Efficiency savings made			
15. Ensure **consistency and independence of decision-making in the child protection conference process (CPC)**. Specifically to: a. Audit application of intervention thresholds in CPC, analysis and decision making b. Develop strong and clear lines of accountability between conference chairs and the CYSCB c. Ensure QA function of conference chairs d. Develop standards and criteria to measure quality and facilitate good practice at CPCs	Professional Practice monitoring group established • Standards developed in respect of child protection conferences ensuring the monitoring of quality, and regular reports to CYSCB • Specialist training in Contributing Effectively in Child Protection Processes developed and delivered through 2010 • Interagency case file audits established in 2011 using the London LSCB audit tool	• CSC to undertake work addressing the issues raised by audits re: a. CP plans b. Core Groups c. Parental written agreements • Transfer of IRO section to the CYSCB Unit to ensure greater independence and accountability to the Board	• Agreement to transfer IRO section to CYSCB Unit	• Develop strategy and action plan for transfer of IRO service to LSCB
16. Develop a **quality assurance strategy** to improve child-safeguarding practice by informing current and future work of the CYSCB. To include quantitative and qualitative measures, be outcome focussed, specifically monitor effectiveness of: a. The CYSCB functions and outputs b. The CYSCB Unit	• Professional Practice Monitoring Group established. The purpose of the group is to oversee and monitor the CP conference processes to ensure CYSCB standards are being maintained. • Established case file auditing function of the PPMG • Serious case review action plans overseen by Serious Cases Panel	• Ensure that current activity is maintained • Respond to identified quality issues • Identify, develop and implement process to quality assure any future activities		• Further actions to be agreed by CYSCB in support of delivery of business plan

Mission statement	What's been done so far	What needs to be done	Progress 2011-12	Future plans (2012-13)
c. Interagency safeguarding practices and arrangements d. Agency safeguarding practice e. Child protection conferences and reviews f. Serious Case Review action plans				