



Leeds Safeguarding Children Board Annual Report
April 2010 – March 2011

Executive Summary

'The LSCB has a key role in achieving high standards in safeguarding and promoting welfare, not just through co-ordinating but by evaluation and continuous improvement.' Working Together to Safeguard Children, 2010, page 93'

1. INTRODUCTION

1.1 This is an Executive Summary of the Annual Report regarding the work of the Leeds Safeguarding Children Board (LSCB). The Annual Report meets the requirement under the Apprenticeships, Skills, Children and Learning Act 2009 for LSCBs to produce and present to the Children's Trust Board (CTB) an account of the effectiveness of safeguarding arrangements in the local area.

1.2 The report covers a year that has been characterised by the implementation of significant change and development in the governance, structure, membership, and operation of the LSCB running parallel to a substantial increase in safeguarding activity in the City, a significant trend seen nationally.

1.3 The LSCB has a voice and influence across the five strategic partnerships across the City and leads the safeguarding system in conjunction with the newly formed Children's Trust Board. It is required to challenge and scrutinise the work of the Children's Trust Board and partner agencies.

1.4 The Annual Report, sets out the evidence available and measures the effectiveness of safeguarding arrangements for children and young people in Leeds at the current time. In addition it considers the efficiency of the work of the LSCB and its partner agencies in fulfilling their safeguarding responsibilities.

1.5 The Report also identifies challenges for both the LSCB and for the CTB. The CTB must consider the report when preparing and refreshing the Children

& Young People's Plan (CYPP) and within its work to drive forward improvements in safeguarding children and young people.

1.6 The format adopted for the report is the one recommended in national guidance.

2. LSCB VISION, VALUES AND PRINCIPLES

2.1 As part of the creation of the LSCB strategic plan 2011-2015 LSCB members worked together on development sessions and reached agreement on the following points.

2.2 Our Vision

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

2.3 Our Values

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

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

2.4 Our principles

As a Board we are:

- **Committed** to putting the child or young person at the centre of all that we do
- **Focused** on getting safeguarding right for children, young people and their families
- **Clear** about what we expect of safeguarding services
- **Informed** about how well children and young people are protected in Leeds
- **Open** about what we do and why
- **Co-operative and collaborative** with each other
- **Challenging** of each other and of the safeguarding services each partner provides
- **Effective** in providing value for money
- **Accountable** to the people of Leeds for how we invest our resources

- **Accessible** to and informed by children, young people and their families, the communities they live in, the staff in our organisations that serve them, and the priorities of the Children's Trust
- **Learning** from everything we do and changing as a result
- **Improving** practice and outcomes for children and young people

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

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

3 COMPREHENSIVE ANALYSIS OF THE SAFEGUARDING CONTEXT

3.1 There are approaching 180,000 children and young people in Leeds. Recent rises in the birth rate have increased the number of 0-14 years olds by 13%. For the majority, growing up in Leeds is mostly a good and positive experience, and recent inspections of children's services in Leeds are positive about levels of performance and capacity to improve.

3.2 A detailed needs analysis of outcomes for different groups was compiled and summarized as follows.

3.3 Children and young people are safe from harm

- The majority of children and young people reported feeling safe. However children and young people are present at 43% of the 8,000 plus incidents of domestic violence reported each year in Leeds.
- There are nearly 1,500 looked after children in Leeds; 80% of these being due to abuse or neglect,
- The overall workload for Children & Young People's Social Care (CYPSC) has increased by 44% on the previous year and individual caseload levels for social workers remain high despite additional investment in staff.
- Over 1,000 children and young people have protection plans. This has a significant impact on health services such as mental health, health visiting, school nursing and emotional health and well being services.
- Leeds is less deprived than other large cities and average income is

above the regional average. However over 33,000 children and young people (23%) live in poverty.

- The majority of children and young people feel safe but some have concerns about night time safety and public transport.

3.4 Children and young people do well in learning and have the skills for life

- There have been significant reductions in the number of young people not in education, employment or training (NEET) in recent years however the numbers still need to be reduced.
- The number of children and young people attaining five good GCSE's has increased and is currently over 50% but some groups don't do as well.
- Only 53% achieve a good level of development in the early years phase leading up to primary school. 1 in 4 don't do as well as expected in Maths and English by the end of primary school.
- Despite recent improvements over 3000 secondary and 1000 primary school pupils are classed as persistently absent from school.
- Levels of healthy eating and physical activity are improving but 10% of 5 year olds and 20% of 11 year olds are obese
- 10 - 20% report involvement in substance abuse.
- Poor health outcomes and poor access to health services tend to be concentrated in specific deprived areas of the City and some groups of children and young people are much more likely to experience a range of poor health outcomes
- 80% of children and young people report that they enjoy life but they would like more places to go and things to do.

4. EFFECTIVENESS OF SAFEGUARDING ARRANGEMENTS FOR CHILDREN & YOUNG PEOPLE IN LEEDS

4.1 Achievements across the Partnership 2010-2011

4.1.1 There has been improved performance overall in the child protection and looked after children processes despite increasing referrals to Children and Young People's Social care, double the number of children and young people subject to Child Protection Plans and continuing high numbers of children looked after.

4.1.2 There were very positive outcomes from an unannounced Ofsted inspection in January 2011 which stated that areas of priority action had been addressed and that contact, referral and assessment processes now met statutory guidance.

4.1.3 Through the annual s.11 of the Children Act 2004 'duty to safeguard' self evaluation audit there is evidence of improvements by partner agencies in the areas of service plans taking account of the need to safeguard, safer

recruitment practices and their understanding of when information should be shared.

4.2 Challenges for the Children's Trust Board

In the light of performance in 2010/11, the LSCB has outlined a number of challenges to the CTB:

4.2.1 Rebalance safeguarding interventions across the continuum of need to ensure preventative work is undertaken appropriately and in a timely manner. To involve:

- Improved multi agency working at locality levels to ensure that children and young people receive the right service at the right time and that the Common Assessment Framework (CAF) is used appropriately to facilitate a "*team around the child*" approach.
- A change in the pattern of referrals and other processes used to communicate concerns between agencies that children and young people are at risk of harm.
- Reducing the number of children and young people who need to be "*looked after*".

4.2.2 Ensure all partners are able to attend and/or provide input in a timely manner to Initial Child Protection Conferences enabling them to be held within timescales laid down in statutory guidance.

4.2.3 Consider how the performance improvements made to date are sustained and built upon within the context of increasing demand for child protection services.

4.2.4 Ensure that partners are able to demonstrate how they meet their safeguarding responsibilities, through internal audit processes and by contributing to the LSCB multi agency auditing programme.

4.2.5 Prepare to respond to the local implementation of recommendations provided by the 'Munro Review of Child Protection'

5. ASSESSMENT OF THE EXTENT TO WHICH LSCB FUNCTIONS ARE BEING EFFECTIVELY DISCHARGED

5.1 Achievements by the LSCB 2010 - 2011

5.1.1 New governance, structure, membership and operation of the LSCB has been developed and implemented in close consultation with the CTB. A new independent chair was appointed in July 2010.

5.1.2 A more focused Business Plan Oct 2010 – Mar 2011 was adopted with clear strategic objectives.

5.1.3 An interim Performance Management System was implemented for 2010/11 focusing on two key areas: child protection processes and care management processes for looked after children.

5.1.4 Two Serious Case Reviews (SCRs) have been submitted and evaluated as 'good' by Ofsted. One Serious Case Review is under discussion with Ofsted. The implementation of action plans from three other reviews has been evidenced as being completed.

5.1.5 Lessons learnt from SCRs have been incorporated into the LSCB training programme and city wide workshops held to disseminate key issues.

5.1.6 Based on the training needs analysis of partner agencies, the LSCB multi-agency core child protection training programme has been restructured and re-launched. This has resulted in increased access for professionals and a significant reduction in waiting lists.

5.1.7 Partners have agreed a funding formula and a core budget for 2011/12 that will ensure that the LSCB can meet its statutory responsibilities. This will enable recruitment to an enhanced and restructured LSCB Business Support Team.

5.1.8 In alignment with the Children & Young People's Plan, the LSCB has developed a Strategic Plan for 2011-15, shared with the CTB, derived from an Outcomes Based Accountability approach to improving life chances for children and young people. Within this framework a Business Plan is in place with outcomes and objectives for 2011/12 identified and a delivery system in place.

5.1.9 A comprehensive Performance Management System for 2011-15 is being established which links with strategic priority (1) of the Children and Young People's Plan "*that children and young people are safe from harm.*"

5.2 Challenges for the LSCB

The LSCB has set itself the following challenges for 2011/12:

5.2.1 To consolidate and develop further the progress that has been made in providing effective leadership and challenge to the safeguarding system in Leeds, engaging with both the professional partnership and the wider community of children, young people and their families.

- 5.2.2 To implement the work plans generated within the Business Plan 2011/12 in order to meet the objectives and outcomes set.
- 5.2.3 To develop and implement a communications strategy that undertakes campaigning and raising awareness activities regarding safeguarding issues.
- 5.2.4 To implement the new Performance Management System in 2011/12 in order to receive improved information and more rounded intelligence about the effectiveness of safeguarding services and the impact of lessons learnt from reviews and audits on outcomes for children and young people.
- 5.2.5 To set up and implement the LSCB multi-agency quality assurance and audit programme, with particular regard to child protection, children in need and early intervention processes and practice. This will include the impact of SCR action plans, compliance with s.11 requirements and arrangements for paediatric medicals.
- 5.2.6 To undertake the annual s.11 self assessment audit with partner agencies seeking improvements in the following areas:
- Understanding when and how to initiate a CAF
 - Ensuring children and young people are made aware of their right to be safe from abuse
 - More consistent engagement with the self audit process
- 5.2.7 To develop a consistent approach to s.11 audit and commissioning standards requirements that takes account of the challenges faced by small Third Sector organisations.
- 5.2.8 To effectively engage children and young people in the work of the LSCB.
- 5.1.9 To continue to develop Quality Assurance processes to ensure safeguarding training undertaken by partner agencies and through the LSCB is of a consistently high standard.
- 5.2.10 To undertake more effective evaluation of the impact on practice of training and development opportunities provided by the LSCB and partner agencies.
- 5.2.11 To improve the process for responding to, collecting, collating and analysing information about child deaths in order to identify, in a timely manner, lessons that may contribute to the prevention of deaths in the future.
- 5.2.12 To monitor the action plan for the development of private fostering arrangements.
- 5.2.13 To more fully engage with community safety activity relating to the safeguarding of children and young people (including responsibilities under the Licensing Act 2003).

5.2.14 To prepare to respond to the local implementation of recommendations provided by the '*Munro Review of Child Protection*'.

6. NEXT STEPS

6.1 In their complementary work to drive improvements in the safeguarding of children and young people both the Children's Trust Board and the LSCB are asked to take account of the challenges identified in this report.

6.2 The CTB is asked to respond through:

- Action to address outcome (1) of the Children & Young People's Plan that '*children and young people are safe from harm*'.
- Continued engagement with the LSCB to support its leadership of the safeguarding system in Leeds
- Ensuring partners engage with and contribute fully to the work of the LSCB.

6.3 The LSCB will respond through implementation of its Strategic Plan 2011-15 and, in the immediate term, its Business plan 2011/12.

7 CONCLUSION

7.1 The LSCB Annual Report provides an assurance that progress has been made in addressing the concerns about safeguarding processes and practices that had been identified by external inspections. Challenges for both the LSCB and CTB are outlined for 2011/12 to ensure progress continues to be made that will improve safeguarding outcomes for children and young people.

7.2 Why is the production of an Annual Report good for children and young people? Because it's important to learn from the past when planning the future. No one wants to keep repeating the same mistakes and no one should miss an opportunity to say 'Well done!'



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1.3 The LSCB undertakes its work of leading the safeguarding system in Leeds in conjunction with the newly formed Children's Trust Board. The LSCB is required to challenge and scrutinise the work of the Children's Trust Board and partners. The LSCB has a voice and influence across the five strategic partnerships across the city.

1.4 The LSCB reports on the evidence available and measures the effectiveness of safeguarding arrangements for children and young people in Leeds at the current time and on the work of the LSCB and its partner agencies in fulfilling their safeguarding responsibilities.

1.5 The Report also identifies challenges for both the LSCB and for the CTB. The CTB must consider the report when preparing and refreshing the Children & Young People's Plan (CYPP) and in its work to drive forward improvements in safeguarding children and young people.

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2.1 The following was agreed through the LSCB members working together at Development sessions as part of the creation of the LSCB Strategic Plan 2011-15.

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- Despite recent improvements over 3000 secondary and 1000 primary school pupils are classed as persistently absent from school.
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- 10-20% report involvement in substance abuse.
- Poor health outcomes and poor access to health services tend to be concentrated in specific deprived areas of the City and some groups of children and young people are much more likely to experience a range of poor health outcomes
- 80% of C&YP report that they enjoy life but they would like more places to go and things to do.

4 KEY SAFEGUARDING BASELINE DATA

4.1 This section provides performance information supplied by Children and Young People's Social Care (CYPSC) relating to key points in the child's journey whilst in contact with Child Protection and 'Looked After' services. The data is reported on a quarterly basis and a commentary is provided in section 5 of this report.

Table 1

<p><u>Indicator title</u> Percentage of children and young people subject to a child protection plan who are not allocated with a qualified social worker</p>
<p><u>What is the indicator measuring?</u> This indicator measures children subject to a child protection plan and whether they are allocated a qualified social worker. It reports this as a percentage of all children subject to a child protection plan (CPP).</p>
<p><u>What is good performance?</u> All children and young people subject to a CPP should have a qualified social worker allocated. Good performance is signified by a 100% result.</p>

Performance

At 31 March 2011, every child subject to a CPP was allocated to a qualified social worker.

Result 09/10	Target 10/11	Result Q1	Result Q2	Result Q3	Prov Q4 result
92%	100%	95.6% 566 of 592	100% 703 of 703	99.74% 765 of 767	100% 970 of 970

Explanation

The data shows a significant improvement this year, despite the doubling of the number of children subject to a CPP in the last twelve months. CYPSC senior leadership team are committed to ensuring that this figure remains at 100%, and managers are held to account.

How do we compare to others?

No comparative data available.

How will performance be improved?

The Assistant Chief Officer CYPSC has been designated the champion for this indicator maintaining an oversight role to address data quality issues and hold team managers to account.

Overall rating


Q1	Q2	Q3	Q4	Direction of Travel	
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Table 2

<p><u>Indicator title</u> Percentage of initial child protection conferences held within 15 days of the meeting which decided that a S47 enquiry was required</p>																																																
<p><u>What is the indicator measuring?</u> The indicator measures the timeliness of initial child protection conferences (ICPCs). These enable professionals most involved with the child and family, and the family themselves, to assess all relevant information, plan how best to safeguard and promote the welfare of a child who may be suffering, or thought to be at risk of suffering significant harm and decide whether a multi agency CPP is required. It is, therefore, a proxy for the effectiveness with which process are carried out and the effectiveness of multi-agency working, and a means of ensuring that rapid steps are taken to ensure the safety of children who are potentially at risk</p>																																																
<p><u>What is good performance?</u> Good performance is be indicated by a rise in the number of ICPCs taking place in 15 days. Historically poor data currently precludes totally accurate reporting; this is a cumulative indicator, so early poor performance continues to have an impact - stand-alone month data shows improvements across the year.</p>																																																
<p><u>Performance</u> Performance has greatly improved across the year, especially when looking at the stand-alone month results. The provisional full-year figure is 31.9, which is three times higher than the 2009-10 result. The number of ICPCs carried out in 2010-11 is approximately double the previous year, as evidenced by the number of children subject to a CPP (511 in March 2010; 1,022 in March 2011).</p> <p>The below shows <i>stand-alone month</i> recorded performance in 2010-11.</p> <table border="1"> <thead> <tr> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> </tr> </thead> <tbody> <tr> <td>19.4</td> <td>7.1</td> <td>12.8</td> <td>9.6</td> <td>24.7</td> <td>30.1</td> <td>62.3</td> <td>22.8</td> <td>51.4</td> <td>28.6</td> <td>70.5</td> <td>51.2</td> </tr> </tbody> </table> <p>It is acknowledged that the electronic recording system did not fully capture performance against this indicator in 2010/11. The use of a temporary management information spreadsheet indicates that performance had improved further over the year:</p> <table border="1"> <thead> <tr> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> </tr> </thead> <tbody> <tr> <td>23.6</td> <td>8.4</td> <td>7.3</td> <td>8.6</td> <td>30.7</td> <td>32.8</td> <td>61.5</td> <td>19.5</td> <td>64.8</td> <td>26.9</td> <td>75.2</td> <td>66.3</td> </tr> </tbody> </table>	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	19.4	7.1	12.8	9.6	24.7	30.1	62.3	22.8	51.4	28.6	70.5	51.2	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	23.6	8.4	7.3	8.6	30.7	32.8	61.5	19.5	64.8	26.9	75.2	66.3
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23.6	8.4	7.3	8.6	30.7	32.8	61.5	19.5	64.8	26.9	75.2	66.3																																					
<p><u>Explanation</u> The number of conferences held each month is greater now than in previous months, with 220 conferences held in March. This reflects the number of conference chairs now employed (ten), giving the service much-needed extra capacity.</p>																																																

How do we compare to others?

CIN census 2009/10 indicates that the Statistical Neighbour average was 70%.

How will performance be improved?

Despite the improvements seen across the year in performance, the service acknowledges that this remains an area for prioritising improvements. The amber rating reflects the service improvement processes put in place, as well as the status of the wider area of work within which this indicator sits.

The creation of an Integrated Safeguarding Unit, to commence in April 2011, will ensure a sustainable service provision, to the required quality thresholds, can be delivered.

Data on multi-agency attendance, and children attending ICPCs is being collected, to add the qualitative data supporting this area of work. This will provide valuable intelligence to help further improve performance in 2011-12.

Overall rating

Q1	Q2	Q3	Q4	Direction of Travel	↑
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Table 3

<p><u>Indicator title</u> Percentage of initial assessments for children’s social care that were carried out within 7 working days of referral (NI 59)</p>																				
<p><u>What is the indicator measuring?</u> The indicator measures how quickly services can respond when a child is thought to be at risk of serious harm. As the assessments involve a range of local agencies, this indicator would also show how well multi-agency working arrangements are established in local authority areas.</p>																				
<p><u>What is good performance?</u> Good performance is indicated by a rise in the percentage of cases where the initial assessment was carried out within 7 working days.</p>																				
<p><u>Performance</u> The 80% (cumulative) target from October to March, as set in the Improvement Notice, was exceeded (80.3%). The Improvement Notice-set targets for the months of June (72%) and October (80%) were exceeded (84% and 88.2% respectively).</p> <p>The full-year cumulative figure (as shown in the below table) has remained stable throughout the year at 80%. The volume of initial assessments carried out during 2010-11 (full-year) is 47% higher than the same period 12 months ago.</p>																				
<table border="1"> <thead> <tr> <th>Result 09/10</th> <th>Target 10/11</th> <th>Result Q1</th> <th>Result Q2</th> <th>Result Q3</th> <th>Prov result</th> <th>Q4</th> </tr> </thead> <tbody> <tr> <td>61.2%</td> <td>80%</td> <td>80% 1294 of 1617</td> <td>79.4% 3012 of 3794</td> <td>79.7% 4762 of 5978</td> <td>79.9% 7102 of 8888</td> <td></td> </tr> </tbody> </table>							Result 09/10	Target 10/11	Result Q1	Result Q2	Result Q3	Prov result	Q4	61.2%	80%	80% 1294 of 1617	79.4% 3012 of 3794	79.7% 4762 of 5978	79.9% 7102 of 8888	
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<p><u>Explanation</u> The improvement in performance, despite the huge rise in volume, reflects the development of capacity in teams and continued effective use of the electronic recording system.</p> <p>An unannounced assessment of contact, referral and assessment services took place on 18-19 January 2011. The report states: “there has been considerable progress to improve the contact, referral and assessment arrangements from the time of the last inspection”, and: “senior managers provide a strong leadership...and this has resulted in a remarkable and impressive improvement in the quality of service inspected and the safety of children in the city”.</p>																				
<p><u>How do we compare to others?</u> Significant work undertaken by CYPSC over the last year has led to a sustained improvement in the last three quarters where the Leeds performance now out-performs all comparators (eg statistical neighbour average of 65.5% at 09-10 year-end; core cities average of 73.2% at 09-10 year-end).</p>																				

How will performance be improved?

Leeds is performing significantly above all comparators, and has sustained this performance across the year. The increasing workload remains a challenge, although the introduction and use of the workload manager dashboard, which provides real time data, has been of great benefit to the service.

Overall rating

Q1	Q2	Q3	Q4	Direction of Travel	↑
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Table 4

<p><u>Indicator title</u> Percentage of core assessments for children’s social care that were carried out within 35 working days of their commencement (NI 60)</p>																	
<p><u>What is the indicator measuring?</u> The indicator measures the percentage of core assessments completed within 35 working days. Successful meeting of the timescales can also indicate effective joint working where multi-agency assessment is required.</p>																	
<p><u>What is good performance?</u> Good performance would be indicated by a rise in the percentage of cases where the core assessment was carried out within 35 days.</p>																	
<p><u>Performance</u> The cumulative target from October to March of 85% set out in the Improvement Notice was exceeded (89.6%). The Improvement Notice-set targets for the months of June (84%) and October (84%) were exceeded (91.1% and 85.7% respectively).</p> <p>The full-year cumulative figure (as shown in the below table) has risen throughout the year. 37% more core assessments were carried out during quarter four than the same period 12 months ago; 62% more core assessments were carried out throughout 2010-11 than the same period 12 months ago.</p> <table border="1"> <thead> <tr> <th>Result 09/10</th> <th>Target 10/11</th> <th>Full Year Result Q1</th> <th>Full Year Result Q2</th> <th>Full Year Result Q3</th> <th>Prov Q4 result</th> </tr> </thead> <tbody> <tr> <td>64.9%</td> <td>Oct-Mar 85%</td> <td>79.9% 366 of 458</td> <td>82.2% 895 of 1089</td> <td>83.8% 1469 of 1753</td> <td>86.2% 2381 of 2762</td> </tr> </tbody> </table>						Result 09/10	Target 10/11	Full Year Result Q1	Full Year Result Q2	Full Year Result Q3	Prov Q4 result	64.9%	Oct-Mar 85%	79.9% 366 of 458	82.2% 895 of 1089	83.8% 1469 of 1753	86.2% 2381 of 2762
Result 09/10	Target 10/11	Full Year Result Q1	Full Year Result Q2	Full Year Result Q3	Prov Q4 result												
64.9%	Oct-Mar 85%	79.9% 366 of 458	82.2% 895 of 1089	83.8% 1469 of 1753	86.2% 2381 of 2762												
<p><u>Explanation</u> The improvement in performance, despite the huge rise in volume, reflects the development of capacity in teams and continued effective use of the electronic recording system.</p>																	
<p><u>How do we compare to others?</u> Significant work undertaken by CYPSC over the last year has led to a sustained improvement in the last three quarters where the Leeds performance now out-performs all comparators (eg statistical neighbour average of 73.8% at 09-10 year-end; core cities average of 74.8% at 09-10 year-end).</p>																	
<p><u>How will performance be improved?</u> Leeds is performing significantly above all comparators, and has sustained this performance across the year. The increasing workload remains a challenge, although the introduction and use an electronic workload manager dashboard, which provides real time data, has been of great benefit to the service.</p>																	

<u>Overall rating</u>					
Q1	Q2	Q3	Q4	Direction of Travel	↑

4.2 Indicators which can be reported quarterly which measure the effectiveness of care management processes for looked after children (LAC)

Table 5

Indicator title						
Stability of placements of looked after children - length of placement (NI 63)						
<u>What is the indicator measuring?</u>						
This indicator measures the percentage of children looked after aged under 16 at 31 March who had been looked after continuously for at least 2.5 years who were living in the same placement for at least two years, or are placed for adoption and their adoptive placement together with their previous placement together last for at least two years.						
<u>What is good performance?</u>						
Good performance is demonstrated by a rise in the percentage, indicating that more children were experiencing greater stability in their placements.						
<u>Performance</u>						
The year-end figure is 71.2%. Performance improved across the first three quarters of the year before dipping slightly in the last quarter. The result is higher than the 09/10 result, hence the direction of travel arrow.						
Result 09/10	Target 10/11	Result Q1	Result Q2	Result Q3	Prov result	Q4
68.4%	75%	70.2%	71.4%	72.7%	71.2%	
<u>Explanation</u>						
Stability has improved, particularly as a result of developmental work that has taken place with kinship carers to improve their understanding of the levels of care they need to provide. This is helping to ensure that placements are suitable for children, which in turn increases the stability of those placements.						
The announced inspection of the Fostering Service in December 2010 resulted in an improvement from 'satisfactory' to 'good' for that service reflecting the improvement in capacity, management and outcomes for LAC which have resulted from the additional investment during this year. Improvements in the outcomes of the Ofsted inspections of residential homes were recorded, with all homes gaining a satisfactory or better rating.						
<u>How do we compare to others?</u>						
The most recently available comparator data available is from 09/10:						
<ul style="list-style-type: none"> • Statistical neighbour - 66.5% • England average - 68% • Core cities - 68.6% 						
<u>How will performance be improved?</u>						
A third fostering team, which will focus entirely on recruitment and assessment, will be established by April 2011. Staff are identified for all						

posts. Support from Education Leeds staff has been provided to develop an improved marketing approach in order to maximise numbers of people who consider becoming foster carers. A full review is currently being finalised of the foster carer career structure, which includes clear criteria for entry to the service at different levels and progression through the levels. This should have a positive impact on foster carer retention levels.

Significant progress has been made in the re-design of services to looked after children. It is proposed that specific looked after children teams will integrate existing support services from across Children's Services, which will be co-located in three teams, and which will provide a more flexible and holistic service to looked after children and their carers. This should increase levels of placement stability and ensure that placement moves are more likely to occur in a planned way.

Overall rating

Q1	Q2	Q3	Q4	Direction of Travel	↑
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Table 6

<p><u>Indicator title</u> Looked after children cases which were reviewed within required timescales (NI 66)</p>																	
<p><u>What is the indicator measuring?</u> The indicator measures the percentage of looked after children that should have been reviewed by Independent Reviewing Officers (IROs) during the year ending 31 March that were reviewed on time. The indicator measures performance over a rolling 12-month period with the year-end figure reflecting the previous 12 months' performance.</p>																	
<p><u>What is good performance?</u> Good performance is indicated by a rise in the percentage of cases where the review took place in the required timescales. By the nature of the indicator, once a review has been missed it cannot be caught up on, so performance deteriorates throughout the year as a result of previous reviews that have not taken place on time.</p>																	
<p><u>Performance</u> The year-end figure is 76.8%, 5.7 percentage points higher than the 09/10 result.</p>																	
<table border="1"> <thead> <tr> <th>Result 09/10</th> <th>Target 10/11</th> <th>Result Q1</th> <th>Result Q2</th> <th>Result Q3</th> <th>Prov Q4 result</th> </tr> </thead> <tbody> <tr> <td>71.1% 943 of 1343</td> <td>90%</td> <td>87.8% 1207 of 1375</td> <td>84.2% 1116 of 1384</td> <td>78.8% 1101 of 1397</td> <td>76.8% 1058 of 1378</td> </tr> </tbody> </table>						Result 09/10	Target 10/11	Result Q1	Result Q2	Result Q3	Prov Q4 result	71.1% 943 of 1343	90%	87.8% 1207 of 1375	84.2% 1116 of 1384	78.8% 1101 of 1397	76.8% 1058 of 1378
Result 09/10	Target 10/11	Result Q1	Result Q2	Result Q3	Prov Q4 result												
71.1% 943 of 1343	90%	87.8% 1207 of 1375	84.2% 1116 of 1384	78.8% 1101 of 1397	76.8% 1058 of 1378												
<p><u>Explanation</u> The direction of travel indicates an improvement in performance over the same period 12 months ago and that the underlying improvements in the timeliness of reviews continue to improve.</p> <p>The service is addressing staffing capacity issues and increasing the use of the workload manager dashboard is enabling potentially non-compliant cases to be identified far more quickly, thus enabling appropriate remedial action to be taken.</p> <p>Reassurance can be given that non-compliant cases does not imply children are left at risk, but rather that set processes are not formally completed. Service delivery managers and team managers take appropriate, considered decisions based on children's circumstances, which may result in some reviews taking place outside proscribed timescales.</p>																	
<p><u>How do we compare to others?</u> The most recently available comparator data available is from 09/10 and shows that last year Leeds performed well below comparator groups.</p>																	

Although performance is better than the same period 12 months ago, this trend is likely to continue.

- Statistical neighbour - 91.6%
- England average - 90.5%
- Core cities - 88.3%

How will performance be improved?

Following the performance clinics that took place in September 2010, further performance clinics took place during quarter four, involving area-based staff and the IRO Team. The outputs will be shared across the service in the new financial year.

Any organisational issues/barriers are being addressed as part of the introduction of the Integrated Safeguarding Unit, and regular monitoring will ensure that timely recording continues throughout the year.

Overall rating


Q1	Q2	Q3	Q4	Direction of Travel	
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Table 7

<p><u>Indicator title</u> Number of looked after children excluding/including unaccompanied asylum seekers (UASC) (i) The number (ii) The rate per 10,000 children in the Leeds population</p>																																									
<p><u>What is the indicator measuring?</u> This indicator provides a snapshot of the numbers and rate of looked after children (LAC) in Leeds.</p>																																									
<p><u>What is good performance?</u> Specific numerical targets are not set for this indicator. 'Good' performance is more a question of whether other thresholds, systems and procedures are being properly applied to ensure that the right children in care and that those who should not be in care are managed elsewhere in the system.</p>																																									
<p><u>Performance</u> The year-end figure is 1,443.</p> <table border="1"> <thead> <tr> <th></th> <th>Result 09/10</th> <th>Target 10/11</th> <th>Result Q1</th> <th>Result Q2</th> <th>Result Q3</th> <th>Prov Q4 result</th> </tr> </thead> <tbody> <tr> <td>Number (exc UASC)</td> <td>1362</td> <td>Not set</td> <td>1381</td> <td>1357</td> <td>1375</td> <td>1392</td> </tr> <tr> <td>Number (inc UASC)</td> <td>1423</td> <td>Not set</td> <td>1440</td> <td>1415</td> <td>1420</td> <td>1443</td> </tr> <tr> <td>Rate per 10,000 children (exc UASC)</td> <td>89.5</td> <td>Not set</td> <td>90.7</td> <td>89.4</td> <td>90.6</td> <td>91.7</td> </tr> <tr> <td>Rate per 10,000 children (inc UASC)</td> <td>93.2</td> <td>Not set</td> <td>94.8</td> <td>93.2</td> <td>93.9</td> <td>95.1</td> </tr> </tbody> </table> <p>Note: from April 2011, one figure (LAC including UASC) will be reported. The LAC figure as reported as one of Children's Services 'three obsessions' does not differentiate between citizen and UASC LAC.</p>								Result 09/10	Target 10/11	Result Q1	Result Q2	Result Q3	Prov Q4 result	Number (exc UASC)	1362	Not set	1381	1357	1375	1392	Number (inc UASC)	1423	Not set	1440	1415	1420	1443	Rate per 10,000 children (exc UASC)	89.5	Not set	90.7	89.4	90.6	91.7	Rate per 10,000 children (inc UASC)	93.2	Not set	94.8	93.2	93.9	95.1
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Number (exc UASC)	1362	Not set	1381	1357	1375	1392																																			
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Rate per 10,000 children (inc UASC)	93.2	Not set	94.8	93.2	93.9	95.1																																			
<p><u>Explanation</u> The number of looked after children have remained relatively stable throughout the year. A review by CYPSC has robustly tested the application of thresholds for taking children into care. The result was that thresholds were deemed to be set at an appropriate level, with no evidence that children are inappropriately being taken into care.</p>																																									
<p><u>How do we compare to others?</u> The most recently available comparator data available is from year-end 09/10 and shows the statistical neighbours' average was 69.3. Leeds' numbers of LAC have historically been high compared to statistical neighbours and this</p>																																									

creates a significant budgetary pressure. Consequently, addressing this has been identified as one of the 'three obsessions' in the new CYPP 2011-2015.

How will performance be improved?

The implementation of clear thresholds for intervention alongside locality-based early intervention work, the CAF, and increasing the number of adoptions, will lead to a reduction in the number of children in care over time. The outcomes based accountability methodology will provide the framework to assist in managing this change; however, this requires a multi-agency approach and commitment.

Overall rating

No targets set


Table 8

<p><u>Indicator title</u> Percentage of looked after children who participate in their review</p>					
<p><u>What is the indicator measuring?</u> The indicator measures the extent to which the views of children and young people are taken account of in terms of planning their care arrangements</p>					
<p><u>What is good performance?</u> Good performance is indicated by a rise in the number of children and young people participating in their reviews.</p>					
<p><u>Performance</u> The year-end figure is 82.2%, 1.7 percentage points higher than the previous year's result.</p>					
Result 09/10	Target 10/11	Result Q1	Result Q2	Result Q3	Prov Q4 result
80.5%	95%	91%	89.3%	84.8%	82.2%
<p><u>Explanation</u> The indicator did not meet its target; however, it is also being investigated as part of the work being undertaken by the Safeguarding and Review Team to understand the reasons for non-compliance. The above figures will include some children and young people who refused to participate in their reviews but the exact data in relation to this is not currently identifiable from the system.</p>					
<p><u>How do we compare to others?</u> No information available.</p>					
<p><u>How will performance be improved?</u> The philosophy of the new CYPP 2011-15 is the creation of Leeds as a 'child friendly city' and an outcome of the CYPP is that all children and young people are active citizens who feel they have voice and influence. Within this, there is a priority to increase the participation, voice and influence of children and young people and it is likely that current processes will need to be reviewed in order to facilitate greater participation for this cohort.</p> <p>The new Care Planning Regulations, to be introduced in April 2011, increase the role of the IRO from being responsible for a child's review to being responsible for the child's entire case. A specific requirement of the new regulations is that the IRO should offer private consultation with a child (or undertake observations of children under five) prior to a LAC review. Whilst this obligation is on the IRO, rather than the social worker, it is hoped that this will help engage more children in the review process.</p> <p>A pilot exercise took place between January and March to identify a best practice model for IROs. The results were overwhelmingly positive, and</p>					

brought benefits to all children in the pilot, even those who felt they were already well supported.

To assist the area teams and the IROs with the implementation of the care planning regulations, a series of mandatory staff training sessions within area teams and for the IROs are underway. These sessions will be completed by the end of May 2011.

Overall rating

Q1	Q2	Q3	Q4	Direction of Travel	
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4.3 Other indicators which provide context about the cohort of children in the child protection system.

Table 9

Indicator	Result 09/10	Stat N'bour 09/10	Target 10/11	Result Q1	Result Q2	Result Q3	Prov Q4 result
Children and young people with a child protection plan: number	511	n/a	n/a	595	703	790	1,022
Children and young people with a child protection plan: rate per 10,000	36.4	40.6	n/a	39.1	46.3	52	67.3

4.4 The number of children subject to a Child Protection Plan (CPP) has doubled during 2010-11, from 511 at the 09/10 year-end to 1,022 in March 2011, which has had a significant impact on the number of Initial Child Protection Conferences required. This is an exponential rate of increase seen over the previous three years (37% between 2007-08 and 2009-10), and reflects the improved safeguarding arrangements that were put in place as well as an increase in the underlying demand. The increase brought the proportion of Leeds children subject to a CPP into line with core cities and statistical neighbours, indicating that the CPP plan thresholds applied in Leeds are appropriate. There was also an accompanying increase in referrals and requests for service received which significantly exceeded the number received last year.

Table 10

C&YP from black minority ethnic (BME) groups

Indicator	Result 09/10	Stat N'bour 09/10	Target 10/11	Result Q1	Result Q2	Result Q3	Prov Q4 result
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Number of children with a child protection plan from BME groups	72 (14%)	n/a	n/a	85 (14%)	124 (17%)	146 (18%)	181 (18%)
Proportion of children with a child protection plan from BME groups	1:7.1	n/a	n/a	1:7	1:5.8	1:5.4	1:5.3
Number of Looked after Children from a BME group (exc UASC)	274 of 1362 (20.1%)	n/a	n/a	286 of 1381 (20.7%)	262 of 1357 (19.3%)	274 of 1375 (19.9%)	279 of 1392 (20.0%)

4.5 BME representation in the Leeds all age population - 16%

BME population on the roll of Leeds school - 21.4%

4.6 At 18%, the number of children and young people with a child protection plan is broadly in line with the general Leeds population but below the population of BME pupils on roll.

4.7 At 20.0%, the LAC population sits between the percentages for over all BME and school roll BME. As such, BME children and young people do not appear to be significantly over or under-represented in the LAC and child protection populations.

5 EFFECTIVENESS OF SAFEGUARDING ARRANGEMENTS FOR CHILDREN & YOUNG PEOPLE IN LEEDS

Evidence has been drawn from Performance Information on key safeguarding activity and also from external inspection.

5.1 Analysis of Performance Information for 2010/11

5.1.2 Although narrowly focused on child protection and 'looked after' processes, Performance Information for 2010/11 provides an overall picture of improvement against a backdrop of a persistent increase in demand for multi-agency child protection interventions. This is consistent with the positive outcome of the Ofsted unannounced inspection of contact, referral and assessment arrangements in January 2011.

5.1.3 There are concerns about the potential impact that increasing child protection pressures on partners might have on maintaining the improvements realised during the year.

5.1.4 The information indicates an improvement in performance of child protection processes over the year in the context of significant increases in demand for statutory interventions where C&YP are suffering, or at risk of suffering, significant harm. Nevertheless, further improvement is required in the timeliness of Initial Child Protection Conferences (ICPCs).

5.1.5 Despite the increasing number of referrals to CYPSC and the doubling in the number of C&YP subject to Child Protection Plans during the year, the number of LAC has remained relatively stable. Nevertheless, the number of LAC in Leeds remains at level significantly higher than that of statistical neighbours.

5.1.6 Whilst the use of the Common Assessment Framework (CAF) activity is increasing, the number initiated during the year remains small in comparison with the number of referrals received by CYSC. This is identified as an area for further investigation and for comparisons to be made with the performance of statistical neighbours.

5.2 Context

5.2.1 LSCB performance reporting for 2010/11 has focused on collating available data about three key safeguarding processes:

- The Child Protection System
- Care management processes for C&YP who are looked after
- Common Assessment Framework

5.2.2 It is acknowledged that this provides a partial picture, and one that is heavily reliant on information from one agency; CYPSC. Nevertheless it was agreed that this would provide the Board with a level of assurance about performance in these areas of activity.

5.3 Child Protection Processes

5.3.1 The accelerating increase in child protection activity across the partnership has continued throughout the year. Projections that the number of C&YP subject to child protection plans would double over the course of the year have proved to be accurate. At the end of March 2011 there were 1,022 C&YP subject to CP plans.

5.3.2 At the end of QTR 1 the rate per 10,000 of C&YP subject to plans (39.1) had increased to a level comparable with statistical neighbours (2009/10), indicating that work across the partnership to revise and establish consistent and appropriate thresholds has been having an impact on responses to C&YP who are suffering, or at risk of suffering, significant harm.

5.3.3 The rate per 10,000 has continued to increase through the remaining three quarters, resulting in a figure of 67.3 at year end.

5.3.4 This trend will need to be closely monitored in 2011/12 and comparisons made with statistical neighbours (2010/11) once that data becomes available.

5.3.5 There has been an increase over the year of the proportion of C&YP subject to CP plans from BME groups (14% at QTR 1 – 18% at QTR4) which indicates that previous concerns that this group may not have been receiving appropriate intervention when suffering, or at risk of suffering significant harm is being addressed. The current figure is slightly higher than the overall (all age) BME proportion in the general population (16%) but lower than the proportion of BME on school roll (21%).

5.3.6 There has been an increasing number of requests for service / referrals to CYPSC. The high number of C&YP subject to CP Plans and the increasing number of referrals to CYPSC (10,500 in 2009/10, 13,600 in 2010/11) indicates that attention needs to be given to ensuring the appropriateness, timeliness and effectiveness of multi agency preventative services; so that assurance can be given that C&YP receive 'the right services at the right time.'

5.3.7 The four CP Process indicators that have been monitored are:

- C&YP subject to a CP Plan who are not allocated a social worker
- ICPCs held within 15 days of the meeting to decide that a s(47) enquiry is required
- Initial assessments undertaken by CYPSC within 7 days of referral
- Core Assessments undertaken by CYPSC within 35 days of commencement.

5.3.8 The RAG ratings ascribed to these indicators show that performance has improved significantly over the year, with three 'reds' and one 'green' at QTR 1 being transformed into three 'greens' and one 'amber' at QTR 4. Given the context of the rapidly increasing demand for child protection interventions and services the improvements are impressive and worthy of note.

5.3.9 The LSCB has identified compliance with statutory timescales in convening Initial Child Protection Conferences (ICPCs) as an area requiring particular attention (RAG rated 'amber' at QTR 4). Whilst improvements have been made (from a low base of 13% at QTR1) performance (~56% at QTR 4) remains a concern when compared to statistical neighbours (70% in 2009/10). Nevertheless, the direction of travel is positive.

5.3.10 CYPSC has driven improvements in performance against this indicator through expanding the number of conference chairs. However, a potential barrier to maintaining and accelerating progress has been identified; the difficulties inherent in convening ICPCs during school holiday periods when many staff from across all partner agencies take leave.

5.4 Looked After Children (LAC) Processes

5.4.1 In 2010/11 the overall number of LAC has remained relatively stable (1440 at QTR 1 – 1444 at QTR 4), although this masks the amount of activity involved in receptions and discharges from care. At 95.1 per 10,000 children

this rate is significantly higher than that of statistical neighbours (averaging 69 per 10,000).

This represented a 1.4% increase on the previous year's rate per 10,000 of 93.7, or 21 more children or young people in care. While continuing to increase, the rate of increase has significantly slowed.

5.4.2 In reporting to the LSCB over the year, the Performance Management sub group has commented on the historically high number of C&YP who are looked after in Leeds and the consequences of this (budgetary, quality of services for both LAC and safeguarding services in general).

5.4.3 The three LAC Process indicators that have been monitored are:

- Stability of placements
- Reviews undertaken within statutory timescales
- C&YP participating in their reviews

5.4.4 All three indicators were ascribed 'amber' RAG ratings at QTR 1. Whilst 'direction of travel' indicators suggest that performance is overall being improved or maintained, at QTR 4 two were ascribed 'amber' ratings and one 'red' (the latter largely the result of the cumulative nature of the measure).

5.4.5 Children's Services and the Children's Trust Board have the reduction in the number of C&YP needing to be 'looked after' as one of their 3 highest priorities, or 'obsessions' and work is underway in key areas:

- Agreeing and starting to implement an 'Obsession' action plan.
- Piloting early intervention strategies and new methodologies for partnership working.
- Developing a consistent approach across localities based on the use of an outcomes based accountability approach.
- Learning from the best, including visits to other successful areas to learn more about how the 'team around the child' approach is working.

5.5 Common Assessment Framework processes

5.5.1 The performance sub group received an interim report on CAF activity at QTR 2. This provided cumulative figures and it was acknowledged that a refinement of performance measures would be required if a more sophisticated assessment of the effectiveness of CAF processes was to be provided in the future.

5.5.2 A report to the Children's Trust Board in April provided a more detailed collation of CAF activity for the first 11 months of 2010/11 indicating approximately a 15% rise in CAFs initiated and approximately 38% increase in CAFs completed on the previous year. Whilst the direction of travel indicated is positive, the absolute numbers involved are small (projected 1098 initiated for the full 12 months) and particularly when compared with the number of referrals received by CYPSC (13,600) over the same period.

5.5.3 The performance sub group has raised concerns about the apparently low level of CAF activity across the City and the need for this to be explored in some detail given the rapidly rising number of C&YP subject to Child Protection Plans and the (also rising) number of referrals to CYPSC.

5.6 Action taken to improve performance

5.6.1 All partner agencies have been requested to review, and where necessary, revise their arrangements to ensure attendance / input throughout the year to enable ICPCs to be scheduled within statutory timescales.

5.6.2 The Children & Young People's Plan 2011-15 includes addressing the number of LAC as an 'obsession'. Monitoring performance in this area will be a component of the LSCB Performance Management System for the same period.

5.6.3 Work is being undertaken to review the level of CAF activity and establish comparisons with statistical neighbours. A research project examining multi-agency responses to children on the threshold of intervention has also been commissioned.

5.7 Performance Reporting process issues

5.7.1 LSCB performance reporting in 2010/11, although a significant improvement on previous years, has been narrow in focus. Nevertheless, the two key areas considered, child protection and LAC processes, are central to the core business of the LSCB and coincide with one of the strategic priorities in the CYPP; that C&YP are safe from harm. The inclusion of CAF activity seeks to provide a broader 'whole safeguarding system' flavour, which has highlighted the need to collate and analyse performance information about preventative responses to vulnerable C&YP.

5.7.2 Work has continued in parallel with reporting for 2010/11 to develop and agree a more comprehensive Performance Management System for implementation during 2011/12. This includes both quantitative and qualitative measures to be presented using 'score cards.' An 'Outcomes Based Accountability' approach is being adopted to driving forward improvements with the child / young person's journey through the 'safeguarding system' as a central focus.

5.7.3 An outline of the proposed system was approved by the LSCB on 23.05.11, with a complete format to be presented on 15.07.11. Key performance areas have been agreed that are consistent with the Children and Young People's Plan (2011-14), the LSCB Strategic Plan (2011-15) and the Business Plan (2010/11) which were approved by the LSCB on 23.05.11.

5.8 Performance Summary

5.8.1 Overall performance in key safeguarding processes has improved during 2010/11 despite significantly increasing demand for services.

5.8.2 The need for further improvements are identified in the following areas:

- The timeliness of ICPCS
- Reducing the number of children and young people who need to be 'looked after'
- Multi-agency working to enhance preventative services for C&YP and to ensure that CAF is used appropriately

5.8.3 The proposals for a revised Performance Information system need to contain an appropriate balance between quantitative, qualitative and outcomes data

5.9 External Inspection

5.9.1 In January 2011 Ofsted conducted an unannounced inspection of contact, referral and assessment arrangements within Leeds City Council Children's Services. The inspectors sampled the quality and effectiveness of these processes and their impact on minimising any child abuse and neglect.

5.9.2 The Report on this inspection noted that the areas of priority action identified at the previous inspection of contact, referral and assessment arrangements in July 2009 has been addressed. The areas of development identified at the previous inspection had been mostly met with firm arrangements in place to deliver on the remaining issues.'

5.9.3 The inspectors noted 'a remarkable and impressive improvement in the quality of services inspected and the safety of children in the City.' The inspectors did not identify any cases where children had been left at risk and were satisfied that the quality of contact, referral and assessment processes now meet statutory guidance.

5.9.4 This objective inspection work, using evidence from the experience of children and young people and their families, supports the progress noted in the Performance Information described and analysed at sections 4 and 5 of this Report.

5.10 Section 11 'Duty to Safeguard' Compliance.

5.10.1 Section 11 of the Children Act 2004 places a duty on local agencies that have contact with children to ensure that their Safeguarding responsibilities are discharged effectively. This also applies to services that are contracted out. The application of this duty will vary depending on the role of each agency.

5.10.2 The LSCB, in accordance with its role of ensuring that constituent

agencies are meeting the Safeguarding requirements placed upon them received the results of the annual s(11) self assessment audit in January 2011. In February 2010 feedback was given to all agencies that participated, and a request was made to address areas identified for improvement.

5.10.3 Twenty-one partner agencies were asked to take part and submit complete information in response to an audit tool devised locally for this purpose.

5.10.4 The audit identified that there is continuing improved compliance across the partnership. For example:

- Service plans more consistently consider how the delivery of services will take account of the need to safeguard and promote the welfare of children.
- Safer recruitment processes are in place across those organisations completing the audit.
- Staff know how and when to share information (in a way that is legal and ethical) in order to safeguard and protect children.

5.10.5 The audit identified common areas for improvement and areas of non-compliance for specific agencies; for example,

- Understanding of when to carry out a common assessment.
- Children being made aware of their right to be safe from abuse.

5.10.6 Continuing challenges in the engagement of partner agencies in the self-evaluation process are also identified, for example;

- Outstanding returns from a small number of agencies
- Lack of senior manager sign off
- Inconsistent use of the audit tool

5.11 Serious Case Reviews and Learning Lesson Reviews

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

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

5.11.2 *Activity in Leeds during 2010/11.*

- There were no new SCRs initiated in this period.
- Three SCRs were completed in this period; know as Child S - July 2010, Child U -Oct 2010 and Child K in November 2010.
- Two SCR evaluations were received from Ofsted; Child N (July 2010) rated as 'Good' and Child S (Dec 2010) rated as 'Good'. The evaluation for Child U is subject to discussion with Ofsted.
- The Executive Summary for Child N was uploaded onto the LSCB website in Dec 2010.

5.11.3 *Progress on implementing Actions from individual SCRs:*

5.11.4 Each SCR action plan remains a dynamic document and the Performance Management Sub Group takes responsibility for monitoring the action plan and receives regular updates on progress in implementing the actions.

5.11.5 The LSCB has developed a composite database, which contains the Action Plans for each of the SCRs undertaken in the past 3 years. All of the SCRs and the Actions for completion from each one are visible on one screen. As well as detailing each action the spreadsheet also details who the responsible agency is, the completion date, progress and a link to a zip file containing an e-copy of evidence from the responsible agency that confirms that the action has been implemented. A traffic light system, (a RAG rating system), is used to clearly highlight the progress of each action.

5.11.6 *Progress on completing individual actions plans.*

5.11.7 The implementation of the Action Plans from three SCRs completed in 2009-10, known as M, L and J has been fully completed and evidenced.

5.11.8 Action Plans from 5 further reviews remain to be fully completed and the LSCB retains close oversight of how these are being progressed.

5.11.9 The SCR regarding child N was completed in September 2009 with 2 of the 10 actions remaining to be fully completed. Both have been actioned by the relevant agency and are awaiting an evaluation by the LSCB Policy and Procedures and Performance Management Sub-groups.

5.11.10 The SCR regarding child K was completed in November 2010. This was a complex case involving the management of a known offender and the recommendations were addressed to both local and national bodies. The majority of the 15 actions have been completed with a small number that remain ongoing.

5.11.11 The SCR regarding child R was completed in October 2009. Of the 11

actions all have been completed except 2, which are on track to be completed within the timescales originally identified.

5.11.12 The SCR regarding child S was completed in June 2010. The majority of the 13 actions have already been completed and although the specific completion date for a small number of the key actions has not been met, this situation is being followed up to ensure the outstanding actions are completed as soon as possible.

5.11.13 The SCR regarding children U1, 2 and 3 was completed in October 2010. The majority of the 15 actions have already been completed and there is clear and timely progress being made on those that are outstanding. None has yet exceeded set the timescales that were originally set.

5.11.14 Two Learning Lessons Reviews were instigated in the time period using Root Cause Analysis Methodology:

- Child 4 commenced in Sept 2010 and the review was carried out in November 2010.
- Child 5 commenced Nov 2010 and work on recommendations and the action plan is ongoing.

5.11.15 Themes arising in SCR action plans have provided impetus to service improvements eg in:

- Supervision for staff working with children
- Record keeping or case file recording, specifically around recording multi-agency communication, information sharing and the views/wishes of children and young people
- Assessment processes
- Engagement of fathers in safeguarding/child protection procedures

5.11.16 In relation to these themes and other learning the key question of 'what difference has this made?' is being addressed through the development of a specific aspect of the LSCB Audit Programme for 2011-12, which will commission themed audits linked to SCR action plans.

5.11.17 The multi-agency SCR process and tool kit has been updated in line with changes to Working Together 2010, and work is ongoing to improve the response of the partnership to serious child care incidents as they occur.

5.11.18 A City wide workshop was held in February 2011 to disseminate lessons from two recently completed SCRs. Interest amongst practitioners and managers from across the partnership was high with 160 attending this session and 180 a repeat event in June 2011

5.12 Quality assurance of Safeguarding Services

5.12.1 As part of the Business Plan 2010/11, the Safeguarding Board developed an interim Performance and Quality Assurance System. It was recognised at the time that this would be an approach prior to the establishment of more comprehensive Performance Management and Quality Assurance System, as part of the revised strategic plan for 2011-15. The PCT seconded an officer for four months, part time, to support the development of part of this work.

5.12.2 The plan identified four sources of information from which to develop a picture of safeguarding activity and through which improvements could be driven:

- *5.12.3 Key Information based on a basket of National Performance Indicators* - This is reported separately in this report. Extensive work has been undertaken to develop a comprehensive Performance Management System for 2011/12.

- *5.12.4 'Section 11' Compliance* - LSCB partners complete the Section 11 self - assessment tool annually. This is reported on separately in this report.

There is a recognition that the LSCB needs to sample audit the self -assessment information provided by partners. A pilot process has been developed focusing on the West Yorkshire Consortium Standards for Safer Recruitment. This audit is described in more detail separately in this report.

- *5.12.5 Review of Serious Case Review Action Plans* - The purpose of this element is to undertake sample audits of the impact of the implementation of improvements identified through recent SCRs. A series of themed sample audits are being developed to evaluate these areas of improvement and will be a priority as part of the Business Plan for 2011/12. The tools developed will take note of audits, review and evaluations undertaken by LSCB partners as part of SCR recommendations and will not repeat work already in place.

- *5.12.6 Single Agency Audit Register* - LSCB partners were asked to share evidence of organisational audits that provide evidence of quality led safeguarding children services. This register is now in place and will be regularly updated. The Register shows that there is considerable audit activity underway across the LSCB partnership.

- *5.12.7* As part of the development of this work the LSCB plans to undertake audits which will evaluate partner commitment to:
 - Ensuring all staff working with children have access to appropriate supervision
 - Improving the quality of referrals/request for social care services
 - Improving case file documentation.

5.12.8 Quality assurance and audit work undertaken by the LSCB is in its infancy, as other priorities have been the focus for the work of the Board in 2010/11. But the importance of this aspect of the LSCBs role is recognised

and reflected in the business planning for 2011/12. This includes the active engagement of children and young people in the audit and evaluation of safeguarding performance and a commitment to drive improvements in services based on an understanding of the impact on outcomes for children and young people.

5.13 Managing Allegations against Professionals

5.13.1 Dealing with allegations made against professionals is the role of individual employing agencies. However, the Local Authority is required to provide a co-ordinating role through the provision of a Local Authority Designated Officer, or 'LADO'. Individual agencies are required to notify the LADO of any allegations made.

5.13.2 The role of the LADO is to provide advice and guidance to employers and voluntary organisations, to liaise with the police and other agencies and to monitor the progress of cases to ensure that they are dealt with as quickly as possible consistent with a thorough and fair process.

5.13.3 Until 31 October 2010, the LADO role in Leeds was undertaken by a Service Delivery Manager in the Safeguarding and Reviewing Section of Leeds CYPSC along with other duties. There is now a dedicated LADO post, which will be located in the Integrated Safeguarding Unit of Children's Services and funding has been agreed for a second dedicated LADO post. This is relevant because the role and the ability to report detailed information is still being developed so, although there is more comparative data available for this Annual Report, plans are now being implemented to provide greater detail and a deeper level of analysis of activity in order to use this information to improve safeguarding practices.

5.13.4 There were 249 referrals to the LADO in this current year. In 2006/7, there were 63 referrals, 80 in 2007/8, 119 in 2008/9, 126 in 2009/10. This increase can be explained in part by changes to the role of LADO, becoming more embedded in professional practice amongst all agencies, and also by the way in which information was presented in previous years. This current year is the first in which there has been a breakdown of referrals to include the proportion of those that resulted in formal strategy meetings. Projections for activity in the first part of the current year suggest the total may head towards 400 referrals for 2011/12.

Employer	Referrals	Physical	Sexual	Emotional	Neglect	Strategy Meetings
Social Care	33	25	8			28
Health	8	5	3			3
Education	103	76	27			45
Foster Care	32	25	3	4		26
Early Years	13	12		1		2
Police	1	1				
YOS						
Probation						
CAFCASS	1	1				1

Secure Estate	15	15			
NSPCC					
Voluntary Youth Organisations	19	14	5		14
Faith Groups	6	3	3		2
Private Nurseries	7	5		2	3
Child Minders	7	5	1	1	
Immigration/Asylum					
Other	4	1	3		2
Totals	249	188	51	8	126

Social Care - Leeds City Council residential care officers and social workers, including staff based at Eastmoor Secure Unit and agency staff

Foster Care - Foster carers living in Leeds, approved by local authority or voluntary agency

Education - All school based staff (teachers, non teaching assistants, ancillary staff) or those who work for education authority (attendance strategy, for example)

Secure Estate - Prison officers at Wetherby YO1

Voluntary Youth Organisations - Predominantly residential care officers in voluntary sector residential provision

5.13.5 The majority of referrals (76%) concerned physical abuse, which is an increase in proportion from previous years (67% in 2008). 20% concerned sexual abuse. These categories cover a broad range of situations, for example there could be two referrals leading to strategy meetings, both labeled physical abuse, one could be about a toddler in foster care sustaining a serious unexplained injury, the other about a teacher and a teenager having a scuffle in a classroom over a mobile phone.

5.13.6 Sixty three of the referrals to the LADO led to Police investigations, which resulted in charges being made in two cases and a caution being issued in one case. Not all of those Police investigations for the period have been concluded, so it may be that number will rise. These figures are very low but are similar to previous years and reflect the evidential difficulties in allegations made by children where there is no corroborating information.

5.13.7 The data for this reporting year did not specifically record allegations made by Looked After Children or Children subject to Child Protection Plans.

5.13.8 Challenges for the future development of the LADO role are;

- Identifying outcomes for C&YP who make allegations.
- Using the information and analysis to improve safer recruitment and working practices.
- Ensuring robust scrutiny of decision making by the LADO.
- Developing an increased awareness of the LADO role amongst partners
- The contribution made to making Leeds a safer city

5.13.9 The improvements that are required to provide a more accurate and comprehensive analysis of trends and activity for future years will be a priority for this role.

5.14 Safer Recruitment Practices.

5.14.1 Between January and March 2011 The LSCB undertook an audit of four partnership agencies. This was a follow up to the self-assessment provided in the Section 11 Audit process, described earlier in this report.

5.14.2 The audit purpose was:

- To identify a process to supplement the current self-reporting approach to Section 11 requirements.
- To audit with 4 agencies the implementation of the West Yorkshire Consortium Safe Recruitment, Selection and Supervision of Staff standards

5.14.3 The methodology used was an audit tool consisting of 26 questions based on the West Yorkshire Standards for Safer Recruitment. This was circulated to participating agencies prior to the auditors' visit, who then viewed evidence of standards being met. One example of this was reviewing the standard for job descriptions against a sample of job descriptions used by each agency.

5.14.4 The four agencies were chosen based on their self-assessment of safer recruitment standards and their size, in order to give a fair representation of the LSCB partnership. The agencies ranged from those reporting to be 100% compliant to those who had identified areas for improvement. On agreeing to be part of the audit, the agencies were told all specific responses would be confidential and that trends and learning would be shared with the LSCB Performance Management sub group. All the agencies were given feedback and ways to improve were suggested, if required.

5.14.5 The findings confirmed that all four agencies were compliant with the West Yorkshire Safer Recruitment Standards. However, it also provided learning for the LSCB in relation to the future development of the Section 11 self audit process and specific issues identified are to be included in a supplement to the standard audit tool for 2011/12.

5.15 Safeguarding in Schools.

5.15.1 As part of the Ofsted Inspection process, schools have to demonstrate that children are proactively and reactively safeguarded and that they feel safe. In 2010/11, 75 schools were inspected with 55 (73%) evaluated as 'good or better' and 20 (27%) evaluated as satisfactory.

5.16 Complaints

5.16.1 Complaints received about services for C&YP can also contribute to our understanding of the effectiveness of safeguarding arrangements and activity in Leeds.

5.16.2 The following information about complaints is drawn from all complaints dealt with by Children's Services. This service is in the process of developing relevant performance information.

5.16.3 In 2010/11 there were 20 complaints made relating to Safeguarding. Of these two have progressed to Stage 2.

5.16.4 The abiding themes relating to safeguarding relate to service responses to allegations made about the abuse / neglect of children and young people. Common assertions were that the investigation had been unfair or was not sufficiently robust.

5.16.5 The following proportion of complaints relating to Safeguarding Services were upheld:

Upheld	5%
Partially Upheld	20%
Not Upheld	60%
Inconclusive	5%
Ongoing	10%

5.16.6 The main remedies were to provide a written apology for errors occurring, ensuring that records on the child's file are accurate and to ensure that staff who may have acted inappropriately or failed to act are provided with training to ensure there is no repetition.

5.16.7 No major cross-service learning opportunities were identified from the complaints investigated in 2010/11.

5.17 Inspections of Local Authority Children's Homes

5.17.1 Children and Young People in residential care are among the most vulnerable groups of young people. The need for high quality Safeguarding Services in this environment is very important. Ofsted inspects these units and their Safeguarding practice is evaluated. The following provides a summary of the outcome of these inspections in Leeds for the year 2010/11:

- Eight homes were evaluated as 'good.'

- Five homes were evaluated as 'satisfactory.'
- Currently there are no Local Authority Children Homes that have an overall rating of 'inadequate'.

5.17.2 This is overall a positive picture, suggesting a solid base from which improvements can be made in 2011/12.

5.18 Private Fostering

5.18.1 Working Together to Safeguard Children 2010 sets out a policy and procedural function for the LSCB in relation to private fostering. The LSCB role includes monitoring and quality assurance, and to ensure that public awareness is raised about private fostering.

5.18.2 It is the duty of local authorities to promote public awareness of the requirement for those considering undertaking private fostering arrangements to notify the local authority. The local authority has a duty to satisfy themselves that the welfare of children or young people who may be privately fostered within their area will be satisfactorily safeguarded and promoted.

5.18.3 In Leeds at the start of the year there were 12 children who were subject to private fostering arrangements. At the end of the year this had reduced to 8. These low figures are typical of the national picture. It is likely the actual figures are higher, hence the need for public awareness raising activities.

5.18.4 The arrangements for delivery of the private fostering service and the assessment of private foster carers is completed by area social work staff by undertaking of a core assessment and support and supervision of the child whilst in placement. The Kinship Care Fostering team are responsible for providing support and advice to private foster carers.

5.18.5 The current service has a number of strengths;

- There is an identified fostering officer with lead responsibility for private fostering who will be responsible, alongside the manager, for driving forward the momentum for meeting minimum standards and working to raise the awareness of private fostering in the community and with other child care professionals
- There are established links with the CYPSC Contact Centre to deal with general queries on potential private fostering arrangements
- Private foster carers receive advice and support from a fostering officer and can access relevant training available to mainstream foster carers

5.18.6 In January 2011 CYPSC commissioned an external review of the Private Fostering Service in Leeds. The review process followed standard Ofsted methodology utilising the framework of the national minimum standards for private fostering. A sample audit of carer files and children's case records was completed, together with an analysis of key documentation including the statement of purpose. Interviews were also conducted with the lead manager and social worker within the fostering service. The findings were that overall, whilst some limited progress has been made since the last Ofsted inspection in July 2008, further improvements are required.

5.18.7 The service has produced an action plan to address the recommendations arising from the audit and a number of the recommendations have already been carried out. How the service is delivered has been strengthened, a Communications Strategy has been produced and the Private Fostering Statement of Purpose has been updated.

6. ASSESSMENT OF THE EXTENT TO WHICH LSCB FUNCTIONS ARE BEING EFFECTIVELY DISCHARGED.

6.1 Development of Effective Multi - Agency Procedures

6.1.1 Leeds is part of a consortium of five West Yorkshire local authorities that contracts with a specialist company to produce the agreed Inter-Agency Safeguarding Procedures. During the course of the year Leeds has supported this arrangement and contributed to updates, which are undertaken on a six monthly basis.

6.2 Assessment of single and multi agency safeguarding training:

6.2.1 The importance of the role of the LSCB in multi agency child protection training was highlighted in the Children's Services Improvement Plan and has been a high priority on the LSCB work plan as a result.

6.2.2 In May 2010 a revised and restructured multi-agency core child protection programme was piloted, with Level 2 training co-ordinated by the LSCB and delivered through a pool of partner agency trainers. Following an initial review and slight amendment, the full programme was delivered from September.

6.2.3 In May 2011 the Learning & Development sub group received the draft Annual Training Review which details the impact of requiring partners to deliver Level 1 training 'in house' and a 33% increase in places taken up for Level 2 events. The emerging Training Needs Analysis currently being completed by partners for 2011/12 indicates that the number of staff waiting for training places has been reduced significantly.

6.2.4 Evaluations completed on the day of a course continue to indicate that the quality of the training is good and that participants are more than satisfied with the delivery. Evaluations undertaken three months after completion of the course show some impact on practice, however this is a pilot process and further work needs to be done to ensure that we are asking the right questions.

6.2.5 Work to consider the best way to manage the overall Children's Services workforce development programme is underway and the LSCB is represented on the CTB Workforce sub group. In addition discussions about the best way to ensure the learning and development capacity of the Children Services Integrated Safeguarding Unit (ISU) is sufficient to support both strong workforce development and the use of evidence informed practice are planned for the second phase of restructuring the ISU.

6.3 Lessons about preventing child deaths (CDOP)

6.3.1 The Leeds Child Death Overview Panel (CDOP) was established from 1st April 2008 under guidance issued in Chapter 7 of Working Together to Safeguard Children 2006. The aim of the CDOP, (as required by the Local Safeguarding Children Boards Regulations 2006) is to undertake a comprehensive and multidisciplinary review of all deaths of children normally resident in Leeds aged under 18 years, in order to understand better how and why they die, and to use the findings to take action to prevent other deaths and improve the health, wellbeing and safety of children and young people.

The Leeds CDOP Process

6.3.2 Under statutory national guidance, Leeds has both a Sudden Unexpected Death in Childhood (SUDIC) process, and a Child Death Overview Panel (CDOP) process. The two are separate processes, but are closely linked.

6.3.3 The SUDIC process involves early notification of the unexpected death of a child, and a prompt process of investigation, led by the SUDIC Paediatrician. This may involve discussion with clinicians at the hospital, Police, Social Care and others. Sometimes a visit to the place of death is undertaken. A meeting is held with professionals involved with the child, to learn lessons. A report into the circumstances of the child's death is produced, which is shared with the Coroner, and with the CDOP.

6.3.4 The CDOP considers the death of each child, and is required to complete a national proforma regarding its findings for each child. The proforma includes factors relating to the child and family, and service provision; categorization of the cause of death; a judgment regarding preventability of the death; learning points and recommendations; immediate follow up actions for the family; and whether the case should be referred to the LSCB Chair for consideration of a Serious Case Review. In addition, during the past year, the Leeds CDOP has piloted a West Yorkshire form to

collect specific information about preventable factors from a public health perspective.

6.3.5 There have been challenges in the running of the Panels over the past year, some of which are reflected in Panel minutes and recommendations. There have been delays in receiving completed Agency Report Forms from various agencies, and these issues have been addressed by direct liaison with those agencies at the time. Certain specialist reports, such as fire investigations and road traffic accident reports, have not been provided to the CDOP routinely, and again arrangements to obtain these for future have been made as each issue arose. By agreement with the Coroner, cases are not considered by the CDOP until the inquest is complete.

6.3.6 The LSCB has a role in ensuring these arrangements work effectively, including how they link with the Serious Case Review Process. One of the objectives in the LSCB Strategic Plan 2011-15 is to review how SUDIC processes and CDOP work.

<u>Notifications and CDOP Activity (April 2008 to End December 2010)</u>									
<u>Year</u>	<u>Notifications to CDOP Administrator</u>			<u>Number of cases reviewed by CDOP</u>			<u>Number of cases outstanding for CDOP review</u>		
	Neo-natal	Older child	Total	Neo-natal	Older child	Total	Neo-natal	Older child	Total
2008-9	25	36	61	24	28	52	1	8	9
2009-10	28	42	70	10	8	18	18	34	52
2010 to end Dec	15	24	39	0	0	0			

6.3.7 A detailed analysis of these figures is contained in the full CDOP Annual Report provided as appendix 1 to this Report.

6.3.8 Progress made on the implementation of the work programme for younger (neonatal) children for 2010/11

6.3.9 The Consultant Obstetrician representatives on the Panel have ensured that a system is established for identifying women who have a pre-term delivery in order to offer a postnatal review and ensure early planning in the next pregnancy.

6.3.10 LTHT providers and NHS Leeds commissioners acknowledge the importance of centralisation of neonatal and obstetric services on the same site as children's services and are giving the matter strategic consideration

6.3.11 The Consultant Obstetrician representatives on the Panel have undertaken an audit of the risk factors and outcomes in twin pregnancies across Leeds Teaching Hospitals NHS trust. The findings have been presented within the Directorate. Specific changes to practice have been made with regard to mid-trimester screening for infection in African women with twin pregnancies, and consideration of cervical screening where appropriate.

6.3.12 The Consultant Obstetrician representatives on the Panel have reviewed and re-written guidelines for assisted conception. Specific changes to practice have been made with regard to growth scans during pregnancy. An audit of the outcomes of IVF pregnancies is also being undertaken.

6.3.13 Work programme for younger (neonatal) children 2011/12

6.3.14 Proposals from the Neonatal Death Overview Panel have been accepted for work to be undertaken in the following areas:

6.3.15 Obstetricians and Neonatologists at LTHT should work together to clarify definitions of the PROM acronym and ensure common understanding and usage (completed)

6.3.16 Obstetricians at LTHT to audit two specific cases in order to review the risk assessment process and care plan (completed).

6.3.17 The Chair of CDOP should review the Panel processes in order to reduce the time taken between the death of the baby, and consideration at Panel. Ideally this should be reduced to 3 months. (Timescale: April 2011)

6.3.18 The Head of Midwifery at LTHT should ensure an audit is undertaken, to explore outcomes and satisfaction of BME women looked after by the team of BME midwives. (Timescale: December 2011)

6.3.19 The Director of Public Health at NHS Leeds and Leeds City Council, and the Head of Midwifery at LTHT should ensure that programmes of work directed at reducing smoking by women during pregnancy are continued and outcomes are monitored. (Ongoing)

6.3.20 Progress made on the implementation of the work programme for older children for 2010/11

6.3.21 There is an ongoing programme of public health work to reduce smoking during pregnancy. Data collection regarding smoking during pregnancy has been improved, with ascertainment now over 95%. The latest data indicate that the current level of smoking during pregnancy in Leeds is 13%, which is better than the national target (15%). All Leeds midwives have received mandatory training, and referrals are made to the Leeds Smoking Cessation Service. Not all women take up the offer of an appointment, but for those who do, success rates in the Leeds service compare favourably with other parts of the country. Leeds has an active Smoke Free Homes

programme, which promotes the importance of parents keeping smoke away from children.

6.3.22 Advice to all parents regarding smoking and co-sleeping is given by health visitors in accordance with the local clinical policy. This policy has been reviewed to ensure consistency of advice.

6.3.23 The CDOP has now considered 3 deaths of young people resulting from road traffic injuries. During 2009-10, the Director of Public Health at NHS Leeds was able to identify an amount of one-off funding (£18k) for Smartrisk UK. This funding was used to fund the HEROES show over a 2 week period in 8 targeted secondary schools, reaching around 600 pupils per school (4800 pupils total). The organization of the events was undertaken by Leeds Road Safety Unit. The HEROES show is an interactive sound and light show featuring an "injury survivor", frequently a young adult with paralysis as a result of an accident. The injury survivor describes their own experience and answers questions from the audience. The sound and light show then highlights the key Smartrisk messages, including: Buckle Up; Get Trained; Wear the Gear; Drive Sober; Look First. In previous years, similar shows have taken place in Leeds funded by the Strategic Health Authority, and one-off funding by the Primary Care Trust. SHA funding has now ceased, and Smartrisk UK currently has no funding to enable it to deliver further interventions in Leeds.

6.3.24 The Chief Executive of LTHT has ensured that strategic plans in the city to develop a Paediatric Assessment Unit are being progressed.

6.3.25 The quality of ethnicity and consanguinity information collected via the CDOP process is much improved, with almost 100% ascertainment of these fields in completed proformas.

6.3.26 Work programme for older children 2011/12

6.3.27 Proposals from the Older Children Death Overview Panel have been accepted for work to be undertaken in the following areas:

6.3.28 The Director of Public Health at NHS Leeds and Leeds City Council should continue to progress work to reduce smoking during pregnancy and smoking by parents with young families. (Timescale: March 2012)

6.3.29 Director of Public Health at NHS Leeds and Leeds City Council should initiate social marketing work to ensure that co-sleeping messages are disseminated widely and appropriately to target populations. (Timescale: March 2012)

6.3.30 Director of Public Health at NHS Leeds and Leeds City Council should take forward work to raise awareness of the relationship between cousin marriage and genetic disorders, and ensure that appropriate genetic services are commissioned to respond to this need. (Timescale: March 2012)

6.3.31 The relevant Clinical Leads at Leeds Community Healthcare, Leeds Teaching Hospitals NHS Trust and Martin House Hospice should put in place a common agreement / guideline regarding the arrangements for End of Life Plans for children. (Timescale: September 2011)

6.3.32 Director of Commissioning at NHS Leeds should ensure that the Children and Maternity Commissioning Team at NHS Leeds, and subsequently GP Consortia, are aware of the high quality service available to the children of Leeds from Martin House Hospice in the context of current funding arrangements. (Timescale: May 2011)

6.3.33 The Chair of CDOP should write to Leeds Continuing Care Case Manager and the manager of Leeds Children's Continuing Care Nursing Team to commend the quality of care provided by these services. (Complete)

6.3.34 The Director of Public Health at NHS Leeds and Leeds City Council, in collaboration with the Health Protection Agency and Early Years Services at Leeds Local Authority, should ensure that materials to raise awareness of Cytomegalovirus and how to reduce risk of transmission, are developed and disseminated through Children's Centres. (Complete)

6.3.35 The Director of Children's Services, the Chair of LSCB and the Joint Director of Public Health at Leeds Local Authority and NHS Leeds should give consideration to strategic support for Smartrisk UK, which is an organization located in Leeds which draws upon the Canadian Smartrisk approach to reduce the risk of accidents among teenagers and young adults. (Timescale: 2011/12)

6.3.36 The Children's Centre Safeguarding Manager at Leeds City Council should liaise with West Yorkshire Fire Service to clarify the nature of existing services for checking fire safety and installing alarms in homes with young children, and to explore options for publicizing these services via Children's Centres. (Timescale: September 2011)

6.4 Progress on priority issues / groups of Children and Young People

6.4.1 During the course of the year the LSCB has continued its role in monitoring and co-ordinating activity and supporting continuous improvement in work with those groups of children and young people that are seen as particularly vulnerable. These are identified as: those involved in 'front door processes' (requests for service, referrals responses and actions); those subject to a Child Protection Plan; and those who are 'Looked After'.

6.4.2 The LSCB is mindful of the need to broaden this approach to other vulnerable groups in 2011/12.

6.5 Work of the LSCB – Actioning the Business Plan (2010/11)

6.5.1 The LSCB functions, contained in national guidance are translated into local Strategic and Business Planning documents.

6.5.2 The Ofsted Inspection in 2009 found partnership working to be 'adequate' and the LSCB viewed as ensuring a strong commitment by all agencies (including the Third and Independent Sectors) to the broad safeguarding agenda. However, it was judged that the LSCB was not providing effective community and professional leadership and was not providing sufficient challenge across the partnership to ensure child protection practice was safe and effective.

Two specific actions were required of the LSCB:

- To strengthen arrangements for the LSCB to provide challenge and monitoring of safeguarding across the partnership in order that more rapid progress be made in the delivery of robust safeguarding services.
- To improve access to staff across the partnership to multi agency child protection training delivered by the LSCB in order that they are well informed and understand their roles and responsibilities

6.5.3 At the LSCB Annual Review in July 2010 it was concluded that business planning processes and formats should be revised for 2010-11 to better facilitate the development of a more strategic and focused approach to promoting improved safeguarding outcomes for children and young people in Leeds.

6.5.4 Consequently a further Business Plan was agreed to cover the period October 2010 - March 2011 and consultation and development workshops were held to develop the new Strategy.

6.5.5 The LSCB identified the following strategic objectives for 2010/11. Progress is noted for each objective as follows (see appendix 2):

6.5.6 Leadership, Focus and Challenge

6.5.7 Focusing on its core business of protecting children and young people from harm, the Board contributed to the new Children and Young People Plan (2011-15) and developed its own Strategic Plan for the same period. The Policy & Procedure sub group considered and commented on revised thresholds for statutory intervention and an audit of their application is included in the work of the Performance Management sub group for 2011/12.

6.5.8 A number of themed sessions were held for board members to contribute to planning key aspects of the work and to ensure that partners were engaged in developing a more strategic focus for the Board. Work to hold partners to account for safeguarding practice continued through the annual Children Act 2004 s(11) 'duty to safeguard' self audit and Serious

Case Review processes were revised. The development of Local Learning Lessons Reviews will include training to use the SCIE methodology in 2011/12.

6.5.9 Communication

6.5.10 The LSCB has approved the establishment of a Communications Task group which will lead on developing proactive and reactive communication systems, participation by families, children and young people, and community engagement.

6.5.11 Increased capacity in the LSCB Business Support Team will enable communication of key safeguarding messages across both the professional and wider communities and the engagement of children and young people in the work of the Board. The LSCB website will be redesigned in 2011/12. This will strengthen the LSCB's ability to deliver effective Professional and Community leadership.

6.5.12 Performance Management & Quality Assurance

6.5.13 Using an interim framework focusing on child protection and 'looked after' children processes, regular performance reports have been provided to the Board. This has given assurance that overall performance in these areas is improving and has identified where further improvements are required. Partners are reviewing and revising their safeguarding arrangements as appropriate in the light of this.

6.5.14 A sample audit with a small number of partners focusing on 'safer recruitment practices' has identified issues that all partners are being asked to consider as a supplement to the 2011/12 Children Act s(11) 'duty to safeguard' self evaluation audit. This experience will help us to develop the more comprehensive LSCB multi agency audit programme that is planned for 2011/12.

6.5.15 The conclusion of a 2 year LSCB participation programme with children and young people identified safeguarding issues of concern and highlighted the need for a more focused approach in 2011/12. The annual governance review is considering the appointment of lay members to the Board

6.5.16 Championing basic good practice in safeguarding for vulnerable groups

6.5.17 Input into the Children and Young people's Plan 2011-15 contributed to identifying which groups of vulnerable children and young people should be priorities for 2011/12. Safeguarding standards for commissioning have been produced and briefings for commissioners have commenced.

6.5.18 Work has commenced to develop multi agency practice standards.

This will be progressed and the standards communicated to practitioners across the partnership in 2011/12. A Comprehensive Performance Management System, using the same methodology as the CTB (Outcomes Based Accountability) was approved by the LSCB in January 2011. The system will provide a framework for all of the Board's performance management, quality assurance and audit activity. It will underpin the Board's ability to provide effective challenge. The populated framework will be available to provide regular reports to the LSCB from Quarter 1 in 2011/12.

6.5.19 Governance and organisational development

6.5.20 The recommendations from the review of the LSCB received in January 2010 were implemented in April. This resulted in a new sub group structure and revised membership. Responding to the plans being progressed by Children's Services for new and enhanced locality working arrangements, the Area Safeguarding Children Groups have been brought to a close. The LSCB Business Plan 2011/12 includes objectives to engage effectively with the new cluster groupings.

6.5.21 Phase 1 of the establishment of an Integrated Safeguarding Unit has been completed with the inclusion of former Education Leeds staff. Work has been undertaken in 2010/11 to address the LSCB's ongoing capacity issues, a new staff structure has been agreed, a revised funding formula accepted and a new budget set. The LSCB Business Unit will be co-located and jointly managed alongside the new Integrated Safeguarding Unit by the Children's Services Head of Safeguarding. Appointments to the new structure are now underway and interim arrangements are in place.

6.5.22 Workforce Development

Links have been established with the Children's Trust Workforce Development sub group that have resulted in the LSCB Business Plan 2011/12 including joint objectives about establishing shared values and behaviours for practitioners that promote effective joint working.

6.5.23 A restructured and enhanced multi agency child protection training programme was launched in April 2010 and, following review is being developed further in 2011/12.

6.5.24 Conclusions

During the year the LSCB has appropriately placed its focus on achieving progress against the improvement priorities.

6.5.25 Central to the Board being able to play its appropriate part in undertaking challenges and monitoring safeguarding across the partnership was the introduction and embedding of new governance arrangements.

6.5.26 These changes have seen a revised structure within which sub and task groups operate and a new Board constituted with senior managers from partner agencies. Significantly a new Independent Chair was appointed in

July 2010.

6.5.27 The LSCB Business Plan (October 2010 – March 2011) was formally reviewed by the Board in March 2011. There has been good progress in progressing tasks, although some slippage occurred against timescales set and this had a knock on effect on the progress possible on a number of other tasks. It was agreed to continue to use the Business Plan to monitor progress until the LSCB Strategic Plan 2011-15 and the Business Plan 2011-12 were approved by the LSCB. This happened in May 2011. Both the Strategic Plan 2011-15 and the Business Plan 2011-12 were presented to the Children's Trust Board in June 2011.

6.5.28 Having focused during the early part of the year under review on the priorities that were identified as a response to the Children's Services Improvement Plan, considerable effort has been devoted to ensuring the Governance arrangements, membership and structure of the LSCB provide the correct foundations to take its work forward to meet the broader aspirations that are now expected. The result of this work, which has been undertaken in the light of ongoing capacity challenges and the demands of the work, has been a Strategic Plan for 2011-15 and the accompanying Business Plan for 2011/12.

6.6 Engagement of Children & Young People in the work of the LSCB

LSCB Participation programme 2009 - 2011

6.6.1 In 2009 the LSCB initiated a participation programme with young people to explore (i) how participation could be most effectively undertaken and (ii) what safeguarding issues were important for them. The Board received a report in November 2010.

6.6.2 The first phase, involving preparatory sessions with a group of eight young people (aged 16 – 17) drawn from the Youth Parliament, culminated in an evening conference with LSCB Members. This identified 'bullying' as a key concern for young people.

6.6.3 Proposals were made for phase 2 of the programme:

- A clearer focus on identifying safeguarding issues for young people.
- Engagement of a group of young people who were not already involved in 'participation processes'
- Regular sessions with a small group of LSCB members.

6.6.4 Phase two involved 4 group sessions with LSCB members, although inconsistent attendance by the young people resulted in the need for a number of 1:1 sessions to be undertaken in order to supplement the information provided. 14 young people (aged 13 – 17) were involved.

6.6.5 Key safeguarding concerns identified by the young people were:

- Relationships between young people and the Police.

- Street violence in particular parts of the city. Attention was drawn to feuds between groups in different neighbourhoods.
- The lack of positive activities available for young people resulting in increased risky behaviours e.g. alcohol and substance misuse.
- Risky sexual behaviour by young people. Sex & relationship education was viewed as inconsistent.
- Hospital wards not being age specific. i.e. not differentiating between young children and young people.
- Adult professionals struggled to talk appropriately to young people.

6.6.6 The outcomes of the programme were forwarded to relevant agencies and partnerships in order to inform their work in the future.

6.6.7 Although phase 2 did generate concerns held by young people, it became apparent that their understanding of 'safeguarding' and the role of the LSCB was very limited and that more time should have been given to addressing this and to considering the different priorities held by the young people and the Board. It was suggested that future work should be based on safeguarding issues identified by the Board for consideration by young people.

6.7 Future LSCB Participation Activity

6.7.1 This is identified as an area of weakness for the LSCB, and developing integral sustainable participation in the work of the LSCB is one of the key objectives for improvement in 2011/12.

6.7.2 The LSCB Business Plan 2011/12 includes an objective to '*secure a sustainable method for obtaining the views of children and young people to influence the work of the LSCB,*' to be led by the Communications task group and the Third Sector reference group.

6.7.3 It is proposed to work in conjunction with participation programmes operating across the city. These include:

- Support to school councils
- CYPSC contracts Barnardos (Children's Rights Service) to facilitate the 'Have a Voice Council' for young people in care.
- West Yorkshire Youth Association (funded through IYSS Youth Service and Children's Fund) provide participation programmes and events
- Annual Every Child Matters Survey undertaken by schools
- Initiatives undertaken within the Third Sector (eg The Market Place – 'Helping Young People through Experience' (HYPE)).

6.8 Communicating with the wider Community.

6.8.1 One of the functions of the LSCB is to promote a greater

understanding of Safeguarding in local communities so that local people can play an appropriate part in protecting children and young people.

6.8.2 The focus during the year under review on the priorities that were identified as a response to the Children's Services Improvement Plan has not allowed work in this area to be progressed. The considerable effort that has been devoted to ensuring the Governance arrangements, membership and structure of the LSCB provide the correct foundations to take a broader agenda forward, now provides the opportunity in the coming year to put greater focus on this area of work. The LSCB Communications Task Group will lead on those objectives in the 2011/12 Business Plan that will create a link with the wider Leeds community to increase capacity to keep children and young people safe.

6.9 The Licensing Act 2003

6.9.1 As a result of the introduction of the Licensing Act 2003 all licensing functions are carried out by the local authority. The LSCB is specified as a "Responsible Authority" in matters relating to the protection of children from harm.

6.9.2 Each licensing application is evaluated to ensure the applicant demonstrates in their operating schedule how they intend to protect children from harm. As a responsible authority the Safeguarding Children Board can make representation to the Licensing Committee in relation to an application that raises concern in relation to the safeguarding of children.

6.9.3 Leeds LSCB has been constrained to an essentially reactive engagement in licensing processes; providing advice in response to specific queries on matters relating to the safeguarding of children and young people. This is an aspect of the Board's broader functions that the increased capacity in the LSCB Support Team will allow a higher priority than has been possible up to now. This is part of the challenge that the LSCB faces in the coming year.

6.10 LSCB Financial Arrangements (see Appendix 3)

6.10.1 With a budget of £639,000 for 2010/11, an 'in year' under spend of £24,000 resulted in a LSCB strategic reserve of £145,000 being carried forward into 2011/12.

6.10.2 A base budget has been set for 2011/12 of £521,000 with a commissioning budget of £50,000. A funding formula between partners was agreed (60% Leeds City Council, 30% Health and 10% other partners – including Police, Probation and Cafcass).

7.0 Summary of achievements in 2010/11

Achievements across the Partnership

7.1 There has been improved performance overall in child protection and looked after children processes, despite the backdrop of increasing referrals to CYPSC, a doubling of the number of C&YP subject to Child Protection Plans and continuing high numbers of children looked after.

7.2 There were very positive outcomes from an unannounced Ofsted inspection in January 2011 which stated that areas of priority action had been addressed and that contact, referral and assessment processes now met statutory guidance.

7.3 Through the annual s(11) of the Children Act 2004 'duty to safeguard' self evaluation audit there is evidence of improvements by partner agencies in the areas of service plans taking account of the need to safeguard, safer recruitment practices and understanding about when information should be shared.

Achievements by the LSCB

7.4 New governance, structure, membership and operation of the LSCB has been developed and implemented in close consultation with the CTB. A new independent chair was appointed in July 2010.

7.5 A more focused Business plan Oct 2010 - Mar 2011 was adopted with clear strategic objectives.

7.6 An interim Performance Management System was implemented for 2010/11 focusing on two key areas: child protection processes and care management processes for looked after children.

7.7 Two Serious Case Reviews have been submitted and been evaluated as 'good' by Ofsted. One SCR is under discussion with Ofsted. The implementation of action plans from three other reviews has been evidenced as being completed.

7.8 Lessons learnt from SCRs have been incorporated in the LSCB training programme and citywide workshops held to disseminate key issues.

7.9 Based on the training needs analysis of partner agencies the LSCB multi-agency core child protection training programme has been restructured and re-launched, resulting in increased access for professionals and a significant reduction in waiting lists.

7.10 Partners have agreed a funding formula and a core budget for 2011/12 that will ensure that the LSCB can meet its statutory responsibilities. This will enable recruitment to an enhanced and restructured LSCB Business Support Team.

7.11 In alignment with the Children & Young People's Plan, the LSCB has

developed a Strategic Plan for 2011-15, shared with the CTB, derived from an Outcomes Based Accountability approach to improving outcomes for C&YP. Within this framework a Business Plan is in place with outcomes and objectives for 2011/12 identified, and a delivery system in place.

7.12 A comprehensive Performance Management System for 2011-15 is being established which links with strategic priority (1) of the CYPP – ‘that C&YP are safe from harm.’

8.0 Challenges for the CTB

8.1 To rebalance safeguarding interventions across the continuum of need to ensure that preventative work is undertaken appropriately and in a timely manner. To involve:

- Improved multi agency working at locality levels to ensure that C&YP receive the right service at the right time and that the Common Assessment Framework (CAF) is used appropriately to facilitate a team around the child approach
- A change in the pattern of referrals (and other processes) used to communicate concerns between agencies about C&YP at risk of harm
- To reduce the number of C&YP who need to be ‘looked after.’

8.2 To ensure that all partners are able to attend / input in a timely manner to Initial Child Protection Conferences so that these can be held within timescales laid down in statutory guidance.

8.3 To consider how the performance improvements made to date are sustained and built upon within the context of increasing demand for child protection services.

8.4 To ensure that partners are able to demonstrate how they meet their safeguarding responsibilities, through internal audit processes and by contributing to the LSCB multi agency auditing programme.

8.5 To prepare to respond to the local implementation of recommendations provided by the ‘Munro Review of Child Protection’

9.0 Challenges for the LSCB

9.1 To consolidate and develop further the progress that has been made in providing effective leadership and challenge to the safeguarding system in Leeds, engaging with both the professional partnership and the wider community of children, young people and their families.

9.2 To implement the work plans generated within the Business Plan

2011/12 to meet the objectives and outcomes set.

9.3 To develop and implement a communications strategy that undertakes campaigning and raising awareness activity of safeguarding issues.

9.4 To implement the new Performance Management System in 2011/12 in order to receive improved information and more rounded intelligence about the effectiveness of safeguarding services and the impact of lessons learnt from reviews and audits on outcomes for C&YP.

9.5 To set up and implement the LSCB multi-agency quality assurance and audit programme, particularly in relation to child protection, children in need, and early intervention processes and practice. This will include the impact of SCR action plans, compliance with s(11) requirements and arrangements for paediatric medicals.

9.6 To undertake the annual s.(11) self assessment audit with partner agencies seeking improvements in the following areas:

- Understanding when and how to initiate a CAF
 - Ensuring C&YP are made aware of their right to be safe from abuse
- More consistent engagement with the self-audit process.

9.7 To develop a consistent approach to s.(11) audit and commissioning standards requirements that takes account of the challenges faced by small Third Sector organisations.

9.8 To effectively engage C&YP in the work of the LSCB

9.9 To continue to develop QA processes to ensure safeguarding training undertaken by partner agencies and through the LSCB are of a consistently high standard.

9.10 To undertake more effective evaluation of the impact on practice of training and development opportunities provided by the LSCB and partner agencies.

9.11 To improve the process for responding to, collecting, collating and analysing information about child deaths in order to identify in a timely manner lessons that may contribute to the prevention of deaths in the future.

9.12 To monitor the action plan for the development of private fostering arrangements.

9.13 To more fully engage with community safety activity relating to the safeguarding of children and young people (including responsibilities under the Licensing Act 2003).

9.12 To prepare to respond to the local implementation of

recommendations provided by the 'Munro Review of Child Protection'.

10. Next Steps.

10.1 In their complementary work to drive improvements in the safeguarding of children and young people both the Children's Trust Board and the LSCB are asked to take account of the challenges identified in this report.

The CTB is asked to respond through:

- Action to address outcome (1) of the Children & Young People's Plan – that 'children and young people are safe from harm'.
- Continued engagement with the LSCB to support its leadership of the safeguarding system in Leeds
- Ensuring partners engage with and contribute fully to the work of the LSCB.

The LSCB will respond through implementation of its Strategic Plan 2011-15 and, in the immediate term, its Business plan 2011/12.

10.2 Why is the production of this Annual Report good for children and young people? Because it's important to learn from the past when planning the future. No one wants to keep repeating the same mistakes and no one should miss an opportunity to say 'Well done!'

11 List of Appendices

- 1) CDOP Annual Report 2010/11
- 2) LSCB Business Plan 2010/11
- 3) LSCB Financial Statement

**LEEDS
SAFEGUARDING
CHILDREN BOARD**

**LEEDS CHILD DEATH
OVERVIEW PANEL**

**Annual Report for the period
1st October 2009 to 31st
December 2010**

Foreword

The national requirement to review the death of every child under the age of 18 years was introduced from 1st April 2008. Over the past two and half years, this has been a learning process for all involved. But though the task has been demanding at times, it has also been hugely rewarding. Members of the Panel (both Neonatal and Older Children) have given their time generously to analyse and debate the sad circumstances and contributory factors in the deaths of Leeds children, and to draw out lessons and recommendations with the aim of preventing, where possible, the tragic loss of children's lives in the future.

The process for the investigation of sudden unexpected child deaths (SUDIC) has made an enormous contribution to work of the Child Death Overview Panel, providing a rich source of detailed information about the deaths of these children, and enabling the CDOP to hold informed discussions and make useful recommendations. The CDOP particularly extends its thanks to Dr John Roper, SUDIC Paediatrician for Leeds, who leads this process, and the Safeguarding Team who support him.

Finally, the CDOP process could not function without the input of many professionals across multiple agencies who give their time to complete the information proformas, and those who sit on the Panels and debate the issues and shape the recommendations, and the hard work of the administrative team at Enterprise House.

This report represents the culmination of the efforts and expertise committed by all these professionals. It summarises the work of the CDOP over the two and half years since its implementation, including statistical analysis of child deaths over this period, and a summary of recent lessons identified the proposed work programme for 2011/12 and a progress report on the work programme from 2010/11.

Dr Sharon Yellin

Chair of Leeds Child Death Overview Panel

Contents

	Page No
1. Introduction to the Leeds Child Death Overview Panel	62
2. The Leeds CDOP Process	62
3. Panel Activity	64
4. Commentary on Neonatal Deaths reviewed by CDOP	65
5. Work programme for 2011/12	69
6. Progress towards implementation of work programme from 2010/11	70
7. Commentary on Deaths of Older Children reviewed by CDOP	71
8. Work programme for 201/12	74
9. Progress towards implementation of work programme from 2010/11	75
Membership of the CDOP Panel	77
Definitions and acronyms	78

1. Introduction to the Leeds Child Death Overview Panel

1.1 Purpose

1.1.1 The Leeds Child Death Overview Panel (CDOP) was established from 1st April 2008 under guidance issued in Chapter 7 of Working Together to Safeguard Children 2006. The aim of the CDOP, (as required by the Local Safeguarding Children Boards Regulations 2006) is to undertake a comprehensive and multidisciplinary review of all deaths of children normally resident in Leeds aged under 18 years, in order to understand better how and why they die, and to use the findings to take action to prevent other deaths and improve the health, wellbeing and safety of children and young people.

1.1.2 The CDOP has specific functions, laid down in statutory guidance, including:

- Reviewing the available information on all deaths of children aged up to 18 years (including deaths of infants aged less than 28 days) to determine whether the death was preventable.
- Collecting and collating an agreed minimum data set on each child who has died.
- Meeting frequently to review and evaluate the routinely collected data on the deaths of all children, and thereby identifying lessons to be learnt or issues of concern.
- Monitoring the appropriateness of the response of professionals to an unexpected death of a child.
- Referring to the Chair of the LSCB any deaths where, on evaluating the available information, the Panel considers there may be grounds to undertake further enquiries, investigations or a Serious Case Review (SCR).
- Monitoring the support and assessment services offered to families of children who have died.
- Organising and monitoring the collection of data for the nationally agreed minimum data set.
- Identifying any public health issues and considering, with the Director of Public Health, how best to address these and their implications for both the provision of services and for training.

2. The Leeds CDOP Process

2.1 Under statutory national guidance contained in Chapter 7 of Working Together to Safeguarding Children, Leeds has both a Sudden Unexpected Death in Childhood (SUDIC) process, and a Child Death Overview Panel (CDOP) process. The two are separate processes, but are closely linked.

2.2 The SUDIC process involves early notification of the unexpected death of a child, and a prompt process of investigation, led by the SUDIC

Appendix 1

Paediatrician. This may involve discussion with clinicians at the hospital, Police, Social Care and others. Sometimes a visit to the place of death is undertaken. A meeting is held with professionals involved with the child, to learn lessons. A report into the circumstances of the child's death is produced, which is shared with the Coroner, and with the CDOP.

- 2.3 Notifications of child deaths may be made directly to the SUDIC Team, or to the CDOP Administrator at Enterprise House in Leeds. Some may be deaths of non-Leeds children, and these notifications are passed to other areas where the child was resident. Close communication between the SUDIC and CDOP Teams is essential to ensure full ascertainment. The Registrar of Births and Deaths now also has a duty to supply information to the Local Safeguarding Children Board (LSCB) regarding the death of any child under 18 years no later than 7 days from the date of registration (Children & Young Persons Act 2008). This has greatly improved ascertainment.
- 2.4 The CDOP Administrator issues and collates the standardised national Agency Report Forms, together with SUDIC reports, death certificates, post-mortem reports, inquest findings and other relevant reports of investigations if available. The collated papers are made available to Panel members prior to each meeting.
- 2.5 In Leeds, neonatal deaths (babies aged under 28 days), where the baby was never discharged from hospital, are considered by a Panel which includes Obstetricians, Neonatologists, and Midwives, from Leeds Teaching Hospitals NHS Trust (LTHT), to ensure appropriate expertise. The process of collating information about neonatal deaths is supported by the Centre for Maternal and Child Enquiries (CMACE) under a contract with the LSCB. Children aged over 28 days, and a few younger babies who died in the community, are considered by a Panel which includes representatives of various agencies (para 2.6).
- 2.6 The Leeds CDOP Panels are chaired a Consultant in Public Health Medicine from NHS Leeds, Dr Sharon Yellin. The following agencies contribute to Panel membership:
 - Leeds Safeguarding Children Board
 - NHS Leeds Public Health
 - Designated Doctor for Safeguarding Children
 - Designated Doctor for Sudden Unexpected Childhood Death
 - Children and Young People's Social Care
 - Leeds Teaching Hospitals NHS Trust
 - Leeds Community Healthcare
 - Leeds Partnerships Foundation Trust
 - Youth Offending Service
 - West Yorkshire Probation Service
 - West Yorkshire Police
 - Coroner's Office
 - Education Leeds

Appendix 1

- Early Years Service
- Martin House Children's Hospice

A full list of current Panel membership can be found at Appendix 1.

- 2.7 The CDOP considers the death of each child, and is required to complete a national proforma regarding its findings for each child. The proforma include factors relating to the child and family, and service provision; categorization of the cause of death; a judgment regarding preventability of the death; learning points and recommendations; immediate follow up actions for the family; and whether the case should be referred to the LSCB Chair for consideration of a Serious Case Review. In addition, during the past year, the Leeds CDOP has piloted a West Yorkshire form to collect specific information about preventable factors from a public health perspective.
- 2.8 There have been challenges in the running of the Panels over the past year, some of which are reflected in Panel minutes and recommendations. There have been delays in receiving completed Agency Report Forms from various agencies, and these issues have been addressed by direct liaison with those agencies at the time. Certain specialist reports, such as fire investigations and road traffic accident reports, have not been provided to the CDOP routinely, and again arrangements to obtain these for future have been made as each issue arose. By agreement with the Coroner, cases are not considered by the CDOP until the inquest is complete. There have also some pressures regarding administrative support in the Safeguarding Team. All these factors have contributed to a backlog of cases.
- 2.9 Panel meetings are scheduled to take place each month (either a Neonatal or Older Children Panel). This should be an appropriate frequency for meetings, based on the expected number of child deaths in Leeds (approx 80 per annum). However, owing to the factors outlined in Para 2.8, many Panel meetings have been cancelled during 2009-10, and this is reflected in the overall level of Panel activity (see Table 1).

3. Panel Activity

- 3.1 Since its implementation in April 2008 until end November 2010, the CDOP Panels have met on 14 occasions (7 Neonatal Panels, 7 Older Children Panels), and considered 70 child deaths.
- 3.2 Table 1 shows the number of notifications of deaths, and Panel activity in the corresponding year. A small number of cases (9) are still outstanding from 2008-9, and these are likely to be cases awaiting the conclusion of Coronial processes.
- 3.3 There are a considerable number of outstanding cases for 2009-10 (52 outstanding cases). This has been raised in the context of the ongoing

Appendix 1

discussions about re-organisation of safeguarding functions to form an Integrated Safeguarding Unit in Leeds City Council, and it is expected that administrative support to the CDOP will be strengthened.

Table 1

Notifications and CDOP Activity (April 2008 to End December 2010)

<u>Year</u>	<u>Notifications to CDOP Administrator</u>			<u>Number of cases reviewed by CDOP</u>			<u>Number of cases outstanding for CDOP review</u>		
	Neonatal	Older child	Total	Neonatal	Older child	Total	Neonatal	Older child	Total
2008-9	25	36	61	24	28	52	1	8	9
2009-10	28	42	70	10	8	18	18	34	52
2010 to end Dec	15	24	39	0	0	0			

4. Commentary on Neonatal Deaths reviewed by CDOP

- 4.1 The CDOP Neonatal Panel has reviewed a total of 34 neonatal deaths. In last year's CDOP Annual Report, 18 of these cases were described, though it was acknowledged that small numbers made it difficult to draw conclusions. The majority of the neonatal deaths reviewed since the last report occurred during the year 2008-9, and therefore the commentary presented in this section covers all neonatal deaths reviewed to date ie including neonatal deaths covered by the previous CDOP Annual Report. This will give a better overall understanding of the issues.
- 4.2 It is important to be aware that a small number of cases reviewed by the Neonatal Panel (5) related to babies aged over 28 days, but who had never been discharged from the hospital neonatal unit. This is appropriate, since the causes of death for babies who are never discharged from the hospital tend to be similar, often being linked to problems during the pregnancy and during delivery, and related to prematurity and low birthweight.
- 4.3 A small number of deaths reviewed by the CDOP Older Children Panel (3) related to children aged under 28 days but who died in the community. These cases could legitimately be considered by either Panel, since they may be similar to the babies who die on the neonatal unit, or there may be a range of contributory factors involving multiple agencies. For administrative reasons, babies who die in the community are considered at the Older Children CDOP.
- 4.4 Most the deaths of babies considered by the CDOP Neonatal Death Overview Panel (32 deaths) were classified under one of the following categories:

Appendix 1

- Category 7: Chromosomal, genetic and congenital anomalies (9)
- Category 8: Perinatal/neonatal event (23)

Two babies' deaths were assigned to Category 5: acute medical or surgical conditions. Both of these were among the babies who died in the community after discharge from the hospital.

4.5 As discussed in the previous CDOP Annual Report, known risk factors for stillbirth and neonatal death include¹:

- Extremes of maternal age (nationally, teenage mothers have the highest neonatal mortality rate)
- Non-White ethnicity
- Maternal social deprivation
- Maternal obesity

These factors have been considered specifically in the commentary that follows.

4.6 Of the 34 neonatal deaths considered in this report, age of mother was available for 28. Of these, only 2 were young mothers aged under 20 years old. 6 babies had mothers aged over 35 years.

4.7 Ethnicity was available for all cases considered. The data collection forms used by CMACE include both ethnicity of mother, and (on the supplementary CDOP form) ethnicity of the baby. In general, these are the same, and therefore they have not been analysed separately. The largest single ethnic group, unsurprisingly, is White British. However, as noted in the previous report, over a third of babies were of non-White origin, with a particularly high prominence of babies born to women of African origin, accounting for a quarter of neonatal deaths. Births to African women account for around 5% of Leeds births, so this group is clearly over-represented, although it is important to be aware that some of these were multiple births (so the actual number of women was fewer than 8).

Table 2
Ethnicity of babies who died aged under 28 days (neonatal deaths) and
breakdown of ethnicity for all Leeds births

	Number (%) neonatal deaths considered by Panel	Percentage of Leeds births*
White British	20 (59%)	68%
African	8 (24%)	5%
Asian and Asian Mixed	5 (15%)	11%
White other	1 (3%)	5%

*Note: Data source is booking data returned to NHS Leeds for monitoring purposes during the period April-October 2010

¹ Reference: Perinatal Mortality 2007. CEMACH, June 2009.

Appendix 1

- 4.8 Consanguinity (the effect of parents being closely related to each other, frequently as a result of first cousin marriage) is known to be a risk factor for infant and later child deaths from genetic conditions. Cousin marriage is practiced widely in certain communities, notably those from parts of South Asia (Pakistan and Bangladesh), and parts of Africa and the Middle East. In the previous CDOP report, it was acknowledged that local data is not readily available concerning cousin marriage, and that staff may be reluctant to enquire about it, as it is perceived as a sensitive issue. Nonetheless, successful interventions may be available in the form of genetic testing and counseling for some conditions, and services to enhance uptake of such interventions have been developed in other parts of the country. It was therefore a recommendation of the previous CDOP Annual Report that efforts should be made to collect this information. Data were collected from hospital records by CMACE for all babies, indicating that, of the neonatal deaths, 2 babies were recorded as having related parents (first cousins). Deaths related to genetic conditions linked to cousin marriage may occur at older ages, or may manifest as illness during childhood, and this issue is therefore considered as a whole later in this report.
- 4.9 Maternal obesity is known to be associated with both neonatal and infant death. Body mass index (BMI) is a measure of obesity, and a BMI in excess of 30 is regarded as obese. BMI was recorded for just over two thirds of mothers (22), which is similar to the level of recording in last year's CDOP Annual Report. However, it is believed that BMI is routinely measured and recorded for all women, but the transfer of that information onto the CMACE forms is incomplete, and efforts are being made to improve this. Of those with a BMI available to the Panel, only 2 women had a BMI in excess of 30, and 3 further had BMIs between 25 and 30.
- 4.10 The neonatal data collection form, notably the supplementary CDOP form, includes information about smoking, drugs and alcohol use by parents, and domestic violence. However, the data suggest that only two women were actively smoking during the pregnancy, and none of the parents were using alcohol or drugs. There is one record of domestic violence. Given the known associations between these risk factors and poor neonatal outcomes, it is surprising that this is not reflected at all by the local data. It is possible to speculate that these factors are not being noted in the hospital records from which the data are collected, or that women are not always open in admitting these behaviours. Whatever the reason, it seems probable that this is an artifact of the data collection rather than an accurate reflection of the prevalence of these risk factors.
- 4.11 Of the 34 neonatal deaths considered by the Panel, 25 were considered to have "no modifiable factors" (note: terminology in the national proformas has changed over this period). 9 deaths were identified as having potentially "modifiable factors". Some of the issues debated by the Panel in relation to modifiable factors included: earlier diagnosis; variation in practice in respect of new or novel treatments or

Appendix 1

protocols which are not nationally standardised; variation in medical practice in other centres or countries which might increase risk, such as the number of embryos re-implanted during IVF; and population level public health interventions, such as improved awareness of genetic services.

- 4.12 A third of the babies (11) considered by the Panel were twins, relating to 10 pregnancies. Twin pregnancies are known to be higher risk of mid-trimester loss, prematurity and perinatal morbidity than singleton pregnancies.
- 4.13 The CDOP Neonatal Death Overview Panel did not refer any cases to the Chair of LSCB for consideration of a Serious Case Review.
- 4.14 The following learning points were identified by the Neonatal CDOP Panel:
- Improved completion of the CMACE form across maternity and neonatal services.
 - The need for early use of transcutaneous CO₂ monitoring in the most extreme preterm babies to reduce the risk of low carbon dioxide levels.

The following learning points were highlighted in the previous CDOP Annual Report:

- Improved communication between services
 - Improved multi-disciplinary antenatal management
 - Targeted teaching to improve antenatal diagnosis.
- 4.15 The Panel also highlighted issues arising from cases, some of which give rise to themes which may be the basis for future recommendations:
- Domestic violence and the importance of arranging protected time for women to speak alone with a professional.
 - Increased risk of genetic disorders in babies born to parents who are closely related, for example, first cousins.
 - The role of the Panel in ensuring that Obstetric staff are made aware of later poor outcomes.
 - The fragmentation of care which can result from high mobility amongst certain ethnic groups.
 - Shared definitions of clinical terms.
 - The impact of late booking for maternity care.
- 4.16 In addition, the following issues were highlighted in last year's report:
- Limited availability of bereavement support services in the hospital.
 - Higher risk related to twin pregnancies.
 - Increasing numbers of people seeking in vitro fertilization (IVF) abroad, where practice is to transfer multiple embryos. The local unit is moving towards single embryo transfer.
 - Transfers between St James's and Leeds General Infirmary.

Appendix 1

- Lack of a breast milk bank in Leeds. Availability of breast milk from the Huddersfield bank may raise thresholds for use.

5. Work programme for 2011/12

- 5.1 Proposals from the Neonatal Death Overview Panel have been accepted for work to be undertaken in the following areas::
- 5.2 Obstetricians and Neonatologists at LTHT should work together to clarify definitions of the PROM acronym and ensure common understanding and useage (completed).
- 5.3 Obstetricians at LTHT to audit two specific cases in order to review the risk assessment process and care plan (completed).
- 5.4 The Chair of CDOP should review the Panel processes in order to reduce the time taken between the death of the baby, and consideration at Panel. Ideally this should be reduced to 3 months. (Timescale: April 2011)
- 5.5 The Head of Midwifery at LTHT should ensure an audit is undertaken, to explore outcomes and satisfaction of BME women looked after by the team of BME midwives. (Timescale: December 2011)
- 5.6 The Director of Public Health at NHS Leeds and Leeds City Council, and the Head of Midwifery at LTHT should ensure that programmes of work directed at reducing smoking by women during pregnancy are continued and outcomes are monitored. (Ongoing)

6. Progress made on the implementation of the work programme for 2010/11

- 6.1 The Consultant Obstetrician representatives on the Panel have ensured that a system is established for identifying women who have a pre-term delivery in order to offer a postnatal review and ensure early planning in the next pregnancy.
- 6.2 LTHT providers and NHS Leeds commissioners acknowledge the importance of centralisation of neonatal and obstetric services on the same site as children's services and are giving the matter strategic consideration
- 6.3 The Consultant Obstetrician representatives on the Panel have undertaken an audit of the risk factors and outcomes in twin pregnancies across Leeds Teaching Hospitals NHS trust. The findings have been presented within the Directorate. Specific changes to practice have been made with regard to mid-trimester screening for infection in African women with twin pregnancies, and consideration of cervical screening where appropriate.
- 6.4 The Consultant Obstetrician representatives on the Panel have reviewed and re-written guidelines for assisted conception. Specific changes to practice have been made with regard to growth scans during pregnancy. An audit of the outcomes of IVF pregnancies is also being undertaken.

7. Commentary on Deaths of Older Children reviewed by CDOP

- 7.1 The CDOP Panel has reviewed a total of 36 deaths of children aged over 28 days, of which the majority (28) occurred during 2008-9, and 8 occurred during 2009-10. Of the 36 deaths considered to date, 21 were reported in the previous annual report. The commentary presented in this section of the report relates to all 36 deaths, thus providing a better understanding of Leeds child deaths which took place largely in 2008-9.
- 7.2 The commentary in this section relates to all children who died aged over 28 days and up to 18 years. The majority, but not all, of these deaths were considered by the CDOP Older Children Panel. 5 of these cases were considered by CDOP Neonatal Panel because these babies were never discharged from the hospital neonatal unit.
- 7.3 The age distribution of the children considered by the CDOP Panel was:
- 14 children aged over 28 days and under 1 year
 - 5 children aged over 1 year and under 5 years
 - 3 children aged over 5 years and under 10 years
 - 7 children aged over 10 years and under 15 years
 - 7 children aged over 15 years and under 18 years
- 7.4 15 of the deaths were classified as “Sudden Unexpected Death in Childhood” (SUDIC) and were investigated under the SUDIC arrangements. Of these, 4 were babies aged under 1 year and 5 were older teenagers aged over 15 years. Among the older group of teenagers, 3 deaths were the result of road traffic injuries.
- 7.5 23 children who died were males, and 13 were females.
- 7.6 20 children were recorded as being of White British ethnicity, 8 as Asian (5 Pakistani, 1 Bangladeshi, and 3 Asian other) and 3 as African. The remaining 5 children were from a range of other ethnic backgrounds.
- 7.7 The CDOP Panel is required to consider the issue of “preventability” or “potential preventability” of the deaths, and this was reported in the previous annual report. However, this terminology was nationally contentious, and has been changed during 2009-10 to classify deaths as having “no modifiable factors” or “modifiable factors”. Of the 36 deaths of older children, 2 were classified as “preventable” (reported in the previous annual report). 8 were classified as “potentially preventable” and a further 3 as having “modifiable factors”. 18 were classified as “not preventable” and a further 3 as having “no modifiable factors”. There was not enough information available to assign a classification to 2 deaths.

Appendix 1

- 7.8 The impact of cousin marriage as a risk factor for genetic conditions has been highlighted in paragraph 4.1.8. Among the older children, 2 deaths were related to genetic conditions and it was recorded that the parents were first cousins. Thus, overall, cousin marriage has been a contributory factor in 4 child deaths of the total 70 deaths considered by CDOP to date. These deaths have been classified as having “modifiable factors”.
- 7.9 Other aspects which were taken into account by the CDOP in assigning classifications of “potentially preventable” or “modifiable factors” included modifiable aspects of unintentional injuries (accidents) such as road traffic accidents, fire, falls and drowning where factors such as speeding, seat belts, alcohol, smoke detectors, or level of supervision could have influenced the outcome. The quality of care by agencies, at birth, throughout life or during the final events, was also considered.
- 7.10 Although the CDOP proformas have specific sections enquiring about use of alcohol and drugs, and about domestic violence, these issues have not been prominent. Only one child death proforma indicated parental use of drugs and alcohol, and one other indicated domestic violence although this was noted to be unrelated to the cause of death. It is unclear why these issues are not more prominent. It is possible that the issues are not recorded in the clinical notes which are used to complete the proformas for young babies, although this seems unlikely. For older children, issues around drugs, alcohol or domestic violence would potentially be known to several agencies, and should therefore appear. It is possible that, for young babies, the impact of these issues result in morbidity rather than death, which might account for the absence of these issues. For older children, it is possible that these issues may be more prominent among cases which have not yet reached the CDOP because they involve safeguarding issues, and are still within the Coronial processes.
- 7.11 The deaths of children considered by CDOP were classified under the following categories:
- Category 1: Deliberately inflicted injury, abuse or neglect (0)
 - Category 2: Suicide or deliberate self-inflicted harm (1)
 - Category 3: Trauma and other external factors (6)
 - Category 4: Malignancy (4)
 - Category 5: Acute medical or surgical condition (1)
 - Category 6: Chronic medical condition (4)
 - Category 7: Chromosomal, genetic and congenital anomalies (10)
 - Category 8: Perinatal/neonatal event (6)
 - Category 9: Infection (3)
 - Category 10: Sudden unexpected, unexplained death (1)
- 7.12 As in the previous annual report, no deaths have yet been assigned to Category 1: Deliberately inflicted injury, abuse or neglect. This probably reflects that there are still outstanding cases even from the first full year

Appendix 1

of CDOP function (9 cases outstanding). These cases are likely to be those awaiting completion of the Coronial processes. An agreement has been reached with HM Coroner that the CDOP will not consider cases before the inquest is complete. Until CDOP has completed its consideration of all children who died in the calendar year 2008-9, a complete overview of the causes of death will not be possible.

- 7.13 The emerging pattern of deaths for Leeds reflects the nationally recognized causes of death among children aged over one year which include: unintended injury; malignancy; infection; and late deaths from congenital anomalies. The number of deaths is small, and patterns must therefore be interpreted with caution. However, Category 7 (Chromosomal, genetic and congenital anomalies) seems to be the predominant category. It is possible to speculate that this may be partly due to better survival of babies with complex condition owing to high quality obstetric and neonatal, and potentially some impact of cousin marriage on the prevalence of serious genetic conditions.
- 7.14 The CDOP did not refer any cases to the Chair of LSCB for consideration of a Serious Case Review.
- 7.15 The Panel identified a small number of learning points which, as appropriate, have been taken back to relevant agencies by their Panel representative. Some of these learning points related to Panel processes, and have been incorporated into way the CDOP operates. Some learning points have related to specific areas of clinical practice, and have been taken back for dissemination within the hospital.
- 7.16 The Panel also highlighted several issues arising from individual cases, which were recorded to be considered in the overall context of the Panel's findings. Some of the same issues arose in more than one case. Recommendations were framed in respect of some issues, whilst others were logged to be considered if themes emerge after consideration of a larger number of cases. The following issues were highlighted:
- The risks of smoking during pregnancy.
 - The risks of co-sleeping.
 - The value of "End of Life" plans.
 - Consanguinity (cousin marriage) as a risk factor for serious genetic conditions.
 - The role of speeding, drunkenness and reckless driving as a cause of child death.
 - The importance of universal early access to antenatal care.
 - The risks of acquiring Cytomegalovirus infection during early pregnancy, and action to raise awareness and reduce risk.
 - The excellent quality of care offered by Martin House Hospice and the Leeds Continuing Care Nursing Team.
 - The impact of swine 'flu particularly on vulnerable children with complex needs.
 - The need for adequate funding for children's hospices.

Appendix 1

- The importance of functioning smoke detectors particularly in rented housing with young children.

In addition, the following issues were highlighted in the previous annual report:

- Lack of availability and timeliness of some key reports to inform the Panel.
- Limited availability of bereavement support services.
- Lack of information concerning consanguinity.
- Transfers between St James's and Leeds General Infirmary.
- Parental smoking.

8. Work programme for 2011/12

8.1 Proposals from the Older Children Death Overview Panel have been accepted for work to be undertaken in the following areas:

8.2 The Director of Public Health at NHS Leeds and Leeds City Council should continue to progress work to reduce smoking during pregnancy and smoking by parents with young families. (Timescale: March 2012)

The Director of Public Health at NHS Leeds and Leeds City Council should initiate social marketing work to ensure that co-sleeping messages are disseminated widely and appropriately to target populations. (Timescale: March 2012)

The Director of Public Health at NHS Leeds and Leeds City Council should take forward work to raise awareness of the relationship between cousin marriage and genetic disorders, and ensure that appropriate genetic services are commissioned to respond to this need. (Timescale: March 2012)

The relevant Clinical Leads at Leeds Community Healthcare, Leeds Teaching Hospitals NHS Trust and Martin House Hospice should put in place a common agreement (guideline?) regarding the arrangements for End of Life Plans for children. (Timescale: September 2011)

The Director of Commissioning at NHS Leeds should ensure that the Children and Maternity Commissioning Team at NHS Leeds, and subsequently GP Consortia, are aware of the high quality service available to the children of Leeds from Martin House Hospice in the context of current funding arrangements. (Timescale: May 2011)

The Chair of CDOP should write to Leeds Continuing Care Case Manager and the manager of Leeds Children's Continuing Care Nursing Team to commend the quality of care provided by these services. (Complete)

Appendix 1

The Director of Public Health at NHS Leeds and Leeds City Council, in collaboration with the Health Protection Agency and Early Years Services at Leeds Local Authority, should ensure that materials to raise awareness of Cytomegalovirus and how to reduce risk of transmission, are developed and disseminated through Children's Centres.
(Complete)

The Director of Children's Services, the Chair of LSCB and the Joint Director of Public Health at Leeds Local Authority and NHS Leeds should give consideration to strategic support for Smartrisk UK, which is an organization located in Leeds which draws upon the Canadian Smartrisk approach to reduce the risk of accidents among teenagers and young adults². (Timescale: March 2012)

The Children's Centre Safeguarding Manager at Leeds City Council should liaise with West Yorkshire Fire Service to clarify the nature of existing services for checking fire safety and installing alarms in homes with young children, and to explore options for publicizing these services via Children's Centres. (Timescale: September 2011)

9. Progress made on the implementation of the work programme for 2010/11

- 9.1 There is an ongoing programme of public health work to reduce smoking during pregnancy. Data collection regarding smoking during pregnancy has been improved, with ascertainment now over 95%. The latest data indicate that the current level of smoking during pregnancy in Leeds is 13%, which is better than the national target (15%). All Leeds midwives have received mandatory training, and referrals are made to the Leeds Smoking Cessation Service. Not all women take up the offer of an appointment, but for those who do, success rates in the Leeds service compare favourably with other parts of the country. Leeds has an active Smoke Free Homes programme, which promotes the importance of parents keeping smoke away from children and outside the house.

Advice to all parents regarding smoking and co-sleeping is given by health visitors in accordance with the local clinical policy. This policy has been reviewed to ensure consistency of advice.

- 9.2 The CDOP has now considered 3 deaths of young people resulting from road traffic injuries. During 2009-10, the Director of Public Health at NHS Leeds was able to identify an amount of one-off funding (£18k) for Smartrisk UK. This funding was used to fund the HEROES show over a 2 week period in 8 targeted secondary schools, reaching around 600 pupils per school (4800 pupils total). The organization of the events was undertaken by Leeds Road Safety Unit. The HEROES show is an interactive sound and light show featuring an "injury

² www.smartrisk.org.uk

Appendix 1

survivor”, frequently a young adult with paralysis as a result of an accident. The injury survivor describes their own experience and answers questions from the audience. The sound and light show then highlights the key Smartrisk messages, including: Buckle Up; Get Trained; Wear the Gear; Drive Sober; Look First. In previous years, similar shows have taken place in Leeds funded by the Strategic Health Authority, and one-off funding by the Primary Care Trust. SHA funding has now ceased, and Smartrisk UK currently has no funding to enable it to deliver further interventions in Leeds.

- 9.2 The Chief Executive of LTHT has ensured that strategic plans in the city to develop a Paediatric Assessment Unit are being progressed.
- 9.4 The quality of ethnicity and consanguinity information collected via the CDOP process is much improved, with almost 100% ascertainment of these fields in completed proformas.

Appendix 1

Membership of the CDOP Panel

Representative	Agency	Job Title/ Role
Dr Sharon Yellin (Chair)	NHS Leeds	Consultant in Public Health Medicine
Older Children Death Overview Panel members:		
Dawn Wilkinson	Coroner's Office	Senior Coroner's Officer
Dr Chris Buller (co-optee)	Leeds Partnership Foundation Trust	Consultant Psychiatrist
Dr John Roper	NHS Leeds	SUDIC (Sudden Unexpected Death In Childhood) Paediatrician
Christina Fairhead	NHS Leeds	Deputy Designated Nurse
Jill Asbury	Leeds Teaching Hospitals Trust	Divisional Nurse Manager
Dr Chris Hobbs	LTHT	Designated Doctor and Consultant Paediatrician
Margaret Hainsworth	Early Years, Leeds City Council	Area Co-ordination Manager
Dr Mike Miller (co-optee)	Martin House Children's Hospice	Consultant in Paediatric Palliative Medicine
Bob Baird	Youth Offending Service	Operational Manager
Bridget Emery	Head of Housing Strategy and Solutions	Environment and Neighbourhoods
Carolyn Eyre	Team Manager Health and Safety	Education Leeds
Deborah Lightfoot	Social Care	Interim Head of Service for Safeguarding
Tanya Cockerill	West Yorkshire Probation	
Joanna Burton	West Yorkshire Police	
Bob Baird	Youth Offending Service	
Bryan Gocke	LSCB	LSCB Manager

Neonatal Death Overview Panel members:		
Dr Lawrence Miall	LTHT	Consultant Neonatologist
Dr Bryan Gill	LTHT	Consultant Neonatologist
Dr Kathryn Johnson	LTHT	Consultant Neonatologist
Ms Tracey Glanville	LTHT	Consultant Obstetrician
Ms Colette Sparey	LTHT	Consultant Obstetrician
Mr Nigel Simpson	LTHT	Consultant Obstetrician
Sue Deighton	LTHT	Matron Maternity Services
Heather Gwilliam	LTHT	Bereavement Support Midwife
Julie Scarfe	LTHT	Head of Midwifery
Dr John Roper	Leeds Community Healthcare	SUDIC Paediatrician

Definitions and acronyms

Definitions

Stillbirth rate: The number of babies born after the 24th week of pregnancy who do not show any signs of life per 1000 total births (live and still births).

Perinatal mortality rate: The number of stillbirths plus the number of babies dying within the first week of life per 1000 total births (live and still births).

Low birth weight rate: The number of babies born weighing less than 2500g expressed as a percentage of total births (live and still births).

Infant mortality rate: The number of deaths of children aged under one year per 1000 live births.

Acronyms

BMI	Body Mass Index
CDOP	Child Death Overview Panel
CMACE	Centre for Maternal and Child Health Enquiries
IVF	In Vitro Fertilisation
LSCB	Leeds Safeguarding Children Board
LTHT	Leeds Teaching Hospitals NHS Trust
Neonatal DOP	Neonatal Death Overview Panel
NICU	Neonatal Intensive Care Unit
SCR	Serious Case Review
SUDIC	Sudden Unexpected Death in Childhood

The Leeds Safeguarding Children Board 6 Month Business Plan October 2010 – March 2011

REVIEW 15.07.11

Bryan Gocke, LSCB Manager .

RAG rating system

The following rating system, consistent with that favoured by the DoE, is used for summarising progress and highlighting slippages and missed deadlines.

RED = not on track

YELLOW = seriously slipping

AMBER = mostly on track but some slippage

GREEN = on track

TASKS	LEAD RESPONSIBILITY	R A G	TIMESCALE PROGRESS
<u>Strategic Priority (1) Leadership, Focus and Challenge</u>			
<u>1.1 Focus clearly on our core business of protecting children for harm.</u>			
1.1.1 To input into and influence the development of the Children & Young People Plan 2011 - 14			
<ul style="list-style-type: none"> LSCB Annual report to be presented to the Children’s Trust Board (CTB) 	Jane Held LSCB Chair	G	Completed Report to CTB 10.12.10.
<ul style="list-style-type: none"> Agree specific areas of responsibility between the CTB and the LSCB and start to develop a two way relationship over the next 6 months 	Jane Held LSCB Chair	G	Ongoing Report to CTB 10.12.10.
1.1.2 To develop and agree LSCB 3 yr Strategic plan 2011 – 15			
<ul style="list-style-type: none"> To present the CTB Joint Strategic Needs Analysis to LSCB at a development session 	Bryan Gocke LSCB Manager	G	Completed LSCB Development Session 22.11.10.
<ul style="list-style-type: none"> To agree priorities, outcomes and actions in a new plan in consultation with partners, the CTB, families and the community 	Bryan Gocke LSCB Manager	G	Completed LSCB 23.05.11. CTB 15.06.11.

Appendix 2

1.1.3 To contribute to ongoing work on thresholds for intervention (s47 / s17)

- | | | | |
|---|--|---|---|
| <ul style="list-style-type: none"> • To consider the proposals and make recommendations to the board regarding the approval of revised thresholds for intervention (s47 / s17) | <p>Jackie Wilson
Chair, Policy & Procedure sub</p> | <div style="background-color: green; color: white; padding: 5px; width: 20px; margin: 0 auto;">G</div> | <p>Completed
P&P sub 16.03.11.</p> |
| <ul style="list-style-type: none"> • To communicate jointly with the Children’s Trust the revised thresholds | <p>Bryan Gocke
LSCB Manager</p> | <div style="background-color: orange; color: white; padding: 5px; width: 20px; margin: 0 auto;">A</div> | <p>Ongoing
Practitioner’s handbook developed for piloting in cluster arrangements</p> |
| <ul style="list-style-type: none"> • To audit the application of those new thresholds | <p>Sam Prince
Chair, Performance Management sub</p> | <div style="background-color: red; color: white; padding: 5px; width: 20px; margin: 0 auto;">R</div> | <p>To be included in LSCB Audit programme 2011/12</p> |

1.2 To establish the effective engagement of partner agencies

1.2.1 To complete the review of the membership of sub groups and confirm new membership

<p>Bryan Gocke LSCB Manager</p>	<div style="background-color: green; color: white; padding: 5px; width: 20px; margin: 0 auto;">G</div>	<p>Completed LSCB 22.11.10</p>
-------------------------------------	--	--

1.2.2 To facilitate 3 development sessions for LSCB members

- | | | | |
|---|---|--|--|
| <ul style="list-style-type: none"> • Input into the Children & Young People Plan | <p>Bryan Gocke
LSCB Manager</p> | <div style="background-color: green; color: white; padding: 5px; width: 20px; margin: 0 auto;">G</div> | <p>Completed
Development session 22.11.10.</p> |
| <ul style="list-style-type: none"> • Performance Management | <p>Sam Prince
Chair, Performance Management sub</p> | <div style="background-color: green; color: white; padding: 5px; width: 20px; margin: 0 auto;">G</div> | <p>Completed
Development Session 16.12.10.</p> |
| <ul style="list-style-type: none"> • 3yr Strategic Plan 2011 - 14 | <p>Liz Murphy C4EO</p> | <div style="background-color: green; color: white; padding: 5px; width: 20px; margin: 0 auto;">G</div> | <p>Completed
Development session 18.02.11.</p> |

1.3 To hold Partner Agencies to account for safeguarding practice

1.3.1 To complete the s(11) 'Duty to safeguard' self audit programme

- Update report on progress made by partner agencies on areas identified for improvement

Sam Prince
Chair, Performance
Management sub



[Completed](#)
[LSCB 21.01.11.](#)

1.3.2 To develop and update SCR and Local Review processes

- Local SCR guidance, toolkit and timeline
- Pilot Local 'Learning Lessons' Review using SCIE methodology

Jackie Wilson
Chair, Policy &
Procedure sub
Jackie Wilson
Chair, Policy &
Procedure sub



[Completed](#)
[P&P sub 24.11.10.](#)



[Ongoing](#)
[2 LLLRs undertaken using root
cause analysis methodology
SCIE training available sep 2011](#)

1.3.3 To support senior level engagement across partners

- Meet with Partner Agency CEO's and Governance Bodies
- Invite overview and scrutiny to examine progress made by LSCB

Jane Held
LSCB Chair
Jane Held LSCB
Chair



[Ongoing](#)



[Ongoing](#)
[Report to Improvement Board
14.02.11.](#)

Strategic Priority (2) Communication

2.1 Communicate what we do to the people of Leeds

2.1.1 To consider the options for building Communications capacity

- To receive a paper outlining proposals for a Communications sub group
- To establish a communication support facility for the LSCB and review the original proposal for a 0.5 FTE Communications Officer for the LSCB Support Team

Executive group



[Completed](#)
LSCB 21.01.11.

Executive group



[Ongoing](#)
Budget agreed for 2011/12
June 11 R&S initiated

2.1.2 To update and re brand the LSCB website

- To commission a review and redesign of the LSCB website

Bryan Gocke
LSCB Manager



[Ongoing](#)
Included in Business Plan 2011/12

2.1.3 To make 'What to do if you are worried about a child' accessible to the public

- To include on the LSCB website
- To produce & disseminate posters highlighting safeguarding information and the LSCB website

Bryan Gocke
LSCB Manager



Included in Communication
Strategy 2011/12

Bryan Gocke
LSCB Manager



Included in Communication
Strategy 2011/12

Appendix 2

2.1.4 To engage with key stakeholders

- To hold a series of stakeholder events to talk about the work of the LSCB

Jane Held
LSCB Chair



Meetings held with third sector organisations.

Strategic Priority (3) Performance Management and Quality Assurance

3.1 Use the LSCB performance information framework to analyse safeguarding performance across the partnership

3.1.1 To finalise and use the framework for 2010/11 based on currently available data / reports

- To provide available data for QTR 2 onwards
- To collate and provide updated CSIP report at each Board Meeting
- To collate and provide key issues from relevant performance, audit and improvement reports from partner agencies
- To summarise and analyse performance information to provide a report to the CTB on the effectiveness of safeguarding arrangements in Leeds

Sam Prince
Chair, Performance
Management sub



[Completed](#)
Q2, Q3, Q4 reported

Sam Prince
Chair, Performance
Management sub



[Completed](#)

Sam Prince
Chair, Performance
Management sub



[Completed](#)
Annual report to CTB

Sam Prince
Chair, Performance
Management sub



[Completed](#)
Consultation with CTB 15.06.11.
Report to CTB 11.07.11.

Appendix 2

3.1.2 To develop a more comprehensive framework for use in 2011/12

- To develop and agree the measures for the 2011/12 performance and outcomes framework
- To support and expect partner agencies to provide monthly performance information in order to report to the Executive and the Board

Sam Prince
Chair, Performance
Management sub

G

[Completed](#)
LSCB 15.07.11.

Sam Prince
Chair, Performance
Management sub

A

[Ongoing](#)
Engagement with partners
throughout 2011/12

3.2 To audit safeguarding practice and processes

3.2.1 To develop a LSCB multi agency QA model, and QA plan for 2011

Sam Prince
Chair, Performance
Management sub

A

[Ongoing](#)
Being developed as part of PMS
2011-15

3.2.2 To undertake a sample audit of the key improvements identified in recent SCRs

Sam Prince
Chair, Performance
Management sub

A

[Ongoing](#)
To be included in LSCB Audit
programme 2011/12

3.2.3 To commission an external audit of cases where C&YP have been subject to CP Plans for longer than 2 years and report to the LSCB.

Sam Prince
Chair, Performance
Management sub

A

[Ongoing](#)
Review received Oct 2010.
Monitoring ongoing

3.3 To ensure the LSCB has sufficient performance management and quality assurance support

3.3.1 To establish and recruit PM & QA Officer posts in LSCB Support team


- | | | |
|---|-----------------------------|---|
| <ul style="list-style-type: none"> • To obtain approval for the establishment of the posts | Bryan Gocke
LSCB Manager | <div style="background-color: #008000; color: white; padding: 5px; text-align: center; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">G</div> Completed
LSCB 21.03.11. |
| <ul style="list-style-type: none"> • To engage a 0.6 FTE agency QA Officer for 3 months | Bryan Gocke
LSCB Manager | <div style="background-color: #008000; color: white; padding: 5px; text-align: center; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">G</div> Completed |
| <ul style="list-style-type: none"> • To engage an agency PM Officer for 3 months | Bryan Gocke
LSCB Manager | <div style="background-color: #008000; color: white; padding: 5px; text-align: center; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">G</div> Completed
Input from LCH PM .
0.2 PM Consultant engaged |

3.4 Involvement of C&YP and their families in improving safeguarding practice

<p>3.4.1 Provide a review of actions taken to promote the engagement of C&YP in the work of the LSCB and identify options for ways forward</p>	Bryan Gocke LSCB Manager	<div style="background-color: #008000; color: white; padding: 5px; text-align: center; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">G</div> Completed LSCB meeting 22.11.10.
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<p>3.4.2 Appoint Lay Members to the LSCB</p>	Bryan Gocke LSCB Manager	<div style="background-color: #FFA500; color: white; padding: 5px; text-align: center; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">A</div> Ongoing Included in Governance review Jun – July 2011
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Appendix 2


3.4.3 Initiate discussions with the Third Sector about their contribution towards supporting the engagement of CYP and their families in the work of the LSCB	Bryan Gocke LSCB Manager	 Completed Third Sector Reference Group business plan 2011/12
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Strategic Priority (4) Championing basic good practice in safeguarding for vulnerable groups (doing simple things well!)



4.1 Prioritise which groups of C&YP to focus on in 2011/12

4.1.1 To provide a report to the LSCB based on the JSNA, the CTB priorities and available demographic data to identify groups to focus on	Bryan Gocke LSCB Manager	 Completed Development Session 18.02.11.
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4.2 Inform multi and single agency commissioning of services to these groups of C&YP

4.2.1 Work with partner agencies and partnerships to provide information about how safeguarding issues are included in commissioning, procurement and contract monitoring processes	Jackie Wilson Chair, Policy & Procedure sub	 Completed LSCB 21.03.11.
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4.3 Establish links with C4EO with a view to bringing sector specialist expertise and resources into Leeds

4.3.1 Review evidence of what works and identify whether any of the learning can be used	Kevin Ball Chair, Learning & Development sub	 Ongoing Professional Development Strategy included in L&D sub business plan 2011/12
4.3.2 Plan and initiate a series of 'what works' events for frontline	Kevin Ball	 Ongoing

Appendix 2

practitioners (invite sector specialist to assist)

Chair, Learning & Development sub

A [Included in business plan 2011/12](#)

4.4 Prepare a set of good practice standards leaflets for frontline practitioners

4.4.1 Develop a set of basic good practice standards relating to child protection across all agencies

Jackie Wilson
Chair, Policy & Procedure sub

A [Ongoing](#)
[Included in business plan 2011/12](#)

4.4.2 Run a series of workshops with practitioners and team managers to test out the standards

Kevin Ball
Chair, Learning & Development sub

R [To await development of standards](#)
[Included in business plan 2011/12](#)

4.4.3 Publish the standards in a quick reference, easy use format

Jackie Wilson
Chair, Policy & Procedure sub

R [To await development of standards](#)
[Included in business plan 2011/12](#)

Strategic Priority (5) Governance

5.1 Complete the organisational restructure and development of governance arrangements

5.1.1 To review and refresh membership of all the LSCB sub groups

Bryan Gocke
LSCB Manager

G [Completed](#)
[LSCB 22.11.10](#)

5.1.2 To agree arrangements to discharge the responsibilities of the Area Safeguarding Children groups

Martyn Stenton

A [Ongoing](#)
[LSCB 22.11.10.](#)
[Business plan 2011/12 includes engaging with new Locality arrangements](#)

Appendix 2

5.1.3 To review the operation of current LSCB task groups

Deborah Lightfoot
Head of
safeguarding

G

[Completed](#)
LSCB 21.03.11.

5.2 Clarify and establish support arrangements for the LSCB

5.2.1 To input into the establishment of the Integrated Safeguarding Unit

Deborah Lightfoot
Head of
Safeguarding

G

[Ongoing](#)
LSCB 22.11.10 + 21.01.11.

5.2.2 To agree LSCB budget 2011/12

Deborah Lightfoot
Head of
Safeguarding +
Bryan Gocke LSCB
Manager

G

[Completed](#)
LSCB 21.03.11.

Strategic Priority (6) Workforce Development

6.1 Ensure that all organisations that work with or come into contact with children operate recruitment and HR practices that take into account the need to safeguard and promote the welfare of children.

6.1.1 To review progress made by partner agencies through the

Sam Prince

G

[Completed](#)

Appendix 2

s(11) self audit


Chair, Performance Management sub  [LSCB 21.01.11.](#)

6.1.2 To initiate a sample audit programme of recruitment practices in partner agencies

Sam Prince
Chair, Performance Management sub  [Completed](#)
[Sample audit Feb – Mar 2011](#)

6.2 To establish how best to work with the Children’s Trust on Workforce Development

6.2.1 To agree proposals arising from an options appraisal for Workforce Development activity.


Executive group  [Ongoing](#)
[Work being undertaken with CTB sub group.](#)

6.3 To improve access to LSCB core child protection training

6.3.1 To co-ordinate the delivery the revised and restructured training programme

Kevin Ball
Chair, Learning & Development sub  [Completed](#)
[Revised programme being delivered as planned](#)

6.3.2 To review the implementation and impact of the revised training programme

Kevin Ball
Chair, Learning & Development sub  [Completed](#)
[L&D sub Annual Review 16.05.11.](#)

LSCB Financial Statement 2010/11

	£
<u>Expenditure</u>	
Staffing	333,572
Independent Chair	19,784
Independent Chair (CD Review Panel)	
Consultancy	25,338
Travel	1,271
Serious Case Reviews	44,786
Adult and Children's Protocols	19,265
Delivery of Training	25,100
Printing & Photocopying	6,075
Participation	4,100
E-Learning Package	0
Tri-x	925
Ceemach	2,444
Web-Site Maintenance	1,131
Conference	0
Miscellaneous	2,772
Premises	15,012
Total Expenditure	501,575
<u>Income</u>	
Grant for child death processes	69,950
PCT	189,532
LCC/Ed Leeds	247,600
West Yorks Police	14,610
West Yorks Probation, CAFASSS	3,300
Additional Income Required from Partners	
Other Income	1,078
TOTAL Income	526,070
(Surplus)/Deficit	(24,495)
Brought Forwards (2009/10)	120,920
Carry Forwards to 2011/12	145,415

LSCB Base Budget for 2011/12

Total staffing Budget 2011/12		382,530
Other Expenditure		
Independent Chair		39,600
Travel Costs		2,500
Serious Case Reviews		50,000
Delivery of Training		15,000
Printing		5,000
Office Supplies		5,000
Equipment		5,000
Communication		5,000
Tri-x		2,010
Ceemach		2,430
Web-site Maintenance		2,000
Miscellaneous		5,000
Total Other Expenditure		138,540
<hr/> Total Expenditure		<hr/> 521,070
Funded By:		
Leeds City Council	60%	312,640
PCT	30%	156,320
Other Partners	10%	52,110
<hr/> Total Funding		<hr/> 521,070