



# **Calderdale Safeguarding Children Board**

**Annual Report  
2011 - 2012**

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# **SECTION 1.0**

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## **Introduction**

## 1.0 INTRODUCTION

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- 1.1 I am pleased to present this annual report, on behalf of Calderdale Safeguarding Children Board, covering the period 1<sup>st</sup> April 2011 to 31<sup>st</sup> March 2012. It reports and reflects on activity in my first year as Chair of the Board. We are also producing an Executive Summary and, for the first time, a version for young people which will be written in conjunction with the Youth Advisory Group. All reports will be placed on our recently upgraded website.
- 1.2 Compilation of this report has been an instructive exercise, offering opportunity to reflect on the safeguarding work that has taken place over the last year and to consider the changes that have taken place. Revisiting last year's annual report in preparation, also demonstrated the scale of changes since the restructure of the Board in 2010.
- 1.3 The report rightly acknowledges the achievements of the last year, but in considering those achievements also highlights some of the steps that need to be taken next to further embed those achievements in the future.
- 1.4 As a Board, a key priority over the past year has been to find out more about safeguarding practice and to enhance the mechanisms for this so that we can be assured that we have an accurate picture. The Board has repeatedly asked the question, 'What difference have we made to the lives of children and young people in Calderdale?', and this question has informed the work streams of both the Board and its Sub-groups. Our information systems have been improved to support this enquiry, and the Quality Assurance Framework has become increasingly robust. From this position, we have been able to scrutinise practice more effectively. The link with the Improvement Board provides additional opportunity for sharing information and keeping the focus on improving services.
- 1.5 The Quality Assurance framework has enabled the Board to ask more informed questions about practice, and most importantly to intervene where there are identified gaps, or unsatisfactory provision. This report offers a range of examples of intervention from the Board into practice.
- 1.6 This scrutiny from the Board therefore has indicated problems, as well as reassurance that some basic practices are now sufficiently robust, but it is important to recognise that areas of strength have also been found, and we have sought ways to ensure that positive messages can be communicated to the workforce and agencies that have received such criticism in the past. The introduction of safeguarding awards this year is a particular example of this approach, recognising both excellent and innovative practice
- 1.7 Undoubtedly, the more we have learned as a Board, the more we recognise that we need to do.

- 1.8 The Peer Review held in 2011 concluded that Calderdale children and young people were 'safer', as a result of recent improvements in practice. Whilst this was a positive message, it also served as an indicator to the Board that there was still so much to do. It remains the case that until sustained improvements can be evidenced, confidence in safeguarding provision in Calderdale remains fragile.
- 1.9 The last year has seen the Board become involved initiatives that actively seek and listen to the views of young people, and this has challenged us to look differently at the work we do. This development is valuable to the Board, and will be a significant feature of our future work.
- 1.10 It has become a cliché to say that safeguarding children is everybody's business but it is none the less true. Families, neighbours and communities all play a part. It remains the case, however, that the task of safeguarding children in Calderdale who are considered to be at risk of harm is supported by many highly trained and committed staff across the agencies. Our thanks are owed to them and it is only with their support and hard work that we will continue to improve services to children and their families. To them I send my personal thanks.



**Jane Booth  
Independent Chair  
Calderdale Safeguarding Children  
Board**

## **SECTION 2.0**

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### **The Calderdale Context**

## **2.0 THE CALDERDALE CONTEXT**

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### **2.1 National Context**

2.2 There is a central government requirement that a Safeguarding Children Board be established in all council areas and its purpose and functions are set out in statutory guidance. In Calderdale, all agencies are committed to working together to safeguard the children and young people of Calderdale and this commitment is shared by members of the local council. The Safeguarding Children Board brings all these agencies together and provides a framework for ensuring that all agencies and professionals work effectively in protecting children from harm.

2.3 In June 2010 the Secretary of State for Education asked Professor Eileen Munro, a professor at the London School of Economics and Political Science, to conduct an independent review of child protection in England. The government responded to the Munro report on 13th July 2011 and stated a commitment to amending statutory guidance about safeguarding children by December 2011. At the point of publication of this report revised guidance is out for consultation and current proposals herald significant changes in respect of inter-agency working and the responsibilities for the Board. Proposed changes to the work of Safeguarding Children Boards will be carried out within a wider context of changes to many aspects of safeguarding practice following the Munro Review, and much of this change will take place during 2012-13.

2.4 As with other local areas, a shift towards working differently with 'Troubled Families' and the use of early intervention strategies to prevent later, avoidable harm to children is a priority for Calderdale's safeguarding agencies.

### **2.5 Local Context**

2.6 Calderdale consists of the towns of Halifax, Elland, Brighouse, Sowerby Bridge, Hebden Bridge and Todmorden as well as a number of villages.

2.7 It is one of the largest metropolitan boroughs at 140 square miles, but has one of the smallest populations of a metropolitan borough. Most of the area is classified as rural; a quarter of its population defined as living in rural areas. Dispersed populations and the mix of service needs, and access issues are distinctly different from that of a more urban area.



**The Piece Hall  
Halifax**



**Lockkeeper Statue  
Sowerby Bridge**



**Rochdale Canal  
Todmorden**



**Town Hall  
Brighouse**

## 2.8 What do we know about our children?

There are about 48,000 children and young people aged 0 – 18 and 64,800 aged 0-25. (2010 HM Government estimate)	Approximately 8000 children live in households with no-one in employment	The quarterly teenage conception rate for quarter 3, 2009 was 48.3, per thousand females aged 15-17. This is a drop of 9.6% from the 1998 baseline.
About 2,744 births per year and the under 15 population is projected to increase rapidly in both 2014 and 2019	17.5% of children are eligible for Free School Meals ( compared with England average of 19.2%)	1083 children and young people have a Statement of Educational Need (31.1.12) compared with 1111 in March 2011
There are over 33,000 children enrolled in 101 Calderdale Maintained Schools of which there are 87 Primary and 14 Secondary (Including Special Schools)	As of March 2012 there were 404 (7.4%) compares with 399 in November 2010 (6.4%) 16 and 17 year olds who were not in education, employment or training, down from 524 (8.6%) in 2009	In 2011, 246 Children had a Child Protection Plan compared with the period 12 months earlier of 180
18.5% of the school population are from a minority ethnic group	There are an estimated 1500 young carers, of which 270 are known to the Young Carers service	There are approximately 775 Disabled Children with a range of needs (based on a census in November 2008)
In 2009-10 the obesity rate for children in reception was 7.7%, however for children in year 6 it increases to 17.4% and this rate is increasing	Approximately 3000 children and young people aged 5-16 will have an identifiable mental health problem	March 2012 366 Looked after children compared with 272
In 2011, at key stage 3, higher numbers of Calderdale children achieved level 5 in English, Maths and Science than the average for England as a whole	48% of young people in the last electronic health needs assessment indicated that they had experience of being bullied	For the period 2006-10 over 130 young people were referred to the child sexual exploitation co-ordinator
For 2006/08 Calderdale had an Infant Mortality Rate of 5.8 compared to an England rate of 4.8	In 2010 2238 children were present at 1251 Domestic Violence incidents (WY police)	For 2008/2010 the rate had increased to 7.4% compared to an England rate of 4.4%

- 2.9 In February 2010 Ofsted and the Care Quality Commission published a report of an inspection which judged the overall effectiveness of the Council's safeguarding services to be 'inadequate'. The council and its partners established an Improvement Board and all agencies signed up to action plans aimed at ensuring good services were delivered to the children of Calderdale and their families. There is no doubt that progress has been achieved in some areas but there have been concerns about the pace of change and the sustainability and lack of capacity in organisations, particularly in Children's Social Care.
- 2.10 These concerns were confirmed when in February 2011 an unannounced Ofsted inspection on contact, referral and assessment was carried out (published 16 February 2011) and the Council itself commissioned a Peer Review in November 2011. On the basis of evidence contained in these reports the Secretary of State issued the Council with an Improvement Notice requiring the Council and Its partners to:
- (i) improve areas of weakness identified in the Ofsted inspection reports dated 26 February 2010 and 16 February 2011 and ensure safeguarding and looked after children's services meet all legislative and statutory guidance requirements; and
  - (ii) put in place arrangements to sustain and build on the improvement secured.
- 2.11 The Children Safeguarding Board continues to work with its partner agencies on the improvement programme and in particular has taken a lead on Quality Assurance systems. The agenda for change is challenging but the Board can see changes for the better in some areas of practice and has a better understanding of where performance still needs to improve and how to provide the balance of support and challenge to agencies.
- 2.12 A key question is whether we can say that children and young people are being more successfully safeguarded as a result of better working across agencies. There are some pointers to help us answer this question in the statistics above which are as of April 2012.
- 246 children are being supported via a Child Protection Plan (180 in the previous year). The majority of these children are living at home with their parents and all are actively supported by a range of agencies. 100% have an allocated social worker (not the case in 2010). The increase in numbers is believed to be a direct result of better practice in the Children's Social Care First Response Team and in their capacity to carry out Initial and Core Assessments both more promptly and more effectively.

- 366 children are being “looked after” by the Council (270 in the previous year). 2011-12 has seen a significant increase in this category and a sharp increase in the number of applications to court for a Care Order. For some of these children, work is going on to support changes that could lead to their return home, some are placed back at home with a view to there being such a reduction in concern that it is likely to be possible for their parents to resume full responsibility for their care and others are placed in foster or residential care, or awaiting adoption. Whilst this is a sharp increase it reflects changes in practice which bring the rate of applications for care orders in Calderdale into the mid range nationally from a previously lower base.
- An identifiable group of children and young people have been referred due to concerns re child sexual exploitation (CSE). Recent years have seen improved inter-agency work, led by the police, in this area and all relevant agencies play their part in supporting these young people and working on strategies to protect them. There is evidence of good cross authority boundary working, and a future development will be the commissioning of a therapeutic service to support this work. The team working with “missing children and the CSE team work closely together.
- 2238 children were present at Domestic Violence Incidents. These are incidents resulting in a call out to the police and all officers have been trained to ensure children are identified. Steps are taken in all cases to ensure information is shared between the police and Children’s Social Care and, where the person subject to the violent incident consents, information is passed to the Women’s Centre who make a follow up call to offer support and access to services. In 2011-12 the Women’s Centre was awarded a grant by the DfE to work with 10 LSCB’s (of which we are one), to look at multi-agency practice and risk assessment in cases of domestic violence and the effectiveness of services in ensuring the impact on children is recognised. We look forward to the outcome of this work and are committed to making any improvements which follow from this.

2.13 Although the Board has comprehensive systems in place, assessing the safety of our child population is a complex matter. It is encouraging that we know much more about our children and how services respond to their needs than we did but much of our information comes from measuring data linked to formal processes. For the first time at our Annual Conference we had a presentation from our Young Advisors who had carried out a survey with other young people about their safety and we were able to receive clear messages direct from them. The annual school survey is already a rich source of information for about children’s experiences and the 2012-13 survey will ask about safety in relation to domestic violence.

2.14 We intend to continue to find more effective ways of knowing about children’s experiences in order to ensure agencies work together and with families in ways that reduce the risk of harm.

## **SECTION 3.0**

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### **The Board – Structure and Membership**

### 3.0 THE BOARD – STRUCTURE AND MEMBERSHIP

#### 3.1 Membership

3.2 Calderdale SCB has the following membership:

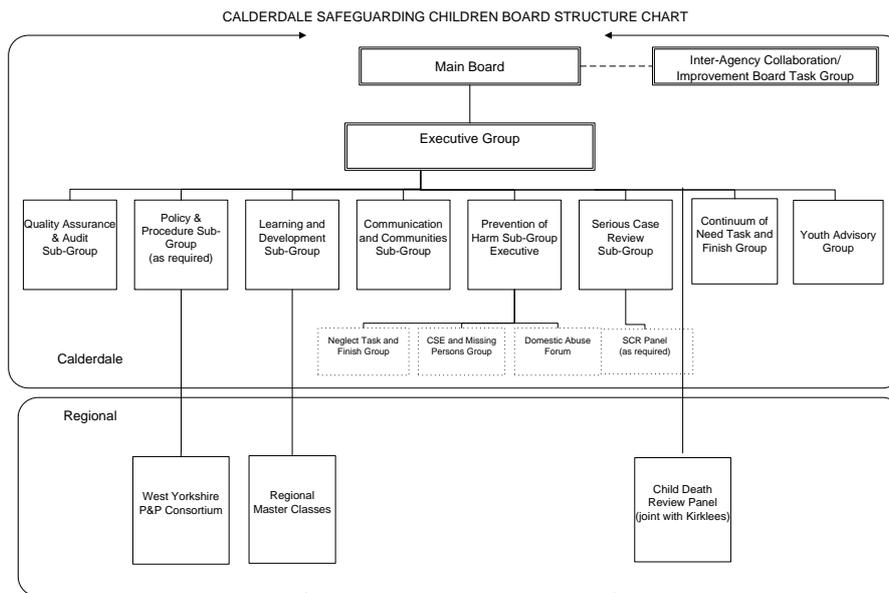
<b>Name</b>	<b>Job Title</b>	<b>Agency</b>
<b>Jane Booth</b>	Independent Chair	Calderdale Safeguarding Children Board
<b>Stuart Smith</b>	Interim Group Director	Children and Young People's Services, Calderdale MBC
<b>Gini Whitehead</b>	Head of Probation for Calderdale	National Probation Service
<b>Noreen Young</b>	Director of Nursing Compliance and Innovation	South West Yorkshire Partnership Foundation Trust
<b>Julie Lodge</b>	Named Nurse for Child Protection	South West Yorkshire Partnership Foundation Trust
<b>Bev Maybury</b>	Interim Group Director	Health and Social Care, Calderdale MBC
<b>Sue Cannon</b>	Executive Director, Quality & Engagement	Calderdale NHS
<b>Chris Hardern</b>	Chief Superintendent	West Yorkshire Police
<b>Helen Thomson</b>	Director of Nursing	Calderdale and Huddersfield NHS Foundation Trust
<b>Dr Pamela Ohadike</b>	Consultant Paediatrician	Calderdale and Huddersfield NHS Trust
<b>Robin Tuddenham</b>	Director of Communities	Safer and Stronger Communities, Calderdale MBC
<b>Ian Hughes</b>	Head of Democratic & Partnership Services	Democratic and Partnership Services, Calderdale MBC
<b>Angela Everson</b>	Joint Chief Executive	Women Centre Calderdale/Voluntary Sector
<b>Fiona Fitzpatrick</b>	Interim Assist. Director, Children's Social Care	Children and Young People's Services, Calderdale MBC
<b>Bernadette Johansen</b>	CSCB Business Manager	Calderdale Safeguarding Children Board
<b>Councillor Megan Swift</b>	Elected Member	Calderdale MBC
<b>Dr Steven Cleasby</b>	General Practitioner/Senior Partner	Spring Hall Medical Centre
<b>Jacque Hellowell</b>	Lay Member	Calderdale Safeguarding Children Board
<b>Ian Hillas</b>	Lay Member	Calderdale Safeguarding Children Board
<b>Leona Binner</b>	Head at St Augustine's School	Primary Heads
<b>Helen Plaice</b>	Head at Todmorden High School	Secondary Heads
<b>Alexandra Sayer</b>	Head of Service	Cafcass

### 3.3 Agency Attendance at the Board

Agency	Attendance at Board Meetings (out of a possible 5)	Attendance at Executive Meetings (out of a possible 6)
Calderdale Safeguarding Children Board Chair	5	6
Children & Young People's Services, Calderdale MBC	4	6
National Probation Service	4	4
South West Yorkshire Partnership Foundation Trust	5	N/A
Health & Social Care, Calderdale MBC	2	N/A
West Yorkshire Police	5	5
Calderdale & Huddersfield NHS Foundation Trust	4	4
Safer & Stronger Communities, Calderdale MBC	2	N/A
Democratic & Partnership Services, Calderdale MBC	0	N/A
Voluntary Sector	4	N/A
Elected Member - Calderdale MBC	2	1
Primary Heads	1	N/A
Secondary Heads	1	*
Lay Member	5	*
Cafcass	2	N/A

\*Only one Head teacher is expected to attend the Executive

### 3.4 How Calderdale Safeguarding Children Board Works



The Board is supported in its work by the Secretariat.

### 3.5 The Secretariat in 2011/2012 included:

- Independent Chair
- Business Manager
- Board Administrator
- CSCB/CDOP Administrator
- Workforce Development Officer, Multi-Agency Safeguarding
- Policy Development Officer – post deleted August 2011

3.6 A new Business Manager was appointed in January 2012. The post of Workforce Development Officer was vacant between January and March 2012, with cover provided by commissioned training staff.

#### Key Achievements

- Streamlining business processes – Calderdale Council awarded the Secretariat for the Board Lean 2 status in recognition of increased business efficiency
- Increased consistency of minutes and reports following the introduction of new templates
- Framework for improved timeliness and presentation of agendas, Board papers and minutes

#### Next Steps

- Continuing development of streamlined business processes
- Further training of staff in order to improve the quality and presentation of Board materials
- Increasing IT skills to improve business efficiency

- 3.7 The work of the Board is conducted through its Board meetings, its Executive and its Sub-groups
- 3.8 The Youth Advisory Group was established in 2011 and also reports to the Board.
- 3.9 The Executive comprises the Chair of the Board, the Director of Children and Young People's Service, the Head of Probation, the Executive Director Quality and Engagement Calderdale PCT, the Chief Superintendent Divisional Commander Calderdale Division West Yorkshire Police, a Head-teacher Representative, and an Elected Member as a participant observer with support from the Safeguarding Manager
- 3.10 Its function is to coordinate and support the work of the Sub-groups, ensure availability of appropriate budget, and drive forward the business of the Board.

#### **Key Achievements**

- The peer review conducted in September 2011 commented that 'the core business of the Board is good'.

#### **Next Steps**

- Continue to embed good practice and consolidate progress made over the last 12 months
- Ensure robust Business Plan for the Board in place

### **3.11 The Board - Governance and Accountability**

- 3.12 Whilst the Calderdale Safeguarding Children Board is responsible for coordinating and monitoring the effectiveness of agencies in safeguarding children, it is not directly accountable for their operational work, but to hold them to account. Each member agency is accountable to its own governing body and is required to ensure that it carries out its safeguarding activity in accordance with the Calderdale Safeguarding Children Board's policies and procedures as well as guidance issued under Working Together to Safeguard Children (2010) and other national guidance.
- 3.13 The Director of Children and Young People's Services holds the statutory responsibility for ensuring an effective Safeguarding Children Board is in operation and meets regularly with the Chair of the Board. The relationship between the two is one of mutual accountability and challenge. In Calderdale the Chair of the Board also meets regularly with the Council's Chief Executive.

### **3.14 Roles and Responsibilities of Members**

- 3.15 Although the majority of the Board's members are nominated by their agency they are accountable for their work as a Board member to the Independent Chair of the Board. The Board has two lay members who bring a different perspective. Calderdale Council has nominated a lead elected member who serves on the Board as a participant observer. The lead elected member has delegated responsibility and is accountable for their contribution to the effectiveness of the Board.

### **3.16 Reporting Mechanisms**

- 3.17 The Board's Sub-groups report on a quarterly basis. Recommendations from the chairs are considered by the Board according to its priorities. Any issues a Sub-group cannot satisfactorily resolve are escalated via the Board

### **3.18 Accountable Body**

- 3.19 Calderdale Metropolitan Borough Council acts as the Accountable Body for the Board and provides support in administration of its HR and financial functions. It is the formal employer of Board's secretariat and provides accommodation and IT support to the Board on a recharge basis. The Council does not however have decision making powers in respect of the Board's work and priorities other than through its representation on the Board.

### **3.20 Progress and Achievements**

- 3.21 Following an adverse Ofsted inspection in 2010 a review of the effectiveness of the Board was completed by Price Waterhouse Cooper. The report proved to be a vehicle for major change and resulted in a complete restructure of the Board. One year on, the changes appear to have improved the efficiency of the Board and two separate, independent processes commented that 'the Board is seen as a strength by partners' ( Peer review 2011) and 'business processes have improved' Improvement Notice ( 2011)
- 3.22 The Board now operates with representation from all the key agencies. Over the past year, there has been an increase in representation alongside plans to further extend this in the next.
- 3.23 The Board is operating with a range of Sub-groups and short life Task Groups. These groups draw on the skills and knowledge of a diverse range of professionals and there are established links with the voluntary sector. The groups have developed work streams which directly relate to both the statutory responsibilities of the Board, as well as locally determined priorities.
- 3.24 The work of the Board is delivered via a Business Plan and the Business Plan for 2012-13 is attached (See Appendix 1). A Risk Register is also in place and regularly updated to enable the Board to act to mediate any potential problems in delivering on its responsibilities.
- 3.25 With the scale of change facing member agencies, the Board seeks to look ahead and continues to review its membership and relationships. With changes in education and management of schools and increasing numbers of Academies, the Board is engaging with the Head Teachers' Representative Groups about the best way to ensure schools representation for the future. Similarly there is active dialogue with health partners about likely changes in health structures to ensure continuing effective representation on the Board.
- 3.26 The work of the Board is made more complex locally by the presence of the Improvement Board. However, Board members have made a significant contribution to the improvement agenda.

- 3.27 Many SCB members participate in and are accountable to both Boards. This creates some challenges for the Safeguarding Board in ensuring relevant issues are presented to the most appropriate Board without unnecessary duplication.
- 3.28 The presence of the Improvement Board is also an indicator that whilst changes have been made, the progress towards improved services has been compromised at times.
- 3.29 The work of the Board's Sub-groups has been hampered, at times, by a lack of continuity of leadership and this is recognised as an ongoing risk in the Board's Risk Register. The lack of consistency over the longer term has resulted in a backlog in tackling a range of practice issues. There are a great number of priorities and it is therefore a challenge for the Board to ensure that the most pressing issues are dealt with immediately, and that the number of challenges does not overwhelm. Inconsistency has also meant that learning from events and transfer of information has not always been as efficient as it could have been. An important priority for the Board has been to develop strong structures for the transfer of learning and embedding of improvements to practice under these conditions.
- 3.30 The drive to improve Quality Assurance processes inevitably uncovers more issues for the Board to consider. We are asking deeper questions about the impact of changes, and the degree to which our own activity has made a measurable and sustainable difference to services to children. The improvements over the past year to Quality Assurance mechanisms have provided a clearer picture of the performance of our partner agencies, leading to increased scrutiny of the Board's role in interrogating the information and using it to improve outcomes. This report provides specific examples of intervention leading to improvement directly resulting from the Quality Assurance framework.
- 3.31 Undoubtedly, there have been pressures and difficult operating conditions, but there have also been some clear achievements over the past year that can be evidenced throughout this report, as well as plans for further improvement.

### **Key Achievements**

- The positive self assessment prior to the peer review proved accurate, and indicated a level of self-awareness of strengths and weaknesses
- Increased membership of the Board with particular representation from schools
- Increased participation in the Board's work by a greater number of agencies
- Increased involvement of young people through the Youth Advisory Group
- Training for lay members, including mentoring and support for them
- Induction for new Board members
- Increased links with the Safeguarding Adults Board (SAB), and collaboration on projects such as publicity. Sharing of Quality Assurance practices from the children's sector with the SAB
- Serious Case Review completed in 2011, and evaluated by Ofsted as 'good'

## **Next Steps**

- Equality Impact Assessment is required in relation to the new structural arrangements as well as the Business Plan
- The frequency of Board meetings will be increased to ensure that sufficient attention is given to all Board priorities
- Further use of development days to allow time to explore whether we are targeting our work appropriately, and responding to national and local drivers effectively
- 'Job descriptions' and appraisals for Board member
- Further measures to increase diversity of representation on the Board
- A mapping exercise will be carried out to further clarify our relationships and accountability with other with local strategic bodies to enhance communication and efficiency, and avoid duplication
- Improved engagement with schools is a priority for the Board in 2012 with the establishment of a Task and Finish Group to address this.
- Continued efforts to ensure that we are asking the right questions in order to be assured of the quality of services to children

## **SECTION FOUR**

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### **The Sub Groups of the Board**

## **4.0 THE SUB-GROUPS OF THE BOARD**

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4.1 The Sub-groups directly link to the statutory responsibilities of the Board and directly report to it. The content of the work streams is agreed by the Board and reflected in its Business Plan. In addition, there are several short life 'Task and Finish' Groups whose work is also described here. The Sub-groups provide quarterly reports of their work to the Board

### **4.2 Audit and Quality Assurance - Chair Deborah Turner**

In our Annual report for 2010-11 we reported that the Board had given priority to its role in monitoring the effectiveness of the work of its partner agencies in safeguarding and promoting the welfare of children and had adopted a comprehensive Quality Assurance Framework (QAF). 2011-12 is the first full year of its operation. The scope of the Quality Assurance work undertaken by the Board is broad and, at the request of the Council's Children's Social Care Improvement Board, encompasses a wide range of activity impacting on children and families.

4.3 The QAF comprises three strands:

- A performance scorecard which measures the position against both nationally and locally set indicators and benchmarks;
- A Risk Register to articulate the level of risk the Calderdale Safeguarding Children Board has with regard to delivering on its objectives; and
- A Quality Assurance report to capture the audit activity across Calderdale, and how this is improving the outcomes for children and young people in Calderdale.

4.4 During the course of the year the terms of reference, membership and work plan for the work of the Audit and Quality Assurance Sub-group were reviewed to align with the revised CSCB Business Plan agreed in February 2012. The work plan focuses on safeguarding in schools, recording keeping, case file audits, child protection plans, Section 11 compliance and training.

4.5 The QAF is now embedded in practice with quarterly data sets and reviews of the Risk Register.

4.6 A significant development has been the transition of the data set onto the LA Making a Difference (MAD) system which enables all agency data to be collected with the minimum of effort and makes the data available at any time to all agency partners.

4.7 Through the year there has been good support across partner agencies.

4.8 The priorities areas of work for 2011-2012 were:-

- Further embedding the Quality Assurance Framework;
- Completion of Section 11 audits;
- Follow up on Private Fostering arrangements;
- A focus on children missing from home and from education; and
- MAPPA attendance.

## **4.9 Variance Reports**

As result of the analysis of data from the performance scorecard (strand one of the framework) the following variance reports were requested:

- Health Visitor Numbers
- MAPPA Attendance
- Children Missing from Education
- Initial Case Conferences held within 15 days of Strategy Meeting
- LADO
- Children Missing from Home

4.10 These reports were scrutinised and either provided assurance to the Board regarding quality of services or led to procedural and practice changes.

## **4.11 Audit Reports**

As part of strand three of the QA framework, the following audit reports were received during 2011/12:

- Multi Agency Record Keeping
- Core Group Attendance
- CSCB Training Activity
- E Health Needs Assessment
- Conference and Review Service
- Probation Assurance
- YOT Assurance
- Section 47 Medicals

4.12 These reports were scrutinised and provided assurance or resulted in the development of actions plans

## **4.13 Private Fostering Arrangements**

4.14 Following the annual Private Fostering Report received by the CSCB, indicators were developed on the data set of the QAF to measure private fostering arrangements.

4.15 A Task and Finish Group was established to increase the awareness of private fostering across agencies, including the development of flowcharts, and leaflets. It was not expected that there would be an immediate impact and indeed this proved to be the case with no private fostering arrangements reported over 3 quarters, with this remaining at zero for the last 3 quarters. It is expected that changes will begin to be seen in the coming year and this is being kept under review.

#### **4.16 Children Missing from Home and Education**

More effective and efficient systems and processes have been developed over time for responding to children missing from home/care following learning from Serious Case Reviews. Since collation of the data started in 2004, the figures for children missing from home have reduced significantly. This is in line with trends across the West Yorkshire Police Force area.

#### **4.17 MAPPA Attendance**

4.18 A focus on MAPPA attendance arose from concerns about agency engagement in the previous year.

4.19 The agency attendance at MAPPA meetings has been monitored over the last 12 months now includes the representation of all statutory agency, with one agency increasing their attendance from 28% to 100% of meetings.

#### **Key Achievements**

- Agencies have successfully prioritised developing data processes and systems to service the data set of the Quality Assurance Framework
- The data collection has moved from a paper based collection service to being a core part of the Making a Difference (MAD) system.
- Risk Register has been updated on a quarterly basis to reflect the risks against the CSCB Business Plan.
- Successfully completed multi-agency audits
- Section 11 Audits in June 2011. Challenge events held with specific feedback to individual agencies and an overall summary report completed and presented to the CSCB
- Scrutiny of private fostering arrangements leading to the development of an improvement plan and agreement on Quality Assurance measures
- Improved inter – agency arrangements in respect of children missing from care or education
- Improved multi-agency attendance at MAPPA meetings

#### **Next Steps**

- Agencies to present the findings from their agency audits of 2011/12 and submit plans for their audit programmes for 2012/13 in July 2012
- Awareness raising of private fostering to be referred to the CSCB Communications Sub-group
- The Voluntary sector to develop indicators which evidence assurance of their performance in relation to safeguarding
- The Board to continue with annual Section 11 challenge panels for agencies to present their audits/action plans;
- A Task and Finish Group to explore engagement with schools and how they should be asked to demonstrate compliance with their safeguarding duties.

#### 4.20 Training and Development – Chair: Julie Lodge

- 4.21 The Learning and Development Sub-group meets bi-monthly and is well represented by agencies from the Board.
- 4.22 The group receives work from the Board and other Sub-groups and considers how it may be usefully included in the programme.
- 4.23 The annual programme (publicised on our website) includes taught courses, briefings, bespoke sessions, regional events, annual conference and an e-learning option. The group actively considers the link between current practice and how we respond to improve it. As part of the group’s work, we consider the need for new courses and how specific agencies can support the programme.

<b>Statistics</b>	<b>2012</b>	<b>2011</b>
Multi-Agency Taught Programme	584	576
E-learning	650	382
Bespoke	299	**
Annual Conference	98	90
Continuum of Need Briefings/Locality Briefings	343	**
<b>Total</b>	<b>1974</b>	<b>1048</b>

*Key \*\* No separate data collected*

#### 4.24 CSCB Briefings/Conferences/Taught Course – 1 Apr 11 to 31 Mar 12

Agency	Annual Conf	Briefings	Taught Courses	Total
CMBC/CSC (SW's and Managers)	11	31	123	165
CMBC (Residential Staff)	2	16	37	55
CMBC (Children's Centre's)	8	13	51	72
CMBC (Family Support)	11	28	32	71
CMBC (Other Adults)	15	17	15	47
CMBC (Youth Service/YOT)	8	54	23	85
Foster Carers	0	0	34	34
Schools/Learning Services	5	38	20	63
Adult Education/Colleges	0	0	3	3
Education Welfare	0	9	6	15
Housing	0	36	5	41
Probation	2	2	10	14
Cafcass	0	1	2	3
Branching Out/Lifeline	2	0	39	41
Connections	0	0	4	4
Health (HV/Community Midwives) }	3	58	30	91
Des Staff }	7	4	10	21
Health (School Nurses)	1	35	11	47
Health (Adults)	0	13	21	34
Health (Other)	1	0	5	6
CAMHS	0	4	4	8
Police	7	17	3	27
Prisons	0	0	2	2
Young Carers	0	0	5	5
Voluntary Sector/VAC/Women Centre	14	16	30	60
Pathway Team	1	0	10	11
<b>Total</b>	<b>98</b>	<b>392</b>	<b>535</b>	<b>1025</b>

#### 4.25 CSCB Bespoke/E-Learning/Training – 1 Apr 11 - 31 Mar 12

Agency	Lead Prof/ CP Plans	Safe-guarding	E-Learning	Induction	Total
CMBC Communities	0	0	1	0	1
CMBC/CSC	0	16	15	0	31
CSC Children's Centre's	8	21	0	0	29
CMBC Councilors	0	20	0	0	20
CMBC Health and Social Care	0	75	7	0	82
NHS GP's	0	35	0	0	35
Police	0	45	0	0	45
VAC	0	0	19	0	19
CSCB Board	0	0	0	4	4
Health	0	0	30	0	30
Schools	0	0	356	0	356
Family Support	0	0	87	0	87
Early Years	0	0	124	0	124
Youth Services/YOT	0	0	4	0	4
UKVC	0	0	7	0	7
CSCB YAG	0	0	0	5	5
<b>Total</b>	<b>8</b>	<b>212</b>	<b>650</b>	<b>9</b>	<b>879</b>

4.26 The taught programme includes a wide range of courses. Some of these offer training around child protection practice such as Working Together, child protection plans and multi-agency assessment. Others are more specialist and address Board priorities such as child sexual exploitation and neglect, as well as learning from Serious Case Reviews.

4.27 The additional grant from the Children's Workforce Development Council has been used to extend provision to address areas highlighted in the Munro report such as management training, training for the voluntary sector. Improvements to the e-learning programme have also been purchased with the grant.

4.28 The purpose of our taught programme is to achieve better outcomes for children and young people by:

- bringing learners together in order to foster shared understanding and improved collaborative working which we recognise as essential to effective safeguarding practice.
- providing the workforce with the awareness, skills and knowledge necessary to safe practice
- complementing the training programmes offered in individual agencies
- learning from Serious Case Reviews and other research

4.29 The programme is judged by the degree to which we meet those outcomes. Therefore, the evaluation of our work is an important element.

4.30 The programme is evaluated in the following ways:

#### **4.31 End of Course Evaluation Sheet**

4.32 The evaluation forms ask for a score of 1-5 and are overwhelmingly 4s and 5s. The most common criticisms relate to arrangements such as venue conditions rather than teaching.

4.33 Rehearsal and role play are often cited as the most valuable aspects of the training despite their unpopularity with learners. The opportunity to 'find out what other people do' in multi-agency training is valued.

#### **4.34 Post Course Telephone Questionnaires**

4.35 The questionnaires are randomly selected over a range of courses. The findings are similar to the evaluation sheets, but have the added advantage of testing knowledge retention.

4.36 One learner reported that she had, 'More understanding of the roles of other professionals and I think it helps when you are working with them'. Another respondent said that it, '*made me stronger and more assertive in multi-agency meetings.*'

#### **4.37 Line Manager Questionnaires**

4.38 The line manager receives a copy of both a questionnaire and the course materials. The intended outcome of this process is to take the learning into the workplace, and it appears to have achieved that in the limited number of responses we have received.

4.39 In one instance, the discussion about the course led on 'to a more in depth discussion within supervision about cultural issues'. Another line manager said that the discussion had increased 'knowledge about the processes around child protection but has also reassured them about their current practice'.

#### **4.40 Tutor Evaluations**

4.41 These are a useful process for gaining a perspective on any specific practice issues. Some are based in Calderdale, others are independent trainers who have experience of training delivery nationally. Their views are enlightening. Many comment very positively on the workforce, and how committed many of them appear. They also say that many of the problems faced here are almost identical to those elsewhere.

#### **4.42 Other Sub-Group Work in 2011**

4.43 In September 2011 the Sub-group also conducted a single agency audit across agencies of their own training provision. The outcome of the audit found significant disparity between agencies, leading to a Board commitment to ensure that this is followed up, and the recommendations for remedial action carried out. It is anticipated that the outcome will be followed up in the 2012 Section 11 process

#### **4.44 Children who Sexually Harm Others**

4.45 Some members of the group expressed concern both about professional practice and training provision, leading to a Short Task and Finish Group being established to improve both. This has resulted in changes to procedures, new practice guidance and a training and communication strategy.

#### **4.46 Areas for Development**

##### **4.47 Improved Transfer to Practice**

4.48 If training is to be effective, the acquired skills and knowledge must be transferred to practice. Strong correlations have been noted ( locally and nationally) between recall of training and discussion within the workplace. More emphasis on post course discussions must be encouraged, together with use of the line manager questionnaire.

##### **4.49 Multi-Agency Participation**

4.50 Both local and national evaluation, and research of multi-agency training emphasise the benefits of staff from different services learning together as a means of improving collaborative working. To support further improvement of joint working, it would be helpful to have higher levels of representation on the courses from a wider range of services.

##### **4.51 Clearer Training Pathways**

4.52 Learners tell us that for the more complex aspects of their role that single agency training is more useful, but recognise that they need a combination of both as part of their development. The inclusion of multi-agency training as part of continuing professional development should be more forcefully promoted.

#### **4.53 Increased Direction from Line Managers**

4.54 The course offered on Child Protection Plans and Core Groups has low numbers of applicants, but we know from other processes that there is sometimes a limited understanding of this field of practice. Learners say that they have attended Core Groups for many years and don't need training but it might be helpful for this view to be more robustly challenged within agencies.

#### **4.55 New Staff**

4.56 A new Workforce Development Officer starts in May 2012, the post having been vacant since January 2012. This is an opportunity to review all our provision and plan for the next year

#### **4.57 Links to Other Developments and Services**

4.58 The Board recognises that the programme must complement other practice developments, such as the Early Intervention Strategy, including both local and national developments arising out of the Munro Report. Collaborative work with the Safeguarding Adults Board has begun, and opportunities to deliver some joint training are under consideration.

#### **4.59 New Ways of Learning**

4.60 The programme has been responsive to requests for additional courses, but more thought should be given over the next year to learning and development provision outside the formal course format including use of the website.



***Calderdale Safeguarding Children's Board  
Annual Conference – March 2012***

## **Key Achievements**

- Evaluations have been carried with learners, their line managers and tutors, both immediately following courses and later, and they have been very positive.
- A successful annual conference attended by a diverse group of agencies
- The introduction of safeguarding awards
- Increase take-up of all our training provision
- The audit of single agency safeguarding provision was carried out by all member agencies, and proved an excellent benchmark for future work of the group
- Continued collaboration with West Yorkshire colleagues in training and master class provision
- Introduction of management training into the programme
- Development of a protocol and training pathway in respect of children who sexually harm others
- Voluntary sector support by funding of safeguarding training

## **Next Steps**

- Follow up audits from the single agency audit to check on progress
- Development of stronger link to other audits to check on effectiveness
- Direct log-ins for e-learning courses to improve take-up
- Further development of our management programme
- Development of the programme to respond to the work streams from other groups e.g. lessons from reviews, new practice developments, child protection plans.
- Further development of the evaluation programme to establish how far our programme is improving the skills of the workforce, and thereby improving services to children
- Sub-group to consider ways to improve the diversity of agency participation in training
- Development and promotion of stronger training pathways to ensure that staff are receiving the most appropriate level of training

### **4.61 Serious Case Reviews following Non-Accidental Child Deaths or Serious Incidents - Chair: Jane Booth**

4.62 Working Together requires all LSCB's to have in place effective arrangements for reviewing serious cases and advising their local authority and partner agencies of the lessons to be learnt. A serious case is defined as follows:-

- Abuse or neglect of a child is known or suspected; and
- Either – a child has died or the child has been seriously harmed and there is cause for concern as to the way in which the authority, the Board partners or other relevant persons have worked together to safeguard the child

4.63 The purpose of a Serious Case Review is to:

- Establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.
- Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result, and
- As a consequence, improve inter-agency working and better safeguard and promote the welfare of children' Working Together to Safeguard Children (2010), Chapter 8.

4.64 This work is managed by the Board's Serious Case Review Sub-group which, during the course of 2011-12 met on four occasions and retains the capacity to call a specific meeting if a case is referred for consideration. The Sub-group responds to referrals of cases to establish whether the criteria for holding a review is met and makes recommendations to the Chair of the Board as to the need for a review, and monitors completion of any action plans arising from reviews. The Sub-group also engages with agencies in respect of cases which do not meet the threshold for a formal Serious Case Review but where it is none the less believed that there are lessons to be learnt. The Sub-group is well attended with most relevant agencies in attendance at all meetings

4.65 Prior to the start of 2011-12 three SCR's, relating to previous years', had been signed off by Ofsted as complete. There was however some concern locally as to the robustness of actions taken. As a result the Sub-group has reviewed all historical action plans and has satisfied itself that all actions have been completed.

4.66 New systems have been introduced to require all agencies to produce evidence of completion of actions (previously assurances were generally accepted) and the Sub-group now holds evidence files which provide a higher level of assurance.

4.67 Two SCR's were completed in 2011 and are still awaiting publication:

- Child I (the review of this child's case was initiated in Blackpool, where the family had recently moved from Calderdale) and
- Child D

4.68 Decisions cannot be made about publication until the outcome of potential criminal proceedings is clear but all recommendations arising from the reviews have been implemented.

4.69 Two developments which arose directly from the SCRs are the implementation of a protocol around working with parents with learning disabilities and the agreement of an interagency strategy for managing cases of neglect.

4.70 During the course of the year the Sub-group has also followed up a number of cases which did not meet the criteria for a serious case review but where there was action by single agencies. For example, the Sub-group received a copy of an independent report commissioned by the Director of Children's and Young People's services in respect of a foster carer who had been convicted of offences against a child. The Sub-group had the opportunity to comment on this and the subsequent action plan and will receive an update on progress.

4.71 During the course of the year the Sub-group has commissioned a thematic case review into the challenges in providing effective services to young people who attempt suicide where there are significant mental health concerns. This review is ongoing at the year-end.

#### **4.72 Prevention of Harm Sub Group - Chair: Angela Everson**

4.73 The Prevention of Harm Sub-group brings together key professionals responsible for the delivery of services across Calderdale and takes forward the development of improved services in accordance with Board priorities.

4.74 The CSE Operational Group links in with this Sub-group, as do Short Life Groups that have been established to take forward Board priorities

4.75 Its work over the past year has focussed on domestic abuse, child sexual exploitation and neglect. The Child Sexual Exploitation Group is a well attended Multi-agency Group providing opportunity to share intelligence, plan and assess risk to children and young people where there are concerns about abuse. The group also discusses children and young people who go missing. The matrix method used is holistic, considering the diverse needs of the individual involved in order to both assess risk and provide appropriate support.

4.76 The group has been challenged by changes in membership over the year, but this has been rectified and completion of some key work achieved

4.77 The Neglect Group has created a multi-agency strategy for managing neglect alongside the development of practice tools. The next step for this group will be to link to other Sub-groups to ensure that it is appropriately embedded in practice. Further development is also being linked directly to early intervention work taking place.

4.78 The Board has participated in a Department for Education funded project aimed at improving inter-agency practice in assessing the needs of children in families where there are concerns about domestic violence. This work is ongoing at the year end.

4.79 Whilst specific work groups have been established, the Prevention of Harm Group has worked on other projects in conjunction with other Sub-groups. The development of a new protocol between children and adults services regarding parental learning disability is an example of this.

## **Key Achievements**

- Restructure of the group in order to increase focus and productivity. Revised terms of reference
- Completion of protocols on parental learning disability and neglect
- Participation in DfE project on domestic abuse
- Effective link between the group's priority themes and different agency activities has been strengthened e.g. the audit work by Safeguarding and Quality Assurance service on CP plans where domestic abuse a feature, multi-agency audit of referrals for domestic abuse, domestic abuse service review of children's views, inclusion in schools survey of a question on domestic abuse
- Participation in a whole system review, 'Is Elizabeth safe in Calderdale?' which explored obstacles to good practice and produced recommendations for multi agency work
- CEOP thematic benchmarking exercise in respect of CSE indicate that services are good
- Close, supportive link to Operational Group dealing with prevention of child sexual exploitation. This group has supported the casework, and is involved in the creation of a new service to deal with this issue.

## **Next Steps**

- Ensure that all current group projects are successfully completed, and linked to other groups to ensure embedding in practice.
- Develop work streams in line with the priorities established within the Business Plan.
- Focus on early intervention with families, and link to other spheres of Board activity
- Respond to the Board's Quality Assurance and auditing processes to ensure transfer to practice, e.g. audit of Child Protection plans and services to deaf children
- Review of strategic frameworks in respect of child sexual exploitation
- Continue to respond to SCRs and other reviews and their implications for practice

### **4.80 Communication and Communities - Chair: Robin Tuddenham**

4.81 The Communications and Community Engagement Sub-Group met bi-monthly throughout the year and had representation from Safer and Stronger Communities, Corporate Communication, Workforce Development and South West Yorkshire Partnership Foundation Trust. The group receives work from the Board and other Sub-groups and the communications plan was derived from the CSCB Business Plan.

4.82 The Communications plan for 2011 – 2012 was as follows:

<b>Audience</b>	<b>Outcomes/ Key Messages</b>	<b>Channel/ Message</b>
All – local residents, including parents and carers	Promote Safeguarding How to report outcome Prevention and positive parenting	Establish brand/website/ good news stories
Children and Young People	Promote Safeguarding How to report outcome	Establishment of Youth Advisory Group
Lay members	Induction, role and responsibilities	Media release
Professionals (Specialist – Senior Managers / Board of Partners)	Training, role and responsibilities	Annual Conference and Training and Development
Professionals (Other)	Training, role and responsibilities	Annual Conference and Training and Development

4.83 Of these planned activities, the new CSCB brand has been established with the logo appearing on both the website and the documentation produced by the CSCB. This is a significant change and will enhance the professional image of the CSCB.

4.84 The voice of the Children and Young People of Calderdale has been heard by the establishment of the Youth Advisory Group. A link to the School Survey has allowed further insight into the things that children and young people are concerned about.

4.85 The induction of 2 Lay Members onto the Board and the development of the Lay Member role and responsibilities have been carried out. One of the reasons behind the recruitment of lay members was to improve the links into the community. This representation of a lay person's perspective has brought a different viewpoint to the Board meetings and work of the Sub-groups.

4.86 During this year, the key messages have been disseminated to professionals by the targeted training and development and by a well-received Annual Conference in March 2012. The conference had a theme of 'The child's journey: our responsibilities, our challenges, our future' with excellent key note speeches, pertinent content and relevant workshops. It also gave the opportunity to recognise good practice and achievement by individuals and teams in the partnership by the presentation of Safeguarding Awards, which will become an annual event.

- 4.87 Over the year there have been challenges. It has at times been difficult to maintain membership of the Sub-group and this is a key area to tackle over the coming year. Another area of difficulty has been the failure to capitalise on opportunities for good news stories in the local press; for instance an article was written for the induction of the new members of the Board in May 2011 but this was never published. The availability of the new website will allow such messages and stories to be included under the 'What's New?' section and will allow better dissemination of information.

### **Key Achievements**

The key achievements during 2011-2012 were as follows:

- Development of new website which was launched at the Annual Conference on 15th March 2012
- Rebranding of the CSCB and development of a new logo for CSCB documentation and website
- Recruitment of a Youth Advisory Group to allow the 'voice of children' to be heard by the CSCB and attendance at the Annual Conference
- Involvement of stakeholders and young people via the Youth Advisory Group in the website development and development of the new Board logo
- Introduction of Safeguarding Awards which was a key recommendation from the Local Government Group Peer Review – which took place in September 2011 - to enhance the CSCB communications and engagement.
- Links to the Schools Survey

### **Next Steps**

- To undertake an Equality Impact Assessment to identify communities and groups for engagement
- To increase membership of and attendance at the group
- To maintain the website and ensure it is 'living' i.e. has regularly refreshed News and Forthcoming Events sections and prompts users when new content is available on the website
- To utilise additional communication channels e.g. e-call weekly newsletter
- To carry out a multi-agency 'communications benchmark' to find useful publications that may be included on the CSCB website
- To have a CSCB page for the CMBC Screen Saver in public buildings
- To have a stronger link to Training and Development

### **4.88 Youth Advisory Group**

- 4.89 Within Calderdale we have 5 trained and paid Young Advisors who advise Calderdale Safeguarding Children Board on decisions that affect children and young people in Calderdale. The Young Advisors were established following a recommendation from the inspection by the Calderdale Young Inspectors of the Safeguarding Children Board Website in September 2011. The group was influential in the changes to the design, graphics, colour and font for the new Calderdale Safeguarding Children Board logo.

- 4.90 The purpose of the Young Advisors is to inform the Board of young people's views regarding aspects of safeguarding in Calderdale.
- 4.91 The Young Advisors have met on three occasions with the Safeguarding Board Chair and Manager. Induction has been provided regarding the purpose of the Calderdale Safeguarding Children Board.
- 4.92 Regular meetings are planned, and there is a commitment from the Board to keep the group informed and consulted. The Youth Advisory Group are committed to keeping other children and young people informed.
- 4.93 The Board was very keen to ensure that this group was not tokenistic, and genuinely involved. Discussions were held regarding the nature and level of their participation, this is currently managed by a number of separate meetings facilitated by Participation Worker, Joanna Heyes. However, this needs to be reviewed on an ongoing basis to ensure that the partnership is working effectively.

### **Key Achievements**

- Inspection of the Board website and publicity materials leading to redesign
- Safeguarding survey carried out with 100 young people in Calderdale, and presented to the annual conference. The survey was subsequently adapted and used to good effect in one of the local primary schools
- Planning and successful delivery of a workshop at the annual conference
- Delivery of the safeguarding workshop at the Young People's Personal Safety Conference run by young people for young people.

### **Next Steps**

- Children and young people's version of this annual report to be produced
- A planned work programme for the year to link to the Business Plan
- The Young Advisors will meet with the Safeguarding Manager in May 2012 to plan future work as well as evaluating their workshop held at the conference in March.

### **4.94 West Yorkshire Policies and Procedures Consortium**

- 4.95 This Regional Group is coordinated by the Calderdale Board who established arrangements for sharing the costs of this important activity. SCB managers share the responsibility for chairing this group. Administrative support and coordination of this group is provided by Calderdale SCB.
- 4.96 The group meets as necessary, in order to coordinate the work across the region to ensure consistency and currency of the safeguarding procedures. The group also considers new practice developments and how they are incorporated into the procedures to support staff and enhance practice. Guidance is customised to reflect local structures and is effectively disseminated.
- 4.97 The challenge for the group has been to ensure completion of documents where several stakeholders are involved, and different planning processes are in place.

- 4.98 Equally, the pace of change within all agencies can hinder effective communication and coordination. However, commitment to the group is high with excellent levels of attendance from all 5 local SCB's.

#### **Key Achievements**

- Policies and procedures are delivered in a cost effective way
- Continuing consistency across the region
- Ongoing work to ensure ratification of West Yorkshire protocols in respect of new practice developments

#### **Next Steps**

- Response to national changes to policies and procedures arising out of the Government response to the Munro report
- Review of procedures following changes to Working Together guidance
- Introduction of more robust tracking arrangements to reduce delays in ratification of changes to procedures

#### **4.99 Continuum of Need and Response, Task and Finish Group – Chairs: Pamela Wharton and Mandy Williams**

- 4.100 This multi-agency group was established in 2011 in order to promote and publicise the Continuum of Need and Response, and ensure its integration into practice. The Ofsted inspection of 2010 identified a lack of common and consistent thresholds across agencies and an intervention model was adapted from Blackburn with Darwen to support this work. ( See Appendix 3)
- 4.101 The group has been highly successful in terms of securing attendance and involvement from a wide range of agencies leading to greater awareness both of the model as well as its implications for intervention in families.
- 4.102 The group recognised the need for discussions between agencies in order to embed a common language as well as recognition of the specific roles of different agencies. It was acknowledged that there were occasions when agreement about thresholds for intervention could not be reached and monthly panels to provide a forum to discuss these individual cases were established. The panels have been popular, and have been valued by agencies as a forum to explore and resolve complex practice issues.
- 4.103 Members of the group have been actively involved in delivering the multi-agency briefings referred to in the learning and development section of this report. However, awareness raising sessions have also been carried out by individual members of the group within their own agencies, as well as to other practice groups.

### **Key Achievements**

- Higher level of awareness across agencies about the thresholds for intervention in families.
- Introduction of new referral documentation and practice guidance in 2011.
- Successful establishment of Locality Panels to discuss specific cases involving disagreement regarding thresholds for intervention
- Briefing sessions, attended by 343 representatives allowing for valuable multi-agency discussion about assessment and intervention in families

### **Next Steps**

- Review of the group, and its future, in order to integrate the model with new practice developments related to the Early Intervention with families.
- Support for the introduction of Ecaf in order to simplify CAF processes, and support early intervention work

## **SECTION 5.0**

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### **Specific Safeguarding Responsibilities**

## 5.0 SPECIFIC SAFEGUARDING RESPONSIBILITIES

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### 5.1 **Managing Allegations** - The work of the Local Authority Designated Officer (LADO)

- 5.2 The prime responsibility of the LADO is to coordinate and oversee the response to individual cases where an allegation of abuse has been made against a person who works with, or is in a position of trust with regard to, children.
- 5.3 All agencies are encouraged to discuss cases of concern with the LADO, and in all those cases where the threshold for further investigation is reached, a strategy meeting will be convened, chaired by the LADO. This is to ensure that the three potential areas of investigation – criminal, disciplinary and child protection – are appropriately managed and coordinated.
- 5.4 All such cases will lead to discussion between the LADO and a Senior Officer in the Police Safeguarding Unit to determine whether police involvement is necessary, and whether relevant information is held by the police.
- 5.5 142 cases were referred to the LADO during the year. This represents an increase of 26.8% over the previous year.
- 5.6 Full data has only been collected in this way since July 2010, when a dedicated LADO post was created in Calderdale, making comparison with any earlier years very difficult. However it appears likely that the increase in recorded cases largely reflects improvements in interagency liaison, reporting of cases, and data collection, rather than a substantial increase in the incidence of abuse by those in a position of trust with children.
- 5.7 The data includes for the first time a detailed breakdown of the type of agency or organisation where the person against whom the allegation is made works. (Appendix 4 shows the source of the referrals).
- 5.8 88.7% of cases were completed within 1 month, and 96.9% within 3 months. This compares favourably with targets recommended in Working Together of 80% and 90% respectively.
- 5.9 The current data set largely reflects the requirements for data previously required from the LADO by DCSF and Government Office. This was discontinued so that no national comparator data is now available.
- 5.10 Current policies and procedures for managing allegations against adults in a position of trust with children are firmly rooted in the experience of individual and institutional abuse in work settings. However, a significant percentage of cases referred to the LADO in fact relate to behaviours outside work which necessitate consideration of the implications of this for the person's contact with children in work. This includes increasing numbers of cases which relate to use of electronic media, e.g. access to inappropriate websites, material shared on Facebook, etc.

- 5.11 The LADO is to begin to collect data to record where the concern originates, which will be included in next year's data set.
- 5.12 The LADO has supported the multi-agency training programme, as well as offering bespoke training to foster carers, the voluntary sector and HR advisors.

### **Key Achievements**

- Increased awareness of the LADO role
- Timeliness of response and resolution to individual allegations
- Increased role in training in development

### **Next Steps**

- Continued link between the LADO and the Learning and Development Group to highlight practice, and identify training needs.
- Training for teaching staff and governors following outcomes of a recent SCR in North Somerset
- New arrangements for data collection to further refine service responses to allegations
- Evaluation of the service with referrers

### **5.13 Children who are Victims of Sexual Exploitation**

- 5.14 A multi-agency operational group has been running since 2006 in Calderdale. The purpose of the group is to share intelligence across agencies regarding victims in order to assess risk and agree on safeguarding actions. The operational group is chaired and hosted by the Police but the administration is currently supported by the Safeguarding Children Board. The group met on 7 occasions over the last year, and regular reports were provided to the Prevention of Harm sub- group and the Safeguarding Board.
- 5.15 The frequency of meetings for the Operations group has increased recently, recognising the need to ensure 'dynamic risk' is identified and appropriate action plans put in place to safeguard.
- 5.16 The group is very well attended and there are representatives from statutory agencies as well as Housing, substance misuse services and the voluntary sector. The group is indicative of the excellent partnership working that has taken place to support young people who are extremely vulnerable, with nominated staff from Children's Social Care working alongside the Police.
- 5.17 It has become increasingly clear that a significant proportion of the work and intelligence gathering occurs across local authority boundaries and there has been a move toward more collaborative work across the regional at both a strategic and operational level.
- 5.18 21 young people were discussed over the last year, although the maximum number discussed at any time was 14. The age of young people discussed varied between 11 and 17, and all of them were female.

- 5.19 The practice of the group has evolved over the years and currently a risk assessment matrix is used to determine risk and allocate actions for the different staff involved. A new Calderdale CSE Threshold Assessment form was introduced in November 2011. The introduction of the enhanced risk assessment matrix has led to improved assurance that those at risk are more easily identified
- 5.20 In September 2011, it was agreed that children who are reported missing would also be discussed by this group in order to offer a coordinated agency response. 7 young people were discussed aged between 13 and 16, 3 were male, and 4 female.
- 5.21 The missing young people discussed are a separate group from those suspected as victims of CSE but this process serves to identify and respond to the needs of this vulnerable group. The majority of the missing children discussed are looked after children. Additionally, a process is being developed to identify those young persons who are recorded as absent on either a temporary or unauthorised basis.
- 5.22 A recent benchmarking exercise was carried out in response to the CEOP Report 'Out of sight, out of mind' and Calderdale was found to be performing well. An action plan and strategic plan have been completed and will offer ongoing focus to the work of the group.
- 5.23 Over time, it has become clear that a specific service was required to respond to the needs of this vulnerable group and funding for a specialist CSE service has been agreed for the next financial year.

### **Key Achievements**

- High levels of commitment and multi-agency partnership
- Collaborative working with regional colleagues
- Development of increasingly refined risk assessment tools

### **Next Steps**

- Males are under represented in terms of referral for CSE, and a campaign to raise awareness of this issue for males is required
- Development of the Calderdale Strategic plan including the four key areas identified in the Home Office Action Plan of awareness raising, promoting multi-agency working, improving justice and ensuring support
- Creation of a specialist CSE service
- Increased focus on the needs of missing children in order to improve practice and reduce risk

### **5.24 Private Fostering - Lead: Pamela Wharton**

- 5.25 Private fostering is defined in the Children Act 1989 as a child under the age of 16 (or under 18 if disabled) being placed for 28 days or more in the care of someone who is not the child's guardian, or close relative, by private arrangement between parent and carer. There is a requirement for parents and carers to notify the local authority before a private fostering arrangement is made, but for various reasons this rarely happens.

5.26 The National Minimum Standards for private fostering are issued by the Secretary of State. The 2011-12 annual report regarding Private Fostering has not yet been presented to the Board. An action plan to improve the service was presented to the Board in July 2011 and the Board received the report and agreed a further report would be received in December 2011 progress on the action plan.

Year	Notification	Assessments	Private Fostering arrangement agreed
2009-2010	5	4	0
2010-2011	3	2	2
2011-2012	3	2	1
<b>Total</b>	<b>11</b>	<b>8</b>	<b>3</b>

5.27 Extensive work has been carried out over the past year to establish greater awareness across the workforce regarding this issue. This has included information within all locality and Continuum of Need sessions, presentation to schools safeguarding leads and inclusion in the local free newspaper. Procedures for staff have been updated and publicised.

5.28 Further publicity campaigns are planned, but these have to be carefully managed owing to the extensive local campaign to recruit foster parents, and it is clearly important to avoid confusion on this. The extensive campaigning so far had not resulted in changes to referral rates.

5.29 As a Board we are concerned about these continuing low levels of reporting, and intend to keep the issue under active review

#### Key Achievements

- Publicity campaign
- Introduction of new procedures for staff

#### Next Steps

- Continuing awareness raising campaigns both with the public and agencies including team and school private fostering returns
- Research with other local authorities where higher rates of referral have been achieved

### 5.30 Child Protection and Looked After children

5.31 The Board receives an annual report regarding the performance of the Conference and Reviewing team which sits within the Safeguarding and Quality Assurance Service, under the auspices of the Commissioning and Partnerships Directorate of Children and Young people's service. The information contained in this section is drawn from that report.

- 5.32 The team is responsible for the chairing of initial child protection conferences and reviews of children who are the subject of a child protection plan. The team is also responsible for chairing looked after children's reviews and to review the statutory care plan for looked after children.
- 5.33 It is acknowledged that this service has a unique role in safeguarding children and ensuring that there are robust plans in place for vulnerable children.
- 5.34 As a result there are strong links with the Board in order to ensure that themes and significant issues are progressed.
- The service manager is a member of the Board
  - Members of the team are included in a range of multi agency audits and Quality Assurance processes conducted by the Board.
  - The Secretariat is situated in the same unit, and part of the Safeguarding and Quality Assurance service
- 5.35 The changes to the service and presence of temporary rather than permanent staff has been challenging but the agreed staff increases and resolution of recruitment issues offers opportunity to significantly improve on the team's performance and further support the work of the Board
- 5.36 There is a specific responsibility for the team to provide scrutiny and challenge by:
- Maintaining independence from social care services;
  - following clear protocols for reporting concerns by means of a dispute resolution process;
  - enabling meaningful participation of children to ensure that planning processes are properly informed by their views, wishes and feelings; and
  - regular communication with parents and carers to do the same
- 5.37 All the above processes complement the work of the Board, and provide assurance regarding safeguarding practice. Equally, the team itself is subject to Quality Assurance processes both internally and externally. There is an agreed Dispute Resolution process, independently commissioned reviews of the service, and routine data reporting via the Quality Assurance Framework.

### 5.38 Looked After Children – as of 31<sup>st</sup> March 2012

Detail	No
Looked After Children	366
Interim Care Orders	97
Care Order	139
Accommodated	77
Freed for Adoption	7
Placement Orders prior to Adoption	41
On Remand	5
Male and with 91 over 10 and 89 under 10	190
Female 74 were over 10 and 102 under 10	176
This was an increase of 30% from 2010-2011 and an increase of 40% from 2008-2009.	
<b>Total</b>	<b>1098</b>

- 82% of LAC reviews were undertaken within timescales
- With the increase in establishment the expectation is that LAC reviews will be at 95%

### 5.39 Dispute Resolution Process Recorded in 2011-2012

Detail	No
Disputes at Stage 1 - Service Manager, Children's Social Care	15
Disputes at Stage 2 - Assistant Director, Children's Social Care	1
Disputes at Stage 3 - Director of CYPS	1
Disputes at Stage 4 – Chief Executive	0
Referrals made to Cafcass	0
<b>Total</b>	<b>17</b>

#### 5.40 Child Protection Plans – as of 31<sup>st</sup> March 2012

Detail	No
Children subject to a Child Protection Plan	237
On a plan for neglect	74
On a plan for emotional abuse	123
On a plan for physical abuse	8
On a plan for sexual abuse	22
<b>Total</b>	<b>464</b>

- The numbers of children who remain on a CP plan for more than 18 months was 13 and the number who were on a plan for 2 years plus was 9.
- In 2011-2012 94% of Child Protection conferences and reviews were completed on time.

#### Key Achievements

- Provision of additional staff which has enabled the team manager to supervise staff and to allocate cases
- Supervision of staff has been undertaken on a monthly basis; returns to Workforce Development indicating 100% compliance.
- All existing staff now have an individual personal development plans.
- Thematic audits have been undertaken and have contributed to the team's Quality Assurance role through the production of monthly performance reports to Children's Social Care.
- The team manager has also ensured that all LAC and CP cases are allocated and recorded on the CASS system used by CSC.

#### Next Steps

- Embedding of framework for observations of IRO practice
- Continuing development of programme to improve skills of IRO's leading to better planning and outcomes for children practice
- Development of improved administrative and data processes under the direction of the new Administrative Manager

#### 5.41 Child Death Overview Panel – CDOP

5.42 The Child Death Overview Panel (CDOP) collects, collates and evaluates information about the deaths of children in Calderdale in order to identify learning and reduce preventable deaths. It is run jointly with Kirklees in order to share costs, expertise and learning.

- 5.43 The implementation of the child death review process was first referred to in the government's response to the Victoria Climbié Inquiry report and the Every Child Matters Green Paper. 'Working Together to Safeguard Children' (2006) set out the guidance to be followed by all Local Safeguarding Boards in the review of all child deaths. The child death review functions became mandatory on the 1<sup>st</sup> April 2008. The Child Death Overview Panel has a permanent fixed core membership drawn from the key organisations represented on the two Local Safeguarding Children Boards. There is an independent chair that is not employed by, or responsible for any services to children, within Kirklees or Calderdale.
- 5.44 Through a comprehensive and multidisciplinary review of child deaths, the Calderdale and Kirklees Joint Child Death Overview Panel (CDOP) aims to better understand how and why children in the two areas die. Through use of the findings it makes recommendations to prevent other deaths and improve the health and safety of the children in the two areas. In carrying out activities to pursue this purpose, the CDOP meets the functions set out in paragraph 7.13 of "*Working Together to Safeguard Children*" (2010) in relation to the deaths of any children normally resident in the area. Namely collecting and analysing information about each death with a view to identifying:
- any case giving rise to the need for a Serious Case Review
  - any matters of concern affecting the safety and welfare of children in the area covered by Calderdale Safeguarding Children Board
  - any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area
  - putting in place procedures for ensuring that there is a co-ordinated response by the authority, their board partners and other relevant persons to an unexpected death.
- 5.45 A total of **17** deaths were reported to the Calderdale Child Death Review Team between 1<sup>st</sup> April 2011 and the 31<sup>st</sup> March 2012. **11** of the 17 cases had been considered at the Child Death Overview Panel by the 31<sup>st</sup> March 2012, and a conclusion reached in **10** of those cases. One case has been deferred awaiting further information.
- 5.46 **6** cases referred to the Child Death Review Team between 1<sup>st</sup> April 2011 and 31<sup>st</sup> March 2012 are yet to be discussed at Panel and will be discussed within the 2012/13 financial year when sufficient information is available.
- 5.47 An additional **10** cases were concluded at Panel during this financial year, from deaths that had occurred the previous financial year, the 1<sup>st</sup> April 2010 to the 31<sup>st</sup> March 2011.
- 5.48 Therefore, between 1 April 2011 and 31 March 2012 a total of **20** Calderdale cases were concluded at Panel. This includes **10** cases that were reported between the 2010/2011 financial year and **10** cases that were reported between the 2011/12 financial year.

- 5.49 There do not appear to be significant differences in mortality rates (0-17 years) over the last decade nor in the proportion of infant deaths but further analysis is underway to check this. Of the Calderdale child deaths occurring in during the four-year period 2008/09 - 2011/12, the ratio of female to male was 1:1.6 and there is no significant difference with the national picture. Over the same four-year period, over one-third (36.5%) of all child deaths are of Pakistani ethnic origin.
- 5.50 For the four-year period 2008/09 – 2011/12 of operation of CDOP, 12% of Calderdale cases were perceived as having modifiable factors /being preventable and 4% had possibly modifiable factors /were potentially preventable. This compares to a national average of 20% of cases 2011/12 having modifiable factors identified and a regional average of 22% for the equivalent.
- 5.51 Of the Calderdale cases identified as having modifiable factors over the four-year period: 64% were of White-British and 27% of Pakistani ethnic origin; 36% were male; 82% were infant deaths; 55% were in the category 10 '*Sudden unexpected, unexplained death*' and 27% were in the category 3 '*Trauma and other external factors*'. For Calderdale, the category that had the highest proportion of cases with modifiable factors identified was Category 10 '*Sudden unexpected, unexplained death*' (67%) which was similar to the national finding.
- 5.52 For Calderdale, for the 2011/12 reported and categorised cases, there were no children subject to a Child Protection Plan, statutory orders or assessed as children in need, nor were their siblings, and no cases were asylum seekers (1 unrecorded). During the four-year period, there have been no Calderdale cases categorised as Category 1 '*Deliberately inflicted injury, abuse or neglect*'.
- 5.53 While a history of domestic violence and a parent being known to police were found in a proportion of cases, these were not considered contributory factors to the death.
- 5.54 In 2011-12, almost half of child deaths (46%) occurred amongst children resident in Halifax Central, and one-third (35%) of all child deaths were in Park ward. During the four-year period (2008/09 to 2010/12), three-quarters (75%) of child deaths have occurred in either Halifax Central or Halifax North & East localities, despite these two localities having only 53% of the under-18 population in Calderdale, and mortality rates (0-17 years) in Central and North & East Halifax localities were almost 3 times higher than the rates in Upper & Lower Valley. The two most deprived quintiles contributed to 71% of all child deaths in 2011/12, despite them only having 45% of the overall child population.
- 5.55 Indicators of good functioning of the CDOP are:
- The proportion (59%) of Calderdale cases being referred, categorised and completed within 2011/12 is similar to the previous year (60%) and compares favourably with a national average of 40% and regional average of 36% of cases being referred and completed within year. Ethnicity was known in 100% of Calderdale cases received over the four-year period 2008/09 to 2011/12 of the CDOP's operation whereas it was not known in 9% of cases nationally

- By 31 March 2012, only 9% of Calderdale cases received during the four-year period 2008/09-2011/12 were uncategorised/not completed compared to a national average for the same of 24% and a regional average of 23% of cases for the same period
- Whereas nationally, it was not known if the child was subject to a statutory order for 7% of the reviews completed or if subject to a CPP for 5% of reviews completed, this information was present for all Calderdale cases reported and categorised in 2011/12.

5.56 A benchmarking exercise was carried out against the findings of the Bristol University study on 'Improving the Effectiveness and Efficiency of Child Death Overview Panels' ( Allen, L and Lenton S) , and the Calderdale/Kirklees panel compared well with other Boards across the country in terms of its organisation, timeliness of response and consideration of cases.

5.57 The group has increasingly concerned itself with how the data is used to inform the work that is done to reduce child death. Production of the CDOP's annual report offers a valuable opportunity to reflect on the previous year, and make recommendations for the Panel's future work and priorities. The Panel has the active involvement of Public Health staff who both contribute to the discussion but also provide a 'double check' on the data, as well linking the CDOP work with other initiatives such as those to reduce infant mortality.

5.58 Locally, there is a link via the Public Health representative with the infant mortality task group, District Leadership team (with Children's Services) and Children and Young Peoples (CYP) Strategic Commissioning Group (which reports to the CYP Planning Executive). Findings from the Panel have been shared with a range of different agencies and community groups in order to raise awareness and enhance practice.

5.59 Significantly, during the last four years, the findings from a case of a rare medical condition of MCADD led to changes to clinical practice in the screening of newborn babies with a specific family history of the condition.

5.60 There are significant and deliberate links with regional groups such as the West Yorkshire Sudden Infant Death group and the Yorkshire and Humberside Congenital Anomalies network, in order to share learning and good practice for use locally. Members of the Panel supported the West Yorkshire awareness raising campaign to highlight the risks of Co-sleeping

### **Key Achievements**

- Efficient, and more timely consideration of cases compared with other local authority panels. .
- Good levels of attendance from agencies
- Effectively chaired panel
- Increasingly robust links to regional and national networks and campaigns

## Next Steps

- Continued collaboration with national networks in order to share learning and good practice
- A local development event for the Panel
- Participation in national CDOP research campaign
- Continued links to local and regional public health campaigns

### 5.61 Locality

A benchmarking exercise was carried out against the findings of the Bristol University study on 'Improving the Effectiveness and Efficiency of Child Death Overview Panels' (Allen, L and Lenton S) , and the Calderdale/Kirklees panel compared well with other Boards across the country in terms of its organisation, timeliness of response and consideration of cases.

- 5.62 The Panel has the active involvement of Public Health staff who both contribute to the discussion but also provide a 'double check' on the data.
- 5.63 The group has increasingly concerned itself with how the data is used to inform the work that is done to reduce child death. Production of the CDOP's annual report offers a valuable opportunity to reflect on the previous year, and make recommendations for the Panel's future work and priorities.
- 5.64 Increased links have been made between panel members, the Board and local infant mortality and health promotion campaigns. Locally, there is a link via the Public Health representative with the Children and Young Peoples Planning Executive (CYPPE), and strategic commissioning groups. Findings from the Panel have been shared with a range of different agencies and community groups in order to raise awareness and enhance practice. .
- 5.65 Significantly, the findings from a case of a rare medical condition of MCADD led to changes to clinical practice in the screening of newborn babies with a specific family history of the condition.
- 5.66 There are significant and deliberate links with regional groups such as the West Yorkshire Sudden Infant Death group and the Yorkshire and Humberside Congenital Anomalies network, in order to share learning and good practice for use locally. Members of the Panel support the West Yorkshire awareness raising campaign to highlight the risks of Co-sleeping

## Key Achievements

- Efficient, and more timely consideration of cases compared with other local authority panels. .
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## **Next Steps**

- Continued collaboration with national networks in order to share learning and good practice
- A local development event for the Panel
- Participation in national CDOP research campaign
- Continued links to local and regional public health campaigns

# **SECTION SIX**

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## **Conclusion**

## SECTION 6 - CONCLUSION

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- 6.1 This report has sought to identify the achievements and the direction of travel for the Board and its member agencies for the forthcoming year.
- 6.2 Undoubtedly extensive efforts are being made to improve services to safeguard children and young people by member agencies individually and collectively, the Board itself and the Improvement Board. Clear evidence is emerging that we are starting to get the basics right.
- 6.3 Many processes are, however, new and not yet fully embedded. We cannot be entirely sure how effective processes now in place to underpin good practice will be in the longer term and are not complacent. The impact of organisational change has been considerable and all organisations continue to face significant change agendas.
- 6.4 Independent scrutiny (Peer Review) provides some encouragement and identifies that recent changes in practice have resulted in improved safeguarding of children in Calderdale.
- 6.5 Despite the well publicised turmoil locally, the Board is reassured by the evidence of excellent levels of commitment across the agencies working with children and their families. There are clear examples of creative and committed collaborative working to improve the lives of children.
- 6.6 There is still much to do to achieve consistently effective services, but the Board remains committed to this challenge.

# **SECTION SEVEN**

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## **Appendices**

## SECTION 7 - APPENDICES

### 7.1 Appendix 1 - Business Plan 2012/2013

<b>STRATEGIC OBJECTIVE 1:</b>						
<b>Ensure Continuous Improvement in Efficiency and Effectiveness of Board/Sub-Groups</b>						
<b>SUB OBJECTIVES</b>	<b>KEY ACTIONS</b>	<b>ACTION REQUIRED</b>	<b>BY WHOM</b>	<b>TIMESCALE</b>	<b>RAG STATUS</b>	<b>PROGRESS</b>
<b>1.1 Effective Sub-groups</b>	1.1.1 Clear work plan drawn up for each group	Groups to complete	Chairs to oversee	After next sub-group (May 2012)	<b>Complete</b>	
	1.1.2 Review membership and purpose/ accountability	Groups to complete	Chairs to oversee	After next sub-group (May 2012)		
	1.1.3 CON Group – Review	Groups to complete	Chairs to complete	After next Sub-group		
	1.1.4 Communications and Communications Sub-Group – review Chairing arrangements	Groups to complete	JB/BJ	After next Sub-group (May 2012)		
	1.1.5 Standardised reporting arrangements for sub-groups	Standard template for reporting work of sub-group – linked to website	JB/BJ	Mar 2012		

**STRATEGIC OBJECTIVE 1: Continued...****Ensure Continuous Improvement in Efficiency and Effectiveness of Board/Sub-Groups**

<b>SUB OBJECTIVES</b>	<b>KEY ACTIONS</b>	<b>ACTION REQUIRED</b>	<b>BY WHOM</b>	<b>TIMESCALE</b>	<b>RAG STATUS</b>	<b>PROGRESS</b>
<b>1.2 The Board is effective</b>	1.2.1 Exec becomes forum for business planning	Review membership/ frequency of meetings/ role of Exec.	JB/BJ	Next Executive meeting (May 2012)	<b>Green</b>	
	1.2.2 Review range and diversity of membership review	Timely review of minutes				

**STRATEGIC OBJECTIVE 2:**

**Strengthen and Further Develop Partnership Working and Promote Services to Safeguard Children and Young People**

SUB OBJECTIVES	KEY ACTIONS	ACTION REQUIRED	BY WHOM	TIMESCALE	RAG STATUS	PROGRESS
<b>2.1 Develop improved partnership working</b>	2.1.1. Recognise progress and ensure that multi-agency improvement targets formally signed off	Annual review of sub-group work	Sub-group chairs	Annually	<b>Green</b>	
	2.1.2 Sub-groups to identify potential priority areas for partnership working as part of work planning	Report to Board on partnership priorities, recommendations and any causes for concern. Board to decide priorities	Sub-group chairs	Every Board meeting		
	2.1.3 Improved engagement with schools	Proactive work to develop links with schools	JB/all Board members			
		Task and finish group	Board reps to lead			

**STRATEGIC OBJECTIVE 2: Continued...**

**Strengthen and Further Develop Partnership Working and Promote Services to Safeguard Children and Young People**

SUB OBJECTIVES	KEY ACTIONS	ACTION REQUIRED	BY WHOM	TIMESCALE	RAG STATUS	PROGRESS
<b>2.2 Promote services to safeguard children and young people</b>	2.2.2 Review of Board connection to current service planning, e. g, Troubled Families/Early Intervention strategies	Board to consider appropriate level of involvement in service planning relevant to QA role.	Executive	June 2012	<b>Green</b>	
		Mapping exercise	Executive	October 2012		
	2.2.3 Assure effective delivery through engagement with CYPPE and establishment of quality standards	Representation at CYPPE and other key planning groups	Chair and Board Manager	October 2012		
<b>2.3</b>	2.3.1 Agree strategy for multi-agency work with families where there are issues of neglect.	Prevention of Harm Sub-group to endorse and recommend strategy to Board	Prevention of Harm sub-group Chair	May 2012		Complete

**STRATEGIC OBJECTIVE 2: Continued...****Strengthen and Further Develop Partnership Working and Promote Services to Safeguard Children and Young People**

SUB OBJECTIVES	KEY ACTIONS	ACTION REQUIRED	BY WHOM	TIMESCALE	RAG STATUS	PROGRESS
	2.3.1 Agree multi-agency tools and practice Guidance	Operational Group for Early Intervention Strategy	Chair of early Intervention Board	September 2012	<b>Green</b>	

**STRATEGIC OBJECTIVE 3:**

**To ensure effective communication and engagement with agency staff and the public in respect of the work of the Board and the wider safeguarding agenda**

SUB OBJECTIVES	KEY ACTIONS	ACTION REQUIRED	BY WHOM	TIMESCALE	RAG STATUS	PROGRESS
<b>3.1 Board has increased links with communications/ service groups</b>	3.1.1 Representation/ involvement of schools increased	Identification of and joint work on projects of priority to schools. Establish task and finish group	JB/BJ	Jun 2012	<b>Green</b>	<b>Ongoing</b>
	3.1.2 Wider engagement with children and young people	Promotion of increased involvement of school reps with sub-group activity	JB/BJ to identify	Ongoing		<b>Ongoing</b>
	3.1.3 Improved communication with all parties	Continued planning of projects with Young Advisory Group. Link to schools projects.	BJ	Ongoing		
	3.1.4 Board is up to date with agency developments that impact on multi-agency arrangements	All Board meetings/sub-groups have communication question on agenda	LGS	Immediately		

**STRATEGIC OBJECTIVE 3: Continued...**

**To ensure effective communication and engagement with agency staff and the public in respect of the work of the Board and the wider safeguarding agenda**

SUB OBJECTIVES	KEY ACTIONS	ACTION REQUIRED	BY WHOM	TIMESCALE	RAG STATUS	PROGRESS
3.1 Continued...		Board reps to ensure that short updates are provided to the Board through the Board or sub-groups (e.g., progress of Child Health Programme, Clinical Commissioning Group)		Immediately	Green	
3.2 Improving communication	3.2.1 Increase the profile of SCB by ensuring coherent communication strategy	Establish communication strategy	Chair of sub-group	Next sub-group (May 2012)	Amber	
		Discuss opportunities for regional communication strategy on joint interest areas. E.g. CDOP	JB	Next Regional Chairs/Board managers event (April 2012)		

## STRATEGIC OBJECTIVE 4:

To quality assure the work of the partner agencies in safeguarding and promoting the welfare of children and challenge any areas of practice needing improvement

SUB OBJECTIVES	KEY ACTIONS	ACTION REQUIRED	BY WHOM	TIMESCALE	RAG STATUS	PROGRESS
4.1 Require all agencies to reflect upon and report on safeguarding performance	4.1.1 Consolidate Quality Assurance Framework	Embed the MAD system	AQA Sub-Group Chair  CSCB Chair and Board	Jun 2012	Amber	
	4.2 Promote compliance with standards as per S11	4.2.1 Receive agency S11 audits	Communication annually from Board to agencies	AQA sub-group Chair		Sep 2012
	4.2.2 Complete agency challenge events in respect of S11 Audits and report to the Board		CSCB Chair and AQA sub-group Chair	Sep 2012		
4.3 Monitor action plans arising from SCRs and internal reviews	4.3.1 Review at least quarterly in sub-group	Escalate incomplete action plans to agency and Exec	Chair of SCR Sub-Group	Immediate effect	Complete	

**STRATEGIC OBJECTIVE 4: Continued...**

**To quality assure the work of the partner agencies in safeguarding and promoting the welfare of children and challenge any areas of practice needing improvement**

SUB OBJECTIVES	KEY ACTIONS	ACTION REQUIRED	BY WHOM	TIMESCALE	RAG STATUS	PROGRESS
<b>4.4 Analysis of any public child death issues by examining all child deaths in Calderdale and Kirklees</b>	4.4.1 CDOP to meet every two months to review deaths	Continue current arrangements	CDOP Chair	Immediate effect	Complete	
	4.4.2 Provide an annual report for the CSCB		CDOP Chair			

## STRATEGIC OBJECTIVE 5:

To ensure effective multi-agency and single-agency training re safeguarding is delivered with a measure of outcomes on practice being embedded across the agencies

SUB OBJECTIVES	KEY ACTIONS	ACTION REQUIRED	BY WHOM	TIMESCALE	RAG STATUS	PROGRESS
<b>5.1</b> Ensure the Inter-agency training plan provides appropriate and effective programmes	5.1.1 Review the current Training Programme to ensure it is comprehensive and effective	Update workplan for sub-group Develop new programme	Chair of Learning & Development Sub-Group and WDO	July 2012	<b>Green</b>	
<b>5.2</b> All member agency staff to be able to access high quality multi-agency safeguarding training	5.2.1 Deliver a high quality programme of multi-agency safeguarding training and development, attended by a diverse range of agencies	Continue to provide programme  Quarterly updates of attendance at multi-agency training	Chair of Sub-group and WDO	Annual Programme		Ongoing
<b>5.3</b> An annual CSCB Conference addresses CSCB priorities to a wider audience	5.3.1 Use conference as vehicle to disseminate practice issues to all agencies	Continue to hold annual conference. Ensure high level of agency involvement, both in organisation and representation	Chair of Sub-group and WDO	March 2013		

**STRATEGIC OBJECTIVE 6:**

**Ensure Effective and Independent Reviews are Undertaken and Learning Disseminated and Embedded**

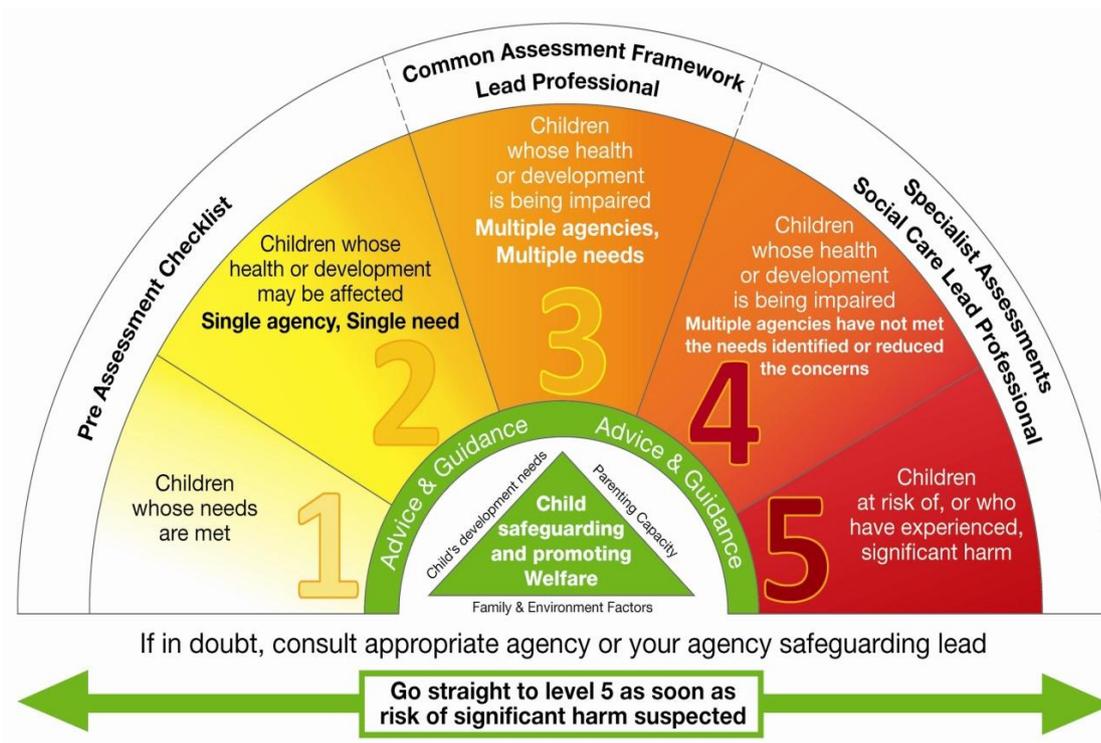
SUB OBJECTIVES	KEY ACTIONS	ACTION REQUIRED	BY WHOM	TIMESCALE	RAG STATUS	PROGRESS
<b>6.1 Case reviews continue</b>	6.1.1 SCR Sub-group to identify cases for review	Reviews are undertaken and recommendations directly linked to the relevant sub-group for action on training/practice developments etc.	JB	At every sub-group	<b>Green</b>	
<b>6.2 Respond to new methodologies for SCRs</b>	6.2.1 Review case under SCIE model	Convene multi-agency case review under new arrangement	JB	July 2012	<b>Green</b>	
<b>6.3 Maximise use of website to embed lessons from reviews</b>	6.3.1 Regular updates to website	Website will have accessible, information about local and national practice issues	WDO	July 2012 Reviewed three monthly	<b>Amber</b>	
<b>6.4 Lessons from SCR's embedded</b>	6.4.1 Discuss at every SCR sub group	Sub-group identifies member to prepare synopsis for each sub -group	JB	Each sub-group	<b>Green</b>	

## 7.2 Appendix 2 – Financial Statement

<b>Expenditure : April 2011 to March 2012</b>		<b>£</b>
Salary Costs		131,520
Travel Expenses		1,107
Staff Insurance/Recruitment Costs		2,182
Resources/Office Expenses		63,716
Subscriptions		8,280
<b>Total Expenditure 2011/12</b>		<b>206,805</b>

<b>Total Income : April 2011 to March 2012</b>		<b>£</b>
Calderdale Primary Care Trust		80,000
Income from other WY Boards		6,265
West Yorkshire Police		6,925
West Yorkshire Probation		2,300
Cafcass		550
Calderdale MBC contribution 2011/12		110,765
<b>Total Funding 2011/12</b>		<b>206,805</b>

### 7.3 Appendix 3 – Continuum of Need and Response



## 7.4 Appendix 4 – LADO Referrals Data

<b>Referring Agency</b>	<b>No</b>
CYP	75
Other LA Dept	8
Police	16
LA Schools	23
Voluntary Sector	4
Independent Sector	10
Health	2
Ofsted	1
Public	3
<b>Total</b>	<b>142</b>

<b>Agency Allegation Against</b>	<b>No</b>
LA Foster Carers	26
LA Residential	2
LA Children's Centres	8
LA Social Worker	2
LA Youth Worker	6
LA Schools	43
Police	3
Voluntary Sector	4
Independent Sports/Recreational	7
Independent Fostering Agency	10
Independent Residential Provision	3
Independent Nursery Provision	5
Independent Schools	5
Independent Tutor	1
Independent Health Provider	1
Health	4
Church/Faith Groups	1
Adoptive Parent	1
Childminder	2
Probation	1
Other LA Depts.	4
Transport	3
<b>Total</b>	<b>142</b>

<b>Categories of Allegation/Abuse</b>	<b>No</b>
Sexual Abuse	24
Emotional Abuse	5
Physical Abuse	45
Neglect	3
Unsuitable	65
<b>Total</b>	<b>142</b>

<b>Outcome</b>	<b>No</b>
Substantiated	41
Unsubstantiated	36
Unfounded – False	20
Unfounded – Malicious	3
Does not meet criteria/Advice to employer	36
Outstanding	6
<b>Total</b>	<b>142</b>

<b>Timescale for Completion of Investigation</b>	<b>No</b>
Less than 1 month	126
Less than 3 months	10
Less than 12 months	0
Over 12 months	1
Outstanding	6
<b>Total</b>	<b>142</b>

**Notes:**

1. “Foster carers” includes family members of foster carers, and fostering applicants.
2. “Public” includes anonymous referrals.
3. “Unsuitable” is defined as “behaved toward a child or children in a way that indicates s/he is unsuitable to work with children.”

## 7.5 Appendix 5 - LSCB Data Set Quarter 4

<b>SOCIAL CARE – 2010</b>										
<b>Population estimate figure of 40,400 (0- 15 year olds) used in calculations per 10,000. Baseline is outturn from C&amp;YP Plan 10/11</b>										
Ref	Definition	2010-2011 Result	Target (where applicable)	Statistical Neighbours	Qtr1 (2011-2012)	Qtr 2 (2011-2012)	Qtr3 (2011-2012)	Qtr4 (2011-2012)	Year to date (2011-2012)	Comments
CAL 1	Number of referrals to CS Social Care (per 10,000 0-15 year olds) <b>During quarter</b>	409.91 (1861)	Not set	N/A	144.8	157.18	215.59	256.19	773.76 (3126)	The volume of referrals to the First Response team continues to rise.
CAL 2	Percentage of referrals that are repeat referrals within 12 months <b>During quarter</b>	20.30%	Not set	N/A	28.70%	25.00%	23.70%	32.90%	21.4% 723 of 3383	The slight increase in repeat referrals is mainly a result of domestic abuse notifications.
NI 68	Initial Assessments as a percentage of the number of referrals. <b>During quarter</b>	88.5% 1643 of 1859	65.0%	74.1% (2010/11)	85.3%	69.3%	50.40%	47.40%	60.3% 3383 Refs, 2041 IA's	Consistent operation of the new guidance continues to impact here in terms of a high conversion rate.
NI 59	Percentage of initial assessment for children's social care carried out within 7 working days <b>During quarter</b>	62.7% 1024 of 1639	85.0%	56.1% (2010/11)	65.9%	89.5%	80.90%	83.30%	79.7% 1627 of 2041	There has continued to be improvement in adherence to the 7 day timescale within the team. The volume remains significant with over 1,000 assessments completed in the team to date this financial year.

**SOCIAL CARE – 2010 Continued...**
**Population estimate figure of 40,400 (0- 15 year olds) used in calculations per 10,000. Baseline is outturn from C&YP Plan 10/11**

Ref	Definition	2010-2011 Result	Target (where applicable)	Statistical Neighbours	Qtr1 (2011-2012)	Qtr 2 (2011-2012)	Qtr3 (2011-2012)	Qtr4 (2011-2012)	Year to date (2011-2012)	Comments
NI 60	Percentage of core assessments completed within 35 working days <b>During quarter</b>	69.3% 490 of 705	81.0%	71.8% (2010/11)	85.6%	92.9%	82.70%	85.80%	87% 876 of 1007	A similar picture to Initial Assessments with nearly 400 completed thus far. Performance has continued to be good in this area.
CAL 3	Number of children subject to S47 investigations (per 10,000 0-15 year olds) <b>During quarter</b>	92.51 (420)	Not set		30.69	51.98	28.96	34.16	148.02 (598)	As the volume of referrals has risen so has the number of Section 47 investigations, this is in part due to consistent operation of the duty guidance in First Response
CAL 4	Number of children subject to Child Protection Plans (per 10,000 0-15 year olds). <b>As at end of quarter</b>	37.66 (171)	Not set		48.02	60.15	66.34	56.68	56.68 (229)	
CAL 5	Initial Child Protection Conferences held within 15 days of Strategy Discussion. During quarter	45.4%	Not set		71.4%	68.1%	68.0%	79.7%	71.3% 268 of 376	

**SOCIAL CARE – 2010 – Continued...**

**Population estimate figure of 40,400 (0- 15 year olds) used in calculations per 10,000. Baseline is outturn from C&YP Plan 10/11**

Ref	Definition	2010-2011 Result	Target (where applicable)	Statistical Neighbours	Qtr1 (2011-2012)	Qtr 2 (2011-2012)	Qtr3 (2011-2012)	Qtr4 (2011-2012)	Year to date (2011-2012)	Comments
NI 61	Stability of looked after children adopted following an agency decision that the child should be placed for adoption <b>During quarter</b>	58.8%	80.0%		66.7%	50.0%	0.0%	0.0%	30% 3 of 10	
NI 62	Stability of looked after children: 3 or more placement moves. <b>During quarter</b>	7.5%	7.0%		0.0%	0.9%	1.7%	1.7%	6.83% 25 of 366	
NI 63	Stability of looked after children: length of placement (same placement for at least 2 years) <b>Can only measure current position - rolling 2 years</b>	63.2%	64.0%		64.4%	N/A	66.2%	68.7%	68.7% 92 of 134	This indicator is calculated on a year to date basis because it looks at children's placements over the last 2 years.
NI 64	Child protection plans lasting two years or more <b>During quarter</b>	14.4% 23 of 155	5.0%	4.7% (2010/11)	17.4%	8.5%	7.6%	11.4%	10.61% 28 of 264	

**SOCIAL CARE – 2010 – Continued...**

**Population estimate figure of 40,400 (0- 15 year olds) used in calculations per 10,000. Baseline is outturn from C&YP Plan 10/11**

Ref	Definition	2010-2011 Result	Target (where applicable)	Statistical Neighbours	Qtr1 (2011-2012)	Qtr 2 (2011-2012)	Qtr3 (2011-2012)	Qtr4 (2011-2012)	Year to date (2011-2012)	Comments
NI 65	Children becoming the subject of a Child Protection Plan for a second or subsequent time <b>During quarter</b>	5.9% 10 of 169	8.0%	13.7% (2010/11)	10.6%	25.2%	4.4%	14.6%	14.42% 46 of 319	
NI 66	Percentage of looked after children reviews carried out within timescales <b>During quarter</b>	85.6%	98.0%		86.3%	92.7%	91.6%	93.2%	80.42% 271/337	
NI 67	Percentage of child protection reviews carried out in timescale <b>During quarter</b>	91.8%	98.0%	95.7% (2010/11)	89.1%	87.3%	95.2%	97.4%	97.8% 178 of 182	

**SOCIAL CARE – 2010 – Continued...**

**Population estimate figure of 40,400 (0-15 year olds) used in calculations per 10,000. Baseline is outturn from C&YP Plan 10/11**

Ref	Definition	2010-2011 Result	Target (where applicable)	Statistical Neighbours	Qtr1 (2011-2012)	Qtr 2 (2011-2012)	Qtr3 (2011-2012)	Qtr4 (2011-2012)	Year to date (2011-2012)	Comments
CAL 6	Children with CPP's from ethnic minority groups as a percentage of children with CPP's. 15% (6000 out of 40,000) children aged 0 - 15 years in Calderdale are from ethnic minority groups. <b>As at end of quarter</b>	8.2% 14/171	Not set		9.27%	7.41%	8.95%	12.23%	12.23% 28 of 229	
CAL 7	Children looked after (per 10,000 0-15 year olds) <b>As at end of quarter</b>	71.14 (323)	Not set	75.2 (2010/11) under 18	86.63	90.59	89.6	90.59	90.59 (366)	

**SOCIAL CARE – 2010 – Continued...**

**Population estimate figure of 40,400 (0- 15 year olds) used in calculations per 10,000. Baseline is outturn from C&YP Plan 10/11**

Ref	Definition	2010-2011 Result	Target (where applicable)	Statistical Neighbours	Qtr1 (2011-2012)	Qtr 2 (2011-2012)	Qtr3 (2011-2012)	Qtr4 (2011-2012)	Year to date (2011-2012)	Comments
CAL 8	Number of Children missing from Education who have been referred <b>During quarter</b>	113 referred (5 open at the end of the year)	Not set		31 cases, 13 still open as at 5 July	43 cases 5 open	48 cases 17 open	51 cases 10 open	177 cases 13 open	<p>1) CME cases have a number of reasons behind them. These figures include children who do not have a known location (e.g. children leaving the area for an unknown destination) as well as others whose location is known but do not have a current school (e.g. children moving into the area who have not managed to secure a school place)</p> <p>2)The date of referral to the CME team may not be in the same reporting period that a child left their previous school - the schools are obliged to keep them on roll for a period of time, attempting to determine their next school, prior to referral to the CME team.</p>

**SOCIAL CARE – 2010 – Continued...**

**Population estimate figure of 40,400 (0- 15 year olds) used in calculations per 10,000. Baseline is outturn from C&YP Plan 10/11**

Ref	Definition	2010-2011 Result	Target (where applicable)	Statistical Neighbours	Qtr1 (2011-2012)	Qtr 2 (2011-2012)	Qtr3 (2011-2012)	Qtr4 (2011-2012)	Year to date (2011-2012)	Comments
CAL 9	Number of CAF's undertaken <b>During quarter</b>	251			45	36	59	56	196	
CAL 10	Number of Private Fostering Arrangements reported to Social Care <b>During quarter</b>	1	Not set		0	0	0	1	1	A detailed action plan is in place and was presented to September's Quality Assurance sub group, it is hoped that there will be an increase in the number of notifications to social care as awareness raising across agencies is raised

**PROBATION TRUST & YOUTH OFFENDING TEAM**

Ref	Definition	2010-2011 Result	Target (where applicable)	Statistical Neighbours	Qtr1 (2011-2012)	Qtr 2 (2011-2012)	Qtr3 (2011-2012)	Qtr4 (2011-2012)	Year to date (2011-2012)	Comments
PT 1	Number of offenders who have contact with a child subject to active CP <b>Baseline is avg per qtr</b>	21			20	21	24	21	86	In these cases the Offender Manager would be actively involved in Core Group work and we would expect a Sentence Plan objective to be included around working with Children's Social Care Services. The Risk Management Plan would reflect the key concerns and risks and how they are being managed, with named professionals identified, along with their phone numbers.

**PROBATION TRUST & YOUTH OFFENDING TEAM – Continued...**

Ref	Definition	2010-2011 Result	Target (where applicable)	Statistical Neighbours	Qtr1 (2011-2012)	Qtr 2 (2011-2012)	Qtr3 (2011-2012)	Qtr4 (2011-2012)	Year to date (2011-2012)	Comments
PT 2	Number of Calderdale offenders known to Probation who present a risk to children (RC flag) <b>Baseline is avg per qtr</b>	72			69	70	72	72	283	The RC flag is shown on Probation's case recording system. This flag means that the offender is a risk to children and the Risk Management Plan should be clear as to the risks and how they are being managed. Another flag, CW, will be useful to report on (PT5?) as this indicates that there are concerns about a child's wellbeing whom the offender has contact with on a regular basis (the offender may not be the parent/carer; they could be related to the vulnerable child, for example). As at 5/10/11 Calderdale Probation had 82 CW flags, 76 RC flags and 24 CP flags - this was amongst 164 offenders, indicating that some offenders have more than one flag.

**PROBATION TRUST & YOUTH OFFENDING TEAM – Continued...**

PT 3	Number of Calderdale offenders who have a RC flag and are Registered Sex Offenders (RSO flag) <b>Baseline is avg per qtr</b>	45			42	46	46	47	181	Registered Sex Offenders have a duty to cooperate with the Police. The Risk Management Plan should specify the Police contact point and detail any restrictions currently in place, along with rehabilitative factors.
PT 4	Number of Calderdale MAPPAs L1, L2 and L3 offenders known to Probation who present a Risk to children <b>Baseline is avg per qtr</b>	27			23	28	27	30	108	These are Multi Agency Public Protection Arrangements (MAPPAs) cases which involve at least Police and Probation liaison. Risk Management Plans of MAPPAs cases should be very detailed, including action points from the last MAPPAs meeting. The number refers to MAPPAs cases who also have an RC flag. L1 MAPPAs cases are managed internally by Probation, L2 are multi-agency; L3 are full multi-agency management, with each L3 MAPPAs Meeting chaired by Head of Calderdale Probation

**PROBATION TRUST & YOUTH OFFENDING TEAM – Continued...**

<p><b>NI43</b></p>	<p>Young People within youth justice receiving custodial sentence after conviction</p>	<p>8.10%</p>	<p>tbc</p>	<p>Custodial Sentences (4)/ Sentences (40) = 4/40 (*100) = 10.0%</p>	<p>Custodial Sentences (6)/ Sentences (57) = 6/57 (*100) = 10.5%</p>	<p>15.60%</p>	<p>11.40%</p>	<p>Although number of Sentences have been reducing, Custodial Sentences is still a cause of concern. That said, the YOT continues to provide the range of interventions identified in quarter one, additionally we have undertaken a number of new measures including Compliance Panels and new Case Management guidelines. Whilst the total number of sentences have reduced, the number of custodial sentences continues to be of concern and exceeds the target set by the YJB. The YJB is reviewing this target and we believe that new guidance will be provided for 2011-2012. Recent development, the Chair of the Youth Bench is now a Member of the YOT Management Board, attended September 22nd. Head of Family Services attended Youth Court. YJB YOT Data summary figures do not match local data set that was submitted to the Youth Justice Board, this is currently being looked at by the YJB and we are awaiting a feedback.</p>
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**PROBATION TRUST & YOUTH OFFENDING TEAM – Continued...**

PT 5	Offending of LAC	Not set			20	19	20	17	76	<p>PT5: this figure relates to 20 young people ( including 7 young people who have been accommodated in residential or Foster care placements by other LA's within Calderdale. The YOT along with a social work team manager, LAC'E' and LAACH meet bi-monthly to review all LAC young people involved in the criminal justice system or at risk of entering. Where the YOT assesses the young person as vulnerable then a VMP is completed and shared with allocated social workers. Future developments are looking at the re-instatement of the protocol to deal with behaviour restoratively and a structured review of LAC cases where there are high vulnerability concerns/ a high risk of re-offending/of harm to others.</p>
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										<p>Additionally it is of note the YOT is currently involved with 9 young people who are either eligible/relevant young people as they have been accommodated. For the beginning of October the following looks like the cases where a young person is either LAC or ex LAC etc 14 Calderdale young people involved with the YOT (including 2 through YOT prevention services and 1 who was Rila)</p> <p>5 young people placed by other Local authorities in private residential settings</p> <p>Also to note at least 9 young people who are involved with the YOT are also "Eligible/Relevant" children</p>
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**PROBATION TRUST & YOUTH OFFENDING TEAM – Continued...**

PT 6	YOT Cohort managed through MAPPA	Not set			0	0	0	0	0.00%	For Quarter 1 and 2 dataset there are currently no young people who as a consequence of their offence, sentence or behaviour are managed by the MAPPA process.
PT 7	Number of young people who are a risk to other children	20.45%	Not set		10.60%	18.10%	24.00%	16.50%	17.30%	This data children a risk to other children relates to the offences dataset for Robbery, Assault and Sexual Offences, in 2011/12.

<b>L S C B</b>										
<b>Ref</b>	<b>Definition</b>	<b>2010-2011 Result</b>	<b>Target (where applicable)</b>	<b>Statistical Neighbours</b>	<b>Qtr1 (2011-2012)</b>	<b>Qtr 2 (2011-2012)</b>	<b>Qtr3 (2011-2012)</b>	<b>Qtr4 (2011-2012)</b>	<b>Year to date (2011-2012)</b>	<b>Comments</b>
<b>LSCB 1</b>	Number of cases considered for SCR's	4			0	0	1	0	1	
<b>LSCB 2</b>	Number of SCR's initiated	1			0	0	0	0	0	
<b>LSCB 3</b>	Number of deaths reviewed by CDOP	29			3	7	0	10	20	Only one Panel meeting held in Q1 and one meeting in Q2
<b>LSCB 4</b>	Number of allegations received by LADO	91			35	39	36	38	148	
<b>LSCB 6</b>	Number of multi-agency case reviews initiated (SCIE)	1			0	0	0	1	1	

**CAFCASS**

Ref	Definition	2010-2011 Result	Target (where applicable)	Statistical Neighbours	Qtr1 (2011-2012)	Qtr 2 (2011-2012)	Qtr3 (2011-2012)	Qtr4 (2011-2012)	Year to date (2011-2012)	Comments
CAF1	Number of children allocated a Children's Guardian	Not set								
KPI 1	Allocation of s.31 cases in two working days	Not set								
CAF2	Number of cases where child protection concerns are identified in private law proceedings and are referred to Children's Services	Not set								

**POLICE & COMMUNITY SAFETY PARTNERSHIP**

Ref	Definition	2010-2011 Result	Target (where applicable)	Statistical Neighbours	Qtr1 (2011-2012)	Qtr 2 (2011-2012)	Qtr3 (2011-2012)	Qtr4 (2011-2012)	Year to date (2011-2012)	Comments
P	Number of Child Protection Referrals to Police	770			268 (all referrals)	226 (all referrals)	247	268	1009	
P	Number of Child Protection Referrals to Social Care	Not set			125	215	241	181	762	
P	Number of cases where Police Powers of Protection used	10			2	2	1	0	5	
P	Percentage of initial case conferences attended by police	Not set			100%	100%	84%	93%		
P	Number of reports sent to initial case conferences	30			42	48	50	29	169	
P	Number of Strategy Meetings Attended by Police	Not set								
P/CSP	Number of crimes where a child is the victim	879			301	109	95	94	599	
P/CSP	Number of crimes where a child is the offender	966			205	187	114	167	673	

**POLICE & COMMUNITY SAFETY PARTNERSHIP – Continued...**

<b>P/CSP</b>	Number of sexual crimes against children	73			12	6	3	8	29	
<b>P</b>	Number of reported Incidents of Domestic Abuse	3718			845	836	793	783	3257	
<b>P</b>	Number of Cases heard at MARAC involving children	112			55	54	37	35	181	
<b>P</b>	Average Caseloads held by Child Protection Officers	45			10	9	9	12	40	
<b>P</b>	Number of harbouring notices issued	22			2	4	4	4	14	
<b>P</b>	Number of children missing from home (In Care)	5			3	6	14	2	25	
<b>P</b>	Number of children missing from home (Not in Care)	22			15	5	8	9	37	
<b>P</b>	Number of children referred to National Police Association (missing over 48 hours)	1			0	0	0	2	2	

**POLICE & COMMUNITY SAFETY PARTNERSHIP – Continued...**

P	Number of referrals to Police where risk of Child Sexual Exploitation identified	Not listed			4	8		4	16	
P	Number of cases currently subject of review with CSE Ops Group	Not listed			12 ( 4 red risk , 6 amber risk, 2 green risk )	14 ( 2 red risk, 8 amber risk, 2 green risk)		9 (3 red risk, 4 amber risk, 2 green risk)	35	

**HEALTH**

Ref	Definition	2010-2011 Result	Target (where applicable)	Statistical Neighbours	Qtr1 (2011-2012)	Qtr 2 (2011-2012)	Qtr3 (2011-2012)	Qtr4 (2011-2012)	Year to date (2011-2012)	Comments
NI 70	Hospital Admissions caused by unintentional and deliberate injuries to children and young people (rate per 10,000 children)	Not set			227 under 16 263 under 18	No data at present see notes	114 under 18 and 97 under 16	nil data		This data is for both Calderdale and Huddersfield, we possibly can break down for the next quarter. Difficult to obtain this data accurately.
H1	Number of DV Referrals to the PCT received from Police	1866			444	418	499	474	1835	
H2	Number of DV referrals to CHFT received from Police	29			48	37	32	31	148	
H3	Number of NAI's Investigations by Paediatrics	192			39	30	24	18	111	
H4	Percentage of pregnant women asked routine direct questions on domestic abuse	Not set			No data at present see notes	No data at present see notes	No Data	No Data	No Data	The question around domestic violence would be asked when it didn't put the mother at risk (i.e. partner present) or when mum was at the visit with a child/adult. We could provide this data yearly accessing data through the supervision process.

HEALTH – Continued...										
H5	Average Caseloads held by SN's	4894			4841	4,900		4,900	4,900	Out to advert for a School Nurse
H6	Number of HV's	39.9 WTE average			41.1+ 1 FNP	40.9	41.33 + 2.4 vac	39.48	39.48	Out to advert to 7.5 Health visitors in the process of recruitment
H7	Average Caseloads held by HV's	322 average			330	350	320	360	360	
H8	CQUIN Indicator PCT Provider re; Child Protection Supervision	0.95			96%	No longer CQUIN	reviewing supervision over the organisation	86%	86%	This is no longer a CQUIN indicator.
H9	Level One Mandatory Training	96%			TBC	TBC	reviewing training over the organisation	100%	100%	This indicator was set when provider services were part of the PCT. Level one training is delivered to all new starters in the organisation. We wouldn't at the moment have current figures as we have just merged are safeguarding training programmes.
H10	Number of women under 20, pregnant with their first baby, supported by Family Nurse Partnership	60 clients			0 clients who are current pregnancy	14	12	42	68	This indicator only asks for pregnancy women not families currently on the programme. We have started recruitment from 1 July and we are currently working on the recruitment of two pregnancy mums.