Calderdale Safeguarding Children Board

Annual Report
2012 – 2013

Contents

1 Foreword

1.1. Everyone who works with children, young people and their families in Calderdale wants to do their best to make sure that all children are safe and happy, and are supported as they grow up. The Calderdale Safeguarding Children Board (CSCB) was set up as a requirement of government guidance to enable all key organisations to work together to safeguard children and promote their welfare. The Board does not take over the work from agencies but its job is to ensure that services do work together in keeping children safe and receive the support they need, and that the quality of that support is as good as it needs to be. You could be a neighbour, friend, parent, relative, childminder, teacher or doctor – or working for any organisation that has contact with children. You could be a councillor or Board Member of a health organisation. Whatever your role this is your business.

1.2. Safeguarding means protecting children from physical, emotional, and sexual abuse and from neglect. It means helping children to grow up to be confident, healthy and happy. Most children enjoy happy childhoods - but not all.

1.3. The responsibilities of the CSCB are set out in government guidance which requires the Board to co-ordinate local agencies' work, to provide robust policies and procedures to support safeguarding practice, and to challenge agencies if their work is not good enough. The Chair of the Board is also required to publish an Annual Report.

1.4. The report which follows covers the period 1st April 2012 to 31st March 2013. It reports and reflects on activity in that period but from a position of some hindsight. The purpose of this report is to '*give a public assessment of the effectiveness of local child protection arrangements, recognising achievements and being realistic about the challenges that remain.' (Association of LSCB Chairs May 2013)*

1.5. It has been a difficult year with agencies under pressure in terms of management of change and tight resources. Compilation of the Annual Report is always an instructive exercise, offering the opportunity to reflect on the safeguarding work that has taken place over the last year and to consider what has changed. Concerns about the quality of safeguarding in Calderdale are well documented and resulted in the Department for Education issuing an Improvement Notice in 2010. We are now three years on and in the intervening period there have been two inspections and one Peer Review. All agencies have sought to deliver improved services and their work has been overseen by an independently chaired "Improvement Board". Whilst there is evidence of some improvement in the quality of services, a recent inspection has judged the progress to be insufficient and services remain inadequate.

1.6. In the context of these continuing concerns, while this report rightly

acknowledges some of the achievements of the last year, the focus is on what we know about our children, how safe they are, what we know about the quality and range of services, and what needs to be done to ensure support for children and their families is good and safeguards those vulnerable to abuse.

1.7. This report also reviews the work of the CSCB itself. The Board established a set of priorities at the start of the year and has continued to develop a Quality Assurance Framework to enable the Board to ask and answer the question 'What difference have agencies made to the lives of children and young people in Calderdale and has the Board been able to impact on the work of the agencies to promote good practice and improvement where this is needed?' This question has informed the work streams of both the Board and its sub-groups.

1.8. The Peer Review of 2012 highlighted that there was an awareness of the challenges to practice, but both the Peer Review and the subsequent Ofsted inspection in December 2012 and July 2013 found that despite the measures taken, some key improvements had not been made. For the Board, the answer to our question 'What difference have we made?' would probably be, 'Not as much as we would have wanted'.

1.9. We have held some events to bring partners together and to promote good inter-agency working. You will see reports on the range of activities in the main body of the report. Participation in the Board and its sub-groups has been extended, bringing new perspectives and positive ways of working with it. The Board has a longer 'reach', and the potential for this to develop further to foster good partnership working. Feedback from those events has been impressive.

1.10. We have identified both good and poor practice from a range of different audits, including the Section 11 process and promoted improved practice by way of response. The safeguarding awards presented at our annual conference this year are particular examples of recognition of both excellent and innovative practice.

1.11. However, some problems have remained more intractable, and caused us to reflect further on how to find a solution. That evaluation process has inevitably led to further questions about the nature of our work, and this will be developed further within the body of the report

1.12. Our information systems have been improved to support this enquiry, and improvements to the Quality Assurance Framework have been, and continue to be a priority. The formal link with the Improvement Board has provided additional opportunity for sharing information and keeping the focus on improving services.

1.13. Whilst this level of scrutiny from the Board has indicated continuing problems, it has also provided some reassurance that some basic practices are improving. The recent inspection findings have, however,

reinforced the Board's own concerns about its effectiveness in terms of impact on agency practice and caused us to consider how to more effectively challenge agencies to deliver on improvement. A programme of work supported by sector experts, C4EO, is underway to help us develop more "intelligent" approaches to data management and understanding. They have re-iterated government guidance about the need to be able to promote better inter-agency working while being able to stand back and demonstrate independence of view and challenge.

1.14. While many of the areas identified in the Inspection report and through the Board's own work are subject to urgent action a number of other issues emerge in this report and are subject of short term and longer term recommendations. These recommendations may not have the same urgency as those issues already reflected in the Council's Single Improvement Plan but need to be given serious consideration if agencies and the Board together are going to ensure the delivery of good quality services.

1.15. We continue to seek out the views of young people, and welcome the increase in this activity across services over the past year. This report provides some examples of the specific activities that we have undertaken with our Young Advisors and how that has then influenced services.

1.16. Whilst concerns about the quality of services remain it is the case that the task of safeguarding children who are considered to be at risk of harm in Calderdale 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 be able to continue to improve services to children and their families. To them I send my personal thanks.

Jane Booth
Independent Chair
Calderdale Safeguarding Children Board

2 Essential Information

2.1 This report has been written by Jane Booth Independent Chair of Calderdale Safeguarding Children Board (CSCB) in conjunction with Bernadette Johansen, Business Manager CSCB. The report was circulated to the Board's Executive Committee for comment on 24th July 2013 and presented to Calderdale SCB on 29th August 2013.

2.2 This report will also be presented to the Calderdale Health and Wellbeing Board and to the Clinical Commissioning Group. It will be forwarded to the Council's Scrutiny Committee and copies will be sent to the Chief Executive and her equivalent in all member agencies.

2.3 Sources of information contained within this report include:

- quarterly and annual reports of CSCB sub-groups
- minutes of CSCB meetings
- reports submitted to the Calderdale Improvement Board
- Calderdale Council data management system (Making a Difference)
- electronic Health Needs Assessment (eHNA) , Public Health Calderdale 2012
- Working Together 2010, 2013
- Local Authority Designated Officer (LADO) annual report 2013
- Child Health profile 2013
- School census, Calderdale Jan 2013
- Calderdale Independent Reviewing Service Annual report 2012/13
- Peer Review 2012
- Ofsted Inspections 2012, 2013
- Calderdale Joint Strategic Needs Assessment 2013

2.4 Reference is also made to the Ofsted Inspection report published in July 2013 as it reflects on practice during 2012-13.

2.5 The report was published and can be found on the CSCB website. For further information about this report, please contact Bernadette.johansen@calderdale.gov.uk

3 Local Background and Context

Local Context

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

3.2 It is one of the largest metropolitan boroughs at 140 square miles, but has one of the smallest populations. Most of the area is classified as rural; a quarter of its population is 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.

3.3 The population is approximately 201,000 and is predicted to grow by 16,500 by 2018.

3.4 The Indices of Deprivation 2010 have recently been published and demonstrate that out of 354 districts in England, Calderdale ranks as the 105th most deprived.

What do we know about children across Calderdale?

- There are about 45,000 children and young people aged 0 – 18 and 64,800 aged 0-25. (2010 HM Government estimate)
- The proportion of under 15's in the population is higher than the national average, and the numbers of under 5's are predicted to grow steadily.
- There are approximately 2,744 births per year and the under 15 population is projected to increase rapidly in both 2014 and 2019
- There were over 33,000 children enrolled in Calderdale Maintained Schools in 2012. By 2013, this number had reduced to 21,621
- In 2012 60% of pupils achieved 5 grade A* to C compared with a national figure of 48%
- 20.5% of children in Calderdale are from a minority ethnic group compared with 18.5% reported last year

What do we know about their vulnerabilities?

Approximately 8990 children live in households with no-one in employment (DWP)	There were 339 Looked After children in March 2013 compared with 336 in March 2012	19% of children are eligible for Free School Meals compared with 17.2% in 2012
1083 children and young people have a Statement of Educational Need (31.1.12) compared with 1111 in March 2011	In 2013, 217 Children had a Child Protection Plan compared with 237 in 2012.	There were 369.6 (per 10,000) "children in need" compared with 319.0 the previous year.
61 young people were referred to the child sexual exploitation group, an increase of 26 on 2011/12	There are an estimated 1500 young carers, of which 312 are known to the Young Carers service compared with 270 last year	There were 267 new CAFs in 2012/13 compared with 196 the previous year
In 2011-12 the obesity rate for children in reception class was 8.9% compared with England average of 9.5%	43.8% of young people in the last electronic health needs assessment indicated that they had experience of being bullied and this has not changed since 2010	The electronic Health Needs Assessment 2012 highlighted inequalities between groups of children in terms of safety, self-esteem and health

3.5 We have seen over the last year an increase locally of those children classified as in need and in those in receipt of free school meals. These increases, as with the increase in Young Carers, are in line with other reported increases in demand for services. This is a cause for concern when many services are contracting at present.

3.6 The numbers of children looked after by the local authority has increased slightly locally, and is in line with increases in this population both in neighbouring authorities and nationally.

3.7 As a local authority area we are better informed than some of our neighbours as a result of the electronic health needs assessment (EHNA) in respect of the emotional well being of our children but we need to ensure that we respond effectively to the difficulties highlighted as well as build on the positives. Where some results remain unchanged and unimproved on the previous year, further research is required together with an evaluation of the remedial measures taken.

3.8 Increases in referrals in respect of child sexual exploitation cause concern but we are also mindful that levels of public awareness of this issue have increased considerably over the last year, and that we have services in place to respond, and that this increase is also echoed in other local authority areas where CSE services are being developed.

3.9 The increased up of Calderdale Assessment Framework Assessments (CAFs) as the vehicle for Early Intervention in families is encouraging. However, comparisons with other statistical neighbours reveal that more effort is still needed to increase the use of CAF locally.

What do we know about the services that need to respond to these children?

3.10 Understanding what is happening to a vulnerable child, within the context of their family and the local community, and taking appropriate action, is a continuous and interactive process, not a single event. Action, intervention and services should be provided according to the assessed needs of the child and family, in parallel with other assessment and intervention where necessary. It should not be necessary to await completion of the assessment process. Immediate and practical needs should be addressed alongside more complex and longer-term ones. The impact of service provision on a child's developmental progress should be reviewed and interventions and services revised accordingly.

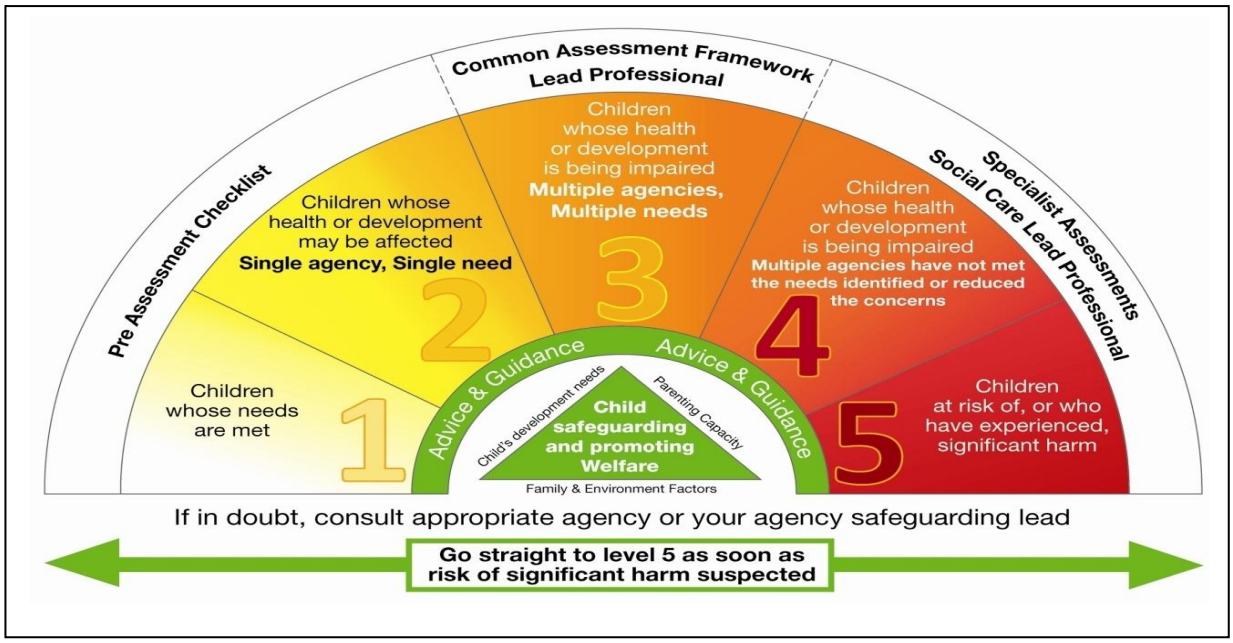
Calderdale Continuum of Need

3.11 In Calderdale this is described within the Continuum of Need and Response Model which seeks to describe the point at which agencies respond. The model refers to all children and young people who live in the borough of Calderdale, with each band representing their different levels of needs/interventions and related responses. Children can enter the continuum of need and response at birth but more along the continuum at any stage in their lives, at any time dependent on circumstances.

3.12 Children, young people and their families will move between levels as their circumstances and needs change and this may result in changes in the services provided. The model is not incremental, it is a continuum of needs and related responses. A specific incident, for example a child at risk of suffering significant harm, will trigger action at level 5. Following intervention, the level of vulnerability may reduce so that services provided at lower levels of need can be accessed.

Level one – Universal services

3.13 As a Board we are satisfied that the range of service provision in place for children and young people at the universal service level is satisfactory. Information considered via our QA framework has, however, raised questions as to whether all children have the same access and whether they know about services. Work undertaken by our Young Advisors has suggested that those that were newly arrived in the country who are often living in deprived areas feel isolated and unsafe at times. This will be a source of further enquiry for the Board and a challenge to ensure service response



3.14 The audit of safeguarding practice carried out with agencies is referred to in Section 10 of this report and has provided further reassurance.

3.15 There are challenges ahead resulting from welfare reform, and changes to housing provision which will effect some children, but we are aware of remedial measures in place locally, and in particular the steps being taken by the Council and local housing providers to mitigate risks.

3.16 The main and most consistent source of support accessed by all children and young people is offered by schools. The Board is actively engaged with schools and aware that all schools fulfill their obligation to designate a teacher and governor to focus on safeguarding. Mechanisms are in place to check that the Board is aware if any school is judged to be inadequate in respect of safeguarding by an Ofsted inspection.

3.17 We recognise, however, that we need to provide more support for schools and are planning a safeguarding audit with individual schools later this year. The advent of academies has resulted in the Board needing more complex arrangements for engagement with schools but we see no evidence that academies are less committed to the safeguarding agenda than other schools.

3.18 As part of the work with school councils across the district, children and young people have been asked about safety and young people have told us what is making them feel unsafe. It is clear from the feedback, that internet bullying is a significant issue and we are keen to support the development of materials for use in Personal Social and Health Education (PHSE) lessons to address this and wider safeguarding issues such as risk of sexual exploitation. In addition issues beyond the remit of the Board, such as the speed of traffic outside schools have also been voiced and followed up by individual schools.

3.19 The Board over the past year has started to ask more questions about early years provision and more information is needed on this, particularly as service provision for this group is under national review.

3.20 Rates of infant mortality remain a concern and the Board is now involved in multi-agency work on this, learning from experiences in other local authorities who have had similar challenges.

Level 2/ Level 3 Children needing some additional support which may be planned through use of the Calderdale Assessment Framework (CAF)

Early Intervention services

3.21 The Board is aware of a wide range of services across agencies to support children and young people of all ages who have some additional needs. Whilst services have been reaching large numbers of children, the concern has been that the most needy families did not always engage with necessary preventative work. Two initiatives now focus on these families - the Troubled Families initiative, and Calderdale's Early Intervention Support strategy – and have led to the development of more locally based targeted support. In September 2012, the Board supported the launch of the Locality Early Intervention Panels which have been established to support agencies working together at a much more local level in order to provide timely help for families. Through the offer of early help the Panels aim to prevent further risk and the need for more intensive services. The use of the CAF is seen as the vehicle for intervention, and the Board is monitoring the level of CAFs being established and the extent to which this is leading to a reduction in the need for service requests to Children's Social Care.

3.22 CAF numbers increased from 196 in 2011 - 2012 to 267 2012 - 13 but this is still a low level compared with some other similar local authorities. With the changes that have been promoted in terms of the electronic-CAF, it is hoped that these will increase considerably, and be a means of providing genuine early help to a wider range of families. It is 'early days' and will take some time to be established but the Board is reassured by the emerging information. Within the strategy there also is a framework for robust evaluation of service outcome.

3.23 The findings from the local electronic Health Needs Assessment carried out annually tells us that there are issues that need follow up, and it is the responsibility of the Children and Young People's Partnership Executive(CYPPE) to tackle them. One such issue is bullying. There is a need for the Board to agree how this will be followed up.

3.24 As a Board we have sought to establish whether the actions taken have led to fewer children in Calderdale feeling unsafe. Specific action taken has resulted in many different and flexible services being offered to support schools to deal with the bullying issue. The range of services

indicates recognition that “one size does not fit all” and the responses tackle both the needs of the vulnerable child and of potential perpetrators. Services include “Safetalk” in schools and work to build self-esteem, and school based services are also linked to the community through the Young People’s Services and Youth Justice providers.

3.25 The CYPPE has commissioned work to support the improvement of well-being for children and young people through a campaign and associated training to ensure that use of “Strengths and Difficulties” questionnaires (SDQ) becomes standard practice with vulnerable children and young people. The SDQ is a brief behavioural screening questionnaire. This practice tool engages children themselves, their families and professionals working with them in periodic evaluation of the child’s well-being and if successful is likely to ensure that children with emotional difficulties are identified earlier and consequently elicit early service response.

Level 4 - children and young people who have needs that cannot be met via a CAF / Children in need

3.26 For these children and young people, intensive support is required by a robust Child in Need plan. The Board has been involved in a major piece of work around the quality of plans and multi-agency training around “SMART” planning. Audits have been completed regarding the robustness of the plans, and the impact on children in terms of their level of need on the continuum of need. The work on planning has not led to reassurance (this is discussed later in the report). An audit of those children whose cases have moved down a level on the continuum in November showed positive practice but external scrutiny during a later inspection produced less positive findings. Inconsistency in practice maybe the reason for these results but further scrutiny is required.

Level 5 – the most vulnerable children who require support, for example, via a CP Plan or need to become looked after by the local authority.

3.27 The data set of the Board focuses deliberately on those children who are most vulnerable.

Management of incoming concerns

3.28 In December 2012 Children’s Social Care, West Yorkshire Police and health agencies established a joint team - the Multi-agency Safeguarding, Screening and Tasking Team (MASSTT) to respond to all incoming work concerning children’s safeguards. This was seen as a key priority to ensure that children with level 4/5 need were promptly screened and signposted to the appropriate service. The new approach to delivering this service is still in its early stages and its development is supported by a multi-agency strategic management group. Immediate benefits were seen through prompt sharing of information but from the very start the team has been inundated by a work load in excess of that predicted. In this context

recent inspection findings have assessed the work in the MASST and the Children's Social Care First Response Team as inadequate.

3.29 Throughout 2012 - 2013, reports to the Improvement Board have highlighted considerable pressures on the 'front door' services and that referrals were not being processed as quickly as they should have been. Both the Safeguarding Board and the Improvement Board has kept a close watch on this, and sought assurance from managers that action have been taken to improve the situation. The inspection findings suggest that we were too easily reassured and that senior managers were not making accurate assessments of the quality of practice. As a result the Board did not fully recognise the serious inadequacies.

3.30 The seriousness of the impact of the volume of work, combined with turn-over of staff, deficits in management oversight and supervision, was not recognised until after the event. The Board was aware that there had been a 56.7% increase in referrals - 1212.53 per 10,000 compared with 773.76 the previous year - but the Board accepted reassurances that several different approaches to managing the increase were being used. Once in the system, the processing of assessments (both initial and core) within timescales has fluctuated (lengthening timescales usually coinciding with spikes in service demand). Throughout the last quarter of the year, staff were moved from other teams and additional staff recruited. Of those additional staff, the recruitment of experienced social workers was prioritised.

Planning for vulnerable children

3.31 The Board was aware from reports to the Improvement Board, that the work with children subject of formal "Plans" (child protection, child in need) was underpinned by an increased internal audit process which was to highlight issues for further action specifically concentrating on the quality of planning, participation of the child, and use of past history to inform practice. The proportion of agency staff employed remains a concern, and the recruitment and retention of permanent staff remains a priority.

3.32 In addition to audits, the Board has also completed three detailed multi-agency case reviews (covered in more detail later in the report) that have shown that poor planning and incomplete assessments have contributed to very poor outcomes for some children.

3.33 In terms of the timeliness of review of Child Protection plans, and compliance with all relevant national indicators, there has been an improvement in performance throughout the year. The additional resources provided to the Independent Reviewing Service has supported this improvement and there are clear plans for continuing quality assurance of this service. There has been a small reduction in the numbers of children subject to a CP plan (237 in 2012 compared with 217 in 2013). Of more significance is the change in category (154 children categorised under neglect in 2013 compared with 74 in 2012), as a result

of the re-categorisation of children experiencing domestic abuse. The outturn report on the ethnicity of children subject to a plan (and also Looked After) is difficult to analyse and worthy of further audit in order to establish if there are specific trends and indeed inequalities for these children.

3.34 A source of assurance as to quality of planning for the Board has to be the extent to which the Independent Reviewing service has been able to challenge practice and there is increasing evidence of this through increased use of the dispute resolution service.

3.35 For looked after children, the Board has been provided with evidence of improvements in fostering practice and has been kept up to date with the plan for improvement in placing children for adoption (this is also being monitored via the Improvement Board). Progress on actions plans for both these areas of work is reported to the Quality Assurance Sub-group and has shown improvement.

3.36 The quality of services for children is heavily dependent on the staff who deliver them, and a consistent and well supported workforce. Supervision of sufficient quality is key. Reports to the Improvement Board have provided some reassurance but the recent Ofsted inspection indicates that the outcome of action taken has not produced the necessary improvement.

3.37 Whilst the Board has sought to focus on the quality of safeguarding practice hindsight suggests that we were too easily reassured and insufficiently challenging. There is some evidence of improvement in some areas but challenging agencies, and in particular Children's Social Care, to improve the quality of services must always a priority for the Board's work.

4 The Board

4.1 Calderdale Safeguarding Children Board is constituted in line with statutory guidance as set out below:-

- 4.1.1 Section 13 of the Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board (LSCB) for their area and specifies the organisations and individuals (other than the local authority) that's should be represented on LSCB's.

- 4.1.2 Section 14 of the Children Act 2004 sets out the objectives of the LSCB's which are:-

a) To coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area.

b) To ensure the effectiveness of what is done by each person or body for those purposes.

4.2 Regulation 5 of the Local Safeguarding Children Boards regulations 2006 sets out the functions in more detail.

4.3 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, its role is 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.

4.4 During 2012-13 the Director of Children and Young People's Services has held the statutory responsibility for ensuring an effective Safeguarding Children Board is in operation and has met periodically with the Chair of the Board. The relationship between the two is one of mutual accountability and challenge. The Chair of the Board has also met regularly with the Council's Chief Executive.

Roles and Responsibilities of Members

4.5 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 to the Cabinet for her own contribution to the effectiveness of the Board.

Reporting Mechanisms

4.6 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.

Accountable Body

4.7 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.

Relationships with other strategic forums

4.8 The relationship and mutual accountabilities of the Calderdale Safeguarding Children Board, the Calderdale Health and Well-being Board and the Children and Young People's Partnership Executive are set out in an agreed protocol. **(See Appendix 1)**

4.9 The Chair of the Board sits on the Council's Improvement Board and acts as its Vice Chair. There is an expectation from the Department for Education that the CSCB will take on the additional scrutiny role in relation to service improvement at a point when the Improvement Board itself and the Notice to Improve are no longer required.

4.10 In addition the Board Chair and Manager attend the Council's Scrutiny Committee twice a year and the Board also presents its Annual Report to the Clinical Commissioning Group.

4.11 The Board maintains its link with the Community Safety Partnership and Domestic Abuse Partnership through members who sit on both bodies.

5 Provision of policies, procedures and guidance

5.1 The West Yorkshire Policies and Procedures Consortium is a regional group for SCBs coordinated by the Calderdale Board. This includes the Boards of Calderdale, Bradford, Kirklees, Leeds and Wakefield Consortium arrangements enable the development of more consistent procedures across the county and all areas benefit from the economies of scale and efficiency of sharing the costs of this important activity. LSCB managers share the responsibility for chairing this group. Administrative support and coordination of this group is provided by Calderdale SCB on a re-charge basis to the other areas.

5.2 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.

5.3 Ensuring the development and updating of policies and procedures across five local authorities, five police divisions, numerous health trust and several Clinical Commissioning Groups is a complex matter. A key success over the last year has been the agreement of West Yorkshire wide policies and procedures in respect of child sexual exploitation which reflect the requirements of governmental guidance and support good practice.

5.4 For much of the period of this annual report, the issue of revised government guidance was being awaited and, though promised for the autumn of 2012, this was not received until March 21st 2013. All five LSCBs remain committed to a regional approach to the guidance, though the increased flexibility to develop local approaches to the policies and procedures underpinning good child protection work increases the challenge in respect of regional consistency.

5.5 In Calderdale all policies and procedures are available via the Board's website. New procedures are disseminated via several routes including electronic alerts, single points of contact within each representative Board agency, Board members and direction to specific work groups. In some cases, specific consultation events have been held.

5.6 During the course of the year the Board and its sub-groups have considered, revised or developed new policies and procedures relating to issues such as :

- Children who go missing from home and from care,
- The Neglect Strategy;

- The Adult Learning Difficulty Protocol;
- The Early Intervention Strategy; and
- Regional CSE policies and procedures.

5.7 Clearer pathways are now in place between the Board and its sub-groups for follow up on these policy developments to evaluate where they have been embedded and if not, to take remedial action. The cycle of identification of need, development of policy, training input and evaluation of effectiveness continues to develop but is aided by the Board's own business planning cycle and priority setting.

Key Achievements

- Continued West Yorkshire Wide arrangements for safeguarding procedures.

Challenges

- To ensure that the changes to Working Together guidance do not undermine existing arrangements
- Ensure that all changes to procedures are disseminated to agencies and embedded in practice.

6 Assessment Framework

6.1 Revision of the assessment framework was 'on hold' for much of this period due to the anticipated revision of Working Together, and is now, at the time of publication, underway under the leadership of Children's Social Care. Our previous annual report referred to the extensive multi-agency work on the Continuum of Need to ensure that the model was understood and embedded within practice leading to more appropriate referrals for services and assessments.

6.2 Information from external inspection processes in December 2012 indicated that whilst the Continuum of Need model was well recognised, there was insufficient consensus across agencies about application of thresholds and that the battle for 'hearts and minds' was not over. This has led the Board with partners to become involved in reflective practice sessions to discuss those contentious cases. During July 2013 the threshold document was revised and will be re-launched alongside the new assessment framework.

Key Achievements

- Successful reflective practice sessions

Challenge

- Ensure that the new Continuum of Need document is successfully launched across all agencies leading to improved understanding of thresholds for intervention.

7 Training Provision

7.1 The Board manages and delivers a comprehensive Training and Development Strategy. The Training and development Sub-group is an active inter-agency group and the pool of trainers also reflects good multi-agency engagement and commitment. There is close working with all agencies but particularly with the Local Authority's own Training and Development section**.** The OFSTED Inspection in December 2012 commented:

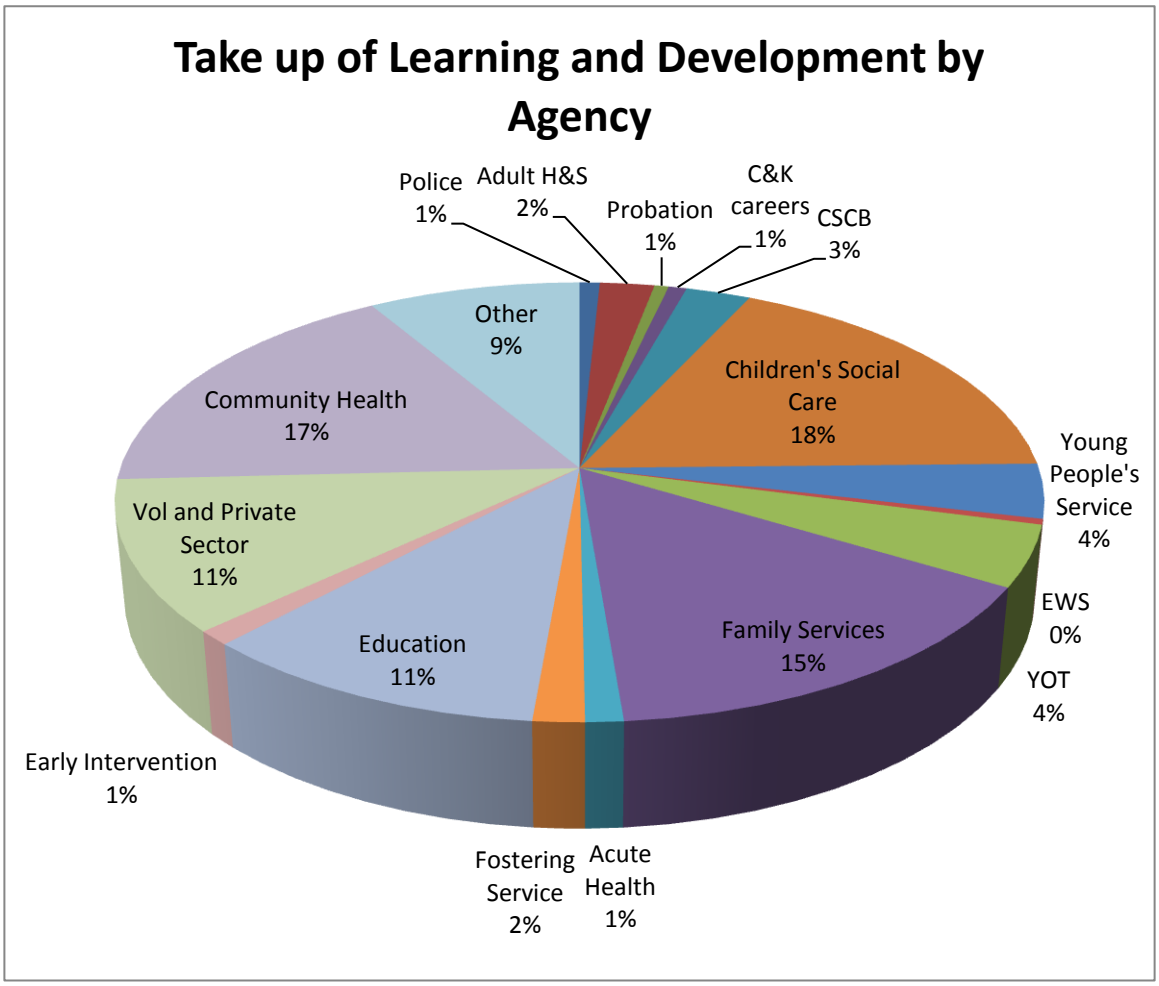
> "*A strong partnership is in place [Workforce Development] with CSCB, whose multi-agency programme is delivered flexibly and provides significant contribution to the Council's in house programme, with input such as lessons learnt from SCRs*."

7.2 Between April 2012 to March 2013, 66 direct learning training events were provided, and involved 1378 participants from a range of agencies. In addition, 1068 individuals completed e-learning courses.

The direct events comprised:

- 1 Single agency session – Basic Child Protection awareness
- 40 Multi-agency sessions (Learning and Development programme 2012-13)
- 15 Multi-agency briefings
- Regional training events
- 1 Multi-agency SCB conference
- 3 Multi-agency launches of procedures/new initiatives
- 1 Masterclass

The chart below shows take up of learning opportunities by agency:



7.3 When asked as part of the course evaluations as to likely impact of the training and what participants might do differently as a result comments included:

"Be mindful of desensitisation and ensure focus remains on the child and not lost on the parent"

"Will take 'toolkit' back to my practice"

"Thinking differently about ... how to coordinate chronologies to make sure they have all the information included"

"Thinking differently about ... supporting women seeking asylum on grounds of DV and how this affects their leave to remain"

"A chance to complete a CP plan in partnership"

"The importance of families having clear, achievable milestones"

"Meeting professionals from a range of backgrounds, different perspectives"

7.4 In addition to immediate feedback at the end of a course the Board has sought to assess the impact of learning from the multi-agency training

courses by undertaking phone interviews with Managers and Participants in six months after attending the training event.

7.5 Though the exercise was small scale it produced useful information. All comments suggested that the participants had, to some extent, embedded learning. For example, change in 'Attitude' was demonstrated by comments that indicated less anxiety relating to dealing with Safeguarding issues; being 'more open' to identifying risks; being more assertive in core groups and at Initial Child Protection Conferences: Increase in 'Knowledge' was evidenced by such comments as, "Learning how easy it is for children to be groomed, bullied and how hard it is for them to ignore the bully/perpetrator"; "having a better understanding of the roles of others in the child protection network".

7.6 One person was able to give very clear examples about how her practice had changed and how she had introduced new systems for supervision in the workplace as a result of her experience. The benefit of developing networks was acknowledged. Managers reported, for example, that their staff were 'more vigilant to activities of young people on-line'; they had been working more effectively with other agencies; they had observed improved relationships with parents; and they had become more focused in their practice which had a positive impact on outcomes.

7.7 Alongside the direct training inputs, a suite of e-learning modules are available to all practitioners (Child Abuse and Neglect at Core and Foundation levels, Integrated working, Working with Children and Young People who display sexually harmful behaviour and a number of courses with limited licences). All courses require participants to undertake a test at the end to demonstrate learning. The table below shows the number of individuals successfully completing courses.

E-Learning Courses Completed

2012 Refresher Courses	5
An Introduction to Integrated Working (Common Assessment Framework; Lead Professional; Information Sharing)	138
An Introduction to Safeguarding Children	94
Awareness of Child Abuse and Neglect - Core	651
Awareness of Child Abuse and Neglect - Foundation	114
Awareness of Child Abuse and Neglect - Young People Version	32
Awareness of Child Abuse and Neglect Core Level - Police Version	3

Common Core of Skills and Knowledge	1
Early Child Development – Foundation	29
Hidden Harm - The effects of parental problem substance use on children	1
Total	1068

7.8 Both agreed priorities of the Safeguarding Children Board and lessons from serious case reviews are referred to the Learning and Development sub-group and incorporated into the annual programme, with other learning opportunities built in as required. Examples of courses delivered in 2012-13 to specifically address lessons from Serious Case Reviews and Board priorities are:

- Seminar planned and hosted by a multi-agency group with representation from Calderdale Safeguarding Children Board, Family Nurse Partnership, Family Support and Youth Works focusing on 'Balancing the Needs and Rights of Young Parents and their Children.'

- The development of a toolkit to assist in the assessment of neglect which was piloted with agencies who work across the continuum of need. The toolkit was then launched and its implementation supported by a series of single agency briefing sessions, overseen by a Neglect Task and Finish group. Feedback in training sessions indicates that practitioners are using the toolkit and usage is being monitored by the Family Intervention Team and via audits of children's plans.

- The launch by the Board of the Multi-agency Early Intervention Strategy which highlighted the importance of those agencies which provide early help.

7.9 While single agency training is not the Board's responsibility, the Board has worked alongside some agencies, for example, Police, Probation, Child Health, Children's Services, Children's Society to co-deliver training and this gives the Board a hands on insight into the quality of their single agency training. The Board has also provided some agencies with assistance on preparation for single agency training including early years providers and children's' social care.

Key Achievements

- A move from a more traditional programme to an increasing diverse menu of learning choices.
- More practical/skills based learning opportunities.

Challenges

- Ensure that the programme continues to develop and diversify to meet the requirements of learners.
- Further improve evaluation to ensure emphasis on outcome.

8 Quality and effectiveness of arrangements and practice

8.1 The scope of the Quality Assurance (QA) work undertaken by the Board is broad and, at the request of the Council's Children's Social Care Improvement Board, the framework for QA has encompassed a wide range of activity impacting on children and families. The work is managed via a Quality Assurance sub-group and focuses on the Board's priorities. The Quality Assurance Framework comprises four strands:

- A performance scorecard which measures the position against both nationally and locally set indicators and benchmarks;
- 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;
- An escalation procedure if performance deteriorates between reporting periods; and
- A Risk Register to articulate the level of risk the Calderdale Safeguarding Children Board has with regard to delivering on its objectives;

Performance Score Card

8.2 The data set is held within the local authority's "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. Through the year there has been good support across partner agencies for this system but it has been increasingly clear that the scorecard is too big and the group can risk 'drowning' in data rather than focussing on the most important issues.

8.3 The regular reporting to the Improvement Board regarding the Single Integrated Improvement Plan (SIIP) and the current audit programme has meant that a whole range of data is being scrutinised in that arena with a danger of duplication. The Board's response has been to become increasingly explicit as to its specific priorities, and to identify those issues that were subject to sufficient scrutiny elsewhere and where reassurance and reporting was more appropriate.

8.4 During 2012 – 13 the Board had itself recognised that its QA framework needed review and begun redevelopment work with the support of sector experts, C4EO. The recent inspection confirmed the need for change with a critical assessment of the current system.

> "*The CSCB has not been sufficiently effective in driving change since the last inspection despite a number of positive developments; in particular it has not effectively monitored and challenged the quality of frontline practice.*
> *The CSCB receives a range of reports, audits and presentations on the work undertaken by its partner agencies, for example through reports and*

monitoring by independent reviewing officers. However, there has been insufficient challenge of the information provided by children's social care to the CSCB which has not enabled the Board to gain an accurate picture of current deficits. The CSCB recognises that it needs to be smarter in its selection and interrogation of the information it receives from partners and that it has not been sufficiently robust in comparing its performance with national and statistical neighbours and learning from good practice elsewhere."

8.5 The Board has had to acknowledge that the work which has been carried out has not been sufficiently effective in ensuring practice improvement in some areas of service.

Variance Reports

8.6 As result of the analysis of data from the performance scorecard and subsequent discussion the following variance reports were requested:

- **Children Missing from home and education (July 2012)**
  Discussion of the variance report led to a clearer understanding of the issues and reassurance that robust procedures were in place in respect of children missing from education. Work in respect of children going missing was a priority training area last year, and new procedures were launched, as well as new arrangements for strategic oversight of children who go missing

- **Private Fostering (September 2012)** Awareness raising campaigns across agencies had led to an increase in referrals (from 1 to 7) and whilst this had not led to increased numbers of ongoing arrangements, there was evidence that assessments had been carried out. Checks in training had found that knowledge of the subject remained limited and that ongoing reinforcement was required.

- **Adoption Timescales (January 2013)** Performance had been challenged and the group heard about the plans in place to improve it. The performance indicators record the length of time until the Adoption order is made, and that sometimes there are defensible delays between placement and the order being made. There are currently 7 children for every prospective adopter but work is ongoing to recruit more adopters, reduce barriers to placement, and more joint work being undertaken between the adoption teams and those teams working directly with the children

- **Recording of children present in families where Probation are involved (February 2013)**. It was noted that there is a regular audit of cases within that agency, but they are not carried out with the emphasis on the children in the family. No inadequate practice was identified, but it was noted that it was not regularly checked for within the usual audit regime. Probation agreed to do regular audits with this perspective in mind, and report back to the group annually.

Audit Reports

8.7 The following areas have been subject of audits:

- **Quality of Child Protection plans (April 2012)**. The quality of Child Protection plans was found to be inadequate and the Board established a multi-agency task and finish group on SMART planning as well as approving a new training programme for the year.

- **Children on a Child Protection plan for a second time (June 2012)**. This audit found a range of different issues. In some instances, the cause for concern had changed from the previous plan, incomplete or inadequate assessment previously, particularly in respect of neglect. The audit also reinforced the findings of the CP planning audit. Findings were communicated to the task and finish groups working on both SMART planning as well as the Neglect toolkit

- **De-escalation following end of Child Protection plans (November 2012)**. A multi-agency audit of 20 cases was carried out. A large majority of the cases were found to have been appropriately de-escalated, but of those where this had not taken place, follow up action was agreed. One case led to further scrutiny in terms of the decision to end the plan, and this was also followed up. The findings of this audit (in terms of de-escalation) did not correlate with findings of the Peer Review and Ofsted inspection carried out at the end of 2012.

- **Evaluation of multi-agency training (December 2012)** The evaluation had taken different forms, and had found that the training had had positive impact. Although limited, less positive evaluation had resulted in reviews of content and in one case a new provider was sought. Other results from the audit included a move towards increased differentiation within training programmes aimed at practitioners at different levels of expertise.

- **Attendance of agencies at sub-groups (March 2013).** This audit found that attendance from different agencies fluctuated following staff changes, and that ongoing vigilance was required across agencies to ensure members were replaced, and the momentum of the work plans of the different groups maintained. Members of the sub-group agreed to follow this up within individual agencies and

membership and participation would continue to be monitored. This has resulted in improvement.

8.8 While some areas of progress can be identified action in response to the audits has not resulted in the desired improvements; the assessment of impact identified in the recent inspection report is disappointing

"Whilst some audit activity has been undertaken by members of the CSCB this is not systematic or regular and has not enabled the Board to recognise the significant weaknesses in key frontline child protection services."

The expectation that in the future, front-line staff will be involved directly as part of audit teams will be a challenge.

Escalation Procedure

8.9 This was introduced following concerns that quarterly reporting ran the risk of the Board being unaware of the development of a significant deficit in performance between reporting periods. It followed a specific concern about unallocated work in Children's Social Care and all agencies are now required to inform the Board if concerns develop and what action is being taken to mitigate risks.

Risk Register

8.10 The Risk Register has maintained the focus on the key risks for Board. There has been recognition that the instability of personnel at key positions across agencies has had negative impact on the ability of the board to take forward and embed some of its priorities such as development of the task and finish groups arising out of serious case reviews. Changes and temporary appointments to senior management posts in Children's Social Care created particular difficulties in relation to engagement in sub-group activity, with a particular impact on the Prevention of Harm sub-group. For the first time in a long period, however, the presence of permanent staff offers the chance of continuity and embedding of new developments.

Membership of the Audit & QA Sub-group

8.11 Whilst there are frameworks in place, the strength of the activity of the group is, in part, reliant on the membership. The quality assurance group has increased in size with increasingly diverse perspectives including commissioners of services but the Board's capacity to manage effective quality assurance is limited.

8.12 For the future, the group's focus must be to better understand the fundamental quality of services and challenge agencies where practice is not good enough. Some audit activities over the past year have been viewed as so important that they have been considered directly by the whole Board or reported to the Improvement Board in order to ensure

awareness and a commitment to respond across all agencies. The outcome of the electronic Health Needs Assessment is an example of this. The success of the group in the future however will be in ensuring issues identified are followed through by agencies and other sub-groups of the Board itself and that there is evidence of improvement.

8.13 A key piece of work through 2012 (referred to earlier in this report) related to the improvement of children's plans following an audit that found cause for concern. A training programme ensued throughout the year, and is still underway trying to improve this aspect of practice. It is worthwhile exploring this issue as an example of the Board's current approach to enquiry into quality. The multi-agency briefings that resulted from the original audit were well attended and well evaluated and yet they did not result in improvement. We have explored the potential reasons for this, and plan to routinely check on progress. Increasingly we have a better awareness that fixing some problems and improving quality is complex, and that change is not achieved by simply reporting concerns and providing training. Follow up of changes to practice or procedures needs to be much more firmly embedded.

8.14 However, the checks on quality are not restricted to the work of this sub-group only, and the thread runs from the Board itself to the other groups 'How well are we doing 'is central to the agenda of all groups, and measurement of performance relating to training or reviewing of cases are all reported back to the Board via the sub-group quarterly reports.

Effectiveness of practice

8.15 Although the Ofsted inspection of December 2012 made an overall judgment that safeguarding practice was inadequate, feedback from both the Peer Review in November 2012 and the inspection itself indicated that there was a good level of knowledge about the difficulties as well as improvements to a range of services. With hindsight the Board took too much reassurance from the positive elements in these reports and engaged with the Improvement Board as the major vehicle for the monitoring of progress. Ofsted's perspective on this gives a helpful insight into the consequences!

> *"There is overlap in the membership of the CSCB and the improvement Board, which facilitates communication between those representatives who sit on both. However, the efforts to reduce duplication and increase efficiency between the improvement board and CSCB have led to the scope and influence of the CSCB being diminished."*

Key Achievements

- Investment in a more robust framework
- Multi Agency audits leading to corrective actions

Challenges

- The improvement of safeguarding practice must be the overriding priority of the Board. All the work of within the quality assurance framework must be improved to ensure that the Board has a clear picture of the quality of practice, can identify deficits, provide purposeful challenge and contribute to necessary improvements.

- Systematic audit programme.

9 Section 11 Audit

9.1 The audit of safeguarding across agencies was carried out in 2012 culminating in a series of challenge events in the autumn. The challenge panel to Calderdale Council services also included the Young Advisors who set questions for them, and responses were included in the feedback to that agency. (Please see Appendix 2 for a summary of those agencies participating in the audit.) The audits run on a three year rolling programme so some agencies' audits were deferred until next year. Written feedback was sent to individual agencies with their requirement for the development of action plans to improve areas with low scores.

9.2 A summary of the findings from all the audits was presented to the Board and included the following:

- There was significant variation in the level of detail agencies were able to provide relating to issues such as take-up of training.

- Whilst the overwhelming majority of agencies/services had operating systems for training, CRB checks etc., evidence of full compliance with these systems was less consistent. Assurance was provided that information was 'cascaded' but there was less evidence regarding checks on whether cascaded information was actually received.

- Good practice was noted in the Fire Service and Calderdale Hospital Foundation Trust who were able to evidence how they would check whether training had been taken up, what impact it had had, and the action taken if it hadn't.

- The presence of a communication strategy for messages including safeguarding is essential.

- Within CMBC, there appeared to be an over reliance on the HR department to record training and CRB completion rather than with the individual manager to oversee this. No evidence was provided that managers confirm that CRB (now replaced by Vetting and Barring checks) checks are in fact completed at agreed intervals for staff in post.

- The trend of generalisation applied to some submissions. Statements that staff worked to the SCB's policies and procedures were invoked regularly but it was less clear whether those agencies had evidence of compliance or checked routinely whether the procedures were accessed in practice.

- CAFCASS provided a corporate response which reflected national practice expectations but was not able to provide assurance about local practice and provision in Calderdale.

- Without exception, every service indicated that changes to service arrangements were due. Many indicated uncertainty about the impact of reductions in services.

9.3 Some examples of good practice were also identified:

- Individual training records followed up during inspections to check on compliance (Fire Service).

- Excellent recording of safeguarding practice data (Youth Offending Team).

- Safeguarding handbook for staff (CMBC Communities).

- Clear pathways regarding training requirements (CHFT).

- Office held templates for renewal dates of CRB checks (Young People's Services).

- Whole team events on lessons from specific serious case reviews-team (Children's Disability Services).

- West Yorkshire wide standardisation of training in conjunction with SCBs (Probation).

- Communication strategies to ensure that safeguarding messages received (CHFT/Fire Service).

- Safeguarding 'crib sheet' for Probation Officers completing assessments to ensure that the child kept in view when assessing adults (Probation).

- Excellent example of a completed section 11 audit – (CHFT Calderdale)

Key Achievements

- Involvement of the Young Advisors in the process
- Dissemination of positive practice across agencies
- High levels of participation in the process

Challenges

- Ensure that all practice issues identified in Section 11 are robustly addressed within agencies.
- Improve the quality of Section 11 audits in some agencies so that richer learning is achieved.

10 Case Review Function

10.1 The Board manages the process of Case Reviews via a specific Serious Case Review sub-group which ensures reviews are commissioned and completed in respect of cases meeting criteria set out in statutory guidance and commissions other reviews where there is reason to believe there are lessons for practice.

10.2 Government guidance in force during 2012-13 defines a serious case review as follows:-

- abuse or neglect of a child is known or suspected; and
- either– (i) a child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child (Working Together 2013).

10.3 An SCR from the previous year is still awaiting publication. The outcome of this review was reported in last year's annual report and all recommended actions have been completed. It cannot yet be published due to legal reasons. The Board awaits resolution of the legal issues and will then publish the report on its website.

10.4 A second review has been completed, identified as Baby E. This SCR was commissioned by the Lancashire Safeguarding Children Board but the child's family had previously lived in Calderdale. Four Calderdale agencies were involved in this review, and produced action plans in response to the findings. Associated criminal proceedings prevented immediate publication but these are now concluded and the report was subsequently published in July 2013 on the Board's website.

10.5 Issues identified in the Baby E review related to:

- Ensuring that lessons from this and other reviews could be inculcated into practice, particularly in relation to assessment processes and the need for child focus.
- Ensuring that training provided had sufficient emphasis on child development and vulnerability
- The provision of performance measures to support and provide evidence of the effectiveness of assessments
- Checking whether local protocols and frameworks supporting effective exchange of information and providing help quickly and effectively
- The development of practitioners levels of confidence, clarity and ability to challenge when working with vulnerable families
- Levels of practitioner knowledge in respect of domestic abuse and substance misuse, and the sources of support and help
- The impact of organisational stress on practitioners and the extent that this was understood by relevant stakeholders

- Further enquiry into the allocation of resources and workloads

10.6 Implementation of the action plans of the individual agencies and the Board is in progress and being regularly monitored by the SCR sub-group, and reported on to the full Board.

Other Reviews

10.7 During the course of the year the Board commissioned a thematic review in respect of service responses to two young women where there were very serious issues of self harm. The findings included:

- Over emphasis on maintaining the cooperation of parents rather than remaining focussed on the needs of the child.
- External placements are sometimes sought because more creative local solutions are not seen as achievable due to bureaucratic processes.
- Additional training on sexual abuse is required.
- Moves out of the borough sometimes result in a breakdown of support networks and a lack of continuity of care.
- Failure to carry out comprehensive early assessments may result in incomplete understanding of need and risk factors for the child
- Reflective practice needs to be embedded more consistently across all services.
- Where children are placed in residential homes outside the borough, they will be best protected through a collaborative process of commissioning and operational planning and review throughout.
- The experience of critical inspections has an impact on the confidence of practitioners locally, and there is a need to re-affirm confidence.
  Implementation of action plans is in progress and is being monitored by the Board.

10.8 A multi-agency thematic review was also commissioned in February 2013 regarding the quality of multi-agency decision making in case of a child with a head injury. The Serious Case Review criteria were not met but there did appear to be lessons to learn and therefore an alternative method of case review was agreed. The findings will be ready for presentation to the Board in October 2013.

10.9 A review of practice was also requested in November 2012 following a request to CSC from the courts for review of care planning in legal proceedings. This was a single agency review and the outcome was reported to the SCR subgroup in May 2013. The conclusions were that the following need to be assured:

- The need for a robust system of recording and checking progress on requests for section 37 reports, and their subsequent allocation to a suitably qualified practitioner.

- When cases are allocated, account is taken of individual professionals experience, knowledge and workload.
- Training and development provides sufficient knowledge to practitioners and their case supervisors in regard to complying with statutory requirements for identifying children who may require protection or where arrangements are made for children to be looked after.
- Appropriate systems of quality assurance that include audits of files should ensure that recorded decision making is robust and that social workers are compliant with relevant placement regulations and notifications. Training, supervision and monitoring should all be in place to enable all staff to comply with the relevant regulations and that chronologies are an integral part of a child's records.
- Systems for enquiring into the safety and circumstances of children includes comprehensive checks with relevant services and professionals and takes account of the views of other professionals who are in daily contact with children especially where there are concerns about the children's safety.
- The commissioning of further work on developing the framework, standards and practice of assessment. This should include developing specific arrangements in how parenting assessments are completed, the views, wishes and feelings of children are seen to be part of the process of assessment and recording as well as identify risk and need relating to the child and provide the basis of future plans and action.
- Ensure that the role and function of Independent Reviewing Officers (IROs) are clear and understood. This should ensure that social workers and practitioners understand the requirement to consult and keep IROs informed where relevant and that IROs are clear about their role and responsibility for quality assurance and are able to raise concerns about specific children and cases.
- Checks should be made during supervision whether there are any significant factors that should require joint working either when visiting a family or when undertaking a parenting assessment. Circumstances include intimidation or fear of reprisal, especially in cases where the social worker lacks experience or where the subject of the assessment is known to have a history of domestic or other violence.
- Social workers who attend court have had a proper handover of the case and there is adequate time to see the children; read the file and become familiar with the case and be in a position to provide appropriate information and advice to the court

Implementation of the CSC action plan is in progress and is being monitored by the Board.

10.10 A further case was considered for SCR following referral from the Calderdale adoption panel, where there were concerns that a parent with

previous offences had misled agencies about his identity and a child was subsequently injured. This did not meet the criteria for a SCR but it highlighted that the Police had had previous opportunity to make checks about the individual and this had not been done. The police completed an internal review which resulted in changes in practice.

10.11 The SCR panel also considered the case of a baby whose body had been found buried and whose identity was initially unknown. Parentage came to light only some years later. There was no evidence of agencies failing to work together, and the cause of death remained unknown. However, the panel noted in both this case and the one above that the parents had assumed new identities in order to deceive agencies, and this was fed back to the Board, and the need for practitioners to approach work with a healthy scepticism included in training content.

10.12 The SCR sub-group considers information from reviews held elsewhere, and the lessons as from our area are disseminated in the training programme.

Child Death Overview Panel

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

10.14 Through a comprehensive and multidisciplinary review the Panel (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 "*Working Together to Safeguard Children"* 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.

10.15 A total of **17** deaths were reported to the Calderdale Child Death Review Team between 1st April 2012 and the 31st March 2013. Review of 9 of the 17 cases had been considered at the Child Death Overview Panel by the 31st March 2013, and a conclusion reached in **6** of those cases. Three cases were deferred awaiting further information (post mortem results).

10.16 **8** cases referred to the Child Death Review Team between1st April 2012 and 31st March 2013 are yet to be discussed at Panel and will be discussed within the 2013/14 financial year when sufficient information is available.

10.17 Additional cases were concluded at Panel during this financial year, from deaths that had occurred the previous financial year, the 1st April 2011 to the 31st March 2012.

10.18 Therefore, between 1 April 2012 and 31 March 2013 a total of **13** Calderdale cases were concluded at Panel of which 46% occurred during 2012/13 and 54% occurred during 2011/12.

10.19 There do not appear to be statistically significant differences in mortality rates (0-17 years) over the last decade but it is noted that the death rate is at its lowest rate for a decade. The proportion of infant deaths (two-thirds) is relatively stable. Of the Calderdale child deaths occurring in during the five-year period 2008/09 - 2012/13, the ratio of female to male was 1:1.4 and there is no significant difference with the national picture. Over the same period, one-third (33.1%) of all child deaths are of Pakistani ethnic origin.

10.20 For the five-year period of operation of CDOP, 11% 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 21% of cases completed in 2012/13 having modifiable factors identified and a regional average of 19% for the equivalent.

10.21 Of the Calderdale cases identified to have modifiable factors over the five-year period: 69% were of White-British and 23% of Pakistani ethnic origin; 38% were male; 77% were infant deaths;46% were in the category 10 *'Sudden unexpected, unexplained death'* and 23% 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'* (60%) which differed to the national finding.

10.22 During the five-year period, there have been no Calderdale cases categorised as Category 1 *('deliberately inflicted injury, abuse or neglect'*). Co-sleeping was not identified as a factor in any of the Calderdale cases reviewed/completed in 2012/13 and consanguinity was only noted in 1(8%) case.

10.23 For Calderdale, for the cases reviewed by Panel during 2012/13, only one child (8%) was subject to a Child Protection Plan which was higher than that found nationally (1%). Whereas nationally it was unknown in 5% and 4% of cases respectively whether a child was subject to a statutory order or CPP, this information was incomplete for 23% Calderdale cases reviewed/completed during 2012/13.

10.24 No Calderdale cases reviewed/completed during 2012/13 were known to be asylum seekers although this information was unknown for over half of cases (unknown for only 8% cases nationally).

10.25 While a history of domestic violence was present in over a third of Calderdale cases reviewed/completed during 2012/13 and a parent was known to police in a fairly high proportion of cases, these were not considered contributory factors to the death.

10.26 During the five years of operation of CDOP, almost half of child deaths (44%) occurred amongst children resident in Halifax Central. Three-quarters (75%) of child deaths occurred in either Halifax Central or Halifax North & East localities during that period, despite these two localities having only 53% of the under-18 population in Calderdale. Child mortality rates (0-17 years) in Upper Valley in 2012/13 were 3 or more times lower than in other localities.

10.27 The two most deprived quintiles contributed to two-thirds of all child deaths in 2012/13, despite them only having 45% of the overall child population, and 40% deaths in the age 1-17 years bracket were in the most deprived quintile.

10.28 Finally, some points which indicate good functioning of the CDOP are:

- Ethnicity was known in 100% of Calderdale cases received over the five-year period 2008/09 to 2012/13 of the CDOP's operation whereas it was not known in 7% of cases completed nationally in 2012/13
- By 31 March 2013, only 11% of Calderdale cases received during the five-year period 2008/09-2012/13 were uncategorised /not completed compared to a national average for the same of 19% and a regional average of 17% of cases for the same period
- Around a third of Calderdale deaths during 2012/13 were reviewed/completed in year which is similar to the national average (38%) and above the regional average (27%).

10.29 On some points relating to good functioning of the CDOP, the process was less good than in the previous year or compared with nationally:

- For deaths referred to Calderdale CDOP during 2012/13, only 35% of these deaths had completed reviews by 31 March 2013 whereas the equivalent figures nationally were for 40% of such cases to be completed by 31 March 2012 and 36% regionally.
- Asylum seeking status was unknown in over half of Calderdale cases reviewed/completed during 2012/13 but only 8% nationally

- Whereas nationally, it was not known if the child was subject to a statutory order for 5% of the reviews completed or if subject to a CPP for 4% of reviews completed, this information was incomplete for child/sibling in 23% Calderdale cases reviewed/completed in 2012/13.
- Information on parental health, smoking or substance/alcohol misuse was frequently absent (almost two-thirds fathers) for Calderdale cases

10.30 During this year, the SCB provided a specific multi-agency event for practitioners to promote use of the Every Baby Matters materials

10.31 Locally, there is a link via the Public Health representative with the infant mortality task group, District Leadership team (with Children's Services), Children and Young Peoples (CYP) Strategic Commissioning Group, and 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.

Key Achievements

- Wider involvement of front-line practitioners within the review processes.
- Continuing affective arrangements for the review of all child deaths.
- CDOP development events

Challenge

- Ensure that learning from reviews is disseminated widely and leads to improved practice and better outcomes for children.

11 Engagement with and participation of children

11.1 This continues to be a priority area for the Board and 2012-13 has seen continuing work with our Young Advisors groups who have supported the Board with training events and survey work. A survey with Czech/Roma young people gave an important insight into the lives of this group, providing an additional perspective of the work being carried out with this group. Some of that information was also shared with the annual conference adding to their knowledge of this group of young people

11.2 The work with Young Advisors has also increased our link with the Voice and Influence Team of the Council who have fed into our work both in the Communication sub-group as well the Prevention of Harm group. The Board is better informed about the views of young people in the school councils and offered support with training events for young people as a result.

11.3 The Young Advisors were included in the Section 11 challenge and set questions for council services, such as 'How do you know your staff are doing what they say they are doing?'

11.4 The training programme this year has benefitted from the input from young people. The Board commissioned young people to produce DVD material to inform practitioners about their experiences of going missing and what helped them most.

11.5 A group of young parents contributed to a training course around supporting young parents so that staff could be made more aware of their motivations and the challenges they face as new parents.

11.6 All training emphasises the importance of the voice of the child, and practitioners have started to feedback information on this. Levels of participation in child protection planning and Looked After Child reviews is being more rigorously collated. Findings from audits evidence increased engagement. Additionally the Improvement Board is receiving regular reports of children being asked their views during assessment processes, and having those views acted upon.

11.7 Further collaborative work is planned in the next year, and the Young Advisors are due to participate in the consultation for young people of the new Working Together guidance for children and young people. Plans are being developed to involve the Young Advisors in eliciting better direct responses from young service users about the quality of the services they receive and on the work of the Board and its priorities. The group will also be supporting the Communications sub-group in a publicity campaign on safeguarding issues. The group is helping design a poster about 'shocking facts'

11.8 The electronic Health Needs Assessment carried out in primary and

secondary schools last year, with 3378 survey returns was the single most important 'window' on what is happening for children and young people. The results have been linked at a strategic level with the planning objectives of the Children and Young Peoples Partnership Executive, and the implications for practice at all levels of the Board feeding into the business planning cycle.

11.9 However, work over the forthcoming year, will be to establish how far the different measures have been effective in reducing the identified issues such as bullying.

11.10 Some of the findings from the survey are listed below:

- *Almost all pupils continue to rate their health positively*
- *Self-esteem has improved*
- *Substance use in general (tobacco, alcohol, illegal drugs) has decreased*
- *The proportion doing strenuous physical exercise remains high and the proportion eating 5 portions of fruit and vegetables per day is unchanged*
- *Most children are happy with the way they look*
- *There has been a reduction in the proportion of pupils bullying others*
- *A large majority of pupils get on well with the people they live with, and with teachers and staff at schools*
- *There has been an reduction in the proportion of pupils reporting being 'sexually touched or held'*

11.11 But on the other hand

- *Alcohol remains the main substance used by young people in Calderdale with a significant proportion regular users and experiencing drunken episodes.*
- *Pupils receiving free school meals are more likely to eat unhealthy foods*
- *Moderate aggression amongst pupils is high and has worsened*
- *Experience of bullying remains high*
- *Pupils perceive a reduction in information about contraception and safer sex*
- *A high proportion of pregnant girls and young mothers are not in contact with a midwife or health visitor*
- *Self-harm remains high particularly amongst year 10 girls.*
- *Feeling unsafe at school has worsened and differs almost tenfold between schools*
- *More pupils are feeling unsafe when using the internet*
- *The proportion feeling threatened, experiencing or witnessing physical harm is unchanged*
- *A sizeable proportion have experienced loss of someone close and are remain upset*

- *There is still a significant minority who have run away from home, live alone and/or have experienced life on the streets*
- *A significant minority still feel unsupported with school life by home*

11.12 The Board is encouraged by the positive findings. There is however a considerable challenge for agencies who support children and young people in addressing the areas where there has been no improvement. The Board must ensure that its own priorities and that of other strategic partners remain aligned to these key areas of concern and the Board maintains focus on this.

Key Achievements

- Continued meaningful involvement of young people in the work of the Board.
- Increased involvement of the Voice and Influence team in the work of the Board to ensure the focus is maintained.

Challenge

- Ensure that better ways are identified for the follow up on processes such as the EHNA to improve strategic planning of the Board and its member agencies.

12 Equality and Diversity

12.1 The SCB completed an Equality Impact Assessment in 2012. The process revealed that while communication with professionals was good, there was a need to ensure improved and more accessible communication with the wider public and vulnerable groups improved. This issue was taken up by the Communications and Communities groups and a strategy is now in place.

12.2 The Board is committed to the principles of equality and respect for diversity, and this has been particularly evidenced in the training provided for staff over a sustained period, as well as scrutiny of data on issues such as numbers of children on child protection plans from an ethnic minority.

12.3 However, the SCB has started to focus more attention on the impact of inequality on specific groups of children and young people. The extension of the SCB and its sub-groups to new agencies and services, such as a housing provider, and increased engagement with Public Health, has brought increased awareness around the impact of wider community issues including the poverty agenda. Findings from the electronic Health Needs Assessment, which involved 3378 pupils, gives much food for thought. This specifically relates to the significant differences between schools. Whilst some risks are reported as reduced, no tangible improvements are noted in respect of bullying even in the schools where there have been a number of initiatives.

12.4 The collaborative work on safeguarding awareness for mosques and madressahs with the Council of Mosques has extended the reach of the Board to groups that previously had limited contact with the Board. The Calderdale Interfaith Council nominated two representatives to the Board but both had to subsequently decline due to other commitments. This is still to be pursued to ensure that the different faith groups, who offer a range of services to children and young people, have a voice and are appropriately engaged with safeguarding.

12.5 The Board has participated in a regional conference for faith groups on safeguarding and specific training on the needs of Czech/Roma populations. Bespoke safeguarding training has been commissioned to support madressahs to be delivered in 2013-14.

12.6 The Board has had evidence of improved safeguarding responses in services for disabled children. The Board also carried out a multi-agency benchmarking exercise regarding services for deaf children which resulted in changes to the referral process as well as offering some specialist input to the youth group for deaf children.

12.7 We know that deprivation, low income and associated unemployment and benefit dependency are closely correlated with a wide range of indicators

of poor health or low levels of well being and the Joint Strategic Needs Assessment shows that these indicators are found in specific areas of the district. The Board will be looking to agencies to provide assurances that resources are being targeted at these additionally vulnerable groups/communities

Key Achievement

- Completion of the EIA providing a more accurate picture of the Boards performance and areas for future work.

Challenge

- Ensure that quality assurance processes positively test for issues of equality and diversity and act on the findings.

13 Priority groups of children

Unborn children

13.1 Whilst not initially identified as a business priority at the start of the year, a serious case review found that some work did need to be done in respect of safeguarding the unborn child. Specifically as a result, the Board reviewed its practice guidance for the Multi-agency Pregnancy Liaison Group (MAPLAG), which provides a forum for those agencies working with substance misusing pregnant women and their partners, and made several improvements to ensure appropriate and effective agency representation. An audit was completed following implementation of these changes at the end of the year and systems were found to be working much more effectively. Indeed, the audit found examples of good practice which were reported to both the LSCB and the Improvement Board, of excellent multi-agency collaboration, with partners and sharing of expertise across agency boundaries. Alongside this, improved procedures for pre-birth assessment by children's social care were developed to ensure that this vulnerable group will benefit from more timely, coordinated response in future, particularly where there are identified concerns. Recent inspection suggests these are not yet fully effective.

Children on CP plans

13.2 There was a small reduction in the numbers of children on a child protection plan over the year from 237 (as at 31/03/2012) to 217 (31/03/2013)

13.3 3 Key performance indicators are in place in respect of child protection plans, and good progress was noted against all the indictors.

- The percentage of Child Protection plans lasting more than 2 years reduced from 10.6% in March 2012 to 7.5% in March 2013.
- The percentage of children becoming the subject of a CP plan for a second time reduced from 14.4% March 2012 to 13% March 2013
- The percentage of CP plans reviewed within timescales increased from 97.8 in March 2012 to 100% in March 2013.

13.4 The three indicators are useful because they relate to key aspects of practice, that is: ensuring that plans are kept on track and do not drift, that when children come off plans the decision is based on sound assessments and that there are suitable arrangements in place to de-escalate, and that plans are reviewed regularly.

13.5 Beneath the "headlines", the Board is reassured by the significant increases in resources to the Independent Reviewing Service that have supported this change. The increasing emphasis on quality assurance processes within the service including practice observations of Independent Reviewing Officers who chair the conferences provide further

encouragement. The Board staff team have been heavily involved, and remain so, with the work to improve SMART planning across the district. The audits of practice now include specific enquiry about the reported views of children and young people as well as their participation in child protection meetings, alongside increased emphasis on advocacy within meetings.

Looked after children

13.6 Calderdale has seen a small increase in children looked after by the local authority over the last year.

13.7 Of that cohort of children, there has been an increase in the numbers subject to Placement Orders from 41 (31/03/12) to 64 (31/03/13) thus achieving legal permanency for those children. The legal status of the remainder of children who are looked after are broadly in step with national and statistical neighbours.

13.8 The Audit and Quality assurance sub-group of the Board has sought reassurance about services for Looked After children. Arrangements are in place for regular reporting particularly in relation to adoption outcomes and children who go missing.

13.9 Importantly, reassurance is required that children's views are heard and responded to, and that appropriate challenge is provided by the Independent Reviewing Service when required. The evidence of increase of the "child's voice" is encouraging alongside the plans for further development of this work over the next year. The service is also increasingly involved with the Child in Care Council.

13.10 A clear framework for dispute resolution is in place and has been used by the service this year. Inspection in June 2013 of the locality teams (which manage cases of Looked After Children) found improvements from the inspection from December 2012. The role of the Independent Reviewing Officer in improving practice is recognised nationally as highly significant and the investment in the team locally both in resources and the provision of stronger frameworks for scrutiny and challenges is very encouraging.

Child Sexual Exploitation (CSE)

13.11 The last year saw considerable development of Board activity around CSE. The operational group was well established but there was a clear need for more strategic oversight. This was provided by means of the establishment of a Strategic Management Group. December also saw the commissioning of a new specialist service in Calderdale, Safe Hands, to work alongside the multi-agency investigative team and provide therapeutic support to those at risk of or experiencing Sexual Exploitation.

13.12 Several benchmarking exercises have been carried out in response to guidance and requirements from a variety of central government bodies

and the Office of the Children's Commissioner. On the whole these have shown that the strategy and service response do reflect good practice guidance. A single comprehensive action plan has been developed to address some gaps that were identified, and those gaps have been included in the Board's priorities for this year. These include further development of the training programme across partners with particular reference to supporting work in schools and support to parents. The last year saw the further development of partnership working between Safeguarding Children Boards and the Police within the West Yorkshire region. The Annual report from the CSE Strategy group is attached to this report as (Appendix 3).

Missing children

13.13 The Board launched the new West Yorkshire- wide procedures in November 2012, this resulted in more effective arrangements being put in place for monitoring children who go missing at both operational and strategic level, and appropriate links with services for children who are subject of Child Sexual Exploitation. This group of vulnerable children and young people are now receiving the appropriate strategic oversight, and, following identification, services are more aware of their responsibilities to this group. There are services in place to support them, including provision for independent return interviews.

Private fostering

13.14 Private fostering is a private childcare arrangement made between parents and a carer of their choice (who is not a close relative, grandparent, sister, brother, aunt or uncle) where the child is:-

- Under 16 (or 18 if disabled)
- Looked after full time for more that 28 days

13.15 The issue of Private Fostering has been a cause for both national and local concern. The last year saw an extensive campaign conducted by the local authority and supported by the Board to raise the profile of private fostering both in its training programme and also on the website. Other agencies such as Health also promoted the campaign and adapted their training programmes accordingly. These actions have not resulted in any significant increase in referrals, and the view is that numbers are likely to be much greater than reported. In addition, the Board has received information that the numbers are likely to have increased further due to the arrival of some migrant groups where this practice is more commonplace.

13.16 The Board will be challenging agencies to complete further work and take a different approach for the future. The starting point should be to learn from other local authorities where the number of referrals for private fostering is significantly higher than is the case in Calderdale, together with targeted work in communities where prevalence is likely to be higher

Children effected by Domestic Abuse

13.17 The Board has been a participant in a research project funded by the Department for Education, and delivered by WomenCentre in partnership with the Foundation for Families and the University of Huddersfield, looking at the effectiveness of assessments of risk to children in households where there is domestic abuse and specifically how well the needs of children are reflected in the multi-agency risk assessment processes. Although the report was not available until after the year-end, the Board had initial findings presented during 2012–13 and initial discussions have taken place about future work with the Foundation for Families to develop improved responses. The key findings highlighted include the importance of engaging directly with children and ensuring their voice is heard and specifically recognising the direct risk to their well-being of experiencing Domestic Abuse or witnessing abuse of others. The Board will have access to the final evaluation report produced by the University of Huddersfield.

Key Achievements

- Continuing work on SMART planning
- Successful launch events for agencies in respect of procedures for missing children and those vulnerable to CSE
- Regional collaborative work in CSE
- Participation in the DfE domestic abuse project

Challenge

- Ensure that all the work carried out in respect of the priority groups leads to better practice and better outcomes.

14 LSCB Effectiveness

14.1 In 2011-12 two separate, independent processes (the Peer Review and Ofsted inspection of December 2012) commented positively about the effectiveness of the Board

> "The Board is seen as a strength" (Peer Review)
>
> **"...***the CSCB is now firmly constituted, with an appropriate structure and membership in place under the leadership of a proactive Independent Chair. Effective multi-agency partnership activities are being delivered by most of the Board's sub-groups, each of which operates to appropriate terms of reference, has a work plan in place that suitably links to the Board's appropriately focused Business Plan and is chaired by a member of the wider partnership." Ofsted 2012*

14.2 However the June 2013 inspection raises a specific key concern about the quality assurance functions of the Board and the degree to which the Board fully understood the quality of practice and challenged agencies appropriately. The Board was already undertaking a review of the QA work with sector experts, C4EO, and will be making major revisions to its Quality Assurance Framework in 2013-14

14.3 The June 2013 Inspection report also suggested that the dynamic between the CSCB and the Improvement Board might be serving to reduce the scope and influence of the CSCB and this is being further explored.

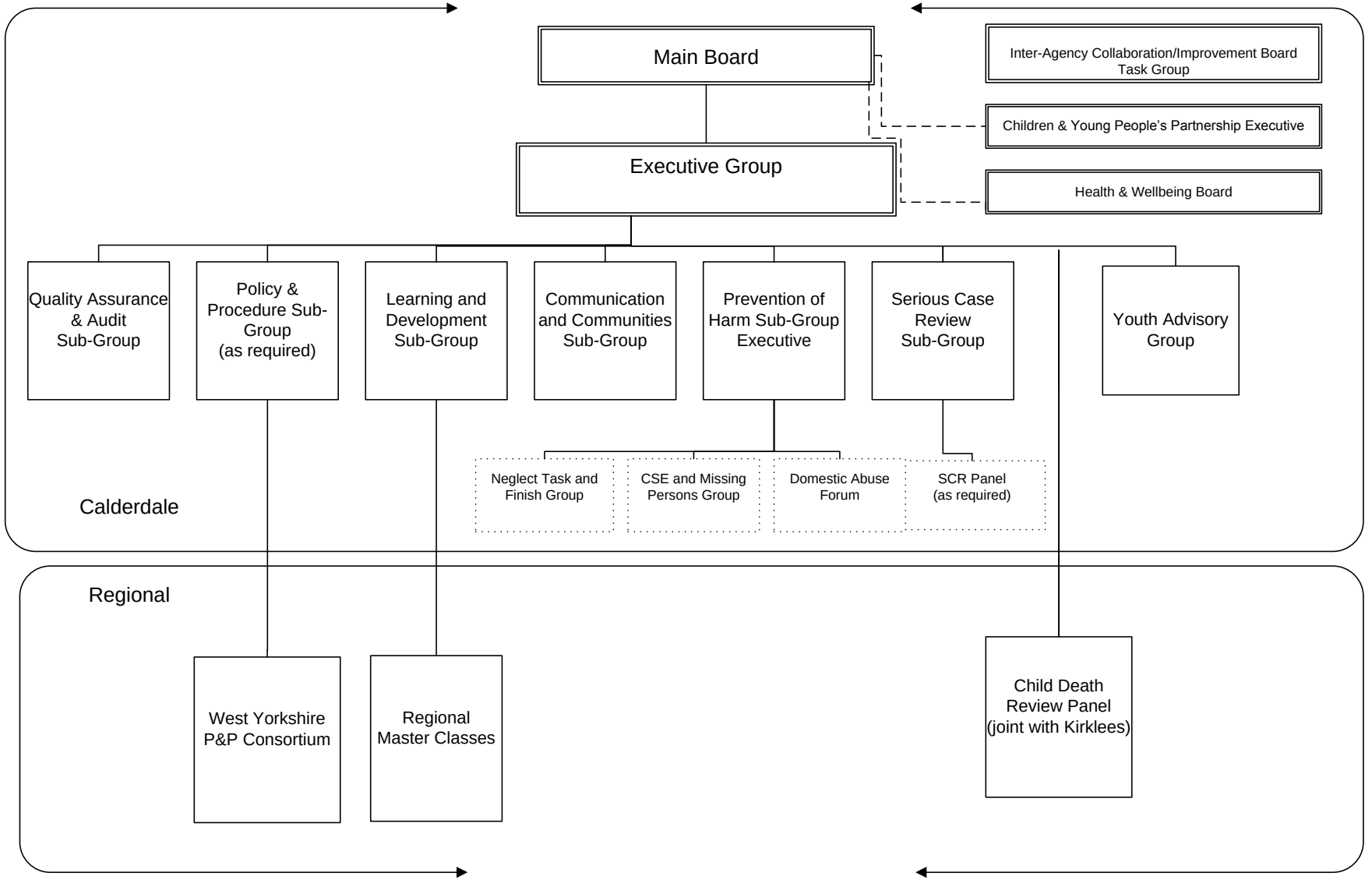
14.4 On March 21st 2013 the government issued revised guidance about the role and functions of the SCBs and the Board has taken action in response to most of the requirements. Over the past year, there has been an increase in representation.

Name		Job Title	Agency
Alexandra	Sayer/Liz Stenton	Head of Service	Cafcass
Angela	Everson	Joint Chief Executive	Women Centre Calderdale/Voluntary Sector, Domestic Abuse Partnership
Bernadette	Johansen	CSCB Business Manager	Calderdale Safeguarding Children Board
Bev	Maybury	Director of Adult Health and Social Care	Health and Social Care, Calderdale MBC
Chris	Hardern	Chief Superintendent	West Yorkshire Police
Chris	Jones	Principal	Calderdale College
Fiona	Fitzpatrick/Sue Ross/Beate Wagner	Head of Children's Social Care	Children and Young People's Services, Calderdale MBC
Gill	Poyser Young	Designated Nurse	NHS Calderdale
Gini	Whitehead	Head of Probation for Calderdale	National Probation Service (now West Yorkshire Probation Trust)
Helen	Plaice/Wendy Moffat	Head at Todmorden High School/Crossley Heath School	Secondary Heads
Helen	Thomson	Director of Nursing	Calderdale and Huddersfield NHS Foundation Trust
Ian	Hughes	Head of Democratic & Partnership Services	Democratic and Partnership Services, Calderdale MBC
Ian	Hillas	Lay Member	Calderdale Safeguarding Children Board
Jacquie	Hellowell	Lay Member	Calderdale Safeguarding Children Board
Jane	Booth	Independent Chair	Calderdale Safeguarding Children Board
Janette	Pearce	Head of Pennine Housing/Together Housing	Housing
Jeff	Rafter	Head of Service/Early Intervention Upper Valley Manager	Youth Offending Team
Julie	Lodge	Named Nurse for Child Protection	South West Yorkshire Partnership Foundation Trust
Karen	Hemsworth	Associate Director for Safeguarding	CHFT

Leona	Binner	Head at St Augustine's School	Primary Heads
Mandy	Williams/Veronica Mellor	Service Manager	Safeguarding & QA Service, CMBC
Megan	Swift	Elected Member	Calderdale MBC
Nigel	Hotson	District Commander	West Yorkshire Fire & Rescue Service
Noreen	Young	Director of Nursing Compliance and Innovation	South West Yorkshire Partnership Foundation Trust
Pamela	Ohadike	Consultant Paediatrician	Calderdale and Huddersfield NHS Trust
Robin	Tuddenham	Director of Communities	Safer and Stronger Communities, Calderdale MBC
Steven	Cleasby	General Practitioner/Senior Partner	GP Board Member CCCG
Stuart	Smith	Director for Children's Services	Children and Young People's Services, Calderdale MBC
Sue	Cannon	Executive Director, Quality & Engagement	Calderdale NHS

14.5 The Board is operating with a range of Sub-groups as set out in the structure chart overleaf:

CALDERDALE SAFEGUARDING CHILDREN BOARD STRUCTURE CHART



14.6 These sub- 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.

14.7 The work of the Board is delivered via a Business Plan. A Risk Register is also in place and regularly updated to enable the Board to act to mitigate any potential problems in delivering on its responsibilities.

14.8 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.

14.9 The work of the Board is made more complex locally by the presence of the Improvement Board. Board members have made a significant contribution to the improvement agenda, and 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.

14.10 The continuing 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. This has been confirmed in the most recent inspection in June 2013.

14.11 For the first half of the year the work of the Board's Sub-groups was hampered, by a lack of continuity of leadership within partner agencies and this was recognised as an ongoing risk in the Board's Risk Register. The lack of consistency over the longer term resulted in a backlog in tackling some practice issues. An important challenge for the Board has been to develop strong structures for the transfer of learning and embedding of improvements to practice under these conditions. The Ofsted inspection raised the particular issue of the absence of Children's Social Care in the work of the Board.

14.12 Whilst the Board has recognised the challenges associated with changes of key personnel, it is important to balance that with the valuable contribution made by its current members. Calderdale is a relatively small local authority area with fewer resources than its larger neighbours, and partners work hard to ensure that effective partnerships are in place to support safeguarding activity. Member's comments demonstrate that they are positive about their involvement:

'It has been a real opportunity to strengthen relationships with partners across the Calderdale health and social care footprint
'Able to contribute to Calderdale's' improvement journey and to improve outcomes for children'
'Had the opportunity to ensure our organisation is involved in moving practice forward – particularly in relation to our named nurse being involved in SMART planning '
'Had opportunity, with partners, to develop reflective learning sessions across the partnership'
'Had the opportunity to be part of the strategic decision making '

14.13 New members of the Board are supported by mentors and sub-groups have membership guides to ensure that they are clear about the task. We have active lay members who are provided both with mentors and separate opportunities for feedback. This year a comprehensive appraisal of the chair was conducted providing positive feedback from the membership on performance.

14.14 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. This report provides specific examples of intervention leading to improvement directly resulting from the Quality Assurance framework but more needs to be achieved, but there has been insufficient positive impact of outcomes overall.

14.15 The past year has seen the development of closer partnership working with the Safeguarding Adults Board, leading to a joint safeguarding audit being planned for this autumn. Joint work between the learning and developments sub-groups of the two boards is also being scoped. Closer links will also provide opportunities to develop closer working relationships between staff across the different sectors.

14.16 Whilst the role of the Board and that of Children's Scrutiny panel are clearly different, both are required to ask the question 'How do we know if children are safe?' As a result, plans for joint work on development of quality assurance functions are underway.

14.17 Owing to gaps in key personnel in the past, the Board has previously involved itself in overseeing the introduction of number of initiatives such as the Adult Learning Disability protocol. Now these gaps have been filled the Board is able to move to a position of greater challenge where it is able to check whether processes are being embedded and effective.

Key Achievements

- The Board had continued to develop its membership
- New members are supported and mentoring processes are in place
- There are clear plans in place for the Board sub-groups

Challenges

- The Board must develop a better and real understanding of the quality of practice across the agencies and challenge where improvement is needed
- The Board develops the capacity to more effectively follow up through audit to ensure evidence of improvement and effective services
- The Board develops in order to take over responsibility from the Improvement Board when practice is sufficiently improved for the notice of improvement to be removed
- The necessary structures and organisation in place to deliver the Quality Assurance function of the Board and evidence effectiveness
- It will be important to ensure that the Board is sufficiently assertive in ensuring its independence and separate identity to allow for the necessary challenge

15 Allegations against professionals

15.1 The Local Authority Designated Officer (LADO) has responsibility for managing all situations where it is alleged that a person who works with children has: behaved in a way that has harmed a child, or may have harmed a child; possibly committed a criminal offence against or related to a child; behaved toward a child or children in a way that indicates s/he is unsuitable to work with children.

Referrals Received by Year

2007/8	2008/9	2009/10	2010/11	2011/12	2012/13
24	**66**	**55**	**112**	**142**	**144**

15.2 The role of the LADO was created in National Guidance in 2006. In Calderdale the duties of the LADO were initially undertaken as part of the responsibilities of a senior manager within the Safeguarding Service of Children's Social Care. However in 2010 a dedicated post of LADO was created on a temporary basis and this was made permanent in 2011.

15.3 Since that point the LADO role in Calderdale has been developed and promoted, and a comprehensive LADO database has been created and maintained. It is not felt that the data available for the first three years of the service is accurate or comprehensive.

15.4 The rapid increase in referrals recorded in 2010/11 and 2011/12 is felt to largely reflect the improved visibility of the service and better recording. The "plateauing" of referral numbers in the last year suggests that recording does now present an accurate reflection of the activity in Calderdale.

Source of Referrals

Children and Young People's Services	43
Other Calderdale LA Services	7
Other Local Authorities	3
Police	25
LA Schools (including Academies)	36
Voluntary Sector	4
Independent Sector	13
Ofsted	3
CAFCASS	4
Sporting Organisations	2
Higher Education	1
Armed forces	1
Members of public	2
Total	**144**

15.5 61% of referrals came to the LADO directly from the manager/employer of the person against whom the allegation was made. The majority of the rest were referred either from the Police or from Children's Social Care following a complaint being made to them.

15.6 The largest number of referrals continues to relate to school staff; the second largest to foster carers. This is consistent with the previous year's data, and with all available national data.

Nature of Allegation

Sexual Abuse	28
Emotional Abuse	4
Physical Abuse	55
Neglect	2
Unsuitable	55 *
Total	**144**

*"Unsuitable" refers to cases where the allegation is that the person has "behaved toward a child or children in a way that indicates that s/he is unsuitable to work with children."

15.7 The small number of cases in the categories of emotional abuse and neglect reflects the facts that few professionals will have the level of care of children that would lead to allegations relating to a persistent pattern of behaviour. Cases in these categories relate almost exclusively to foster carers or childminders.

15.8 Of the 144 referrals, 95 involved work based allegations, and the remainder outside work.

15.9 This is the first occasion on which the above information has been recorded. It differentiates between allegations that have been made directly relating to a person's work activity, and concerns that have implications for a person's work but originate elsewhere, e.g. an allegation of abuse within the person's own family, or a safeguarding concern relating to use of electronic media.

Outcome of Enquiries

Substantiated	43
Unsubstantiated	53
Unfounded - false	20
Unfounded - malicious	5
Did not meet threshold	17
Outstanding	6
Total	**144**

15.10 These are the categories by which the LADO is required to record the outcome of cases referred. These will not necessarily coincide with

outcomes of enquiries of other agencies, e.g. the Police or CPS may conclude that there is insufficient evidence to secure a criminal conviction, but a case may still be recorded by the LADO as substantiated. There were 43 cases recorded as substantiated this year, compared with 42 in the previous year.

15.11 83% of cases were concluded within 1 month, compared with 89% in the previous year. Where a case takes more than a month to conclude, this is invariably because of protracted police or disciplinary enquiries. Of the 19 cases recorded as taking more than 1 month to conclude, 5 involved police enquiries, 7 disciplinary enquiries, and 7 both police and disciplinary enquiries.

15.12 An evaluation exercise was carried out with users of the service by the LADO service this year, and the outcome was extremely positive. In terms of other aspects of LADO performance indicators, Calderdale's service performs as well or better than its neighbours.

16 Conclusions

16.1 The inspections have caused us to reflect on the measures we have taken and why the extensive efforts have not resulted in the outcomes we would have wished for.

16.2 As a matter of some urgency there is a need to ensure that the current multi agency audit programme of the Board is established on a more systematic footing. Clearer processes for recording, monitoring and follow up actions are required. More transparency is required for Board members with different perspectives to promote increased challenge.

16.3 Whilst the inspections confirmed some of the difficulties known to the Board, it is undoubtedly the case that the Board has been too easily reassured that remedial actions taken have led to improvements in safeguarding practice. The efforts taken did not lead to the desired outcomes and the Board placed too much emphasis on effort rather than outcome.

16.4 The results of the inspections of 2012 and 2013 were disappointing but it is important to ensure that the positive work of the Board and its achievements for the year are not lost. We have brought together hundreds of learners at different events and reached groups such as the voluntary sector who were not previously engaged with the Board. We have intervened and challenged practice.

16.5 Proactive measures have been taken to improve our quality assurance mechanisms, and this work will continue. The revision of Working Together has offered opportunity to take a fresh look at all our processes and we are well underway in developing a new learning and improvement framework.

16.6 The coming year will see the development of a closer working relationship with the Safeguarding Adults Board and a number of joint projects are planned. These achievements should not be ignored and represent a huge investment in improved practice. We have put in place the building blocks to ensure that the Board is ready for the challenges it will face in the future.

16.7 The over-riding task however must be to refocus the work of the Board on those things which will ensure that children and young people of Calderdale and their families receive the range of quality and services they deserve and to challenge, and keep challenging, agencies and the bodies to which they are accountable where this is not the case.

17 Recommendations

The recommendations arising out of this report are linked to the four strategic objectives namely,

Strategic Objective 1 - Ensure continuous improvement in efficiency and effectiveness of the Bard and it's sub-groups to ensure focus on its key priorities of quality assurance and challenge of safeguarding practice.

Recommendations:-

- The Board must ensure that the necessary framework is in place to deliver the primary quality assurance function of the Board effectively.
- The Board should complete further work to explore the possible inequalities in access to services for children and young people from newly migrant communities (3.12, 3.16, 3.33 & 11.11)
- The Board's Prevention of Harm Sub-group should prioritise the work on the development of multi-agency supervision standards (3.36)
- The Chief Executive of the Council, Chair of the Improvement Board and Chair of the Safeguarding Children Board should, as a matter of some urgency, review the mutual and single roles and responsibilities of the two Boards to address the concerns voiced in the Ofsted Inspection June 2013. (8.15, 14.3 & 14.9)
- The Chief Executive of the Council should ensure that the work of the Board is properly resourced and in particular consider issues of capacity if the Board is to deliver an effective QA function (14.8)

Strategic Objective 2 - Strengthen and further develop multi-agency understanding of thresholds for intervention and SMART planning in order promote more effective services to safeguard children and young people.

Recommendations:-

- Though the number of CAFs is increasing more work needs to be done across all agencies to raise the level of usage to that of statistical neighbours (3.25)
- The Board should ensure that its engagement in the development of "SMART" planning for children does not compromise its ability to challenge if practice remains inadequate (3.26)
- The Board should ensure all agencies understand thresholds for access to social work support, make effective referrals and engage appropriately in the delivery of early help via the CAF process (3.33)

Strategic Objective 3 - To ensure that all agencies are aware, and respond to, the specific needs of young people for support and protection.

Recommendations:-

- The Children and Young People's Partnership should review its priorities to ensure they address key findings from the eHNA (3.7 & 3.25)

- The Board should consider commissioning a review of safeguarding practice across early year's providers (3.19)

- The Children and Young People's Partnership should evaluate the impact of the Strength and difficulties questionnaire and consider recommending its use more widely (3.28)

- The Director of Children and Young People's Services should undertake a review of the effectiveness of strategies to address bullying in schools (11.11)

- The Board should work with agency partners through the CSE Strategy Group to ensure that PHSE Session in school address safeguarding issues such as domestic abuse and child sexual exploitation (13.11 & 13.12)

- Continuing support of multi agency initiatives to reduce infant mortality.

Strategic Objective 4 - Ensure Effective Reviews of Practice are Undertaken and Learning Disseminated and Embedded.

Recommendations:-

- The Board's Prevention of Harm Sub-group should prioritise the work on the development of multi-agency supervision standards (3.36)

- The Board should work with agency partners through the CSE Strategy Group to ensure that PHSE Session in school address safeguarding issues such as domestic abuse and child sexual exploitation (13.11 & 13.12)

18 Financial Statement 2012-13

Expenditure	
Salary costs	138,706
Staffing costs (e.g. car allowances, insurances)	1540
Chair expenses	21,004
Costs of Trainers and training material	19,782
Policies and Procedures	6,775
Board development	5,476
Office expenses	1,774
Website and e-learning	6,835
Case Review work	3,188
Child Death Overview Panel	1,211
Miscellaneous expenses	1,218
Total	**207,509**

Inter-agency contributions received	
Calderdale Primary Care Trust	80,000
West Yorkshire Police	6,925
West Yorkshire Probation	2,231
CAFCASS	550
Munro grant	37,284
Any other income	4,225
Calderdale MBC contribution 2012/13	122,997
Total	**254,212**
Carry forward for use in planned projects for 2013/14	46,703

Appendix 1

A protocol between the Calderdale Children and Young People's Partnership Executive, the Calderdale Safeguarding Children Board and the Calderdale Health and Wellbeing Board

1 AIM

1.1 To clarify the relationship between the Children and Young People's Partnership Executive, the Calderdale Safeguarding Children Board and the Calderdale Health and Well-Being Board

2 OBJECTIVE

2.1 This protocol will:

- Confirm the functions, responsibilities and organisation of the two Children's Strategic planning forums – The Children and Young People's Partnership Executive and the Calderdale Safeguarding Children Board - and describe the inter-relationship between them
- Articulate the link between these two boards and the Calderdale Health and Wellbeing Board

3 BACKGROUND

3.1 Calderdale's Safeguarding Children Board (CSCB) is a statutory Board and the Calderdale Children and Young People's Partnership Executive (CYPPE) is a key leadership forum. Both have important but distinctive roles in ensuring that the strategic planning needs for children and young people in the borough are met. This includes keeping children safe.

3.2 There is not a hierarchical relationship between the Calderdale Safeguarding Children Board and Children and Young People's Partnership Executive but a joint responsibility to ensure the needs of children and young people in Calderdale are addressed and prioritised.

3.3 The Children and Young People's Partnership executive is accountable for the Children and Young People's Commissioning Plan (which is the Calderdale Children and Young People's Plan). In progressing this plan, the CYPPE is accountable for ensuring all services which are commissioned or provided improve outcomes for children and young people in line with the agreed priorities.

4 THE CALDERDALE SAFEGUARDING CHILDREN BOARD (CSCB)

4.1 The core objectives of the Calderdale Safeguarding Children Board which are prescribed in Working Together are to:

- Co-ordinate what is done by each agency to safeguard and promote the welfare of children and young people in the area
- Ensure the effectiveness of that work.

4.2 The CSCB is the decision making body for multi agency arrangements for safeguarding of children within Calderdale. It is a statutory partnership and its work is directed by statutory guidance. This guidance dictates the functions to be undertaken by Safeguarding Children Boards and the criteria/functions against which they will be measured during Ofsted Safeguarding Inspections.

4.3 The Director of Childrens Services (DCS) has a statutory responsibility for ensuring that an effective Safeguarding Children Board is in place for the Local Authority area.

4.4 The agreed functions of the CSCB ensure compliance with the Regulations governing the work of Safeguarding Children Boards. The functions of the CSCB which are set out in Working Together are therefore:-

a) Develop multi-agency policies and procedures for safeguarding and promoting the welfare of children.
b) Raise awareness of the need to safeguard children and protect their welfare
c) Monitor the effectiveness of what is done by the local authority and partners to safeguard children and promote their welfare, advising them of how to improve if necessary
d) Organise and ensure delivery of a programme of inter-agency training, co-ordinated by the CSCB Training Co-ordinator via the Training Pool, or by identifying appropriate deliverers
e) Advise in the planning and commissioning of services for children
f) Undertake reviews of serious cases, advising on lessons which can be learned
g) Establish appropriate processes to collect information relating to child deaths.

4.5 The Safeguarding Children Board is supported in discharging its functions by thematic sub-groups.

4.6 The Calderdale Safeguarding Children Board (CSCB) is responsible for challenging each relevant partner, as defined by the Children Act (2006)[1] on their success in safeguarding children and ensuring their welfare. The statutory guidance covering its work determines its role to '…provide robust challenge to the work of the Children and Young People's Partnership Executive partners in order to ensure that children are properly safeguarded.' (para 3.40)

5. THE CHILDREN AND YOUNG PEOPLE'S PARTNERSHIP EXECUTIVE (CYPPE)

5.1 The Children and Young People's Partnership Executive [2] is the local partnership that brings together the organisations responsible for services for children, young people and families with a shared commitment to improving children's lives.

5.2 The functions of the CYPPE are to[3]:

a) develop and promote a local vision – set out in the CYP Strategic Framework – to drive improved outcomes for local children, young people and their families
b) have in place robust arrangements for inter-agency co-operation
c) develop integrated strategies such as commissioning with pooled or aligned budgets, shared data and workforce development
d) support those strategies via more integrated processes, including effective joint working
e) develop and promote integrated front line delivery, organised around the child in a setting which supports family life rather than professional or institutional barriers.
f) develop and publish the Commissioning Plan, keeping it under review and revising it as necessary
g) monitor progress and produce a report on the extent to which the Children and Young People's Partnership Executive Board partners are delivering their commitments in the Strategic Framework and Commissioning Plan
h) lead on the CYP elements of the Wellbeing Strategy and update the Health and Wellbeing Board as appropriate

5.3 The CYPPE is chaired by the Director for Children and Young People's Services who sits on the Calderdale Health and Well- Being Board.

5.4 The CYPPE is supported in discharging its functions by thematic sub-groups.

[1] 'The Local Safeguarding Children Boards Regulations 2006 (Statutory Instrument 2006 No.90)
[2] Determined as a statutory obligation under the Apprenticeships, Skills, Children and Learning Act 2009
[3] Extract from consultation of 'Statutory Guidance on co-operation arrangements …..' para 1.7

6. THE RELATIONSHIP BETWEEN THE CSCB AND CYPPE

6.1 The Independent Chair of the CSCB is a member of the CYPPE, and the Chair of the Children and Young People's Partnership Executive is a member of the Calderdale Safeguarding Children Board and the CSCB Executive.

6.2 The CSCB produce an Annual Report which is presented to the CYPPE. The Annual Report follows a format which accords with statutory guidance and should be completed by September each year.

6.3 The Board minutes for both the CYPPE & CSCB are shared.

6.4 The CSCB will be formally consulted by the CYPPE when the CYP Commissioning Plan is being drafted. The consultation phase will be sufficiently long to allow a thorough debate to support the CSCB response to the consultation. The CYP Commissioning Plan will draw on the 'support and challenge'[4] from the CSCB.

6.5 In recognition of the inter-relationship between the CSCB and the CYPPE, a joint 'Communication Strategy Group' will be established to focus on engagement with the media, particularly with regard to issues around safeguarding and child welfare and in relation to community awareness raising for both Childrens related forums.

7 THE RELATIONSHIP BETWEEN CALDERDALE HEALTH AND WELLBEING BOARD; CYPPE AND CSCB

7.1 The CSCB will provide reports to the Calderdale Health and Wellbeing Board twice each year:

- Presentation of the CSCB Annual Report; and
- a 6 monthly update report on progress

7.2 The Health and Wellbeing Board will ensure that:

- The Joint Strategic Needs Assessment and Joint Wellbeing Strategy recognise and take account of children's' safeguarding issues, including the priorities set out in the CSCB Business Plan; and
- the relationship with the CSCB through the reporting outlined above is referenced in the Health and Wellbeing Board governance arrangements.

[4] See 'Working Together…' para 3.63

7.3 The Health and Wellbeing Board may request the CYPPE and/or the CSCB to consider issues for development, action or scrutiny.

7.4 The CSCB and/or the CYPPE may request the Health and Wellbeing Board to consider issues for development, action or scrutiny.

Appendix 2

Section 11 Overview Report

Name of Agency	Returned Audit	Invited to Challenge	Attended Challenge Event	Deferred until next year	Recommendations made
CAFCASS	x	x			
Calderdale and Kirklees careers	x	x	x		x
CMBC Adult Education	x				
CMBC CSC	x	x	x		x
CMBC Commissioning	x	x	x		x
CMBC Communities	x	x	x		x
CMBC Democratic and Partnership		x	x		x
CMBC Disability Services	x	x	x		x
CMBC Family Support	x	x	x		x
CMBC Adult Health and Social Care		x			
CMBC HR and Change	x				
CMBC Safeguarding and Quality assurance	x	x			
CMBC CYPS	x	x	x		x
CMBC Youth Offending team	x			x	
CMBC Vulnerable Pupils	x				
Calderdale Foundation Health trust	x	x	x		
NHS Calderdale				x	
Pennine Housing	x	x	x		x
Police	x			x	
Probation	x	x	x		x
South West Yorkshire Foundation Health trust	x			x	
Schools				x	
WY Fire Service		x	x		x

Appendix 3

Annual Report on CSE Work

Management accountability

The management of Child Sexual exploitation in Calderdale is delivered through the Calderdale Local Children's Safeguarding Board. The strategic group consisting of senior managers within the key statutory partner agencies and chaired by a district lead – Detective Chief Inspector Crime Manager West Yorkshire Police, meet on a quarterly basis. There is full partnership buy-in from statutory agencies and becoming embedded within the partnership as a newly commissioned service Safe Hands (part of the Children's Society). Safe Hands have been commissioned to support victims of child sexual exploitation and to assist in their exit from this crime. There is also developing work in education of children and parents of those potential victims.

There is a West Yorkshire Multi Agency CSE Group chaired by the independent chair of the Bradford Safeguarding Children's Board which is attended by the district lead and the Safeguarding Board manager. From the development of work within the Multi Agency Group and the developing national picture, the newly produced West Yorkshire CSE Procedures were agreed and are being embedded into the Calderdale response to tacking CSE.

Awareness Raising

There is recognition that offences of child sexual exploitation regularly go un-noticed and the need of professionals, practitioners and families of those at risk of CSE are aware of the signs of vulnerability. West Yorkshire Police have launched a recent 'Know the Signs' Campaign and Calderdale have fully participated in its delivery locally. The partnership delivered two seminar days in June 2013 for partner agencies in relation to the CSE procedures. The step-by-step guidance prepared by the Department of Education and supplemented by a locally produced risk assessment form has been circulated across the district.

Operational Group

The multi-agency CSE Operational Group continues 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 supported by the Safeguarding Children Board. The group met on 9 occasions over the last year, and regular reports were provided to the Prevention of Harm sub-group.

The frequency of meetings for the Operations group is six-weekly and recognises the need to ensure 'dynamic risk' is identified and appropriate action plans put in place to Safeguard.

Recently the Police have introduced trigger plans for those vulnerable victims who have been identified as being at highest risk.

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.

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.

38 young people were discussed over the last year, although the maximum number discussed at any time was 18. The age of young people discussed varied between 11 and 18, and all but 1 those was female. There has been an increasing recognition of the need to support victims exiting CSE and the transition period from child to adult.

The practice of the group continues to evolve and the group currently assess risk from a matrix devised locally with a recognised scoring matrix.

Missing Persons

Within the Calderdale partnership there has been a recent implementation of a strategic and operational group to monitor missing persons with a strong focus on Looked After Children. The groups work in parallel and the CSE group fully recognise the implications of children going regularly missing as a potential trigger for identifying CSE.

Audit

Calderdale continually seeks to improve its response to CSE and have fully utilised the Office of Children's Commission CSE Gangs and Groups Review and the University of Bedfordshire Self-Assessment Framework.

Key Achievements

The Calderdale LSCB continue to demonstrate high level of commitment to tackling CSE and strengthening partnership working. The collaborative work with regional colleagues and the implementation of CSE procedures across the district.

Next Steps

1. Recognising the signs and symptoms for victims who are at risk of child sexual exploitation.

2. The timely referral of identified CSE risks and the commitment of the district to safeguard children.

3. The development of effective mechanisms to identify perpetrators; locations where child sexual exploitation occurs and targeting those offenders and locations.

DCI Terry Long

West Yorkshire Police