Calderdale Safeguarding Children Board

Annual Report 2013/14

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Annual Report for 2013 – 2014

Introduction

Welcome to the Annual Report of the Calderdale Safeguarding Children Board (CSCB). The purpose of this report is to provide an account of how the Board and its members met its statutory responsibilities and functions in the year commencing 1st April 2013 and concluding 31st March 2014.

The report also details the difference this has made and what this means in terms of the sufficiency of safeguarding arrangements to protect children and promote their welfare in Calderdale.

The report is formally presented to the Chief Executive of the Local Authority and the Police and Crime Commissioner. It is also shared with all partners and is published on the CSCB website: www.calderdale-scb.org.uk.

This year we have adopted a different approach to the report, the reasons for this are as follows:

- In response to feedback from previous reports we have tried to make the report more accessible and understandable so that the reader can learn more about what the CSCB is and what it has to do, as well as being able to look at details about what it did and whether this made a difference;
- All Local Safeguarding Children Boards (LSCBs) are now rightly subject to increased levels of scrutiny and need to be able to show how they are effective, how they know this and how they are improving; and
- The past year has been an unusual and challenging one for the Board and its partners, and we need to say a little more about this as it has impacted on how we have presented the report.

The local context regarding the governance relationships is complex in Calderdale due to the improvement journey being undertaken. In June 2013, the Local Authority was subject to an Ofsted inspection and this resulted in some findings that gave a clear indication that the LSCB needed to improve both its performance and its effectiveness. The resulting Directions Notice from the Secretary of State has set both pace and direction for change, which is being led and coordinated by the Improvement Board.

In the year, the Board has experienced the added complexity of three Independent Chairs and a number of interim arrangements in terms of business support. In January 2014, a new Independent Chair and Business Manager were appointed. This has achieved continuity and resulted in the production of a revised Business Plan for the current year designed to rapidly implement changes in internal governance, structure and a refocusing on statutory functions.

The year has therefore been one of considerable transition and turbulence and throughout this period, partners and their representatives who serve on the sub-groups have worked hard to maintain consistency, and to implement the priorities and objectives agreed as a result of the last Annual Report.

With this backdrop, the approach we have adopted in writing this Annual Report can be summarised in the following way:

- We have reviewed the objectives and priorities set as a result of the last Annual Report and reported on the progress made and the learning that has been identified as a result;
- We have where possible signposted or hyperlinked the reader to further evidence and detail in order to reduce the length of the report;
- We have built the report around the key questions that are most likely to be asked by anyone who is wanting to know what a LSCB does;
- We have shared our own view of how effective we have been but also invite the reader to form their own view;
- We have summarised as a Board, our judgement as to the overall sufficiency of joint working arrangements; and
- We have given an indication of how the learning from the year will inform the review and revision of the current priorities and Business Plan.

The report therefore aims to show why and how the Board has needed to make some significant changes to the way it does things, in order to incorporate and embed past learning and effect improvement.

This took substantive form in the final months of the reporting year and is still 'work in progress' (progress since the start of the year can be accessed through the Improvement Board and the required letters by the Independent Chairs of the Improvement Board, and the LSCB to the Secretary of State). The current Business Plan is attached to the report as an appendix to help understand this.

Finally, during the year, all partners faced difficult and challenging conditions, and the report will show how they all maintained and increased their commitment and contribution to the Board. This demonstrates the wish of the partners to ensure that children and young people are effectively protected on the basis of effective joint working, and that they see an effective LSCB as being one of the essential ingredients for achieving this.

We would welcome feedback and this can be made either to the Independent Chair or the Board Business Manager at cscb@calderdale.gov.uk or 01422 394098.

If there are points that require clarification, or you would like to access this report in a different format or language, please use the contacts above and we will do all we can to help.

Contents and how to use the report

Where possible we have used a hyperlink to take you to additional information and/or more detail. We have also included appendices that contain further information and detail in relation to key areas of the report.

Where possible we have introduced each section with a clear question. What follows the question will be a range of information explaining the 'why', the 'what', the 'how' and what difference this made. There is in most sections a concluding question which addresses what has been learned and what this is likely to mean for future actions and priorities.

Not all questions have been asked or answered; so we have made some judgments about this. This does not mean that as a reader you should not ask questions or seek to challenge any conclusions we make.

We hope that the format and approach we have used will encourage you to do just this and to form your own judgements.

This is a list of what is in the report and where you can find it:

Section 1: The LSCB – what it is and what it is required to do

Section 2: Our last Annual Report – what we as a partnership said we would do and what the result of this was

Section 3: Assessment of the effectiveness of the Board

Section 4: Conclusion and some considerations for the future

In the appendices you will find the following:

- Membership of the Board (Appendix 1);
- The organisations the Board members represent (Appendix 1);
- Member attendance at the CSCB and sub groups (Appendix 2);
- Structure Chart to Feb 2014 and Structure Chart from Feb 2014 onwards (Appendix 3);
- Partner agency financial commitment (Appendix 4);
- Business Plan for 2013-2014 (Appendix 5);
- Interim Business Plan produced in February 2014 (Appendix 6);
- Revised Structure Chart from March 2014 (Appendix 7);
- Governance Relationship Map and accompanying narrative (Appendix 8); and
- Demography of children living in Calderdale from the Joint Strategic Needs Assessment (JSNA) (Appendix 9).

Section 1: The LSCB – what it is and what it is required to do

If you follow these links they will take you to information that helps to explain the statutory basis and expectations of LSCBs:

- Department for Education;
- Working Together To Safeguard Children March 2013; and
- Working Together to Safeguard Children March 2013 Chapter 3.

These are the statutory objectives and functions of a LSCB:

Section 14 of the Children Act 2004 sets out the objectives of LSCBs, 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; and

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

Regulation 5 of the Local Safeguarding Children Boards' Regulations 2006 sets out that the functions of the LSCB, in relation to the above objectives under Section 14 of the Children Act 2004, are as follows:

1. (a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:
    i. the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;
    ii. training of persons who work with children or in services affecting the safety and welfare of children;
    iii. recruitment and supervision of persons who work with children;
    iv. investigation of allegations concerning persons who work with children;
    v. safety and welfare of children who are privately fostered;
    vi. cooperation with neighbouring Children's Services authorities and their Board partners;

    (b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;

    (c) monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;

    (d) participating in the planning of services for children in the area of the authority; and

    (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

Regulation 5 (2) which relates to the LSCB Serious Case Reviews function and regulation 6 which relates to the LSCB Child Death functions are covered in chapter 4 of the guidance.

Regulation 5 (3) provides that an LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

If we look at these statutory objectives and functions in practical terms, this list will help you to better understand about Safeguarding Children Boards.

- The CSCB is a partnership, some of the organisations that sit around the table are required to be there and others are requested to participate because of the expertise they offer.
- Some Board members represent organisations and the interests of those who have a direct responsibility for setting local priorities about the use of resources and services; these are set by other strategic partnerships such as the Health and Wellbeing Board, the Children and Young People's Partnership Executive (CYPPE) and Adult Safeguarding Board.
- The CSCB is not directly responsible for the provision and delivery of services, but does seek to make sure that protecting children is a common priority amongst agencies who work with children and those that commission services for children and families.
- The CSCB oversees and expects agencies who work with children to ensure their staff know how to respond whenever there is a concern for the safety of a child or young person.
- The CSCB is also expected to know how well this is working and know when it is not working as well as it should be.
- If there is a serious or critical incident or when a child dies and there is reason to believe that people were not working together as they should, the CSCB has a responsibility to consider and when necessary carry out a review of those circumstances.
- The CSCB on the basis of collaboration and cooperation sets standards, provides guidance and training, and scrutinises whether agencies who work with children are doing what they said they would.
- The CSCB also has to check its own effectiveness in order that it can be assured that the risks of children being harmed are minimised.

In a nutshell, the CSCB leads the way to help prevent children from being harmed, neglected or abused. It promotes the ways in which people and organisations have agreed to achieve this. To accomplish this, Board members work together to look, listen, learn and advise on the basis of a wide range of information about needs, performance, quality and the effect they have for children

Section 2: Our last Annual Report – what we as a partnership said we would do and what the result of this was

The table below shows the important things we said we would do following our last Annual Report (the three Strategic Objectives), and:

- The recommendations agreed by the Board (Column 1);
- What the Board and its partners did in the year and some of the evidence for this (Column 2); and
- Our explanation of when we were not able to make the progress we hoped for and why (Column 3).

2012 – 2013 CSCB Annual Report Strategic Objectives and Recommendations

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

Recommendation	What we did	Next Steps
The Board must ensure that the necessary framework is in place to deliver the primary Quality Assurance function of the Board effectively.	Restructured Board and sub groups to reflect priority of Quality Assurance function. Priority 3 of the Business Plan is headed '**Robust Performance Management and Quality Assurance demonstrated effective Safeguarding'** and the content of this and other sections reflect the development and continued ambition of the Quality Assurance aspect.	PMQA Framework has been recently reviewed ready to be published in November 2014.
The Board should complete further work to explore the possible inequalities in access to services for children and young people from newly migrant communities.	Newly Settled Communities Protocol led by and written by Multi-Agency Prevention of Harm sub group. The 'Every Baby Matters' leaflet, which is a communication tool of the Infant Mortality Task Group for keeping babies healthy and preventing infant deaths, is available in East European languages (Czech, Slovak, Polish) as well as English and Urdu and is given to every pregnant women at booking.	Protocol to be promoted, monitored and reviewed by the Business Group.
The Board's Prevention of Harm sub group should prioritise the work on the development of multi-agency supervision standards.	Supervision Framework was reviewed, rewritten and passed through the Board in March. From the feedback there needs to be more development on the standards and framework and re-promoted.	Learning and Improvement sub group now have this as an action to develop true multi-agency.
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.	The Governance Relationship Map states how and where responsibilities lie for the Improvement Board and the CSCB. The work plan indicates the areas of work of the HWBB, CYPPE, CCG, CSCB, Scrutiny Panel and the Improvement Board to increase understanding and remove duplication. Both documents are on the CSCB website.	
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 Quality Assurance function.	During the year the Board has set up a Business Group that has taken some responsibility for performance, in addition there has been a full programme of work from the Performance and Quality Assurance Sub Group and the Case Review Sub Group, which has overseen the work of the Multi-Agency Audit Task and Finish Group. These meetings of CSCB partners have been supported by the LA's CYP performance and data officer who has in particular helped to develop the CSCB Performance Management Framework. One example of the outcome of this work is the Multi-Agency Audit Report produced in August this year. C4EO were commissioned in Autumn 2013 to develop the Quality Assurance framework, toolkits, performance management scorecard and areas of the LIF.	

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

Recommendation	What we did	Next Steps
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.	Replacement of the CAF in Calderdale has meant that this recommendation has changed. The need to increase single assessments and referrals into the Early Intervention Panels has taken priority and is being monitored by the Performance Management Group. Current statistics show the rate of increase of Early Intervention referrals have increased and the trend continues upwards.	Early Help and Prevention Sub Group working on Thresholds documents to refresh and promote, and to ensure children get the right help at the right time.
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.	Robust Performance Management Outcome Dataset with ongoing development focusing on priorities in Child's Journey published. Audit programme challenges practice where identified by sub groups, Business Group and Board, e.g. identification of children on CP plans over two years – multi and single-agency response resulted in 19 of the 31 removed from plan with a view to the removal of all 31 by December 2014. Voice of the child is strengthening with excellent practice around listening to, recording and acting on the voice of the child. SMART training taken up by multi-agency practitioners through the CSCB Learning and Development Programme.	Output dataset to strengthen Outcome Performance Management Dataset. Due to be published for December Board (with quarters one and two stats).
The Board should ensure all agencies understand thresholds	Signatures of Risk document launched. Continuum of Need revisited and successfully re-promoted.	Revision of Signatures of Risk underway. Timescale December

for access to social work support, make effective referrals and engage appropriately in the delivery of Early Help via the CAF process.		for promotion. Single Assessment Framework launched – due to be reviewed in December 2014.
Strategic Objective 3 - To ensure that all agencies are aware, and respond to, the specific needs of young people for support and protection.		
Recommendation	**What we did**	**Next Steps**
The Children and Young People's Partnership should review its priorities to ensure they address key findings from the eHNA.	In June 2014, CYPPE approved the Emotional Wellbeing Plan for our Children 2014-15 to establish a framework for the transformation of services to support the emotional health and wellbeing of Calderdale's children. A review of priorities and performance indicators has been undertaken for approval by CYPPE on 10th October 2014 which includes the findings from the eHNA 2013.	Each CYPPE meeting now focuses on a specific strategic priority for each meeting. The December 2014 meeting will be focusing on Start Healthy, Stay Healthy, which will discuss the results of this years eHNA and future actions arising. A one-year project funded by the NHS Calderdale CCG is being led by CYPS to support schools to develop bespoke action plans in relation to the eHNA findings.
The Board should consider commissioning a review of safeguarding practice across Early Years providers.	After the Ofsted 2013 visit, this recommendation was reprioritised, however, safeguarding practice was monitored and improved by the Quality Improvement Support Officers across all Early Years settings. As a commissioned service, Children's Centres Early Years providers complete a Section 11 before tendering to be the provider. These are scrutinised and organisations only 'pass' if they meet good practice requirements. This, and the annual Section 11 is part of CYPS Commissioning Team requirements for all commissioned services.	Section 11 is planned to develop and roll out across this sector (private, statutory and voluntary) in 2015. The safeguarding grade of Early Years settings will be monitored and reported through the Performance Management Sub Group Output Report.
The Children and Young People's Partnership should evaluate the impact of the Strength and Difficulties Questionnaire (SDQ) and consider recommending its use more widely.	In October 2012, CYPPE agreed that SDQs would be adopted by the Council as the standardised assessment tool in relation to mental health and wellbeing. A report to CYPPE April 2013 confirmed good uptake of the training. During 2012, paper-based SDQs were used. Last year that partnership took the decision to commission an online SDQ which is just being introduced now and will be used widely.	A report to CYPPE in December 2014 on progress with SDQs will form part of the focus on Start Healthy, Stay Healthy.

	An SDQ evaluation group oversees the implementation and effectiveness of this. SDQs are a requirement of the Tier 2 service to provide information on SDQ scores as part of performance monitoring evidence. SDQ KPIs are included within the CYPPE Emotional Wellbeing Plan for our Children 2014-15.	
The Director of Children and Young People's Services should undertake a review of the effectiveness of strategies to address bullying in schools.	Monitoring young people's perception and experience of bullying happens through the electronic Health Needs Assessment (eHNA): "Reduce the % of respondents who have been bullied in the previous month" (currently 22%, eHNA 2013). This is now part of the emotional wellbeing strategy performance indicator. Calderdale has taken the learning from Targeted Adolescent Mental Health in Schools (TAMHS) into the Child and Adolescent Mental Health Service (CAMHS) Tier 2. The Emotional Wellbeing Project is supporting schools to develop bespoke action plans following eHNA results which will look at actions required around any bullying taking place in schools.	
The Board should work with agency partners through the CSE Strategy Group to ensure that PHSE Sessions in school address safeguarding issues such as domestic abuse and child sexual exploitation.	Safe Hands have carried out awareness-raising in Calderdale Secondary schools; over 2350 children and young people have now received CSE awareness-raising sessions. The Communities Directorate leads on Commissioning Domestic Abuse Service which includes specifying preventative work in schools. They have submitted a bid to Department for Communities and local government to support improvements to domestic violence support services. All the Designated Safeguarding Leads Training includes awareness-raising around both domestic abuse and child sexual exploitation, and delegates are encouraged to think about how they address these issues within their Safeguarding Curriculum. Furthermore, since December 2013, the Schools Safeguarding Advisor has worked closely with Safe Hands encouraging all secondary schools to incorporate their sessions around CSE into their curriculum, and have recently worked with Safe Hands to help develop a programme based on protective behaviour to be delivered to Year 6. School Nursing Team deliver PHSE in schools including safe relationships and sex education.	The Sex Factor is a theatre in education production that has been offered to all secondary schools in Calderdale and it covers sex and relationships, underpinned fully by safe relationships and covers consent, delay, sexting, e-safety, etc.

	The School Nursing Team receives notifications of any child or young person who attend A&E with alcohol or substance abuse. The School Nursing Team has a face-to-face intervention with all of these young people under the age of 16 to ensure there are no other underlying issues, whether it is a one off or whether more serious intervention is required.	
Continuing support of multi-agency initiatives to reduce infant mortality.	The Chair of the Infant Mortality (IM) Task Group is a Board member and Public Health Consultant; she analyses the CDOP data for the Annual Report and infant mortality data for the JSNA on Infant Mortality. The Board Manager of the CSCB is a member of the IM Task Group as are representatives from multiple services/agencies that can impact on prevention. She and the IM Task Group Chair attend CDOP; the learning and multi-agency initiatives from there are implemented. The most recent Infant Mortality Rate (2010-12) for Calderdale has reduced and is now not significantly different to the England average.	

To sum up:

Despite the difficult circumstances and changes experienced during the year, the Board has been able to respond to the vast majority of the recommendations. The recommendations included both inward and outward looking actions, some related to the collective role of the Board and its members, others to particular partners.

Inevitably, progress and indeed direction varied, as stated intentions do not always fully reflect either the complexity, or the reality, when they are addressed and applied.

As a Board, we have identified significant learning from this review of strategic objectives and the questions we pose are summarised as follows:

- Have we got the balance right between ‘form’ (i.e. the way the Board as a collaborative partnership organises itself) and ‘function’ (the statutory responsibilities we have to address)?
- Are our priorities and actions sufficiently focused?
- Are we matching capacity to capability to ensure we do the right things and do them really well?
- How can we better manage the wider range of competing priorities?

It is clear from this review that some important steps were taken in respect of most of the strategic objectives, but the need to revisit and reset these in the early part of 2014 is evidence that progress was both partial and possibly not as focused as it needed to be.

The revised Business Plan therefore represents our focusing on, and an effort to build on, the progress achieved during the majority of the year, and Section 3 will expand on this in more detail.

It is fair to observe that the context in which these strategic objectives and recommendations shifted significantly during the year, and changes in leadership that may have failed to fully recognise this, ensured that recommendations were reviewed and where necessary reset. The learning from this is that the Board will and has paid more attention through its revised structure to setting, monitoring, reviewing and adjusting the actions it takes to deliver statutory responsibilities and progress continuous learning and improvement.

Section 3: Assessment of the effectiveness of the Board

There are some important questions we can ask to help to form a view of how effective we were as a Board in the year and the difference the work of the Board made to children and young people

1. Did the Board meet regularly? Were meetings well attended? Did the agendas and minutes show that the Board achieved impact?

The Board met as planned on six occasions during the year, and agendas and minutes can be accessed on request by contacting the CSCB through the website: www.calderdale-scb.org.uk.

Attendance by partner organisations and their members was good and attendance is detailed in Appendix 2.

For most of the year, until the commencement of restructuring in January 2014, the Board structure followed an Executive model, whereby a smaller group of key partners met regularly to oversee work in progress and to make decisions that were then taken to the Board. The attendance at this group can be found in Appendix 2 and the structure in place until January can be found in Appendix 3. The Business Group was formed in March 2014 and the new structure of the Board can be found in Appendix 7.

The sub groups also met regularly and the evidence for this can be found in Appendix 2.

From January 2014, the Board started to move into a form and structure that intended to focus on key functions and responsibilities, directed by the Board and its members. The new Business Group coordinated and integrated the work of the sub groups within the Business Plan, and has employed key benchmarks for progress to be measured against.

A review of minutes for the period evidences how the Board and its members engaged with key issues and topics. However, in part due to changes and transition there is some evidence that continuity, consistency and transparency may have been impacted upon.

Through January and into March some Board members were able to meet with the new Chair and outline what they saw as key learning points, and these were adopted as a part of the revised structure and internal governance arrangements that are now ongoing in the present year.

In addition to the time members gave directly to Board meetings and attendance at sub groups, those members required to contribute financially did so in the year. (For details of the Board budget, expenditure and income sources please see Appendix 4). Percentages indicate that partners are making a positive contribution so that the Board is not overly reliant on any one partner.

Although the Board did not have in place any formal benchmarks for member attendance and contribution, the analysis (see Appendix 2) indicates the following:

- Board members or their representatives are commendable in their attendance at the CSCB and at least one other sub group, in some cases many more;
- There were clear arrangements in place for representative Head Teachers (primary and secondary) to be full Board members and report into and from the respective clusters. The Board also benefited from the Principal of the College being an active and committed member;
- The Voluntary Sector was and is well represented through both individual providers and voluntary infrastructure services. During the year further steps were taken to develop relationships especially in respect of commissioned Community and Voluntary Sector providers, and those Board members who represent commissioners and the commissioning function took a lead in this; and
- Statutory partners were active and committed.

To sum up:

Board members actively supported the work of the Board by attending meetings and ensuring that sub groups were attended by representatives from a range of partners and skill sets. Meetings took place as planned and attendance levels were good. Minutes of Board meetings show that the Board maintained a focus on key issues, took a range of reports and monitored progress.

It is fair to observe that the year falls into three parts:

- Pre-Ofsted inspection in June 2013;
- changes and challenges resulting from this inspection and the appointment of a new Independent Chair (shared with the Adult Safeguarding Board) until December 2013; and
- the appointment of a new Business Manager and Chair in January 2014.

The Board maintained a focus on key themes relating to the implementation of Working Together 2013: the establishment of a Learning and Improvement Framework, the revision with the aid of C4EO (a specialist external consultancy) and of the arrangements to monitor performance and analysis of this.

The Executive Group also met regularly to oversee other work relating to case review (the Board commissioned two SCRs in the year), the delivery of multi-agency training, policy and procedures and wider engagement with children, young people and the community. Following the restructure in January 2014, the Business Group played a key part in the refocusing with targeted skills provision and practical, hands-on support to the secretariat.

What has been learned from this and what will be different in the coming year?

The need for further work on internal governance was acknowledged in January 2014 and this is likely to lead to the setting up of a formal constitution and a revised membership.

As with other LSCBs the 'ask' made of partners is a significant one when contributions to the practical, hands-on work of sub groups is taken into account, and there is some evidence that smaller partners and some of the larger statutory ones have struggled to maintain this. In this coming year, this is an area the Board must watch carefully and seek wherever possible to rationalise work streams and be as specific as possible about what the 'ask' is. The Board may also seek to innovate by encouraging the best placement of skills in sub groups as well as seeking to ensure a balanced contribution from partners.

As part of this review, it is clear that the Board is not overly reliant on any one partner more than another. However, further analysis going forward may suggest that more opportunities exist to ensure as full a partnership approach as possible

The development of the capacity to assess contribution and monitor this will be an important step forward, so that partners can evidence and evaluate their contribution. Active monitoring will also allow the opportunity to explore any areas where performance may be compromised.

During the year, Board members committed to increased transparency and accessibility, and commissioned a new website to ensure that minutes of meetings and member contributions are easily accessible.

2. How did the Board ensure that it was listened to and able to influence other key strategic bodies?

During the year, Board members demonstrated through reports into the Board and actions resulting from Board meetings that they actively maintained and strengthened links with the CYPPE, and the Health and Wellbeing Board.

During the year, a draft protocol was developed and in conjunction with the Improvement Board, a Governance Relationship Map showing relationships and interactions was finalised.

This ran in parallel with development in these other strategic partnerships and meant that in the year a firm foundation of working relationships was established to build upon.

During the year, there was a change in approach to this. In collaboration with the Improvement Board, members agreed to formally take responsibility for key areas of the Single Improvement Plan.

Board members also began an internal dialogue and development around the strengthening of common understanding of the nature of the Board member role, leadership and the development of a robust approach to scrutiny and challenge.

What was learned from this and what will be different in the coming year?

As the Improvement Board, under its new Independent Chair, reset objectives it became clear in the final quarter of the year that one of the areas where the Board needed to demonstrate capacity and effectiveness was with regard to the relations with other key strategic partnerships, as well as preparing to assume parts of the role the Improvement Board carries out.

This resulted in revised priorities and actions set out in the new Business Plan that was developed in the last quarter of the year.

It was also recognised that for the Board's role in being listened to and influencing the other strategic bodies to be effective, further progress had to be established in respect of the Board's capacity to monitor, scrutinise and quality assure key aspects of the 'child's journey' so that all partners could be assured that joint working arrangements were effective and that there was a clear fit between this and the wider strategic priorities and commissioning arrangements set by other partnerships. This also became a key priority in the revised Business Plan.

This represents a significant change and as such will be seen as a long-term development, and is not unlike the position other LSCBs are adopting, in part in response to the implementation of Working Together 2013 and in part because the expectations of the LSCB continue to change.

3. Did we make sure that policies and procedure were maintained, updated, accessible and relevant?

The Board contributed to and benefitted from the West Yorkshire Consortium arrangements.

New and amended policies and procedures were developed and introduced in the year. These were the following:

Updated Chapters	
Chapter Title	**Details**
1.3 Recognition of Significant Harm	This chapter was updated to reflect publication of Working Together to Safeguard Children 2013. The definition of Emotional Abuse now includes cyberbullying.
1.7 Statutory Framework	This chapter was updated to reflect changes introduced by Working Together to Safeguard Children, 2013.
2.1 Local Safeguarding Children Board - Role and Function	This chapter was updated to reflect changes introduced by Working Together to Safeguard Children, 2013.
2.2 Agency Roles and Responsibilities	This chapter was updated to reflect changes introduced by Working Together to Safeguard Children, 2013.

Updated Chapters	
Chapter Title	**Details**
3.4 Section 47 Enquiries and Core Assessments	A link has been included in this chapter for Calderdale staff only, to a Calderdale local protocol: Medical Assessment for Child Protection Concerns in Child Protection Clinics held in Paediatric Outpatients.
5.7 Safeguarding Children and Young People from Child Sexual Exploitation: Policy, Procedures and Guidance	This chapter was amended to include a link to the DfE Tackling Child Sexual Exploitation Action Plan.
6.2 Allegations Against Persons who Work with Children	This chapter was amended to reflect the publication of Working Together to Safeguard Children, 2013. Section 13, Post Investigation has also been amended to state that if an organisation removes an individual (paid worker or unpaid volunteer) from work it must make a referral to the Disclosure and Barring Service.
7.1 Risks Posed by People with Convictions Against Children	This chapter was amended to include a link to the MAPPA guidance, as above.
10.1 Serious Case Reviews	This chapter has now been replaced with a link to the Serious Case Review section in Chapter 4, Learning and Improvement Framework in Working Together to Safeguard Children, 2013.
Abuse Linked to Spiritual and Religious Beliefs	This chapter was updated to include a link to the National Action Plan to Tackle Child Abuse linked to Faith or Belief.
Female Genital Mutilation	This chapter was updated to include a link to the Female Genital Mutilation Helpline.
Safeguarding Children who may have been Trafficked	Section 4.1, Initial Assessments and Section 6, Returning Trafficked Children to their Country of Origin have been updated and should be re-read.
Local Contacts	Details for Calderdale SCB Business Manager have been updated.
New Chapters	
Cross-Border Child Protection Cases Under the 1996 Hague Convention	This chapter is based on non-statutory advice from the Department for Education.
Safeguarding Children and Young People Who May be Affected by Gang Activity	This chapter summarises Safeguarding Children and Young People Who May be Affected by Gang Activity published by the Department for Children, Schools and Families in 2010.
Supporting Children and Young People Vulnerable to Violent Extremism	This chapter is based on and summarises the document 'Prevent and Safeguarding Guidance: Supporting Individuals Vulnerable to Violent Extremism', which has been issued by the Association of Chief Police Officers (ACPO). It provides advice on how to manage and respond to concerns of children and young people identified as being vulnerable to and affected by the radicalisation of others.
Learning and Improvement Framework	This chapter covers the requirements within chapter 4 of Working Together to Safeguard Children 2013, which describes the way that professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. It explains the requirements for an integrated local learning and improvement framework and the principles to be used when undertaking Serious Case Reviews, as well as other forms of reviews and audits.

The effectiveness of some procedures was tested through audit and included in the terms of reference of the Serious Case Reviews. The work plan of the Prevention of Harm Group was determined by the previous SCRs alongside priorities of the CSCB, and also fed into the L&D programme. The development of the joint protocol for Adult and Children's Services was directed by this group, particularly in respect of Parental Learning Disability. The neglect toolkit and guidance and SMART planning are other examples of learning, response and implementation for front-line practitioners which have aided the improvement journey for Calderdale and seen improvements in front-line practice as tested through extensive SMART auditing and the revisiting of the Neglect Toolkit in the latest SCR.

Checking on the effectiveness of procedures was included in the terms of reference of the baby E Serious Case Review. The action plan resulting from this included updating the Inter-Agency West Yorkshire Procedures in May 2013 in respect of pre-birth assessment, and the service standards updated in July 2013 to reflect this. Audits of pre-birth assessments have been undertaken at regular intervals to check on compliance with this and on quality of practice.

Learning from case reviews has resulted in further audits on SMART planning. Another area for focus was the reinforced need for multi-agency chronologies. These have been promoted within the new multi-agency referral form to MAST, which the Board approved. Further development and embedding continues, with the CSCB Early Help and Prevention sub group concentrating on developing tools and a framework for this.

At the same time, there was significant development and ground work undertaken in respect of whole system change resulting from the implementation of Working Together 2013, especially around the development of Early Intervention and Early Help arrangements, in preparation for the introduction of single assessments.

What was learned from this and what will be different in the coming year?

The Board recognised that not only did it need to provide leadership in developing and agreeing policies and procedures for joint working, but it also needed to ensure that these were effectively reviewed and tested. There was limited scope and capacity for this in the year, in part due to the transitions described in this introduction. Nevertheless at the end of the year there was a clearer view of how the policies and procedures could be further strengthened and accessibility promoted. This resulted in Board members being asked to assume a role in ensuring that policies and procedures were monitored within their own organisations as well as within the Board.

During the year, the Continuum of Need, the recognised threshold handbook in Calderdale, was updated and re-launched in summer 2013 to reflect both the introduction of Working Together 2013 and the need to identify and link to Early Help services. Alongside this, the Early Intervention Panels launched in 2012 continued to develop and strengthen.

The development of the single assessment framework was undertaken in a staged approach to ensure safe implementation across Early Help and Child Protection.

4. Did we make sure that everyone who works with children and young people were aware of the standards to work to in order to ensure that children and young people were protected?

The Multi-Agency Training Programme made sure that basic standards and expectations were embedded in the training people attended. Although the work around performance management and quality assurance did not proceed as quickly as planned this also focused on measuring against clear standards as did the case file audit work undertaken.

In the year, the Board also adopted a strengthened approach to the undertaking of the Section 11 audit and committed to an ambitious three-year strategy to develop and extend this as a clear standard-setting exercise across all organisations and groups who have regular contact with children and young people. This resetting also involved the development of the audit model to support assurance within organisations and local governance arrangements. Board members felt this to be more important given that many areas of provision were subject to different types of governance.

The Case Review Sub Group, and the Panels convened for the SCRs, also focused on how well standards were understood and adhered to.

During the year, the Board took formal reports from a number of partners that evidenced how they were applying standards.

What was learned from this and what will be different in the coming year?

There continued to be, as would normally be the case, a focus on standards at the point at which children and their families came into contact with statutory services such as Children's Social Care. It is possible to observe that the Board and its partners focused on this especially, following the June 2013 Ofsted inspection.

Although a large part of the year was given over to developing new ways of using data and information about how partners were working together, how timely this was and the extent to which it was having the desired impact, there was also a recognition, especially in the later part of the year, that clearer measures and standards were needed. This means that the Board will become better at identifying, agreeing and committing to measures that relate to standards. In turn this will enable the Board and its members to develop their capacity to understand and challenge when it appears that standards are not being met.

The other major learning point is the need to recognise and respond to the changes that have taken place in how services are commissioned and governed, especially in the Health and Education Sectors, as well as the intention to reach out to Community and Voluntary Sector provision.

5. Did we make sure we looked effectively at whether or not partners were doing what they said they would to protect children and young people?

During the year, a number of statutory partners presented information and evidence to the Board as to how they were achieving this, through formal reports, single-agency audits and participation in SCRs.

The Board had previously identified that its arrangements for Performance Management and Quality Assurance needed revision, especially in the light of the publication of Working Together 2013. To this end external help was commissioned from C4EO. It is fair to say that along with changes in Board administration that the Board's scrutiny function could have been more robust during the year. This is not to say that scrutiny did not occur, but it did appear to lack consistency and focus, and did not always evidence challenge at a Board level.

It may also be significant that the undertaking of SCRs (which in effect also assume this function) have diverted limited time and resources, and focused instead on a child or children subject to specific circumstances as opposed to wider trends and variations.

Despite this, by the end of the year progress had been made in restructuring the sub groups (see Appendix 7) and starting to focus in on the key ways in which the PMQA function would be implemented to ensure that Board members are able to effectively scrutinise and challenge where necessary.

There was also an additional level of scrutiny of joint working arrangements undertaken by the Improvement Board, and the Independent Chair and a number of CSCB members who sit on this Board. The acceptance of responsibility for certain sections of the Single Integrated Improvement Plan (SIIP) by the Board reflects this.

What was learned from this and what will be different in the coming year?

One of the things learned was to find better ways of managing competing and increasing demands from a limited resources base within a partnership-based collaborative arrangement. The revised Business Plan and arrangements for monitoring performance and quality assurance provided by the end of the year gave the opportunity to reset this key activity.

It should be noted that this demand management process is a challenge for all LSCBs and it will be important that the Board arrives at a proportional, incremental and targeted approach in the coming year.

A clear priority for the coming year will be the agreement and setting by all partners of key indicators that will provide the basis of analysis and scrutiny, in order that the LSCB can demonstrate both its independence and effectiveness as it focuses on the impact of joint working arrangements and the difference these make for children and young people.

6. Did we look on a regular basis at how well professionals worked with families to see how well this was working and the effect this was having on outcomes for children?

As previously mentioned there was some dilution in focus as the year progressed, and whilst there is evidence that both partners and the Board looked at practice and the impact this was having, there were limited examples of multi-agency case file audits being completed and reported through to the Board. The Board was able to support and draw on single-agency efforts to look at practice, and during the year, plans were agreed to improve on this.

The following examples show how the Board was able to demonstrate how it looked at practice and what changed as a result of this:

SMART Plans: Following an audit of Child Protection Plans in April 2012, the Safeguarding Children Board started a programme of work to improve the quality of plans and make them SMART.

By the end of 2012, two separate external inspections found that the plans were not SMART, and therefore in 2013 different measures were tried, and it was agreed that the plans would be audited again in September 2013.

A sample of 10 plans was used, all of which had started in 2013. Additionally, all the plans selected related to the category of 'neglect', this was done on the basis that previous work had shown that neglect was often more difficult to manage than other categories, and neglect cases constitute the largest proportion of Child Protection Plans.

Safe Practice Review: In July 2013, a Safe Practice Review was carried out in respect of over 600 cases in MAST and FRT, which was 100% of 'live' cases. This was instigated by the Director of Children's Services in order to seek reassurance following June 2013 Ofsted inspection that children were safe. Corrective actions identified were captured and corrected in real time. Following the audit, which included Children's Social Care and Children and Young People's Commissioning Team, a follow up audit by the CSCB Board Manager was carried out to triangulate findings and found 90% of the cases to be either satisfactory or better.

In August 2013, the Independent Chair requested that a follow up audit was carried out to establish if there had been any change in the quality of front-line practice in the intervening period. Board members were asked to nominate staff to participate in this process.

It was also agreed that the audit would be of a small number of randomly selected cases (10) that had been referred after the period examined during the Safe Practice Review, and look at some distinct areas of practice.

There is acknowledgement through the audit findings and report that there were areas of improvement (e.g. range of agencies involved in interventions with family members, and most plans considered in the audit were acceptable or good) but there is a recognition that further work is to be done to continue to enhance the quality and consistency of SMART plans.

Monthly joint audits were conducted between MAST and agencies between October 2013 and March 2014. The agencies involved were: Health, Adult Health and Social Care, Schools, CAFCASS, Probation and the Voluntary Sector. The results are detailed in the section below.

The Multi-Agency Audit Group has also received further audit reports for the following:

1. CSE audit and evaluation – an audit that had commenced during 2013 and is continuing to be taken forward with the action points. The audit was completed and reported in April 2014 and recommended actions completed and taken forward.

2. Schools audit and evaluation (October to December 2013) to examine the provision of Early Intervention and the quality and appropriateness of the referral to MAST. This audit also links with the re-referral audit being done in September 2014 and the consideration of appropriate referrals by agencies done in December 2013.

3. SMART and the quality of Child Protection Plans to consider whether or not the training and support programme has resulted in SMARTer plans and if the Strengthening Families approach to Initial Child Protection Conferences is having an impact on writing SMARTer plans.

What was learned from this and what will be different in the coming year?

We have learned that we need to ensure priority is given to undertaking case file audits (as per Working Together 2013) so as to be able to better connect with front-line practice from a multi-agency and joint working perspective.

We believe that our approach to audit needs to be more clearly defined and channelled, and that as our capacity to monitor and evaluate performance of joint working arrangements develops this will help us to refocus audit activity to strengthen both professional practice and process.

Case file audits give Board members a real feel for how people are working together. Some of the themes that will help refocus our learning and improvement efforts, especially in respect of how neglect is understood, are the capacity to focus on the child's voice and children as victims, and working with families with complex needs, at key stages in the child's journey from Early Help through to formal interventions.

- The action plan from the multi-agency audit of SMART plans is being taken forward with the Chairs of the relevant sub groups as there are recommendations from the audit which relate to more than one area of partner involvement.
- The CSE audit recommended some findings and actions that were taken forward through the multi-agency response in terms of the make-up of the team and the procedures and processes. These were implemented early in the new reporting year and further checking is planned.
- Schools' referrals audit and evaluation: there was limited engagement in terms of self-assessment from schools (seven completed) but multi-agency audits of a sample of CASS (the software database for children and young people in the Local Authority) records were also undertaken which added to the information being considered. Specific recommendations have been reported and the Multi-Agency Task and Finish Group felt these were particularly relevant and useful to take forward. The corresponding action plan will be updated with progress and further communication rolled out to schools via the Schools Safeguarding Advisor from September. Further updates on progress are being reported in the current 2014 to 2015 year to the Task and Finish Group in September 2014.
- The key recommendations were to look further at the referrals considered to be contacts. As the recording improvements have embedded it would be useful to review these cases within the sample to look at how they would have been recorded within these guidelines. It was also agreed to sample a small number of cases still open, to look in detail at the support around the child/family from agencies and consider if there could be any changes to the way a review process may be a part of any referral or re-referral process. Reports from these actions will come back to the Task and Finish Group.
- The key findings from the MAST audits were fed back to the respective agencies for corrective actions. However, the key outcome from the audits was that the agencies involved obtained a much clearer view of the work of each other. This specifically impacted on their interpretation of the roles and responsibilities of that agency and served to adjust expectations as well as improve communication.

7. Did we make sure that there was training available for all the different professionals and people who work with children and young people? Did we make sure that they were well informed and that this improved their skills and joint working practices?

During the year, over 1387 people from 33 organisations were able to attend 125 face-to-face training and learning events.

Partner Agency	Number	%
Calderdale MBC	502	36%
Education	276	20%
Housing	19	1%
Health	188	14%
Police	11	1%
Private and Independent Sector	181	13%
Foster Carers and Residential Homes	52	4%
Probation	17	1%
Commissioned Services	45	3%
YOT	14	1%
Voluntary Sector	40	3%
Other	42	3%
Total	**1387**	**100%**

A further 1451 learners completed e-learning safeguarding courses, the majority of users completing the core course in 'Awareness of Child Abuse and Neglect'.

The Annual Report can be accessed on the website which gives more detail about the way in which training and learning opportunities were organised and this includes e-learning, which continues to be an important part of the way we ensure that a wide range of people are able to access learning.

An example of the breadth of areas offered by the multi-agency training programme was Child Sexual Exploitation (CSE) training where a total of 132 practitioners attended five different learning events throughout the year, from formal training on procedures to the 'Impact of CSE' and 'CSE briefing' learning events and attendance at the Regional CSE Working Conference. Full details of attendance can be found here.

There was good evidence of responsiveness to emerging issues and needs such as Child Sexual Exploitation (CSE) with a range of courses and events planned and additional ones commissioned during the year.

A joint Adult and Child Safeguarding Annual Conference was held in March 2013. The focus of the conference arose out of discussion in the planning group about the common areas for learning from local Serious Case Reviews in both Adults' and Children's Services. Themes that emerged included:

- The importance of early identification/help;
- Sharing examples of good practice;
- Using intelligence;
- Applying professional curiosity/cynical curiosity;
- Demonstrating professional challenge (of families and professionals);
- Avoiding over familiarity and acceptance of cultural norms;
- Demonstrating dignity and respect/challenging stigma;
- Empowering people; and
- Using 'gut instinct'.

Good practice was celebrated through the Calderdale Safeguarding Awards, which provided an opportunity for practitioners who had excelled in safeguarding practice with adults and children in Calderdale during 2013 to be acknowledged for their work.

Services that work with children and young people were represented by 24 different agencies including statutory, private, commissioned, elected members and Voluntary Sector services.

Again it is fair to note that interim and transitional arrangements in the second half of the year may have resulted in some lost ground, as there were difficulties in progressing the collection, collation and analysis of information regarding training course attendance and impact due to an out of date, manual, paper-based recording system. This has now been replaced by a bespoke software database that is still being developed, but which is already producing much better collection, collation and analysis.

The Board regularly took update reports on training course delivery, however in the final three months of the year the Board attached a priority to ensuring that future programmes reflect:

- the single-agency offer;
- a developed view of whole workforce training and development needs; and
- delivery that matches priorities and can provide improved evidence of how it is improving professional and joint working practice.

What was learned from this and what will be different in the coming year?

There has been a recognition that this area of the Board's activity is critical in both the short and longer term, and that we need to reassess the basis on which we plan for and deliver this as a partnership and in conjunction with direction from the CYPPE as to how they see the future learning and development needs.

The challenge for any multi-agency safeguarding training programme is to help maintain basic standards across all partners' workforces, through effective coordination and evaluation of single-agency training. And to ensure that levels of input meet demand for specialist working, and developments in our understanding of the factors that contribute to abuse and harm.

New arrangements started to be put in place at the end of the year, in order to collect, collate and use key information around outcomes and impact. This synchronises with other areas that the Board is focusing on and is an area in which continued development is critical.

For the coming year, in recognition of the need to move away from an informal appreciation of the training provided, a clear challenge from the Board, at the end of the year, was in recognising the high levels of informal appreciation of the training provided, and to shift this into a more objective and evidence-based framework. This is in order to better demonstrate how giving up precious time to development, results in improved outcomes for children and young people, as well as improved joint working.

8. Did we ensure that our statutory review functions were in place and effective?

The Board has a responsibility to ensure that all child deaths are reviewed. This is called the Child Death Overview Panel (CDOP). From April 2013 to March 2014 there were 19 Calderdale child deaths, amongst the lowest for a decade, of which two-thirds were infants.

Other data to note:

- There were 140 Calderdale child deaths in the six years of operation of CDOP, of which 91% have completed reviews;
- The CDOP completed 19 child death reviews for Calderdale in the year to 31 March 2014, of which about half (47%) died during 2013/14;
- Death rates for children and infants are significantly higher in the Asian Pakistani than White-British ethnic group in the six years of CDOP;
- Child death rates are highest in Halifax Central and in the lowest two quintiles of deprivation;
- Most Calderdale child deaths have been categorised as being due to 'chromosomal, genetic and congenital anomalies' (33%) or 'perinatal /neonatal event' (30%) over the last six years;
- For only 16% of Calderdale child deaths reviewed/completed in 2013/14 were 'modifiable factors' identified (13% over the last six years). A modifiable death is defined as being where there are factors that may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths;
- None of the Calderdale child deaths reviewed/completed in 2013/14 were subject to a CPP or statutory orders, and the CDOP did not recommend a Serious Case Review for any case; and

- The functioning of the CDOP has improved even further in the last year and outperforms the national average on multiple parameters including timeliness of reviews and completeness of data.

Further information and details can be found in the CDOP Annual Report which will be available after the CSCB has approved this, from cscb@calderdale.gov.uk. It will also be published on the website. The Calderdale CDOP will:

- Reflect on recommendations/actions from the last year and present to the CSCB an action plan for agreement; and
- Collectively reflect on the 'so what'. (The ‘what is happening?’ and ‘what has happened as a result of our efforts?’) An audit for the 16 cases over the last six years where modifiable factors were found, to formally record that all action that could be taken was taken to prevent any further deaths.

The Board managed the process of case reviews via a specific sub group that 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. The sub group produced the work plan for the group with the then Business Manager. The group also managed and monitored action plans from all reviews contributing to strengthened and further developed partnership working (the e-learning can be found below) and is developing new ways of disseminating lessons from recent reviews.

Two Serious Case Reviews (SCRs) were considered during the 2013/14 period:

- Child J – In September 2013 following the death of a 13-year-old child, the SCR Panel recommended to the Independent Chair that the criteria for a SCR were met. The decision was made to commission a SCR. Following the publication of the Working Together 2013 Guidance the decision was made to look at commissioning a Learning Lessons Review using the Significant Incident Learning Process (SILP). The findings from this review are awaiting publication; and
- Child K – In December 2013, an SCR Panel was called to consider the death of an infant. There were multiple agencies involved with this family and the decision was made by the Independent Chair to commission an SCR following a modified Social Care Institute of Excellence (SCIE) methodology. The findings from this review are awaiting publication.

An SCR from 2009 to 2011 is still awaiting publication. The outcome of this review was reported in the 2011/12 Annual Report and all recommended actions have been completed. There remained outstanding legal issues so the Board was unable to publish the overview report until these had been concluded.

An SCR run jointly with Lancashire Safeguarding Children’s Board was completed in 2012 but due to the legal process was unable to be published until July 2013. The outcome of this review was reported on in the Annual Report for 2012/13. All recommended actions have been concluded.

A multi-agency thematic review was considered in February 2013 regarding the quality of multi-agency decision-making in case of children who were not related but present in a house where a child died. 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 and a thematic review was commissioned that commenced in April 2013. The learning and action plan arising from this is managed by the current Case Review sub group.

A Serious Case Review was initially considered for a young person in October 2013 and has since become the subject of a SCR in October 2014 after further exploration into the circumstances of this case.

During the year, as with other LSCBs there was a need to develop a Learning and Improvement Framework, including the arrangements for case review and how the Board will apply systems approaches. A draft was prepared and considered by the Board in autumn 2013 and has resulted in some challenge. As a result this remains draft and further development work is being undertaken. It was felt that it was important to conclude the current SCRs, learn from the differing approaches to these, and therefore evidence and inform the best way forward for the Board.

What was learned from this and what will be different in the coming year?

The shared approach with another LSCB has resulted in consistent performance in delivering child death review. The Board will, in the coming year, improve its scrutiny both of the process and how learning can have maximum effect locally. The change in chairing arrangements does not appear to have had an impact in the short term but will need to be monitored.

The decision to adopt an incremental approach to finalising how as a Board we approach Serious Case Review (in the light of the new Working Together 2013 Guidance) and other forms of proportionate review is appropriate, especially as in the last part of the year we have had to address the volume of work that review creates and ensure that the Board’s commissioning and quality assurance processes meet with current standards and expectations.

Some of the findings from the reviews commissioned have included:

- Multi-agency lessons included ensuring that the CAF, Child in Need (CIN) and Child Protection Plan (CPP) planning processes have robust procedures to monitor the effectiveness of services that are provided to families - *SMART plans training delivered by CSCB learning and development;*
- To include current and historical information into assessments; agencies need to ensure all available information is shared - *referrals*

to Children's Social Care must now include chronologies of agency involvement with the child and family;

- Plans should not be allowed to drift, they must be child-focused and be based on all relevant information being shared between agencies - *audits of CPP undertaken by CSCB Multi-Agency Audit Group and use of CPP as agenda for core groups and case file audits being undertaken by Children's Social Care to monitor quality;*
- Services working with adult family members did not fully assess the impact of adult issues e.g. substance abuse, learning difficulties, mental illness, on the children they lived with. They were adult-focused rather than child-focused - *joint protocol for Adults and Children's Services working with parents where substance abuse, learning difficulties and mental illness are a feature developed; and*
- Practitioners being knowledgeable enough about how to compile and analyse family histories and also knowledgeable enough to know what the risks are from 'the toxic trio' - *referrals to Children's Social Care must now include chronologies of agency involvement with the child and family.*

What difference has this made?

- Child protection plans continue to improve, demonstrating SMART outcomes for children and young people;
- All referrals to Children's Social Care and Early Intervention Panels now have agency chronologies that contribute to the decision-making process;
- Multi-agency audits being undertaken, following themes identified by Ofsted and case reviews; and
- Joint protocol for both Children and Adult Services now developed with guidance notes available on the CSCB website.

9. Did we make sure that organisations In Calderdale recruited safely and that all allegations made against people who work with children were effectively managed and the learning from this was shared?

The Board accepted the Annual Report from the Local Authority Designated Officer in respect to the preceding year and maintained an overview regarding how allegations against adults who work with children were managed and what learning there was for partners from this.

Year	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
No. of allegations	24	66	55	112	142	144	142

Referrals during the year have stabilised and the Board concluded that this was a sign of a maturing system and approach. In the year, the continued shift from the number of direct referrals to the LADO as opposed to Social Care and or the Police further indicated that awareness of the role of the LADO had increased. Allegations and or concerns matched national figures in terms of source and type. In the year, 56 referrals were received from schools.

Nature of Allegation/Concern	2011/12	2012/13	2013/4
Physical abuse	45	55	46
Sexual Abuse	24	28	31
Neglect	3	2	3
Emotional Abuse	5	4	1
Unsuitable Behaviour	65	55	61
Total	142	144	142

Outcome of Enquiries	2011/12	2012/13	2013/14
Substantiated	41	42	43
Unsubstantiated	33	52	39
Unfounded	20	20	21
Unfounded – Malicious	3	5	2
Did not meet Threshold/Advice to Employer	33	17	24
Referred to other LA LADO	7	2	5
Outstanding	6	6	8
Total	143	144	142

There were two face-to-face training sessions of 'Managing Allegations Against Staff', which were attended by 17 members of staff from a range of agencies. The CSCB members agreed the report showed a constructive and consistent approach but suggested some further analysis would be helpful to better understand the trends and patterns emerging.

What was learned from this and what will be different in the coming year?

Arrangements and trends were felt to be stable and robust, so this means that the Board can further develop its scrutiny and support for partners' arrangements to respond to allegations. There continues to be a need to ensure that all partner organisations, especially with the continuing changes in commissioning and localised governance, are aware of and supported to have arrangements in place across all aspects of recruitment and safeguarding.

10. Did we make sure that there was an effective joint working response, to children who we knew to be or felt to be especially vulnerable, in place and effective?

During the year we:

- Promoted and progressed the implementation of the Strengthening Families approach to Child Protection Conferences as a pilot (this is a way of making sure that there is an improved focus on involving families), which has led to improved experiences and ownership of risk by children and families and is showing early signs of having a positive impact on SMART planning and improved outcomes for children;
- Promoted and supported the implementation of the Single Assessment (this replaces the two levels of Children's Social Care led assessments, and will mean that partners and children are able to benefit from more timely and thorough assessments);
- Supported CSE, Missing and Trafficking work through revision of and setting up governing strategic and operational groups;
- Supported Multi-Agency Pregnancy Liaison and Assessment Group (MAPLAG) work to ensure that pre-birth arrangements are in place and risks fully assessed across the multi-agency partnership, where drugs and alcohol abuse of the parents are a concern;
- Supported new developments to improve the focus on safeguarding vulnerable young people which has led to the establishment of the Vulnerable Young People Panel and the virtual Vulnerable Young People Team by Children's Social Care;
- Promoted enhanced joint working between Adults' and Children's Services to safeguard children and vulnerable adults, resulting in the joint working protocol and flowchart subsequently agreed by both the CSCB and the Adult Safeguarding Board, as well as the joint conference;
- Continued to support the embedding of the neglect strategy and the neglect toolkit; and
- Supported enhanced multi-agency arrangements for the protection of children in domestic abuse situations and missing children.

What was learned from this and what will be different in the coming year?

During the year we were able to make a significant range of contributions across many aspects of joint working arrangements.

We have however learned that such a broad approach may not be sustainable in the light of the findings of the June Ofsted inspection.

We have therefore refocused the attention and capacity to focus on significant groups of vulnerable children and young people whilst shifting the focus on thematic and system wide improvements through the Board/Business Plan and better integration of sub group activity.

In reality, and it is likely to remain the case for the foreseeable future, this sub group will focus on the children we know to be most vulnerable, and these include children who are at risk of or are sexually exploited, missing or trafficked.

11. How have we been able to promote awareness of safeguarding and reflect a focus on the child?

During the year, Board members have brought to the Board a range of perspectives and initiatives. The Board was also able to contribute to and draw on the following:

- The Calderdale Talkback Survey provided a good baseline of the awareness of the communities of Calderdale about the nature of safeguarding, and an indication of the areas of communication work required to enhance communities' awareness;
- The Private Fostering advertisement in the local press at the end of October 2013 resulted in the reporting of an additional arrangement, which was significant in the light of only a handful of notified arrangements per year. This activity provided a positive impact for at least one child in Calderdale;
- Links to the Voice and Influence Team have meant that the voice of the child has been more apparent. Highlights included the production of a Young Advisors' version of the Annual Report for 2012-2013 and Young Advisors' attendance at the Annual Conference on 19/3/2014. The Young Advisors continue to play an important role for the CSCB and will continue to have influence of the work of the CSCB; and
- The Safeguarding and Faith Group was set up by the Board in January 2014 to oversee and support the development of safeguarding awareness and structures in mosques, madrasahs and other faith groups. A programme of safeguarding training was delivered to mosques and madrasahs by the CSCB. The training evaluated positively and participants identified other training and support issues. The Safeguarding and Faith Group meet quarterly to work towards the goal that faith groups in Calderdale are

sufficiently informed and have structures in place to safeguard and promote the welfare of the children and young people who access their organisations. Since the beginning of this engagement, DBS checks have been facilitated and funded by the Voluntary Sector Infrastructure Organisation, six mosques have requested a formal link to the Voluntary Infrastructure Organisation, some schools have become 'buddies' to the madrasahs for peer support and this work is ongoing to build stronger links and ensure its sustainability.

What have we learned and what will be different in the coming year?

Board members have agreed that raising awareness, understanding and promoting effective relationships between partners, as well as the Board's relationship with the wider community is a key area of improvement. Safeguarding Week has been planned for March 2014 and is being planned and promoted by many agencies.

This means that we will work harder to ensure that all activity seeks to demonstrate and evidence how it will make a difference to children and young people who are in need of protection.

12. What does this Annual Report tell us about the effectiveness of the Board and therefore the 'sufficiency' of joint working arrangements to protect children and promote their welfare?

During the year, the Board identified a number of areas where it felt change was needed, in part as a result of the previous Annual Report and the learning identified from this, and also as a response to the publication of Working Together 2013.

It should also be noted that all partners faced fiscal challenges and continuing changes to governance commissioning and delivery arrangements, both at a strategic level and often within their own organisations.

Significantly, in the year, in terms of the arrangements for Independent Chairing and business management there were three changes and distinct periods. These changes and the transition they represent follow on from a period where leadership and support arrangements for the Board were stable.

There is no doubt that these changes along with the changes required as a result of Working Together 2013, posed a significant challenge in terms of continuity, evidencing impact and, therefore, effectiveness.

As the report shows, the strategic objectives set at the beginning of the year have been progressed, and the Board supported a wide range of developments and activities, perhaps too wide to sustain. It maintained its multi-agency training programme and provided partners and professionals with a policy and procedure framework, as well as meeting the case review function.

Although it can be argued that the baseline scrutiny arrangements of the Board did not develop as planned, there is evidence of practice and joint working arrangements being looked at in some detail, though it is not always possible to fully evidence what impact this has had.

In terms of assurance it is important to note the role that the Improvement Board played for a significant part of the year in terms of scrutinising the effectiveness of the Local Authority and its partners. This went some way to addressing any temporary deficits in terms of the LSCB.

It is also clear that throughout the series of transitions, the Board members and in particular Board advisors worked hard to maintain progress and quality, whilst responding to the findings of the Ofsted Inspection and Directions Notice. In this sense it is clear that the way in which Board members have played their role has mitigated against any deficits in evidence, and it is therefore possible to conclude that notwithstanding these identified deficits, joint working arrangements were both durable and robust during the period.

Section 4: Conclusion and some considerations for the future

This has been a difficult Annual Report to compile, in part as a result of transitions and circumstance, and in part because of the changes impacting on partners in terms of resources and on LSCBs as a result of the implementation of Working Together 2013.

Equally, the focus and drive produced by the requirement for any partner to improve can have a significant impact on how the Board and its relationships develop. This is particularly true when this applies to the Local Authority, which has an additional responsibility to ensure the Board and their partnerships are effective.

There is no doubt that during the year all partners, especially statutory ones responded to the challenges and have committed to an ambitious programme of change and development. During the later stages of the year many of the initiatives identified earlier in the year started to impact, especially in relation to external governance relationships.

There was one letter from the Independent Chair to the Minister as required by the Directions Notice and this set out the plan to realign the role of the Board to provide strategic leadership and the revised function/objective-focused sub group structure and the intention to be able to formulate an ongoing assessment as to whether or not the Board was meeting its statutory responsibilities.

Further letters have indicated that the Board is meeting these but there remain a number of significant areas of risk, and the letters evidence the Board members' response to these and progress.

This ongoing assessment when seen alongside this Annual Report results in a confirmation that commitment and direction of travel are sound. In effect, the vision for and understanding of the LSCB is being renegotiated and reset, which parallels processes other LSCBs are undertaking. This has added significance and impetus in the specific context of Calderdale, and clear benchmarks and areas for improvement have been identified.

The Annual Report confirms both a strength and a weakness, in terms of high levels of commitment tending to express themselves in process rather than clear outcomes. Further analysis can suggest it is not that the outcomes are not there; just that they are not recognised or evidenced in the ways in which it would now be expected they would be. However, we are not alone in this. Many organisations and LSCBs are on a learning curve in this area. Therefore, the move from process to outcome, and outcomes that demonstrate the difference this has made to the ways in which people work together to protect children and promote their welfare, will be a significant objective for the present year.

The challenge for partners in the present year is likely to be in addition to maintaining commitment and pace, clarifying vision and aligning roles with effective core functions that both reflect the qualities of partnership working and where needed provide challenge that is constructive and focused.

Appendix 1 - CALDERDALE SAFEGUARDING CHILDREN BOARD MEMBERSHIP

JANE BOOTH – Independent Chair April 2013 to September 2013
ISOBEL PORTER - Independent Chair October 2013 to December 2013
RICHARD BURROWS – Independent Chair January 2014 to present

STUART SMITH, Director
Children & Young People's Services, Calderdale MBC

MAGGIE SMALLRIDGE, Head of Probation for Bradford & Calderdale
National Probation Service for England and Wales (West Yorkshire)

JULIE LODGE, Named Nurse/Trust Lead
South West Yorkshire Mental Health, NHS Trust

TIM BREEDON, Executive Director of Nursing, Clinical Governance & Safety
South West Yorkshire Mental Health, NHS Trust

BEV MAYBURY, Director,
Adults Heath & Social Care

CHIEF SUPERINTENDENT CHRIS HARDERN - April 2013 to November 2013

CHIEF SUPERINTENDENT ANGELA WILLIAMS - December 2013 to present
West Yorkshire Police

KAREN HEMSWORTH, Assistant Director for Safeguarding Children & Vulnerable Adults
Calderdale and Huddersfield Foundation Trust, NHS

DR PAMELA OHADIKE, Designated Doctor and Consultant Paediatrician
Calderdale & Huddersfield NHS Trust

ROBIN TUDDENHAM, Director for Communities
Calderdale MBC

IAN HUGHES, Head of Democratic & Partnership Services
Calderdale MBC

ANGELA EVERSON, Joint Chief Executive
WomenCentre Calderdale

BEATE WAGNER, Head of Service, Children's Social Care & Early Help
Children & Young People's Services, Calderdale MBC

VERONICA MELLOR, Service Manager
Safeguarding & Quality Assurance Service

COUNCILLOR MEGAN SWIFT
Elected Member

HILARY BARRETT, Head of Service
CAFCASS

DR STEVEN CLEASBY, Deputy Chair & Safeguarding Lead
Calderdale Clinical Commissioning Group (CCG)

GILL POYSER YOUNG, Designated Nurse
Calderdale CCG

LEONA BINNER, Head Teacher
St. Augustines Primary School

JEFF RAFTER, Head of Youth Offending Team
Calderdale MBC

JANETTE PEARCE, Head of Pennine Housing 2000
Pennine Housing 2000

NIGEL HOTSON
Fire Service

JACQUIE HELLOWELL
Lay Member

IAN HILLAS
Lay Member

WENDY MOFFAT, Head Teacher
Crossley Heath Grammar School

CHRIS JONES, Principal
Calderdale College

PENNY WOODHEAD, Head of Quality
Calderdale CCG

IAN CURRELL, Director of Finance
NHS England

STEVE BLACKMAN, Sector Support – Calderdale
North Bank Forum

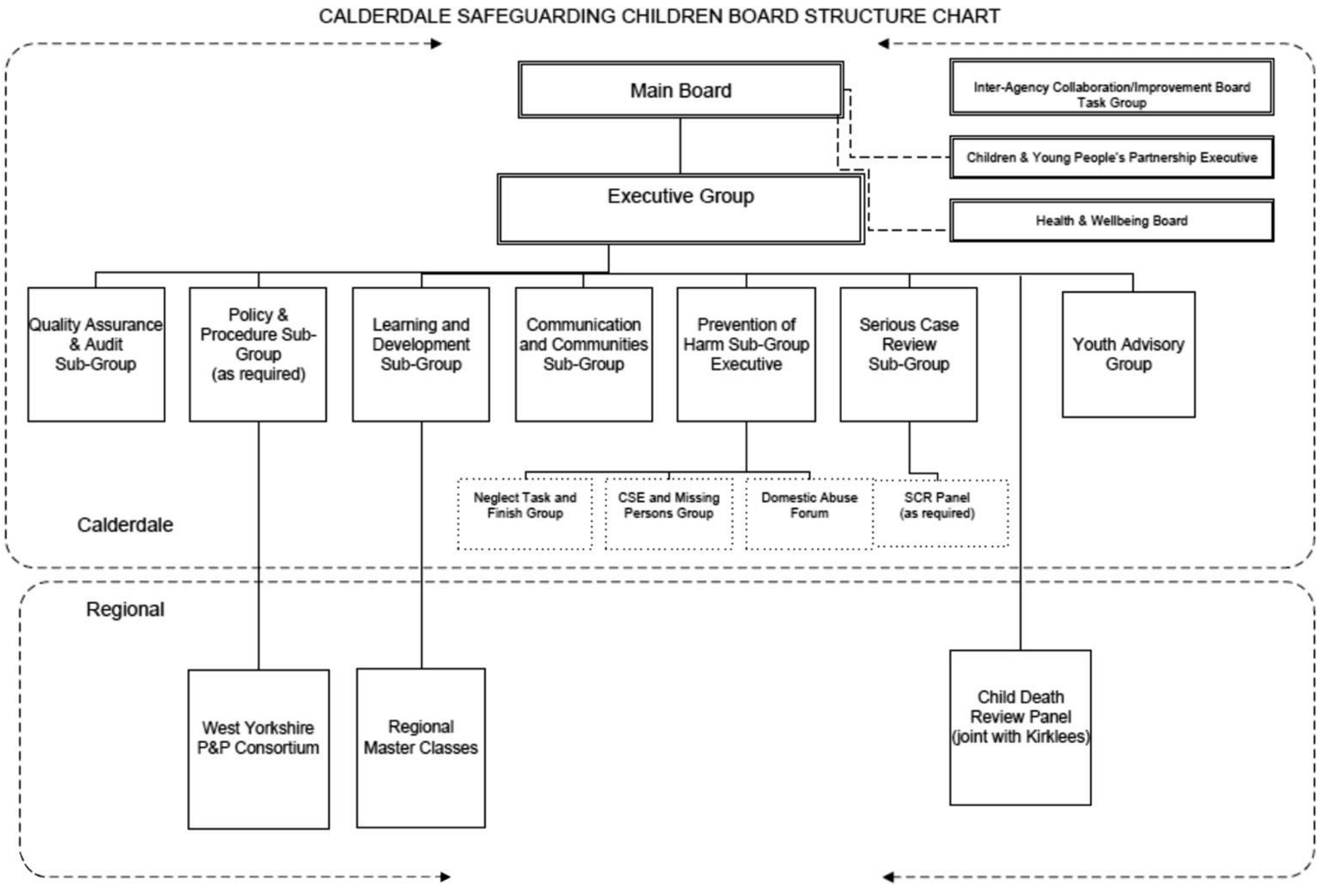
DR JILL FARRINGTON, Consultant in Public Health Medicine
Public Health Team, Chief Executive's Office, Calderdale MBC

Appendix 2 - Attendance at CSCB Meetings April 2013 – March 2014

Meeting		CSCB Agency Attendance																							
		CSCB Chair/Managers	CYPS	SWYPFT	CCG	CHFT	Lay Members	Police	Adult S'Guard Board	Probation	NHS England	Councillors	College	Voluntary Sector	CAFCASS	Democratic & P'ship Services	Housing	Secondary Heads	YOT	Public Health*	Fire Service	Communities	Primary Heads	Other Education	
CSCB (6)		6	6	6	6	6	6	6	6	6	6	5	5	5	4	4	4	3	2	2*	2	2	1	1	
L&I sg (6)		6	5	6	-	5	-	0	-	-	-	-	-	5	-	-	-	-	2	-	-	-	-	-	
Executive (3) Business Group(2)		5	4	2	4	-	2/ 2	5	-	2/ 3	-	-	-	-	-	-	-	-	2/ 2	-	-	-	2/ 3	-	
Case Review (5)		5	5	5	5	5	-	4	-	-	-	-	-	1	-	2	-	-	-	-	-	-	1	-	
C&E sg (5)		5	5	3	3	2	5	4	-	-	-	-	-	2	-	-	-	-	-	2**	-	-	-	-	
P&R sg (4)		3	4	-	4	4	-	4	-	-	-	-	-	2	-	-	-	-	-	-	-	-	-	-	
PMsg (6)		5	5	5	4	4	2	2	-	5	-	-	-	3	-	-	-	4	5	5	-	-	-	-	

*Public Health joined as a non-statutory member in autumn 2014 and attended both scheduled meetings.
**Public Health are not members of this group and only attended when agenda required

Appendix 3



Appendix 4 – Budget Contribution 2013-2014

Agency		Commitment sought	Percentage
Children and Young People's Service Calderdale MBC		£125,165	58.2%
Primary Care Trust/Clinical Commissioning Group		£ 80,000	37.2%
West Yorkshire Police		£ 6,925	3.2%
West Yorkshire Probation Service		£ 2,300	1.1%
CAFCASS		£ 550	0.3%
	Total	**£214,940**	**100%**

Annual Budget Breakdown

	Actual Spend	Original Forecast	Under / Overspend
Pay, NI & Pensions & Travel Costs	131,278	142,825	11,547
Chair & Board Training & Development	767	4,500	3,733
Policy & Procedures	6,063	6,225	162
Advertising	4,972	5,000	28
All Training Costs	9,018	12,000	2,982
CSCB Chair Expenses	24,810	15,000	-9,810
Case Review Work	14,551	15,000	449
Website & E-learning Costs	7,673	8,000	327
Expenditure funded by Munro Grant	46,704	46,704	0
CWDC Munro Grant not used in 2011/12	-46,704	-46,704	0
Joint Partners Contribution to Board	-90,327	-89,775	552
	108,805	**118,775**	**9,970**

Appendix 5

Calderdale Safeguarding Children Board

Business Plan 2013 – 14

(NOVEMBER 2013)

Introduction

In December 2012, Calderdale SCB met to review progress and discuss its plans for the forthcoming year. It was agreed that the plan would focus on no more than five key priorities.
It was also agreed that, whilst the plan would be drafted, that findings from the Peer Review and Ofsted inspection held at the end of 2012 would also influence it. Both of those processes, indicated that the Business Plan of the previous year was too focused on process, and would benefit from being more focused on outcomes for children and young people. Therefore, this Business Plan aims to improve on previous plans, and address outcomes more forcefully. In April 2013, the plan will be further reviewed following the reissue of Working Together 2013.
This Plan was updated in October 2013 following further inspection and discussion at the Board.

The five strategic objectives for 2013-14 are:

STRATEGIC OBJECTIVE 1:
Ensure continuous improvement in efficiency and effectiveness of the Board and its sub groups to ensure focus on its key priorities of quality assurance and challenge of safeguarding practice

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

STRATEGIC OBJECTIVE 3:
To ensure that all agencies are aware, and respond to, the specific needs of young people for support and protection

STRATEGIC OBJECTIVE 4:
Ensure effective reviews of practice are undertaken and learning disseminated and embedded

STRATEGIC OBJECTIVE 5:
To quality assure the work of the partner agencies in safeguarding and promoting the welfare of children, and challenge any areas of practice needing improvements

Sub-objectives and key actions are set out in the tables on the following pages

STRATEGIC OBJECTIVE 1: Ensure continuous improvement in efficiency and effectiveness of the Board and its sub groups to ensure focus on its key priorities of quality assurance and challenge of safeguarding practice						
SUB OBJECTIVES	**KEY ACTIONS**	**ACTION REQUIRED**	**DESIRED OUTCOME**	**BY WHOM**	**TIMESCALE**	**RAG**
1.1 Effective sub groups to ensure that SCB's key responsibility for the quality assurance of safeguarding practice is discharged	1.1.1 Clear work plan drawn up for each sub group/Task and Finish Group – focusing on priorities and quality of safeguarding 1.1.2 Review membership and purpose/ accountability 1.1.3 Review Schools Task and Finish Group 1.1.4 Review Learning and Development (L&D) sub group, and explore increased links to Adult Safeguarding Board 1.1.5 Self-evaluation by SCB of all group activities	Groups to complete SCB to complete Review progress of the group against its objectives Agree next steps Sub group to complete work mapping exercise Executive to keep oversight of groups effectiveness	The resources available to the SCB result in tangible improvements to safeguarding practice thereby benefitting children and young people	Chairs Chairs Independent Chair (IC)/ Business Manager (BM) Chair of L&D group Executive	After next sub group following SCB in February 2013 As above June 2013 After next sub group (May 2013) Sept 2013	G

STRATEGIC OBJECTIVE 2: Strengthen and further develop multi-agency understanding of thresholds for intervention and SMART planning in order to promote more effective services to safeguard children and young people							
SUB OBJECTIVES	**KEY ACTIONS**	**ACTION REQUIRED**	**DESIRED OUTCOME**	**BY WHOM**	**TIMESCALE**	**RAG**	**UPDATE**
2.1 Contribute to multi-agency work on thresholds for intervention with the outcome that children receive the most appropriate service and are kept safe	2.1.1. Ensure that thresholds for intervention are linked to the Learning and Development Programme 2.1.2 Identify key indicators linked to Early Intervention panels to evaluate changes to practice 2.1.3 Continued work to develop links with schools 2.1.4 Audit and QA sub group to monitor data at all levels of intervention	Support to establish range of different learning opportunities for all agencies Board to receive reports on trends and any causes for concern, and consider further action Continued work to develop links with schools Data on CAFs, repeat referrals for Initial Assessments repeated Child Protection Plans to be monitored. Audits to be completed and reported back to SCB	Children receive services appropriate to their needs Where children are at risk, the services recognise this and access services to protect them Improved engagement with schools	Learning and development sub group members Early Intervention Rep to Audit and QA (AQA) sub group Schools reps Audit and QA (AQA) sub group	Immediately At quart mtg	G A G R	2013/14 training plan circulated Scorecard under development Initial review completed. Further meetings with Heads scheduled for June; approach made to School Governors, regarding representation on Board Recent review of data set completed Update: The increase in volume of referrals which do not progress to further involvement indicates that these actions have not been effective and different actions required

STRATEGIC OBJECTIVE 2: Strengthen and further develop multi-agency understanding of thresholds for intervention and SMART planning in order to promote more effective services to safeguard children and young people							
SUB OBJECTIVES	**KEY ACTIONS**	**ACTION REQUIRED**	**DESIRED OUTCOME**	**BY WHOM**	**TIMESCALE**	**RAG**	**UPDATE**
2.2 Contribute to improvements in planning at all levels of intervention in order to safeguard children and young people, and support them most effectively	2.2.Continue multi-agency work on Child Protection Plans	Review of current training provision, and action plan. Continue training programme (both multi-agency and bespoke) Continue quality assurance audits to check on progress Receive reports from other audits, including those with children and young people Triangulate findings from data as for 2.1.4 by checking data on MAD system and audits regarding repeat plans, timeliness	Children receive services that they need for their welfare and protection and they receive them at a pace that recognises the brevity of childhood and the limit to opportunities to intervene effectively	Chair, Learning and Development (L&D) sub group Service Manager (SM), Safeguarding and Quality Assurance Service	Mar 2013 Ongoing, but reported quarterly following audit 2013 findings to SCB on a quarterly basis	G	Work on SMART planning underway Board to consider latest plans in April 2013 Briefings planned April onwards Update: Work on CP Plans continuing audit September 2013 shows improvement
2.3 Professionals are knowledgeable about the impact of neglect on children and are able to assess and intervene to support children	2.3.1 Continue multi-agency work to embed the neglect strategy, including promotion of the toolkit and practice guidance	Review the work programme of the task group and agree the future programme Review links with other practice developments/ groups in order to ensure that there is consistency and duplication is avoided Audit and QA (AQA) group to conduct audit of neglect cases	Children's life chances are improved by the provision of effective services to support positive parenting and overcome the effects of neglect	Prevention of Harm (POH) sub group Chair Chair, AQA group BM, CSCB	Jan2013 June 2013	G	Audit scheduled for June Update: Audit undertaken September Some improvements in SMART planning noted but agencies not recording use of toolkit and impact not clear

STRATEGIC OBJECTIVE 3: To ensure that all agencies are aware, and respond to, the specific needs of young people for support and protection							
SUB OBJECTIVES	**KEY ACTIONS**	**ACTION REQUIRED**	**DESIRED OUTCOME**	**BY WHOM**	**TIMESCALE**	**RAG**	**UPDATE**
3.1 The findings of the eHNA are used to focus work to improve outcomes for young people	3.1.1 Board reviews findings and agrees multi-agency response Representation/ involvement of schools increased 3.1.2 Wider engagement with children and young people 3.1.3 Improved communication with all partners 3.1.4 Board is kept informed of agency developments that impact on multi-agency arrangements	Review action plan, to cover issues identified by young people, e.g. cyber bullying, self-harm Identification of and joint work on projects particularly with schools Continued planning of projects with Young Advisory Group Increased link with schools council network Review of action plan arising from Thematic Review in 2012 All Board meetings/ sub groups have communications question on agenda Board reps to ensure that short updates are provided to the Board through the Board or sub groups (e.g. progress of Child Health Programme, Clinical Commissioning Group)		IC, BM, CSCB Schools reps As above BM, CSCB SCR sub group LGS All	June 2013 Ongoing Ongoing June 2013 Immediately Immediately	G	Scheduled for June LSCB Events planned to target Schools on CSE Conferences on working with teenagers, self-harm, bullying, young parents also planned Action plan being reviewed by SCR sub group Incorporated into standard agenda Health update requested for April LSCB MASSTT development reported to Executive March 2013

STRATEGIC OBJECTIVE 3: To ensure that all agencies are aware, and respond to, the specific needs of young people for support and protection							
SUB OBJECTIVES	**KEY ACTIONS**	**ACTION REQUIRED**	**DESIRED OUTCOME**	**BY WHOM**	**TIMESCALE**	**RAG**	**UPDATE**
3.2 Prevention and disruption of Child Sexual Exploitation (CSE), and support to victims remains a priority	3.2.1 SCB to coordinate benchmarking exercise using Bedfordshire assessment tool	Terms of reference for operational group to be refreshed following benchmarking Establish areas for development and create action plan Links to work with young people who go missing to be strengthened	The community including both services and families are aware of the dangers, the support available to them and that action will be taken to protect victims and prosecute offenders	CSE Strategic Lead/CSE Strategic Group report to SCB	Next sub group (May 2013)	G	Bedfordshire audit completed March 2013 CSE Strategy in process of review to complete April 2013 National advertising campaign underway
	3.2.2 Continued development of Operational and Strategic Groups 3.2.3 Links to regional and national work to continue 3.2.4 Agencies are aware of the warning signs of CSE, know how to respond and offer support to young people	Discuss opportunities for regional communication strategy on joint interest areas, e.g. CSE Attendance at relevant meetings to ensure information relevant and timely Robust learning and development programme Take-up to be monitored Communication strategy to be developed to ensure greater agency and public awareness of the vulnerabilities of young people	There is zero tolerance of this abuse within Calderdale As above As above Awareness of CSE and its warning signs is demonstrated across agencies, evidenced by operational practice	IC, CSCB CSE Strategic Lead/CSE Strategic Group report to SCB CSE Strategic Lead BM, CSCB WDO, CSCB Chair LD sub group Chair, Communication sub group	Ongoing Ongoing Quarterly reporting to Learning and Development Group June 2013	G R	Regional meetings ongoing West Yorkshire Policy and Procedures agreed West Yorkshire collaboration on master classes Warning signs document distributed across all agencies Feb 2013 Campaign of community awareness needed but not yet underway Update: National advertising campaign underway

STRATEGIC OBJECTIVE 4: Ensure effective reviews of practice are undertaken and learning disseminated and embedded							
SUB OBJECTIVES	**KEY ACTIONS**	**ACTION REQUIRED**	**DESIRED OUTCOME**	**BY WHOM**	**TIMESCALE**	**RAG**	**UPDATE**
4.1 Case reviews and audits both within agencies and on a multi-agency basis continue to inform the work and priorities of the SCB Reviews will be conducted both by agency staff and by independent reviewers	4.1.1 SCR sub group to identify cases for review 4.1.2 Reviews of cases that do not meet the criteria for SCR to be reviewed including examples of good practice 4.1.3 New methodologies for review to be tried 4.1.4 Results of audits and internal reviews to be fed back to the SCB to inform planning and learning	Reviews are undertaken and recommendations directly linked to the relevant sub group for action on training/practice developments etc. Learning to be disseminated via existing communication strategies	The Board and all its partners learn from practice and continue to develop so that services provided to children improve and continue to improve services that render children safer as well as providing them with help that improves both their childhood experience their life chances	IC, CSCB	Review June 2013	G G	All referrals discussed at SCR Panel All resulting actions fed into relevant sub group Two reviews ongoing that do not meet SCR criteria A variety of review methodologies have already been used and sub group is meeting in May to consider implications in revised WT All SCR outcomes reported to LSCB and recommendations built into action plans

STRATEGIC OBJECTIVE 5: To quality assure the work of the partner agencies in safeguarding and promoting the welfare of children, and challenge any areas of practice needing improvements						
SUB OBJECTIVES	**KEY ACTIONS**	**ACTION REQUIRED**	**DESIRED OUTCOME**	**BY WHOM**	**TIMESCALE**	**RAG**
5.1 Quality Assurance framework is applied systematically and informs priorities 5.2 LIF ensures that learning is identified and disseminated	5.1.1 Agree QA framework 5.1.2 Apply QA framework 5.2.1 Agree LIF 5.2.2 Apply LIF	CSCB agree proposed framework; apply QA framework; reflect on recommendations from previous QA work; identify outstanding issues and include these for further action CSCB agree proposed LIF; apply LIF - generate learning from different methodologies; feed learning into relevant sub groups for action as required; Disseminate learning via training, briefings, reports, reflective practice sessions etc.	Agencies are clear about improvements required Areas of priority feed into next year's Business Plan Safeguarding practice improves All agencies receive consistent messages regarding good practice and areas for improvement based on current learning Safeguarding activity improves	CSCB QA Sub group BM CSCB Learning and Development sub group, WDO, Communication and Communities sub group	Review March 2013	G

Appendix 6 - CSCB Outline Interim Business Plan 14/15 Draft 1 (March 2014)

Introduction

The Board has agreed to the following:

- Lead role in respect of key safeguarding elements of SIIP (14) in the context of revised governance arrangements and relationships; and
- The need to be expedient and pragmatic in 'catching up' as an effective Board regarding overall core functions and priorities to ensure and be assured that joint working arrangements to protect children and promote their welfare in Calderdale are effective, responsive, partnership-based, child and family centred and are able to demonstrate that the Board and its members can account for and will be held to account for how these arrangements are working, how they can work better and how as a Board we will know this.

This Interim Business Plan reflects consultation and analysis to date and reflects the 'must do' actions as opposed to the 'it would be nice to do' actions.

This has direct implications for Board members and their staff in terms of their engagement with joint working arrangements both strategically and operationally in terms of priority, cooperation and collaboration, and the capacity to, on the basis of a common evidence base and a clear way of using this, and being prepared to challenge the overall fit and effectiveness of the way we do things.

The Interim Business Plan does not at this point reflect the significant learning that the three current Serious Case Reviews will identify and this will be both a test of and an opportunity for the Board. Board members and their organisations are to demonstrate how collectively we can respond to and improve upon things that need to be improved. As this will be conducted, appropriately given the role of the Board in the public arena, this will require us to be clear, focused, transparent and united.

This Interim Business Plan therefore serves to build on the high levels of collaboration that exist, but provide a clearer focus and identify the key leadership role that Board members have.

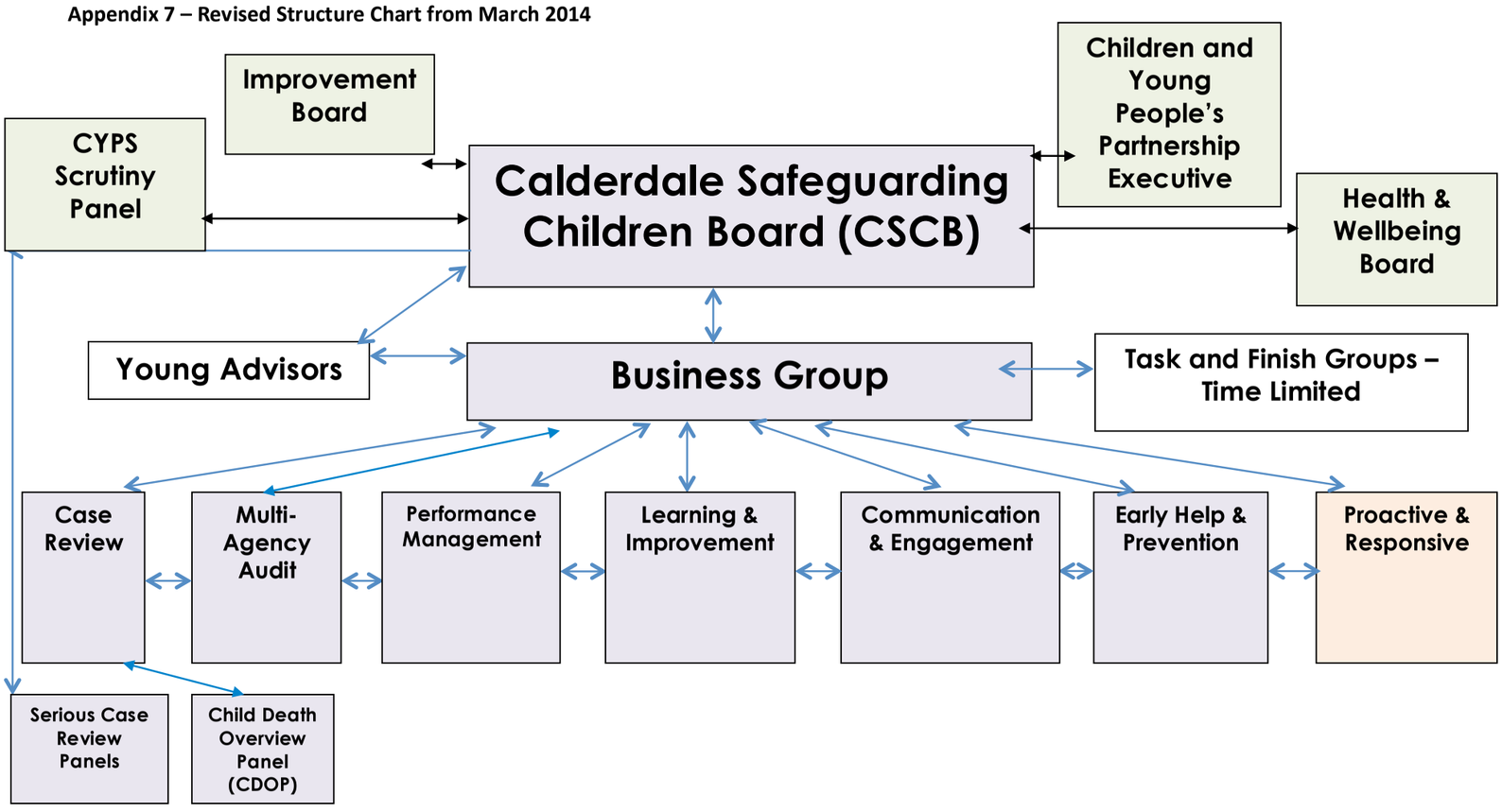
It is also timely and positive in terms of the changing and developing role of LSCBs that we will be able to benefit from the new Ofsted review of LSCB; and the Interim Business Plan has been developed with this in mind.

Priority	Key Outcomes
1. Review and set clear core business processes regarding meetings/minutes and actions	- Agendas planned and reflect core business/priorities - Agendas meet requirements to evidence standards and Ofsted evaluators - Planned 12-month rolling programme of scrutiny reports - Revised minutes to reflect and set evidence base for above - Revised minutes to capture: Board decisions; Board actions; actions for members - Revised minutes to demonstrate continuity and follow through - Minutes to be posted on website
	- CSCB standards and protocols for reports and submission/circulation to be published and form a measure of effectiveness - Calendar of meetings to be published for members and public - Chairs and membership to be compiled and profiled re: multi-agency representation and skills/interest match
2. Review and realign CSCB sub groups to demonstrate fit with core functions and priorities	- Form and agree terms of reference for Business Group - Consult with each current sub group Chair regarding current priorities and objectives and to agree revised priorities and objectives - Each sub group to produce a clear plan for this - Business Group to coordinate the above and complete Interim Business Plan - All sub groups and members to have clear terms of reference and understanding of how what they do fits with other sub groups - Process and activity are focused on core functions and priorities, and demonstrate effectiveness - Identify what additional support and training are required to manage the above - Publicise rationale and progress regarding the above - Identify key performance and impact measures
3. Establish routine and focused scrutiny of performance information to establish effectiveness of joint working arrangements across the child's journey	- Identify core performance indicators and analysis for immediate consideration and scrutiny by the Board - Review past scrutiny of performance information and identify links of this to actions regarding further enquiry and challenge - Review priority being given to current PM/alternative measures to assess short and long-term options - Implement clear action plan and consider resources/personnel required to achieve this
4. Finalise and publish a Performance Management and Quality Assurance Framework to tie in with 5	- Review and reassess work done to date - Consider interim framework to reflect Interim Business Plan and intended shift in focus - Link to immediate actions in 3 - Clear and accessible for all; setting out of how we do things - Ensure that Board is fully engaged and owns end product
5. Finalise and publish a Learning and Improvement Framework to tie in with 4 & 12	- Review and reassess progress to date - Consider interim framework as per 4 (e.g. SCR) - Has to be clear and accessible, setting out - this is how we do things - Board needs to own and agree
6. Bring forward and introduce CSCB Assessment Protocol in conjunction with 7 & 8	- Identify present position regarding this - Clear plan and timeline for introduction and agreement in principle by Board
7. Identify and confirm LAs intentions regarding the introduction of Single Assessment (and Early Help Assessment)	- Consult with LA - Agree Board date for consideration of recommendations - Agree process for supporting, challenging, fitting in, risk managing and evaluating implementation - Demonstrate clear fit with Board role and 6,8 & 9
8. Reconsider and revise in the light of 6, 7 & 9 CSCB information and guidance re 'continuum of need' and	- Review and reassess re-accessibility, current fit, take up to date, link with wider Early Help Strategy and realignment and reorganisation of EIP and MAST - Identify reviews and take to Board for formal approval - Identify as required, further efforts and measures to promote this ref 20 and this Business Plan

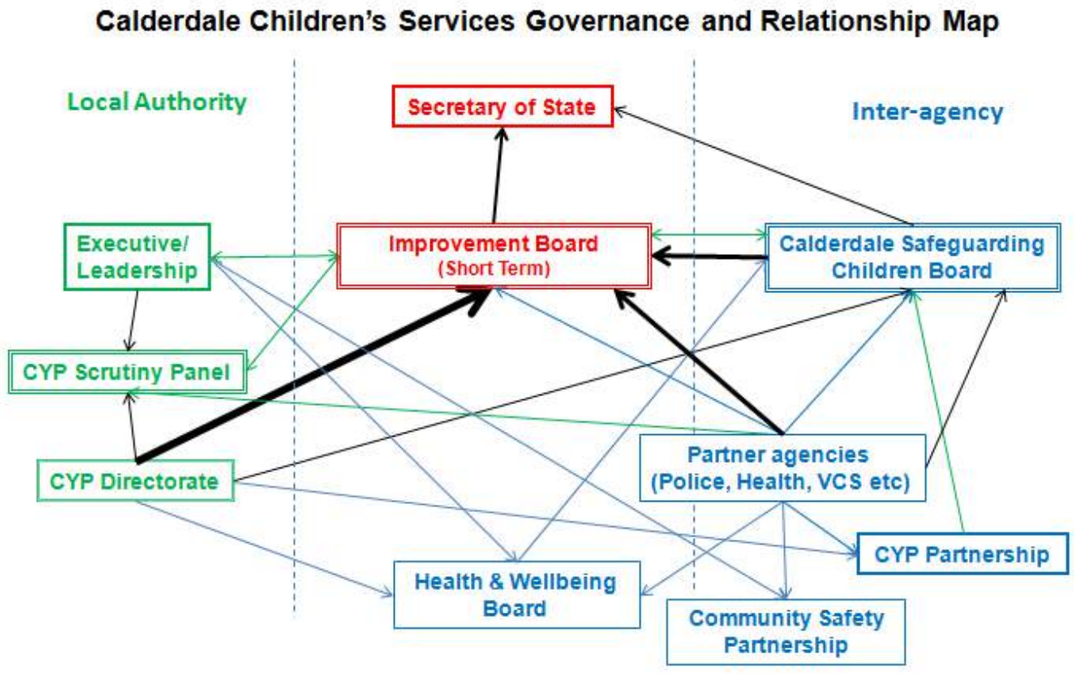
'thresholds'	
9. Review current arrangements (multi-agency and LA) for management of referrals re Early Intervention Panels and MAST and link to 7 & 8	- How well is this working and how do we know this? - Are the objectives and definitions clear? - Is the CSCB role in relation to pathways and the child's journey clear enough? - Is sufficient detail about plans and risk management available from partners who lead on this? - Produce an assurance and direction/options paper for Board to consider The assessment and analysis has already commenced with the following actions: - Further clarification and development of relationships and governance arrangements - Dialogue with CYPPE in order to contribute to the above and focus shared priorities around service development and commissioning across universal/preventative/Early Intervention and Early Help steps in child and family's journey in order to ensure that capacity and resources are strengthened to identify and respond to needs and risks within shared approach and common ways of working - Dialogue with CSC regarding introduction of Single Assessment and what opportunities this creates to further strengthen Early Help/CAF and effective joint working responses to risk and neglect - Immediate revision of CBSC performance monitoring, analysis/commentary and Board-led scrutiny/action - Commissioning of Sect 11 audit/self-assessment for 13/14 to start to underpin annual scrutiny of core aspects of joint working arrangements which should in future (14/15) reflect partners and organisations engagement with and assessment of impact regarding interface between universal services/Early Help and MAST arrangements - Commissioning of specific Task and Finish Group to prepare and present report to May Improvement Board
10. Review and amend current polices and procedures in light of 6, 7 & 8	- Ensure regular audit and updating - Do we know they are used, if so how? - Do we have evidence that there are gaps or they are not being used? - If so what are we doing about this? - Appraisal and action plan paper for the Board
11. Review and revise 14/15 multi-agency training programme to reflect 4 to 10	- As per Feb Board minutes - Planning now for 15/16 - Robust overview and monitoring arrangements identified and in place
12. Review case review function regarding 5	- Establish clear terms of reference and objectives for sub group - Map and publish current process for managing case review - Identify options paper and action plan regarding future use of systems methodology - Identify and clarify commissioning and QA role of Independent Chair - Establish effective relationship with National Panel and DfE officials - Establish strong links with regional and national sources of learning and sharing - Identify clear process and hierarchy of review as per WT2013
12A. Case review immediate	- SCR (1) establish clear scrutiny and QA process involving IC prior to Board consideration - Special Board to be convened for final consideration alongside draft Board response proposal - Clear pre-publication strategy in place (legal/redaction/liaison with DfE/media prep/all relevant partners on Board and signed up) - Clear timeline for publication and action plan
	- SCR (2) Finalise terms of reference and commission of Lead Reviewer to involve IC - Appoint independent Panel Chair; establish clear terms of reference and process for oversight and management of process - Advance planning for publication - Clear review points regarding process and wider learning to inform ongoing revision of 5
12B. Case review immediate	- Review current multi-agency audit programme and amend to address priority and delivery criteria i.e. need ongoing programme urgently with key reports into Board that result in judgement/further action as required - Longer-term programme established to reflect Board priorities and core functions/measures of Board effectiveness - Identify these asap
12C. Case review immediate	- Child D
12D. SCR Framework	- Sub group to consider framework and comment before March sub group - Final draft framework to be presented to April Board if ready
13. Multi-agency training programme and strategy 14/15 to 15/16	- Bring forward detailed proposal as per Feb Board requirements to evidence intended impact/how this will be measured/risk management/reporting points and how the programme contributes to CSCB priorities, core functions and learning - Establish robust ongoing process to embed MAT within Board governance and effectiveness cycle/measures - Identify longer-term objectives regarding link with Sect 11 audit and single-agency provision - Link this into a position on PMQA of workforce requirements and CSCB contribution to workforce development and management across partners
14. Sect 11 audit	- Immediate undertaking of Sect 11 audit as per Board/IC decision - Identify fit for purpose format and issue with guidance and support - Identify ways in which returns will be analysed, reported on and shared/challenged - Ensure that results and impact are identified in time for preparation of Annual Report for 13/14 - Identify longer-term strategy for ensuring this is an annual self-assessment and assurance exercise extending to all providers and people that work with children and young people in Calderdale
15. Annual Report 13/14	- Identify and seek Board agreement to timeline and process - Decide regarding process and requirements - Use Annual Report to help establish long and short-term improvements and progress
16. Preparation for Ofsted review	- Identify clear action plan for self-assessment and preparation, cross-referencing to Board improvement agenda and effective Board benchmarking - Identify risks and mitigate - Risk register
17. Improvement Board	- Agree CSCB lead on SIP actions relevant to CSCB role and purpose - Ensure that CSCB improvement/effectiveness agenda reflects this - Identify and plan for key reporting points - Identify other ways of strengthening relationship, challenge and assurance - CSCB PMQA function has to directly evaluate and report on IB measure of progress and vice versa - Evaluate appropriateness of which roles LSCB should assume post IB
18. CYPPE	- Identify key areas of shared priorities and objectives - Formalise actions for CSCB and incorporate into this plan and forward cycle - Identify and plan for key reporting points - Identify other ways of strengthening relationship, challenge and assurance

19. CSCB accountability and demonstrating relevance	- Review current strategy and objectives, and revise to reflect this Business Plan - Identify and establish all reporting into and reports from points across the child's journey and schedule into calendar and Board agendas - Complete revision of website to reflect this Business Plan and revised key messages regarding: What the Board is and is not; what it does and does not do; how it works; key functions and principles; the different forms of evidence we draw on and how we do this; the role of individuals, groups and professionals/organisations to take responsibility for safeguarding and joint working and what this means; key responsibilities regarding recognising neglect, actual and potential significant harm and abuse; knowing what to do and who to talk to; being sure that they will be responded to appropriately and that timely action will result, and so on
20. Involvement of children, young people and their families/community engagement and ensuring that joint working is child centred	- CSCB has a clear position on where it is and wants to be regarding how it ensures child centeredness in joint working arrangements and how it involves children, young people and their families in what it does - Review and assess present position and main options – draw up options paper and outline strategy for each option - Ensure that all guidance and outputs reflect child centeredness

Appendix 7 – Revised Structure Chart from March 2014



Appendix 8 - Relationship and Governance Map



Key: Double-lined box indicates governance function.
Relative thickness of connecting lines indicates level of accountability

Governance relating to Children and Young People's Services, with particular preference to Children's Social Care and the wider Children and Young People's Partnership.

Calderdale MBC Children and Young People's Scrutiny Committee

- This committee provides scrutiny and public accountability to the entire range of CYP functions (Education, Early Help and statutory Social Care), as its primary function. As part of this responsibility there may be scrutiny and comment on the role of partners, particularly schools. This committee may request reports from LSCB and IB.

Calderdale LCSB

- This Board provides support and challenge, in relation to the work of the entire CYP partnership, as it relates to all aspects of agencies' safeguarding functions, including: Serious Case Review. The LCSB holds all partners to account equally.
- This Board is accountable for its work to the Improvement Board while it remains in place and is preparing to continue the work of the Improvement Board, once disestablished.

Calderdale Social Care Improvement Board

- This Board is responsible for ensuring that all aspects of Social Care work with children are improving with specific reference to those concerns detailed in the DfE improvement notice. This is primarily concerned with the Council's Children's Social Care function, though the work of all partners as they perform their safeguarding role is also of concern to the Improvement Board.
- All partners and the LCSB itself are accountable to the Improvement Board for their work in this regard. Once the improvement notice is lifted the role and function of the Improvement Board will revert to the LCSB.
- All three Boards will maintain a strategic planning and information sharing relationship with both the CYPPE and the HWBB.

Appendix 9 – How we understand the needs of children and young people in Calderdale from the Joint Strategic Needs Assessment data in 2013

Children and young people under 20 years comprise a quarter (24.5%) of the Calderdale population, with an estimated 48,101, 0 to 18-year-olds and 64,100, 0 to 25-year-olds in 2012. Just over a fifth (21.3%) of school children are from minority ethnic groups. The recent JSNA updates, several years of local school health (eHNA) surveys together with national benchmarked datasets[123], indicate some marked improvements for the health of children and young people in Calderdale as well as some persistent challenges.

- Child poverty levels are similar to the England average with a fifth (20.9%) of under-16-year-olds living in poverty in 2011. Rates of family homelessness are better than the England average.
- Less than half (45.2%) of children achieved a good level of development by the end of reception in 2013 (school readiness), which was worse than England average.
- GCSE achievement was better than the England average in 2012/13, with two-thirds (65.7%) gaining at least five GCSEs at A* to C grade including English and Maths.
- The proportion (5.9%) of 16 to 18-year-olds who were not in education, employment or training was similar to the England average in 2012.
- In 2013, the majority (96%) of young people in Years 7/10 report their health as 'good' or 'OK'. Just over a quarter (26.2%) reported having one or more common illnesses, with asthma the most common (12.9%). During 2010/11, 5.1% of total emergency admissions for under-19s in Calderdale were related to diabetes, epilepsy or asthma.
- Prevalence of smoking, drinking and drug taking in Years 7/10 has been reducing in recent years: by 2013, 6% were regular smokers and 17% regular drinkers. Alcohol-related and substance-misuse-related hospital admissions are worse than the England average but the former has reduced.
- Levels of obesity were similar to the England average in 2012/13 (8.3% of 4 to 5-year-olds and 17.6% of 10 to 11-year-olds are obese in Calderdale) but there has been some improvement in the proportion of older children overweight and physical activity levels have increased.

[1] ChiMat (2014) Child Health Profile for Calderdale, March 2014
[2] ChiMat (2014) Child and Young People's Health Benchmarking Tool, January 2014
[3] Atlas of Variation in the Health of Children and Young People, 2013

- Breastfeeding initiation in 2012/13 was better than the England average but by 6 to 8 weeks of age; it had deteriorated to below average.
- Dental health of children in Calderdale is significantly worse than the England average: in 2011/12, two-fifths (39.2%) of Calderdale children aged 5 years had one or more decayed, missing or filled teeth.
- Teenage conception rates have reduced and by 2012 were similar to the England average, although the proportion of deliveries in 2012/13 where the mother is under 18 years (1.7%) is worse than England average.
- Nearly half (46%) of young people have experienced bullying but the proportion of bullying others (14%) has reduced.
- Prevalence of self-harm has been rising: by 2013, 20% of Years 7/10 have ever self-harmed with rates highest in Year 10 girls (32%). In 2012/13, hospital admissions as a result of self-harm (10 to 24 years) were worse than the England average although mental health admissions (0 to 17 years) were better.
- Infant and child mortality rates were similar to the England average for the period 2010-12 however the rate of 0 to 15-year-olds killed or seriously injured in road traffic accidents was significantly worse than the England average in 2010-12 as were hospital admission rates caused by injuries for children (0 to 14 years) and young people (15 to 24 years) in 2012/13.
- 1278 of the Years 7/10 surveyed in 2013 identified themselves as young carers and 237 young carers 8 to 15 years old were known to Young Carers Services.
- Numbers of looked after children (LAC) in Calderdale have been reducing in recent years; by February 2014, there were 327 LAC and overall indices such as immunisation rates and attainment, as well as the proportion receiving annual health assessment and dental check, are better than the England average.
- In December 2013, 1453 children and young people aged 0 to 19 years resident in Calderdale were accessing services for children with disabilities within Calderdale, which would equate to 2.9% of the Calderdale population aged 0 to 19 years.

For more information please contact:

Web: www.calderdale-scb.org.uk

Tel: 01422 394074

Calderdale Safeguarding Children Board