Calderdale Safeguarding Children Board

Annual Report 2015/16

Calderdale Safeguarding Children Board

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2. Independent Chair's foreword and Executive Summary

Welcome to our annual report, and this is third report since I had the pleasure of becoming Independent Chair in 2014. This year has seen continued progress being made by partners, in ensuring effective outcomes for children and young people are achieved, especially when in need of help and protection.

The report seeks to summarise and evidence two things;

1. Firstly, the basis on which partners are able to form a view as to the sufficiency of joint working arrangements in Calderdale, and

2. Secondly, to demonstrate how as a Safeguarding Board partnership we have been able to progress the things we feel have and will make a difference in order to make sure that children are safe and supported. (This is also measured against current inspection benchmarks and current research.)

This report has therefore to establish and evidence the basis of how the latter has enabled the former to be determined.

It is the conclusion of this report, that the joint working arrangements continue to be robust and that they demonstrate the capacity for continued development and improvement.

It recognises that as a safeguarding partnership we are at the point where we have the capacity and capability to provide objective scrutiny of joint working arrangements, the impact this has on children and to be able to challenge each other when the evidence indicates that outcomes for children need to be improved.

The capacity of the safeguarding partnership to set standards and hold partners to account is an important and essential element of a safe and resilient system for joint working arrangements to protect children, and the report evidences continued progress in this respect.

The report does not conclude that there are grounds for complacency as partners and the system remain under pressure and the very nature of child protection is fragile and dependent on difficult judgements. The current wide-ranging proposals for services for children currently being considered by parliament may also be a reason for caution.

The report highlights the important steps that are being taken across strategic partnerships to integrate priorities and improve integration at both a strategic and an operational level and sets this as a priority going forward.

It also identifies the key steps and learning that the partnership will need to act on to further shape, inform and develop its overview and scrutiny of how well people are working together to protect children across early and statutory interventions.

The report shows how partners have positively responded to a challenging and changing environment and have maintained their commitment to the partnership.

It is unlikely that the factors that drive change will lessen and therefore partners will need to continue to operate within a complex and dynamic environment, making sure that the 'balances and the checks' provided through the safeguarding partnership remain a priority.

The recently published government review of Local Safeguarding Children Boards indicates that there will be an opportunity in the coming years to look at whether there are other ways in how we ensure that there is assurance that joint working arrangements to protect children are effective and that the risk of error is well managed.

The report, as with previous reports, demonstrates the partnership's commitment to transparency, how it recognises and is able to learn from things that did not work out as well as was intended. It also demonstrates that where an area of joint working practice has required formal review,

that partners have undertaken this on the basis of a thorough, independent, objective basis, have published the findings and acted on the recommendations. The report also provides evidence of achievement and success.

Partners are responsible for the services they provide, but also in this context for how they come together as a partnership with a purpose. The report therefore focuses on the discharge of statutory responsibilities, as the core business.

The staff that support the Board and staff partners to take part in the Sub-groups have worked hard to shape the purpose and develop the approach and evidence base. Without them the partnership would not be able to achieve an objective and clear line of sight into and across practice. The report highlights the need to maintain, support and develop this capacity and capability in order to underpin continued improvement.

Partners that form the Board reflect the breadth and the complexity of the safeguarding landscape. The report demonstrates positive and proactive steps taken to ensure that the role of Board members is supported and focused on both their collective and individual role. There has continued to be an emphasis on the requirement for them to implement decisions and agreements within the areas they lead and are responsible for.

The report also evidences how partners have maintained their commitment to put in place a different approach to how standards for safeguarding have altered, on the basis of self-assessment and openness to challenge. During the year there was continued development in achieving more of a 'whole-system view and perspective', and an improved understanding of the different places and roles partners hold. This has strengthened the wider view as well as internal and local governance arrangements in respect of an increased capacity to account for safeguarding standards.

Along with other developments, achievements and learning have highlighted the importance of the need for partners to continue to work to articulate, communicate and develop a more shared and joined-up approach to safeguarding at all levels.

This report shows how the partnership has continued to take steps to improve its own effectiveness, as judged by external evaluation or by the learning from when practice does not result in the best outcomes for children. But also on the basis of an agreement of what 'good' looks like and having the means and ways to become clearer about this.

During the year partners have listened to what children say, and sought their active involvement in testing out and informing some of the things the partnership felt to be important. It has been recognised that partners, within their own services increasingly focus on outcomes for children and how they hear the 'voice of the child'. In the coming year whilst maintaining the relationship with 'Young Advisors' as a partnership, we will work collectively across Calderdale with others to promote an integrated response to enabling children and young people to influence strategic priorities and for joint working practice to become more child-centred.

The learning from the past year also signals the need for the partnership to be stronger about the key points in a child's journey through services where protection and joint working are most important. It also has to make more relevant the guidance and support it provides to the wide range of professionals and agencies, especially as these roles develop.

The report highlights key learning about and therefore the need for the partnership to develop its focus on early help and intervention arrangements, the promotion of the 'child's journey' and its focus on 'child protection' across this journey.

Equally, the report raises a further challenge to consider the learning from the response to children who are, or at risk of being, sexually exploited. This will require continued attention to both strategy and operational outcomes within both the local and West Yorkshire context. It also highlights the need to further recognise and respond to the significance of children missing from home, care and education. When this is looked at through the lens of 'neglect' we might reasonably conclude that in the coming year(s) children 'missing from sight' are going to be an important driver for how the partnership focuses on vulnerable children in Calderdale.

It is also reasonable to consider whether the learning in terms of practice has implications for other parts of the child's journey and, correspondingly, the joint working. Given that sharing information and using this to make decisions has always been a central part of protecting children, the learning from Child Sexual Exploitation along with the increased importance of early help may give cause to consider whether there are opportunities to look at new ways of managing the child's journey.

In either case the report indicates a need to focus in on early help, the significance of 'front door' arrangements and the dialogues partners have when sharing information to reach positive outcomes for children. Positive attributes such as the approach to thresholds can sometimes inadvertently serve as a barrier or a risk.

The partnership has a key role in stimulating and informing dialogue and decisions that will be considered by others in terms of how early intervention is supported and resourced. For the safeguarding partnership, early intervention represents the opportunity to be assured that children are protected and if necessary rescued at an early point. The report highlights the need for the partnership to be sure that these arrangements are robust and sustainable. It also indicates that there are opportunities to develop how we understand partnership working in this context. It requires the partnership to address risk in ensuring that all partners are able to maintain the pace, quality and resilient relationships to build on current success.

The continued reconfigurations of the wider architecture along with pressure on resources, has further evidenced the partnership's capacity to recognise and respond to risk. As the relationship between partnerships strengthens, the Children and Young People's Strategic Framework and priorities are refreshed, significant areas of services are reset and recommissioned. It is therefore likely that this will continue to be the case. This is compatible with the stated ambition to become more strategic as a partnership.

The report confirms that if partners continue to strive to improve communication, quality of scrutiny and analysis will improve, as will the focus on core business and what 'good' looks like. The report identifies some of the key areas and choices that may need to be considered, to maintain trajectory and improvement.

The report provides encouragement, that being able to see things from the child's (and their family's) point of view, is at the centre of how partners approach safeguarding. The challenge for the partnership is how to progress this.

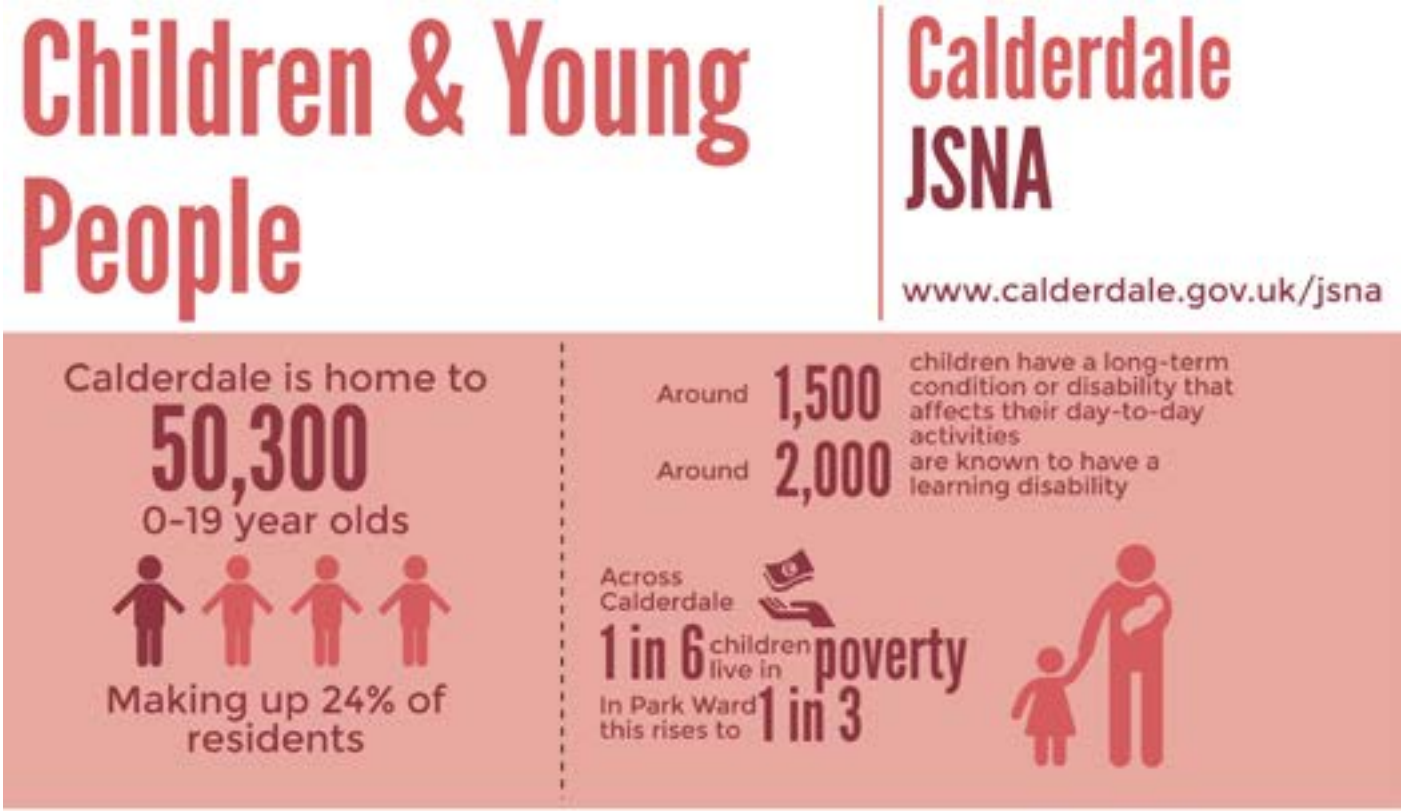
Reports such as this have to speak to a wide audience and do not easily lend themselves to answering every question or seeing things from everyone's point of view. We have tried to address this but understandably some of the language and things the report talks about are technical and particular to some areas of interest.

This means we will continue to promote conversations around the work of the partnership and it is hoped that this report, summing up as it does the achievements, progress and learning will help with this.

On this basis and from this perspective I hope that you will consider the report and that it will contribute to strengthening confidence in and informing the future direction of how we all work closely together to protect children in Calderdale.

Richard Burrows
Calderdale Safeguarding Children Board
Independent Chair

3. Safeguarding in Calderdale: context and overview

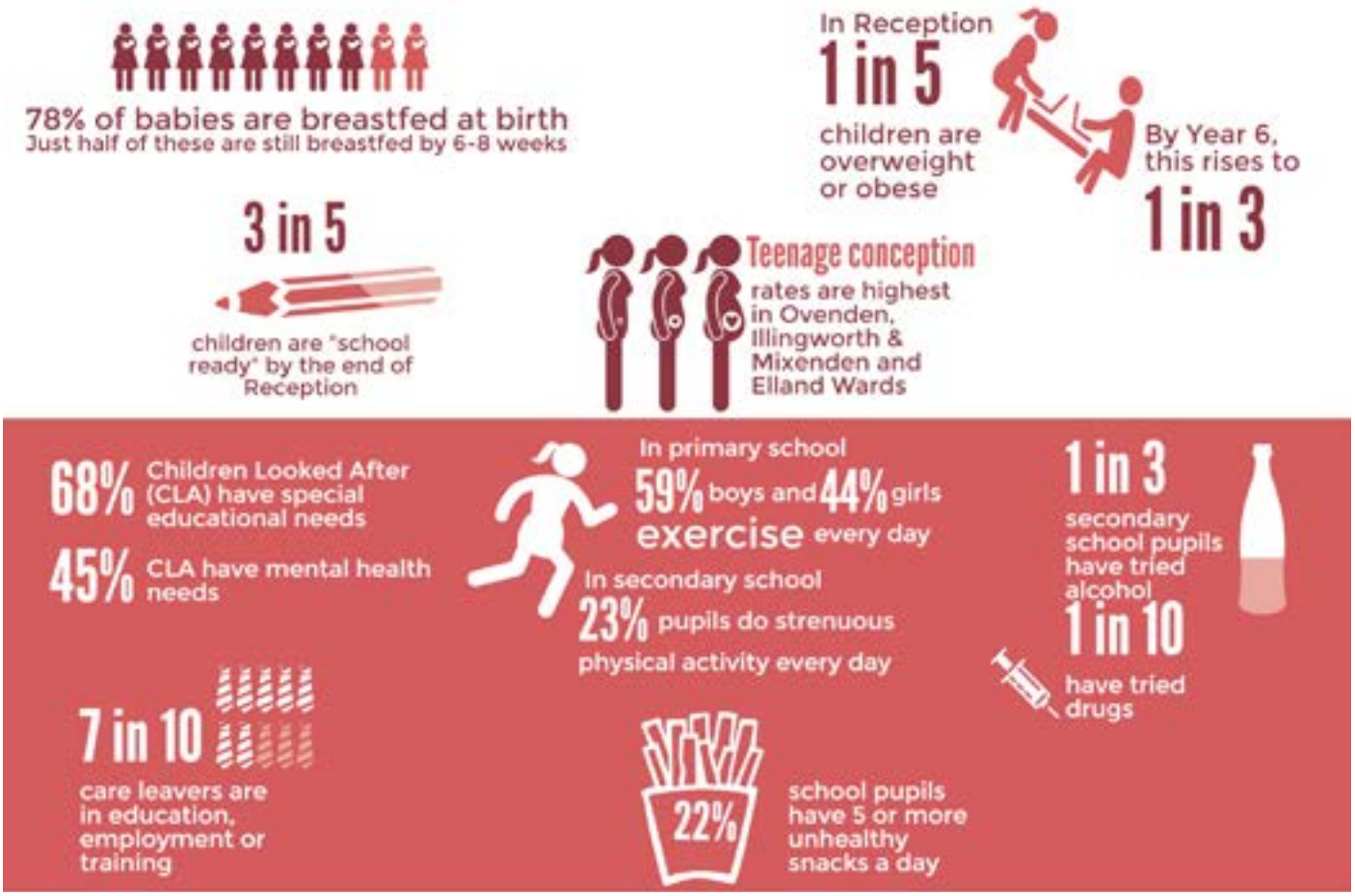


Calderdale is one of the smallest districts in England in terms of population (207,000), but one of the largest in terms of area. Over four-fifths of the Calderdale area is described as rural by the national census 2011 but over three-quarters of the population live in urban areas.

The largest ethnic group in Calderdale is White British (88.7%), as recorded in the national census 2011. The second largest ethnic group is Asian/Asian British (8.3%) of which the majority (6.8%) is Pakistani. The Asian ethnic category accounts for 15.6% of nought to four-year-olds and 13.4% of five to 14-year-olds.

21.4% (one in six) of children aged under-15 in Calderdale live in families that are income deprived (IMD 2015). However, this varies significantly with some wards as high as 38.1% (one in three) living in poverty, and some wards as low as 7.9%. In Calderdale, the South Asian population is particularly concentrated in the most deprived wards and according to the Office of National Statistics 2015, the child population within this group is forecast to grow.

There are 110 schools in Calderdale, 28 academies, one free school and six independent schools. There are also two education colleges. Schools perform well and are generally improving the achievements and attainments reached by their pupils. We know that in 2014-2015, 100 children were educated at home. (Appendix 6 shows the Ofsted judgements of educational establishments in Calderdale.)


78% of babies are breastfed at birth
Just half of these are still breastfed by 6-8 weeks
In Reception
1 in 5
children are overweight or obese
By Year 6, this rises to
1 in 3
3 in 5
children are "school ready" by the end of Reception
Teenage conception
rates are highest in Ovenden, Illingworth & Mixenden and Elland Wards
68% Children Looked After (CLA) have special educational needs
45% CLA have mental health needs
In primary school
59% boys and 44% girls
exercise every day
In secondary school
23% pupils do strenuous physical activity every day
1 in 3
secondary school pupils have tried alcohol
1 in 10
have tried drugs
7 in 10
care leavers are in education, employment or training
22%
school pupils have 5 or more unhealthy snacks a day

4. What children and young people have told us

Increasingly all partners are able to evidence how they decide what to do; and how they improve the quality and impact of what they do, as informed by dialogue with, and the participation of, the children and young people they work with. This is something the partnership will support and promote in the coming year.

Young Advisors have supported and advised the safeguarding partnership, who have in turn drawn on: the electronic Health Needs Assessment (eHNA), which is an annual survey carried out across schools by Public Health; children and young people who work with the Council; children who are looked after by the Local Authority (LA); and national work carried out by the Office of the Children's Commissioner. As a result we have a good idea of some of the things that matter to children, which means that as we go forward we are better able to balance what matters for adults and what matters for children when it comes to deciding where as a partnership we should focus.

There remains more work to do. Partnerships and partners are recognising that bringing together what children tell them and how this helps them to prioritise and improve what they do will benefit from continued priority in the coming year.

Children and young people have shared with us some of the following key messages which have given us cause to change some things, and more importantly how we see things:

- How they know about what help and services are available is important, especially as they place some priority on social media and online access
- Bullying continues to be an important issue
- Children that often run away are more likely to have significant reasons for doing this that reflect what we know about abuse and harm
- That children who engage in behaviours and activities that adults are likely not to approve of are more likely to 'keep secrets' and are more likely to be harmed
- That self-harm is likely to be a significant indicator of other forms of harm and grounds for concern
- That children and young people value opportunities to be listened to and understood

This means that in the coming year we will focus more on when and why children go missing and children who may be missing from sight. We will also support the development of improved services for children's mental and emotional wellbeing, whilst making sure that when there is a concern this is acted on quickly, information is shared and used across professional and organisational boundaries so that informed judgements can be made. This will also mean that we target some of our key messages and work with other strategic partnerships to support some of the priorities set out in the next section

5. Local priorities and what we are aiming to improve for vulnerable children and young people in Calderdale

Partners in Calderdale have signed up to the following strategic priorities through the Children and Young People's Partnership Executive (CYPPE), which underpin and drive partnership working, so that children and young people in Calderdale:

1. Start healthy and stay healthy
2. Are safe at home, in school and in the community
3. Enjoy learning and achieve their best
4. Make friends and take part in activities
5. Stay in education and get a job

For the safeguarding partnership our efforts are directed by Priority 2 (above): "Children are safe at home, in school and in the community", this means we want to:

- Increase the number of children and young people who feel safe at school
- Increase the number of children and young people who feel safe in the community
- Increase the number of children and young people who feel safe online
- Decrease the number of children and young people who are at risk of child sexual exploitation
- Support family and community resilience to keep children and young people safe within their families
- Reduce the harm caused to children and young people through domestic violence, parental alcohol abuse and mental health

Some of the background for these local priorities and how the safeguarding partnership contributes to these

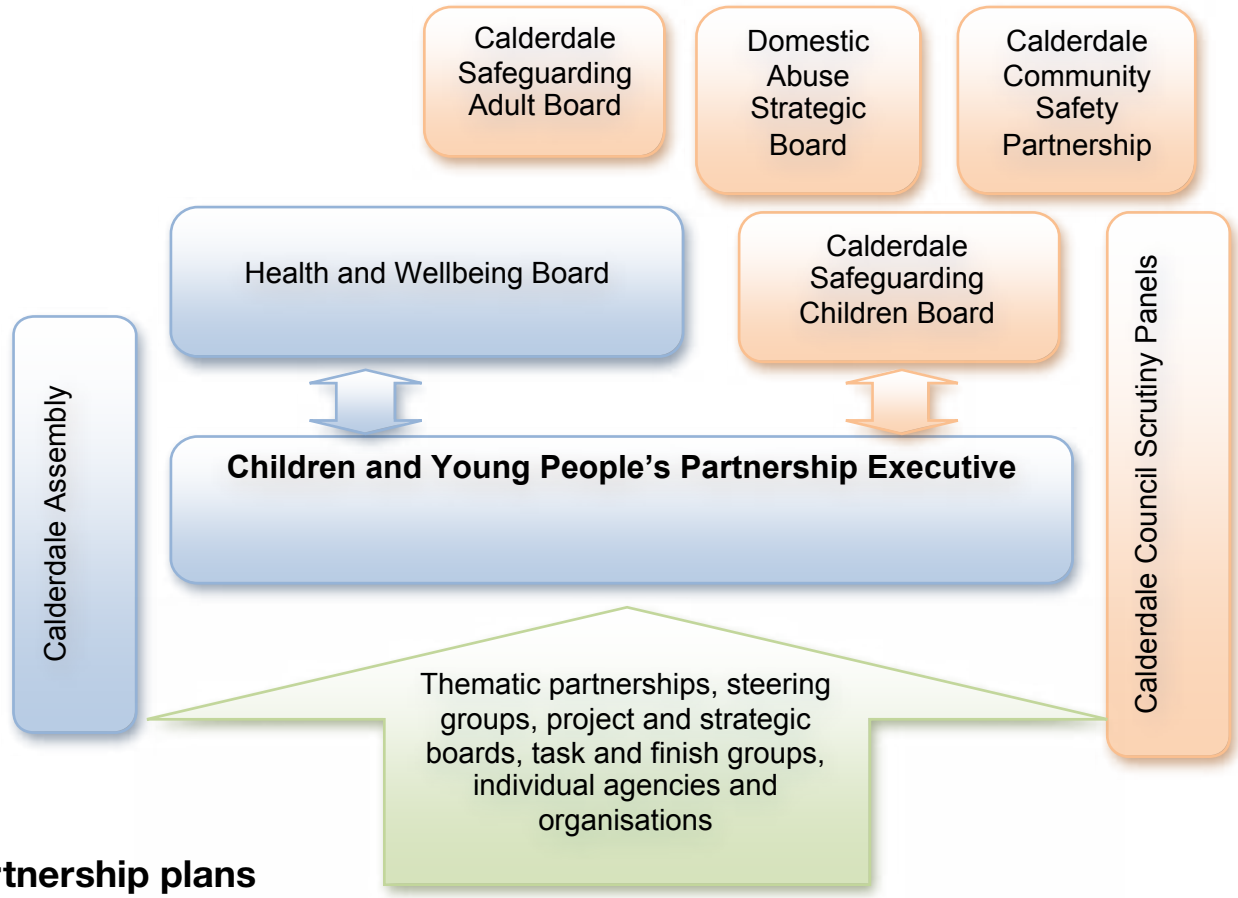
Children and young people in Calderdale have similar opportunities and challenges as in other parts of England, but there are some key differences, and partners have a good understanding of why this might be, which is reflected in the Children and Young Persons' Commissioning plan: http://www.calderdale.gov.uk/community/children/plans/index.html. The Joint Strategic Needs Assessment shows how some key issues and areas are explored and understood: http://www.calderdale.gov.uk/v2/residents/health-and-social-care/joint-strategic-needs-assessment. There are also other important plans that set out priorities, such as the Police and Crime Commissioner's Police and Crime Plan: https://www.westyorkshire-pcc.gov.uk/our-business/the-police-crime-plan.aspx.

The Health and Wellbeing Board is a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities within an integrated approach.

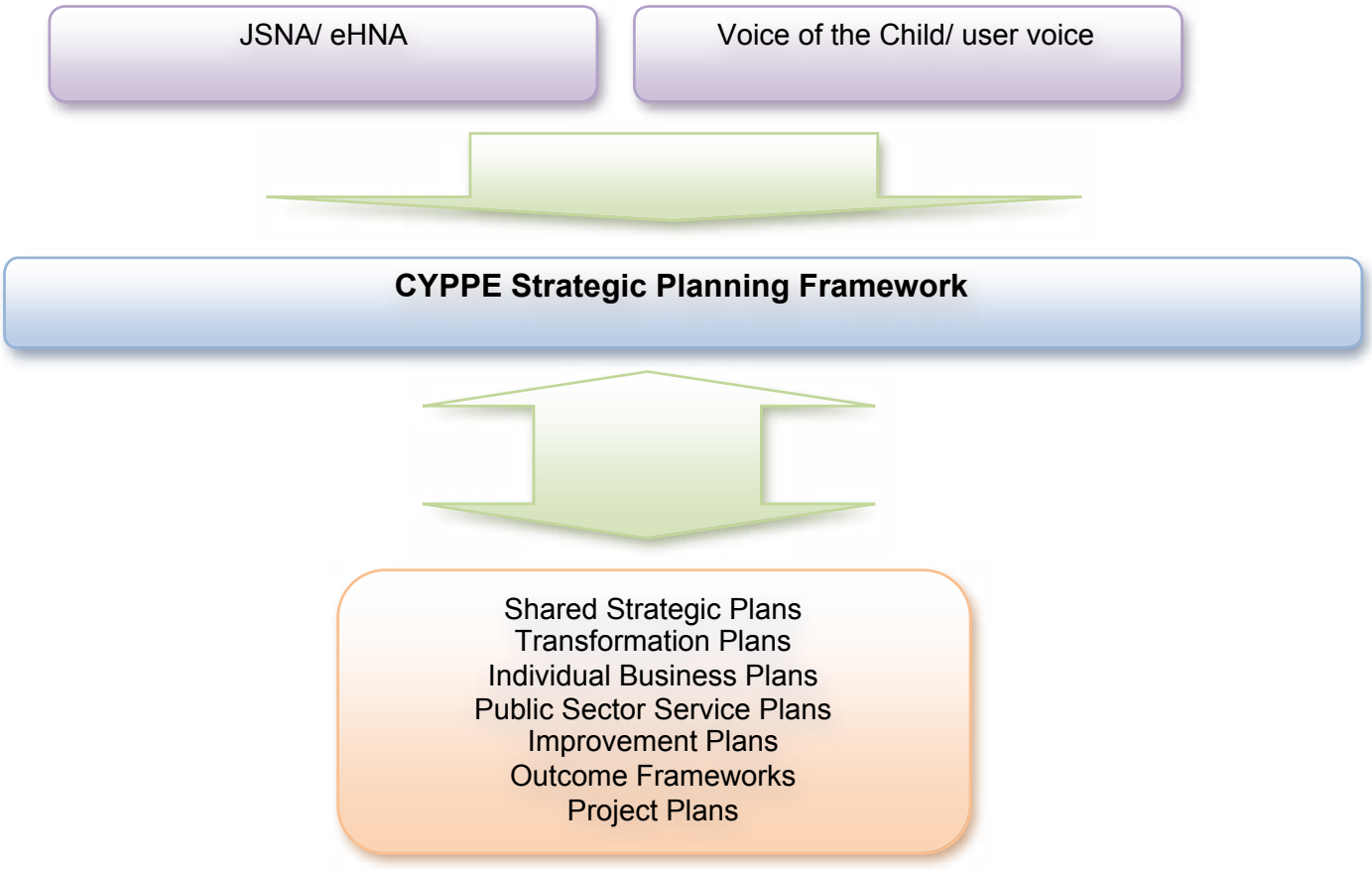
The role and focus of the LSCB partnership is to be able to reflect on and influence these priorities. This is important because we know that children are more likely to suffer neglect, harm and abuse when there is not a joined-up understanding and response to the wider factors and circumstances that can contribute to this. During the year there has been good progress in identifying the key areas and issues where there can be improved collaboration, such as how commissioning processes can more fully reflect current safeguarding standards and expectations.

The Children and Young People's Partnership Executive sits beneath the Calderdale Health and Wellbeing Board and takes the lead on the Health and Wellbeing Board's strategic priority that **"Every child will have a healthy start and continue to lead a safe, happy life with every opportunity to achieve their potential within their families and communities."**

Partnership structure



Partnership plans



The **Safeguarding Board Business Plan** is influenced by and informs the other plans and shared partnership priorities providing focus, assurance and feedback to ensure those children's safety and protection is paramount. The coming year will see an improved alignment with other plans and processes.

The plan expresses its purpose in the following ways:

- Seeing things from the perspective of children, young people, families, professionals and partners
- Setting standards and expectations for joint working arrangements to protect children
- Providing information support and guidance
- Monitoring and assessing the effectiveness and impact of joint working arrangements
- Providing assurance through learning and challenge

These are translated into action through the three-year Business Plan, which is reviewed and refreshed bi-annually. The current Business Plan (2015-18) provides continuity with the previous plan (2014-15). There are five priorities for the Safeguarding Children Board:

Priority 1: We are assured that children receive the right help and protection at the right time

- How we know or are assured that Early Help joint working arrangements in Calderdale are in place and effective
- How we know that thresholds are well informed and understood

Priority 2: We know which children are vulnerable and are assured that they are protected

- How we know how efficient and effective the local safeguarding system is in reaching vulnerable children and those who may be 'missing from sight'
- The monitoring and scrutiny of joint working arrangements in relation to the abuse, harm or neglect of children, including CSE, is in place and continues to be developed

Priority 3: Scrutiny and challenge evidences effective safeguarding

- How we know the quality of interventions with children and young people meet standards/ what 'good' looks like
- Performance Management Quality Assurance (PMQA) Framework is used to inform and evidence improving and improved outcomes for children and young people
- The Section 11 self-assessment audit is embedded within all organisations working with children and young people to support their capacity to evidence standards/what 'good' looks like

Priority 4: Create a learning culture, which consistently improves outcomes for children and young people

- Learning from everything we do and what changes as a result
- Improving practice and outcomes for children and young people
- The impact of learning from Serious Case Reviews and child deaths on multi-agency safeguarding arrangements, procedures and practice
- Multi-agency training evaluation to evidence impact

Priority 5: Effective leadership strengthens joint working arrangements for safeguarding children and young people

- How strategic leadership across all stakeholders works
- How we engage with and influence the wider community to keep children and young people safe
- How we ensure transparency and public accountability

This report will look at the ways in which the safeguarding partnership has taken forward these priorities in the context of:

- How these demonstrate the partnership has met its statutory responsibilities
- How the partnership has had an impact
- What the partnership has learnt and what this will mean for the coming years
- How this has informed the judgement the partnership has been able to make about their own performance and therefore the sufficiency of joint working arrangements to protect children and young people in Calderdale

6. Vulnerable children and young people and their journey through services; what we know about the joint working response to early help and protection

The majority of children and young people do well at school, at home and in other aspects of their lives. We know however that at certain ages, or in certain situations that some children are more likely to do less well than others.

It is the role of the safeguarding partnership to help make sure we know who these vulnerable children are and be assured that partners are working together to make sure that these children and young people are protected. Early intervention can not only help children fulfil their potential, it can increase the chances that families are safely able to change their circumstances, solve their problems and be less reliant on the support and services professionals provide in the longer term. Early intervention can also mean that where there are concerns for the safety of a child prompt action can be taken.

The protection of children and young people remains paramount, and as the early intervention approach has developed in the year, partners are more aware that this has implications for how safeguarding joint working arrangements are set and reviewed. Increasingly as different types of professionals and others who work with children become involved at earlier points in a different way of working, this means that they have an even more important part to play in recognising and responding to the signs of neglect, exploitation and abuse. The safeguarding partnership will need to provide a clear lead in the coming year to articulate and strengthen the ongoing implications of a successful approach to early intervention and the protection of children.

There is a wide range of information collected and held by partners for many different purposes, so bringing together this information for the purpose of providing early help and protection continues to be an ongoing challenge and priority. This was mirrored by the ways in which the partnership used information about this and tested practice.

The safeguarding partnership has invested in additional capacity to support its scrutiny function and to contribute to the wider understanding of where this reporting and analysis sits and what it means. In the year, partners agreed to maintain this additional investment for a further year. As a result we have a better understanding of how the needs and risks that children face are recognised and what happens as a result in terms of the joint working arrangements and thresholds, i.e. how partners agree to work together to assess and agree how best to respond to any concerns.

This information is assessed in a number of different ways:

- How it can be compared with the targets set by partners and others
- How it can be compared with past achievements
- What we understand this to mean from our perspective as a safeguarding partnership
- How it can be compared to national and statistical neighbour data

As a partnership we work closely with other partnerships and partners to achieve two things:

- A better understanding of the wider context of the impact of preventative measures, including areas where there is a shared focus such as domestic abuse, Prevent, the transformation of child mental health services, and special educational needs reform
- A better understanding in the context of the safeguarding partnership as to the impact of joint working arrangements for child protection and early intervention

  At the end of the year we were able to draw the following conclusions based on some of the key information and trends we have looked at. This is not a comprehensive picture but illustrates and evidences some, but not all, of the ways in which as a partnership we have a clear line of sight. During the year we noted:

- That 2015/16 saw a continued reduction in contacts and referrals into children's social care, seeing an 18% reduction in contacts and a 21% reduction in referrals compared to the previous year and the trend continues into 2016/17. This has been achieved through the better understanding of children's social care thresholds about what is an appropriate referral by partner agencies, supported by the work of the Early Intervention Panels and development of the early intervention single assessment and multi-agency referral form. It is important that children and families are directed to and receive a timely and appropriate response from all partners, professionals and services. Changes to how and where requests for help or sharing of concerns can be significant, as the concern is always to ensure that risks and needs are not misunderstood. It has therefore been important to make sure that the reasons for the changes in contacts and referrals are understood and that there is assurance that this has not resulted in unnecessary delays or any reluctance to step forward. To achieve this we have looked at the work of Early Intervention Panels, the front door and individual cases to be assured that children are not subject to drift where there is a concern, that professionals feel able to challenge each other's decisions and that there is sufficient monitoring of cases on the basis of being able to recognise when there may be a need to think again. This will continue to be important and the report suggests that as a partnership we will need to evidence a clearer overview of the potential and actual significance of these trends and the future direction they take. This will be complimented by an increasingly focused Performance Management Quality Assurance (PMQA) function, promotion of thresholds, information sharing and the regular scrutiny of this part of the child's journey. This report highlights the opportunity to focus on promoting confidence and capacity across partners to challenge and develop joint working arrangements.
- There have also been reductions in the number of children and young people subject to child in need plan, child protection plan and the number of Children Looked After (CLA) by the authority. The number of children on a child in need (CIN) plan reduced by 13% in 2015/16 and children on a child protection (CP) plan reduced at a similar rate (15%). The number of CLA reduced by 7.5%, ending the year at 65.4 per 10,000 under-18 population. This is now in line with the statistical neighbour average of 66 per 10,000 and closer to the national average of 60. These changes have been understood by the partnership of further evidence of some of the 'whole-system shifts' that are taking place, to support earlier intervention on the basis of a shared approach, whilst improving capacity to be assured that children are safe and protected. It is the view of the partnership that these changes need to be monitored closely, as they represent tentative steps towards a different way of doing things

Summary and what we will do next

The capacity of the partnership to be able to look at the wider trends and implications of how well partners respond to occasions where concerns are raised, has improved. On the one hand there is a need to consider how each partner accounts for and explains what is happening and what this means; and on the other hand there is a need for the partnership to translate this into a view that gives ground for assurance.

It is clear that by the measures and indicators utilised, there has been a continued shift towards earlier and therefore often less formal interventions, which are intended to address and resolve factors that may be impeding a child's wellbeing and development. The partnership continues to seek assurance that earlier intervention does not mean that a child's safety or protection will be compromised and has sought and received assurance throughout the year that this is the case. This assurance has also highlighted the areas that need continued development, whether judged by the wider trends or on the basis of other measures that indicate healthy joint working.

As a result the partnership will need to continue to develop its capacity to monitor and present an overview as measured against key indicators and also to focus on things that can reduce any risks and support improvements.

7. What the safeguarding partnership has achieved in helping partners to coordinate services

1. Making sure that partners and professionals have access to policies, procedures, protocols and guidance for joint working and that these support effective and high-quality joint working

We have actively reviewed, amended and written new policies, procedures, guidance and protocols, as a part of the West Yorkshire consortium. The Board agreed the following as a result of learning, feedback from partners and practitioners, or because of new developments:

- Implementation of the Child Protection Plan - clarified lead social worker and core group responsibilities
- Abuse Linked to Spiritual and Religious Beliefs – provided more up to date information and research
- Safeguarding Children and Young People from Child Sexual Exploitation: Policy, Procedures and Guidance – updated to reflect best practice and regionally agreed changes
- Children from Abroad (including Migrant Children and Unaccompanied Asylum Seeking Children) – updated to reflect changes in legislation and responsibilities
- Children Moving Across Local Authority Boundaries – clarified expectations placed on LAs and partners
- Female Genital Mutilation – as result of the partnership strategic response and the introduction of mandatory reporting provided policy, procedure and guidance
- Safeguarding Children who may have been Trafficked – provided up to date information and guidance
- Cross-Border Child Protection Cases Under the 1996 Hague Convention – as above

- Joint Protocol for Children Missing from Home or Care – as a result of past scrutiny and learning, revised local arrangements
- Investigation Strategy for Harbourers of Children and Young People – introduced new guidance
- Information Sharing and Confidentiality – maintaining ongoing updates
- Safer Recruitment, Selection and Supervision of Staff – reflected changes in requirements for partners
- Learning and Improvement Framework – reviewed and updated to reflect learning from management of case review process
- Investigation of Sudden Unexpected Deaths in Childhood – revision of protocol
- So Called 'Honour' Based Violence – a new chapter introduced across West Yorkshire

We have also promoted policies by asking Board members to take responsibility for ensuring that these are incorporated into their existing arrangements. We have made sure that multi-agency training and other learning events address and promote changes and we have improved accessibility on our website. Where case review has indicated a need to amend existing policies or develop new ones we have acted in a timely way.

Summary and what we will do next

It remains a priority to make sure that partners and practitioners have access to policy, procedures, guidance and protocols, that these are understandable and current and provide an important base line and foundation for how people work together and what is expected from them, and therefore what children and their families can expect.

We continue to benefit from a shared approach across West Yorkshire and recognise the importance of making sure that this is an activity that we keep on top of and actively work to promote awareness of its use.

As our capacity to evaluate impact, performance and quality improves, as with case review it will be important to make sure that this important 'baseline' is given priority.

In order to achieve this we will:

- Maintain our contribution to the West Yorkshire Consortium
- Introduce a planned programme of review to proactively manage developments through the relevant sub groups
- Be clearer about the status of and differences between policies and guidance ensuring that the Board formally approves the introduction of new or significantly revised policies, procedures and protocols
- Consider how we can improve how we test single agency/partner policies and procedures either as a result of case review, audit of cases or feedback from the Section 11/157 self-assessment
- Continue to integrate policy and procedures into awareness raising, learning events and training and to support Board members in their role in this within their own organisations
- Ensure that the partnership provides a clear leadership role

2. Making sure that all partners and professionals understand how to respond when they have a concern about the safety and wellbeing of a child, what to expect and what is expected from them

2.1 During the year we have reviewed and revised the thresholds document; the **'continuum of need'**. This sets out for all partners and professionals the steps they should take and who to work with when there is a level of concern about the safety and wellbeing of a child or children they know. It helps to make sure that the right people become involved, that everyone shares information about the child and their family and that this results in a whole-system response with outcomes that mean the child is protected.

2.2 We also relaunched the Guidance on Referral Processes between Adult Services and Children's Services. This was to reflect the changes in thresholds and was in response to local learning from case review and audit. Making sure that when professionals know about or are involved with adults in a family, it remains important that everyone makes sure child protection and joint working arrangements are followed.

2.3 We also introduced the Pathway for Resistant Families with a helpful letter for practitioners to use. For many different reasons there are sometimes occasions when children and families find it hard to cooperate with professionals, so this pathway shows how people can come together and find ways of engaging the family and if this does not work it supports escalation to make sure that the child's need for protection is not lost sight of.

2.4 Last year we placed an emphasis on the **multi-agency referral form** and how this fits with the **multi-agency single assessment process**. This has continued and the form was subject to further improvement in the year and both this and the assessment format are designed to help people share information, to form a clearer understanding of needs and risks, reduce the need for children and their families to have to retell their story and to help make sure that people are working together to help change things and be clear that the protection of the child is paramount. The introduction of Chronology Guidance and training was as a direct result of the multi-agency audits carried out, which identified that improved performance and quality of how the key information and knowledge of significant events in the child's life is used to support judgements and makes an important difference to decisions and outcomes for children.

2.5 As a result of focused scrutiny and case file audits that looked at key parts of the child's journey, a Risk Indicator Tool was produced as well as an Assessment Tools Table. This means that practitioners at all points have access to more resources to inform how they understand risk. This was promoted especially in training and at Early Intervention Panels.

2.6 In the year there continued to be a focus on what are called SMART plans, (SMART stands for Specific, Measurable, Attainable, Realistic, and Time-sensitive). A multi-agency audit produced some important feedback which indicated that this was still a difficult area for professionals. The training provided continued to focus on the formal and statutory points of intervention in the child's journey such as child protection meetings, but also how the principles can help everyone who works with children and their families to work to specific, measurable, achievable, realistic and timely objectives.

2.7 Importantly, the Board members, through the improving focus on and scrutiny of the child's journey, tested, approved and agreed to actively support the continued promotion of thresholds and continuum of need framework. There was an increased level of attention paid to how important it is to ensure that all partners and practitioners were aware of and felt that the threshold document and the tools were helpful and relevant and that continued development and testing was an important activity for the Board.

2.8 During the year Board partners have demonstrated an increasing capacity to address some of the challenges that can characterise and constrain the development of more effective joint working. Whilst partners understand and respect the key role that children's social care and social workers play, there have positively been a number of challenges to better

understand and check out that the integrated approach to early intervention and child protection is an inclusive one.

Summary and what we will do next

The year has seen an increasing emphasis on thresholds that reflect the importance as to how we monitor joint working, and how we are better able to exercise strategic judgements as to what will make the most difference. Therefore we will need to continue to invest in the arrangements that set out, describe and guide all practitioners and partners through the child's journey to help and protection. This means we will need to introduce an additional focus and emphasis on how we communicate this and how we support people to play their part. We know that there are challenges in getting across this message, especially as making judgements as to when a child needs more help or protection is often complex and difficult. So we will maintain our efforts to promote and communicate how the child's journey works from everyone's point of view.

Whilst thresholds, pathways, SMART plans etc. are necessary professional and system constructs, we also need to remember and recognise that for some people who work with children and for children these are not necessarily understandable. Therefore we need to make sure that as a priority we are able to promote a wider awareness and understanding of what people should do when they have a concern and what they can expect. This ties in with the learning we have identified from our listening to young people and our recognised development area in terms of our communication and engagement plan.

We will continue to review and develop ways in which we can be sure that people know what they are expected to do, who they should do this with, and the best ways to achieve the right outcomes for children is clear and at the heart of our scrutiny arrangements. This means we will continue to test key points in the child's journey regarding how well thresholds and guidance are understood and being applied. This will improve our focus on and support for the front door, early intervention panels, as well as how information is shared and used to form clear decisions and plans. We will do this by looking at performance and quality at key points, promotion, provision of training and resources. Board members will be asked to provide leadership in giving priority to this within their own organisations and as a Board.

We will need to explore how we support practitioners and partners to have confidence in resolving the inevitable tensions that can arise when people are trying to form a judgement as to what is the best thing to do.

We recognise that as the protection of children at earlier points becomes more embedded, the ways in which we collect, use and share information develops, for example the arrangements for sharing information and how we collectively manage risks in relation to missing children and CSE. We therefore will need to make sure all partners and practitioners are able and committed to continuing learning and change, as pressures remain on partners being able to resource earlier interventions. In this respect it seems sensible to explore how as a partnership we can model and develop ways in which the known risks and traditional barriers can be managed.

We will continue to work with the other strategic partnerships especially in terms of the local priorities and arrangements for commissioning as it is important that arrangements are supported by resources, skills and the principles of joint working focused on the protection of children. The development of new approaches to mental health services, the impact of 0-19 service changes, the recommissioning of Early Years and domestic abuse provision and how the voluntary sector are able to support early help are examples of how the safeguarding partnership will need to consider a more defined approach to how it seeks to influence, and ensures in terms of ongoing scrutiny that the wider strategic and commissioning decisions are congruent with and strengthen effective joint working to protect children.

3. How we have made sure that partners and practitioners have been able to develop their skills and knowledge to more effectively work together to protect children

As well as providing a map for the child's journey (continuum of need) that is supported by partner commitment, guidance and tools and closely monitored through the partnership's performance monitoring and quality assurance arrangements (PMQA), we have continued to develop our approach to multi-agency training and as a result of an Ofsted recommendation (See Appendix 1), the wider challenge of workforce development.

Our goal is to reach a position where the partnership can be confident and assured that all of those who work together to protect children have the appropriate knowledge and skills. The responsibility for this primarily rests with each partner as well as with the professions who play a key role. It is important for us to remember that successful and effective joint working requires not only an agreed way of doing things, but also a shared understanding of how information is used and how professional judgements need to result in effective actions and interventions.

The multi-agency training we have provided in the year continues to play an important part in how the partnership influences outcomes for children as a result of joint working.

The programme for 2015–16 reflected: what we had learned from feedback from previous training, our five priorities and the continued aim to support the wider improvement agenda. Board members have exercised a clear leadership and scrutiny role in setting and learning from the programme. This has included recognition that our analysis and understanding of training needs, and how we evaluate the effectiveness and impact of delivery, and therefore how we form a strategic view going forward, needs to continue to be worked upon. Board members were able to note progress in the year as to how the information we have was used in different ways, the commencement of a Training Needs Analysis across partners and the first steps in a shift towards a more strategic focus on workforce development.

In the previous year there has been an identified issue with the numbers of cancellations so the Board responded by introducing a 'charging policy' for non-attendance and a number of other measures to help with booking and planning. This has been closely monitored in the year and has been successful in reducing the number of courses cancelled and ensuring that take-up is maximised.

Although the programme and attendance prioritises the child protection part of the child's journey there were a range of other events and courses intended to provide opportunities for people to come together where the focus was on other stages or aspects of the child's journey. (For further information please refer to Appendix 7.)

During the year we have continued to a) develop our capacity to manage and monitor delivery, and b) further develop how we know this is making a difference.

It is possible to observe the following:

1. The numbers attending is a crude but important measure and we saw a small decline overall, reflecting the trend from previous years, but an increase in the average attendance on courses. This we feel is partly attributable to the fact that the workforce may be more stable (as monitored through the CSCB Performance Management), and is not growing. Some elements of the training are focused on providing a baseline level of knowledge and skills (and therefore renewal rates have settled) and a shift away from the need to target training on priorities related to the impact of the LA and the LSCB being in intervention. Critically, one of the main reasons we saw reduced numbers attending training was that in 2015, Safeguarding Week took place in March and Safeguarding Week 2016 will take place in October (to be aligned to other West Yorkshire LSCBs) and therefore this large scale event has not occurred during the financial year.

2. This year we have been better able to monitor and assess the role and impact of e-learning, which is now a significant way in which training needs (single and multi-agency) are addressed. Feedback confirms this and for many but not all partners it represents a significant part of their core training and development arrangements.

3. As a Board we have worked hard to move to a position where we are able to analyse and assess the effectiveness of delivery from a strategic perspective, so as to inform future planning and further progress with a whole workforce approach, and the year has demonstrated some important progress has been made. The Board took regular reports and made a number of recommendations and provided advice to support this. There was also a greater emphasis placed on the role of Board members to promote, support and provide feedback in respect of the multi-agency training provision, and this contributed to the progress made.

4. Being able to tell whether, and if so in what ways, attendance has impacted on how people work together and the overall quality and reliability of joint working practice and arrangements is a considerable challenge. In the year we have continued to test this at the point of course completion, and these indicators remain very positive, we have also been able to maintain, on a limited scale, follow up after a period of time and again this provides a positive message. The higher average of people attending courses indicates a better balance between provision and demand, which is reassuring.

Our challenge remains to find ways in which we can continue to test the impact of learning, so as to make this more useful in determining our future strategy, as well as demonstrating in terms of delivery what we can improve. This report notes elsewhere that there are other ways in which we are now able to inform a view of effectiveness and impact such as audits, case reviews, Section 11s and the introduction of the partnership supervision principles and framework.

We are committed in the coming years, as a result of our learning, to exploring how we can better understand and respond to the following:

- Being clearer as to how each partner ensures that their workforce has the right knowledge and skills, to make sure that any gaps (current or projected) are addressed

- To ensure that the multi-agency training provided through the partnership compliments and reflects immediate and longer term impact. As a partnership being able to demonstrate how all aspects of what we do as a partnership has a direct and a positive impact on joint working and therefore outcomes for children and young people

During the year the sub group responsible for providing a lead in this area has been strongly led and has developed a clear approach to addressing the strategic and the delivery oversight issues. Like other Sub-groups it has also worked with the Business Group to ensure that this important area of activity and how we understand it is not done in isolation of the other things we have been doing.

Capacity and capability to achieve a more strategic approach in terms of future objectives and an understanding of impact and effectiveness (delivery and on practice/outcomes for children) remains an ongoing challenge. The evidence suggests that the sub group and the partnership remain committed to developing this capacity and capability.

The partnership has a good and developing understanding of this and are alert to some of the significant trends and risks that can impact on future achievement, and are addressing these through the Training Needs Analysis, improved understanding of delivery, and impact and planning. This is focusing on engaging partners to provide more information and analysis of how they understand and meet the needs of their workforces, and this will better inform how future part-

nership-led delivery is set and targeted. It will also lay the foundation for the further assessment of the scope for and feasibility of a partnership workforce development-led approach as recommended by Ofsted (see Appendix 1).

In the meantime it is recognised that the role and impact of e-learning needs to be considered in order to make a strategic judgement as to how and to what extent this will be prioritised as a means of ensuring that effective joint working is supported.

Continuing to improve our understanding of and response to trends in terms of demand and take-up will support improved planning, and identify whether further evidence and assurance is required from partners who meet identified needs within their own arrangements, and therefore as measured by attendance can appear to be potentially missing out from taking part.

This also requires an improved understanding of the composition of the children's safeguarding workforce, which in turn will enable a more informed understanding of how effectively the partnership has reached those people who need to have the required skills and knowledge.

Summary and what we will do next

Each partner remains responsible for ensuring that their workforce has the necessary skills and knowledge to protect children and work effectively with other partners. The safeguarding partnership is not required to deliver multi-agency training but is required to ensure that partners coordinate and provide a workforce that is equipped to meet agreed standards of joint working to protect children. This report concludes from the evidence that as a partnership we continue to prioritise the need to ensure and be assured that all of those who work together to protect children have the necessary skills and knowledge to produce high-quality outcomes for children. The partnership has recognised in adopting a strategic approach as well as focusing on the delivery it commissions, that this is a considerable challenge, and is therefore adopting an incremental approach to this.

Our multi-agency training continues to reflect key themes, learning from case reviews and our scrutiny of performance and quality, as well as complimenting the thresholds arrangements.

There are a number of headline challenges to be considered by the partnership and incorporated into future plans and arrangements:

1. As a partnership are we are doing enough or could we do things differently in ensuring that the parts of the workforce engaged in early help have what they need in terms of joint working skills and knowledge?

2. To what extent and how would we know that partners are meeting the basic level of skills and knowledge given the increased use of e-learning and the reliance on partners taking responsibility for this?

3. How can we be assured that when services are commissioned these arrangements reflect the requirements in terms of joint working skills and knowledge?

4. If bringing people from different organisations and professions is important should we consider how we maintain and place further value on this in terms of the ways in which this is achieved given what we know about trends in terms of take-up and the different ways partners meet needs?

4. How partners have been able to improve the ways in which they evidence how they are meeting joint working standards and how this impacts on outcomes for children

The partnership has continued to invest in and prioritise the development of the two key frameworks required by the statutory guidance:

- The Performance Management and Quality Assurance Framework
- The Learning and Improvement Framework

These are essentially the ways in which we organise and prioritise our resources and approach to meet our statutory responsibilities and how the partnership articulates this in terms of priorities based in the wider understanding of local needs and what we know we want to improve on.

During the year the partnership was able to:

- Implement and benefit from, on the basis of additional funding from three partners, a new post dedicated to the development of PMQA. Therefore significantly improving what is monitored, how and on what basis this is subject to more intensive scrutiny and analysis so as to enable Board members to exercise their scrutiny, challenge and assurance role
- Further improve and refine as a result of development sessions, ongoing review of the ways in which the Sub-groups, the Board and the Chair work together. During the year we were able to focus with more effect on particular areas, highlight solutions to address problems and make more inroads into making the complex easier to understand on the basis of the better use of evidence and analysis from the partnership and an objective perspective
- Develop capacity, competence and confidence in managing all aspects of the case review process. As a result partners have further developed their capacity to engage transparently and objectively in a rigorous and thorough review that identifies recommendations that are owned, acted upon and tested to see if these are making a difference
- Successfully maintain and develop its Section 11/157 strategy as a baseline for standards and assurance. During the year we have seen partners recognise how this supports other aspects of the partnership responsibility and how it can complement their own arrangements for assurance. It has also meant that we have taken further steps to clarify and develop our wider messages and how we respect, trust, but will challenge, the role partners need to play in making sure children are protected

There are many examples of where the partnership has been able to evidence progress and impact on partners, professionals and children. These are some examples that are felt to be strategically significant and support the overall objectives of this report and the partnership's role.

Multi-agency and single agency audit including case file audits

Audits are focused and targeted at areas of joint working practice in order to better understand how well these arrangements are working and whether or not there is positive learning that can be shared or whether the findings give cause for further enquiry or concern.

Most partners have ways of looking at their front-line practice and may have different understandings and applications of this. It is therefore important that the partnership establishes a shared understanding of this activity and what this means when they commission and take part in multi-agency audit. During the year the partnership was able to finalise the framework, process, arrangements and outcomes for how it delivered its audit activity. This enabled the Board to be assured and to be able to see, through the programme, how areas for audit were identified and

prioritised. This also enabled the Board to focus more on how findings were reported on, what this required of them and how the agreed outcomes were incorporated into the ongoing work programme of the Board. There were also a number of examples of how areas for audit could be triggered by the analysis of performance information, learning from case reviews and direct suggestions from partners.

Some of the examples we learnt from and were able to identify impact include:

- Feedback from front-line practitioners to test their understanding of early help arrangements in Calderdale, this feedback helped shape revisions to the thresholds guidance and to influence how the partnership defines and meets the requirement to assess the effectiveness of these arrangements
- Examples of learning from multi-agency audits, which were selected to compliment the partnership's focus on key points in the child's journey and to further demonstrate that the partnership was ready to assume some of the responsibilities of the Improvement Board, including:
    - Re-referrals to children's social care
    - SMART planning
    - Quality of assessments and support to families at tier 3 of the continuum of need
    - The effectiveness and quality of de-escalation of cases closed at Early Intervention Panels
    - Pre-birth assessments

The learning from these audits can be seen in the shaded box below.

Re-referrals to children's social care

Re-referrals to children's social care are significant as they may indicate that previous responses may not have fully appreciated the circumstances and available information. Equally a re-referral might mean there have been important new developments and/or that those partners working with the family have reached the point where they have a better understanding of needs and risk. When the level of re-referrals is thought to be higher than it could reasonably be expected (as judged by other areas across the country and other local indicators) it rightly can be a cause for further investigation.

The 41 cases demonstrated strengths and weaknesses about the importance of working together to ensure that referral from one part of the child's journey to another is not seen as a cut-off point, that information, analysis and dialogue between the referrer and the person taking the referral are important especially when information may be incomplete or inaccurate. There were still challenges to be addressed in order to improve when families found it difficult to cooperate and when domestic violence, substance misuse or neglect were felt to be an issue, and how professionals reach an agreement on the significance of these things. As a result the partnership ensured that the following learning was acted upon:

1. Partners agreed to improve how contacts and referrals are recorded correctly
2. Relaunched the Guidance on Referral Processes between Adult Services and Children's Services
3. Introduced the Pathway for Resistant Families with a helpful letter for practitioners to use
4. Agreed that if a child is re-referred to MAST within a 12-month period the case will automatically go to an Early intervention Panel (EIP)
5. Introduction of Chronology Guidance and training

Re-referrals reduced from 39% in June 2014 to 26% in September 2015. At the same time referrals into Early Intervention Panels continued to increase and the numbers of children being subject to child protection plans remained stable. This appeared to indicate that the quality of the joint working process and arrangements improved as a result.

There was an important additional dimension to this scrutiny and challenge, which reflected some of the tensions inherent in the ways in which partners manage thresholds and referral processes. This was a further acknowledgment across the partnership that there needed to be continued investment in the ways in which we understand how things should work, the importance of shared systems and relationships. This is always important when one partner has a significant statutory responsibility and other partners therefore look to them for leadership. As a result it was possible to observe that as a partnership we needed to look towards how we can better manage the child's journey at key transition points, what makes this work well, and how we can ensure that children and their families do not experience a 'stop start and start again' experience and that as partners we are able to challenge each other when it may be felt that we are passing the parcel as opposed to negotiating a key transition and changes in roles.

Ten cases were examined to audit how SMART plans to safeguard and protect children were effective (all children had been subject to an Initial Child Protection Conference (ICPC) and Child Protection (CP) plan for at least nine months).

From the multi-agency perspective what happens when professionals come together at a child protection meeting is very important and central to how as a partnership we are assured that the right decisions are being made. The partnership also monitors this in other ways such as reporting on attendance and contribution, providing partners with the opportunity to address and explain where attendance and participation can be seen to potentially impact on outcomes of these meetings. The LA service area also provides an annual report to the Board and during the year there was improved engagement with the Independent Reviewing Officers who chair child protection meetings and provide partners with valuable insight as well as assurance.

The outcome of the audit offered some grounds for assurance especially when seen alongside other performance information, but confirmed the need to increase attention on meeting attendance/participation standards, how meetings are chaired and conducted, especially when information and/or attendance may compromise the meeting outcomes. There needed to be a stronger focus on the child's voice and including parents especially when they may struggle to understand, and to address the fact that the tools and guidance available for partners and practitioners could be more consistently used.

As a result the following impact was agreed:

- Updated and revised the multi-agency meeting agreement to include set agenda items; Strengthening Families template added to focus discussion and consideration of risk
- Conference Chair identifies which core group member will invite key agencies to core group meetings
- Risk Indicator Tool produced
- Assessment Tools Table and use of tools promoted in training and at Early Intervention Panels

There were a number of other audits completed in the year, namely: the quality of assessments and support to families at tier 3 of the continuum of need; the effectiveness and quality of de-escalation of cases closed at Early Intervention Panels; and pre-birth assessments.

Quality of assessments and support to families at tier 3 of the continuum of need

Regular bi-monthly multi-agency audits take place and one was specifically undertaken in light of the introduction of the Early Intervention Single Assessment, (EISA) looking at the quality of the EISAs, quality of plans and outcome measures along with timeliness of 'step up step down' procedures. We learnt:

- There has been an increase in the number of partners accessing EISA
- Attention to detail in assessment recording is improving; basic information is not omitted as frequently since the introduction of the EISA
- Consistent increase in the number of EISAs being undertaken
- Professionals used toolkits familiar to their organisations to establish baselines from which to measure change
- Some examples of exemplary plans and voice of child

However, the audit also found:

- SMART target setting not consistent in all cases
- Evidence that assessments focus on the risk element of the author's area of expertise
- Assessments would benefit further from recognised resources, e.g. neglect toolkit
- Voice of child not always evidenced

In response:

- The auditors gave feedback individually to people involved in the cases
- EISA training was re-promoted to lift overall skills and awareness
- Multi-agency flow chart was produced to improve how the process is understood
- Raise awareness of toolkits to provide further resources and support
- EISA coordinator to meet with CMBC workforce development to progress audit themes in order that future training reflects needs

The effectiveness and quality of de-escalation of cases closed at Early Intervention Panels

An audit to identify where opportunities had potentially been missed was instigated in April 2015. This commenced in June 2015 with the following findings:

- Assessments were evident in only 50% of cases
- Most cases had a plan but these varied in quality and effectiveness
- Intermittent recording of dates meant auditors could not assess drift
- Where chronologies were present, auditors could quickly see progress or drift
- Where cases were closed due to non-engagement there was lack of analysis and lack of clarity of whether families would receive any further support
- Where cases had been closed with positive outcomes, it was not clear if these had been followed up to see if changes had been made
- Lack of senior management oversight and sign off

In response, we required partners to:

- Amend the closure form for Early Intervention Panels
- Where cases are closed for non-engagement they are audited for management footprints
- Deliver further EISA training
- Plan further audits to establish progress from actions taken

Pre-birth assessments

The pre-birth assessments audit was commissioned due to historical concerns with the quality and timeliness of referrals from partner agencies to children's social care and the quality and timeliness of assessments by children's social care. This audit was the fourth in a series of audits which spanned over two years. The results from this fourth audit found:

- Cases which involved a mother under the age of eighteen: some documents were kept on the mother's file, not the unborn child's
- Parental consent was evident in every case
- It was not clear from reading the referral form, what the expected delivery date of the unborn child was
- Throughout the two-year audit process, the auditors felt that the pre-birth protocol was becoming embedded and the quality of referrals was improving
- The third and fourth audit did not identify any deficiencies in practice in relation to referral, assessment or decision making. These issues were present in some form in the first and second audit
- In the fourth audit all the cases were responded to promptly by CSC
- In the fourth audit, three cases identified that the referral from health was made late into the pregnancy

In response to these findings:

- Social workers were reminded that documentation for unborn children and mothers under eighteen need to be held on the appropriate file
- The referral form was revised to include EDD (Expected Delivery Date)
- Cases which had been referred by Health late into pregnancy were fed back to the organisation
- Overall, and in part due to the audit findings from these series of audits, improvements in the quality and timeliness of referrals and assessments mean that plans are made earlier, reducing the risks to new-born babies

Summary and what we will do next

The approach to multi-agency audit has significantly developed in the year as evidenced by the agreement of and bedding in of the arrangements for commissioning, delivering, reporting and ensuring that the Board provides additional scrutiny, oversight, leadership and takes responsibility for follow through.

As the performance management arrangements (see below) have developed, it has been possible to strengthen the relationship as to how a need and the priority for an audit are agreed. The impact of audit is an area of significant development in the year and evidences an increasing capacity to reach into joint working practice through audit. It remains a challenge for partners to identify resources to support what can be an intensive process, and whilst proportionate forms of audit are considered, there is a need to ensure scale and depth for learning to be viable.

This means that:

- We will maintain a focus on key parts of the child's journey in terms of scrutiny and the way we reach decisions about what requires further scrutiny, why and how/where this should be done and by when
- Our approach to audit has recognised that we need to take more account of and seek to influence the audits undertaken by partners, so as to better share learning and further target the limited resources partners have for multi-agency audit
- We have recognised that we need to maintain the move to a wider whole-system approach recognising that there is an ongoing need to monitor and test the social care-led parts of the child's journey from a partnership role and perspective as well as the increasing significance of early intervention
- We have learnt that our commissioning model is robust but could further take into account lines of enquiry/areas of concern identified through our scrutiny of performance information
- We have recognised the need to further refine and develop, a) the methodologies we use and how audit is understood differently by partners, b) the different types of audit we may require, and c) how we analyse and report the results
- We have recognised and are seeking to identify ways of involving a wider range of people from across the partnership in delivery, as this can be a resource intensive approach. We are also looking, in the light of this report, to form key judgements as to how many audits we need to undertake, given that two of the examples cited require a commitment to re-audit, as managing demand and priority is a challenge and a risk
- As we continue to develop our capacity and capability we intend to rationalise and be able to better judge priority and proportionality. It is already clear that in many instances audit is a reliable way of taking a further look at joint working practice where there may be cause for concern or a desire to confirm good practice. Therefore the partnership will have to carefully consider how it manages demand and risk whilst improving quality and showing impact

5. How we have been able to use the performance information that partners provide us with to make sure we have an objective clear line of sight across and into the child's journey

One way of looking at a safeguarding partnership is to consider how it knows what it knows and how it knows what it does not know. This of course means that to address this we have to be clear about what we are here to achieve, how we are going to go about this, and, possibly, where is the best place to start.

Over the past few annual reports we have shown how we have built our approach on the development of a capacity for and capability to independently determine a view of how well partners are working together. As we have mentioned, this is not an isolated or an easy activity, and requires us to coordinate, integrate and control information that takes many different forms from sources that categorise and understand this information in different ways and often use it for different purposes.

Just as sharing information is critical to people making good decisions for and with children, so it can be argued this is true for the safeguarding partnership that have to step above some of the understandable sensitivities that can constrain people from sharing information. Equally, we know from joint working practice when people understand why it is important to share information and they can see the impact it has, that they are more likely to support and do this.

This is our experience over the past year, and being able to deploy dedicated time and skills to this process as well as developing the methodology and its application in practice has contributed to significant progress in the past year and has matched the Ofsted requirement around the effectiveness of scrutiny and challenge (this can be seen in full at Appendix 1).

As with other areas of learning from this report it also highlights the need to attend to how we analyse and share this information, especially in terms of strengthening the Board's role in scrutiny, challenge and assurance.

In the year we have:

- Firmed up the range of indicators we monitor to reflect a whole-system/child's journey approach at a high level so we are clearer about what we need to keep an eye on
- Developed better ways of how we recognise trends that justify consideration for further enquiry and who/how and what triggers further enquiry, i.e. we know when to look more closely
- Undertaken further scrutiny/enquiry and as with our audit development, have focused on identifying whether there are causes for concern and what significance this might have if not better understood and/or challenged
- Continued to ensure indicators are as inclusive and compatible as possible, and that partners understand the need to share what is required from them in terms of how the information is processed, presented and accompanied with analysis. We have also moved to a position where we have assessed the significance of delay or lack of availability in order to escalate this as appropriate
- Further developed the partnership dialogue and narrative analysis, which is required to consider the contributors' analysis but not always accept this
- Begun to incorporate information and feedback from other exercises such as Section 11/157 self-assessments in order to strengthen our overview and to further check and balance where appropriate
- Increased our awareness that enabling the effective access to and use of what is a considerable range of information and a systematic process of management and application is a challenge. Especially as the traditional organisational paradigm does not easily apply to the partnership. There are therefore a number of risks relating to how we maintain capacity and

progress without compromising the principles for a whole-system view, whilst remembering that this is generated in order to produce a capacity to challenge all or some of partner joint working arrangements

In the last annual report we noted, in the context of commenting on CSE arrangements, that as the expectations rose in respect of how information is used in practice and is required by the partnership, there appeared to be obstacles that reflected the complexity of interests and issues. These could, it was noted, give the impression that this meant it was therefore difficult to verify with confidence all aspects of practice. It is likely that such examples will continue to occur; these should be seen to justify the enquiry and challenge by the partnership but do highlight the need to qualify and explain that in reaching judgements about the effectiveness of joint working arrangements there will always be some unanswered questions.

There are some wider and significant questions that both the safeguarding partners and other partnerships may want to address:

- If, as it appears, this type of approach (i.e. led by the scrutiny of performance and quality) is valid in helping to form a clearer and objective view of joint working, but is potentially constrained by the resources available and the extent to which challenge that results is effectively communicated and acted on, are there sufficient measures in place to address this in the longer term?
- As a partnership we appear in the year to be working out how to balance and order the other things we have to do and therefore how our view of performance impacts on these either in terms of priority, how we go about them or whether they remain a valid activity e.g. the discussion around multi-agency training possibly reflects this, and may need further examination
- What do we do when this kind of information and analysis consistently raises questions and can be seen to raise further questions around performance and impact?
- In this way, the report reflects, as a strength, the capacity of the partnership to be engaging with the consequences of its approach to meeting requirements in a strategic way. This also reflects the wider debate taking place in other parts of the country

Summary and what we will do next

Coherent and consistent progress has been maintained with improved capacity and capability evidenced throughout this report and there are other examples that could have been included. This is a complex and challenging area of activity, and as the capacity and the applied context continue to develop, the substance and significance of this will be further tested. We are some way from a position where each Board member can look at and engage with all of the information and data, but significant steps have been made in terms of process and process management. This has in turn allowed us to begin to develop and test the best ways of achieving scrutiny, analysis and a story that holds all to account.

This means we will:

1. Maintain as agreed by the Board, a) the priority and primacy of the development and application of our capability to monitor partner performance focused on impact and outcomes for children, b) the additional post and identify ways in which we can ensure we can keep up with demand and the level of sophistication this emerging approach may require, and c) improve transparency and understanding of how it works and what this means for partners and the partnership
2. Further develop the way in which we decide what is a priority for further scrutiny and be clearer as to the triggers for this
3. Ensure we have a firm grasp and grip on risk, pace, direction and outcomes as a partnership and with the sub groups

6. How we have been able to improve our case review role and what we have learned from this

Our Learning and Improvement Framework sets out how we promote a learning culture, and a key element of this is how as a partnership we learn from when things go well and not so well. This applies as much to joint working practice as it does to how we conduct ourselves as partners and a partnership. The capacity to recognise mistakes and misjudgements and act on these is a characteristic of good practice and strong partnerships.

During the year, the CSCB published two Serious Case Reviews (SCRs). Both cases had deferred publication dates due to criminal proceedings. A third SCR commenced in September 2014 and it is expected that this will be published in the summer of 2016.

Three cases were considered during the year and a decision will be made as to whether they meet the criteria for a SCR in the next financial year. Two further SCRs were considered and notified to the National Panel of Experts and the Department for Education; however they did not meet the criteria for a SCR. The National Panel of Experts has agreed with these decisions.

A SCR was undertaken by Sutton LSCB, the child at the centre of this SCR was placed, at the time of his death, in Calderdale. Calderdale agencies partook in this SCR process, and in August 2015 Board members were made aware of its publication and the Case Review sub group continues to monitor actions and the learning for CSCB and partners locally.

We have improved how we commission and set the terms of reference, and strengthened our quality assurance arrangements and further refined how we forward plan. We have also implemented a more structured approach to monitoring the impact of and progress on recommendations by partners and the partnership

The other significant area of learning relates to how we engage and involve family members in the review process.

Summary and what we will do next

Case review remains a clear requirement, and will be subject to change as a result of pending legislation. It remains a complex, challenging and sometimes controversial undertaking and requires from partners their continued commitment to transparent exposure and review.

A revision of the Learning and Improvement Framework, by the Case Review sub group, which will be working to benchmark against national standards and quality marks, which will be released in 2016.

Continuing to improve how we ensure learning from review results in measurable and sustainable changes.

Child Death Overview Panel (CDOP)

A total of 11 deaths of children were reported to Calderdale Child Death Review Team between 1 April 2015 and 31 March 2016. This is the lowest number recorded since the introduction of Calderdale CDOP.

Of the 11 reported deaths, four have been considered at the joint CDOP and a conclusion reached in three cases. The remaining deaths will be discussed within the 2016/17 financial year or when sufficient information is available.

A total of 14 cases were finalised at CDOP during 2015-2016 (including cases outstanding from previous years).

The CDOP arrangements for Calderdale are shared with neighbouring authority Kirklees, in a bid to enable more meaningful analysis given the relatively small numbers involved.

Overall, across Calderdale and Kirklees 52% of cases had potential modifiable factors, higher than the national average of 24%. Efforts will be made in 2016-2017 to understand this variance.

Consanguinity was noted as a potential modifiable factor in two (5%) completed cases with 'other chronic illness' noted in a further three cases (7.5%). Emotional/behavioural/mental health condition in the child, alcohol/substance misuse by the child, housing, co-sleeping, access to healthcare and obesity were each noted in small numbers of cases. As is usual in these cases, the numbers are small therefore caution must be exercised when considering any emerging trends. The data will be monitored closely to assess any significant changes and measured against the three-year rolling averages collected by Public Health.

Of the cases completed across Calderdale and Kirklees 52% were male and 48% were female. This compares with the national averages of 55% and 45% respectively.

Ethnicity was recorded in all completed cases. Across Calderdale and Kirklees 52% were white British ethnicity, followed by 24% who were of Asian Pakistani ethnicity.

Summary and what we will do next

We will continue to ensure that whenever a child dies in Calderdale we will bring the appropriate organisations and professionals together to ensure that any potential learning is identified and acted on.

Where there is something that can be done locally we will provide clear leadership.

One of the main areas of consideration for the CDOP, alongside responding to local and national learning, will be preparing to respond to the Alan Wood Report in determining the accountability, responsibilities and footprint of the CDOP function in Calderdale.

8. Significant strategic partnership support for scrutiny, assurance and impact that represents a whole-system perspective

Board member and partnership contribution

During the year, the partnership has continued to develop as a Board; there are always some challenges to achieving consistency when people move on, sometimes organisations have to send deputies or, as is the case with some national organisations that have a regional footprint, they struggle to attend meetings in every locality.

Appendix 4 provides a brief analysis of attendance and it is important to note that all partnership minutes provide a 'running record' of attendance (as per the Constitution) as this helps Chairs, the Business Manager and most importantly Board members to monitor and escalate when the level or pattern of attendance might be of concern. In addition, the Chair maintains a dialogue with partners; one trigger for this is that their presence is being missed.

We have included comment at this point in the report this year because we feel that it potentially impacts on the partnership's overall strategic capacity and effectiveness. All partnerships are reliant to a greater or a lesser extent as to the priority the partners places on them.

Although there have been some fluctuations in attendance patterns at the Board level, these rarely meet the threshold where there is a need to escalate, and the use of designated deputies appears to be consistent. Board members are reasonably diligent in submitting apologies and an increasing number of members submit comments on key issues if they do.

There has been a Board-led dialogue with some partners who have correctly flagged up reviews within their own organisations as to future capacity to attend and participate. This has been evidence of the constructive and understanding approach partners have, but it is important to note that the underlying issues and implications especially in relation to the requirements placed on statutory members were set as a benchmark. As the year progressed, positions have been clarified and remain under review.

In terms of capacity to reflect the breadth of the safeguarding system, as well as its complexity it is well recognised that the size of the partnership can, unless mitigated, work against its effectiveness. As attendance records show the partnership has maintained an inclusive approach. Steps to manage this have been:

- Agenda setting and management
- Considering how the meetings are chaired, and feedback
- Considering how we present and share information
- Induction for all new members
- Formal Board agreement to changes in membership
- Development sessions and stand-alone meetings for special issues such as SCR
- Feedback form provided to evaluate impact from meeting/role and effectiveness of Chair
- How the sub and business groups support Board members and meetings
- Where a sector is complex and/or diverse (e.g. health, education, voluntary sector) ensuring membership ties into effective networks
- Introduction of Board member appraisals for some members in the year

Attendance at Sub-groups has been more of a challenge with a number of business groups and Sub-groups being cancelled. It was noted last year that it is understandable that some partners struggle to release time and staff. The factors that impact on this are varied and complex so it best not to generalise. But it is important to note that cancellation or poor representation can have a disproportionate impact on progress, as unlike organisations it is not always possible or easy to reconvene or relocate the activity elsewhere. In the last annual report we stated that improving clarity around purpose and role of Sub-groups, strengthening leadership and integrating this into the Business Plan and the business group/Board were priorities and these have been maintained in the year. As with last year, the Board review session included members of the Sub-groups and this, it is felt, is a positive and a significant innovation.

Financial and contributions in kind

Statutory partners are required to ensure that the partnership has the means to achieve its responsibilities as an independent body. It is easier to quantify and evaluate direct financial contributions and these can be seen in Appendix 3.

In addition the partnership relies on 'in kind' contributions that are difficult to quantify and evaluate. These are considerable but of course susceptible to other pressures and priorities at an organisational and a personal level. This places a responsibility on dedicated and designated roles which have to minimise and manage the risks arising from this vulnerability.

During the year the partnership made significant steps in improving how it sets a budget, how this is managed and how this influences risk management and prioritisation. Significant amendments to process for the coming year have been identified and agreed.

Summary and what we will do next

Partner support and enthusiasm remains positive as evidenced by feedback, review and engagement at Board level. Arrangements to mitigate against some of the inherent weaknesses of the partnership scope and size remain the subject of active attention and development.

Steps to strengthen engagement with the education sector have been a notable achievement in the past year as evidenced by active and leading roles played by Board members, the support of the LA specialist support officer, termly meetings with education Board members and the Chair, and an increasing participation and ownership of the Section 11 self-assessment.

This means we will:

- Maintain the arrangements to support and develop the Board member role and the Board as a whole
- Fully implement the steps we agreed to set future-year budgets for
- Maintain and improve how we monitor our attendance and promote self-challenge and escalation
- Continue to balance priorities on the basis of consideration of risks and continued refinement of the sub group, business group and Board interrelationship
- Continue to test and set clear standards for participation and representation to ensure we reflect both the statutory and non-statutory aspects of the safeguarding agenda
- Consider whether or not we need to change or stop doing some of the things we are doing now

9. Whole-system impact

Having looked at some of the key aspects of how we worked together as a partnership, the rest of the report will look at how we develop a whole-system approach.

In the previous year the Board was asked to support the introduction of the implementation of Systemic Practice and Strengthening Families by the LA. Initially partners had some reservations as to the Strengthening Families approach and it was agreed that the proposal should be resubmitted on further evaluation of the pilot. This was endorsed by the partnership and the process illustrated the strength that partners felt able to raise questions and have these answered. This, it should be noted, is a trend that has continued in that all partners appear to be more sensitive to and aware, that success is to some extent dependent on how they engage as partners.

The Strengthening Families approach and the way child protection meetings are conducted have been formally and informally looked at by the Board, as well as from the perspective of performance information. It has required some significant adjustments to how professionals prepare for and take part in these meetings and the initial evidence appears to indicate that it is contributing to both a change in the ways in which children, parents and professionals experience these difficult meetings but also in producing better and more reliable outcomes.

Equally the view of the partnership responded to the introduction of systemic social work practice by seeking to better understand what this was and what implications this might have for joint working. During the year the partnership has monitored impact through its PMQA arrangements and will hear about progress in the coming year.

The report suggests that these and other areas supported and incorporated by the partnership into joint working practices and the arrangements to 'test', and work through, any implications, have progressed significantly in the year.

Child Sexual Exploitation (CSE) and children missing from home, care or education

These have remained priorities for partners and the safeguarding partnership to have a view as to the effectiveness of local arrangements (see Ofsted recommendation in Appendix 1).

This view is that the LSCB continue to benefit from the priority and attention that is given to this by partners both in terms of the core capacity to respond, assess and manage risk and the need to have effective recognition and an early response. The evidence available to the partnership supports a view that there is an effective response that is keeping pace with the developing capacity to better recognise the indicators and respond in a timely and a proportionate way. The partnership is also aware as a result of the strong leadership provided by the LA and the Police, of those efforts to prevent, disrupt and prosecute, and that some of the practice in Calderdale has been recognised nationally.

Over the past few years there has been a consistent and successful response to CSE and it has therefore been important to know that partners are able to share information, assess and manage risk on a shared basis within and outside of the statutory processes.

Increasingly, the response to CSE has highlighted the importance of knowing more about children who are missing both in relation to CSE but also in respect of other forms of abuse such as children who are not in school who may be at risk of harm or be in situations that are unsafe.

Practice has continued to develop in relation to Children Missing Education (CME). We now have standardised procedures across the Yorkshire and Humber region as part of our commitment to the Regional CME Network, with the LA now receiving lists of CME contacts for all LAs across the country on a three-monthly basis direct from the Department for Education to help to share information quickly and accurately with peers.

Functions are being developed to help categorise the reasons for and status of all CME to further enhance the data provided for a central record.

The partnership has maintained both their support and scrutiny of arrangements and has benefited from and contributed to the lead provided by the Police and Crime Commissioner to a West Yorkshire approach. The partnership has also planned a joint self-assessment against the learning from the Joint Targeted Area Inspections for this year which will provide the basis for a review of the current objectives held by the partnership.

The ways in which we have maintained and contributed to the response are as follows:

- Dedicated sub group taking forward the action plan and linking into operational arrangements
- Performance sub group has monitored and scrutinised key indicators
- Active participation in West Yorkshire CSE group
- Promotion and awareness raising
- Incorporation as necessary into policies, procedures and training
- Regular reports into the Board
- Inclusion in Section 11
- Respective Board members have provided a strong lead and have been open to challenge
- Commissioned a SCR that focuses on the learning from a victim of CSE
- Coordinated partner response to high-profile prosecutions and support of the development of links with particular communities affected by this issue
- Promoted and supported clear response to licensing requirements for taxis, the night-time economy and accommodation providers
- Regular scrutiny by the partnership of a report from the LA regarding CME. This has evidenced a proactive approach by schools and the LA, giving a good picture of incidence and the steps being taken to improve monitoring and response
- The planned review which includes a peer challenge element with other areas will further inform what we need to do next but we have already identified the following:
    - Improve the effectiveness and reporting of key performance information and analysis
    - As a result of the learning from the pending SCR, assess the availability and quality of support and services for victims
    - Identify and formalise any wider learning for the whole system from CSE, including how we monitor front door contacts, risk assessment and management and information sharing
    - Consider whether our understanding of and response to children who are missing from school, home, care and from sight is proportionate and fit for purpose

Private fostering

The partnership has maintained regular and formal scrutiny of the LA arrangements and set standards for the partners' role in this. The last report from the LA evidenced that they were maintaining a focus and were able to evidence, a) how they were meeting standards, and b) that they were continuing to invest in improving. Partners have also been asked to share and evidence how they ensure that they are able to recognise children who may be subject to private fostering and the partnership are committed to ensuring that guidance is readily accessible.

After the Ofsted Recommendation in 2015 (see Appendix 1), awareness-raising activity has been undertaken by the Board by way of flyers for parents, information guides and screensavers for professionals via targeted dissemination through schools and GP surgeries. However, it is difficult to measure incidence and public awareness in areas such as private fostering. We seek to ensure that we approach this from the perspective that we would want to be assured we are not missing any child who may be subject to private fostering.

Children Looked After (CLA)

The partnership has maintained regular scrutiny of the recognised performance indicators which evidence how effectively partners are working together to meet the needs of and protect children who are looked after and care leavers. Performance has been to the required standards and has therefore not triggered the need for further consideration.

However, learning from a local SCR that had direct lessons for how partners respond to CLA, in addition to the learning already being acted on and in advance of the publication of the report, we commissioned a full report explaining to the partnership how they saw and were able to evidence their responsibilities for CLA and care leavers. This usefully set the agenda for further consideration by the Board in addition to current monitoring of how it might be further assured that joint working was as effective as possible. We are therefore looking to incorporate some or all of the following into our revised work plan:

- Confirming that our high-level monitoring is fit for purpose and that partners are providing appropriate and timely information and analysis
- Being assured that CLA have access to appropriate specialist services and support especially in regard to self-harm
- Working more closely with the Adult Safeguarding Board to ensure transition retains an appropriate focus on safeguarding
- Working with and taking reports from the other bodies that exercise and oversee the corporate parenting role

Female Genital Mutilation (FGM)

LSCBs were assigned an additional role and responsibility in respect to FGM. The partnership responded confidently and quickly, and also took the opportunity to refine on the basis of learning from CSE how it would achieve its objectives. The result was that instead of committing partners and the partnership to a strategy, the Board decided that a strategic response was the proportionate approach. This was mainly because it was recognised that rather than take on responsibility it was more appropriate to clarify responsibilities and roles across a number of partners. Therefore the partnership focused on holding itself and these partners to account on the basis of, a) ensuring that information was subject to independent scrutiny and analysis, and b) that key points in the current joint working process and arrangements reflect the duties and requirements resulting from FGM (i.e. front door; referral forms and assessments; mandatory reporting and training). As the national and local data reaches a point where a fuller picture can be understood the CSCB plans to review the strategic response in the coming year.

Multi-agency supervision principles and framework

The year saw the partnership taking what was initially a single agency-led initiative and working this up into an approach that partners felt would have maximum benefit. This built on the learning from FGM and efforts have been focused on promoting and supporting its implementation, which will be monitored and evaluated though each partner's self-assessment and through the PMQA arrangements. Partners clearly agreed that it was a good idea to ensure that their staff who were directly involved with the difficult judgements that have to be made when protecting a child would benefit from dedicated support and time to help them. The significant learning from this is that the partnership has worked out a better way of taking the strengths from one area of the system and sharing this in a way that is compatible with and contributes to other areas of the system; and also in a way that allows them to apply this in accordance with the nature of their activities, and demonstrate through the Section 11 and their own governance and accountability arrangements, the impact this is having.

Section 11 self-assessments against common standards for safeguarding in Calderdale

As noted in previous reports and highlighted through the Ofsted recommendations (see Appendix 1), the partnership has given a high priority to the long-term transformation of this requirement. This has meant finding ways to make it more relevant and helpful to partners who range in size and scope, to self-assess their position in relation to agreed and common standards that reflect good safeguarding. It is also a deliverable that wherever possible this would support internal governance and scrutiny.

It has involved a significant shift away from the term 'audit', which can imply 'pass or fail', to the use of 'self-assessment'. This has also meant that as a partnership we have had to address the means for and by which we form a view of the returns. This continues to be a challenge in terms of resources and capability, and as a result the original three-year timeline has been extended to a five-year timeline. Progress by the raw measure of completed returns is on target and in some cases ahead of target. The year saw the introduction of the first challenge events where a number of partners were invited to share their experiences and outcomes in order to test quality and inform the wider view formed by the partnership. A group of Young Advisors also took part. These were helpful and successful events as evidenced by feedback and impact on overall analysis; they also informed the setting of a template and standard for future events.

Appendix 5 shares some of the findings and results, but these can be summarised in the following way: take-up by statutory partners remains strong and learning has already impacted on how they integrate this in their own arrangements; progress has been made in respect of commissioners and how they require completion from their providers and how as an intermediary they support the partnership. Schools, with the help of the relevant Board members, and changes in the way the process is communicated and executed, are more enthusiastically taking part, and in this year the first steps were taken to engage the non-commissioned voluntary sector. The Board also affirmed the revised timeline and agreed to hold to the original objectives.

It is possible in this year to comment on what this means and what the returns and challenge events are telling us, although this is still quite generalised as we have recognised that one of the objectives for the partnership is to work out a more fit for purpose way of evaluating what conclusions we can draw. From the analysis of the returns it appears to be a positive indicator that self-assessments are not producing a universal 'fully met' and there is some early indication that partners are approaching this with rigour and transparency on the basis of partially meeting the standards. As this is an annual process it will be possible to track and assess this in more detail. The challenge events encouraged participants to share good practice and common struggles; they also provided a challenge in asking people to consider the evidence on which they made

their assessment. In the next round of events, more attention will be paid to follow through and how people were able to act on areas they felt they needed to improve.

Therefore at this point it is possible to conclude that we are near to reaching a tipping point in embedding the self-assessment process across large parts of the system. This demonstrates the view that partners are serious about and committed to reaching basic standards that support their own capacity to demonstrate and be assured that safeguarding is a priority against a common benchmark. This provides a degree of whole-system assurance and provides a platform to develop the potential.

Commissioning arrangements

During the year, as a result of closer working with the CYPPE, improved monitoring arrangements and a more proactive approach from partners, the partnership has been able to contribute to, and where necessary provide support and challenge to, commissioning arrangements as they impact on present and future joint working safeguarding arrangements.

This became more significant as we developed more of a strategic overview and understanding of the increasingly complex arrangements for how, and from where, services are commissioned.

As a result we have agreed to:

- Continue to escalate occasions where information is required but is not being supplied by the organisation and the commissioning body
- Work with commissioners to develop a more detailed and current set of requirements and expectations in respect of both general and core safeguarding responsibilities
- Continue to work with commissioners to further develop the potential of Section 11
- Work with commissioners to plan for and formalise consultation and provision of advice from the safeguarding partnership
- Reflect changes in commissioning arrangements in our core performance management arrangements, Board membership and in response to any identified risks relating to significant changes in services
- Continue to work with commissioners to develop expectations and learning arising from SCRs

Partnership collaboration

During the year, the first significant steps have been taken to develop and build on the existing cooperation with the Adult Safeguarding Board and also the Community Safety Partnership in the context of how their roles and responsibilities fit together, and also with the role of the Health and Wellbeing Board.

The Domestic Violence Strategic Group is also included in this work, which has highlighted a number of areas of potential collaboration and integration at a thematic and functional level. At the time of writing, negotiations are at an early stage so it is not appropriate to comment in detail as to the opportunities for sharing resources but thematically and in terms of priorities, and therefore leadership and accountability, it is possible to comment on the potential opportunities and risks:

- From initial work there appears to be good ground to believe that each partnership can assume a lead role in respect of particular issues such as FGM or Prevent, and in respect of the latter the two partnerships have explored how this might work in practice
- This raises the issue of primacy, i.e. which partnership is ultimately accountable and what is the level of risk in terms of compromising a partnership's achievement of objectives as measured by, for example, inspection
- There are certain themes and issues that all partnerships can relate to such as domestic violence, neglect, mental ill health and substance misuse but these require a number of different perspectives to be taken into account to identify more of shared approach

The Wood Review and future partnership arrangements for safeguarding

During the year, the government announced a fundamental review of LSCBs, CDOP and SCRs, which was completed by Alan Wood at the end of the year. Its recommendations are subject to legislative process and the outcomes from this are not yet determined.

It is reasonable to speculate that local arrangements for the independent scrutiny of child protection arrangements will, on the basis of a revision of statutory obligations, be open to development on the basis of leadership from the LA, Police and Health. In addition, it is proposed that the system for SCRs will be changed with a more centralised system for reviews of national significance and a local system for other forms of review. It is proposed that leadership for the CDOP will be transferred to the Department of Health for them to determine viable scale and scope of arrangements.

These proposals and the wider implications of the legislation of which they form a part, herald the potential for further significant changes that will present opportunities and threats. As a partnership it has been agreed to maintain the present arrangements into the current year pending the outcome of legislation, and to promote local discussion and determination of the options that will best address the needs and safety of children and young people in Calderdale.

10. Conclusion

This annual report identifies key learning that partners and the safeguarding partnership will consider when taking forward their responsibilities and priorities.

Our vision for safeguarding and the five priorities we use to take this forward and to evaluate whether we are making a difference remain helpful. We have made progress in making sure that our vision fits with, and contributes to, the wider vision and partnership priorities in Calderdale, reflecting our understanding of the needs of the population. But we know that this can be further developed.

We will improve work with other strategic partnerships to understand how we ensure that children are safe and that the measures to reduce abuse, harm and neglect are focused on improved collaboration, coordination and efficiency.

As a partnership we are now at a point where we are able to be clearer about what we do, why we do it, how we do it and how we can measure the impact. This means we can confidently take things to the next level, but that we will need to carefully consider how we do this.

We are also, importantly, at the point where we are sufficiently confident that we can focus what we do more effectively, as well as think about what we may need to do less of and how we manage any risks this might represent.

11. Key messages

1. Assurance

In terms of assurance, these are the things that as a safeguarding partnership we will want to be clearer about:

- The strategic response and an increase in focus on joint working to protect children at the point of early intervention
- The strategic response to neglect – that we have a comprehensive understanding of the incidence of neglect and as a result are assured that partners are able to strengthen the joint working response across the early help and child protection arrangements
- The strategic response to domestic abuse – we know that the partnership response is strong and want to make sure that we are assured that the response to families and protection of children remains a priority within the safeguarding joint working arrangements
- The strategic response to children's mental ill health and emotional wellbeing – we know that services are being transformed and as a safeguarding partnership we want to be assured that safeguarding joint working arrangements support this. We also want to be assured that children will receive the right help in a more timely way
- The strategic response to children missing from home, care and education - we know that these children are more likely to be at risk of and subject to harm and abuse, especially CSE. We are assured that there is a strong partner response but that this means we now need to ensure that what has been learnt from this is looked at to see whether we can improve all joint working arrangements to protect children
- The strategic response to CLA - children in care have often experienced neglect, harm and abuse and we want to be assured that their needs are being fully met across the different types of placement and that their potential vulnerability continues to be proactively safeguarded
- The strategic response to children with disabilities and special needs is subject to transformation and we want to be assured that the opportunities this presents for assurance are taken forward
- The points at which information is shared to make decisions about what should be done to protect a child

2. Scrutiny

The ways we look at how partners work together reflects our capacity to manage performance information, looking at cases through audit and review, looking at practice and listening to all those involved.

We recognise that scrutiny helps to inform the priority we place on what we do, as well as, how we understand and approach this. We have recognised that we need to continue to develop our capacity to horizon scan so that we can look further into specific areas or issues.

We will continue to learn more and improve. But also that we need to keep a balance between process and capacity development, and how as a partnership we can achieve objective scrutiny that focuses on what is right and best for children.

We have recognised that we need to be able to see the bigger picture but this only makes sense if we can relate this to the points and circumstances where people come together to help children and to protect them. Our default position must always be the scrutiny of front-line practice.

We now feel we are at the point to review and reset the points in the child's journey and the measures we apply to establish the effectiveness of joint working arrangements and practice:

- To improve how we scrutinise, and are assured of, how information is shared and risk recognised and managed, at the key points where partners bring together their concerns, assessments and information at the front door and other points or hubs
- Sharpen our focus on the child protection system
- Ensure that our focus on our assurance themes is informed and supported by effective scrutiny
- Continue to improve how we can be assured that partners have the capacity and capability to meet their commitments and maintain standards
- Ensure that as a partnership we are able to hold ourselves and each other to account for our contribution and the commitments we have made
- We will maintain and improve how we review child deaths and notifiable incidents, within current frameworks and to best practice standards. We will consider the need for other forms of review and prioritise, making sure that where we have agreed to learn lessons that this is making a difference and that it continues to influence our priorities

3. Setting the standard (what 'good' looks like)

We have learnt that setting standards and helping people to be clearer about what works and what is expected, continues to demonstrate the potential for strengthening and improving joint working arrangements.

We recognise that effective safeguarding and child protection in partnership terms is complex, but we remain committed to making this as clear and uncomplicated as possible, as this helps reduce barriers and promotes working and strategic relationships that are more likely to recognise and respond to concerns about the safety of children.

This means we will:

- Continue to develop how we are assured that safeguarding standards support a consistent response to safeguarding concerns and promote a culture of trust (Section 11 self-assessment)
- Maintain policies, procedures, protocols and guidance, and approved tools that are current, accessible and useful
- Continue to improve the multi-agency training we are responsible for; making sure this is aligned with our priorities, the strategic partnership agenda and what other people provide. At the same time we will continue to work out whether the partnership is able to ensure that everyone has the right skills and knowledge
- Engage with commissioners to support their efforts to integrate and incorporate the standards the partnership expects

Our annual report will continue to be how we tell the story of how partners have worked together, what has been achieved and what this may tell us about the overall arrangements and position for the effectiveness of joint working arrangements to protect children in Calderdale.

As a partnership we met with Young Advisors to have further dialogue about how they have helped and can help in the future for us to consider things from the points of views that children and young people have. This has meant that we will bring together how partners and other partnerships engage with and listen to, and learn from, their service users, to explore a more joined-up approach.

This also signals the importance of recognising that continued progress as a safeguarding partnership is perhaps more reliant on, and a reflection of, the ways in which, other forms of strategic partnerships are able to share in and contribute to the ways in which we are able to demonstrate that children and young people are effectively protected.

Appendix 1: March 2016 revision of 2015-2018 CSCB business plan

Calderdale Safeguarding Children Board Business Plan 2015-2018

This is the three-year business plan for the Calderdale Safeguarding Children Board (CSCB).

The five priorities represent both our vision and our statutory responsibilities and function. They also reflect what children, young people, their families and the citizens of Calderdale might reasonably expect of the joint working arrangements to protect children and young people and to promote their welfare.

Version	Update and by whom	Date signed off
V1	Approved by the CSCB Meeting 4th June 2015	4th June 2015
V2	JC update 11th September 2015	
V3	JC updated 16th October 2015 and JW / JJ / JH / LK / DM / LH / RB / JP / JR	
V4	Business Group update November 2015	
V5	Completed items archived to rear of business plan. Updated 8th February 2016 JC, EC, LH, JJ, LK	
V6	Approved CSCB March 2016	3.3.16

Progress Key	**Red**	Tasks or outcomes have not been met or timescale slipped.
	Amber	Tasks and outcomes are on track, milestones met but not completed.
	Green	Tasks and outcomes are completed or performance is on target.

Acronyms:

CDOP	Child Death Overview Panel	C&E sg	Communication & Engagement sub group
C&YP	Children & Young People	CLA	Children Looked After
CR sg	Case Review sub group	EH&P sg	Early Help & Prevention sub group
EIP	Early Intervention Panel	Ind Chair	Independent Chair
L&I sg	Learning & Improvement sub group	MA	Multi-Agency
MAAG	Multi-Agency Audit Group	MAST	Multi-Agency Screening Team
PARS	Proactive & Responsive sub group	PM sg	Performance Management sub group
PMQA	Performance Management Quality Assurance	SCR	Serious Case Review
WT15	Working Together 2015		

1	We are assured that children receive the right help and protection at the right time					
No	**Outcome**	**Action**	**Timescale**	**Reporting**	**Evidence & Progress**	**RAG**
1.1	**Professionals understand thresholds ('continuum of need' and 'signatures of risk') and apply appropriately**	Finalise review of CSCB thresholds documents after multi-agency consultation, WT15 revision and alignment with Single Assessment.	September 2015	EH&P sg	Review completed and new document produced. Signed off in January 2016.	G
1.2		Launch revised thresholds documents across all sectors, specifically targeting Adult Services and Voluntary Sector.	December 2015	C&E sg		A
1.3		Review Multi-Agency Workforce Training Programme to establish owner, lead and provider of threshold training.	August 2015	Business Manager L&I Officer	Complete. CSCB leads Threshold training and regular meetings between CMBC and CSCB ensures no duplication or gaps.	G
1.4		Data from EIPs tracks contacts and referrals and referring agencies to MAST and EIPs to identify child's journey, outcomes, step ups / step downs; gaps in referring agencies; reported to EH&P sg as necessary.	June 2016	PM sg EH&P sg	Revised dataset to include this info from April 2016.	A
1.5		Complementary soft audit with front-line practitioners show level of understanding of thresholds.	October 2016	EH&P sg	This will be compared to results from 2014-2015 soft audits.	A
1.6		Adapt and re-pilot MA Chronologies with emphasis on benefits of earlier collation at tier 3.	June 2016	EH&P sg	To be started in January 2016.	A
1.7	**CSCB is assured that Early Help is having positive impact on outcomes: children are being safeguarded in a timely and proportionate way**	Complementary soft audits with C&YP showing impact and outcomes on children and young people.	June 2016	Young Ads EH&P sg	To be started in April 2016 – case studies tied into themed reporting.	A
1.8		Establish the tools available for overcoming non-engagement/ non-consent / disguised compliance. (cross ref to 1.6 MA chronologies)	December 2016	EH&P sg	Non-engaging pathway and letters written for Calderdale. To be presented to EH&P sg in November 2015.	G
1.9		Create training for overcoming non-engagement/ non-consent / disguised compliance.	December 2016	L&I Officer L&I sg	See L&I Programme: Course: Ongoing Work with Complex Families including Disguised Compliance, Working with Highly Resistant Families, Using Tools.	G
1.10		Audit of escalated / de-escalated cases from EIPs to show and share good practice and need for improvements.	March 2016	MAAG	Report and Action Plan received by MAAG and challenged. Action Plan to be monitored by MAAG.	A
1.11		Publicise, raise awareness and promote guidance, training and tools (cross ref with 1.9 & 1.10) using the marketing strategy.	April 2017	C&E sg	Tools, guidance and training on website. Further development of Communication strategy to publicise and promote.	A
1.12		Audit the use of strategies and examine any impact on non-engagement, non-consent and disguised compliance.	December 2017	MAAG	Audits from EIPs (1.8) highlighted the need for further audit of non-engagement cases.	A

2	We know which children are vulnerable and are assured that they are protected					
No	**Outcome**	**Action**	**Timescale**	**Reporting**	**Evidence**	**RAG**
2.1	**Key areas of joint working arrangements for vulnerable children and young people continue to be developed; learning is applied across the child's journey (CSCB has reflected on the quality of CSE services and learnt from own practice and that of others)**	The Joint Strategic Needs Assessment, electronic Health Needs Assessment & the C&YP Strategic Framework for Calderdale informs a 'vulnerability matrix' to map joint working arrangements which provides reassurance to the Board the CSCB or highlights where improvement in joint working arrangements are needed. This is turn informs 2.2.	January 2016 and annual	Business Group	Delay due to JSNA report not being ready. eHNA currently being analysed and results due to the Board in Spring 2016. RAG not red due to JSNA being secondary to what is collated through CSCB PMQA.	A
2.2		There are clear joint working arrangements and effective pathways, procedures and local guidance which are compliant with national guidance for the following areas identified by the CSCB: (cross reference with 5.13 to 5.15) Female Genital Mutilation (FGM) Trafficking Forced Marriage / Honour Based Violence Extremism / Radicalisation (Prevent) Child Emotional Wellbeing / Mental Health Domestic Abuse	Dec 2015 July 2016 June 2016 April 2016 Sept 2016 Sept 2017	PARS EH&P sg	Meetings established between SAB, CSP and CSCB to ascertain leads for each area. Strategic Partnership Group led by Chief Exec set up January 2016.	A
		Update for each area: **FGM** - Strategy and Action Plan written, agreed by Board in August with amends. Signed off at December 2015 Board. PM Dataset will monitor numbers in Calderdale. T&F Group to implement actions to ensure awareness, training and PMQA arrangements are in place. **Trafficking** – Calderdale part of West Yorkshire Pilot for new referral mechanism. Calderdale Anti-Trafficking Group established which CSCB Manager is part of – currently preparing to write strategy and action plan (based on CSE and national learning). Led by Regional Group / Hope for Justice – CSCB Manager requested policies and procedures consistent across West Yorkshire where possible. Safeguarding Adults Board will monitor numbers, trends of children in Calderdale – TBC. **Forced Marriage / Honour Based Violence** – This is part of the Domestic Abuse and Sexual Violence Strategic Group which falls under the Community Safety Partnership (to be agreed). This group will report annually to the CSCB in a rolling report the prevalence, the successes, the risks and the future services planning. Forced Marriage Protection Order numbers will be included in the Scorecard annually. **Extremism / Prevent** – Led by the CSP, Annual Report due to CSCB in December 2016 detailing effectiveness of provision, trends and any safeguarding risks to children. CSCB assisting with awareness raising of policies and procedures, training and communications. **Child Emotional Wellbeing / Mental Health** – HWB lead, however the CSCB will monitor performance across the three tiers – TBC from April 2016 PM Dataset. **Domestic Abuse** – led by the Domestic Abuse and Sexual Violence Strategic Group which will report annually to the CSCB in a rolling report the prevalence, the successes, the risks and the future services planning.				
2.3		PMQA review of joint working arrangements of areas highlighted in 2.2 through task & finish groups.	1 year from dates in 2.2	MAAG PM sg	The Chief Exec of the Council is reviewing all Boards (CSCB, Adults H&WBB and CSP) responsibilities to ensure clear accountability and reduce duplication.	A
2.3a		Further development of local guidance and PMQA arrangements for neglect.	December 2016	Business Group	L&I Officer rewriting neglect tool.	

2.4	**Joint working response to Child Sexual Exploitation continues to be effective and strategic aims are fully met Ofsted 15: Para 166**	Revise and update the CSE Action Plan to ensure that it is outcome focused and measures impact in all areas of work.	August 2015	PARS	Revised August 2015 – Reviewed at PARS September 2015. Updated again at October 2015 meeting.	G
2.5		Numbers and protected characteristics of children and young people at risk of and / or involved in sexual exploitation are monitored through PM dataset.	August 2015	PM sg PARS	Delay in obtaining CSE figures from Police. Agreement to retrieve all figures from April 2015 and forward.	R
2.6		National Working Group to Peer Review joint working arrangements for CSE in Calderdale.	December 2015	PARS	NWG Delayed – new West Yorkshire Peer Review arrangement agreed with Independent Chairs.	A
2.7	**Professionals have access to and are trained in the most appropriate and effective resources to improve outcomes for vulnerable families**	Identify the best strategies and approaches to be used for parents with learning difficulties, mental health issues, sensory impairments, English as an additional language and other vulnerable groups. (from SCR)	December 2015	EH&P sg	Adult Child Protocol revised October 2015. Agreed November 2015. Assessment tools launched and on website.	G
2.8		Professionals have access to and are trained in the most appropriate and effective resources to improve outcomes for vulnerable families Develop training for tools identified in 2.7 and implement across the Calderdale partnership.	January 2016	L&I sg C&E sg	30 minute briefings agreed – to be piloted with ASC in December 2015 with the Adult / Child Protocol then rolled out to all other adult/ community based services.	G
2.9	**The LA and its partners have in place effective arrangements to identify children and young people who are privately fostered Ofsted 15: Para 169**	Ofsted 15: Para 169 Undertake further work to raise awareness and understanding of the need to report private fostering; target partner agencies and the public using the marketing strategy.	January 2016	C&E sg	Private Fostering Safeguard Guide produced for professionals. Leaflets for families for January 2016.	G
2.10		Private fostering lead to assess the LA response to private fostering arrangements and ensure that the LA is meeting its statutory responsibilities.	August 2015	Business Group	Board accepted private fostering report and noted implications for ongoing monitoring and future reporting.	G

3	Scrutiny and challenge evidences effective safeguarding					
No	**Outcome**	**Action**	**Timescale**	**Report-ing**	**Evidence**	**RAG**
3.1	**The Perfor-mance Man-agement data-set is further developed to enhance Board mem-ber scrutiny, assessment and challenge Ofsted 15: Para 167**	To ensure all remaining data gaps are filled and to produce a fully populated indicator report.	December 2015	PM sg	Dataset reviewed with taking the following docs into consideration: Evidence for LSCBs (from West Midlands and Gtr Manc); Ofsted Inspn Framework; The child's safeguarding perf infor-mation framework; and good practice by LSCBs.	G
3.2		To continue to identify areas of challenge arising from data and implement a rolling programme of investigation of these to support the Board's challenge function.	Through-out the year	PM sg	See PM reports to the Board and Rolling Re-port Schedule / Board minutes.	G
3.3		The Performance Management dataset is further developed to enhance Board member scruti-ny, assessment and challenge. Ofsted 15: Para 167 To review the Performance Management dataset – alongside the Audit Framework and feedback from service users and professionals - to further enhance its out-come and impact focus.	December 2015	PM sg	Dataset reviewed.	G
3.4	**Safeguard-ing Quality Standards are in place in Calderdale to help or-ganisations respond to the needs of C&YP across the continuum of need**	Provide a Safeguarding Quality Standards Framework including Supervision Standards for all providers. (annual milestones identified in plan) (cross reference to 3.5 to 3.9)	March 2018 (March 2016 March 2017 March 2018)	EH&P	Due to be commenced in Spring 2016.	A

3.5	**The Section 11 audit ensures that Safeguarding Quality Standards are embedded within the governance and accountability arrangements of all organisations working with children and young people in Calderdale** **Ofsted 15: Para 168**	2014/15 – Updated position required from partners who completed Section 11 in 2014. Completion and return of full audit for 40 schools that did not complete in 2014.	July 2015	PMQA Officer MAAG	Complete.	G
3.6		2014/15 – Results are subject to rigorous challenge and moderated effectively.	December 2015	PMQA Off'r MAAG	Analysis complete. Challenge events took place 2015.	G
3.7		2014/15 - Engage non-commissioned voluntary and community sector and Early Years providers.	December 2015	PMQA Officer MAAG	EY sector engaged with through Safeguarding audit which will feed into S11 in 2016 cycle. VCS / Faith sector delayed to Dec 2016	A / R
3.8		2015/16 – Year 3 of Section 11 Plan – as per S11 plans.	December 2016	MAAG	Including the exploration of using an online tool.	A
3.9		2016/17 – 3-year cycle recommences. Learning from previous cycle, review audit tool, broaden issues covered, effective timely challenge process.	December 2017	MAAG	MAAG continues to oversee Section 11, next update on Action Plan due Feb 2016.	A
3.10	**Case file audits scrutinise multi- agency joint working arrangements, impact and outcomes on children, young people and families. Audits cover all key points in the child's journey and learning is integrated with other forms of evidence**	Explain rationale for the scope and type of audit undertaken. Record numbers of cases audited.	October 2015	MAAG	Complete – see MAAG Schedule.	G
3.11		Review Audit pro formas to ensure they are robust and can be used to evidence impact of practice and outcomes for children and young people.	December 2015	PMQA Officer MAAG	Audit proformas now include section relating to impact on practice and outcomes for children. Audits undertaken will now be asked to comment upon impact and outcomes.	G
3.12		MAAG adopts the Learning Implementation & Action Pathway to show overarching learning themes from all areas of PMQA and identify proposed outcomes.	September 2016	PMQA Officer / L&I Officer		A
3.13		MAAG adopts 'Lessons Learnt' system to show impact of audit and share good practice in accordance with the Learning and Improvement Framework.	December 2016	MAAG	Communication from audit is being developed for front-line staff.	A
3.14	**Performance Management Quality Assurance Framework assesses the effectiveness of help being provided to children and families**	Review Performance Management Quality Assurance Framework in light of learning from 2014-2015.	December 2015	PMQA Officer PM sg MAAG	Revision done. Slight delay so sign off in Feb 2016 by PM sg.	A

4	Creating a learning culture which consistently improves outcomes for children and young people					
No	**Outcome**	**Action**	**Timescale**	**Reporting**	**Evidence**	**RAG**
4.1	**The Learning and Improvement Framework provides a clear understanding of how we learn and how we are working towards a 'learning culture'**	Annual review of the Learning and Improvement Framework.	April 2016	L&I sub group	Short delay due to writing of Strategy. LIF due to be revised Spring 2016.	A
4.2		2016-2017 Multi-agency Learning and Improvement Programme reflects CSCB priorities, national learning and areas detailed in the Learning and Improvement Framework.	March 2016	L&I sub group	The 2015-2016 programme reflects CSCB priorities, local and national learning. Sub groups have made requests. Learning fed through from SCR, CDOP and audit. Training Needs Analysis complete Oct 15, programme agreed by Business Group in February 2016.	G
4.3	**Lessons learnt from child deaths, Serious Case Reviews, serious incidents and examples of good practice are used to improve multi-agency safeguarding arrangements, procedures and practice**	Improve methods of communication and engagement through the marketing strategy to ensure that learning reaches front-line practitioners, influences practice and results in positive outcomes for c&yp.	As and when reviews are underway	CR sg L&I sg C&E sg	Case Review sub group explored comms methods. Plans and proposals changed will feed into SCR Framework Review. Pilot for new approach for Child J in Autumn 2016 and Child M in Winter 2016. MA Audit currently being undertaken to consider Historical SCRs.	A
4.4		Case Review sub group members to take part in half day training to audit previous SCRs and establish rationale for methodologies and deeper understanding with which to challenge and support the SCR and LL processes.	March 2016	CR sub group	Completed September 2015.	G
4.5		SCR Framework to be updated after learning from 2015-2016.	May 2016	CR sg		A
4.6		Challenge events evidence learning implementation from action plans and recommendations.	6 months after briefings	CR sg L&I sg	Single agencies written to as part of first step in challenge process: October 2015. Challenge events will be held in Spring 2016 for Child J and K.	A

4.7	**Partners agree future development and resources for multi-agency workforce development Ofsted 15: Para 170**	Seek agreement with strategic partnerships for priority and strategy re future arrangements for multi-agency workforce development.	December 2016	L&I sg CYPPE	Draft strategy written. In consultation process.	A
4.8		Clear quality standards set out workforce expectations across partnerships. (cross reference 3.4)	December 2017	L&I sg		A
4.9	**Impact and effectiveness of multi-agency training is evaluated to evidence impact Ofsted 15: Para 170**	Develop different methods to evaluate MA training to ensure it is reaching the right people and is effective.	June 2016	L&I sg L&I Officer	Identified best profile models from other LSCBs to consider what will work for Calderdale to implement and measure the impact of training on practice. Further work to report on this in May 2016.	A
4. 10		Target practice which needs improvement (identified through audit and serious case review) and offer training.	As required	MAAG L&I sg L&I Officer	The CSCB Learning and Improvement Officer sits on MAAG to ensure any learning is fed into training. Need more robust way of evidencing impact of this. Communication from audit for front-line staff is currently being developed.	A
4. 11		MA Audit to ask if there is evidence that training has had an effect on practice and outcomes for C&YP.	Every audit	L&I sg and MAAG	Audit group ensure that as part of the challenge to each lead auditor on proposal and completion of audit that training and its impact is questioned.	A
4. 12		Consider alternative learning practices including length of courses and platforms.	March 2016	L&I sg	Online Platforms explored by Chairs, B mgr and L&I officer and dismissed due to technical / content and priority inaccuracies. 30 minute briefings developed. Other alternative methods to be explored e.g. video / webinar.	A
4.13	The Child Death Overview Panel Annual Report informs the CSCB Annual Report	The CDOP Annual Report informs the CSCB Annual Report to maintain the efficient and effective operation of CDOP processes.	August 2015	CDOP	CDOP continues to operate effectively. Report received by Oct 2015 Board. Further work to be done on governance and admin arrangements.	G
4.14		To ensure key themes and lessons from local child deaths are identified and acted upon in a timely manner.	Annually July 2015	CDOP L&I sg	Recommendations are clear and being acted on from modifiable factors however more work needs to be done longitudinally due to small number of cases in Calderdale.	G

5	Effective leadership strengthens joint working arrangements for safeguarding children and young people					
No	**Outcome**	**Action**	**Timescale**	**Reporting**	**Evidence**	**RAG**
5.1	**Minutes are more accessible and stakeholders are able to hold to account Ofsted 15: Para 171**	Minutes are more accessible and stakeholders are able to hold to account. Ofsted 15: Para 171	August 2015	Business Group Secretariat	Meeting Standards written for secretariat, sub group admin, sub group Chairs, Business Manager & Independent Chair.	G
5.2		Minutes of Board are easily accessible on the LSCB website one month after every meeting.	Monthly	Secretariat	Complete.	G
5.3		All LSCB produced documentation available on website one month after approval.	As needed	Business Group	Complete.	G
5.4	**The CSCB listens to children and young people and demonstrates the impact of this**	Evidence of all partner agencies listening to the voice of children and young people through Section 11 audit and challenge.	November 2015	PMQA Officer C&E sg	S11 shows how each agency does this and to what effect. Good examples given from single agencies.	G
5.5		Young Advisors to triangulate evidence with views from c&yp. Board to identify the role they wish children and young people to have in Board governance.	December 2015	Young Advisors C&E sg	Good consultation with CSE and Early Help (lots of yp response, results fed to appropriate forums).	G
5.5a		Strengthen Section 11 questioning, reporting and challenge to effectively show partners listening and giving evidence of how they safeguard children.	April 2017	PMQA Officer MAAG	Cross reference with 3.8.	A
5.5b		Produce thematic case studies to evidence and triangulate the impact of the Board on c&yp.	April 2017	Business Group		A
5.6	**Services are delivered in accordance with the West Yorkshire Safeguarding procedures for. Local guidance is clear and coherent**	Establish procedure for reviewing, creating and accepting policies and procedures and for localising to Calderdale.	December 2016	Business Group	Procedure written – Business Group to assess how it is working in Spring 2016.	G
5.7		Audit and other quality assurance functions test out the use and relevance of the policies and procedures.	July 2017	Business Group		A
5.8	**Human Convention of Rights of the Child is evident throughout the work of the CSCB**	CSCB develops a clear position and arrangements in terms of standards, oversight and scrutiny for the use of physical restraint.	March 2016	Business Group	Report on physical received through annual CLA report.	A
5.9	**Annual Report provides a clear commentary on effectiveness of local safeguarding arrangements and impact of the Board**	Annual Report provides a clear commentary on effectiveness of local safeguarding arrangements and impact of the CSCB. Completed annual report recognises good practice, acknowledges strains, reports impact and availability of resources to drive effective practice.	August 2015	Ind Chair Business Manager	Annual Report complete. Results will feed into business planning process in December 2015 Board.	G

5.10	**The CSCB has arrangements in place to embed progress, so that systems, processes and frameworks are fully effective**	CSCB has arrangements in place to embed progress, so that systems, processes and frameworks are fully effective post-improvement.	September 2015	Business Group	Led by Ind Chair, DCS and IB Chair.	G
5.11		Identify the key reporting requirements post- Improvement Board.	August 2015	Business Group	PM dataset amended to include necessary indicators. Rolling report reflective of whole-system approach to safeguarding.	G
5. 12	**Work with SAB, Health & Wellbeing, C&YPPE, CSP, Family Justice, Domestic Abuse Forum ensures joint working arrangements are Think Family focused and safeguarding is high priority**	Shared protocols and shared objectives are established as appropriate.	When needed	Business Group	The Chief Exec of the Council is reviewing all Boards (CSCB, Adults H&WBB and CSP) responsibilities to ensure clear accountability and reduce duplication.	A
5.13		Identification and development of ways in which the Boards and their sub groups can collaborate and work together.	August 2016	Business Group		A
5. 14		Identification of common areas of PMQA and joint policies / procedures that focus on vulnerable cyp and adults.	August 2016	Business Group		A
5.15		Child and adult protocol and referral pathways are in place.	October 2015	Business Group	Update complete. Training being delivered to Adults Services in December.	G
5.16	**Board members are supported to further develop their role as a Board member and champion of safeguarding within their own organisations and partnerships**	Board member Induction and appraisal process developed and implemented.	September 2015	Business Group	First Board members inducted in September with new documents.	G
5. 17		Buddy Board members established and used as peer support.	December 2015	Business Group	Not prioritised.	A
5.18		Board feedback influences governance of the Board.	Annually Sept 15	Ind Chair / Business gp	Ind Chair receives feedback to influence CSCB governance.	A
5.19		Members asked about understanding of this Business Plan during Section 11 challenge. (cross reference with 3.6)	Annually December 2015	PMQA off'r MAAG	In Section 11 report.	G
5.20	**The composition of the Board and sub groups fully reflects the types of organisations involved in safeguarding. We have the right people in the right place at the right time with the right skills and knowledge**	The composition of the Board and sub groups fully reflects the types of organisations involved in safeguarding. We have the right people, in the right place, at the right time and with the right skills and knowledge: review of CSCB sub group membership.	November 2015	Business Group	Membership and attendance reviewed quarterly by each sub group, PM sg and Business Group.	G
5.21		Away day planned to develop Board role, development of challenge and scrutiny, working in partnership, accountability.	May 2016	Business Group	Complete – January 2016.	G

Improvement from the January 2015 Ofsted Report for CSCB

Ofsted referencing for CSCB Business Plan 2015 - 2018:

Ofsted 15: Para 166: - Managing the response to CSE

Revise and update the CSE action plan to ensure that it is outcome focused and measures impact in all areas of work.

Ofsted 15: Para 167: - Effectiveness of scrutiny and challenge

Ensure that the performance management framework for the LSCB includes a comprehensive multi-agency data set that will provide information about all aspects of service delivery and enhance the ability of the Board to routinely evaluate and monitor front-line practice across the agencies.

Ofsted 15: Para 168: - Effectiveness of scrutiny and challenge

Ensure that Section 11 audits are completed annually by all agencies and organisations involved in safeguarding children and young people, that audits include questions about CSE and learning from Serious Case Reviews, and that results from audit are subject to rigorous challenge.

Ofsted 15: Para 169: - Private fostering

Undertake further work to raise awareness amongst partners of private fostering and ensure that the LA reviews and strengthens the response to private fostering arrangements to ensure that it is meeting its statutory responsibilities.

Ofsted 15: Para 170: - Multi-agency training

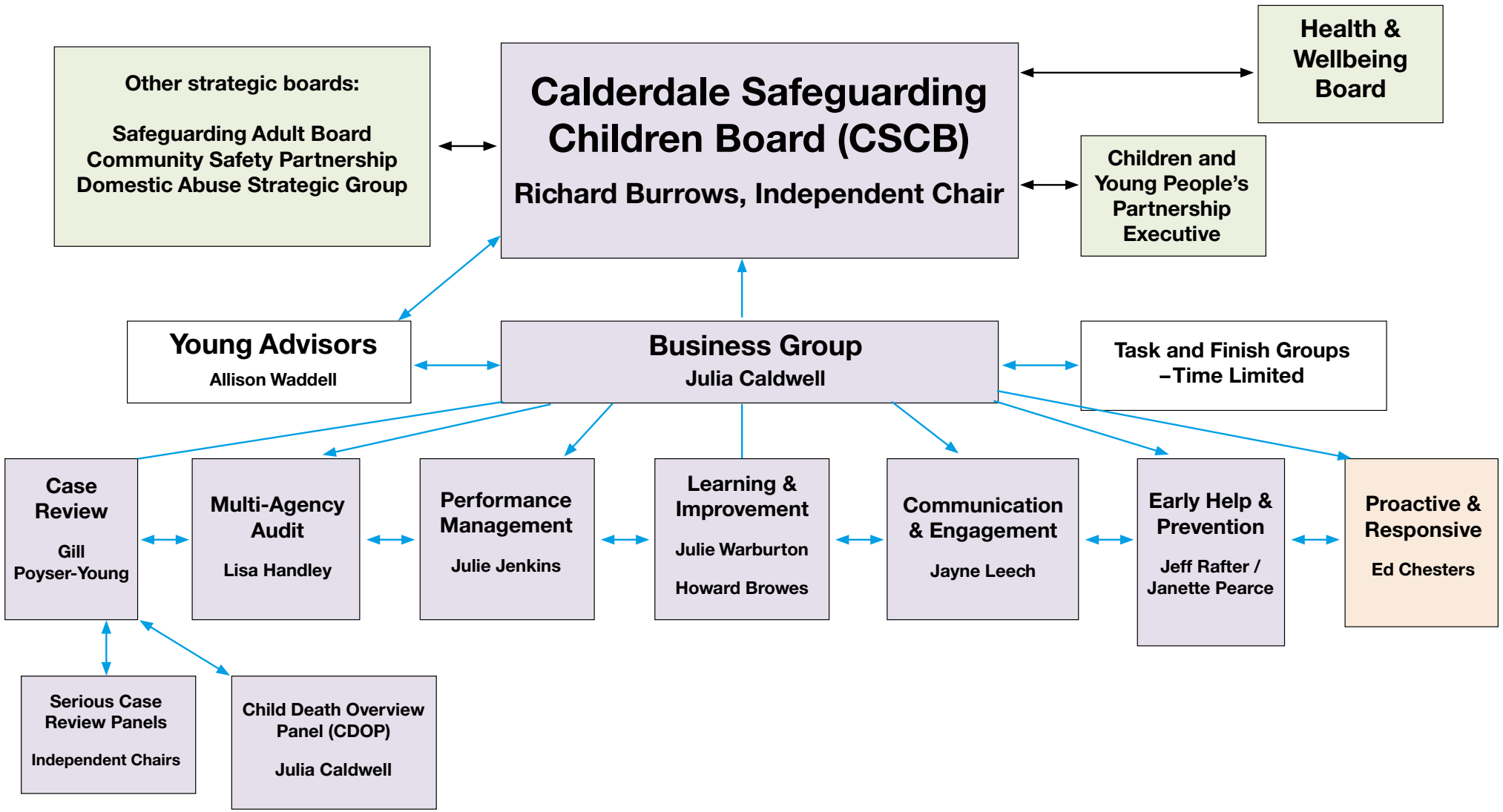
Develop a comprehensive multi-agency children's workforce strategy, and evaluate the impact and effectiveness of the multi-agency training that is being delivered to ensure that those working with children and families are suitably trained and that training resources are being targeted effectively.

Ofsted 15: Para 171: - Openness and transparency

Ensure that the minutes of Board, Business Group and sub group meetings are more accessible and enable stakeholders, including children, young people, parents and carers, to monitor the LSCB's activities and hold it to account, and that they are easily accessible on the LSCB website.

For more information, go to www.calderdale-scb.rog.uk or contact the Business Manager, Julia Caldwell on 01422 394098 or julia.caldwell@calderdale.gov.uk.

Appendix 2: CSCB structure and governance chart



Appendix 3: CSCB financial arrangements

Outturn 2015/16

Expenditure	Total Spend	Budget	Balance
Staff salaries (including NI & Superann)	179,900.25	180,020.00	119.75
Chair & Board training & development	1,519.36	1,000.00	-519.36
Policy & procedures	9,550.00	8,800.00	-750.00
Advertising	0.00	500.00	500.00
All training costs	2,822.69	7,670.00	4,847.31
Room hire & catering	5,010.71	5,000.00	-10.71
Car allowances	841.98	1,000.00	158.02
Printing & stationery	47.00	50.00	3.00
CSCB Chair expenses	25,229.69	28,000.00	2,770.31
2014/15 Chair expenses carried forward from previous year	13,000.00	20,000.00	7,000.00
Postages (Royal Mail)	15.71	50.00	34.29
Computers	120.58	250.00	129.42
Case review work	26,277.67	31,436.00	5,158.33
Website & E-learning costs	5,749.17	5,500.00	-249.17
Miscellaneous expenses	1,285.47	1,750.00	464.53
	271,370.28	291,026.00	19,655.72

Income	Total Income	Budgeted Income	Balance
Cont towards PMQA Officer (Police, Pennine Housing & CMBC contributions)	34,200.00	34,200.00	0.00
Joint partners' contribution to Board	215,425.00	215,425.00	0.00
Policy & procedure income	8,210.00	6,400.00	1,810.00
Misc income other grants reimbursements	1,795.04	700.00	1,095.04
2014/15 underspend carried forward to use in 2015/16	34,301.00	34,301.00	0.00
CMBC additional contribution for website & safeguarding week	3,000.00	0.00	3,000.00
	296,931.04	291,026.00	5,905.04

Underspend to carry forward into 2016/17 **25,560.76**

Appendix 4: Attendance at CSCB and sub group meetings

Meeting and number held	Legal	Police	CYPS	Housing	National Probation Service	Communit Rehabilitation Company	CHFT	CCG	SWYPFT	CSCB Rep	Adult Health \SC	YOT	CAFCASS	Lay Member	Lead member	Public Health	Dem & P'ships	Voluntary	Business & Perf	Commissioning	Schools/College	WFD	E.I	S&QA Service	CAHMS	Voice & Influence	Comms	Equality	HomeStart	Governors	Locala	Total
CSCB (6)	3	6	6	5	5	3	4	6	5	6	3	6	5	4	4	3	3	6			5		6	6			4			4		78%
Business (12)		10	9	5			5	8		12		7						6		9	4											63%
Performance Management (8)		7	7		5		8	5	6	8						4			8					6			4				3	74%
Learning and Improvement (7)			2				3		4	7		6						6			7	4		4								68%
Case Review (6)	4	4	6				5	6	5	4						4					3		3	1								68%
Comms and Engagement (5)							3		4	5								4								3	4	3					74%
Early Help and Prevention (5)		1	2	4			3		4	4		5				3		2			4		5						2			65%
Proactive and Responsive (5)		5	5				4	3	2	4								3					5	4	4		5					80%
Multi-agency Audit group (9)		5	9					5	6	9								4			4			7						4		65%
Average																																70%

Appendix 5: Section 11 returns

Agency / Partner	Number requested	Number submitted
Board members	17	17

The following numbers of submissions were received from commissioned services and schools:

Agency / Partner	Number requested	Number submitted
Public Health commissioned services	11	11
CCG collective commissioned services	3	3
Schools	107	96

The Local Authority Children and Young People Commissioning Service request their Section 11 returns at a later date - in January 2016 using the same tool. 18 out of 19 commissioned services that were requested to complete, did so on time; the 19th service is currently undertaking the self-assessment.

Appendix 6: Public services in the local area

This document provides a way of recording the judgements across a number of services responsible for safeguarding and providing services to children and their families in the local area. To be completed once a year as part of the preparation for Annual Report.

INSPECTIONS AND REVIEWS	Date of most recent inspection	Judgement	Links with any comments
Single Inspection of LA children's services and review of the LSCB	13/1/2015	1. Children who need help and protection -Requires Improvement 2. Children looked after and achieving permanence 2.1 Adoption performance - Inadequate 2.2 Experiences and progress of care leavers – Requires Improvement 3. Leadership, management and governance - Requires Improvement	Inspection of services for children in need of help and protection, CLA and care leavers and Review of the effectiveness of the Local Safeguarding Children Board http://reports.ofsted.gov.uk/sites/default/files/documents/local_authority_reports/calderdale/055_Single%20inspection%20of%20LA%20children%27s%20services%20and%20review%20of%20the%20LSCB%20as%20pdf.pdf
Police:	11/2/2016	Effectiveness - Good Efficiency - Good Legitimacy - Good	HMIC PEEL (Police effectiveness, efficiency and legitimacy) assessment http://www.justiceinspectorates.gov.uk/hmic/peel-assessments/peel-2015/west-yorkshire/
Health (CCG):	April 2016	Awaiting outcome	CQC Inspection
Calderdale Royal Hospital (Calderdale and Huddersfield NHS Foundation Trust):	13/8/2013	Respecting and involving people who use services - Met Care and welfare of people who use services - Met Safety and suitability of premises – Not Met Assessing and monitoring the quality of service provision - Met Complaints - Met Records - Met	CQC Inspection https://www.cqc.org.uk/sites/default/files/old_reports/RWY02_Calderdale_Royal_Hospital_INS1-719775389_Scheduled_01-10-2013.pdf
Calderdale Royal Hospital	5/2/2014	Safety and suitability of premises - Met	CQC Inspection https://www.cqc.org.uk/sites/default/files/old_reports/RWY02_Calderdale_Royal_Hospital_INS1-1228820612_Responsive_-_Follow_Up_04-03-2014.pdf
Youth Offending:	23/11/15	"Overall, we found that that assessment work was carried out well and that there was good engagement with children and young people. Staff were enthusiastic, knew their cases well and it was clear they had been encouraged to work innovatively."	HMI of Probation Short Quality Screening of youth offending work in Calderdale http://www.justiceinspectorates.gov.uk/hmiprobation/inspections/calderdalesqs/

Education providers in Calderdale:

Date as at/period: June 2016

	Number of schools or settings:					% Good or Better
	Total number inspected	Outstanding Number (%)	Good Number (%)	Satisfactory/ Requires Improvement/ Adequate Number (%)	Inadequate	
Early Years Settings	323	36 (11%)	239 (74%)	39 (12%)	10 (3%)	85%
Primary Schools	86	19 (22%)	56 (65%)	11 (13%)	0	87%
Secondary Schools	14	4 (29%)	6 (43%)	3 (21%)	1 (7%)	72%
Post-16 Provision	2	0	1 (50%)	1 (50%)	0	50%
Special Schools	1	1 (100%)	0	0	0	100%
PRUs	1	0	1 (100%)	0	0	100%
Residential/ children's homes External *	8	1 (12.5%)	5 (62.5%)	1(12.5%)	0	75%
Residential/ children's homes Internal	3	1 (33%)	2 (67%)	0	0	100%

* 1 setting not yet inspected

Appendix 7: Multi-agency training statistics from 2015-2016

Number of course held/ % of course cancelled

Number of courses held in 2014-2015	% of Cancelled courses in 2014-2015	Number of courses held in 2015-2016	% of Cancelled courses in 2015-2016
53	18%	64	6%

Attendance across partnership aggregated to agency/sector (with previous year figures for comparative purpose)

Agency	Attendance 2014-2015	Attendance 2015-2016
CafCass	2	4
Calderdale Metropolitan Borough Council	321	448
Clinical Commissioning Group	7	9
CSCB	2	12
Education	62	137
Housing	12	18
Ministry of Justice	1	5
NHS Foundation Trust	47	71
Police	10	9
Private	24	20
Probation	3	8
SWYP NHS Foundation Trust	13	25
Voluntary Sector	192	319
Safeguarding Week	505	Not held this year
TOTAL	**1201**	**1094**

Number of e-learning courses completed:

2014-2015	2015-2016
1269	1042

List of courses to illustrate the type of courses and where they sit regarding levels/journey of the child:

Course Title	Number Attending
Foundation Level	
CSE briefing	28
Human Trafficking Briefing	56
Introduction to Safeguarding	21
Supporting Young People to Stay Safe online	40
Understanding the needs of children & families by parental offenders	44
Sub Total	**189**
Intermediate Level	
BLAST Workshop (Not just our daughters)	32
Child Sexual Abuse & Child Sexual Exploitation	47
Children's Needs Compromised by Parenting - Toxic Trio	30
Emotional Wellbeing Conference	110
Essential Knowledge Briefing - What's New	78
Human Trafficking	38
Identifying and Responding to Vulnerable Children & Young People	76
Introduction to FGM	23
Learning Lessons from Serious Safeguarding Incidents in Calderdale	70
MA Assessment of and Planning for Vulnerable Children	40
MA Planning in Practice	64
MA SMART Planning in Practice	16
Multi-Agency Reflective Practice Session	28
Ongoing Work with Complex Families	26
Safeguarding Children Who Experience Domestic Abuse	30
Train the Trainer	11
Understanding Sex Offenders	18
Working with Children and Young People involved with CSA & CSE	33
Working with Young People Who Sexually Harm	23
Writing and Contributing to MA Chronologies	27
Sub Total	**820**
Advanced Level	
AIM2 Refresher	13
Designated Safeguarding Lead	19
Introduction to Supervision and Risk Management	9
MasterClass - Disguised Compliance	35
YHMAST Regional Conference	9
Sub Total	**85**
Grand Total	**1094**

Appendix 8: Statutory and legislative context for LSCBs

Calderdale Safeguarding Children Board (CSCB) is a statutory body established under the Children Act 2004. It is independently chaired and consists of senior representatives of all the principal agencies and organisations working together to safeguard and promote the welfare of children and young people in Calderdale.

The CSCB's statutory objectives are to:

- Coordinate local work undertaken by all agencies and individuals to safeguard and promote the welfare of children and young people
- nsure the effectiveness of that work

Children and young people, their welfare, protection and the promotion of their best interests are at the heart of everything the CSCB does. The CSCB is:

- Committed to putting the child/young person at the centre of all that we do
- Focused on getting safeguarding right for children, young people and their families
- Clear about what we expect of safeguarding services
- Informed about how well protected children and young people are in Calderdale
- Open about what we do and why
- Cooperative and collaborative with each other
- Challenging of each other and of the safeguarding services each partner provides
- Effective and providing value for money
- Accountable to the people of Calderdale for how we invest our resources
- Accessible to and informed by children, young people and their families, the communities they live in and the staff in our organisations that serve them
- Learning from everything we do and changing as a result
- Improving practice and outcomes for children and young people

For more information please contact:

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Calderdale Safeguarding Children Board