



Calderdale
Safeguarding
Children
Partnership

Annual Report 2020- 2021

Introduction

This report describes some of the incredible work that has been undertaken by the Calderdale partnership over the past year, and how effective these arrangements have been during this irregular, challenging and unfamiliar period of the Covid-19 pandemic.

There is a need to coordinate the shared responsibility to safeguard and promote the welfare of children in a local area. In Calderdale, the responsibility for this sits with the three safeguarding partners, the Local Authority, Clinical Commissioning Group, and the District Police Force who have a shared and equal duty to make arrangements to effectively work together to safeguard and promote the welfare of children.

The Calderdale Safeguarding Children Partnership (CSCP) has been established since April 2019, following the Sir Alan Wood National Review and the revised Working Together to Safeguard Children (WTSC 2018). This report reflects the work undertaken by the CSCP to embed those changes during 2020, following a year of transition.

The report also reflects how the CSCP responded to the COVID-19 pandemic, which began in March 2020, and how services in Calderdale adapted and endeavoured to keep children safe during lockdown. The CSCP monitored service changes when social distancing was introduced and sought assurance about how professionals and subsequently how families were responding to those changes.

The COVID-19 pandemic has had a very significant impact on the work and priorities of the safeguarding partners. The CSCP focused on maintaining effective support for vulnerable children and families. Timely and appropriate arrangements for Serious Incident Notification and Rapid Review were maintained. New approaches to seeking assurance were piloted, and innovative methods of Independent Scrutiny were tested and appraised. The three key partners increased commitment to tripartite leadership with 100% attendance and response to the Partnerships Manager, the Subgroups, and the direction of the CSCP.

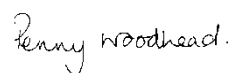
The CSCP transformed its engagement and meeting activity to virtual platforms and continued throughout the pandemic to facilitate policy change and practice improvements. The learning culture was sustained with additional safeguarding training, focussed not only on safeguarding risks, but also on risks which were specific to the impact of the virus and to lockdown. This report describes this activity and attempts to evidence the impact of this, however at the time of writing, the country is still emerging from lockdown, and hidden risks remain a concern.



Julie Jenkins
Director of Children
& Young People's Services
Calderdale MBC



Sarah Baker
Chief Superintendent
Calderdale District
West Yorkshire Police



Penny Woodhead
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Table of Contents

Annual Report 2020- 2021.....	1
Introduction	2
1. Context.....	4
2. Governance, Alignment and Accountability (<i>Appendix 1 for CSCP Structure</i>).....	9
CSCP Business Plan Objectives for 2020-2021:.....	9
3. CSCP Response to COVID	10
COVID-19 VULNERABLE CHILDREN UNDER 5	10
COVID-19 NON-ACCIDENTAL INJURY TO BABIES AUDIT	11
COVID-19 ICON PREVENTION OF NON-ACCIDENTAL INJURY TO BABIES	13
COVID-19 SECTION 11 COVID AUDIT.....	13
4. Independent Scrutiny & Assurance	15
Overview of Independent Scrutiny undertaken in 2020:	15
The CSCP approach to independent scrutiny of multi-agency safeguarding arrangements	16
5. Independent Scrutiny: Child Safeguarding Practice Review	18
Independent Scrutiny SCR Challenge Events	18
6. Independent Scrutiny & Assurance: Child Death Overview Panel.....	20
CHILD DEATH OVERVIEW PANEL LEARNING SAFE SLEEPING	20
7. Independent Scrutiny & Assurance: Engagement - Seeking and using feedback from children, young people, and families	22
Young Advisors.....	22
8. Independent Scrutiny & Assurance: Quality Assurance	23
9. Learning & Improvement.....	26
Learning & Improvement: Multi-agency Safeguarding Training & e-learning.....	26
Learning & Improvement: Safeguarding Week	28
Learning and Improvement: Socio-Economic contexts	29
10. Conclusion.....	31
11. Future Priorities for the CSCP	32
Appendix 1 Structure Chart	34
Appendix 2 – Relevant Partner Agencies.....	35
Appendix 3 – Changes to Local Multi-Agency Safeguarding Procedures for Children	36

1. Context

Calderdale is home to around 50,000 children, making up 25% of residents. Around 1 in 6 children live in poverty, and in some areas, this rises to 1 in 3.

Context from Calderdale MBC Children and Young Peoples Services

Children services are currently rated overall 'Good' by Ofsted. Improvement work and work to manage demand has continued at pace and we have made a number of further changes since the last inspection where early help and child protection required improvement to be good.

The Early Help Hub was established in the summer of 2020 and provides advice, guidance, and support to multi agency professionals in Calderdale. Children, young people, and families who may have multiple unmet needs are being supported by an Early Help Pathway, a collaborative process enabling partner agencies to ensure they work effectively together to offer the best support possible to the family. The Hub is a multi-agency decision making forum with representatives from Multi Agency screening Team, Early Intervention, Police, Youth Justice Service, Youth Service, Family Intervention Team and Early Help Team. A recent expansion has included the Liaison and Diversion Team. The early indicators would suggest that the introduction of the Early Help Hub has had a positive impact on reducing the numbers of referrals that progress to children's social care.

In the front door multi-agency screening and assessment team (front door) systems, processes, policies, and procedures have been updated which now better support crisp and clear decision making. Staffing levels have increased to respond to increasing demand at the front door. The council has a highly skilled workforce who are clear on what they are expected to do. They work to agreed standards of practice and fully understand thresholds and delegation of responsibility. Information gathering processes have been reviewed from all relevant agencies and family members to inform decision making and to make sure the children are safe.

Children services has created an environment where good social work practice can flourish and where social workers feel 'safe' and have access to their managers who are highly visible. The Social Workers' relationship with children and families is at the heart of the systemic practice approach to support and intervene whilst retaining a focus on the child and their lived experience. Social workers and other early help practitioners who work with families in the borough have been trained in systemic practice.

The daily Domestic Abuse Hub continues to provide a robust partnership response to this issue in Calderdale. The Child Exploitation Team responds to all forms of child exploitation and in particular the growing issue of Child Criminal Exploitation. Data shows that there is a difference in relation to sexual exploitation and criminal exploitation referrals received, with more females being referred for Child Sexual Exploitation (CSE) and more males being referred for Child Criminal Exploitation (CCE).

A national independent review of children's social care is underway. The work is called the 'Case for Change' and it sets out the urgent need for a new approach to children's social care in England. The lead of the review is Josh McAllister who has said *'Our children's social care system is a 30-year-old tower of Jenga held together with Sellotape: simultaneously rigid and yet shaky. There have been many reviews and attempts at reform since the landmark introduction of the 1989 Children Act and though each has ushered incremental progress, we are now left with a high stack of legislation, systems, structures, and services that with their sheer complicatedness make it hard to imagine*

something different, let alone address foundational problems. But we know that children's social care isn't just a system. It's a collective endeavour involving all of us and we have stepped back from playing our full part in the way that we need to. Some of this is because the system pushes away help from neighbours, extended family and the wider community'. In the call for evidence, it sets out the review's big question: how do we ensure children grow up in loving, stable and safe families and, where that is not possible, care provides the same foundations? The review is currently taking evidence from all stakeholders and will shape the future delivery of early help and child protection work.

Julie Jenkins

Director of Children's Services
Calderdale MBC

Message from the Calderdale Clinical Commissioning Group

NHS Calderdale CCG is a membership organisation consisting of 23 general practices. Our purpose is to improve the health and lives of the estimated 220,260 people living in Calderdale and/ or registered with a Calderdale GP practice.

This is achieved by working collaboratively with our partners and stakeholders to:

- Ensure that healthcare is available for anyone who needs it.
- Keep people safe.
- Ensure continued improvements in the quality of care.
- Support people to maintain a healthy lifestyle.
- Address health inequalities locally, as well as ensuring financial sustainability.

Clinical Commissioning Groups work with patients and health and social care partners, such as local hospitals, local authorities, and local community groups, to ensure services meet local needs.

Safeguarding is firmly embedded within the core duties of all organisations across the health system. It remains the responsibility of every NHS-funded organisation, and each individual healthcare professional working in the NHS, to ensure that the principles and duties of safeguarding children are holistically, consistently, and conscientiously applied; the well-being of those children is at the heart of what we do.

Every NHS funded organisation needs to ensure that sufficient capacity is in place for them to fulfil their statutory duties; they should regularly review their arrangements to assure themselves that they are working effectively. Organisations need to co-operate and work together. As commissioners of local health services, CCGs need to assure themselves that organisations from which they commission have effective safeguarding arrangements in place.

CCGs need to demonstrate that their designated experts (for children, children in care and adults), are embedded in the clinical decision-making of the organisation, with the authority to work within local health economies to influence local thinking and practice and the capacity to do so. The CCG demonstrates its compliance through an [Annual Report](#) to its Governing Body.

Through this challenging year, the CCG has continued to work with health partners in Calderdale to deliver the safeguarding requirements. As described throughout this report many services, and supporting functions had to be adapted during the course of the pandemic.

The **Health Assurance and Improvement Group (HAIG)** has developed during this reporting period and continues to support the partnership and is a mechanism that supports the CCG in working with a wide range of health providers operating in Calderdale. The group provides strategic oversight, assurance, improvement, and the scrutiny of safeguarding children arrangements across the local health sector, to achieve a consistent and responsive approach to meeting the needs of children specifically those who require safeguarding interventions and support the CCG and CSCP in fulfilling their statutory duties.

These are a number of key highlights from across the health sector, it is by no means exhaustive but demonstrates the diversity in the work undertaken.

- Focus on the intrinsic links between health inequalities, living in poverty and the experience of trauma and adversity for children and young people who require safeguarding interventions. (you can find out more about this later in the report)
- Securing funding for and development of the ICON programme Phase 1 (Health Partners) & Phase 2 (Wider Partnership) (you can find more about this later in the report)
- Prepare for and support the implementation of the new Liberty Protections Safeguards including updating the CCG Mental Capacity Act policy (Children aged 16-17)
- Multi-Agency Health Audit into the response to Domestic Abuse' by health professionals
- CCG funding to support a review of and make recommendation regarding the health contribution to front door services of MAST and DA Hub
- An audit on Children Looked After in Calderdale placed from out of area' to review the impact on the use of health services in Calderdale and to establish any gaps in provision
- Revisit of 2018 Children looked after and safeguarding CQC inspection to test how well actions had been embedded
- GP's have continued to participate in the GP Safeguarding Leads meeting facilitated by the Named GP's so that they continued to receive safeguarding updates and new learning

Looking forward following the publication in November 2020 of *Integrating Care – the Next Steps*, published, we are entering a period of significant change, the CCG is leading, engaging on, and driving the process for delivering Safeguarding requirements at West Yorkshire by being an active voice in the development of safeguarding structures and operating model. This will be of interest to the CSCP, and we will continue to engage during the next reporting period.

Penny Woodhead

Chief Quality and Nursing Officer/ Deputy Chief Officer
NHS Kirklees CCG
Chief Quality and Nursing Officer
NHS Calderdale CCG

Message from West Yorkshire Police: Calderdale District

As the fourth largest force in the country, West Yorkshire Police (WYP) works in partnership with five Local Authorities. Our Neighbourhood Policing model lies at the heart of our service delivery and is underpinned by local response, crime investigation and safeguarding functions. The most recent independent inspection by Her Majesties Inspectorate of Constabulary and Fire and Rescue took place in 2021 and has not yet been published, however the last Police Effectiveness, Efficiency and Legitimacy Inspection rated WYP good at reducing crime and keeping people safe and in the way it treats the public and its workforce legitimately. It also graded WYP as Outstanding in the way it operates efficiently and sustainably and whilst crime data integrity did not form part of the 2021 PEEL inspection, West Yorkshire were also judged as Outstanding for our ethical and legitimate approach to recording crime during our last CDI inspection.

This Police and Crime Plan 2016-21 was created by the Police and Crime Commissioner and is currently used by the Mayor to hold West Yorkshire Police to account. This will be refreshed in time but currently sets the strategic direction, reflecting the views and priorities of local people and partners, with the aim of making sure that all our communities across West Yorkshire are safe and feel safe.

The West Yorkshire Violence Reduction Unit moved within the Combined Authority in 2021 and continues in its efforts to tackle serious violent crime through a unique public health-led approach, bringing together organisations across local communities to tackle underlying causes and funding vital local projects that undertake positive preventative work with children and young people. The unit has a partnership emphasis, with specialists from health, police, local authorities, education, youth justice, prisons, probation, community groups and others aiming to cut violence together through early intervention, prevention, and education. In 2020/21 alone 36 programs were delivered with 14,328 young people (24 and under) supported across a range of interventions.

A regional work stream led by West Yorkshire Police and ACC Catherine Hankinson has been instrumental in progressing the transformation from Safeguarding Children Boards to Multi Agency Safeguarding Arrangements across the region. The West Yorkshire lead worked with Lorraine Parker as the Police national lead for MASA along with her LA and Health colleagues to facilitate a Strategic development event in WY for senior leaders from the three responsible partners along with independent scrutineers. The Strategic Development event for leaders across West Yorkshire took place in April 2021, and enabled system leaders to come together, challenge and learn from each other, exploring common themes and questions and supporting partners in taking action where possible to move things on. The strategic leadership and desire to bring partners together demonstrates the commitment of West Yorkshire police to ensuring the MASA arrangements work and work well. This commitment is reflected in the ongoing engagement and dedication shown by all Calderdale's partners in coming together under the Child Safeguarding Partnership arrangements.

Police officers respond daily and investigate calls regarding mental health, missing persons, Domestic Abuse, online safety, radicalisation, and child safety concerns but we also work with colleagues to try and prevent harm and reduce risk, working with the voluntary sector to support victims or developing our early intervention delivery for children and young people.

The investment in the Early Action Team and the deployment of neighbourhood policing to deal with Anti-Social Behaviour and work more closely with the secondary schools as well as the 'Chance for Change' roll out in the Youth Offending Team are all examples of our commitment to working with partners in Calderdale. Our commitment to the Early help hub has been maintained throughout the last 12 months, with regular and frequent meetings taking place with associated partners despite COVID. Referral rates have remained steady, and we have continued to fill the void for those who in the past may have fallen through the gaps due to not reaching existing thresholds. Thanks to the Partners commitment we have been able to take real strides to address concerns and vulnerabilities in family networks, as well as with individuals and have clear lines of sight around referrals, actions, and outcomes. The partnership Hub ensures that key decision makers are present and positive progress is made through this process. Some of the districts most challenging individuals have been discussed and provided with dedicated partnership responses, improving the lives of young people and their families - less children committing crime, less children in need of protection and an increase in liaison and diversion activity.

The Domestic Abuse Hub has undergone a challenging last 12 months with COVID, lockdowns and an increase in the volume and complexity of Domestic Abuse cases. Despite the challenges of extra demands on all services, not being able to interact face to face with victims, perpetrators or children, all staff have managed the situation well. The police and partners have innovated to ensure victims and the voice of the child are heard, identifying those considered more at risk and targeting vulnerable households to ensure victims and children were safeguarded. Performance regarding Domestic Abuse show that Calderdale remains in a good position, with high arrest rates, improved outcome rates and a reducing trend in repeat victimisation. The teams are however managing a high levels of crime incidents and we continue to see an upward trend of Domestic Abuse.

West Yorkshire Police work closely with our partners across all areas of safeguarding and understand that Safeguarding is everyone's business. Policing plays a key role in the success of our partnership when it comes to protecting vulnerable children and we are involved in Safeguarding at every level as part of our daily business, as well as through strategic boards and delivery groups. We have continued to do this throughout COVID, working with partners to ensure we have identified our most vulnerable and doing everything we can to reduce the risk of harm to them. I'm extremely proud of the care and commitment shown by officers and staff, working with our communities and partners, to deliver effective and supportive safeguarding to those that need it.

Chief Superintendent Sarah Baker
Calderdale District Commander
West Yorkshire Police

2. Governance, Alignment and Accountability (Appendix 1 for CSCP Structure)

The aims of the Calderdale Safeguarding Children Partnership (CSCP) are to support and enable local organisations and agencies to work together in a system where:

- children are safeguarded and their welfare promoted
- partner organisations and agencies collaborate, share, and co-own the vision for how to achieve improved outcomes for vulnerable children
- organisations challenge appropriately and hold one another to account effectively
- there is early identification and analysis of new safeguarding issues and emerging threats
- learning is promoted and embedded in a way that local services for children and families can become more reflective and implement changes to practice
- information is shared effectively to facilitate more accurate and timely decision making for children and families

The CSCP Business Plan details how these aims are delivered by the CSCP, but it also includes increased regional working; streamlining operations; developing independent scrutiny and embedding new statutory functions. In addition, the plan featured the assurance and recovery model for responding to safeguarding issues during COVID-19.

The Business Plan is overseen by the three key partners and the Chairs of each Subgroup which includes voluntary and education reps, (collectively known as the CSCP Executive). Each aspect of the plan is delivered by the CSCP Subgroup Chairs and managed by the Safeguarding Partnerships Manager (who also manages the Safeguarding Adult Board and is Domestic Homicide Review lead).

CSCP Business Plan Objectives for 2020-2021:

1. The CSCP is assured that services can respond to safeguarding issues in relation to COVID-19
2. The CSCP works with all partners to identify and respond to existing and emerging needs
3. Independent Scrutiny evidences improved outcomes for children
4. The CSCP provides strategic leadership, initiates effective joint working practices, and gains assurance of the effectiveness of safeguarding arrangements

The CSCP aligns itself and influences the strategies and priorities of other strategic partnerships:

- the Safeguarding Adult Board (which is jointly staffed by the same Secretariat)
- the Community Safety Partnership
- the Health and Wellbeing Board
- the Domestic Abuse Strategic Group
- West Yorkshire Risk and Vulnerability Group from the Mayoral Office
- West Yorkshire and Harrogate Integrated Care System (ICS) regional meetings
- The Association of Safeguarding Partnerships (TASP) (The Safeguarding Partnerships Manager is one of two Business Managers who are part of the TASP Advisory Board)

This report outlines the evidence of the impact of the work of the safeguarding partners and relevant partner agencies (See Appendix 2), including training, on outcomes for children and families from early help to looked-after children and care leavers. It also details an analysis of any areas where there has been little or no evidence of progress on agreed priorities. Finally, the report concludes and summarises the next steps for the CSCP and how it will be further developed in 2022.

3. CSCP Response to COVID

This section is highlighting the work done immediately following lockdown, by the CSCP, focussing on the most vulnerable and how we sought assurance from partners about their services delivery models and the identification of and response to safeguarding concerns.

COVID-19 | VULNERABLE CHILDREN UNDER 5

During the COVID Pandemic, children did not attend education establishments and were not seen by professionals. [Government Guidance](#) (5.6) detailed how: 'Settings should work with local authorities to monitor the welfare of vulnerable children who are not attending provision and any other children they might wish to keep in touch with, for safeguarding purposes.'

In Calderdale: Children who were classed as 'child in need', on child protection plans or who were Children Looked After were risk assessed and had regular contact and welfare checks (remote and face to face) with professionals. In addition, Schools conducted remote welfare checks to school-age children where there were previous concerns. Early years providers, Children's Centres and health services were also undertaking welfare checks.

There was a potential gap for vulnerable children who were not school age, and who did not have statutory interventions. The risks included the closure of early years settings, the reduced ability for young children to verbalise and seek help outside the family, a perceived increase in family stress, tensions, poverty, domestic abuse or drug and alcohol misuse.

The CSCP therefore sought to identify young children who had been assessed as vulnerable prior to COVID, due to living with parents or carers who had reported domestic abuse, drug or alcohol issues, or potential signs of neglect, and were not involved with statutory services. Following identification, efforts were made to contact and gain assurance about their welfare during lockdown.

An Information Sharing Agreement was agreed which complied with Data Protection laws. Over 1500 vulnerable children aged under 5 were initially reported by Children's Centres (nurseries and family support); Portage; Early Years providers, Health Visitors and the drug and alcohol service. Duplicates and children who were reported as having regular welfare checks were removed. Over 750 remained on the list.

Through the process (April 2020 to June 2020), more children were added through information received from the Domestic Abuse Hub when they did not meet the threshold for intervention (high risk cases are picked up by social workers or family support).

If families were registered with Children Centres, they made contact. Families who were not registered (less than 60), were approached by the Health Visiting Team. All families who were contacted were asked about wellbeing, offered support, and were followed up by family support.

There were a handful of families where contact was not able to be made – in these cases individuals were risk assessed and contact made with face-to-face visits. No contact was made if it was deemed there was no further risk.

The operation ceased at the end of June when early years settings were able to welcome children back (From 1st June 2020).

The outcomes from Children's Centre included: families were reported to appreciate professionals for the offers of support and for signposting to information and other services. Learning resources were delivered to family homes, and family support referrals were made as a result.

Children's Centre Senior Managers reported how helpful this work was to re-engage with families, to remind them what support is on offer – and helped them to identify and target more families in need. See [Halifax Opportunities Trust COVID impact report](#) for more information.

When families were identified within Calderdale Recovery Steps drug and alcohol service; the worker had enhanced contacts throughout this period with particular attention on the fact that there were vulnerable children in the home.

This Calderdale project has been highlighted as good practice at national events, such as The Association of Safeguarding Partners (TASP) and at other regional discussions. It is a positive example of how agencies have worked together, under very difficult circumstances, to safeguard children during COVID.

COVID-19 | NON-ACCIDENTAL INJURY TO BABIES AUDIT

Following national concerns about the increased number of non-accidental injuries to babies during the Covid-19 pandemic; Vicky Ford MP asked all Local Safeguarding Children Partnerships (LSCPs) to review the circumstances of families who had recently stepped down from child protection plans, but who were expecting a baby.

In February 2021, multi-agency partners reviewed 14 cases to ascertain whether (due to the perceived increased risks linked with lockdown and social distancing) the current status and safeguarding of children was appropriate.

The 14 families included all families who had stepped down from CP plan and had a new baby in this period (7). The audit also included cases where a Single Assessment had resulted in either 'No Further Action', 'CIN plan', or 'signposted to Early Help services.

The audit included factual questions based on historical information known about the family; known referrals and interventions; subsequent concerns and referrals following step down and the existing statuses of the children and families.

The audit group were assured that no further follow up actions were required for 71% of cases (10/14). This included families where:

- Social care were still involved through CIN plans, through escalation to Children Looked After or through Single Assessment following further concerns raised with MAST.
- Some fathers (who had posed the highest risk through assessments) were in prison and therefore the risk levels were reduced.
- Babies had passed away due to previously known health reasons, or the pregnancy had been terminated; therefore there was no further risk involved, and these cases were deemed not applicable to this specific audit.

For 3 cases, auditors agreed to undertake further checks about the safety and well-being of the children: subsequent follow up actions were agreed and completed, and it was agreed that the assessments showed there was no further escalation needed:

- A child focused risk assessment was undertaken for a baby to identify the risk from the father. Following the audit, it was confirmed that the baby was safe, and the risk had been reduced due to the work done with the father.
- Health visitors were tasked to check for any concerns at the next face to face contact (the following week). An update assured the group that there were no concerns raised and Health Visitors were due to see them again shortly.
- During preparation for the audit, lead auditors had concerns about potential escalation of risk for one family, so they raised this with the MAST Team. Children Social Care fed back that they were assured that no further work was required from their service.

For 1 case, auditors had to chase up a family support referral that had been suggested, which had been missed at the Early Intervention Panel. Since the audit, the Family support team at the Children's Centre prioritised the referral, and it was assured that the Early Help process has since changed, and an Early Help representative is now always present at panel meetings so this should not be missed again in the future.

Other issues that were identified:

- Domestic abuse was a risk factor for 93% (13/14) of cases.
- For the majority of cases, pre-birth assessments were not completed. Other LSCP's have undertaken similar audit activity as requested, and it appears there is a difference in the number of pre-birth assessments taking place between Calderdale and other LA's. This is being further explored through CSPR activity.
- For 71% (10/14) of cases, further contacts and referrals to CSC were made after the step down of intervention meaning that there were still apparent risks to families following step down.
- For some cases it was recorded that the mother and father of the baby were separated, and therefore seen as a protective factor but research has suggested that coercion and other factors mean that this is not necessarily a true position, and children may still be at risk because parents are not always truthful about their relationship status.
- For 6/14 cases it is known that at least one of the parents were known to child protection services as a child.
- A key priority for CSCP is to explore how poverty and deprivation is linked to safeguarding, abuse and neglect. The level of deprivation of the families audited showed that all the cases were in the 60% most deprived areas, with the majority in the under 30% Super Output Areas (SOA).
- The National Panel have undertaken a thematic review on Non-Accidental Injury to babies. When this is published, Safeguarding Leads in all partner agencies need to disseminate the learning from this report.
- Due to nationally rising numbers of non-accidental injuries to babies and the impact of covid related pressures on all families, professionals need to be aware of hidden vulnerabilities.

COVID-19 | ICON | PREVENTION OF NON-ACCIDENTAL INJURY TO BABIES

A triennial review of Serious Case Reviews highlighted that nationally the highest category of fatal physical abuse amongst children was severe non-accidental head injury from suspected shaking injuries. Nationally, abusive head trauma affects up to 25 children per 100,000 in the UK although this is felt to be an underestimation. In practice, an average sized District General Hospital can expect to see a case every 1 or 2 years.

Both Kirklees and Calderdale Safeguarding Children Partnership were informed of the significant National intelligence during the initial Covid wave evidencing the increasing serious incident notifications involving very young babies who have been seriously harmed or died recently from abuse.

As a result of this, the partnership worked with midwifery and 0-19 services to ensure that with new lockdown restrictions families with babies were given as much face-to-face support as possible, working to all National guidelines.

NHS England funded the license for ICON to be implemented across Yorkshire and Humberside:

Phase 1 saw the roll out of ICON amongst health partners (Maternity, 0-19 service and GP's) from 7th Dec 2020. Resources distributed which included ICON banners, leaflets and posters at GP Practices, Midwifery Services and Health Visiting Services. Phase 2 included Social Care, Family Support, Police, Voluntary Sector services, Children Centres, Pharmacists, Mental Health Trust and more. ICON was promoted on billboards, buses and refuse wagons across Calderdale and Kirklees.

ICON:

- Infant crying is normal
- Comforting methods can help
- It's OK to walk away
- Never, ever shake a baby

COVID-19 | SECTION 11 COVID AUDIT

It was decided to undertake a COVID specific audit in Summer 2020, to formally seek assurance about how service changes were affecting child and adults safeguarding practice.

Assurance was sought about five service areas:

- Service Changes
- Multi-Agency Working
- Learning & Improvement
- Engaging with Service Users
- Long Term Consequences

Responses were received from 19 organisations across the partnership and the responses showed good assurance across all five areas. Safeguarding remained a priority; changes that had been made included new ways to identify those most at risk and some improvement in family engagement.

It was detailed that multi-agency working had improved, training had remained a priority and was available online.

Long term consequences are still not fully known and certain agencies/services specified a wish to undertake audits to look at the impact the different way of working has had on outcomes.

Some examples of positive development included the speed of changes to IT provision, improving engagement with some service users and young people, better attendance at multi-agency meetings, less cost (in terms of both time and expense) for professionals attending meetings, an increased use of Clare's Law, and an increase of sharing data and intelligence.

Some of the challenges highlighted have included the unpredictable demand and staff illness / absence which was hard to prepare for. Fewer face to face visits could have potentially made risks harder to identify. Some service user engagement has been more difficult due to data poverty. A major concern for some service leaders was the reduced ability for staff to debrief, offload and reflect following traumatic case involvement – the possibility of staff suffering from vicarious trauma, weariness, stress etc was identified and leaders responded that they would be improving levels of support for staff both formally and informally.

The data during this time showed a slight increase of contacts to Children's Social Care by 5.5% but a reduction in referrals by 17.5%. Both Child in Need and Child Protection plans were reduced significantly (24.3% and 34.4%) but the number of Children Looked After increased slightly (2.7%).

Health organisations reported a reduction in interactions for 5–15-year-olds; but for 16–17-year-olds, harmful substance misuse rose by 20%. Alcohol and substance use rose by 17% but the most significant increase was self-harm up by 48% for that age group.

It is recognised nationally that both children and adults have had a decline in mental health and wellbeing, and the CSCP, along with the local Open Minds Partnership, Commissioners and Public Health will be responding to national guidance, campaigns as well as coordinating our activity around mental health to try to address this rise in demand.

The annual Section 11 Audit process will continue to be developed in 2021: West Yorkshire Safeguarding Partnerships and Safeguarding Adult Boards are continuing to work on one online system that can be adopted across the region using the Calderdale approach to a joint Adult and Child Tool. This Regional Section 11 and Safeguarding Adult Audit processes and a shift to an online system will be beneficial to partners who work across borders.

4. Independent Scrutiny & Assurance

Overview of Independent Scrutiny undertaken in 2020:

The following is a list of independent scrutiny undertaken in 2020, individual details of which can be found later in this report.

1. Independent Scrutiny of 12-month report by Independent Scrutineer Professor Nick Frost
2. Child Exploitation Holistic Report
 - a. Independent Scrutiny of Child Exploitation arrangements by CSCP Secretariat
 - b. Independent Scrutiny of the Holistic Report by the National Working Group (NWG) and the National Police Chiefs Council (NPCC) – experts in Child Exploitation
3. Progress Review of Child N & Child P SCR to ascertain whether learning from SCRs is disseminated, embedded, and has impact on practice.
 - a. Undertaken by CSCP Executive Members interviewing other agency practitioners and managers.
4. Multi-Agency Audit of the quality and effectiveness of Safeguarding Supervision in Calderdale.
5. Social Work Masters Student commissioned by Calderdale CCG studied the impact of Poverty, Austerity, and Implications in Safeguarding in Calderdale.
6. New CSPR commenced January 2021 with Independent Reviewer on Non-Accidental Injury
7. Nationally informed Audit into potential Non-accidental Injury to babies during lockdown.
8. COVID S11 / Safeguarding Adults Audit
9. Review of Tri-borough CDOP and CDR arrangements.
10. Young Advisors Schools Transitions survey, Report and Presentation to Calderdale School Leaders.

In September 2020, the CSCP Independent Scrutineer retired; Independent Scrutiny is delivered through the Independent Scrutiny and Assurance Framework. The three partners now make the decisions that were previously made by the Independent Chair. This relates not just to Child Safeguarding Practice Reviews (CSPRs), but to areas of focus, collaboration with regional activity, addressing gaps and raising concerns.

CSCP Independent Scrutiny follows the six steps identified by the University of Bedfordshire:

1. The three partner leads are actively involved in strategic planning and implementation
2. The wider safeguarding partners (including relevant agencies) are actively involved in safeguarding children
3. Children, young people, and families are aware of and involved with plans for safeguarding children
4. Appropriate quality assurance procedures are in place for data collection, audit, and information sharing
5. There is a process for identifying and investigating learning from local and national case reviews
6. There is an active program of multi-agency safeguarding children training

The CSCP Executive acts and prioritises work based on the bottom-up learning from the CSCP Subgroups and work streams. CSCP activity is based on the evidence from each subgroup, from

reviews, audit findings, data, and intelligence from families and front-line practitioners. The CSCP has a holistic approach to systemic learning, which is based, not just on one case, but on how systems operate and how governance arrangements affect change and improvement.

The CSCP measures its effectiveness on how priorities are progressed, how actions are delivered and how change or improvement can be measured.

Priorities are determined using localised learning, national areas of scrutiny and horizon scanning. All decision making is made using evidence based on local or national learning, and all actions arising from this are based on best practice and up to date research.

The three partners agree a process for developing, reviewing, and funding a child centred strategic safeguarding children business plan: identifying agreed desired outcomes in line with national guidelines and recent research findings, including contextual safeguarding. These representatives are strategically placed on relevant partnership meetings and subgroups.

The wider safeguarding children partnership, including all relevant agencies are appropriately informed of and engaged with the CSCP arrangements and business plan through business groups, engagement events and training activity. There are overarching information sharing agreements, staff training protocols and communication methods to ensure the wider partnership is engaged with, consulted on, and collaborates with learning and improving practice from the CSCP.

Children and young people are consulted - they input and influence the development, implementation, and review of the CSCP business plan and related activities through the Young Advisors. Opportunities are in place for children and young people to lead and coordinate safeguarding initiatives and attend relevant meetings, subgroups, and partnership conferences. There are mechanisms in place for the three core partners to collect and analyse relevant data pertaining to safeguarding children through the Performance Management Subgroup, agencies provide learning from single agency audit through the Quality Assurance subgroup, and these are used along with the CSCP multi-agency performance management and quality assurance to review the impact of safeguarding initiatives on outcomes for children.

The Learning & Improvement Subgroup identifies training needs, evaluates the uptake and effectiveness of it and commissions training, which is informed by the business plan, the learning from reviews, national policy, research, and legislative contexts.

All partners are aware of the criteria and process for referral of cases for consideration of meeting the threshold for local or national review and case reviews and are adequately resourced to enhance learning as is detailed in the Child Safeguarding Practice Review (CSPR) Framework. Learning from reviews is cascaded and used to improve outcomes for children, their families and community.

The CSCP approach to independent scrutiny of multi-agency safeguarding arrangements

The CSCP focusses on:

- areas of good practice.
- areas which require improvement.
- how effective arrangements are for practitioners.
- what we need to examine in more detail.

- what difference the CSCP has made to outcomes for children and to practice.
- how we can support and challenge partners to improve practice; and
- how we can inform standards and agreements for joint working.

There are four elements of the independent scrutiny and assurance process:

1. Quantitative data and intelligence
2. Qualitative evidence through quality assurance
3. Engagement with service users and
4. Engagement with front line staff

The triangulation of these four elements results in recommendations to change and develop practice through learning and improvement. This can include changes to procedures, training, guidance, tools, communications, and recommendations for single agency practice change. The process is cyclical and continuous.

Plans for Independent Scrutiny in 2021:

1. Children's Society to review Child Exploitation across West Yorkshire.
2. Baby Q Challenge Events led by Critical Friends within the Partnership to review progress of implementation and change.
3. Review of CSCP Multi Agency Safeguarding Arrangements by the wider Safeguarding Partnership.
4. Scrutiny of Rolling Reports from multiagency safeguarding services by the CSCP Executive
5. Domestic Abuse Needs Assessment by [Safe Lives](#)

5. Independent Scrutiny: Child Safeguarding Practice Review

The objective for the Child Safeguarding Practice Review Group is to ensure that learning from Child Safeguarding Practice Reviews is acted upon, that real change occurs, and improved practice is embedded.

Throughout the Covid Pandemic the subgroup has continued to conduct meetings virtually and has maintained quoracy throughout the reporting period. Additionally, the subgroup has managed to progress learning from Learning Lessons Reviews, Thematic Reviews for the Childs Safeguarding Practice Review Panel and Safeguarding Practice Review's throughout the Covid pandemic.

Challenge Events for the Child N & Child P have independently scrutinised how learning from SCRs has been embedded throughout the partnership. All agencies involved were interviewed by a panel and how this changed practice can be evidenced. The overall outcome of the challenge event was that most of the learning remained embedded in practice and any gaps highlighted during the challenge process, assurance was immediately sought.

The subgroup has undertaken a Learning Lessons review as a result a young baby presenting as severely underweight. This learning lessons review involved health agencies. A robust action plan has been formulated including all health agencies involved, to ensure the recommendations in this report have been considered, new processes devised, and learning disseminated.

Use of research and evidence-based practice is to respond to issues highlighted in case reviews and audits.

The CSCP has undertaken its first Safeguarding Practice Review in line with new guidance (WTSC, 2018) and we have received positive written feedback from the Child Safeguarding Practice Review Panel regarding the analysis of a case involving a young baby who suffered abusive head trauma.

The partnership has agreed a new approach to decision making when a Serious Incident has been reported. This decision is to be reached between three key partners i.e., Children's Social Care, Police and Health (CCG). This will be reflected in the new Children Safeguarding Practice Review Framework.

Independent Scrutiny | SCR Challenge Events

Report on Progress Meeting for two Calderdale Serious Case Reviews

The CSCP undertakes Progress Reviews after Serious Case Reviews (SCR) or Child Safeguarding Practice Reviews (CSPR) have concluded. The intention is to ascertain whether learning from SCRs has been disseminated, acted upon, and embedded across the multi-agency partnership. Reviewing each case highlights any good practice and additional areas for improvement. Reviews are expensive, and contributions in terms of staff time is considerable, therefore it is critical to evaluate how effective learning processes have been and whether indeed anything has changed or improved as a result of undertaking one.

The organisations and professionals being interviewed included General Practitioner, Children's Centres, Mental Health Trust, Housing Organisation, Hospital Trust, Health Visiting Team and Children's Social Care. The interviews were conducted by the Superintendent of Police, Director of Children's Services, Designated Nurse, and Safeguarding Partnerships Manager.

Findings and Good Practice

It was obvious that a great deal of work had been undertaken by agencies to act on and embed the learning from the two SCRs. Practitioners were passionate, well informed, knew what the learning was and how it had impacted on their and other organisations practice. The interviewers were assured with actions taken and how well changes were embedded.

Good practice was noted around the use of Systemic Practice, '[working with hostile and resistant families' guidance](#) and the '[Was Not Brought](#)' Safeguard Guide when working with families through Early Help. Excellent practice was evident in the Housing Association, who provided evidence of how guidance and tools produced in Calderdale were shared with their wider geographical footprint and how this was disseminated through multi-disciplinary teams on the periphery of safeguarding.

Supervision was evidenced to be good, but the terms 'supervision' was often interchangeable with 'reflection', 'debrief' and 'case management'. Safeguarding Champions were described by agencies as critical, especially for when there was turnover of staff.

The Child Protection Medical process had changed significantly following one SCR. Both CHFT and Children's Social Care were able to talk about and demonstrate the changes made to this process. Additionally, one agency spoke about the [Professional Curiosity and Challenge Safeguard Guide](#) being 'massively helpful' and increasing staff confidence to ask difficult questions.

Changes were made to Early Help forms used following SCR learning - questions about second or subsequent children and the impact on risk were also added, and professionals from a variety of agencies reported the usefulness of the [Parental Mental Health toolkit](#).

There were some additional areas for development:

Early Help: Practitioners expressed the need to improve contingency planning when families do not engage with early help interventions, particularly when de-escalated from statutory interventions.

Families moving across borders: Even though a portal used by health organisations for missing people seems to be producing some good results, notifications of children moving into or being placed in the area are still not always received by Calderdale agencies.

Mental Health Services: Practitioners reported some confusion with mental health pathways and services. There were, however, signs of improvement and positive examples such as mental health practitioners being co-located within other teams, and single points of access. These seemed to be improving service access and understanding by professionals.

[Hidden Men / Significant Others Safeguard Guide](#) had been disseminated and used in practice. Good examples of positive outcomes were given including from the GP practice. Although practitioners described getting better at asking details about partners and 'significant others', they also said it needed to improve. Some computer systems only identify one partner, and not a history, so the use of genograms in risk assessments would help to record this key area of family dynamics.

6. Independent Scrutiny & Assurance: Child Death Overview Panel

Kirklees, Calderdale, and Wakefield share arrangements for reviewing the deaths of all children in the area. During 2020/2021, the Child Death Overview Panel (CDOP) reviewed a total of 46 cases. During this year, CDOP has continued to use the eCDOP system, this has ensured that we have been able to manage the cases in a more effective and efficient manner.

With the ongoing COVID19 pandemic, arrangements have been put into place to ensure that meetings were still able to be held, and these were arranged virtually.

Reflecting on the discussions had by the CDOP over the last 12 months the following key issues had been identified as priorities and had been addressed:

- 1) Improve the engagement of Mid Yorkshire Hospitals Foundation Trust midwifery team, to ensure they are represented at panel meetings. There is now a team of midwives who regularly complete the reporting forms and there is a nominated person to attend meetings.
- 2) To reduce the number of cases where safe sleeping has been a contributory factor to the child death. There is ongoing work around safe sleeping, a working group has been established (See Safe Sleeping section below).
- 3) To highlight topical issues to professionals. This is done via websites and newsletters to help identify the risks posed and how to put measures into place to keep children safe.

The following priorities have been identified by the CDOP panel for 2021-2022:

Priority 1: Increase professional's awareness and understanding of roles and responsibilities within child death processes and eCDOP system to assist meeting timescales.

Priority 2: Work towards smoking prevention in the population as a whole and recognising the knock-on impact on women in pregnancy.

Priority 3: Consanguinity: To provide information which can be understood by families in order that they can make informed choices.

Priority 4: To create a sub-group to look at: Smoking cessation; Alignment of Processes & Procedures; Themes and trends; Socio-economic impacts.

A new National Child Mortality Database has been developed to capture intelligence across the country. A national report has been produced looking at the socio-economic impact on child deaths, which is an area we will start to focus on by initiating new recording measures and reporting our local positions regarding this.

Modifiable factors continued to be associated more with child deaths in Calderdale than the England average. This has been the case in previous years and demonstrates one of the fundamental challenges of the CDOP process – the different categorisation of contributory factors nationally.

Child Death Overview Panel Learning | Safe Sleeping

National Picture: Despite the substantial reduction in the incidence of SUDI in the 1990s, at least 300 infants still die suddenly and unexpectedly each year in England and Wales ([NHS Digital Report](#)).

Importantly, although there has been an overall reduction in incidence of SUDI (Sudden unexpected deaths in infants), there has been a steady shift towards these tragedies happening predominantly in families from deprived socio-economic backgrounds.

In July 2020 the national Safeguarding Children Practice Review Panel (the Panel) published its second thematic report 'Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm'. Whilst it is acknowledged these deaths represent only a proportion of all SUDIs, the data clearly indicates that these tragic deaths occur more frequently in families that are particularly vulnerable, with many of the risk factors associated with SUDI overlapping with those for child abuse and neglect. Our own 'Austerity, Poverty and Implications on Safeguarding' Conference highlighted these issues, and the National Child Mortality Database (NCMD) report on 'Child Mortality and Social Deprivation April 2019 to March 2020' also detailed the number of SUDI rose significantly as the level of deprivation increased.

Local Picture: In Calderdale in June 2021, it was identified that over a 5-year period there have been 8 SUDIs of children under the age of 1 years where unsafe sleeping practice was found to be a modifiable factor.

The Designated Nurse for Safeguarding Children, Children Looked After and Care Leavers in Calderdale is working with a Designated Nurse for Safeguarding Children in North Yorkshire and a Team Leader from Calderdale PHEYS (Public Health Early Years' Service) is now developing SUDI Assessment and Risk Tool in response to the fact that there is no nationally agreed assessment or tool.

The same Designated Nurse for Calderdale is also working on Safer Sleeping materials for use across the partnership – this includes changes to policy and procedures, training materials and induction resources.

7. Independent Scrutiny & Assurance: Engagement - Seeking and using feedback from children, young people, and families

In 2020, the previous adult focussed communication and engagement subgroup was opened up to be a joint CSCP and CSAB subgroup, focusing on strengthening the voice of children, adults, and communities in Calderdale in regard to safeguarding. This streamlined approach is reflected in both CSCP and Safeguarding Adult Board Business Plans and is also looking at the learning from engagement through COVID, social distancing and lockdown.

Young Advisors

There have been Young Advisors working in a paid role for the Calderdale Safeguarding Children Partnership for over five years. Young Advisors are a committed group of young people aged between 13 – 17 years from different schools and colleges who advise the partnership from a young person's perspective. It's important to the CSCP that young people have a voice and can influence the partnership.

At the beginning of the year, 6 new members joined the group bringing new ideas and skills. Due to the pandemic, the Young Advisors meetings were put on hold from April until July and are now being held virtually via Zoom however this has not impacted on the quality of work. They have continued to undertake a multitude of tasks this year which has been instrumental in informing the work of the safeguarding partners in Calderdale.

An example of this work is the Transitions Survey. The Young Advisors wanted to find out about student's experiences of transitioning between education settings. They produced an online survey for secondary school and college pupils in Calderdale.

Out of over 200 responses, the majority of students gave a positive response and rated their transition experience as excellent or good, however, some said their mental health had been affected (both positively and negatively). Students said barriers to their transitions included the impact of Covid-19.

The Young Advisors produced a PowerPoint presentation highlighting the key findings and recommendations for schools and colleges to consider how to improve the transitions process for children and young people. Impressively, Schools fed back that this presentation and report had influence their approach to transition. One school added a transition week rather than a day, others amended the running of the transition events and introduced phone calls to welcome new parents.

Transitions continues to be a priority for CSCP; the invaluable information from the Young Advisors will be included in a future holistic report looking at transitions.

The CSCP will continue to listen to and be guided by the work of the Young Advisors. The next ambition for them is to write a Calderdale Young Persons Manifesto for a Calderdale they would like to be a citizen of, in the future.



8. Independent Scrutiny & Assurance: Quality Assurance

As detailed above, the Performance Management and Quality Assurance Framework details how the partnership seeks assurance about how well children in Calderdale are safeguarded. One of the elements of this is through quality assurance or audit. The following section details some of the audit work undertaken by the Partnership in the year 2020.

The objectives of the Quality Assurance subgroup are set out in the CSCP business plan with the terms of reference being reviewed and updated to include holistic reporting on priorities.

Virtual meetings were held quarterly, and attendance levels remained high. The following multi-agency audits were undertaken which provided learning for the partnership to inform changes to practice, training, and key messages.

The Impact of Parental Mental Health Audit

The audit was undertaken following our SCR where issues of parental mental health were raised. The findings of the audit demonstrated consistency, good practice and good understanding of the safeguarding expectations, specific tools and guidance and training. Positively a number of examples of the impact on practice were given from the 80 practitioners interviewed, including:

- 1. Supporting the adult to secure a more accurate diagnosis of their mental health condition which prompted a change in medication, more stable mood and resulted in the young person choosing to spend more time at home, thus reducing offending behaviours.*
- 2. Supporting the adult to seek medical intervention for their own mental health issues and assisting the whole family to access therapy to address bereavement issues.*
- 3. Working with a Care leaver who had complex mental health issues that were not being managed effectively. The young person had recently transitioned to Adult Mental Health services but had not received confirmation of the referral. The Practitioner acted as the young person's advocate and after much persistence secured an appointment which led to specialist oversight and an appropriate mental health care plan.*
- 4. Practitioner noted a change in the child's behaviour. This was discussed with the parent who acknowledged Post-natal depression. Referred for family support and given advice. Mother engaged with services resulting in noticeable positive impact on the child's behaviour.*
- 5. Children living with a parent with mental health issues removed from home despite a robust multi-agency plan which set out consequences if expectations were not adhered to. Relevant support secured for young person who was aged 17 years.*
- 6. Professionals concerned about the impact of Mother's mental health on the child. New assessment tool (Assessment of the Impact of Parental Mental Health on Children Tool) produced by the CSCP was used which identified that the family had little protective factors. Practitioners focused on developing these to reduce impact on the child.*

There were some areas for development too including wider knowledge and access to the CSCP assessment tool, further information needed about referral pathways and access to specialist advice and better communication between Adult Mental Health Services and Children's Services. The CSCP has produced [Guidance](#) and the [Assessment Tool](#) to aide practitioners.

The Supervision Audit

Effective safeguarding supervision, reflection or case management is routinely raised nationally through review, and this is reflected locally. Therefore, the audit, which was first undertaken in 2019, was repeated in 2020. 115 responses were received from both practitioners and managers. Questions were asked about supervision policies, timing, and scope of supervisions but the audit sought to understand the quality of supervisions.

Responses differed between the cohort of Managers and the cohort of Practitioners – with managers responding more positively. Overwhelmingly, when asked about the opportunity and support around ‘reflection’ which was described as *‘Reflection to understand what is happening, how this links to other similar experiences, to make sense of the information that is gathered, to identify next steps and is therefore an important element in achieving positive outcomes for children’* the responses showed both managers and practitioners are using reflection during supervisions.

Surprisingly, more practitioners rated their supervisions as Excellent, and managers who rated their supervisions as ‘satisfactory’ with some describing not being able to give enough time to staff in supervisions. 60% responded to say that COVID had affected supervisions (78% of managers and 49% of practitioners), with some describing the virtual space as a barrier, but some positively explaining they were more reliant on supervisions to identify staff well-being and behaviours as they are not in the office to observe. High workloads and issues with technology were also raised as barriers to effective supervision.

The survey was followed up with telephone interviews and good examples of reflection, accountability, support, and mediation were given. As some ‘supervision’ is optional, i.e., GPs, education sector, they felt it would be beneficial to have training and firmer guidance in this area. Additionally, the voice of the child / adult or ‘A Day in the Life’ approach was recommended to be captured in supervisions. The CSCP is reviewing its Supervision Framework as a result of this audit which will be published in 2021.

Early Help

The Early Help Pathway was launched in November 2020. The Quality Assurance subgroup are gathering feedback from practitioners about the new process which will feed into an overarching piece of work on assurance around the holistic approach to Early Help in Calderdale.

Holistic Reporting – Child Exploitation

The Child Exploitation holistic report was the first of its kind for Calderdale Safeguarding Children Partnership (CSCP). It attempted to find a coherent way of providing assurance about a single topic, using evidence-based analysis of multi-agency safeguarding arrangements.

The CSCP identified Child Exploitation (CE) as the first subject to be scrutinised. CE is an area of national interest; being a topic for the Joint Targeted Area Inspections and the focus for the first National Panel report. Historically, the Calderdale Safeguarding Children Board led the multi-agency working arrangements for Child Sexual Exploitation (CSE) and the CSCP now has intelligence, data, audit findings, young people’s views, and practitioners’ feedback. Therefore, the CSCP and its partner agencies could provide a rich picture and a more complete report about CE in Calderdale.

The CSCP Independent Scrutiny and Assurance Framework informed the methodology of this holistic reporting approach. This approach gave the CSCP an enhanced analytical capacity and we were able to move beyond traditional performance and intelligence metrics. A range of sources were used:

1. Quantitative evidence through multi-agency performance management data, procedures, training statistics and uptake.
2. Qualitative findings from audits, serious case reviews (local and national) observations of practice and recommendations from peer review and inspection.
3. Views of young people and the community from service user feedback and from consultation with wider populations.
4. Views of practitioners and managers on processes, interagency working arrangements and impacts for children.

National research, guidance, and best practice examples from other areas of the country also informed this scrutiny of practice. Once information was gathered it was verified with professionals from across the multi-agency partnership, who provided additional information, or challenged accuracy.

The Holistic Review found evidence of good practice in the approach, in training, awareness raising, systemic practice, co-location and consistency of staff. The review also found assurance of children being kept safe through COVID lockdowns, with proactive contacts and welfare checks undertaken by the Child Exploitation team, Youth Services, Families Intervention Team, Youth Justice Officers and School staff. Evidence of good practice around children's transition to adulthood was found through Serious Case Review findings and from feedback from victims.

Areas for improvement were identified where practice could be further improved to be outstanding, rather than areas of concern. They included learning from the National CSPP Panel report 'it was hard to escape' about education, early intervention and prevention and a view to determining whether a West Yorkshire Risk Assessment Tool was viable (a Tackling Child Exploitation project is underway in West Yorkshire to address this).

The review report was independently scrutinised by the NWG (National Working Group). Their feedback was positive, and some areas were described as 'doing yourself a disservice'. The review included a letter from a young person which demonstrated the impact of the interventions and was described as a powerful piece of evidence by NWG. NWG observed that Calderdale policies and procedures had been formulated through examining regional / national best practice.

An action plan is in place addressing the areas found by the CSCP and the NWG, this is managed by the Child Exploitation Operations Group and reported through the Quality Assurance Group to the CSCP.

One-page briefings from all audits are shared across the partnership, to encourage service improvement specifically from these important findings.

9. Learning & Improvement

Overview

Working Together 2018 states that employers should ensure that staff are supported and undertake safeguarding training to identify children and families who would benefit from early help.

The CSCP utilises learning from previous multi-agency safeguarding children training; learning and action plans from Child Safeguarding Practice Reviews; CDOP; section 11 and multi-agency audit; new and amended legislation/policy/practice/guidance; and feedback from practitioners and managers.

Learning and Improvement is managed in Calderdale across both adults and children services through a strategic multi agency group. Learning from reviews in children's services is amalgamated with learning from Safeguarding Adult Reviews, Domestic Homicide Reviews, and audit findings to produce collaborative improvement for Calderdale professionals. Links have been developed in a regional framework across West Yorkshire and across Yorkshire & Humber with examples such as shared quality standards being used to ensure quality of learning.

Learning & Improvement: Multi-agency Safeguarding Training & e-learning

In 2020 Calderdale purchased a new Learning Management System with Virtual College called Enable, this went live on 8th July 2020. The system allows learners to book courses and use the E-Learning offer. The system also allows for various performance data reports to be created regarding the courses or the learners. It was important for the CSCP to ensure learning and improvement was a high priority for the partnership and that the focus on high quality training was paramount.

A total of **5106** licences were allocated during the first quarter alone (April to June 2020). This is reflective of the need and ability of professionals to proactively seek professional development during the first lockdown. A total of 4095 eLearning licences were used in the last 3 quarters of 2020-21. There were 4557 licenses used in the 4 quarters of 2019-2020.

In quarter 1, high number of users registered and trained on: awareness of domestic abuse, FGM, child and adult sexual exploitation, modern slavery, and safeguarding children with disabilities. 'Awareness of Domestic Abuse' is pre-requisite of the face-to-face training that has continued throughout the year on a virtual platform. The predicted increase in domestic abuse during lockdown has influenced the numbers seeking training.

Most attendances, both virtual and eLearning, were from health (school nurse and health visitor), education (both schools and early years), local authority (Social care, family support and others), and the voluntary sector.

All 'face to face' training was stood down in line with national requirements from March 2020. Initially, three on-line sessions to raise awareness about Safeguarding Children and Adults were held, aimed at Calderdale Covid-19 volunteers. These sessions were attended by approximately 140 people and provided an opportunity for the volunteers to ask questions and to clarify their safeguarding responsibilities.

The Learning Improvement Officer and others from across the partnership began re-writing face to face training to be delivered online – by quarter 4 (Jan to March 2021) 11 courses were delivered online and attended by 179 people. A full multi-agency safeguarding training program is now being

delivered online for 2021-2022. Exploitation, drug and alcohol awareness, mental health (which formed the majority) and domestic abuse were the virtual training courses most accessed.

94% of attendees were satisfied with their learning experience with 86% claiming that their skills and knowledge had improved a lot, and the remaining 14% stating their skills and knowledge had improved 'a little bit'.

Some of the quotes identified as being the 'best' part of the training included:

- *Interactive and not having to travel to a venue - having the breakout rooms for discussions is good too. These factors have been identified across the year and show the value of multi-agency training; the importance of application of theory to practice (via case studies); having tools to take back to practice; and the variety of methods used in training to meet the needs of different learners.*
- *I found the discussion around how to approach conversations with YP particularly useful and it helped give me confidence to continue supporting YP in the future. Sometimes, you are unsure if you are doing/saying the correct things, but it was reassuring to know that sometimes being direct is the best way.*
- *It was easily accessible as online.*
- *The trainer was knowledgeable, really wanted the best outcomes for young people and she used real life examples, break out rooms and listening and hearing other professionals' experiences and views, A good balance between listening and activities.*

Quotes for how practice will change as a result of attending training included:

- *The event was run very well, and the trainers used the online platform very well to fit the training. I gained a deeper understanding of the condition which will inform my work with young people.*
- *The information received was a great help and has made me look at how I can support the young children differently.*
- *I found it helpful listening to others sharing their experiences of working with people who are or are at risk of self-neglecting. It enabled me to further my knowledge about the challenges other services can find when working with people and families at risk.*
- *I know more places to seek out information and advice for concerns*
- *I came away with lots of useful tools to use within practice. to understand everyone's individual reasons that could be contributing to parental conflict and why this might be occurring*
- *even though I think of myself as being very tolerant, I think this session helped me to understand the more widespread effects and symptoms of depression.*
- *I will be a lot more aware of the difficulties children deal with day to day.*
- *I feel that I will now be better at supporting the adults and not just the children that access the organisation.*
- *My practice will change by making sure I fully assess a situation and record it thoroughly, go with my instinct and keeping an open mind that things may not always seem as they are portrayed.*

Some provided additional comment that they would like to return to face to face training, for networking opportunities and to get more breadth of knowledge. This is being planned for as and when we are able.

West Yorkshire Multi Agency Safeguarding Procedures

New policies have been written and procedures updated during 2020 following audit, review findings and national guidance. See appendix 3 for the full list of updated Procedures during this period.

In addition to policy and procedures, the CSCP produces a number of resources to aid practitioners and managers to improve services and outcomes for children. The CSAB and CSCP produce a range of resources to support practitioners, for example, safeguard guides, 7-minute briefings, key learning points to include in single agency training but also members of the public and service users, for example, a guide to referral to Adult Social Care. The requirements around accessibility of all documents before they can be shared on websites means that options around video versions of the 7 Minute Briefings will be tested and could possibly extend to other guidance that was reliant on flow charts and diagrams.

Some examples of the tools and guidance produced by the CSCP can be seen in the Child Safeguarding Practice Review Section above, and the rest can be found on the website www.calderdale-safeguarding.co.uk or by contacting the CSCP Secretariat.

Dissemination

Dissemination is undertaken using briefing papers, training modules, bespoke learning events, information on the website, cascading through subgroup leads and safeguarding champions. A Dissemination Log is kept as evidence of who, when, how and in what way info is disseminated from the CSCP. The bi-monthly Newsletter started in October 2020 for both CSCP and CSAB news and the response to key articles and numbers booking on training are positive responses to this.



Learning & Improvement: Safeguarding Week

Calderdale held its first ever virtual safeguarding week in 2020; this was due to the Covid-19 outbreak. It was agreed to focus on a 'topic per day', which included:

- Monday: Safeguarding is everyone's responsibility; Kindness
- Tuesday: Domestic Abuse and impact on children; Peer on peer abuse; Controlling and Coercive Behaviour; Reducing Parental Conflict
- Wednesday: Adverse Childhood Experiences (ACE's); Transitions in Safeguarding
- Thursday: Online Safety; Scams and Exploitation
- Friday: Resilience; Promoting Emotional Health and Well-being

The virtual programme included online learning sessions, live chats, podcasts, research reports, academic articles, resources, links, and videos aimed at practitioners and managers and was available via the Safeguarding website. Contributions were received from across the multi-agency partnership and included a good mix of resources for practitioners who work with Children and/or Adults.

The CSCP/CSAB website was viewed 2478 times throughout the week, with Monday being the most popular day, with almost 1250 hits. The most popular method of learning was through videos.

From the 22 Facebook and Twitter social media posts throughout the week, this generated a total of:

- 64,456 impressions (*Impressions: The social media post has been delivered to someone's social media feed*)
- 899 engagements (*Engagements: a measure of the number of public shares, likes and comments on the social media post*)

A particular Facebook post highlighting the contacts details of the Multi Agency Screening Team (MAST) and Gateway to Care created the largest impression (9241). The Halifax Courier also covered the story [online](#).

Contributions to the programme came from over 60 local and national organisations. Some examples of YouTube 'hits' include a keynote speech video 'Working Together in Challenging Times (change, challenge and innovation)' - by Professor Nick Frost (CSCP Independent Scrutineer & Professor of Social Work Leeds Beckett University received 96 unique viewers. A Video Message from Helen Madden – Police Lead for Partnerships and Early Action in Calderdale received 145 unique viewers.

Survey Monkey was used to gather evaluation from practitioners, about the resources available and the virtual method of learning, receiving 114 responses in total. Overall, the virtual week was evaluated as very positive; practitioner knowledge increased as a result of accessing the resources, and practitioners said it would enhance their practice now, and in the future.

Evaluation revealed that early preparation is key to ensure practitioners can book time out to access the resources, and work is needed to be done by all contributors around accessibility standards to ensure resources are available past safeguarding week.

Learning and Improvement: Socio-Economic contexts

The CSCP, together with the Safeguarding Adult Board, hosted an 'Austerity, Poverty and the Implications on Safeguarding' Conference in Calderdale in December 2020. The event was based on a thesis written by Social Work Masters Student Jessica Keenan who was commissioned by Calderdale CCG to undertake the piece of work. The thesis received one of the highest grades recorded by Leeds Beckett University.

The conference detailed research on the implications of austerity and poverty on safeguarding in Calderdale which was especially important due to COVID and the impact on (global) poverty.

The links to our Calderdale Vision 2024 and especially being 'Kind and Resilient' are clear. And the presentation gave an evidenced based view on the following issues:

- What, if any, are the impacts of poverty, deprivation and inequality on maltreatment and abuse of both children and adults?
- Has austerity affected the prevalence of poverty in the United Kingdom?
- Have austerity policies contributed to the rate of abuse and maltreatment and the types of abuse that are recorded?
- If there is a connection between poverty and abuse, what are the causes of this connection?
- Is there any evidence of systematic oppression and prejudice within professional practice?

The virtual conference was attended by over 120 professionals from Calderdale and West Yorkshire and included an online facilitated discussion. The participants were invited to join breakout groups

to discuss the implications for Calderdale from the presentation and discussion. The focused-on actions and the 'So What?' for Calderdale. The participants captured "what we can implement based on our learning? And considered:

- How can we place poverty more centrally on our agendas?
- Any implications for multi-disciplinary working?
- What will a post-COVID-19 era look like – how can we prepare?
- The differences/shared features of the children's and adult's agendas?
- How we do more to empower poorer children, families and adults at risk and their carers'?
And the impact of the power imbalance in our relationships with people who require services
- Ensure our local data is sufficient in terms of poverty and inequality?

The impact of Adverse Childhood Experiences, use of language, and shared opportunities between children and adult services were looked at along with digital poverty, and the existing services looking at poverty and social inequalities.

The results were fed into the Calderdale Anti-Poverty Strategic Group who are taking actions forward, and into the regional work looking at Trauma, Adversity and Resilience in West Yorkshire. Specifically, the CSCP adjusted the Business Plan as a result and now records indices of multiple deprivation alongside other indicators to inform our picture of safeguarding and peoples individual needs.

10. Conclusion

The Partnership considers there is increased accountability and transparency of safeguarding arrangements in the Borough since the inception of the new arrangements. The partners made the decision to trial a wider approach to independent scrutiny that was not reliant on one individual ‘Scrutineer’. The three key partners have established independent scrutiny as one of the primary focusses for the Partnership, exploring a range of review, scrutiny, and inspection methodologies. Expert organisations have been commissioned to provide independence from a national perspective alongside a new model of Holistic Reporting, which has brought a new clarity in examining and challenging how well partners in Calderdale work together to safeguarding children. The partners are involved in meeting with front line staff from across the wider partnership, following up on Child Safeguarding Practice Review activity and questioning how learning is embedded in Calderdale. The 12-month report broadly describes this activity, and its impact on local practice - this in turn is then independently scrutinised and the learning from this is acted on by the wider partnership in October 2021, where challenge and critical friendship is sought.

Stubborn Challenges

Although this report does highlight areas of impact, it does need to be recognised that the priority for organisational leaders and the CSCP was responding to the COVID crisis in this reporting year. Obtaining and seeking out evidence and impact was not the focus for the partnership during this year – the assurance about the single and multi-agency response to the unprecedented crisis, the changes being made to services and the approach to contacting potentially hidden victims was. The CSCP proactively sought out live updates of working arrangements and met to consider horizon scanning issues and ‘what was keeping people awake at night’ as well as assurance of how children were being safeguarded during this period and communicated any service changes across the partnership to inform the joint approach.

The Independent Review of Children’s Social Care: A Case for Change points out – the responsibility for services supporting children and young people is *‘split between several government departments – DFE, MHCLG, DHSC, MOJ, Home Office, Treasury, DWP, HM Revenue and Customs, Department for Digital, Culture, Media and Sport – this has led to uncoordinated policy initiatives that see children and families through the lens of the individual challenges they are experiencing’* (page 75, 2021); Locally, partnerships in Calderdale have an advantage in that the authority is small, the need for streamlining and reducing duplication is ever present and there remains a healthy critical friendship between partners who are all trying to improve services for children. Initiatives such as combining the back office of the CSCP and SAB, the inclusion of Domestic Homicide Reviews in the portfolio and the links with wider regional activity results in more cohesive policy making and a greater understanding of what is going on in other strategic partnerships. The three key partners all sit across the other strategic groups to ensure a coordinated approach with fewer gaps.

The past decades have seen safeguarding children services subject to numerous national reviews and strategies, from Laming, Munro, DFE (Putting Children First), What Works Centre, Child in Need Review, Care Leaver and Adoption Strategies, Wood Review of Safeguarding Arrangements, Narey review of foster and residential care, social work taskforce, National Panel reviews etc; they all describe changes to arrangements with recommendations, some with national regulation and reform. The ADCS (Children’s Services Statutory Duties – Working Document 2018) identified 298 new duties imposed by nine different central government departments. So, on top of responding to

this 'top down' reform, children's services from across the Calderdale partnership have also responded to the 'bottom up' learning from our local reviews, audit, and data analysis – the evidence of which has been apparent in challenge events, performance management, practitioner surveys and self-assessment.

Added value and impact of new arrangements

The coherent joined up local strategies for safeguarding children is apparent in Calderdale through the multi-agency groups at co-location, operational, subgroup and strategic level. CSPRs, SCRs and audit consistently find that information sharing is not an issue for the local partners, similarly, multi-agency working is apparent in all evidence from performance management, quality assurance and from reviews. What is in need of improving is how effectiveness of interventions is measured, which is replicated across the country and relates to the findings in national reports.

There have not been issues with regards to fulfilling statutory obligations, and partners are held accountable, can speak on behalf of their organisations, are able to make decisions and are fully engaged in the multi-agency partnership arrangements. Even when different services have different footprints, objectives, accountability arrangements and inspectorates, Calderdale partners overall capitalise on this – an example of this is the Housing provider who has a footprint outside of Calderdale and West Yorkshire, which shares the learning from our Reviews with their other geographical areas. New arrangements, such as the Integrated Care System reforms and Mayoral Authority, are considered as to how each will impact on and be influenced by the Calderdale partnership.

11. Future Priorities for the CSCP

There are a number of upcoming opportunities and challenges which need to be explored, and the wider partnership symposium in October 2021 will lead the partnership decision making.

The priorities for the CSCP will include establishing new working arrangements with the new WY Integrated Care System, the Mayoral Office and ensuring agendas and priorities are streamlined and maximised across the different strategic partnerships. The HM Government publication and priority 'Tackling Violence Against Women and Girls' will be among the priorities as we work with the Domestic Abuse Strategic Group on the Needs Assessment and the resulting Calderdale Domestic Abuse Strategy. Learning from our current CSPR and DHR will inform this issue which blights the lives of so many.

The CSCP will be leading strategic work around the multiagency changes to the Early Help offer in Calderdale. This will include using the Independent Scrutiny and Assurance Framework to seek evidence of impact and outcomes of children and families.

The newly formed CSCP group 'Risk and Vulnerability in Adolescence' will be looking at the transitions from childhood to adulthood with particular regard for safeguarding. The age group looked at will cover 12–24-year-olds and will link with the other regional and national workstreams focusing on this area.

A change in line management for the Safeguarding Partnerships Manager to the Assistant Director for Commissioning and Partnerships across Adults and Children's Services will provide opportunity to explore how commissioning in the Local Authority is influenced by CSPR, DHR and SAR findings, and to be better able to respond to demand and changes in resource.

A renewed effort will be made to focus on learning from success and methods to do this will be explored through serious success reviews, reflective practice sessions and recognition of good practice in the borough.

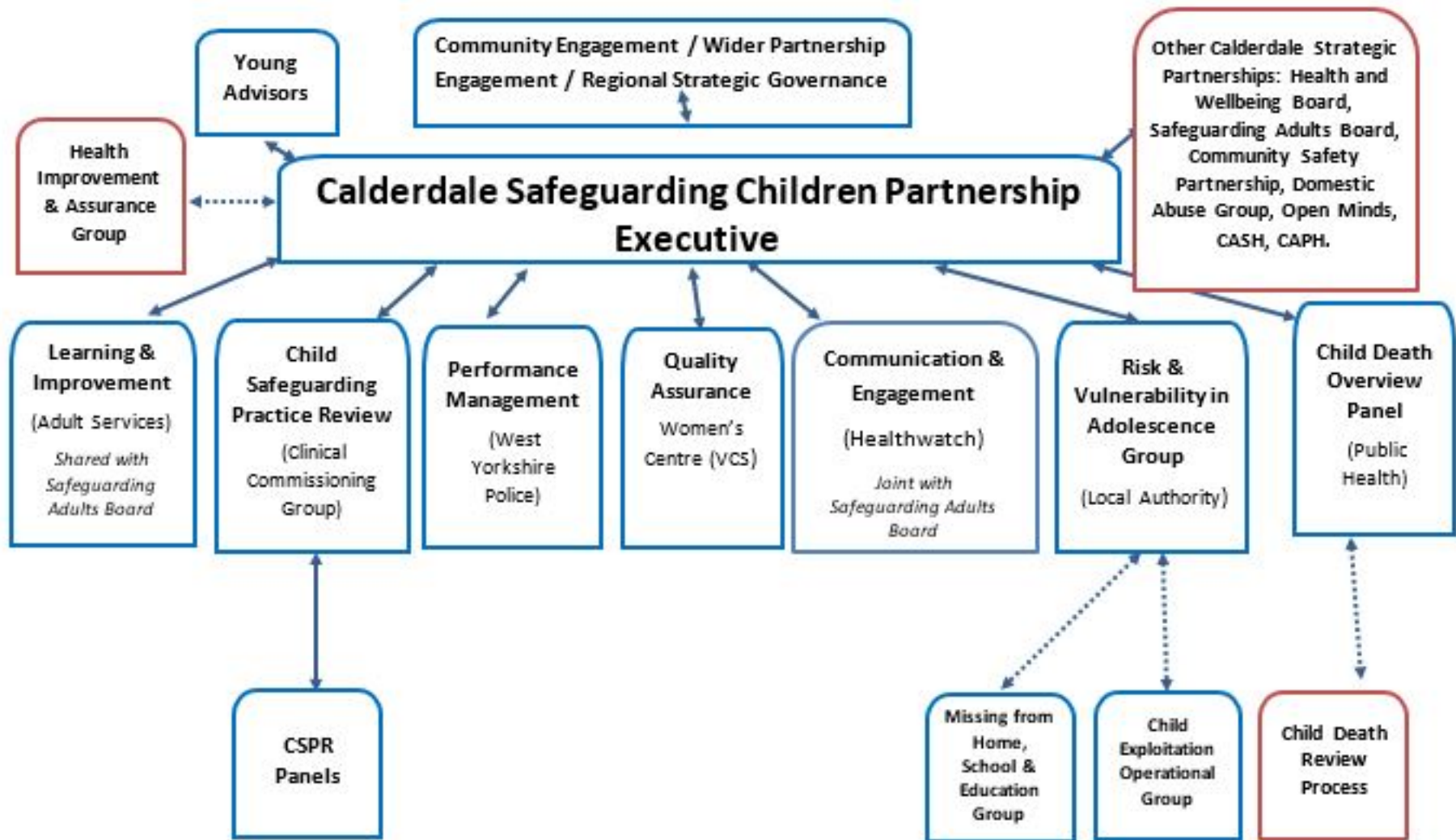
A recent WY bid for funding from NHS England for Trauma Informed Practice was unsuccessful, however the determination of the CSCP and its partners to prioritise using a trauma informed approach remains steadfast. The CSCP, along with other strategic local and regional bodies will be exploring how this approach is advanced and developed in West Yorkshire.

It is anticipated that a widening of health inequalities and social poverty further exacerbated by the covid pandemic will have an impact on the safeguarding of children, young people, families, and the wider community. This is evidenced in research and the increase risk associated with abuse, neglect, domestic abuse, increased mental health concerns of children and young people and concerns of parenting capacity due to parental substance misuse and mental health concerns. The CSCP's focus on socio-economic factors, and the impact of poverty on safeguarding will continue with the collation of data and intelligence to inform the approach. The CSCP will continue to link with the Anti-Poverty Strategic Group to ensure children, families and safeguarding are represented on the Council-wide priority.

Following this tumultuous year of change and difficulty, the CSCP will renew its efforts to seek out evidence of impact on the lives of children and young people and will be exploring how interventions can best be evaluated.

The Partnership remains committed to delivering the Business Plan based on local intelligence, learning, analysis of current strengths and areas for development. The CSCP recognises more is achieved through working together in partnership and will continue to support multi-agency working to improve safeguarding outcomes for children.

Appendix 1 Structure Chart



Appendix 2 – Relevant Partner Agencies

- Adult Services and Wellbeing
- CAFCASS
- Calderdale and Huddersfield Foundation Trust (CHFT)
- Calderdale College
- Calderdale Governors Association (CGA)
- Early Years Quality and Improvement (Representing Childminders, Early Years Settings, Out of School Clubs)
- Locala School Nurse and Health Visiting Service
- National Probation Service (NPS)
- NHS England
- Together Housing Group
- Education (Primary and Secondary Head Teachers Association & Designated Safeguarding Lead Network)
- Public Health
- South West Yorkshire Partnership Foundation Trust (SWYPFT)
- Voluntary Sector Infrastructure Service (VSI)
- West Yorkshire Fire Service
- Women’s Centre
- Youth Justice Service
- Children’s Residential Homes including private providers
- Independent Fostering Agencies
- Halifax Opportunities Trust and North Halifax Partnership (Children’s Centre, Family Support and Community Engagement delivery)
- Yorkshire Ambulance Service
- One Adoption
- British Transport Police
- Sports and Leisure Organisations
- Religious Organisations

Appendix 3 – Changes to Local Multi-Agency Safeguarding Procedures for Children

[Children Missing from Education](#) - This guidance has been reviewed throughout and extensively updated.

[Female Genital Mutilation \(FGM\)](#) - This guidance has been reviewed and updated throughout to reflect the latest statutory guidance on Female Genital Mutilation.

[Children Visiting Psychiatric Wards and Facilities](#) - This chapter has been refreshed throughout and terminology updated. Additional information has also been added into Section 3, Visiting Patients in the High Security Psychiatric Services: Ashworth, Broadmoor and Rampton, in line with the High Security Psychiatric Services (Arrangements for Safety and Security) Directions 2019 and associated Guidance.

[Children Visiting Prisons](#) - This guidance has been reviewed throughout and updated as required.

[Information Sharing](#) - This guidance has been reviewed and updated throughout to reflect amendments in the statutory guidance Working Together to Safeguard Children (DfE).

[Allegations Against Persons who Work with Children](#) - This procedure has been reviewed and updated as required to reflect the most recent versions of the statutory guidance Working Together to Safeguard Children and Keeping Children Safe in Education. A fourth bullet point has been added in Section 1, Introduction and Criteria to include situations where an individual in those settings has behaved or may have behaved in a way that indicates they may not be suitable to work with children. This is to capture concerns around transferable risk; for example, where a person who works with children is involved in a domestic abuse incident at home and this may have implications for their suitability to work with children.

[Safer Recruitment, Selection and Supervision of Staff](#) - This guidance has been updated as a result of the UK's exit from the European Union. Information has been added on how employers can now check that an individual has the right to work in the UK during the recruitment process.

Single Assessment - The link to the digital referral system for reporting potential victims of Modern Slavery has been updated.

Children from Abroad, including Victims of Modern Slavery, Trafficking and Exploitation - This guidance has been updated to take account of the new NRM digital referral form and the change to a Single Competent Authority (SCA).

Child Exploitation: Policy, Procedures and Guidance- This chapter contains information about child exploitation (CE) including how to recognise indicators that a child or young person is being exploited, the roles and responsibilities of relevant agencies and the procedures practitioners should follow to ensure the safety and well-being of children and young people where there are concerns that they have been, or are at risk of, being exploited. It also links to relevant local resources for each local authority in West Yorkshire.

Bullying - This chapter has been updated with new links added to resources for addressing bullying linked to race/faith, and resources to help make schools, colleges or other settings LGBT inclusive. See Section 5, Further Information and Sources of Support.

[Elective Home Education](#) - A small, but growing number of children are educated at home. Elective home education (EHE) is not, in itself, a risk factor for abuse or neglect, and there is nothing to suggest children who are educated at home experience a higher incidence of abuse or neglect than the wider population of children. However, when children who are educated at home are maltreated, this can be more difficult for professionals to identify. This new section explains the actions practitioners should take if they have concerns that a child who is being educated at home is at risk of abuse or neglect. Links to local EHE contacts are also included.

Interpersonal Violence and Abuse (IPVA) Young People's Relationships West Yorkshire Practice Guidance - This practice guidance covers situations where a young person under 18 years of age has been harmed through interpersonal domestic abuse from a partner (boyfriend or girlfriend) or is causing harm to a partner.





Safeguarding Partnerships Manager
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