Calderdale Safeguarding Children Board

Annual Report 2014/15

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Foreword

Welcome to our Annual Report for 2014 -15 which provides an account of what the Board and its members have achieved during the year. It is an assessment both of the impact of these efforts and the overall position of joint working arrangements to safeguard children and young people in Calderdale.

We hope that you will find that the report helps you to better understand how organisations and people work together and the contribution the Safeguarding Board has made to this. It sets out how these arrangements can continue to improve on the basis of the Safeguarding Board and partners being able to objectively and critically learn from what works well and act to improve what may not work as well as was intended.

The report is organised in two main sections. The first considers the context, the role of the Safeguarding Board and forms a view of the overall position regarding the effectiveness of joint working arrangements to protect children and young people in Calderdale. The second section looks in more detail at how the Board has fulfilled its statutory responsibilities and forms a view as to how effective this has been. Seen together this contributes to the forming of a wider view of, and judgement, about how well children and young people are protected in Calderdale.

We have tried to make this report as easy to use and understand as possible, but as safeguarding is a complex area involving literally thousands of people from many different organisations and professions, it may not fully succeed in this. The report will therefore seek to summarise, and provide some examples as well as links to further information and evidence.

The report is intended to provide you with enough information to improve your understanding of joint working arrangements to protect children and young people in Calderdale, and to assist you in forming your own view as to the effectiveness of these arrangements on the basis that "safeguarding children, young people and adults is everyone's business".

As a public record the report provides the opportunity for dialogue and also seeks to provide a challenge to all concerned, and invites challenge to the Board and its members, as to how we each can play a full and improving role in ensuring that children and young people do not suffer harm, neglect or abuse.

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Appendices:

1. Introduction

Working Together 2015 sets out that the Annual Report should provide a rigorous and transparent assessment of the performance and effectiveness of local services. This report identifies areas of strength and weakness, the causes of those weaknesses and the action being taken to address them. The report includes lessons from serious case reviews undertaken within the reporting period.

It is also an assessment of the effectiveness of the Board and the partnership it represents and this judgment is made on the basis of providing an account of, and an account, for how the Board fulfilled its statutory functions and responsibilities (as seen in Appendix A).

The report was formally commissioned by the Board on 2nd April 2015 and was signed off by Board members ready for publication on 26th August 2015. Once Board members have had time to consider the learning and implications of the report, an Executive Summary will be published in autumn 2015.

Please see below for a glossary of terms used and wherever possible we have sought to avoid the use of acronyms, overtly technical language or jargon (please see Appendix B for the glossary of terms). If we have fallen short in this respect or you have any other questions or queries then please contact:

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01422 394074, cscb@calderdale.gov.uk

In order that the report is as concise and focused as possible we have used hyperlinks to take you to fuller information and/or supporting evidence. If you are not able to utilise these then please contact us and we can arrange for this information to be made available.

If you require a version of this report in a form or language that would assist in accessing the report contact us. The CSCB Business and Quality Assurance Manager, Chairs of the Sub Groups and contributions from Board members have supported the Independent Chair in writing this report.

The report is formally sent to;

- The Chief Executive of the Local Authority
- The Chair Person of the Health and Wellbeing Board
- The Police and Crime Commissioner for West Yorkshire
- The Chief Executives and/or senior leadership of all organisations who constitute the CSCB. (For membership see Appendix C)
- The report is published on the CSCB website www.calderdale-scb.org.uk
- The report is formally tabled at the Health and Wellbeing Board, The Children and Young People's Partnership Executive (CYPPE), Calderdale Council Scrutiny Committee, Calderdale Safeguarding Adult Board (CSAB), Calderdale Community Safety Partnership and Calderdale Domestic Violence Partnership.
- Board members assume responsibility for ensuring the report is considered within their own organisations.

2. Independent Chair's Executive Summary

This is my second annual report and it sets out the results from the continued hard work that partners and professionals that support the work of the Board. Their contribution has been on the basis of the learning from last year's report. This in turn reflected the need to address the fact that as a Board our performance and contribution was not yet good enough.

The effectiveness of a Safeguarding Board is in part a reflection of the partners that comprise it, in terms of what they contribute and take from it and how this results in high quality joint working arrangements. The extent to which we are a pro active and learning partnership is reflected in part through this report.

This report sets out not just how we have made progress in defining and refining how we provide this pro-active approach and the evidence for this, but also the necessary background information as to the standards against which judgments in the report are made.

It also demonstrates the other ways in which working as a strategic partnership adds value to the important work people do and most importantly how it impacts positively on outcomes for children, young people and their families.

The report sets out the considerable challenges and turbulence that partners face in being able to maintain a focus on safeguarding and in particular how the Board as a partnership has sought to bring both a level of stability and continuity to support improvement.

Board members have continued to embrace and commit to the need to develop their role as individual members and to the collective endeavour, working hard to build an understanding of and a view of the "whole system" as well as the need to focus on key points in the child's journey as this relates to current priorities.

Board members have demonstrated that they understand the need to develop the capacity to scrutinise a wide range of information and data, learn from this and act to change the contributions each make to joint working arrangements. The report indicates that some further important steps have been taken to ensure that the focus of this is the quality and the effectiveness of these arrangements have on the lives of children and young people.

The report demonstrates significant and sustained development and improvement overall and specifically in relation to the learning and goals set from the last annual report.

Our last report told us that we had made a good start and that we had done our best to value and take forward past learning; that it was understandable why we needed to focus on process and capacity development, but that we needed to ensure that we were more focused on the impact and outcomes this resulted in.

The process of preparing this report has shown that we have been able to progress, amend and augment what we need to do, and there is stronger evidence of impact. It shows that we have maintained follow through and as partners are developing their capacity to contribute and respond in the context of a scrutiny and assurance driven way of doing things.

The report demonstrates the progress made in key areas that relate to setting standards, setting out how these should be met, putting in place the means for monitoring and measuring these standards and outcomes. The report also demonstrates how as a Board we have developed both our approach to and confidence in constructive and appropriate challenge in the context of what is essentially on the basis is a consensus based and collectively driven arrangement.

The year also saw considerable progress and challenge, in terms of the undertaking of Serious Case Reviews, which in themselves always provide a reminder of the need to strive for practice and joint working arrangements that minimise risks and reduce error where this is a factor. In order to produce a sustainable level of assurance that the system, the organisations and the people that are a part of it can and do improve. As a result the Board during the year significantly developed its ability to engage with the requirements of the Case Review process.

The report also demonstrates the ways in which wider partnership and engagement developed, that as a Board we are further developing reporting arrangements and relationships that are influential in making sure that safeguarding is a central commitment. It also evidences that we are influenced by the wider priorities that reflect how the needs of children, young people and their families are understood and acted on locally.

Although the local context is not unique, the need for improvement has rightly been a central focus in the year, and it has been important to further distinguish the different contributions that the Board has to make to this, as well as the interrelationship this has with the need for the Board to become an effective board.

The outcome of the Ofsted inspection in January 2015 was therefore a welcome affirmation of the progress made by the Local Authority, partners and the Board itself. This outcome has set a further agenda in terms of the Board's role and contribution, but has significantly, allowed the Board to continue to re-position itself so that its future contribution can have increased impact.

This report is an important part of a wider approach to assurance, as partners and the public all want to have a clear and substantiated view of the effectiveness of local arrangements to protect children and young people and the promotion of their welfare.

This is not a view that can be solely formed on the basis of just the Local Authority's contribution and impact, though this is a significant and a critical determinant; it has to be formed on the basis of partnership and joint working approach and arrangements. Implicit in this is the need to be assured that the Board contribution to this assessment is a valid and a viable one. It is hoped that this report will contribute to a growing understanding of and the credibility of the Board's role and contribution in this respect.

Reports such as these are not easy to produce or to take in, as they have to cover both general and specific areas across a very broad and complex context.

The report therefore provides the following messages;

- A reminder of the purpose of the LSCB and the requirements placed upon its members in the national and local context
- A review against the priorities and learning coming out of the last report of progress and the conclusion that the Board is a more effective board than it was at this point last year.
- Evidence of how this view was reached and the areas where continued effort and improvement need to be focused
- It also helps to form a wider view and level of assurance as to how the whole system is ensuring that children and young people are protected and concludes that from the LSCB perspective these arrangements are more robust and maintaining an improving profile.
- The report also highlights some of the challenges, opportunities and risks that the Board faces in its own continued development and more general in the context of the wider partnership responsibility and accountability for safeguarding.
- A reminder that the next steps need to be taken with similar commitment so that the next report can further evidence learning, improvement, challenge that makes a difference on the basis of rigorous and consistent monitoring of performance and quality, as the basis for assurance.

In conclusion I believe that the report provides reasonable grounds for the judgement that the Board and therefore joint working arrangements to protect children and young people have a sound foundation and continue to improve.

As the Independent Chair I would like to formally acknowledge and thank Board members past and present, the staff who support the Board and all those who continue to show their commitment to protecting children and young people for their sustained efforts and achievements during the year.

Richard Burrows

Independent Chair

3. Statutory Responsibilities, Priorities and how we go about this in Calderdale

- The Safeguarding Board and its members on the basis of agreement and consensus seek to achieve the following in order to fulfil the statutory responsibilities and functions vested in the LSCB.
- Setting clear standards for those who work with and are involved with children and young people in order to ensure that their welfare is promoted and that they are protected from harm, neglect and abuse. In Calderdale we use the Section 11 Self Assessment and Audit to provide baseline standards for all those who work with children and young people. These are supplemented by further single agency standards and the West Yorkshire Multi Agency Policies and Procedures.
- Setting out what people should do, how, with who and under what circumstances people should act when they are concerned that a child or young person is not or may not be safe and/or needs help. In Calderdale we call this the Continuum of Need which sets out the "thresholds" for the provision of help and intervention to protect children and young people.
- Setting out and ensuring that information is shared effectively so that children and young people are protected. In Calderdale we recognise that all types of information and intelligence are important and as a Board we encourage the sharing and effective use of information and embed this in all of the strategies and arrangements that partners agree.
- Providing clear, accessible and current policies and procedures for joint working. In Calderdale we share the provision of these across West Yorkshire and ensure they are effective through regular review, formal Board approval and making sure that all training and communications promote their use. We further test this through our performance monitoring, case review and auditing of practice.
- Providing multi agency training and learning opportunities for those who work with children and young people. In Calderdale we organise and deliver an annual programme of learning opportunities for all people who work with Children and Young people, and we also make sure this fits with the other training that is available and are working towards a joined up strategic approach to making sure that we have a comprehensive "Children's Safeguarding Workforce Development Strategy" across partnerships.
- Ensuring that recruitment arrangements are safe and that allegations made against professionals who work with children and young people are in place and effective. In Calderdale as a Board we support and review the arrangements that partners have in place and formally review the Local Authority's discharge of its duty to manage allegations. (Formerly known as the Local Authority Designated Officer (LADO) arrangements)
- Ensuring that children and young people who are privately fostered are safe and their welfare is promoted. In Calderdale we support and formally review the Local Authority's role in regard to private fostering and partners actively ensure that awareness of and response to children who may or who are privately fostered is a priority.
- Ensuring that all notifiable incidents are responded to and where appropriate subject to the right form of review in order that learning is identified, appropriate actions are taken to reduce future occurrence and that changes are monitored to ensure improvement. In Calderdale we ensure that the Board is notified of all incidents and that these are coordinated and subject to scrutiny in order to determine whether review is necessary and if so what form this review should take and by whom it should be undertaken, so as to promote learning and accountability.
- Promoting awareness and understanding of what is expected in order to ensure children and young people are protected, and the different forms harm and abuse can take, in order to reduce the likelihood of this happening. In Calderdale we work closely with other strategic partnerships to ensure that plans and priorities reflect safeguarding priorities. We also engage with children, young people their families and carers, front line professionals and non professionals who come into contact or who hold positions of responsibility in the community so that there is an improving understanding and awareness of safeguarding of children, young people and adults.
- Ensuring that partners are able to respond as a result of learning to the risks and needs of children and young people who may be especially vulnerable. In Calderdale we have made sure that children at risk of, or who have been subject to, Child Sexual Exploitation (CSE) are receiving help and protection through a clear strategy and action plan. We have also made sure that other groups of children who we know to be, or are concerned may be, vulnerable are subject to scrutiny.

How do we do this?

Working Together to Safeguard Children 2013 and 2015 requires us to have in place a Performance and Quality Assurance Framework (PMQA) and a Learning and Improvement Framework (LIF). We use these as a Board for the basis of our scrutiny, assessment and actions.

Together with the wide range of experience Board members bring to the table this enables a "direct line of sight" to be established which increasingly focuses on the quality of front line practice and the impact this has on children, young people and their families.

Our "wider view of the safeguarding and partnership landscape" enables us to respond to new developments and signs that there may be grounds for further enquiry leading either to assurance and/or improvement.

These frameworks set out how we:

1. Collect, collate, assess and scrutinise a wide range of information and data supplied by partners to assess performance, quality and impact of joint working as these comply with the standards, policies and procedures, strategies and agreements and targets the Board has agreed
2. Use the results from monitoring, scrutiny and review to ensure that;
    a. Board arrangements and responsibilities are being effectively discharged
    b. Partners are able to act on advice and recommendations resulting from their scrutiny and challenge the evidence and learning that the frameworks produce
    c. Standards for safeguarding (Section 11) are triangulated through the Board and within each partner's own quality assurance, accountability and governance arrangements.

Working Together 2015 sets out the priorities for how we use the frameworks for our monitoring, review and improvement role and as such these serve as a baseline for the overall assessment of our performance as a Board and that of joint working arrangements;

- assess the effectiveness of the help being provided to children and families, including early help;
- assess whether LSCB partners are fulfilling their statutory obligations set out in chapter 2 of this guidance (see below);
- quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned; and
- monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

Chapter 2 of Working Together sets out the statutory obligations of partners to individually and collectively have in place arrangements that reflect the importance of safeguarding and promoting the welfare of children and how they should contribute to and cooperate with the CSCB. Partners remain responsible and accountable for the services they provide and statutory duties placed on them.

The Local Authority, its Chief Executive and Director of Children's Services (DCS) have additional and specific duties and responsibilities for ensuring that the welfare and safeguarding of children and young people are effectively met through coordination and cooperation of all those involved.

The Local Authority also has a duty to ensure that there is a LSCB in place and that it is effective; this includes ensuring that the LSCB is a distinct and independent body, able to meet its statutory responsibilities which include supporting and holding the Local Authority to account.

In Calderdale, the CSCB approach and frameworks are making sure that there is a comprehensive and evidence based approach to supporting, advising and where appropriate providing challenge to partners and other strategic partnerships.

4. The CSCB Vision, Values and Plan

Our vision is founded on the belief that "Safeguarding is everyone's business" and that therefore as a Board in conjunction with other strategic boards and partnerships we are working towards a position where children and young people are protected and as safe as possible.

This means as a Board we have to be clear about how we do this and what this means for Board members, partner organisations, children, young people and their families as well as the wider community.

This was articulated earlier in the year by the first Calderdale Safeguarding Week, which saw widespread press coverage raising awareness and understanding across Calderdale. It also provided partners with an opportunity to showcase and share how they contribute to safeguarding. It was also the first time the Board had used social media for which the response was greater than any expectations; reaching over 1000 people.

Our vision is further defined by our statutory responsibilities and obligations and during the year we did further work on how this worked through into priorities for our business plan. (NB Our business plan shows how we translate our priorities and ambitions into measurable steps that enable each Board member and the sub groups to progress and join these up).

For 2014 to 2015 our five vision led priorities were:

1. **We are assured that children receive the right help at the right time**
2. **We know which children are vulnerable and are assured they are protected**
3. **Scrutiny and challenges evidences effective safeguarding**
4. **The CSCB drives Safeguarding and Practice Improvement for children and young people**
5. **We create a learning culture which consistently improves outcomes for children and young people.**

Appendix D details the structure of the CSCB and provides an overview of the Business Plan 2014-2015 with a link full Business Plan.

This report will provide some examples of the progress and learning made in respect of each priority as it looks at the statutory functions and the year as a whole. In March 2015 the Board met for a development day with the specific purpose of reviewing the Annual Report for 2013/14, the business plan and the findings from Ofsted; this led to the re setting of priorities and a move into a three year business plan.

5. The National Safeguarding Context

Many public and voluntary sector services have continued in the year to experience the impact of the wider economic situation often termed as 'austerity'. This has required organisations, large and small, to consider their priorities and how best to use the resources they have available.

At the same time there has continued to be change as a result of national political priorities and these especially as they have affected health as well as local government sectors have been far reaching, especially when combined with the need to respond to austerity led financial strategies.

During the year we have also continued to see further change and developments in terms of how and where 'governance and accountability' responsibilities are located for example with the extension of Academies and Free Schools in the education sector. Also in the year we saw continued changes to the ways in which and from where services were commissioned.

The impact of historical abuse allegations, prosecutions and reviews gained further significance in the year with a number of high profile 'celebrities' being convicted, and the working through of reviews and reports across a number of sectors as a result of past convictions impacting on partners and LSCBs. The welcome and increasing focus on listening to and acting on the experience of victims has created an additional dynamic that has further challenged us, and we saw the first difficult steps being taken to commission a national enquiry.

Perhaps the most significant influence and development in the year was the important response to and understanding of Child Sexual Exploitation. This dominated both the public and the policy agenda, bringing out the best and the worst of how as a society we respond to such learning.

The year also saw the recognition and better understanding of the range of issues around Female Genital Mutilation (FGM) which further challenged us to be able to understand and engage with cultural and religious based practices and beliefs in the context of the law and the need to ensure that children and young people are protected irrespective of particular cultural and religious justifications for illegal acts.

Issues relating to public safety in the light of the perceived threat to national security by terrorism and the risk of radicalisation of children and young people were also a significant influence in the year, and demonstrated the need for the various strategic partnerships to work more closely together. As with all public and media informed debate there was challenge in the year to ensure that responses were proportionate especially in relation to safeguarding, radicalisation and the balance between rights and responsibilities.

These and other developments have placed further pressure on the various sectors and areas including the "third and community" sector which has had a number of impacts on safeguarding nationally and therefore locally;

- An increasingly complex policy and provision landscape
- Challenges about how best to maintain priorities and match resources to meet existing and new statutory obligations and responsibilities
- A continuing challenge of how to find the right balance between national and local approaches and priorities, the emphasis placed on responding to acute or crisis factors set against the capacity to invest in longer term preventative and development programmes to meeting need across a social policy, economic, health, law and order, and education landscape.
- In terms of safeguarding, this has raised two challenges; how best to ensure that safeguarding remained a priority in real time and current commitments, and to what extent can "safeguarding" be seen as an integral part of the broader response to the wider challenges and pressures.
- The year also saw significant proposals and developments to clarify and change the expectations of and legal requirements placed on groups of professionals
- For partners in the education and health sectors there continued to be changes to the ways in which provision and safeguarding were organised and overseen.

In safeguarding terms the year saw the following;

- The continued impact of changes made to Working Together in 2013 as a result of the Munro review of child protection and consultation regarding further changes and developments resulting in further revisions to Working Together in March 2015.
- A growing understanding of the expectations and implications of changes regarding Serious Case Reviews (SCR) from the National Panel of Experts through the publication of its first annual report. Although there was some evidence in the year that SCR models and methodologies were starting to bed in, this remains a difficult and challenging area for all concerned.
- The publication of SCRs served on most occasions to raise awareness and understanding but remained in some instances a point for questions to be asked about the effectiveness of joint working to protect children.
- Ofsted and its inspection programme and the publication of its Annual Report continued to be influential. Some steps were made in respect of moving towards a different approach to inspection on the basis of joint inspectorate led inspections, especially relevant in respect of LSCBs, so it was disappointing when this was subject to further delay. However other inspectorates were able to evidence how they incorporated a common approach to the assessment of safeguarding. The current approach to inspection which in the year included the inclusion of LSCBs as a separate focus for review, remained an area of debate, especially in respect to the quality and consistency of judgements and the extent to which these fully take into account the fragile nature and importance of public confidence in safeguarding.
- Nationally the Association of LSCB Chairs was able to evidence impact and influence and has provided Chairs and LSCBs with access to support, information that has enabled steps to be taken toward promoting more effective LSCBs and improved sharing and consistency.
- LSCBs had placed on them additional expectations in respect of both Child Sexual Exploitation (CSE) and Female Genital Mutilation (FGM), to provide leadership and accountability for the effectiveness of partner responses.
- As the year progressed there were encouraging indications that government was seeking to promote a Ministerial and cross departmental focus on issues relating to safeguarding with the announcement of a Ministerial task force in March.

Summary

Safeguarding in the national context has in the year been subject to high profile and often volatile attention at all levels of the system and across society. This had produced a further challenge on local partnerships including the LSCB to respond and manage the implications of this attention so that this results in changes that further demonstrate the effectiveness of partnerships and local joint working arrangements.

Whilst this has served to produce a focus, it has also demonstrated the increasing difficulty for partnerships to be able to do more with less as well as doing it differently and to continue to attend to the other key areas that ensure children and young people are protected.

6. The Local Safeguarding Context

The local safeguarding context can be reflected upon in two ways; how partners and the respective strategic partnerships responded to the national context set out above and; the focus locally on driving forward improvement in the light of the Directions Notice placed on the Local Authority and the LSCB.

For the purposes of this report the focus will be on the latter with reference to the former in respect of specific areas of achievement and impact.

The 2013-2014 CSCB Annual Report described and set out the measures being taken in response to the outcome of the 2013 Ofsted inspection, the role of the Improvement Board (which was put in place to support, peer challenge and scrutinise the work of the local authority to lead the change required) and the key contribution the LSCB needed to make.

The majority of this report for 2014-2015 provides an account of and assessment of the role, contribution and level of achievement partners have achieved generally and specifically in respect of the CSCB. The examination of this will demonstrate the progress made and the impact improvement efforts had during the year. It is not the purpose of this report to describe the progress of the Local Authority other than when this impacted upon the CSCB meeting its objectives; offering assurance and challenge to the Local Authority in the context of its improvement efforts.

The following are however important to note and will be emphasised elsewhere in the report;

- Ofsted inspected the Local Authority and reviewed the LSCB using the Single Inspection Framework in January and February of 2015. The report and judgment were published in March 2015. The finding was that the Local Authority had moved from the 'inadequate' judgment to one of 'requiring improvement'
- This was a validation of the CSCB interim business plan which set out the measures partners agreed to undertake to address both remedial issues and put in place new arrangements for going forwards.
- The Improvement Board had received and endorsed the Annual Report for 13/14 and the initial business plan for 14/15 as this developed over the year into a longer term plan (three years) including the challenges and risks this indicated.
- The Improvement Board took regular progress reports and exercised direct and indirect scrutiny of the CSCB and the progress it made during the year, and this included the start of planning to look at the future role of the CSCB and other strategic boards and partnerships to be able to offer performance monitoring and quality assurance based scrutiny and challenge in the future.
- The CSCB business plan reflected the need to focus on the required areas of report to the Minister and to the Improvement Board and these were the main areas of the Board's statutory responsibilities and functions.
- These included the development of the Performance Management Quality Assurance (PMQA) function and capacity across both whole system as well as a closer focus on the "child's journey" and the Continuum of Need. It also addressed how the CSCB delivered and developed all aspects of learning and training, as well as the case review and Child Death review functions.
- The last annual report set a challenge to members of the Board of 'Moving from process to impact" and this was formulated at the Board review day which considered progress and learning in the context of the 2013/14 Annual report and the wider Improvement Board led objectives. This resulted in a revised plan which consolidated on progress, maintained the development of internal capacity, process and structures (the sub groups for example) and how the Board members would oversee, learn and challenge each other and collectively as a Board.
- The last CSCB annual report concluded that joint working arrangements to protect children and young people met the "sufficiency" threshold on the basis of the role the Improvement Board was playing in focusing partners and providing evidence based assurance. The report set out that further work and commitment from partners would be required to mitigate risk and achieve the desired shift in approach and outcomes on the basis of the board members providing leadership and the CSCB staff and partner representatives leading and attending the business group and sub groups.
- In the year, partners and the LA therefore had to focus on the "day to day" business as well as the need to move to a position whereby the Board was more fully meeting its statutory responsibilities and was therefore in a position to further advise partners on the basis of scrutiny as to their progress and impact.
- In this regard, both the Ofsted judgement and this Annual Report form a significant indication of the steps forward that have been achieved and highlight the challenges for coming years.

7. How our Approach to Safeguarding is informed by what it is like to be a Child in Calderdale

Calderdale is one of the smallest metropolitan districts in terms of population, but one of the largest in terms of area. According to the Child Health Profile, March 2014, children aged 0 to 19 make up 24.5% of the population of Calderdale at 50,300. There are 13,100 0-4 year olds and the largest minority ethnic groups of children and young people in the area are Asian or Asian British and mixed.

The borough is made up of 17 wards, the profiles vary significantly; In the Park Ward area, average household incomes are £18,800, this area also has 41.3% of households with less than £15,000 income. Park Ward also has the highest number of households with dependent children, the highest fertility rate, highest still birth rate and highest infant mortality rate. In contrast, the Hipperholme and Lightcliffe ward has average household incomes of £33,700, 20.7% of households with less than £15,000, a significantly lower than average number of households with dependent children and a lower fertility, birth, still birth and infant mortality rate.

20.9% of children in Calderdale live in poverty, which is lower than regional figures (21.7% in West Yorkshire), and slightly higher than National levels (20.6%). This matters because children's life chances are affected just by being born into poverty; a child's health, education and their day to day lives are affected by poverty. Infant mortality is 10% higher for infants in the lower social group than the average and by GCSE level, there is a 28% gap between children receiving free school meals and their peers.

In primary schools 16.8% of pupils are eligible for Free School Meals, 22.6% in secondary. The take up of 2 year olds accessing funding at the end of the Spring Term was 80%. The DfE national average take up in March 2015 it was 63%.

At 31 January 2015, 204 children and young people were the subject of a child protection plan. This is a reduction from 249 at 31 March 2014. At 31 January 2015, 322 children were being looked after by the local authority (a rate of 70 per 10,000 children). Overall looked-after children under the care of Calderdale Council seem to do better than nationally in terms of educational and social outcomes. There is a Looked-after Children Education Service ("Virtual School") that provides support to children and young people aged 3-19 years who are looked-after.

Calderdale services for children and young people have been on a steady journey of improvement. Assessed as inadequate by Ofsted in 2010, each year since has seen a step change in the quality and effectiveness of its services. Improvement has been driven through:

- The Calderdale Improvement Board: Children's Services Senior Management Team supported by partners and political leaders determinedly improving services for children in Calderdale
- The Children and Young People's Plan; which has provided stability, sustained focus and strength of purpose based on shared principles
- Early Intervention Services; which provide good support for children and families. The Troubled Families programme was judged 'outstanding' by the Department for Communities and Local Government in July 2014.

8. Partnership Working, Governance and Accountability

The agenda for the local safeguarding context is arrived at across a number of key strategic partnerships and bodies; these are

- The Health and Wellbeing Board (HWB)
- The Children and Young People's Partnership Executive (CYPPE)
- The Safeguarding Adult Board (SAB)
- The Community Safety Partnership (CSP)
- The Family Justice Board
- The Domestic Abuse Strategic Board
- CMBC Children and Young People's Scrutiny Committee
- In addition in Calderdale there is a Children's Improvement Board (IB)

There is no national or consistent approach to how these arrangements take form and effect in practice, so it is a question of how at a local level these are addressed. This was a priority last year and has remained one during this year and the following progress was achieved;

- Regular reporting from the CSCB to the HWB, CYPPE and CIB
- Attendance and reporting from the CSCB to CMBC Scrutiny Committee
- Developing links at strategic level with SAB in addition to established joint ventures, for example: Learning Events and Safeguarding Week
- Contribution to meetings convened by CIB Chair regarding the development of reporting and accountability across bodies
- Challenge from and to CSCB Chair to CYPPE regarding the fit and accountability between priorities
- Formal flagging by the CSCB for reporting from across the partnerships and need for these to be submitted to other boards
- CSCB response to CMBC Scrutiny report regarding the Voice of the Child
- Active contribution of Lead Member at CSCB meetings

Summary and next steps

Understanding of and across the respective Boards and partnerships has developed on the basis of increased contact and dialogue. The extent to which the form these take in the future is the subject of continued discussion and consideration, especially in the light of possible future arrangements should the CIB be stood down.

It is intended that in the current year (2015-2016), largely as a result of a focus on the improving role and capacity of the CSCB PMQA function that in respect of the following there will be further progress:

- Scrutiny and reporting to respective partnerships on the performance and quality of joint working arrangements to protect children - including Early Help, on the basis of a regular schedule and agreed exception/variance conditions

- The CSCB will report to the CMBC Scrutiny Committee in order that they may be assured as to the performance of the Local Authority in respect of its responsibilities for safeguarding and early help and to account for the effectiveness of the CSCB
- Agreement will be sought that the Chairs and Business Managers (CSCB/CSAB and CCSP) meet regularly to form and implement closer leadership and coordination across key strategic themes such as CSE & Sexual Abuse, FGM, Domestic Abuse, Radicalisation and Trafficking and to explore best shared use of resources.
- Further work will continue to align priorities and reporting regarding the CYPPE strategic framework to ensure that safeguarding priorities and learning are reflected, building on the steps taken in the year around listening to children, and planning for the mental health needs of children and young people.

The Financial Contribution Partners Make

It is noted that a number of partners made available additional financial and other types of resources during the year and Appendix F shows the baseline contributions and how these were used during the year.

There is no nationally agreed formula for how partners meet the obligations placed on them under Working Together, and technically the requirement to contribute financially rests with "Statutory" Board partners. This means that the inherited contribution pattern may not reflect current priorities and demands, and that therefore the funding of the LSCB may fall disproportionately on a single or number of partners.

Whilst elements of expenditure are predictable, there are a number of significant variables which can relate to the number and cost of Serious Case Reviews undertaken, provision relating to improvement objectives and unforeseen events or requirements.

- During the year the Board took the following steps to manage this risk and to look at the longer -term issue of achieving a proportionate sharing of funding across partners.
- Board meetings review income and expenditure and consider risk factors – this as noted resulted in some Board members coming forward with additional resources.
- Internal efficiency programme to identify different and cost effective ways of using resources
- Ongoing discussion re longer term solutions

It is important to note that whilst the position was sustainable and an appropriate balance between partners was achieved in the year, the variables remain and there is emerging indications that some statutory partners may not be in a position to maintain or respond to a revised formula, and that therefore as we move into 2015/16 this is an issue of risk and vulnerability for the CSCB.

9. How the Board Undertakes its Work

In the last report we noted the high level of commitment from Board members (Appendix C shows CSCB membership as at 1st April 2015) and partner organisations, and this has been maintained in the year.

Although attendance at Board meetings and the Business, Sub and Task and Finish Groups is only one element of how contribution is measured, it does provide a base line.

This is something we said we would continue to address and during the year the recording and sharing of information was improved and regularly considered by the Business Group and the Business Manager. This resulted in more responsive follow up to variations in attendance and these were shared with the Board, who took more of a leadership role in ensuring that the "right people were in the right place at the right time".

This is an ongoing process and a part of the wider development the Board is committed to as to what kind of leadership and approach do we want to achieve.

Other improvements continued to bed in and to be developed, including;

- Standardised induction for Board members including a meeting with the Independent Chair.
- The Appraisal of the Independent Chair and confirmation that he will remain in post for two further years.
- Formal Board approval of changes to and appointment of Board members
- The recruitment and appointment of new members, including a review of the existing membership resulting in negotiations with the Calderdale Governors Association (CGA) (NB This resulted in the appointment of a Board member from CGA early in the year 15/16 and complemented the revision of how the education sector is represented on the Board)
- Board oversight through the Business group and through direct report of appointments to the sub groups and the strengthening of the links between agency representatives on these groups and their respective board members.
- Parallel discussions through the CYPPE and the commissioning arrangements regarding the representation of Voluntary and Community sectors on the Board, which resulted in a clearer understanding of roles and relationships.
- Chairing of the Board continued to develop to reflect the focus on individual and collective responsibilities, accountability based on evidence and a dialogue around defining and understanding the different forms "challenge" and "learning" can take. Within this approach further steps were taken to focus more on "actions – follow through – impact" through improving business processes and behaviours.
- During the year the Board undertook to review its governance arrangements and developed and agreed a formal Constitution. This brought the Board in line with best practice elsewhere, clarified some key areas around roles and process and set some clear standards and measures.
- In the year 15/16 as per the Constitution we will be introducing appraisal for members and further refine core business processes with a particular focus on results and impact.
- As a result of the improved way in which the Board manages itself, it was particularly significant that Board members were able to recognise and respond to key risks especially in respect of having in place the necessary PMQA and Learning & Improvement (L&I) arrangements. One of the ways this was demonstrated was a number of partners coming forward with additional

financial contributions to enable the appointment of a Performance Management Quality Assurance Officer (who took up post early in this reporting year).

- Further examples of improved responsiveness were the strong lead provided by the Proactive and Responsive Sub Group which provided leadership and challenge for the CSE strategic response and action plan (and was also nominated and commended by the Municipal Journal Awards). An additional time limited sub group was formed to drive forward Multi Agency audit and case file audit in response to the risks identified in the last report.
- A more detailed review of the Board minutes demonstrates an increase in Board members taking responsibility for follow through and exercising challenge and accountability.

During the year the following Board members were appointed and the following members stood down:

Representing	Stood Down	Appointed
Calderdale & Huddersfield Foundation Trust	Karen Hemsworth – Associate Director	Janet Youd, Acting Head of Safeguarding
Calderdale CCG	Dr Steven Cleasby – Assistant Clinical Chair	
Calderdale College	Chris Jones – Principal	Howard Browes – Assistant Principal, Quality & Learner Services
Calderdale Governors Association		Raj Unsworth – Vice Chair
Children & Young People's Service, CMBC	Veronica Mellor – Service Manager – Safeguarding & QA Service	Laura Knights – Service Manager – Safeguarding & QA Service
Councillors	Councillor Megan Swift – Lead Member for Children's Services	Councillor Colin Raistrick – Lead Member for Children's Services
Lay Member	Ian Hillas Jacquie Hellowell	Jo Taylor Shaheen Khawaja
NHS England	Geraldine Sands – Assistant Director of Patient Experience	Chris Stoddart – Safeguarding Advisor/Regional Prevent Coordinator
Primary Heads	Leona Binner –St Augustine's School	Lesley Bowyer – Halifax Academy Laura Newcombe – Lee Mount School (deputy)
West Yorkshire Community Rehabilitation Company(CRC)		Kevin Ball – Head of Service (Bradford & Calderdale)
Public Health	Jill Farrington – Consultant in Public Health	Paul Butcher – Director of Public Health
Secondary Heads	Wendy Moffat – Crossley Heath Grammar School	David Lord – Ryburn Valley High School
South West Yorkshire Partnership Foundation Trust	Julie Lodge – Named Nurse / Trust Lead	

Appendix E shows the levels of attendance from Board members and their representatives on the sub groups.

At Board level attendance patterns were good, with most members respecting the agreement that in the case when a Board member was not able to attend they ensured that a named and agreed deputy could attend in their place and that they were briefed.

As is sometimes the case in respect of the representatives Board members identify to attend sub groups and task and finish groups, attendance was at times identified as an issue. We have developed our response to this, understanding that there are different contributory factors, such as communication, capacity issues, pressures on partners, lack of clarity re: role and purpose of meetings. This is resulting in swifter identification of issues and is supporting Board members to manage and ensure that sub groups are more effective. Our approach to this is, on the basis of improved monitoring at the sub group level by the Chair, to initiate direct discussion with the representative and to ensure the respective Board member is aware and can act in the instances when this does not result in resolution and improvement this is escalated through to the Board by the Business Manager and the relevant Board member. Both the Business Group and the Sub Group chairs who sit on this group have a clear remit to resolve and to assess the impact on capacity to meet objectives and this is included in ongoing risk assessment and reporting to the board.

It is important to note that there were problems in the year in getting the new structure adopted in 2013/14 to bed in. One manifestation of this was setting the frequency of the Business Group meetings which for the first four months of this year was meeting weekly to ensure the pace of change was kept before moving to fortnightly and eventually monthly. Another area was addressing key issues around how the Business Group and other aspects of the structure and inter-relationships between the sub groups and the board could work to optimum effect. During the later part of the year there was some evidence to suggest this was improving.

Summary and next steps

During the year we have taken clear steps to develop the way we see and measure our role and as a Board whilst strengthening, not just monitoring, but linking this to a clearer vision about and understanding of how the new structure will work. A clear emerging theme which in turn is evidence of us stepping on from focus on process into impact is becoming better at supporting and making sure that we have 'the right people in the right place doing the right things'.

10. Summary and Whole System Analysis

The commitment of partners remained robust and the evidence from the year suggests that they remain in support of the changes introduced in 2013/14 and many Board members took a direct responsibility for providing leadership in priority areas.

This has resulted in a steady development of how as a Board we understand and see our role and the role of the Board. The Independent Chair has sought to pace and guide this within a longer-term sustainability based approach.

The performance of the Secretariat (the group of people the Board funds to support and administer the Board) has improved during the year, though the volume and pace of demand set alongside different ways of doing things and measured standards has placed considerable pressure on them.

It also has to be remembered that the Board meets 6 times a year (and for 2 development sessions), and is reliant on the contribution and commitment of members and their organisations, who in turn face their own sets of ever increasing pressures.

Therefore this report suggests that the following challenges will serve as a focus to guide the Board and the colleagues who support it;

- Maintained commitment to continuous improvement of "what we do and how we do it and how we know this is having the intended impact"
- Continuing to be clearer and smarter about how we use Performance Management and Quality Assurance information and process to have a "clear line of sight" of the whole safeguarding system and the quality and impact of joint working practice at key points in the child's journey so as to be assured that children and young people are safe
- Continuing to be clearer and smarter about how we deal with accountability and learning at organisational and professional practice level so that this results in continuous improvement
- Continuing to find smarter ways of seeing things through the eyes of children, young people and their families and ensuring that we better understand how their experience, cultures, identity and beliefs impact on safeguarding effectiveness
- Continuing to establish smarter ways of influencing and being influenced by the responsibilities and priorities set by other processes and strategic partnerships so that safeguarding standards and performance are at the heart of these.
- Continuing to learn how we can further develop the effectiveness of our roles as Board members and as a Board in order to be responsible and accountable for continued improvement.

As the Ofsted judgment confirmed (and this is supported by the Board's own assessment), progress has been made and the areas where further progress is needed are identified and addressed in the current three year business plan.

There is however a vulnerability and level of risk associated with the rising expectations placed on LSCBs, the resources available to partners to support this and the need to sustain the focus on Board members being able to embrace the developing implications of a more effective Board. An effective Board in these terms must continue to improve its setting of standards and capacity to scrutinise in order to create continuous improvement.

The additional level of risk relates to the work started in the year and the role the Board will play in any transition from the Improvement Board led approach.

This section of the report necessarily focuses on and reflects the challenges relating to how we do things, and importantly underpins the next sections of the report which reflect how the exercise of statutory responsibilities and functions resulted in effective scrutiny, challenge and learning and how this

a. informed our view of the overall sufficiency of joint working safeguarding arrangements and

b. Had a measurable and positive impact on outcomes for children and young people.

How the LSCB has undertaken its work

This section of the Report reviews the way in which the LSCB has carried out its functions and responsibilities during the year, met its statutory requirements and progressed its priorities (self challenges). It considers:

- How the LSCB has undertaken its work
- How the LSCB has responded to the challenges it set itself for 2013/14
- How it has promoted a shared culture of continuous improvement

A Business Plan was created for the period covered by this Annual Report (2014-2015) and a link to this can be found in Appendix D. This was completed in March 2015 and the new Business Plan for 2015-2018 was produced. We have chosen to focus on the five priorities as they were revised in the year as this demonstrates our capacity to respond to the learning from last year's report and assists with our capacity to assess ongoing performance and progress in the current year. Please also note that we have addressed reporting and learning in a summary form and on a thematic basis against each of the priorities in order to assist with engagement and this will not always accord with the allocation and level of detail found in the Business Plan.

1. We are assured that children receive the right help at the right time

As with each priority there were key areas of activity that underpin our capacity to meet each of these and in this first section we will describe progress, impact and learning as this relates to each and then in subsequent priorities identify further progress, impact and learning.

1.1 Making sure that everyone had access to Joint Working Policies and Procedures and that these were "fit for purpose"

We work with other Boards in West Yorkshire to ensure that these are current and as far as is possible common across boundaries.

We learned last year that we needed to maintain and actively contribute to these arrangements and as a result the Business Manager and the Business Group have prioritised this. Evidence of updates, changes and improvements to the West Yorkshire Policies and Procedures can be found in Appendix G.

In the year we took further steps to clarify and prioritise how learning from PMQA and L&I was identified and coordinated through the sub group and Business Group arrangements, as it is important to ensure that the current policies and procedures and any changes are fed through to partners and front line practice. The main way of doing this has been through the Multi Agency Training programme and the website.

We have realised in the year that there are further improvements we can continue to make and these have been identified as:

- Further strengthen Board member roles in making sure that Policies and Procedures are accessible to and used by their staff and colleagues
- Develop within the sub group functions the capacity to test out the effectiveness and impact of policy and procedures
- To further check that single agency and multi agency Policies and Procedures sufficiently "bridge" regional ones into local context and practice
- As a part of the Section 11 strategy ensure that there is a focus on localised assurance and assessment that Policies and Procedures are accessible, current and applied.
- As a part of the Case Review process to ensure that Policies and Procedures application is included in terms of reference for review.
- Ensuring that where the Board leads on, or contributes to the development of strategies that these proposals reflect any implications for joint working or single agency policies and procedures.
- As a part of our Communications and Engagement strategy further develop the effectiveness of our website and supporting communications.

In addition to this the following changes and improvements made through the arrangement are listed in Appendix H; the Learning Implementation and Action Pathway.

Summary

Making sure that people know about and use policy, procedure and guidance is an essential part of ensuring that children and young people get the right help at the right time.

The Board has fulfilled its responsibilities and made significant steps in the year to further strengthen and develop this in the coming year. Responsibility and accountability for how these are applied rests with individual professionals and practitioners, and partner organisations. The Board has a key role to play in ensuring these are agreed and in place and in supporting members so that a view can be formed as to the overall effectiveness and impact.

During the year the Board formally agreed a number of changes to and introduction of Policies and Procedures and made progress in being able to assess the impact and effectiveness of these.

Further steps have been identified and included in the current plan and will be reported on in the next Annual Report.

1.2 The Child's journey and making sure that thresholds and how people should respond are clear

The Board is responsible for agreeing and publishing the expectations of and arrangements for how partners and professionals will understand needs and the risks children and young people face. This is then organised on the basis of "levels" or "stages" of need so that early recognition and intervention can be encouraged and that there is an effective and timely response to any situation or concern that a child or young person may be being harmed or may not be safe.

In Calderdale we call this the "Continuum of Need" This document and the agreements it represents forms the foundation for how people will work together in practice and how partners will plan and commission services.

The Board has an important responsibility to make sure that this reflects the reality and that as a Board we are able to work closely with other strategic bodies and partnerships who are responsible for overall priorities, plans and arrangements for commissioning services.

This area was a priority in respect of the Improvement Plan and was integrated into the priorities and plans for the CSCB and in the year this resulted in the following;

- Development of CSCB Performance Data and Indicator set to include and reflect measures around the 'Continuum of Need' – this has required the Local Authority and other partners to develop and identify the measures they have in place in order to share these with the CSCB. This has led in the year to partial reporting and analysis.
- Further clarification and development around the impact of and intentions for the development of Early Intervention and Help services and arrangements resulting in clearer measures that can be exported to the CSCB PMQA process.
- Audit activity to further test and understand the impact of current arrangements
- Promotion of current arrangements through the Board, website and training
- Revision and resetting for primary objective or revised "Continuum of Need" by CSCB pending the clarification and agreement of measures
- In the light of the learning from CSE (both the aims of the strategy and the operational arrangements) to consider what this may tell us about future revisions to the "Continuum of Need"

Summary and what this means

The Board has maintained the present Continuum of Need otherwise known as a "Threshold" Document which is required to:

- Confirm the process for the early help assessment and set out the type and level of early help services
- Confirm the criteria and level of need for referring to Local Authority Children's Services for assessment and statutory services for children in need, including those in need of support, protection, accommodation and care (sections 17, 47, 20 and 31 of the Children Act 1989)

However as a result of continued change and learning it has become clearer in the year that this is now a more complex task than initially thought. This is because of the following;

- The increased awareness of the Board's role and the improving capacity to require and evidence information that is necessary to establish the effectiveness of current arrangements and therefore to develop these further
- The impact of the learning from CSE in respect of information sharing and the need for clear risk management for the escalation or de-escalation of statutory service intervention.
- The growing impact of the current Early Intervention and Early Help strategy and arrangements led by the Children and Young People's Partnership and the concomitant requirement to evidence effectiveness and share this information.
- The introduction of the Single Assessment and Early Intervention Single Assessment
- The constraints identified elsewhere in this report in terms of Board and sub group capacity

This therefore means that the review and re launch of thresholds alongside an assurance that sufficient partner information is available and the Board PMQA function has reached the state of readiness whereby it can effectively monitor and assess impact is a significant priority for the current year.

From the Board perspective it is important to ensure that children and young people get the right help and protection at the right time and from the right people, and that the level of intervention is proportionate. This means that Board members need to understand and be able to interrogate the information and indicators that have been and are being developed so that they can recognise on the basis of key indicators whether these goals are being met.

Equally there is a growing understanding that Early Help to protect children and young people requires an increased understanding of, and capacity for, responding appropriately and much of this falls increasingly to teachers, head teachers and governors as well as other areas and people with whom children and young people have regular contact. Based on the monitoring and audit undertaken in the year the board formed a view that the Early Intervention Panels were robust and inclusive, but flagged that there was a need to develop further information around what happened as a result especially when the statutory threshold was crossed or when for various reasons outcomes of early intervention were inconclusive.

These developments were felt to be positive and this was recognised by Ofsted, but as this Annual Report shows there was further learning and challenge to the Board to ensure that all of its statutory responsibilities reflected these developments. In order that in the coming year we are able to confidently monitor, inform and where necessary challenge any indications that children may not be being protected as a result of the move into early help and the increased expectations this places on partners.

The challenge of the learning from this year is therefore for the Board to ensure that;

- The child's journey is clearly explained and understood at a strategic and an operational level
- The Board has in place sufficient measures and sources of data and information to monitor and assess progress and performance
- Early Help arrangements are able to evidence that capacity to respond is there and that the system is able to distinguish between when it is necessary to immediately safeguard a child and whether it is appropriate to protect them without recourse to statutory interventions
- Resources are in place to build capacity across the system to ensure high quality assessment, decision making and work with children, young people and their families to ensure that their needs are met and they are protected.

2. We know which children are vulnerable and are assured they are protected

2.1 Child Sexual Exploitation (CSE)

It is important to note that in regard to Child Sexual Exploitation (CSE) a general expectation was made more explicit during the year; that the LSCB should produce regular assessments of the arrangements for CSE. In future it is likely in addition to internal reporting and the Annual Report that the CSCB will publish separate assessments and if so these will be incorporated into the next Annual Report.

Previous Government guidance placed an expectation on the LSCB that it would provide a clear leadership role in respect of the response to CSE as well as focusing on an evaluation of the effectiveness of these arrangements. CSE had been the main focus of the Proactive and Responsive Sub Group for a number of years and had allocated an equally high priority to this area in 2014-2015. This has, however, meant that the Proactive and Responsive Sub Group has had to compromise on the meeting of some aspects of its other objectives.

All partners and in particular West Yorkshire Police and Calderdale Metropolitan Borough Council have demonstrated a significant commitment to ensuring that strategic and operational responses to CSE are effective and subject to scrutiny in order to promote learning and improvement. Equally the lead provided by the Police and Crime Commissioner to ensure a regional and a force wide approach has been helpful, as has his inclusion of LSCBs in this.

During the year the sub group reviewed the Strategic response, drawing on comparators and making best use of the performance information available. The Board was also asked to commission a retrospective audit and analysis of past arrangements and response based on published data and information. The Board also commissioned a number of case audits and the Chair decided that a case met the criteria for Serious Case Review. Additionally the multi agency Audit Group completed a multi faceted audit in early 2014 including statistical analysis, interviews with front line practitioners, young people and parents / carers. The Strategy, website and briefings for staff were developed from the findings from these.

During 2014-15, the substantive work of the sub-group has been to support with development and implementation of the Calderdale's Child Sexual Exploitation (CSE) multi-agency Hub. This sub group has led the increased co-ordination of services across the partnership and developed a comprehensive strategy and action plan which includes:-

- Continued awareness raising, understanding and implementation amongst professionals, children and young people, families and communities
- Close links with neighbouring authorities in West Yorkshire and surrounding counties to facilitate a local and regional approach and expanding engagement with the West Yorkshire Police "know the signs" campaign.

The sub group have been innovative; specifically looking at legislation: Through the Detective Chief Inspector and Chair, the district significantly influenced legislation change under the Modern Slavery Bill around trafficking offenders. Those guilty of trafficking children for the purposes of sexual exploitation will now become offenders who will be registered as sex offenders, whereas previously this had not been the case. This has resulted in the control of those individuals which will be much greater.

The sub group continues to receive the support from the National Working Group (NWG) for CSE; as such the daily operational group was nominated for an award at the NWG national awards. In addition to this, the sub group have also had recognition for their work and have been shortlisted and commended by the Municipal Journal national wards.

Progress was slower than anticipated in arriving at a point whereby the necessary multi agency data and information that fully evidenced the impact of the joint working arrangement in respect of CSE and Children who are missing from home, care and education was integrated into the PMQA framework driven by the Performance sub group. This was disappointing given the understanding that there was a comprehensive range of information relating to children missing from care, education and home available. Equally information relating to the delivery, effectiveness of and learning from return interviews only began to feed through late in the year.

This perhaps reflected the growing understanding of the central role the PMQA process now has to play in the work of the Board.

The Strategic response and action plan was subject to regular reporting to and scrutiny by the Board, in addition the Independent Chair met with the chair of the Sub group and the Business Manager to review progress and learning. These were also reported to the West Yorkshire Strategic Forum and formed part of a regionally LA led self-assessment.

As a part of Safeguarding Week West Yorkshire Police organised and hosted a conference which headlined current CSE issues and formed the major event of the week.

The Proactive and Responsive sub group identified that there was a need for integration between providers and Board requirements to ensure that the emotional well-being of children and young people was considered in cases of CSE. Consequently the Safeguarding Children Team, CAMHS Practice Governance Coach and Calderdale's Designated Nurse developed a pathway for children and young people at risk of or who have been subject to CSE. The pathway involves a member of the CAMHS team attending the weekly multi-agency CSE meeting to ensure that the child or young person received a timely and appropriate intervention from Calderdale and Kirklees CAMHS. The team manager from Calderdale and Kirklees CAMHS has also become an active member of this group, which continues to have excellent representation from statutory, voluntary and community sectors.

Board members were also briefed as to current developments elsewhere especially in regard to the publication in the year of high profile reports, and the Independent Chair was included in wider meetings to look at these.

Board members were asked to report agency by agency as to their assessment of their organisation's position and response to the Jay Report and as a Board there was a regular focus on CSE both strategically and operationally.

Board members sought and received assurances that the daily sharing of information, application of risk assessment and follow through was being maintained. During the year the Board took the lead on initiatives with a broad range of partner agencies with community based interventions regarding requirements to ensure providers of taxis and hotel accommodation that required a license were able to meet criteria put in place re: safeguarding and CSE. The Board facilitated a number of training events for taxi drivers and hotel operators, as well as ensuring that there were learning opportunities for all partners. Partners were also able to account for the training and support they were providing in their own organisations and where applicable in services they hold commissioning responsibilities for.

Ofsted noted in their inspection that the CSCB CSE action plan could be more SMART and this accorded with the Board's own ongoing assessment. As a result the Board has commissioned the sub group and partners to bring forward a revised action plan.

Considerable numbers of children and young people have had the opportunity to learn about and better understand CSE during the year. (56 sessions have taken place in secondary schools engaging a total of 1456 young people. 24 sessions have taken place in primary schools engaging a total of 239 children).

The Board is a Gold Member of the National Working Group (NWG) so that partners have benefited from access to their services and resources.

Summary and the next steps

As a Board and a partnership we have achieved significant learning as well as a level of assurance that partnership responses to CSE have brought the best out in relationships and practice. The Local Authority provided a clear lead alongside the WY Police and the commissioned provider (The Children's Society; Safe Hands Project) has provided both additional capacity and a perspective that has strengthened the local response.

The publication of the Jay Report and subsequent high profile media reports along with the approach taken by Government, was on the whole helpful and further raised awareness of CSE. The Board played its role in this new level of dialogue holding all partners to account, promoting and supporting the current approach on the basis of regular review, improving sharing and assessment of performance information, the testing of the quality of arrangements. The Board sought to serve as a check and balance so that partners were maintaining their efforts and not at risk of being distracted.

Local and national learning raised the need to ensure that as a Board and therefore in terms of joint working arrangements we had an appropriate understanding of and approach to the role local communities and faith groups have as a part of our strategy for CSE. Equally the Jay report produced a challenge that the cultural and racial background of suspected and convicted perpetrators should not impact on the effectiveness of this strategy. The Board's response to this was to review within the wider Council led response that arrangements to engage with all parts of the community and communicate the priorities regarding CSE and child abuse in general were fit for purpose. This resulted in changes to the action plan and impact will be monitored and reported into the Board. This learning highlighted the further need for the Board to develop its understanding of and engagement with 'uncomfortable' issues.

As a Board we have emerged with some clear learning from the year and have incorporated this into our plan;

- Prioritise reaching the point where the PMQA process has the requisite information from partners to ensure a more robust and rigorous assessment of performance against the targets set by the Board.
- Ensure that this aligns in key areas with the revised Strategic Response and Action Plan
- Maintain and develop case and case file audit to test quality and impact
- Identify the wider learning for the whole system re information sharing and joint decision making – the focus of safeguarding strategy on prevention, early intervention, disruption activity, prosecution and focus on being victim led.

- Maintain and revise current Board contribution to and leadership for partner awareness raising and education.
- Identify across the strategic partnership context learning from and risk factors for the 'whole system response'
- For the Board to further strengthen its current priority development area around the abuse and cultural contexts.

2.2 Children and Young People who are subject to Private Fostering

This is an ongoing focus and requirement of and for the Board and last year's report highlighted that there was a need to sharpen our role and impact. The LSCB role includes its usual roles of co-ordination, monitoring and quality assurance, and a specific role with regard to raising awareness. Last year we confirmed that we would take an annual report from the Local Authority which holds the statutory responsibilities and duties in respect of the monitoring of Private Fostering.

The Board took the report and agreed the following outcomes;

- It noted that the LA arrangement appeared to be improving and supported their proposed development
- Partners were formally asked to promote information about private fostering and arrangements and to report back to the Board
- It was agreed to improve the quality of information on the CSCB website and to consider a further promotional campaign for 2015/16
- The Board PMQA framework would include key indicators re private fostering numbers

Summary and next steps

Nationally achieving an informed position regarding the incidence of occasions when a child or young person may be subject to or require private fostering is a challenging one. This is for a number of reasons - incidence is to some extent determined by location and local community characteristics such as nearness to ports of entry, ethnicity profiles, population movements, impact of dispersal programmes.

The other two variables that can influence impact are;

- The capacity to and level of performance of the Local Authority to discharge its duties
- The capacity for the LSCB and partners to achieve sustainable measures to raise awareness across communities and professional systems, and therefore be able to assess and report on the effectiveness of these.

(NB British Association of Adoption and Fostering research published in June 2015 highlighted 91% of the British adult population do not know what private fostering is http://www.baaf.org.uk/node/7936)

This research provides a fresh challenge for the Board and the Local Authority as we know that children who may be privately fostered but who are not known about may be at risk of harm and it is planned to run an awareness raising campaign early in 2016.

3 Robust Performance Management and Quality Assurance demonstrates effective Safeguarding

As mentioned earlier in the report Board members are expected to be able to have a "clear line of sight" across and into the safeguarding landscape, in order to be able to scrutinise, analyse, assess and if necessary act to ensure that the joint working arrangements they have identified and committed to are protecting children and young people.

(Priority 1 shows how the Board sets the standards for this and the provision of guidance; priority 4 demonstrates how this is driven forwards and priority 5 how we seek to ensure that standards and learning are sustained.)

Earlier in the report we have explained how the two frameworks; the Performance Management Quality Assurance Framework (PMQA) and the Learning and Improvement Framework (LIF) provide the focus and methodology for this. We have also explained how each of the sub groups with the Business Group and the Board bring together developments to ensure that these relate to and are informed by the evidence base these frameworks produce.

During the year recognising the priority placed on this and the challenges highlighted in last years report the Board achieved the following;

- PMQA and L&I were addressed at every meeting and Board members were asked to review and challenge progress
- An additional sub group was formed to address the development of multi agency audits and case file audits
- The Performance Management Group continued to develop data and information sets that addressed the need to "horizon scan" and to be able to "drill down" into key points of the child's journey, and started to bring to the Board examples of where the data suggested a need for further enquiry or challenge to members.
- The Business Group also developed capacity to "join up" scrutiny and enquiry across the sub groups so as to ensure that hypotheses or areas of concern/interest were tested to produce a multi dimensional view.

A good example of how this worked is an area identified by the Performance Management sub group for further exploration; the number of children on a child protection plan for longer than two years. This resulted in a number of single and multi agency actions which resulted in significantly improved performance and a reduction in numbers of children on a child protection plan for long periods of time.

Another area the performance management sub group identified, which was strengthened by findings in local Serious Case Review and the 2014 Section 11 results was a need for further development in Supervision arrangements for frontline safeguarding staff. A Supervision Framework was collaboratively produced by Schools, statutory and voluntary services for adoption by partners as a part of setting standards for supervision in the present year. The impact will continue be monitored by the Performance Management Sub Group and Audit activity. Further examples can be found in Appendix I (Identification and Outcomes).

3.1 Performance Management

The year confirmed that investment in this area of activity was the right priority and it became clear that addressing what is a complex and challenging series of activities would require persistence and additional resources. To this end the Board agreed to identify additional funding for a post of Performance Officer and a number of partners identified additional funding to enable this to happen. Arrangements for this were completed by the end of the year and the Board agreed key performance indicators and review points for this post as it came into operation in 2014-2015.

Achieving a "line of sight" that encompasses the full width of safeguarding activity and enables the detailed scrutiny of key aspects of joint working arrangements and performance on the basis of multi agency information, should not be underestimated in terms of scale and capability, especially in the light of the following requirements;

- This view and analytical process needs to be able to demonstrate independence and be objective, thorough and reliable.
- Information and data is collected from multiple sources and systems and often takes different forms.
- The availability of information and data is reliant on partners being in a position to release and share it.
- Information and data as well as the creation of relevant and reliable indicators that contribute to the LSCB role and functions require considerable development activity in itself.
- Information, data and lines of enquiry are triangulated and are the subject of iteration in themselves from the various sources external to the board and from within the Board process. These require management and key judgments; for example whether a numerically based trend or variation is best tested through audit, further numerical analysis and or other sources of evidence such as SCR recommendations evidence or direct dialogue with the agencies concerned.

In order to create the optimum conditions for the Board to monitor this activity and engage in further scrutiny and challenge the following needed to be in place and were further developed in the year;

- Board members need to understand what they are managing and what it is they are looking at and why.
- Board members need to undertake further scrutiny and challenge in order to agree points at which assurance thresholds are met.
- Board members need to be prepared to support the process and be subject to public accountability that can involve confronting a range of issues around relationships and reputation.

Summary and next steps

It is the conclusion of this report that given the above factors, sustainable progress has been achieved during the year, with both the horizon scanning data set and the focused key lines of enquiry of the child's journey being further advanced. This has resulted in greater understanding of and engagement with by board members, and a higher level of scrutiny leading to challenge and or assurance during the year.

Equally across the business plan and the Board meetings (as evidenced by minutes and measures) during the year the Board began to regularise and internalise all of the key aspects of its system and approach to scrutiny.

This means that as the year developed members were able to improve their "line of sight" and their understanding of both the approach and the need to be able to monitor and review the wider system of safeguarding joint working arrangements from an increasingly independent and evidence based perspective.

Towards the end of the year and in the light of the Ofsted inspection it became clear that further work and sustained investment of time and energy would be required, in order to ensure ongoing development of the "horizon based " data set and scanning and most importantly the child's journey. This as the new Business Plan (2015-2018) demonstrates is in part reliant on and determined by continued progress in other areas such as threshold development, better measures of early help, improved reporting in from partners and strategies and action plans that are SMART in the way they report into and from the PMQA arrangements.

In the coming year the Board has to set as an additional priority; the need to report performance and quality externally to other boards and partnerships in relation to both the whole system and partners such as Children's Social Care who hold particular responsibilities for key parts of the "child's journey".

It would be misleading to conclude that this scrutiny and challenge development was just about process and numbers; it is in fact a complex equation of many sources of evidence and having capacity, understanding and behaviours that allow us to collectively identify and agree what we are looking at and what this means as it impacts on the lives of children and young people. On the one hand good partnership relations relies on being able to take each other's word for what we have done and intend to do, but on the other hand it is right that individually and collectively there is a source of assurance that what people say they will do is what they will do, and as we shall demonstrate in later sections, that what they do is the best thing to do for the child.

3.2 Multi Agency Audit

Elsewhere in the report we explain the important role audit has to play as another source of evidence. We have highlighted the creation of a special multi agency sub group to drive this forward.

Learning is at the heart of effective audit, as this goes beyond, though of course includes, standard compliance measures. Audit of cases and case files tends to be an activity that finds most relevance in social care settings, though other partners will have approaches to audit of practice and outcomes and in the year we started to find out what these were in order to draw better on the learning these hold. As with many aspects of partnership working in our context, one of the key achievements of the year has been to establish and agree a shared approach to the audit task.

The board therefore took regular reports and contributed to the development of the terms of reference and programme for audit activity. All agencies considered what audits they undertake as a single agency so that the Multi Agency Audit Group could scan across the partnership for gaps. It was also acknowledged that there was a need to consolidate and confirm the results from and impact of past Board led audits and saw evidence that this was being addressed and that the learning was being shared across partner organisations.

During the year the board was assured that past audits had been scrutinised and learning tested in respect of;

- CSE – resulted in assurance that practitioners were engaging with children at risk of CSE and identified learning in respect of referral pathways. The impact of this was awareness raising and a decision to commission further ongoing audit, including the commencement an audit of historical cases in the year.
- Pre-birth assessments, safeguarding in schools and SMART planning audits completed in the previous year were quality assured and learning implemented.

It should be noted that the Board has occasion to challenge partner attendance at this new sub group, which in itself was evidence of improved monitoring and resulted in increased commitment.

During the year a fuller and forward looking programme was undertaken, as the impact of the Performance Management Quality Assurance Framework and learning from case reviews started to feed through the Business Group.

Summary and next steps

Multi agency audit was an area identified in the previous year where significant drift had occurred and the decision was taken to focus resources on the establishment of the Performance Management framework and sub group. During the year it became clear that an additional commitment would be required from partners in respect of multi agency audit and therefore a separate sub group was formed.

Although progress has been slower than hoped, which perhaps reflects the pressure on partners, as the year developed the scale of the task became clearer, enabling scoping and remedial work to be addressed. The development of an appropriate methodology and plan for taking this forward has also taken up time, but this was important if the longer term shift into multi agency audit delivery alongside and as a part of the PMQA and L&I frameworks was to be realised; Terms of Reference have been confirmed, along with appropriate methodologies for undertaking audits and the development for processing of audits to be accepted, challenged and reported. There is clear tracking in place for audits and a 'golden thread' for future audits linked to Performance Management and Learning and Improvement.

This raises the bar for the current year in making sure that the audit activity of partners is effectively scrutinised and utilised, and that the Board is able to commission and deliver targeted multi agency audit and case file audits. These will need to focus clearly on the threshold for audit criteria, and produce a clear view of the quality of joint working practice as it focuses on the child or young person at key points in the child's journey.

As with other aspects of PMQA this raises the challenge and the bar for Board members to ensure that there is both delivery and that the learning results in improvement and where appropriate challenge.

4. The CSCB drives Safeguarding and Practice Improvement for children and young people

As the report endeavours to show, we seek to take an approach that actively integrates areas of activity whilst being able to demonstrate how the respective statutory responsibilities are accounted for and contribute to improved outcomes and impact on joint working with children and young people.

4.1 Learning and Improvement – Multi Agency Training

In the last report we noted that this area of activity carried a degree of risk on the basis of it needing to be able to demonstrate the following;

- Clear measurement of the impact attending training and learning events was having on practice
- How the programme reflected past learning and current Board priorities
- Reach and take up of training and events by the multi agency workforce and how this reflected our understanding of workforce needs as seen through the safeguarding standards, policies and procedures and priorities.

In the previous year the Board took the position that it would provide a lead for and assume responsibility for ensuring that this area of activity was 'fit for purpos' and improving. Whist noting that the balance of evidence, which was to some extent anecdotal, it still indicated that provision was valued.

As a result of its scrutiny of the last annual report and approval of the programme for the year the Board noted the following concerns;

- A high level of cancellations
- Limited progress re: impact assessment
- Analysis and presentation of information required improvement
- The appearance that fewer people were benefiting from delivery and that the different types of delivery may compromise the measures of effectiveness given the statutory requirement to focus on training.
- A proposal to further develop models of delivery in response to some of the above concerns
- That the requirements around Children's Social Care improvement objectives had been a significant feature of delivery

As a result in the year the Board exercised close scrutiny through regular reports and through the Chair in order to better establish an understanding of any underlying issues and assess the impact of agreed measures to drive forward improvement.

The Ofsted report and recommendations confirmed the efforts being made and indicated that the Board needed to consider a more strategic approach and impact.

The Board took regular reports and although as is the case with a number of cycles the availability of the annual report falls outside of the reporting period it is possible to summarise progress as follows;

- In the third quarter of the year, the Board agreed to introduce a charging policy in respect of cancellations and non-attendance in order to reverse the current rate of c.30% per annum (NB for 2014/15 this equates to lost opportunities for about 200 people). This was introduced in January 2015 and an in depth analysis of impact was not available at the time of writing this report. Experience elsewhere shows that if successfully implemented such policies have a significant effect in reducing non-attendance and a resulting reduction in the need to cancel courses/events.
- Members agreed to act as champions and promote courses and events, as well as responding to and providing data regarding attendance and targeting, so as to increase engagement and take up.
- First steps were taken (appointment of new chairs for the sub group and revision of terms of reference), so as to ensure that the programme reflected an understanding of the multi agency workforce needs as these relate to current priorities and to continue to map in order to coordinate and reduce potential duplication of single agency training and learning provision.
- Confirmation that current delivery reflected learning from case review and other areas of priority within the business plan.
- More than 93 multi-agency learning events have been provided to 1201 people with over a third attending from the local authority and almost a third attending from the voluntary sector.

Summary and next steps

The Board is fortunate to benefit from a full time Officer and an established programme of core provision. The steps taken by the Board to manage and scrutinise this core activity reflect the level of risk that has been attached and reported to the Improvement Board and Minister.

The approach taken to this has been to maintain a level of stability so as not to negate the many positives but also to reflect the need to undertake longer term change to achieve a more strategic and multi agency focus that complements existing single agency learning and training and matches the need for and reflects the significant shifts that are occurring in relation to safeguarding as a result of improvement and learning.

As in some other areas the pace of progress has been difficult to predict accurately, and some concern remains over the pace of progress and underlying trends.

That is not to conclude that as a result those who work with children and young people are not provided with a range of opportunities for training and learning, and the inclusion of new types of events to promote reflective learning from specific areas of learning that arise from board driven processes should be minimised.

It does however set a challenge for the current year in that the next annual report will need to evidence measurable progress in the following areas;

- The development of a safeguarding workforce development strategy
- A revised programme that sets a clear balance between “training” and “learning” courses and events, that further support respective professional development frameworks
- A programme that demonstrated fit with other forms of single agency provision to compliment and help partners to prioritise release.
- The full implementation of quality assurance and impact measures so as to demonstrate the difference attendance and participation made

- The further development of in house monitoring and reporting in a timely way.
- Continued use of the new matrix to fit emerging board led learning with delivery
- Stabilisation and reversal of current trends re cancellation and non attendance
- Being in a position by the year 16/17 to have a long-term vision and development plan for ensuring that the children’s workforce is suitably equipped with targeted and appropriate training and learning opportunities.

4.2 Listening to and engaging with children and young people

During the year we have become clearer about how we understand the different ways in which we can become more focused on the child and their voice.

Specifically we are identifying from our learning from CSE the ways in which the system as whole listens and responds to children and young people who tell us things. Our experience from CSE tells us that we need to improve capacity and capability across joint working arrangements to better recognise the signs and what children are telling us and what this might mean. Our experience is teaching us that the ways in which we respond to what children tell us through their behaviour and what they say requires careful consideration and assessment using a far wider range of different types and sources of information.

Although this learning is primarily focused by our response to CSE at present it is clearly an emerging priority for the coming years to apply this on a wider basis.

This means that we are developing both audit and performance management arrangements to test this out and to ensure that revision of thresholds, policies and procedures and training focuses on the ways in which children can be listened to and understood.

During the year the Board followed through on its initial challenge to the Local Authority in terms of changes it was making to the way in which children and their families were more involved in Child Protection meetings. The Board’s challenge was not about principle but concerns re capacity, implications for other partners and the extent to which the Board could be assured that risk and benefits were clearly identified and managed. The Board took further reports about the Strengthening Families model and was assured that this was starting to make a significant contribution to ensuring that there was a focus on the child in these meetings and that this was contributing to more effective outcomes.

During the year the Board benefited from work undertaken by the Council’s Scrutiny Committee looking at arrangements for the child’s voice and this highlighted the important contribution that this was making to the way in which the Local Authority reflected and acted upon the child’s voice. This served as a further trigger to encourage consideration of how the Board takes its understanding of these issues forward.

Progress has been made, though specific outcomes were not planned for this year, however the following activity and impact took place, which is informing the wider discussion and decisions that will need to be made in the current year.

- Sought and given views to change the CSCB website to be young people friendly.
- Received a 90% return rate (270 responses) from a Child Sexual Exploitation Survey; the results of which have been used to inform a Calderdale wide Youth Services mapping exercise for developing services for children and young people

- Designed and reported on an Early Help Questionnaire providing the Board with the voice of the child and how they choose to or are able to access services.
- Contributed to the Ofsted Review

See Appendix J for the Annual Report from the Young Advisors

Summary and next steps

Progress in this area has been made, but still requires further clarity from the board in terms of direction and priority. We have made some significant shifts in terms of the focus of Section 11, audits and performance information, which will support a further shift to ensure that our scrutiny is always able to see things from the point of view of the child and that our primary focus is the "child's journey".

We also in the year begun to re-form and re-negotiate our working relationship with children and young people who act as 'advisors' and we were also able to contribute to and draw on the annual survey of young peoples' views by introducing some areas related to safeguarding priorities and to look at these in terms of how these inform our priorities. Particular sections of the eHNA were used by the Proactive and Responsive sub group to identify areas where there may be gaps in services. One such area was the number of boys reporting that they were being sexually harmed. This was recognised by the Board and Public Health (who leads on the eHNA) as needing further development and scrutiny and subsequently advised the Children and Young People's Partnership to lead an exercise to establish that services in Calderdale are able to meet the demands of this vulnerable population.

The year and this report clarifies our need to be clearer about where and how we target our finite resources in respect of how we involve children and young people in the governance and processes of the Board and how we better understand and draw on how partners seek to take account of their views and understand needs. In order to better formulate our priorities given we need to ensure that our understanding of practice as well as the practice itself is focused on the child and the young person.

5. Clear priorities are set and core business processes are strengthened which establish effective joint working arrangements for safeguarding children and young people

This priority perhaps reflects our ultimate goal in that we seek to have as a Board an impact on not just what people do, how well they do it but also on the less tangible aspects of what really makes a difference.

In this respect this report identifies a number of key areas the Board has looked at;

5.1 Section 11 Audit and self-assessment

Last year the Board made a significant strategic and long-term decision to re-focus and extends the requirement for partners to assess and report on how they meet standards for safeguarding. The Board adopted an initial 3-year plan to;

- Re set the audit to reflect core safeguarding standards in order to take into account the changing and more complex landscape of how organisations and services we commissioned and governed. This was judged to be especially important as whole system changes around early intervention and early help developed as by definition this requires the engagement of a wider number of people and partners in joint working to help and protect children and the capacity to ensure that when it is necessary for formal and statutory intervention this is timely and seamless.
- This meant that more and many different types of organisations would be able engage with the audit, and therefore raised the questions as how best to promote local ownership and accountability as well as the Board's role and capacity for testing this in order to reach a point whereby a view could be formed as to whole system assurance levels in terms of the eight basic safeguarding standards. Or put in another way, the key things we know that contribute to being able to demonstrate a proactive and improving approach to safeguarding and joint working.
- Last year's report demonstrated that a good start had been made and that there was clear learning to be taken on board. It demonstrated a good level of awareness and understanding across a wide range of partners and feedback was generally positive.
- Lessons learnt during 2013-2014 were acted on and specific training has address shortfalls in knowledge (Safe Recruitment and LADO), procedures were given greater prominence on the website and additional literature was sent to front line staff to communicate key messages and information (in the form of posters, newsletters and electronic communications).
- In 2014/15 we were able to build on this progress by developing the audit in response to feedback and ensuring currency by asking respondents to address CSE and learning from case reviews. We were also able to take to the next stage our analysis and arrangements for testing and challenging findings, as well as aggregating the lessons to inform the next audit. (This will be reported on in the next report as the process crosses years of report).
- From the 100% response rate from Board Members and Commissioned Services in both years there is evidence that organisations have a greater and growing awareness of their responsibilities in safeguarding children and young people. There is confirmation within the analysis of the 2014-2015 Section 11 results of good progress in the two years of the Section 11 strategy and a trajectory of improvements is evident.

Summary and next steps

Section 11 can be seen as a necessary and sometimes perfunctory exercise that does not fully demonstrate or connect organisations with the role and purpose of the Board. This is not our view of, or vision for Section 11, which we see as an increasingly important way of strengthening localized awareness of and accountability for joint working safeguarding standards. We remain ambitious in wanting to ensure that all those who work with children and young people are able to take part and benefit from an annual exercise that produces assurance and grounds for continued improvement and contributes to a whole system view of assurance and contribution.

This will require from us the need to sustain and grow with the process and to work through some of the key issues we face as a board more generally in terms of how, when and what form do we challenge each other when there may be a question that we are not able to be sure that we are doing all we need to do to ensure children and young people are safe. In 2015-2016 Board Members who represent large organisations will be required to separate their returns into service areas.

This year's audit demonstrates that progress made last year has been sustained and that learning and improvement are being carefully driven forward. This has not been without challenge in terms of the scale of the task, the complexity of the undertaking and the shifts it requires in how we see things and how we engage with an outcome focused approach.

As the annual audit develops and if partners are able to make this a key part of their own assurance and quality systems it will continue to provide an important baseline that demonstrates shared standards and a culture of self assessment, accountability and improvement.

5.2 Safer recruitment and management of allegations (LADO)

The Section 11 audit, Board policies and procedures, as well as legislation set out clear standards in respect of the steps partners need to take to ensure that children are protected and risks are reduced from the adults they come into contact with when they access services, receive help or take part in faith based and other types of activities such as recreation and leisure.

Although this part of the report could be positioned under another heading, it is placed here because our learning tells us that choosing the right people and managing them is one of the important determinants in achieving high quality outcomes with and for children and young people.

The 2013/14 Section 11 audits demonstrated grounds for confidence that those who responded give safe recruitment priority. This was further evidenced during the year by reports of the work undertaken with schools by the Local Authority Schools Safeguarding Officer, as well as the Board hearing from partners the implications and learning from various enquires and reports focusing on the health sector.

The LADO and allegations management process is a responsibility of the Local Authority that requires cooperation from partners, and further requires the Board to be assured that the arrangements are effective and that learning and improvement is acted upon by all partners.

During the year headline data was incorporated into the PMQA framework to complement monitoring through the existing annual report presented to the Board.

The report demonstrated consistent patterns of reporting and response and highlighted that efforts to further improve management of reports and outcomes was progressing. Board members were able to challenge and be challenged in terms of the need to be assured that awareness and response in their own organisations was meeting standards and to require future reporting to focus more on particular areas and issues.

The Board found that enquires and responses were managed in a timely way, but noted that there was a fall in the number of cases where allegations were substantiated. The Board accepted the assurance that this was likely to reflect improved awareness and preventative measures but noted that it would need to consider this trend at the next report and advised the service to monitor this carefully.

Summary and next steps

Responsibility for meeting standards and requirements clearly rests with partners, the board has to remain sighted of how partners are ensuring that safer recruitment standards are met and the Section 11 is set to become the main vehicle for this and will also be informed by the performance management data set which looks at some of the other key indicators that can demonstrate how workforce management and development plays a significant role in ensuring that children and young people are protected.

This monitoring will need to be maintained and reported on in the next report, but on the basis of the evidence considered by the board it appears that partners are able to demonstrate that this is a priority activity and that they have in place the measures to quality assure this.

The Board was assured on the basis of the report from the LADO that this process was resulting in reliable outcomes and that there were arrangements in place to manage trends, identify learning and implement improvement. The Board did however identify some challenges in terms of trends, improvement and reporting as well as being reminded that board members needed to ensure that their organisations were sharing in the report and responses were effective.

The next steps from the Board's point of view relate to further integration of evidence, ensuring that key measures are in place that the Board and members are in a position to support and account for their role.

5.3 Case Review, Serious Case Review and Child Death Review

The capacity and delivery of review in respect of child deaths and other cases that meet the criteria for review as set out in Working Together represent one of the most important and challenging areas of work the Board and partners are required to undertake.

It also highlights some difficult issues that the Board, partners and all those who work with or engage with children and young people have to face.

- The certain knowledge that no one or any system is perfect, therefore errors will occur and some children will be subject to harm or die.
- This highlights the importance of effective ways of ensuring that all child deaths and what are called "notifiable incidents" I.e. when we know or believe that a bad situation could have been prevented or avoided are subject to impartial and thorough review that does not pre judge the establishment of fact and what people did or did not do.
- It raises the clear dilemma around creating the optimum circumstances for establishment of fact without recourse to, or fear of, blame and unjustifiable reputational damage.
- This in turn highlights the wider principle that to some extent the way things work relies on levels of trust at the front line, across organisation and partnerships and certainly in terms of the relationship between the public and those with professional responsibilities.
- The Board and its members therefore have to ensure that review is objective, thorough, transparent and fair.
- This too often also involves having to respond to the way in which learning and outcomes from reviews can be used for different ends and how these can be represented across the media.

During the year the Board achieved and was able to evidence progress in the following areas;

- Revision of and supplementation of the Learning and Improvement Framework to reflect learning from the management of review processes and to set new standards for undertaking these.
- Remedial work to address and bring up to standard one completed SCR and prepare for publication and the moving forward to two ongoing SCRs. The Board convened an extraordinary Board meeting in December 2014 to formally scrutinise and sign off two SCRs.
- Two reports were completed within the year and publication is planned for 2015/16 once legal and consultation matters have been completed.
- A Serious Case Review was commissioned in December 2014 relating to CSE and will have a victim led focus.
- The Board was involved in a SCR commissioned by another LSCB – which will not be published until 2015-2016

- Further development of notification system and role and recording of initial review and decision making process
- The development of how learning recommendations are managed and monitored
- The assessment of the different types of methodologies used to date
- Participation in a SCR commissioned by another LSCB
- Board member engagement and challenge of SCR reports and development of Board response.

Some examples of multi-agency learning outcomes are:

- Amended 'Missing' Procedure to ensure similar robustness is in place for 'absent' children
- Exclusion policies re-written for all Calderdale Schools to include how to keep children safe in these circumstances
- E-safety protocol written and e-safety training promoted to Residential Homes and foster carers
- Guidance around 'professionals meetings' written to encourage professional reflection when working with families in crises and accompanying 'Multi-Agency Reflective Practice Sessions' delivered to support this
- Risk Indicator Tool developed which is child focussed and is envisaged to be used alongside the new Early Intervention Single Assessment
- Threshold document 'Continuum of Need' has been updated
- Information Sharing Protocol for the Multi Agency Screening Team (MAST) written
- Regular Multi Agency Audits completed to quality assure early intervention joint working arrangements; deep dive into escalation and de-escalation of early intervention underway at the time of writing this report
- Supervision Framework written and launched
- SMART Planning training re-written and delivered
- Adult and Child Protocol written and launched to encourage referrals from Adult Services to Children's Early Intervention and Statutory Services and from Children's Services to Adults – particularly around mental health, learning difficulty, domestic abuse and substance abuse.

Some examples of where these have been further developed can be found in Appendix H. Challenge events with front line practitioners will be held in November 2015 to test whether the changes, training and guidance have had the intended impact on outcomes for children and young people.

Some examples of single agency learning from SCRs are as follows:

- Following an out of area Serious Case Review, an action plan for Calderdale CAMHS was developed regarding quality assurance to ensure children and young people received timely interventions from CAMHS; this has further influenced the development of a new 'Comprehensive Risk Assessment' which asks specific questions around looked After Children and it has also influenced the introduction of the Care Programme Approach (Framework to ensure children's wellbeing is followed through) process into CAMHS. It has changed and contributed to the audit cycle within CAMHS.
- On the back of findings from SCRs Pennine Housing have introduced a new recording system and are holding refresher training for key staff.

5.4 Child Death Overview Panel (CDOP)

As in the previous year this was a shared arrangement with the Kirklees LSCB and regular reports were presented to the Board.

During the year the Board was concerned to ensure that it was responsible for and supported an effective review process so that this resulted in the opportunity to implement locally learning.

A total of 15 deaths of children were reported to Calderdale Child Death Review Team between 1 April 2014 and 31 March 2015. This is the lowest number recorded since the introduction of Calderdale CDOP. Calderdale has reviewed 92% of all deaths reported since the introduction of CDOP; the National rate is 82% and the rate for Yorkshire and Humber 87%. This reflects positively upon the efficiency of the joint Panel and Secretariat Support staff.

Of the cases completed in 2014-2015, 38% were noted as having modifiable factors against the national average of 24%. The modifiable factors included consanguinity (which it is important to note that not all CDOPs record this as a modifiable factor), alcohol or substance misuse by parent, smoking in pregnancy, domestic violence, and emotional, behavioural or mental health conditions in the parent or carer. No issues relating to service provision were raised by the Panel.

In Calderdale, the numbers of child deaths are small and so caution must be exercised when considering any emerging trends. The data will be monitored closely to assess any significant changes and measured against the three year rolling averages collected by Public Health.

Death rates for children and infants are significantly higher in the Asian Pakistani than White-British ethnic group in the six years of CDOP. Child death rates are highest in Halifax Central and in the lowest two quintiles of deprivation. Most Calderdale child deaths have been categorised as being due to 'chromosomal, genetic and congenital anomalies' or 'perinatal /neonatal event' over the last seven years

The functioning of the CDOP continues to outperform the national average on multiple parameters including timeliness of reviews and completeness of data

The full report will be published in autumn 2015 on the CSCB website: www.calderdale-scb.org.uk

Summary and next steps

The end of the reporting year saw the publication of revisions to Working Together and in the year the first annual report of the National Panel of Experts (who scrutinise decisions about and quality of SCRs). The year also saw the Department of Education allocate significant innovation funding to a project intended to help improve SCRs.

Therefore the expectations and a wider set of implications around SCRs remains an area of high profile interest. This demonstrates the importance of maintaining and building capacity and expertise to undertake reviews of all forms, and to work towards a position whereby Serious Case Reviews continue to have a significant and a proportionate influence and impact on joint working arrangements, within a culture of learning and improvements.

As a Board we have made progress, and have got better at some of the practical and managerial parts of the process, though review remains a time rich and resource intensive process across all those involved.

It is harder to quantify the progress made in respect of capacity to engage, reach clear standards of thoroughness, rigour and transparency and to ensure that learning and recommendations are evidenced and will make a significant difference.

We have also learned about the importance of and ways in which we can engage the family and victims in the review process.

11. Conclusion: The Effectiveness of Calderdale Safeguarding Children Board

This report and the Ofsted judgment indicate that we are becoming a more effective Board. This report necessarily has to summarise and highlight in order to be as accessible as possible. The effectiveness of a Board cannot be solely assessed by the length or brevity of its annual report, but it provides signposts to further evidence, and indicates clear direction based on what has been learned. This year we have reason to believe that we have moved forwards and are setting in place a focus on outcomes that are sustainable, responsive and take into account the risks and challenges that we have been able to identify.

The commitment of Board members has remained high and has shown evidence of an increasing degree of focus in terms of role and accountability. The agendas remain wide and full; this can make it hard for all members to evidence and contribute. Continued efforts will be made to clarify role and expectations, support these and ensure that we can demonstrate relevance and fit in terms of what we do.

As the report clearly indicates we continue to know our strengths and that these continue to require improvement and that we have a handle on, and a strategy for, our weaknesses.

As the year has progressed we have been able to move forwards on the basis of more than 'sidelights' and even on occasion 'full beam' resulting in us having a clear view and line of sight of the performance and quality of joint working arrangements to protect children.

There are areas where we have yet to fully form and work out fit and detail of the next steps such as how we communicate more effectively, or how we further involve children and young people, but this report (and the current business plan) evidences the intention and next steps. As the year progressed we continued to see the benefits of steps taken in the previous year.

The current year therefore requires benchmarks that remain high, and there will be a significant transition as we develop our PMQA to have a wider impact and we further develop how we influence and are influenced by other strategic partnerships.

We have however as we believe this report evidences continued to make real and sustainable progress as an effective Board and realise that over the next two years we will need to maintain and consolidate the pace of change and improvement.

12. Recommendations: Challenges and Messages

The Board recognises achievements and the progress that has been made in joint working arrangements by all partners and is providing a realistic assessment of the challenges that still remain, however the improvements to the Board needs to show the impact on children, young people and families in Calderdale:

- Keeping the pace up, further integrating the work and the frameworks around a focus on the child and the impact this is having
- Maintain the development of the PMQA and L&I Frameworks
- Improving partner and Board member focus and contribution on the basis of improving and more effective process and understanding of roles
- Further developing Board role, identity and partnership focused on setting the standard, scrutiny, learning, challenge and assurance
- Improving how we communicate and engage so as to sharpen impact and become more inclusive
- Establish more effective ways of understanding and demonstrating how identity, culture and beliefs impact on the effectiveness of safeguarding
- Be able to produce as required assessments of areas such as CSE and other headline strategies
- Work out more effective sharing of priorities and leadership across strategic partnerships
- Develop a strategic approach to training and learning.

Appendix A: LSCB role and statutory responsibilities

Chapter 3 of Working Together 2015: Local Safeguarding Children Boards

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

Statutory objectives and functions of LSCBs
1. An LSCB must be established for every local authority area. The LSCB has a range of roles and statutory functions including developing local safeguarding policy and procedures and scrutinising local arrangements. The statutory objectives and functions of the LSCB are described in the two boxes below.

Statutory objectives and functions of LSCBs
Section 14 of the Children Act 2004 sets out the objectives of LSCBs, which are:

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

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

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

1(a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

(i) the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;

(ii) training of persons who work with children or in services affecting the safety and welfare of children;

(iii) recruitment and supervision of persons who work with children;

(iv) investigation of allegations concerning persons who work with children;

(v) safety and welfare of children who are privately fostered;

(vi) cooperation with neighbouring children's services authorities and their Board partners;

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

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

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

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

Regulation 5(2) which relates to the LSCB Serious Case Reviews function and regulation 6 which relates to the LSCB Child Death functions are covered in chapter 4 of this guidance.
Regulation 5(3) provides that an LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

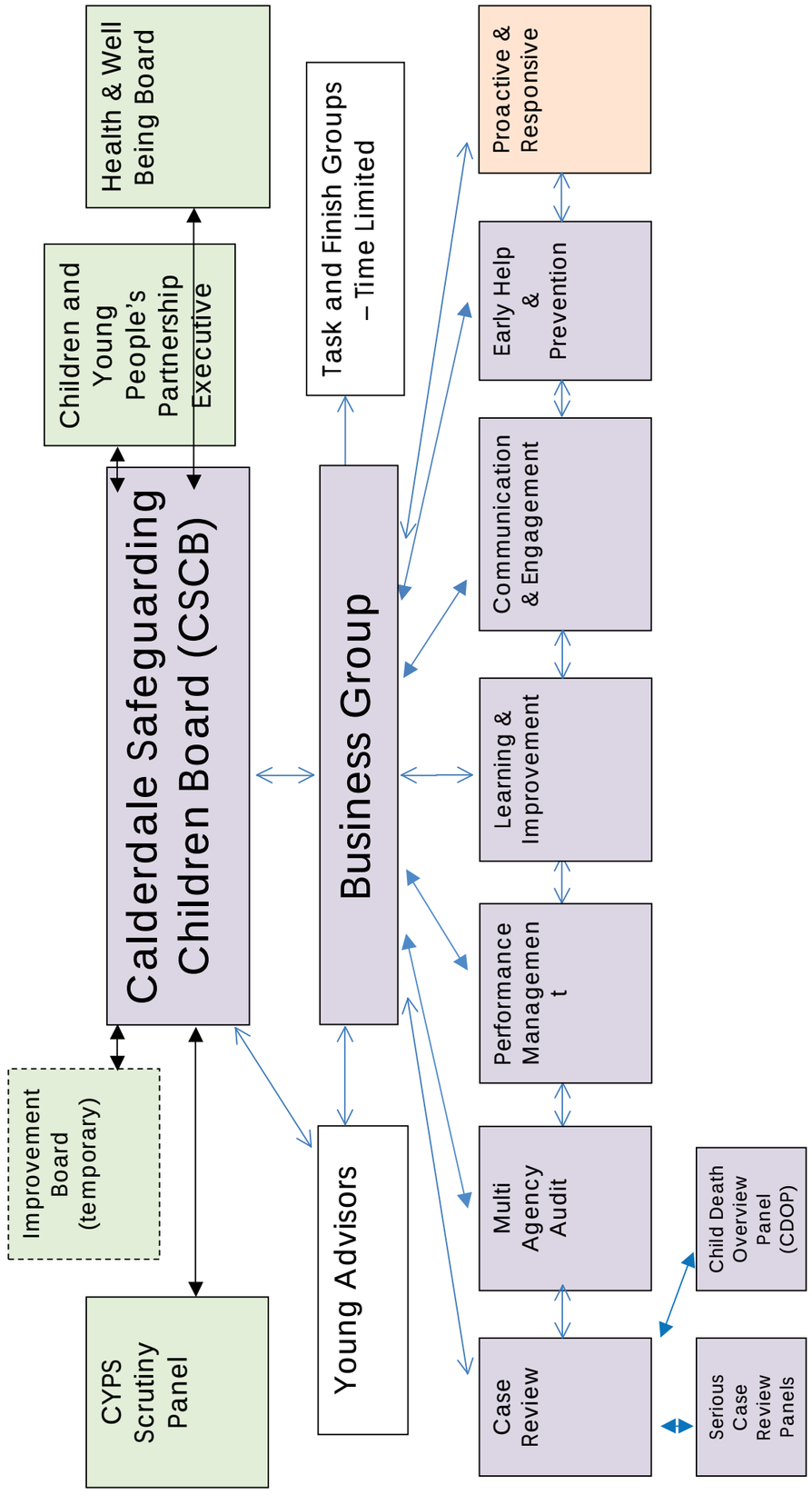
Appendix B: Glossary of Terms

The Board	Calderdale Safeguarding Children Board
CDOP	Child Death Overview Panel
CIB	Calderdale Improvement Board
CLA	Child Looked After (term preferred by young people)
CoN	Continuum of Need (Threshold Model)
CP	Child Protection
CSCB	Calderdale Safeguarding Children Board
CSE	Child Sexual Exploitation
CYPPE	Children and Young People's Partnership Executive.
DCS	Director Children's Services
DV / DA	Domestic Violence / Domestic Abuse
EI	Early Intervention
EIP	Early Intervention Panel
EISA	Early Intervention Single Assessment
FGM	Female Genital Mutilation
FIT	Family Intervention Team
GP	General Practitioner
HWB	Health and Wellbeing Board
LA	Local Authority
LADO	Local Authority Designated Officer
LIF (L&IF)	Learning and Improvement Framework
LSCB	Local Safeguarding Children Board
MARPS	Multi Agency Reflective Practice Session
MAST	Multi Agency Screening Team
PMQA	Performance Management Quality Assurance
SAB	Safeguarding Adults Board
SCR	Serious Case Review
VYPP	

Appendix C: CSCB Membership at 1st April 2015

Representing:	Name:
Independent Chair	Richard Burrows - RBA Consulting
Adult Safeguarding Board	Iain Baines – Head of Safeguarding & Quality
CAFCASS	Jo Sewell – Service Manager
Calderdale & Huddersfield Foundation Trust	Dr Pamela Ohadike – Designated Doctor for Safeguarding Children
Calderdale CCG	Gill Poyser Young – Designated Nurse Penny Woodhead - Head of Quality
Calderdale College	Howard Browes – Assistant Principal, Quality & Learner Services
Children & Young People's Service, CMBC	Beate Wagner – Head of Service Early Intervention & Safeguarding Stuart Smith – Director of Children's Services Laura Knights – Service Manager – Safeguarding & QA Service
Communities, CMBC	Robin Tuddenham – Director for Communities and Business Change
Councillors	Councillor Colin Raistrick – Lead Member for Children's Services
CSCB	Julia Caldwell – Business & QA Manager
Democratic & Partnership Services, CMBC	Ian Hughes – Head of Democratic & Partnership Services
Housing	Janette Pearce - Head of Pennine – Together Housing Group
Lay Member	Jo Taylor Shaheen Khawaja
NHS England	Chris Stoddart – Safeguarding Advisor/Regional Prevent Coordinator
Primary Heads	Lesley Bowyer – Halifax Academy Laura Newcombe – Lee Mount School
West Yorkshire National Probation Service	Maggie Smallridge – Head of Service (Bradford & Calderdale)
West Yorkshire Community Rehabilitation Company(CRC)	Kevin Ball – Head of Service (Bradford & Calderdale) w
Public Health	Paul Butcher
Secondary Heads	David Lord – Ryburn Valley High School
South West Yorkshire Partnership NHS Foundation Trust	Tim Breedon – Director of Nursing
Voluntary Sector	Angela Everson – Joint Chief Executive, WomenCentre Steve Blackman – Sector Support Calderdale, North Bank Forum
West Yorkshire Fire and Rescue Service	Martyn Greenwood
West Yorkshire Police	Chief Superintendent Angela Williams Acting Chief Superintendent Darren Minton
Youth Offending, CMBC	Jeff Rafter – Head of Youth Offending Team

Appendix D: Calderdale Safeguarding Children Board Business Plan 2014 - 2015



Appendix D continued: Calderdale Safeguarding Children Board Business Plan 2014 - 2015

Calderdale Safeguarding Children Board identified 5 priorities to focus on between April 2014 and March 2015. These were:

1. The Calderdale Safeguarding Children Board has assurance that children receive the right help at the right time and are clear about how this impacts on safeguarding
2. Assure the Calderdale Safeguarding Children Board of the effectiveness of the identification and safeguarding of the most vulnerable children in Calderdale
3. Robust Performance Management and Quality Assurance demonstrates effective Safeguarding
4. The Calderdale Safeguarding Children Board drives Safeguarding and Practice Improvement for children and young people
5. Clear priorities are set and core business processes are strengthened which establish effective joint working arrangements for safeguarding children and young people

The 2014-2015 Business Plan was used as a risk management tool which highlighted progress and risk in respect of the improvement of Board process and internal governance. Partners continued to demonstrate commitment to safeguarding through both attendance and active participation.

Steady progress in performance management was achieved and the Board is now in a position to call upon and look directly at practice through the multi agency case file audits. The Board has started to engage with the findings of these in order to further scrutinise and challenge both the performance of partners and the Board itself.

The delivery of multi agency training has been developed to further assure partners how the provision is meeting needs and changing how people work with children, young people and each other. The Board has introduced a charging policy In order to help address low take up of some courses.

Case review and in particular Serious Case Review have been subject to a significant change in expectations and approach: the Board invested considerable time and resources in attending to four SCR's and effecting a Case Review Framework.

As with other LSCB's the Board took on new responsibilities in relation to the evaluation of early help: Steady progress was made alongside the review and updating of the Board responsibility to make sure that people know how to recognise when a child may not be safe or is being harmed and what to do and who to talk to.

A major focus for the CSCB has been Child Sexual Exploitation, and the Board has supported and provided leadership for local arrangements being reviewed and strengthened.

The Ofsted Review in February 2015 confirmed the progress made by the Board and the full report can be found here.

Appendix F: Financial Contribution from Partner Agencies and Budget 2014-2015

Expenditure

Pay, NI & Pensions & travel costs	146,390.20
Chair & Board Training & development	504.68
Policy & Procedures	2,800.00
Advertising	376.00
All training costs	5,897.75
CSCB Chair expenses	18,465.74
Case Review Work	16,499.00
Website & E Learning costs	11,500.00
Other miscellaneous costs	330.30
	202,763.67

Funding

CAFCASS	-550.00
Calderdale CCG	-81,800.00
West Yorkshire Probation	-2,346.00
West Yorkshire Police	-7,113.50
Calderdale MBC	-122,535.00
Underspend carried forward from 2013/14	-9,970.00
	-224,314.50
Underspend to carry forward to use in 2015/16	**-21,550.83**

Appendix E: Partnership Attendance at CSCB and Sub Group Meetings from 1st April 2014 to 31st March 2015

Meeting and number held	CSCB (6)	Business (19)	Performance Management (9)	Learning & Improv't (6)	Case Review (11)	Comms & Engagement (8)	Early Help & Prevention (7)	Proactive & Responsive (8)	Multi-agency Audit group (6)
Legal	3				6				
Police	6	12	7		8	1	4	8	1
CYPS	6	18	9	1	11	6	5	8	6
Housing	3	13					6		
Probation	5		6						1
CHFT	6		7	4	10	7	6	4	2
CCG	6	9	6		11		0	6	3
SWYPFT	6	9	4	6	5	6	3	5	1
CSCB Rep	6	19	3	5	10	8	3	5	6
Adult Health \SC	5		1				2		
YOT	6	11	1	5			7		
CAFCASS	6		1						
Lay Member	6	13	2			5			
Lead member	4								
Public Health	5		3		5		2	1	
Dem & P'ships	2		1						
Voluntary	5		4	5		5	2	5	
Business & Perf			8						
Schools	4		5	3	4			5	1
WFD				4					
E.I			5		1		0	3	1
S&QA Service	3		6	1				3	5
CAHMS				2					
V & I						4			
Communication	3		2			2			
Equality						6			
HomeStart							3		

Appendix G: Policy and Procedure Changes

Updated Chapters	
Chapter Name	**Details**
Initial Assessments	This chapter was updated with reference to the Single Assessment processes which are being introduced across the five authorities in the Consortium.
Section 47 Enquiries and Core Assessments	The requirement to carry out a s.47 enquiry when a child under 10 is in breach of a child curfew order was removed from the chapter. In the section on outcomes of s.47 enquiries, the number of possible outcomes was reduced from four to two, to reflect Working Together to Safeguard Children 2013.
Children and Families who go Missing	A reference to the most recent statutory guidance on children who go missing or run away from home or care was added.
Safeguarding Children and Young People Vulnerable to Violent Extremism	Links to the ACPO Channel Factsheet and Channel Framework for Assessing Vulnerability were added to this chapter.
Agency Roles and Responsibilities	This chapter was updated to include reference to a document published by NHS England on Safeguarding Vulnerable People in the Reformed NHS.
Safer Recruitment, Selection and Supervision of Staff	This chapter has been reviewed locally and updated.
Local Contacts	This chapter has been reviewed locally and updated as necessary.
Action Taken when a Child is Referred to local authority children's social care services Flowchart	The flowchart was replaced with the most recent version from Working Together to Safeguard Children 2013.
Action Taken for the assessment of a child under the Children Act 1989 Flowchart	The flowchart was replaced with the most recent version from Working Together to Safeguard Children 2013
Immediate Protection Flowchart	The flowchart was replaced with the most recent version from Working Together to Safeguard Children 2013
What happens after the Strategy Discussion Flowchart	The flowchart was replaced with the most recent version from Working Together to Safeguard Children 2013
What happens after the Child Protection Conference, including the review process Flowchart	The flowchart was replaced with the most recent version from Working Together to Safeguard Children 2013
Referrals	References to Initial and Core Assessments were replaced with Single Assessment throughout to reflect the Single Assessment Process introduced by Working Together to Safeguard Children 2013.
Section 47 Enquiries	This chapter has been amended throughout to reflect the introduction of the Single Assessment under Working Together to Safeguard Children 2013.
Abuse by Children and Young People who Display Sexually Harmful Behaviour	References to Initial and Core Assessments were replaced with Single Assessment throughout to reflect the Single Assessment Process introduced by Working Together to Safeguard Children 2013. Additional Guidance and tools for use by professionals when assessing Sexually Harmful Behaviour were also added (see above). It should be read throughout.

Appendix H: Changes as a result of learning from Calderdale SCB

Learning Implementation and Action Pathway

Date Identified	Source of Learning	Action Required	Who is Responsible	Ways of Implementation and Evidence Gathering	Impact of Learning
May 14 Jul 14 Nov 14 Jan 15 May 15	MARPS x 2 MA audit	1. Ensure practitioners have knowledge of child development, are aware of tools to assist and make use of colleagues' expertise as required. **Practitioners to have access to a range of tools and use tools more frequently to measure baselines and changes.**	CSCB	1. Cascade via CSCB – Marketing Strategy 2. Assessment audit – use of tools/ evidence based practice – MA audit group 3. MA SMART Planning in Practice workshops - target audit of case files of participants 4. Introduce use of tools in MARPS to embed practice e.g. discrepancy matrix, strengthening families risk assessment 5. Update tools table – add to CSCB website 6. Deliver short presentation to EI panels 7. Also see 3.	Plans are smart Tools identified and used
Evidence	Jul & Aug 2015: Tool table updated; EI Assessments audited bi-monthly; Use of tools promoted in SMART planning workshops Assessment Guide.docx \s				
May 14 Jun 14 Jul 14 Oct 14 Dec 14 Jan 15	MARPS x 3 Learning Lessons MA Audit (BB SCR)	2. Core group works effectively to produce and monitor SMART plans. **Refreshed core group agreement/TAC agreement i**s used to clarify roles and responsibilities. SFA to ICPC highlights risks which are the focus of the SMART plan and core group discussions.	CSCB CSC CSCB	1. MA SMART Planning in Practice workshops - Take up of places, evaluation comments, SMART plan audit. 2. Refreshed core/TAC group agreement 3. Request directive from CSCB to use Multi-Agency Meeting Agreement 4. Senior Worker to facilitate meeting if stuck or plan needs to improve	MA agreements used Proportion of children managed at level 3 increases
Evidence	July 2015: Core group agreement refreshed; Feedback from SMART planning workshops is positive; Mini audit planned but lack of plans produced by practitioners who have attended training.				

		2 a. Introduce model for facilitating 'stuck' core groups e.g Professionals meetings Produce and implement guidance on holding professionals meetings so that practitioners can identify and agree how to challenge resistant and hostile service users and those who demonstrate disguised compliance		1. Professionals meetings guidance written and meetings take place 2. Senior Worker to facilitate meeting.	
Evidence	May 2015: Guidance for professionals meetings produced. Amended Aug 2015  Professionals Meetings.docx \s				
Dec 13 May 14 Jul 14 Nov 14 Jan 15	MA Audit MARPS x 3 Learning Lessons (K SCR)	**3. Ensure that the protocols for assessment are clear and understood by practitioners and Managers**. (Ch 1 s. 62-63 Working Together 2013). Ensure that any specialist assessments are coordinated and result in a single planning process focused on outcomes. **Select the most appropriate general and/or specialist assessments** to determine needs/ risks alongside Single Assessments Practitioners develop skills in 'asking the right (focused) questions' of multi-agency partners and family members	CSCB CSCB	1. Protocol/guidance for selecting the most appropriate assessment produced (who can provide information?) and implemented 2. Risk Indicator tool produced which links to need for further assessment – briefings to support (Single assessment updated) 3. Also see 1.	Needs/risks identified clearly. SMART plans produced. Proportion of children managed at level 3 increases. Quality of referrals to MAST and EI panels improve
Evidence	July 2015: Guidance for assessment and updated table of tools produced. Risk indicator tool produced. Assessment Guide.docx \s				

May 14 Jan 15	MARPS x 2	**4. Improve working relationships and understanding of roles and responsibilities between Adults and Children's Services**. Implement the flowchart for referrals to Children's and Adults services. Involve Adult Services in multi-agency training events	ASB CSCB/ASB	1. Adult Safeguarding Board promoting Referral Processes guidance 2. Promote during Safeguarding week 3. Evaluation of Safeguarding Week events and activities	Joint Referral Processes Guidance agreed and implemented. Increase no of referrals into EI panel and MAST from Adult Services and vice versa.
Evidence	July 2015: Referral Processes for Children and Adult Services almost complete – going to CSCB and ASB October 2015				
May 14 May 15	MARPS	5. Parents need access to support/information once child removed to prevent 'replacement' behaviour Develop parenting courses for parents without children	CHFT Public Health Children's Centres/FIT CYPS Commissioning CYPEE	1. Raise at CSCB 2. Provision of contraceptive advice; grief counselling; parenting skills; child development e.g. via Stress Programme (Occupational Health) 3. If parents unknown to services, refer to Adult Psychology with their consent	Increased referrals to Adult Psychology (if child removed)
Evidence	July 2015: None Aug 2015: Set up Task and Finish Group to take forward				
May 14 Jun 14 Nov 14	MARPS Learning Lessons x 2	6. Agencies to begin to compile single agency chronologies at first indication of unmet needs or identification of risk. **Chronologies to be combined at earliest opportunity** e.g. EI panel and maintained by LP at multi-agency meetings (see 2 above)	CSCB	1. Pilot project running. Review Feb 2015. Practice workshops provided and importance of MA chronologies included in other training. 2. Audit of referrals will evidence implementation 3. Deliver short presentation to EI panels	MA chronologies evident in referrals to MAST (if previously worked at tier 3)
Evidence	July 2015: Pilot extended. MAAG agreed to defer audit to December 2015. MA Learning and Improvement programme delivers training in 'Writing and Contributing to MA chronologies'				
Jul 14	MARPS (K SCR)	**7. Make more use of Family Group Conferences** at an early stage to identify protective networks in the extended family and/or to rule people out.	Early Help and Prevention sub group	1. Explore evidence base and potential sources of funding to increase numbers and bases of qualified Co-ordinators – initiate FGC at earlier points on the CoN.	Audit of EI cases
Evidence	July 2015: None Aug 2015: Forward to Early Help and Prevention sub group for action				

May 14 Jul 14 May 15	MARPS x 2 MA Audit	**8. Continue to promote the importance of listening to children and recording their views** in all activities (assessment and interventions) that affect them. Demonstrate how views of children are acted upon or why not	CSCB/WFD C&YP consultation	1. Induction training continues. 2. Cascade messages in bulletins and training and reminders re: Communication toolkit (link to Marketing Strategy) 3. Themed audits of organisations to demonstrate 'voice of child' 4. Child's plan audits 5. Included in S.11 audits	No of children attending ICPC and reviews MA SMART plan audits Records of meetings/case file audits
Evidence	July 2015: None				
Nov 13 Jul 14 Jan 15	MA Audit MARPS x 2	9. Improve **quality of referrals** for services – EI panel and CSC to provide feedback to referrers. Continue to promote clarification of thresholds	MA audit group CHFT audits of referrals to MAST	1. MA audit group action plans show improvements in quality and relevance of referrals to EI panel and CSC (audits of referrals to EI panel not currently undertaken)	Timely response.
Evidence	July 2015: None July 2015: Referral process to EI panels and MAST changed				
Jul 14 Jun 15	MARPS Learning Lessons	10. Improve and facilitate **sharing of key information between agencies, especially across borders** – explore creative ways of including agencies in order to maximise understanding and capture historical information	Learning and Improvement subgroup – Policy and Procedure task and finish group	1. Procedure/guidance produced. 2. Practitioners clear about process to follow and what information can be shared under what circumstances. 3. Transfer out documents completed 4. Ensure named person is available during School Holidays	Practitioners aware of circumstances to share information. Children receive support/response identified in MA plan Key agencies are represented at meetings
Evidence	July 2015: Information Sharing Guidance produced; Schools Safeguarding Advisor working on identifying Named person during School Holidays Information Sharing protoco...				

Jun 14 Oct 14 Dec 14 Jan 15 Jun 15	Learning Lessons x 2 MARPS x 3	**11. Individual Practitioners develop skills and confidence to improve and challenge** more effectively including parents and carers who display disguised compliance, **Share examples of good practice and develop skills** that are required to ensure staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children	CSCB	1. Working with hostile and resistant clients and disguised compliance included in training programme. 2. New training event to be developed 'Motivational Interviewing' already in programme, 'Restorative Approaches' in WFD programme, 'Clever Questioning'. Attendance at and evaluation of events.	Examples provided of how families challenged and progress is made or evidence gathered to escalate concerns in supervision and MA meetings.
Evidence	July 2015: Masterclass being organised with a view to developing a course from the materials. Aug 2015: Work commenced on developing 'A day in the life of a child' approach to assessment of neglect which will address disguised compliance				
Oct 14	MARPS	**12. Agencies to demonstrate inclusive practice and involve significant others (including extended family members) in assessment and interventions or give clear account of attempts to engage and/or reason for no involvement**	CSCB	1. Cascade messages in bulletins and training. 2. EI and CSC audits of referrals and assessment 3. Include in guidance for assessment (see 3. and 7. above). 4. Link to SMART plan audit. 5. Add to integrated 2 year old progress check.	Quality of referrals. Audits of SMART plans
Evidence	July 2015: Single assessment document includes relevant section; SMART plan audit planned for December 2015 Aug 2015: Health includes section on groups and relationships in records. Still to add to 2 year old progress check				
Dec 14	MARPS	**13. Improve access to suitably qualified and trained interpreters, especially during unplanned visits** Take into account vicarious trauma for those involved	CSCB	1. Paper written with examples to be presented to Business Group/CSCB for consideration	Calderdale adopts robust policy re: use of interpreters with financial support
Evidence	July 2015: None Aug 2015: Forward to Jo Richmond in her role as SPOC for trafficking and work with Communities				

Nov 14 Dec 14	Learning Lessons MARPS	**14. Revisit policies, procedures, practice guidance and protocols for children and young people at levels 3 and 4 of the Continuum of Need** to ensure that the most vulnerable children in Calderdale are safeguarded – this includes information sharing protocols	CSCB	1. Paper written with examples to be presented to Business Group/CSCB for consideration 2. Refresh of CoN. 3. Link to tools and assessments (see 3 above). List of tools and assessments to be added to CSCB website. 4. Discuss adopting a West Yorkshire child development framework (WY Consortium) e.g. Ages and Stages tool	Children and young people receive the right help at the right time (EI and CSC Audits)
Evidence	July 2015: CoN refreshed. Tools table updated and assessment guidance produced.				
Jan 15	MARPS	**15. Develop Practitioner guidance and pathway for responding to children and young people who display self harming behaviours or who are suicidal**	CSCB/CSC	1. Yorkshire and Humber funding an initiative to promote emotional well-being 'Mental Health Innovation Hub' 2. CAMHS pathway in place 3. Produce guide	Emotional well-being of children and young people will improve as a result of receiving the right help at the right time. (EI and CSC Audits) Practitioners will follow the pathway and make necessary referral to relevant agency.
Evidence	July 2015: Work in progress re: 'Mental Health Innovation Hub'				
Jan 15	MARPS	**16. Promote, clarify and extend the function of VYPP and the Net so that children who do not meet the threshold for some services are recognised and their additional needs are addressed e.g. SHB, Self harm** **Develop referral guidance**	CSC	1. Make request for CSC to develop materials to explain the VYPP and Net 2. Produce proposal/rationale for need to extend service	Children receive more appropriate support when required
Evidence	July 2015: None				

Jun 15	Learning Lessons (Child J)	**17. Adopt systemic approach to practice to ensure needs of all family members are addressed.**	CSC	1. Roll out systemic approach to practice	Family members supported in a timely way. Needs of child met.
Evidence	Systemic Practice now being implemented in CSC Aug 2015: Safeguarding Guide produced				
Jun 15	Learning Lessons (Child J)	**18. Ensure information about local resources and services is readily available to practitioners.**	CSCB	1. Maintain website with current information about services and links. 2. Utilise Marketing strategy to ensure key messages cascaded to staff in timely manner.	Practitioners can access appropriate support for families
Evidence	July 2015: EI services directory now on CSCB website				
Jun 15	Learning Lessons (Child J)	**19. Consider identifying a person to co-ordinate sharing of information (not necessarily the Statutory lead) and use creative ways to involve people in professionals meetings e.g. video conferencing in order to accurately assess need and risk**	CSCB/CSC	1. Produce guidance on the role of Co-ordinator of information *(systemic practice may address this matter)*	Information is coordinated and shared in a timely way to ensure child's welfare and development is promoted.
Evidence	July 2015: None Aug 2015: Defer until Systemic Practice is rolled out to other agencies				
Jun 15	Learning Lessons (Child J)	**20. Increase awareness of potential negative impact of social media on young people**	CSCB	1. Identify a range of ways to promote awareness with children, parents, practitioners 2. Make e-safety guidance readily available 3. Undertake soft audit via Young Advisors re: habits and awareness of social media issues	Practitioners are more confident in engaging parents and children in conversations about use of social media etc
Evidence	July 2015: None Aug 2015: CSCB website includes greater range of materials for children, parents/carers, professionals. E-safety guidance produced				

Appendix I: Performance Management Identification and Outcomes

Area identified for further exploration	Actions taken/progress made	Outcome	Target date for Board Sign off
Children with a child protection plan 2 years +	Single and multi-agency actions identified and completed	Performance in this area has improved significantly	4th December 2014 **Complete**
Re-referrals to children's social care	Referred to audit sub-group Multi-agency audits complete Awaiting report back from sub-group for sign off	Early Help & Prevention group to lead on non consenting and non engaging families. Systemic Practice introduced in Children's Social Care.	4th June 2015 No further action from the PM sub group
Low number of early intervention single assessment	Highlighted and referred to the Early Intervention Sub-group ongoing improvement action	Re-launch of the Early Intervention/Early Help strategy Review and further alignment of the Early Intervention Single Assessment under way - to be presented to CSCB on 4th June	4th December 2014 No further action from the performance sub-group
Supervision arrangements for front line safeguarding staff	Cross referenced with work undertaken by the Early Help sub-group on supervision standards – awaiting report back from the Early Help sub-group Further action flagged up for school safeguarding staff	Action has been taken by health to ensure that this is now in place for all staff groups	1st October 2015
Care leavers in suitable accommodation appear too high	Further cross agency challenge scheduled to take place	Challenge has led to review of the definition applied, which is now in line with the DfE.	6th August 2015
Low numbers of children with a disability with a child protection plan	Cross-referenced with the disability steering group, who are reviewing their census criteria to ensure improvements Further work under way with social workers to ensure disabilities are recognised and recorded		6th August 2015
Attendance at child protection conferences	Data has in the past been too poor to allow analysis – this is being addressed Work to be cross referenced against ACPO guidance and outcome of HMIC Child Protection Inspection Action Plan		6th August 2015

Appendix J: Young Advisors Annual Report

Written by Georgie from the Young Advisors in May 2015:

In August 2014, 7 newly recruited young people aged between 13 – 15 years old were trained as Young Advisors to Calderdale Safeguarding Children Board. The group of Young Advisors are employed by the board to make sure that children and young people are being represented. It's important that young people are part of the board and able to have their say on issues that occur and are meaningful to children and young people.

The Young Advisors meet monthly in the Town Hall from 4pm – 6pm.

We have done many things such as…

- Given our views along with other Calderdale young people on the new Calderdale Safeguarding Children Board website. As a result changes were made to the website
- Met with Ofsted and spoke about what we as Young Advisors have done so far and what we have planned
- Meet with Allison Waddell Calderdale Safeguarding Children Board Learning and Improvement Officer monthly who is our link to the board
- Met with the Head of Service Commissioning and Partnerships and Calderdale Safeguarding Children Board Business and Quality Assurance Manager to discuss what our work plan is for the next 12 months
- Designed a questionnaire on Child Sexual Exploitation and gave it out to 300 young people in Calderdale, with this being current in the news. We have written a report for the board on the findings (Editors note: *The Young Advisors received 270 responses! The finding of this will be scrutinised by the Proactive and Responsive Sub Group and feature in the 2015-2016 Annual Report)*
- Planned a work programme
- Undertaken training on what Calderdale Safeguarding Children Board is and does
- Designed a questionnaire on Emotional Health and Well-Being and wrote a report on the findings which was given to the Calderdale Safeguarding Children Board (Editors note: *the findings were presented to the Board in June 2015 and the Communication and Engagement are taking forward the proposed recommendations. This will feature in the 2015-2016 Annual Report)*
- Gave opinions on Emotional Health and Well-Being websites for young people e.g. Childline
- Looked at documents ensuring that they are user friendly and jargon free so that they can be understood by everyone

Abhishek, Sufyan, Lucy, Joel, Jake, Maia Rose, Georgie. May 2015

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Calderdale Safeguarding Children Board