Appendix 1

NHS
Calderdale
Clinical Commissioning Group

Safeguarding Annual Report 2015-16

Version number:	1
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Date of the Report	1st April 2015 to 31st March 2016
Name of responsible director/ assistant director:	Penny Woodhead – Head of Quality
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Date of previous submission to the Board/ committee:	This is the first combined Children and Adults Safeguarding report submitted to Governing Body

CONTENTS

Acknowledgment

NHS Calderdale Clinical Commissioning Group (CCG) would like to take this opportunity to thank its partner agencies in working collaboratively in ensuring the agenda for both children's and adults safeguarding is meeting its statutory responsibilities in safeguarding vulnerable people in Calderdale between 2015/ 2016.

NHS Calderdale CCG would like to thank both the Children's and Adults Safeguarding Boards in driving its responsibility across Calderdale.

NHS Calderdale CCG would finally like to thank NHS England, the Yorkshire and Humber Safeguarding Network and other regional and national partners in helping drive the safeguarding priorities across Calderdale CCG's and Local Authorities to enable us all to learn lessons, share knowledge, skills and expertise for assurance purposes.

Declaration

The authors assert that NHS Calderdale CCG Safeguarding Annual Report has not been published before and is a true record of the work that has been undertaken during 2015 / 2016. NHS Calderdale CCG is not responsible for the content of the external links included in this report.

FOREWORD

It is my pleasure to introduce the safeguarding adults and children annual report of the NHS Calderdale CCG for 2015-16. Safeguarding is fundamental to all the work of the CCG. This report provides assurance to the Governing Body that the CCG is fulfilling its statutory safeguarding responsibilities and demonstrates a strong commitment to safeguarding within the local communities.

The work of safeguarding adults and children from abuse and neglect is a never-ending process with an ever increasing agenda. The past few years have seen the linked agendas included in the work of the safeguarding team such as Female Genital Mutilation, Prevent (part of the government's anti-terrorism strategy), Human Trafficking and Modern Day Slavery.

There are robust governance and accountability arrangements within the Clinical Commissioning Group (CCG). This ensures that safeguarding is core to the business and there is continued commitment to the priorities of the safeguarding agenda from executive level and throughout all CCG employees.

Whilst the adults and children's safeguarding priorities and work can be very different, there are also many areas that overlap. When overlap occurs the CCG Designated Nurses and Named Nurses who are part of the Shared Safeguarding Team complete the work jointly. So this year the previously separate adults and children's annual reports have been combined giving an overarching view of the safeguarding work.

Safeguarding is at the heart of everything we do in the CCG. In order to prevent abuse occurring and to help protect the most at risk people in our communities a partnership approach is essential. It is therefore crucial that all staff within the CCG, across all agencies work together with our communities to safeguard those at risk of abuse and neglect. This report describes the significant progress made towards this goal in 2015-16

I hope the report helps you to see the both challenges and the commitment of the CCG Safeguarding team to this agenda, and overall the report provides you with assurance that the CCG has been and continues to be engaged in this very important safeguarding work.

Penny Woodhead

Head of Quality

1.0 BACKGROUND

The twelve months from April 2015 to end of March 2016 has seen NHS Calderdale Clinical Commissioning Group (CCG) continue to ensure that the well-being and safety of children and adults at risk in Calderdale is a high priority.

NHS Calderdale CCG continues to work across the Local Authority, Calderdale Safeguarding Children and Adult's Boards, NHS England and local health providers to meet NHS Calderdale CCG business objectives.

Clinical Commissioning Groups (CCGs) are statutorily responsible for ensuring that the organisations from which they commission services provide a safe system that safeguards children and adults at risk of abuse or neglect. This includes specific responsibilities for Looked After Children and for supporting the Child Death Overview Process, to include sudden unexpected death in childhood (SUDIC). Local authorities have the same responsibilities in relation to the public health services that they commission.

The vision for safeguarding within NHS Calderdale CCG is to maintain robust, resilient and effective safeguarding services and to strengthen arrangements for safeguarding children and adults at risk across the Calderdale health and social care economy by working with all partner agencies.

2.0 INTRODUCTION

This report provides Calderdale CCG's Governing Body with an overview of safeguarding across health services in Calderdale during 2015/2016 and the forward plans for safeguarding. This is the first year the safeguarding annual reports for children and adults have been presented as a combined report. Previously separate Safeguarding Adults and Safeguarding Children annual reports have been provided to the CCG Governing Body; however the boundaries between safeguarding adults and children's priorities and work have become more interlinked. Therefore a combined report has been produced this year providing an overview of the work and activity undertaken by the CCG Safeguarding Team.

The report reviews the work across the year, giving assurance that the CCG has discharged its statutory responsibility to safeguard the welfare of children and adults across the health services it commissions. Additionally information is included about national changes and influences, and local developments and activity and how challenges to business continuity relating to safeguarding are being managed.

There is a distinction between health provider responsibilities and those of commissioners of healthcare, whose role includes the need to be assured of the safety and effectiveness of the services they have commissioned, that safeguarding adults principles along with those of the Mental Capacity Act (2005) and Deprivations of Liberties Safeguards (2009) and Prevent

priorities (part of the Government's plan Contest, which aims to tackle terrorism), are embedded within organisations.

Safeguarding children and adults remains a key priority for all NHS funded organisations and all healthcare professionals working in the NHS have a duty to ensure that the principles underpinning safeguarding are applied.

This report reviews and gives some highlights of work undertaken in the previous year by the CCG safeguarding team to monitor and work with commissioned providers, providing assurance that the CCG is actively engaged in discharging its responsibilities.

Although the report does include information regarding Looked After Children, a separate report has been authored under the current commissioning arrangements about how the health needs of this cohort of children and young people have been met.

2.1 Local Context

The Safeguarding Team are hosted by the Greater Huddersfield CCG and provide safeguarding services and support to the health economy in Calderdale. The Safeguarding Team includes: Head of Quality, Designated Nurses for Children and Adults, Named GP for Safeguarding Children and Adults and Safeguarding Advisor for Adults. The team is supported by a project support officer. The team have recruited a Named Nurse Safeguarding Children who commenced work on 7th March 2016.

The role of Designated Nurses is to provide clinical expertise and strategic leadership for the local health community. Designated Nurses provide a vital source of expert advice and support to the CCG, NHS England, the local authority, the Local Safeguarding Boards and other health professionals.

The Head of Quality reports to the Chief Officer and the Governing Body. The Chief Officer in the CCG holds overall accountability for safeguarding.

2.2 Statutory Responsibilities for safeguarding Children and Young People and Adults at Risk.

The Calderdale CCG is a statutory NHS body with a range of statutory duties, including safeguarding children and adults at risk. The Local Authority is the lead agency for children and adult safeguarding, with the Chief Officer of the NHS Calderdale CCG holding responsibility for safeguarding children and adults arrangements across the health economy.

NHS Calderdale CCG has a legal responsibility to ensure the needs of children and adults at risk of abuse or suffering abuse are addressed in all the work they undertake and commission on behalf of the people of Calderdale. The CCG works closely with providers and key partner organisations to ensure services are effective and that staff are able to meet

the needs of these at risk individuals.

Calderdale CCG has legal duties and responsibilities in line with the revised edition of Working Together to Safeguard Children (2015) which sets out expectations as to how these duties should be fulfilled. The Care Act (2014) provides the statutory framework for safeguarding adults at risk. Safeguarding Vulnerable People in the NHS - Accountability & Assurance Framework (2015) clearly sets out the safeguarding roles, duties and responsibilities of all organisations commissioning NHS health and social care. https://www.england.nhs.uk/wp-ontent/uploads/2015/07/safeguarding-accountability-assurance-framework.pdf

CCGs need to ensure the needs of children and adults at risk of abuse are addressed in all the work undertaken and commissioned on behalf of the people of Calderdale. The CCG needs to be assured that the agencies which they commission services from have effective safeguarding arrangements in place.

Calderdale CCG is required to have a Designated Doctor and Nurse for Safeguarding Children, a Looked after Children Designated Doctor and Nurse, a Paediatrician for Sudden Unexpected Death in Childhood (SUDIC), a Designated Nurse for Safeguarding Adults and a lead for the Mental Capacity Act (MCA). Calderdale CCG is compliant with this requirement: The Calderdale CCG has Designated Nurse Safeguarding Adults/lead for MCA, a Designated Nurse for Children and a Named GP. The Designated Doctor for Safeguarding Children and the Designated Doctor and Nurse for Children Looked After and SUDIC Paediatrician are commissioned through a service level agreement from the Calderdale and Huddersfield NHS Foundation Trust. Safeguarding Vulnerable People in the NHS - Accountability & Assurance Framework (2015) makes recommendations as to the whole time equivalent staff numbers for each role and Calderdale CCG meets these requirements.

2.3 Safeguarding Governance

Clinical Commissioning Groups (CCGs) are membership organisations that bring together general practices to commission services for their registered populations and unregistered patients who live in their area. CCGs are responsible for commissioning most hospital and community healthcare services.

In this regard Calderdale's arrangements for safeguarding children and adults are well established.

2.4 Delivering Assurance

Whilst the responsibility for coordinating safeguarding arrangements across Calderdale lies with Calderdale Metropolitan Borough Council (CMBC), effective safeguarding is based on a multi-agency approach. NHS

Calderdale CCG is a willing multi-agency safeguarding partner and has robust governance arrangements in place to ensure that its own safeguarding structures and processes are effective; and that the agencies from which the CCG commission services meet the required standards.

The Head of Quality remains the Executive Lead for Safeguarding and continues to take an active role in both the Local Safeguarding Children's Boards and the Local Safeguarding Adults Board.

It should be recognised that the Designated Nurses undertake a leadership role in the whole health economy role, and also work with the local safeguarding boards and CMBC to support safeguarding work, details of which can be seen throughout this report, providing further assurance that the CCG is fulfilling its responsibilities.

The Designated Nurses role is to work across the local health system to support other professionals in their agencies on all aspects of safeguarding and child and adult protection. Designated Nurses are clinical experts and strategic leaders for safeguarding and as such are a vital source of advice and support to health commissioners in CCGs, the local authority and NHS England, other health professionals in provider organisations, quality surveillance groups (QSG), regulators, the LSCB/SAB and the Health and Wellbeing Board.

Internal governance for reporting safeguarding children's and adults national and local developments and key priorities has continued throughout the previous year. Quarterly safeguarding reports have been provided to the CCG Quality Committee that provided an overview of the work and activity being undertaken throughout the year and explored the key changes and describing the implications for the CCG.

2.5 Population Overview and Deprivation

Calderdale is one of the smallest districts in England in terms of population. The estimated population of Calderdale (mid 2014) was **207,376.** The Indices of Deprivation (2014) ranked Calderdale as the 105th most deprived district in England with an estimated 10,050 children and young people growing up in poverty.

Child and Maternal Health Observatory (ChiMat) data indicates that 98.5% of Calderdale residents are registered with a GP practice that is a member of NHS Calderdale CCG.

2.6 Key Development and Achievements during 2015 - 16

Calderdale CCG has remained committed to the work around safeguarding during this reporting period. This report will highlight some of these key developments and achievements.

2.6.1 Designated Nurse Safeguarding Adults

In June 2015 the CCG saw the retirement of Ann McPherson the Designated Professional Safeguarding Adults. Recruitment took place and in September 2015 Luke Turnbull, Designated Nurse for Safeguarding Adults joined the team with safeguarding adults priorities agreed. Broadly speaking the 4 priority areas for 2015-16 are:

- Continue to ensure that all commissioners are fulfilling their statutory obligations to safeguard the people of Calderdale from abuse and neglect and protect individual human rights.
- Assist with the development of the Calderdale Safeguarding Adults Board in line with responsibilities in the Care Act, 2014.
- Ensure that the required Deprivation of Liberty applications are made to the Court of Protection for those patients who are funded by Continuing Healthcare
- Further engagement with GP practices in order to fully embed the Mental Capacity Act in practice, further develop safeguarding assurance and provide expert safeguarding advice in complex cases

2.6.2 Named GP for Adult Safeguarding

In January 2016 Dr Paul Glover, the Named GP Safeguarding Children extended his role to become the Named GP for Safeguarding Adults.

This role provides expert safeguarding support to GPs in Calderdale including developing lead safeguarding GPs, planning training, producing Individual Management Reports for Safeguarding Adult Reviews and Domestic Homicide Reviews and provides expert advice as required to the Calderdale Safeguarding Adults Board.

2.6.3 Named Nurse for Safeguarding Children

Additional capacity for the safeguarding team to support the children's side was agreed at Senior Management Team (SMT) and the recruitment of a Named Nurse for Safeguarding Children took place. Sarah Booth an experienced Paediatric Liaison Nurse from Barnsley has been appointed and commenced work on the 7th March 2016.

Sarah's role will be to work across the shared safeguarding team in Calderdale and Kirklees and support the Designated Nurse Safeguarding Children with the, ever-increasing, work within the safeguarding children agenda e.g. delivery of training and attending/working with multi-agency partners on some of the CSCB Sub Groups.

2.6.4 Commissioning Domestic Abuse Health Service

The CCG has supported a business case to commission a dedicated health domestic abuse service. The work was led by the Designated Nurse Safeguarding Children.

The aim of this service is to improve the outcomes for victims of domestic violence and abuse by being the link to signposting to advice and support for GPs, providing training for GPs and A&E staff, being the interface for all health providers within the DVA Hub in Calderdale and collating information on the prevalence of attendance at A&E with issues relating to DVA and monitor outcomes for victims of DVA.

There are three main aspects to the service:

- Deliver training advice and support to Calderdale GPs and CRH A&E staff to help them identify and refer individuals at an early stage in order to avoid escalation, to reduce repeat victimisation and help to prevent domestic abuse related homicides and suicides.
- Improve reporting systems of A&E attendance with regard to DVA so accurate information can be gathered and outcomes monitored.
- Information gathering from all health providers to share within the Calderdale DV Hub and provide outcomes from the discussions back to the agencies/practitioners and attendance at all the Calderdale DV Hub meetings.

A review will be undertaken in December 2016 with regards to the future commissioning arrangements.

2.6.5 Multi-Agency Protocol for the Assessment of Bruising, Burns & Scalds in Non-Mobile Babies

The protocol has been developed by a multi-agency group of professionals led by Mid Yorkshire Hospitals NHS Foundation Trust following a serious case review in Kirklees. The protocol was presented to a joint Calderdale, Kirklees and Wakefield meeting and has been agreed by all partner agencies.

Bruising is the most common accidental injury experienced by children and research shows that the likelihood of a baby sustaining accidental bruising increases with increased mobility. The evidence suggests that it is extremely rare for a non-mobile baby, for example one that is not yet crawling, to sustain accidental bruising. Therefore all such bruising should be suspected by professionals to be an indicator of physical abuse and should be thoroughly investigated.

This protocol requires that all actual or suspected bruising, burns or scalds to babies who are not yet self-mobile should be subject to multi-agency

investigation in order to assess risk of harm. For this reason, any professional who identifies such an injury to a non-mobile baby is required to make a referral to the Children's Social Care, Referral and Response Service regardless of the explanation offered by parents or carers and regardless of the professional's own opinion about how the injury may have been caused.

The protocol was circulated to all GP Practices in Calderdale and is accessible on the CSCB Website via this link – http://www.calderdale-scb.org.uk/

2.6.6 Mental Capacity Act and Deprivation of Liberty Safeguards

A system has been agreed and set up for making Deprivation of Liberty applications to the Court of Protection for those people who lack the mental capacity to consent to their care and treatment arrangements which constitute a deprivation of liberty, in their best interests in community settings.

A CCG Mental Capacity Act Policy has been written and agreed.

Further training has been delivered to GPs and Continuing Healthcare staff to aid the implementation of the Acts and to create an empowering culture for individuals who lack capacity to make certain decisions.

2.6.7 Human Trafficking and Modern Day Slavery

On 3rd September the Designated Nurse Safeguarding Children attended a Human Trafficking Event facilitated by West Yorkshire Police. The event was attended by multi-agency professionals from across West Yorkshire who are, in some way, involved in Human Trafficking. The event was extremely useful and was very much a workshop rather than solely the opportunity to listen.

The meeting discussed the many issues with regard to Human Trafficking and Modern Slavery and the implications for all agencies. Including the Legislation which states that - **All Local Authorities are 'First Responders' and have a legal duty to report. If a victim presents at any Local Authority service they are responsible to refer.**

All legislation around Human Trafficking is telling us 'Safeguarding victims' is first and foremost. (See section 5.4)

2.6.8 CCG Safeguarding Policy

Calderdale Clinical Commissioning Group (CCG) has in place a Safeguarding Policy for safeguarding children and adults at risk which provides procedures and guidance for staff. In 2015/2016 this was updated to reflect the new NHS England accountability and assurance framework for

Safeguarding Vulnerable People in the NHS (2015), the Care Act (2014/5) and guidance issued from central government including Working Together 2015. It is in this one document that requirements in relation to the Mental Capacity Act and Prevent can also be found. A decision has been made to develop a stand-alone policy and guidance focusing on Prevent for 2016/2017.

Alongside the Safeguarding Policy the CCG has a number of policies which are particularly relevant to this area of work and include: - whistleblowing, complaints, information sharing and managing serious incidents.

2.6.9 Prevent

A focused approach to ensuring all CCG staff have accessed the appropriate Prevent training has been undertaken in the last year. Basic awareness for Prevent training has been delivered to CCG staff, and the CCG can declare itself compliant with the need for all CCG staff who require a full WRAP (Workshop to Raise Awareness of Prevent) have attended a WRAP session delivered by the Designated Nurse Safeguarding Adults.

2.6.10 NHS England Assurance visit

Preparation has been undertaken for an NHS England Safeguarding Assurance visit scheduled to take place during 2016. Prior to the visit the team completed a self-assessment template that was submitted to NHS England. The team will meet with NHS England to provide detailed evidence to demonstrate that the CCG is compliant with its safeguarding statutory responsibilities. The meeting is scheduled to take place in July 2016.

3.0 NATIONAL CONTEXT AND LEGISLATION

In response to national developments within safeguarding the agenda and activity has increased particularly during the last two years. New safeguarding subjects have been added to the agenda and there have been changes to the priorities of existing issues. Examples of these:-

- Child Sexual Exploitation (CSE),
- Female Genital Mutilation (FGM)
- Prevent
- Human Trafficking and Modern Slavery
- Forced Marriage
- Honour Based Violence
- Domestic Homicide Review (DHR). There has been an increase in the number of DHRs completed in which CCG Safeguarding Team engage.

Changes to NHS England structures and CCG commissioning arrangements.

3.1 **NHS England Accountability and Assurance Framework, Safeguarding Vulnerable People in the NHS (2015) -** In July 2015 the publication of NHS England Accountability and Assurance Framework, Safeguarding Vulnerable People in the NHS clarified the roles and responsibilities of commissioning arrangements setting out clear safeguarding roles, duties and responsibilities of all organisations commissioning NHS health and social care. The framework has been refreshed in partnership with colleagues from across the health and social care system, the Department of Health (DH) and the Department for Education (DfE); particularly recognising that the new responsibilities set out in the Care Act 2014 came into force on 1st April 2015.

The CCG is able to provide assurance to the Governing Body that they are in a position to meet the requirements of the NHS England Framework. Of specific note:-

Key specific point	CCG action/assurance/process
Provide the services of Designated Nurses and Doctors and Safeguarding Adult Leads for the NHS to have oversight of the whole health economy.	There is a CCG safeguarding Team in place with Designated Nurses and Doctors in place. The team undertakes the safeguarding work and activity detailed within the Framework with the support of the Head of Quality.
Identify a clear line of accountability for safeguarding, properly reflected in the CCG governance arrangements,	Internal Governance processes are established via quarterly and annual CCG reports to the CCG.

and be able to demonstrate that their Designated Team is embedded in the clinical decision making of the organisation, with the authority to work within local health economies.	
Establish effect inter-agency working with local authorities, the police and third sector organisations which includes appropriate arrangements to cooperate with local authorities in the operation of LSCBs, SABs and Health and Wellbeing Boards.	The Safeguarding Team are engaged on a regional level with NHS England and others - please section 5 for details
Clear CCG policies setting out their commitment, and approach to safeguarding including safe recruitment practices and arrangements for dealing with allegations against people who work with children and adults as appropriate.	The last year has seen the revision and updating of the CCG Combined Safeguarding Children and Adults Policy, and the development of some new other related policies by the team, including a policy for Mental Capacity Act and Deprivations of Liberties Safeguards, Prevent, and Domestic Abuse.
Assure themselves that the organisations from which they commission have effective safeguarding arrangements in place including safeguarding leadership (through named doctors, safeguarding leads and a lead for MCA), training, effective supervision arrangements and effective safeguarding Policies. This includes within GP Practices where co-commissioning arrangements are in place.	The CCG gains assurance from commissioned health providers throughout the year via reports and provider contract monitoring and the implementation of required safeguarding standards Section 4.6 provides a review of the GP Safeguarding Standards and the work to support and engage GP Practices
Key specific point	**CCG action/processes**
Establish effect inter-agency working with local authorities, the police and third sector organisations which includes appropriate arrangements to cooperate with local authorities in the operation of LSCBs, SABs and Health and Wellbeing Boards.	Throughout this report details are provided of the engagement work undertaken with all partners, with Local Safeguarding Boards and on a regional and national basis. The CCG has committed financial support for the Safeguarding Boards.

3.2 Jimmy Savile

In July 2015 a letter was issued by Hilary Garratt Director of Nursing – Nursing Division NHS England with a briefing note relating to Kate Lampard's *'Themes and Lessons Learnt report from NHS investigations into matters relating to Jimmy Savile'*. The report built on the findings from 44 NHS investigations into allegations of abuse by Savile on NHS premises. The report was published in February 2015, and can be accessed via the link below:-

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/407209/KL_lessons_learned_report_FINAL.pdf

There were 9 recommendations directly relating to NHS Provider Trusts arising out of the report. These addressed the key findings of the report, which related to:-

- Security and access arrangements, including celebrity and VIP access.
- The role and management of volunteers.
- Safeguarding assurance, capability, governance and training.
- Raising complaints and concerns by staff and patients.
- Fundraising and charity governance.
- Observance of due process and good governance.

In order to provide assurance that individual Trusts had reviewed their practice against these recommendations and taken action to comply, NHS Trusts were required by Monitor to submit an action plan by 15 June 2015 indicating any issues they had identified within their Trust, planned action, progress to date and the due date of completion.

Locala, CHFT and SWYPFT have submitted action plans against the 9 recommendations and these have been reviewed by the Commissioner/Provider Quality Boards and evidence scrutinised.

In November 2015 the DoH published the report '*Jimmy Savile NHS investigations:*

Update on the themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile'. This report provides a summary of actions taken in response to the 13 recommendations for the NHS, Department of Health and wider government. All NHS trusts and foundation trusts have responded and those responses have been collated by Monitor and NHS Trust Development Authority. The report can be accessed via the link below:-

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/480059/lessons-response.pdf

The conclusion of the report is that progress has been made against all recommendations and the majority of Trusts responding had already taken action on the recommendations or were in the process of doing so.

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3.3 **Independent Inquiry into Child Sexual Abuse (2015) -** In July 2015 Justice Lowell Goddard opened her Inquiry looking into the extent to which institutions and organisations in England and Wales have taken seriously their responsibility to protect children. The inquiry is to investigate a wide range of institutions including:

- local authorities;
- the police;
- the Crown Prosecution Service;
- the Immigration Service;
- the BBC;
- the Armed Forces;
- schools;
- hospitals;
- children's homes;
- churches, mosques and other religious organisations;
- charities and voluntary organisations;
- regulators; and other public and private institutions.

The inquiry will publish interim reports as it proceeds but is not due to conclude until 2025.

In December David Cameron made a series of announcements relating to changes to safeguarding agencies. He announced that poorly performing children's services risked being taken over by high-performing authorities, experts or charities.

3.3 **The Care Act 2014 -** The Care Act was implemented on the 1st April 2015, delivering key elements of the Government's response to the Francis Inquiry, increasing transparency and openness and helping drive up the quality of care across the system. The Act brought some changes to the Safeguarding Adults agenda and for the first time has been spelt out in the law that local authorities must make enquires, or cause enquiries, if they believe an adult is, or is at risk, of being abused or neglected. (see Appendix C for details of changes to the Safeguarding section of the Care Act)

Perhaps even more importantly the Care Act (2014) brought safeguarding adults onto a statutory footing, with Clinical Commissioning Groups identified as key statutory partners, together with the local authority and police.

The Government published updated statutory guidance on the Safeguarding Adults part of the Care Act 2015 in February 2016. The guidance has not changed significantly and the CCG can demonstrate it is able to meet the requirements. The implications for the CCG and further detail can be accessed via the link below:-

https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

3.4 **Mental Capacity Act (2005) and Deprivations of Liberties Safeguards (2009) -** In the past year there has been continued national focus on embedding the Mental Capacity Act. A new National Mental Capacity Act Forum was set up led by Baroness Finlay in 2015, and in advertised a Mental Capacity Action day in 2016 to:-

- Profile current best practice from around England and Wales
- Identify MCA improvement priorities for the coming year
- Gather commitments from attendees for projects and work to improve MCA implementation at the front-line.

Health and social care leads were invited to submit details of work that had been undertaken locally to further develop and embed MCA and DoLS. The Designated Nurse submitted details of work, including MCA requirements within the Safeguarding Standards developed for Provider organisations (and presented in the quarter 2 report to the committee), and successfully secured attendance at the action day event on the 15th March. The presentations from the day can be viewed on the National MCA Directory on the link below:
http://www.scie.org.uk/mca-directory/forum/

The Law Commission has commenced a review of the Deprivation of Liberty Safeguards (DoLS) following the House of Lords report describing DoLS as unfit for purpose. The aim of the report is to overhaul the DoLS system in order to make the process more responsive and cost effective whilst continuing to protect the human rights of some of the most vulnerable members of society. The after extensive consultation, in which the Designated Nurse continues to be involved with, a report, is due at the end of 2016. It is expected that changes to legislation may take a further 2 years.

Key Success:

- The CCG Combined Safeguarding Children's and Adults at Risk Policy has been amended to be in line with the Care Act and to reflect other new national legislation. The policy was approved in June 2015 and includes Safeguarding standards for commissioned providers and GP Practices
- A bespoke CCG MCA DoLS Policy was written and approved is available on the CCG intranet for staff to access

3.5 **Wood report: Review of the role and functions of Local Safeguarding Children Boards (A. Wood, March 2016) -** The Secretary of State for Education, the Rt Hon Nicky Morgan MP, and the Minister of State for Children and Families, Edward Timpson MP, asked Alan Wood to lead a fundamental review of the role and functions of Local Safeguarding Children Boards (LSCBs) within the context of local strategic multi-agency working. This was to include;

- Multi-agency arrangements for protecting children
- The child death review process
- Consideration of how the intended centralisation of serious case reviews (SCRs) will work at local level.

The review began in the first week of January 2016 and the report presented on 31st March 2016.

The report sets out a new framework for improving the organisation and delivery of multi-agency arrangements to protect and safeguard children. It contains recommendations for government to consider. These recommendations suggest that appropriate steps should be taken to recast the statutory framework that underpins the model of Local Safeguarding Children Boards (LSCBs), Serious Case Reviews (SCRs) and Child Death Overview Panels (CDOPs). "

There have also been two other related national consultations, one proposing a new definition of Child Sexual Exploitation and other seeking views on protecting children from seeing pornographic material online. Both of these consultations report in May 2016 and are likely to result in an update to the statutory guidance 'Working Together to Safeguard and Promote the Wellbeing of Children' later in 2016.

4.0 CALDERDALE'S STRATEGIC APPROACH TO SAFEGUARDING

Calderdale CCG is required to provide assurance that safeguarding activity within all commissioned services meets national safeguarding standards and demonstrates a model of continuous improvement. This is reflected in local policy and procedure and reflected in the CCG governance framework and delivery plan.

Commissioning and planning of most health services are carried out by Calderdale CCG and the local authority

- Acute hospital services and many community health services are provided by Calderdale & Huddersfield Foundation Trust (CHFT).

- Adult mental health services are provided by South & West Yorkshire Partnerships Foundation Trust (SWYPFT)

- Child and adolescent mental health services (CAMHS) are provided by South & West Yorkshire Partnerships Foundation Trust (SWYPFT) for Tier 3, and Tier 2 is provided by Northpoint Wellbeing Limited

- Individually commissioned placements through Continuing Healthcare in care homes, own homes and Supported Living placements

- Smaller community based projects provided by voluntary sector organisations

Nationally, the commissioning arrangements for School Nursing Services transferred to Public Health (Local Authority) in April 2013; from October 2015 Public Health became responsible for the commissioning of Health Visiting Services.

- Health visitor services are provided by Calderdale & Huddersfield Foundation Trust (CHFT).

- School nurse services are provided by Locala Community Partnerships.

- Contraception and Sexual Health Services (CASH) are commissioned by Public Health (local authority) and provided by CHFT.

- Child substance misuse services are commissioned by Public Health (local authority) and provided by Branching Out – Lifeline Project

- Adult substance misuse services are commissioned by Public Health (local authority) and provided by Developing Initiatives for Support in

the Community (DISC).

Contractual governance ensures that compliance with core safeguarding standards is in place and assurances given by providers. Contractual specifications for all providers are included within the schedule of all contracts and actively monitored.

Calderdale CCG safeguarding team receive safeguarding assurance from CHFT and SWYPFT through regular attendance at their Safeguarding Committees, an annual safeguarding self-assessment, though contract monitoring meetings and regular monitoring meetings between the Designated Nurses and Head of Safeguarding at CHFT and Safeguarding Team at SWYPFT. The Designated Nurses also provide safeguarding supervision to members of the CHFT and SWYPFT safeguarding team as well as expert advice and support on an as required basis.

The Designated Nurses from the shared team across Calderdale and Kirklees share the attendance at provider safeguarding committees. The advantage of this approach is that more focus and engagement can be delivered with each committee by the Designated Team that is attending:-

- Calderdale and Huddersfield Foundation Trust: Held bi-monthly, the meeting is attended by Luke Turnbull and Gill Poyser-Young.
- South West Yorkshire Partnership Foundation Trust: attended by Luke Turnbull and Gill Poyser-Young.
- Locala: Held bi-monthly, the meeting is attended by Christina Fairhead and Clare Robinson

Feedback of information and headlines from the committees is established within the CCG team to ensure that all are aware of the key headlines and issues and to deliver assurance that safeguarding is of the highest priority within commissioned providers.

Monitoring of Serious Case Review, Adult Review and Domestic Homicide Review recommendations is done collaboratively with the Safeguarding Adult and Children Boards and Community Safety Partnership to ensure external scrutiny.

4.1 Provider Safeguarding Standards

At the end of the previous reporting year and in view of the new national and legislative changes the Designated Nurses for Safeguarding Adults from CCG's across Yorkshire and the Humber met to review and re-define a previously developed safeguarding adults standards for commissioned providers. This was approved by the CCG Quality Committee in June 2015.

The document continues to take the form of a self–assessment tool for commissioned providers to complete/self-declare compliance via a RAG rating process and return the document to the CCG Safeguarding Team.

The document was implemented with the three main health commissioned providers for which the CCG's across Calderdale and Kirklees hold lead commissioner responsibilities (SWYPFT, CHFT and Locala) in a staged approach at the end of the reporting year. Once all providers have returned the self-assessment document the Designated Nurses are meeting with each of the Heads of Safeguarding from the providers to review the document, discuss the assurance evidence presented and agree the RAG ratings/action plan for each. The overall goal of the standards is two-fold:-

- To provide assurance to the CCG's as commissioners of the provider services
- To support the provider with any shared knowledge, skills and information that might be available in order to improve practice.

Updates will be provided to the CCG Quality Committees via quarterly safeguarding reports and an overview of the assurance exercise will be delivered in the annual report next year's annual report.

4.2 Calderdale and Huddersfield NHS Foundation Trust (CHFT)

Calderdale and Huddersfield NHS Foundation Trust provides acute and community health services. The trust serves two populations; Greater Huddersfield which has a population of 248,000 people and Calderdale with a population of 205,300 people. The Trust operates acute services from two main hospitals - Calderdale Royal Hospital and Huddersfield Royal Infirmary In total; the Trust has approximately 824 beds and 5,831 staff.

Accountability lies with the Director of Nursing, and there is delegated responsibility to the Deputy Director of Nursing, who is supported by the Head of Safeguarding. There are two Named Nurses for Safeguarding Children, one Named Nurse Safeguarding Adults and an MCA DoLS advisor, a Named Midwife, and a Paediatric Liaison Sister within the Trust.

Safeguarding Adults and Children remains an integral aspect of patient care at CHFT, and requires services to work effectively together and across boundaries to prevent harm and intervene when harm, neglect, or abuse is suspected. A Trust Inspection from CQC in March 2016 afforded CHFT the opportunity to critically review safeguarding procedures and practices, highlighting areas of good practice, as well as those requiring development or improvement.

Internal lines of accountability and structures within the Trust have been reviewed to support both the safeguarding adult and children's agendas to enable a clearer process for the safeguarding committee to actively support

and seek assurances from the divisions and departments. Work has also been undertaken to review the safeguarding structure and committee functions to promote inclusion of all divisions and departments. The CHFT safeguarding team continues to work closely with the risk department to provide advice and support in relation to complaints and incidents where safeguarding concerns have been identified. Further governance work is ongoing in engaging with divisions ensuring safeguarding continues to be a priority, and attendance at Divisional Patient Safety and Quality Boards is ongoing.

4.2.1 Safeguarding training - is mandatory for all staff depending on their role and responsibility within the Trust and contact with adults and children. A significant piece of work has taken place this year that has reviewed the different levels of training in line with the Intercollegiate document (2014) for safeguarding children and the draft intercollegiate document for safeguarding adults.

Comparative figures prior to the review of the staff groups training up to Mid-March 2016; compliance is:

- Level 1 training figures have gone up from 66% at the end of quarter 3 to 72.6%
- Level 2 was at 53.2% and is now 47.3% (adults) and 50.49 % (children). This training is now delivered via eLearning in order to improve compliance.
- Level 3 Adults – has never been captured before and now at 11.54%. This target group is under review and reconsideration. Updated figures will be provided once completed.
- Level 3 Children was 64% and is now 41.55%. This target group is also under review and updated figures will be provided once completed.

4.2.2 PREVENT - is a one off training session that can be delivered in any organisation as long as it is the WRAP training advised by NHS England. New staff do not need to complete this if they can produce evidence of previous attendance. Prevent figures are increasing each month, previously at 51.4% and is now 55.35% the target is 85% before December 2016. Additional sessions have been planned for the year.

4.2.3 Supervision - Both individual and group supervision has been developed further and uptake is closely monitored. Target groups have been established identifying the type and frequency of supervision. The uptake for safeguarding supervision is being closely monitored by the Trust.

4.2.4 Communication and Information sharing - The health visiting team have established strong links with Early Years providers such as children's centres and nurseries in Calderdale. Every Early Years provider has a named health visitor or child development worker as a single point of contact. This makes the health visitor service more accessible and

responsive so they are able to offer targeted early help to children with emerging needs that will help to improve their outcomes and aid school readiness.

GP practices benefit from having a named link health visitor who regularly attends practice meetings to discuss vulnerable children, young people and families. The exchange of information between these services is contributing positively to the identification of emerging concerns and initiation of support for vulnerable children, young people and families. Review of child records demonstrated that when they discuss the child at a GP practice meeting health visitors record the actions agreed and resulting outcomes in the child's notes. This joined up approach helps to safeguard children and young people by ensuring all practitioners are aware of actions they should be taking and can take account of current concerns during consultations.

4.2.5 Child Protection Information Sharing Project

The Child Protection – Information Sharing (CP-IS) project is an NHS England sponsored work programme dedicated to developing an information sharing solution that will deliver a higher level of protection to children who visit NHS unscheduled care settings. Calderdale and Huddersfield NHS Foundation Trust were within the first phase of the role out of CP-IS. Due to the trust's involvement with the process the trust was in attendance at the first National CP-IS Conference as guest speakers, having been recognised as an exemplar site.

The system works by connecting local authorities' child protection social care IT systems with those used by staff in NHS unscheduled care settings. The information sharing focuses on three specific categories of child:

- Those with a child protection plan
- Those with looked after child status (children with full and interim care orders and voluntary care agreements)
- Pregnant women whose unborn child has a pre-birth child protection plan

Data is being collated as to the effectiveness of the CP-IS and will be shared at the Trust Safeguarding Committee..

4.3 South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) continues to prioritise the safety of all children and adults at risk who are or whose parents or carers are in receipt of services. The safeguarding team ensure SWYPFT meets its statutory requirements outlined in Working Together 2015, The Care Act 2014 and the Mental Capacity Act 2005.

Accountability lies with the Executive Director of Nursing, Clinical Governance and Safety and there is delegated responsibility to the Deputy Director of Nursing, Clinical Governance and Safety who is supported by two Assistant Directors, two Named Nurses for Safeguarding Children within the Trust, one who works Trust wide across mental health and learning disability services both adult and children's services and the second who works within the Barnsley locality for community services. SWYPFT practice area covers four Local Safeguarding Children and Adult Board's and are supported by the Director, Deputy or Assistant Director and subgroups are attended by the named nurses with support from the safeguarding children nurse advisors. The Designated and Named Professionals support the LSCB and are accountable to Children's Trust arrangements and the Trust Board via Sub groups.

Two regulatory inspections by the Care Quality Commission (CQC), a themed inspection in Wakefield in November 2015 and a Trust Inspection in March 2016 afforded SWYPFT the opportunity to critically review safeguarding procedures and practices, highlighting areas of good practice, as well as those requiring development or improvement.

4.3.1 Safeguarding Training

Safeguarding training compliance rates across SWYPFT (target 80%)

Training level	Adult safeguarding	Children's Safeguarding
Level 1	90%	90%
Level 2	89%	83%
Level 3	N/A	82%

4.3.2 Safeguarding Supervision

All staff are well supported with safeguarding supervision delivered through a variety of approaches. This includes quarterly, group safeguarding supervision, facilitated by the trust's safeguarding team. Data is collated and presented at the Trust safeguarding operational group attended by the Designated Nurses.

Additionally staff receive dedicated one-to-one supervision sessions where safeguarding is a standing agenda item and particular cases are reviewed to reflect or guide decision making and offer pastoral support. The safeguarding team also provide case specific supervision to practitioners or teams for particularly difficult cases.

4.4 LOCALA

On the 1st April 2015 LOCALA were awarded the contract to deliver school nursing services within Calderdale by the Local Authority Public Health Team.

School nursing provision in Calderdale is focused on pathways and targeted support for school aged children and young people. The introduction of a duty role ensures children, young people and their families have good access to a service that is responsive to their needs and has reduced the numbers of children waiting for support. The duty worker can deliver, where appropriate, a brief intervention following an initial referral to the duty triage team.

The school nursing service recognises the need to strengthen their operational links and ongoing communication with GP practices and Locala have focused on this since January 2016.

The school nursing service is developing ways to make the team more visible to schools and young people following the service specification which saw the removal of school nurses drop-ins. They have consulted with service users and are considering alternative ways to reach children and young people through the use of electronic referral forms, social media and apps for access to the service or for advice and support. Being visible, accessible and confidential is important to children and young people as outlined by the British Youth Council (2011) and helps to identify opportunities to intervene early to improve the health and wellbeing of children and young people.

4.4.1 Safeguarding Training

Locala are able to demonstrate compliance with the Intercollegiate Framework for safeguarding training and all school nurses are up to date with mandatory level 3 training and have demonstrated good engagement with the CSCB multi-agency training on offer.

4.4.2 Safeguarding supervision

Safeguarding supervision data – target is 90%

Quarter	Q1	Q2	Q3	Q4
Number Eligible	12	12	12	11
Number attended	11	12	12	10
Compliance %	92%	100%	100%	91%

4.5 Yorkshire Ambulance Service (YAS)

NHS Wakefield CCG are the lead commissioners for YAS and there are communication mechanisms for safeguarding performance issues

established between Wakefield and Calderdale CCGs.

A Memorandum of Understanding has been agreed between the Calderdale Children's and Adults Safeguarding Boards and YAS to ensure that YAS is represented on each board and is kept informed of any safeguarding issues which require YAS to take to action.

4.6 General Practitioner Services (GP)

CCGs have a duty to support improvements in the quality of primary medical care (NHS England Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework 2015).

On the 1st April 2015 the CCG took over responsibility for the commissioning of primary care GP services. The CCG now has full delegated responsibility for contractual arrangements and has implemented a cycle of GP engagement.

The CCG Safeguarding Team have continued to communicate safeguarding updates with General Practice in Calderdale throughout the previous year. This has included:-

- Continued provision of contact details for safeguarding specialist roles i.e. Designated Nurse, Designated Doctor and Named GP to all independent contractors.
- Advice and support - The CCG Safeguarding Team are always available during office hours to provide advice, information and support to whoever requires this. The team contact numbers are readily available on the CCG website and intranet and are re-sent to all practices when the contact leaflet is updated.
- Named GP newsletters providing regular updates on national and local issues
- Briefing and links are included on a regular basis in the CCG electronic newsletter 'Members Connect'

4.6.1 GP Safeguarding Leads Meetings

A quarterly GP safeguarding leads meeting commenced in 2015-16. All GP practices in Calderdale now have a nominated GP safeguarding lead who is invited to attend the meetings. The meetings aim to explore safeguarding and related issues and to share initiatives, best practice and opportunities, in order to develop the safeguarding adult's agenda within Calderdale, for the good of children and adults at risk of abuse.

These safeguarding leads provide a named contact form the CCG safeguarding team to communicate with. GP safeguarding leads have a higher level of knowledge and skills in order to provide safeguarding advice and updates to other staff with their practice.

4.6.2 GP Safeguarding Children and Adults Standards

Two years ago NHS England developed and circulated a safeguarding self-assessment tool for General Practices. The responses were collated providing assurance to NHS England that practices were meeting their safeguarding responsibilities or had identified areas of work required to address deficits.

To reflect recent safeguarding legislation the safeguarding team have further developed this tool and, earlier this year and reissued them The completion of the GP Standards serves two purposes in that;

i. The collated responses will give the CCG a degree of assurance that practices are meeting their safeguarding responsibilities and

ii. The responses will enable the safeguarding team to better understand the areas in which practices need safeguarding support, guidance or training and to plan accordingly.

Practices that had completed the standards prior to their CQC Inspection visit have reported to the Designated Nurses that the process of completing the standards was useful preparation for the inspection and also provided evidence of their safeguarding assurance.

The safeguarding team has developed a GP safeguarding database which collates information from a variety of sources, including CQC ratings and the outcomes of the GP Safeguarding Standards, to monitor assurance and progress and identify any issues that require support from the safeguarding team.

Key Success:

- All GP practices now have a named safeguarding lead
- GP safeguarding leads meetings are established
- Safeguarding standards for GP practices agreed

4.7 CCG Mandatory Training

There are a number of documents which influence the safeguarding training requirements for staff. In addition to multi-agency guidance in 'Working Together to Safeguard Children' (2015), there are three documents which are specifically aimed at providing a safeguarding training framework for health staff. These are:-

1. Safeguarding Children and Young People: roles and competences for health care staff Intercollegiate document third edition: March 2014
   https://www.rcoa.ac.uk/system/files/PUB-SAFEGUARDING-2014_0.pdf

2. NHSE - Safeguarding Adults: role and competencies for health care staff. (Awaiting Publication)
3. NHSE Prevent: training and competencies framework**.** **https://www.england.nhs.uk/wp-content/uploads/2015/02/train-competnc-frmwrk.pdf**

The CCG is required to ensure that all staff have undertaken safeguarding training in accordance with requirements for their role and responsibilities.

Safeguarding children training level 1 Elearning 'An Awareness of Child Abuse & Neglect' and level 1 Elearning 'Basic Awareness Safeguarding Adults' is part of the CCG the mandatory training programme. The training programme includes all CCG employed staff regardless of their role, which includes governing body members

Previously the Designated Nurses had worked within the CCG to agree staff training requirements, according to role, with workforce development staff to ensure that the correct level of training required is assigned to each person's 'Electronic Staff Record (ESR). This allows the CCG to reliably monitor staff compliance with training requirements.

A bespoke training package for governing body members has been developed in compliance with the specific requirements within the safeguarding children intercollegiate document. The last training session was delivered in November 2014 and currently being arranged for later in 2016. The mandatory requirement is three yearly.

At the end March 2016 recorded compliance for safeguarding training is:

Training Required	Staff	Governing Body
Safeguarding Children	60%	67%
Safeguarding Adults	59%	67%
Prevent	100%	

A CCG Safeguarding Training Strategy is currently under development but cannot be completed until the Safeguarding Intercollegiate Document for adult safeguarding has been re-published. This is anticipated to be December 2016.

4.8 **Safer Recruitment** The CCG received human resources support from the commissioning support unit (CSU) in 2015-16. There is a recruitment policy in place which is due for revision. Pre-employment checks are carried out as appropriate and those involved in recruitment have been appropriately trained to undertake this role.

4.9 Incident and Risk Management

The CCG has a number of different systems which record incidents including STEIS and Datix. All incidents are reviewed by the CCG Quality Team.

Safeguarding areas of risk are recorded on the CCG Risk register at the end of the reporting period of March 2016 there were no risks identified.

4.10 Listening to Children and Adults at Risk

The CCG has joint commissioning arrangements with the Local Authority for children's commissioning and events have been held to obtain service user feedback in a number of areas including the development of Children Looked After Service Specification and the rec-commissioning of CAMHS.

In January 2016 the Designated Nurse for Adult Safeguarding delivered safeguarding training to the Disability Partnership Calderdale. It was clear from this event that many service users had misconceptions about the role of safeguarding and were concerned that safeguarding processes resulted in adults at risk having actions imposed rather than feeling there was a supportive and collaborative approach to adult protection.

The Calderdale Safeguarding Adults Board (CSAB) has prioritised ensuring that Safeguarding becomes takes a more individualised approach to adult protection where decisions are made by the person themselves. The CSAB has also prioritised increasing the voice of adults at risk on the Board and its subgroups.

5.0 ENGAGEMENT AND PARTNERSHIP WORKING

Safeguarding is most effectively delivered through multi-agency arrangements where partners work collaboratively to achieve a shared vision. The Calderdale Safeguarding Children Board (CSCB), the Calderdale Safeguarding Adults Board (CSAB) are the primary Boards that scrutinise multi-agency safeguarding arrangements.

Other key strategic partnership meetings include the Health and Wellbeing Board, Calderdale Community Safety Partnership (CSP) and the Children and Young Peoples Partnership Executive. In addition to these there are a number of operational meetings which focus on specific issues and include Multi-Agency Public Protection Arrangements (MAPPA) for high risk offenders and Multi-Agency Risk Assessment Conferencing (MARAC) for high risk victims of domestic abuse.

Calderdale CCG is represented at senior level on the CSCB/CSAB and their associated sub groups as well as the other board meetings. Attendance at operational meetings is on a needs led basis.

A full list of local and strategic groups can be found at Appendix B

5.1 NHS England Sub Groups of the National Safeguarding Steering Group

Attended by the Designated Nurses.

5.1.1 Yorkshire Region Safeguarding Network

The first meeting of the newly formed Yorkshire Regional Safeguarding Network meeting facilitated and led by NHS England, was held in July 2015. The network aims to provide an expert, collaborative safeguarding forum which strengthens accountability and assurance within the NHS commissioning system and adds value to existing NHS safeguarding work across Yorkshire and the Humber.

5.1.2 Mental Capacity Act

The Designated Nurse (Adults) is the chair of this national subgroup. The stated aim of this sub group is to take lead responsibility for implementation of the recommendations relevant to health following the House of Lords Select Committee report into MCA 2005. Membership of this group benefits CCG through the ability to shape national policy and increase the profile of the CCG.

5.1.3 Child Sexual Exploitation

The Designated Nurse (Children) is a member of this national sub group. The stated aim of this sub group is to provide national leadership, support

and advice in the delivery of Department of Health (2014), Health Working Group Report on Child Sexual Exploitation and additional publications relating to Child Sexual Exploitation involving health.

During this reporting period the group led on the development of the CSE pocket guide for health practitioners which was launched at the national CSE conference on the 18th March 2016

5.2 Health Alliance

The Designated Nurse established a commissioner and provider Safeguarding Adults forum across Calderdale, North Kirklees, Greater Huddersfield, and Wakefield for Named Nurses in Safeguarding Adults roles, to share ideas, lessons, good practice and provide peer support.

The meeting first started in late 2013, and have continued to be held quarterly throughout the year, with effective engagement from all main health providers.

Facilitated by the Designated Nurses from the shared safeguarding team, with the support from the Designated Nurse Safeguarding Adults from Wakefield, the agenda is largely set by the attendees at the meeting, with some core agenda items that have included PREVENT and MCA DoLs approaches.

In 2015-16, it has been agreed that the second half of each meeting is dedicated to group safeguarding supervision. A supervision contract was developed by the group that all have utilised to demonstrate within their own organisations that they are engaging in safeguarding supervision, and attendees nominate cases for discussion at each meeting. The meeting also provides a mechanism for Nurses to record their learning and reflection for nursing re-validation as required by the Nursing and Midwifery Council (NMC).

5.3 Domestic Abuse

5.3.1 The Domestic Abuse and Sexual Violence Strategic Board has been established and is Co-Chaired by Director of Children's Services, Stuart Smith and Martyn Greenwood, District Commander, West Yorkshire Fire Service. The purpose of the Board is to oversee the work of joint commissioning on Domestic Abuse and the implementation of the Transformation Challenge Award (TCA). £335k was awarded to Calderdale under the TCA in April 2015 to enable us to transform our response to domestic abuse.

5.3.2 Domestic Abuse Hub – In response to the review of Domestic Abuse services in Calderdale the Domestic Abuse (DA) Hub was established on the 4th January 2016 with daily meetings at Halifax Police Station, led by the Police and including partners from CMBC Children's Social Care and Family Support, Calderdale Women's Centre, Pennine Housing, Health and Probation. A number of other agencies are involved in sharing information

and taking action to ensure victims get the right support on the same day where possible. The Hub is underpinned by a Partnership agreement and information sharing protocol.

The aim of the Hub model is to improve communication, make risk assessments more consistent and provide an earlier and improved victim and perpetrator response. Early feedback from partners is positive, for example in enabling support workers to make contact with victims while the perpetrator is in custody - a time where successful engagement is more likely.

A review of the Hub took place at the end of March. Initially the Hub looked at Police referrals only. The intention is that referrals will be taken from wider partners in the longer term, in the same way as the Multi Agency Risk Assessment Conference (MARAC) so that those who may not have reported to the Police will also be considered. The MARAC continues to run alongside the Hub but it is proposed that the two will merge in July 2016.

HUB Data – First Quarter

From 1st January 2016 to 31st March 2016, the HUB discussed 311 cases the daily meetings.

The data collected from cases discussed in the Hub show that on average 89.42% of victims are female, with 10.58% being males. It also shows that on average 86.49% of victims were aged between 16 and 45 years old. The age bracket with the highest involvement in domestic abuse were 26-35 years old, with the data showing that 37.99% of the victims were between these ages.

For the 311 cases discussed in the HUB between January and March 2016, there were 529 children linked to the victim and perpetrator. Of the 529 children involved, 241 were present at the actual domestic incident. Out of the 311 cases, children were present at 128 incidents (41.16%). Upon discussing the referrals at the daily meeting, 45 were then referred to MAST for a S.47 assessment to be conducted.

As the HUB develops, there has been an increase in those cases that have previously been discussed. In total, we have had 60 repeat referrals discussed in the HUB, which equates to 19.48% of the total discussed. This means that of the 311 incidents discussed, 120 of them involve the same victim/perpetrator. This occurred on 5.71% of the time over January, then increased to 20.56% in February and 30.30% in March. This increase is understandable as it is likely that there would be an increase in repeats as the year progresses due to the core numbers of cases discussed on a daily basis.

Out of the 311 cases discussed, 22 involved the female party being pregnant.

5.3.3 Coercive control - A new coercive or controlling behaviour offence was introduced in December 2015 which will make it illegal for someone to exercise psychological, emotional or financial control over their partner. Coercive control is often a prelude to violence and can include the abuser preventing their victim from having friendships or hobbies, refusing them access to money and determining many aspects of their everyday life, such as when they are allowed to eat or sleep. The maximum penalty for the new offence in England and Wales will be five years in prison and a fine.

5.3.4 Domestic Homicide Reviews (DHR)

Domestic Homicide Reviews are carried out to ensure that lessons are learnt when a person has been killed as a result of domestic violence. The Home Office multi-agency statutory guidance defines a Domestic Homicide Review as a review of the circumstances in which the death of a person aged 16 or over, has or appears to have resulted from violence, abuse or neglect by:

- a person whom he/she was related or had been in an intimate personal relationship, or
- a member of the same household

The purpose of a Domestic Homicide Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply those lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working

The Designated Nurses within the CCCG are core members of the Calderdale DHR panels where case specific DHR's scrutiny is undertaken to support the writing of an overview report. The Designated Nurses provide an independent health overview to the panel and also provide health specific advice to each case.

Calderdale services are currently involved in two DHR's one in the local community and another historical case out of area led by Lincolnshire Community Safety Partnerships.

Key Success:

- The CCG commissioning of a dedicated health domestic abuse service to support GPs and to work across the whole health economy, deliver bespoke in-house domestic abuse training and attend the new Domestic Violence and Abuse Hub, contributing to the CCG clinical priorities namely Priority 1 – Improving Health Outcomes and Priority 6 Empower Citizens and Resilient Communities
- Designated Nurses continued contribution to DHRs

5.4 Human Trafficking and Modern Day Slavery

The Modern Slavery Act 2015 (‘‘the 2015 Act’’) received Royal Assent on 26 March. The 2015 Act will ensure that the National Crime Agency, the police and other law enforcement agencies have the powers they need to pursue, disrupt and bring to justice those engaged in human trafficking and slavery, servitude and forced or compulsory labour. The 2015 Act also introduces measures to enhance the protection of victims of slavery and trafficking.

Part 1 of the Modern Slavery Act 2015 introduces the consolidated slavery and trafficking offences, tougher penalties and sentencing rules, ensures the main offences are subject to the toughest asset recovery regime under the Proceeds of Crime Act 2002, introduces bespoke slavery and trafficking reparation orders, and provides for the detention and forfeiture of vehicles, ships and aircraft used for the purposes of trafficking.

Work to create Human Trafficking / Modern Day Slavery Forums has started across the 5 West Yorkshire Districts to bring together a Partnership response towards dealing with Human Trafficking issues. This will provide each district with a co-ordinated and established response cementing Partnership roles when responding to incidents. Currently four out of five districts have established forums, Calderdale Kirklees, Bradford, and Leeds. Their work to date has resulted in locally focused Modern Day Slavery Plans, local terms of reference and the identification of key priorities, similar to those of WYATN. In some districts, further staff training has been identified and delivered, processes for the sharing and gathering of soft Intelligence developed.

The Designated Nurses are members of the West Yorkshire and Local ‘Human Trafficking & Modern Slavery’ Groups. The aim of the groups is to work in partnerships to combat modern day slavery by developing preventative approaches; strengthening support and protection of victims; and improving the identification, disruption and prosecution of offenders.

Statistics are collated by the National Crime Agency who released figures (January 2016) of potential victims referred to the National Referral Mechanism (NRM).

- In 2015 the UK NRM received 3266 referrals of potential victims which represent a 40% increase on 2014 referrals.
- The potential victims were reported to be from 103 countries and this represents a 7% increase on the 2014 countries of origin.
- The potential victims are comprised of 53% females and 46% males. In the remaining 1% the gender was either not recorded or was recorded as transsexual.
- Adults were predominantly forced into labour exploitation including

criminal exploitation (whereas in 2014 it was sexual exploitation) Minors were also predominantly forced into labour exploitation (including criminal exploitation) this is the same as in 2014. 70% were adults and 30% minors.

Calderdale Data: To date there have been 5 referrals to the NRM from Calderdale agencies.

5.5 Female Genital Mutilation (FGM)

Female Genital Mutilation (FGM) is illegal in the UK, as is taking a child abroad to undergo FGM, as legislated in the 2003 Female Genital Mutilation Act. It is also recognised as a form of child abuse. FGM is medically unnecessary, extremely painful and has serious health consequences both at the time when the mutilation is carried out and in later life.

The FGM Enhanced Dataset requires organisations to record and collect information about the prevalence of FGM within the female population as treated by the NHS in England. This includes women receiving treatment for unrelated condition; it is not limited to reporting upon women receiving treatment for FGM-related conditions.

The first annual statistics shows that there were 5,700 new cases of female genital mutilation recorded in England in 2015-16. The figures from the Health and Social Care Information Centre covering the period of April 2015 to March 2016 show that in 18 cases the practice had been undertaken in the UK.

The most common time when FGM was undertaken was between the ages of five and nine, accounting for 43% of the total number of cases where the age at the time of being cut was known.

From October 2015, all GP Practices in England have been required to submit information to the Health and Social Care Information Centre when they have identified that a patient has FGM through the standard delivery of care, or if she has disclosed this. NHS England has circulated a package to all practices to support them in commencing this process.

In all there were 8,660 attendances where FGM was identified or a medical procedure for the practice was undertaken, according to the statistics, the first to be published since the government introduced compulsory reporting for NHS trusts and GP surgeries. The newly recorded cases are those where women and girls have had their information collected in the FGM enhanced dataset for the first time, and include cases where the person may have been cut many years ago.

The vast majority (87%) of women whose pregnancy status was known were pregnant at the time of attendance, suggesting that this was what led

to FGM being self-reported or identified by a medical professional. Self-reporting accounted for 73% of FGM identification, where the identification method was known.

Women and girls born in Somalia accounted for 37% of all newly recorded cases of FGM with a known country of birth. Of the women and girls with a known country of birth, 90% were born in Africa. Of the total number of newly recorded cases, 43 involved women and girls who said they had been born in the UK.

More than half of all cases – 52% of newly recorded cases and 58% of total attendances – related to women and girls from the London NHS commissioning region.

To date the reporting on data is on a North of England basis so we are unable to break this down to Calderdale only figures but the highest reporting areas in the North Region are Manchester (310 newly recorded women and girls), Sheffield (165), Leeds (125).

On 31st October 2015 a new duty to report cases of FGM in girls under the age of 18 years to the Police came into Force. – *'Duty of health professionals to report abuse against a girl under 18 – FGM'.* Health Professionals who come under the following regulators;

- General Chiropractic Council
- General Dental Council
- General Medical Council
- General Optical Council
- General Osteopathic Council
- General Pharmaceutical Council
- Health and Care Professions Council (whose role includes the regulation of social workers in England)
- Nursing and Midwifery Council

The Serious Crime Act 2015 introduced mandatory reporting required regulated health and social care professionals to report known cases of FGM in under 18-yearolds to the police. Information regarding FGM has been disseminated across all areas.

5.6 PREVENT

The Prevent Duty is applicable to all NHS organisations which become statue on 1 July 2015. PREVENT is designed to illicit a proportionate and reasoned response, research shows that wherever possible, early intervention has a much higher success rate then a "reactive" safeguarding response.

Calderdale is one of around 50 PREVENT priority areas across the UK, this means that the risk of radicalisation and extremism in Calderdale is considered high, this risk is not restricted to the Muslim community and includes extremism from the far right amongst others.

The number of individuals travelling to Daesh territory and the Syria/Iraq conflict zone has been increasing; across the UK around 800 individuals are known to have travelled with around 400 who have subsequently re-entered the UK. The number of individuals who have attempted to travel is significantly higher. A high proportion of these individuals have been from the West Yorkshire area (over 40% of those who have travelled). Calderdale borders a number of other PREVENT priority areas and the PREVENT teams work closely however, given the nature of the risk and our communities, the CONTEST board requested that the PREVENT Coordinator develop a protocol for the Local Authority and partners to respond to any situation where an individual(s) attempts to travel to/has successfully travelled to the Syria/Iraq or other conflict zones.

The protocol aims to provide a practice framework to initially protect individuals and then to consider and manage any associated risks to communities and individuals both through direct risk of travel to a conflict zone and through the possible risks associated with radicalisation to extremist views.

The protocol is part of a wider set of PREVENT policies and procedures. Specified Authorities have a duty to ensure that they give “due regard” to the need to prevent terrorism (Counter Terrorism and Security Act, 2015) as a result, these procedures will have an impact on the Calderdale Safeguarding Boards as they outline the duties and responsibilities of staff. The procedures can be accessed via the safeguarding board website.

Work is currently being done across Calderdale around PREVENT to address extremism in all of its forms. A clear emphasis is placed on the fact that individuals who support Daesh are a minority and that extremism itself takes many different forms.

Dialogue with local communities on PREVENT and the issues it raises are on-going and we continue to encourage open and constructive dialogue on the impact of PREVENT on and within communities.

Health care staff are well placed to recognise individuals, whether patients or staff who may be in vulnerable situations and therefore susceptible to radicalisation by violent extremism or terrorists. It is fundamental to our ‘duty of care’ and falls within our statutory safeguarding responsibilities. Every member of staff has a role to play in protecting vulnerable individuals who pass through our care. Prevent is about protecting and supporting individuals and all staff have a role to play. The Department of Health will continue to oversee the implementation of Prevent to ensure all healthcare staff are aware of their roles and responsibilities.

Calderdale CCG must seek assurances from our providers and evidence that they are committed to ensuring at risk individuals are safeguarded from supporting terrorism or becoming terrorists themselves as part of the Home Office counter terrorism strategy Prevent.

The safeguarding team provide support and advice to health care professionals to help identify staff and patients in their organisations who may be at risk of radicalisation and appropriately signpost for intervention. We maintain close links with the Regional Prevent Coordinator and the local authority Prevent coordinator. The safeguarding team ensures that relevant referrals are made to the Channel panel, which aims to divert those at risk of radicalisation. The CCG as a commissioning body is not a member the multi-agency channel panel but seeks assurance that relevant provider agencies engage with this panel.

Depending on their role, all CCCG must receive Prevent training either basic level – delivered through written material or through a 1 hour Health WRAP training session delivered by an accredited Prevent trainer. At the end of Quarter all CCCG staff had received the appropriate level of training.

Key Success:

- A bespoke CCG Prevent Policy is now in place for staff to utilise
- All staff have undergone the appropriate level of Prevent Training in the last year

6.0 SAFEGUARDING CHILDREN

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

Calderdale is home to 50,300 0-19 year olds making up to 24% of residents. Around 1,500 have a long-term condition or disability that affects their day to day activities. Around 2,000 are known to have a learning disability.

The Indices of Deprivation (2014) ranked Calderdale as the 105th most deprived district in England with an estimated 10,050 children and young people growing up in poverty. 21.4% (1 in 6) of children aged under 15 in Calderdale live in families that are income deprived (IMD 2015), however this varies significantly with wards as high as 38.1% (1 in 3) living in poverty, and as low as 7.9%. This level of child poverty is worse than the England average. The rate of family homelessness is better than the England average.

The largest ethnic group in Calderdale is White British (88.7%), as recorded in the national Census 2011. The second largest ethnic group is Asian / Asian British (8.3%) of which the majority (6.8%) are Pakistani. The Asian ethnic category accounts for 15.6% of 0 to 4-year-olds and 13.4% of 5 to 14-year-olds.

In Calderdale, the South Asian population is particularly concentrated in the most deprived wards and according to the Office of National Statistics 2015; the child population within this group is forecast to grow.

Children and young people under the age of 20 years make up 24.3% of the population of Calderdale. 23.1% of school children are from a minority ethnic group. The health and wellbeing of children in Calderdale is mixed compared with the England average. Infant and child mortality rates are similar to the England average.

Children in Calderdale have average levels of obesity: 8.4% of children aged 4-5 years and 18.2% of children aged 10-11 years are classified as obese.

In 2014/15, children in Calderdale that required admission for mental health conditions were lower than in England as a whole. The rate of inpatient admissions during the same period because of self-harm was similar to the England average.

6.1 Safeguarding Children Activity

There has been a significant drop in numbers of children on Child Protection plans during the year. This could be for a variety of reasons and

probably not one alone: more effective early Intervention, heightening of thresholds, reduction in poverty etc.

There have also been reductions in the number of children and young people subject to child in need plan and the number children looked after by the authority. The number of children on a child in need (CIN) plan reduced by 13% in 2015/16 and children on a child protection (CP) plan reduced at a similar rate (15%). The number of children looked after reduced by 7.5%, ending the year at 65.4 per 10,000 under 18 population. This is now in line with the statistical neighbour average of 66 per 10,000 and closer to the national average of 60.

Data suggests that at the end of March 2016 there were:

- 188 children subject to a Child Protection Plan
- 297 children living in care
- 316 children subject to Child in Need Plans

2015/16 also saw a continued reduction in contacts and referrals into children's social care, seeing an 18% reduction in contacts and a 21% reduction in referrals compared to the previous year. This has been achieved through the better understanding of children social care thresholds about what is an appropriate referral by partner agencies, supported by the work of the early intervention panels and development of the early intervention single assessment and multi-agency referral form. It is important that children and families are directed to and receive a timely and appropriate response from all partners, professionals and services.

6.2 Child Protection medicals

The provision for undertaking all child protection medical examinations within Calderdale is a well embedded service and ensures all medicals in Calderdale are undertaken in timely way.

During the reporting period for 2015-16 there were 80 child protection medicals undertaken in Calderdale.

6.3 Children Looked After

Children Looked After (LAC) are vulnerable to a range of poor health outcomes and can face particular difficulties in accessing health services. The framework for the planning and commissioning of health services for LAC provide for joint working across agencies to achieve a more integrated approach and for ensuring the health needs of children placed outside of their originating area are met effectively.

When children are placed in care by local authorities, their responsible health commissioner has a statutory responsibility to commission an initial health assessment and conduct six monthly or yearly reviews. When the

child is placed out of area, the originating commissioner retains this responsibility. The purpose of the health assessment is to enable the child to have his or her health needs assessed holistically and to develop a plan to meet these needs; it should be seen as part of continuous activity to ensure the provision of high quality health care and not just an isolated event.

NHS Calderdale CCG has a statutory responsibility to ensure that initial and review health assessments are undertaken within agreed timescales, Calderdale and Huddersfield NHS Foundation Trust is commissioned to co-ordinate the delivery of statutory health assessments. At its highest point in 2011 the number of Children Looked After (CLA) was 379. However between 2012 and to the end of March 2016, apart from some fluctuations the number of Children who are Looked After has steadily declined to 297. The reduction in our CLA numbers may be due to a number of factors which has meant a more robust approach to children entering care and earlier identification of needs.

The CLA population has overtime shown a gradual reduction. The number of children on Placement Orders has reduced which implies a lower number of children expected to be adopted and this is likely to be the impact of case law and is replicated in the National and Regional picture.

The reduction in numbers reflects the robustness of early intervention support, robust gatekeeping at the point of entry into care and dynamic care planning. The percentage of young people aged between 10 and 17 is slightly higher than average. The national average is 37%. This age group is often the most challenging in terms of placement stability and placement availability. It is recognised that there is not currently sufficient resources to meet need and the Fostering and Adoption Team are actively working on a strategy to bring children back into in house provision and to stop external placements being made. This will be achieved by:-

- Proactive fostering campaigns,
- A review of the fostering service in terms of its support offer to carers, including financial support.
- Seeking joint commissioning arrangements with neighbouring authorities
- Opening of Hebble Lodge, our in house provision for young children
- Scrutiny and review at external resource panel
- Increased use of fostering to adopt placements

A national dispersal scheme for unaccompanied child asylum seekers in Britain is under way with Calderdale projected to receive 32 children and young people. At the end of March 2016 there were 11 unaccompanied asylum seekers, mainly form Afghani backgrounds.
There are currently have 45 children placed with connected carers, and the drive is to encourage permanence through Special Guardianship.

6.3.1 **Health Needs of Children Looked After**

The Children Looked After Health Service is commissioned jointly by the CCG and Local Authority through CHFT. Children that enter care in Calderdale benefit from having their initial health assessment undertaken by the designated doctor for children looked-after. This ensures that children's physical health and wellbeing needs at this key stage are assessed by an appropriately qualified and experienced medical professional. The designated doctor for children looked-after demonstrated a public health focus in her contacts with children looked-after. This involved engaging in health promotion activities such as discussions on sexual health and smoking cessation. These discussions maximise the opportunity to make every contact count which can contribute to improving and sustaining good health outcomes.

Children remaining in care for 12 months or more are eligible for statutory Review Health Assessment (RHA). Children aged less than 5 years are reviewed every 6 months, children over five are reviewed annually. This is a rolling programme of assessment; the timing of assessments is dependent on the date of the child's initial health assessment. RHA's are undertaken by appropriately qualified health professionals (Statutory Guidance on Promoting the Health and Well-being of Looked After Children, DH 2015).

The target for undertaking these assessments locally has been set at 95% to maintain higher than average England performance figure, and whilst the national target does not reflect timeliness, it is reflected locally. An important aspect of the data collection for this is that it examines performance for small numbers of children, therefore performance is easily skewed by effects from issues with return of data in a timely fashion from partners and other Local Authorities (for Calderdale children who are placed out of area).

Arrangements for the completion of review health assessments (RHA) by a range of health professionals are well defined. Children looked-after aged under-five are reviewed by health visitors, whilst school nurses undertake those for school aged children in education. The children looked-after named nurse completes the assessments for young people who are aged 16-18 years or for those not in education or training. Children looked-after placed out and in area continue to have their health needs reviewed as part of a reciprocal arrangement. However, a significant number of children looked-after are not benefitting from having their health needs reviewed within statutory timescales. Performance monitoring data indicates that whilst 97% of 313 RHA were completed in the 2015-16 only 78% were completed within statutory timeframes. This is poorer performance than in 2014-15 when 86% were completed in timescales. There is a risk that children looked-after experiencing delays in having their RHA may have continuing or unmet health needs that are not being addressed. This may delay the achievement of improved health outcomes for children looked-after.

The assessment process provides an opportunity to identify physical and emotional health needs of children remaining in care, these children will be referred to appropriate health professionals or services for interventions, support and if appropriate referral to specialist health services. By addressing health needs, children will enjoy robust physical and emotional health which in turn will positively improve their life chances and outcomes and provide the foundation for healthy adulthood.

Narrative is provided for any data showing less than 100% to understand and resolve issues which inhibit the process (usually waiting for assessments to be returned for children placed out of area).

The children looked-after service is responsible for the implementation of a flagging process within the trust's emergency department index system (EDIS) to aid the identification of vulnerable children and young people. This involves the placement of an alert on the system, accompanied by a narrative explanation for ED staff. This flagging system extends to children who are looked after by the neighbouring Kirklees local authority as well as children placed in Calderdale from elsewhere. This ensures that all children who present at ED can have their clinical presentation considered in the context of them being looked after and this supports good outcomes.

6.3.2 Strengths and Difficulties Questionnaires (SDQs)

SDQs are an important way to check on the emotional wellbeing of a child or young person. They do not take long, and ensure that practitioners keep a focus on the child and their emotional state. They help to highlight concerns and therefore contribute to assessment processes and work that is done with the child or young person. The SDQ can be used for children from the age of two years up. In Calderdale we complete SDQs for children looked after from the age of 4 upwards. We also complete them for other children we are working who are in early interventions, children in need, children on child protection plans and children receiving adoption support.

There are three types of SDQ:

- For children and young people over 11years old to complete them
- For parents or carers
- For teachers or other professionals who know the child

However, all three can be completed in order to obtain a broad picture of the child's emotional state. They may also be repeated at intervals to measure progress or change and to see whether the work and care we are undertaking is meeting that child or young person's needs.

When SDQs are repeated, the comparisons over time should ideally be done by the same person for consistency's sake.

For children who are looked after they should be completed by the carer

within 12 months of becoming Looked After and at least 6 monthly after that (DOH guidance). The views of the child and the social worker are requested at the same time as the foster carer, hence avoiding delay for those cases where the scores are elevated.

The scoring and the questions are not suitable for use with children with a learning disability

A strengths and difficulties questionnaire (SDQ) was used to assess the emotional and behavioural health of looked after children within Calderdale. The most recent average SDQ score of 14.2 is considered to be borderline cause for concern and is above the England average of 13.9.

6.4 Calderdale Safeguarding Children Board Sub Groups

The Calderdale Safeguarding Children's Board has a range of roles and statutory functions including developing local safeguarding children policy & procedures and scrutinising local arrangements. The statutory objectives and functions of the LSCB are described in Chapter 3 of Working Together (2015). The Board does not commission or deliver direct frontline services though they may provide training. While they do not have the power to direct other organisations they do have a role in making clear where improvement is needed. Each Board partner retains its own existing line of accountability for safeguarding.

NHS Calderdale CCG makes a significant contribution to the work of the CSCB, not only financially but also through the work undertaken by the designated and professional leads for safeguarding. Such work includes contributing to and or chairing subgroups of the board; contributing to multi-agency audits and peer reviews; and providing the health perspective into serious case reviews and learning reviews.

Child Sexual Exploitation has continued to be 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 2015-2016.

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. A new and improved risk assessment tool kit was introduced in February 2016.

The Performance Management and Quality Assurance (PMQA) framework is a key part of this assurance process. The PM Dataset is part of the PMQA Framework - made up of both quantitative and qualitative data – and along with feedback from both service users (crucially including the voice of the child) and practitioners this framework allows the triangulation of evidence provided by the data. The Learning and

Improvement Framework sits at the centre of this, enabling the CSCB to iteratively complete the Learning and Improvement cycle to constantly identify and feed in improvements to the local joint working arrangements, an activity that is essential for an effective LSCB which is discharging its statutory responsibilities under Working Together 2015.

During this first 12 months of operation, useful indicators have been those which have allowed trends to be followed and acted upon. One example was the indicator that looked at the Percentage of Child Protection Plans lasting 2 years or more ceasing during the year; the data showed a level that was perceived to be too high and not in line with comparator data. This scrutiny and challenge of the data resulted in an action plan and led to improvements in practice and to the children's social care electronic record system to alert when a CPP has reached 15 months. Practice has changed as a result of this and a review of the cases reaching the 15 month 'threshold' take place to ensure timely progress, 'Reflect' meetings to take place to expedite 'stuck' core groups and improved outcomes for those children involved have become apparent. It has not always been possible to ensure that the Board can see how the scrutiny of the PM data leads to learning and change which then improves outcomes but the link can definitely be made here.

The Performance Management reporting for the CSCB has come a long way in the first 12 months of operation. Data is regularly captured now and in some areas is having an impact on practice. The dataset was seen to need to evolve to reflect changes in the local safeguarding environment i.e. changes in governance due to the Improvement Board standing down, changes in commissioning / service provision and developing priorities of the Board. The format of the report needs to change to make the safeguarding data more accessible. The processes around scrutiny and challenge must be developed to ensure that the Board can function at a high level in horizon scanning and following up focussed lines of enquiry. To this end a new data set will be introduced in 2016-17.

Section 11 of the 2004 Children Act sets out the provision for Local Safeguarding Children Boards undertaking a self-assessment audit of how organisations and services are meeting standards to safeguard children and young people. Calderdale CCG completed two Section 11 audits again this year. One on behalf of the CCG and one of which was a consolidated audit for the 26 GP practices following the completion of the safeguarding standards document by GPs.

A challenge event was held by CSCB and attended by the CCG Head of Quality and Designated Nurse. Important themes emerged from the Challenge Events across the partnerships, including the volume of change within the partnership, and the impact of this at strategic and operational levels. The issue of evidencing the impact of training was a key discussion in the challenge meetings; and the impact to the training remains a key area of challenge for the partnership as a whole.

6.4.1 Case Reviews (SCRs) Sub Group

Serious Case Reviews (SCRs) are a statutory requirement led by the Local Safeguarding Children Boards and are undertaken following the death or serious injury to a child where abuse or neglect are thought to be a factor: and there are concerns about the way agencies have worked together (Working Together, 2015).

The CSCB Case Review Sub Group oversees and quality monitors serious case reviews and individual organisation chronologies and/or Independent Management Reviews (IMRs) with their associated action plans. Through membership of the Board and its subcommittees the CCG has oversight of provider organisations progress in implementing and effecting change as a result of the learning lessons/serious case review processes. The CCG Quality Committee also monitors progress of SCRs as a standing item on the Designated Nurse's Quarterly Safeguarding Children Report. The Designated Nurse is the current Chair of the CSCB Case Review Sub Group.

In the reporting period two serious case reviews were published. The first was originally commissioned in August 2011 following the death of a child in 2009. Legal considerations delayed the publication of this report until July 2015. The second commissioned in September 2013 was published in December 2015. Both reports can be accessed on the CSCB website at:
http://www.calderdale-scb.org.uk/professionals/serious-case-reviews/

Calderdale services also contributed to an SCR that was commissioned by Sutton LSCB following the death of a looked after child in May 2014 who had been placed in Calderdale prior to death. The report was published in July 2015. There was very limited service involvement by local agencies as the statutory notification process had not taken place.

6.4.2 Child Death Overview Panel (CDOP)

From 1 April 2008, Local Safeguarding Children Boards have had a statutory duty to review deaths of all children from birth (excluding still born babies) up to 18 years old, who are normally resident within their area.
Until 31 March 2010, panels were asked to assess whether a death was preventable or potentially preventable but due to difficulties distinguishing between these two categories, they were grouped and redefined as "modifiable factors". Since 1 April 2010, Local Safeguarding Children Boards have therefore been required to determine whether there were modifiable factors in the death of a child when reviewing the death. Factors may be judged modifiable if they could use nationally or locally achievable interventions to reduce the risks of future child deaths. Reviewing deaths involves collating information on the cause, location and other circumstances of the death, but is not an investigation into why

a child has died and it is not a serious case review, although a serious case review may be completed in respect of a death where abuse or neglect is considered to be a factor

Numbers of deaths in Calderdale are relatively small, so in order to improve identification of significant recurrent contributory factors, the Safeguarding Children's Boards of Calderdale and Kirklees come together with the aim of identifying any factors which could be modified to prevent or reduce the chances of a similar death in future.

The 'First Statistical Release' of National Data pertaining to the Child Death Review Process contains information on child death reviews that were completed in the year 1 April 2015 to 31 March 2016 was released earlier this year. Data has been provided by all 148 Local Safeguarding Children Boards on behalf of 86 Child Death Overview Panels.

The number of child death reviews that were completed has shown a rise in the most recent year after decreasing steadily over previous years. There were 3,665 reviews completed by Child Death Overview Panels in the year ending 31 March 2016, compared to 3,515 in the year ending 31 March 2015.

A serious case review was carried out for 3% of all deaths reviewed in the year, which is slightly higher than in previous years. Of the deaths reviewed in 2015-16 that were subject to a serious case review, 53% were deemed to have modifiable factors, compared to 79% in 2014-15, although this is still much higher than the figure for those not subject to a serious case review, where only 23% were deemed to have modifiable factors in 2015-16.

53 children out of 3,626 (1.5%) whose death was reviewed during the year were the subject of a child protection plan at the time of their death. Of these 53 children, 53% had modifiable factors identified compared to 23% for children who had never been the subject of a plan.

49 children were subject to a statutory order at the time of their death. This is just 1% of all reviews, which is unchanged from the year ending 31 March 2015. 24% of children who had never been subject to statutory orders had modifiable factors identified, compared to 35% who were subject to statutory orders at the time of the death and 30% who had previously been subject to statutory orders.

Consistent with previous years, approximately two thirds of reviews completed were of children who died under the age of one; with 43% for children aged 0-27 days; and a further 21% for children aged between 28 and 364 days at the time of death. The age group where child death reviews identified the highest proportion as having modifiable factors were children aged 28 to 364 days (34%) and the lowest were those aged 5 to 9 years (17%).

Boys' deaths have consistently accounted for over half of deaths reviewed. The panels in the year ending 31 March 2016 were more likely to identify modifiable factors in reviews of boys' deaths (26%) than in girls' deaths (21%).

Reviews of deaths of children from a White background have consistently accounted for around two thirds of reviews completed where the child's ethnicity was recorded. By contrast, 17% of the deaths reviewed were for children from an Asian background.

The Department collects information on reviews of deaths of asylum seeking children but this has not been included in the statistical first release due to small numbers in the groups.

Calderdale data:

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

Infant Mortality rates within Calderdale have been significantly higher in previous years in comparison to both the Yorkshire & the Humber and England & Wales averages but since the three year rolling data was published for 2010-2012, the rate has no longer been significantly higher. The most recent data available for infant mortality rates in Calderdale is 3.87 per 1000 live births, which is a 3-year rate covering 2012-2014. Once again, and continuing last year's positive trend, this is not significantly different from the England and Wales average. Additionally, the rate is the lowest it has been since we started reporting data, and is for the first time lower than the England and Wales average.

In summary:

- The majority of child deaths were infant deaths (under 1 year old).
- Prematurity and congenital anomalies accounted for 61% of infant deaths in Calderdale. (2007-11 data).
- Across Calderdale, 13.9% of women smoked during pregnancy in 2014/15, significantly higher than the England average of 11.4%.
- The still birth rate has shown a downward trend since 2007 and it is now comparable to the England and Wales figure at 4.6 per 1,000 (4.7 per 1,000 in England and Wales).
- Breastfeeding initiation during 2014/15 was significantly higher in Calderdale at 77.5% compared to the England average of 74.3%.

Source: Child health profile 2016, ONS deaths
http://fingertipsreports.phe.org.uk/health-profiles/2016/e08000033.pdf&time_period=2016

6.5 Work with the Calderdale Local Authority

Following the Ofsted Inspection into Children and Looked After Services in January 2015 when a 'Requires Improvement' notice judgement was given a Ministerial Visit took place on the 29th September 2015 to review the progress being made. The Improvement Board met on the 12th November 2015 and the Independent Chair reported that the Improvement Board has had less of a central role in driving improvement over the last 6 months as the CSCB, council service areas, Scrutiny and the Corporate Parenting Board have stepped up into their roles as part of the transitioning arrangements and as such has written to the Minister with the recommendation to lift the Direct Notice that expired at the end of October be formally lifted.

A letter from the Minister was received the 1st December and stated that he agreed Calderdale have made good progress in addressing the issues raised by Ofsted In January 2015 and in consolidating improvements since previous inspections. Evidence had been submitted of strong leadership, a shared vision for children's services, successful workforce recruitment, improved quality assurance systems and effective partnership. The Minister writes that these put Calderdale in a strong position for the next phase of the improvement journey and on the basis of these findings is content to conclude his Department's formal intervention in Calderdale children's services.

Whilst it is clear that the service provided for children, young people and their families has significantly improved, some challenges still remain which will require a continued sharp focus. These include embedding and sustaining recent improvements across the service and specifically in practice to support adoption and permanence. With this in mind the Minister will keep the progress against Calderdale's Improvement Plan under review until September 2016.

The Improvement Board agreed to hold a Peer Challenge event in 6 months' time to assure them of the continued progress. The Head of Quality and Designated Nurse will participate in this review which is due to take place in April 2016.

6.6 Joint Targeted Area Inspections of services for vulnerable children and young people (JTAI)

In January 2016, it was announced that new Joint Targeted Area Inspections of services for vulnerable children and young people (JTAI) were to be launched in March 2016. The inspectorates from Ofsted, Care Quality Commission (CQC), Her Majesty's Inspectorate of Constabulary (HMIC) and Her Majesty's Inspectorate of Probation (HMIP) will jointly assess how local authorities, the police, health, probation and youth offending services are working together in an area to identify, support and protect vulnerable children and young people.

The new short inspections will allow inspectorates to be more responsive, targeting specific areas of interest and concern. They will also identify areas for improvement and highlight good practice from which others can learn. Each inspection will include a 'deep dive' element, with the first set, to be completed by summer 2016, focusing on children at risk of sexual exploitation and those missing from home, school or care. Future areas of focus will be decided upon with input from key stakeholders.

The new approach was consulted on in July 2015 and over 200 responses were received from those working in the children's social care, health, police, probation and youth offending services. The inspections were successfully piloted in December 2015.

JTAIs are carried out under section 20 of the Children Act 2004. They are an inspection of multi-agency arrangements for:

- the response to all forms of child abuse, neglect and exploitation at the point of identification
- the quality and impact of assessment, planning and decision making in response to notifications and referrals
- protecting children and young people at risk of a specific type (or types) of harm, or the support and care of children looked after and/or care leavers (evaluated through a deep dive investigation into the experiences of these children)
- the leadership and management of this work
- the effectiveness of the LSCB in relation to this work.

The inspection report will include narrative findings that clearly set out what the local partnership and agencies are doing well, and what they need to do to improve.

When each set of inspections by theme are completed, a thematic overview report is published to highlight the learning more widely. The inspections will replace Ofsted's current thematic inspection programme.

The first of these inspections will concentrate on child sexual exploitation and the second on domestic abuse.

Key Success:

- Contribution to the CSCB performance monitoring data set review
- Contribution to partnership work undertaken through the Improvement Board

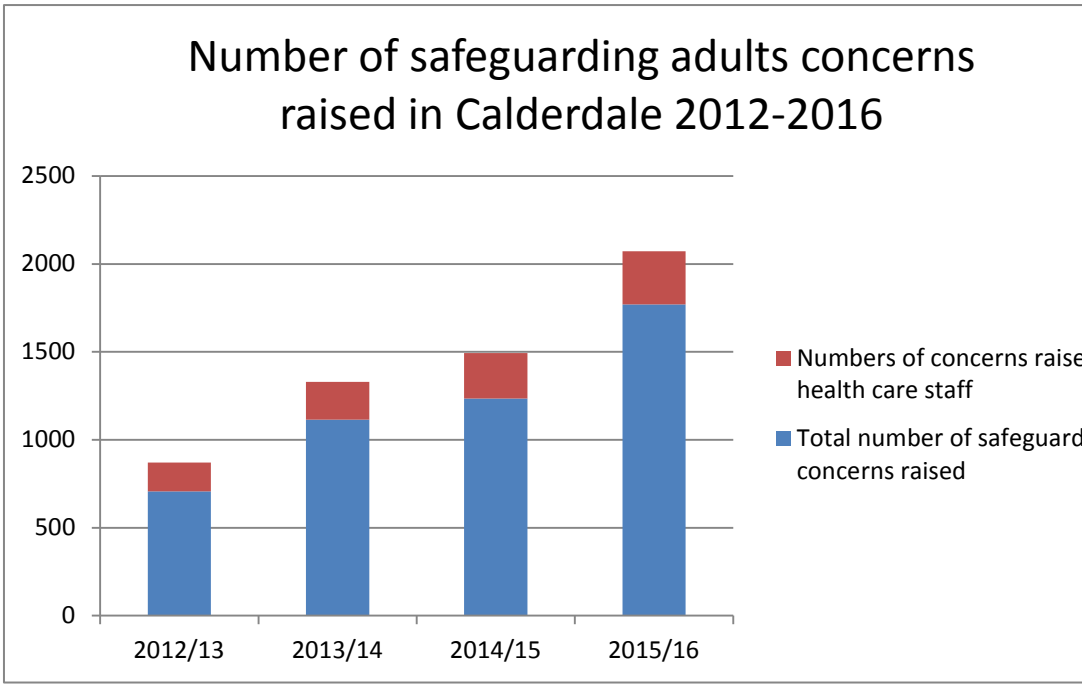
7.0 SAFEGUARDING ADULTS

7.1 Safeguarding Adults Activity

Any person may raise a concern with the local authority where they are concerned that an adult with care and support needs is experiencing, or at risk of abuse and neglect (including self-neglect). In these circumstances, the local authority will undertake an Initial Enquiry to determine how to respond. This includes working to understand the adult's desired outcomes and agreeing with the adult how their concerns will be acted upon. Where the concern is not resolved by the Initial Enquiries, the local authority will need to decide on the most proportionate response. This may include either:

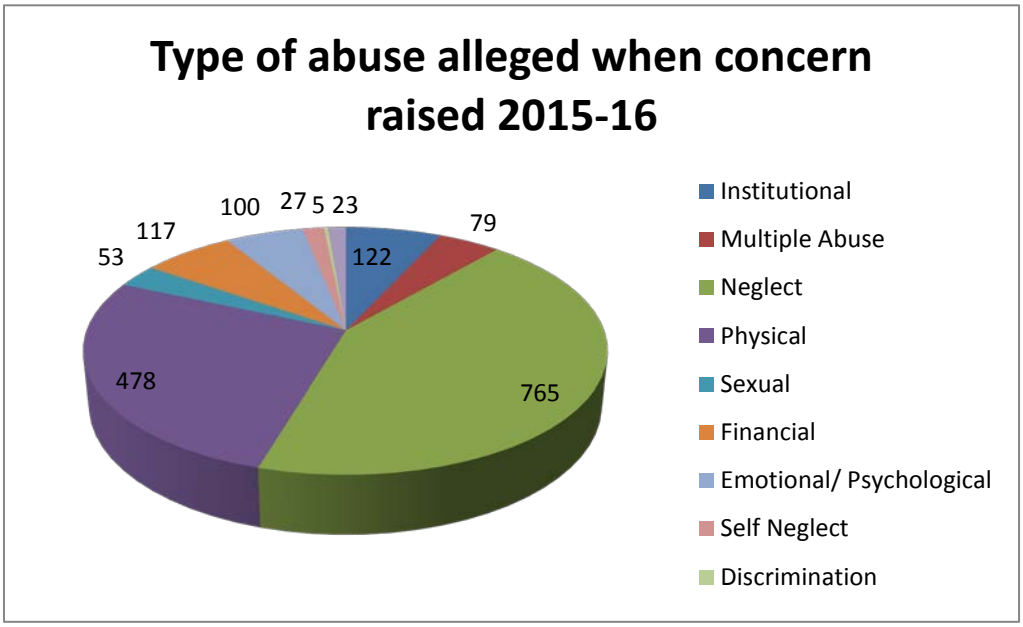
- A Formal Enquiry to establish the facts, and gather evidence to support a Safeguarding Plan. This will involve a Strategy Meeting/Discussion and Case Conference Meeting or Discussion.
- Risk Management Response, the term given to a range of actions that may be required to safeguard the adult from the risk of abuse and neglect.

The graph below shows that the number of safeguarding adults concerns raised has increased significantly over the previous 4 years. There has been a 43% increase in the amount of concerns raised between 2014-15 and 2015-16. This is unlikely to be as a result of more abuse occurring in Calderdale but an indication of greater awareness of safeguarding and safeguarding procedures. The numbers of concerns raised by health staff has increased by 17% between 2014-15 and 2015-16.



The majority (55%) of the concerns raised result from incidents taking place in care homes.

At the point of the safeguarding concern being raised with the local authority, the most common type of abuse alleged is neglect followed by physical abuse – see chart below.



During 2015-16 the Calderdale Safeguarding Adults Board (CSAB) Quality and Performance sub group has been examining some apparent differences between safeguarding adults activity in Calderdale and other comparable geographical areas.

Multi-agency audits are planned for 2016-17 to provide assurance to the CSAB in relation to the safeguarding activity and adherence to process.

7.2 Calderdale Safeguarding Adults Board (CSAB)

Following the introduction of the Care Act, each local authority must establish a Safeguarding Adults Board (SAB) for its area. The objective of an SAB is to help and protect adults in its area and it must do this by co-ordinating and ensuring the effectiveness of what each of its members does. The CSAB is jointly funded by the CCG and the Calderdale Council.

In 2015-16 the CSAB has been co-chaired by the Head of Safeguarding and Quality, Calderdale Council and the Head of Quality, Calderdale Clinical Commissioning Group. From April 2016 a new Independent Chair will commence work. This role will provide greater independence to the CSAB and dedicated time to build on the excellent work of the co-chairs.

The Care Act requires SABs to conduct multi-agency Safeguarding Adult Review according to a set criterion and produce an annual report and business plan. These tasks have been achieved in 2015-16 and the business plan and annual report are available on request.

During 2015-16 the CSAB has developed structurally including establishing multi-agency subgroups to drive forward the agenda. The sub-groups (Safeguarding Adults Reviews, Quality and Performance, Community Engagement and Communications and Learning and Development) have established terms of reference and are meeting on a regular basis.

The Designated Nurse chairs the Safeguarding Adult Review sub group and a toolkit has been developed to ensure that Safeguarding Adult Reviews are undertaken as per Care Act guidance, in Calderdale.

The Learning and Development subgroup has developed a multi-agency safeguarding training programme to improve access to and quality of training.

The Quality and Performance subgroup is developing a high level board assurance framework, safeguarding audits and a partner assurance audit.

The Community Engagement and Communications subgroup is developing a safeguarding communication strategy and has been the lead group for the SAB in organising a safeguarding week for October 2017 together with the Safeguarding Children's Board.

In 2016-17 the SAB has prioritised the appointment of a full time Board Manager, the development of local policies and guidance, greater lay member / service user engagement and further assurance mechanisms. The SAB structures will be reviewed including improved partnership working and effective sharing of resources with the Children's Safeguarding Board and Community Safety Partnership.

7.2.1 Safeguarding Adults Reviews (SAR)

The Care Act (2014) modified the criteria for when a Safeguarding Adult Review (formally known as a Serious Case Review) must be conducted by the Safeguarding Adults Board. The purpose of a SAR is for all agencies to learn lessons from serious incidents and improve multi-agency working. As reported earlier, a SAR toolkit has been developed in Calderdale which gives local guidance to all agencies about the aims and process for conducting a SAR. There have been no cases referred to the CSAB that fit the criteria for a SAR in 2015-16. In 2016-17 the toolkit will be evaluated and reviewed and assurance sought from all partner agencies that appropriate cases are referred to the SAR subgroup of the CSAB.

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7.3 Care Homes

There are established oversight, assurance and governance mechanisms for managing safeguarding and quality in Calderdale's care homes. This aims to ensure that the learning from the Elm View Serious Case review commissioned in December 2011 and published in 2014 continues to be implemented and the challenges faced by financial pressures and recruitment difficulties in the public sector are minimised.

The majority of safeguarding adults concerns raised in Calderdale are related to incidents in care homes and there has been a number of whole service safeguarding investigations in 2015-16.

The Safeguarding team works closely with the local authority, Care Quality Commission, continuing healthcare team, Quest matrons and other community healthcare providers to ensure that safeguarding incidents are reported and effectively managed to keep residents safe and protect their human rights.

The CCG safeguarding, quality and CHC team have developed a shared database to identify and intervene, at an early stage, care homes which are on a downward trajectory.

Care home monitoring, intelligence sharing and improvement actions are coordinated through multi-agency Operational and Executive monitoring groups attended by the CCG safeguarding team.

Case example

Concerns were raised by an anonymous member of staff at a care home about the conduct of night staff around the administration of medication to sedate patients. A multi-agency safeguarding alert was raised and a safeguarding strategy meeting was organised. CCG staff from the CHC and safeguarding teams were able to bring further intelligence to this strategy meeting and an investigation was planned which included police investigating whether any criminal acts had been committed. The operational group collated and shared intelligence from a range of health and social care providers and all parties were given actions to assist the care home to make improvements and to monitor the safety of residents. The operational group escalated difficulties in engaging with the manager of the home to bring about required improvements to the Executive Monitoring Group. Members of the Executive Monitoring Group arranged to meet

with the area and national managers to undertake relationship management, help the care home to fully understand the nature of the concerns and seek assurances that remedial actions required were implemented. The CHC team agreed to undertake reviews of all CHC funded placements which provided assurance that whilst improvements were required no residents were at immediate risk of harm. The CQC decided to bring forward a planned inspection and legal action was initiated to ensure that unless improvements occurred the home would face closure. The safeguarding action plan is currently being monitored by members of the Operational group and where progress is insufficient; this is being escalated to the Executive Monitoring Group.

Key Success:

- CSAB subgroups are established
- Safeguarding Adult Review Toolkit published

7.4 Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

7.4.1 National Picture

The House of Lords Select Committee on the Mental Capacity Act (MCA) 2005 described the Act as a visionary piece of legislation that was well regarded but poorly implemented.

Following the Supreme Court Judgment in “Cheshire West” in 2014, which resulted in a 10 fold increase in the number of applications, DoLS in hospitals and care homes have placed significant resource pressures on local authorities (as the authorising body). This has resulted in backlogs of DoLS applications not being processed within legal timeframes.

The “Cheshire West” judgement also ruled that the Court of Protection is required to authorise a Deprivation of Liberty in Supported Living, Shared Lives and domestic settings and extended this to those aged between 16-18. This has had significant implications for Continuing Healthcare teams who commission these placements. It is the responsibility of the CCG to ensure that, where it is commissioning individual packages of care for people in these settings, to make applications to the Court of Protection for authorisation of the deprivation of Liberty.

7.4.2 Local Picture

A great deal of work has been undertaken in 2015-16 to improve the implementation of the MCA and DoLS across Calderdale. This has included partnership work with hospitals, care homes, supported living

providers, the local authority, NHS England, the CCCG Continuing Healthcare team (CHC), care homes, the Care Quality Commission (CQC), CCCG Senior Management Team, the Coroner's office, GP practices and local and national committees.

The following outlines the most significant achievements in 2015-16:

7.4.3 Deprivation of Liberty applications - CCG

There is now a fully funded plan in place to manage those funded from CHC in order to make deprivation of Liberty applications to the Court of Protection. In 2016-17 applications will be made. This will further reduce litigation risks to the CCG for unauthorised DoLs. It is estimated that approximately 60 applications will be required. Close working relationships have been established between the safeguarding team, CHC team and a legal firm.

The Designated Nurse for Safeguarding Adults and the CHC team have been involved with a number of Section 21a appeals in 2015-16. These cases are heard by a judge in the Court of Protection, when a person who lacks capacity to consent to their care arrangements, objects to these arrangements and has a right to bring their case for legal review. In all these cases, in 2015-16 the CCG were found to be acting appropriately.

There is currently a complex case in the Court of Protection where the CCG is funding care in a supported living placement.

7.4.4 Hospital and Care Home DoLS

There has been a significant increase in DoLS awareness by hospital and care home staff, which is demonstrated by a large increase in the numbers of DoLS applications made by hospital and care homes. Work continues with the local authority to ensure that that staff recognise a potential deprivation of liberty and make appropriate, high quality applications to the local authority for authorisation.

7.4.5 General Practice and DoLS

When someone dies who was subject to a Deprivation of Liberty authorisation it is considered a death in custody and must be reported to the coroner. The Designated Nurse and a group of GP practices collaborated to produce guidance on reporting these deaths to the coroner. This piece of work has been well received by GPs in Calderdale and has been recognised nationally as good practice.

7.4.6 General Practice and the Mental Capacity Act

Nationally, it is recognised that the implementation of the MCA in general practice requires improvement in order to provide care that protects people's human rights. In 2015-16 a series of seminars by an eminent Human Rights Lawyer for GPs was commissioned by the CCG. These seminars were well attended and were positively evaluated by participants.

The safeguarding team continue to offer safeguarding training for GP practice staff which includes MCA and DoLS training. MCA / DoLS updates are provided to GPs through GP safeguarding leads meetings and regular bulletins. The safeguarding standards for GP practices (described in section 4.6) contain sections on the MCA and future work is being planned to seek more detailed assurance from practices in order to further improve practice.

The shared CCG Safeguarding Team commissioned bespoke training in the previous year for GP Practices from an experienced solicitor specialising in MCA, DoLs and Mental Health Legislation. A total of three sessions were delivered at venues in Calderdale, Huddersfield and North Kirklees in September 2015, and each session was open to attendance from GP's from any of the areas. The feedback from the sessions has been very positive, with reports that the sessions were very useful in helping GP understanding of their roles and responsibilities under the legislation.

7.6.7 NHS Trusts and MCA / DoLS

The CCG gains assurance in relation to MCA / DoLS through a variety of mechanisms including the safeguarding assurance framework, attendance at trust committees and through contract monitoring. CHFT and SWYFT have both been subject to CQC inspections in 2016 where positive work was recognised. However areas for improvement were also identified and the CCG safeguarding team is working closely with the Trusts to ensure these improvements happen. In 2016-17 the safeguarding assurance framework will seek more detailed assurance for the MCA.

Key Success:

- A bespoke CCG MCA DoLS Policy was written and approved is available on the CCG intranet for staff to access
- Processes are in place to make Deprivation of Liberty applications to the Court of Protection for Continuing Health Care funded placements
- Guidance written and circulated to GPs on reporting deaths of people who were subject to Deprivation of Liberty Safeguards.
- Significant rise in the number of Deprivation of Liberty Safeguard applications made by CHFT

8.0 CONCLUSION AND SUMMARY OF ACHIEVEMENTS - 2015/2016

The purpose of any annual report is to provide the reader with a comprehensive picture of an organisation's activity in the preceding year and to gain a sense of their priorities and challenges for the coming year. NHS Calderdale CCG safeguarding team hopes this report demonstrates how we have met a number of challenges in 2015-16.

The following is a summary of the achievements the team is most proud of in 2015-16:

- Policy development – we have new / revised policies for the Mental Capacity Act, Safeguarding, the Mental Capacity Act, domestic abuse and Prevent
- Developed systems to ensure that applications for Deprivation of Liberty Applications are made to the Court of Protection
- All GP practices in Calderdale now have a named GP lead for safeguarding and the establishment of regular GP leads meetings
- The appointment of a Named GP for Adult Safeguarding
- The appointment of a Named Nurse Safeguarding Children
- Commissioning of a dedicated health domestic abuse service lead
- Considerable input into the development of the Adult Safeguarding Board including the appointment of an Independent Chair, developing Board subgroups and the development of a Safeguarding Adult Review Toolkit
- Ensuring most CCG staff have received safeguarding and Prevent training and further training for CHC staff in the Mental Capacity Act
- The Designated Nurse for Adult Safeguarding being asked to Chair the NHS England national MCA subgroup.

9.0 OVERVIEW OF THE KEY PRIORITIES FOR 2016-17

Priorities identified for the year 2016-17 will be monitored through the CCG Quality Committee. The key priorities for the forthcoming year are:

- Continued partnership work with the Local Safeguarding Boards
- To ensure that the voice of the adult at risk and their carers influences the development of safeguarding adults within the CCG and CSAB
- To ensure that the voice of the child continues to influences the development of safeguarding children within the CCG and CSCB
- To ensure that appropriate DoLS applications are made to the CoP
- To ensure internal governance for safeguarding activity is effective within the CCG via internal reporting processes
- Further improve engagement from GP in safeguarding adults
- Continued and extended support to General Practice and support for commissioned providers
- Continued monitoring of commissioned Providers to deliver assurance of their continued engagement with the safeguarding work and agenda
-
- Review the current arrangements for Children's Looked After Heath Service
- To review the outcomes of the first year of the commissioned domestic abuse health service

10.0 RECOMMENDATIONS

It is requested that the CCG Governing Body:-

1) Receives and notes the contents of report.
2) Makes any further comments or recommendations as appropriate

11. REFERENCES

1. Accountability & Assurance Framework (2015)

   https://www.england.nhs.uk/wp-ontent/uploads/2015/07/safeguarding-accountability-assurance-framework.pdf

2. Being visible, accessible and confidential is important to children and young people as outlined by the British Youth Council (2011)

   https://www.rcoa.ac.uk/system/files/PUB-SAFEGUARDING-2014_0.pdf

   https://www.england.nhs.uk/wp-content/uploads/2015/02/train-competnc-frmwrk.pdf

3. Child health profile 2016, ONS deaths http://fingertipsreports.phe.org.uk/health-profiles/2016/e08000033.pdf&time_period=2016

4. Counter Terrorism and Security Act, 2015

   http://www.legislation.gov.uk/ukpga/2015/6/pdfs/ukpga_20150006_en.pdf

5. Deprivations of Liberties Safeguards (2009)

   http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/socialcare/deliveringadultsocialcare/mentalcapacity/mentalcapacityactdeprivationoflibertysafeguards/index.htm

6. House of Lords Select Committee report into MCA 2005
   http://www.publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/139.pdf

7. Independent Inquiry into Child Sexual Abuse (2015)

   https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

8. Mental Capacity Act (2005)

   http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf

9. National Census 2011 https://www.ons.gov.uk/census/2011census

10. Statutory Guidance on Promoting the Health and Well-being of Looked After Children, DH 2015

    https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/276500/promoting_health_of_looked_after_children.pdf

11. The Care Act (2014)

http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf

12. The Modern Slavery Act 2015
    http://www.legislation.gov.uk/ukpga/2015/30/pdfs/ukpga_20150030_en.pdf

13. Wood report: Review of the role and functions of Local Safeguarding Children Boards (A. Wood, March 2016)

    https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/526329/Alan_Wood_review.pdf

14. Working Together to Safeguard Children (2015)

    https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

APPENDIX A - GLOSSARY OF TERMS

ADULT AT RISK	An 'adult at risk' is someone who is 18 years or over who:- has care and support needs and is experiencing, or is at risk of, abuse or neglect and is unable to protect themselves because of their care and support needs.
CHILD	Includes all children and young people less than 18 years of age and below 25 if the young person has a disability
CiN	Child in Need
CLA	Child Looked After
CP	Child Protection
CPS	Crown Prosecution Service
CSC	Children's Social Care
CSCB	Calderdale Safeguarding Children's Board
CSP	Community Safety Partnerships
CCG	Clinical Commissioning Group
CHFT	Calderdale & Huddersfield NHS Foundation Trust
DHR	Domestic Homicide Review
DoLs	Deprivation of Liberty Safeguards
GP	General Practitioner
EI	Early Intervention
EIP	Early Intervention Panel
EISA	Early Intervention Single Assessment
FGM	Female Genital Mutilation
LA	Local Authority
LAC	Looked After Child
MAST	Multi-Agency Screening Team
MCA	Mental Capacity Act
PCC	Police and Crime Commissioner
PSW	Principle Social Worker
SAB	Safeguarding Adults Board
SCR	Serious Case Review
WYP	West Yorkshire Police
YOT	Youth Offending Team

Appendix B

The table below lists the significant local strategic groups in Calderdale relating to safeguarding and membership from the CCG on these groups.

Board	Membership
CSCB	Head of Quality (Deputy Chair) Designated Nurse Safeguarding Children
CSAB	Head of Quality (Co-Chair) Designated Nurse Safeguarding Adults
Sub Groups:	
Child Death Overview panel (CSCB) This is a joint CDOP with Kirklees Safeguarding Children's Board	Designated Nurse Safeguarding Children (Attending on behalf of Calderdale and the two CCGs in Kirklees)
Case Review Sub Group (CSCB)	Designated Nurse Safeguarding Children (Chair)
Safeguarding Adults Reviews (SAB)	Designated Nurse Safeguarding Adults (Chair)
Performance Monitoring & Quality Assurance (CSCB)	Designated Nurse Safeguarding Children
Performance Monitoring & Quality Assurance (SAB)	Designated Nurse Safeguarding Adults
Proactive & Responsive Sub Group (CSCB)	Designated Nurse Safeguarding Children
Learning & Development Sub Group (CSCB)	Designated Nurse Safeguarding Children
Learning & Development Sub Group (SAB)	Safeguarding Advisor Adults
Communication & Engagement Sub Group (CSCB)	Designated Nurse Safeguarding Children
Communication & Engagement Sub Group (SAB)	Safeguarding Advisor Adults
Early Help (CSCB)	Named GP
Multi-Agency Audit Group	Designated Nurse Safeguarding Children (Now taken over by the Named Nurse Safeguarding Children)
Health and Wellbeing Board	Chief Officer
Community Safety Partnerships	Head of Quality
Domestic Violence & Sexual Violence Strategic Board	Designated Nurse Safeguarding Children (Also attends the DV Operational Group that reports to the DVSV Strategic Board)
Children & Young Peoples Partnership Executive	Service Improvement Manager
Corporate Parenting Panel	Designated Nurse Safeguarding Children
District Leadership Team Meetings (Social Care, Education & Health)	Designated Nurse Safeguarding Children and or Service Improvement Manager

Appendix C - Changes to the Safeguarding Section of the Care Act

Details of the change	Implications for the CCG
Self-neglect – clarifies that self-neglect will not necessarily require a safeguarding response. It will depend on the ability of the person to protect themselves by changing their behaviour.	The CSAB will require a Self Neglect policy to aid clinicians across the partnership.
Updated definition of Domestic Abuse –to include new offence of "Coercive and controlling behaviour", government definition of domestic violence and the Serious Crime Act 2015	A CCG bespoke Domestic violence and Abuse Policy has been written by the CCG Safeguarding Team and is due to be presented to the Committee for approval imminently, this will include new definitions
Financial abuse – updated to include internet, postal and doorstep crimes. Should always be reported to police and Trading Standards. Safeguarding Adults Boards to consider how to engage with Trading Standards.	No direct implications for the CCG – need to continue to support CSAB in delivering this work
Safeguarding process – strong message that safeguarding process should not be used to intimidate families or service providers.	No direct implications for the CCG – need to continue to support CSAB in delivering this work
The previously described Designated Safeguarding Adults Manager (DASM) has been removed from the Act – there remains a clear duty and responsibility to respond to people in positions of trust and emphasis that this is a responsibility of LAs and other partners, as well as the large and diverse independent provider sector. Important link made to children's safeguarding and considering risk in the round.	The Designated Nurse has received agreement from providers that an overview report of allegations against persons of Trust will be provided to the Lead commissioner of the health service (this will be anonymous overviews, but will provide an overview of the organisations' actions)

Details of the change	Implications for the CCG
Safeguarding Boards (SABs) – explicit statement about SABs having intelligence about all health and social care providers in the area not just those which are commissioned by partners represented on the SAB. - SAB annual reports should be published on partners' websites. - SABs should consider publishing Safeguarding Adult Reviews (SAR) in line with legal parameters concerning confidentiality.	The CSAB is continuing to develop mechanisms to monitor provider safeguarding activity Links to CSAB Annual reports are already provided via the CCG Intranet Safeguarding pages for all CCG Staff and GP member Practices to access. The Designated Professional will explore placing the link on to the CCG website. SAB appropriately publish SAR's on the CBMC website. A CSAB website in in development
All commissioners and providers of healthcare should ensure that staff have the necessary competencies and training in place, strengthened by the Safeguarding adults roles and competencies for health care staff – and clear roles for professional and practical leadership within Safeguarding Adults work CCGs must have a Designated Professional lead that leads on complex cases and supports and advises the Governing Body. More information on the role of Principle Social Workers and police should have arrangements for advice and guidance.	Each main health provider from which CCCG commission care has in place a Safeguarding Adults team with clear leadership. The Provider safeguarding teams provide details of the safeguarding training levels within the organisation. The CCG has a Designated Nurse Safeguarding Adults in post with clear lines of Governance up to Governing Body.