annual report 2013-14

barnsley safeguarding children board

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365

children young people families

May 2014

Contents

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Chair's foreword

Preparing an annual report is, by its very nature, an opportunity to reflect upon the year that has just ended and to look forward to the year ahead. This report gives a detailed explanation of the work of the Barnsley Safeguarding Children Board (BSCB) and its sub committees, together with an analysis that identifies areas for further work and priorities for 2014/15.

At the time of writing this report, Barnsley Metropolitan Borough Council (BMBC) is still the subject of the Improvement Notice that was issued by the Parliamentary Under Secretary of State for Children and Families, following the Ofsted inspection of July 2012. We are awaiting the next inspection by Ofsted at any time in the near future, which will also include an inspection of the BSCB.

The BSCB and its members have continued to be fully engaged with the work of the Improvement Board that is addressing the concerns raised in the Ofsted report. Just as importantly, however, the BSCB has been leading on improvements to safeguard children on issues that it has identified as priorities outside the Ofsted inspection.

During the last 12 months, the BSCB has led on many pieces of work aimed at improving the safety and welfare of children and young people in the borough, including:

- the development of a Child Sexual Exploitation Strategy and action plan. This is an area where Barnsley had not previously reacted with the same level of activity as other parts of the county.
- the introduction of a Section 11 audit challenge board. This has strengthened the section 11 audit process and provided more cogent assurance to the Board about partners' safeguarding arrangements.
- robust response to the limited return of the Annual Headteachers' Report on Safeguarding, which has led to a much improved return rate.
- improved co-ordination between the BSCB and the Children's Trust Executive Group.
- acceleration of the ongoing improvements to the performance management framework.
- a number of multi-agency audits, including an independent review of the application of thresholds for service.
- a gap analysis against the Working Together 2013 guidance. This gave reassurance that the BSCB's working practices accorded with the new guidance.
- work to explore the establishment of a Multi-Agency Safeguarding Hub has commenced. This a further development on the improved working created by the Joint Investigation Team.
- strengthened the Early Help offer with the introduction of the Stronger Families Teams.
- report commissioned in respect of private providers of children's homes in Barnsley, which has led to a number of actions to improve oversight and partnership working.
- approval of a range of new polices/procedures, including Learning and Improvement Framework and a new Assessment Framework for addressing risk.
- a review of the sub-committees; there is now a greater consistency in chairing and improved attendance is being reported. A requirement for all sub-committees to have a standing item of 'Items to the escalated to the BSCB' has proved beneficial in providing support to the sub-committee chairs

whilst reinforcing the relationship with the BSCB.
- increased representation of schools on the BSCB; there are now three primary school representatives.
- a review of the Child Death Overview Panel and strengthened governance, with the panel now reporting direct to the BSCB.
- consolidation of the established dedicated group to take forward work in respect of children with disabilities and complex health needs into the BSCB's governance.
- development and delivery of new multi- agency training courses in response to identified need and priorities, for example, awareness raising sessions relating to child sexual exploitation
- published a Serious Case Review that reported on the tragic death of a child in 2011 and the learning that has been taken forward.

The appointment of a new Director of Children's Services, Rachel Dickinson, and changes to the senior management team have brought a fresh impetus to the improvement agenda. Rachel's personal leadership has been recognised by partners and has helped to develop the willingness to challenge existing working practices. I also wish to acknowledge the strong political support received by the BSCB.

There is recognition by all agencies that there is no room for complacency and that there is more to be done to ensure that we collectively do our best for the children and young people in Barnsley.

Issues that require further work in the year ahead include:

- continued action to address child exploitation, including helping to keep young people safe in their use of technology.
- ensuring that the application of thresholds for service ensures that those children who are in need of support get the service they require.
- strengthening the engagement with young people and their families to inform service development.
- continuing the work to improve the performance framework.
- further work in addressing child neglect.

In conclusion, I am pleased to report that partners consistently display their commitment to the work of the BSCB and that there is clear evidence of improvements being made.

Bob Dyson QPM, DL
Independent Chair
Barnsley Safeguarding Children Board

Introduction and local safeguarding context

Barnsley Safeguarding Children Board comprises representatives from a range of statutory partners, who are passionate about promoting the safeguarding and welfare of local children, young people and families in Barnsley.

Our vision is that:

Every child and young person should be able to grow up safe from maltreatment, neglect, accidental injury/death, bullying and discrimination, crime and anti-social behaviour.

Children are entitled to a strong commitment from the BSCB and its constituent agencies to ensure that they are safeguarded. Where possible, this will be done in partnership with parents and carers, and by engaging the active support of the public. We will do as much as we can within the resources available to us and, with every agency providing services, we can maintain an inter-agency safeguarding system directed at safeguarding and promoting the welfare of all Barnsley's children.

We will endeavour to ensure that every child is safe, well cared for and thereby supported to fulfil their potential to make the transition from childhood to adulthood.

Safeguarding Board's prime responsibilities are:

- to co-ordinate what is done by each person or body represented on the Board for the purpose of safeguarding and promoting the welfare of children in the area, and
- to ensure the effectiveness of what is done by each person or body for that purpose.

The Board oversees work undertaken by partners to provide integrated services for children and families, with particular focus on safeguarding and promoting the welfare of children and young people.

This Annual Report provides:

- an outline of the main activities and achievements of the Barnsley Safeguarding Children Board during 2013-14.
- an assessment of the effectiveness of safeguarding activity in Barnsley.
- an overview of how well children are safeguarded in Barnsley.
- ambitions for future service developments and identification of key priorities.

The emphasis of the work undertaken by the Board and partners continues to move towards effective early intervention and prevention, focusing on promoting the child's wellbeing, rather than reactive work to deal with the consequences of difficulties. However, discharging safeguarding children responsibilities remains at the heart of service provision.

The Board is strongly committed to further strengthening its relationship with other strategic partners, including the Children's Trust Board, the Health and Wellbeing Board established in April 2013, and the local strategic partnership, **'One Barnsley'**, whose membership is drawn from public, private, community and voluntary organisations. One Barnsley is responsible for ensuring the delivery of an effective local Sustainable Community Strategy and developing a better future for the area. This strategy has been renewed until 2015, with two main priorities for collective

action, which both have a direct relationship and implications for the promotion of safeguarding and wellbeing:

- growing a 21st century economy in the borough
- growing a 21st century relationship between citizens, voluntary/ community groups and public sector agencies and organisations within Barnsley.

To affirm all these relationships, the Board has approved a protocol covering governance arrangements and the degree to which they enable partners to assess whether they are fulfilling their statutory responsibilities to help, protect and care for children and young people. The Board also articulates clear improvement priorities in its Business Plan, with actions to accomplish improved outcomes.

Local demographic context

(Informed by the Barnsley Joint Strategic Need Assessment)

Barnsley is part of a broad South Yorkshire conurbation located around traditional community bases of former mining and market towns. It has an increasing population, currently around 233,700 which is projected to increase by 3.6% to 242,000 by 2017. The most significant predicted increases over that period are in the under 16s and over 65s populations by around 7% and 13% respectively. Under 18s comprise around 24% of the total population. 96% of the population describe themselves as white British, although 5.6% of school children aged five to 16 are from a black or minority ethnic group.

Barnsley is the 47th most deprived local authority in England, with significantly higher than national average unemployment. The level of child poverty is worse than the England average, with 24.9% of Barnsley's children under 16 years living in relative poverty, compared with a 21.1% national rate. 26% of Barnsley children are reported as living in a household reliant upon out-of-work benefits. Deprivation is linked to ill health and life expectancy is lower than the national average. Infant and child mortality rates are similar to the England average, but there is a recognised link between infant mortality and deprivation. Although local educational attainment continues to improve, results at age 16 remain well below the national average in relation to the proportion of children attaining 5 A* to C grades at key stage 4, including English and Maths.

The local teenage pregnancy rate is significantly higher than the national average, with a known link between teenage conceptions and alcohol misuse. The number of women smoking during pregnancy is significantly higher than regional and England averages. Both of these issues are being actively addressed by the Children's Trust Executive Group (TEG - see section on effective partnership working).

The predicted population increase has implications for increased demands on all services, including those providing child and family support. Recent years have seen a continuing increase in the number of families and children from ethnic minority backgrounds, with around 4% of the population being from diverse non-white British backgrounds. The local minority ethnic population has a younger age profile than the Barnsley average and data from the school survey indicates that almost 8% of primary pupils are from minority ethnic origins.

Coordinating local work to safeguard and promote the welfare of children

Governance and accountability

The Board's constitution was reviewed in November 2013 to ensure continuing relevance and reflect membership changes dictated by national changes in health service structures. We also agreed to maintain the quorum, which was revised on a trial basis the previous year to ensure efficient conduct of business. In July, a gap analysis against the new Working Together 2013 provided assurance that operational practice accords with the statutory guidance.

The Board has six planned business meetings each year, together with additional sessions, to allow time for member development and reflection on specific issues. Special meetings are convened when required, for example to receive the findings from Serious Case Reviews.

To promote optimum focus on priority issues, the Board revised its sub-committee structure in 2012. These arrangements were largely retained in 2013-14, with the addition of two new sub-groups with direct reporting lines to the Board in recognition of emerging priorities relating to child sexual exploitation/runaways and services to children with disabilities and complex health needs.

The current sub-committee structure, as depicted in Appendix 1, provides for focus on our priorities and promotes activities aligned to the Board's statutory functions. The functions of the sub-committee and sub-groups, which all meet at least six times a year, are:

- **Performance, Audit and Quality Assurance Sub-Committee (PAQA)**
  Oversight of performance management data, review of a rolling programme of audit activity and improvement to service quality.

- **Policy, Procedures and Practice Development Sub-Committee (PPPD)**
  Ensures that policy and procedures are current, implemented, embedded and reflective of practice. Addresses practice developments over a broad range, including e-safety, sexual exploitation/runaways, anti-bullying, adult mental health, substance misuse and domestic violence.

- **Workforce Management and Development Sub-Committee (WMD)**
  Addresses all aspects of multi-agency safeguarding training, including evaluation of impact and reviews, aspects of workforce management concerned with safer recruitment and supervision.

- **Serious Case Review Sub-Committee (SCR)**
  Oversees commissioning and management of Serious Case Reviews, ensuring agencies are accountable for implementing recommendations and action plans and promotes strategic learning from local and national reviews, including Domestic Homicide Reviews. (A separate, independently chaired, Serious Case Review Panel is convened to review individual cases as required)

- **Child Death Overview Panel (CDOP)**
  Examines the deaths of all Barnsley children, in accordance with statutory guidance. The panel has recently

reviewed and strengthened its governance through direct reporting to the Board.

- **Child Sexual Exploitation and Runaways Forum (CSER)**
  In January 2014, the Board reviewed the CSER Forum's terms of reference. It approved the establishment of a strategic group to oversee the forum's work and monitor progress of the Child Sexual Exploitation Action Plan and an operational group to review individual cases of concern and ensure provision of appropriate services.

- **Children with Disabilities and Complex Health Needs Sub-Group (CWDCHN)**
  To provide more robust oversight under the Board's governance and support to the increased vulnerabilities of this group of children and young people, the Board formalised its relationship with the Safeguarding Disabled Children Working Group in November. The newly created Children with Disabilities and Complex Health Needs Sub-Group ensures continued provision of a multi-agency response.

  This enhanced structure provides additional capacity to address emerging priorities in terms of child sexual exploitation and children with additional needs. It retains valued input from adult services in areas of mutual safeguarding concern such as domestic abuse, adult mental health and substance misuse. During the year, the Board Chair undertook a personal review of the sub-committees to gauge their effectiveness, as a result of which we have improved attendance and a greater consistency in multi-agency input through chairing.

  Communication between the Board and sub-committees is strengthened through the regular Board and Sub-Committee Chairs Forum. In July, the Board introduced a new escalation process to encourage the sub-committees to report issues of concern direct to the Board. This has provided beneficial support to the sub-committee chairs and reinforced their relationship with the Board.

- **Focus on priorities**
  Each year, the Board reviews its current **Business Plan** to identify success in achieving objectives and identify new priorities for next year. The Independent Board Chair and the Sub Committee Chairs meet regularly to review progress and ensure that workload is managed and implemented effectively, in line with the Business Plan. These meetings also consider emerging issues of interest or concern in light of the Board's priorities.

  All Board members and specialist advisors have a strategic safeguarding role in relation to their own agencies. Accountability to local communities is promoted through the two lay representatives, both of whom were new appointments in 2013/4. Building their role in terms of independent challenge and contribution to the development of public engagement in safeguarding is an area for further development

- **Effective partnership working and relationships with strategic partners**
  The Safeguarding Board's functions and responsibilities complement those of the Children's Trust and provide for

leadership and ownership of safeguarding at all levels in the council and partners. The Children's Trust, chaired by the DCS, secures the cooperation of partners to strategically plan and align service commissioning to improve children's outcomes. These arrangements encompass all strategic partners, with a focus on working together to improve the wellbeing, life chances and outcomes of every local child. Our high aspirations for children and young people, relating to their ability to secure optimum health, safety, educational attainment and contribution to their communities, recognises that families need support across the whole spectrum of services, including social care, education, health, police, voluntary organisations, safeguarding and other stakeholders.

Responsibility for establishing a secure continuous service improvement system for children, young people and families rests with the Children's Trust and Safeguarding Children's Board. The BSCB, independently chaired, provides a forum to hold partners to account and test effectiveness of multi-agency working to safeguard children

In April 2013, a joint meeting with the Children's Trust Executive Group (TEG) included substantial input from a representative group of young people. Three key issues were explored:

- review of the 2012-13 Children's Trust Prospectus and identification of priorities for 2013-14 onwards
- review of partnership arrangements under the One Barnsley Strategic Partnership to examine how partnerships might be better configured to meet the requirements of the Community Strategy, the Health and Wellbeing Board, the council, the Children's Trust and the Safeguarding Board
- aspects of the Improvement Plan relating to strengthening partnership working.

The independent role of the Safeguarding Board in challenging and holding partners to account in their service delivery was addressed in the question "Making our partnerships fit for the future - what needs to change?" Participants identified current strengths, weaknesses and opportunities and agreed key areas for further development to strengthen the relationship between the Board and its strategic partners to be more effective in shaping and securing services.

- Further work to agree a Children's Trust/Safeguarding Board workforce strategy
- Increase challenge by all groups asking "What difference have we made today for children, young people and families in Barnsley today?"
- Facilitating engagement of and participation by young people and their families in partnership arrangements and relevant meetings, where appropriate, particularly for development of new policies, ways of working etc.

The Children's Trust Children and Young People's Plan 2013-16 recognises the nature and value of its relationship with the Safeguarding Board through its three main safeguarding priorities:

- improving the safety of children by developing the engagement and focus of all partners via the Safeguarding Children Board.
- increasing confidence and understanding of referral processes and thresholds

- developing data use, information and quality assurance.

During the year, these priorities were progressed as the Safeguarding Board continued to hold individual agencies to account in discharging their responsibilities to keep children safe. From 2013-16, the Trust and partners have identified the following as continuing priorities:

- maintain oversight of and take forward actions from the Ofsted Improvement Programme relevant to the Safeguarding Board
- ensure all Board members are up-to-date with changes in policies, guidance and practice to provide strategic direction and scrutiny of core safeguarding and child protection processes and data, and provide effective challenge.
- develop and improve performance management and quality assurance systems to ensure robust and continuous service improvement, supported by workforce development programmes to secure safe practice.
- ensure that the Board maintains a comprehensive overview of the work of partner agencies involved with safeguarding, including the voluntary sector.
- ensure the implementation of actions within the Child Sexual Exploitation Strategy.

These will be addressed as major priorities in the Board's 2014-15 Business Plan.

To articulate the relationship between itself, the TEG, and the Health and Wellbeing Board, the Safeguarding Board approved a formal protocol in January 2014. The Board will continue to challenge and scrutinise the work of the Children's Trust and strategic partners effectively through common membership, including the Board Chair who holds the TEG to account for the quality of services and outcomes. A chart of the structural relationship between the Board and its strategic partners is shown below.

To ensure effective safeguarding and child protection, the Board operates under an up-to-date information sharing agreement to which all partners are signed up.

Worried about a child or need some advice?

Contact the Safeguarding Children's Unit

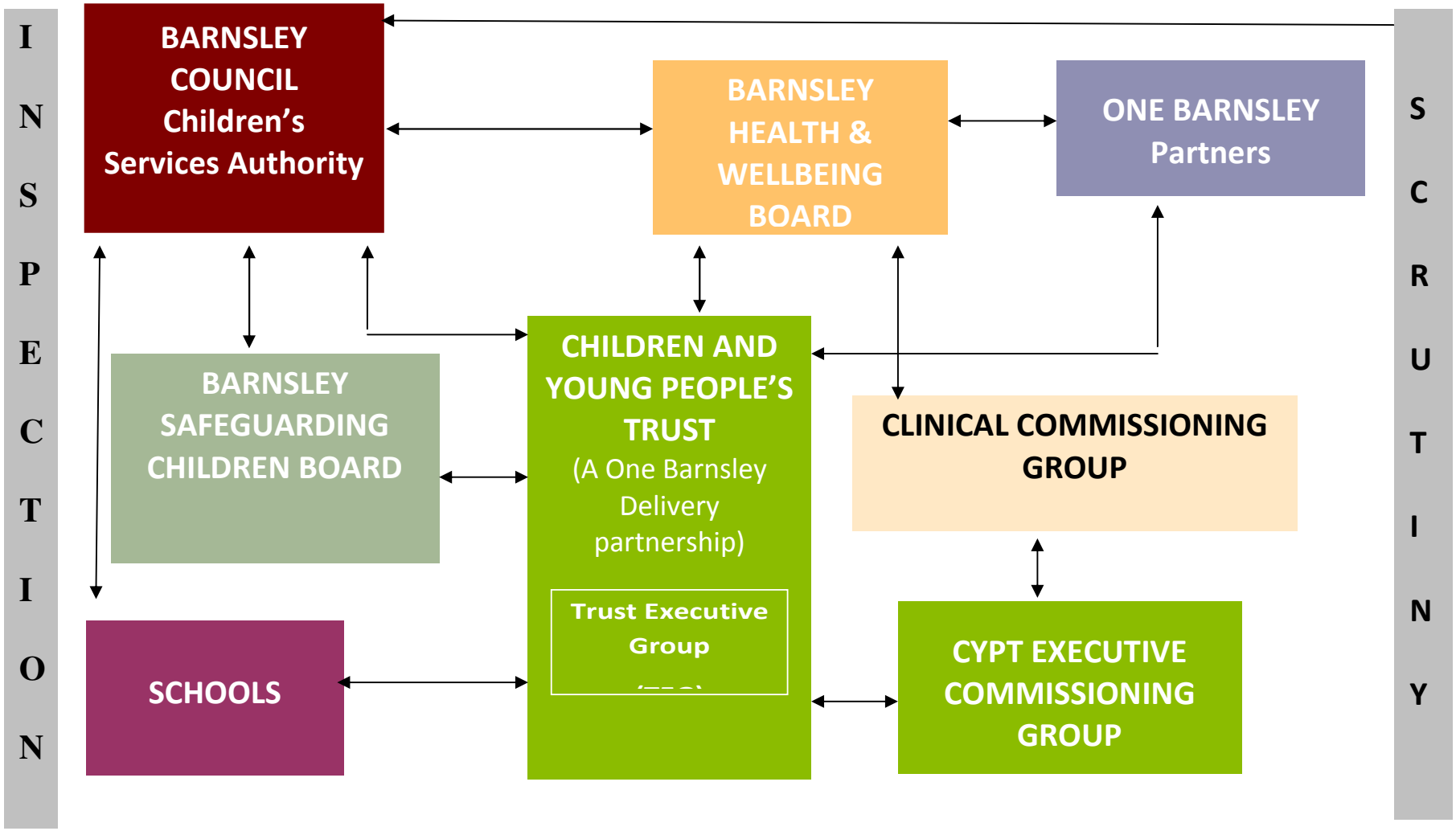
Call 01226 772400

Need police advice?

Contact Barnsley Police Public Protection Unit

Call 01226 736341 or 01226 736009

WORKING TOGETHER Partnership Groups



Progress on key priorities and achievements in 2013-14

Last year's key priorities to coordinate local safeguarding activity and promote children's welfare are set out below, with commentary on the extent to which they were achieved. More detail and examples of specific activities relating to each priority is contained in the sections of this report relating to the sub-committees that have progressed the work throughout the year.

Maintaining a strong commitment to continuous improvement and challenge through oversight and taking forward relevant actions from the Ofsted Improvement Programme
The Barnsley Safeguarding and Looked After Children Improvement Board oversees work in response to the outcomes of the Ofsted inspection and the subsequent Improvement Programme. Its work will be complete when children's services in Barnsley are judged adequate and a sustainable system is in place to secure continuous service improvement.

The first two phases of our Improvement Programme are now complete. Phase 3 represents a continuous service improvement journey. Our aim of consolidating good practice and addressing areas identified for improvement has continued to be driven, initially through actions linked to the Ofsted Improvement Programme, but now transitioning towards continuous service improvement with strong focus on improving outcomes for children.

The Board has maintained oversight of activity under the Improvement Programme though regular updates, individual reports on particular areas of concern, such as missing children, statistics relating to child protection conferences and looked after children, and evidence from specific audit activity. The Board has sought to encourage more open challenge during debates in order to secure service improvement and has developed a 'challenge log' to evidence instances. We have also introduced a Section 11 audit challenge board to strengthen the audit process and provide a reality check to agencies' self-assessments.

Continuing to develop and refine our Performance Management Framework.
In January, the Board approved a revised Performance Management Framework under which we are refining performance reporting through identification of relevant key performance indicators (KPIs). This was an area of particular weakness the previous year when the Board identified that "performance management and the ability to obtain assurance from relevant, accurate and timely performance information was insufficiently robust with inadequate information and analysis".

Moving from this position to one in which the Board is able to secure systematic reporting of valid and useful KPIs, with sufficient contextual analysis to understand and identify improved performance across all partners, has been challenging. Following commitment of additional resources, the pace of progress is now accelerating, with recent identification of a Board scorecard of KPIs and a wider suite for scrutiny by the PAQA sub-committee.

Addressing the increasingly high profile risk relating to child sexual exploitation and young runaways, in conjunction with relevant partners.
The Board's oversight of this issue has been slower to develop than in other regions. However, it was recognised as an area for priority action and a number of

measures introduced to provide a more cohesive and robust response:

- approval of a Child Sexual Exploitation/Runaways Strategy and Action Plan.
- revision of the Child Sexual Exploitation/Runaways Forum terms of reference and operation.
- provision of additional multi-agency training and awareness raising.
- staging a dedicated conference in February.
- active participation in the county-wide campaign ("Say something if you see something"), coordinated and promoted by the South Yorkshire Police and Crime Commissioner.

Improve our learning from Serious Case Reviews

In November. the Board approved a new Learning and Improvement Framework, incorporating alternative models for undertaking Serious Case and Learning Lessons Reviews to provide additional opportunities to promote learning and desirable practice changes. The SCR Sub-Committee continued to disseminate learning through multi-agency training activity, specific single agency learning events, monitoring action plans and a specific report to the September Board on neglect.

Continue to promote activities to mitigate the risks to children arising from domestic abuse, adult mental health, substance misuse and digital technology

These areas of safeguarding are progressed by the PPPD Sub-Committee. Maintaining oversight of all these vital areas, together with other emerging areas such as bullying, and promoting activities to mitigate the risks, has been difficult and had limited success. More effort will be required next year to ensure sufficient resources are available and deployed to address these areas in a more systematic and consistent way.

Accelerate joint working arrangements with the Barnsley Safeguarding Adults Board where this could be mutually beneficial

The Safeguarding Adults Board is represented on the Safeguarding Children Board and its sub-committees to facilitate joined up working around those issues that mainly affect adults, but also impact on their children. In November, a joint meeting of both Boards considered issues of mutual concern to develop closer joint working between the two Boards, including:

- exploring opportunities for closer collaborative working.
- development of a local Multi Agency Safeguarding Hub and links to the Stronger Families agenda.
- implications of adult mental health on children.
- lessons to be learnt by partners from the case of Daniel Pelka.

Workforce management and development

The Workforce Management and Development Sub-Committee's extended remit includes oversight of partner agencies' workforce responsibilities, in addition to the planning, design, delivery and evaluation of the multi-agency safeguarding children Training Strategy and Programme. Adult services and community representation maintain a strong link with adult workforce training and promote a wider overview and input to safeguarding training.

The multi-agency training programme is dynamic and flexible to meet the needs of the workforce and their capacity to access

training. Notable improvements this year include:

- quality assurance of all e-learning courses undertaken by sub-committee members resulting in revision and updating of some courses.
- responding to priority areas of concern, for example an intensive programme of awareness sessions in relation to child sexual exploitation has been attended by around 200 delegates, together with a very well received one-day conference. New courses were developed on raising awareness of the 'Prevent' agenda around radicalisation of young people, safeguarding children online; communicating effectively with children; safeguarding the older child; teenage brain development and engaging teens; sleep issues and impacts and understanding autistic spectrum disorders.
- as part of the development of a new course on safeguarding, children with disabilities plans are in train to undertake consultation with young people, parents, carers and professionals.
- introduction of lunchtime seminars on prominent safeguarding topics, which have proved to be extremely popular with full attendance.

The multi-agency programme was considerably enhanced from previous years and new courses added throughout the year when gaps in provision were recognised, either in response to high profile media cases or local Serious Case Reviews /learning events following the death of a child, for example, Child Sexual Exploitation and Engaging with Fathers. Although the Think Family principles are included in all training courses, further effort is required to ensure that practitioners consider and involve fathers in their work with children.

In November 2013, we staged a dedicated anti-bullying conference and in February 2014, a child sexual exploitation conference. Both attracted maximum attendance and rated very highly on evaluation forms. Innovative ways of delivering training continue to be explored, such as the use of actors/theatre groups, which have proved an excellent way of communicating key messages. The sub-committee escalates concerns to the Safeguarding Board relating to attendance or identified gaps in provision, for example, inadequate engagement with local faith communities. Work is ongoing to remediate these issues.

Supervision of partner agency staff is monitored by the sub-committee, as are agencies' safer recruitment practices. In November 2013, all practice managers in primary care received training on safe recruitment as this had been identified as a gap in provision.

The sub-committee has continued to ensure the training programme is relevant, updated and promotes learning from Serious Case Reviews. Regular monitoring of course evaluations and attendances evidences the value of the courses and provides quality assurance. During the year, very few courses have been cancelled.

Contribution from partner agencies
Many multi agency courses benefit from participation and contribution of partner agency colleagues, who regularly provide input through co-delivery with the multi-agency trainer or sole delivery. These include South Yorkshire Police; Trading Standards; Barnsley Hospital, CAMHS; Pathways; Addaction; Child Protection Conference Chairs; multi-agency co-ordinators and the Local Authority Designated Officer. This input is valued in providing a wider multi-agency perspective. In addition, the programme is supported by reciprocal contribution from neighbouring authorities, which brings a broader regional view and economic benefit.

E-Learning
In addition to traditional classroom based courses, we have continued to improve our e-learning offer. The learning packages have interactive screens, learner challenges and online assessment, and issue a certificate on completion.

E-learning is becoming increasingly well used and valued, with 2,602 learners completing a safeguarding e-learning course in the reporting period. Our varied range of courses includes:

- awareness of child abuse and neglect – foundation and core levels
- runaways – the South Yorkshire Protocol
- integrated working –introductory level and strategic manager overview
- hidden harm
- safeguarding children with disabilities
- safeguarding children from abuse by sexual exploitation
- think safe, stay safe, see safe
- e-safety
- child development.

During the year, in response to identified need, we introduced additional courses on:

- basic awareness of domestic violence and abuse, including the impact on children, young people and adults at risk
- equality and inclusion in health, social care or children and young people's settings
- an introduction to female genital mutilation, forced marriage, spirit possession and honour-based violence
- safer recruitment.

Evaluation of multi-agency training
Our training receives very positive feedback:

"More than addressed my needs - very up- to-date and relevant evidence presented of recent cases."

"Very informative and challenging of preconceptions."

"An incredibly powerful course. The films were very hard-hitting and emphasised the seriousness and impact of domestic violence."

"Given me confidence to challenge other professionals and obtain advice."

However, we recognise the need to secure clear evidence of positive impact of training on the attendees' work with children and families and, ultimately, on securing improved outcomes for children.

During the year, we revised the evaluation process and redesigned the feedback forms to capture delegates' intentions in terms of planned actions to improve their own practice and outcomes. Participants are now asked to complete a personal action plan at the end of their course,

identifying proposed changes to practice as a result of the training, through specific identification of:

- three things they will personally take forward from the training and implement immediately.
- three ways in which participating in the training has improved outcomes for children.

We also produced a guide for managers to promote the benefits of multi-agency training in terms of staff development and transfer to improved practice and outcomes. This acknowledges managerial support as the most important factor influencing the effectiveness of training and embedding training messages into improved practice. This strengthened evaluation process has challenged delegates to identify improved outcomes, but there are early examples of positive intent:

"By adapting questioning style, approach and dynamics during a client session, this will improve an outcome for a child as workers are then able to follow concerns up with social care."

"Making sure I always put the children's safety first."

"Now trained in appropriate self care practices regarding the skills to care for children in care."

"Will be able to refer young people to an independent advocate."

Need information about voluntary or community groups?

Contact Voluntary Action Barnsley

Call 01226 320100 or visit www.vabarnsley.org.uk

The number and nature of multi-agency courses delivered in 2013-14 and agency attendance is set out in the table:

	Number of courses	CYPF	Other council including Berneslai Homes	Health inc BHNFT	Police	Probation	Independent & Voluntary Sector	Foster Carer	Other	TOTALS
Addressing child sexual exploitation	1	35	20	13	10	1	13	8	2	**102**
Assessing and working with female sex offenders	1	4	1	4	0	6	1	0	0	**17**
Basic drugs awareness	1	3	1	5	0	0	7	1	0	**17**
Becoming culturally competent	1	4	2	3	0	0	4	8	2	**23**
Better outcomes for families with mental health issues	2	14	1	4	0	0	10	4	0	**33**
Child and adolescent mental health disorders and Illnesses	3	15	1	13	1	0	11	5	0	**46**
Conferences & core groups (Working Together Part 2)	2	21	0	15	0	0	7	1	0	**44**
Courtroom skills	2	8	2	10	0	0	9	0	0	**29**
Drama-based workshop examining safeguarding attitudes and behaviour	1	16	3	20	0	1	0	0	7	**47**
Dealing with child sexual abuse from a police perspective	1	5	1	0	0	0	5	8	0	**19**
Designated safeguarding leads	1	9	0	7	0	0	6	1	1	**24**
Domestic abuse awareness and the effects on children & adults	3	10	13	8	1	0	20	11	4	**67**
Domestic abuse Risk assessment & MARAC	3	15	12	13	1	4	23	4	1	**73**
Engaging with children & families assessment processes	2	11	3	6	0	0	10	0	0	**30**
E-safety conference	1	44	0	4	0	0	2	3	5	**58**
Forced marriage, honour based violence and FGM	2	7	0	9	2	2	6	9	3	**38**
Forensic awareness	2	4	1	1	1	0	4	11	0	**22**
Improving supervision skills	2	8	1	5	0	0	6	0	0	**20**
Interviewing skills	3	15	1	5	0	0	8	1	4	**34**
Introduction to child & adolescent mental health issues	2	18	3	6	0	0	4	6	1	**38**
Learning lessons from Serious Case Reviews	2	8	1	4	0	0	6	0	0	**19**

Multi-agency public protection arrangements (MAPPA) awareness	2	3	4	4	0	0	6	8	2	**27**
Neglect and Serious Case Reviews	1	16	1	7	0	0	3	1	0	**28**
Parental problematic substance use	4	16	9	8	0	0	26	6	0	**65**
"Pay me-don't feed the kids"	2	3	2	1	0	0	5	10	1	**22**
Physical abuse and the role of the paediatrician	2	12	0	5	4	0	4	15	0	**40**
Prejudice based bullying: signs, symptoms and response	1	29	12	6	0	0	10	2	0	**59**
Protecting children online	1	3	0	1	0	0	2	5	1	**12**
Raising awareness of child sexual exploitation	14	68	15	67	4	2	32	11	1	**200**
Recognising and responding to children and young people who display harmful or concerning sexual behaviour	1	2	0	3	0	0	8	4	0	**17**
Safe@Last - safeguarding young runaways	1	9	1	1	0	0	4	7	0	**22**
Safe practice to prevent allegations against professionals	1	6	0	7	0	0	8	2	0	**23**
Safer recruitment	1	8	0	2	0	0	4	1	0	**15**
Self-harm awareness	3	13	0	9	2	0	15	10	1	**50**
Sexual exploitation of children and young people	4	15	2	24	8	0	22	5	0	**76**
Solution focused brief therapy	4	12	4	2	0	3	10	3	0	**34**
The impact of adult mental illness on the parenting of children	1	7	0	11	0	2	1	0	0	**21**
Understanding Attachment	1	9	0	7	0	0	6	1	1	**24**
Understanding thresholds and Stronger Families	3	***20***	***2***	***6***	***0***	***1***	***14***	***3***	***4***	***50***
Working Together Part 1	11	80	7	75	2	2	61	4	9	**240**
Working with parents with learning difficulties	1	11	0	3	0	0	2	2	0	**18**
Working with neglect	4	18	2	28	2	0	17	14	0	**81**
Working with sex offenders who use the internet	1	5	0	3	0	0	4	0	0	**12**
TOTALS	102	**639**	**128**	**335**	**38**	**24**	**436**	**195**	**50**	**1845**

Safeguarding vulnerable children and young people

Children in care

The Board's oversight of children and young people in care is maintained through membership of the Care4Us Council and receipt of individual reports, including the Children in Care KPI Scorecard. The Care4UsCouncil, which comprises young people in care, Board members and relevant council officers, meets regularly to address issues important to this group. During 2013-14, the council, led and chaired by young people, considered:

- a revision of the national Charter for Care Leavers
- a new information website for children in care
- review of the council's Pledge for Children in Care
- implications for young people of the new Children and Families Bill.
- children and young people's wish to change their names
- review of policies relating to the Care2Work Programme
- establishing a mentoring scheme in schools to provide support to children in care
- financial issues, including the Junior ISA scheme.

Young people in care contributed to a range of local, regional and national meetings and consultations including:

- participation in March in a day long event to allow children in care to take part in discussions around life story work
- training for foster carers
- Yorkshire and Humberside Children in Care Council meetings, including a residential event
- Children in Care Council Together regional showcase event
- local consultation on awareness about designated teachers
- development of young people's booklets on adoption and entering care
- participation in an event in May to feedback on proposed structural changes
- consultation on provision of mental health services
- participation in a 'We said - you did?' consultation event and National Care Week activities in October
- participation in a regional event sponsored by a national charity, 'Taking it to the next level event'
- Police and Crime Commissioner survey that established the three main priorities for young people as drugs and alcohol, child exploitation and gangs
- attendance at a parliamentary inquiry on looked after children and care leavers' entitlements
- attendance at a very well attended and enjoyable celebration evening.

Substantial work has been undertaken by partner agencies to improve health outcomes for children in care. The designated doctor and nurse have improved data collection quality and audited LAC health assessments to inform future work. A new Health of Children in Care and Care Leavers Steering Group, reporting to the Child Health Programme Board, meets monthly to identify service improvements to address the health needs of this group and to ensure ongoing improvement. A review of the existing LAC service specification against national standards has led to recruitment of a senior post of named nurse LAC to address and improve the health needs of children in care.

The Steering Group is:

- revising current use of a Strengths and Difficulties Questionnaire so that issues identified will be relayed effectively to the professional undertaking the review health assessment
- assessing the quality of care leavers' health plans
- monitoring the timeliness of initial and review health assessments.

In November and January, the Board commissioned reports in respect of private providers of children's homes and young people missing from care to gain assurance about safeguarding arrangements for this provision. This led to a meeting of private providers and further audit work.

Private fostering

The Board oversees local arrangements to safeguard privately fostered children and young people and monitors the extent to which the local authority undertakes its responsibilities. A private fostering arrangement is one made without the involvement of a local authority for the care of a child under the age of 16 (under 18, if disabled) with someone other than a parent or close relative for 28 days or more. Anyone involved in, or knowing about, such an arrangement must notify the local authority at least six weeks before it begins and the fostering service takes active steps to advertise this responsibility through a range of measures:

- information disseminated via specific information sessions and training
- distribution of an updated Statement on Private Fostering to key stakeholders, including schools, school nurses, health visitors, GPs, children's social care teams, housing and voluntary sector professionals, setting out notification requirements, the local authority's duties and the role of local professional agencies
- distribution of a private fostering flyer to the same stakeholders.

Specific awareness raising activity, supported by the Safeguarding Board, has continued throughout the year, including local advertising. Information leaflets are available for carers, parents, children and young people and professionals. Leaflets, posters and business cards are displayed in major public buildings and information is available on the Safeguarding Board and council websites.

Parents, carers, children and young people can receive advice and support, including training opportunities, from the private fostering social worker.

Do you want to know more about adoption, fostering, private fostering or children in care?

www.safeguardingchildrenbarnsley.com

Call 01226 775876

Are you concerned about a child? Do you wish to make a referral to Children's Social Care?

Call our Joint Investigation and Assessment Team on 01226 772423 or 438831

Out of office hours, call our Emergency Duty Team on 0844 984 1800

The table below shows the figures for private fostering for the last three years.

		31.3.12	31.3.13	31.3.14
1	Number of children in private fostering arrangements as at 31 March	14	18	12
2	Number of new private fostering arrangements which commenced over the last 12 months	13	18	14
3	Number of private fostering arrangements that ended during the past 12 months	18	17	20
4	Number of arrangements that were visited within timescales	100%	100%	100%
5	Number of arrangements initially assessed as suitable	10	12	14
6	Number of arrangements initially assessed as not suitable	0	0	0
7	Number of arrangements that ended following an assessment by the local authority that the arrangement was no longer suitable	0	0	0

Children with disabilites, complex needs and/or special educational needs

The Integration, Assessment, Disability and Inclusion Service works with partner agencies and the Barnsley Parents and Carers Forum to develop and improve services for children and young people with complex needs and difficulties.

Key areas of work have taken place in reviewing and developing services around speech and language therapy, paediatric therapy, short breaks, special educational need reforms, Early Help and the Autism Strategy.

The first information event for children and families was held in June, with a theme of 'Child First' to ensure the voice of the child is central to all our work. The day included contributions from children and young people, parents/carers and professionals. Excellent feedback was received from the 200 parents/carers and young people who attended the event.

On behalf of the Board, the multi-agency group on safeguarding children with disabilities and complex needs has completed a gap analysis to determine how we ensure an outstanding service for this vulnerable group. Eight areas for development have been agreed and the group will be focusing work on new areas over the next 12 months.

A recent Ofsted inspection of our short breaks residential establishment has seen the unit receive a 'good' rating with 'outstanding' for quality of care.

Over the next few months, a review of One Path One Door will be completed. A key area of work will be on SEN reform and ensuring we are in a strong position to implement the reforms in September 2014.

Stronger Families teams
Following a successful pilot, the Children's Trust approved a roll out of four Stronger Families teams to cover the borough from July 2013. These are multi-agency teams and, although there have been challenges to get all of the practitioners into the teams, progress is being made and the identification and engagement of vulnerable children and families at an Early Help stage is seeing positive signs.

Education welfare service (EWS)
The EWS works in partnership with schools to support and advise on safeguarding and attendance issues. School attendance is tracked, including vulnerable groups such as children in care and those subject to a child protection plan. The EWS also oversees children missing education (CME) and those whose parents elect to provide education at home (EHE). The service also contributes to a number of the Board's sub-committees and related multi-agency safeguarding forums.

Last year, the EWS revised various policies for consideration by school governors in spring 2014. These include Promoting Good School Attendance, incorporating model school attendance policies for schools including nursery schools, and policies on Children Missing Education and Elective Home Education.

The EWS delivers school designated safeguarding lead and governor training, including e-safety training, together with the schools S175/157 safeguarding training. The service audits case files to ensure minimum standards are met. A revised EWS referral and initial assessment form was implemented in October 2013, which captures the student and parental voice at initial referral and case closure.

In November, managers audited feedback on the outcome of referrals made to social care, through a review of selected random cases. The service also completed its second year of work with vulnerable families over the summer holiday period which included:

- 135 home visits to vulnerable families who required a safe and well visit
- 202 home visits as part of attendance sweeps to pupils whose attendance fell below school's attendance targets - including year 6-7 transition
- 14 safeguarding meetings that included two case conferences,
- nine home visits to children identified as missing education and three home visits regarding elective home education.

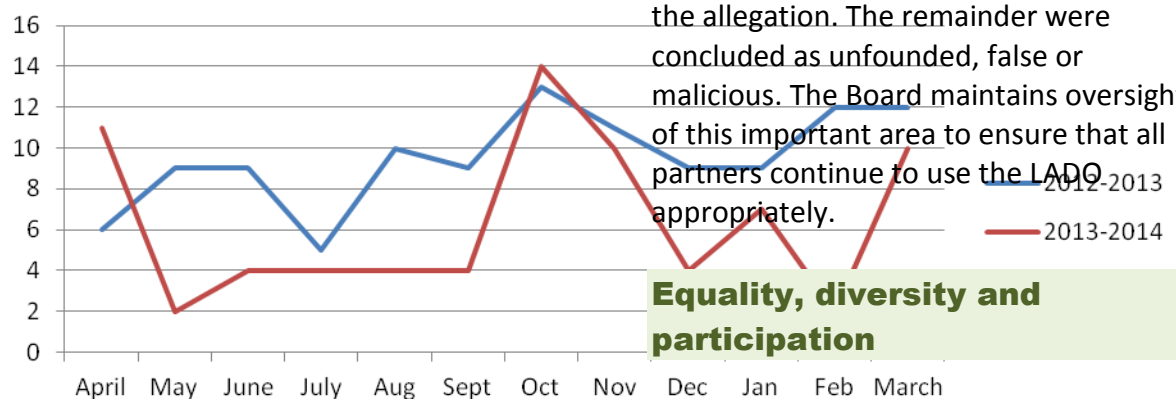
Dealing with allegations against professionals

Maintaining a consistent rate of contact with the Local Authority Designated Officer (LADO) indicates that the practice of dealing with allegations against staff, carers or volunteers is well established with partner agency staff. Contact was made with the LADO in relation to 234 cases in 2013-14, representing a small increase of around 6% on the previous year.

An update of the Board's procedures in March 2013 amended the criteria for allegations to those where there is a risk of harm to child/ren, or a criminal offence may have been committed. The removal of the criteria of behaviours which indicates an individual may be unsuitable to work with children has led to aspects of unprofessional behaviour no longer being subject to these procedures. These issues continue to be dealt with by the employing organisation. This amendment has reduced the number of recorded allegations to the level in 2008-9, the lowest level since the introduction of these

processes. While there has been an overall reduction in allegations, the peak period of October/November has remained a feature of the yearly pattern.

Allegations reported per month 2013-2014



There were 76 reported allegations which were deemed to meet the criteria of a risk of harm to child/ren, or a possible criminal offence committed against or related to a child. The majority of behaviours reported were of a physical nature (51%), with sexual and emotional abuse accounting for 22% and 20% respectively, and the remaining 8% being neglect of a child's needs. The referrals were made by a wide range of statutory and voluntary agencies. The schools sector accounted for 39% of all referrals, reflecting the numbers of schools and the frequency, duration and intensity of their direct work with children.

Awareness raising activities have taken place during the year. Training has been provided to early years settings, including children centres, private day nurseries and child minders, foster carers, hospital and health-based staff and taxi drivers, and to a multi-agency audience looking at safe practice to prevent allegations arising.

Records evidence that referrals receive a timely and robust response that ensures that children and young people are protected. The majority (88%) of the allegations had been concluded by the end of the year. Of these, 33% had been concluded as substantiated in that there was sufficient evidence to prove the allegation. A further 28% were concluded as unsubstantiated because there was insufficient evidence to prove or disprove the allegation. The remainder were concluded as unfounded, false or malicious. The Board maintains oversight of this important area to ensure that all partners continue to use the LADO appropriately.

Equality, diversity and participation

The Board is strongly committed to promoting equality of opportunity and ensuring that all safeguarding activities take account of the diverse needs of all children and young people in the borough.

The council's Equality Scheme 2012-15 reaffirms this commitment, to be achieved through development and provision of relevant, appropriate and accessible services.

Equality objectives for children and young people include:

- providing support to schools and settings to meet their public sector equality duty
- helping schools and settings identify, record and deal with bullying and harassment in schools
- narrowing the gap between different sections of the community, including where different levels of achievement are related to disability, gender, ethnicity or economic background
- challenging the barriers faced by looked after young people
- fulfilling the Pledge to children in care.

- meeting the needs of children and young people with special educational needs, learning difficulties, disability and complex health needs
- concluding implementation of the developments in the One Path One Door strategy
- continuing to reduce the number of young people not in education, employment or training and address the needs of specific groups
- undertaking work to improve transition of vulnerable groups, particularly those with learning difficulties.

All newly developed strategies, policies and procedures are subject to an equality impact assessment. Active steps taken to facilitate inclusion include the provision of appropriate support for families to enable them to participate fully in child protection conferences and representation of young people's views at the Board's sub-committees. Where necessary, specialist support, for example, interpretation and translation services are engaged to support families. In February, the Board led a safeguarding workshop as part of a multi-agency disability harassment conference.

Awareness raising and promotional activities

Throughout the year, the Board promoted and supported activities and events to enable practitioners and managers to develop and learn together. Where possible, events included parents, carers and young people. Over 2013-14, activities included:

Drama-based experiential workshop
In February, almost 60 attendees from partner agencies participated in an interactive workshop that explored attitudes and behaviour around children's safeguarding; challenging perceptions and prejudices as the scenarios developed.

Designated lead seminars to promote good practice
The Board continues to promote multi-agency workshops for designated safeguarding leads from partner agencies. A well attended seminar in July explored implications for practice from changes in Working Together 2013, improvements to child protection case conference reporting, the reconfiguration of Children's Social Care and the impact of the new Stronger Families teams.

E-Safety conference
In January, a group of young people provided their own unique perspective to an E-Safety conference that attracted around 60 frontline practitioner and managers from partner agencies. The event focussed on latest trends and changing risks, the local position, Ofsted proposals for inspecting e-safety and available help and support. The input from the young people was particularly valuable and thought provoking.

Prejudice based bullying - signs, symptoms and responses
In November, around 60 designated safeguarding leads in schools and partner organisations attended a multi-agency anti-bullying event with a focus on prejudice-based bullying. Issues included how to address prejudice-based bullying; the PREVENT agenda and extremism; Cyberbullying and the Public Equality Duty and Hate and Hidden Crime. As in the e-safety conference, the experiences and perspective provided by a group of young people had the biggest impact.

Adoption Panel development day
A very successful development day in March focused on the child's journey to adoption. Delegates welcomed the

opportunity to examine current challenges, including shorter approval timelines, in conjunction with staff from different teams.

Speakers provided information on legal issues and training to achieve quality Child Permanence Reports.

Foster Panel development days
Dedicated development days in March and September examined the significant changes underway in our fostering service, including a clearer route for enquirers considering fostering and a more timely response to applications.

Safeguarding Board development events
In July the Board held a development session to consider the following safeguarding issues in depth:

- Stronger Families Project
- outcome of a Lessons Learnt Event held in relation to the death of a child
- Implementation Plan to improve the effectiveness of partnership working drawn up following the joint session with the TEG in April

In November, a joint development event with the Safeguarding Adult's Board explored and debated the following issues.

- Joint Safeguarding Children Board/Safeguarding Adult's Board Opportunities for closer collaborative working
- Multi-Agency Safeguarding Hubs and link to Stronger Families
- effects of adult mental health on families -
- learning for children's and adult's services from the Serious Case Review on Daniel Pelka.

Consultation events
Multi-agency consultations were held during the year to secure partner agency input to the Board's response to the following government consultations:

- running away from home or care in August
- changes to the care planning Placement and Case Review (England) Regulations 2010 in September
- inspection of Safeguarding Children Boards in October
- criminal offence of ill treatment or wilful neglect in health and social care in March.
- the care of unaccompanied asylum seeking and trafficked children in March.

In each case, a composite Board response was returned by the given deadline.

Child Safety Week - June 2013
The theme for last June's Child Accident Prevention Trust child safety week was 'Safety Heroes', with the opportunity for frontline practitioners to obtain their own toolkit to create a local focus for accident prevention and engage families on key safety issues. This theme complemented the Public Health key target to reduce hospital admissions from unintentional and deliberate injuries.

Information was circulated to partner agencies to assist them participate in the week's events.

Reviewing Barnsley Safeguarding Children Board effectiveness

Throughout last year, the Board continued to address the strong challenge provided in 2012 through the **Ofsted Inspection of Safeguarding and Looked After Children's Services,** and resulting **Improvement Notice**. Significant progress and practice improvements have continued to address recommendations from the original Notice and also to develop new areas of safeguarding to improve our overall effectiveness. To ensure business is tracked and progressed effectively, the Board introduced an action log in May to hold partners accountable for identified actions.

The initial phases of our Improvement Plan and Programme have developed into a Continuous Service Improvement Programme under which we aim to consolidate the actions taken and further embed the improved practice we are introducing. This will remain as a top priority for next year.

A self-assessment of the Board's effectiveness, based on a government model and incorporating findings from the Ofsted Inspection, found good evidence that we were addressing all of the factors to some degree. We also identified significant areas for further development which were reviewed as the year progressed.

In March 2014, the Board undertook a further self assessment against the standards and measures in the current Ofsted Inspection Framework, the findings from which are shown below, together with plans for further improvements:

EFFECTIVNESS		
What we need to do	**How are we doing and what difference did it make?**	**How do we plan to improve?**
Overall: 'good' characteristics are widespread and 'common practice'	"Good" characteristics are not yet consistently embedded in daily practice.	Actions are ongoing to improve performance and embed good practice through our continuous service improvement programme.
Overall: How effectively LSCB evaluates and monitors the quality and effectiveness of partners	Multi agency performance data was provided but the Board was not been satisfied that it routinely reported the right measures. Special meetings in February and March 2014 have identified the KPIs to be routinely monitored by the Board and PAQA Sub-Committee. The Section 11 audit challenge process evaluates and monitors the quality of partners' effectiveness.	The PAQA Sub-Committee will continue to refine its suite of KPIs and monitor audit outcomes from the single and multi-agency audit schedule. A programme of multi-agency audits will be undertaken to examine priority areas of concern.
Complies with its statutory responsibilities in accordance with the Children Act 2004	The Board was established on 1 April 2006 and CDOP on 1 April 2008 in accordance with legislation. The Annual Report and Business Plan are produced and published each year.	The Board will undertake more rigorous and systematic review of its Business Plan objectives to ensure continuing relevance and evidence of achievement
Complies with the Local Safeguarding Children Board Regulations 2006.	Enshrined in Constitution. Board and CDOP established in accordance with legislation. SCRs are commissioned when criteria are met and findings published.	Where criteria for holding SCRs are not met the Board will undertake alternative Learning events in compliance with its Learning and Improvement Framework to promote and disseminate learning.
Able to provide evidence that it coordinates the work of statutory partners in helping, protecting and caring for children in its local area	Section 11 self assessments Multi-agency training is available. The Board produces multi-agency policies, procedures and strategies e.g. CSE A multi-agency Sub-Committee structure is operational Action plans are created and monitored for SCRs, Learning Lesson events and specific strategies are developed e.g. CSE Strategy	Section 11 challenge process to be more rigorous. The Board needs to review its policies and procedures more systematically to ensure they are all up to date and relevant. Action Plans from SCRs, other learning events and strategies need to be SMART
There are mechanisms in place to monitor the effectiveness of those local arrangements	Section 11 challenge process Multi-agency training evaluation process Action plans monitored	We need to improve a more systematic review of multi and single agency audit activity The Board will improve its evaluation process for multi-

	Multi agency audit programme in place and findings reviewed by PAQA Committee.	agency training to evidence impact of training more effectively.
Multi-agency training in the protection and care of children is effective and evaluated regularly for impact on management and practice.	Comprehensive programme of multi-agency training provided Evaluation process in place with plans to develop this further to evidence improved outcomes for children. Guidance published to encourage management support in ensuring that messages from training are embedded in practice Regular monitoring of evaluations by the WMD Sub-Committee	Training will continue to be monitored and developed to address emerging priorities, Evaluation of impact to be improved
LSCB checks that policies and procedures in respect of thresholds for intervention are understood and operate effectively and identifies where there are areas for improvement	New thresholds document approved and disseminated February 2014. Staff leaflet in development. Multi-agency training provided on thresholds Multi agency thresholds group working to further develop and embed understanding of thresholds across all agencies. Email to all safeguarding leads Feb 2014 to encourage use of escalation policy re thresholds. Process established to collate use of escalation policy.	Further work required to raise partner agency understanding of thresholds. Use by agencies of the escalation policy to be reported back to the Board Multi-agency audit will be undertaken to check agency understanding of thresholds
Challenge of practice between partners rigorous and leads to improvement	Section 11 challenge Encourage challenge on debate at Board and Sub-Committee meetings Log of challenges and outcome is developing. Use of Escalation policy is encouraged and monitored	Maintain and strengthen challenge relating to attendance and representation at the Board and Sub-Committee. Report on log of challenges to the Board
Casework auditing is rigorous and used to identify where improvements can be made in front-line performance and management oversight	Substantial audit work undertaken however quality of audits undertaken need to be improved. Outcome of multi-agency audit on child protection conferences received at special PAQA and Board in March 2014. Further multi-agency audit work in planning	The programme of single and multi agency audits reported to PAQA Sub-Committee needs refining and more systematic scrutiny. The Board will undertake an agreed programme of multi-agency audits
Serious case reviews,	SCRs undertaken when criteria met - where not met	The Board will continue to promulgate lessons derived

management reviews and reviews of child deaths are used by the local authority and partners as opportunities for learning and feedback that drive improvement.	learning lessons reviews commissioned if appropriate. Action plans monitored by SCR Sub-Committee. Multi agency training provided on SCRs Individual reviews disseminated through relevant forums e.g. Head teachers meeting SCR lessons dissemination event for 150 frontline practitioners in September 2012	from SCRs and similar reviews and develop specific multi-agency training to address identified need.
The LSCB provides robust and rigorous evaluation and analysis of local performance that influence and inform the planning and delivery of high-quality services.	Performance management system still developing. Safeguarding Board's set of key indicators identified for regular review at each meeting. Wider set also identified for the PAQA Sub-Committee to review and escalate issues of concern to the Board. Supplementary audit programme to evidence practice improvements. Much improved data for LAC. Areas of poor performance identified for action as part of Improvement Plan - to be transferred to SCB over time.	Further strengthen the role and function of the BSCB through building on current work to improve performance management, including: • Co-ordinate the process to evaluate the impact of multi-agency and single agency training to secure a consistent response from delegates • Performance data and audit activity - Integrate child protection and IRO activities to provide learning from quality assurance
WHAT GOOD LOOKS LIKE		
What we need to do	**How are we doing and what difference did it make?**	**How do we plan to improve?**
The governance arrangements enable LSCB partners (including the Health and Well-Being Board and the Children's Trust) to assess whether they are fulfilling their statutory responsibilities to help (including early help), protect and care for children and young people.	Clear relationship articulated between SCB and Children's Trust (TEG report November 2013) Common members on all 3 bodies i.e. SCB/TEG/HWB provides opportunity for mutual reporting Protocol agreed to articulate relationship between SCB, TEG and HWB at the March 2013 Board.	Embed the developing performance management process to clarify and understand how well statutory responsibilities are fulfilled
The LSCB effectively prioritises according to local issues and demands and there is evidence of clear improvement priorities identified that are incorporated	Priorities are set out in Board's Business Plan and Annual Report. New priorities identified as local issues arise and action taken e.g. CSE Strategy and Action Plan. Sub-Committees review their Business Plan priorities	The Board needs to monitor its own priorities more systematically and develop a clear delivery plan More formal evidence of Board and Sub-Committee achievement required to ensure continuing validity of the purpose, values and vision

into a delivery plan to improve outcomes.	regularly for achievement and relevance.	The Board will improve its oversight of the extent of neglect as a local feature and the processes in place to monitor the efficacy of interventions to ensure that all partner agencies are addressing neglect robustly and without compromise. The Board aims to improve oversight of missing children
Regular and effective monitoring and evaluation of multi-agency front-line practice to safeguard children identifies where improvement is required in the quality of practice and services that children, young people and families receive. This includes monitoring the effectiveness of early help.	Regular audits. Performance reporting with escalation system from PAQA Sub-Committee.	Report planned on effectiveness of Early Help offer to SCB in May 2014
Partners hold each other to account for their contribution to the safety and protection of children and young people (including children and young people living in the area away from their home authority), facilitated by the chair.	Board Chair encourages open debate at Board meetings and culture where respectful challenge is encouraged. Performance information provides transparency to rate partners' performance.	More clarity and systematic reporting needed on children placed out of district
Safeguarding is a priority for all of the statutory LSCB members and this is demonstrable, such as through effective section 11 audits. All LSCB partners make a proportionate financial and resource contribution to the main	Revised more rigorous Section 11 self assessment undertaken in 2013; completed by all statutory partner agencies and subject to challenge process. LSCB partners contribute to SCB Budget although contributions are at standstill or reduced over past years. Contributing partners recognise the need for additional funding to resource unexpected demand.	Feedback to be provided by school representatives to all schools through the weekly bulletin following key meetings (BSCB, Schools Forum, SEE, Improvement Board, Trust Executive Group, Challenge Board, Children and Families Act Project). Sub-Committee attendance will continue to require proactive oversight and action to address unsatisfactory

LSCB and the audit and scrutiny activity of any sub-groups.	Sub-Committees have multi-agency representation. Multi-agency audits undertaken	attendance The Board will need to meet challenges posed by partner agency reorganization and impact on attendance
The LSCB has a local learning and improvement framework with statutory partners. Opportunities for learning are effective and properly engage all partners. Serious case reviews are initiated where the criteria set out in statutory guidance are met and identify good practice to be disseminated and where practice can be improved. Serious case reviews are published.	Learning and Improvement Framework approved and published on the SCB website. Learning lessons opportunities undertaken with frontline practitioners and resulting action plans monitored through SCR Sub-Committee. SCRs initiated where criteria are met and are published Learning from SCRs and learning events disseminated by partner agencies and through multi-agency training.	Learning from SCRs and learning events will continue to be disseminated to partner agencies and through multi-agency training.
The LSCB ensures that high-quality policies and procedures are in place (as required by *Working Together to safeguard children*) and that these policies and procedures are monitored and evaluated for their effectiveness and impact and revised where improvements can be made. The LSCB monitors and understands the local application of thresholds	Policies and procedures in place and accessible via website. Chair's message to encourage use of escalation policy February 2014. .	Undertake more regular and systematic review of the Board's Polices and Procedures to ensure they are comprehensive, up to date and relevant Need better evidence of the effectiveness and impact of policies and procedures and when they are revised following review. Application of thresholds needs to be more consistent and better understood by partner agencies
The LSCB understands the nature and extent of the local issues in relation to children missing and children at risk of sexual exploitation and oversees effective information sharing and	SCB received reports on children missing and at risk of CSE in January 2014. Local CSE Strategy and Action Plan in place. Strategic CSE Group maintains coordinated oversight and monitors CSE Strategy Action Plan. CSER Forum monitors individual cases. The Board is represented on the South Yorkshire Police and	The Strategic CSE Group will monitor and periodically report on achievement of the CSE Strategy Action Plan.

a local strategy and action plan.	Crime Commissioner's county wide forum and is participating in the county wide CSE campaign lead by the PCC. In March 2014 the Board agreed a county wide addendum to the information sharing Protocol re CSE.	
The LSCB uses case file audits including joint case audits to identify priorities that will improve multi-agency professional practice with children and families. The Chair raises challenges and works with the local authority and other LSCB partners where there are concerns that improvements are not effective.	Case file audits undertaken including multi-agency audits to identify priorities for improvement. Log of challenges developing to evidence challenge from Chair and Board to partners, including the local authority. Board minutes evidence challenge by partners to improve effectiveness of services e.g. health service DNA polices.	Findings from the multi - agency and case file audits will be incorporated into Action Plans where appropriate for monitoring by the PAQA Sub-Committee and report back to the Board. In overseeing partner effectiveness the Board will provide challenge in respect of any areas of concern
Practitioners and managers working with families are able to be involved in practice audits, identifying strengths, areas for improvement and lessons to be learned. Experiences of children and young people are used as a measure of improvement.	Practice audits undertaken by managers. Developments ongoing to capture voice of young person e.g. in cp conference reports.	More development is needed to capture and use the experiences of children and young people as a measure of improvement and to inform service delivery
The LSCB is an active and influential participant in informing and planning services for children, young people and families in the area and draws on its assessments of the effectiveness of multi-agency practice. It uses its scrutiny role and statutory	The LSCB has influenced service delivery e.g. continued concerns on thresholds has led to additional work. The report on private providers of Children's homes led to new meetings and additional work to ensure compliance. DNA concerns led to additional work to ensure effectiveness. The SCB contributes to the C&YP plan. The Chair has influenced the Health and Well Being Section of the C & YP Plan to ensure that CSE was captured under	The Board will continue to influence the planning of services for children in areas of identified need e.g. next year the issue of neglect will be addressed by the Board.

powers to influence priority setting across other strategic partnerships such as the Health and Well-being Board.	the Sexual Health section in response to a consultation on the draft plan. The Board had approved a Protocol to clarify relationships between the SCB, TEG and HWB	
The LSCB ensures that sufficient, high-quality multi-agency training is available and evaluates its effectiveness and impact on improving front-line practice and the experiences of children, young people, families and carers. All LSCB members support access to the training opportunities in their agencies.	The Board provides a comprehensive programme of high quality multi-agency training which is flexible and adapted to meet newly identified needs e.g. response to CSE. Effectiveness and impact on frontline practice evaluated through new evaluation process. Multi-agency membership of Sub-Committee promotes take up of training plus wide promotion through website, flyers etc. Managers are encouraged to ascertain impact on practice through guidance approved by Sub-Committee and published on website	Better evidence of the impact of multi-agency training is required - this will be addressed next year.
The LSCB, through its annual report, provides a rigorous and transparent assessment of the performance and effectiveness of local services. It identifies areas of weakness and the causes of those weaknesses, and evaluates and where necessary challenges the action being taken. The report includes lessons from management reviews, serious case reviews and child deaths within the reporting period.	LSCB's Annual Report provides assessment of performance and effectiveness of local services, including areas of weakness and future priorities for action. Annual Report includes information from SCRs, lessons learned reviews and child deaths.	

Monitoring the effectiveness of local work to safeguard and promote the welfare of children

The work of the Board is progressed largely through its sub-committees and sub-groups who have progressed the following work last year:

Performance, audit and quality assurance sub-committee

This is the key forum through which the Board examines and verifies the quality of individual agency safeguarding practice. It oversees performance management, scrutinises a developing suite of key performance indicators (KPIs) and secures quality assurance through findings from single and multi-agency audit activity.

Performance management and quality assurance framework

In December, the PAQA Sub-Committee agreed an updated Quality Assurance and Performance Management Framework, subsequently endorsed by the Board. This confirms the need for continuous service improvement and delivery to be driven through quality standards, monitoring of improvement targets and focus on a suite of selected KPIs. The Board and sub-committee held a special development sessions to determine the data to be received by the Board and sub-committee. Respective scorecards of multi-agency KPIs have been identified for regular reporting. The sub-committee will escalate any issues of concern to the Board. The Board is now moving towards a more effective performance management culture through increasing focus on performance and quality assurance. More valid data with contextual information will enable constructive challenge and provide proper reassurance about safeguarding from partner agencies.

The Board's own set of KPIs, framed around the child's journey from early intervention through to Tier 4 and looked after status include:

Early Intervention

1. Number of CAFs reported and completed by agency
2. Number of escalations received and resolved in respect of threshold disputes
3. Percentage of referrals to assessment, ie conversion rate
4. Total number of referrals

Assessment and Section 47 investigation - contacts in and conversion rates

5. Number of contacts received
6. % of contacts to referral
7. Number of Section 47 Investigations
8. % of Section 47 Investigations converting to child protection conference
9. % of assessments completed within 20 days
10. % of assessments completed within 45 days and those out of timescale
11. Number of unallocated cases
12. Number of Section 47 investigations relating to children at risk of CSE
13. Number of strategy meetings and referrals to the CSE Forum
14. Number of children/young people identified as being at risk of CSE where the case has progressed to a criminal investigation and criminal charge of the perpetrator.

Children in Care

15. Number of children/young people missing from care.

Assurance from audit activity
The sub-committee promotes practice improvement through review of audit outcomes, drawn from an evolving programme of planned single and multi-agency agency audits. Efforts continue to improve systematic reporting of single and multi-agency practice in terms of identifying priority areas and promoting multi-agency contribution. Findings from partner agency audits included:

Audit of compliance and quality of feedback on the outcome of referrals to children's social care: To address concerns about the number of referrals where social care had not provided feedback to the person making contact. The audit in January, which followed introduction of a new electronic stimulus to provide feedback, found limited compliance with a 29% feedback rate. However, a follow-up audit in June saw a much improved position, with 66% feedback.

Child protection case conference reports: Overall report quality and adherence to the Board's Minimum Quality Standards remains an area for improvement, both in terms of agencies supplying reports and their quality, particularly in relation to analysis. Adherence to the required standards has been reinforced in designated safeguarding lead and multi-agency training.

Education welfare case file audit: A baseline audit, in preparation for an annual case file audit, examined the standard of case recording and common themes regarding strengths and weaknesses to enable the establishment of a benchmark standard.

Elective home education (EHE) audit: Following a revision of the EHE Policy, undertaken in the light of recent Serious Case Reviews, this audit identified some disparity between the primary and secondary sectors in terms of knowledge about the school's responsibilities. Additional questions were therefore added to the Headteachers' Annual Report on Safeguarding to cover both EHE and Children Missing Education (CME) Policies to provide an annual check for schools to evidence that they had governor endorsed policies in place.

BHNFT midwifery service audits: A case note audit in February found substantial evidence of continued and sustained improvement in terms of notes returned promptly, antenatal information transfer to postnatal records and confirmation that questions about domestic abuse were routinely asked in all cases. An audit of pre-CAF completions in June found that, nine months after introduction, the sections relating to family, service provision and risk factors had been completed appropriately in most cases.

BHNFT record keeping in paediatrics, emergency department and midwifery There were positive findings in the audit undertaken against the standards in the Clinical Health Record Keeping Policy, with all records in all areas covered being legible.

BHNFT vulnerable young people pathways, alcohol and substance misuse and self-harm: Two audits undertaken since introduction of new pathways for young people attending A & E found a mixed picture in terms of adherence to the referral for appropriate support. Further awareness raising was instigated to promote use.

BHNFT joint audit with Yorkshire Ambulance Service: The audit of handover documentation in cases that had been referred to children's social

care, identified Barnsley as one of the safest areas for safeguarding children

SWYPFT qualitative health visitor records audit: The outcome from a qualitative review of health visitor records produced overall positive findings, although one theme emerging for action was a need for clarity in record keeping.

Section 11 audit: Partner agencies undertook a further refresh of their original 2008 Section 11 self assessments to verify that compliance evidence was still available and standards were being maintained. Standards relating to development of safeguarding policies and procedures; lines of accountability; safer recruitment and selection; staff training and effective inter-agency working were assessed. The audit tool was revised to require more comprehensive information with supporting evidence. Audits were completed over the winter and subject to a challenge process in February/March. The findings from the Section 11 audit will be reported to the Board next year.

Multi-agency audit on neglect: Five cases of children referred to children's social care with a primary concern of neglect, whose cases had received increasing tiers of service, were audited. The audit, which sought assurance that decision making and practice was robust, found a mixed picture, often attributable to the variation in the cases. However, there was evidence of good practice and the report recommended that recent initiatives, such as the Continuum of Assessment, should be further promoted and used in dealing with allegations of neglect. Agencies were also reminded to ensure robust, specific and thorough record keeping.

Looked after children's health Assessment audits: A review of looked after children's records for those placed both inside and extra-borough examined the timeliness of assessments, status of immunisations and whether the child was registered with a dentist. This had been identified in our Ofsted inspection and the findings showed an improving picture over the audit period.

Audit of children made subject to a second child protection plan within a year of their last plan being discontinued: This annual audit, based on analysis of all the children made subject to a child protection plan for a second or subsequent time within a one-year period, again identified recurrent themes relating to domestic abuse, alcohol/substance misuse, hostility and lack of engagement. This year's analysis found that, in three cases, the second plans were essentially due to lack of parental honesty, which had implications for staff training.

Overview of vulnerable groups: In fulfilling its objective to review the welfare of vulnerable groups of children, the sub-committee questioned information on the following during the year:

- **Children missing education (CME) -** This relates to children of compulsory school age, not on school roll or educated otherwise, who have been out of any educational provision for at least four weeks. The sub-committee sought information on local numbers and how the children were monitored to ensure they receive suitable education and are safeguarded. Although potential complications relate to school transfer and relocation to another area, the EWS request a safe and well visit to ensure a child's welfare as soon as relocation is known. The service has revised its CME policy and procedure guidance during the year in response to a

national consultation. Ofsted has commended our procedures as robust.

- **Looked after children -** The sub-committee reviewed a statistical report containing performance indicator data relating to looked after children.

- **Children with a disability or complex health needs** - Services provided to this vulnerable group were reviewed in terms of numbers of children, short break provision, audit findings, related training and links with the Parents and Carers Forum.

- **Children living with domestic violence:** In July, the multi-disciplinary Stronger Families teams were extended across the borough to refocus resources on early help and intervention, address increasing levels of domestic abuse and mitigate against the reduction of services previously available from the voluntary sector. All standard/ medium referrals are now referred direct to a Stronger Families team, whose allocated worker provides or signposts to an appropriate service for the family.

Policy, procedures and practice developments sub-committee

This sub-committee oversees a range of areas of safeguarding practice. In acknowledgment that many safeguarding issues relevant to children and young people are derived from adult behaviours, membership of the sub-committee contains representation from adults services. These clear links to adult mental health and substance misuse provide for more cohesive working in these areas of safeguarding concern and forge stronger alliances with relevant partner agencies. The sub-committee has found this extensive remit to be a challenge in terms of addressing all issues thoroughly, and has therefore established periodic time-limited task groups to address particular pieces of work. Last year, it built on this approach in its considerations to:

- develop and consult on new multi-agency protocols, policies and procedures on specific safeguarding issues or in response to Serious Case Review findings
- ensure relevant communications to frontline staff
- identify any gaps in safeguarding practice that need to be addressed through development of new safeguarding policies/procedures
- respond to national and local policy changes and advise the Board of the implications of relevant publications and safeguarding developments
- work with the Serious Case Review Sub-Committee to undertake 'lessons learnt' reviews, and identify required amendments to policy and procedure
- ensure development of a holistic approach to the safe use of digital technology and ensure that e-safety safeguards are audited and evaluated within the Board's Performance Management Framework
- provide advice and support on digital technology safeguarding requirements
- maintain oversight of interagency arrangements to protect young people who are vulnerable/exposed to risk of harm through sexual exploitation and/ or running away from home and/or substance misuse. Receive reports from the Sexual Exploitation and Young Runaways Forum. Report on specific areas of unmet need to advise

the Board of potential and necessary resources/services to meet these needs

- Ensure multi-agency training on the impact of adult mental health on parenting children and promote shadowing opportunities for relevant staff in partner agencies
- strengthen engagement of young people with the Board through maintenance of links with relevant forums, such as the Youth Council, to secure the voice of the young person
- promote better awareness of the impact of adult mental health, learning difficulties, substance misuse and domestic abuse.
- ensure that work relating to anti bullying policies and strategies reflects a zero tolerance approach.

During the year, the sub-committee considered and provided consultation on many individual areas of significant safeguarding concern, including:

- consultation on a new pre-birth assessment pathway and additional pathways established at BHNFT to provide appropriate services to young people attending A & E under the influence of substances, including alcohol or with mental health/self-harm problems
- update on the Board supported Addaction Family Fun Day, to raise awareness of services around substance misuse and hidden harm, including support for individuals, a needle training programme and young people's drug services
- major project to quantify the extent of hidden harm through parental substance misuse and the potential numbers of affected children. Also work by health services in relation to Foetal Alcohol Syndrome
- Safeguarding Board Communications Strategy; Health Visiting Implementation Plan and Early Implementer experience
- Effective means of disseminating new policies/procedures to secure assurance through monitoring of their impact on practice
- new process for discontinuing a child protection plan when a child becomes looked after to streamline the process and reduce duplication of meetings for families
- safeguarding presentation from South Yorkshire Fire and Rescue Service, including risk management, community safety, emergency response and promotional activities.
- addressing domestic abuse as an integral part of the sub-committee's activities
- implications and changes arising from Working Together 2103
- the findings from an e-safety survey of young people that confirmed national trends in increasing use of mobile devices, activity involving webcams and transmission of images between young people. It also identified significant numbers of children spending longer on the internet, the extensive and increasing use of social media, lack of engagement by parents and the range of devices used to access the internet. The number confident they knew what to do to report abuse was encouraging, but there were concerns around online bullying and lack of parental knowledge
- promotion and dissemination of information relating to e-safety in schools by the CEOP Ambassadors
- support for the November Anti-Bullying workshop and the July designated lead safeguarding event.
- Ofsted Report: What about the Children; on the impact of adult mental health and neglect

- "Did not Attend" polices from BHNFT and SWYPFT
- update on work to support CSE and young runaways.
- oversight of the work of the Street Pastors.
- new Framework for Assessment
- new arrangements to strengthen support for young carers in Barnsley.
- update on Review of Hidden Harm and Needle Exchange polices.

Development of new policies and procedures

The Board's web enabled policies and procedures were revised and updated in September and March, with addition of new polices and updating to reflect Working Together 2013. In response to identified needs or recommendations from SCRs/learning events, the Board approved the following new policies and procedures, developed with multi-agency consultation:

- referral to advocacy service for child protection conferences
- new Learning and Improvement Framework incorporating a Serious Case Review Toolkit
- process to assist agencies in their collective response to a critical incident involving a child
- Section 47 Joint Investigation Protocol between children's social care and the police
- procedure for responding to challenges to a child protection case conference
- information sharing addendum for child sexual exploitation.

In addition, the Board approved updated versions of the following polices:

- revised Elective Home Education and Children Missing Educated
- protocol on dealing with allegations against staff, carers and volunteers
- revised Minimum Quality Standards for child protection conferences
- Child in Need Procedures.

Serious case review sub-committee

The Serious Case Review (SCR) Sub-Committee monitors and drives progress of outstanding actions from Barnsley SCR /Learning Event Action Plans; provides effective dissemination of lessons to practitioners and oversees arrangements for any new SCRs/Learning Events. It also examines SCR reports and recommendations from other areas with a view to learning transferable lessons for Barnsley and highlighting common themes for partner agencies.

During the year four Barnsley Action Plans were monitored to completion. These related to 2 SCRs initiated in 2011 and 2 learning events held in 2012 and 2013. The Board subsequently signed off three of these Action Plans in March and January. The Action Plan from the 2013 Learning Event was completed in February 2014 and will be submitted to the Board for signing off early next year.

The Sub-Committee also:

- reviewed seven SCRs from other areas to extract lessons with local resonance and implications for related activity, such as multi-agency training
- considered a report commissioned by the NSPCC on learning derived from a study of SCRs involving neglect. This later resulted in a report to the Board
- received the outcome of a thematic review of 12 cases of concern

prepared by Sheffield with potential local lessons
- received a presentation on a pilot scheme in CAMHS to improve service provision.

In all cases, messages were disseminated by the sub-committee and Board members to frontline staff to highlight common themes, difficulties and best practice.

Serious Case Review Panel

During 2013-14, the SCR Panel met twice to consider potential new cases. In both cases, the Panel determined that the criteria for undertaking a SCR had not been met; recommendations subsequently endorsed by the Board Chair and, in the second case, by the National Panel of Independent Experts.

However, in recognition of potential learning, specific events were arranged to examine the circumstances of each case, using a Root Cause Analysis technique. A third learning event was held in January 2014 in response to concerns raised by the Board on receipt of a Serious Incident Report from health. The findings of the first event were received by the Board in July. Reports from the second and third events will be reported to the Board next year.

The Safeguarding Board also held a special meeting in January to receive the findings from a learning event held in 2012. In addition the Overview Report and Executive Summary of a SCR completed in 2012 were published in December 2013, on the conclusion of legal proceedings.

What have we learnt?

Although the Board did not commission any new SCRs last year, it initiated three learning events and signed off three completed action plans. The circumstances and profile of each child differed, but some common themes emerged as lessons for frontline practice from identified shortfalls, notably in terms of engaging with family members and exercising professionals and exercising professional curiosity. This learning, which was disseminated through multi-agency training, specific single and multi-agency learning events for practitioners, Board reports and electronically, resulted in a range of actions including:

- revise and add to multi-agency training programme to address issues such as engaging with fathers/father figures
- deal with a child within the impact of their family setting and environment, not in isolation, through comprehensive assessment of the whole family to gauge what life is like for the child
- development of a new policy on working with hard to engage families, including actions to mitigate parental failure to bring their child to medical appointments, for parents who failed to engage with services or demonstrated veiled compliance
- improve interagency communication
- improve recording and record keeping generally by all agencies, particularly in respect of the legal status for placements and of 'others in household or at a contact'
- strengthen Emergency Duty Team arrangements.
- ensure clear understanding by all agencies in respect of thresholds for access to services.
- ensure availability of support for children with complex needs when attending child protection medicals

and ensure that their needs remain at the centre of the work
- review the Child in Need procedures and role of lead professional to clarify the circumstances in which a lead professional is defined to 'manage' work with a family
- provide policy guidance for nursery and non-compulsory school age provision
- improve admissions data collection for Early Years settings plus better identification of additional support needs
- monitor cross-border cases by the CDOP
- develop a new protocol on interagency communication when a child attends different hospitals
- improved family history recording in antenatal records and ensure that pregnant women are routinely asked about domestic violence
- Improved recording of baby weight and caring experiences of responsible adults
- health visitors and midwives to discuss Shaken Baby Syndrome with parents
- improved transfer of information between HV and midwives
- overall review of health visiting service leading to significant restructure and development of new competency based standards.
- health visitors and social workers engage better with GP practices
- new maternity discharge paperwork to prompt safeguarding questions
- new guidance for paediatricians and amended forms/templates to prompt better recording re cause of injuries
- GP computer systems to cross reference family members and ensure safeguarding concerns are passed to a new GP.

The Board will gauge how well this learning is embedded in practice through evidence from quality assurance and audit findings.

Child Death Overview Panel

The Safeguarding Board is responsible for reviewing the deaths of all children normally resident in their area. The key purpose is to learn lessons in order to improve the health, safety and wellbeing of children and to seek to reduce the number of future deaths. The current system for child death reviews was introduced in 2008 to collect information on all child death reviews which have been undertaken by the Child Death Overview Panel on behalf of the Board. This is the 6th year of data collection.

Each review requires the collection of information about the circumstances of the death, categorising the death in accordance with the national dataset, assessing whether there were any modifiable factors that may have prevented the death and determining whether there are lessons to be learned.

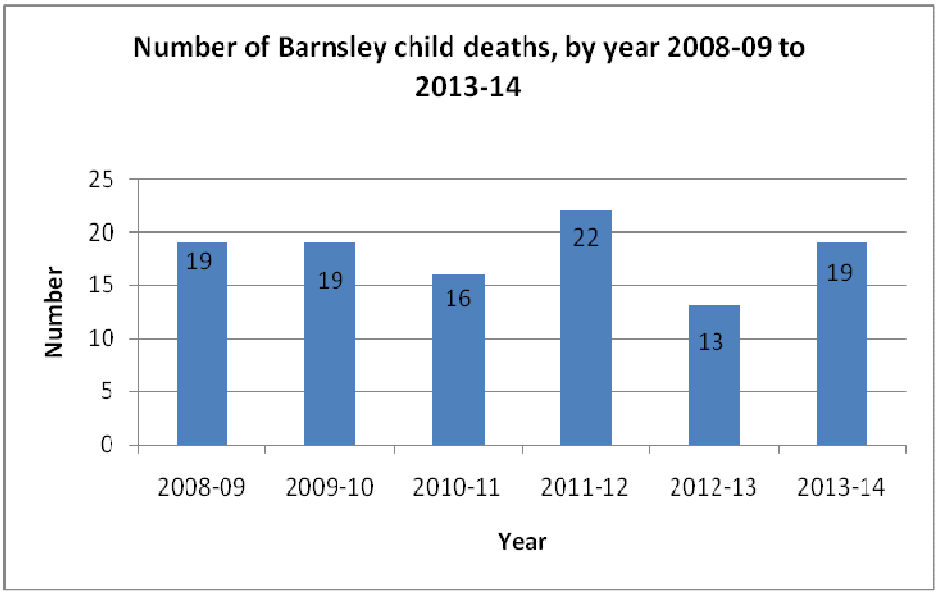
Child Death Overview Panel terms of reference

CDOP is a multi-agency panel responsible for reviewing information on all deaths of a child or young person under the age of 18 years in Barnsley. CDOP meets at least quarterly to review individual cases in accordance with the guidelines set out in Working Together to Safeguard Children 2013. The Terms of Reference, including membership are available to download from the Board's website

Number of child deaths notified

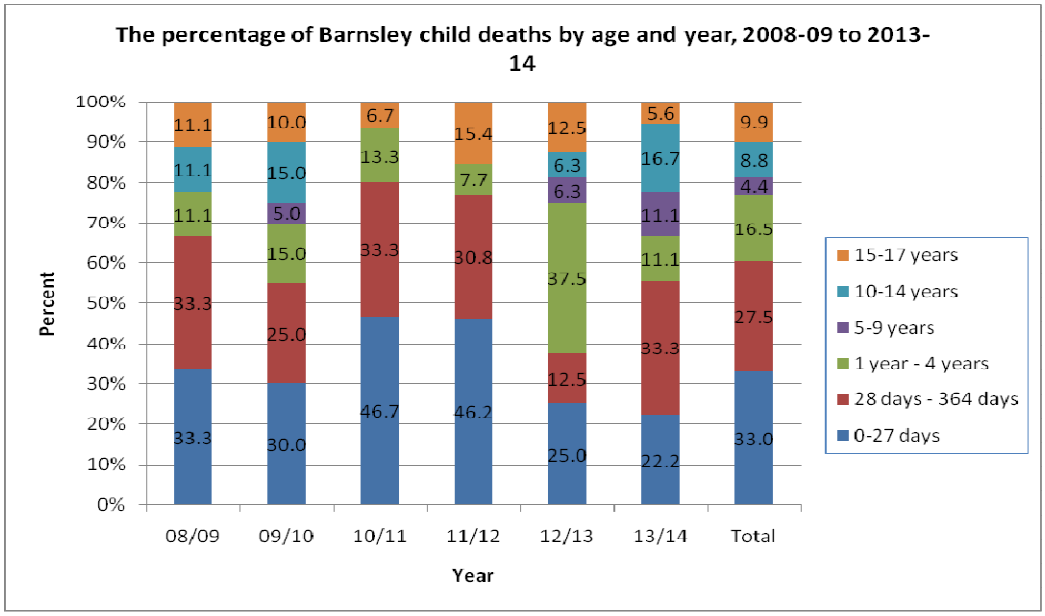
From 1 April 2013 to 31 March 2014, there were 19 deaths notified to Barnsley CDOP. To demonstrate the consistently low numbers of child deaths in Barnsley, the table below shows the number of

deaths each year since the establishment of CDOPs in 2008-09 to 2013-14.



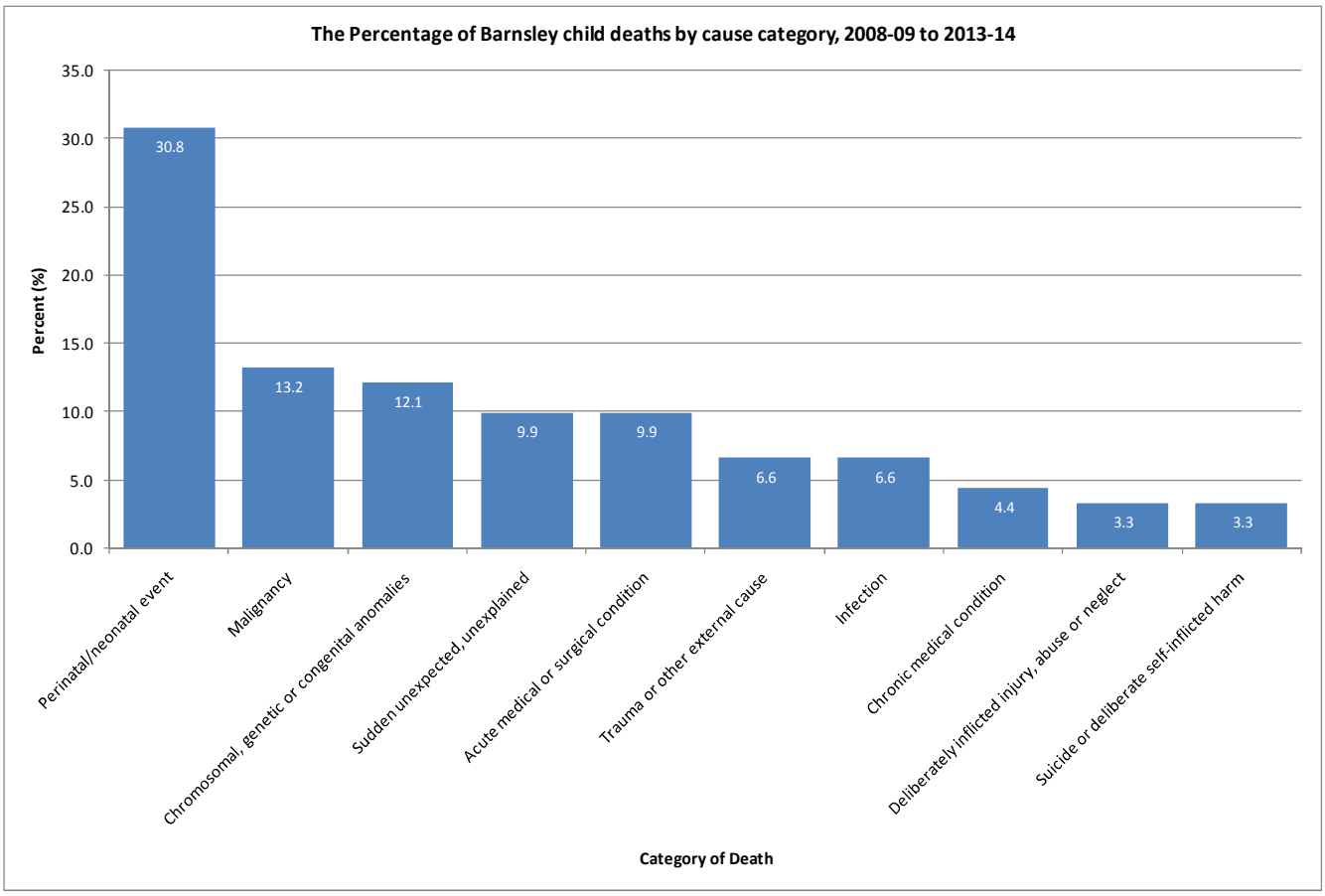
Cases reviewed

The Panel met five times and completed 18 reviews during the reporting period. Because of the small number of deaths each year in Barnsley, identifying trends and patterns is difficult. An analysis of the child death information held on the CDOP database over the period 2008/09 to 2013/14 provides a picture of what is happening over a longer time period.



The table shows the breakdown of child deaths reviewed by CDOP by age over the period 2008-09 to 2013-14 (total 91).

This graph shows the percentage of child deaths by cause over the period 2008-09 to 2013-14.



The pattern of local child deaths reflects those identified in national findings, with approximately one third of deaths being associated with premature birth.

National and local data show that there is a significant link between inequalities and child deaths. The evidence base shows that it is the following interventions that will have the greatest impact on reducing the gap in inequalities and giving every child in Barnsley the best start in life:

- reducing smoking during pregnancy and in the home
- reducing the prevalence of obesity in the population and obesity during pregnancy
- promoting early access to antenatal care ie before 12 weeks into the pregnancy
- reducing teenage pregnancy
- reducing Sudden Unexpected Death in Infancy (SUDI) through safe sleeping risk assessment and promotion of safe sleeping practices
- reducing child poverty
- reducing parental alcohol and/or substance misuse.

Progress against 2012-13 recommendations

In accordance with the previous year's proposed service developments, the following have been successfully undertaken:

- revision and strengthening of governance arrangements and administrative processes, including a review and update of the CDOP Protocol and Rapid Response Protocol.

- establishment of Terms of Reference and guidance for multi-agency case review meetings. Communication has been strengthened across all elements of the child death review process.
- Terms of Reference have been revised and updated to reflect the new NHS organisations established on 1 April 2013.
- following the transition of Public Health into the local authority, a review of the information governance framework was undertaken in line with the Information Classification and Handling Protocol to ensure recipients of child death information are rightfully receiving and storing such information in a secure way.

In addition to the above:

- quarterly CDOP Highlight Reports have been received by the Safeguarding Children Board.
- safeguarding processes have been strengthened through the CDOP administrator supporting the Serious Case Review Sub Committee of the Barnsley Safeguarding Children Board.

Recommendations for 2014-15
The Panel has discussed and agreed the following actions during 2014/15 to improve the efficiency and effectiveness of the child death review process:

- the national data collection Form C to be completed at multi-agency case review meetings for each unexpected child death. This will then be ratified at CDOP instead of the current process of the Panel repeating much of the work undertaken by the multi-agency case review meeting.

- any actions/recommendations raised at the multi-agency case review meetings to be received by the SCR Sub Committee for monitoring until completed.
- an analysis of modifiable factors identified from reviews of still births and neonatal deaths will be undertaken to identify areas where care can be improved during pregnancy and labour.
- ongoing detailed analysis of child mortality will be developed as part of the new approach to the Joint Strategic Needs Assessment.

Further references
Barnsley Joint Strategic Needs Assessment

Partner agency contributions to safeguarding

The Board values the contributions of all partner agencies in promoting and monitoring the effectiveness of safeguarding in the area. An effective Board requires all partner agencies to participate fully, engage in the Board's business and transfer the safeguarding ideology into their own sphere of activity.

Barnsley Hospital NHS Foundation Trust (BHNFT)

BHNFT continues to meet the requirements of an ever challenging safeguarding agenda. The safeguarding children team fulfils regular commitments to training, supervision, advice, support, audit, supporting the child death process and representing the Trust at various Board sub-committees.

The team is promoting awareness of the Thresholds for Intervention to ensure early initiation of offers of help and support. Staff are encouraged to seek advice where required to ensure that cases do not become 'stuck' and also to

provide challenge where there might be a professional disagreement.

BHNFT undertakes regular audits of records, child protection reports and court reports to ensure they meet minimum quality standards and identify improved actions, planning and decision making.

The Safeguarding Children Training Strategy provides that staff who have significant involvement with children must be knowledgeable and access training in relation to domestic abuse, sexual exploitation and the WRAP prevent agenda. We also continue to raise awareness and knowledge through single agency training, multi-agency training and learning events.

The hospital's 'Did Not Attend' policy has been revised and updated to ensure that, when a child misses a hospital appointment, a safeguarding review is undertaken to assess risk. Cancelled appointments are also reviewed to assess issues of veiled compliance to ensure improved health outcomes for children and addressing of neglect.

To improve their experience, the team actively seeks the views of children and families through an evaluation questionnaire, the findings from which are reviewed. The ongoing audit programme seeks to ensure effective high quality practice. Audit findings demonstrate improved practice following introduction of pre-birth and substance misuse pathways.

BHNFT has updated its Safeguarding Supervision Policy to ensure that community midwives and community nurses receive individual and group supervision to enhance their knowledge and ensure they are supported in their work.

Next year, the Trust will continue to support implementation of the continuous service improvement programme, in particular developments around looked after children, and ensure that staff are ready for the forthcoming Ofsted re-inspection.

NHS Barnsley Clinical Commissioning Group

In addition to safeguarding requirements incorporated into closely monitored contracts with health care providers, the designated nurse and the named doctor have continued their 'safeguarding stock take' of primary care to ensure that providers adhere to Safeguarding Board policies and procedures.

The issue of children failing to attend health appointments has featured in national and local child deaths and is of concern to the Safeguarding Board. The Board has received assurance that health providers are monitoring failure to attend medical appointments and poor engagement with services more effectively to assess risk to children. The Board has accepted the findings and recommendations of a review to strengthen the process via contract monitoring.

South West Yorkshire Partnership Foundation Trust (SWYPFT)

South West Yorkshire Partnership Foundation Trust covers four local authorities and Safeguarding Boards across the region. The strength of that spread is that learning experience and confidence can be shared across the service for the direct benefit of children, young people and their carers. Services provided for children include health

visiting, school nursing, family nurse partnership, therapy services, child sexual health services, child and adolescent mental health services and early intervention in psychosis for young people from 14. The service also promotes the think family agenda and offers services across health and wellbeing and mental health.

Key achievements last year have been:

- all services have safeguarding adults and children in their annual planning cycle which is monitored via the governance arrangements.
- the service met its section 11 challenge and has the necessary infrastructure to promote safe working.
- all services are required to be compliant with the CQC Standards for safeguarding and the compliance team provide support for achievement of these standards.
- focus on care planning reporting and recording; concentrating on thresholds and getting the right services in place to support families. A management oversight tool used in health visiting will be further developed for other services.
- annual completion of a record keeping audit.
- rolling out of the Did Not Attend and no access visit policy, with emphasis on holistic assessment, inclusive of risk. An audit process and improvement cycle will be required by all services for 2014/2015.
- development of services for looked after children to promote their health and wellbeing and monitor statutory service requirements.
- dissemination of learning from SCRs though attendance at forums and specific events, to include all local and some national reviews.
- provision of a Trust-wide service to support the voice of the child, with positive examples of involvement and feedback. This remains a priority area for 2014/2015.
- a safer recruitment development process to continually improve and aspire to best practice. A quarterly review group examines all potential disciplinary situations to ensure robust compliance with LADO and DBS and professional standards.
- transformation work across four CAMHS services to secure best practice in risk management is being undertaken.
- risk assessment in CSE which remains a priority area for development across the services
- work to strengthen the response to missing children in line with learning from the Hamza Khan SCR.
- targeting of PREVENT training to areas which provide services to young people, as recommended by the Home Office.
- incorporation of a safeguarding assessment into any redesign of services.

SWYPFT promotes the following messages to staff:

- assessment should be thorough and utilise all information available; systematic risk assessment should look at all aspects of the child's journey and all adults involved in the delivery of care.
- the rule of optimism should be understood by all staff and objective assessment of the facts should take place taking account of all the interrelated dynamics, always ask is this child safe and healthy? Is this the whole picture?

- non-attendance at appointments should always be assertively challenged and risk assessed.
- children should not be invisible, all children – grandchildren, partners children.
- be observant and ask key questions.
- share information – understand the NHS code of confidentiality and when it is important to share information.
- good record keeping is essential to facilitate high quality care.
- families can be vulnerable, vulnerable adults can be perpetrators – Think Family.

South Yorkshire Police

The restructuring and centralisation of the South Yorkshire Police Public Protection Unit (PPU) has been completed in terms of governance and managerial oversight. All the units, including Barnsley, now fall under the direct control of the Specialist Crime Services with an Assistant Chief Constable holding responsibility for all areas of protecting vulnerable persons. However, the provision of services in terms of safeguarding children remains locally delivered, with strong ties to the Barnsley district command who has responsibility for local children's safeguarding.

A fully staffed central referral unit takes all public protection referrals from across the region. The unit reviews cases initially then liaises with the Barnsley Public Protection team to provide a local service. The Barnsley PPU has undergone further change last year with recognition of the need for additional resources to deal with increasing contacts from the public and partner agencies. This has resulted in an allocation of additional staff to both child abuse and child sexual exploitation investigations to enable a more timely and effective response and provide greater reassurance to victims.

Another major change over the last year was creation of a dedicated approach to child sexual exploitation, initially driven through resources offered by the Police and Crime Commissioner. This provision was bolstered by locally provided staff, as well as the important addition of the voluntary sector in the shape of a dedicated worker from Barnardo's. This partnership approach, in conjuncture with the co-located Joint Investigation social care team, allows for a more joined up approach to tackling this important area of work and better safeguarding children at risk

Berneslai Homes

Berneslai Homes' main contribution to safeguarding is through our Vulnerability Strategy: 'Something Doesn't Look Right', which provides significant practical support in reducing cases that could escalate to social care or the police. The strategy capitalises on the service's unique position to identify early warning signs during routine visits to thousands of homes. Practical support can be provided and housing application assessments provide an opportunity for intervention. Berneslai Homes undertakes proactive visits to council properties, specifically to identify any support or vulnerability issues. Of the 4,000 support visits undertaken last year, over 1,100 lead to some kind of support intervention, including over 700 for families and 10 where the safety of children was concerned. We also undertook a large number of additional visits to families affected by welfare reform.

Berneslai Homes Family Intervention Service (FIS) provides cross tenure

intensive family support to families with multiple and complex needs. The FIS continues to make significant progress in achieving positive outcomes for families under the Troubled Families Programme; turning around 108 families and supporting a further 20 into progress to work. The primary aim is to secure clear behavioural change, thus reducing the effect of a family on the surrounding community. Positive changes are evidenced through reduced antisocial behaviour and homelessness, addressing worklessness and improved progress to work, improved opportunities for children, through better school attendance and families sustaining positive changes. The FIS combines a triple track linked approach of early intervention/prevention, support and enforcement to provide a positive incentive to change.

Barnsley College

Barnsley College is committed to safeguarding the total college community, including learners, staff and visitors. In 2013, the college continued to embed safeguarding across all college activity by:

- having a robust safeguarding structure led by the Vice Principal (Teaching, Learning & Student Support), operationally led by the Assistant Principal (Access to Learning). The college continues to provide dedicated frontline support through the work of the safeguarding officer, safeguarding advisors and departmental safeguarding representatives. These staff provide a range of advice, guidance and safeguarding support to learners, staff and visitors;
- implementing the Safeguarding Scheme and Action Plan to monitor activity and drive forward improvements;
- continuing professional development for staff to improve skills and knowledge and excellent partnership working arrangements, so the workforce is able to safeguard the college community;
- The college will continue with its approach to embedding safeguarding throughout college activity in 2014, with a particular focus on:
  - strengthening the safeguarding policy around commissioned and sub-contracted services
  - improving staff checks by securing declarations re any changes in their circumstances
  - accelerating the provision of financial support through student bursaries for looked after children.

Voluntary and community sector

Over the past year, a lot has been achieved in the voluntary and community sector in relation to safeguarding children, young people and vulnerable adults.

An informal consortium has been formed, following a meeting with the Executive Director of Children's Services in July. The consortium meets regularly and shares information and good practice knowledge with each other. At the meetings, safeguarding is a standing agenda item and within the meeting compliance with Section 11 has been discussed. Currently, five organisations have refreshed their Section 11 self-assessment and the other members of the consortium have either committed to completing it or have completed it within the last three years.

The consortium has voluntary and community sector representatives on the

Safeguarding Board, the Serious Case Review Sub Committee, the Think Family Board and the Improvement Board.

Information has been disseminated to the consortium members, as well as other voluntary sector and community groups on the following matters (this list is not exhaustive):

- Multi-agency Safeguarding Children Training Programme
- Think Family Programme Board
- Barnsley's Children in Need procedures
- Continuum of Assessment of Need
- Section 11
- Barnsley's Local Offer in relation to the Children and Families Act
- South Yorkshire awareness raising campaign on child sexual exploitation
- NSPCC lessons learnt from serious case reviews including:
    - learning from case reviews where domestic abuse was a key factor
    - learning from case reviews around child sexual exploitation
    - learning from serious case reviews involving people whose first language is not English
    - learning from case reviews involving parental substance misuse

Voluntary Action Barnsley is committed to supporting the start-up of new groups and has supplied safeguarding policy templates to 15 groups in the last financial year.

As a consortium, safeguarding is vitally important and should be evidenced as such. However, due to the diverse nature of the voluntary and community sector, Section 11 requirements may be covered in a different way that meets the individual needs of that service and, for some groups, completing the Section 11 is not always appropriate.

The Children and Young People's Consortium will create an action plan for the Safeguarding Board that fulfils the safeguarding needs of the groups, identifies gaps, and addresses development, the results of which will be presented to the Board. The aim of this plan is to ensure that safeguarding is on each voluntary and community group's agenda and all Barnsley's children and young people are safe.

Integrated working with partners

Integrated and partnership working is a particular local strength and all the individual partner agency contributions to safeguarding are valued. The Board maintains links with partners and contributes to local initiatives on a variety of safeguarding themes, through representation on a range of multi-agency working groups including:

Alcohol, Crime and Disorder Group – reviews the effects of harmful drinking and implications for crime and anti-social behaviour, especially amongst young people.

Elective Home Education and Children Missing Education Group - to oversee children and young people not accessing mainstream education.

Families at Risk Panel - to ensure appropriate support for those families most in need.

Hate and Harassment Performance Group - addresses aspects of hate crime and promotes community cohesion.

Multi Agency Public Protection Panel - reviews the management of persons posing a risk to children and adults in the community.

Multi Agency Risk Assessment Conference - reviews victims of domestic violence.

PREVENT Silver Group - to address and prevent radicalisation of vulnerable young people.

Regional LSCB Relationships - the regional Safeguarding Board Chairs and officers joint meetings coordinate regional initiatives and explore common safeguarding issues.

Safe in Sport Forum - safeguarding children involved in all aspects of sport.

Sexual Abuse and Rape Crisis User Group - regional co-ordination of services to affected young people.

Sexual Abuse User Group - to ensure that correct procedures are followed in cases of disclosure.

South Yorkshire Child Sexual Exploitation Practitioners Tactical Group – to review the issue on a county wide basis and plan coordinated approaches.

Young People's Substance Misuse Expert Group - to ensure that commissioned services are appropriate and young people are safeguarded.

Yorkshire and Humber Regional LADO forum - coordination of allegations management.

Yorkshire and Humber multi agency trainers group - sharing best practice and resources to promote multi-agency training opportunities.

Planned future developments and key priorities for 2014-15

Barnsley Safeguarding Board's strong commitment to continuous service improvement and addressing the needs of the most vulnerable children and young people is evidenced through the objectives in our 2014 -15 Business Plan. Future aims and priorities are identified in the context of significant change, nationally and locally, particularly in the light of continuing budgetary pressures. The continuing effectiveness of the Board's work will continue to be subject to close scrutiny. The synergy obtained from strong partnership working remains an essential element of effective safeguarding. The objectives of the Board and sub-committees/groups for the coming year have been determined with multi-agency input and will be subject to regular review throughout the year to measure their achievement and impact.

Oversight and progress of actions from the Ofsted Improvement Programme
The Board will assume responsibility for driving and monitoring practice to secure mainstreamed continuous improvement. It will assimilate learning from the Improvement Programme and use it to inform future safeguarding developments through partner agency participation. The Board will also require regular update reports of specific case file and general audit activity, to include audits on:

- the effectiveness of child protection conferences
- allocation management

- compliance and quality of child protection plans
- receipt of child protection conference reports two days in advance of conference
- thresholds relevant to the work of the Board.

Encourage challenge
The Board will seek to strengthen and evidence its own effectiveness through rigorous challenge, participation and engagement. This will include challenge sessions for each refresh of the Section 11 self assessment, encouraging challenge at Board debates, monitoring use of the escalation policy and promoting participation and engagement of stakeholders wherever possible. The Section 11 challenge will also seek evidence that current austerity measures and budget reductions are not having an adverse effect on the ability of partner agencies to fulfil their responsibilities.

Child sexual exploitation
Although the Board has an approved strategy and action plan, this remains an area where is a need for continued focus.

Promote understanding on thresholds
Continued work to ensure that the thresholds policy is understood and correctly applied by partner agency staff and that effective use is made of the escalation process in cases where there are concerns about the decision making. Promote understanding and monitor to ensure appropriate use of the Step up and Step down process.

Strengthening work with partners
The Board will seek to improve its overview of the work of partner agencies involved with safeguarding children, including the voluntary and community sector and local faith groups through issues reported and escalated by the sub-committees. It will actively seek to strengthen existing links with the VCS and associated groups and continue to explore the benefits of closer co-operation through multi-agency working, building on establishment of the Joint Investigation Team.

Performance management/quality assurance
Development of the Board's Performance Management Framework and routine reporting of key indicators has continued to be refined during the year. The Board is now able to scrutinise performance in a more informed and systematic way and challenge areas where it appears that improvements are required. This approach will continue to evolve to ensure the Board receives the necessary information to be assured about the safety and quality of frontline services. Responsibility for regular mainstream scrutiny rests with the PAQA Sub-Committee, who will escalate areas of concern to the Board through exception reporting.

Through oversight of a comprehensive audit programme, the PAQA Sub-Committee will continue to scrutinise findings from commissioned single and multi-agency audits to ensure actions are embedded through practice changes. The Board has also agreed to receive themed presentations on performance from partners for challenge at Board meetings.

Developing stronger means of engaging with young people and their families to be clear about how they feel safe in the borough
Securing the voice of children and young people to inform strategic and service planning is underdeveloped and an area for further work. There are examples of engagement with young people for

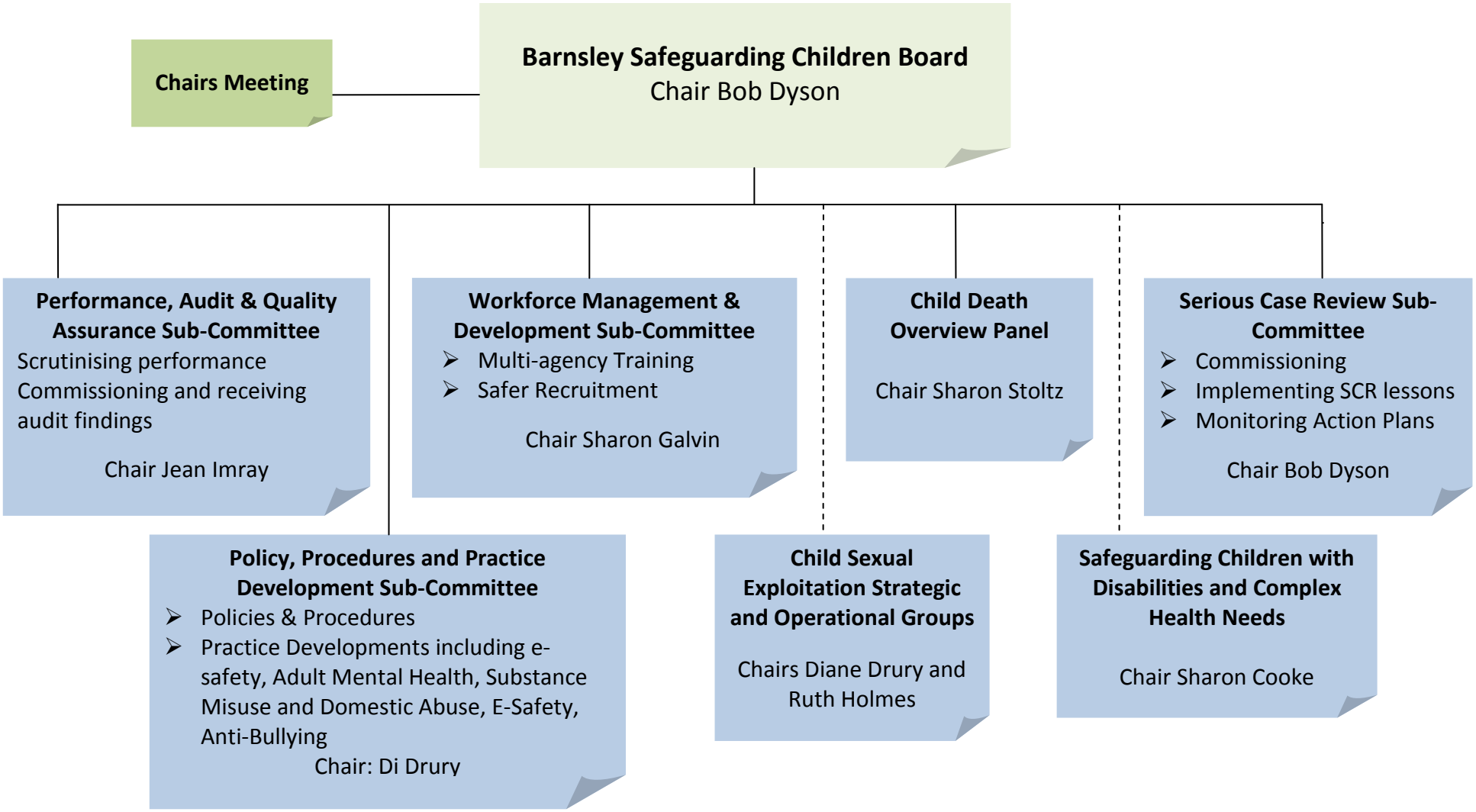
specific activities and the Board maintains participative links to the views of young people through membership of the Care4Us Council and the Youth Council which is represented on the Policy, Procedures and Practice Developments Sub-Committee. Although the Board is addressing this through plans to hold meetings in schools, and enter a dialogue with young people about their priorities/ views on safeguarding, more systematic engagement is required.

Learning from serious case and other reviews to inform practice

Continue to assimilate and act on the learning and improvements derived from Serious Case Reviews, the CDOP, and other learning events in order to improve practice and service delivery. The SCR Sub-Committee will continue to inform local practice through examining findings from SCRs held elsewhere to identify lessons with local resonance for dissemination to agency practitioners.

Appendix 1

BARNSLEY SAFEGUARDING CHILDREN BOARD GOVERNANCE STRUCTURE



Appendix 2

MEMBERSHIP AND ATTENDANCE

The list of members and advisors to the Barnsley Safeguarding Children Board, as at 3 March 2014, is set out below.

Members	**Representative Agency**
Bob Dyson	Independent Chair
Susan Barnett	Barnardos/Voluntary and Community Sector representative
Tim Breedon	Director of Nursing, South West Yorkshire Partnership NHS Foundation Trust
Andy Brooke	Chief Superintendent, South Yorkshire Police
Karen Butcher	Primary Head Teachers' representative
Cillr Tim Cheetham	Lead Elected Member (Participant Observer)
Rachel Dickinson	Executive Director of Children's Services, BMBC
Ben Finley	Service Manager Barnsley Youth Offending Team,
Susan Hayter	Secondary Head Teachers' Association
Max Lanfranchi	Director of Probation , Barnsley
Gary Mangham	Primary Head Teachers' representative
Dr Ken McDonald	Named Doctor Barnsley Clinical Commissioning Group
Heather McNair	Chief Nurse Barnsley Hospital NHS Foundation Trust
Erica Pursley	Primary Head Teachers' representative
Brigid Reid	Chief Nurse, NHS Barnsley Clinical Commissioning Group
Pat Sokell	Lay Member
Steven Szocs	Lay Member
Sue Symcox	Service Manager, CAFCASS
Diane Wall	Safeguarding Officer, Barnsley College
Judith Wild	Quality & Patient Safety Manager, NHS England SY and Bassetlaw
Advisors	**Representative Agency**
Colin Brotherston	Principal Hate and Hidden Crime Officer, BMBC
Yvonne Butler	Service Manager, Safeguarding Adults, BMBC
Steve Eccleston	Assistant Director, Legal Services, Sheffield MBC
Sharon Galvin	Designated Nurse Safeguarding Children, Barnsley CCG
Pete Horner	Head of Public Protection Unit South Yorkshire Police
Jean Imray	Interim Assistant Executive Director of Children's Services, Safeguarding, Health and Social Care, BMBC
Dr Saqib Iqbal	Designated Doctor, Barnsley Hospital NHS Foundation Trust
Mark McGee	Director of Housing Management Berneslai Homes
Kathryn Padgett	Assistant Director of Children's Health Improvements, SWYPFT
Dawn Peet	Safeguarding Officer South Yorkshire Fire & Rescue
Claire Simpson	Safeguarding Children Board Manager
Sharon Stoltz	Acting Director of Public Health

Board membership represents all key local partner agencies. Last year saw a limited number of membership changes, the most notable of which was the appointment in June of Rachel Dickinson, the new Executive Director of Children's Services. Rachel has demonstrated distinctive and committed leadership to bring impetus to the improvements required to Children's Services and support the Board's contribution. The Board has also benefited over the past 15 months from an increasingly productive leadership from the Independent Chair.

During the year, both lay members stood down and were replaced. We expect the new lay members will continue to bring independent oversight to the Board and provide additional challenge through their objective viewpoint. Following the retirement of the primary headteacher representative, the Board increased this sector's representation to three, which has facilitated more consistent attendance.

Previous limited representation from the voluntary sector and Barnsley College has improved greatly during the year, providing a strengthened contribution from these partners. The contribution from all former Board members and advisors to safeguarding in Barnsley has been much appreciated and the Board looks forward to equally valuable working with their successors.

Member attendance at Safeguarding Children Board meetings in 2013-14

The Board met on 10 occasions from January 2013 to March 2104. This comprised eight ordinary meetings, one special meeting to receive the outcome of a Learning Lessons event following the death of a child, and a joint meeting with the Children's Trust Executive Group (TEG). In addition, a joint development session was held with members of the Safeguarding Adults Board, following the November 2013 meeting.

The Board maintains regular oversight of attendance to promote regular and consistent participation. Analysis shows that attendance and participation is generally very good, especially by key stakeholder representatives from the local authority, including the Lead Elected Member, health services, secondary schools, Barnsley College, the police and the voluntary and community sector. There have been some variations between agencies, particularly where specific pressures such as organisational restructures impact. During the year there was reduced attendance from probation, primary headteachers, Cafcass and the Youth Offending Team, attributable partially to illness and staff movements. Areas of poor attendance have been addressed with individual agencies.

Are you considering the need for a Common Assessment Framework (CAF) referral?

Contact the Multi Agency CAF coordinators on:

Telephone 01226 775878 or 01226 775692

Further information about a CAF can be found on:

http://www.barnsley.gov.uk/common-assessment-framework

Member attendance at Safeguarding Children Board meetings in 2013-14			
Agency	Attendances by nominated member	Attendances by a substitute	% attendance
Independent Chair	**9**	**1**	**100**
Director of Children's Services	**8**	**0**	**80**
Lead Elected Member	**8**	**1**	**90**
Barnsley College	**10**	**0**	**100**
Barnsley Hospital NHS Foundation Trust (BHNFT)	**9**	**1**	**100**
CAFCASS	**6**	**0**	**60**
Children, Young People and Families Directorate, BMBC	**10**	**0**	**100**
Designated Doctor BHNFT	**10**	**0**	**100**
Named Doctor, CCG	**7**	**0**	**70**
Designated Nurse, CCG	**5**	**2**	**70**
Lay Members	**7**	**0**	**70**
Probation	**3**	**2**	**50**
Primary Headteachers	**6**	**0**	**60**
NHS Barnsley, Clinical Commissioning Group	**9**	**1**	**100**
NHS England SY & Bassetlaw	**10**	**10**	**100**
Secondary Headteacher	**9**	**0**	**90**
South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)	**8**	**1**	**90**
South Yorkshire Police	**4**	**4**	**80**
Voluntary and Community Sector	**8**	**0**	**80**
Youth Offending Team	**6**	**0**	**60**

Budget

The Board is funded by contributions from partner agencies, in accordance with a locally agreed formula. The budget breakdown and contributions made by member organisations for the 2013-14 year are shown below.

The budget reduced in real terms last year due to inflation, standstill contributions from the CCG, Probation, Cafcass and Connexions and an actual contributory reduction from South Yorkshire Police. The apparent local authority reduced contribution reflects a transfer of provision for administrative support into the local authority budget. Although the Board has continued to operate effectively within this reduced budget, it has inevitable impact on our ability to promote safeguarding and it will be necessary for partners to ensure continued support to ensure that safeguarding remains a priority area. For next year (2014-15), all partners have confirmed that their financial contributions will be the same as in 2013-14, which again represents a reduction in real terms.

Barnsley Safeguarding Children Board Budget 2013/14			
Income £		**Expenditure £**	
Partner Contributions			
Barnsley MBC	109,770	Staffing	85,550
NHS Barnsley CCG	29,175	Multi-agency Training	18,525
Probation	2,314	Professional Fees	20,000
South Yorkshire Police	8,024	Serious Case Reviews and Learning Events	10,000
Cafcass	550	Policies and Procedures (TriX)	3,000
Connexions	2906	Service Developments	10,214
Training Income	2,000	Board Running Costs	11050
Carried fwd from 2012-13	2,694		
SIDS Funding from 2012-13	906		
TOTAL	158339	TOTAL	158339