



Annual Report on the Effectiveness of Safeguarding Children in Bury 2015/16

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1. Foreword by Outgoing Independent Chair of BSCB



Gill Rigg
Independent Chair of BSCB

As the Independent Chair of BSCB during 2015-6, I am very pleased to introduce this, the Board's eighth annual report. This annual report is a requirement of Working Together 2015, the statutory guidance and the report is expected to identify the effectiveness of child safeguarding and promoting the welfare of children in Bury. It is required to provide a rigorous and transparent assessment of the performance and effectiveness of local services. I hope this report does that and it will be of relevance and useful to anyone with an interest in safeguarding in Bury.

This year the Board has benefited from external scrutiny. In the autumn of 2015, the Board commissioned a Peer Review of its work, and in February, Ofsted conducted its review of the effectiveness of the Board, and judged it to be good. The detail of their findings is contained within in the state of safeguarding section of this report. However, in no way is the Board complacent, and whilst this report describes the activity of the Board in 2015-6, there are significant plans developed to continue to improve safeguarding activity in 2016 and beyond.

The report details the activity of the Board, which is made up of the main Board, the Business group, and the sub groups. It describes a significant amount of highly effective work by partner agencies, who work tirelessly to keep children and young people as safe as possible in Bury. I have been so grateful for all the work which constituent agencies undertake on behalf of the Board.

The report describes an analysis of how effective safeguarding is in Bury, the auditing activity and the performance data. It describes performance against the Business Plan, and some key areas of activity, the continued implementation of findings from Serious Case Reviews, and the ongoing development of the Child Sexual Exploitation activity.

It also describes how the Board continues to hear the voices of children and young people. The Board was particularly pleased to see the Lilac Standards report. This was a report by a project run by A National Voice which draws on the experience of care experienced young people to carry out assessments of how well services involve and consult with children and young people. Bury Council was awarded seven "petals", the highest possible judgment, which was an excellent achievement.

A National Review of LSCBs was announced in December 2015. It is clear that whatever structural changes may come, all agencies in Bury will remain committed to work very effectively together to continue to safeguard Bury's children and young people.

I would like to thank all of you who work so hard in Bury. It has been a privilege to be work with you and to be the BSCB Chair. This is the final foreword which I will write as I stepped down from the role at the end of March after seven years.

I am delighted to introduce Sharon Beattie as your new Independent Chair; Sharon Beattie took over the role at the beginning of April 2016.

Gill Rigg
Outgoing Independent Chair of BSCB



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3. Essential Information

This report covers the period April 2015 - March 2016.

The annual report is published in relation to the preceding financial year in order to influence local agencies' planning, commissioning and budget cycles for the forthcoming financial year.

Organisations working with children and young people can use this report to develop their understanding of safeguarding in Bury and the work that Bury Safeguarding Children Board is doing to support them and to be aware of the critical safeguarding issues relevant to their organisation.

Members of the public are encouraged to use this document to develop understanding and to consider how there can be wider community engagement in safeguarding issues.

The report has been circulated to BSCB Business Group members and to BSCB members for comment and finalised during September 2015. It will be submitted to the Bury Council Chief Executive and Lead member on 6th October 2016. It will be presented to the Bury Health and Well-Being Board on 15th December 2016. It will be submitted to the Greater Manchester Police and Crime Commissioner & Chief Executive or equivalent of all member agencies.

Sources of information which informed this report include:

- Data reports from BSCB partner agencies
- Reports of the BSCB sub groups
- Minutes of BSCB meetings
- Report from 'Ofsted Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the Local Safeguarding Children Board' published May 2016
- Bury Child Health Profile
- BSCB Peer Review

3.1 Glossary

A&A	Advice & Assessment Team
AD	Assistant Director
CAF	Common Assessment Framework
Cafcass	Children and Family Court Advisory and Support Service
CAMHS	Child and Adolescent Mental Health Services
CDOP	Child Death Overview Panel
CEOP	Child Exploitation and On-Line Protection Service
CIN	Child in Need
CME	Children Missing Education
CP	Child Protection
CQC	Care Quality Commission
CPS	Crown Prosecution Service
CSC	Children's Social Care
CSE	Child Sexual Exploitation
CT	Children's Trust
CYPIC	Children & Young People in Care Team
CYPP	Children and Young People's Plan
DASH	Domestic Abuse, Stalking and Harassment and Honour Based Violence Risk Assessment
DBS	Disclosure & Barring Service
DCS	Director of Children's Services
DfE	Department for Education

DPA	Data Protection Act
EPO	Emergency Protection Order
FAS	Foetal Alcohol Syndrome
FGCs	Family Group Conferences
FGM	Female Genital Mutilation
FII	Fabricated or Induced Illness
GMC	General Medical Council
GMSP	Greater Manchester Safeguarding Partnership
HCPC	Health & Care Professions Council
ICO	Interim Care Order
ICS	Integrated Children's System
IDVA	Individual Domestic Violence Advocate
IRO	Independent Reviewing Officer
JSNA	Joint Strategic Needs Assessment
LAC/CLA	Looked After Children/Child Looked After
LADO	Local Authority Designated Officer
LSCB	Local Safeguarding Children Board
MAPPa	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MFH	Missing from Home
NAI	Non Accidental Injury
NSF	National Service Framework

PACE	Police and Criminal Evidence Act
PPIU	Police Public Protection Unit (Police)
PSHE	Personal, Social and Health Education
S.47	A section 47 enquiry is an investigation carried out by Children's Services when they have reasonable cause to believe that a child living in their area has suffered or is likely to suffer significant harm.
SARC	Sexual Assault Referral Centre
SCH	Secure Children's Homes
SCRs	Serious Case Reviews
STC	Secure Training Centre
SUDCI	Sudden Unexpected Deaths in /Childhood
UASC	Unaccompanied Asylum Seeking Child
UKBA	United Kingdom Border Agency
UKHTC	UK Human Trafficking Centre
YJB	Youth Justice Board
YOI	Young Offender Institution
YOT	Youth Offending Team

4. *Formal summary statement: How safe are children and young people in the BSCB area?*

The annual report is expected to identify the effectiveness of child safeguarding and promoting the welfare of children in Bury. It is required to provide a rigorous and transparent assessment of the performance and effectiveness of local services. This section is intended to provide this analysis.

In 2015-6, the BSCB had the opportunity for two sources of external and independent scrutiny of how well the Board was carrying out its statutory functions, and protecting children and young people in Bury. In the autumn of 2015, the LSCB commissioned an independent Peer Review and in February, 2016, Ofsted undertook a review of the effectiveness of the BSCB, as part of its inspection of services for children in need of help and protection; children looked after and care leavers within Bury. Whilst the latter was published in May 2016, the review was carried out during the period captured by this annual review.

This section will draw heavily on both reports as they have the additional advantage of being external to the Bury agencies. It has been a significant opportunity to compare how the BSCB believes the state of safeguarding to be with what the external Peer Review and Ofsted concluded.

The Peer Review report was presented to the Board in December 2015, and concluded that the BSCB was in "good health" and committed to a continuous improvement journey. The report identified that the Board was well-administered and managed, had clear and strong leadership and had effective levels of participation and partnership working. There was positive engagement from partner agencies, and good relationships between key professionals. The Board would agree with this summary. The report did identify a number of areas for development and highlighted that the handover to the incoming Chair would need to be handled carefully. The handover was put into place over a period of time, and took place smoothly. It highlighted the need to develop the analysis of performance data, and noted that plans were in place to recruit to a specific role to help with this. This had been identified as a priority by the Board. The report also identified that the BSCB needed to increase its profile, perhaps by hosting an annual conference. The report was warmly accepted and received by the BSCB.

The Ofsted report judged that the review of effectiveness of the Board was good. This was a very welcome judgment on how well the Board is performing, and more importantly, is working as a partnership to protect Bury's children and young people.

The report concluded that the Board met its statutory responsibilities, the structure was well established and effective, and the sub groups are making good progress on

their work programme. It concluded that the Board was well chaired and efficiently run. The minutes were transparent and thorough. Board members reported strong working relationships within a culture of constructive challenge.

The report also identified that there were sufficient processes to ensure a good understanding of the effectiveness and quality of frontline practice, and also, very positive to see, that challenges from the Board resulted in improved services and outcomes for young people. It also concluded that procedures and the threshold document were up to date, and there was a good oversight of Child Sexual Exploitation (CSE) and young people who go missing.

The report also outlined that the Business plan was appropriately focussed on three key priorities. The learning from Serious Case Reviews and case reviews was given a high priority.

There were five recommendations for action. These relate to ensuring that the Board was sighted on the outcome of individual agency audits, issues relating the capacity of the police resources, improvements in the performance management of the data set, to the Private Fostering arrangements and the annual report. These recommendations have been drawn up into an action plan, and work has started on them.

The Board was pleased with the outcome of both the Peer Review and the Ofsted report, believing that they are broadly in line with their own assessment of the state of safeguarding in Bury. However, there is no room for any complacency and there still remains much more to achieve, in addition to continue doing the things that are being done well.

Gill Rigg
Outgoing Independent Chair



5. The Board

1. The Bury Safeguarding Children's Board (BSCB) is the key statutory body overseeing multi-agency safeguarding arrangements across Bury.
2. Governed by the statutory guidance in Working Together to Safeguard Children 2015 and the Local Safeguarding Children Board (LSCB) Regulations 2006, the BSCB comprises senior leaders from a range of different organisations. It has two basic objectives defined within the Children Act 2004:
 - (a) to co-ordinate the safeguarding work of agencies and
 - (b) to ensure that this work is effective.

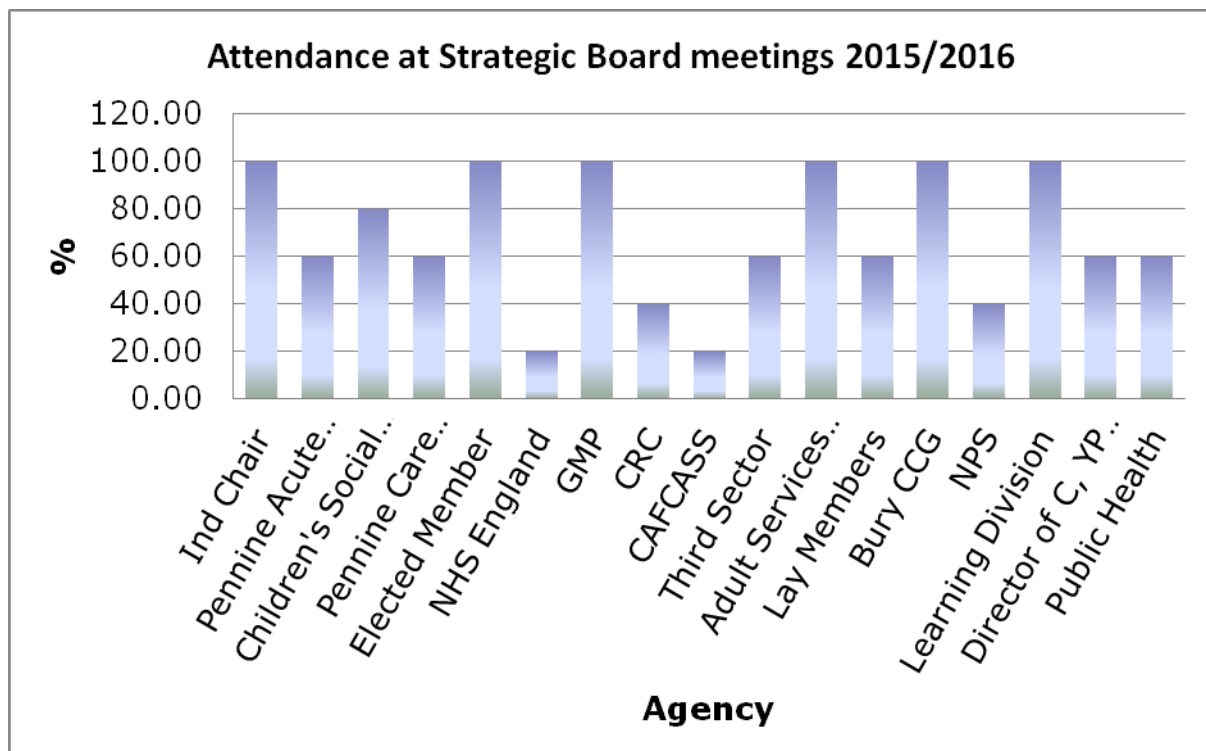
5.1 Key roles and relationships

1. The Independent Chair of the BSCB up until March 2016 was Gill Rigg. Supported by a Board Manager and a dedicated team, the Chair is tasked with ensuring the Board fulfil its statutory objectives and functions. Key to this is the facilitation of a working culture of transparency, challenge and improvement across all partners with regards to their safeguarding arrangements.
2. The Chair is accountable to the Chief Executive of Bury Council and is contracted for 24 days per year.
3. Whilst being unable to direct organisations, the BSCB does have the power to influence and hold to account for their role in safeguarding. This influence can touch on matters relating to governance as well as impact directly on the welfare of children and young people.
4. Bury Council is responsible for establishing a Local Safeguarding Children's Board in its area and ensuring that it is run effectively. The ultimate responsibility for the effectiveness of BSCB lies with its political leaders. The Chief Executive of Bury Council is accountable to these leaders. The Lead Members for Children's Services has the responsibility for making sure the organisation fulfils its legal responsibilities to safeguard children and young people.
5. All partner agencies across Bury are committed to ensuring the effective operation of BSCB. Members of the Board hold a strategic role within their organisations and are able to speak with authority, commit to matters of policy and hold their organisation to account.
6. There is a clear expectation that LSCBs are highly influential strategic arrangements that directly influence and improve performance in the care and

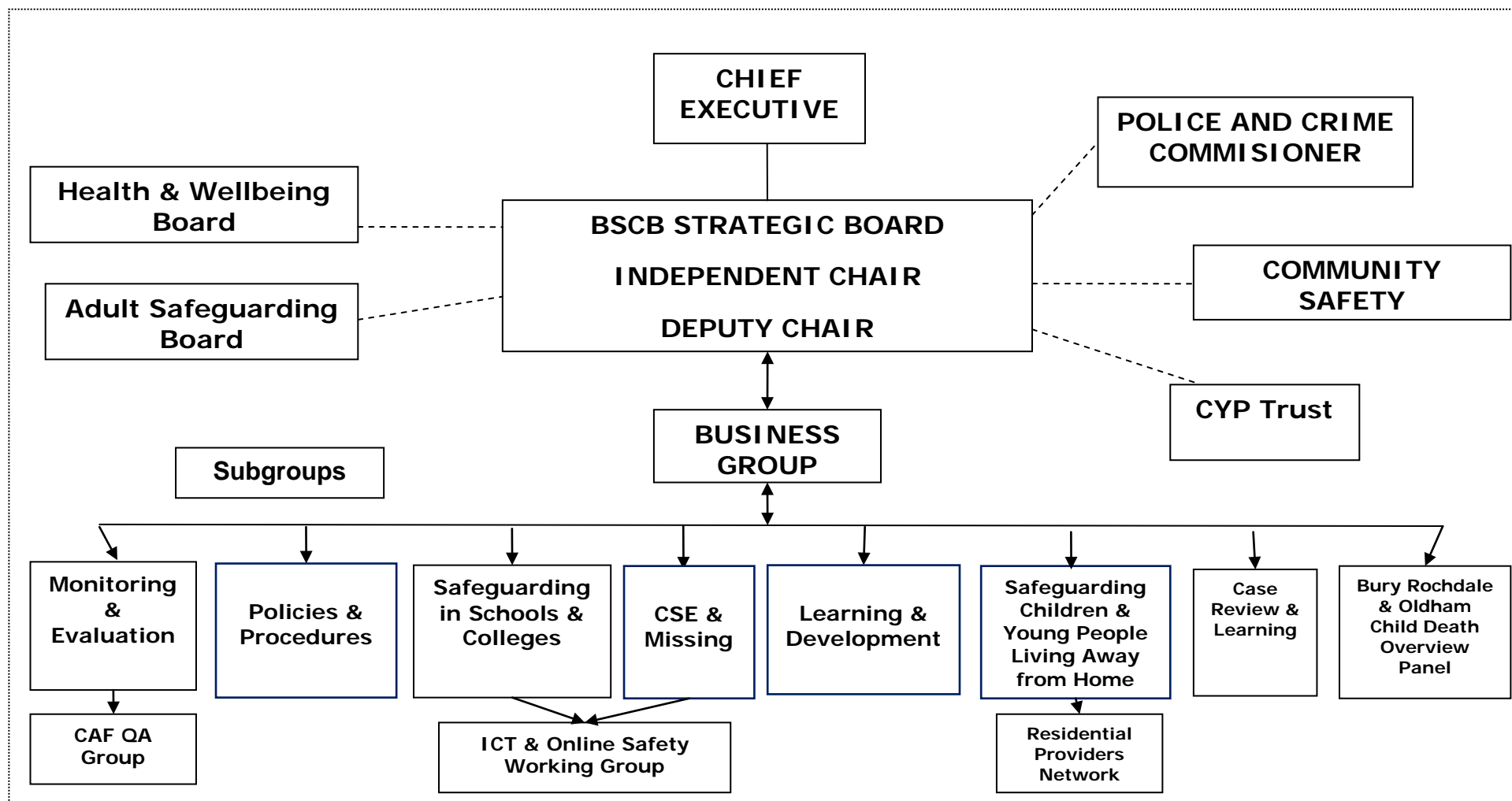
protection of children. There is also a clear expectation that this is achieved through robust arrangements with key strategic bodies across the partnership. During 2015/16, engagement continued with the Bury Adult Safeguarding Board, the Health and Wellbeing Board and Community Safety Partnerships across Bury. From the BSCB's perspective, this helps ensure that the voice of children and young people and their need for safeguarding is kept firmly on the agenda in terms of multi-agency work involving vulnerable adults, health and wellbeing and the local response to crime.

5.2 Board Attendance

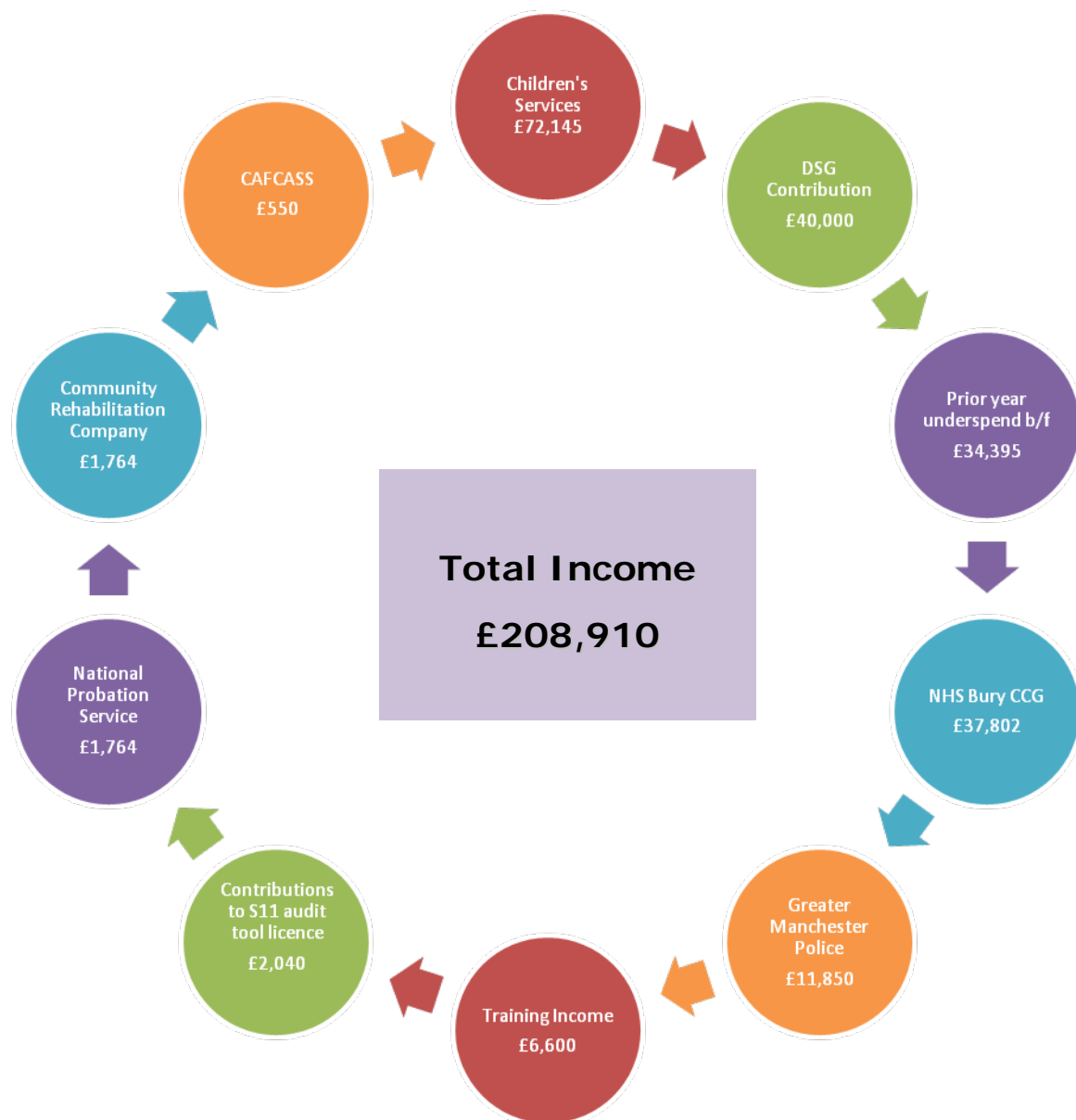
The Board continued to experience good attendance during 2015-16 with new members adding additional value to co-ordinated partnership working.



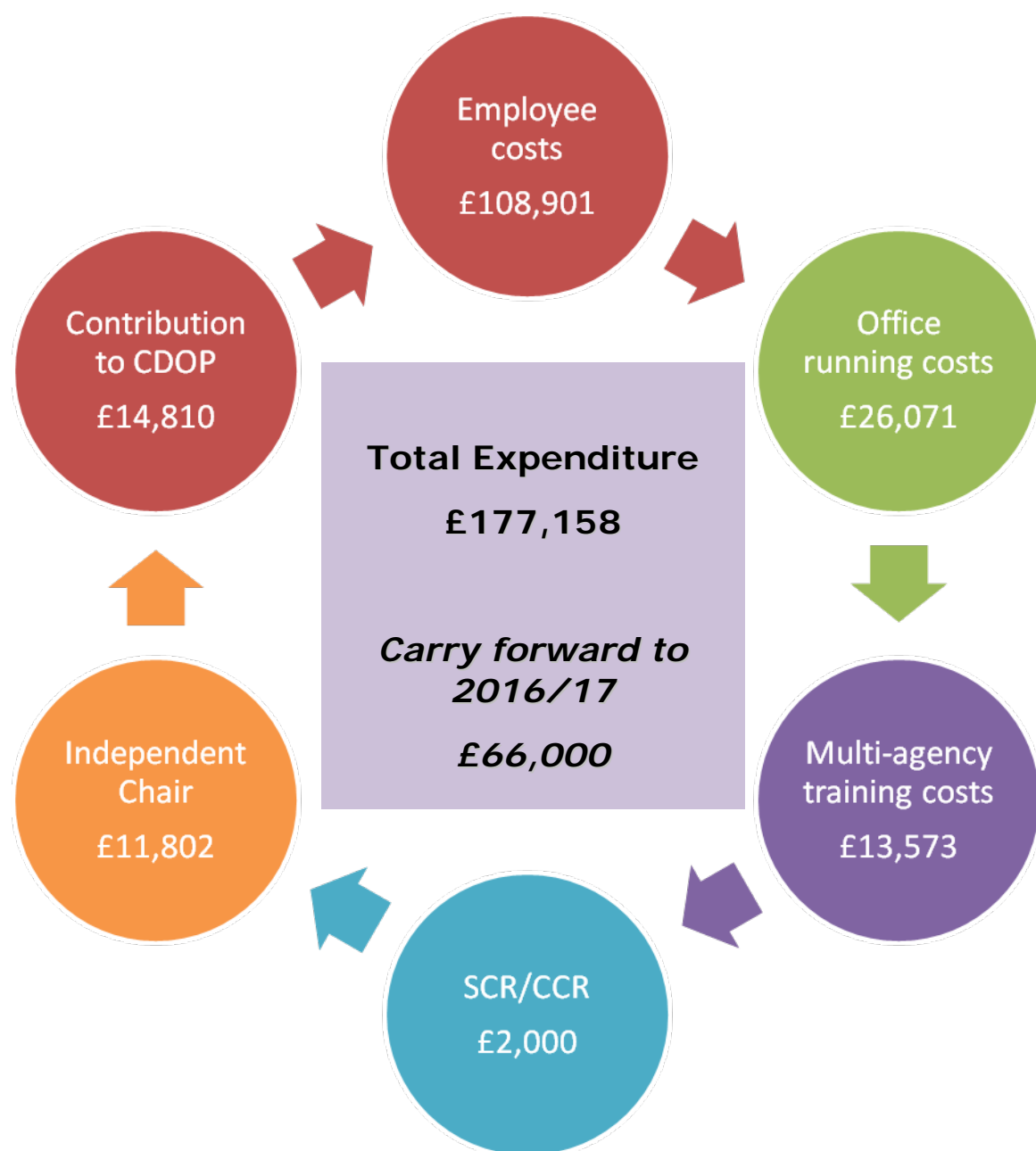
5.3 Board Structure



5.4 Financial Arrangements - Income



5.5 Financial Arrangements - Expenditure



5.6 Projected Income & Expenditure 2016/17

Contributions/Income	£
Prior Year Underspend Brought Forward	66,000.00
Bury CCG	37,142.00
Greater Manchester Police	11,850.00
CAFCASS	550.00
National Probation Service	915.56
Community Rehabilitation Company	1,231.00
Connexions	1,100.00
Social Care	62,112.00
Learning	4,900.00
Youth Offending	4,033.00
EDS	200.00
Training Income	8,300.00
DSG Contribution	40,000.00
TOTAL INCOME	237,102.00
Expenditure	£
Employee Costs	153,100.00
Multi-Agency Training Costs	14,800.00
Serious/Critical Case Reviews	20,000.00
Independent Chair of BSCB	11,800.00
Travel & Substance	3,400.00
Advertising - Staff	0.00
Postage	400.00
Telephone	1,000.00
Office Overheads incl Equipment, Tools & Materials	5,200.00
Printing & Stationary	1,500.00
Central Recharges (Admin Buildings etc)	13,000.00
Staff Training	500.00
Contribution to CDOP Centralised Budget (Oldham MBC)	10,600.00
Miscellaneous	0.00
Employers Liability & 3rd Party Insurance	500.00
TOTAL EXPENDITURE	235,800.00
Total Net Budget 2016/17	1,302.00

This year there has been a reduction in financial contributions to the work of the BSCB from two of our statutory partners, the Community Rehabilitation Company and the National Probation Service.

6. *Bury Safeguarding Snapshot*

43,000 children and young people live in Bury

23% of the total population

16.4% of children living in poverty



14.9% (lower than national average) of primary school children and **15.3%** (higher than national average) of secondary school children in receipt of free school meals.

128 children, young people and families worked with Team Oasis (Early Help Panel).

326 children in need were recorded as having a disability, **19%** of the total number of referrals (open cases) received at the end of 2015/16.



221 children and young people were reported missing on **714** occasions.

2,078 referrals to Children's Social Care - **28.9%** were re-referrals.

2,161 assessments completed by Bury Children's Social Care, **92.7%** within the timescale

254 children subject to Child Protection Plans at the end of 2015/16

1,713 open Children in Need cases as of March 2016

311 looked after children and young people

65% MARAC cases involving children and young people living in families with domestic violence

19 LADO referrals proceeded to investigation

0 private fostering arrangements as of March 2016

36 child road casualties with **0** fatalities

31 households where children live with adults who have been assessed as having a substance misuse problem

374 hospital admissions caused by unintentional and deliberate injuries to children and young people

25 young people with a total of **48** YOS interventions (**52.1%**) in suitable education training or employment

86.1% of primary and secondary schools graded outstanding



good or

2,089 referrals to Healthy Young Minds (CAMHS) received in a year

7. Bury Safeguarding Context

7.1 Bury Demographics

Bury is one of the 10 metropolitan boroughs of Greater Manchester.



The total population of Bury is 185,060 (2011 census).

- 19.7% of the population live in areas which are among the 20% most deprived in England (IMD 2013).

7.2 Children and young people living in this area

- Approximately 43,000 children and young people under the age of 18 years live in Bury. This is 23% of the total population in the area.
- Approximately 16.4% of the local authority's children and young people are living in poverty.
- The proportion of children and young people entitled to free school meals:
 - in primary schools is 14.9% (the national proportion is 15.6%)
 - in secondary schools is 15.3% (the national proportion is 13.9%).
- Children and young people from minority ethnic groups account for 17.6% of all children and young people living in the area, compared with 21.5% in the country as a whole.

- The largest combined minority ethnic groups of children and young people in the area are Asian/Asian British. The single most populous 0 to 17 years minority ethnic group is Pakistani.
- The 2011 census indicates that 5.6% of the population of Bury record their religion as Jewish compared with the England proportion of 0.5%.
- The proportion of children and young people with English as an additional language:
 - in primary schools is 17.5% (the national proportion is 19.4%)
 - in secondary schools is 14.6% (the national proportion is 15.0%).

7.3 *Contacts, Referrals and Assessments*

Table 1: Contacts and Referrals

	Total initial contacts (number)	Progressed to referral (number)	% contacts progressing to referral	Rate of referrals/10k child population
Full Year 2013-2014	8613	3215	37.3%	759 (SN Group Mean 620.7) (Regional Mean 687.6)
Full Year 2014 - 2015	7899	2555	32.3%	617.5 (SN Group Mean 533.7) (Regional Mean 616.8)
Full Year 2015 - 2016	8536	2078	24.3%	487.8 (Rate calculated on rounded 0-17 child population of 42,600)

In 2015-2016 the number of recorded Contacts returned to the level of 2013-2014 after a fall in the previous year. Less significant than the annual count of Contacts is the variation that occurs within the year and the overall trend. In August 2015 527 Contacts were recorded, a low count only partly attributable to the schools being closed, whereas in March 2016 was recorded the highest ever monthly count of 912 Contacts. The two-year trend was down from August 2014 to October 2015, it was level for November and December 2015, and then started to rise from January 2016.

Table 1 does not reveal the inverse relationship between the two-year trends for Contacts and Referrals. In 2015-2016 a much smaller proportion of Contacts gave rise to a Referral than in the two previous years. The two-year conversion trend was up until December 2014, it was level for just one month and it has been down since February 2015. And although as with the recording of Contacts considerable variation can occur within the year – for example, just 16.3% of Contacts in December 2015 giving rise to a Referral but 30.8% of Contacts in February 2016 – there has been a sustained trend for fewer and fewer Contacts being resolved by means of a social care Referral.

There are several possible reasons for the decline in the Referral rate. The first point to note is that Referral rates in previous years have been very high relative to the mean rate for our statistical neighbours. Since November 2014 the Referral rate has generally been within or below the expected range, returning to its previous high level only in February and March 2016. Likely factors contributing to the reduction in Referral rates are the influence of individual MASH managers, the introduction of further enquiries into the process of assessing Contacts and the availability of new alternatives to Referral, such as an Early Help or CSE referral.

Table 2: Contact Sources

Contact source	% of Contacts 2014 -2015	% of Contacts 2015-2016
Police	50.5% (3950)	43.1% (3682)
Via Emergency Duty Team (EDT) and social care	2.5%	4.3% (363)
Health	9.7% (766)	11.9% (1013)
Education and Schools	11.0% (869)	12% (1033)
Members of the public (including anonymous and self referrals)	7.7%	9.2% (786)
Others including children's centres and Voluntary and independent agencies	4.1%	5.8% (491)
Other local authorities	2.8%	3.1% (265)
Other Legal agencies e.g. probation, courts and CAFCASS.	5.5%	6% (509)

Housing	2.8%	2.1% (177)
Other sources	3.2%	0.6% (50)

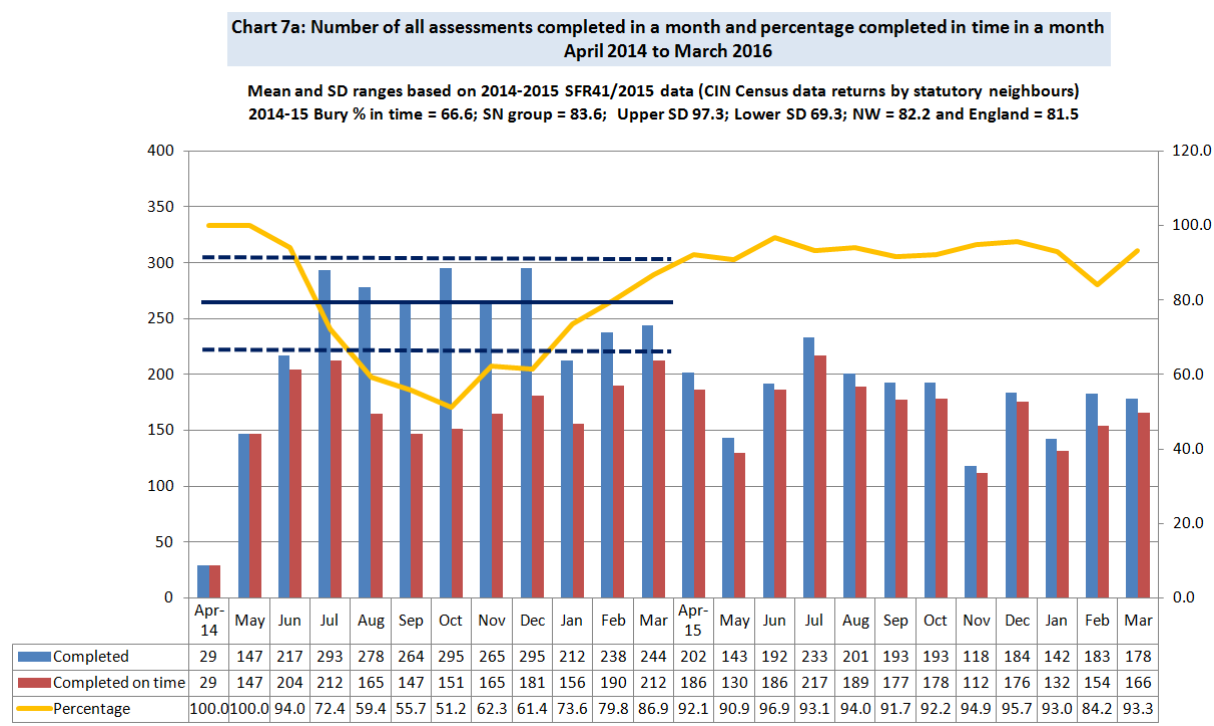
Table 3: Referrals by Source

Referral Source	% of Referrals 2014 -2015	% of Referrals 2015-2016
Police	38.8% (1019)	26.3% (547)
Health	11.8% (309)	14.2% (296)
Education and Schools	16.9% (443)	20.8% (434)
Members of the public (including anonymous and self referrals)	9.1% (238)	10.8% (226)
Other e.g. Children's Centres, Voluntary and Independent Agencies	5.7% (149)	6.3% (131)
LA's including other local authorities and social care	11.3% (296)	13.7% (286)
Other Legal including Courts, Probation and CAFCASS	3.6% (95)	4.6% (96)
Housing	2.8% (75)	2.8% (58)

The police account for the largest number of Contacts attributable to the actions of a single agency and for a little over forty per cent of all recorded Contacts. In the previous year just over half of all Contacts originated with the police. A detailed analysis of the factors underlying Contact decisions has revealed that the majority of police Contacts are associated with domestic violence, often associated with drug and alcohol misuse in the presence of children.

The police also account for the largest number of Referrals attributable to a single agency. It is noteworthy that police Referrals constitute a smaller proportion of all Referrals than do police Contacts as a proportion of all Contacts. This can be explained by reference to the frequent intervention of the police as the first point of contact in circumstances where children are at risk and their working protocols, which result in notifications being passed to the Multi-agency Safeguarding Hub (MASH) without prior assessment. So the police observe many incidents and refer the majority, whereas other agencies, particular those who have other knowledge or a working relationship with the families in question, may be able to make a finer discrimination between the circumstances that justify a MASH referral and those that can be dealt with by other means. Those agencies that customarily develop a detailed knowledge of individual children's circumstances, for example schools and health services, constitute a much larger proportion of Referral sources than Contact sources. In other words, the more an agency knows about a child or children the greater the likelihood that their Contacts will progress to the Referral stage.

Chart 1 (Chart 7a in the suite of CSC performance reports) – Assessments and assessment timescales



Throughout 2015-2016 the overwhelming majority of single assessments were completed within the expected 45-working day maximum, this being a marked and sustained improvement on performance in the previous year. The number of assessments completed was fewer than in 2014-2015, reflecting the reduction in the number of Referrals. Improvement in assessment timescales was commented on favourably during the course of the February-March Ofsted inspection of safeguarding services.

7.4 Child Protection

Table 4: Child Protection Activity April 2015 – March 2016

Rate/10k child population Or %	Bury 2015 -16	Bury 2014 -15	SN Mean Average 2014 -15	NW Region Mean Average 2014 -15	England Mean Average 2014 -15
Referral rate	487.8	617.5	533.7	616.8	548.3
% Re- Referrals within 12 months	23.2%	25.1%	24.1%	-	-
Rate S47	125.0	114.7	154.7	149.3	138.2
% Conversion S47 to ICPC	72%	65.8%	51%	46%	46%
% ICPC within 15 days	85.9%	56%	80%	70.9%	69%
Rate of ICPC	89.9%	75.4	63.5	62.9	56.8
Rate of CP Plans 31 st March 2016	59.6	49.9	48.8	42.1	50.8
% CPP re- registration	20.1%	20.1%	20.1%	17.1%	16.6%

A low re-referral rate usually taken as indicative of a good safeguarding service, based on the belief that the timely identification and offer of effective help to children in need will reduce the likelihood of those children being referred again. The re-referral rate for 2015-2016 is the lowest recorded in five years and is comfortably below the last-published mean average for our statistical neighbour group. The reduction in the re-referral rate has been achieved despite there being fewer Contacts progressing to Referral; this is interesting because one might have expected the enhanced MASH assessment process to have resulted in a larger proportion of children with enduring problems progressing, and these children to have previously been referred.

The rate of Section 47 investigations was low throughout the year and only reached the previous year's mean rate for our statutory neighbours in four of the twelve months. On the other hand, and certainly relative to the mean for the statistical neighbour group, a large proportion of Section 47 enquiries gave rise to an ICPC. This is encouraging in that it suggests that the S47 process is efficient, with the high proportion of ICPC progression providing some validation for the decision to conduct a S47 enquiry in the first place.

The year ended with a high rate of open plans, although this was an improvement on the position in November and December 2015 when there were 300 open plans. The year-end and comparator data does not reveal the considerable variations that occurred within the year; there was a 50% increase in the number of open plans between March and November 2015, followed by a 15% fall from December 2015 to March 2016. The increase in the number of children on a plan largely resulted from an very high rate of commencements; the rate of cessations was within or above +/- 1 SD of the 2014-2015 group mean for 9/12 months of 2015-2016.

As with Referrals, a low repeat CP rate is considered to be an indicator of a good safeguarding service. Although with a rate higher than for England as a whole and for the North West, Bury ended 2014-2015 with a re-registration rate exactly that of its statistical neighbour group mean. The same rate was achieved in 2015-2016, helped by three months in which there were no repeat plans.

Table 5: Conference Monitoring¹

	2014 -15	2015 – 16
Number of Initial Conferences held (children)	300	383
Parents seen Social Work report before conference	86%	90%
Parents seen other agency reports before conference	70.5%	No longer counted
% Initial conferences starting late.	54%	No longer counted
Child's views (where of an age) recorded in initial conference reports	89% (24% not of an age to be able to express view)	93% (41% not of an age able to express a view)
Review conferences within timescale	85%	96%
Child's views (where of an age to express a view) recorded in review conference reports	90%	97%
% core groups at required frequency	85%	97%
% plans progressed appropriately between review conferences	83%	80%

¹ These figures are based on records maintained in the Safeguarding Unit rather than being derived from children's case records held in LCS.

Table 6: Attendance at Initial & Review Conferences²

Agency	ICPC - % attendance of possible attendance	Review CPC - % attendance of possible attendance
Parents	89%	95%
Health Professionals (e.g. HV/SN)	87%	95%
CDAT (One Recovery)	53%	59%
Mental Health	68%	38%
CAMHs	47%	36%
Midwifery	74%	n/a
Education	80%	67%
Children's Centres	58%	86%
Police	79%	2%
Probation	69%	49%
Case Holding Social Worker	99%	98%
Receiving Social Worker	56%	n/a

Table 7: Children Subject to Child Protection Plans – by Age

Age	Bury	Bury
	31 March 2015	31 March 2016
Unborn	5 (2.4%)	6 (2.3%)
Under 1 year old	22 (10.7%)	17 (6.6%)
1-4 years	56 (27.3%)	84 (32.8%)
5-9 years	70	79

² These figures are based on records maintained in the Safeguarding Unit rather than being derived from children's case records held in LCS.

	(34%)	(30.9%)
10-15 years	46 (22.4%)	64 (25%)
16 years and over	6 (2.9%)	6 (2.3%)
Total	205	256

Table 8: Child Protection plans by category (as at 31st March 2016)

Category	Bury March 31 2016 Number and rate /10000	Bury March 31 st 2015 Number and (Rate/10,000)	<i>England Children becoming subject of a plan 2014/10,000</i>
Neglect	132 (30.9)	81 (19)	18.3
Physical abuse	5 (1.2)	10 (2.4)	4.1
Sexual abuse	7 (1.6)	16 (3.7)	1.9
Emotional abuse	111 (26)	85 (20)	13.8
Multiple categories	1 (0.23)	13 (3.1)	3.9
Total number of Bury Plans	256 (60)	205 (48.35)	42

7.5 Categories of Plan

'Neglect' and 'Emotional abuse' accounted for the highest percentage of child protection plans as at March 31st 2016. The categorisation of 'Neglect' has increased hugely by comparison with last year whilst the categorisation of sexual abuse has decreased. It may be a result of continued austerity that the issue of neglect has increased so significantly.

It is unclear whether there is consistent choice between categories of need. The categories provide only the broadest discrimination between different types of harm and risk and their selection is unlikely to reflect the underlying prevalence of specific problems, either among the children subject to plans or in the general child population. Domestic violence is generally contained within the Emotional Abuse category, based on the criterion that the child or children is or are 'seeing or hearing the ill-treatment of another'.

8. Progress in Bury

8.1 Children and young people who are looked after away from home

The Safeguarding Children and Young People Living Away from Home sub group have the responsibility for overseeing actions in respect of young people who are looked after or living away from home. In 2015/2016 the sub group has met quarterly and membership has been consistent and well attended. The sub group is chaired by the Strategic Lead Strategic Lead Health, Families, Partnerships & Complex Care. Members of the group have worked together to achieve the priorities set out in this year's action plan. Key achievements in 2015/16 have been:

- Ensure that effective Safeguarding Arrangements are in place for Children who are living Away from Home, in Hospital (long stay admissions) - Section 85 and 86 CA 1989 are effective.
- Ensure arrangements are in place to effectively safeguard young people looked after who are missing. The sub group has worked with the CSE & Missing sub group to revise the local 'Missing from Home' procedures. The sub group has received regular quarterly reports ensuring that the procedure for return interviews is embedded across services.

Going forward into 2016/17 the sub group will retain oversight of the Private Fostering action plan, improving the identification assessment and support to privately fostered children young people and their carers. Appendix 4 contains a detailed Private Fostering annual report and action plan for 2016/17.

The sub group will also scrutinise the Local Authority action plan developed in response to Ofsted's findings in respect of outcomes for some 'Looked After Children'.

A comprehensive report from the Safeguarding and Quality Assurance Unit Independent Reviewing Officer Service can be found as Appendix 11.

‘Services for children and young people who are looked after require further work to ensure good outcomes for all children and young people’

Ofsted May 2016

8.2 Children who are disabled

In response to the strategic priorities contained in the BSCB Business Plan in 2015/16 the BSCB commissioned an independent audit of the children with disabilities service. This auditing activity has identified examples of positive safeguarding practice being undertaken however the audit report also identified a number of shortfalls in practice. A service improvement plan was developed in response to the audit findings and the BSCB Business Group has maintained oversight of the progress. This scrutiny will continue in 2016/17.

8.3 Children who are vulnerable to sexual exploitation (CSE) and / or missing

CSE -Through the implementation of the BSCB CSE & Missing strategy the BSCB receives information relating to the multi-agency response to children at risk. Progress against the BSCB strategic priorities and action plan is reported quarterly to the CSE and Missing sub group and to the BSCB.

This year we have also enhanced our understanding of local practice in the form of a Project Phoenix Peer Review undertaken in October 2015 and via the Report of Ofsted in May 2016.

‘Child exploitation is a key priority of the BSCB business plan, and the board has a detailed understanding of local activities to tackle child sexual exploitation, to help children and young people and to disrupt perpetrators’.

‘Arrangements for identifying and supporting children and young people at risk of child sexual exploitation are robust and improving’.

Ofsted May 2016

Appendix 5 of this report contains a detailed report by the Bury Phoenix Child Sexual Exploitation Team. This report provides an overview of key performance information gathered during this period, together with an explanatory narrative. The findings from the Project Phoenix Peer Review are also discussed within the report.

Missing - We have established robust data analysis and performance mechanisms this year in respect of Bury young people who are 'missing'. The Local Authority Strategic Lead now presents a quarterly report to the BSCB CSE and Missing sub group analyzing any emerging issues or trends that may require a strategic response. The report also goes to the BSCB Business Group for scrutiny. A comprehensive 'Missing' report is available as Appendix 6.

8.4 Children who are living with the impact of domestic abuse, parental substance misuse, or poor parental mental health

The term "toxic trio" is used to describe the co-occurrences of mental health problems, substance misuse and domestic abuse in families. Children of parents who are affected by the toxic trio are at an increased risk of significant harm. Work in this area has shown that there is large overlap between these parental risk factors and cases of child death, serious injury and generally poorer outcomes for children across all ages.

Achievements this year have been:

- We have maintained oversight of the production of the Bury domestic abuse strategy, challenging delays where necessary and ensuring that the experiences of children and young people are incorporated into the Bury Domestic Abuse action plan.
- We have undertaken a multi-agency audit of professional responses to young people who are experiencing domestic abuse in their relationships. The findings of this audit have been taken forward by the Marac Task and Finish Group.
- BSCB members have contributed to the revised Joint Strategic Needs Assessment to ensure that needs of this group are fully reflected in service planning.
- The Monitoring and Evaluation sub group has scrutinised the findings of the Children's Social Care single agency Toxic Trio audit.
- The sub group has also welcomed the enhanced contribution of the local service provider Addiction Dependency Solutions (ADS).

8.5 Children who are emotionally vulnerable

In 2015/16 the BSCB Business Group has scrutinised the local [CAMHS Transformation Plan](#).

We have worked with the Children's Trust to deliver workshops and events in response to identified training needs. This has included workshops on self-harm, facilitated with staff from CAMHS. As a result of the positive feedback, more have been planned to take place in 2016/17.

8.6 Early Help

Ensuring that children and young people have access to early help is a priority for both the Children's Trust and the BSCB. The Bury vision set out in the [Early Help Strategy](#) is that children and young people will have access to the right help at the right time and from the right person.

The Bury Early Help Strategy provides a set of principles developed to build a culture of early help, and actions for us all to work together to develop an Early Help Offer that meets the needs of children, young people and families in Bury.

The Children's Trust Board are responsible for driving forward this strategy. The BSCB brings scrutiny and challenge to ensure the quality of that Early Help Offer.

The BSCB has received regular and detailed reports to support its evaluation of the effectiveness of early help services since July 2013. This has enabled the BSCB to challenge the Children's Trust and partners when necessary. Effective challenges in 2015/16 have included:

- the integration of the family nurse partnership with the early help offer
- highlighting some gaps in local parenting programmes.

'Early help interventions are often successful in improving children's and young people's outcomes and avoiding the need for statutory intervention.'
Ofsted May 2016

A comprehensive report from the Children's Social Care, Early Help Team can be found as Appendix 7 to this report.

8.7 Allegations management

Key BSCB achievements in 2015/16 in respect of the recruitment and supervision of persons who work with children & investigation of allegations concerning persons who work with children:

- The BSCB has delivered Safer Recruitment Training to 57 participants.
- The Bury Designated Officer has delivered Managing Allegations training to 45 participants from a wide range of partners. These training figures reflect an increase from the year 2014/15.
- The Managing Allegations training & Safer Recruitment training has been revised to include the learning from national Serious Case Reviews and local critical cases.
- The total number of LADO related enquiries between 1st April 2015 and 31st March 2016, were **224** down from **236** last year. Of the 224 LADO related enquiries, **32** reached the LADO threshold to referral. (**54** in 2014/2015)
- A full annual LADO report containing commentary and analysis of these trends can be found as Appendix 8 to this report.

***Good arrangements are in place to manage allegations against professionals who work with children and young people'.
Ofsted May 2016***

8.8 Thresholds and child's journey arrangements re assessment protocols

The BSCB has an agreed approach to identifying and responding to the needs of children and families in Bury. In July 2013 the BSCB concluded a consultation with partners on a new '[Thresholds for Intervention](#)' document. The document was endorsed by BSCB in September 2013 and is published on the BSCB website. This guidance is intended to provide professionals with clear thresholds that should be applied consistently to ensure the right help is given to a child at the right time.

The guidance around its application is regularly reviewed and was updated in 2015-16 to include changes in statutory guidance relating to Female Genital Mutilation (FGM), radicalisation, and sexually harmful behaviour (following the learning from a Critical Case Review).

The application and understanding of thresholds is tested by BSCB scrutiny of single and multi-agency performance data and audit. A recent example of this is a multi-agency audit undertaken of GP referrals to the MASH Team that found that the majority of referrals were appropriate and sufficiently detailed.

The BSCB is confident that the threshold for statutory agency referral is well understood by all agencies. Audit activity will continue in 2016/17 to test the consistent application of thresholds.

The local threshold document is clear and supports professionals' and the public's understanding of when a child or young person may require additional help or protection'. Ofsted May 2016

9. Learning and Improvement

Working Together 2015 states that "Local Safeguarding Children Boards should maintain a local learning and improvement framework which is shared across local organisations who work with children and families. This framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result." Learning and improvement is undertaken in Bury in a number of ways, including reviews of practice, auditing, quality assurance and external learning.

9.1 Quality and effectiveness of arrangements and practice

In 2013/14 the BSCB reviewed and updated its Quality Assurance framework. This framework was used throughout 2015/16 to evaluate the quality and effectiveness of local safeguarding arrangements and practice. The Monitoring and Evaluation sub group is responsible for the implementation of the framework, including the co-ordination of BSCB multi-agency audit activity, the Greater Manchester Safeguarding Partnership multi-agency data set, and section 11 audit activity (see section 12). The Monitoring & Evaluation sub group is chaired by the Assistant Director, Safeguarding & Social Care, Department for Children, Young People and Culture.

9.2 Multi-agency audits

A cycle of multi-agency audits is planned every year as part of the sub group's action plan. Audits are scheduled in accordance with BSCB Business Plan priorities and allow for flexibility to respond to emerging issues. Efforts are made to involve front line practitioners in BSCB audit activity. The findings from audit activity are communicated via the BSCB e-bulletin, multi-agency training and through the BSCB practitioner forum.

Throughout 2015/16 we have undertaken audits of practice in respect of children with disabilities, the marac and young people, neglect, supervision and we have undertaken observations of child protection conferences. This auditing activity has identified numerous examples of positive safeguarding practice being undertaken across the partnership. Lessons have also been identified that have led to tangible improvements such as the adoption of the NSPCC Graded Care Profile 2, the re-launch of the role of the young persons' domestic violence advocate and the development of a children with disabilities service improvement plan.

9.3 Multi-agency data set

In Q2 of 2014/15 the BSCB agreed to adopt the Greater Manchester Safeguarding Partnership [multi-agency data set](#). The purpose of the data set is to enable the BSCB to hold partners to account by providing a rationale for the emergence of patterns or trends. This year three examples of challenge and the subsequent impact are:

- the timeliness of the completion of single assessments by Children's Social Care
- high numbers of children subject to a child protection plan
- attendance by the police at child protection conferences and reviews

9.4 Impact

- Throughout 2015/16 there was a significant improvement in performance data relating to the timeliness of completion of single assessments. (see chart 1 page 14)
- Although numbers are high partners have provided reassurance to the BSCB that children subject to a cp plan are subject to regular review and quality assurance processes escalating where necessary.
- Reassurances have also been received from the police that all request to attend cp conferences and reviews are risk assessed with high risk cases being prioritised.

The sub group reported in 2014/15 that the GMSP data set was not sufficiently well developed and was focused too narrowly on Children's Social Care. The sub group has highlighted previously in the Annual Report 2014/15 that effective implementation and development of the GM data set has been impeded by the lack of a dedicated BSCB Performance Officer. Partner commitment to the multi-agency data set was also variable.

In 2015/16 BSCB partners agreed to recruit to a dedicated BSCB Quality Assurance and Performance Officer post. A part time officer joined the BSCB in Q4 of 2015/16. Going forward into 2015/16 the sub group will be focusing its efforts to improve the quality of multi-agency performance data so that the rigour of our scrutiny of frontline practice across all partner agencies is improved.

The sub group will also be strengthening the BSCB's understanding of the effectiveness of frontline services by requesting that our partners provide a clearer picture of single agency quality assurance activity sharing local lessons learned and improvement actions being taken across the system.

9.5 Section 11 audit

The Section 11 audit is the BSCB's primary audit to examine safeguarding arrangements within agencies and provides the BSCB with reassurance that agencies are prioritising the safety and welfare of children and young people. The BSCB carries out a section 11 audit every three years.

In 2013/14 BSCB members agreed to invest in an online audit tool to conduct section 11 audits. The findings of the section 11 audit are scrutinised by the BSCB with an action plan developed. The section 11 audit will be repeated in 2016/17 and there are plans to strengthen partner's self-assessments through the development of a section 11 challenge day. This work will be led by the BSCB Quality Assurance & Performance Officer.

9.6 Effectiveness of the BSCB, contribution and challenge

Through the work of the BSCB we have continued to monitor our effectiveness and functioning. This year we have participated in:

Peer Review undertaken by an Independent Chair of a North of England LSCB. The Peer Review identified: -

- good engagement and energy from partner agencies and that it was well led, organised and administered.
- The strengths include excellent level of partnership engagement, good working relationships between agencies; proactive approach to tackling challenges such as financial issues; evidence of challenge; well placed to address key practice areas (eg Early Help, child sexual exploitation (CSE) and radicalisation); good networks with other local partnerships; clear line of sight of frontline practice; regular reports on key issues (eg LADO & private fostering); working in line with Working Together 2015; undergone "step change" in ways to approach CSE; learning from serious case reviews is embedded; multi-agency training is valued; 1:1 sessions with Independent Chair and strong links with Bury CCG and GPs.

Areas for development were also identified including:

Maintaining energy and enthusiasm of partners; ensuring a smooth transition with the appointment of a new Independent Chair; development of more strategic participation

work with young people; quality assurance function (although this is in hand with new post created); and raising public awareness (holding a conference).

9.7 Risk Register

Over 2015/16 the BSCB members regularly reviewed performance through reference to a risk register and updates on the Business Plan being submitted to each BSCB meeting.

9.8 Self-Assessment

The BSCB also introduced a self-assessment process to reflect on its progress against the expectations of the single inspection framework.

9.9 Challenge Log

The BSCB continued to raise challenges with a number of our partners in 2015/16. A challenge log is regularly updated by the BSCB Business Manager with contributions from partners.

Areas for scrutiny in 2015/16 have included:

- Holding the CSP to account for its effectiveness in safeguarding children and young people at risk of radicalisation.
- Professional responses to neglect and the use of the graded care profile
- High numbers of children and young people on a child protection plan
- Case loads in the children's social care safeguarding service; and
- Progression of multi-agency actions from Serious Case review

The BSCB needs to improve in 2016/17: -

- Its oversight and challenge in respect of the outcomes for all looked after children.
- The identification and assessment of children living in private fostering arrangements.
- Its scrutiny and challenge of multi-agency performance data.
- Actively listening to the voices of children and young people, particularly children from diverse backgrounds.

These recommendations have been incorporated into the Business Plan for the BSCB and its sub groups over the next 12 months.

10. Engagement and participation of children and young people

The BSCB has a wide range of methods of listening to the voice of children and young people. Since 2014/15 we have begun all BSCB meetings with a standing 'Voice of the Child' item.

This year we have been reassured that our partners have a strong ethos of engagement with children and young people ensuring that they are seen, heard and that their voices influence both their own outcomes and that of how partners safeguard children. Achievements from our partners this year have been:

- Bury Children's Social Care - Lilac Standards accreditation for Looked After Children
- Children's Trust - Participation strategy
- Bury Youth Cabinet - Circles of Influence Report
- Third sector engagement with young people via use of social media
- Bury Children's Rights Team - heard feedback from young people in respect of their experiences of services via the Bury Children's Rights Annual Report available at Appendix 3.

Moving forward into 2016/17 the BSCB will seek to strengthen the involvement in the work of the BSCB by the development of an engagement strategy. Plans are underway to produce a young people's version of this year's annual report.

11. Serious Case Reviews

The BSCB Case Review & Learning Sub Group is responsible for coordinating serious case reviews and learning reviews and for monitoring the implementation and effectiveness of all of the reviews action plans on behalf of the BSCB. Sub group members act as independent panel members for serious case reviews where their agency is not directly involved with the case. The sub group is chaired by the Head of Safeguarding for Bury Clinical Commissioning Group and the group meets four times a year. Progress on the actions arising from serious case reviews (SCRs) and learning reviews are monitored by the BSCB Case Review and Learning sub group. Progress and exception reports on the actions are presented to the Business Group on a six weekly basis and to the BSCB on a quarterly basis as required.

In 2015/16 the sub group changed its name from the Serious Case Review Sub group to reflect the new models of learning to reflect the final 'Review of Child Protection' report by Professor Munro which recommended that LSCBs adopt a 'systems'

methodology approach to conducting SCRs in order to move beyond identifying what happened, to explaining why it happened. This approach aims to improve the current SCR process on a national and local basis by increasing the depth of learning and quality of the findings through greater involvement and meaningful engagement with front-line practitioners and managers involved in working with the subject child and their family. The approach to reviewing serious child care incidents and the new learning and development requirements placed on LSCBs and their partner agencies is now clearly set out in Chapter 4 of Working Together to Safeguard Children (2015).

Two briefing sheets have been developed in 2015-16 and circulated to all front line professionals via their board member. Additionally, a practitioners' forum is held quarterly and enables further exploration of the learning. All learning is incorporated into the BSCB multi-agency training programme.

'Practitioners who spoke to inspectors during this inspection were able to describe the learning from SCRs and BSCB training that they had attended'. Ofsted May 2016

11.1 Summary of learning from completed reviews

No Serious Case Reviews have been undertaken or commenced in 2015/16, however the sub group has undertaken a learning review.

A Critical Case Review was undertaken in 2015/16. The review centred on professional responses to children and young people who display harmful sexual behaviour. The case showed that children and young people who display harmful sexual behaviour are likely to have considerable levels of unmet need themselves. Such children are likely to be a "child in need". Children who harm others should be held responsible for their harmful behaviour while being identified and responded to in a way which meets their needs as well as protecting others.

The review exposed a significant gap into how the AIM (**A**ssessment **I**ntervention **M**oving on) assessment connects into established multi-agency processes and how the safeguarding of both alleged child perpetrator and victim was compromised as a result of this. An absence of multi-agency challenge allows gaps in single and multi-agency approaches to continue to the detriment of the overall case management.

In response the BSCB threshold document has been amended to ensure that all children who are undergoing an AIM assessment should be considered to be a "child in need".

The voice of the child must be stronger. There is a consistent message from this and many other local and national learning reviews. This review identified that the statement of the victim was insufficiently heard. Practitioners across agencies failed to

consider in sufficient depth what the child had actually said and the impact of this upon the ongoing risk assessment in relation to the alleged perpetrator.

'Learning from SCRs and critical case reviews is given a high priority in Bury'. Ofsted May 2016

12. Child Death Overview Panel

The [Child Death Overview Panel \(CDOP\)](#) enables the BSCB to carry out its statutory functions relating to child deaths. In April 2008 Bury, Rochdale and Oldham joined to form a tripartite arrangement. The joint working of the three local authorities provides a wider data set to conduct analysis and investigate emerging trends. This year we have welcomed the Bury Consultant in Public Health who now chairs the CDOP.

From 1 April 2015 to 31 March 2016 the CDOP discussed and closed a total of 74 cases.

Bury	17	23 %
Rochdale	28	39 %
Oldham	29	38 %

All three of the local authorities found the highest number of deaths occurred in neonates (deaths within 0-27 days of life) with a joint total of 32.4% (24) of the overall deaths.

The second highest proportion of the deaths occurred in children aged 28 - 364 days, calculating 21.6% (16).

If we combine the two categories this would indicate that 40 (54%) of the 74 child deaths occurred within the first year of life highlighting children under the age of 1 as the most vulnerable.

The largest number of child deaths in Bury occurred in children under the age of 1 totalling 8 (47%) of the 17 deaths. Of the 8 deaths under 1, 5 (63%) of these were neonatal deaths and 3 (38%) died between 28 - 364 days of life.

Of the three local authorities Bury has the least number of child deaths (17) when compared to Oldham (29) and Rochdale (28). From viewing year in year statistics there has been no drastic increase/decrease in specific age groups.

Greater Manchester Sector Lead Improvement review

Bury Safeguarding Children Board recently took part in a North West sector lead improvement event hosted by the Greater Manchester Public Health Network. This involved carrying out a multi agency self evaluation of all the work which Bury does to

address infant mortality. The evaluation was peer reviewed by other local authorities in the North West, then ideas and approaches were shared between organisations on how each area could improve.

'Effective arrangements...are in place to review child and young person deaths'. Ofsted May 2016.

13. Training and Development

Through the Learning and Development sub-group, the BSCB facilitates a wide range of training linked to local priorities. Take up of BSCB training is good, with a wide range of agencies represented (See Appendix 2 for a detailed analysis of attendance.)

The delivery of the multi-agency training programme was challenged this year following the resignation of the multi-agency training co-ordinator in August 2015. During this period, however, training was commissioned from independent trainers ensuring that all planned courses took place. An appointment has now been made to the post of Learning & Development Officer.

The Learning and Development sub-group co-ordinates a multi-agency training needs analysis every two years. In 2015/16 we repeated the analysis, receiving a very positive response from our partners. As a result of the feedback received we have (with our partners in education, CAMHS and Pennine Care NHS Foundation Trust), delivered additional training, this has included training on the issue of suicide and self-harm working. Feedback has been positive and more sessions are planned for 2016/17.

In 2015/16 the sub group focused on improving the evaluation of the impact of BSCB training on staff practice. In addition to providing immediate feedback, course participants were contacted three months after attending for scrutiny of impact. Feedback has been positive, with practitioners reporting changes to their practice.

***'Multi-agency training is of high quality, is valued by participants and is helping contribute towards positive outcomes for children and young people'.
Ofsted May 2016***

Quotes from participants on BSCB training courses

Very, very good! I have learned so much, feel so much more confident. It really has opened my

*Very knowledgeable trainers;
Great pace & balance;*

A real eye-opener. So much I was unaware of with regard to e-safety.

Networking, extremely experienced trainer with a very varied knowledge base/ professionalism

Group activities, working with others & sharing ideas & experiences was good. Very interesting course

Looking at case study to compare to real scenarios; Egs of SCRs etc helped show how it's put into practice

14. Provision of policies, procedures and guidance

The Policies and Procedures Sub Group is responsible for developing and reviewing multi-agency policies and procedures for safeguarding and promoting the welfare of children.

Due to the development of the pan Greater Manchester Safeguarding Partnership (GMSP) multi-agency policies and procedures the sub group became a virtual group in 2014/15. This project has led to a successful harmonisation of multi-agency safeguarding procedures across all ten LSCBs in Greater Manchester.

The BSCB is represented on the Greater Manchester group by the Business Manager, who is also the sub group chair, and by the Designated Nurse for Safeguarding, Bury CCG. The sub group also forms short Task and Finish groups in response to emerging issues and BSCB priorities. A number of local procedures remain subject to review to ensure where possible there is no duplication.

In 2015/16 two successful updates of the procedures were completed, revisions included mandatory reporting in respect of Female Genital Mutilation, the Prevent duty and escalation procedures

As the on line procedures are now well developed the Greater Manchester group also considers how to evidence that they are embedded and used across the 10 partnerships. Locally the procedures are promoted in all BSCB training courses, SCR learning materials, the practitioner forums, and BSCB e-bulletins, practitioners are encouraged to sign up for 'alerts'.

'Safeguarding procedures are up to date, comprehensive and reflect local and national priorities.' Ofsted (May 2016)

15. Issues and challenges facing safeguarding

15.1 Issues and developments for Partner Agencies

The Public Sector continues to face the challenges of financial restriction and increasing demand for services that were identified and considered in the 2014/15 Annual Report. The concern about the impact of further 'austerity' has been included in the BSCB risk register.

In their annual safeguarding reports to the BSCB partner agencies have identified the key challenges that they are facing and the steps that they are taking to respond to them. These reports can be found in Appendices 1-12.

15.2 National Developments

In December 2015, Alan Wood was invited by Secretary of State 'to lead a fundamental review of the role and functions of Local Safeguarding Children Boards.

The report, and the Government response, was published on 26 May 2016. The report makes a total of 34 recommendations for radical proposals for reform *but* there is not going to be any immediate change. Legislation will need to be brought forward to create the statutory framework which will replace LSCBs with locally defined alternatives. Different areas may also choose different approaches, keeping things that work for them from the current arrangements; so it may take time for the Authorities in Bury to decide what changes (if any) they need to make to form the successor to its LSCB.

A significant challenge for the BSCB over the next twelve months will be to maintain an essential focus on today's child protection challenges whilst clarifying future BSCB structures.

15.3 Regional Developments

When the original Greater Manchester (GM) devolution proposals were agreed by government in the summer of 2015, they included a proposal to undertake a fundamental review of the way children's services were delivered across GM, building on some of the strengths in practice and performance that exist.

Work has been on-going since then to develop detailed proposals for consideration by the DfE in terms of the additional funding needed to develop and implement them. There are three key elements of the programme

1. Improved services for looked after children

Building on good practice across GM, children and families would have a tailored package of support, based on need. Interventions would include the extension of adolescent support units, intensive family outreach programmes and better support for adolescent mental health. Other areas of focus will be improved sufficiency and permanence for looked after children and better Co-ordinated support for care leavers across GM.

2. A new model for complex safeguarding

A new model will be implemented to respond to complex safeguarding (CS) challenges. This will involve a central hub of excellence, led by one of the GM authorities, which will set strategy and oversee delivery of "spokes" made up of clusters of local authorities. This would be based on the successful Phoenix model for Child Sexual Exploitation.

3. Transforming the quality assurance process and impact

Two specialist boards will oversee quality and standards, and be the driving force behind improving standards across all ten authorities:

- A GM Standards Board (GMSB) will be established to assure the quality of multi-agency safeguarding and provide support and challenge to the ten Authorities. This role will lead on the development of a sustainable, single leadership and practice culture across children's services in the region.
- An Education and Employability Board (EEB) will be a partnership between the Regional Schools Commissioner, the education sector and the business community. It will ensure integrated planning for pupil places, promote employability through education and promote a leadership role for schools in Early Years.

The new system will embed a culture of continuous improvement across the workforce to create a system in which staff work more efficiently, hold each other to account and are responsive to feedback.

Work is also on-going to look at best practice in Early Years and Health.

Financial proposals to develop this work are being considered currently by the DfE and the way forward will be partly dependent on the level of resources available.

16. Recommendations for future priorities and business plan

In 2016-17 BSCB will focus its activities and achieve its aims by focusing on 3 key areas:-

1. Safeguarding children & young people from key priority vulnerable groups, including children who are looked after away from home, children who are privately fostered, children who are disabled, children who are vulnerable to sexual exploitation and/or are missing, and children who are living with the impact of domestic abuse, parental substance misuse, or poor parental mental health, children who are emotionally vulnerable. This will include the oversight of early help and preventative work being undertaken to support these vulnerable groups.
2. Strengthening the voice of the child in all BSCB core activities.
3. Strengthening the BSCB Quality Assurance functions.

17. Acknowledgements

BSCB wish to thank the following organisations for their contributions as follows:-

Provision of training pool members/specialist trainers

Pennine Care Foundation NHS Trust

Department for Children, Young People & Culture, Bury Council

Early Break

Ruth Pearson

Reconstruct

ADS One Recovery

Zoe Lodrick

Barnardo's

Jaria Hussain-Lala

Provision of meeting rooms/training venues free of charge

Bury Council

Greater Manchester Police

Contributors to the Annual Report

BSCB and Business Group members

BSCB Team

BSCB Sub Group Chairs

Accountancy Department, Bury Council



18. LIST OF APPENDICES

The appendices can be downloaded from the [BSCB Annual Report webpage](#).

APPENDIX 1 - BSCB and sub group members 2015/16



APPENDIX 1 sub
group membership 15

APPENDIX 2 – Training figures



APPENDIX 2 Training
data 18.05.16.pdf

APPENDIX 3 – Bury Children's Rights report



APPENDIX 3 BCR
annual report 2015 to

APPENDIX 4 – Private Fostering annual report



APPENDIX 4 Private
Fostering BSCB Annu:

APPENDIX 5 – Bury Phoenix Team annual report



APPENDIX 5 Annual
Phoenix Report 2015.

APPENDIX 6 – Children missing from home annual report



APPENDIX 6 Missing
from home report BSCB

APPENDIX 7 – Early Help Panel and Early Help Team annual reports



APPENDIX 7 Early
Help Panel Report Ma



APPENDIX 7 Early
Help Report 2015 201

APPENDIX 8 – Local Authority Designated Officer (LADO) Managing Allegations annual report



APPENDIX 8 LADO
Annual report April 15

APPENDIX 9 – Road casualty annual report



APPENDIX 9 Road
Safety report.pdf



APPENDIX 9 Child
Road Casualty Repor

APPENDIX 10 – State of Safeguarding (partner information)



APPENDIX 10 State
of Safeguarding part

APPENDIX 11 – Safeguarding Unit annual report



SQAU annual report
2015 16.pdf

APPENDIX 12 – Pennine Acute Hospitals NHS Trust safeguarding annual report



APPENDIX 12 PAHT
Safeguarding Annual