Bury Integrated Safeguarding Partnership

Annual Report 2020-21

Bury COUNCIL NHS GREATER MANCHESTER POLICE

Contents

Foreword

Kathy Batt – Independent Chair

The work of the Bury Integrated Safeguarding Partnership (BISP), from 1st April 2020 through to 31st March 2021 was dominated, as were so many other areas of public service, by the Covid pandemic and the subsequent restrictions. In this report it will be possible to read about how each agency responded to the crisis with a determination to keep vulnerable children and adults safe and support families .It has been an extremely challenging time and the impact of some the changes to working practices which were necessary, as well as the aftermath of the restrictions, e.g. the disruption to schooling and the increase in poor mental health amongst young people and, indeed, the general population will require a robust response from services which are already overstretched in Bury and across Greater Manchester.

Within hours of the first lockdown being announced the BISP had moved all its meetings online. Although the duration of BISP strategic and business meetings were shortened, not one was cancelled, and attendance has been excellent. The agendas for the business meetings enabled each agency to give a summary of how their services were being delivered under the restrictions and to highlight any barriers to multi agency safeguarding. These forums became a vital exchange of information. especially in the earlier months of the lockdowns.

In parallel with the planned meetings of the BISP partners, the business group and working groups there were the Rapid Reviews and full Safeguarding panel meetings which took place throughout the year. The number of referrals for Rapid Reviews for children became a matter of concern and there has been some work about the interpretation of the criteria by other agencies, particularly the police. A flowchart for the process of referral and decision making has been produced but there is still opportunity for professional judgment and there has been much debate about how decisions are made about progress to full Local Child Safeguarding Practice Reviews (LSCPRS). The same issues do not affect safeguarding Adult Reviews, a protocol for which was implemented this year.

The findings of some of the LSCPRS have become depressingly familiar, e.g. lack of communication between agencies, lack of curiosity about past history, professionals not having the confidence to challenge each other or escalate concerns, over optimism , especially in cases of domestic abuse, inconsistent decision making in applying thresholds ,poor or incomplete assessments, and finally situations where adults with severe mental health problems are not recognised as parents who have caring responsibilities towards vulnerable children. This last issue was starkly prominent in Serious Case Review G19, “Joshua“ where a child died at the hands of his father. This review looked at services in both Bury and the City of Manchester and highlighted the current fragmentation and confusing multiplicity of some mental health services. This issue, alongside others raised by the reviews in Bury have been escalated to the Greater Manchester Social Care Alliance as solving them will not be possible in one Borough alone.

Of course, reviews such as these focus on cases where the outcome has been tragic and it is important to remember that there are many other families where intervention and support has been timely and effective but the reoccurrence of the themes of the child reviews is a matter of great concern to the BISP and requires commitment and leadership from the Strategic Partners to ensure blockages and barriers to good practice, whether it be staff turnover or ineffective structures, are addressed.

This report contains evidence of the many assurance systems and audits that agencies undertake on a regular basis. It is not the role of the BISP to duplicate these but to ensure that there is similar scrutiny for multi- agency arrangements and apart from the ample data and analysis produced by the business unit, this scrutiny needs to be independent and robust. The Strategic Partners have been evaluating how far the current structures and arrangements align with the recommendations of Sir Alan Wood's review; and although in many ways the BISP is progressing in the right direction, e.g., in the efforts to link up the many different forums operating in Bury and clarify governance under the Children's Strategic Partnership Board; there are still a few important gaps, not least in ensuring independent scrutiny. While the role and function of having an Independent Chair for certain meetings allows for some impartial oversight it is not enough on its own, to reassure the Strategic partners for Children's safeguarding services that multi - agency working is effective and improving the lives of children. Several models for commissioning independent scrutineers are being considered and implementing a new system will be a priority for 21/22.

Sir Alan Wood's review also considered the role of the Business manager for the Partnerships and Boards that exist. He emphasised that the role carries much more responsibility than simply ensuring that certain administrative tasks are completed, when done well it has a key role in facilitating multi -agency co -operation. The business unit has coped very well with the never-ending demands that the year has brought yet a review of the capacity within in the unit is overdue and is planned for the coming year.

There are future challenges including the recovery from the Covid pandemic, the dissolution of the CCG and the introduction of the Integrated Care System, the new Protection of Liberty standards and the ever-present issue of budget constraints across all agencies and how Bury carves out a role within the context of the Greater Manchester Care Alliance. I will be stepping down as Independent Chair in the coming months, but looking back it is possible to see that, notwithstanding the many challenges the BISP has faced and will face, the individuals, practitioners, managers, and support staff who deliver services to the families, children and adults at risk in Bury, remain committed and determined to provide the very best response they can to the needs of service users.

K. Batt – Independent Chair, Bury Integrated Safeguarding Partnership

Introduction

This report is the first, full combined Annual Report to be published by the Bury Integrated Safeguarding Partnership and focuses on the work undertaken by the Bury Safeguarding Childrens Partnership and the Adults Board, in the April 2020 – March 2021 reporting period.

As part of their statutory requirements defined in Working Together to Safeguard Children (2018), the Children Act (2014) and the Care Act (2014), the Childrens Safeguarding Partners and the Adult Safeguarding Board are required to produce a report at the end of each financial year which highlights:

- What BISP has done during that year to achieve its objectives
- What BISP has done during that year to implement its strategy
- What each BISP member has done during that year to implement to implement the strategy
- The findings of the Safeguarding Reviews for both Children and Adults arranged by the BISP which have concluded in that year (irrespective of whether they have started in that year or not)
- The reviews arranged by BISP under that section which are ongoing at the end of that year (whether or not they began that year)
- What BISP has done during that year to implement the findings of reviews arranged by it under that section, and where it decides during that year not to implement a finding of a review arranged by it under that section, the reason for that decision

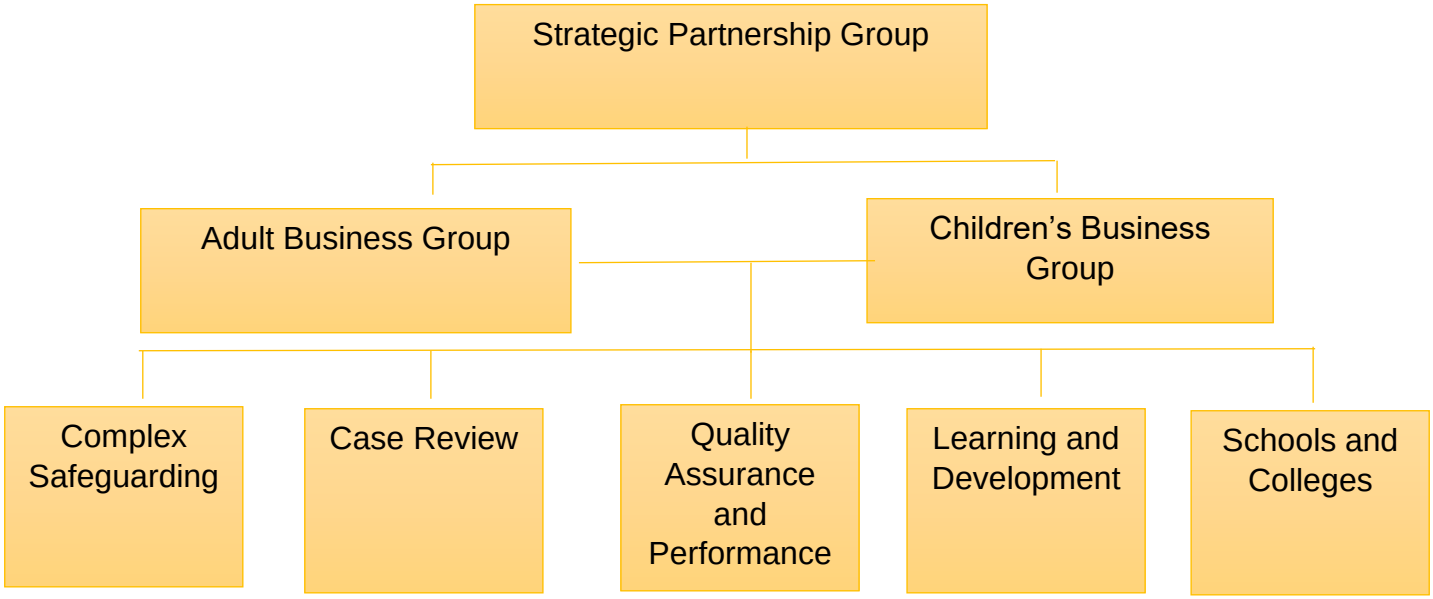
About Bury Integrated Safeguarding Partnership

Due to the changes in statutory requirements, learning from service /practice reviews and development sessions with both the Bury Safeguarding Adults Board (BSAB) and Bury Safeguarding Children Board (BSCB) it was decided in 2019 that Bury would transition to having one integrated safeguarding board which will be known as the Bury Integrated Strategic Partnership (BISP).

The benefits of moving to this integrated model are seen as follows:

- Drive a more rounded approach to safeguarding i.e., via shared learning, joint workforce development, developing/improving joint practice, an all-aged, shared focus, and agenda.
- Avoid duplication both of officer time and resource investment
- Strengthen the links with and learn from local, regional, and national partnerships
- Ensure that Bury meets its obligations in relation to adult and child safeguarding statutory requirements and Greater Manchester Health and Social Care transformation plans
- Ensuring that the customer/patient voice in entrenched in developing Bury's overall response to safeguarding

Structure:
The BISP's structure consists of Strategic Partnership Group, Business Groups for both Childrens and Adults, and five specialist subgroups. (As highlighted below)



Each subgroup may create Task and Finish groups with specific, specialist members in order to undertake work-schemes to further investigate priority areas or developing patterns and trends in the local areas.
In the case of the Case Review Subgroup, there has been additional support given to the Business Groups in the form of disseminating learning from children's and adult's safeguarding cases and the scoping and commissioning of Safeguarding Reviews and Learning Reviews for both Children and Adults and monitoring the response to actions coming out of those reviews.
This has become an essential process, due to the significant number of Rapid Reviews that have been applied for during the last year, and the number of case reviews that have been carried over from previous years.

Priorities and Plans

The plan for 2020-21 has included the following target areas focusing on scrutiny and challenging the system with specific focus on the areas below, including "Where will the assurance be sought from?"

1. **To ensure interagency safeguarding practice is informed by the lived experience of children and at-risk adults**
2. **To establish effective sharing of information between all partner agencies working with children and at-risk adults**
3. **BISP should be confident that safeguarding services are accessible to every community and especially those who may be at risk**
4. **To reduce the risk of harm and abuse through early intervention strategies and nurturing positive relationships.**
5. **To ensure practitioners working with children and at-risk adults are well trained, well informed, and confident in fulfilling their roles and responsibilities**
6. **To ensure that safeguarding remains effective during Covid-19 and responds to local pressures**

Business Unit:

The Bury Integrated Safeguarding Partnership is supported by a jointly funded Business Unit that provides expert guidance, administration, quality assurance, development work, communications, and training. The unit is hosted by Bury Local Authority.

The officers currently located together are:

- Integrated Safeguarding Partnership Business Manager
- Learning and Development Officer
- Quality Assurance and Performance Officer
- Senior Administrator
- Administration Officer

During the first year of the BISP, the Business Unit established its workforce and began to support the BISP in the development and implementation of its strategic priorities and the subsequent processes to allow the different subgroups to undertake specific and specialised work. This work has continued into 2020-21, as the Covid-19 pandemic has placed additional challenges on the operation of the BISP.

The primary work stream for the business unit this reporting period has been to manage the increased number of referrals for Rapid Review and Safeguarding Reviews that have been received by the BISP. At present, there are still a number of active Serious Case Reviews, Safeguarding Adult Reviews and Safeguarding Reviews, as well as others that are open for consideration for a Rapid Review or have been taken forward for initiation or are to be completed as learning reviews. These are discussed later in the report.

The unit has also supported the undertaking of a re-structuring of subgroup processes and timescales in order to ensure a more fluid relationship between the sub-groups, Business Groups and Strategic Partners, and to provide structure for collecting data and evidence to ensure all statutory responsibilities are being met. More details on Safeguarding Reviews, Training and Development, and Quality Assurance activities of the BISP are detailed later in this report.

Reporting

All BISP groups have been asked to comment on their activities in relation to the six priority areas identified in the 2019-20 Strategic Priorities Plan. These can be found in Appendix 1.

Overview

In a difficult year, there has been a number of trends and patterns identified in both children's and adults safeguarding.
With regards to children, some of the notable changes occurred during the second and third quarters, where there were fluctuations across many areas. Within social care, there was a reduction in the number of locality hub episodes open during the month, from 370 down to 301, before rising again to 397 by the year end, a significant fluctuation of around 25%. There were also 2047 referrals into children's social care over the year, with around 22% of these being repeat referrals. What is positive to see is that over 90% of these referrals went on to Single Assessment, with around 85% being completed to timescale. In Bury, by year end, there were 201 children subject to a Child Protection Plan, with two thirds of these plans (66.5%) being subject to a plan for a subsequent time, however only 3 plans had lasted for over 2 years.
The number of Looked After Children has reduced over the year, down from 364 to 347, with a total of 113 children becoming looked after during the year. The rate of Section 47 enquiries being held at the end of the year was 217.8, with 82.2% of Initial Child Protection Conferences being held within 15 days of the strategy meeting.

With regards to specific safeguarding, there were 1747 domestic violence notifications received by Greater Manchester Police from addresses where a child is present over the year, with 958 repeat notifications. Again, this saw an increase in Quarters 2 and 3 for the year where there as an increase of 67 cases per quarter from Quarters 1 – 3, and a reduction of 23 by Q4.
There were 328 missing from home incidents over the year and 360 missing from care incidents, with 78% of return interviews taking place within 72 hours of the child returning home. There were also 35 CSE episodes open at year end with an average of 1.91 of new referrals being high risk. All data can be found in more detail in Appendix 2.

With regards to adult data, there were 1724 individuals per 100,000 involved in safeguarding concerns over the year, with 828 per 100,000 being involved in a Section 42 enquiry and 133 per 100,00 involved in other safeguarding enquiries, 252 individuals had more than one Section 42 enquiry in the year.
There were 1407 Deprivation of Living Protocols applications submitted, with 654 being authorised, and 4 Safeguarding Adult Reviews were undertaken in the year.
Further details can be found in Appendix 4.

Business Group Reporting 2020-21

Both the Children's and Adults Business groups are expected to provide a summary of their achievements during the reporting period. Below is a brief summary of the contributions of each of these Business Groups in the 2020-21 period and highlights some of the key themes and areas that will be priorities in 2021-2022.

It has been felt, that while there has been a number of operational challenges as the result of the Covid-19 Pandemic, there has been a very positive shift within the Business Groups, and

as a result there is a better working relationship between members. While some workstreams and priorities were placed on hold at the beginning of the pandemic, many of these have now been resumed, with only a small number still waiting for an increase in capacity to allow them to resume. There has been a significant increase in the attendance of members within both groups, and the attendees have been consistent, with all member agencies having both a clear voice in the group, but also an equal level of engagement and value of their contribution. All agencies not only feel they are seen as equal partners in the groups, but also that there has been a better link developed between the Children's Business Group (CBG) and the Adult Business Group (ABG), with a more equitable focus on both.

There has been some evidence of planning ahead, with both the CBG and ABG encouraging the development of local training and audit programmes through the subgroups that are directly linked to outcomes and actions of case reviews, which has led to a clear link to the various subgroups, with consistent feedback and reviews of their activities. There has also been an added interaction on a Greater Manchester level, contributing to a number of combined workstreams with other Local Authorities, where Bury is well represented by members of the Business Unit and the Business Groups.

This BISP CBG and ABG both also obtain regular assurance from partners through their individual agency reports and audits, for example the NHS CCG's Nursing Home audit, and this is reflected in reports to the Business Groups.

Sub-Group Reporting 2020-21

As stated earlier, the BISP has a number of sub-groups that support the business groups. This year, group chairs have been asked to provide feedback on the successes and challenges that they have identified over the last 12 months.
Many of the activities undertaken by these groups, especially the Case Review, Learning and Development and Quality Assurance Sub-Groups, are directly taken from findings and recommendations of Rapid Reviews and Case Reviews undertaken since the inception of the BISP in 2019.

Case Review Sub-Group

Chair – Sandra Bruce (CSC), Deputy – Amanda Symes (ASC)
The Case Review Sub-Group has had an unprecedented number of reviews to manage in the last year. The first task undertaken by this group was to identify the historical learning and outstanding actions for case reviews initiated previous to the inception of the BISP and identify any practice that had been made by partners and other services to complete those actions. With the support of the BISP Business Unit and the other sub-groups, most actions were completed and signed off within the year. This group has also contributed to the new Rapid Review process which has now been implemented throughout Bury.

Complex Safeguarding Sub-Group

Chair – DCI Kate Atton (GMP), Deputy – Janice Barr (CSC)

The Complex Safeguarding Team Sub-Group (CST) have had a number of successes in the last year, mainly focusing on Operation Burgos, a multi agency 3-year investigation into non recent child sexual exploitation in Bury. As a result, two brothers have now been convicted

and sentenced for a variety of child exploitation offences. The victims from Burgos have worked with GMP's press office and produced videos detailing their journey which can be found at https://youtu.be/WsXR7MS7jm0
In relation to the sub-group's general activities, the CST have collected information via the production of the Quarterly Complex Safeguarding Insights and impact framework. This contains a wide range of performance data ranging from the number of referrals into the complex safeguarding team to the associated pathways and current caseload.

The group collects the feedback from Peer reviews (facilitated through GM CST) including points for improvements that are assimilated into the Complex Safeguarding Team Action plan, and Voice of the Child data is collected at Domestic Abuse incidents to ensure safeguarding practice is informed by the lived experience of children. There is also a working group looking at the Rapid Reviews relating to complex safeguarding and associated action plans.

Within the group, Health representatives have completed risk assessments for visiting service users at home, and vulnerable children and families were prioritised, especially during the Covid-19 pandemic. This has also meant that the social workers from the Complex Safeguarding Team have moved out of the Police Station due to covid regulations and as a result virtual working has supported this transition and meeting attendance has been improved. Children's services and Health are in the process of reviewing their estates and ways of working safely during Covid also.

In relation to service development, there has been an establishment of a Complex Safeguarding Nurse role to work directly with Complex Safeguarding Team and improve communication between health and other agencies A joint Complex safeguarding action plan has been produced in conjunction with partners and a new complex safeguarding room has been developed at the police station in the Haven; this room is to support children in crisis. Additionally, Child Protection status is checked by all out of hour's health services when a child attends and helps identify CSC involvement.

Achieving Change Together (ACT) Model Social Workers have joined the CST in addition to Trusted Relationships Psychologist/Health representative to increase the range of service available.

Externally, it has been agreed and implemented that Taxi drivers have to complete mandatory safeguarding training, and while COVID has impacted on this there is a requirement that all new applicants now need to undergo safeguarding training. It is also now mandatory for all applicants and licence holders to have enhanced DBS checks every three years; this is being reviewed currently with a view to undertake an enhanced DBS check every 6 months. Licensing has powers to suspend or revoke Hackney Carriage and Private Hire Drivers Licences if it is in the interests of public safety, this is done in consultation with the Chair of the Council's Licensing and Safety Committee and the Head of Service/Licensing Unit Manager.

In March 2020, Pennine Care in partnership with BISP, planned & delivered four multi-agency Safeguarding Adults half-day training sessions in order to improve awareness and understanding of how to recognise respond and refer in relation to the needs of vulnerable adults at risk of abuse and harm. These sessions were delivered by the Pennine Care Safeguarding Team to a number of practitioners from various services across Bury in April 2021, via the Zoom platform.

It has been identified by the group that Children's Services have seen an increased amount of data breaches because of the increased use of electronic information sharing, and work is

being undertaken across Social Care to ensure that staff are aware of the need to share information-sharing in a safe and effective manner.

The Complex safeguarding team have completed targeted work with vulnerable children throughout the Covid lockdown period where the Local Authority led an engagement campaign to target vulnerable communities who may be experiencing domestic abuse. The Complex Safe guarding Team is committed to ensuring safeguards are in place for all by developing communications with the Jewish Community through Operation Parachute, establishing Philomena Meetings, where Philomena Forms are completed by all Children's/Semi Independent Provisions in Bury to support Police with high risk missing young people and also Operation Mezzanine (CCE/CSE operation dealing with victim/offender, night-time economy) focused on visiting the most vulnerable children at weekends and out of hours and "Soft" intelligence is gathered to inform plans and interventions.

Pennine Care NHS Foundation Trust level 3 safeguarding training packages (both children and adults) have been refreshed in early 2021 to ensure that learning from local Serious Case Reviews / Local Child Safeguarding Practice Reviews and Safeguarding Adult Reviews is embedded. In addition to this, learning from local SCR's / LCSPRs, SARs and DHRs is shared at the borough Quality Forum which has representation from each Service within Pennine Care. This is an opportunity to discuss, share, and embed the learning as it applies to us from 7-minute briefings etc. It is also shared at the Healthy Young Minds (CAMHS) Quality Forum which includes staff from both Healthy Young Minds (HYM) community teams as well as in-patient Child and Adolescent Mental Health Service (CAMHS) provision.

The ongoing vulnerabilities and risk of abuse as children enter adulthood are highlighted in the Pennine Care NHS Foundation Trust Safeguarding Adults training package as above (this includes risks of criminal exploitation and sexual exploitation), to enable a better transition from children to adult services. There has also been an implementation of "Health Passports" for some young people with mental health issues (inpatients in children's wards at Cygnet Hospital and one of our therapeutic homes that primarily supports young adults aged 18-22) if they need to attend Accident & Emergency. The aim of this is to ensure vulnerable young adults are cared for appropriately and any safeguarding issues can be addressed.

Multi-agency adult safeguarding sessions have been facilitated in order to build stronger working relationships with Adult Services to enhance focus and awareness regarding Transition, and there is a named link for CST for those young people who are turning 18.

In order to reduce the risk of harm to children from individuals identified by the CST, health services led an early intervention update in relation to safe sleeping, an area that seems to be an emerging theme in some Rapid Reviews.

The ACT Model /Signs of Safety plans have been developed to improve relationship building and to give more intensive support for the most vulnerable young people and Bury is a pilot are for the PIED (Prosecution, Intervention, Education and Diversionary) project. This is a prevention, intelligence, and diversion project whereby all juvenile victims and offenders of crime are discussed by a multi-agency group including Youth Offenders Service, Police, Early Break, Children's services, Victim services and the voluntary sector Early Break/CSC. Early intervention and diversionary pathways are considered, and actions implemented to prevent escalations in offending behaviour

The CST group has also linked with the BISP Learning & Development officer who has a working group that looks at all Rapid Reviews to pull out learning and themes. This helps to ensure services/professionals are learning from SCR's and Rapid Reviews.

Finally, the Greater Manchester (GM) Complex Safeguarding Hub audited four cases during their peer review process in September last year. One of the cases was highlighted for its best practice and shared with other Complex Safeguarding Teams throughout Greater Manchester. The key positive aspects were: -

- The support for Child was young person centred, relational based and prioritised his needs.

- Child's character, strengths and interests were well documented in case files and assessments and has clearly been nurtured by Education, Social Care and Youth Justice. Child's case highlights how impactful strength-based practice can be when services invest in the young person's assets and not solely focus on the concerns.

- The recording and assessments of Child were of a very good standard.

- 'This is a very good case example of effective multi-agency working, comprehensive assessments and young person focused/strength-based interventions. It was a pleasure to review this case, the team are dedicated and clearly have Child's best interests at the forefront of their work.'

This can be seen as a very positive response from the GM Complex Safeguarding Hub group and indicates that the Bury CST group are operating effectively.

Quality Assurance Sub-Group

Chair – Helen Delamare (CSC), Deputy – TBC

The QA subgroup went through a number of changes in 2020-21, with the addition of extra data sources and the changing of the Deputy Chair, however a number of multi-agency audits were carried out in the period, and further areas for review were also identified as the result of a clearer working process with the other sub-groups.
On the whole, a data set for adults was agreed, and additional data sets for further investigation within children's social care were also identified, while audits into Transitions, Standardisation Review of MASH Referrals Advice, and Babies being born to Mothers Recently having Social Care involvement cease, were well received. In addition, the Section 11 audit was completed with Action Plans reviewed, and the Section 157/175 School Safeguarding audit is currently ongoing.

What was noted from the subgroups data, is that there were varying trends throughout the year, and this has been attributed to the ever-changing situation with the Covid-19 pandemic, and some challenging families who met service thresholds on a number of occasions, for example one family accounted for a significant of missing episodes in Quarter 4, and a distinct pattern has formed around some major themes.

As a result, there has been a plan of working initiated within the group, where there is the intention going forwards to have three Multi-Agency Audits each year, influenced by the

outliers and exceptions indicated in the Performance Data and the outcomes of any case reviews that have been published, linking in with the other sub-groups.

The planned Multi-Agency audits for 2021-22 are on the Think Family Approach within Bury, Criminal Exploitation of Vulnerable People in Bury and finally Child Death and Serious Injury as a Result of Overlay, while there is also the intention to review any outstanding audit activities planned for 2021-22 from Historic Case Reviews.

Learning and Development Sub-Group

Chair – Bev Johnson (Adult Social Care), Deputy – Bernie O'Brien (CSC)

The Learning and Development sub-group has started to shift its priorities this year to focus on outcomes of Case Reviews and Rapid Reviews, in order to ensure that the learning programme offered is appropriate to current themes that are emerging from the Case Review sub-group.

The BISP Learning & Development officer is part of a working group that looks at all Rapid Reviews to pull out learning and themes. This then determines future courses and identifies in the courses that are being delivered where updates need to be included or topics need to be changed/covered in more detail. This helps to ensure services/professionals are learning from all types of formal reviews, re-occurring themes are identified, and agency staff can access a range of development opportunities. Multi-agency training has still taken place during Covid, with some uptake from across all multi-agency partners, however, there has been some challenges regarding uptake from staff on some courses. This has led to some difficulty in identifying the impacts of training and learning, as there needs to be sufficient uptake to measure this impact effectively.

There are currently 16 live courses being offered by the BISP, with 13 in development and a further 6 gaps in training available to meet the learning from case reviews. These gaps link to Mental Health Pathways, Dementia Awareness, and the Impact of Covid. There is to be a further focus on 3 other areas, Safeguarding, Domestic Violence and Bruising on Immobile Babies.

Schools, Colleges and Adult Learning Sub-Group

Chair – Gail Branch (School/College), Deputy – Adele Williams

A number of changes affected the Schools, Colleges and Adult Learning Sub-Group (SCAL) in 2020-21, with changes to the chair, deputy and some of the Strategic Partner representatives all occurred over the year. This has meant that an accurate report from the group has been difficult to collate, however designated leads have been identified going forwards, and a direct source for support in the new Assistant Director Isobel Booler has agreed to support the restructuring the group.

BISP Partner Service Reports

Children's Social Care

Children's Social Care have, during the pandemic and associated lockdowns, continued to ensure vulnerable children are safeguarded and supported. The Multi-Agency Safeguarding Hub (MASH) moved out of the police station and operated from 3 Knowsley Place along with Initial Response Teams and Safeguarding Teams operating in smaller bubbles on a rota basis in accordance with agreed safety protocols. The roll out of new IT equipment prior to the Covid pandemic allowed staff to engage with new technology to aid working at home. The Microsoft Teams system was rolled out to all staff to enable virtual meetings across the service, with partners and parents able to participate and thus ensure services continued with business as usual. Staff have successfully adapted to home working and have been proactive in their approach.

The priority at the start of lockdown was to ensure the safety of children in Bury and that Statutory Processes for Children in Need (CIN), Child Protection (CP) and Looked After Children (LAC) continued, whilst ensuring the safety of staff; especially those having to carry out face to face visits. It was envisaged that the continued lock-down would result in increased pressures within families which in turn may put some children at a higher than usual risk. Every child at CIN, CP or LAC continues to have an updated risk assessment which is clearly recorded on the child's record to ensure that in the event of the child's social worker not being available, there is an up-to-date statement in respect of need, the agreed visiting / contact frequency and the current risks and concerns associated with each child.

A REACT meeting took place with Ofsted and the DfE on 30/04/20 to review Children's Services actions in respect of Schools, Social Care, SEND and Early Help and to consider any support required. The meeting was positive and in October 2020, Ofsted carried out a Focused Visit of Children's Social Care and Safeguarding. The remit of the visit was much broader than the usual focused visits and was to "look at what has happened for children and families in the last 6 months before the visit to understand children's experiences." The focus was on child-centred practice that that been carefully risk assessed to result in the best possible decisions for children in the context of the pandemic locally. This was a positive visit, and whilst some improvements were identified, inspectors saw that progress had continued to be made within the service during Covid, and that staff had been creative in ensuring that children continued to be seen in spite of the restrictions of the pandemic. Despite the restrictions and delays within the court processes, services have also continued to match children for adoption and place children with their adoptive parents.

Routine work continues within the Practice Improvement and Quality Assurance Service and the regular audit programme has continued, including Performance Management Meetings and Insight into Social Work Practice. These meetings continue to be the driving force promoting service improvements and learning across the department. Following a move to virtual initial child protection conferences at the start of the pandemic, it was found that parents were having difficulty engaging in the process. There is now a hybrid model in which parents meet face to face with the Conference Chair, whilst the remaining partners attend by virtual means. With regards to the provision of services via virtual means, there has been a maintenance throughout the pandemic of Priority 1 Services, and these have retained a high level of staffing. Regular communication takes place with peers and managers and staff have used WhatsApp groups, Coffee and Cake sessions (Via Teams) and 'walk and talk' sessions when lockdown restrictions allowed to provide team comradery.

Signs of Safety has been rolled out as the chosen strength-based practice model with an extensive staff training and support program, meaning that the end of year performance

against a number of key performance indicators was in line or better than our statistical neighbours.

Early Help

There has been much more of an opportunity to reflect on Early Intervention with families as services have shared the learning from Rapid Reviews. Specifically, these have focused on our Think Family approach and the need to ensure that at the earliest opportunity service are organising themselves into the team around the family to ensure that support is given earlier. As a result, there has been an increase in the Team Around the School meetings which have also led to some decrease in referrals into social care.

As locality early help teams are embedding services, they are making more connections across prevention services including better links with Education Welfare Officers, Connexions workers and the Youth Service. This has allowed teams to look at more creative ways to reach out to families and support them. The early years team has also been working with some projects delivered through Greater Manchester Care Alliance and services are seeing the impact of the approach especially in terms of pathways to talking and welcome. The early years team is reaching into local early years provider settings and working with them to raise the profile of early identification of need and early help.

There is no doubt that the impact of covid affected all services in 2020-2021, especially as services are all focused on the principle of “wrap around” within the community and especially schools and early years settings. The universal offer was reduced due to non-access to buildings and workers were not able to visit and see families as often and in the way they would like. However, services have continued to embed the model of Team Around and staff have used the time to look at more creative ways to work with families. They have used videos to share and support families in terms of parenting and child development, and they have been creative in developing YouTube channels through the local youth service to develop interactive timetables and activities and services have concentrated on greater detached work out in the community, meeting young people and engaging them around how to stay safe but connected. However there has been an impact as a result of the number of schools and settings that have had to close or send large groups of children home due to infections and it has been found that services have had to move into a much more reactive space than they would have liked and there was an increase in demand for practical support in terms of food parcels etc. for some local families.
Early Help Services are looking forward to recovery and re-setting and thinking of how they take some of the innovation forward in engaging families and resolving issues before they escalate. They have seen a higher demand for locality teams to be lead professional in team around and there has also been an increase in young people experiencing poor mental health.

Services have embedded a quarterly performance clinic and all services in Early Help provide key data to help them track their work and the impact they are having. Some key trends include remaining static in the two-year take up at 79% but they are hopeful to see this improve as Bury is a pilot authority working with a project to increase take up. We are in line with our statistical neighbours and above England averages of 69%.

There has been a reduction in repeat referrals into Early Help from 21% at the start of the year to 15% at the close. Its early days but audit work shows improvement in the quality of the current offer and resolution at closure. There was an increase of 50% of contacts from school into the Multi-Agency Safeguarding Hub where there had been an early help

response prior to referral. It is a key priority to see all but the most urgent safeguarding referrals to have evidence of early support.

Services have continued to see improvement, despite covid, on young people who are in Education, Employment and Training. (EET) which is at 97%, an improvement from 95% the previous year - It places Bury in the second quintile making it only one of two authorities in Greater Manchester achieving this output.

Bury saw a rise of Elective Home Educated children, up by 40% and this reflected the increase seen across England. There has now been a shift and we have started to see a reduction as parents have felt more confident in sending their children into school again.

Finally, there has been the integration of the Troubled Families offer into the Early Help offer and there was an improvement in turnaround from 40% to 80%.

Learning from Serious Case Review G19 has been embedded in procedures within the Locality Team, ensuring that stepped down plans from children's social care are managed through a robust system to ensure multi-agency planning within Team Around the Family and that clear bottom lines have been established.

Following audit baselining activity in quarter 4, 19/20 on reflection of the findings, thematic sampling of a larger number of cases was completed throughout April, May and July 20 which allowed the review of more cases and to test the progress on themes and learning. There were some strengths noted around case recordings, management footprint and supervisions being held and documented but more work needs to be done on chronologies, case summaries and the child's voice.

Learning opportunities were completed across the locality teams and a practitioner pack developed to improve areas identified in order to strengthen and develop the workforce. There were continued quality assurance functions which have been embedded within management practice and the outcomes of ongoing audits have shown an improvement in the overall grading with more needing improvement rather than being judged inadequate and as a result some emerging good practice has been identified.

The focus for 21/22 has been around compliance however in 21/22 this is moving into a more mature model of quality assurance that is considering quality and impact of intervention.

Education

The Education Service has reviewed and strengthened its arrangements for sharing information on vulnerable children as they transfer between school placements. This arrangement is implemented; it will be reviewed during the coming academic year to evaluate its effectiveness

With the appointment of a new Safeguarding Officer for Education the service has begun a systematic review of safeguarding processes and training. This work is in progress and some cumulative evidence is being collated.

A Task Group investigating service arrangements for combatting bullying in schools has nearly completed its work. This work will be completed during the current term. There will be a conference launch when restrictions allow.

The Education Service has reviewed and is strengthening the cross-service supports for vulnerable children, and additional funds from the DFE Safety Valve allocations to support this, which will enable the service to accelerate the transformation.

The White Paper on Skills has prompted the development of an integrated cross- council approach to pathway planning post-14 to age 25 for vulnerable young people in Bury. The audit of resources has been completed and is available. A workshop has been set up to develop the service's vision and priorities, and this will take place after the coming elections. It has also been recognised that the impact of the Covid 19 pandemic during the past year has changed things, however partnership working has strengthened, service priorities have changed to meet new challenges and progress in others has been accelerated. The service recognises additional strains and pressures in the service and sees well-being as a necessary priority as the service is reset.

Local Authority Designated Officer (LADO)

The total number of LADO related enquiries were 318 between 1st April 2020 and 31st March 2021, down 12 from 330 last year. Of the 318 LADO related enquiries, 60 reached the LADO threshold to referral, with 7 being classified as No Further Action after Initial Consideration, 19 being substantiated, 13 Unsubstantiated and 9 Unfounded, False or Malicious, with 12 investigations ongoing. For a more detailed breakdown, see Appendix 3.

Adult's Social Care

2020-2021 was a demanding year for health and social care services due to the Covid pandemic. Practitioners worked hard to ensure that our vulnerable residents were supported and protected. In relation to the pandemic response specifically, a virtual "command centre" staffed by senior leaders across health and social care was established to direct the local response to the pandemic, the Safeguarding Operations and Deprivation of Liberty Safeguard response continued with minimal disruption and the Standard Operating procedures were developed which ensured continuity across services and gave assurance regarding our approach.

A weekly report to care providers was mobilised giving advice and instruction on changing policy guidance, ensuring care providers were well informed and supported and that a consistent message was disseminated. The duty function available to care providers was also strengthened, allowing a quick response to requests for support/emerging issues.

Lead officers from Adult Social Care were commissioned to develop a number of protocols/policies for the BISP, which included the Safeguarding Adults Review Local Protocol and Procedures which was agreed by BISP Jan 2021, the Managing Allegations Protocol (People in A Position of Trust) was agreed by BISP March 2021 and finally the Inter-Agency Risk Management Protocol was agreed by BISP March 2021 and is awaiting agreement of responsibility discharge.

A new Adult Social Care Quality Assurance framework was developed by the Principal Social Worker. It is centred around 4 key outcomes:

- Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm.
- Enhancing the quality of life for people with care and support needs
- Ensuring that people have positive experience of care and support
- Delay and reducing the needs for care and support.

This document also addresses how we will increase the strength of and raise the quality of reflective supervision, as per learning identified in Safeguarding Adult Review "Amy".

Following a query from Her Majesty's Coroner on the role of Section 42 enquiries, Bury's Principal Social Worker co-led a Tri-Borough adult safeguarding learning event. A practitioner event was held on the 9th of December with over 70 officers attending from the Boroughs of Bury, Oldham and Rochdale. Each area then developed its own learning action plan. A follow up event was also held on the 22nd of March which brought together Board members from across the 3 areas.

In 2020-21, the ACM (Active Case Management) standard operating procedures were devised. This document and way of working standardises the response across Bury for the Integrated Neighbourhood Teams (teams containing both health and social care officers) and clarifies the procedures around adult safeguarding as identified in the learning outcomes[1] for SAR "David".

This year Adult Social Care has been involved in all adult Safeguarding Adult Reviews (SAR's). Single agency audit summaries have been produced in each instance and learning taken from each Review. This information is then disseminated via a number of routes:

- Community Commissioning Management Team meetings
- Social Work Forum – run by the Principal Social Worker
- Safeguarding Champions Forum – which not only supports safeguarding practitioners in Adult Social Care but also supports other partner organisations.

This ensures that learning from these SAR's has been integrated into current practice.

NHS Bury Clinical Commissioning Group

Along with all our colleagues in health, the CCG has faced significant pressures during the COVID19 pandemic. Despite this, we have continued to keep safeguarding children and vulnerable adults at the heart of all we do. At the start of the pandemic, Safeguarding was considered Priority 1 within the CCG and therefore no activity was stood down. Despite this, we as a team have also contributed to the vaccination response across the Borough. We have ensured Mental Capacity Act (MCA) (2005) is highlighted during decision making in COVID e.g., testing and swabbing of vulnerable groups

We have developed systems and processes to allow us to work remotely, ensuring continuity in the service we deliver and accessibility to our colleagues within the CCG and the wider partnership. We have invested in Information Technology to support staff in new ways of working to ensure compliance with 'COVID secure' working, meaning mandatory training has continued throughout the pandemic as online training packages have been developed and these are well attended and well evaluated. A Level 3 Adults and Children Safeguarding training session was delivered to General Practice virtually in September 2020

and January 2021 by the safeguarding team alongside Prevent training in December 2020. The sessions were a focus on safeguarding in Primary Care during COVID and included challenges of virtual consultations, domestic violence, Mental Capacity Act (2005) and consent. In addition, the safeguarding team deliver 2 Development Sessions per year to our Safeguarding Leads from each GP Practice. These sessions focus on the learning from statutory reviews undertaken by the BISP.

Bury CCG are represented on the Strategic Board, at the Children and Adult Business Groups and on the subgroups. Attendance at these is prioritised to support the work of the BISP and to ensure we are equal partners in the Tripartite agreement
In order to comply with expected standards, the CCG has in place a safeguarding policy, assurance framework and a training strategy and they are available on the CCG website alongside a Safeguarding Information pack for member practices.

The training figures at the end of March 2021 of staff who had completed online Level 1 Safeguarding training were; 86.1% for children's safeguarding and 85.4% for adult safeguarding which meets the required standard of 80% and demonstrates a quarter-on-quarter improvement throughout 2020/21. As standard, the CCG collects and collates data from all the services it commissions in relation to safeguarding activity. It requests and monitors regular assurance from providers against all requirements in Section 11.
There have been significant changes in the team and a period of change and transformation. Despite this, 'business' has continued as normal.

The CCG have worked closely with our Looked After Children provider team to ensure that statutory health assessments continue to be completed to a good standard and in accordance with government advice. Engagement from young people during this time has been high.
The Greater Manchester LAC Designated Nurse network is collecting feedback from LAC across GM to inform changes to usual processes that will support a continued high-level engagement
Training and support has been offered to Cygnet Hospital to enable practitioners to complete LAC health assessments and reduce the need for external visitors during lockdown restrictions
An ICON (Infant is crying normally, Comforting methods can help, Ok to walk away, Never, ever, shake a baby) steering group has been developed and is being led by the CCG, with the first meeting being well attended. This meeting will also consider the safer sleeping messages and how these are implemented across the Borough.

Greater Manchester Police

GMP is represented on the Strategic Board by the District Commander Superintendent Suzanne Downey, and DCI Kate Atton in the Children's and Adults Business Group's. In the subgroups, DCI Kate Atton (Chair – CST Subgroup), DI Partington (Deputy Chair CST Subgroup) and DI Kenneth Blaine

GMP's focus continues to be ensuring interagency safeguarding practice is informed by the lived experience of children and at-risk adults. The police collect the 'voice of the child' all relevant domestic and child concern incidents. Recognizing risks and issues that affect children is a fundamental part of protecting and safeguarding. Officers are trained to always speak and listen to the child as well as to closely observe their environment to gain an understanding of the child's lived experience. This information is then passed through to a team of specialist triage officers who review the incident within 24 hours and ensure

information is shared with the most appropriate safeguarding partners. There has been single agency training initiative this year to improve the front-line officer's awareness and understanding of adverse childhood experiences emphasizing the importance of identification of traumatic experiences and the need for the early interventions. Bury police have worked in partnership with business to fund a child centric room at the police station which provides a place of comfort for children who have experienced trauma and need to attend the police station to provide video recorded evidence.

GMP revised its adult at risk policy in May 2020, this policy is designed to ensure vulnerability is a top priority for policing services and to provide a standardised and coherent response to all allegations of abuse against adults at risk, in a manner which ensures the best possible protection is afforded to victims and witnesses. The vulnerability assessment framework (VAF) is completed for Adults at Risk concern incidents which capture their experiences and the wider circumstances.

All high-risk domestic abuse cases and high risk vulnerable adult case are discussed in the district 'Engine room' daily domestic abuse meetings, which has been developed as part of Bury's public service reform agenda. The Engine Room's Daily Domestic Abuse Meeting is attended virtually by multiple partner agencies in order to provide a 24-hour response to high-risk domestic abuse cases.

Throughout the Covid pandemic GMP has engaged with new technology (Teams) to ensure these processes continue in a remote and COVID secure fashion.

To ensure effective sharing of information between all partner agencies working with children and at-risk adults, learning bulletins are shared force wide by the dedicated Serious Case Reviews and Safeguarding Adult Reviews team.

GMP ensures safeguarding services are accessible to every community and especially those who may be at risk. Telephone and Face to face interpretation services are available for all people whom English isn't their first language. GMP safeguard people with complex mental health issues via the vulnerable adult framework completion and referral into relevant BISP and other partners via Care Plan processes. Various strategic and tactical meeting are established to understand the complex mental health picture in Bury and to support continuous improvement.

To ensure practitioners working with children and at-risk adults are well trained, well informed, and confident in fulfilling their roles and responsibilities, GMP has increased it detective Child Protection specialist training (SCADIP). The Vulnerable Adult Framework has been delivered to all front-line staff for Adults at Risk.

To ensure that safeguarding remains effective during Covid and to responds to local pressures GMP engages with the LA on a weekly basis at the gold COVID contingency meetings. A two weekly strategic domestic abuse meeting was also established at the start of COVID to maintain effective partnership working.

The learning taken from this year includes the complex safeguarding Peer Review which will be completed again at a GM level, which will focus on complex safeguarding; the Complex safeguarding action plan came from the previous review (and the Child Protection Action Plan from the benchmarking exercises).

Pennine Care NHS Foundation Trust (PCFT)

During a challenging year for all, Pennine Care NHS Foundation Trust has ensured that all our services continued to be delivered during the year, although they have had to embrace different ways of working, referral criteria did not change.
Our Safeguarding Team has been fully established from May 2020 including 3 new practitioners who joined during Covid, and we have provided advice, support, and guidance throughout Covid, so our staff had access to safeguarding advice, support, and guidance. In addition, we continued to support the work of the BISP and all its subgroups despite the demands of Covid.

Due to having to cease face to face training as a result of Covid by May 20 the safeguarding team had transferred the full mandatory safeguarding training offer on to a virtual platform enabling staff to continue to access training to develop their safeguarding knowledge and skills. As a member of the Learning and Development Subgroup we led on the development and delivery of domestic abuse training via a virtual platform.

As an area of focus, it is still clear that respiratory conditions remain the most significant causes of premature mortality for people with a Learning Disability in Greater Manchester and nationally. It is therefore vital that the seasonal flu vaccination is offered to people with Learning Disabilities. This year the urgency of this action is amplified by the risk of avoidable admissions and to support the NHS response to the COVID- 19 pandemic. Pennine Care Foundation Trust Learning Disability Directorate has established a Seasonal Influenza Vaccination referral pathway which is targeted at those hard-to-reach patients.

In relation to our learning as a service, Working Age Adult Inpatient Safeguarding Audit was undertaken. The aim was to assess whether safeguarding concerns are recognised, assessed, documented, and acted upon, based on the relevant policies. The Key findings were: -

- The results suggest that patients admitted to hospital who have caring responsibilities for a child / children or vulnerable adult are identified and the safeguarding process is commenced
- Details of patients caring responsibilities are recorded but not fully enough to fulfil the standards. Risk assessments are completed but not every element is completed, carried out or documentation of risk assessments is incomplete
- The results suggest that staff are not contacting or liaising with the appropriate professionals who should be involved in the safeguarding process, this includes contacting the PCFT Safeguarding Team and social care; staff, are not documenting this activity correctly.
- No clinical practitioners challenged the Local Authority Management for safeguarding therefore we could not measure their knowledge of the escalation policy.

To support our practitioners recognising, understanding, and addressing cuckooing/mate crime and to be confident in reporting crimes to the police on behalf of a client, when appropriate we produced a safeguarding briefing and delivered a ‘lunch and Learn session on Adult Grooming. This can be accessed at
https://www.youtube.com/watch?v=T_4Pi0aYHcs

Our trust identified a key priority to establish support and guidance for staff to be able to routinely enquire about domestic abuse and be confident in how to manage when there is a disclosure to ensure this is able to be evidenced in a robust way. A survey was undertaken to establish a base line of staff knowledge and awareness of domestic abuse to support a trust wide domestic abuse learning programme. It also was to establish the level of awareness of the Trust Domestic Violence and Abuse Policy – Support for Managers and

Staff. 233 staff participated in the audit, 70% of surveys completed by clinical staff and 30% by non-clinical staff. 71% of staff felt they would benefit from domestic abuse training and a further 9% thought they would benefit from certain types of domestic abuse training (the most common suggestions being Female Genital Mutilation, honour based coercive control and forced marriage). The results revealed our staff lack confidence in their abilities on this subject more than any lack of knowledge and that they are aware of what domestic abuse is, the different types of abuse, and who can be affected but lack confidence in their abilities to identify these in practice

Northern Care Alliance (NCA)

During the period 2020/21 the NCA Safeguarding Children and looked After Children team continued to bring together newly appointed and existing staff to create a Care Organisation safeguarding children team for acute and community services in Bury. The team aims to provide place based safeguarding advice, support, training, and supervision to staff in our community services and at Fairfield General Hospital.

The detail of work undertaken for the period of 2020/21 is as follows: -

Firstly, a programme of work has been undertaken, with oversight by Bury CCG, to ensure that the Greater Manchester Contractual Standards for Safeguarding Children, Young People and Adults at Risk are achieved, and compliance thresholds are maintained for the period 2020/21. Each Care organisation now has a Safeguarding children steering group aiming to embed safeguarding at every level across the organisation. The steering groups link frontline staff into key safeguarding issues within their locality, enabling the sharing of lessons learnt from both single and multi-agency reviews.
A process has been undertaken for the recruitment of a new Complex safeguarding nurse for Bury, funded by Bury CCG and the Safeguarding Team continues with the provision of organisational support with “Managing allegations of abuse against staff” and People in Positions of Trust (PIPOT) across the acute and community settings.

Work has been undertaken to strengthen and improve organisational links with governance teams across the Trusts to ensure safeguarding is considered within the NHS Patient Safety strategy for serious incidents (SI). This is achieved by the implementation of alert DATIX/Safeguarding notification pathways and the attendance by the Safeguarding Team members at relevant SI meetings within each organisation.

Safeguarding Children supervision arrangements are under review to bring one to one supervision in line with the other NCA care organisations. Targeted supervision has continued and access to group supervision has been improved by opening access to dates available across the NCA. The use of Microsoft teams has enabled group sessions to continue throughout the pandemic and the NCA safeguarding children training programme has been developed to increase accessibility across a range of platforms.
This includes:

- Microsoft teams sessions replacing some face-to-face training
- Face to face continuing in smaller socially distanced groups to deliver bespoke sessions
- A filmed version of Level 3 delivered in modules that can be accessed 24/7 for all mandated staff

The NCA Safeguarding Team and colleagues from Childrens Community Services fulfil the Trust’s statutory duty in attendance at BISP meetings, ensuring representation for the service across all groups and sub-groups, including any working groups where necessary.

The increase of Children and Young people presenting to A&E in emotional distress and /or mental health concerns has highlighted the inadequacy of safe and appropriate care provision nationally. During 2020/21 there has been a notable increase in presentations at A&E of young people in distress, with self-harm or suicidal risks. The partnership challenges are to recognise the urgency of improvements in our link to with mental health providers. This has been developing over the latter part of 2020/21 and continues to be an area of priority concerns for our services. The completion of statutory health assessments for Looked After Children has continued to be impressive for Children placed in Bury. This performance needs to be matched for Bury Children placed out of the locality.

National Probation Service & Community Rehabilitation Company

The National Probation Service (NPS) and Community Rehabilitation Company (CRC) have had a primary focus on safeguarding during the COVID-19 pandemic, which has constituted most of workloads in 2020-21. There has been a focus on staff training and development of virtual learning internally, allowing both services to maintain operational performances.

This has meant a continuation of focus on risk, including ensuring there is no gap in the delivery of Multi Agency Public Protection Arrangements (MAPPA) during the pandemic and alternative delivery methods following the temporary pause on the delivery of the group work that focused on sex offender and domestic abuse intervention.

The NPS/CRC has mapped both qualitative outcomes following review of priority cases and collated quantitative data based on attendance at the office and enhanced levels of contact of priority groups during pandemic. They have also collected learning and development data and data regarding alternative intervention delivery.

Updates have been issued for all staff regarding safeguarding children, adults, and domestic abuse, including feedback into the national update on child safeguarding training, while all offender management staff, and managers have completed e-learning programmes relating to working with men who commit sexual offences.

Prior to the COVID lockdown, Bury NPS commenced a mental health support group for people on probation who were unable to engage with third sector organisations to address emotional wellbeing issues. When unable to continue with group-based sessions, 1-1 engagement was introduced on both a virtual and face-to-face basis (via doorstep visits and at the office). Distraction packs and books were delivered to people on probation on requests, as well as the continued delivery of food parcels for people struggling with finances. A survey was conducted with our people on probation prior to increasing office reporting levels and comments shared highlighted how individuals felt they were treated with compassion during this period as probation practitioners were considering the additional emotional impact of isolation resulting from lockdown. One person on probation reported daily phone contact with their probation practitioner who focused not only on their risk, but they also felt cared for by someone.

Six Town Housing

At the time of writing, Six Town Housing had not submitted a report for the Annual Report

Case Review and Rapid Review Outcomes 2020-21

In the last year there have been several Rapid Reviews and Case Reviews initiated and also completed, in addition to a number of Adult Reviews, and Local Child Safeguarding Practice Reviews.
There were some reviews that linked very closely with other referrals that had been submitted in the same period or were initially rejected but further evidence provided at a later date triggered re-referrals, where others were identified as not requiring a Rapid Review or LCSPR, however learning needed to be taken from the incident, and so Local Safeguarding Practice Review was conducted.
In total, 11 referrals were made between April 2020 and March 2021, 2 of which were found not to meet the criteria for a Rapid Review. 5 were completed as Rapid Reviews, while 2 Safeguarding Adult Reviews were requested however both were rejected and one LCSPR was instigated. This LCSPR is still outstanding as it has not yet been published, however it is nearing completion and will be ready for the next reporting period.
In addition, C20 LCSPR was completed in the 2020-21 reporting calendar, and had links to G21 and learning has been taken into that review with similar themes, which will be combined into a Local Learning Review. The B20 Rapid Review relating to bruising on non-mobile babies was also completed, as was the SAR for “Albert”.
Much of the learning from these Rapid Reviews, LCSPRs an SARs has influenced the training offered by the BISP and the Multi-Agency audits it has undertaken through it’s respective subgroups. The BISP Training Officer has worked to extract learning and develop a 7-minute briefing for each Rapid Review and has linked this into a clear map of training provision and potential training and learning needs. The Quality Assurance Subgroup has begun an audit of the use of the “Think Family” approach within cases across partners, as there being an unclear picture of the family of the subject of a referral has been identified in a number of Rapid Reviews. The topics of Criminal Exploitation of Vulnerable People in Bury and Child Death and Serious Injury as a Result of Overlay have also been identified as topics for Multi-Agency audits for the remainder of 2021-22, as both have been areas of concern as a result of the 2020-21 Case Review process. In relation to some recommendations from these Case Reviews, an audit was undertaken into the recording process within the MASH, which due to system changes was inconclusive and rescheduled for 2021-22,

It is clear that there has been a high volume of cases being instigated and completing during 2020-21, and this has put additional challenges on the BISP and its business unit, however what has become apparent from this high volume, and the responses from the National Panel, is that Bury is providing an accurate level of decision making within its reviews and learning is being written into practice and training across the safeguarding partners.
All current published reviews can be accessed via the BISP website and others are available on request once published.

Real-Life Examples of Good Practice and Consumer Voice

There have been a number of good examples of customer voice, where even in difficult circumstances, the lived experience of the service user has been captured, for example by GMP in the Operation Burgos victim collaboration and collecting voice of the child data from Domestic Violence incidents.

Within Children's Social Care, Early Help services supported a young person who was referred to Young Carers due to their mother's mental health issues. Young carers team worked with the young person alongside the school pastoral team to ensure she had the wrap around support she needed and knew who she could contact if mum's mental health deteriorated which included professionals and relatives. The young person was fully involved and informed of the plan around her and together with her mother all agencies worked to keep her at home but with continuous support.

Early Help support was also requested following a mother and toddler aged 3 moving to Bury on a temporary basis after the family sought asylum. Mother presented at A&E due to a significant dip in her mental health and was struggling to cope and wanted to move to Manchester to be nearer to others in her community and church. The Early Help Worker worked quickly to support the family to be accommodated in the Manchester area, from the start of the early help support mother reported feeling heard and seen and this made her feel much more positive about her future in the UK. She reported feeling able to cope and manage her daily living and her mental health had improved as a result of having direct support at a time where she felt isolated. The early help worker supported mother to move to a new house and secure nursery provision for her daughter. She was also supported with furnishing her property and accessing services in her new local area. The family also attended several of our park sessions which had a positive impact on her mental health, feelings of isolation and allowing them to interact with other parents and children. Adult Social Care have shared the journeys of two customers, identified as "Albert" and "Matthew". Albert is an 80-year-old man who lives on his own, his wife died approximately 10 years ago. Albert had a long military career and is a very proud of his time spent in the forces. Neighbours however had started to complain about the number of rubbish bags which were building up outside his property and called environmental services. On visiting, environmental services found him to be in a dishevelled state, looking poorly and his house cluttered. They voiced their concerns to him, but he was reluctant to accept any help. The officers raised a safeguarding referral. On attendance safeguarding officers managed to ascertain that Albert, as he had been feeling poorly for a while, had not been able to keep on top of the housework or shopping and was also scared to go anywhere due to Covid, his house was extremely cluttered. He also advised that he was un-befriended as he had no family and most of his friends had died; he had not properly spoken to anyone in months. He was however reluctant to have his house cleaned as he was very attached to some of the belongings he had collected.
Working with environmental services, officers arranged initially for the clean-up of the outside of the property then worked with Albert over several weeks to clean the inside of his property – going at his pace meant that he felt in control of what was happening and didn't become distressed. Officers also worked with the community hubs to arrange for Albert's shopping to be delivered and put him in touch with the local veteran's association who continue to provide much needed social contact and have arrange for a reputable cleaning service to help keep his property clean and tidy. Following contact with his GP Albert is now receiving medication for a long-term health condition.

Matthew is a 50-year-old man who it was suspected was being financially exploited by his "friend". On speaking to Matthew social care staff found that he had a dependence on alcohol, a mild learning difficulty and had some significant untreated health issues. He reported that is friend had control of his money as he "wasn't good with it" but he sometimes didn't have enough money to buy what he wanted. His friend would also access his flat whenever they wanted. Neighbours had reported seeing Matthew sleeping out on the street. Matthew was asked what he wanted to happen, he replied that he wanted more access to his money and didn't want his friend visiting his flat.
Staff worked with the local housing service, police, doctor's surgery, alcohol dependency service and a local charity to ensure Matthew was safe and was able to achieve his independence. Working at Matthews pace, staff were able to support Matthew to get control back of his property and install target hardening measures which meant that Matthews locks were changed, and he could also see who was at his door before he let them in. He built a good rapport with his GP and is now receiving appropriate medical treatment for a long-term health issue as well as accessing support for his alcohol dependence. Supported by a local charity he also has an environment which provides him with long-term social support. A police prosecution against the "friend" is currently pending.

Pennine Care NHS Foundation Trust also identified some areas of good practice and documented their customer journey.

As a child Andrea had experienced bereavement and had spent some time as a looked after child. She had significant attachment difficulties and there were historical concerns relating to sexual abuse and she was known to Healthy Young Minds. She was initially diagnosed with an eating disorder and as an adult had an admission to an adult inpatient unit and was diagnosed with emotionally unstable personality disorder with impulsive behaviours of running away and self-harm. She had developed a mistrust of professionals and had little understanding of how to respond to care and support. Andrea was unable to understand and maintain safe emotional and sexual relationships. She became a mother as a teenager and the father also had experience of being a looked after child. There was domestic abuse in this relationship which resulted in a referral to the Multi-Agency Risk Assessment Conference (MARAC). She had periods of homelessness and spent time in a refuge. Andrea and her child were known to the local Children's Services due to her chaotic lifestyle.
The Safeguarding Team became aware of Andrea when they were contacted for advice and support by a mental health practitioner. The practitioner had identified a number of safeguarding concerns which included repeat presentations at A&E in relation to alcohol use, nutritional deficiencies, bruising and self-harm. There was a history of past sexual assaults from a number of males going back to childhood and a number of unknown males visiting her accommodation. There were concerns about a relationship with an older taxi driver and possible sexual exploitation and concerns about her sexual health and the risk of future pregnancies.
Andrea was well known to Children's Services as the mother of a child where there were concerns but it was identified that she needed safeguarding as an adult at risk of abuse and/or neglect. An adult safeguarding concern was raised by the practitioner that triggered a multi-agency response. Andrea was involved at each stage to ensure making safeguarding personal principles were followed, however she did disengage with some agencies after a period of time. To date the concerns remain and Andrea remains open to our services who continue to monitor her mental health.

These examples of customer journeys show some of the direct impact that services have had on the wider public during the last year and indicates both the successes and the learning that has come from working with customers.

Action Plans

Services have been asked to provide actions that have been developed from practice learning and review this year.

Children's Social Care
Children's Social Care has a number of planned actions for 2021-22, first to improve the management direction and decision making in MASH in order to support timelier assessments of Children's Needs
Secondly there is a plan to improve the quality of strategy meetings to clearly define multi-agency actions to keep children protected during the investigation period and define how investigations should be undertaken.

There is the intention to improve the assessment of parental ability to sustain change before a decision is made to move children between different tiers of social care support
Finally, there is the intention to improve the quality of child protection and child in need plans, and planning, with focus on children's experiences, and on the timeliness of taking swift authoritative action when children's circumstances are not improving

Adult Social Care
ASC is involved in all adult safeguarding reviews and lead officers are identified to sit on each SAR panel, or Rapid Review panel where there is a link with Child Reviews. Where learning from adult social care is identified, via the multi-agency action plans produced from the review, we report action progression via BISP Case Review Group and have oversight of progression at our Community Commissioning Management Team Meetings (CCMT). Blockages or issues would initially be reported via our CCMT and from there escalated via the BISP Case Review Group or Adults Business Group.

Pennine Care NHS Foundation Trust
Pennine Care intends to enhance the work within the Trust in relation to the Mental Capacity Act 2005, establish support and guidance for staff to be able to routinely enquire about domestic abuse and be confident in how to manage when there is a disclosure to ensure this is able to be evidenced in a robust way. There is also a plan to review the Trust model for representation at Bury MARAC and develop a robust information sharing process.
There is a plan to ensure safeguarding is embedded in the new trust Integrated Leadership Model with clear safeguarding roles, responsibilities and assurance processes including a robust system for oversight and completion of action plans that arise from serious case reviews to prevent drift and ensure dissemination of the learning.

National Probation Service/Community Rehabilitation Company
The focus of the next 12 months for the NPS/CRC will be on unification and personal learning plans, ensuring all practitioners feel confident and competent in their safeguarding practice.
There will be an emphasis on the strengthening of partnership relationships developed during COVID and the implementation of community based integrated rehabilitative services to enhance positive outcomes for our people on probation, increase desistance from reoffending and reduce victimisation, this includes work with families of people on probation.

MAPPA training is to be arranged for partners to ensure effective engagement in collaborative risk management planning and safeguarding activity for complex, high/very high risk of serious harm cases. There is also the intention to embed learning emanating

from serious further offence reviews, safeguarding adult reviews, child learning reviews and inquests.

Northern Care Alliance

The NCA's Key Safeguarding priorities for 2021/22 are that the team will continue to build on and strengthen achievements set out from the previous period of 2020/21 by continuing to work towards complete compliance of the Greater Manchester Contractual Standards for Safeguarding Children, Young People and Adults at Risk are achieved and compliance is maintained for the period 2021/22.

They will also focus on Improving the application of the mental capacity act for 16 &17 years in preparation for the implementation of Liberty Protection Safeguards in April 2022 and will continue to work with Bury CCG in the development of an outcome focussed service specification for Looked After Children. Moving from compliance based Key Performance Indicators to a trauma informed outcome focussed will be a challenge that will be pursued over the next year. The initial goal will be to agree the service specification along with any business cases required to develop existing services to meet the challenge.

The NCA safeguarding team will continue to develop our training offer and provide an annual workshop calendar, linked to lessons learnt from across the NCA and following the successful launch of our NCA safeguarding children week in June 2021.

Finally, then NCA will work with the partnership to develop and promote a trauma informed approach across our services.

BISP Targets 2021-2022)

It was agreed in 2020, that the Strategic Priorities would be carried out over a 2-year block, owing to the difficulties that were faced during the Covid-19 Pandemic. Therefore the 2021-22 Strategic Priorities have remained as follows:

1. To ensure interagency safeguarding practice is informed by the lived experience of children and at-risk adults
2. To establish effective sharing of information between all partner agencies working with children and at-risk adults
3. BISP should be confident that safeguarding services are accessible to every community and especially those who may be at risk
4. To reduce the risk of harm and abuse through early intervention strategies and nurturing positive relationships.
5. To ensure practitioners working with children and at-risk adults are well trained, well informed, and confident in fulfilling their roles and responsibilities

Acknowledgements

The Bury Integrated Safeguarding Partnership would like to first of all acknowledge the hard work and commitment made by all services throughout the last year, especially in the challenging times faced during the Covid-19 pandemic. Despite the many changes, there has been a shift in working for many services work, from face-to-face to online working and a virtual environment.
Thank you to all services who have provided reports and feedback, and for the contributions from the sub-groups and their chairs.
Finally, it would be pertinent to recognise the high volume of work undertaken by the business unit due to the unprecedented number of case reviews received in the previous year and historical cases that were still to be closed.

Learning from this year's report has been actioned for the 2021-22 reporting period, including the identification of a number of representatives for all partner agencies who are in a position to complete all review and feedback of service activities over the year and report back to the BISP Business Unit in order to ensure an accurate picture of the activities of the BISP and its partners over the year.

Glossary of Terms and Abbreviations:

ABG – Adult Business Group

ACM – Active Case Management

ACT – Achieving Change Together

ACCT – Assessment, Care in Custody, Teamwork

BISP – Bury Integrated Safeguarding Partnership

CBG – Children's Business Group

CCE – Child Criminal Exploitation

CCG – Clinical Commissioning Group

CCMT – Community Commissioning Management Team

CIN – Child in Need

CP – Child Protection

CSC – Children's Social Care

CSE – Child Sexual Exploitation

CST – Complex Safeguarding Team

DBS – Disclosure and Barring Service

DoLS – Depravation of Liberties Safeguards

DHR – Domestic Homicide Review

EET – Employment Education and Training

FGM – Female Genital Mutilation

GM – Greater Manchester

GMP – Greater Manchester Police

GMCA – Greater Manchester Care Alliance

GMCA – Greater Manchester Combined Authority

ICON – Infant is crying normally, Comforting methods can help, Ok to walk away, Never, ever, shake a baby

ICS – Integrated Care System

KPI – Key Performance Indicator

LA – Local Authority

LAC – Looked After Child

LADO – Local Authority Designated Officer

LCSPR – Local Children's Safeguarding Practice Review

MAPPA – Multi Agency Public Protection Arrangements

MASH – Multi Agency Safeguarding Hub

MCA – Mental Capacity Act (2005)

NCA – Northern Care Alliance

PCFT – Pennine Care Foundation Trust

PIED – Prosecution, Intervention, Education and Diversionary

PiPoT – Person in a Position of Trust

PMM – Performance Management Meeting

PMT – Performance Management Team

RR – Rapid Review

SAR – Safeguarding Adult Review

SCAL – Schools, Colleges and Adult Learning

SCR – Serious Case Review

SEND – Special Educational Needs or Disability

TAF – Team Around the Family

Appendix 1: 2019-2020 Strategic Priorities

The following are about scrutiny and challenging the system with specific focus on the areas below Where will the assurance be sought from?

1. ‘To ensure interagency safeguarding practice is informed by the lived experience of children and at-risk adults’
    - What information do we collect?
    - Linking into outcomes of access to services
    - Impact of Covid-19 on access to services
    - Service development and co-production
2. ‘To establish effective sharing of information between all partner agencies working with children and at-risk adults’
    - Utilise the new skills using digital technology, for example CPP, adult safeguarding meetings, core groups, BISP meetings
    - Risk of technologies e.g., images
    - Issues that arise using IT esp. around information sharing and ensuring the relevant sharing to safeguard all.
3. ‘BISP should be confident that safeguarding services are accessible to every community and especially those who may be at risk’
    - Consider some targeted work with communities
    - Revisit the SCR and SAR learning
    - Also people who English isn’t their first language
    - inequalities
    - how do we safeguard people with complex mental health issues (needs unpacking)
    - people who are disenfranchised and don’t meet thresholds for services or do not want to engage
    - transition planning, children to adulthood and then into older adults
4. ‘To reduce the risk of harm and abuse through early intervention strategies and nurturing positive relationships’.
    - Identifying system leader at neighbourhood work
    - Ensuring linking between the work and safeguarding
    - New AD for PSR needs to link in after appointment
    - ICON
    - Safe sleeping
5. ‘To ensure practitioners working with children and at-risk adults are well trained, well informed and confident in fulfilling their roles and responsibilities’
6. To ensure that safeguarding remains effective during Covid and responds to local

Appendix 2: Key Performance Data submitted to QA Sub-group

Key Performance Indicator			Q1	Q2	Q3	Q4	End
1.1	% Children Living in Poverty						
1.2	Infant Mortality (Per 1000 live births)		4.1	4.1	4.1	4.1	4.1
1.3	Child Population						
2.1	No. of CIN with a Disability (%)						
2.2	No. of Children/YP living in the area who are the responsibility of other LA's	Total	235	234	251	259	259
2.3	No. of Private Fostering Arrangements	Total	2	1	1	1	1
3.1	No. DV Notifications from Police where a child is present		395	451	462	439	1747
3.2	No. DV Notifications from Children's Social Care that led to referral						
3.3	No. Repeat DV call outs by Police to an address where a child lives		238	277	231	212	958
3.4 (a)	No. Children Missing from Home	Total	92	72	86	78	328
3.4 (b)	No. Children Missing from Care	Total	121	85	81	73	360
3.4 (c)	No. Children Missing from Education						
3.5	% Children who had an independent return interview	Average	76.9	73.4	79.1	82.6	78
3.6	The rate of violent and sexual offences against children aged 0-17						
3.7	Number of CSE Episodes Open at Month End	Month End	31	30	30	35	35
3.8	No. of new CSE referrals recorded as being at 'high' risk of CSE	Average	2.3	2.67	1.67	1	1.91
4.1	Number of Locality Hub episodes open at end of month/year	Month End	370	317	301	397	1385
4.2	Number of Early Help The Story So Far assessments authorised in month/year	Average	61.3	32.3	35	40	42.15
4.3	Number of referrals to Children's Services where a CAF has already been in place.						
4.4	Number of MASH Referrals	Average	834	829.7	951.3	871.3	872
4.5 (a)	Average number of working days until MASH decision	Average	1.79	3.37	2.31	1.08	2.14
4.5 (b)	% of MASH Episodes with outcome of Early Help	Average	8	7.1	10.3	10.97	9.1
4.5 (c)	% of MASH Episodes with outcome of CSC	Average	19.5	21.8	20.9	22.4	21.15

5.1	Number of referrals to children's social care in quarter	Total	404	530	577	536	2047
5.2	% of referrals to Children's Social Care which are repeat referrals within 12 months.	Average	17.5	21.6	23.9	25.4	22.1
5.3	% of referrals leading to social care's Single Assessment	Average	94.6	88.5	95	94.6	93.2
5.4	% of completed assessments to timescale	Average	84.6	86.7	87.7	84.9	85.9
5.5	Number of children in need and rate per 10,000 0-17 population (RATE)	Average	171.8	176.5	196		181.4
6.1	Rate of accident and emergency attendance caused by unintentional and deliberate injuries to CYP aged 0-17						
6.2	Number of times police powers of protection were applied	Total	2	7	6	12	27
6.3	Rate of S47s per 10,000 0-17 population (Cumulative)	Month End	43.4	103.7	136.1	217.8	217.8
6.4	% ICPCs held in month where ICPC held within 15 working days of strategy discussion	Average	77.5	86.7	74.7	89.8	82.2
6.5	Number of children subject of Child Protection Plans	Total	161	204	207	201	201
6.6	No. child protection plans lasting 2 years or more	Month End	3	1	1	3	3
6.7	No. % percentage of children subject to a CP Plan for a subsequent time	Average		64.3	68.7		66.5
6.8	Number of child deaths with modifiable factors						
7.1	Number of looked after children (responsibility of our LA) including those living outside of the area	Total	364	356	349	347	347
7.2	Number of Children becoming looked after (Total)	Total	34	28	16	35	113
7.3	Number of children ceasing to be looked after	Total	12	36	23	38	109
8.1	Number of allegations referred to LADO.						318
8.2	Number of FTE social workers, health visitors and school nurses						
8.3	Vacancy rate of social workers, health visitors and school nurses						
8.4	Turnover rate of social workers, health visitors and school nurses						

Appendix 3: Bury Integrated Safeguarding Partnership Yearly LADO report – Mark Gay (LADO)

Total number of LADO related enquiries were 318 between 1st April 2020 and 31st March 2021

Distribution of 318 LADO related enquiries

LADO related enquires in sector where person works	No. of LADO Related Enquiries
Education	81
Nursery & Childminders	25
Residential Homes	22
Children's Services	14
Health	81
Faith Setting	7
Fostering	38
Voluntary	3
Police	4
Other	30
Sport	10
Transport	3
Total	**318**

Referring Sector	No. of LADO Related Enquiries
Education	60
Nursery & Childminders	16
Residential Homes	18
Children's Services	73
Health	71
Faith Setting	3
Fostering	22
Voluntary	3
Police	26
Other	19
Sport	2
Ofsted	3
Transport	2
Total	**318**

Category of 60 LADO referrals going on to investigation

Sector	Sexual	Physical	Conduct	Neglect	Emotional	Total
Education	2	1	4			**7**
Nursery & Childminders	1	3	2			**6**
Residential Homes	1	2	5			**8**
Children's Services		1	2			**3**
Health	1	1	10	10	**1**	**23**
Faith Setting	2					**2**
Fostering	1	2		1	**1**	**5**
Police						**0**
Other	4			1		**5**
Sport			1			**1**
Total	**12**	**10**	**24**	**12**	**2**	**60**

Key:

Education – Primary/Secondary/Independent/Out of School Care

Nursery & childminders – including private nurseries.

Residential – Private Children's Homes

Foster Carers - includes Independent Foster Carers and family/friends' carers

Children's Services –, social workers, Ed psychology, support/family workers for LA

Police – GMP officers

Health – including private health care providers

Other – including escort services and other support agencies

Voluntary – including agencies like scouts

Faith – including teachers in religious settings (mosque/church/synagogue)

Sports – Any sport related employer/agency who leads for person of potential concern

Transport – Escorts for the LA

Outcome of 60 investigations 1/4/20 – 31/03/21 ***(*) includes cases which are ongoing***

Sector	*NFA after Initial Consideration*	*Substantiated*	*Unsubstantiated*	*Unfounded*, false or malicious*	*Total*
Education		2	1	2 (2)	**7**
Sport		1			**1**
Residential Homes		5	2	(1)	**8**
Children's Services	1			1 (1)	**3**
Health	3	6	7	4 (3)	**23**
Faith				(2)	**2**
Foster Care	2		2	(1)	**5**
Early Years		3	1	2	**6**
Voluntary					**0**
Other	1	2		(2)	**5**
Police					
Totals	**7**	**19**	**13**	**9 (12)**	**60**

Appendix 4: Adult Safeguarding Data

	Safeguarding Benchmarking	Quarter 1	Quarter 2	Quarter 3	Quarter 4
SGA1 - Individuals involved in safeguarding concerns per 100,000 population.	**SGA1**	494	903	1288	1724
SGA2 - Individuals involved in a Section 42 Enquiry per 100,000 population.	**SGA2**	222	588	594	828
SGA2A - Individuals involved in an OTHER SAFEGUARDING ENQUIRY per 100,000 population	**SGA2a**	42	88	107	133
SGA4 - Number of individuals with more than one Section 42 enquiry	**SGA4**	133	171	207	252
SGA5 - Distribution of Types of Risk - Input the total number for each type of risk	**SGA5**				
	SGA5 Physical	59	119	178	243
	SGA5 Sexual	8	34	47	57
	SGA5 Psychological	21	55	95	111
	SGA5 Financial	32	91	145	184
	SGA5 Discriminatory	0	3	3	4
	SGA5 Org	2	6	10	13
	SGA5 Neglect	88	183	259	355
	SGA5 Domestic	11	41	72	82
	SGA5 Sexual Exploitation	5	6	12	14
	SGA5 Mod Slavery	0	1	3	3
	SGA5 Self-Neglect	15	38	65	80
SGA6 - Distribution of Location of Risk - Input the total number for each location of risk	**SGA6**				
	SGA6 Own Home	81	247	386	487
	SGA6 Community (exc comm serv)	14	5	48	0
	SGA6 Community Service	5	0	0	2
	SGA6 Care Home – Nursing	36	60	82	99
	SGA6 Care Home – Residential	53	114	160	228
	SGA6 Hospital – Acute	9	12	12	15
	SGA6 Hospital – Mental Health	27	36	56	655
	SGA6 Hospital – Other	1	3	6	
	SGA6 Other	5	14	22	27
SGA7a - Risk Outcome Measures - Input the total number for each risk outcome	**SGA7a**				

	SGA7a Risk Identified and Action Taken	34	194	282	387
	SGA7a Risk Identified and NO action taken	15	94	145	163
	SGA7a Inconclusive and Action Taken	11	40	49	63
	SGA7a Inconclusive and NO action taken	11	28	42	51
	SGA7a No Risk identified and Action Taken	26	27	42	60
	SGA7a No Risk Identified and No action taken	25	51	80	109
	SGA7aEnquiry Ceased	6	73	98	114
SGA7b - Where was a risk identified , what was the outcome?	**SGA7b**				
	SGA7b Risk Remained	18	26	35	48
	SGA7b Risk Reduced	6	220	324	409
	SGA7b Risk Removed	6	44	70	92
SGA8 - Number of enquiries that were recorded as lacking capacity and where they were supported by an advocate, family, or friend	**SGA8**				
	SGA8 - Number that lacked capacity	1	10	14	21
	SGA8 - Of those lacking in capacity, how many of these cases was support provided by an advocare, family or friend?	1	2	2	4
SGA9 - No. of Safeguarding Adult Reviews per 100,000 population. Total number or SARs that have taken place	**SGA9**	1	2	3	4
SGA10 - Number of DoLS applications received per 100,000 population [YTD]	**SGA10**	378	850	1407	
SGA11 - Number of DoLS applications authorised per 100,000 population [YTD]	**SGA11**	183	413	654	
SGA12a - Making Safeguarding Personal - Was a person asked about their desired outcomes? Provide the total figure from SAC table SG4a & SG4b	**SGA12a Yes Outcomes Expressed**	85	207	296	352
	SGA12a Yes No Outcomes Expressed	17	36	54	61
	SGA12a No/Don't Know/Not recorded	113	266	48	53

SGA12b - Making Safeguarding Personal - Where a person was asked about their desired outcomes, were they achieved? Provide the total figure from SAC table SG4a & SG4b (Section 42 & other enquiry).	**SGA12b Yes – outcomes fully achieved**	55	119	169	203
	SGA12b Yes – outcomes partly achieved	25	73	101	120
	SGA12b Yes – outcomes not achieved	5	15	26	29