Bury Integrated Safeguarding Partnership

Children & Young People

Annual Report 2021-22

Contents

Foreword

Introduction

About the Bury Integrated Safeguarding Partnership

The Business Unit

Governance

BISP Strategic Priorities 2021-22

Evidence of the impact of the work of safeguarding partners and relevant agencies, including training

Analysis of impact through Multi-Agency Audits

Local Children's Safeguarding Practice Reviews

Priorities and Plans for 2022-24

Acknowledgements and closing

Glossary of Terms and Abbreviations

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Foreword

The Bury Integrated Safeguarding Partnership (BISP) Children & Young People Annual Report 2021-22 is delayed for several reasons. The time covered was a challenging time for the UK as the country began to emerge from the devastating early stages of the Covid 19 pandemic. The country remained in lockdown at the beginning of April 2021 and restrictions were slowly lifted during the spring and early summer. Covid cases continued to occur although with the ongoing vaccine campaign, the impact for most people was less serious.

Bury was not exempt from the challenges Covid 19 brought with staff working in different ways than pre pandemic, rising workloads and intense activity within all partner agencies. This led to practitioner burnout and high levels of staff absence and sickness, which was seen nationally. The challenges within individual agencies led to reduced BISP activity due to the need to focus on front line work. The Business Unit of the BISP experienced, as outlined in the report, staff vacancies and staff absence, which impacted on the ability of the Partnership to maintain activity and momentum. High levels of referrals were being received for Rapid Reviews, which were mostly being completed in time, but not being submitted to the National Panel. This has now been remedied. The usual data flow was interrupted and therefore there are gaps in data. It has not been possible to understand the reason for lack of data. Little progress was made against the stated priorities.

The report is published alongside the CDOP (Child Death Over Panel) report. The author of that report also reported the difficulty in accurate reporting due to lack of information and data flows and an inability to progress the work of the Panel.

Additionally, there were considerable changes in the senior leaders across the partnership which created instability and loss of organisational memory within the BISP leadership, as well as the absence of a Business Manager for consideration time during 2021-22.

Writing now, in April 2023, it is helpful to reflect that 2022-23 was the opportunity to scrutinise the arrangements and to reset by developing a clear improvement plan to drive performance and to ensure learning is disseminated and embedded to improve practice. There is now a clear way forward, agreed by the statutory partners. As a result, the Partnership was restructured in 2022 and a separation of the adult and children's functions of BISP was enacted in September 2022. The vision for the Partnership has been reset, priorities agreed, and the work is gaining momentum. The changes during 202-2023 will be outlined in the next annual report.

Maxine Lomax

Interim Independent Chair

April 2023

Introduction

As part of the statutory requirements defined in Working Together to Safeguard Children (2018), the Children Act (2014) and the Care Act (2014), the Bury Integrated Safeguarding Partnership (BISP) 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

This Annual Report relates focuses on the work undertaken by the BISP and relevant partners in relation to Children and Yong People in the period April 2021 to March 2022.

About Bury Integrated Safeguarding Partnership

In 2019, 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), the boards were merged to form the Bury Integrated Safeguarding Partnership, or BISP.

2021-2022 has been a challenging year for Bury Integrated Safeguarding Partnership. Services have continued to be under significant pressures due to the Coronavirus pandemic, agencies prioritising activity as well as responding to practitioner burnout, resulting in sickness and staff vacancies.

In summary, the BISP has been through a period of destabilisation in 2021-2022. The partnership has remained sighted on the position throughout and has responded to the risks as required. Alongside the significant changes in BISP, there have been changes to the senior leadership structure across all three of the partners.

Structure:

Over the last 3 years, due to the evolving nature of the BISP, and the effect the Covid-19 pandemic, it has been identified that a change of structure is now required to provide a more effective operational process, and increase the capacity of the Business Unit

The BISP's original structure consisted of Strategic Partnership Group, Business Groups for both Children and Adults, and five specialist subgroups. (As highlighted below)

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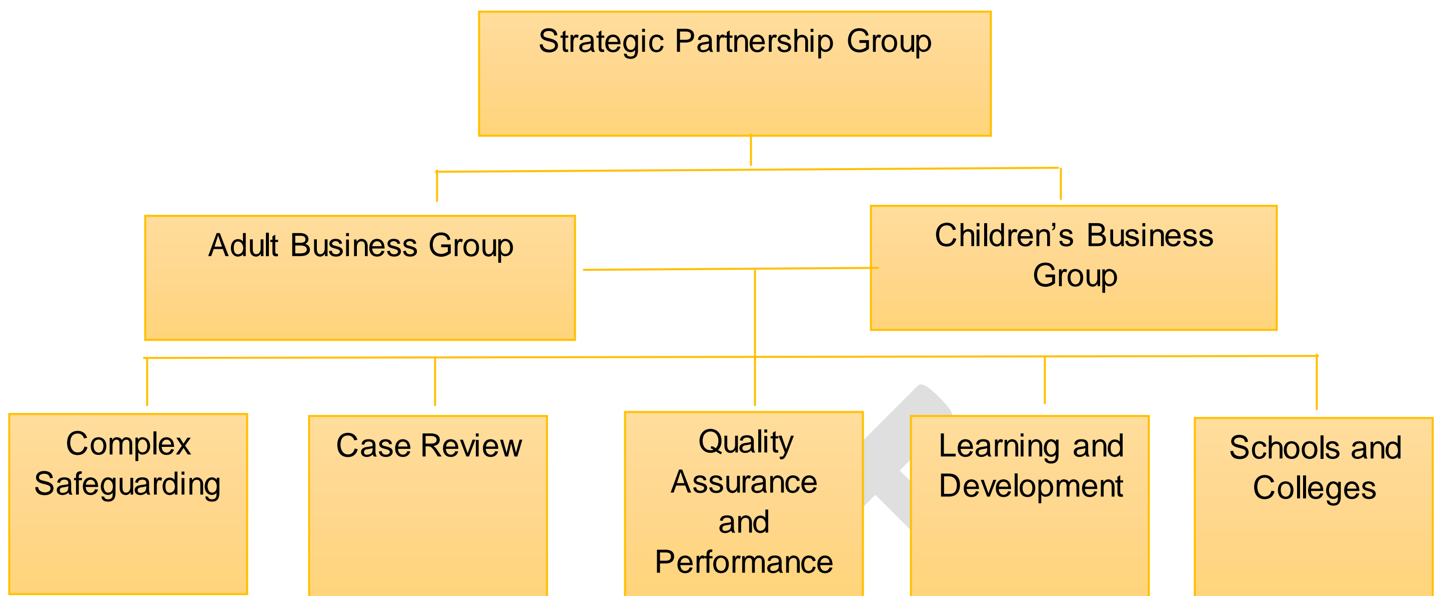

Each subgroup could create Task and Finish groups with specific, specialist members in order to undertake work-schemes to further investigate priority areas or developing patterns and trends in the local areas. In reality this has not happened as planned due to reasons outlined below.

There has been a subsequent split in the Case Review Subgroups, to separate Children's and Adult cases, which became an essential move, due to the significant number of Rapid Reviews and Safeguarding Adult Reviews that have been applied for during the last year, and the number of case reviews that have been carried over from previous years.

Currently, there is a new proposed structure that will commence during the 2022-23 reporting year, in which there is a proposal to reduce the number of subgroups and replace them with specific working groups, while streamlining the Case Review Process by finalising the split between the Case Review Group into Children and Adults and increasing the oversight of the partnership at an executive level.

This will be described in detail in the 2022-23 Annual Reports.

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 and during 21/22 the unit was hosted by Bury Local Authority.

The team based at the Business Unit were:

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

During the year 2021-22, there were a significant number of changes within the BISP Business Unit, and difficulties in recruiting to vacant posts. The unit operated on reduced capacity throughout 21/22 (down by 50 %) yet at the same time was having to, as a service to an integrated partnership, respond to a record number of SAR referrals. The strategic partners were aware of the problem and the detrimental impact on progressing reviews and implementing action plans and there was an agreement that there should be a specific Case Review Officer, to manage the increasing number of Reviews that are being reported into the BISP. This role was out for recruitment and had been agreed for a period of 12 months but has since been delayed due to the external review of the Children's Safeguarding partnership which commenced in January 2022.

Governance

Strategic Partnership Group

The Strategic Partnership Group consisted of the senior partners within the BISP and included the 3 Statutory Partners (the Local Authority, NHS CCG and Greater Manchester Police), and the representatives of the other partner agencies, and were responsible for driving forwards the BISP's Strategic Priorities and plan and holding the Business Groups and other Subgroups to account for their actions.

The membership of the Strategic partnership changed during the year with the departure of the Director of Children's services in September, the role was filled in the interim by the Director of Education and the AD for Early Help until a new DCS was appointed in January 2022. In addition, the longstanding Police representative left in 2021 and there was a period when the police presence relied on different officers attending.

The Strategic Partnership Group (SPG) met every 10 weeks after the Business Groups and Subgroups in order to review the actions from these groups and discuss any matters arising from them and was chaired by the Independent Chair who provided one level of independent scrutiny of the partnership and was tasked with holding partners to account when required.

To provide scrutiny, the SPG would have access to the BISP Performance Data Report, Exceptions Reports and Multi-Agency Audits from the Quality Assurance Subgroup, reports from the Case Review Subgroup pertaining to all active Case Reviews, and the minutes from each of the individual Business and Subgroup meetings. They were also provided the Local Authority Performance Management Meeting Report, and ChAT dataset to give an overall picture of the status of children and young people. As the year progressed it became more difficult to obtain information from statutory agencies and the SPG was therefore bereft of proper analysis of progress. The concern about problems in reporting and gathering evidence was one of the main drivers in the decision to commission an independent review of the governance, structure, and efficiency of the children's partnership in January 2022.

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Business Group

The Children's Business Group, was responsible for overseeing the work of the subgroup, for analysing performance data,

The Business Group met every 10 weeks and was chaired by the Independent Chair and was provided with the minutes and data from the Subgroups, including the datasets, audits and reports that were provided to the Strategic Partners. It is recognised that there was the absence of a business plan, which made the work of the subgroups challenging.

Subgroups

Each subgroup had its own chair, who was a manager in one of the partner agencies. A deputy from a different partner was also allocated to these groups, and a member of the Business Unit was also in each subgroup.

Case Review Subgroup

The Case Review Subgroup (CRS) was responsible for the management of all Case Reviews in Bury over the last year. During the year it has undertook 6 Rapid Reviews for Children, 3 of which went to a full Local Children's Safeguarding Practice Review (LCSPR) and 3 went to local or other learning review, and 8 Safeguarding Adult Reviews (SAR).

It was decided that due to the significant number of adult referrals that were received, that there would be two separate groups, one for Children and Young People, and one for Adults.

The Children and Young People's group was chaired by the Assistant Director for Early Help and School Readiness, Bury Council.

Complex Safeguarding Subgroup

The Complex Safeguarding Subgroup (CSS) developed an action plan to ensure that it monitored more complex cases, for example Child Sexual Exploitation (CSE), Child Criminal Exploitation (CCE), Radicalisation and the PREVENT Duty and community safety. It considered the effect that COVID-19 had on safeguarding and focused on communication between teams and services to ensure that safeguards are in place. Training has been rolled out to update the knowledge of professionals.

This group was chaired by GMP.

Learning and Development Subgroup

The Learning and Development Subgroup (L&D) identified learning from Case Reviews and from local training needs analysis to identify areas where there is further practice change required and agrees ways in which this learning can be delivered and disseminated to the wider partnership workforce. It also managed the training courses delivered on behalf of the BISP and managed the training pool of delivery personnel via the Learning and Development Manager.

This subgroup was chaired by the Principal Social Worker – Adults, Bury Council, and was attended by the BISP Learning and Development Officer.

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Quality Assurance Subgroup

The Quality Assurance Subgroup (QA) monitored the performance of the partnership by completing multi-Agency, and statutory audits, reviewing the learning from single agency audits and case reviews, and analysing the local authority Key Performance Dataset. The Quality Assurance Subgroup collected and collated performance data for review by both the subgroup and by the safeguarding partnership. These figures were provided largely by the Local Authority, with some contribution from Greater Manchester Police. This data informed the partnership where there are significant variations in the performance of partner agencies and the exceptions that were reported in each quarter influenced the multi-agency audits that are conducted over the next year.

2021-22 was a challenging year for the QA subgroup, as there were significant changes in membership and attendance at meetings, meaning that there was significant drift in the planned work. As a result, the membership of the QA subgroup and the Terms of Reference were reviewed as part of the BISP's independent review in 2022-23.

The QA subgroup was chaired by the Head of Service for Quality Assurance - Children, Bury Council) and was attended by the BISP Quality Assurance and Performance Officer.

Schools, Colleges, and Adult Learning Subgroup

The Schools, Colleges, and Adult Learning Subgroup (SCAL) reviewed safeguarding within Burys's education providers and the group consisted of representatives from these providers and the local authority. It was identified that the representation on the subgroup was not reflective of multi-Agency practice, and so this subgroup has also been identified as one for review in the Independent Review

The chair position in this group was vacant throughout most of the year.

BISP Strategic Priorities 2021-22

The safeguarding partner set out the following priorities for the year.

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

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- 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 needs.

Throughout 2021/22 the majority of BISP meetings took place virtually initially due to Covid restrictions but as these were lifted professionals preferred online meetings to save time and for ease of access. Whilst these advantages ensured good attendance there was a negative impact on the group dynamics and team building. To this end development sessions were held in person as much as possible.

Evidence of the impact of the work of the Safeguarding Partners and relevant agencies, on outcomes for children and families.

In some areas there has been little evidence of progress on the agreed priorities, for the reasons mentioned earlier in the report. However, the in-depth independent review during 2022 would make recommendations to improve the effectiveness of the BISP to ensure deliver of priorities.

Below are some of the significant changes that have been observed in the 2021-22 reporting period and a full report of the data can be found in Appendix 1. It should be noted that this dataset is incomplete and has also been affected by changes in the way data is collected and reported by the Local Authority during 2021-22.

Children's Social care

Children in Bury were being referred into services more regularly and were more likely to become known to services.

The number of referrals to local children's services and MASH increased, indicating that there was an increased concern for the welfare of children and young people in the locality. While numerical data is not necessarily accurate due to the significant changes in the recording methods used (there is an increase of 213% for MASH referrals and 65% into Children's Social Care over the year), the general pattern of increase would indicate that there is an upward shift in the number of children being referred into service.

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There has been a 20% increase in the number of repeat domestic violence incidents where a child is present over the last 12 months, which may have contributed to this rise, and there has been an increase in the number of referrals into the LADO, which would indicate the number of incidents involving concern in relation to children has also increased.

There has been an increase in other figures also, including a 56.6% increase in the number of children that are looked after who are missing from home and a 13% increase in the number of children also going missing.

There is also a significant increase in the number of high risks CSE case that have been identified in the year, compared to the single recorded incident the previous year, a 70% rise, indicating that there is again a greater number of children at risk in the year before, or at least, the number that are recorded has increased.

Finally, there was a significant increase in the number of child deaths with modifiable factors recorded, from 10 in 2020-21, to 17 up until Quarter 3 of 2021-22, an increase of 70% before quarter 4 data is included.

The challenge that this increase brings, is that there is an effect on the effectiveness of services, as the time for the Return Interviews has increased (a decrease of 26% in interviews occurring on time) and there has been no significant change in the average percentage of single assessments being completed to timescale.

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Early Help

The new approach to early help adopted by the partnership in late 2019, through the formation of the early help locality teams, has continued to strengthen despite the restrictions still experienced throughout most of 2021. We have seen an increase in early help activity with an increase from 819 episodes in 20-21 to 989 episodes in 21-22 with a 19% increase in referrals into the locality early help teams.

We have continued to see the early help locality teams acting as lead professional in 80% of families supported and we want to see a shift towards other partners taking the lead professional role as we move into 22-23.

We have seen the team around the school model gathering greater traction this year despite the restrictions placed on us and we now have 73% of schools engaged in the team around approach. Over the year 800 children have been discussed as part of the team around approach with pathways for support identified. We are seeing a corresponding increase in schools completing early help assessments (story so far), but this is not yet reflected across other partners. Over the year schools completed 293 assessments with the second highest partner being health visiting with 22 assessments registered. There is a huge difference between schools and the rest of the partnership, and we want to see this gap narrowing in 2022-23.

As the early help teams have embedded and particularly through our team around approach, we have started to see some reduction in referrals into social care from schools which suggests that the support is being offered earlier and with better outcomes for children who are supported at a lower level of intervention through the team around approach. We have seen a reduction of 22% in referrals from schools to social care.

This year we have had our first whole year of quality assurance activity as part of our new approach which has supported the partnership in determining a base line for the quality of our support to families at an early help level. As we have completed child case audits, we have seen 50% of audits graded as good which has increased from 6% in 20-21 as we have driven up both the timeliness and quality of early help assessments. We have taken regular feedback from children and families and have seen high levels of satisfaction from the support provided. We have equally seen much more evidence of the voice of children through direct work. A direct work sample of cases evidenced work on 63% of cases. We are not complacent, and we want to improve further on this in 2022-23.

The early help offer continues to report into the Starting Well and Early Help board which has come together as a single board under the Childrens Strategic Partnership. As a board we are currently working on a new Early Help strategy for launch in 2022-23 and working with GMCA and the Innovation Unit to develop principles of early intervention. We are also now beginning work on the Family Hub initiative and how we might, as a partnership, build on the work of this year to improve our offer to families, local to where they live.

At the end of 22 agreement has been reached to move the Multi Agency Safeguarding Hub (MASH) into the Early Help division and broaden its approach to align more strongly with the locality early help offer and support the interface between early help and social care so that families receive a more streamlined service with an emphasis on a strength-based approach. A new MASH implementation group has been formed with commitment from all partners, to take this plan forward

There has been much to celebrate this year but in 22-23 as we move back into 'business as usual' and return to the workplace we have set some priorities for 22-23.

- Coproduction and launch of our vision for Early Help though our new strategy
- Reduction in referrals to social care through location of the MASH into Early Help and, improved interface between early intervention and statutory services
- Development of the Family Hub offer

Northern Care Alliance

During the period 2021/22 the NCA Safeguarding Children and looked After Children team consisted of a team of specialist safeguarding nurses and a Looked After Children nurse, working across hospital and community health services.

Specialist nurses were also co-located in the Bury Multi Agency Safeguarding Hub (MASH) and the Complex Safeguarding team, providing a vital health voice, and supporting decision making in the progress of referrals to Childrens Social Care. The complex safeguarding children nurse managed a caseload of young people open to the multi-agency team, providing access to health provision for the most vulnerable children in our localities.

The team aimed to provide place based safeguarding advice, support, training, and supervision to staff in our community services and at Fairfield General Hospital.

The detail of workstreams focus for the period of 2021/22 was follows: -

- Improving recognition and response to safeguard children in Accident and Emergency, through audit, task & finish groups and supported by the Trust QI team.
- The management of 16 and 17-year-olds on adult wards.
- Phasing out the use of existing Information Sharing forms as a referral to Children's social care
- Development of a new model of safeguarding supervision aligned to the NCA model used across the other NCA Care organisations, incorporating both 1 to 1 and group sessions across the footprint.
- Undertaking an assurance visit to Community Services to identify areas for improvement in relation to safeguarding issues.
- The NCA Safeguarding Team and colleagues from Children's Community Services fulfil the Trust's statutory duty in attendance at BISP meetings.
- Ensuring the Trust is compliant with mandatory level 2 & 3 safeguarding training.

The NCA safeguarding children training programme continues to be delivered with an aim to increase accessibility across a range of platforms including:

- 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.

A multi-agency Children's improvement Board is now leading on the transformation with the NCA represented by the Safeguarding team and Children's community services from Bury Care Organisation, alongside other health partners and GM ICB Bury (CCG).

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The 0-19 service in Bury is developing a new School Nursing offer for School aged children in Bury. This model will focus on prevention and early intervention and support for the most vulnerable children (5 – 19), following on from the role of the Health Visiting service. The new model is to commence as a pilot project in Ramsbottom before roll-out across Bury in 2022/23.

Work continues to have 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 2021/22.

NCA Safeguarding children steering groups continue to run 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. There is a rolling programme to support both adults and children's services, then a joint one to support 'think family'.

The completion of statutory health assessments for Looked After Children has continued to be of a high standard for Children placed in Bury. This performance needs to be matched for Bury Children placed out of the locality. Joint working also needs to be looked at in relation to improving access to initial health appointments for children & young people.

Bury NHS Clinical Commissioning Group (CCG)

Despite the unprecedented number of reviews, capacity issues across the system, a global pandemic, and significant changes in leadership across all parts of the partnership, the CCG continued to work together in an attempt to improve outcomes for the residents of Bury. The new relationships that have developed were built upon in the following year.

NHS Bury CCG faced significant pressures throughout 2021-2022 due to the Coronavirus pandemic and through the recovery period. Despite this, the CCG strove to keep safeguarding children at the heart of all their work to ensure that NHS Bury CCG continued to comply with statutory responsibilities.

NHS Bury CCG was represented on the Strategic Board, at the Children Business Group and on the subgroups. Attendance at these meetings was prioritised, to ensure the CCG were effective members of the partnership, through proactive engagement, striving for system improvement and challenge. The Designated Nurse Safeguarding Children undertook the author role in several reviews and the Safeguarding Team contributed to the action plans and partnership audits where there has been progression. The Safeguarding Team are currently supporting the Local Authority with the Children's Improvement Plan that is now in place. There were significant changes in the team and a period of change and transformation took place. Despite the continued pressure on the Safeguarding Team, the core functions continued as normal.

NHS Bury CCG have continued to gain assurance from commissioned services with regards to their safeguarding activity throughout 2021-2022, providing support and advice where required. As standard, the CCG collects and collates data from all the services it commissions in relation to safeguarding practice and activity. The CCG requests and monitors assurance from providers against all requirements in Section 11.

Recruitment took place for a Designated Doctor for Child Deaths which was supported by the CCG Safeguarding Team and the Safeguarding Team regularly attended the local Child Death Overview Panel. Additionally, funding was secured, and recruitment undertaken for a

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Complex Safeguarding Nurse to work alongside partner agencies in the Complex Safeguarding Team, which provided successful evaluations to date.

During the pandemic, systems and processes were developed to allow staff to work remotely, ensuring continuity in the service and accessibility to colleagues within the CCG and the wider partnership. Mandatory training continued throughout 2021-2022 as online training packages were developed and these were well attended and well received. A Level 3 Think Family Safeguarding and Prevent training session was delivered to General Practitioners.

In addition, the safeguarding team delivered 2 Development Sessions to the Safeguarding Leads from each GP Practice. These sessions focused on the learning from statutory reviews undertaken by the BISP as well as regional and national learning. The CCG Safeguarding Team also provided case support and supervision to NHS provider safeguarding colleagues as well as practitioners within the Complex Care Team and Primary Care services.

The CCG Safeguarding Team participated in a multi-agency Domestic Abuse workstream established by Greater Manchester Police. The aim of the workstream was to monitor the incidence of domestic abuse during the coronavirus pandemic and the response by the multi-agency partnership to assess and manage the risk at this time.

An ICON (Infant is crying normally, comforting methods can help, Ok to walk away, Never, ever, shake a baby) steering group led by the CCG continued throughout 2021-2022.

The BISP identified learning from Children's reviews completed in 2021-2022, however due to the challenges reported earlier, the BISP has been unable to progress embedding the learning throughout practice in Bury.

Going forward, a thematic approach to learning will be considered, alongside community of practice events. NHS Bury CCG developed and circulated a briefing across primary care services with regards to the risks of de-registering patients who may be vulnerable.

NHS Bury CCG delivered various training sessions for Primary Care throughout 2021/2022, including domestic abuse training, Prevent training, abusive head trauma training and level 3 Think Family Safeguarding training. NHS Bury CCG Safeguarding Team also delivered training for GP trainees.

Greater Manchester Police

During the year GMP Team Bury established an entirely new Senior Leadership Team. There was an increased focus on partnership worth, particularly around safeguarding and vulnerability and within the CSP.

Establishment changes have been made to introduce/reintroduce investigative and safeguarding teams such as Complex Safeguarding, Domestic Abuse Governance for example. Additional resources have been invested in the DST/MASH. Improvements have been made in triage, attendance times and outcomes for multiple crime types.

At present, many functions that would benefit from co-location which would encourage information sharing are not integrated. Until recently, agencies were predominantly working in isolation, and this does not seem conducive to effective information sharing.

Additionally, there are often significant delays to strategy meetings which suggests subsequent interventions may be not as expedient as they should be.

GMP have led/supported the design and delivery of the CST (complex safeguarding team) action plan based on peer review and audit findings. A similar process is currently being undertaken for the MASH.

Pennine Care Foundation Trust (PCFT)

The delivery of safeguarding training remained a key priority for the PCFT safeguarding teams, with the requirement that all staff were provided with the appropriate level of training, according to their role and responsibilities. The Safeguarding team continued to deliver the safeguarding Level 3 Safeguarding Families Training and Looked after Child training. In addition, the team also completed some," lunch and learn sessions" for teams across the organisation on subjects such as disclosures of historical sexual abuse, grooming, financial abuse.

The Safeguarding team supported BISP partnership in 2021, to provide some level 3 training to service providers in Bury locality and provided the local teams in Bury with a "lunch and learn," session on the safeguarding process in the area to ensure they are fully up to date on the safeguarding process in Bury. The Safeguarding team also delivered some training and learning sessions on safer sleep (ICON).

The safeguarding team are to start to complete more quality walks across the organisation. The next quality walks will be focusing on Liaison Mental Health Teams and Home Treatment Team.

There was participation in the Bury Integrated Safeguarding Partnership Multi Agency Involvement of Services in the Transition of Young People from Children Social Care into Adult Social Care Case study audit, to identify the gaps in service provision and establish a robust picture of the journey of those transitioning from childhood to adulthood in the care system.

Internal audit themes included early recognition of domestic abuse and use of a risk assessment to support victims and safeguarding children, the application of the Mental Capacity Act and having a 'think family' approach as children and adults do not live in isolation of each other.

The Head of Service devised a basic domestic abuse awareness training, which will be added to training matrix of staff within the Trust.

Bury Volunteer, Community and Faith Alliance

State of the Sector 2021 estimates there to be over 1200 VCSE groups and organisations in Bury – 71% of which are micro (under £10k income p/a). The remaining 29% of VCSE organisations are registered charities and social enterprises – many with employed staff who are delivering across a range of commissioned contracts and funded services. There are an estimated 26,000 volunteers in Bury providing approximately 131,145 hours each week equating to an estimated economic contribution using the 'real' living wage of at least £65 million per annum.

The VCSE sector delivers a wealth of services across a range of activity including health and wellbeing, children and young people, older people, disability, skills and education, equality and inclusion and environment and climate. Bury VCFA is the Local Infrastructure Organisation for Bury, delivering a range of capacity building and volunteering support and

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providing a voice and champion for the VCSE sector's role as a key deliverer of preventative services for people and communities.

Bury VCFA facilitates a number of networks and forums including the Bury Community Support Network, VCSE Leadership Group, and the Health and Social Care Network. These provide an opportunity for VCSE groups to come together to share challenges and good practice and highlight insights being gathered by frontline VCSE services, paid staff, and volunteers. These insights have been used to demonstrate the impact of the sector and shape strategies such as the Cost-of-Living Strategy in tackling the wider determinants of health. Although many VCSE organisations closed their front-facing services during Covid, others kept going – including mutual aid and food banks.

VCSE groups tell us they are seeing increased complexity of need impacting on whole families and that mental health is a key issue – with VCSE groups being referred into as a 'stop-gap' whilst people wait for statutory services, resulting in VCSE struggling to meet demand and/or lack of expertise. There are, however, collaborative opportunities that we are working on to bring additional capacity to the sector to manage some of these challenges – e.g., VCFA are working with Early Break to roll-out Trauma Informed training to the VCSE sector in order to better equip staff and volunteers. We are shortly going to be rolling out training in partnership with Bury Children's Services, supporting the VCSE sector to consider how they recruit young volunteers and encourage youth leadership within local groups, charities, and social enterprises – this training is delivered by young people. Youth volunteering and leadership will be a key element within the refreshed Bury Volunteering Strategy 2023.

Bury VCFA are keen to work with the BISP to co-design Children and Young People's Safeguarding training specifically for the VCSE sector, incorporating equality and diversity and acknowledging and responding e.g., to cultural differences when supporting communities of identity.

The VCSE sector is represented on Children's Strategic Partnership by Bury VCFA and Early Break and by Bury VCFA on the Children's Improvement Board. Bury VCFA also sit on the Multi-agency Improvement Steering Group, working with partners to identify challenges and opportunities to work collaboratively across sectors.

Local Children's Safeguarding Practice Reviews (LCSPRs)

Local Children's Safeguarding Practice Reviews (LCSPRs) (previously known as a Serious Case Review (SCR)) are undertaken when a child dies, or the child has been seriously harmed and there is cause for concern as to the way organisations worked together. A Rapid Review is normally held upon receipt of the referral and a panel of representatives from the BISP's statutory partners reviews the referral and decides if it meets criteria and threshold for a LCSPR, or whether another form of localised learning review should be undertaken.

During the reporting period, there were eight Rapid Review referrals submitted to the BISP, of which three were deemed to meet the criteria for a LCSPR, E21, G21 and H21. One, Q21, was a resubmission of a previous case, D21 and this as well as one other case, J21 did not meet the criteria for a Rapid Review but a case review was initiated. There was also R21 that did not meet any criteria for review, and B22 which was referred for a National Review.

There was also the review for James and Joseph (C20) with three more local learning reviews for I20, A21 and C21 all concluding in the year.

It was evident from case reviews, that learning themes and patterns were repeated in a number of cases and this contributed to the decision to commission an independent review of the role and function of the BISP in 2022.

Local Authority Designated Officer (LADO)

The Local Authority Designated Officer (LADO) works within Children's Services and gives advice and guidance to employers, organisations and other individuals who have concerns about the behaviour of an adult who works with children and young people.

The main headline is that LADO contacts for 2021 – 2022 went up by 30% from the previous year (318 to 413), mostly in education as schools were back, having been closed/restricted for Covid in 2020 – 2021.

Even though figures went up for contacts to LADO in 2021 – 2022 the number of full cases that reached LADO threshold went down from 60 to 51. In terms of the ratio of contacts to full cases, this dropped as per below: -

- 2020 – 2021 is 60 divided by 318 = 18.8%
- 2021 – 2022 is 51 divided by 413 = 12.3%.

In health the number of full cases dropped from 23 full cases in 2020 – 2021 to 6 in 2021 – 2022. This may have been a result due to Covid and lockdowns as children on secure Mental Health wards had their leave/visits restricted and were more involved in restraints by staff and there were also significant numbers of agency covering for staff sickness.

Sexual allegations remained stable, and the LADO continues to deliver 1hr training sessions to agencies who work with children around staff behaviour on the internet and/or social media who interact with children. Although staff do not get convicted as often when the children, they work are the victim, they still engage with children they randomly meet online that are not connected to their employment, although some of the children are undercover police officers.

Physical handling issues are consistent, and there is a 1 hr sessions to those staff who may have to use restraint at all in their work to explain to them the guidance around the "use of reasonable force" when it comes to handling children.

Yearly multi-agency training delivered by the LADO on behalf of the BISP.

- 3 x half day sessions for Managing Allegations against those who regularly work/volunteer with children
- 2 x full days sessions for Safer Recruitment
- 2 x full days for E-safety and online safety

Peer review and Ofsted Inspection

Children's Social Care initiated a peer review in early 2021 and an Ofsted inspection was carried out from 25th October to 5th November 2021. Both processes drew the same

conclusions about the improvements required in Children Social Care, especially in relation to staff recruitment and retention, the use of agency staff and the changes in leadership.

The Ofsted inspection graded Children Social Care inadequate in three areas,

- The impact of leaders on social work practice with children and families
- The experiences and progress of children who need help and protection.
- Overall effectiveness.

The experience and progress of children in care and care leavers was judged to be requiring improvement.

The same inspection also noted the positive experience of children in in care and the well-resourced, effective support offered to care leavers.

The Ofsted inspectors recognised that action was already being taken in relation to improvements for child safeguarding. Since the 2021 inspection there have been two Ofsted monitoring visits which have both noted an improving situation, not least in the increase on social work posts and the restructuring of teams and management. The work of the improvement board plus the establishment of the new governance arrangements for the partnership should result in steady progress in securing better outcomes for children, young people, and families.

Analysis of impact through Multi-Agency Audits

The Quality Assurance subgroup conducted Multi-Agency Audits in relation to significant exceptions in the data return, and also as a result of learning from Case Reviews.

In 2021-22, four Multi-Agency Audits were conducted:

- Agency Involvement in Selected Pre-Birth Cases
- Neglect – Use of the Graded Care Profile (GCP2)
- Think Family
- Initial Report into the Multi-Agency Involvement of Services in the Transition of Young People from Children's Social Care into Adult Social Care

The BISP also conducted a Section 157 and 175 audit on schools during the year in partnership with the local authority.

In the Agency Involvement in Selected Pre-Birth Cases Audit, there was overall, there some evidence of information sharing, however it was unclear as to how much and how effective this information sharing is. There seemed to be more evidence of service involvement post-birth rather than pre-birth, however as there was a wide range of responses in different formats, and so it was identified as being pertinent going forwards to re-evaluate this piece of work as a full multi-agency audit with a generic tool that can identify common themes across services and is better suited to a multi-agency response. Some of the themes highlighted in the audits did have links to other audits, including the Think Family audit, and therefore it was considered that any further investigations may tie in with these audits.

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The Neglect audit identified that there was an uncertainty around who was using the GCP2 profile and ultimately if it was effective. It was suggested that a lead for the programme be identified and further training and a re-roll out be introduced in line with the neglect strategy due in 2022-23.

The use of Think Family in assessments was also audited, however the results were inconclusive as there was insufficient engagement from partners in the final stage that would allow for a more comprehensive investigation. It was identified that while services were aware of the process, they were not always able to evidence it in their caseloads.

In the Initial Report into the Multi-Agency Involvement of Services in the Transition of Young People from Children' Social Care into Adult Social Care audit, it was evident from the responses that there was some effective sharing of information between services. Where there was opportunity for improvement, was in the sharing of information between Children's and Adults Social Care, as there is sometimes a disconnect between the two. This was more evident in cases where the young person refuses support from ASC, which can then allow them to drift away from services.

There was a concern that when a young person transfers local authorities at or around 18, there is the opportunity to lose track of the young person, especially when unsupported by the previous local authority, it was felt that it may be appropriate to include CSC in the process to ensure that all information is shared, and the best options are taken for the individual.

The Section 157 and 175 audit identified that there were a number of actions for the BISP if it was to conduct the audit again and the local authority to assure that all children are safeguarded in school in that the BISP should have less of a direct role in the process going forward, only collecting assurance that practices are being undertaken. The overall auditing of schools safeguarding should be being completed regularly by the Local Authority.

The local authority was issued the following recommendations:

- There was a 53.8% return rate overall, with a significantly lower return rate in Secondary schools than in any other. It will be essential to establish why there was such a low return rate, especially in Secondary Schools, and the BISP will seek assurance as to how this can be improved in the future.
- There were also a number of schools that are a concern, as they assessed themselves notably lower than others in the self-assessment. The BISP would like to seek assurance that these schools will be supported to improve their arrangements and how this will be undertaken.
- In the audits, it was established that there were a number of criteria that required further investigation by the Local Authority
- Finally, there is a significant need for further support around Private Fostering in all schools, as this was indicated as being challenge in many schools. While Private Fostering is a challenge nationally in many authorities, schools are often best placed to identify if a Private Fostering Arrangement (PFA) is in place, and therefore staff in schools should be appropriately trained to identify the signs and support families where necessary. BISP will be looking to be shown evidence of how this is to be addressed.

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Priorities and Plans for 2022-24

The Priorities for 2022-2023, were agreed by Safeguarding Executive, as part of the scrutiny process and are as follows

- Overall architecture of the Partnership and review of effectiveness of the arrangements that had been in place since September 2019
- Multi agency Child Protection processes to ensure they have children and their families at the centre
- Complex Safeguarding to understand the current position and the improvements that will need to be implemented to move towards an effective service
- A review of all case reviews to ensure the process is effective and learning is rapidly identified, disseminated, and embedded

Closing Statements

2021-22 was a challenging year for the BISP. Whilst there are plans in place to ease this pressure and increase capacity, it is accepted that this will take time. Although outside the remit of this report, it is possible to see that there has been a steady improvement in 2022/23 not least in the stability in leadership and senior roles and investment by the local authority in social work posts. This report, albeit delayed is a snapshot of how things were rather than how they are now (**spring 2023),** and the ongoing improvement is testament to the commitment, hard work and aspirations of staff and managers across the multi -agency partnership.

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Appendix 1:

Key Performance Indicator			Q1	Q2	Q3	Q4	Year Av/Total	2021	Diff from '21+/-
1.1	% Children Living in Poverty		22.9	22.9	22.9	22.9	22.9	22.9	0
1.2	Infant Mortality (Per 1000 live births)		4.1	4.1	4.1	4.1	4.1	4.1	0
1.3	Child Population		43180	43180	43180	43180	43180		0
2.1	No. of CIN with a Disability (%)	Percentage	18	18	18	16	17.5		
2.2	No. of Children/YP living in the area who are the responsibility of other LA's	Q End	270	257	260	263	262.5	259	-4
2.3	No. of Private Fostering Arrangements	Total	1	1	1	2	2	1	1
3.1	No. DV Notifications from Police where a child is present	Quarter End	413	325	395		377.6667	439	
3.2	No. DV Notifications from Children's Social Care that led to referral						0		
3.3	No. Repeat DV call outs by Police to an address where a child lives	Annual				254	254	212	42
3.4 (a)	No. Children Missing from Home	Total	86	97	100	70	88.25	78	10.25
3.4 (b)	No. Children Missing from Care	Total	86	131	129	111	114.25	73	41.25
3.4 (c)	No. Children Missing from Education				75	93	84		
3.5	% Children who had an independent return interview (within 72hrs)	Average	56	73	65	51	61.25	82.6	-21.35
3.6	The Number of violent and sexual offences against children aged 0-17	Quarter End	354	309	366		343		
3.7	Number of CSE Episodes Open at Month End	Month End	42	36	35	46	39.75	35	11
3.8	No. of new CSE referrals recorded as being at 'high' risk of CSE	Total	2	3	3	8	8	1	7
4.1	Number of Locality Hub episodes open at end of month/year	Quarter End	372	326	345	401	361	397	-36
4.2	Number of Early Help the Story So Far assessments authorised in month/year	Average.	57.3	55.3	35.3	35.3	45.8	40	5.8
4.3									

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4.4	Number of MASH Referrals	Total	3514	2832	2439	2139	2731	871.3	1859.7
4.5 (a)	Average number of working days until MASH decision	Average	0.43	0.59	1.32	1.3	0.91	1.08	-0.02
4.5 (b)	% of MASH Episodes with outcome of Early Help	Average	8.9	11.8	7.5	17.1	11.325	10.97	9.6
4.5 (c)	% of MASH Episodes with outcome of CSC	Average	18.8	42	48.5	41.6	37.725	22.4	-6.9
5.1	Number of referrals to children's social care in quarter	Total	610	593	1223	954	3380	2047	1333
5.2	% of referrals to Children's Social Care which are repeat referrals within 12 months.	Average	21.8	22.9	22.9	27.3	23.725	25.4	4.4
5.3	% of referrals leading to social care's Single Assessment	Average	87.1	94.1	88.2	90.2	89.9	94.6	2
5.4	% of completed assessments to timescale	Average	86.2	78.1	88.1	87	84.85	84.9	-1.1
5.5	Number of children in need and rate per 10,000 0-17 population (RATE)	Q End	888	958	1088	1064	999.5	196	-24
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							
6.3	Rate of S47s per 10,000 0-17 population (Cumulative)	Month End	46.3	85.5	153.3	209.6	209.6	217.8	8.2
6.4	% ICPCs held in month where ICPC held within 15 working days of strategy discussion	Average	71	65.4	83.7	91.5	77.9	89.8	7.8
6.5	Number of children subject of Child Protection Plans	Total	200	210	220	239	239	201	38
6.6	No. child protection plans lasting 2 years or more	Month End	3	2	3	5	5	3	2
6.7	No. % percentage of children subject to a CP Plan for a subsequent time	Average	25	35	17	28	26.25	68.7	11
6.8	Number of child deaths with modifiable factors		3	11	3		17	10	7
7.1	Number of looked after children (responsibility of our LA) including those living outside of the area	Total	342	348	354	361	351.25	347	7
7.2	Number of Children becoming looked after (Total)	Total	18	28	36	30	112	113	-1

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7.3	Number of children ceasing to be looked after	Total	23	31	20	21	95	109	-16
8.1	Number of allegations referred to LADO.	Total	104	81	111		413	318	95
8.2	Number of FTE social workers, health visitors and school nurses								
8.3	Vacancy rate of social workers, health visitors and school nurses	Q End	9.99	11.05	12.35		11.13		
8.4	Turnover rate of social workers, health visitors and school nurses						0		

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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

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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

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