Annual Report on the Effectiveness of Safeguarding Children in Bury 2013/14

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Foreword by Independent Chair of BSCB

Gill Rigg
Independent Chair of BSCB

As the Independent Chair of Bury Safeguarding Children Board (BSCB), I am very pleased to introduce this, the sixth BSCB annual report.

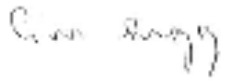
As ever, in safeguarding activities, it has been a busy and challenging year. April 2013 saw the introduction of Working Together to Safeguard Children guidance (2013), and we particularly welcomed the freedom to move away from a prescribed way of undertaking serious case reviews towards more of a learning culture. We also saw the piloting, and then the introduction of the new Ofsted framework of inspections, and the new approach of Ofsted reviewing the work of Local Safeguarding Children Boards (LSCBs).

The BSCB welcomed the implementation of the new Multi-Agency Safeguarding Hub (MASH) team, co-located at the police station, and breaking new ground in the initial responses to contacts and referrals. We also took a step forward in our work to protect sexually exploited young people. Additionally, we undertook three serious case reviews and published them.

We also had the advantage of a peer review of the safeguarding service, and their comments that Bury's greatest asset was its staff, that there was a passion and commitment to the right things, and that there was a genuine attempt to improve outcomes for children and young people in Bury, were particularly pleasing.

There has been a strong focus on Early Help, and in January 2014, Ofsted undertook a thematic review of our Early Help offer. The inspectors were pleased with the work in progress, felt that we knew ourselves well and were able to identify the gaps and the BSCB was described as "energetic."

The work of the BSCB, its Executive Group and the sub groups continues to drive the safeguarding agenda forward, and I am immensely grateful to all my colleagues in all of the agencies who work so hard to keep children and young people safe in Bury.
As ever, I feel privileged to have the role as the Chair of the BSCB and I would like to thank all of you who work so tirelessly.



Gill Rigg, Independent Chair of BSCB

June 2014

Role and scope of Bury Safeguarding Children Board (BSCB)

1. **Regulation 5 of the Local Safeguarding Children Boards Regulations (2006)** sets out that the functions of the LSCB as follows:

(a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

(i) the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;

(ii) training of persons who work with children or in services affecting the safety and welfare of children;

(iii) recruitment and supervision of persons who work with children;

(iv) investigation of allegations concerning persons who work with children;

(v) safety and welfare of children who are privately fostered;

(vi) cooperation with neighbouring children's services authorities and their Board partners;

(b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;

(c) monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;

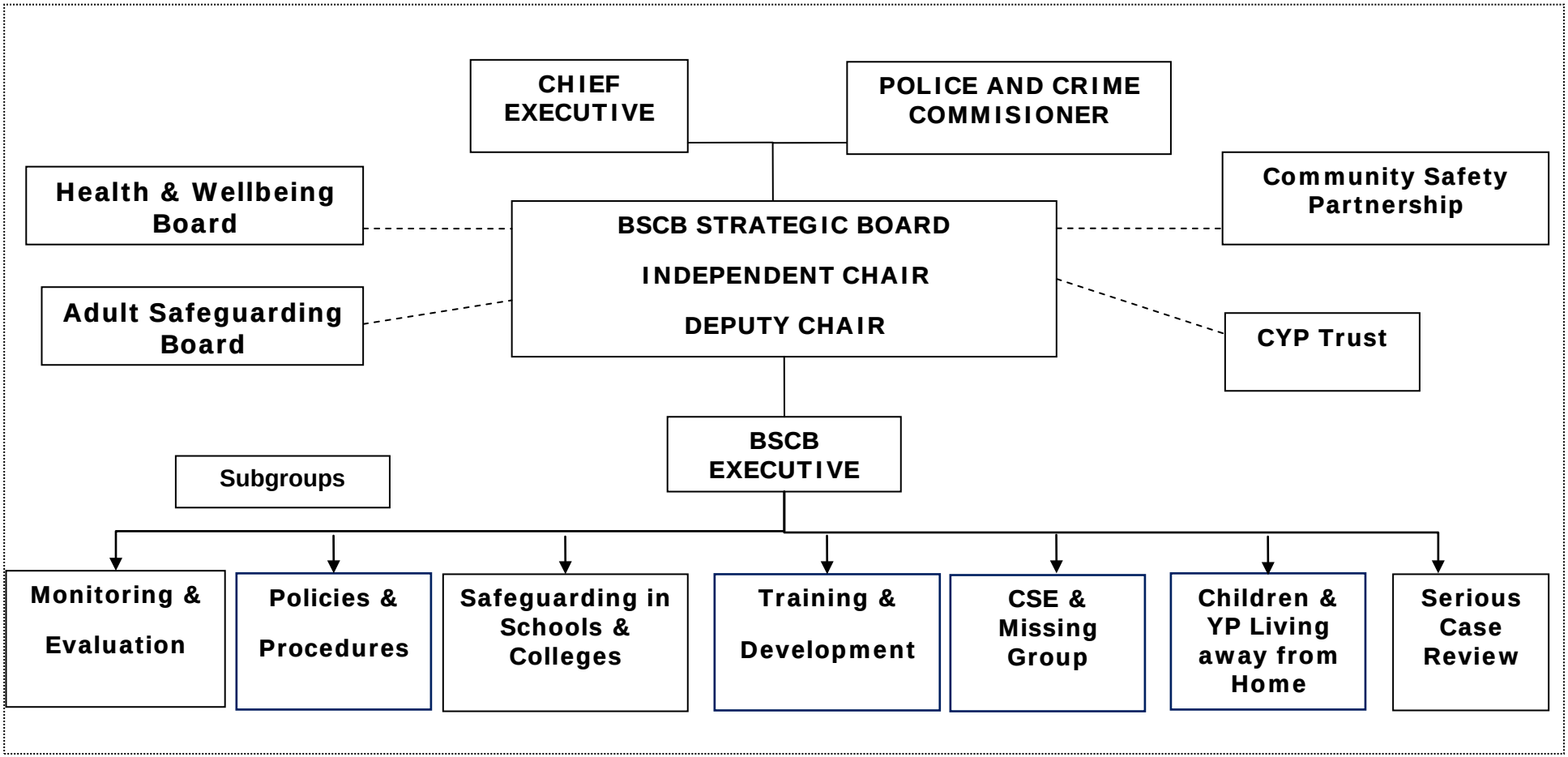
(d) participating in the planning of services for children in the area of the authority; and

(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

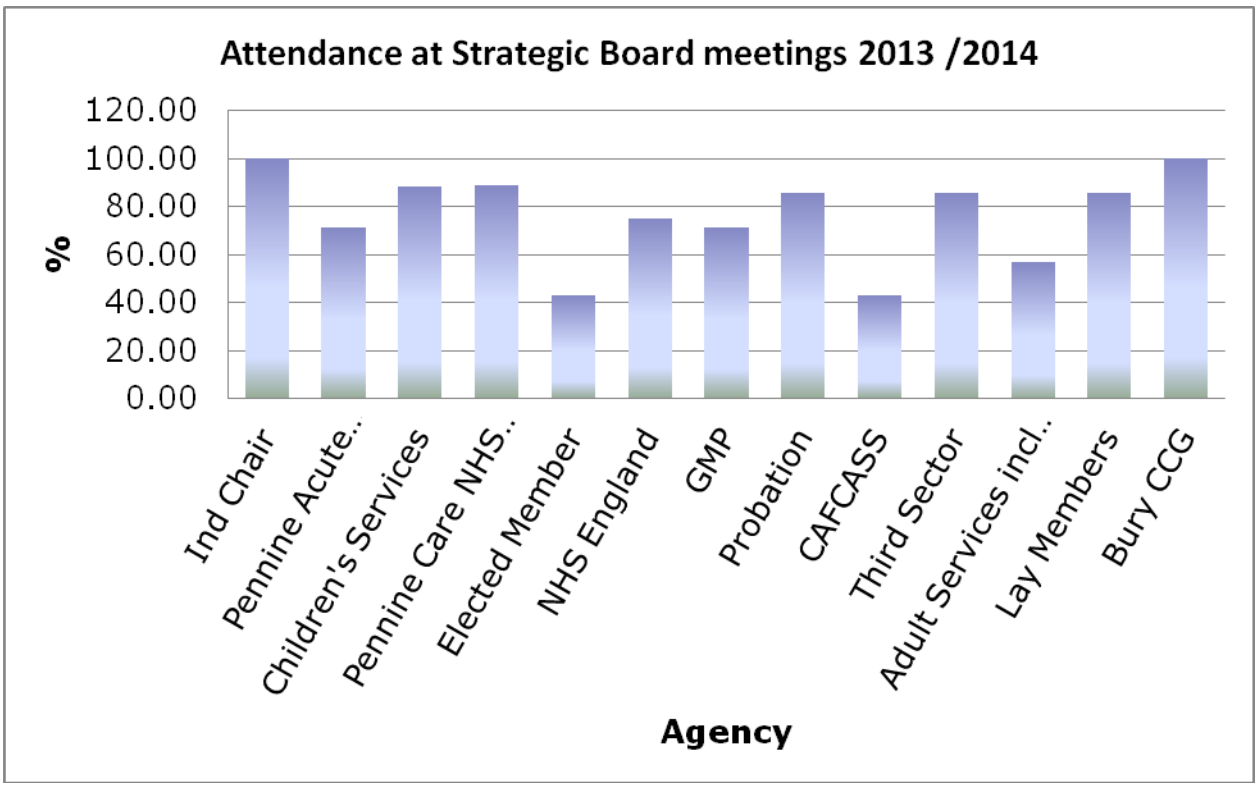
2. Regulation 5 (3) provides that a LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

3. The BSCB and Sub Group membership list is included as Appendix 1.

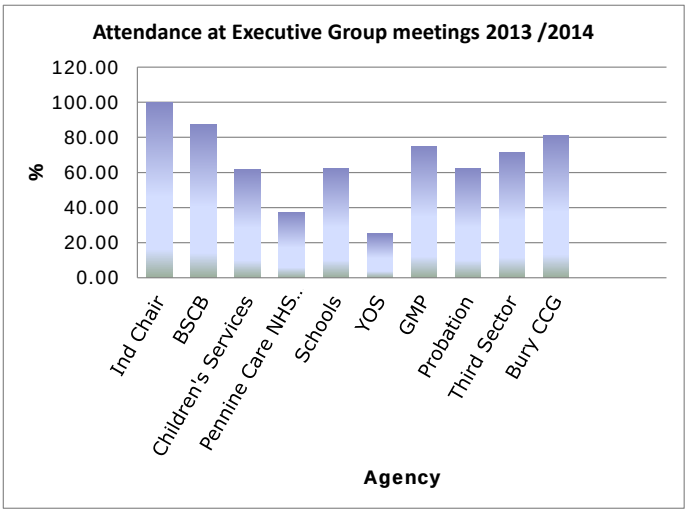
Structure of Bury Safeguarding Children Board BSCB (2013/2014)



Attendance at BSCB meetings 2013/2014



Attendance at Executive Group Meetings 2013/2014



The Bury Safeguarding Children Board (BSCB) met regularly in 2013/14. It has been a challenging year for some of our partners who have undergone further workforce reform and have experienced financial pressures. Accordingly the capacity of some of our partners to commit to the work of the Board has been challenged. This issue has been identified and is being addressed at the BSCB. We are pleased to note this year that we have increased representation at the BSCB from Cafcass.

The BSCB sub groups have met regularly and have continued to develop and deliver the BSCB key tasks as outlined in the Business Plan for 2013/14.

BSCB income and expenditure 2013/2014

Contributions/Income	**Pounds (£)**
Children's Services	72,145
Strategic Housing Unit	0
EDS	2,000
Bury CCG	37,142
Greater Manchester Police	11,850
CAFCASS	550
Probation Service	3,468
Brought Forward	47,955
Grant CDOP	34,900
Training Income	9,550
DSG contribution	39,850
TOTAL INCOME	**259,410**

Expenditure	**Pounds (£)**
Employee costs	179,105
Multi-Agency Training Costs	3,365
Serious Case Review	34,065
Independent Chair of BSCB	10,275
Travel & Subsistence	455
Advertising – staff	0
Postage	44
Telephone	996
Office overheads incl Equipment, tools & materials	9,539
Printing & Stationery	1,769
Legal – Courts & Community	2,000
CDOP	9,770
Staff Training	337
Miscellaneous	1,435
Emp Liability & 3rd Party ins	514
TOTAL EXPENDITURE	**253,669**
Carry forward to 2014/15	**5,741**

Projected income and expenditure 2014/2015

Contributions/Income	**Pounds (£)**
Children's Services	72,145
EDS	2,000
Strategic Housing Unit/Adults	0
Bury CCG	37,142
Greater Manchester Police	11,850
CAFCASS	550
Probation Service	3,468
Contribution from General Balance b/fwd	5,741
DSG	40,000
CDOP	34,900
Training income	7,500
Partners contribution for licence for section 11 audit toolkit	3,000
TOTAL INCOME	**218,296**

Expenditure	**Pounds (£)**
Employee costs	122,000
Multi-Agency Training Costs	10,000
Serious Case Review	40,000
Independent Chair of BSCB	10,000
Travel & Subsistence	1,200
Postage	200
Telephone	1,000
Office Equipment, tools & materials including licences	6,000
Photocopying	500
Printing & Stationery	2,600
Legal – Courts & Community	2,000
CDOP	10,600
Staff Training	1,000
Miscellaneous	2,500
Emp Liability & 3rd Party ins	500
TOTAL EXPENDITURE	**210,100**
Balance of funding – carry forward to 2015/16	**8,196**

Main achievements 2013/2014

- This year the BSCB took a keen interest in the welfare of young people placed in secure mental health settings in Bury. This led directly to improvements in safeguarding practice for those young people.
- We have undertaken a section 11 audit this year. Our partners agreed to share the costs of purchasing the 'e-academy' electronic tool.
- The BSCB communication strategy has been revised and the BSCB website has been upgraded.
- The BSCB has overseen the development of the Multi-Agency Safeguarding Hub (MASH).
- We have published a revised 'Thresholds for Intervention' document. A series of multi-agency workshops were held to launch the document.
- We have reviewed how we undertake Serious Case Reviews in accordance with Working Together to Safeguard Children (2013).
- We have employed a Learning Event model to undertake a Serious Case Review involving front line practitioners more fully in the process.
- This year we have concluded and published 3 Serious Case Reviews.
- We have delivered multi-agency safeguarding training to 771 participants.
- We have identified a higher number of privately fostered children.
- We have collaborated with the Greater Manchester Safeguarding Partnership to produce the first and second updates of the pan Greater Manchester Safeguarding Procedures.
- We have increased participation from Public Health partners in the Child Death Overview Panel (CDOP).
- Our lay members have begun to take an enhanced role by representing the BSCB in local community groups and forums.
- We have developed a BSCB Quality Assurance Framework.
- We have developed the Child Sexual Exploitation (CSE) & Missing strategy.
- We have participated in the development of the Phoenix Team.
- We have developed the CSE Task and Finish Group and Missing from Home Group into a full CSE & Missing Sub Group.
- We have appointed an Interim Board Manager.

State of Safeguarding in Bury

The BSCB is required to ensure the effectiveness of the work that is done to safeguard and promote the welfare of children and young people in Bury. The BSCB does this by discharging its statutory functions as detailed in this report at page 23 **'Discharge of statutory functions'.**

Our statutory partners have also prepared an analysis of their own agency contribution to keeping children safe in Bury which can be found on page 9 **'Main Achievements'**.

There has also been external scrutiny of the safeguarding arrangements in Bury through a *Local Government Association (LGA)'Peer Challenge' Review* and an Ofsted Thematic Inspection of Early Help discussed at page 33 **'Effectiveness of the BSCB'**

Multi-agency performance data analysis also assists us to understand whether a difference is being made to the lives of children and young people in Bury and is found at page 35.

How safe are children in Bury?

Together these reports tell us that 2013/14 has been a year characterised by rising numbers of children who are subject to a child protection plan and a marked increase in the conversion rate of contacts to Children's Social Care that progress to referrals. Improvements in service delivery such as the Multi-agency Safeguarding Hub, the implementation of a revised Threshold of Need document together with improvements in the reliability of children's social care performance data have indicated that historically, the threshold for access to children's social care was too high.

The result has been a rising rate of referrals to children's social care as a response to concerns about children's welfare. In 2013/14 we have seen a significant increase in the number of children requiring a statutory assessment and services and rising social work (including Independent Reviewing Officers) caseloads. The timeliness of the completion rate of assessments in 2013/14 is low and the number of child protection plans has almost doubled in two years. In response to these issues being identified the BSCB will continue to scrutinise social work capacity and children's social care performance reports over the next twelve months.

Domestic abuse continues to account for the largest number of child protection plans (over half), with neglect accounting for one third of plans. The largest number of referrals to Children's Social Care continues to be from the police and is in response to concerns regarding domestic abuse. The BSCB has held the Community Safety Partnership to account for the production of a revised domestic abuse strategy and over the next 12 months the BSCB will be producing a multi-agency strategy to respond to the issue of neglect.

The number of looked after children reduced in 2013/14 and is now stable and comparable with our statistical neighbours. More successful outcomes for children and young people have been achieved by increasing the options available to secure permanence for them.

The capacity of the Greater Manchester Police to respond to the rising number of child protection plans not just in Bury but across Greater Manchester has been challenged in 2013/14. This has been a difficult financial year for many of our partners who have faced rising demands on their services in the context of cuts to public sector funding. In response the BSCB has sought reassurances from the police that resources are

being prioritised and all referrals to the Public Protection Division to attend child protection conferences and reviews are being risk assessed. The local Police Public Protection Unit in Bury has also been challenged by an increasing workload with a rise in the numbers of historical cases of sexual abuse being reported and increasing requests for police participation in section 47 strategy meetings. In response a 'strategy meeting protocol' is being developed between Children's Social Care and the Police to ensure that those strategy meetings requiring an urgent response are prioritised.

Bury has an excellent record on road safety for children and young people and for the fifth consecutive year there have been no road traffic deaths involving children and young people (figures are for 0-16 years). The Bury Road Safety team undertakes a proactive campaign of road safety in Bury schools and faith groups to keep children safe on Bury roads.

The further development of an integrated Early Help offer is a priority for 2014/15 and this work is being driven through the Children's Trust Board. A number of initiatives have already taken place this year such as the development of the Early Help Panel to ensure that children and families who require co-ordinated services below the threshold for statutory intervention receive timely services, appropriate to their needs.

This year we have seen rising numbers of children and young people referred to local CAMHS due to concerns in respect of self-harm, the largest increase in referrals coming from schools. This has come at the same time as significant capacity issues in the school nursing service have been identified. Together with the Bury Children's Trust as part of the Early Help offer the BSCB has prioritised for scrutiny children who are emotionally vulnerable in 2014/15. Capacity issues in the school nursing service have been raised with providers and commissioners by the BSCB and will remain subject to scrutiny over the next 12 months. There have been no deaths by a suspected suicide in Bury reported to the CDOP this year

External scrutiny of safeguarding arrangements in the Ofsted Thematic Inspection and the *Local Government Association (LGA)'Peer Challenge' Review* found no significant safeguarding concerns in the work they reviewed.

There are many indications that there are effective safeguarding arrangements in Bury with a real commitment to safeguarding children demonstrated by BSCB partners. However the BSCB also recognises that there are significant challenges ahead and is not at all complacent about what more needs to be done to improve. The BSCB is grateful to its members for their continued commitment to safeguarding and to continue to strengthen and improve effective safeguarding arrangements for children in Bury.

Name of partner agency	Key achievements during 2013/14
Adult Services	It is essential that we empower and support our most vulnerable children, when the time comes, with the skills they need in order to navigate the adult world. Where they lack those skills, support links between services must be robust enough in order to make the transition into adult services as smooth as possible. Both Children and Adult social care services have been working hard this year to maintain clear and supportive cross-departmental collaboration in order to ensure successful transitions. Prevention however will continue to remain the key focus of adult safeguarding therefore it is essential that we work not only with our children who are transitioning into adult services to ensure they are best equipped to protect themselves from harm, but also with our counterparts in Children's Services in order to identify areas of risk and need.
Cafcass	Cafcass is a non-departmental public body, sponsored as of April 2014 by the Ministry of Justice. Its principal functions are to safeguard and promote the welfare of children who are subject to family proceedings, and to provide advice to the family courts. It employs about 1870 staff, over 90% of whom are frontline. In 2013/14 a total of 9,680 care applications (public law) were received, which is a decrease of 12% compared with the number received in 2012/13. Similarly there has also been a decrease in private law cases where a total of 42,888 applications were received in 2013/14 - a 7% decrease compared to 2012/13. Shorter case durations (within s31 cases), together with proportionate working and more efficient working practices have led to the stock of open cases reducing in both private and public law. In 2013/14 Greater Manchester Cafcass received a total of 695 care applications. Of these 47 were issued by Bury. Additionally Bury issued 5 discharge of care applications and 4 revocation of placement order applications. A total of 3,083 private law applications were received across Greater Manchester, the highest percentage age group being under 10. The following are examples of activities undertaken by Cafcass in 13/14 to improve practice, better safeguard children and make a positive contribution to family justice reform: Working with partners in family justice e.g. the Family Justice Board, Local Family Justice Boards (11 of which are chaired by Cafcass), judges; the Family Justice Young People's Board; and the ADCS, to promote family justice reform in preparation for the implementation of the Children and Families Act (April 2014). Contributing to the development of the Public Law Outline and Child Arrangements Programme (Practice Directions 12A and 12B respectively); and working with partners to reduce the duration of care

	cases (35 weeks as of quarter 3). Setting up demonstration projects designed to accelerate family justice reform e.g. a telephone helpline service in the North-East to divert from court cases where there are no safeguarding issues. Strengthening the workforce through a number of measures including: the talent management strategy; MyWork (a mechanism by which staff can understand and regulate their own performance); development of a health and wellbeing strategy. Revising the Child Protection Policy, Operating Framework and Complaints and Compliments Policy. Drafting service user minimum standards which will be joined with our workstream on child outcomes. Undertaking a number of pieces of research into the work of Cafcass and family justice including research into: expert witnesses in s31 cases; the work of the Children's Guardian; learning derived from Cafcass submissions to Serious Case Reviews (Cafcass having contributed to 30 such reviews in 13/14). The National Ofsted inspection took place in February and March 2014. Both private law and public law practice were judged to be good as was the management of local services. National leadership was judged to be outstanding. All of the Key Performance indicators, relating to the allocation of work and filing of reports, have been met.
Children's Social Care	The 2012/2013 Annual Report described the local authority Children's Social Care service as being in a state of transition. That Report covered a period in which many changes were taking place, many having been introduced by the new Assistant Director, Social Care and Safeguarding, appointed in January 2013. A service review in early 2013 identified a number of potential improvements that could be made to the performance management and information systems. Limited information about social care demand had meant that too few social workers were in post, particularly in Advice & Assessment (A&A). Better systems were needed to measure service impact and to improve the overall level of service. A service improvement action plan was drawn up. In May 2013 a consultant Head of Improvement was appointed on a temporary contract, to advise on performance measures. Case file auditing was introduced in September 2013. Reports on trends in social care events are now made available to every tier of Social Care management. A new post was created of Strategic Lead, Quality Assurance and Performance Management, to which an appointment is expected to be made in the summer of 2014. Steps are being taken to automate the creation of performance information, such that all managers will have available 'real time' data on team and service performance.

	During the year the Children's Social Care staff group increased in size. Whereas there was previously one Strategic Lead post covering the whole service, from May 2013 separate interim appointments were made for a Strategic Lead (Placement Services) and Strategic Lead (Safeguarding). A permanent appointment was made to the first of these in January 2014 and to the second in March 2014. The A&A service increased from one team manager to three, with an additional team manager being appointed to what became the Multi-Agency Safeguarding Hub (MASH) in October 2013. The A&A team was supplemented with a number of agency social work appointments and was divided into three teams following a duty rota. In addition to the MASH an Early Help service has been formed, delivered by a team which includes four experienced social workers. The Early Help Panel assesses the suitability of cases for help and support. New threshold guidance was introduced in September 2013. The Children with Disabilities service now has within it social workers with substantial safeguarding experience and is led by a social work Team Manager. The review revealed both strengths and relative weaknesses in the safeguarding service. The service's greatest strength is the quality and commitment of many of its staff, as reported through the Local Government Association (LGA) 'Peer Challenge' review conducted in February 2013. The January 2013 Ofsted Thematic Inspection of Early Help services also identified many positive and impressive features, both in individual work with families and in collaboration with other agencies. The LGA advised that the Children's Social Care service should be enlarged. An immediate response was to recruit some agency team managers and social workers but the long-term solution will be to recruit permanent staff. It has been found that the salary structure in Bury places the local authority at a disadvantage relative to its immediate and regional neighbours. To give one example, the Independent Reviewing Officer (IRO) post vacated in December 2012 remains without a permanent replacement, despite two rounds of advertising, and has otherwise been occupied by an agency IRO during the year. Ofsted's new inspection regime for safeguarding and looked after children services took effect in the autumn of 2013. Children's Social Care was throughout the remainder of the year in a state of constant alert and preparation. In anticipation of an inspection the service prepares weekly data lists of all current and recently closed referrals. The lists provide managers with the opportunity to weekly review all referrals involving safeguarding and this has led to a significant improvement in the completeness and accuracy of case recording. It is anticipated that the changes effected during 2013/2014 will become established features of the service in 2014/2015. The Independent Safeguarding Unit is in the process of reviewing and improving all business processes relating the planning and conduct of child protection conferences and reviews; social care and safeguarding quality assurance and performance management will be among the Unit's new functions. Experimentation and testing of the consultation and referral arrangements between A&A, the Safeguarding and Quality

	Assurance Unit, MASH, the Early Help Team and the safeguarding teams is expected to provide for the more certain identification of children in need of help and support, and of services appropriate to their needs.
Clinical Commission-ing Group (NHS Bury)	The last 12 months have been a period settling for the newly reformed NHS and NHS Bury Clinical Commissioning Group (the CCG) have continued to ensure that the wellbeing and safety of children in Bury is a high priority. The CCG continues to work across the Local Authority, the Bury Safeguarding Children Board, the Children's Trust and health providers to meet its aim. The vision for safeguarding within the CCG is to maintain robust, resilient and effective safeguarding services and to strengthen arrangements for safeguarding adults and children across Bury by working collaboratively with partner agencies. NHS Bury Clinical Commissioning Group will prioritise the safety and welfare of children and vulnerable adults across all commissioned and contracted services. The CCG will support and work to empower the health professionals across the health economy of Bury to be confident and knowledgeable in their decision making within safeguarding. To enable the CCG to fulfil its vision the CCG has an Executive Lead for Safeguarding and is accountable to the Governing Body of the CCG, who is a local GP and is an experienced safeguarding professional and is a member of the Strategic Board of BSCB. The CCG also has in place Designated Professionals who are members of the executive group and a number of sub groups of the BSCB. The designated professionals provide support to the named professionals in the health provider services, namely, Pennine Care Foundation Trust and Pennine Acute Hospital Trust. The CCG has a role in monitoring training within the providers and levels of safeguarding activity via an annual audit of safeguarding standards. Primary care services are commissioned by NHS England but the CCG has responsibility to ensure quality and equitable services are provided. Within this remit the CCG remains committed to providing proactive and responsive training for GPs locally and provides training to local GP's and practice nurses and has a rolling programme of training and peer support. During the last year there have been sessions on child sexual exploitation, lessons learnt for serious case reviews and domestic abuse, alongside basic awareness training.
Greater Manchester Police	The Bury Division of Greater Manchester Police (GMP) has been fundamental in supporting our new Multi-agency Safeguarding Hub, working closely with colleagues from the Public Protection Division and our partner agencies. We are proud of the fact that the project has been recognised by the Home Office as an area of good practice and colleagues from other boroughs have visited to see the practices and principles that we have adopted. GMP has increased its resource contribution within the team to support the early identification of children and young people at risk and it is our intention to increase even further with the inclusion of a Detective Sergeant post.

	We are committed to exploring new opportunities for expanding this work with partners, focusing on those individuals and families that are most at risk both as victims or offenders by co-ordinated screening, identification, support and enforcement.
Greater Manchester Probation Service	Quality of Safeguarding Work: This year the Rochdale office has volunteered for an internal audit or NOMs Audit to establish effectiveness of delivery of Child Safeguarding work locally. **Findings from the audit:** **Positive Points** • Found satisfactory to good on Delius contact logs - entries provided sound details of case history and order of events could be followed. • Logs confirmed Offender Managers (OMs) having regular contact with agency partners at key and critical stages of the cases. • Cases are appropriately flagged on the system. • Home Visits when recorded indicated that events were being undertaken with partner agencies. Found some quality recording by OMs. • High risk of harm cases reviews (RAMA) were being completed in a timely manner. • SARA (Risk of Serious Harm tool for Domestic Abuse) reports were found on all applicable case files, and of satisfactory quality. • There was good initial child/children screening found in most standard Pre-sentence reports (PSRs) reviewed. • Sentence plans on the whole reflected safeguarding issues. • Reports to Case Conferences by OMs were timely and meetings were mainly well attended by Officers. **Possible Improvements** (from Bury/Rochdale; Tameside and Salford) • Management focus on Home Visiting - example found in one case where HV not completed – offender did not live with children in this instance. • RAMA reviews to include standard review point on Child Protection (Child/Children Wellbeing - Last seen, how they were, school attending etc) - Reviews varied in this approach. ** New template for immediate implementation agreed. • Standard Child Protection review point to be included within Offender Manager case supervision sessions, eg wellbeing reviews – in all cases not just those of a higher risk/subject to child protection plan or child in need.

	• Standard template for RAMA reviews, found inconsistent recordings within contact logs, some of excellent quality. • Improvement to generic induction form requesting more in depth details of child/children (eg Schools, Known address other than offenders etc). • Trust wide protocol required with Police and DVU's in respect of daily DV call-out intelligence to OM's. However, this is fully implemented already in Bury Domestic Abuse: Findings from recent domestic homicide reviews and serious further offence reviews collated and briefing developed for delivery to staff by end May 2014. MASH: We continue to have daily representation at the MASH with referral information being analysed and information shared in a timely and proficient manner. This can at times include an assessment of non-statutory cases as well as input on those currently subject to probation intervention. There will be a change in attendance at the operational managers' group due to a staff member leaving, but our engagement continues with a view to robust engagement within the screening process. Quality and Performance : The aforementioned focused audit as well as structured random audits demonstrate positive working practices and qualitative information to allow us to understand quality of performance. Toxic Trio Audit information is about to be shared. Serious further offence and case reviews are another source of information which looks at the quality of risk assessment, management planning and intervention delivery. Learning from this is disseminated.
Learning Division	Safeguarding continues as a priority for Bury's Primary and Secondary Schools. This work continues to be well supported by the Safeguarding in Schools and Colleges Sub Group and by work of teams such as the Children and Young People in Care Education Team and the School Attendance Team . There is now a permanent member of the School Attendance Team on the Multi-Agency Safeguarding Hub. In the 23 school inspections undertaken by Ofsted between September 2013 and July 2014 in Bury, 83% of Primary, Secondary and Special Schools were judged to be good or outstanding in respect of the Behaviour and Safety of pupils. 3 schools were judged to have outstanding outcomes: Emmanuel Holcombe CE Primary, St Stephen's CE Primary and Tottington Primary. In 4 inspections – 3 Primary schools and the KS3/4 PRU - Behaviour and Safety was judged to be requiring improvement. However in each of these reports safeguarding was judged to be good whilst behaviour was the aspect that required improvement. These schools will now be receiving additional support from the Local Authority to help them move to Good or better. Attendance at Bury schools is well above national averages and the level of Permanent and Fixed Term Exclusions from Secondary Schools continues to decline, but is still an area for focused work. Over the last year substantial work has been done with schools on anti-bullying,

	including work on homophobic behaviour and bullying of disabled young people. The "Be Safe Be Cool" event for Y9 pupils has continued to be run in every High School and there has also been training provided to High Schools on the Prevent agenda (prevention of radicalisation). In Children's Centres a pilot project in Radcliffe of employing a social worker to support outreach workers on early intervention safeguarding work has proved very effective and will now be rolled out across all our Children's Centres.
NHS England	NHS England Safeguarding People in the Reformed NHS guidance outlines the area team's responsibilities to safeguarding children. Significant changes to the structure of the NHS came into effect on 1 April 2013. New organisations were created and others such as primary care trusts (PCTs) and Strategic Health Authorities (SHAs) were abolished. NHS England is a new national organisation with a local area team covering Greater Manchester. Its main role is to ensure that the overall system of planning and buying NHS services works well and that the NHS delivers better outcomes for patients. NHS England oversees the operation of CCGs making sure they successfully plan and buy services for their local population. It also looks at how well CCGs operate their budgets, engage with their local populations, and deliver the pledges, rights and values in the NHS Constitution. NHS England also plans and buys health services at a national level. These include: • Specialised services (such as those for rare diseases) including Tier 4 CAMHS • Prison health services • Some services for members of the armed forces. • Primary Care e.g. GP services, dentists, pharmacy and optometry. **Our responsibilities for safeguarding children** NHS England 'Safeguarding people in the Reformed NHS' guidance outlines the Area Teams responsibilities to safeguard both Children and Adults who are vulnerable. Our responsibilities are managed through the Greater Manchester Strategic Safeguarding Collaborative which is hosted by the Area Team. A full report is attached as Appendix 2.
Pennine Acute Hospitals NHS Trust	The Trust continues to ensure representation on all LSCBs and LSABs within its footprint. A full report provides evidence to the LSCBs of the safeguarding work undertaken within the Trust to enable it to discharge its duty against national guidance. A copy is attached as Appendix 3. The Safeguarding Team continue to develop systems and processes and work with staff and patients and other agencies to ensure the potential to protect adults at risk is maximised.
Pennine Care NHS Foundation Trust	**State of Safeguarding in Bury for BSCB Annual Report** Pennine Care NHS Foundation Trust (PCFT) provides mental health and community services to people living in the boroughs of Bury, Oldham and Rochdale. We also provide mental health services in Stockport and

	Tameside and Glossop, as well as community services in Trafford. **Community services include:** • Dentistry • Health visiting and school nursing • District nursing • Sexual health services • Cancer and end of life care • Long term conditions management • Health improvement and wellbeing • Learning disabilities • Paediatric and adult therapies PCFT Community Services Bury is committed to working across the Bury health economy in partnership with statutory, non statutory and third sector partner agencies to safeguard and protect children. PCFT contributes to the work of the Bury Safeguarding Children Board (BSCB), Children's Trust Board and Health and Wellbeing Board to achieve this. PCFT Community Services Bury contributes to the wider work of the BSCB with representation on the MASH, SEAM, MARAC and DV Steering groups. Safeguarding is represented at all levels within the organisation with the Executive Director of Nursing as PCFT Board lead for safeguarding. This role is supported strategically by a head of safeguarding. Within Community Services Bury Division, the Service Director has overall responsibility for safeguarding and sits on the BSCB board. This role is supported in Bury by the named nurse and the safeguarding team. The named nurse fulfils the role as outlined in Working Together (2013) and in the Intercollegiate Document guidance 2014. The named nurse ensures advice, support, supervision and training is in place for all frontline staff and provides assurance that PCFT Community Services Bury; fulfil their statutory requirements with regard to safeguarding children. Assurance at Borough level is given via the Quality Governance Assurance Group which reports to PCFT integrated Governance Group and to the Board. Safeguarding children training competencies for all health staff is outlined in the Intercollegiate Document 2014 and is mandatory. All staff are required to undertake safeguarding children training at induction and receive a mandatory refresher every three years at Levels 1 - 3 depending on the post holder's role and responsibility. Safeguarding audit is embedded in the Trust safeguarding calendar and ongoing and new audits are being developed to demonstrate compliance with safeguarding standards. Two cross-borough audits were developed and completed in 2013-14 on *Safeguarding Standards*

	in Record Keeping and *Management of Domestic Abuse Notifications.* PCFT Community Services Bury has representation on the subgroups of the BSCB along with the Executive group and the Board itself. It also contributes to Serious Cases Reviews and any additional critical case reviews and actively participates in multiagency audit. PCFT Community Services Bury will continue to work with partners to maintain and develop good practice in ensuring all children within the borough of Bury are safeguarded and protected.
Third sector	The third sector within the borough has undergone huge changes over the last year and has been impacted by the economic pressures faced by all. According to the Third Sector Survey June 2014 this has heightened unease in the sector not least with the 40% cuts to the Charity Commission itself. The vision for a Big Society where voluntary agencies flourish and take a bigger part in public service delivery is yet to be seen on the whole. Specific to Bury the sector has as always looked to rise to the challenges set before it. There has been consistent attendance at Bury Safeguarding Children Board and the BSCB Executive Group, with information shared within the sector when it is available. The sector has been represented on the Safe Networking Regional Forum and information flow has taken place within the Borough. Training by Bury Third Sector Development Agency (B3SDA) continued to support the sector with free training to smaller groups on Basic Safeguarding through its one day course. It's been over three years since this started and groups in the sector were reminded that they should repeat the course after three years. Three courses were run over the year, which saw over 30 attendees and 14 different small groups local to the borough. The review of the course was started in the year with the help of the BSCB. The sector also attended more advance courses delivered through the BSCB. The sector was also involved in the BSCB Training Needs Analysis to which they responded well. In terms of communication B3SDA has a quarterly newsletter which has carried safeguarding issues and its website has a Safeguarding Section and a link to the Safeguarding Board's website. Agencies were also able to support the Early Help Thematic inspection. The sector expects further infrastructure upheaval in the coming year an element of this will be a commitment to the Children and Young People Forum which is a platform for sharing experience and promoting safeguarding practice. The sector also bid a fond farewell to Barbara Jack Chief Executive of Early Break who retired in the year. She tirelessly represented the third sector on the BSCB for many years and who will be missed for her commitment, foresight and professionalism.

A word from our lay members

The Lay Members have continued to attend full Board meetings, Serious Case Reviews meetings and sub groups (Policies and Procedures and Training and Development), as well as at community level we are both school governors with responsibility for safeguarding. Our governor role provides a view of the practical interpretation and implementation of BSCB policies and recommendations at grass roots level and the opportunity to raise any issues arising.

To further extend our knowledge we have attended various training sessions, including the recent DBS conference. We have also attended an interesting meeting with the Children & Young People in Care Council where participants spoke openly to us about their experiences of services.

From September 2014 the new Children and Families Act will bring significant changes to schools, and to children and families with implications for all Local Authorities and other agencies involved with children, in particular those with SEN, SEND, in the care system or from military families. Working Together 2013 became mandatory for all agencies, creating even further demands on already over-stretched personnel, but hopefully this will be an opportunity to work more closely with families to enable these children to reach their full potential.

It will be interesting to follow the progress of implementation of the act in Bury and to see how tighter partnership working is reflected in all aspects of safeguarding.

Challenges ahead 2014/15

National

- National responses to historic cases of child sexual abuse.
- Impact on resources and the workforce in the context of austerity measures.
- Office of the Children's Commissioner progressing actions to address child sexual exploitation.
- The consultation launched by Ofsted, CQC, HMIC, HMI Probation and HMI Prisons on a targeted programme of integrated inspections of services for children in need of help and protection, children looked after and care leavers. The consultation includes proposals for joint inspections of the effectiveness of local safeguarding children boards.

For the BSCB

- Continuous self assessment so that as a LSCB we are effective and we are making a difference.
- Finance and resourcing challenges.
- Strengthening the voice of the child in all BSCB core activities.
- Strengthening the BSCB Quality Assurance functions by embedding the quality assurance framework.
- Ensuring commissioners have a clear understanding of the needs of vulnerable children in Bury when commissioning services.

For multi-agency safeguarding practice

- The development of a BSCB 'Neglect strategy'.
- The development of the Phoenix Team to tackle child sexual exploitation.
- Safeguarding children & young people from key priority vulnerable groups identified in the BSCB Business Plan 2014/15.
- Working with providers of newly commissioned services to ensure that safeguarding remains a priority.

BSCB Business Plan Objectives 2014/15

This year the Monitoring & Evaluation Sub Group commissioned an independent consultant to develop a revised BSCB Quality Assurance Framework. As part of this work a new approach was taken to the development of the BSCB Business Plan for 2014/15. BSCB Executive group members and sub group chairs were asked to complete a 'Safeguarding Needs Summary Template'. This summary contributed to the development of the business plan for the coming year (2014/15).

In addition to the "Safeguarding Needs Summary", the business plan was informed by the BSCB Hydra Development event, the learning from local research & audits, Serious Case Reviews, the refreshed Joint Strategic Needs Assessment 2014, BSCB Chair dialogue and annual structured sessions with partner agency leads. This has enabled us to identify vulnerable groups warranting higher priority over the next three years.

The Business Plan for 2014/15 has clear outcomes for the BSCB and for children and families in Bury. Each of the BSCB sub groups will draw up their (SMART) work plans based upon the outcomes and milestones in this plan. The plan will be reviewed at every BSCB meeting and in March 2015, new outcomes for each priority group will be considered.

This plan outlines the key priorities for Bury Safeguarding Children Board (BSCB) over the next three years.

Discharge of functions

Regulation 5 of the Local Safeguarding Children Boards Regulations (2006) sets out the functions of the LSCB. In order to fulfil its statutory functions the BSCB has undertaken activity in the following areas:

1. The action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention

In July 2013 the BSCB concluded a consultation with partners on a new 'Thresholds for Intervention' document. The document was endorsed by BSCB in September 2013 and is published on the BSCB website. This guidance is intended to provide professionals with clear thresholds that should be applied consistently to ensure the right help is given to a child at the right time.

To support the guidance the BSCB delivered a series of multi-agency workshops to our partners. In November 2013 the BSCB also held a series of practice workshops on the Graded Care profile tool. The workshops were attended by 89 participants.

2. Developing Policies and Procedures

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

Due to launch of the pan Greater Manchester Safeguarding Partnership (GMSP) policies and procedures in February 2013 the sub group changed the frequency

of meetings from six weekly to three monthly. This project has led to a harmonisation of safeguarding procedures across all ten LSCBs. The GMSP group meets at frequent intervals and there are two updates per year. The BSCB is represented on the group by the Board Manager and by the Designated Nurse for Safeguarding, Bury CCG who is also the sub group chair.

The key areas of work for the 2012/13 have been as follows:-

- All BSCB polices were reviewed to ensure they were compliant with Working Together 2013. Member organisations of the BSCB were asked to review their policies and confirm that they are aligned to WT 2013.

- The group continue to review policies as they reach their review date. This is a large undertaking and takes considerable time.

- The group oversaw the development of a threshold document of intervention for the BSCB. This was launched in the autumn of 2013 with group members being part of the team that rolled it out to front line staff.

- Commenced work on guidance for professionals working with young people who are at risk of self-harm or suicide.

- Consideration is being given to routes of sharing information from the police where young people age 16 and 17 are living in household where there is domestic abuse.

3. Participation in planning of services

a) Phoenix Team

The CSE & Missing Sub Group was established in 2013 to oversee the implementation of the action plan developed by the Task and Finish Group that preceded it.

In a busy first year the group had three priorities:

- To ensure that there was an effective response to CSE in Bury;
- To develop a greater understanding of and response to children who go missing;
- To embed the use of the SEAM process.

<u>To ensure that there is an effective response to CSE in Bury</u>

A programme of awareness-raising for new staff in frontline services was maintained throughout the year, to ensure that the level of awareness of CSE was maintained at that of the previous year during which an extensive training programme had been delivered. Elected members were also invited to attend as it was felt important they should be aware of the issue. Training aimed at workers who may work directly with young people affected by CSE was also available. The uptake of training and feedback about the courses was consistently good. A follow up questionnaire indicated that awareness amongst participants was embedded.

The group considered the Government's response to the Home Affairs Select Committee report and concluded that the most effective way to ensure a consistent response to CSE was through participation in the Greater Manchester Project Phoenix. The approach was to secure a multi-agency team of specialist staff to work together to provide a co-ordinated response to young people and families affected by CSE and a CSE consultancy service to professionals. The team could work across Local Authority boundaries as part of a coordinated response if required. As the project had been led by Greater Manchester Police, police officers had already been identified to work exclusively on CSE cases; a bid from members of the sub group to the Local Authority for funding for social care staff was successful and Early Break (young people's substance misuse service) also committed to the project. A BSCB request for Public Health funding is still being considered.

The Team will be fully operational in July 2014.

<u>To develop a greater understanding of and response to children who go missing</u>

The group was aware that children who go missing were also in need of a more coordinated response and that this was an area where early identification and intervention might play an important preventative role. The group undertook a review of the procedures and practice in place and concluded that whilst the notification process by the Police was effective, Children's Social Care was not effective in its response and monitoring of these cases. The sub group oversaw work on the establishment of more effective practice in Children's Social Care that included a differentiated response for children who go missing for the first time, children who were the subject of Child in Need or Child Protection plans and children who go missing from care, including those who are children resident in Bury but looked after by other Local Authorities.

Improvements in the way the Emergency Duty Team record their work and changes to the electronic record system led to an immediate improvement in management oversight and the introduction of a pro-active approach to children who go missing from the Early Help Team has led to a significant improvement in Children Social Care practice.

The group reviewed the progress made against the Government's Statutory Guidance on children who run away or go missing from home or care, issued in January 2014 and used this as an opportunity to update practice and procedures.

The changes made in the way cases are managed and recorded will mean that more effective reporting to the BSCB will be in place in 2014/15.

The group was also mindful of the vulnerability of children who regularly go missing from school. In line with the DfE Guidance on missing from school the School Attendance Team has established a reporting mechanism for schools and a response from their service. There is a concern that two secondary schools in the borough do not buy their service and children missing from these schools may go unreported and enquiries may not be made into the circumstances of their absences. Work on this area will continue in 2014/15.

To embed the use of the SEAM process

The group has received regular reports and had the opportunity to comment on the operation of the SEAM process. In particular the group identified as part of its missing strategy that it would like to see more referrals to SEAM of children who go missing before CSE is identified as a concern. This will be the focus of an awareness raising exercise in 2014/15.

It is likely that the operation of the SEAM group will need to be reviewed once the Project Phoenix Team is operational and its practice embedded.

A full report from the SEAM Panel is available as Appendix 4 to this report.

Future plans

The group envisages that much of its work in 2014/15 will be to monitor the systems that have been put in place during the year; to ensure that good practice is properly embedded and that the linked issues of CSE and children missing from home and school continue to be recognised and young people and their families receive a timely and effective response. In order to reassure the BSCB that this is the case the group will undertake a multi agency audit of compliance by agencies with the recommendations arising from SEAM and will be making quarterly reports to the BSCB on children missing from home and care.

b) Multi-Agency Safeguarding Hub (MASH)

This year the BSCB has overseen the development of a Multi-Agency Safeguarding Hub (MASH). The MASH became operational in October 2013 and is the single point of contact for all safeguarding concerns regarding children and young people in Bury. It brings together designated officers from Children's Social Care, Police, Education, Probation, Health and Six Town Housing, who are now co-located within Bury police station. The team have responsibility for screening and risk assessing referrals and making decisions as to the most appropriate intervention or signposting to other agencies to meet identified need. Consultations are ongoing through the MASH strategic partnership group to identify and secure additional stakeholders to ensure that there is effective cross organisational representation and communication in decision making to safeguard children. Early identification of vulnerability, timely responses and targeted allocation of resources is one of the central objectives of the MASH. The BSCB receives six monthly performance reports detailing progress and developments in practice.

c) Domestic Abuse Strategy

The Bury Domestic Violence Strategy highlights the need for services to support children, education and reassurance that it is not their fault and opportunities to share their experiences. Partner agencies respond to this in a variety of ways; Police always refer children who have witnessed domestic violence to Children's Social Care, where a risk assessment is undertaken and support from a specialist children's worker is offered to children; most secondary schools have commissioned a service to counsel young people affected by domestic violence and ways of extending this to

younger children are being explored as the new strategy is being developed. As part of the strategy Children's Social Care have also commissioned Barnardo's to work with couples with children who want to stay together, the programme is child focussed assessing risk as the work develops and giving parents strong messages about the impact of domestic violence on children's health, development and emotional well being.

Young people who have affected by violence for partners are also now receiving support from the Young People's Violence Advisor, a new role for which a social worker from the Early Help Team has been trained by CAADA.

In an initiative arising out of the recommendations of a Serious Case Review a discussion was held between representatives of the SCR sub group and colleagues from adult services arising from which a number of services agreed to review their training on Domestic Violence to ensure that it dealt with the impact on children and the pathways for referrals of Safeguarding issues.

The Domestic Violence Strategy is under review in 2014 and the Business Group of the Board will receive regular reports to ensure the needs of children, young people and families are addressed within it.

4. Communicating and raising awareness

Key Achievements:

- The BSCB has reviewed and revised its Communication Strategy this year and this can be found on the BSCB website link to website www.safeguardingburychildren.org

- The BSCB has developed specific training events 'road shows' in response to emerging issues such as the lessons learned from our Serious Case Reviews, the Graded Care Profile & the DASH in order that the messages get out to front line staff.

- The BSCB website www.safeguardingburychildren.org has been upgraded this year and contains up to date information on key safeguarding issues and procedures, links to useful web sites, a page for children and young people, training information and training dates.

- The BSCB produces a quarterly communication e-bulletin which summarises recent BSCB activity. This is widely disseminated via e-mail.

- The BSCB lay members have promoted the work of the BSCB to community groups helping to improve public understanding of the BSCB's safeguarding work.

Lay members have:

- Represented the BSCB at the Bury Youth Cabinet.

- Represented the BSCB the North West Safe network.

- Represented the BSCB at a regional NHS England Safeguarding event.
- Represented the BSCB at a Bury third sector safeguarding event.
- Met with a focus group of young people from the Children in Care Council and reported key messages to the BSCB.

5. Recruitment and supervision of persons who work with children & investigation of allegations concerning persons who work with children

Key Achievements:

- The BSCB has delivered Safer Recruitment Training to 34 participants. The Bury Local Authority Designated Officer (LADO) has delivered Managing Allegations training to 27 participants from a wide range of partners.
- The Bury LADO has delivered targeted Managing Allegations training to a local secure mental health provider in response to emerging issues.
- In response to the learning from a national Serious Case Review (East Sussex) and a local critical case the Bury LADO has delivered an awareness session to Bury high schools and college staff. This focused on the use of personal social media and the inappropriate engagement with pupils through such mediums. The take up of this offer was high and the presentation was provided to 14 Bury high schools and colleges.
- In October 2014 in response to a critical case the Serious Case Review Sub Group undertook an audit of Safer Recruitment practice with all Bury high schools. High schools were requested to provide the BSCB with assurances around safer recruitment, managing allegations and safeguarding training. Responses have been followed up both by the Safeguarding in Schools & Colleges Sub Group and the Serious Case Review Sub Group.
- The Managing Allegations Training & Safer Recruitment Training has been revised to include the learning from national Serious Case Reviews and local critical cases. A full annual LADO report can be found as Appendix 5 to this report.

6. Safety and welfare of children who are privately fostered

The Private Fostering Steering Group was disbanded this year in favour of establishing a Safeguarding Children and Young People Living Away from Home Sub Group with a private fostering lead from Children's Social Care being identified. The full BSCB Private Fostering annual report can be found as Appendix 6 to this report.

Key achievements:

- The BSCB has continued a programme of awareness raising through BSCB training and by partner agencies.
- Publicity material has been made available in a range of languages. The material emphasises the legal requirement to notify the Local Authority and includes a variety of information within a poster and three leaflets; for parents & carers, children & young people & professionals.

- This year the number of private fostering arrangements identified has increased from 1 to 6.

7. Training

The BSCB Training & Development Sub Group is responsible for the implementation of the BSCB training strategy. Key achievements this year have been:

- *The development of a quality assurance framework*: The BSCB multi-agency trainer now submits a quarterly performance report to every Training & Development Sub Group meeting. This report contains an analysis of feedback from course participants, evidence of course revision including messages from local and national research, serious case reviews and policy development.

- *Single agency Group 3 safeguarding training*: Agencies/organisations that do not have their own well-established single agency training arrangements can purchase single agency training from the BSCB. In 2013/14 the sub group has delivered 8 one day courses to a range of private providers. This year a follow up audit was undertaken with course participants. All participants followed up rated the course as 'excellent' or 'good'. Participants were also asked to cite examples of how they had put the training into practice. Examples cited were being more confident in recognising signs and indicators of abuse and cascading the learning within their own organisation.

- *Further audit activity:* In September 2013 the sub group undertook an audit to test the impact of a series of CSE learning events on practice. The responses received were considered by the CSE & Missing Sub Group & the Training & Development Sub Group in October 2013. Responses included testimonial evidence from participants who cited examples of how they have put the training directly into practice.

- *Learning & Improvement Framework:* In response to the learning from Serious Case Reviews the BSCB has delivered a one day course 'Working with Black African Children & Families', we have also commissioned a new course 'Professional Challenge' in child protection decision making forums to be delivered in June 2014.

- The BSCB Multi-Agency Trainer has revised the BSCB Domestic Abuse training to include key learning from these reviews and from a Domestic Homicide Review undertaken by the Community Safety Partnership. The BSCB has also commissioned an external auditor from HAARV to review the BSCB Domestic Abuse training.

- The sub group has undertaken a refreshed training needs analysis. Responses were received from 25 partners. All responses have been scrutinised by the sub group to maximise learning across the partnership.

The analysis will inform the BSCB strategy over the next twelve months. A copy of the Training Needs Analysis can be found as Appendix 7 to this report.

- Training figures can be found at Appendix 8.

8. Cooperation with neighbouring children's services authorities and their Board partners

Bury Safeguarding Children Board collaborates on a Greater Manchester basis with other Greater Manchester Local Safeguarding Children Boards and is represented on the Greater Manchester Safeguarding Partnership (GMSP). The GMSP consists of representatives from all Local Safeguarding Children Boards and key agencies across Greater Manchester and coordinates collaborative projects and promotes a consistency of approach. The BSCB continues to be involved in the development of the pan Greater Manchester Multi-Agency Safeguarding Procedures.

This year the BSCB also participated in the GMSP's development of a multi-agency training tool 'Voice of the Child'. This powerful film was made by young people across Greater Manchester, who have all had experience of professional support from a wide range of services. It has been developed as a training resource for staff development and learning and serves as a reminder of why it's important to listen to the voice of the child. The BSCB held a Communicating with Children and Young People learning event on to launch the DVD on 4 February 2014 attended by 25 participants.

9. Monitoring effectiveness

The BSCB's responsibility for monitoring the effectiveness of safeguarding practice is carried out by the Monitoring & Evaluation Sub Group. The work of the sub group was challenged this year by a number of changes of key personnel. The sub group was chaired by the Interim Service Manager Safeguarding Unit from April to December 2013. Since January 2014, the sub group has been chaired by the BSCB Board Manager, pending the appointment of a Strategic Lead for Quality Assurance by Children's Social Care. The post holder will assume the responsibility for chairing the sub group when recruited. Despite these challenges the key achievements of the sub group this year have been:

- *Quality Assurance framework*: The sub group has revised the terms of reference for the sub group including the commissioning of an independent consultant to develop a BSCB Quality Assurance Framework. This has included a revised multi-agency data set (published on BSCB website).

- *Multi-agency audit activity:* An audit of the extent of practitioners' understanding of the *Concealed and Denied Pregnancy* procedure (developed in response to the learning from a Serious Case Review) was co-ordinated by the sub group during January & February 2014. Responses were analysed by the sub group and demonstrated that awareness of the procedure remains high across the Bury Children's Workforce.

- In September 2013 the sub group undertook a multi-agency audit of domestic abuse practice. Domestic abuse was identified as a key priority area for scrutiny in the BSCB Business Plan 2013/14. The audit was conducted between October & December 2013. The methodology was that each agency representative audited a sample of cases. In all cases chosen the children were subject to a child protection plan (14 children in total). The auditors considered their own agency findings, and results have been compared the recommendations will form part of a multi-agency tracker to monitor progress to be overseen by the sub group.

- A section 11 audit of statutory partners' compliance with their duties under section 11 of the Children Act (2004) to safeguard and promote the welfare of children has been undertaken. All section 11 statutory partners were requested to complete the audit by 17th April 2014. Although the audit has been slightly delayed by the purchase of the tool BSCB members considered that the delay was purposeful as the tool brings added advantages in terms of data analysis and efficiency. The sub group will be responsible for analysing the findings and this action will be carried forward to the sub group action plan for next year.

- *Child Protection Conference Audit:* In response to a recommendation from a Serious Case Review the BSCB has undertaken a multi-agency audit of observations of child protection case conferences. The recommendations will form part of a multi-agency tracker to monitor progress to be overseen by the sub group.

- The sub group now receives reports from the Children in Care Council reflecting the experiences of children who are in public care in Bury. In 2014/15 we are looking forward to hearing the voice of children and young people who are subject to a child protection plan leading on from the implementation of an advocacy project.

10. Serious Case Reviews

The BSCB Serious Case Review Sub Group oversees and quality assures all Serious Case Reviews (SCRs) undertaken by the BSCB. The sub group is also responsible for screening cases as and when necessary and determining whether any new reviews should be initiated and if so under which model the review will be conducted. The sub group is also responsible for monitoring the implementation of the action plans arising out of reviews. The sub group is also responsible for the implementation of the Learning and Improvement Framework in conjunction with the Training & Development Sub Group.

The Serious Case Review Sub Group has met at a minimum frequency of every eight weeks with a settled membership. This year the sub group has concluded three Serious Case Reviews. The sub group has considered the implications of Working Together (2013) in respect of the BSCB's responsibility for the conduct of Serious and Critical Case Reviews. Whilst the criteria for Serious Case

Reviews has not changed the expectation is that more cases will fall within the remit of Critical Case reviews and screening panels should exercise their judgement to include a wider range of cases within the review process. Working Together (2013) also gives the BSCB the opportunity to conduct reviews in a way that is proportionate to the needs of the case and following different models. Using this flexibility the sub group commissioned the most recent SCR (C13) to be held as a Learning Review Event.

- The first Serious Case Review (E12) concerned the death of an eleven week old baby girl (Baby E). It was reported that her parents had been drinking at home and both fell asleep, the mother on one sofa with the baby and the father on another sofa by himself. The Serious Case Review findings were discussed at Bury Safeguarding Children Board on the 8th July 2013 and recommendations agreed. Due to concerns expressed by BSCB that members of the family would be identified if the Overview Report was published in full, an Executive Summary was commissioned. With the agreement of the National Serious Case Review Panel the Executive Summary was published on 21st February 2014.

- The second Serious Case Review (B13) followed the death of a 17-year old young person (Child F). The young man was looked after by the local authority and placed in supported accommodation for young people aged 16 years and over. On the 3rd February 2013 Child F went missing. He was later found on the 4th February 2013 and had used a cord to hang himself. The Serious Case Review findings were discussed at Bury Safeguarding Children Board on 21 August 2013. The report was published in full on 21st February 2014. In response to the recommendations made, the BSCB established a Task & Finish Group to develop a multi-agency suicide & self-harm pathway/procedure. A multi-agency training course is also being developed to raise awareness of mental health issues in young people. A joint Working Together protocol has also been established between Housing Choices and Children's Services that aims to tackle and prevent homelessness of sixteen and seventeen year olds.

- The third Serious Case Review (C13) concerned the circumstances of a child aged 8 years old, who suffered a fatal asthma attack (Child H). At the time of his death Child H was subject to a child protection plan. The Serious Case Review on Child H (Case C13) was submitted to an extraordinary Bury Safeguarding Children Board (BSCB) meeting on Monday 6 January 2014. BSCB members agreed to accept the Serious Case Review Report and multi-agency action plan for submission. The report was published in full on 17th April 2014.

The learning from all three reviews has been disseminated to front line professionals by the BSCB. During February, March & April 2014 the BSCB held a series of SCR Learning Events to promote the lessons learned. The events were attended by 131 professionals from a wide range of agencies. Audit activity to assess the impact of the learning events on practice will be undertaken in the year 2014/15.

11. Child Deaths (Child Death Overview Panel)

In April 2008 Bury, Rochdale and Oldham joined to form a tripartite arrangement. The joint working of the three local authorities provides a wider data set to conduct analysis and investigate emerging trends. This year we

have welcomed the enhanced contribution to the CDOP from partners in Public Health who have agreed to chair the CDOP on a rota basis from January 2014. The CDOP is currently chaired by the Oldham Director of Public Health.

There has been no significant rise or fall in the number of deaths reported to the CDOP since 2008. Excluding 2012, Oldham has been the local authority with the largest number of child deaths each year and has the largest child population of the three local authorities. Of the three boroughs Bury continues to have the lowest number of child deaths year on year and has smallest child population of the three local authorities.

The 2007 Index of Multiple Deprivation average score gave Bury a national rank order of 122 out of 342 of the most deprived districts in England. Of the three local authorities, Bury is the most affluent and has much smaller pockets of deprivation in comparison to Rochdale and Oldham. Bury has the smallest child population (41,952) of the three local authorities as well as the comparatively lower levels of deprivation.

This year the CDOP has reviewed the deaths of 18 Bury children. In Bury chromosomal, genetic and congenital anomalies account for the most common cause of death followed by complications relating to a perinatal/neonatal event. One child died from a life limiting condition, one child was suffering from a terminal illness, one child died as a result of an asthma attack. This last case has been subject to a Serious Case Review (SCR C13).

In 2012/13 the CDOP reviewed 5 child deaths following a suspected suicide. All 5 children died as a result of hanging which all occurred at the parental home. The largest number of those deaths occurred in 3 children (60%) resident in Bury. In response to the death of one of those young people the BSCB has undertaken a Serious Case Review (SCR B13) concluded and published this year.

There have been no deaths following a suspected suicide reported to the CDOP in 2013/14. The BSCB has however identified children who are emotionally vulnerable as a priority group in the BSCB Business Plan for 2014/15.

Effectiveness of the BSCB

Through the work of the BSCB we have continued to monitor our effectiveness and functioning. We have undertaken BSCB development activity in the form of a MACIE Hydra event. The BSCB has also participated in external an Ofsted Thematic Inspection of Early Help and a Local Government Association (LGA) 'Peer Challenge' review.

In October 2013 a *Hydra Multi-Agency Critical Incident Exercise (MACIE)* was delivered by the College of Policing. As part of this event BSCB members participated in a multi-agency scenario of safeguarding practice.

At this event the following emerging eight themes were identified for further action by BSCB:

- Walking in the child's shoes
- Celebrating and learning from success

- Multi-agency work & understanding the perspectives of others
- Austerity
- Making a difference
- Communication and positive relationships
- Challenging normality the experts and poor practice
- Maintaining confidence in staff and providing motivation

In January 2014 the BSCB participated in an *Ofsted Thematic Inspection of Early Help*. Inspectors found:

- No significant safeguarding concerns in the work they looked at.
- There is strong partnership working and there are clear lines of accountability within the BSCB & Trust; mechanisms are there to provide challenge.
- We know ourselves well and have a realistic understanding of where we are. We know our own areas for development.
- There is a clear understanding of priorities and of the collective needs for commissioning services. We know where the gaps are and are using the local knowledge below the JSNA to identify gaps in service.
- Learning from Serious Case Reviews was evident in all the practitioners spoken to.

Areas for Development identified were:

- At a strategic level we need to strengthen the partnership and input from adult services.
- The recording of the child's voice & experience need to be strengthened.
- Feedback from families needs to be consistently sought to inform planning & to review impact of the help provided.

In February 2014 the BSCB participated in a *Local Government Association (LGA) 'Peer Challenge' review.*

In response to feedback from that review the BSCB has:

- Revised the agenda for BSCB meetings, to ensure that challenge is more explicitly recorded in BSCB minutes.
- Reviewing and clarifying expectations of inter agency co-operation with regard to strategy discussions and/or meetings and holding agencies to account for any non compliance.

The BSCB has also raised challenges this year with a number of our partners. A challenge log is regularly updated by the BSCB Interim Board Manager. Areas for scrutiny this year have included:

- high social work caseloads;
- rising numbers of child protection plans;
- attendance by key agencies at BSCB meetings and at strategy meetings;
- pre-birth assessments;
- engagement with MASH;
- partnership working;
- uptake of preventative CSE work;
- capacity in the school nursing service; and
- the welfare of young people placed in secure mental health settings .

Multi-Agency Safeguarding Performance Data

Table 1: Contacts and Referrals

	Total initial contacts (number)	**Accepted as Referral (number)**	**Dealt with as Contact only (number)**	**% of contacts proceeding to referral**
Full year 2009-10	2875	1956	921	68%
Full Year 2010-11	3775	2647	1128	70%
Full Year 2011-12	5088	3337	1751	66%
Full Year 2012-13	7876	1818		23.1%
Full Year 2013-2014	**8613**	**3215**		**37.3%**

- **There has been a slight upward trend in the Contacts measured over the last twenty-four months (April 2012 – March 2014)**
- **The figures pre and post 1 April 2012 cannot be compared because of changes in definitions and thresholds**
- **Conversion rate of Contacts to Referrals increased markedly in 2013-2014**
- **Previously published provisional figures for 2012-2013 have been updated**
- **The number of Contacts increased relative to the previous year, though the most significant change was in the rate of conversion from Contacts to Referrals.** The growth in Referrals is likely attributable to several factors, including changes in staffing, the introduction of the MASH and relaunch of revised threshold guidance.

Table 2: Contact sources

Contact source	Percentage of Contacts* 2011-2012	Percentage of Contacts 2012-2013	Percentage of Contacts 2013-2014
Police	40%	34%	48.7%
Via Emergency Duty Team (EDT) and social care	8%	6%	2.5%
Health	12%	10%	10.1%
Education	10%	12%	9.8%
Members of the public (including family)	4%	6%	11.0% (includes anonymous and self referrals)
Voluntary agencies	4%	2.5%	0.0%
Other local authorities	4%	5%	2.3%
Probation	2.5%	3%	0.3%
Housing	3%	2%	2.7%
Other sources	12%	19.5%	11.8%

*Note: The RAISE recording system did not distinguish between Contacts and Referrals. Figures for 2011-2012 are based on a distinction by outcome in order to provide a reasonable comparison between successive years.

- **The largest number and the greatest proportion of Contacts and Referrals come from the Police.** The most frequently recorded factor in police Contacts and Referrals is domestic violence, often associated with drug and alcohol misuse in the presence of children. The number and rate of Children's Social Care Referrals is therefore open to the influence of changes in policing policy and practice.

- **Preliminary analysis suggests a relationship between referring organisation and Referral outcome.** Referrals from organisations or individuals than know the child and family well (e.g. schools and health visitors) tend to progress to assessment.

- **A repeated referral rate to Social Care within 12 months of previous referral was 24.7%.** This represents a slight increase over last year's figure of 24%.

- **The number of Initial Assessments commenced increased significantly** from 1646 last year to 2571 this year.

- **The conversion rate from referral to Initial Assessment increased from 49% in 2012-2013 to 80.9%.** The conversion rate was previously improbably low compared with the then national average of 75% and the statistical neighbour rate of 78%. The conversion rate for 2013-2014 was within the range of what would be expected.

- **Timeliness of Initial Assessments remained poor, though an improvement on the two previous years.** Of the assessments commenced in the year, 54.3% were authorised within 10 working days. Of the assessments completed within the year, 62% were finished by the social worker and 57.4% were authorised by a manager. The 2012-2013 mean average for an extended group of statistical neighbours was 76.3%

- **There was a massive growth in the number of Core Assessments commenced in the year.** 1715 assessments commenced, compared to 601 in 2012-2013 and 573 in the year before that. Bury's rate of completed Core assessments in 2012-2013 was 131.1, well below that of the extended group of statistical neighbours at 211.7. For 2013-2014 the annualised rate per 10,000 child population was 328.6, which is a rate higher than for any comparable local authority.

- **The timeliness of Core Assessment has improved slightly in three years, but remains very low relative to the standard (i.e. authorisation within 35 working days) and to the extended statistical neighbour average.** The 2012-2013 report estimated that 48% of Core assessments in the year had been finished in time. Of the assessments commenced in the year, only 45.5% were authorised within 35 working days. Of the 2013-2014 assessments completed within the year, 65.4% were finished by the social worker and 57.3% were authorised by a manager. The 2012-2013 mean average for an extended group of statistical neighbours was 76.7%

- **The conversion rate from Section 47 Child Protection investigations to an Initial Child Protection Conference was 47.7%.** This figure represents a drop from 53.5% in the previous year but remains well above the 36% achieved in 2011-2012 and is broadly in line with the England average.

Conference Activity

There has been a dramatic reversal in the number of children subject to Child Protection plans. 115 children were subject to plans at 31 March 2013; 222 were subject to plans at 31 March 2014.

The growth is children subject to plans reflects an increase in commencements and a reduction in the number of children ceasing to be on plans. 299 plans commenced in the year, by comparison with 181 in 2012-2013; 192 plans ended, compared to 227 in 2012-2013.

The number of conferences held has almost doubled in two years.

The number of conferences resulting in a child protection plan has doubled in two years.

The rate of conversion from conference to CP plan has remained almost constant. 82.4% of Initial Child Protection Conferences held in 2013-2014 resulted in a plan.

Relatively few children remain the subject of plans for more than twelve months. The proportion of children of children on plans of less than twelve months at 31 March 2014 reflects the large number of plans that commenced in the year.

Table 3: **Current length of time subject to a plan**

Subject to plan as at end of:	Subject to plan less than 12 months	Subject to plan between 12 and 18 months	Subject to plan between 18 and 24 months	Subject to plan longer than 24 months	Total
March 2013	100	10	4	1	115
June 2013	130	8	2	1	141
September 2013	170	11	5	1	187
December 2013	202	10	4	1	217
March 2014	207	9	3	3	222

Table 4: Child protection conference activity

	Full Year 2011-2012	Full Year 2012-2013	Full Year 2013-2014	Q1 Apr-Jun 2013	Q2 Jul-Sep-2013	Q3 Oct-Dec 2013	Q4 Jan-Mar 2014
Total number of initial conferences held	105	124	**194**	**39**	**60**	**50**	**45**
Number of conferences resulting in CP plan	89	105	**160**	**36**	**49**	**39**	**36**
% of conferences resulting in CP plans	85%	85%	**82.4%**	**92.3%**	**81.6%**	**78%**	**80%**
Number of children involved in conferences	221	217	**369**	**78**	**115**	**98**	**78**
Children made subject to CP plans at conference	192	181	**299**	**70**	**90**	**78**	**61**
Total number of plans ended in period	208	227	**192**	**44**	**44**	**48**	**56**
Number (temporary) other local authority plans at end of period	11	4	**8**	**2**	**9**	**6**	**8**
Number of Bury children subject to plans at end of period	162	115	**222**	**141**	**187**	**217**	**222**
Total number of plans at end of period	173	119	**230**	**143**	**196**	**223**	**230**

Categories of Plan

One third of plans as at 31 March 2014 cite 'Neglect' and over a half cite 'Emotional abuse'. 'Emotional abuse' invariably incorporates domestic violence as a background factor and appears in almost exactly the same proportion as in the previous year.

The percentage categorisation of 'Neglect' is lower than the most recently published statistics for England as whole, which was 41.7% and lower than for 'Emotional abuse', which was 34.1% (CIN Census, 2012-2013, Table D4). The most noticeable divergence from the England statistics is in the 'Multiple' categorisation. This will almost certainly reflect differences in recording conventions rather than the distribution of risk.

Table 5: Current Child protection plans by category (as at 31st March, not necessarily the category that initially applied)

Category	**Bury March 31st 2012**	***England March 31st 2012***	**Bury March 31st 2013**	***England March 31st 2013***	**Bury March 31st 2014**
Neglect	64 (39%)	*42%*	38 (33%)	*41.7%*	**74 (33.3%)**
Physical abuse	19 (12%)	*11%*	12 (10%)	*9.9%*	**22 (9.9%)**
Sexual abuse	11 (7%)	*5%*	3 (3%)	*4.7%*	**6 (2.7%)**
Emotional abuse	68 (42%)	*29%*	63 (54%)	*34.1%*	**118 (53.2%)**
Multiple categories	0	*13%*	0	*9.5%*	**2 (0.9%)**
Total number of Bury plans	162		116		**222**

Children subject to Child Protection Plans – by Age

The age profile of children subject to a plan is broadly in line with the average for England.

Table 6: Child Protection Plans by Age

Age	Bury March 31st 2012	*England March 31st 2012*	Bury March 31st 2013	*England March 31st 2013*	**Bury March 31st 2014**
Unborn	-	*2%*	-	*2.0%*	**-**
Under 1 year old	13 (8%)	*11%*	14 (12%)	*11.3%*	**25 (11.3%)**
1-4 years	47 (29%)	*31%*	47 (40%)	*30.3%*	**64 (28.8%)**
5-9 years	40 (25%)	*29%*	31 (27%)	*28.7%*	**64 (28.8%)**
10-15 years	56 (34%)	*25%*	22 (19%)	*25.2%*	**61 (27.5%)**
16 years and over	6 (4%)	*2%*	2 (2%)	*2.6%*	**8 (3.6%)**
Total	162		116		**222**

Time subject to Child Protection Plan

There has been a decrease in ceased child protection plan which were of lengthy duration. Only 2 of the 192 plans ended were of 2 years+ duration (1%). In 2012-2013 16 plans of 2 years+ duration ended, equating to 6.8% of the 234 plans ended in the year, which is very high (England average for 2012-13 was 5.2%).

Table 7: Ceased Child Protection Plans by length subject to a CP Plan

Length of time subject to plan when ended	Number of Bury plans ceased full year 2011-12	*% plans ceased England 2011-12*	Number of Bury plans ceased full year 2012-13	*% plans ceased England 2012-13*	Number of Bury plans ceased full year 2013-14
Under 3 months	35 (17%)	*20.4%*	32 (13.7%)	19.3%	45 (23.4%)
3 to 6 months	16 (8%)	*9.7%*	34 (14.5%)	10.1%	38 (19.8%)
6 months but under 1 year	105 (50%)	*38.3%*	95 (40.6%)	39.0%	79 (41.1%)
1 year but under 2 years	49 (24%)	*25.9%*	57 (24.3%)	26.4%	28 (14.6%)
2 years and over	3 (1%)	*5.6%*	16 (6.8%)	5.2%	2 (1.0%)
Total	208		234		192

Repeated Child Protection Plans

The rate of repeat Child Protection plans has risen. The 2012-2013 rate was below the England average of 14.9% and was judged to be 'Good'. The 2013-2014 rate, though higher than that of statistical neighbours and England in previous years, possibly reflects the recovery of plans closed without full resolution in 2012-2013.

Table 8: Repeated child protection plans – percentages

	2010-11	2011-12	2012-13	2013-14
Bury	17.9%	20.3%	12.3%	**19.7%**
Statistical neighbours	11.6%	13.1%	14.4%	
England	13.3%	13.8%	14.9%	

Table 9: Conference monitoring: practice issues

	2011-12 Full year	2012 – 13 Full year	**2013 – 14 Full year**
Number of Initial Conferences held (families)	105	124	**194**
Conferences within 15 day timescale of initiating strategy meeting	91%	93.5%	**75.6%**
Parents seen Social Work report before conference	60%	74%	**80.9%**
Parents seen other agency reports before conference	Not recorded	61%	**54.6%**
% Initial conferences starting late	67%	59%	**54%**
Child's views recorded in initial conference reports	66%	90%	**52% (43% too young to express views)**
Number of Reviews held (families)	257	239	**280**
Reviews within time	99%	100%	**99.96%**
Child's views recorded in review conference reports (where applicable)	78%	79%	**50% (49.6% too young to express views)**
Number of reviews where children visited at standard monthly expected frequency (%)	219 85%	85%	**90.35%**
Number of reviews where core groups took place at required frequency (%)	220 86%	87%	**82.14%**
Number where plan progressed appropriately between reviews (%)	215 84%	80%	**74.28%**

Table 10: Attendance at Initial & Review Conferences

INITIALS	No. attending / total possible	%	REVIEWS	No. attending / total possible	%
Parents	172/194	89%	Parents	248/262	95%
Health Profs (HV/SN)	190/218	87%	Health Profs (HV/SN)	299/315	95%
Mental Health	13/19	68%	Mental Health	8/21	38%
CDAT	17/32	53%	CDAT	26/44	59%
CAMHS	8/17	47%	CAMHS	20/55	36%
Midwifery	32/43	74%	Midwifery	0/0	n/a
Education	135/168	80%	Education	162/243	67%
Children's Centres	64/110	58%	Children's Centres	128/148	86%
Police	152/192	79%	Police	6/248	2%
Probation	24/35	69%	Probation	36/73	49%
Social Worker (Current) Social Worker (Receiving)	193/195 73/131	99% 56%	Social Worker (Current) Social Worker (Receiving)	239/243	n/a 98%
Other	72/111	65%	Other	113/146	77%

SAFEGUARDING PERFORMANCE INFORMATION FOR CHILDREN IN CARE

Number of children and young people

Bury's LAC population has gradually declined from a high point in August 2012.

The rates for England, the North West and the statistical neighbour group rose between 2011-2012 and 2012-2013, continuing a trend evident since 2009.

Bury's rate was noticeably higher than all three comparative measures until October 2012. Bury's rate had fallen below the North West average by November 2012 and by February 2014 had fallen below the 2012-2013 mean for the extended group of statistical neighbours.

The month-end population rate in February and March 2014 was the lowest for three years.

At the end of March 2014 there were forty fewer children Looked after than eighteen months previously.

Table11: Number of Looked After Children per 10,000 child population

	2008 - 2009	2009 - 2010	2010 - 2011	2011 - 2012	2012 - 2013	2013 - 2014
Bury	67.1	69	77	77.6	76.7	73.4
Statistical neighbours	58.5	59.9	63.8	66	68	Not available
England	55	58	59	59	60	Not available
North West region	71	75	77	76	79	Not available

Table 12 Number of Looked After Children at 31 March 2014

	2008 - 2009	2009 - 2010	2010 - 2011	2011 - 2012	2012 - 2013	2013 - 2014
Number of looked after children	285	290	324	326	322	310
Child population	42,450	42,045	42,082	41,993	41,971	42,219

Registered Common Assessments between 1st April 2013 – 31st March 2014

Performance and activity

There were 439 CAFs registered in Bury between 1 April 13 and 31 March 14, this figure shows a decline of 74 registered CAFs in comparison to the previous year. However, due to changes in practice and policy there are various reasons for this reduction in numbers. Previously CAFs have been registered for all siblings in a family group even if the concerns were not about the siblings, since the latter end of 2013, this practice has changed and CAFs are now being registered as a family rather than individuals. Should issues be raised regarding individual children/siblings then it would be expected that a separate CAF was completed and registered in respect of this child.

Prior to March 14, the CAF was used as the referral document for concerns to social care and because of this there were many issues in regards to the quality and worth of these CAFs as they were not true assessments of need, rather a document of concerns; therefore in March 2014 a separate referral document was developed. Since the implementation of the referral there has been, a positive impact on CAFs received in terms of meaningfulness and quality. Taking a small look at the figures for March 14 in comparison to the same dates in March 2013 there is a decrease of 17 CAFs registered which I would hypothesis is due to the separation of the referral and CAF document.

Since December 2013, there has been a drive by the CAF Consultants to raise awareness with partner agencies. Consultation sessions have been held in schools, children centres, nurseries and health centres to improve the working relationship between practitioners and the CAF team.

There is growing confidence that practitioners are improving in their ability to identify when they need to commence a CAF and due to the support from the CAF Consultants are developing a greater understanding of the CAF as a process rather than a singular event. All assessments and team around the child minutes are quality checked by the CAF Consultants and should these documents not meet expected standards the author is contacted and advice given.

These numbers represent only the CAFs that have been completed and submitted to the CAF Team for registration, there remain some practitioners who are not submitting their CAF's and therefore these are not represented in the figures. The CAF Team have identified some areas where these CAFs are not being sent for registration or quality assurance and these appear to be when practitioners are completing them for a service such as parenting courses, children centre outreach or young carers. Work is being undertaken to develop a pathway to ensure that all CAFs are captured by the CAF team and registered therefore giving a true representation of completion rates in Bury.

For the full CAF report please see Appendix 9.

Below is a summary of key performance items that have informed the BSCB Business Plan priorities for 2014/15 reported as part of the BSCB multi-agency data set.

Content area	Quantitative	Commentary
Number of young people referred to young people's substance misuse service 2013/14	199 accessed Early Break for support for their drug and alcohol use a 3% increase from the previous year.	This increase demonstrates the efforts that have been made between services to improve referral pathways and to ensure young people have access to the appropriate information and support. Fewer young people re-present to the service compared to our local neighbours and national data. This data is fairly consistent with previous years. 110 using one substance alone. 64% using cannabis as their primary drug of choice 33% consuming alcohol as preferred drug of choice 3% stimulants such as cocaine and ecstasy 89 reported using two or more substances including: 60% Cannabis 29% Alcohol 4%Stimulants 68% male 32% female Alcohol-specific hospital stays (under 18s) are not significantly different from the England average (source Public Health England & Early Break).
No of young people accessing CAMHS 2013/14	Referrals 1587	Referrals resulting in assessment 72%. Few referrals require assessment without intervention. 90% of referrals result in active engagement with the service. A low DNA rate is reported. The Pennine Care Foundation Trust follows a DNA policy. All DNAs are tracked & re-appointed depending upon presenting concerns.
No of young people on waiting list for	57	Stable figure. CAMHS operate a "priority" and "routine" slot system, children waiting will be slotted into depending on

CAMHS 2013/14		practitioners' capacity. A daily "emergency'' appointment slot is managed daily by the appointed duty worker. Children slotted into this appointment are not on the waiting list. The waiting list includes those children waiting for a Tier 2 or 3 service (CAMHS and IAPT).
No of children presenting to CAMHS for self-harming behaviour 2013/14	150	Significant increase of 55% 2013/14. Largest increase -schools referring for deliberate self-harm. We no longer have an inpatient children's ward at Fairfield General Hospital and a number of children presenting at A&E are admitted to either Oldham or North Manchester paediatric wards. These admissions are counted in the numbers as children being discharged from hospital will receive a 7 day follow up from Bury CAMHS. Current coding systems do not allow for the differentiation between attempted suicide and other forms of deliberate self-harm. Referrals received are screened on a daily basis and coded under a deliberate self harm coding system.
Number of parents in treatment for substance misuse problems whose children are living with them 2013/14		New presentations year to date: Number of parents in treatment for substance misuse problems whose children are living with them-(drugs) 111 (46%) New presentations year to date: Number of parents in treatment for substance misuse problems whose children are living with them-(alcohol) 46 (16%) New presentations year to date: Individuals in treatment for alcohol misuse issues: living with children 72 (25%) New presentations year to date: Number of parents in treatment for substance misuse problems whose children are not living with them (alcohol) 43 (15%)

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Provision of training pool members / specialist trainers

NHS Bury

Pennine Care Foundation NHS Trust

Children's Services, Bury Council

Early Break

Greater Manchester Police

Sara Swann

AFRUCA

Barnardo's

Provision of meeting rooms / training venues free of charge

Children's Services, Bury Council

Greater Manchester Police

Greater Manchester Fire and Rescue Service

Contributors to the Annual Report

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LIST OF APPENDICES

The appendices are also included in the separate document “Appendices to BSCB Annual Report 2013-2014”.

APPENDIX 1 - BSCB and Sub Group members 2013/2014

BSCB and Sub Group members 2013-2014.

APPENDIX 2 – NHS England report

Information for LSCB Annual Reports V2 Ju

APPENDIX 3 – Pennine Acute Hospitals NHS Trust report

PAHT LSCB report 2014.doc

APPENDIX 4 – SEAM Panel report

BSCB SEAM - first annual report June 2(

APPENDIX 5 – LADO report

Final 2013 2014 yearly LADO report 1

APPENDIX 6 – Private Fostering Annual Report

Private Fostering Annual Report to BSC

APPENDIX 7 – Training Needs Analysis

Training Needs analysis for 2014.doc

APPENDIX 8 – Training report

BSCB TRAINING REPORT 2013.docx

APPENDIX 9 – CAF report

CAF Report 2013 2014.doc