Bury Safeguarding Children Partnership

Yearly Report

2023 - 2024

Version - final

Contents

Foreword from Bury's Safeguarding Executive

Welcome to the yearly report covering the work of Bury's Safeguarding Children Partnership (BSCP). The report provides an overview of the contribution of each safeguarding partner to the multi-agency safeguarding arrangements from April 2023 to March 2024, to achieve our agreed vision:

"We want all children and young people in Bury to enjoy safe childhoods and to be protected from harm".

Importantly, the report includes evidence of the impact of the work of the safeguarding partners and relevant agencies on outcomes for children and families, professionals and the effectiveness of the safeguarding arrangements.

Over the last year, several changes to Bury's safeguarding arrangements have been introduced. The Independent Scrutineer recommended a new way of working, which we embedded in this reporting year. This has provided us with a strong foundation to move forward with the changes outlined in Working Together 2023, so that we continue to strengthen safeguarding leadership and improve multi-agency safeguarding practice.

Compliance with the requirements of this revised statutory guidance will be a key focus for the remainder of 2024 when we will publish our updated partnership arrangements in December.

Lynne Ridsdale

Chief Executive, Bury Council
Lead Safeguarding Partner

Catherine Jackson

Associate Director Nursing, Quality and Safeguarding
NHS Greater Manchester Integrated Commissioning Board

Chief Superintendent Chris Hill, District Commander, Greater Manchester Police

Independent Scrutineer

The new independent Scrutineer commenced in role in July 2024.

Comments are based on a retrospective consideration of activity during this reporting period.

This has been a demanding and positive year for the Bury Safeguarding Children Partnership. This report evidences significantly improved governance and "grip" and partnership accountability through the performance year under consideration. This has been independently verified through regulatory inspection by Ofsted through monitoring activity of improvement, and through the work of the previous Independent Scrutineer. The Safeguarding Executive, chaired by the Council's Chief Executive, and the Safeguarding Children Partnership and relevant subgroups have all met and driven forward priorities and actions to further safeguard children.

In my opinion, the Bury Safeguarding Children Partnership is embracing the reforms in Working Together to Safeguard Children 2023 and is continuing to work on compliance through this new performance year. The Partnership is grounded and realistic about the achievements to date and priorities for further improvement.

1. Bury Local Profile

Bury is one of ten areas that form the Greater Manchester (GM) Safeguarding Alliance.

At the 2021 UK census, Bury had a total population of 193,846, with 38,800 aged 0-15 (c20% of Bury's population). Bury is amongst the less deprived local authorities in Greater Manchester but inequalities within Bury vary significantly across neighbourhoods.

Safeguarding in Bury

Measure		2022/2023	2023/2024
Number of under 18s in Bury		43,574	43,965
Number of contacts received in Multi Agency Safeguarding Hub (MASH)		9,814	11,010
Number of contacts accepted as MASH referrals		3,242	2,540
Number of Section 47 investigations commenced		916	822
Number of Section 47 investigations completed		897	829
Number of children supported through early help		902	1,106
Number of children on Child in Need Plans		408	386
Number of children with a Child Protection plan		212	223
% initial categories of abuse for children supported by a child protection plan	Emotional	53.8%	52.3%
	Multiple	1.9%	5.7%
	Neglect	42%	33.7%
	Physical	1.9%	4.9%
	Sexual	0.5%	3.4%
Number of children supported via complex safeguarding team		41	42

2. Review of the effectiveness of the partnership arrangements and their impact on practice

2.1 Impact of the three safeguarding partners

In this reporting year the Safeguarding Executive comprised the Chief Executive of Bury Council as the Lead Safeguarding Partner for the local authority, who chaired the Safeguarding Executive meetings. The Delegated Safeguarding Partners – the Executive Director of Children's Services in Bury Council, the Associate Director of Nursing, Quality and Safeguarding in NHS GM ICB and the Chief Superintendent Bury District Commander in GMP, were also members of the Safeguarding Executive, together with the Independent Chair. From April to December 2023, the Executive met fortnightly to drive forward the improvement plan following a number of recommendations made by the Independent Scrutineer.

In this reporting period, the Safeguarding Executive achieved the following:

- Implemented and monitored delivery of an improvement plan in response to independent scrutiny.
- Approved the revised multi agency safeguarding arrangements in response to independent scrutiny.
- Reviewed and refreshed the partnership's overarching priorities.
- Approved several policy documents including a neglect strategy, continuum of need, early help strategy, complex safeguarding strategy and operating principles of the complex safeguarding team, Multi Agency Safeguarding Arrangements (MASA), joint information sharing protocol with the Coroner and Rochdale and Oldham and a legal support agreement.
- Approved the partnership's Working Together 2023 project plan.
- Oversight of delivery of actions following rapid reviews and child safeguarding practice reviews.
- Approved a new data dashboard as a way of providing insight and assurance on safeguarding partnership arrangements.
- Considered Bury's multi-agency approach and response to the following:
    - Right Care Right Person
    - The partnership's performance in relation to the statutory timeframes for Rapid Reviews
- Continued to review the attendance of relevant agencies at all partnership meetings and subgroups.
- Provided a regular forum for discussing and sharing safeguarding arrangements for each statutory partner.

In 2024/2025, the arrangements will be developed in response to Working Together 2023. The Chief Executive of Bury Council, the Chief Executive of NHS Greater Manchester (GM) Integrated Care Board (ICB) and the Chief Constable of Greater Manchester Police (GMP) are the three Lead Safeguarding Partners (LSP) who have a shared responsibility for the effectiveness and outcomes of multi-agency safeguarding arrangements in Bury.

Each LSP has appointed a Delegated Safeguarding Partner (DSP) for its agency, who can take decisions on behalf of the LSP and hold their sectors to account.

The DSPs are the Executive Director of Children's Services in Bury Council, the Chief Nurse in NHS Greater Manchester Integrated Care board who has delegated responsibility to the Associate Director of Quality in NHS GM ICB, and the Chief Superintendent Bury District Commander in GMP.

The detail of how the shared responsibility amongst the three LSPs will work in practice will be developed in 2024 and included in the new published arrangements in December 2024.

2.2 Impact of the Bury Safeguarding Children Partnership (BSCP)

Bury Safeguarding Children Partnership (BSCP) is responsible for ensuring that safeguarding arrangements in Bury work effectively and function in line with the key safeguarding legislation for children, details of which are included in Working Together to Safeguard Children 2023.

The Safeguarding Partnership is essential because no single agency can fully address the complex and multi-faceted risks that children may face. By working together, safeguarding partners can share information, resources and expertise, ensuring that vulnerable children are identified early, supported effectively, and protected from potential harm. The success of safeguarding efforts depends on the strength of the partnership, and we were proud that our partnership working has been recognised externally as an area of strength. In September 2023, the Department for Education provided feedback on its third six-month review of Bury's Children's Services, which focused on the safeguarding assurance arrangements. They reported that "it was encouraging to hear of progress made and the strengthened relationships supporting stronger working together across partnerships".

The BSCP brings together the three safeguarding partners and Relevant Agencies whose involvement is required to safeguard and promote the welfare of children and young people in Bury, are also members of the BSCP. Relevant Agencies include Bury Voluntary Community and Faith Alliance, Early Break Drug and Alcohol Services, Greater Manchester Probation Service, Pennine Care NHS Foundation Trust, Northern Care Alliance NHS Foundation Trust, Greater Manchester Mental Health NHS Foundation Trust and Local Authority Housing, Education, Early Help and Public Health. The BSCP also ensures alignment with other partnerships including the Community Safety Partnership, Children's Improvement Board, Children's Strategic Partnership, Child Death Overview Panel and Bury Safeguarding Adults Board.

Until the end of March 2024, an Independent Chair led the BSCP meetings. In light of requirements in Working Together 2023, a Delegated Safeguarding Partner will be appointed as Partnership Chair from April 2024, and details will be included in the revised multi-agency safeguarding arrangements, which will be published in December 2024.

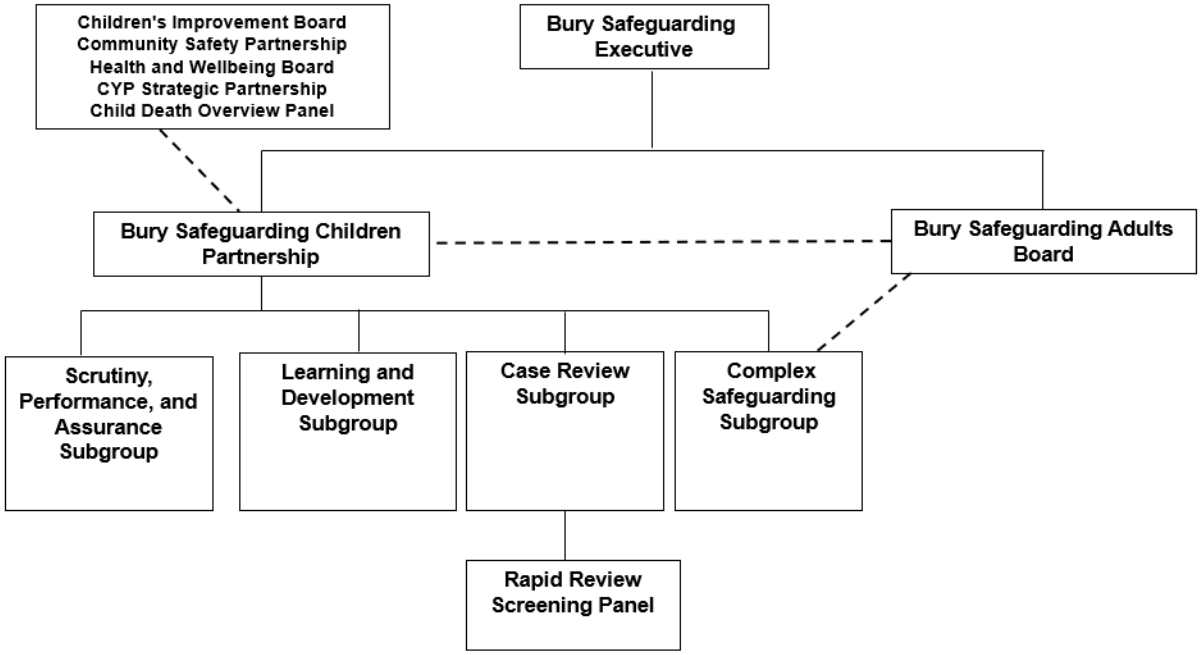


Figure 1: How the Safeguarding Children Partnership is organised

The BSCP oversees the delivery of the strategic priorities and business plan, and achievements included the following:

- Local Authority Monitoring Visit identified that partnership working is a strength.
- Agreed the final published report for two Local Child Safeguarding Practice Reviews.
- Developed a new model of scrutiny, which was approved by the Executive.
- Significant progress in completing actions in rapid review/local child safeguarding practice review action plans. Down from 226 to 215 at the end of the reporting year.
- Revised the Terms of Reference for BSCP and its subgroups.
- Consideration of Greater Manchester Safeguarding Alliance reports on Safeguarding Babies Under 1 and Children Affected by Domestic Abuse.
- Implementation readiness for Right Care, Right Person.
- Oversight of improvements to the Multi Agency Safeguarding Hub.
- Launch of new safeguarding partnership website.
- Assured that national reforms were implemented, such as Out of Routine and Unseen men.
- Discussed learning from a high-profile safeguarding case within Greater Manchester seeking assurance from partners.

2.3 Impact of Education within the safeguarding arrangements

The involvement of education in the partnership is an area that we have already begun to address, following the recommendation of the Independent Scrutineer, who reviewed the architecture of the partnership.

The Executive Director of Children's Services is accountable for education and therefore is accountable for ensuring that the voice of education at a strategic level is represented in the Safeguarding Executive.

The Partnership now includes the roles of Director of Education and Skills, Virtual Head, Strategic Lead SEND and Inclusion and the Lead Officer for Safeguarding in Schools, at a strategic level in BSCP meetings, and at an operational level through membership of the subgroups.

Schools are engaged in rapid reviews, so that their voice is included in the review of serious incidents. The role of the Lead Officer for Safeguarding in Schools also ensures that key multi-agency safeguarding learning is shared with schools' designated safeguarding leads (which includes schools, colleges and alternative providers) and designated teachers for looked-after-children.

Further strengthening of the voice of education in the safeguarding arrangements will be included in the revised multi-agency safeguarding arrangements, which will be published in December 2024.

2.4 Impact of Partners

All BSCP partner agencies were asked to provide assurance by way of a self-assessment of on key areas of safeguarding. A summary of the responses has been provided below.

Children's Social Care

- Launch of Family Safeguarding model in October 2023 (following soft launch in June 2023) supported by multi-agency training, drop-ins and briefing sessions. Multi-agency Family Safeguarding Operational Board in place to oversee implementation (chaired by Director of Children's Social Care and Early Help), along with a multi-agency Strategic Board.
- Opened our first Family Hub (Redvales) to provide multi-agency support to families in the community, supporting a place-based approach to family help.
- Aligned Early Help services within Children's Social Care to support a family help approach.
- Launch of the first Mockingbird Constellation in March 2024, with planning underway for the second. This will increase the support available to our foster carers in meeting the needs of the children and young people they care for.
- Extensive learning and development offer provided, and a refresh of the Learning & Development Plan to reflect the enhanced offer. Includes Being Brilliant at the Basics, Family Safeguarding, Motivational Interviewing, in addition to themes identified through audit.
- Complex Safeguarding training delivered through Research in Practice – how to assess, support and understand research.
- Neglect training across all practitioners focusing on identifying neglect, use of the neglect toolkit, poverty vs. neglect and improving outcomes; Neglect toolkit now online.
- Graded Care Profile 2 (GCP2) Train the Trainer group identified, rolling out GCP2 training to all practitioners to support where there is suspected/actual neglect.
- Continue to embed and expand reach of Quality Assurance Framework (QAF) with audits taking place monthly and learning from audit and dip sampling activity influencing the Learning & Development offer.
- Ofsted monitoring visit in August 2023 noted "steady progress on our improvement journey with strengthened arrangements for children at risk from sexual exploitation".
- Corporate Parenting Training for Executive Team and Councillors facilitated by LGA in April and June 2023, to ensure responsibilities understood.
- Working with DfE Adviser on a Recruitment Summit, to bring together senior leaders to review activity to date and agree any additional activity needed to reduce proportion of agency staff and support enduring relationships for our children and young people.

Education

- 170+ DSLs trained in the Academic Year 2023/24.
- Multi-agency training delivered to schools/colleges which includes Lead Officer for Safeguarding (Schools/Colleges), MASH Education Lead, Social Work Consultant from Children's Social Care.
- Attendance Forums delivered to Attendance Leads for Schools and Colleges.
- Electively Home Educated (EHE) children - multi-agency meetings to discuss suitability and safeguarding issues around EHE.
- Children Missing from Education (CME) – implemented robust tracking for children who are CME; multi-agency meetings and close liaison with schools.
- Worked with Connexions and post 16 Providers to ensure that children who are NEET (not in education, employment or training) are tracked.
- Providing schools and colleges with a Safeguarding and Child Protection policy as well as guidance and DBS protocol.
- Expanded Virtual School training offer for all Bury schools.
- Implemented new Quality Assurance protocols for Alternative Provision used by education settings in Bury.

Housing

- Roll-out of safer sleeping messages has seen positive outcomes for residents e.g. identified a cot was needed and this was provided alongside other essential items for the family.
- Eyes Wide Open training is mandatory for all staff. This includes safeguarding, so that all staff are aware of how to report concerns.
- Proactive visits to tenants within the home.

NHS Greater Manchester Integrated Care Board (NHS GM ICB) (Bury Locality)

- Safeguarding team delivered mandatory Level 3 Safeguarding Children training to Primary Care.
- Complex Safeguarding Nurse delivered bespoke training to Safeguarding Lead GPs in relation of how GPs interlink within complex safeguarding.
- Designated Nurse for Child Protection led on the priority of Safer Sleeping in a safeguarding context and worked with BSP to produce the Safer Sleeping Toolkit for use across the partnership. Several training events were facilitated by the Designated Nurse for Child Protection to launch this.
- ICB safeguarding team lead on and support learning events. L&D group chaired by ICB member.
- Engagement with education and within the community regarding key messages to safeguard babies.

Greater Manchester Police

- Increased the detective resilience across the child protection portfolio, resulting in a fully established Child Protection Investigation Unit and Complex Safeguarding Team.
- Bury have achieved the 2nd highest outcome rate for Child Protection investigations securing a positive outcome rate of 12.1% against a Force average of 10%.
- First child protection dedicated Operation Avro resulted in a number of arrests, warrants executed, drugs and weapons seizures.
- Problem profile developed in relation to complex safeguarding.
- Multi Agency Partnership Stand promoted across town centre.
- Helicopter visit to a school.
- Neighbourhood engagement across Bury.
- Community Football engagement event.
- Provided training to foster carers, schools and wider partnership.
- Licensing visits resulting in seizures of illegal goods.

NHS Northern Care Alliance

- Co-delivery of multiagency training on abusive head trauma.
- Co-delivery of Complex Safeguarding Learning Event.
- Specialist nurse worked collaboratively with the principal social worker to support the implementation of the new 'Family Safeguarding Model'.
- Increased nurse provision in the Multi Agency Safeguarding Hub (MASH).
- MASH health screening template providing much more detailed analysis of health information, interpretation and impact.
- Commenced internal MASH health information screening audit.
- Co-development of IHA (initial health assessment) pathway with childrens social care to improve timeliness of notifications and IHA.
- Collaborative end of year working with childrens social care for statutory annual children looked after return.
- Level 3 LAC training in house.
- Updated court report template and improved QA process – standardised across NCA.
- Improved model of safeguarding supervision delivery and consistently good compliance above 90% for Health Visitors/School Nurses.

Pennine Care

- New Safeguarding Supervision Policy.
- New Peer-on-Peer Abuse Guidance.
- New Managing Allegations against Staff Guidance
- Increase in compliance by around 20% in the 2023-24 period.
- Increased the number of children's teams that the safeguarding team provide safeguarding supervision to.
- Rolled out a pilot to train CAMHS colleagues to deliver safeguarding supervision within their teams.

Greater Manchester Probation Service

- Enhanced approach to the gathering of Safeguarding and domestic abuse information.
- Ensuring all staff complete mandatory training in relation to child safeguarding and domestic abuse – this now forms part of a competency-based framework.
- Implementing the family safeguarding model and having co-located practitioner staff within these teams.
- Implementation of probation reset which has required expeditious response to earlier release on licence for some custodial cases. Ensuring effective safety planning is in place via the risk management plan is a key control measure underpinning decision making.
- Mandatory home visits in line with refreshed policy – risks to children, other vulnerable persons, as well as the person on probation themselves is central to purposeful home visiting, with an aide memoir of considerations pertaining to different types of risk/offending.
- Home visits to homes of families with babies and will check out sleeping arrangements where relevant.

Bury Voluntary, Community and Faith Alliance (VCFA)

- Violence Reduction Programme: continue to strengthen relationships with social care and GMP through the VRU Alliance Programme.
- Input into the design of new training programme on serious youth violence which will be rolled out in high schools in 2024-25, a film project created by a number of VCSE organisations and Bury Youth Service.
- Scheduled the first children's safeguarding training course for the VCSE sector in collaboration with Bury Safeguarding Partnership.
- Disseminated partnership safeguarding messages to the VCSE sector through ebulletin and social media.
- Essential Trustee and Volunteer Management training contains input around trustee eligibility and disclosure and barring.
- Organisational health checks provide diagnostic assessment on groups' needs – and this includes safeguarding.
- All staff and Bury VCFA volunteers undertake mandatory online safeguarding training.
- Continued to champion the voice and role of the VCSE sector in the development and shaping of local services and sharing of insights at strategic level.

3. Delivery of our shared priorities 2023-2024 – evidence of impact

The Safeguarding Executive agreed the priorities for the year, informed by themes from rapid reviews, local child safeguarding practice reviews, social care data, feedback from inspections and recommendations from the independent scrutineer. Each priority had an identified strategic lead, an operational lead and a subgroup with responsibility for the work. There was an agreed view of "what success looked like", as outlined in the strategic priorities and business plan 2023/2024.

Figure 2: Bury Safeguarding Partnership's Priorities 2023/2024

Below is a summary of our work on our priorities, including the impact and outcomes and how these were achieved, together with analysis from our former Independent Chair.

3.1 Safer Sleeping

Impact

- Increased awareness of safer sleeping messages across wider partnership. Examples include Probation Service, Police and Housing who, when carrying out visits to homes of families with babies, will check sleeping arrangements.
- Over 300 Local Authority and NHS Greater Manchester Integrated Care Board staff aware of safer sleeping toolkit.
- Practitioners report that real-life examples being shared have helped them better understand the risks associated with unsafe sleeping and how to communicate these risks to parents in a relatable and impactful way.
- All Health Visitor staff attended Safer Sleep training delivered by the Lullaby Trust.
- Safer sleeping discussions are family specific, enabling families to make safer choices.

- Generic safer sleeping messages continue to be delivered. In addition, targeted messages are provided to those families at higher risk of SUDI or SIDS.
- Increased awareness of ICON and Safer Sleeping messages within education.
- Increased awareness of safeguarding babies' messages delivered in the community.

How the Partnership achieved this:

- Analysis of the findings of the national report 'Out of Routine' and the subsequent guidance from the National Child Mortality Database report to inform policy approach.
- Multi-agency risk stratification toolkit and policy developed for staff to support identification of higher risk families.
- Deputy Designated Nurse attended the DSL Forum for Education to discuss ICON and Safer Sleeping and will continue to support the forum.
- Deputy Designated Nurse attended the Jewish Mental Health Network.
- Deputy Designated Nurse attended Bury's Family Hubs.
- Staff briefing held to launch the safer sleeping toolkit with Local Authority and NHS GM ICB staff.
- Partnership briefing held to launch the toolkit, with partners tasked in cascading this in their organisations.

What our Independent Chair told us:

"A toolkit has been developed and is available on the BSCP website. It was soft launched at the partnership learning event in June 2023.

A staff leadership session was held with Local Authority and NHS Greater Manchester ICB (Bury) to promote the toolkit – with over 300 staff in attendance.

A multi-agency session is scheduled for Q1 of 2024/2025 to roll-out the Safer Sleeping Toolkit, and examples of how to apply this in practice. A rapid review in Bury will be used as a case study. This will also focus on perinatal mental health – delivered by the specialist team to raise awareness of their service offer".

3.2 Complex Safeguarding

Impact

- Targeted activity in relation to serious youth violence with focus on exploitation.
- Operation Revoke tackling threat from serious organised crime, resulting in significant disruption of drug supply and criminal exploitation, with more than 100 arrests and in excess of 50 warrants and searches were made. This led to more than £1m worth of drug seizures.
- Engaged with children at risk in an open and honest way. Feedback is obtained at step-down, case closure and during the WISE (working to increase safety in exploitation) assessment.

- Child protection Operation AVRO launched to tackle criminal and sexual exploitation and safeguard young people, with arrests made, warrants executed, and drugs and weapons seized.
- More young people aware of exploitation.
- More young people aware of healthy relationships.
- More primary school children aware of internet safety.
- More young people aware of healthy relationships and what exploitation looks like.
- School based interventions by training Designated Safeguarding Leads in Schools, Pupil Referral Unit and Colleges to recognises signs of external risks.
- Listened to young peoples' lived experiences to inform the complex safeguarding strategy.

How the Partnership achieved this

- Independent scrutiny review of complex safeguarding.
- Feedback from young peoples' experiences of exploitation was used to shape the complex safeguarding strategy and delivery plan.
- Research in Practice training delivered to Complex Safeguarding Team, providing team with tools to use for assessments.
- Reflection and learning activities. Multi-agency sessions on complex safeguarding – working through case study examples.
- Missings - safety plan format has been reviewed and updated, implemented in June 2023. Standalone safety plan now in place.
- Bespoke training delivered to Safeguarding Lead GPs in relation to how GPs link within complex safeguarding.
- Child protection day of action held with partners to reduce and highlight Child Sexual Exploitation and Child Criminal Exploitation issues
- Co-located multi-disciplinary team that works together to support those identified as being at risk of exploitation.
- Problem profile developed to better understand need and inform service delivery.
- Regular updates provided to Community Safety Partnership.
- Training provided by the police within schools on internet safety awareness, exploitation awareness and healthy relationships.

What our Independent Chair told us:

"The borough's complex safeguarding team is now co-located and well resourced. The Standard Operation Procedures enable all agencies and individuals to be aware of their roles and responsibilities. An evaluation of the service led to a comprehensive Partnership Strategy being developed alongside a delivery plan, which is overseen by the Complex Safeguarding Subgroup. The Greater Manchester tool of assessment and intervention has been adopted and information is shared between agencies to support young people and their families. A programme of development has and continues to be delivered to the team and the wider workforce and a local problem profile has been completed and is being provided by GMP.

A data set has been developed and now needs to be presented quarterly to the subgroup and the BSCP for assurance.

In August 2023, Ofsted carried out a monitoring visit and covered the areas of children at risk of sexual or criminal exploitation, children who are missing from home or care and children at risk of radicalisation. Their findings highlighted that senior leaders had strengthened arrangements for children who are at risk of exploitation and the co-location of the multi-agency complex safeguarding team in the multi-agency safeguarding hub has enhanced the holistic offer to children and families. Importantly, they recognised that the risks and needs of children are identified early by the multidisciplinary team, and this collaborative partnership approach supports the reduction of risks for many children. They also found that there were effective strategic and operational relationships in Bury, which underpin the work to identify and protect vulnerable children".

3.3 Neglect

Impact

This reporting year has focused on getting the building blocks in place to support the identification and reporting of neglect; however, work amongst safeguarding partners has begun to raise the profile of how the partnership addresses issues relating to neglect.

One of the specialist nurses led an exploration of neglect tools in use elsewhere to inform BSCP regarding the best tool for use in Bury.

All officers in Greater Manchester Police (GMP) receive specialised training on the nuances of neglect, including physical, emotional, and educational neglect, to better identify and address these issues during their interactions with children and families. GMP conduct regular reviews of neglect cases to identify lessons learned and areas for improvement.

Neglect remains a priority for the partnership in 2024/2025.

How the Partnership achieved this

- Neglect Strategy developed.
- Continuum of Need developed.
- Multi-agency launch of neglect strategy delivered through several awareness raising sessions.

- Decision made to use the Graded Care Profile 2 (GCP2) toolkit to promote consistent and collaborative working across the partnership.

What our Independent Chair told us:

"The priority around neglect has made the least progress among all the priorities, due to the requirement for a toolkit to be developed to support frontline practitioners. The Neglect Strategy was rolled out via a number of online briefing sessions, but the development of a full day training session was delayed by ongoing discussion about the implementation of a tool for practitioners. A task and finish group was established and at the January 2024 meeting this was strengthened. This will continue as a priority for 2024-2025".

3.4 Embedding learning

Impact

- Over 90 safeguarding training events promoted for professionals to access.
- Over 500 professionals engaged in multi-agency training from April 2023 to March 2024.
- 3 multi agency learning days held to share learning from 14 reviews.
- Over 20 multi agency training events delivered from April 2023 to March 2024.
- Professionals provided reflective feedback following learning events on how they would do things differently going forward.
- Increased awareness of the partnership and multi-agency safeguarding, through the introduction of a multi-agency learning and development package.
- All volunteers in Bury Voluntary, Community and Faith Alliance undertake mandatory online safeguarding training.
- Over 170 Designated Safeguarding Leads in education trained in the Academic Year 2023/24.
- Increased Virtual School training offer.
- Increase in the number of schools engagement for DSL training.
- Increased awareness of safeguarding, through the provision of training to schools and colleges on:
    - Safeguarding and Child Protection Training
    - Designated Safeguarding Lead Training
    - Online Safety for Professionals
    - Attendance forums/drop-in sessions for Electively Home Education
    - Attachment and Trauma training provided by the Virtual School

How the partnership achieved this

- Annual learning and development programme in place for professionals to access, linked to themes from reviews.

- Multi-agency safeguarding training in place for new starters / refresher for current staff.

- Good practice across Bury, Greater Manchester and nationally shared.

- A comprehensive programme of learning for the workforce, that clearly links to local and national learning, and includes a variety of learning models including learning circles, face to face interactive classroom style training, short online sessions, and eLearning.

- Monitoring of take up of multi-agency safeguarding training from partners and relevant agencies.

- Analysis of themes from reviews undertaken, and the 2023/2024 learning and development programme aligned to the analysis.

- Multi-agency training delivered to schools/colleges which includes Lead Officer for Safeguarding (Schools/Colleges), MASH Education Lead, Social Work Consultant from Children's Social Care.

- Training offer for Safeguarding and Child Protection Training delivered to schools/colleges across Bury.

- Expanded Virtual School training offer for all Bury schools, including topics such as FASD, working with children who have been sexually abused, relational practice, supporting transitions, attachment and trauma, supporting parents and carers to manage anxiety at home.

- Virtual School Conference attended by 120 delegates.

What our Independent Chair told us:

"The subgroup for learning and development has had a number of Chairs during the reporting year, but from September 2023 has benefited from the same Chair and the appointment of a learning and development officer for the Partnership.

Successful learning events were held throughout the year, and several topics, directly linked to local case reviews were presented and explored with attendees. This included safer sleeping where there are increased vulnerability, suicide in young people, the murder of a baby by a parent, specific training on complex safeguarding and a case around a young person who had been criminally exploited.

The training programme that has been developed in the latter part of 2023, reflects the learning from cases and includes. There are clear links between the L&D subgroup and the Case Review subgroup to ensure is captured and acted upon in a timely manner".

3.5 Effectiveness of Partnership arrangements

Impact

- Strong leadership – “the Safeguarding Partnership Board’s improved structure and subgroups have put in place the foundations to ensure sustainable change” (feedback from the Department for Education’s third six-month review of Bury’s Children’s Services, focusing on the safeguarding assurance arrangements).

- Collaborative relationships - “there are effective strategic and operational relationships in Bury, which underpin the work to identify and protect vulnerable children” (feedback from Ofsted monitoring visit on progress made in relation to child exploitation, in August 2023).

- Alignment to other strategic partnerships to share information and intelligence.

- Reducing risks - “the risks and needs of children are identified early by an effective multidisciplinary team and this collaborative approach supports the reduction of risks for many children” (feedback from the Department for Education’s second six-month review of Bury’s Children’s Services).

- Scrutiny - the Department for Education, in their second six-month review of Bury’s Children’s Services, recognised the partnership’s openness to scrutiny in their second six-month review of Bury’s Children’s Services, stating it was an “encouraging step to introduce independent scrutiny”.

- Clear accountabilities through the refresh of terms of reference for the Safeguarding Executive, Safeguarding Partnership and its subgroups.

- Timely decision making through improved tracking of serious incidents.

- Dataset to support learning and analysis.

- Awareness of safeguarding practice.

How the partnership achieved this

- Strategic direction provided by the Safeguarding Executive and BSCP.

- Independent scrutineer reviewed the overall effectiveness of the safeguarding partnership and made recommendations which formed an improvement plan, overseen by the Safeguarding Executive.

- Using case reviews, audits, scrutiny, learning events and reviews to get a good understanding of the quality of multi-agency safeguarding practice.

- Establishing a Children and Young People Multi-Agency Working Group made up of senior/middle managers who have both strategic and operational responsibilities.

- Streamlining subgroups, with each having its own terms of reference to provide clarity on responsibilities and accountabilities.

- Developing a dataset to identify and analyse safeguarding issues.

- Linking to other partnership arrangements, including the safeguarding adults board, the community safety partnership, the Children's Improvement Board and the Children's Strategic Partnership Board, ensuring representation on each of these to share what's happening locally to support children and families.

- Policy development in relation to neglect, continuum of need, complex safeguarding, early help.

- Strengthened case tracking processes, in response to the independent scrutineer recommendations.

- When serious incidents are referred to the partnership, the school, where relevant, is contacted for an offer of support, and to engage in the rapid review.

- Review of support offered through the business unit, and consideration of roles and responsibilities.

- Review of cases from September 2019 to this reporting year was carried out by the Independent Scrutineer and the Safeguarding Partnership Business Unit. A task and finish group of the Case Review Subgroup took the lead on considering the outcomes of the review and progressing actions from plans.

- Information sharing - School/Colleges receive the Tensions Report, which may include contextual risks as well as additional risks in the local area/community, so that schools can risk assess their provision.

What our Independent Chair told us:

"Early in the 2023-24 reporting year, the Safeguarding Executive were meeting bi-weekly to support the development of the governance and to scrutinise progress. From the autumn they met less frequently to allow an alignment of the Executive, the BSCP and the subgroups and allow for a streamlined process of reporting.

The key areas that provide the Safeguarding Executive with assurance should be as follows:

1. A comprehensive data set. The data set needs to provide assurance to the exec as it is mainly social care data and needs to evolve. Several iterations have been provided, including a Complex Safeguarding set, but there is still work to be completed before the Exec can be assured that they are sighted on the "right" data.
2. Learning from case reviews. The case review group has continued to work through the historic cases, closing actions and ensuring either training or briefings are shared across the Partnership. New cases are now being actioned quickly and in timescales. A highlight report that captures learning and the dissemination of learning has been developed, to support assurance to the Exec. There is now a developing area of learning on the BSCP website".

4. Evidence of Scrutiny

4.1 Scrutineer activity – overall effectiveness of multi-agency safeguarding arrangements

The Independent Scrutineer reviewed the effectiveness of our safeguarding arrangements, assessing current strengths and areas for development in a number of areas including:

- Overall architecture, including terms of reference and membership.
- Better links with other partnerships.
- Making use of existing groups and networks.
- Publish new multi-agency safeguarding arrangements.
- Multi-agency strategies, policies and procedures including neglect and thresholds.
- Dataset to be developed.
- Bespoke plan for complex safeguarding.
- Strengthened business management, through a review of the business unit.

An improvement plan was developed, overseen by the Safeguarding Executive. See Section 3.5 for impact and outcomes.

4.2 Scrutineer activity – complex safeguarding

The Independent Scrutineer worked with several partners to understand the strategic direction and action needed to progress the work in relation to complex safeguarding. A series of recommendations were made:

- Produce and share information describing the work of the Complex Safeguarding Team.
- Define what good looks like to inform service standards and quality assurance work including audits.
- Produce a written multi-agency agreement covering line management arrangements for the multi-agency complex safeguarding team and accountabilities (both single and multi-agency).
- Revise the Terms of Reference of the Complex Safeguarding Subgroup.
- Develop a framework which enables the lead representatives from the 3 partner agencies to assess the effectiveness of multi-agency Complex Safeguarding work.

In response to the scrutiny recommendations, a Complex Safeguarding Subgroup was established, with clear terms of reference. The Subgroup led the development of the Complex Safeguarding Strategy and associated delivery plan, together with Operating Principles setting out responsibilities of the Complex Safeguarding Team and accountabilities. See section 3.2 of this report for impact and outcomes in relation to our work around complex safeguarding.

4.3 Scrutineer activity - case reviews

Case review tracking was identified as a priority by the Safeguarding Executive, following the initial scrutiny review of overall effectiveness of the multi-agency partnership, to ensure the process was effective and learning was rapidly identified, disseminated and embedded.

The Independent Scrutineer and the Business Unit reviewed the status of all cases from 2019 to the current reporting year. Action plans were updated, and a new way of tracking cases was introduced, with regular reports to the Case Review Subgroup, the Partnership, and the Safeguarding Executive.

Significant progress was made by agencies during the reporting year to complete actions in rapid review/local child safeguarding practice review action plans. Following the review of all cases 226 actions were identified, of which 215 were completed during the reporting year, with only 11 being carried forward due to their complexity.

4.4 Reviews

During the reporting year, the Department for Education (DfE) undertook a six-month review in June 2023, focusing on the safeguarding assurance arrangements. They recognised the progress in implementing the Family Safeguarding Practice Model, stronger multi-agency partnership working including a renewed focus on learning.

The DfE noted that the Safeguarding Partnership Board's improved structure and subgroups have put in place the foundations to ensure sustainable change. They also acknowledged the feedback from the partnership in relation to strengthened relationships, allowing for a joined-up approach to supporting families.

They highlighted the importance of utilising the data, and now focusing on impact and what this means for children.

Ofsted carried out a monitoring visit in August 2023, focusing on complex safeguarding. They recognised that senior leaders had strengthened arrangements for children who are at risk from exploitation and that governance arrangements have been enhanced as the complex safeguarding subgroup now reports directly to the safeguarding executive and partnership board, providing greater accountability. Importantly, they reported that the risks and needs of children are identified early by an effective multidisciplinary team and this collaborative partnership approach supports the reduction of risks for many children.

Areas that required improvement included the timeliness of strategy meetings, the quality of assessments, plans and supervision, and the response to children who go missing.

4.5 Audit

The Scrutiny, Performance and Assurance Subgroup undertakes assurance activity, and provides multi-agency scrutiny and challenge of all audit proposals and reports. It ensures that any scrutiny and quality assurance focusses on impact and outcomes for children or families.

Core Groups

An audit was conducted on the impact of Core Group Meetings driving forward Child Protection Plans. Learning identified that the most effective core groups were those where at least one of the parents was present and contributed to the planning about their children. The audit also highlighted that attendance from partners was not always consistent, and as a result there was oversight and reporting to the Safeguarding Executive in relation to this. Action plans also needed to include the role and actions of partners, not just social care. This learning was fed back to frontline practitioners. It is proposed to re-audit Core Groups in the next reporting year.

Complex Safeguarding Team (CST)

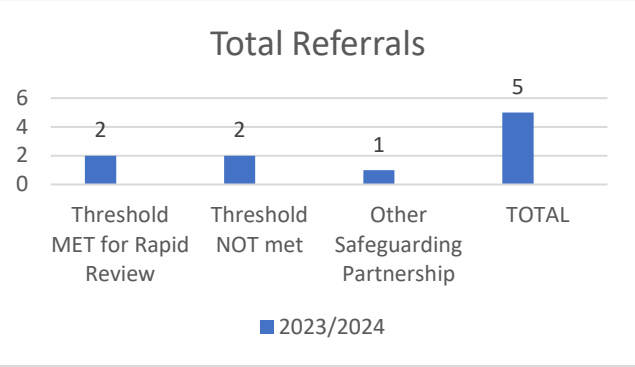
The Safeguarding Executive considered the outcome of the audit of the complex safeguarding team. 12 cases were chosen at varying levels of concern for exploitation. Professional challenge was a theme within cases, as was the requirement for more effective transitions to adult services. The audit identified that all schools have a link CST worker. A 'grab and go' parenting pack is issued to each team which comprises of an overview note of exploitation and further signposting information to enhance knowledge, for parents with children who are not open to CST.

Education

The Lead Safeguarding Officer for Education has undertaken safeguarding audits in some of the Bury Schools. This has included a number of policy areas related to safeguarding including safeguarding and child protection policy, safer recruitment, attendance policy, DBS checks, whistleblowing policy and procedures, managing allegations. The audit also includes meeting with children and analysis of the child's voice, together with desktop reviews of early help assessments/plans, child protection/safeguarding files. A report was then prepared for the school.

5. Rapid Reviews and Local Child Safeguarding Practice Reviews (LCSPRs)

During the reporting year the Bury Safeguarding Children Partnership received 5 referrals for Rapid Review, 2 of which met the criteria for a Rapid Review. These did not proceed to a Local Child Safeguarding Practice Review (LCSPR).



Following the review of cases by the Independent Scrutineer in 2022/2023, where it had been identified that there needed to be greater awareness of the application of thresholds for referring into the safeguarding partnership, the numbers of rapid reviews have reduced, which was expected (Table 1).

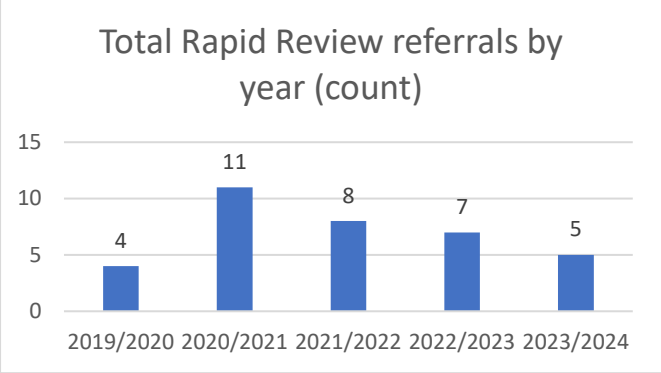


Table 1: Total referrals received

Infants aged 1 and under account for the highest number of referrals (3), which is comparable to Greater Manchester. One of the 16+ referrals was for another safeguarding partnership (Table 2).

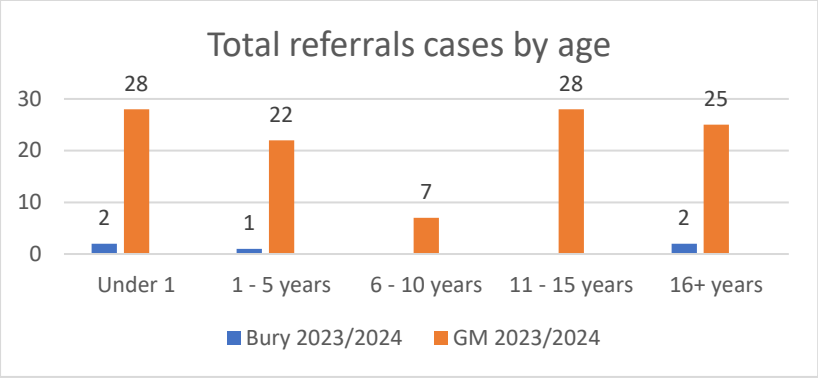


Table 2: Age profile of the children subject of the referral

In line with Greater Manchester, the majority of children subject of the referral, were White British (Table 3).

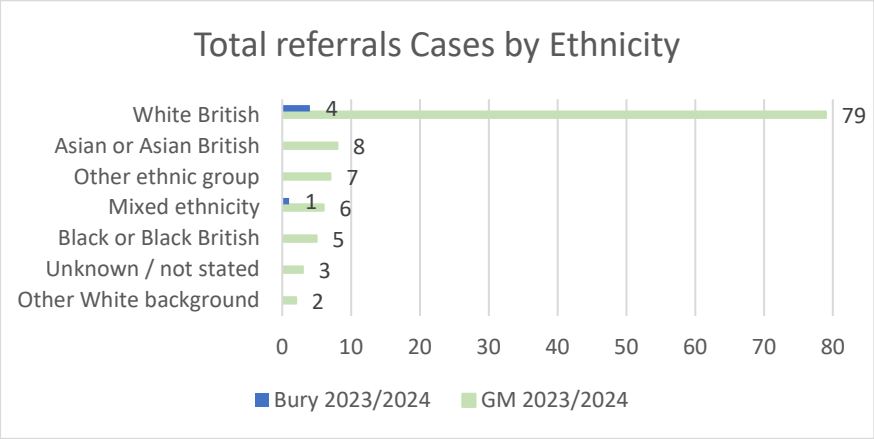


Table 3: Ethnicity of the children subject of the referral

The data below includes the reasons for referral in cases that resulted in serious harm but were not fatal. It can be seen from the data that that there can be multiple reasons for a referral (Table 4).

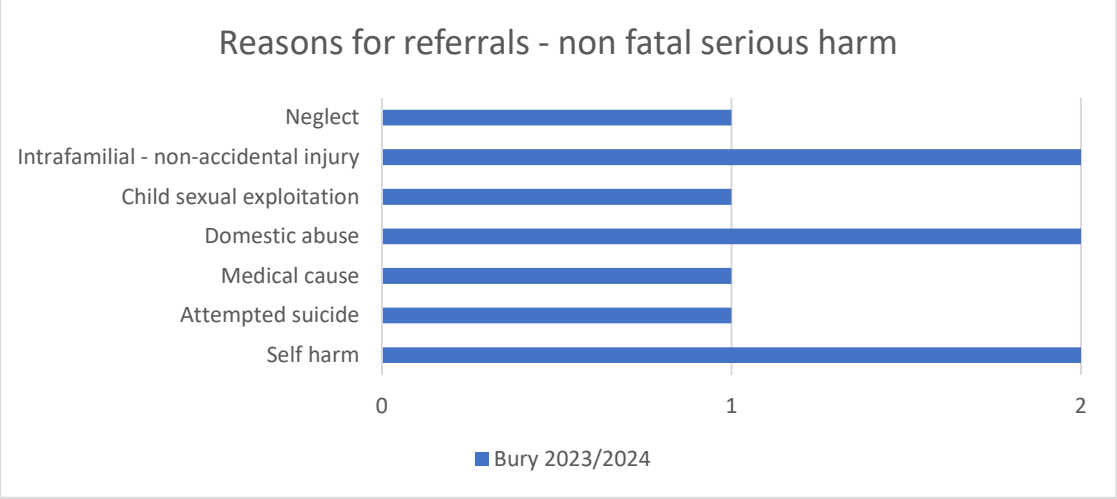


Table 4: Reasons for referrals related to non-fatal serious harm

The data below includes the reasons for referral in relation to fatal incidents. It can be seen from the data that there can be multiple reasons for a referral (Table 5).

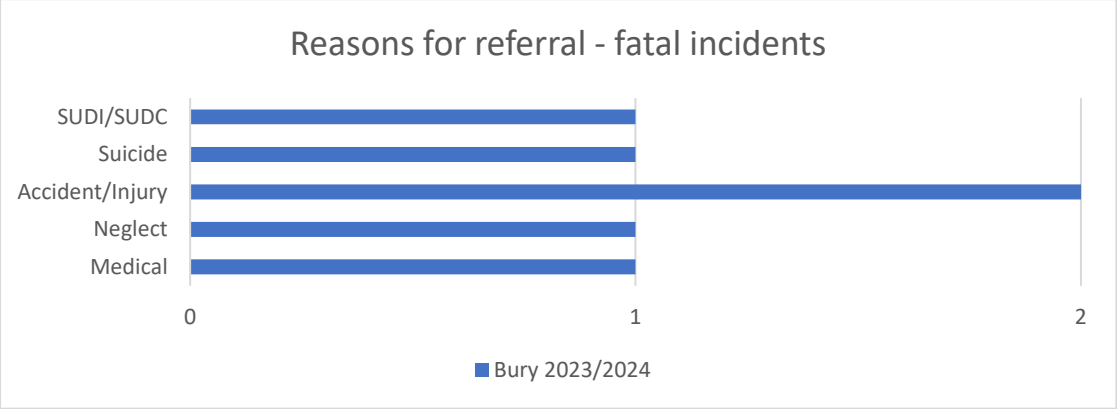


Table 5: Reasons for referrals related to fatal incidents.

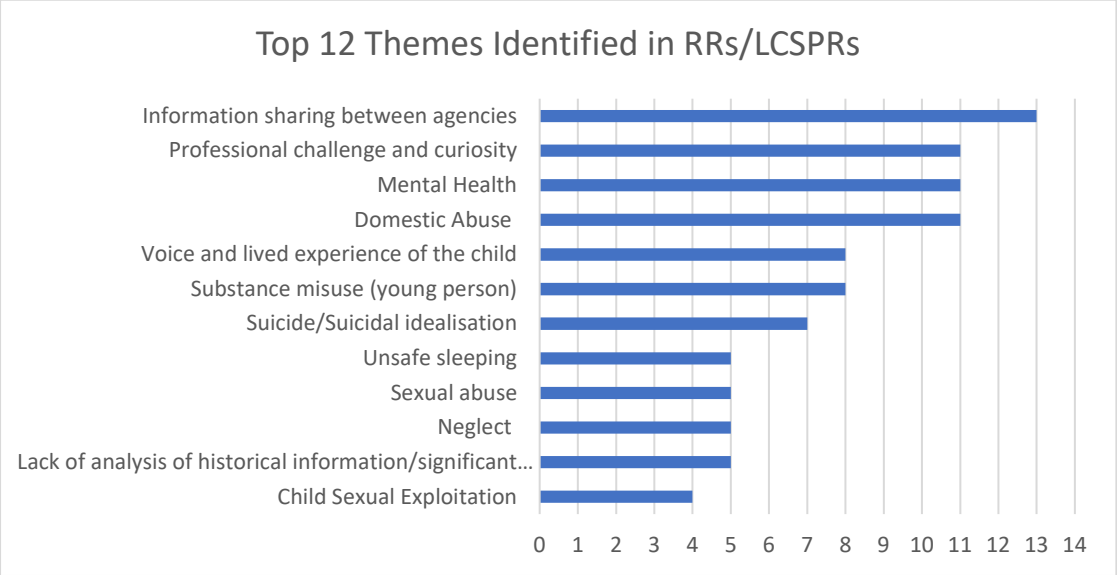
Two LCSPRs concluded during the year, having been identified after reviewing the cases, as part of the internal scrutiny process. These reviews were not published, given the length of time that had occurred since the serious incident, together with the potential for the likelihood of identification of the child and family; however, 7-minute briefings were published by the Learning and Development Subgroup, so that the learning could be disseminated to staff. The themes from the LCSPRs included extra-familial sexual abuse, adultification, mental health, voice of child/young person, criminal exploitation, children missing from education, and culture and ethnicity.

The Case Review Subgroup met monthly to discuss all serious incident cases and any agreed actions. The Subgroup is required to make recommendations following a statutory Rapid Review in response to a serious incident (including whether a Local Child Safeguarding Practice Review should be commissioned). Key agency representatives offer insight into how recommendations can be translated into action in a meaningful and achievable way for their organisation and commit to owning and following up implementation and measuring impact. Any identified learning from cases is shared with the Learning and Development Subgroup for consideration of how best to disseminate and embed throughout the partnership.

6. Acting on Learning

Analysis of learning themes

A key priority for the Learning and Development subgroup was to review the themes from legacy case reviews, to inform the programme for 2023/2024.



Multi agency learning days

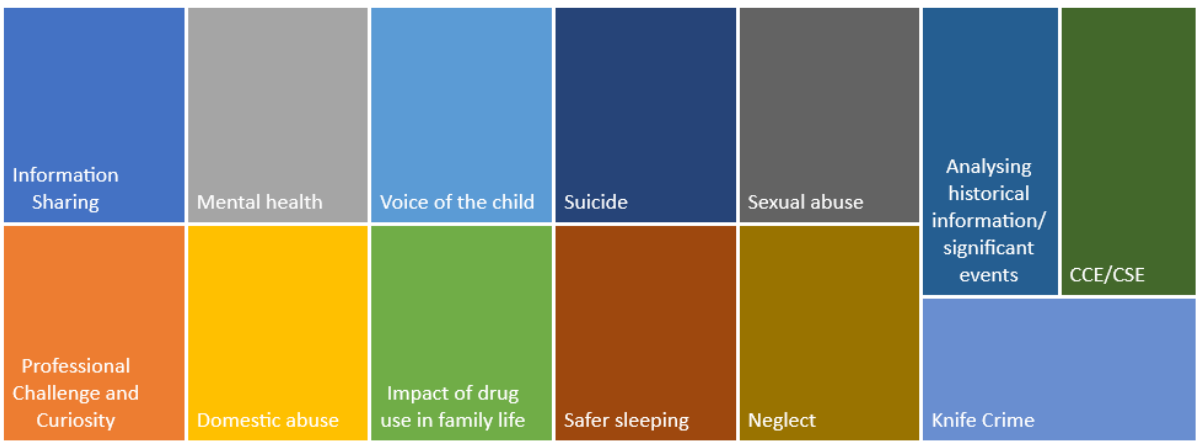
Three learning days were held to disseminate the learning in an effective and efficient manner. The themes were:

- Adolescent harm
- Parental mental health
- Adolescent mental health
- Safer sleeping in the context of safeguarding
- Information sharing
- Professional challenge
- Professional curiosity

The learning days were a series of interactive presentations covering 14 cases and attendees were asked to reflect on their learning and share that with the partnership.

Multi agency training

This year has seen the refresh of our approach to learning and development, so that multi-agency training forms a core part of the partnership's learning and development programme, with further expansion in 2024/2025. A calendar of training events was developed to disseminate learning identified within cases, in response to the following areas, which had been identified in the top 12 themes, following the analysis of cases.



Over 20 multi agency training events were delivered during the year, using a range of methods including e-learning, face to face events, virtual sessions, case studies, lunchtime learning sessions, learning and development newsletter, and updated content on the partnership website.

See Section 3.4 for the impact of our learning and development, as this was a key priority for the partnership during the reporting year.

Embedding the learning

Partners take a range of approaches to embedding learning in their organisations. Examples include:

- Learning is shared via formal structured meetings within the agencies governance arrangements.
- Relevant materials and learning are shared and disseminated and discussed within team meetings and in continuous professional development sessions.
- A summary of reviews and learning themes is shared with staff on a bi-monthly basis.
- Information is shared with schools, colleges and alternative providers in relation to learning from rapid reviews and local child safeguarding practice reviews.
- Learning from rapid reviews and LCSPRs is shared with schools.
- Learning identified from LCSPRs is shared with Primary Care via the Safeguarding Lead GPs and within the training sessions.
- Monthly quality forum updates and quarterly newsletters are issued.
- Learning from reviews is embedded into level 3 safeguarding training in health which is reviewed yearly.
- A 'learning from incidents' meeting takes place on a monthly basis.

Using data to encourage learning

Safeguarding partners use data, both quantitative and qualitative in a number of ways to support learning.

The Safeguarding Executive approved a new data dashboard as a way of providing insight and assurance on safeguarding partnership arrangements. There are plans to evolve this in the following year.

Greater Manchester Police developed a Complex Safeguarding Problem Profile for the BSCP and Safeguarding which has contributed to partnership activity by providing data on who, what, where and when, thereby allowing key stakeholders to drive targeted activity to improve effectiveness. The problem profile consolidates data from various sources, providing a detailed and comprehensive understanding of the scale, nature, and patterns of complex safeguarding issues within the community. By highlighting key trends and emerging threats, the problem profile helps partners recognise specific issues that may have previously been underreported or misunderstood. The problem profile serves as a foundational document that aligns the strategies and actions of all partners. This ensures a unified and coordinated approach to tackling complex safeguarding issues and by providing a clear picture of the problems; the profile helps establish shared goals and priorities among partners, fostering a collaborative environment.

The problem profile provides evidence-based insights that inform the development of targeted interventions and strategies. This ensures that resources are directed towards areas of greatest need and potential impact.

Single agency audits are also conducted, and we are looking at how headline information can be shared with the partnership in the next reporting year.

7. Voice of the Child

Partners have engaged with Bury's Youth Cabinet on a range of subjects during the reporting year. For example, Early Break discussed the issues around substance misuse in schools and how the Youth Cabinet thought it should be dealt with, to help shape a policy.

The Circles of Influence is held each year and is hosted by the Bury Children's Strategic Partnership. In July 2023, young people attended an event and explored a number of themes. The areas that were the focus of the conference were:

- Transport
- Cost of Living Crisis
- Knife Crime and Youth Violence
- Education and Life Skills
- Mental Health and wellbeing of young people

Within the ICB, there was a consultation with the Children in Care Council regarding Health Summaries for Care Leavers. This influenced a process change, and impact will be assessed in the next reporting year.

The Voice of the Child is captured in a number of ways within the Northern Care Alliance, such as feedback from the Friends and Family test and IHAs (initial health assessment) and RHA (review health assessment) and all health visitor and school nurse contact include a section specific to capturing the child's voice. In addition, voice of the child is a mandated field within SystmOne electronic health record.

Within education, schools record on CPOMS/MyConcern the voice of the child. Advice is given by the local authority related to hotspot mapping to capture if children feel safe in their setting, and any hotspots where they do not feel safe. All looked-after children have their voices heard and views captured in their Personal Education Plans. The Three Houses Social Work Toolbox – capturing the wishes and feelings is used by DSLs to capture the voice of the child. These areas will form part of the Section 157/175 audit scheduled for the next reporting year.

Bury Voluntary, Community and Faith Alliance promoted youth leadership through their grants programmes. Two awards were made to a school and a youth group, and projects focused on challenging hate crime and increasing awareness of the impact of hate crime on the lives of young people.

Quality assurance activity in Children's Services has shown improvements in how well the voice of the child is represented in recording – with between a third and 40% of audits finding child's voice to be good or better in the child's record – up from 20% earlier in the year. There has also been steady improvement in how well we are building consistent relationships with children and families we work with – with over 50% of audits now viewing this work as good, up from a fifth earlier in the year. The quality of multi-agency working with children and families is another area of improvement according to audits, with over 50% of audits judging this work to be good in the past 2 months, up from a third earlier in the year.

Our impact on children and families is a key area of focus for Children's Services. We have created an online questionnaire to be completed by parents/carers, asking qualitative questions about the impact of our intervention and our relationships with families. This is seeking to increase the volume of feedback and enable us to use this as key indicator of quality of practice and progress. This is now piloted in the Safeguarding Unit after Child Protection Conference/Review and after reviews for children in care.

Examples of feedback where we have been getting It right:

- Feedback from young person: '*When I call him and he answers, and if he is busy he will call me back, I ask him about something and he sorts it out, he gets things done. I feel he listens to me, he gets back to me....it is better'.*

- Feedback from parent: *'Enjoyed the experience of assessment – just telling you about me, didn't mind at all. Nothing was not right. Just told her what it was. A good assessment – we looked forward to her coming every week. we were always waiting for her to come!'*

- Feedback from foster carer: '*The support we receive from the fostering service is good. We have always had consistent SW's and we have a good relationship with our SW who is visiting today*
  .
- *[The PA] spent a huge amount of time and took Y to various appointments with different housing officers. [PA] had to get medical reports and all sorts of reports to get Y his accommodation. It is not easy getting supported accommodation and [PA] did it.*

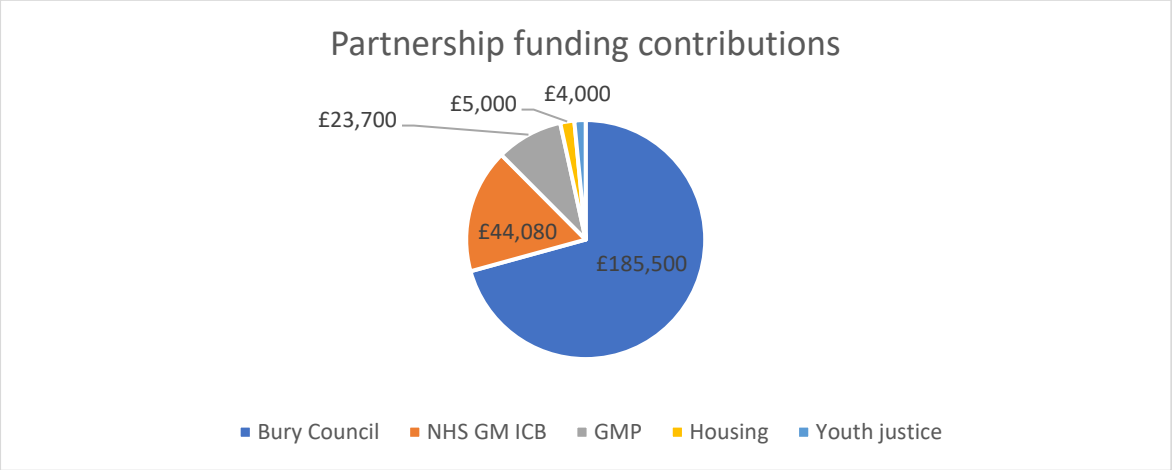
- Feedback from parent: *[The SW} is a really a good social worker, she is the best one I have had by far. SW has my back all of the time in the Core Group Meetings. Some people (professionals) do not see me at all, they attend and give their views which can be negative towards me. SW will address this with professionals and highlight their lack of understanding about my family, she is polite about this but will make it clear it is not fair to judge us. I can talk to SW, I feel at ease with her in situations which are nerve racking, she will always tell me what she has written in reports in preparation for conferences. SW is advocating for my children to be taken off a Child Protection Plan.*

8. Funding the Bury Safeguarding Children Partnership

Each of the statutory partners, and some relevant agencies contribute to the Bury Safeguarding Children Partnership budget.

Safeguarding partners and Relevant Agencies offer their time and expertise to the activities of the Partnership. These activities include participating in meetings, multi-agency audits, child safeguarding reviews, analysing and submitting data, delivering training and ensuring the roll out of key learning and messages.

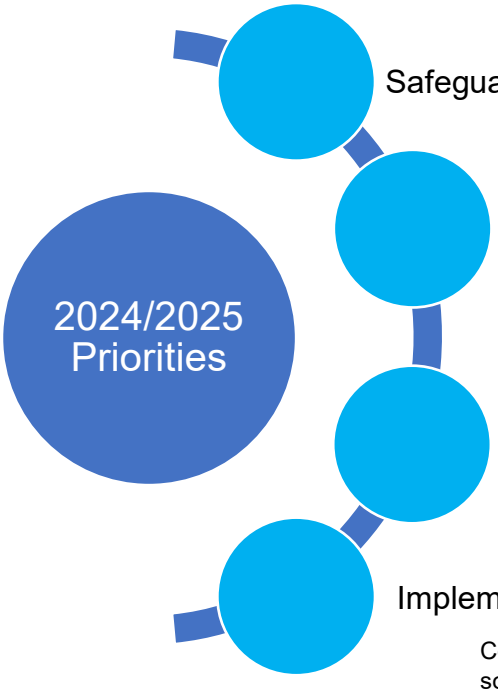
Funding has remained at the same level for several years, due to the financial challenges and constraints within public services.



The funding contributions are essential and support the partnership to have a business unit that can effectively co-ordinate all multi agency safeguarding activity, including management of case reviews and the commissioning of independent reviewers where appropriate, governance support, learning and development, policy and strategy development, audit work, partnership website, performance reporting, implementing legislative changes, horizon scanning for national reforms to be implemented, co-ordinating action tracking, writing and publishing the safeguarding arrangements and analysis of themes and learning. In comparison to some safeguarding partnerships across Greater Manchester, Bury has a small business unit (6 FTE) covering both the safeguarding children partnership and safeguarding adults board.

In this financial year the Department for Education gave all local safeguarding partnerships a one-off grant of £47,300 to help implement the new iterations of Working together. This grant stipulated it was required to be used against the 2023-2024 financial year. In Bury this was used to fund independent scrutiny work, staffing to support implementation of the improvement plan following independent scrutiny and learning and development.

9. Strategic Plan for the Year Ahead



Safeguarding Babies

In response to the number of cases we've had related to infants aged 1 and under, we want to raise awareness of how to keep babies safe

Embedding our Neglect Strategy

Continuing our work in 2022/2023, to ensure that the needs of children are identified and responded to at the earliest opportunity

Protecting children and young people from sexual abuse

In response to the reviews we've carried out where Harmful Sexual Behaviour, and intrafamilial and extra familial sexual abuse have been a theme, we want to protect children and young people from sexual abuse

Implementing Working Together

Continuing our work to strengthen our multi agency safeguarding arrangements, so that we are compliant with the new statutory guidance

Appendix 1: Compliance with Working Together 2023

Working Together to Safeguard Children was republished in December 2023 by the Department for Education and sets out the reporting requirements for safeguarding partnerships. The table below sets out these requirements alongside where our local response can be found:

Working Together 2023 requirement for annual reporting	Section(s) in BSCP Annual Report
What the partnership has done as a result of the arrangements, including on child safeguarding practice reviews	2, 3, 5, 6
How effective these arrangements have been in practice	2, 3, 4
The contribution of each safeguarding partner to the functioning and structure of the multi-agency safeguarding arrangements	2, 3
Any themes emanating from aggregated methods of scrutiny, for example, reviews and scrutineer activity and multi-agency audits	4, 6
Evidence of the impact of the work of the safeguarding partners and relevant agencies, including training, on outcomes for children and families	2,3,4
An analysis of any areas where there has been little or no evidence of progress on agreed priorities	3.3
An analysis of learning from serious incidents	5, 6
A record of key decisions and actions taken by the safeguarding partners in the yearly cycle, including in relation to implementing the recommendations from any local and national child safeguarding practice reviews and the impact this has had	2
Ways in which the safeguarding partners have sought and utilised feedback from children and families to inform their work and influence service provision	7
The breakdown of costs in delivering the arrangements for that period, including the financial contributions of individual partners, any changes to funding and an assessment of the impact and value for money of this funding	8
Evidence of how safeguarding partners are ensuring the adequate representation and input of education at both the operational and strategic levels of the arrangements	2, 3, 4
An overview of how data is being used to encourage learning within the arrangements and evidence of how information sharing has improved practice and outcomes	2,3,5,6
A review of the impact and learning from independent scrutiny arrangements to ensure the leadership is strong and the arrangements are leading to the desired and necessary impact	4
Any updates to the published arrangements with the proposed timescale for implementation	2
Evidence that national reforms have been implemented, taking into account key decisions and actions taken by safeguarding partners in response to reforms, and any issues or concerns encountered within the yearly cycle	2,3