Report to:	Bolton Health and Wellbeing Board		
Date:	13.10.2015		
Report of:	Bolton Safeguarding Children Board	**Report No:**	
Contact Officer:	Shona Green, BSCB Officer	**Tel No:** 01204 337964	
Report Title:	**Bolton Safeguarding Children Board Annual Report 2014-2015**		

Non Confidential:	This report does **not** contain information which warrants its consideration in the absence of the press or members of the public
Purpose:	To share the contents of Bolton Safeguarding Children Board's Annual Report for 2014-2015
Recommendations:	• Bolton Health and Well-being board members to note the contents of the report and the priorities in the business plan • To consider any collective or individual action required by members to address the challenges highlighted in the annual report and/or to promote awareness of BSCB's key priorities
Decision:	
Background Doc(s):	

BOLTON SAFEGUARDING CHILDREN BOARD

Annual Report 2014-2015
Business Plan 2013-2016

Bolton Safeguarding Children

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This Annual Report was endorsed by Bolton Safeguarding Children Board on 5 October 2015. The report is produced by Bolton Safeguarding Children Board (BSCB) in accordance with The Apprenticeships Skills, Children and Learning Act 2009 which requires the LSCB to produce and publish an annual report on the effectiveness of safeguarding in the local area. This report will cover the extent to which the functions of BSCB as set out in the LSCB Regulations 2006, the LSCB (Amendment) Regulations 2010 and "Working Together 2015 "are being effectively discharged.

If you have any comments about the Boards work or wish to find out more you can contact BSCB:-

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Large print, interpretations, text only and audio formats of this publication can be produced on request. Please call on 01204 337479 or email boltonsafeguardingchildren@bolton.gov.uk

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1. A welcome from our Chair….

I am pleased to present this year's annual report of Bolton Safeguarding Children Board for the year ending March 2015. Whilst the necessity to produce such a report is a formal government requirement, it nonetheless provides a welcome opportunity for partner agencies to reflect upon the Boards achievements over the preceding twelve months as well recognising the on-going challenges it faces. In so doing it serves as a reminder of the unrelenting commitment of all those dedicated people who strive to keep our children safe in Bolton.

The report covers a wide range of activity but it must be recognised that it can still only provide an overview of the Boards overall activity in 2014-2015. By way of introduction however, and notwithstanding the progress made against our Business Plan, I wish to single out two areas for particular mention.

Firstly in response to our recognition that we should do more at an earlier stage for our vulnerable children and minimise the risk to which they are subsequently exposed, the Board embarked upon a lengthy project to review its early help strategy. This culminated in the re-launch of our local early help processes (Framework for Action) in October 2014. Already we are seeing encouraging progress with more schools, health services and other sectors using the processes and with emerging evidence of their impact. We hope to report upon the wider success of this in next year's report.

Secondly we recognise that those children who go missing from home and care are amongst those at the highest risk. In order to address this problem it is essential that clear steps are taken to understand not only the scale of the problem but the specific reasons why this occurs by speaking directly to those who take such action. Over the last twelve months we have achieved a strengthening of these processes for all children in Bolton, but particularly for Bolton's Looked after Children placed outside the area and those placed locally by other authorities. Further details of the progress made in these two areas can be found in section 4 of the report.

When things go wrong, can be done better or are indeed done well it is imperative that there are reliable systems in place to learn the necessary lessons and take appropriate action. This year has seen the first full year of operation since the Boards revised Learning and Improvement Framework was introduced. It is evident from the information contained in this report that this is more than just a process and is making a demonstrable difference to enhancing existing arrangements to safeguard children in Bolton

I hope you find the report illuminating and useful and that you may be motivated to provide any constructive feedback to me using the details provided.

Once again I wish to place on record my acknowledgement of the never ending commitment of all partner agencies, staff and volunteers to safeguarding children in Bolton. Without the excellent partnership working which prevails in Bolton we simply could not achieve what we have**.**

Independent Chair
Bolton Safeguarding Children Board

2. Safeguarding Children in Bolton

Awaiting Final Infographic

3. Who we are and what we do…

3.1 Our Children

Bolton has a total overall population of around 279,000 living in approximately 116,400 households, predominantly in the main urban areas of Bolton, Farnworth, Kearsley, Horwich, Westhoughton and Turton. Using current data, it is projected that Bolton's population is set to increase by around 12% or around 33,000 people by 2035. Although the borough is set to gain approximately 30,000 migrants from other countries, it is projected that Bolton will lose around 14,000 residents who will move elsewhere in the UK. The borough is projected to experience a marginally higher birth rate than the national average.

Bolton is categorised as one of the most deprived boroughs in England. According to the Index of Multiple Deprivation 2010, Bolton is ranked 48th most deprived of 326 local authorities. Bolton has higher levels of severe deprivation than its statistical neighbours. According to statistics published annually by HMRC, 22.9% of children in Bolton are living in poverty; 16% are living in low income working families. This challenges beliefs which put poverty down to drug and alcohol dependency, family breakdown, poor parenting, or a culture of worklessness are not supported by the facts.

In terms of Bolton's child population there are approximately 68,000 children in who are aged 17 or under. This is broken down as follows:-

- 18,760 aged 0-4
- 20,700 aged 5-10
- 17,800 aged 11-16
- 11,000 aged 17+

Bolton's overall population has been increasing steadily over the past decade, with an increase of 16,300 people in the last ten years. Each year around 3,900 babies are born. Bolton has seen a 24% increase in its birth rate in the last decade, with higher birth rates in the more deprived areas and areas with the highest black minority ethnic communities. Between 2012 and 2013 there were 1,200 more births than deaths.

Almost 30% of births are in the most deprived fifth of the population. Over a quarter of births in Bolton today are to mothers born outside the UK. The increase in new and emerging communities is significantly changing the profile of children currently entering full time education. The largest BME groups in schools are Indian and Pakistani although the fastest growing groups are Black African, Black Other and White Other reflecting the international migration patterns in the Borough. In the Academic Year 2014-15, 30% of Bolton's school children were from a BME community. In the coming year, 2015-2016 will seek to further develop relationships with key community groups, building on our success of securing Bolton Council of Mosques membership on BSCB.

The infant mortality rate, although higher than the national rate, is reducing and now much closer to the Statistical Neighbour average. A key contributing factor has been the impact of Bolton Safeguarding Children Boards 'Sleep Safe campaign' which has reduced the average rate of sleep related infant deaths from 4.6 deaths in April 2008-

March 2011 to 3 in the period April 2011 to March 2014. There were no reported sleep related infant deaths in 2013-2014 and this was sustained in 2014-2015. This is a real success for Bolton and a reflection of how well all agencies have worked together to deliver a co-ordinated message to reduce infant deaths.

It is important for all services to consider the impact of Bolton's changing child population. The higher birth rate coupled with an increase in children living in Bolton's more deprived areas is likely to mean we will have more children in need of extra help and possibly protection. **Services should be alert to this and ensure that they make best use of Early Help processes to ensure their resources are utilised to safeguard and promote the welfare of children in our area.**

3.2 Our Remit - Bolton Safeguarding Children Board

The Children Act 2004 required all Local Authority areas to establish a Local Safeguarding Children Board (LSCB). LSCB's are inter-agency partnerships with statutory responsibilities to co-ordinate local arrangements to safeguard and promote the welfare of children and to make sure that they are working effectively. Membership of Bolton's Board includes Health Services, Probation, Greater Manchester Police, Children's Services, Housing Services, the voluntary and faith sector. A full list of members can be found in Appendix 2.

Bolton Safeguarding Children Board (BSCB) is responsible for:-

- Developing policies and procedures for safeguarding and promoting the welfare of children
- Raising awareness within communities and organisations of their responsibility to safeguard and promote the welfare of children and support them to do this
- Co-ordinating and evaluating inter-agency training and evaluating single agency training to safeguard and promote the welfare of children
- Monitoring and evaluating the effectiveness of the Board and its partners in carrying out these legal duties
- Contributing to local planning for children and their families
- Undertaking Serious Case Reviews and advising the Board and its partners on lessons to be learned

In fulfilling these functions it is our aim to keep children safe in Bolton and support them to achieve their full potential.

The Board itself meets every two months and focuses its attention on the implementation of the Business Plan, the priorities within this and the impact action is making to improve safeguarding outcomes for children in Bolton.

In order to promote and strengthen partnership work which exists in Bolton, all Board members are required to commit to a members agreement which stipulates 80% attendance at meetings across the year. There has been a slight decrease in members achieving this target this year and this been reviewed by the Independent Chair. The factors influencing attendance over the year have included changes within organisational structures and the re-commissioning of services, particularly within Probation Services, NHS England and Health Services, has led to lack of consistent attendance. Members

have been reminded by the Chair of their attendance requirements and this will remain under review.

4. Evaluation of Safeguarding Arrangements in Key Areas

This section of the Annual Report will focus on some of the areas contained within the business plan to give a flavour of how well Bolton Safeguarding Children Board and their members assess progress to safeguard children. A full evaluation of progress against the business plan is contained within Section 5. BSCB have focussed on the following for this Annual Report:-

- Priorities for 2014-2015
  - Impact of Early Help
  - Children Missing from Home/Care
  - Child Sexual Exploitation
- Core Business for 2014-2015
  - Child Protection System
  - Looked After Children
  - Private Fostering Arrangements
  - Learning Reviews
  - Child Death Overview Panel
  - A Safe Workforce

4.1 Early Help and Multi-agency Working

Further developing multi-agency working and re-launching Bolton's Framework for Action was a key priority for the Board in 2013-2014. In October 2014 the revised guidance was launched. Since this time the Board has been keen to evaluate the impact of this re-launch. Success measures identified by the Board include:-

- Increased use of the Early Help Process to provide the right help at the right time for children and avoiding the need for statutory services
- The quality of Early Help Assessments (EHA) and Action Plans improve and services embed the model
- Evidence that where statutory services are required, early help has been provided

In 2014-2015 almost three times the number of Early Help Assessments have been undertaken compared with the same period last year. Graph 1 illustrates this:-

Graph 1 – Comparison of new CAF/EHA undertaken in 2014-2015 compared with 2013-2014

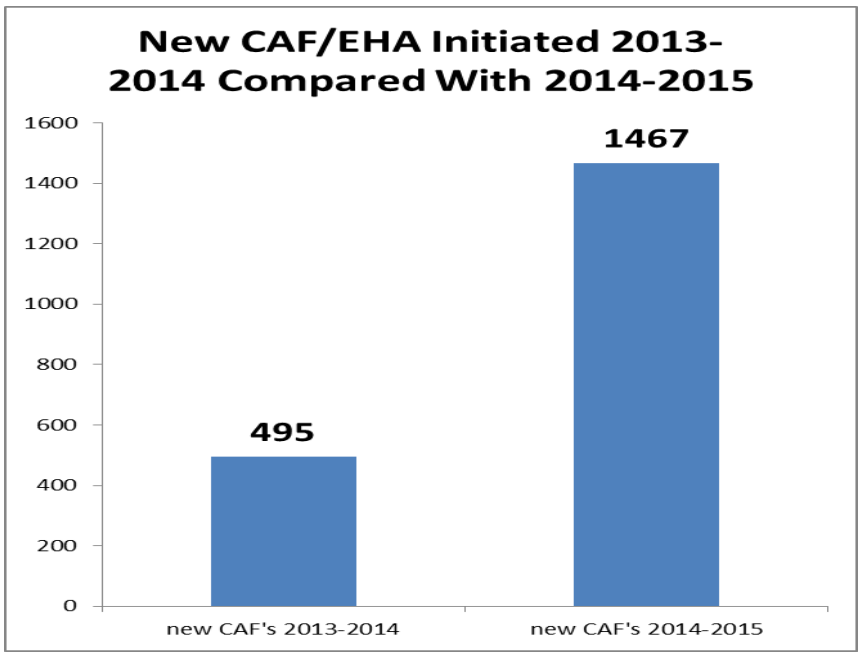


Table 1 shows the range of services starting the Early Help process in 2014-2015 and how this compares with the previous year.

Table 1 – Number of Early Help Assessments by Service and Number Started

SERVICE	2012-2013	2013-2014	2014-2015
EARLY YEARS (PRIVATE NURSERIES)	11	18	55
BOLTON AT HOME	3	0	14
INCLUSION AND ACCESS	28	63	94
MIDWIFERY	54	53	58
HEALTH VISITING	64	49	339
SCHOOL NURSING	11	4	20
CAMHS	Not reported	3	12
CHILDREN'S HEALTH SERVICES - OTHER	61	25	44
PRIMARY SCHOOLS	159	159	550
SECONDARY SCHOOLS	53	62	169
SPECIAL SCHOOLS	2	2	11
5-19 SERVICE	2	2	0
TARGETED YOUTH SUPPORT	0	9	11
CHILDREN'S VOLUNTARY SECTOR	5	11	18
YOUTH OFFENDING TEAM	2	14	32
OTHER	4	21	40

It is encouraging that the number of education settings using the process has significantly increased. More primary schools are using the process - **55 in 2013-2014** to **83 in 2014-2015**; as are more secondary schools **14 in 2013-2014** to **17 in 2014-2015**. This indicates that schools are developing their understanding of the process and seeing the value in working with children and families using the early help approach.

The case study below illustrates one primary school's experience.

EARLY HELP - ONE SCHOOLS EXPERIENCE

Primary school A had noticed in the last few weeks that Jack's behaviour had changed. He had gone from a boy who obeyed the school rules, listened to his teachers, did his work in class, got on with his class mates to a little boy who was talking back to teachers and challenging their requests, fighting with his friends, getting angry – this worried the school and they felt they needed to access behaviour support as the strategies being used were not working.

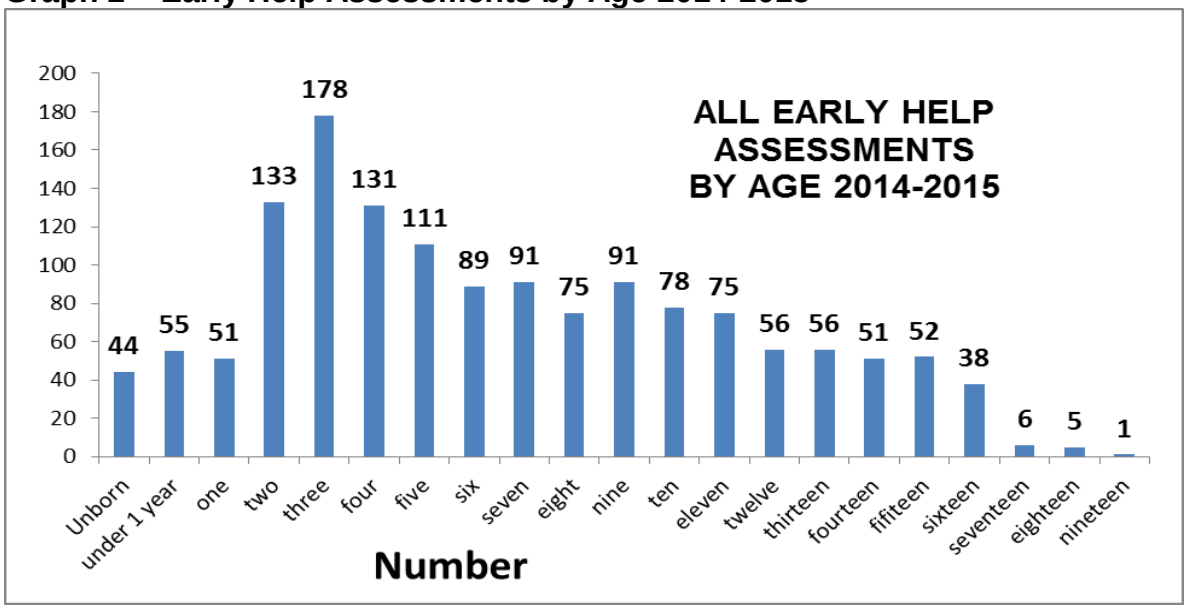
They asked mum into school to talk about the problems, the need for behaviour support and to introduce the early help assessment – during this discussion and working through the elements of the early help assessment framework, the school found out that a close relative had died and this was what was affecting both Jack and his mum; both were struggling with their grief.

This changed the schools planned actions – rather than behaviour support they were able to offer direct support to Jack and link mum and Jack into bereavement support.

By using the Early Help process the school were able to better identify the issues, provide a therapeutic intervention, support Jack and his mum to get the right extra help. This avoided the need for unnecessary services getting involved.

When we look at the age profile for Early Help Assessments, however, questions remain as to whether all children who need early help support are receiving this, and if they are, whether it is part of a co-ordinated early help offer. This is particularly important as children move into adolescence.

Graph 2 – Early Help Assessments by Age 2014-2015



It should be noted this is the first year that this data has been reported and is a benchmark for future analysis.

As Table 1 shows, the vast majority of services have evidenced an increase in the number and use of early help in 2014-2015. Since the re-launch, new service developments and initiatives have ensured that the Early Help is embedded into their business processes. This indicates a strategic commitment to Early Help and will undoubtedly have contributed to the overall increase. Local services that have embedded Early Help within their pathways include Access and Inclusion Services and the Early Years Improvement Team as a key component of their new delivery model for children aged 0-5.

Moreover to support the re-launch in October 2014 a number of services reviewed their own referral processes and as a consequence have adopted the Early Help Assessment as the key document to access their service. Using the Early Help Assessment in this way supports the service to identify whether their service is required as well as ensuring that they can deliver the desired outcome for the child. In 2015-2016 the Board will be seeking to understand how well other services have embedded Early Help within their pathways.

For the first time, BSCB is able to report on the reasons why the Early Help Assessment process is used. Table 2 highlights the reason.

Table 2 – Summary of Reasons for Early Help Assessment

REASON	NUMBER
Multiple	923
Health	214
Behaviour	123
Education	73
Domestic Abuse	13
Adult Mental Health	2
Adult Substance Misuse	1
Neglect	0
Emotional Health	14
Child Substance Misuse	5
Parenting	35
Safeguarding	17
Teenage pregnancy	12
Family First	28

Predominantly, services have identified 'multiple' reasons for completing an Early Help assessment; BSCB has reflected on this and agreed it is not helpful and the option to identify more than one need will be removed for future reports. Health reasons are identified as the next highest reason for delivering Early Help and this includes children with Speech/Communication needs and child development support – these will be reported on separately in 2015-2016 to better evaluate the use of the Early Help process and to track the outcome and impact of how well services have met the child's needs.

Local processes in Bolton require that any referral made to Children's Social Care is followed up in writing using the Early Help Assessment Template to share information and evidence the referral. In 2014-2015 only 27 Early Help Assessments have been identified and recorded by the Integrated Working Team as referrals to social care. This is an extremely low number when compared to the 4327 referrals made to social care in 2014-2015.

This indicates to BSCB three potential scenarios:-

1. Practitioners are not following up telephone referrals at all in writing
2. Practitioners do follow-up in writing but not in accordance with the requirements of Bolton's Framework for Action;
3. Practitioners are following-up referrals in writing but are not sending a copy to the Integrated Working Team

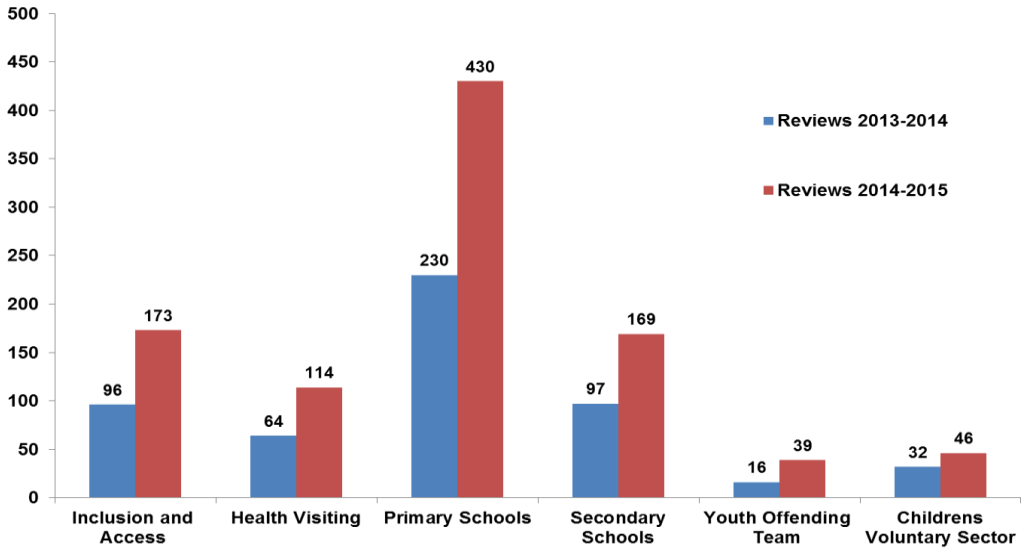
Whatever the reason it is important that those making referrals to children's social care follow-up in writing to ensure accurate information is shared and to evidence that they are discharging their duty to safeguard children effectively. **In 2015-2016 we will be seeking the support of all Board members to promote this requirement across their services.**

There were 632 assessments completed across this education sector but only 73 of these identified education as the main reason for using the process. This provides assurance and evidence to BSCB that education settings are responding to the whole child; seeking to meet not only a child's learning needs but also their emotional and social needs.

In order to identify if the goals set in the action plan are effective and making a difference to children and families, Early Help Action plans should be reviewed regularly. Each time a review is held, an updated copy of the form should be sent to the Integrated Working Team, who update the system, noting whether the Lead Professional role has changed or the process needs to be closed. In 2014-2015, a total of 1015 reviews were undertaken for 640 individual children.

Again, the figures are significantly higher compared to the previous year – both in terms of the numbers of cases reviewed and also the number of services undertaking reviews. 434 children had their plans reviewed only once during the year, however the remaining 206 were reviewed 2 or more times to a maximum of 7 reviews (3 young people) in the period, reflecting use of the Child Action Meeting process.

Graph 3 – Comparison of Early Help Reviews 2013-2014 and 2014-2015 in Key Services



In 2014-2015 1368 CAF/EHs were closed. This compares to 158 during 2013-2014. Measurement of the impact of Early Help is an area that is difficult to quantify and has been a topic of discussion and scrutiny both in the Early Help Steering Group and at regional Early Help meetings. Many cases will have had successful outcomes but this will not have been recorded on the assessment nor sent to the Integrated Working Team. For 2015-2016 there will be a focus on improving and reporting on

the outcomes arising from Early Help Assessments. **BSCB will seek to evaluate this on a quarterly basis by strengthening our current closure processes.**

In February 2014 Bolton's Early Help Processes were inspected and evaluated as part of Ofsted's "Inspection Of Services for Children In Need Of Help And Protection, Children Looked After and Care Leavers And Review Of The Effectiveness Of The Local Safeguarding Children Board". Ofsted's view of the arrangements were

"Agencies in Bolton work well together to provide early help to children and their families. The Framework for Action underpins this and provides partners with a pathway to prioritise and determine what services are required to support, respond to and coordinate a range of early help services to children and young people. Agencies use the common assessment framework well to assess the needs of children and young people. Together with families, they agree which services should be offered through child action meetings before difficulties become serious enough to need intervention from children's social care."

While this positive feedback is welcomed, it is important that we continue to develop and challenge partners to ensure that our local processes remain effective.

Quality assurance of Early Help assessments is a key focus for Bolton Safeguarding Children Board. A number of methods are used to evaluate quality, evidence compliance with local processes and evidence impact for children, this includes:-

- All Early Help Assessments are being reviewed by the integrated Working Team to assess that consent is recorded, action plans are in place and action plans are Specific Measurable Achievable Relevant and Timely (SMART) – where issues are identified with individual assessments, the lead professional is contacted and one-to-one support offered to improve quality
- Three multi-agency quality reviews are carried out each year; themes identified from this process include continuing to improve the quality of action planning, ensuring the children and parents fully involved in the process and challenging a 'referral culture' and creating a culture of accessing help – these issues inform future training and development of guidance and other supporting documents
- Case studies are also collated to evidence the impact of using Early Help well, one of these is included below

The importance of this work has been recognised by BSCB as a key element of keeping children safe in Bolton and as such the Board has formally endorsed and embedded the Early Help Steering Group within its governance. Particular thanks are extended within this annual report to the Boards Lay Member, Elsie Rigby.

Elsie has worked tirelessly to promote the ethos of early help to ensure that children who have additional needs are helped and supported; potentially preventing child abuse or neglect. As a member of the Early Help Steering Group she has spoken to a significant number of workers at the 'grass roots'; this has included interviews with Family Support Workers, Nursery Managers, Health Visitors and Social Workers. Elsie has sought the views of parents and spoken to a number of families about how Early Help has worked for them and where improvements can be made.

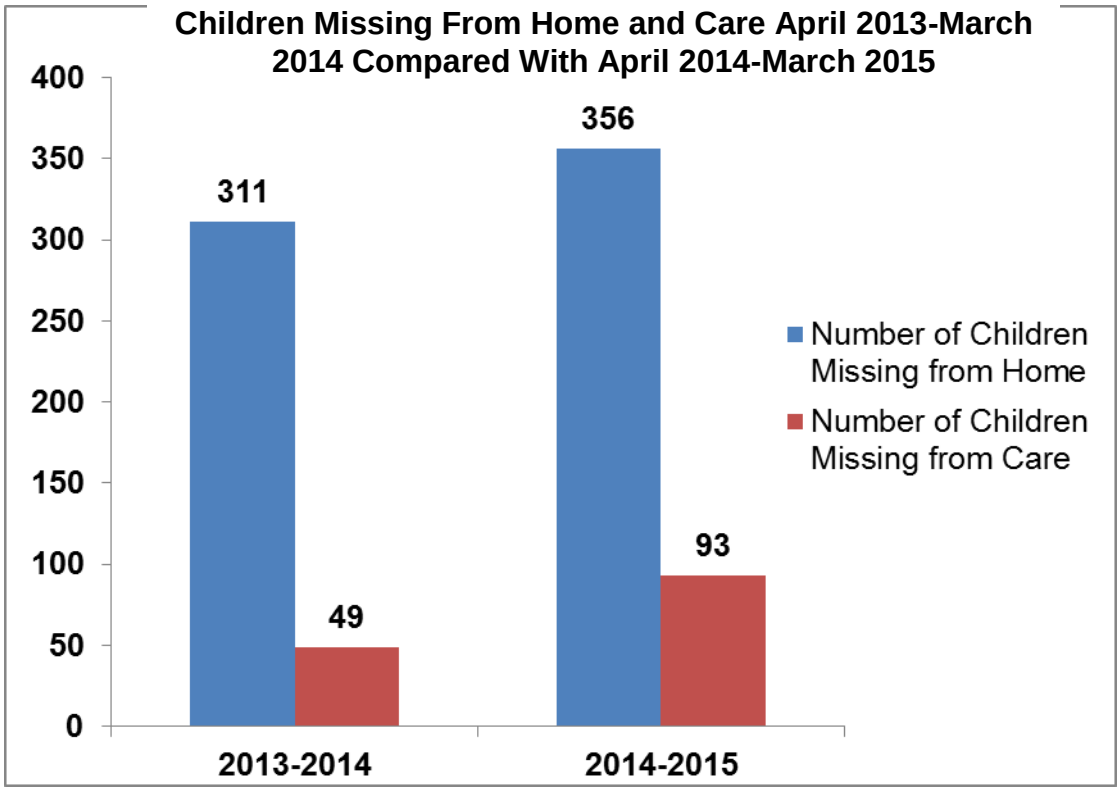
Elsie has brought all these experiences to the table and in doing this has shaped the redevelopment of local policy and improved practice.

4.2 Children Missing from Home

BSCB collate data on a quarterly basis about the children who are reported missing from home or care.

From April 2013 to March 2014 there were 788 reported missing episodes involving 360 children. This has increased in 2014-2015 to 1004 missing episodes involving 444 children. This equates to a 27% increase in reported missing episodes and a 23% increase in children who are missing compared to the previous year. The majority of children who are reported missing are in their teenage years, aged 13-17 years old.

Graph 4 – Comparison of Children Missing from Home and Care



93 children were reported as missing from care compared with 356 from home in 2014-2015. This is an increase of 90% in children missing from care on the previous year, but remains a small proportion of the overall number of children who are missing each year. This figure has to be viewed with some caution as BSCB believe some of the increase is due to improved data sharing and awareness raising as opposed to 'real' increase in the number of children missing from care. That being said there is an older cohort of children who came into care in 2014-2015 as a consequence of their history of missing; and again this may be impacting.

In 2013-2014 the BSCB annual report identified that information was not readily available regarding missing episodes of Bolton young people who are 'Looked After

Children' but living outside of Bolton; and equally there was a gap in knowledge about children accommodated in Bolton from another Local Authority area. This gap has been addressed and a process embedded in 2014-2015. This has shown that there were 31 children who were reported as missing in Bolton who were the responsibility of another local authority area.

Where there are risks for these children liaison takes place with the other authority social worker and Bolton services are delivered to the child to keep them safe. Being able to identify these children means any potential risks can be fully assessed and discussed at Sexual Exploitation and Missing[1] (SEAM) if required. In 2013-2014 this was not possible and as such is a significant improvement in safeguarding these vulnerable children. Those working with the children are able to review and update current care plans to address missing from home concerns.

There remains an inconsistency in reporting episodes of missing for Bolton children placed outside the area. A process has been agreed to resolve this challenge and from 2015-2016 BSCB can be better assured as to the safety of our looked after children placed outside the area.

Also in the 2013-2014 annual report it was recognised that,

"An area of development of the group is to work towards meeting the timescale for return interviews for children who are missing; to record and report on this and to better understand why there may be delay in conducting a return interview"

In Quarter 3 of 2014-2015 mechanisms were implemented to improve recording and reporting of return interviews for Bolton children. Analysis of this data from Quarter 3 and 4 has shown that 45% of return interviews were undertaken within the required timescale. Some return interviews cover more than one missing episode if a young person goes missing more than once in a short time period.

Being compliant with the statutory guidance and undertaking return interviews within 72 hours has proved challenging in most cases, the reasons being:-

- Current systems for reporting that a child has returned means that often neither RUNA[2] nor Children's Services are informed by the police that a child is missing or returned within a timescale that supports interviews to be completed within the 72 hours
- RUNA's process is to allocate cases on a weekly basis and their policy is to seek consent from parents before contacting a young person to undertake an interview

6.4% of return interviews have not been taken up or refused either by the child or their parents. The reasons provided by children or their carers include:-

- The young person does not deem themselves to be missing
- Young people minimising the risks to themselves by being missing

[1] SEAM – multi-agency arrangements to ensure children who are missing from home/care have plans in place to keep them safe and reduce risk of harm

[2] RUNA – a commissioned service providing support to children who go missing from home

- Young people not wanting to share information about what they are doing when they are missing, where they go, or who they are with
- Parents say they themselves or the police have spoken to the young person regarding risks and dangers and they view this to be sufficient
- Other support services are in place, or referrals have been made and they don't feel RUNA's involvement is needed
- The young person has told their parents they don't want an interview
- Parents don't respond at all to the offer of a return interview

Missing episodes for children from other authorities but accommodated in Bolton have not been included in the return interview percentage as the responsibility for these sits with their home authority.

SEAM CASE STUDY

A young male aged 15 was referred to Phoenix EXIT (CSE Team in Bolton) following a strategy meeting. He had a number of professionals working with him, including Children's Social Care and Targeted Youth Support. He had a difficult relationship with his mother and stepfather. Although he was frequently reported as missing there were many occasions when he wasn't reported and was known to have been 'sleeping rough' in car parks and behind a local pub.

The case was discussed at SEAM and information identified:-

- He was assessed as a high risk of Child Sexual Exploitation using the CSE Risk Assessment Tool
- He had a serious and entrenched addiction to 'legal highs' which were being supplied by older males- some of whom worked at a local 'legal high' shop
- He was going missing and staying with some of these male

SEAM members agreed the following actions, which not only secured the safety of this child but also prevented future harm to other children:-

- Abduction notices served to adults found in the young person's company
- CSE disruption visits to premises
- Housing providers visited addresses to establish legitimacy of tenancy/property
- A closure order granted was granted in respect of the legal high shop as a result of evidence gathered by the partnership
- Individual civil orders were applied for against all individuals working at the shop

This case highlights how the work of the SEAM group came together to support a young person and outlines how use of tools and processes can make a difference to an individual to reduce missing episodes and CSE overall.

As a Board we have developed our understanding of children who are missing in Bolton over the last two years and are able to evidence some excellent practice in recognising and responding to the risk this presents to the child and their family. The case study above provides just one such example.

There is, as ever, still work to be done to ensure that the Board continues to evaluate and scrutinise work in this area in particular:-

- **Understanding and responding to the reasons why there has been an increase in the number of children being reported as missing**
- **Developing new initiatives to address some of the systematic issues that hamper swift return interviews**

The impact of any revised strategies will be reported in 2015-2016.

4.3 Child Sexual Exploitation (CSE)

BSCB can be proud of its commitment to improving practice in this area. A brief history shows BSCB has been responding to this issue since 1999 when the then Area Child Protection Committee (ACPC) became aware that some young people were at risk of sexual abuse from predatory adults or groups of adults. Over the years the ACPC and now BSCB have continued to develop partnership responses and services in this area and 2014-2015 has been no exception.

The specialist CSE team in Bolton, Phoenix EXIT continues to offer a multi-agency co-located approach and response to CSE in Bolton, as well as contributing to wider CSE work across Greater Manchester. Phoenix EXIT consists of the following operational staff:-

- 1 Detective Sergeant
- 2 Detective Constables
- 1 police intelligence analyst
- 1 Police Constable
- 1 Children's Services Manager
- 2 Social Worker (Additional social worker in 2014-2015)
- 3 Support Workers

Health interventions are delivered by a Specialist Senior Practitioner at The Parallel Adolescent Health Service in Bolton.

In 2014-2015 there were 81 new referrals to Phoenix Exit; this is an 11% decrease on the previous year. The number of 'high risk' CSE referrals remains low compared with the overall number of referrals made to the team in 2014-2015; 4 of the 77 (10%) being assessed as 'high risk of CSE' following the initial risk assessment.

In terms of children's level of need as defined in Bolton's Framework for Action, of the 81 new cases opened to EXIT in 2014-2015: -

- Level 2 - Early help = 5%
- Level 3 – Child in Need = 86%
- Level 4 – Child Protection= 4%

  Looked After = 6%

In 2013-2014 Phoenix Exits' re-referral rate was 19%, in 2014-2015 this reduced to 10%. In terms of age ranges 13-15 years remains the key age band accounting for 58% of referrals to Phoenix EXIT. There has been a 3% reduction in 2014-2015 in the number of under 12's receiving a service from Exit from 10% in 2013-2014 to 7% this year. This reflects the impact of the preventative approaches implemented as part of BSCB's Child Sexual Exploitation Strategy.

The cohort remains predominately female however there has been an increase in the number of young males receiving a service – from 3.2% in 2013-2014 to 10% in 2014-2015. This increase is a consequence of the work undertaken by the CSE Steering Group to raise the profile of males as potential victims of CSE, including the commissioning of an external evaluation of practice completed by BLAST[3].

When reviewing outcomes for young people accessing the service the evidence indicates that therapeutic interventions reduce the risk and improve longer-term outcomes. The level of risk is determined at the first Phoenix EXIT assessment following referral to the team. All subsequent re-assessments are measured and evaluated against this initial score; re-assessments are carried out every three months or following a significant event. Of the 89 cases closed in 2014-2015 the level of risk was reduced in 65% of these. In 20% of cases the level of risk remained unchanged as it was already low; however young people still benefited from direct work to increase their awareness of risk and knowledge about what to do to keep themselves safe. 2014-2015 has seen a 58% increase in cases closed during the year when compared to 2013-2014 providing evidence that the team continues to increase the number of young people it works with over the course of the year.

Prosecutions against CSE offenders are challenging and not as easy to achieve as perhaps the popular media would have you believe. Young witnesses need considerable emotional and practical support to provide their evidence and overcome their fears and anxieties of making a statement to police or giving evidence in court. Victims also may not wish to pursue a criminal conviction either as a consequence of the emotional impact on them or their family or because of fear of repercussions from the alleged offender. There are also occasion when agencies working with the child identify that pursuing a criminal prosecution is not in the best interests of the child; this is usually the case where children may not have the physical or emotional resilience to withstand a full court case.

[3] BLAST Project (part of Yorkshire MESMAC Group of Services) is the UK's leading male only sexual exploitation service supporting and working solely with boys and young men who have experienced, are experiencing or are at risk of experiencing child sexual exploitation (CSE)

However this does not mean that no action is taken against known or suspected CSE offenders. A range of civil and other criminal routes to deter offenders are utilised. Since the integration of Phoenix Exit in September 2013-2014, weekly disruption operations have taken place; this built on previous targeted operations and the lessons learned from these. The aim of disruption is to:-

'*Identify vulnerable children and take action to safeguard them Identify offenders and take action to prevent child abuse; provide a community presence to re-assure the public and deter any CSE related offences'*

During disruption activity Phoenix EXIT will visit children at risk of CSE, children identified as high risk of missing from home, hotspot areas in Bolton where local intelligence indicates this is a risk area for potential CSE offenders and victims. Uniformed officers visit offenders and target addresses where intelligence suggests CSE activity is a risk.

The operations take place on a different day and time each week. Table 4 shows the evolving picture of how disruption is making a difference in Bolton.

Table 3 – CSE Disruption Activity in Bolton

CSE Disruption Activity	**2013-2014**	**2014-2015**
Offender Addresses visited	128	449
Offenders seen	91	235
Victim Addresses visited	76	280
Victims seen	61	198
Number of hotspots	18	22
Number of times Hotspot locations visited	269	377
Police Interviews with Children	30	36
Number of Abduction Notices	Not reported	49
Number of CSE related cases sent to CPS	Not reported	34
Number of CSE related convictions	Not reported	6
Current Investigations at Year End	15	19

It is clearly evident from the data relating to prosecutions, abduction notices served and other 'hotspot' activity that disruption is making a difference in Bolton and is producing successes in keeping children safe; 50% of all CSE Related Intelligence submissions during this period were generated as a result of disruption activity. It will be important for all Board members to ensure that their workers continue to support the work of Phoenix Exit.

While it is encouraging that there is an increase in the number of convictions related to CSE; it is still considered to be too low a percentage of the number of referred to CPS and will require further attention by BSCB.

What Young People tell us of their Experiences…

THANKS FOR STAYING WITH ME EVEN THOUGH I AM HORRIBLE AT TIMES.

I HATE TALKING TO YOU, 'CAUSE I ALWAYS END UP TELLING THE TRUTH

PHOENIX EXIT CASE STUDY

In the early hour of the morning a resident in Bolton came out of his home as he had heard noise and there had been a spate of burglaries in the area. He saw a car with three young girls in it and an older male. When he approached the car, it drove off . The resident felt this was worrying and alerted the police. Sometime later a Police patrol car stopped the vehicle with the children inside and the male was arrested. The male insisted he was just 'chillin' and the girls were outraged at their 'friends' arrest and the children were returned home.

An immediate referral was made to Phoenix EXIT to investigate the incident and work with the children; all three girls were allocated a Phoenix Exit worker. The three girls were initially resistant to working with EXIT, insisting that the older male was a friend who gave them free food and had never behaved in an inappropriate manner. All three girls struggled to recognise and understand the grooming and manipulation process. They initially blamed the police and agencies. Parents struggled to accept that their daughters had been manipulated and that their loyalty was with the older male.

Direct work was provided by EXIT which included regular visits with each girl, direct work sessions focused on develop their understanding of CSE and recognising the signs of grooming and the risks. Direct work and support was also provided with all parents helping them understand about CSE and how their children had been groomed into believing this man was their friend and therefore safe

Work with parents and the children resulted in a greater understanding of the true motivation of the male and the risk he posed to children. From an initial start of non-co-operation all the girls accepted the risk the man posed and ultimately supported a prosecution.

As a consequence of the direct work, the girls provided interviews and statement to the police and the male was sentenced to 3 years imprisonment and an extended period on licence once released.

I KNOW I GET ANGRY BUT I DON'T WANT YOU TO LEAVE ME

I FEEL LIKE A BAD PERSON, SOMETIMES I FEEL BROKEN

4.4 Child Protection System

The Quality Assurance group have continued to scrutinise and evaluate performance information in respect of children subject to a Child Protection Plan and their journey once referred to Children's Social Care.

Referrals

At the end of 2014 Bolton's rate of referrals per 10.000 under 18s at 728 was considerably higher than the England average (573), the statistical neighbour average (672) and the regional average (688). The increase in rate in Bolton, however, mirrored similar levels of increase (around 10% over the year) nationally and so Bolton's relative position has remained unchanged. Compared to our statistical neighbours we saw a much bigger rise in the rate of referrals between 2012 and 2014; during that period Bolton experienced a rise of 20% compared to an 8% rise for our statistical neighbours.

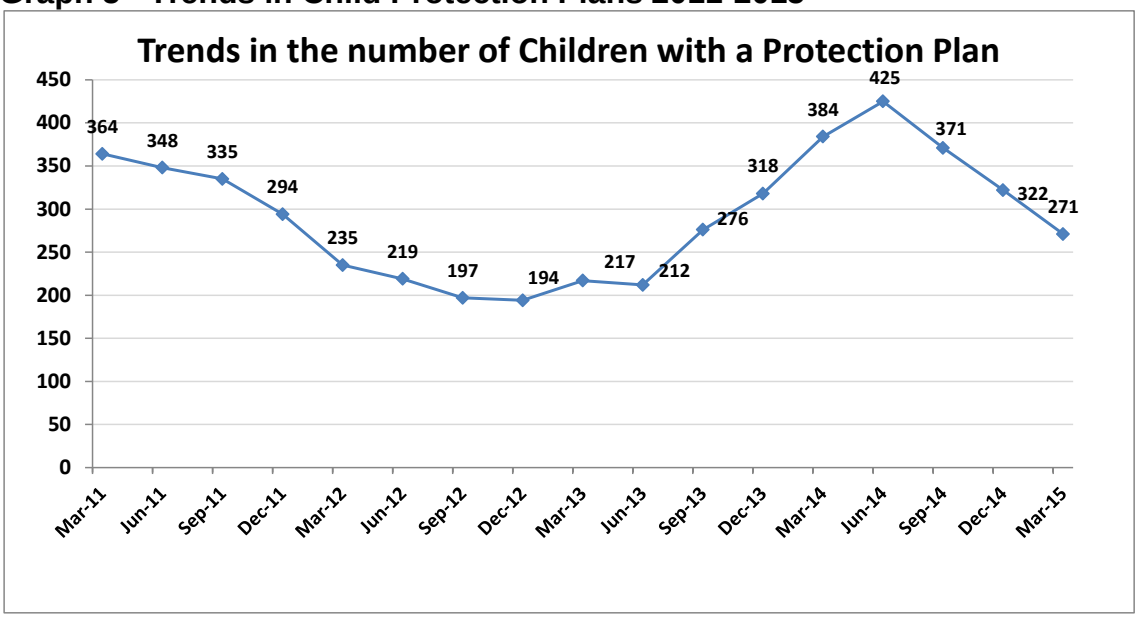
During 2014-15 the rate of referrals has fallen by almost 10% which at 657 would per 10000 would place Bolton between the England 2014 rate, the 2014 regional and statistical neighbour averages.

The percentage of referrals during 2014-15 which were within 12 months of a previous referral at 23% has remained relatively constant for the last 5 years and within our target range of between 20% and 25%. Bolton is in line with the England 2014 average and below the regional average and that of our statistical neighbours.

Children Subject to a Child Protection Plan

As previously noted in BSCB's annual report 2012-2013, there has been an increasing trend in numbers of children subject to a plan. As Graph 6 illustrates this trend continued into 2014-2015 with a peak of 425 in the summer of 2014.

Graph 5 - Trends in Child Protection Plans 2011-2015



It was important for BSCB to understand the factors influencing this increase and take action if possible to address any root causes this was achieved through a combination of case audits and scrutiny of current available data. In preparing for the audit, key lines of enquiry were identified as potential root causes for the significant increase by members of BSCB, its Safeguarding Executive and its Quality Assurance Group. These and the related findings are detailed below:-

- **Changing ethnic populations**

The audit found that ethnicity of children subject to a Child Protection Plan has changed significantly over the last three years from 87.6% White British in March 2011 to 70.6% in March and June 2014, however over the same period we have seen the numbers of plans fluctuate from a low in March 2013 of 216 to a high of 425 in July 2014.
This would therefore suggest that this is not a significant factor.

- **The impact of judicial changes to Childcare Proceedings, in particular implementing Public Law Outline (PLO) has resulted in an increase in children being made subject to a child protection plan**

A report was run on all children with PLO and a Child Protection Plan and between August 2013 and July 2014. This report identified that 36 children from 21 families were identified as being the subject of a Child Protection Plan and PLO. A further 19 children from 17 families were identified as being subject to PLO but no Child Protection Plan.

Therefore while there may have been some increases in children becoming the subject of a plan as a consequence of judicial reforms, it alone does not account for the significant swell in the number of children subject to a child protection plan.

- **Impact of CAF/Early Help - either identifying increasing needs and risks resulting in an increase in cases 'stepping-up' or failing to be used effectively to provide co-ordinated early help and prevent escalation**

The sample of children was cross-referenced against Bolton's 'One' database to identify where the CAF process had been used. Of the 40 cases audited only 4 were identified as 'having' a CAF – of these 4,

- 1 was information sharing for a referral
- 1 was open but not actively reviewed
- The remaining 2 indicated a level of Early Help

It is clear that in this sample Early Help has not been used effectively to provide co-ordinated action to prevent or reduce the likelihood of escalation into statutory Child Protection processes. It would have been reasonable to expect a higher proportion of the children subject to a plan to have been supported using Early Help processes. **This conveys a significant message for the future in terms of embedding Early Help processes and will be an area that receives future scrutiny in 2015-2016.**

- **Larger sibling group's i.e. same number of families but families with greater numbers of children**

Since April 2013, data relating to the number of families and children subject to an Initial Child Protection Plan has been collected. The data indicates that there was a

slight increase in the number of families made subject to conference in 2013-2014 and this was further compounded with larger sibling group sizes; together these led to increasing numbers of children subject to a plan.

Data relating to sibling group size will continue to be collated to ensure the influence of this factor can be monitored and support BSCB in its on-going analysis of themes and trends in Child Protection Plans,

In summary what we found was that whilst changing demographics and the PLO may have had some impact this was found to be less significant than the emergence of an unusually high number of large sibling groups and of particular significance ineffective use of early help processes. **An additional factor which is now under consideration is the effectiveness of step-down processes and whether the re-launch of the Framework for Action will have a positive impact on stepping down from social care and ensuring that change is sustained for children in the longer-term.**

Child Protection Plan Category

Table 4 - Annual trend in Categories of Abuse of Children with a Protection Plan

Category	Bolton 2012 (%)	England 2013 (%)	Bolton 2013 (%)	England 2014 (%)	Bolton 2014(%)	Bolton Q1(%)	Bolton Q2(%)	Bolton Q3(%)	Bolton Q4(%)
Emotional	27	32	34	33	45	45	48	46	39
Neglect	48	42	48	43	33	35	34	38	45
Physical	16	11	14	10	18	16	14	14	13
Sexual Abuse	9	5	4	5	4	4	4	2	3
Multiple	0	11	0	9	1	0	0	0	0

Categories of abuse

An analysis of the proportion of children on plans during 2014-14 categorised by type of abuse showed that compared to the national average, Bolton had a lower proportion of plans relating to neglect and a higher proportion relating to emotional abuse and physical abuse. During 2014-15, the proportion of plans due to neglect has increased with a significant increase during January – March 2015. By March 2015 the proportion of children are on plans for each category of abuse is now broadly similar reasons to the national profile in 2014.

Ages of children on plans

The decrease in the number of children on protection plans is not spread evenly across all ages. Whilst the proportion in the younger age ranges has fallen during 2014-2015, the 10-15 age groups rose by 5 percentage points. At the end of the year the age profile of children with a plan reveals that Bolton has a smaller proportion of under 1s and a higher proportion of 1-9 year olds than the 2014 England average.

Ethnicity of children on plans

The ethnic profile of children on plans has shown some movement over the year. The proportion of children on plans who identify as ‘African and ‘White and Asian’ has

increased. The ethnic groups with the largest proportional decreases during the quarter are 'Pakistani' and 'Indian'. This makes the overall cohort of children with plans closer to being representative of 0-17 population of the Borough as a whole, although BME children on plans remain slightly overrepresented.

Duration of plans
Since March 2014 the proportion of plans lasting between one and two years and those open for two years or more has increased significantly. This is an issue that requires further investigation to understand the factors influencing this.

Reasons for discontinuation of plans
Although the number of discontinued plans has increased over the year, the reasons for discontinuation are broadly proportionate to last year. The vast majority are discontinued because the original reasons no longer apply although there has been a 6% increase in children becoming looked after.

4.5 Looked After Children

Bolton's rate of LAC per 10,000 children increased significantly during the final quarter of 2014-2015, and by the end of March had reached 88 per 10,000; the highest rate in the last 6 years. This rate represents a 9% increase over the whole year; with a steep rise in Quarter 4 which significantly impacted on the overall number at the year end. It is known that at 2014 Bolton was in line with its statistical neighbours. It will be important to explore this increase in further detail in 2015-2016 and consider implications for local services should it continue.

In 2014-2015 the age profile of Looked After Children has changed with a smaller proportion of under 1s becoming looked after than previously and the proportion of children aged 1-9 being admitted to care rising with a particular increase in 4-6 year olds. The age profile on discharge from care shows that the largest proportion of discharges were for children aged 5 and under, with the greatest increase being shown in the discharge of under 1s.

At the end of 2013-2014 the proportion of LAC placed with parents had increased slightly on 2012-2013 and this has increased still further during 2014-2015. It is now more than three times the 2014 England average and more than twice the average of our statistical neighbours in 2014. A larger proportion of children placed with parents are on an interim care order compared with the position at March 2014. **It will be important for Board members to consider the particular needs of this vulnerable group as well as to fully understand the underlining reasons for this and take action as necessary.**

Of the 361 Looked After Children in foster care, 81% are placed with Bolton foster carers; 15% are placed with kinship carers and the remaining 4% are placed with agency carers. Over the year this represents a significant increase of 8% in the use of Bolton foster carers– with a corresponding decrease in the use of kinship carers.

At 31st March 2014 the proportion of all LAC placed for adoption in Bolton at 8% was higher than the England and regional average of 5%. There has, however, been a reduction during 2014-2015 and currently 6% of Bolton's Looked After Children are

placed for adoption. In 2013-2014 Bolton had a higher proportion of children adopted than any other local authority in the country. 54 children in Bolton have been adopted during 2014-2015 compared to 59 during 2013-2014. This represents a continuation of the exceptionally good performance, especially given the recent changes in case law relating to care proceedings.

The proportion of Bolton's LAC placed outside of Bolton at 26% represents a small reduction on the 27% at March 2014 and remains low compared to the 2014 England average of 38% and the regional average of 35%.

4.6 Private Fostering Arrangements

Private Fostering

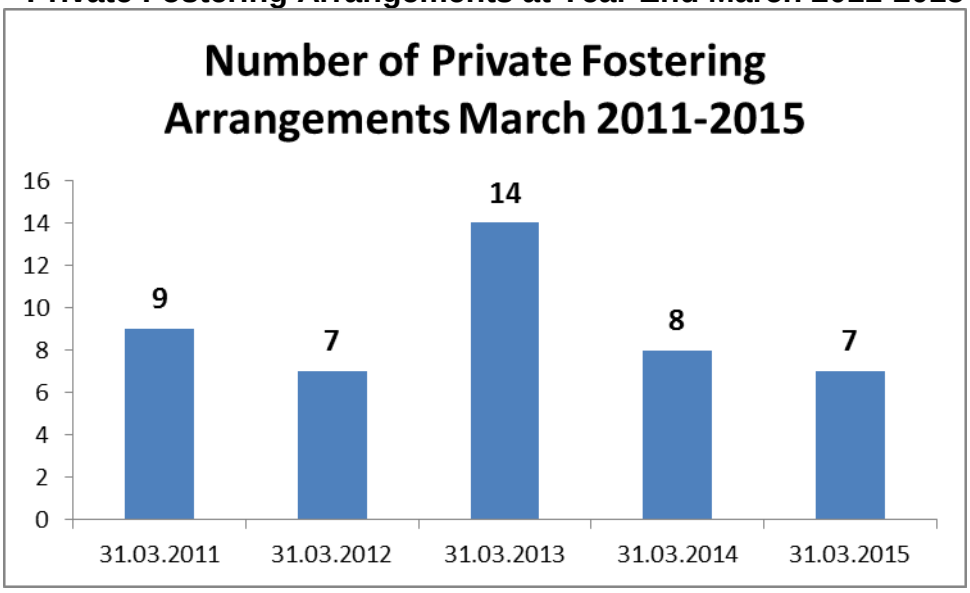
Many people don't realise that by law the local authority must be notified by parents and carers when they make arrangements for their any of their children aged under 16 to be cared for by friends, neighbours or extended family for more than 28 days. When parents make plans for their child to be cared for like this it is called a Private Fostering Arrangement. While it is not an arrangement that is made or paid for by the local authority, the local authority does have a duty to assess such arrangements to make sure children are safe.
Private Fostering happens for lots of different reasons some of which include:-

- Children living with a friend's family as a result of separation, divorce or problems at home
- Children sent to this country for education or health care by birth parents living overseas
- Teenagers living with the family of a boyfriend or girlfriend
- Teenagers who have broken ties with their parents and are staying with friends or non-relatives
- Those living with host families whilst pursuing courses of study

Since March 2011 in addition to monitoring the number of Private Fostering Arrangements in Bolton, BSCB have requested a qualitative profile of the children and young people in such arrangements to ensure the Board identifies any themes, trends of gaps in this area.

Although an often small cohort, there has been a fluctuating picture in the numbers of Private Fostering Arrangements in the borough from March 2011 to March 2015.

Graph 6 - Private Fostering Arrangements at Year End March 2011-2015



Looking over time, there continues to be no discernible patterns in terms of age of the child or the number of Private Fostering Arrangements at any given time. However one of the factors that may influence an increase in both numbers and in a larger proportion of teenagers at specific times, is the presence of a 'Language and Sports School' in the area. This school provides a range of courses for differing periods of time to young people aged 12-18 from across the world. Adults have been recruited from Bolton to act as 'host families'. Many of the courses on offer last longer than 28 days and therefore need to be assessed as a Private Fostering Arrangement. BSCB has developed links with this provider to ensure they understand their responsibilities in relation private fostering and provide up to date information on relevant processes, contact numbers etc.

BSCB has developed and utilised a range of awareness raising and training materials to increase workers and the general public's knowledge of Private Fostering. The response to these has been good however it is an area that requires continual emphasis. **There will be a focus in 2015-2016 in re-developing the awareness materials and seeking support from Board members to raise awareness of Private Fostering within their organisations and the communities they support.**

4.7 Learning Reviews

BSCB is committed to the ongoing development local practice to keep children safe and to learning lessons from local cases. In November 2013 BSCB established the Learning and Improvement Group. The aim of this group is to:-

- Identify local cases where the threshold for a Serious Case Review (SCR) is reached and ensure that SCR is completed and that lessons are learned
- Where cases do not meet the threshold for an SCR that opportunities to learn and develop local safeguarding children practice are identified and responded to

The Learning and Improvement group is well attended by all members and provides an open and secure environment to promote discussion and constructive challenge in respect of local practice to keep children safe. This is a demonstrably strong commitment to promoting a learning culture. More information about the Learning and Improvement Group, including referral processes can be found here.

Since the group was established, 7 local cases have been reviewed; 6 related to individual children and 1 to learning from an organisational review where safeguarding concerns had been raised. Only 3 of the reviewed cases were notified to Ofsted and the National SCR panel as required by Working Together 2013[4] and screened against the threshold for Serious Case Review (SCR). 2 cases were recommended locally as not reaching the threshold for an SCR, while 1 was. All three recommendations were shared with National SCR Panel who endorsed BSCB's decisions.

In addition to reviewing local cases, the Learning and Improvement group have considered lessons to be learned from two published SCR's conducted by other LSCB areas – taking a 'True for Us' approach;

The table on the following page summarises the learning from these reviews and action taken to further improve local safeguarding practice. NB - Case 7 is currently subject to an SCR and the findings and resulting action will be reported in 2015-2016.

Table - Summary of Learning from Local Reviews

CASE	LEARNING POINTS	ACTION	IMPACT
1	Previous SCR's and Initial SCR Panels have highlighted the importance of GPs and GP Medical Staff **stripping young infants** (under 12months) on presentation Previous SCR's and Initial SCR Panels have shown the importance of GPs and GP Medical staff **recording whether or not infants (under 12months) have been stripped** and what has been observed Briefings have previously been issued via the Designated Doctor outlining this learning and recommending Good Practice – however from the cases reviewed this has not been embedded fully as at November 2013	Practice guidance has been re-issued to all GP practices in Bolton in January 2014 by CCG GP Practice Newsletter included an article on the importance of this issue Significant liaison with Local Medical Council to support and promote the learning from local reviews with GP's NHS England to be advised of the learning and challenged to support embedding this message into local practices	NHS England have agreed that practices that submit reports that have not specified whether or not a baby has been stripped for examination will be contacted and advised by Designated Doctor "*I have since reflected on this case to try to learn and improve my practice. I had only recently commenced work in the Bolton area prior to seeing the child and was unfamiliar with the local safeguarding policies. I have since made myself familiar with them. With regards to my notes, I now strive to document to what extent I have undressed any child. I appreciate the local guideline calling for a full head to toe examination of all immobile children and have implemented it in my day to day practice*."

[4] All cases were screened against the criteria in Working Together 2013 as decision making pre-dated the publication of Working Together 2015 which was released on 25 March 2015

CASE	LEARNING POINTS	ACTION AND EVIDENCE	IMPACT
2	The Child Protection plan was discontinued at three months this is not compliant with BSCB policy; BSCB may wish to seek assurance that pre-birth plans are not routinely being discontinued at three months Health visitor was not invited to the pre-birth conference and this is a gap The GP practice did not have an alert on their system to show this child was on a child protection plan	Audit of pre-birth child protection cases to evaluate whether:- • Health visitors are routinely invited and attend pre-birth conferences • GP practices routinely place an alert on their systems for children subject to a child protection plan • Plans are not discontinued at three months Directive prepared and circulated to Children's Social Work District Managers, Social Work Team Managers, IROs, Head of Service Business Support and CPU Manager reminding them of Bolton's Child Protection Plan discontinuation policy Child Protection Conference administrators have implemented a standard prompt/reminder to invite Health Visiting Team Leaders to all Pre-Birth Initial Child Protection Conferences	Audits completed in December 2013 and April 2015 evidenced that:- • Case audit of 24 pre-birth conferences from Jan 2013 to November 2013 showed 14 health visitors invited and attended, 5 did not and the remaining 5 were not invited – a repeat audit in 2015 after implementation of the actions evidenced that all health visitors were invited and attended • A Child Protection audit carried out in July 2014 showed that 97% of GP practices had flagged their records appropriately • Agency compliance with Bolton's Child Protection Plan discontinuation policy – no plans for either audit cohort in 2013 and 2015 were discontinued at three months Audits established there is no evidence that Child Protection Plans are routinely being discontinued at three months; a unique case
3	The sharing of information between social workers, police and medical practitioners about the child's condition was not clear and robust; it led to confused communication which impacted on decision making	Meeting held between LSCB Independent Chair, Consultant Paediatrician, Senior Lawyer Legal Services & AD Staying Safe on 25.11.13; Proposal for clarity and control of information sharing developed 30.01.2014 - Interim 'S47 Child Protection Immediate Response Form' developed and being trialled the template will be completed by Paediatrician and given to Social Worker on completion of S47 medical examination. Photocopy to be placed with medical documentation.	This development has been embraced by Social workers and Paediatricians Formal feedback from staff has been positive and they state it has supported effective communication and decision-making. The process is embedded.
4	Multi-agency review completed with a full report presented to BSCB in November 2014	Action plan in progress and reviewed regularly via Safeguarding Executive – next review July 2015	Yet to be fully evaluated; the plan is in progress and will be full evaluated during 2015-2016

CASE	LEARNING POINTS	ACTION AND EVIDENCE	IMPACT
5	GP records indicate a very thorough assessment of the infant which when discussed with GP indicate a strong likelihood the child was stripped – however this is not explicitly recorded in the GP records – still indicating some challenges in promoting the importance of recording this information with GP's The S47 Child Protection Immediate Response Form is only used in Bolton – when the case transferred to a Manchester Hospital it was not used	There is a need to re-evaluate how infant examinations are being recorded Share the learning from this review with GMSP policies group and recommend adopted across Greater Manchester	CCG have provided case studies to support how learning for GP's continues to be promoted – one of the case studies is highlighted in this section
6	Safeguarding training was not up to date within the organisation Gaps in the organisations safeguarding policies and not fully linked or compliant with BSCB requirements Safeguarding recording systems and information process for sharing concerns not robust Safeguarding leadership to be strengthened	Safeguarding improvement plan developed in partnership with the school New performance management now includes reporting on safeguarding issues within the organisation Safeguarding issues are reported to parents/carers via the organisations newsletter Safeguarding is now a part of the organisations wider Improvement Plan Senior Leaders undertake safeguarding audits annually Staff safeguarding training is up to date	There has been an increase in the number of Early Help assessments; Children feel they are more supported and are able to discuss their feelings with staff The organisation completed a staff questionnaire; staff report they now feel empowered in reporting concerns about pupils and staff, they are more aware of the managing allegations process and the first five minutes and feel empowered to whistleblowing if a concern became apparent Mandatory staff meetings, safeguarding is now a standard item on the agenda and the numbers of staff attending staff meeting has increased by 60%

LEARNING INTO PRACTICE

A recommendation was first made with regard to the stripping of babies for examination within the GP report of a local SCR in 2012, stating:
'*Promote as good practice stripping off of babies fully for examination by GPs'*

This recommendation was reinforced following a subsequent SCR, giving some background context and stating:
"*……. This will mean consideration being given to fully stripping off of babies when clinical examination is needed and ensuring that you document your actions and reasons for this*".

Communication was sent out to GP practices in Bolton and confusion arose as the wording "when clinical examination is needed" appeared to have been omitted from this recommendation at that time.
This resulted in challenge from GP's via their Local Medical Committee, who suggested that the recommendation was instructing that all babies had to be stripped and examined and was not practical or achievable within standard general practice.

This resulted in a stressful period of impasse and a chain of communications back and forth. However, following persistence and repeated clarification of the background, context, purpose and function of SCR's and agencies roles within this, a solution acceptable to all parties was reached and the confusion was clarified. As a result, the LMC agreed that babies should be thoroughly examined when clinically indicated and the findings clearly recorded.

This recommendation has now been approved, as above, by the LMC and shared among member practices but this situation has served to evidence difficulty which may be encountered during the process, including:-

- In trying to challenge one's peers to view an alternate perspective
- The importance of the wording of recommendations and subsequent communication to minimise the risk of misinterpretation and confusion
- The importance of gaining a wider professional view regarding practicalities of implementing guidance within a number of varied, independent contractor organisations prior to submission to the safeguarding board

4.8 Child Death Overview Panel

Child Death Overview Panels (CDOP'S) are a multi-disciplinary sub-group of Local Safeguarding Children Boards that work across Local Authority boundaries based on population numbers. The CDOP reviews the deaths of all children aged from birth to

under the age of 18 years old (excluding still births and planned terminations carried out under the law) who normally reside within the geographical boundaries of that CDOP.

There are 4 CDOP's across Greater Manchester 3 of which are 'tri-partite' such as Bolton, Salford and Wigan (BSW) with one CDOP covering the area of Manchester City Council. This report provides information on the child deaths which have occurred in 2013/14 known as 'notifications' and cases concluded by the CDOP referred to as 'closed'.

Please note that the data reported in the following section relates to all child deaths across Bolton, Salford and Wigan unless otherwise stated.

The Panel and its functions

Government advice is that Child Death Overview Panels should cover populations of at least 500,000 and it was for this reason that the three authorities of Bolton, Salford and Wigan came together from 1st April 2009. The CDOP carries out a multi-disciplinary review of child deaths (0-17 years inclusive) with the aim of understanding how and why children in Bolton, Salford and Wigan die. Panel members consider whether there are any factors which could have been modified to prevent or reduce the chances of a similar death in future.

Childhood deaths and key issues

One of the significant challenges for the Panel is to draw conclusions from a relatively small number of cases each year. CDOPs have been gathering data since 2008 and the collection of data from various agencies has improved year on year. The main issues for the CDOP are to consider the number of deaths and the reasons for those deaths with a view to detecting trends and/or specific areas which would appear worthy of further consideration.

Numbers of Childhood deaths

There were a total of 63 childhood deaths notified to the CDOP in 2014-2015. Since 2007/8 there have been a total of 519 child deaths across the 3 areas. As might be expected there are year on year variations. When the numbers of deaths 2007-2015 across the CDOP are compared to the Rate per 10,000 Pop 0-17years it can be seen that Wigan has the lowest rate at 2.51 with Bolton at 2.88 and Salford has the highest at 5.91. This compares to an average across Greater Manchester (GM) of 3.91.

Ages of children

In 2014/15 of the 66 cases closed 69.7% were children under 1 year old. In 2013/14 this figure was 68.9. In both cases this was above the average for GM which in 2014/15 stood at 64.5%

In 2014/15 the rate for 0-27 days was 44% in this CDOP. The average across GM was 41.6. In the main this can be explained by premature births where the infant is too under developed or because of severe life limiting conditions when the child is at its most vulnerable.

Ethnicity

In the early years of CDOP data around ethnicity was not always collected in a robust manner which limits year on year comparisons. Equally when broken down into local authority areas, in individual years the relatively small numbers must carry a warning on

their statistical significance. In 2014/15 closed cases showed that in Bolton 50% of the deaths were children classified as white. In Salford this figure was 68% and in Wigan the figure was 85%.

These figures can in some way be accounted for by the population make-up in the 3 areas. The BME community in Bolton comprise just under one third of the under 19 population. In 2014/15 the panel identified 4 cases where parents were 1st cousins. Of these it viewed that 2 of the deaths were linked to genetic anomalies.

Sudden Unexplained Death in Infancy (SUDI)
In 2014/15 the CDOP identified 3 SUDI cases. Across GM there were 19 cases and only Bolton did not have at least 1 incident. The common features in these cases were that parents smoked and/or had been co-sleeping with their child in bed or on a settee (see modifiable factors at 1.9 below). Research shows that the North West and Wales have the highest rate of sudden unexplained deaths in England and Wales. Since 2011 BSW have run a joint campaign to highlight factors such as safer sleeping and the risks of parental smoking. Of the 66 cases closed in 2014/15 only 1 death involved safe sleeping issues with that case and 1 other featuring parental smoking.

Unexplained deaths in young people
The nature and intention of these deaths involving, in the main, adolescents, is often unclear and accordingly Coroners in GM rarely if ever record a finding of suicide. In 2014/2015 CDOPs closed 9 such incidents in GM where children died and where illness was not the cause and there was no evidence of third party involvement. There were 3 such incidents in the CDOP area; none in Bolton. In addition to the work by all CDOPs research is being carried over the next 2 years at the University of Manchester into deaths of this nature.

Modifiable Factors
National guidance defines potentially preventable child deaths as those in which modifiable factors may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.
Cases can only be closed when all other processes such as Inquests, criminal investigations and Serious Case Reviews have concluded. In 2014/15 a total of 66 cases were closed by the panel. Of those, 17 (25.7%) were identified as having modifiable factors. In 2013/14 this figure was 17%.

In 2014-2015 the 4 CDDOPs across GM identified modifiable factors in 63(24%) cases from 262 cases they closed. There was a wide variation in that Manchester identified 14% of cases and Stockport, Tameside and Trafford identified modifiable factors in 31% of cases. Where modifiable factors exist consistent features are smoking by mothers in pregnancy, prematurity and associated low birth weight.

4.9 A Safe Workforce

i. Managing Allegations against people who work with children

Each LSCB area is required to have a nominated officer whose role it is to co-ordinate responses and action where an allegation of is made that someone who works or volunteers with children may have:-

- Behaved in a way that had harmed, or may have harmed, a child
- Possibly committed a criminal offence against, or related to, a child; or
- Behaved towards a child in a way that indicates s/he may pose a risk of harm, if they worked regularly and closely with children

This is role is known as the Local Authority Designated Officer (LADO).

LADO Awareness Raising and Development

This year has seen many changes to guidance around managing allegations. Consultation and a subsequent review of 'Working Together to Safeguard Children, March 2015' proposed changes around the future role of LADO. The process for managing allegations in Schools is now firmly embedded within 'Keeping Children Safe in Education March 2015 (KCSIE)' and within the 'Ofsted Inspecting Safeguarding in Maintained Schools and Academies January 2015' and in the 'Governors' handbook January 2015'.

With an Ofsted spotlight on managing allegations the demand for training and briefings to Schools has risen and additional sessions has been provided, by LADO, via the workforce development team and the BSCB multidisciplinary training programme.

Partnership working with Bolton Council of Mosques (BCOM) continues with LADO providing/assisting in safeguarding level 1 training over six twilight sessions. The number of delegates has yet to be reported but was very well attended. This has enabled clusters of mosques and madrasahs to come together and has highlighted many examples of good practice.

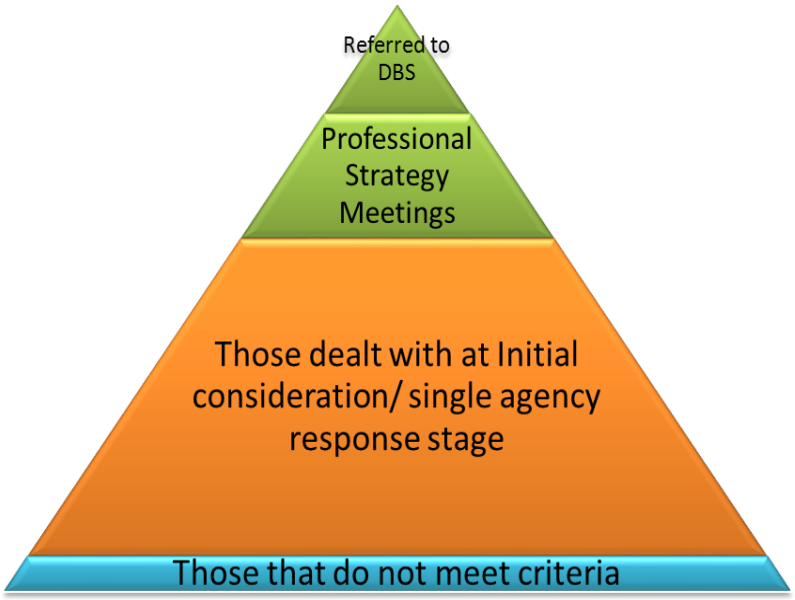
In January 2015 the Department for Education (DfE) issued supplementary guidance to KCSIE 2014, which applied regulations that previously only impacted on Early Years settings to Early Years provision in Schools. This regulation 'Disqualification by Association' means that if a person in the children's workforce lives in the same household as someone with offences against children they must declare this and it could lead them to potentially being disqualified from working with children. This previously unaddressed legislation required an immediate response. The LADO worked with Human Resources for Schools and the Early Years Advisory Team to bring together clear guidance and processes to respond to this regulation. The LADO continues to support the Early Years sector with advice and within training regarding this complex issue.

During this reporting period the LADO highlighted issues in recruitment within Early Years sectors which impacted upon allegations. The LADO made recommendations that the Local Authority and Early Years Advisory Team reviewed training available to

this sector and brought together a working party to progress this. The workforce development and training unit were able to fund a series of briefings and training sessions on safer recruitment for the Early Years sector. This training includes managing allegations and is open to the whole sector including child-minders and out of school clubs.

DATA OVERVIEW

The breakdown of LADO referrals can be broadly illustrated by this diagram:-



Whilst managing allegations procedures are well embedded within Bolton there remain organisations and schools who are not regular users of the process i.e. seeking LADO advice, making referrals etc.

LADO REFERRALS

For the period 2014-2015 the total number of referrals to LADO is **206** compared to **217** last year, a slight decrease. Allegations referred to the Local Authority Designated Officer (LADO) from 1st April 2014 to 31st March 2015, which resulted in professional strategy meetings, was **72,** which represents an 18% increase on the previous year's figure of **61**. In addition to this, there were **134** cases which required a single agency response (and no further action was taken by LADO), a decrease of 14% on the previous year's figure of **153.** There have also been **19** Strategy Review meetings, held to bring further information forward, as an investigation progresses or to categorise and resolve a case where the information is complex. Table X below shows the breakdown by agency of referrals made that lead to a Managing Allegations Strategy Meeting; as expected and in line with national data, Education settings have the highest number of referrals overall with the greatest proportion that lead to a strategy meeting. The police number is higher than would be expected as they are the agency who through the course of their investigations, are more likely to identify and refer adults who work with children and meet the LADO criteria.

Table 6 –Referral to LADO by Agency and Progress to Strategy Meeting from March 2012-2015

Agency	Number of Referrals by Agency 2014 –2015	Number of Referrals by Agency 2013 –2014	Number of Referrals by Agency 2012-2013
Social Care	17	14	21
Health	3	1	2
Education	28	24	23
Early Years	1	3	2
Police	16	10	12
Voluntary Organisations	2	1	2
Ofsted	0	1	3
Other	5	6	9
CAFCASS	0	1	0
Total	**72**	**61**	**74**

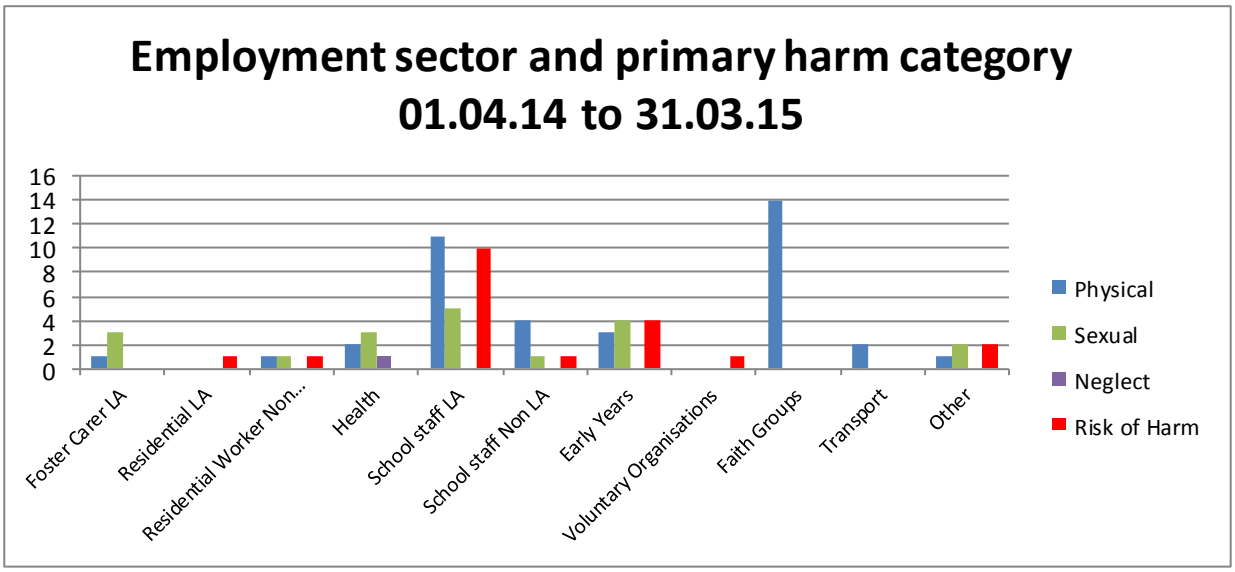
Over past years the LADO reported ONLY those referrals which lead to professional strategy meetings. Over this year the LADO has gathered data in order to more accurately present a picture of all referrals to LADO. By including those referrals which resulted in no further action was taken, as well as those which resulted In a professional strategy meeting this report should show those agencies who seek out the advice and support of LADO at an earlier stage. In this way issues /allegations can be resolved quickly and lessons learned which adds to good safeguarding within the agency. Table X shows a breakdown of all LADO referrals by agency.

Table 7 – Total Number of LADO Referrals 2014-2015 by Agency

Agency	Referrals to Strategy Meeting	Referrals to No further Action	Total Agency
Social Care	17	36	**53**
Health	3	10	**13**
Education	28	44	**72**
Early Years	1	10	**11**
Police	16	14	**30**
NSPCC	1	0	**1**
Voluntary Organisations	1	8	**9**
Ofsted	0	3	**3**
Other	5	8	**13**
Faith Groups	0	1	**1**
Total	**72**	**134**	**206**

Employment Sector

Graph 7 shows the employment sector of the person, against whom an allegation is made, and the primary harm category. The LADO feels that to highlight those agencies which sought advice at an early stage and therefore resulted in no further action could be viewed as punitive. Therefore only those which resulted in a Professional strategy meeting are shown in this graph.



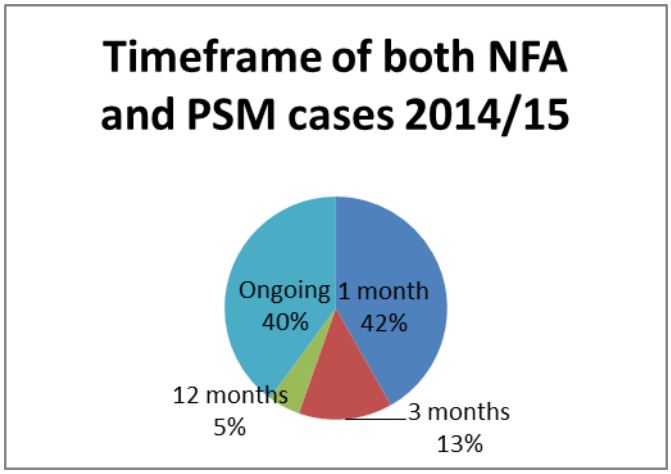
Faith groups were the highest group in this period. This reflects work with Schools and communities to disclose and also the work within Bolton to deal with these disclosures.

Timescales for LADO Referrals

Working Together 2015 does not indicate any time frame for cases however KCSIE 2015 states that 'it is reasonable to expect that 80% of cases should be resolved within one month, 90% within three months and that all but the most exceptional cases should be completed within twelve months.' The BSCB procedures state that we endeavour to work towards these targets.
This year all referrals to LADO, including those which resulted in no further action, have been included as a more realistic overview of timescales for all referrals. The pie chart below shows 42% of cases were resolved within one month, a total of 55% within three months. If we remove the 'on-going' cases from this category then 69% of the cases resolved would have been resolved within one month, a total of 92% within the three month period. All cases resolved during this period were dealt with within a twelve month timeframe.

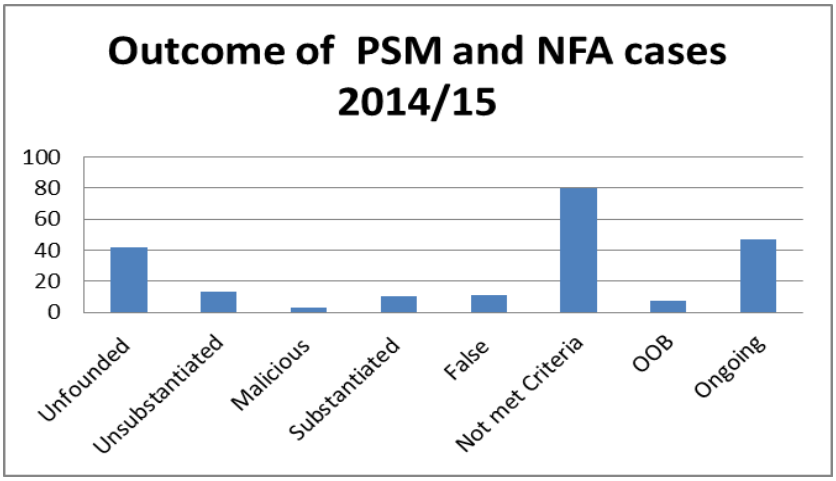
Issues have been raised by Board members about the impact of the few cases that take over a year to resolve – as a consequence the Board has committed to track this via the performance framework to ensure timely resolutions where possible

Pie Chart 1 – Timescales for Outcomes for LADO Referrals



Outcome of Referred Cases
Graph 8 below illustrates the outcomes of all cases that were referred to LADO within the period 2014-2015 and includes those which resulted in no further action.

Graph 8 – Outcomes of LADO Referrals



The table shows the high number of referrals that did not meet LADO criteria. These are where advice was given and recommendations made by LADO. These organisations seek advice in dealing with allegations at an earlier stage from someone independent and objective of their organisation i.e. LADO. Any investigation is therefore under advice and accurate records are made. Recommendations around additional training or further embedding safeguarding, within the organisation, are put into place. Thus further safeguarding the whole workforce and building confidence in senior leadership teams.
Where counselling and training has not prevented further incidents occurring and repeated allegations are made, an evidence based picture can begin to emerge which highlights risks posed by an individual and action can then be taken to minimise this.

What Has Worked Well?

Recent referrals from the Early Years sector have shown that safer recruitment training has already impacted on greater scrutiny of applications and references, with one case leading to a referral to DBS service. Referrals from Health, in particular Royal Bolton Hospital (RBH) have increased and work undertaken by the safeguarding team at RBH has directly impacted on referrals and advice sought by RAID team. The number of referrals to LADO from Health colleagues is increasing.

The number of referrals to LADO from the voluntary sector this year has increased however this remains low overall.

The recording of all cases this year has allowed for a more accurate overview of timescales of LADO cases and shows that we are actually in line with DfE guidance.

What Would Be Better?

The LADO data management system requires upgrading in order to reduce time spent retrieving data for reports, FIO requests and to enable a more robust analysis of trends and

themes etc. The LADO and Bolton Council Information Management Unit are looking at options to improve the current systems.

Referrals from the voluntary sector remain low despite briefings throughout the year. This remains an objective to be carried forward for next year and the LADO would welcome input from our voluntary sector representatives on the board.

File reviews by the LADO should be undertaken every month however due to increasing workload this can be delayed, which could result in cases remaining open longer than required, which would impact upon timescales. A review of the LADO workload needs to be undertaken and steps taken to reduce duplication of tasks and improve efficiency. This may achievable, in part, with the new data system indicated.

Training remains an important feature of the LADO role and allows face to face contact with agencies and builds confidence in those agencies to seek advice, improving safeguarding. This does however impact greatly on the Child Protection Unit team, as LADO cover is required, and in the LADO capacity to manage an ever increasing workload.

ii. Multi-agency Safeguarding Children Training

Over the last twelve months BSCB has built on the success of past training years. This year has been very positive with the same number of training sessions being delivered to the workforce while the number of practitioners attending training has risen to 93%. All training is delivered in accordance with BSCB's training strategy which was refreshed and endorsed by BSCB in 2014-2015.

Course Delivery and Attendance
During the period 1 April 2014 – 31 March 2015, 54 multi-agency safeguarding training sessions were scheduled and 49 sessions were actually delivered (91%).

Of the 5 sessions that were cancelled, 2 were due to low delegate numbers, 2 sessions were cancelled due to the trainer not being available, and one session was cancelled at the last minute due to sickness of the trainer. The two sessions cancelled owing to trainer availability were for resistant families. This has highlighted insufficient capacity to deliver the sessions and a gap in the training pool as there are no other trainers to deliver this session. This will be addressed in 2015-2016.

924 delegates were offered places on courses this year with 858 delegates actually attended the sessions – a 93% attendance rate. The breakdown of attendee over the year is as follows:-

- Quarter 1 - 90% (225 available places – 221 attended)
- Quarter 2 - 96% (157 available places – 151 attended)
- Quarter 3 - 92% (225 available places – 208 attended)
- Quarter 4 - 88% (317 available places – 278 attended)

After analysing the dip in attendance during Quarter 4 , the key factor in the lack of take up in this quarter was mainly from practitioners attending a previous session either earlier in the programme from freed up spaces or attending additional sessions that had been delivered.

There were also a number of delegates that were no longer in post when training was delivered.

Delegates who attend training are asked to complete an evaluation on the day. Some of the evaluation comments include:-

- Improved knowledge of processes/ a good refresher
- I found out a lot of information about other agencies that can be used
- It was an informative training course and will be an essential tool to utilise in my new role at work
- Review our policies/changes in guidance both local and statutory
- An awareness of the tools available to support in practice
- Thanks for the Training last Thursday it was one of the best courses I have ever been on during my time here. Really informative and well presented, Just wanted to say thank you
- Thank you for your support and resources you sent through to enable us to share best practice within our establishment

There remains a challenge to BSCB in assuring itself that all those who need to be trained are accessing this training appropriately. **Member agencies will need to reflect and consider how they can provide assurance to the Board.**

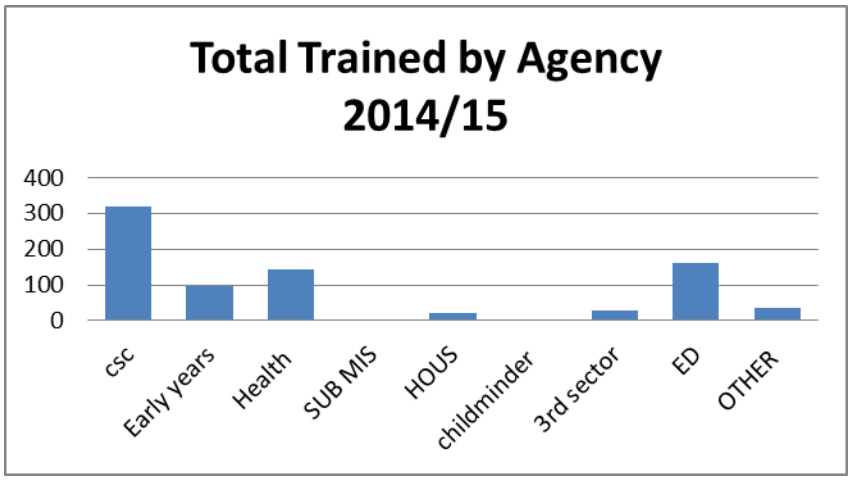
Of the 924 delegates that confirmed their place on the sessions, 57 (6%) did not attend on the day (this is a reduction from 8% in 2013-2014). In order to quality assure and further explore why training was not accessed by 6% of the delegates they were contacted personally by the Multi-Agency Training Co-ordinator.

Reasons for non-attendance:-

- 7 Workload/staffing
- 18 Annual leave/sick/no longer in post
- 11 No reply – even though numerous attempts were made to follow up the delegates both by email and phone
- 11 Other reasons (funeral, child care etc.)
- 2 Left the session early so were logged as non-attendees
- 8 completed e-learning

Staff and volunteers from Health, Early Years and Children's Services are the most significant users of the multi-agency programme with education settings, predominately schools, close behind. This is to be expected as these are the sectors likely to work with the most children.

Graph 9 - Staff Accessing Safeguarding Training by Agency



One of the on-going challenges is still to monitor the long term impact and influence of training on practice. The online survey tool that was introduced initially showed a slight improvement in returns of evaluation at 10%

It is important to note that in 2014 Ofsted identified attendance at training as an area for improvement for BSCB

"Improve the attendance at child protection training and resolve the issues that have resulted in cancellation of sessions"

Ofsted Inspection of LSCB 2014

There is clear evidence that the strategies the Board has taken to improve this are working. Since 2012 attendance at training sessions has increased from 667 to 858, while cancellations and non-attendance has decreased from 249 in 2012 to only 57 in 2015. This has also been achieved during a time of change for many agencies and a decrease in the overall workforce

Early Years Training Development

BSCB continue to deliver training to the Early Years sector, recognising them as a key agency in safeguarding children and promoting early help. In March 2015 the first combined session of Safeguarding Level 2&3 for child-minders was delivered. This session was created in response to feedback from child-minders who needed to understand the processes for Early Help and Child Protection but were likely to have limited involvement with them. The first session was delivered to 20 child-minders and was very well received. Some of the evaluations from the session include:-

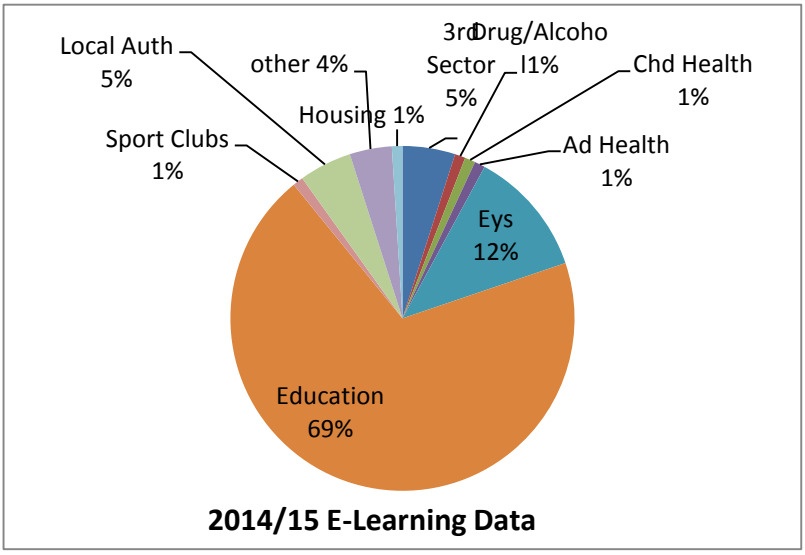
- Enjoyed the content and the hands on aspect, good discussions took place.
- Will check the safeguarding website regularly
- This training has given me the confidence to complete and Early help Assessment if I need to
- The session was very informative and everything I needed answering was answered

There are currently 193 registered child-minders in Bolton and three additional sessions are planned for 2015-2016 to ensure that they all benefit from this session.

E-Learning Package

The Level 1 Keeping Children Safe e-learning package continues to go from strength to strength. From May 2014 when it was re-launched to March 2015, 4681 workers have completed the training. This is a considerable rise in practitioners using the session from 2013/14. This is may be due to the promotion of the session as a refresher (which is the main reason it was developed), practitioners are also using the session to consolidate the face to face training. There has also been a rise in practitioners completing the session who do not have regular direct contact with children e.g. dental hygienist, GP receptionist, voluntary workers etc.

Workers using the package have been identified over 10 agency groupings see Pie Chart 2 below:-



Evaluations of the package include:-

- A good refresher session
- Reinforced understanding of the Framework for Action
- Consolidated the face to face training I attended
- Made me more aware of signs and indicators to look for especially in behaviour
- How to report a concern or incident
- Changes in the FFA
- How to act on information received
- The programme was easy to use and clear
- I wasn't aware of Private Fostering until I completed the course

Staff Care Scheme
During the past twelve months we have had three requests from practitioners about the Staff Care Scheme; two of these practitioners have taken up the staff care scheme

5. BSCB Effectiveness

BSCB routinely evaluate their progress and the contribution of partners to safeguarding children via six monthly reviews of the Business Plan. Included in this year's annual report is a summary of the Boards progress across 2014-2015 in achieving their core business and addressing local priority areas.

SUMMARY OF BSCB EFFECTIVENESS AND PROGRESS 2014-2015

Ref	Core Objective	Evidence To Support RAG Rating and Outcomes Met	RAG Rate
1.1	Develop policies and procedures for safeguarding and promoting the welfare of children	• BSCB officer regularly attends Pan-Manchester LSCB Safeguarding Guidance Steering Group • BSCB have identified and contributed local policies to the Pan-Manchester safeguarding manual including a Learning and Improvement Framework, SCR Systems Approach for SCRs, Sleep Safe guidance etc. • Links between Pan Manchester Safeguarding manual and BSCB local information and guidance are up to date and regularly reviewed by BSCB officer • Bolton's Framework for Action has been revised and re-launched in October 2014; in this month the website had its third highest monthly views since launch (5168) and in particular access to Early Help resources has increased 7.5 times when comparing access in Sept-Nov 2013 with the same period in 2014; by year end 2014-2015 almost 1500 Early Help Assessments had been started in Bolton • Achieved alignment between Greater Manchester safeguarding manual and Bolton's social care manual to improve access for staff in this sector • BSCB website is well used with **over 47000** views since launch in November 2013to year end 2014-2015; 552 clicks from the site to GM safeguarding manual evidencing practitioners using the multi-agency procedures • The Domestic Abuse Handbook has been completed and was signed off in December 2014 by BSCB; it is available online and has been accessed 254 times since launch to March 2015	
1.2	Safe recruitment and supervision of persons who work with children	• The strategic Section 11 audit has been completed and current compliance levels have been reported to BSCB; all agencies who have completed the audit and identified areas for action are progressing these • In the first six months of 2014-2015 16 briefings - this supports BSCB in increasing awareness of Managing Allegations processes and sustaining a safe workforce **Outstanding 2015-2016 -** Section 11 worker survey	
1.3	Deliver a training programme and evaluate impact of the programme in supporting the workforce to safeguard and promote the welfare of children **(Ofsted Area for Improvement 143)**	• BSCB training strategy has been reviewed and endorsed in May 2014 ; the training delivery is reviewed annually to ensure it meets the needs of the workforce • Review of course delivery for 2013-2014 shows 91% of sessions delivered an increase from 56% in 2012-2013; at year end 2014-2015 this remained at 91%; 49 sessions delivered out of 54 **(Ofsted Area for Improvement 143)** • Review of course attendance shows an increase from 73% in 212-2013 to 85% in 2013-2014; at year end 2014-2015 this had increased again to 93% **(Ofsted Area for Improvement 143)** • Regular reports are provided to BSCB on usage of the E-learning package – in 2013-2014 1765 individuals had completed the Level 1 E-learning package – Keeping Children Safe from 9 organisations; 42% of users were from the Education Sector, the next biggest users were health and housing; at year end this had further increased to 4681 workers completing the package from 10 sectors • The e-learning package has been reviewed and re-launched in May 2014 • BSCB have implemented a quarterly training survey to engage the workforce in providing feedback on how training has developed their practice – comments in the last six months include 'more confidence and less asking colleagues', ' feel that I am able to involve families more and that I am more confident in undertaking the assessment process.'	

Ref	Core Objective	Evidence To Support RAG Rating and Outcomes Met	RAG Rate
1.4	Robust investigation of allegations concerning persons who work with children	• LADO reporting is embedded within the safeguarding quarterly report; members routinely receive this and analyse any themes or trends identified, including gaps in agency referrals and timeliness of conclusions; this is also reported in BSCB's Annual Report – 1.10 identifies GMP contributions to this process as identified in para 141 Review of Effectiveness of LSCB, Ofsted 2014 • LADO has a dedicated page on BSCB's website and has received 754 hits since launch in November 2013; 397 for the period 2014-2015 – there has been a consistent picture of the workforce accessing LADO information with an average of 33 views per month in 2014-2015; there has been a particular spike in October and November 2014 and again in February and March 2015 • Local LADO guidance has also been developed and endorsed by BSCB on 6 September 2013 to ensure consistency and compliance with Working Together 2013 and rolled out to all partners; this will be re-evaluated in 2015-2016 following the publication of Working Together 2015; the number of LADO referrals made in 2014-2015 showed an 18% increase on the previous year	
1.5	Safety and welfare of children who are privately fostered	• Six monthly profiles completed by BSCB identifying any local themes and trends in private fostering leading to recommendations arising from the analysis • Greater Manchester developments have been discontinued; Bolton currently has a suite of resources to promote Private Fostering and a dedicated web page which has received 332 views to date and continues to build on the 184 views by year end in 2013-2014 • One private fostering audit has been completed to date and identified areas for learning this will be repeated on an annual basis **Outstanding** – PFA audit to be completed, including seeking the views of children and revised PFA publicity to be produced in 2015-2016	
1.6	Undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned **(Links to Ofsted Area for Action 144)**	• The Learning and Improvement group has met routinely since November 2013 with consistent membership and good attendance – two cases referred to National SCR panel both with recommendations not to progress and both decisions supported by national panel • SCR Systems process developed and uploaded to Greater Manchester procedures - this provides a framework to conduct a systematic approach to SCR's and has now been tested in a recent case; this produced positive and practical outcomes to improve safeguarding arrangements for children • The Learning Review for a recent case, Child R was conducted and completed within SCR timescales and with full co-operation of all relevant agencies – action plan review is scheduled within the BSCB forward plan • Child J Action Plan reviewed and update included in Annual Report 2014-2015 and further review by Safeguarding Executive **(Area for Improvement 144);** this action plan is now completed and signed off • BSCB updated on impact of Learning and Improvement Group Summary Paper in July 2014 **(Area for Improvement 144)** • Reports are produced on a bi-annual basis for BSCB to summarise the learning reviews completed and the impact on practice	

Ref	Core Objective	Evidence To Support RAG Rating And Outcomes Met	RAG Rate
1.7	Participating in the planning of services for children in the area of the authority	• BSCB Independent Chair and BSCB Officer attended Health and Well-being Board to present CDOP annual report on 2.10.2013 and 19.03.2014 and there will continue to be annual attendance at this partnership • Attendance at Children's Trust to present current key safeguarding issues including Missing from Home, CSE etc. in June 2014 - this will continue for 2015-2016 • BSCB consulted as part of 5-19 service reforms to ensure all Framework for Action processes embedded within commissioning framework in addition to key safeguarding standards • Standing items relating to Health economy and probation services changes and safeguarding children; presentation relating to local implementation of national child protection notification project in September 2014; further progress update planned for 2015-2016 • BSCB membership of Domestic Abuse Steering Group, with particular aim of ensuring services to support and safeguard children who live in households where domestic abuse present	
1.8	Cooperation with neighbouring children's services authorities and their Board partners	• Bolton LSCB is represented at the Greater Manchester Safeguarding Partnership (GMSP) by the Chair of the Safeguarding Executive; BSCB officer also attends to represent LSCB business managers • Minutes from GMSP are circulated and items considered at BSCB meetings • Active contribution to GM Phoenix CSE Project from BSCB, and contribution from BSCB to Coffey report on GM CSE – 'Real Voices' • GM safeguarding manual is launched and data on usage is included in 1.1 of this document • Members return annual reports and this is reviewed by BSCB officers • BSCB officer regularly attends GM business managers meeting; peer review of SCR decision making sought by Independent Chair within regional chairs network; Independent Chair attends LSCB Chair Network meeting; BSCB and partners respond promptly to information requests from other LSCB areas for example info requests for SCR's in other areas, sharing sleep resources etc.	
1.9	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 **(Links to Ofsted Area for Improvement 139)**	• 1 Lay member vacancy and 1 lay member fully engaged and active in BSCB work programme, in particular Early Help Steering Group • News feed developed as part of BSCB website; weekly articles uploaded; since launch 1374 views to the news page; at year end 2014 -2015 there were 1108 views, • Since the launch of the website and the dedicated 'Worried about a Child' page, BSCB has received a number of direct contacts from members of the public asking for help about children – to date there have been 1396 views of this page and 971 in 2014-2015; from January 2015 BSCB will be logging the number of contacts from the public relating to child welfare concerns to further evidence the impact and value of this resource in safeguarding children ; in this period there were 50 contacts from the public regarding the welfare of children which were referred to children's social care • Lay members job specification and job description has been reviewed and recruitment process is underway to fill the current lay member vacancy	

Ref	Core Objective	Evidence To Support RAG Rating And Outcomes Met	RAG Rate
1.10	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 **(Ofsted Area for Improvement 140, 141 & 142)**	• BSCB is currently undertaking a mapping exercise with partners to identify single agency safeguarding audits and improve how the findings and lessons learned are shared and evaluated by BSCB – this was completed and implemented by January 2015 **(Ofsted Area for Improvement 140 &142)** • BSCB scoped GMP attendance at Strategy Meetings (S47 and LADO) to ensure they are able to take part in all aspects of child protection work, including strategy discussions and meetings, child protection conferences and LADO meetings; this report was presented to BSCB in July 2014; GMP achieved 85% attendance at S47 Strategy Meetings, 70% attendance and 100% contribution to initial case conferences and this is complaint with GM Safeguarding Policy 3.6, Section 12.2 and 97% attendance at LADO strategy meetings – based on this data BSCB did not identify a specific challenge to GMP but have agreed to review six monthly **(Ofsted Area for Improvement 141)** • Audit of GP Case Conference reports has been completed in summer 2014; Of the 40 GP cases audited there was a CP flag on 96.66%, 42.5% CP conference reports were provided (a 10% increase on previous return rates) and in 2.5% of cases a GP attended the conference • Systematic audit exploring the rise in number of children on a plan has been completed and the key findings reported to BSCB January 2015 and summarised in the Annual Report 2014-2015**(Ofsted Area for Improvement 140)** • Early Help Assessment quality audits have been completed and findings have been shared with BSCB – the audit continues to note the increasing and sustained quality of the assessments, however this may be challenged when the revised Framework for Action is fully launched and embedded and use of the single service request form ends • BSCB have been actively engaged with Greater Manchester Safeguarding Partnership in the development and roll out of a standard LSCB Performance Framework; although still a developing process and it is leading to further enquiries and challenge from BSCB on key areas of safeguarding**(Ofsted Area for Improvement 140)** • BSCB membership is continually reviewed as services change and evolve; currently the Board is fully compliant with the requirements of Working Together 2013 and is preparing for the changes within the Probation Service and any changes required as a consequence of Working Together 2015; membership will be reviewed again in 2015-2016 • BSCB routinely receives service updates in respect of the actions arising from the Ofsted Single Inspection carried out in January/February 2014; it also reviews its own response to the inspection of the LSCB; BSCB also reviews learning from other published inspections, most recently the thematic inspection of CSE to evaluate current local performance – evidence of progress against improvement areas is scrutinised by BSCB **(Ofsted Area for Improvement 140)** • Attendance and function of sub-groups has been reviewed by the Independent Chair and established that key groups are working well with good attendance; some membership gaps identified within CSE and Quality and Performance group – this will be addressed in 2015-2016	

Ref	Core Objective	Evidence To Support RAG Rating And Outcomes Met	RAG Rate
1.11	Collecting and analysing information about all child deaths identifying any — • serious case reviews • concerns affecting the safety and welfare of children • wider public health or safety concerns arising from a child's death or from a pattern of deaths • an effective rapid response to an unexpected child death	• See 1.6 for progress in respect of SCR's – one SCR is in progress and no SCR's awaiting publication; • BSCB ensure 100% representation at CDOP meetings • CDOP Chair attendance on a bi-annual basis is scheduled in Forward Plan as a minimum and this will continue for 2015-2016 • BSCB Action plan developed in response to CDOP findings and learning from CDOP shared with key partnerships in particular Health and Well-being Board and Children's Trust • Sleep Safe campaign has reduced the number of deaths where sleep safe risk factors are present; worker and family views have been collated to further evidence the impact of the campaign in ensuring consistent messages and influencing positive behaviour changes; the campaign has raised awareness in a range of agencies and resulted in the development of a successful 'cot referral scheme' which also provides a home fire risk assessment from the fire service • News section of BSCB website has a carried a few articles related to child safety including; Hair Straighteners and Risks to Children following a number of presentations at Royal Bolton Hospital, currently working on a campaign linked to dangers of cell batteries	

Ref	Core Objective	Evidence To Support RAG Rating And Outcomes Met	RAG Rate
2.1	Respond to the findings and implement the recommendations from the review of Bolton's Framework for Action	• Framework for Action launched in October 2014 at a multi-agency event; primary school launch events also held; 'roadshow' delivery to social work teams completed; significant increase in use of website to access Early Help resources as evidenced in 1.1; South Secondary schools cluster are trialling a peer review Evaluation of their Early Help Assessments • Evaluation of roll out and impact completed by Early Help Steering Group members in March 2015; this evidence how services have embedded the revised processes within their services; this will continue to be reviewed through 2015-2016 as part of BSCB's core performance information • Consistent attendance and completion of tasks by Early Help Steering Group members provides strong evidence for commitment to the model and framework – individual member agencies continue to attend the group to evaluate effectiveness • Early Help key changes presentation to BSCB September 2014 and web documents/resources revised to reflect changes • Early Help multi-agency performance framework has been rolled out and will inform robust evaluation of Early Help in 2015-2016	
2.2	Further develop and evaluate multi-agency response to children and young people missing from home and care	• Sexual Exploitation and Missing (SEAM) arrangements established and working effectively to safeguard children as evidenced in BSCB annual Report 2013-2014 • Performance reports for Missing from Home have improved significantly in the last twelve months and provided BSCB with a more robust understanding of the issue in Bolton • Areas for further development have been identified in particular reporting on rate of return interviews and Bolton Looked After Children living outside the Bolton boundary; both these issues have been addressed and systems in place to report and evaluate the data • **Outstanding 2015-2016**– Case audit for Missing from Home cohort to be completed and findings shared with BSCB	
2.3	Continue to monitor and evaluate multi-agency responses to Child Sexual Exploitation (CSE) in Bolton	• CSE Steering Group has achieved completion on 92% of tasks identified in their Action plan for 2011-2014 – the group has also evaluated its performance and the effectiveness of CSE interventions against national tools such as Bedfordshire CSE Self-assessment Tool, House of Commons Select Committee report and Ofsted Key Lines of Enquiry for CSE – while it has identified some gaps it has also provided evidence of robust arrangements in place in Bolton • Phoenix Exit Team fully integrated and additional police resources allocated, weekly disruption activity is undertaken and has resulted in an increase in abduction notices and CSE related prosecution, with further cases pending – this is further evidenced in the Annual Report 2014-2015 • CSE performance framework established as part of GM work and CSE themed discussion at BSCB embedded within forward plan • The CSE Strategy and Action plan have re-freshed and key priorities for 2015-2017 have a focus on impact and CSE outcomes from direct work, improving communication and awareness raising with communities, children and young people and parents • Targeted awareness raising event held for the hospitality industry in December 2014 • Phoenix Exit team subject to a peer review from colleagues Greater Manchester and practice found to be good	

Ref	Local Priority	Evidence To Support RAG Rating And Outcomes Met	RAG Rate
2.4	Evaluate the effectiveness of current responses to Neglect across all levels of Bolton's Framework for Action	• Health staff have been consulted on use and effectiveness of Graded Care Profile • Neglect guidance is part of GM safeguarding manual and is up to date, however there is a need to re-develop our local tools to support neglect assessment and take account of immediate, medium and long-term impact of neglect • Neglect audit is planned to be completed in 2015-2016 • Neglect training has been revised and updated **Outstanding for 2015-2016**– Neglect audit and development of local neglect assessment toolkit supported by a Neglect Strategy to be completed in 2015-2016	
2.5	Further develop quality assurance and reporting arrangements to BSCB to ensure that Board members are able to evaluate the impact and effectiveness of what is done individually and collectively to safeguard and promote the welfare of children	• See 1.10 for further detail of progress	
2.6	Review and evaluate the effectiveness of child protection processes to keep children safe	• Child Protection audit completed and findings reported to BSCB; progress to implement the findings will be completed in 2015-2016 • Agency attendance/contribution to strategy meetings benchmarked and will be reviewed as part of performance framework • BSCB understand the factors that influenced a significant increase in Child Protection Plans and strategies are in place to further develop the quality of Child Protection Planning and recording of core groups	
2.7	Complete joint work between BSCB and Community Safety Partnership in respect of Domestic Abuse	• Domestic abuse practitioner forum established and operates three times per year with good practitioner attendance • A Domestic Abuse Handbook has been published and signed off December 2014 by Safeguarding Executive – this addresses good practice in Domestic Abuse, risk assessment checklists for victims and children, legal powers available to safeguard, local and national resources etc.	

6. BSCB Resources

To function effectively BSCB needs to be supported by member organisations with adequate and reliable resources. The budget is made up of contributions by member organisations and the business plan has been formulated to ensure the work of SSCB can be achieved within budget. The total budget to support SSCB activity in 2013/14 was made up as follows

BSCB Income	
Organisation	**Contribution (£)**
Bolton Children's Services Dept. (Inc. Schools)	232,079.00
Greater Manchester Police	17,296.00
Greater Manchester Probation Service	3,399.66
Bolton CCG	85,741.20
CAFCASS	550.00
Supervision, Support and Cover for CDOP	3,000.00
Total Income	342,065.86
BSCB Expenditure	
Item	**Cost**
Staff Costs:- Safeguarding Officer Safeguarding Administration Safeguarding Administration Safeguarding Trainer Safeguarding Training Administration Local Authority Designated Officer	183,607.53
Independent Chair	14,850.00
Operational Costs:- Room Hire Refreshments Books / Leaflets / Publications Transport IT Costs / Website Training / Conferences Contribution to GMSP On-line Policies Advocacy Pilot Scheme Case Reviews Legal Costs Operational Expenses Contribution to CSE Contribution to IRO Conferences Contribution to Multi-agency Training	96,530.45
Total Expenditure	294,987.98
Year End Reserve 2014-2015	47077.88

BOLTON SAFEGUARDING CHILDREN BOARD BUSINESS PLAN 2013-2016 Priority Areas 2015-2016

BUSINESS PLANNING APPROACH

For 2013-2016 Bolton Safeguarding Children Board (BSCB) is adopting a two tier approach to its business plan to ensure compliance with the LSCB statutory aims identified in Section 14, Children Act 2004 and Working Together 2013 :

- To co-ordinate what is done by each person or body represented on the board for the purposes of safeguarding and promoting the welfare of children in the area
- To ensure the effectiveness of what is done by each such person or body for those purposes

And to ensure it satisfies the LSCB functions as set out in Regulation 5 and 6 of the 'Local Safeguarding Children Boards Regulations 2006' and developed.

Tier 1 will outline BSCB's current position in respect of Regulations 5 and 6 and identify the on-going work it will undertake over the three year period to ensure continued compliance with these core elements of LSCB business.

Tier 2 identifies the local priorities that BSCB has identified for particular focus in 2014-2015, how these will be responded to and builds on the achievements of 2013-2014. This element of the plan will be refreshed on an annual basis. The local priorities have been identified in response to learning from Case Audits, Serious Case Reviews, Working Together 2013, Thematic Inspections etc.

The plan also supports and contributes to the work of the Children's Trust in their priority of 'Keeping Children Safe' and the Local Strategic Partnership priority theme 'Children and Young People'.

All the work by BSCB is underpinned by the principle outlined in Bolton's Framework for Action for All Children, Young People and their Families

- The child's welfare and safety is paramount
- Assessments of need will be child centred and holistic
- All organisations are committed to the duty to safeguard and promote the welfare of all children
- All organisations demonstrate commitment to integrated processes for all children
- Integrated working will avoid duplication and unnecessary intrusion into family life

This plan and the priority area for 2015-2016 were reviewed and identified by BSCB on 17 March 2015. It was endorsed by BSCB on 22 May 2015.

BSCB BUSINESS PLAN - TIER 1

BP Ref	Core Objective	Action	Review Progress	Lead	Outcome	RAG Rate
1.1	Develop policies and procedures for safeguarding and promoting the welfare of children in the area of the authority.	Support the Operation Encompass Pilot and any subsequent roll-out across Bolton	January 2016	Safeguarding Executive	• Children are supported effectively in school following a domestic abuse incident in their home	
		Launch FGM screening tools and flow charts	October 2015	Safeguarding Executive	• Workers have improved knowledge of FGM and response consistently to safeguard children	
		Develop a Core Group Practice Guide	October 2015	Quality Assurance and Performance	• Improved consistency in how core groups operate • Core groups are effective in evaluating the impact of the child protection plan	
		Review safe sleeping guidance	July 2015	Sleep Safe Project Group	• Sleep safe messages are compliant with current research and learning • All partners are clear about how they promote safe sleeping	
		Develop a CSE community cohesion strategy	November 2015	Child Sexual Exploitation Steering Group	• Support all communities in Bolton to tackle and reduce Child Sexual Exploitation in Bolton	
		Evaluate use and impact of the Domestic Abuse handbook	March 2016	Quality Assurance and Performance	• BSCB is assured that the handbook is being used in practice to improve outcomes for children	
		Evaluate awareness and use of BSCB policies and procedures	December 2015	Quality Assurance and Performance	• BSCB is assured that the Greater Manchester Safeguarding policies are being used in practice to improve outcomes for children	
		Develop a set of safeguarding children commissioning standards	October 2015	Safeguarding Executive	• BSCB is assured that safeguarding children is embedded within member organisations	

BSCB BUSINESS PLAN - TIER 1

BP Ref	Core Objective	Action	Review Progress	Lead	Outcome	RAG Rate
1.2	Promote and support the on-going development of a safe and effective multi-agency workforce	Deliver the core BSCB safeguarding children programme and maintain the current high rates of attendance	November 2015	Staff Development Group	• Workers develop their knowledge and skills to safeguard children	
		Assess BSCB's current multi-agency training offer against the requirements of Working Together 2015	December 2015	Staff Development Group	• BSCB is delivering a good quality and effective safeguarding children training programme	
		Continue to report on the effectiveness of Managing Allegations (LADO) processes	Quarterly	Safeguarding Executive	• BSCB is assured that organisation understand and use managing allegations processes effectively • BSCB is assured that organisations take action to promote a safe workforce	
		Support the development of training for voluntary sector trustees and their board members in respect of their safeguarding roles and responsibilities	March 2016	Staff Development Group	• Trustees understand their requirements to safeguard children • Trustees evaluate their organisations current safeguarding arrangements and develop these where necessary	
		Redevelop the Section 11 template and provide an online tool to collate evidence	September 2015	Quality Assurance and Performance	• BSCB is assured that organisations can evidence their commitment to safeguarding children and that it is embedded across their organisations	
		Continue to report on the findings from routine evaluations	November 2015	Staff Development Group	• BSCB is assured that the training programme improves the effectiveness of front-line practice	

BSCB BUSINESS PLAN - TIER 1

BP Ref	Core Objective	Action	Review Progress	Lead	Outcome	RAG Rate
1.3	Ensure the voice of children and their families develops local safeguarding priorities, processes and services	BSCB members share learning from their complaints and compliments processes in respect of safeguarding children	March 2016	BSCB	• BSCB is assured that services listen and respond to the views of users • BSCB identifies and responds to any themes or trends in practice across member organisations	
		Consider and respond to the findings from children and young people who took part in the 'Growing Up in Bolton'	September 2015	BSCB	• Children identify key safeguarding issues for them • BSCB is able to evaluate current work and responses from member organisations	
		Seek the views of children and their families of their experiences of the Child Protection System	October 2015	BSCB	• BSCB understands how Child Protection processes impact on children and their families • BSCB is able to offer support and challenge in this area to member organisations to develop practice	
		Seek the views of children who are privately fostered about their safety and access to support	December 2015	BSCB	• BSCB is assured that Privately Fostered children feel safe and they are supported • BSCB is able to offer support and challenge in this area to member organisations to develop practice	

BSCB BUSINESS PLAN - TIER 1

BP Ref	Core Objective	Action	Review Progress	Lead	Outcome	RAG Rate
1.4	Communicate to the public and partners the need to keep children safe and promote their welfare	Re-launch and distribute 'Worried About A Child' leaflet and posters in Bolton	November 2015	Safeguarding Executive	• Bolton residents have access to local contacts to share their concerns about a child's welfare	
		Re-launch and distribute 'Private Fostering' resources t in Bolton	September 2015	Safeguarding Executive	• Bolton residents and workforce have access to help them recognise and report possible Private Fostering Arrangements • Children have an awareness of Private Fostering and know who they can speak to	
		Support Public Health to deliver the 'Button Cell Batteries' Campaign	September 2015	Child Death Overview Panel	• Parents and workforce are aware off the dangers and can take action to reduce risk	
		Work with Public Health and the CCG to develop and deliver a 'Safe Storage and Use of Medication' Campaign	February 2016	Safeguarding Executive	• Parents and workforce are aware off the dangers and can take action to reduce risk	
		Pilot and roll out the secondary schools Child Sexual Exploitation awareness package for Years 9/10	November 2015	Child Sexual Exploitation Steering Group	• Children understand what Child Sexual Exploitation is and know where to get help and support	
		Host Parents Child Sexual Exploitation Awareness events in the area	November 2015	Child Sexual Exploitation Steering Group	• Parents understand what Child Sexual Exploitation is and know where to get help and support	

BSCB BUSINESS PLAN - TIER 1

BP Ref	Core Objective	Action	Review Progress	Lead	Outcome	RAG Rate
1.4	Communicate to the public and partners the need to keep children safe and promote their welfare	Review and update current BSCB Safeguarding Leaflets	November 2015	Safeguarding Executive	• Parents and children have access to up to date information about safeguarding processes	
		Continue to publish BSCB Annual Report to evaluate effectiveness of safeguarding	July 2015	BSCB	• BSCB provides a robust evaluation of local arrangements to safeguard children, including the effectiveness of child protection processes • BSCB is able to offer support and challenge to local organisations to develop practice	
		Request Bolton Youth Council review and comment on the BSCB Business Plan and contribute to the Annual Report	July 2015	BSCB	• Children evaluate and comment on the work of BSCB, providing challenge where needed • BSCB responds to the views of children	
		Raise awareness of the mandatory reporting requirement for FGM in under 18's	October 2015	Safeguarding Executive	• Workers have improved knowledge of FGM and response consistently to safeguard children • Workers understand their roles and responsibilities to report FGM	

BSCB BUSINESS PLAN - TIER 1

BP Ref	Core Objective	Action	Review Progress	Lead	Outcome	RAG Rate
1.5	Participate in the planning of services for children in Bolton	Continue to make an active contribution to national plans and local service developments/re-designs likely to impact on children and their families	March 2016	BSCB	• BSCB influences local and national decision making in respect of safeguarding children • BSCB promotes safeguarding children with all members	
		Continue to strengthen the reporting and communication arrangements between BSCB and key partnerships outlined in Working Together 2015	April 2015	BSCB	• BSCB promotes safeguarding children with all local strategic partnerships • BSCB is assured that local strategic partnerships embed the requirement to safeguard children within their planning arrangements • BSCB is able to offer support and challenge to develop practice	
		Review membership and functioning of BSCB working groups	November 2015	BSCB	• BSCB has an effective and efficient structure to support delivery of its objectives	
		Continue to support representation at regional safeguarding meetings and partnerships	March 2016	BSCB	• BSCB shares its learning and practice with regional partners	
		Continue to include the minutes and actions from regional meetings as a standing item on BSCB agenda	March 2016	BSCB	• BSCB is able to respond and contribute to regional developments • BSCB is able to offer support and challenge to develop practice	

BSCB BUSINESS PLAN - TIER 1

BP Ref	Core Objective	Action	Review Progress	Lead	Outcome	RAG Rate
1.6	Operate effective arrangements to review all child deaths, including those where abuse or neglect may a factor and to respond to the learning	Review the progress and impact of action from completed learning reviews	March 2016	Learning and Improvement Group	• BSCB ensure that learning and any practice developments are shared with the workforce • Workers know about the learning and frontline practice improves	
		Conduct Serious Case Reviews within timescale and with full engagement of member agencies	March 2016	Learning and Improvement Group	• BSCB is able to evaluate the quality and effectiveness of safeguarding practice • BSCB develops practical responses to learning form Serious Case Reviews • BSCB provides relevant challenge and scrutiny to develop practice	
		Continue to receive the Child Death Overview Panel Annual Report and develop a responsive action plan	September 2015	Bolton, Salford and Wigan Child Death Overview Panel	• BSCB understands why children die in Bolton • BSCB develops co-ordinated responses to address any modifiable themes • BSCB continues to support the Sleep safe Campaign	

BSCB BUSINESS PLAN - TIER 1

BP Ref	Core Objective	Action	Review Progress	Lead	Outcome	RAG Rate
1.7	Monitor and evaluate the effectiveness of what is done locally to safeguard and promote the welfare of children	Embed the BSCB performance report to ensure it provides a robust assessment of the effectiveness of safeguarding children arrangements	December 2015	Quality Assurance and Performance	• BSCB offers challenge and scrutiny to develop practice • BSCB identifies and responds to emerging themes	
		Complete and publish a robust BSCB annual report by September 2015	July 2015	BSCB	• BSCB provides a robust evaluation of local arrangements to safeguard children, including the effectiveness of child protection processes • BSCB offers challenge to develop practice	
		Co-ordinate an assessment of the effectiveness of local agencies responses to Child Sexual Exploitation and children missing from home in Bolton	November 2015	Child Sexual Exploitation Steering Group	• BSCB is assured that local arrangements for safeguarding children at risk of Child Sexual Exploitation and/or who are missing from home are robust and improve outcomes for children	
		Review the progress and impact of action from completed audits	October 2015	Quality Assurance and Performance	• BSCB influence and develop practice from sharing the findings from an annual programme of safeguarding audits	
		Understand the impact of the adolescent nursing redesign	May 2015	BSCB	• BSCB is able to evaluate and consider whether this service change has impacted on the safety and welfare of children	
		Review how members have responded to learning from inspections	July 2015	BSCB	• BSCB evaluates current responses and progress against learning from inspections • BSCB offers challenge to practice	

BSCB BUSINESS PLAN - TIER 1

BP Ref	Core Objective	Action	Review Progress	Lead	Outcome	RAG Rate
2.1	Evaluated the impact of re-launched Early Help Processes in promoting the welfare of children and keeping them safe	Seek the views of children and their families of their experiences of Early Help processes	September 2015	Early Help Steering Group	• BSCB understands how Early Help impacts on children and their families • BSCB is able to offer support and challenge in this area to member organisations to develop practice	
		Evaluation report from Early Help Steering Group	September 2015	Early Help Steering Group	• BSCB understand how and in what ways organisations have embedded the revised guidance • BSCB understands the current issues in implementing Early Help effectively • BSCB offers guidance on how to address issues • BSCB offers challenge to members as needed	
		Seek the views of the workforce of their experiences of Early Help processes	September 2015	Early Help Steering Group	• BSCB understands how Early Help impacts on children and their families • BSCB is able to offer support and challenge in this area to member organisations to develop practice	
		Ensure compliance of Bolton's Early Help Processes against the requirements of Working Together 2015	September 2015	Early Help Steering Group	• BSCB is assured that local processes to keep children safe are compliant with national guidance	

BSCB BUSINESS PLAN - TIER 2

BP Ref	Core Objective	Action	Review Progress	Lead	Outcome	RAG Rate
2.2	Understand current responses to children's emotional health needs and assess their effectiveness	Ensure there is information about support services available to children to promote good emotional health, including specific support for those who may be at risk of suicide or self-harm	October 2015	Safeguarding Executive	• BSCB are confident that children have access to emotional health advice and support • Children know where to go for help and support	
		Contribute to the development of a local Emotional Health and Well-being Strategy for children	December 2015	BSCB	• A co-ordinated multi-agency strategy is in place and is compliant with Bolton's Framework for action • A range of emotional health services and support for children is available • The strategy reduces the instances and severity of self-harm and reduces the incidence of suicide	
		Contribute to the re-development of local guidance for identifying and responding to children and young people with emotional health needs	December 2015	Safeguarding Executive	• Workers have access to practical guidance to support children in this work • Workers are clear about their roles and responsibilities and know when and where to access help and support for children • Ensure there is a clear pathway for children where engagement with services is an issue	

BSCB BUSINESS PLAN - TIER 2

BP Ref	Core Objective	Action	Review Progress	Lead	Outcome	RAG Rate
2.3	Further strengthen the partnership arrangements between BSCB and key partnerships in particular the Health and Well-being Board, Adult Safeguarding Board, Children's Trust Board and Be Safe Community Safety Partnership	Develop a protocol between BSCB and Health and Well-being Board	September 2015	BSCB	• BSCB and Health and Well-being Board working relationships are further improved and clarified	
		Ensure respective partnership business plans and priority areas are shared	September 2015	BSCB	• Shared priorities are identified • Work between the strategic partnerships is co-ordinated and there is effective use of resources	
		BSCB submits its annual report for consideration and comment by all partnerships	August 2015	BSCB	• Partnerships use the assessment of the annual report to influence their work	

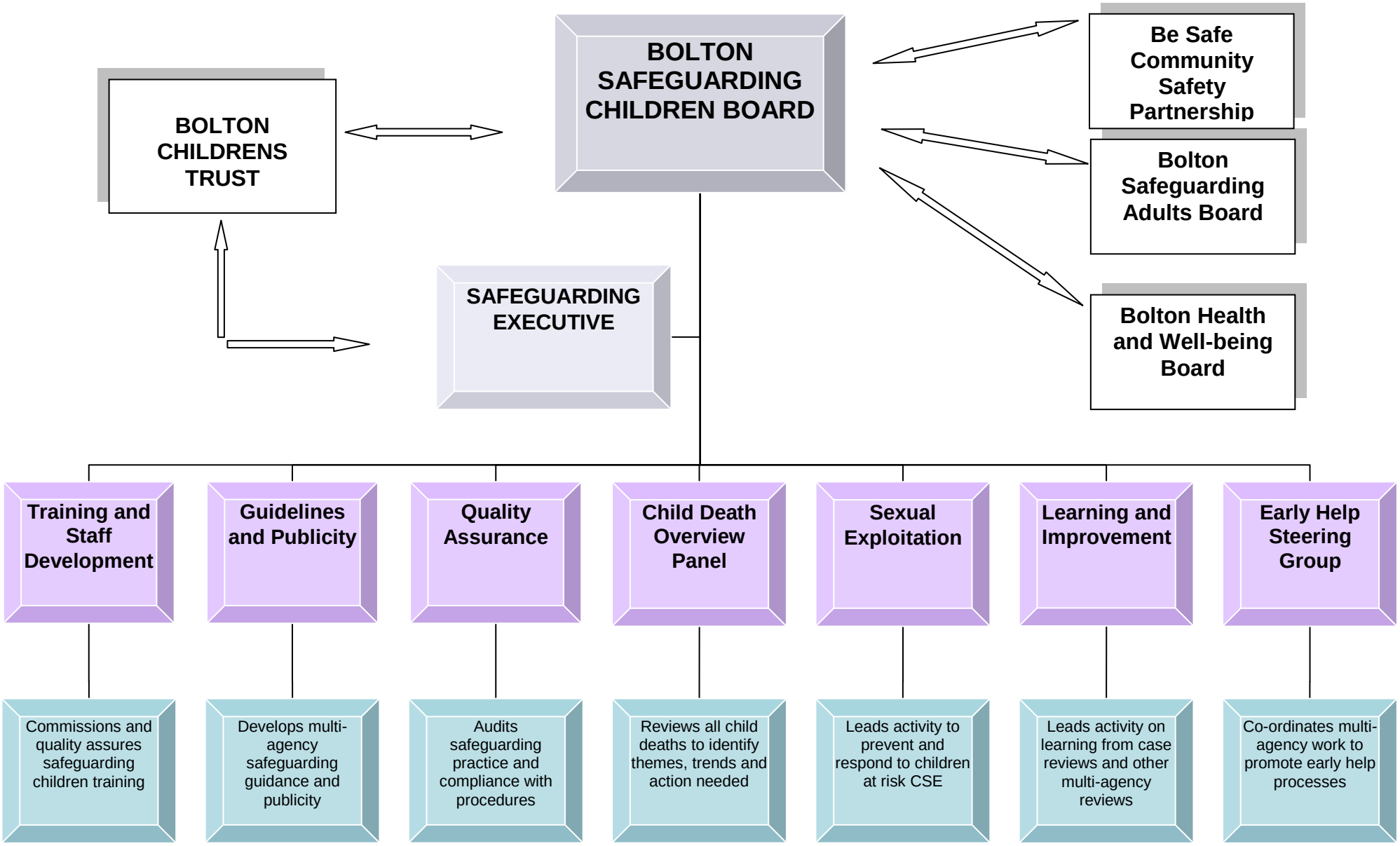
BSCB BUSINESS PLAN - TIER 2

BP Ref	Core Objective	Action	Review Progress	Lead	Outcome	RAG Rate
2.4	Review and revise current responses to neglect in Bolton	Re-develop local guidance and supporting tools	December 2015	Safeguarding Executive	• BSCB improves quality and effectiveness of assessment and interventions with child neglect	
		Complete a benchmark audit of current multi-agency neglect cases	September 2015	Quality Assurance and Performance	• BSCB provides an assessment of current practice in working with neglect • BSCB understands the areas of strength and is able to identify where developments are needed	
		Review current Neglect Training and update in accordance with revised guidance	March 2016	Staff Development Group	• Training is effective in supporting worker to recognise and respond to neglect • The effectiveness of planning and intervention with neglect cases improves	
		Key questions for managers/supervisors to support analysis and impact of neglect cases during supervision	December 2015	Safeguarding Executive	• Managers are supported to offer challenge and scrutiny • The effectiveness of planning and intervention with neglect cases improves	

BSCB BUSINESS PLAN - TIER 2

BP Ref	Core Objective	Action	Review Progress	Lead	Outcome	RAG Rate
2.5	Identify and respond to current E-Safety issues in Bolton	Host an E-safety consultation involving children, workers and parents	November 2016	Safeguarding Executive	• Multi-agency consultation event identifies current issues in this area • Consultation identifies the range of e-safety resources being used in Bolton • Evaluates the effectiveness and impact of current strategy	
		Develop key objectives and an action plan to address issues from the consultation	January 2016	Safeguarding Executive	• BSCB supports the development of resources to support e-safety practice	

Appendix 1 BSCB Structure



Appendix 2 – BSCB Members

SAFEGUARDING BOARD MEMBERS 2014-2015	
CHAIR	**DEPUTY**
Mike Tarver Independent Chair Bolton Safeguarding Children Board Paderborn House Civic Centre Howell Croft North Bolton BL1 1UA 01204 337479 mike.tarver@bolton.gov.uk	Head of Community Housing Services Bolton Council 1 Silverwell Lane Bolton BL1 1QN

COUNCILLOR	
EXECUTIVE MEMBER	**DEPUTY**
Councillor Madeline Murray c/o Members Secretariat Town Hall Bolton BL1 1RU	N/a

HEALTH ECONOMY	
NHS FOUNDATION TRUST	
MEMBER	**DEPUTY**
Deputy Director of Nursing, Bolton NHS Foundation Trust Minerva Road Farnworth Bolton BL4 0JR	tbc
MENTAL HEALTH TRUST	
MEMBER	**DEPUTY**
Consultant Adolescent Forensic Psychiatrist FACTS Team Greater Manchester West Mental Health Trust Bury New Road Prestwich Manchester M25 3BL	Named Nurse Greater Manchester West Mental Health Trust Trust Headquarters Bury New Road Prestwich M25 3BL
PUBLIC HEALTH	
MEMBER	**DEPUTY**
Public Health Consultant Le Mans Crescent Bolton BL1 1UA	N/a

HEALTH ECONOMY	
CLINICAL COMMISSIONING GROUP	
MEMBER	**DEPUTY**
Executive Board Nurse Bolton Clinical Commissioning Group St Peters House, Silverwell Street Bolton BL1 1PP	n/a
GP WITH SAFEGUARDING SPECIAL INTEREST	
MEMBER	**DEPUTY**
GP Safeguarding Lead C/o St Peters House Silverwell Street Bolton BL1 1PP	n/a
NHS England Greater Manchester Area Team 4th Floor 3 Piccadilly Place London Road Manchester M1 3BN	n/a

LOCAL AUTHORITY	
DEVELOPMENT AND REGENERATION	
MEMBER	**DEPUTY**
Head of Community Housing Services Bolton Council 1 Silverwell Lane Bolton BL1 1QN	Manager Housing Options & Advice Services Group Manager Bolton Council Silverwell Street Bolton BL1 1QN
CHILDREN'S AND ADULTS SERVICES	
MEMBER	**DEPUTY**
Director of Children and Adults Services Bolton Council Strategy Division 5th Floor, Paderborn House Bolton BL1 1UA	Assistant Director Staying Safe Childrens Services Bolton Council 5th Floor Paderborn House Civic Centre Bolton BL1 1UA

EDUCATION REPRESENTATION	
MEMBER	**DEPUTY**
Special Schools Head Teacher - Ladywood Special School Masefield Road Little Lever Bolton BL3 1NG	Headteacher The Orchards Federation Highfield Road Farnworth Bolton BL4 0RA
Secondary Schools Head Teacher Ladybridge High School New York Junction Road Bolton BL3 4NG	n/a
Primary Schools Head Teacher Susan Isaacs Nursery Vernon Street Bolton BL1 2XN	n/a

GREATER MANCHESTER POLICE	
MEMBER	**DEPUTY**
Bolton Divisional Superintendent Bolton Divisional Headquarters Greater Manchester Police 10 Scholey Street Bolton BL2 1HX	n/a

GREATER MANCHESTER FIRE AND RESCUE SERVICE	
MEMBER	**DEPUTY**
Community Safety Manager Bolton Borough HQ GM Fire Service Moor Lane, Bolton BL3 5DB	n/a

CAFCASS	
MEMBER	**DEPUTY**
Service Manager 7th floor, Piccadilly Gate Store Street Manchester M1 2WD	

PROBATION SERVICES	
MEMBER	**DEPUTY**
Assistant Chief Executive National Probation Service St Helena Mill St Helena Road, Bolton BL1 2JS	N/a
Assistant Chief Executive Community Rehabilitation Company St Helena Mill St Helena Road, Bolton BL1 2JS	

VOLUNTARY SECTOR	
MEMBER	**DEPUTY**
Chair Bolton Young Persons Third Sector Forum 18 Ashness Place Breightmet Bolton BL1 5EW	N/a

FAITH GROUPS	
MEMBER	**DEPUTY**
Bolton Council of Mosques 1 Vicarage Street Bolton BL3 5LE	

LAY MEMBERS	
Mrs Elsie Rigby c/o Bolton Safeguarding Children Board Paderborn House Civic Centre Howell Croft North Bolton BL1 1UA 01204 337479	Vacant