BOLTON SAFEGUARDING CHILDREN BOARD

Annual Report 2016-2017

Bolton Safeguarding Children

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This Annual Report was endorsed by Bolton Safeguarding Children Board on **tbc**. 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. It reports on matters relating to the preceding financial year.

The purpose of the Annual Report, as stated in Working Together to Safeguarding Children 2015, is to provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action. The report should include lessons from reviews undertaken within the reporting period.

In addition to being made available to the public, this report will be submitted to the Chief Executive, Leader of the Council, the local Police and Crime Commissioner and the Chair of the Health and Well-Being Board.

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

Contents

This annual report has been designed for readers to use as an active resource; the following sections are included: -

NB - Children and young people's identities have been changed to maintain their confidentiality

A Message from Bolton Safeguarding Children Board's Independent Chair

As the new Independent Chair of the Bolton Safeguarding Children Board (BSCB) I am delighted to introduce the Board's report for 2016/2017. I would firstly like to thank and congratulate Mike Tarver, former Independent Chair who retired in July this year, for his excellent contribution to the work of the Board during the past seven years. This report allows us to look back on what has been a very successful period with Mike in the chair, but a period which has also thrown up many challenges in terms of the changing nature of issues facing practitioners on a day to day basis. It also allows us to set our successes and challenges into the context of increasing financial constraints, and the proposed changes to the shape of LSCBs in light of the Wood Review, and Children and Social Work Act 2017. Within this context, it is testament to all partners, their staff and their volunteers, and our Board officers, that their continued commitment to children and young people in Bolton has delivered the progress outlined in this report.

The report does not intend to provide a comprehensive account of everything BSCB has undertaken during the year. It is, however, a succinct overview of progress regarding many of the complex challenges it has faced, including a review of our Business Plan. We have provided a brief overview of the child population within the Borough, as well as some of the challenges faced by services and practitioners in meeting the local needs of children.

The report aims to present some partially anonymised case examples illustrating the impact the Board have made in key areas. For example, our Early Help processes, which BSCB relaunched in October 2014, have delivered demonstrable progress with around 20% more services engaged and a similar percentage increase in better quality assessments completed over the last 12 months. This represents a significant step forward in achieving timely delivery of support before children present in crisis. However, we must not be complacent, as we have seen evidence of the Early Help process not being used when it could have been, with opportunities missed to deliver more coordinated services to some children. This coming year, we must do more to improve on this. Our Early Help Hub will **need** be a key part of those improvements.

The impact of the Child Sexual Exploitation Strategy continues to unfold and this report highlights progress made in respect of all the strategy's main elements of awareness raising, supporting young people at risk, robust diversionary tactics and prosecution. This work provides clear evidence of the benefits of a holistic approach. The recognition of an increasing number of male victims and increase in successful convictions over the last year is encouraging. This coming year there will be scrutiny by the office of the Deputy Mayor of all CSE work undertaken across Greater Manchester, and whilst we are confident our CSE work is of a high standard, we will of course look closely at any opportunities for improvement which are highlighted from that review.

Overall, the last year has been one of considerable success for BSCB, with a number of key pieces of work completed. Attendance at the Board by representatives from key partners has remained on the whole strong, and effective multi-agency work has been evidenced throughout the year. The section on progress against the business plan shows in detail the work which has been completed successfully this year.

However, despite these achievements this report seeks to identify further work needed to achieve our aim of successfully safeguarding all children in Bolton, which is what they should expect. Whilst progress against the business plan and other workstreams has been encouraging, we are acutely aware that the next twelve months will be a time of considerable challenge for BSCB. Our work to date has shown that we still have several areas of improvement to work on, including: -

- Wider engagement opportunities for young people and their families to ensure 'the voice of the child' is heard; we know the value of involving Young People and their parents / carers in helping us to shape future developments, and we need to maximise the opportunities for this to happen.
- Developing training strategies which widen the training offer, and improve links across children and adults safeguarding; and which promote the use of GM policy and procedures
- We need a broader connection of joint Board priorities across key themes such as Neglect, Access to Mental Health Services, Suicide Prevention Pathways, Early Help, and Transitions - ensuring that the move from child to adulthood is a safe and positive experience
- Responding to new complex areas of safeguarding, such as online safeguarding in the context of rapidly-changing use of technology and social media by children and young people
- We must continue to improve our work to combat the effects of domestic violence & abuse on children and young people, as well as continue our work around female genital mutilation, organised crime, trafficking and modern slavery and so-called honour based violence

During a coming year of significant change, the Board will also need to consider future developments at a National, Greater Manchester, and local level, as a result of the changes following the Wood Review 2016 and Children and Social Work Act 2017. The future shape of local Safeguarding arrangements is unclear, but we have the opportunity to assist in developing the new arrangements, and as Chair of the BSCB I will ensure that our voice is heard in these key developments.

John Brimley
Independent Chair
Bolton Safeguarding Children Board


BOLTON'S CHILDREN 2016-2017
66374 children live in Bolton
3788 babies were born
25% of children aged 15 and under are living in poverty
35% of school age children were from a minority ethnic community
Approximately 12% of children aged 5 to16 experience mental or emotional health difficulties
12% of primary and secondary aged children identified themselves as young carers
2041 Early Help Assessments were started in 2016-2017
231 children subject of a child protection plan; 584 looked after by the local authority

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 representatives from Health Services, Probation Services, Greater Manchester Police, Children's Services, Housing Services, the voluntary and faith sector. A full list of members can be found in Appendix 1.

The functions of a Local Safeguarding Children Board are set out in the LSCB Regulations 2006, the LSCB (Amendment) Regulations 2010 and Working Together to Safeguard Children 2015. These documents state that 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.

VISION

Children get the right help at the right time from the right people

Bolton Safeguarding Children Board 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. All Board members are required to commit to a member's agreement which stipulates 80% attendance at meetings across the year; this is 4 meetings out of 5. 53% of members have met the attendance threshold. Where members have not ensured consistent attendance, this has been challenged by the Independent Chair. Members have been contacted and reminded of their commitments. Changes within organisational commissioning, delays in representatives being identified and capacity/resource demands have accounted for the deficit in attendance. As we move towards Safeguarding Partnership arrangements theses issues will be considered.

Evaluation of Safeguarding Arrangements in Key Areas

This Annual Report focuses on key areas contained within the Board's business plan. The evaluation will take account of the requirements in Working Together 2015, paragraph 2, page 67: -

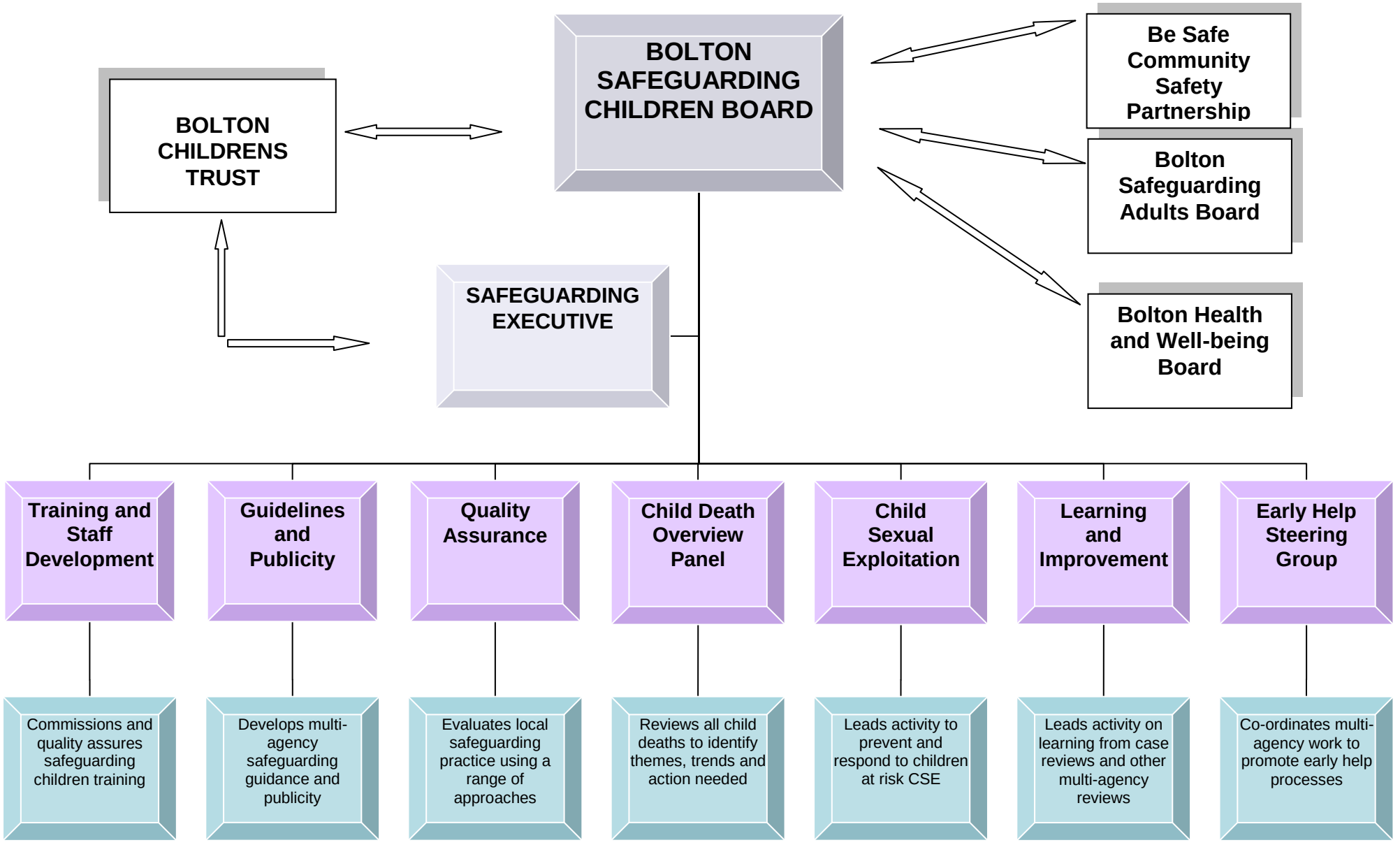
- Assess the effectiveness of the help being provided to children and families, including early help
- Assess whether BSCB partners are fulfilling their statutory obligations
- Quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned
- Monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children

BSCB Resources

To function effectively BSCB needs to be supported by member organisations with adequate and reliable resources. As there was no national guidance or requirements on funding for LSCB's, despite their statutory functions, Bolton developed a local formula a number of years ago. The budget is made up of contributions by member organisations and while members continue to contribute, the lack of any statutory funding requirements leaves the Board vulnerable to unilateral reductions by members at a time of ongoing financial challenge.

BSCB Income	
Organisation	**Income(£)**
Bolton Children's Services Dept. (Inc. Schools)	232,079
Greater Manchester Police	17,296
National Probation Service and Community Rehabilitation Company	3537
Bolton CCG	89,205
CAFCASS	550
Total Income	**342,667**
BSCB Expenditure	
Item	**Expenditure**
Staff Costs:- Safeguarding Officer Safeguarding Administration LADO Administrator Safeguarding Trainer Local Authority Designated Officer Quality and Performance Officer	219,722
Independent Chair	15,615
Operational Costs:- Room Hire Refreshments Transport Training / Conferences Contribution to GMSP On-line Policies Advocacy Pilot Scheme Case Reviews Legal Costs Contribution to CDOP Contribution to IRO Conferences	107,65
Total Expenditure 2016-2017	342,402
Year End Balance 2016-2017	265
Spend per Child	5.16

BOARD STRUCTURE 2015-2016



The Child's Journey
Early Help to Looked After Children

What is Early Help?

Early Help describes the co-ordinated support that is offered to children and their families at the earliest opportunity. The aim is to improve outcomes for the child and reduce the need for specialist services including children's social work. Help can be provided by one service or by a number of different services. Where more than one service is needed to help a child, BSCB requires an Early Help Assessment (EHA) to be undertaken and a multi-agency action plan developed.

How will we know we're making a difference in Bolton?

More Early Help Assessments are being completed; more services using the Early Help Assessment process

The majority Of Early Help Assessments are closed because outcomes are achieved

Early Help Assessments evidence involvement of child and parents

Early Help assessments are of good quality and supported by SMART action plans

Early Help is used to refer to Children's Social Care when this is required

Improving the use of Early Help will reduce the number of referrals to Children's Social Care

Early Help is used to support children when Children's Social Care involvement ends

The use of local early help processes continues to increase year on year in;
2014 - 495 EHA; 71 per 10000
2015 -1467 EHA; 219 per 10000
2016 - 1773 EHA; 255 per 10000
2017 – 2041 EHA; 307 per 10000

Data also evidences that the overall number of Early Help Assessments is increasing with 3293 open EHA at the end of March 2017; this is a 14% increase when compared with 2016 and a 70% increase compared to 2015

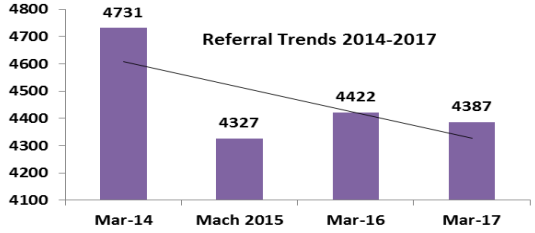
135 services initiated the Early Help process compared to 129 in 2016 and 108 in 2015. Reviewing EHA to track progress and impact for children also continues to strengthen with a 251% increase in the number of reviews takin place

The primary reasons for initiating an EHA have remained consistent with the top four being Speech and Language, Education, Behaviour and Health; there has however been some shift in the proportions with Education now being the second most prevalent reason for EHA

At the end of 2017 3972 EHA were closed this is a significant increase on the previous year; 10% were closed as outcomes achieved; 2% were closed as they stepped-up to specialist assessments

3 Early Help multi-agency quality audits were completed; each one focused on a specific practice area. Practitioners were encouraged to start the audit session by developing a shared understanding of what 'good' looks like; the audit findings have influenced the Early Help Strategy

Since the relaunch of Early Help processes in October 2014 referrals to Children's Social Care are on a downward trend and indicates that Early Help is having an impact



In Practice; Early Help and Developing Bolton's Autism Pathway

In May 2016, following the Special Education Needs and Disability Inspection (SEND), it was identified that an area for development was improving local responses to demand for referrals and diagnosis of Autistic Spectrum Disorder (ASD). At the time Bolton had two Referral pathways for diagnosis for children; this resulted in a lack of clarity for families and for the workforce. Given that the same inspection had highlighted the strengths of Early Help within the SEND pathway,

'*The local areas 'early help' assessment process is a good example of joint working across education, health and care workforce. It's supported by high quality training, information and guidance to inform processes and establish consistency in assessment*'

(SEND Inspection report July 2016)

Leaders in the sector agreed that Early Help should be the foundation for the ASD pathway. A multi-agency group was brought together, including parents, commissioners, education representatives and GP's, to develop the pathway using their combined expertise and learning from previous work. From this a set of resources have been agreed which include:-

- 'Early Help' compliant Information Sharing paperwork for GPs
- An Autism diagnosis pathway and guidance document
- Training and workforce development for practitioners to implement the pathway

The multi-agency pathway will ensure greater transparency for families, improved information sharing between key health staff and education settings and children receiving co-ordinated support to meet their needs at the earliest opportunities.

Effectiveness of Early Help Arrangements

Local Early Help arrangements are effective. There is clear evidence from the data that Early Help processes are embedded across a diverse range of services and integrated within their delivery models. In particular the use of Early Help continues to grow within the private, voluntary and independent Early Years sector. This is encouraging as these small organisations often develop good relationships with parents and are better placed to respond to children's emerging needs. Early Help is being delivered to more children across Bolton than ever before and is contributing to an overall downward trend in referrals to Children's Social Care. The significant increase in the number of Early Help reviews is positive and demonstrates that practitioners are using the process to develop, implement and regularly track the impact and effectiveness of their plans. This needs to be sustained and enhanced for 2017-2018.

The EHA quality process has been further developed over the year; not only does it continue to provide learning points for practice, but it is also taking a lead in developing our local understanding of '*what good looks like*'. These messages will be developed over 2017-2018 to share across the wider workforce

Where we can improve

The vast majority of Early Help assessments were closed this year for 'other' reasons; this is either because practitioners did not record a closure reason or it was closed by the Integrated Working Team as there was no activity in a 12-month period. It is important that this gap is addressed to enable Board members to be confident that Early Help remains effective in Bolton. A further area for improvement is the use of Early Help for older children. Our data shows that only 17% of EHA started in 2016-2017 were for children aged 12 or over and it is likely for some children in this age range that they are not receiving the co-ordinated help and support they need. Finally, a key area for Board members will be the effective implementation of Bolton's Early Help Strategy.

What is Child Protection?
This is the action that is taken to stop children from suffering abuse or neglect. In 2016, the most recent published data, 50,310 children in England were identified as being subject of a child protection plan from abuse; this equates to 44 children per 10000. Neglect accounts for 45% of all child protection plans in England.

How will we know we're making a difference in Bolton?

Child protection strategy meetings will be multi-agency and effective in assessing and responding to risk

Rate of child protection plans in Bolton will be consistent with, or below, the England rate

Child protection plans are Specific Measureable Achievable Relevant and Timely (SMART) and effective in keeping children safe

Children's experiences and voices will be reflected within the child protection process

Of the 4387 referrals made to Children's Social Care 43% (1871) led to a multi-agency strategy discussion with 66% (1228) progressing to a Child Protection (S47) Assessment. This means that 185 per 10000 children in Bolton were the subject of enquires about abuse/neglect

279 Initial Child Protection Conferences (ICPC) were held in 2016-2017 this is a 23% increase on the previous year; at year end 231 children were the subject of a Child Protection Plan (CPP) this represents 0.3% of **all** children in Bolton

Overall 87% of ICPC's were held within the 15-day timescale, this is a 14% improvement on the previous year; agency attendance at ICPC's is good overall and Greater Manchester Police have attended 79% of ICPC's

35 children per 10000 are subject to a plan in Bolton; this remains lower than the England average of 44 for 2016. In terms of age ranges;
40% are four or under
31% are five to nine
26% are 10 to 15
4% are 16+

Since 2014 there has been a downward trend in White British children subject to a child protection plan. In the same period there has been an upward trend in children from Black African and Gypsy Roma families becoming subject to a plan

247 plans ended in the period; 72% ended as risks had been managed and reduced. 20% stepped up to become looked after while 7% ended as the child transferred to another Local Authority area

Improving the quality of child protection plans remains a key priority; SMART action planning has been promoted across the partnership. A recent audit of plans indicated 64% of plans met the SMART criteria; this is a 4% decrease on the baseline set in 2016

An audit of plans showed direct work with children is taking place evidencing the child's voice is heard and responded to; in the best plans the risks to individual children, even within sibling groups, were specific to them and supported by clear interventions

In Practice; Improving Participation of Children in Child Protection Conferences

A local study was completed by Child Protection Conference Chairs to consider how well children in Bolton participate within their Child Protection Conference, the impact it has on outcomes and decision making. For the purposes of the study participation was defined as,

"Children and young people's involvement in individual decisions about their own lives, as well as collective involvement in matters that affect them"

The study demonstrated that children are being asked for their opinions and experiences however there is no consistent practice for formally inviting children to their Initial or Review Conference; there is disparity around completion of conference packs and workbooks and the level of participation evidenced for the initial case conferences was not carried forward to the review conferences. As result of this study a number of recommendations were agreed, including;

- Children over an agreed age should be formally invited by letter; where children do not wish to attend, their social worker should ensure their experiences, wishes and feelings are shared
- Consideration should be given to developing and implementing a Conference Participation Charter with children and local partner agencies

These recommendations are being presented to the Safeguarding Board in 2017-2018 to request their support in taking this important area of work forward.

Effectiveness of Arrangements

Bolton continues to have one of the lowest rates of children subject to a plan when compared with regional neighbours. However, the rate of children becoming the subject of a plan for a second or subsequent time has increased locally and this will need to be tracked over 2017-2018 to assure the Board that plans for children are effective in managing and reducing risk over the long-term. There is clear improvement in the timeliness of initial conferences and Bolton is now above both the England and statistical neighbour average. In October 2016 a number of case conferences were observed to evaluate their effectiveness. These observations highlighted that all the meetings were chaired well, facilitated families and practitioners to fully participate and demonstrated that when children are encouraged and invited to attend they are able to share their experiences in creative ways.

Where we can improve

In 2017-2018 there is a need for board members to: -

- Support their workforce in developing SMART and effective Child Protection Plans; in the coming year Conference Chairs will be asked to ensure that all conference attendees complete the action plan section within their conference report; where there are gaps or the quality is not good Chairs will be asked to challenge this
- Develop an understanding of the factors that have contributed to the 6% increase in children becoming subject to a plan for a second or subsequent time and respond accordingly
- Further scrutinise the changing demographics of children subject to a plan to ensure effective support is in place for children from new and emerging communities
- Contribute to further audits to evaluate the effectiveness of planning

What is a Child Looked After (CLA)?
Care is a vital part of our child protection system. A child who is being looked after by their local authority is known as a child in care. They might be living: -

- With foster parents
- At home with their parents under the supervision of the local authority
- In residential children's homes
- Residential settings like schools or secure units

Children can become looked after for a number of reasons but in the main it is because parents struggling to cope and placed their child in care voluntarily. Or, children's services may have intervened because a child was at significant risk of harm.

How will we know we're making a difference in Bolton?

The number of children who need to be looked after will reduce

Children have stability in their placements

Children's care plans will be reviewed on time and their experiences will be reflected within the process

Children are supported to access effective education and their attainment is comparable with that of all children

Adoptions are progressed within the agreed timescales

Between March 2015 and 2016 there had been a 1.5% decrease in CLA; this decrease has not been sustained in 2017 and at the end of the year there were 584 CLA. This is equivalent to 88 children per 10000 and is above the England and Statistical Neighbour average

67% of children have their future secured with a full care order while 13% are subject to an Interim Care Order. 12% of children are voluntarily looked after. This compares well with the England average with 52% of CLA having a full care order, 18% an interim and 27% voluntarily CLA

77% of children have lived in the same placement for the last twelve months and this in line with the England average; 51% of children have lived in the same placement for 18 months or more

From the age of three every child looked after should have a Personal Education Plan (PEP). The plan helps track and promote educational achievements. In Bolton 427 children were identified as requiring a 'PEP'; 94% are recorded to have such a plan in place

27% of CLA are aged 0 to 4 years while 23% are aged 5 to 9; both percentages are slightly higher than the England average. Since 2015 there has been a steady local increase in CLA aged 10 to 15 and this is now closer to the England average. CLA aged 16 and over remains stable at 13%; this is lower than the England average

While Bolton has some of the highest percentages in the North West for CLA placed at home with parents -13%; it is the 3rd lowest when it comes to placing children out of area - 23%. The vast majority of children in Bolton are cared for by Foster Carers in the local area

Every child who is looked after has their care plan reviewed every six months. In 2016-2017 94% of reviews were held on time; 83% of children contributed their views, while 43% of children chose to attend their review. All these figures are an improvement on the previous year

An average of 27% of children left care in Bolton to be adopted between April 2014 and March 2017. This is significantly better than the England average of 16%. On average it takes 401 days for a child to move to their adoptive family; the England average of 490 days

In Practice; Using Children's Experience to Create Effective Practitioners

The majority of children enter care owing to their experiences of abuse and neglect; as a consequence they often have statistically poorer health outcomes than their peers. This year Bridgewater Community Healthcare has worked with children who are looked after to seek their views on what they want from their health practitioners. The children developed their 'wish list' and this is now embedded in staff training.

In Practice; Jodie's Story

Jodie, 15, has been looked after for a number of years; she did not want to have a health assessment and refused twice to be seen. Practitioners worked with Jodie to explore how they could reach an agreement; planning the assessment at a time and place that suited Jodie helped her to access health support and see the benefits. Building on this positive outcome the young person agreed to attend The Parallel (the young person's health centre in Bolton town centre) where further health work was delivered. The young person was introduced to other members of staff at The Parallel and now is confident in going there and attends the regular daily clinics as necessary

Effectiveness of Arrangements

In the last year the number of children looked after has increased and this is placing additional pressure on resources. The complexity of family issues and larger sibling groups are identified as two of the factors continuing to drive the increasing trend. It will be important for local agencies to understand in more detail the factors leading to children becoming looked after and use this research to inform our existing and developing multi-agency strategies such as Early Help, Missing and Neglect.

The vast majority of Bolton children live with foster carers and it is a strength that so many experience stable placements. In 2016-2017, 184 children ceased to be looked after and the primary reasons for this were successful rehabilitation with their parents and adoption. Both of these outcomes evidence the impact of multi-agency work to secure permanence for children in Bolton.

In 2015-2016 only 46% of eligible children had a 'PEP' in place. Research has demonstrated the importance in securing good educational outcomes for CLA, so it is positive that in 2016-2017 94% of children now have education plans in place.

Where we can improve

The high number of CLA living at home is an area that requires further scrutiny. In Bolton and across the North West 21 of the 23 local authorities are significantly higher than the England average. Work is on-going across the region to understand the drivers behind this; it will be important for Board members to receive the findings from this research to address the issue as well as consider any local prevention opportunities.

RESPONDING TO SAFEGUARDING RISKS

What is CSE?
Child Sexual Exploitation (CSE) is a form of sexual abuse where children are sexually exploited for money, power or status. Children are persuaded or forced into exchanging sexual activity for money, drugs, gifts, affection etc. Child Sexual Exploitation doesn't always involve physical contact and can happen online. A significant number of children who are victims of sexual exploitation go missing from home, care and education at some point.
BSCB takes this issue very seriously and over the last decade and a half has worked with partners to safeguard children from this threat.

How will we know we're making a difference in Bolton?

Reduce the number of high risk victims of CSE

Improve recognition of males as victims of CSE

Increase the number of CSE related prosecutions and continue to disrupt offenders

Interventions to manage and reduce risk are effective - **NB** all assessments will score low even where all CSE risks are addressed

Events are effective in increasing awareness of CSE to the children, parents, practitioners and the wider public

There has been a 58% increase in referrals to Phoenix Exit when compared with 2015; and an 11% increase on 2016. High risk cases account for 11% of children assessed as at risk of CSE; this is comparable with previous years

38 abduction notices have been served on individuals to prevent offences being committed against children; this is a decrease of 10 on the previous year. There have been two CSE related convictions and a further six pending

67 CSE cases were closed in 2017, with 41 of these having received an assessment and intervention. 46% evidenced risk reduction; 32% started at low risk and remained low; 22% were medium risk

Bolton has continued to promote community awareness by supporting the CSE weeks of action. BSCB also hosted its annual CSE summit attended by over 120 multi-agency practitioners; 30 practitioners attended the one-day targeted training

187 children have received a CSE service this year; this is an 8% decrease on the previous year. 10% of the young people who received a service were male; this is a 6% decrease on 2016 but remains percentage points higher than the 2014 baseline

Weekly multi-agency disruption activity takes place and this often provides the intelligence to support more punitive responses. Routine offender visits and visits to those on bail for CSE related offences have been integrated within the work of neighbourhood police teams

In addition to the Boards one day CSE; Recognise and Respond Training a number of additional awareness sessions have been held including Bolton Taxi Drivers, Bolton Pharmacists, Foster Carers and staff at the Bolton Genito-Urinary Medicine

919 practitioners have clicked to access the CSE e-learning training, a significant increase on the 224 at the same time last year. Equally use of the BSCB CSE web resources has further increased from 591 in 2015-2016 to 1093 for this year; an 85% increase

In Practice; Sasha's Story

Sasha is 16, and is an intelligent young person whose early life was one of neglect and emotional abuse; because of this she became looked after by the Local Authority. As a result of her life experiences she found it difficult to form and maintain friendships with her peers. Sasha became involved with the EXIT team aged fifteen following a missing from home episode – she had spent the night at a hotel in Manchester with older men and other young people. Although Sasha disputed this, it was clear that this was not the first time this had happened. There was no allegation of sexual assault, however it became apparent that Sasha believed these men where her friends paying for social activities, alcohol and substances.

Sasha was initially hostile as she felt 'we' had spoiled her fun, disrupted her friendships and stopped her socialising with these older men. However with persistent and consistent support from her worker, Sasha began to engage with her Exit Social Worker. Direct work focused on improving self-esteem, recognising exploitative behaviour and developing Sasha's considerable strengths to help her make positive relationships. Work was also completed with Sasha's foster carers. At the same time Phoenix EXIT Police ensured the males in question were served with abduction warnings.

Sasha began to understand the grooming process and acknowledge the vulnerable situations she had previously been in and the potential for harm posed by these individuals. As a result of the intervention Sasha's missing from home episodes significantly reduced and she was able to recognise that the group of men where 'not OK'. Sasha has high aspirations, has achieved well in her GCSE's and is studying health and social care at college. She has a healthy relationship with an age appropriate boyfriend. Sasha was reluctant for her involvement with her worker to end despite the risk of CSE being significantly reduced.

Sasha intends to pass on learning to others on her college course!

Effectiveness of Arrangements

Tackling CSE in Bolton remains a high priority and the evidence indicates that agencies are alert to risk and take action when required. This can be seen in the continued increase in the number of new referrals to Phoenix Exit, up 11% on the previous year. Increased publicity and training is likely to be a contributing factor to this overall increase; this is evidenced in the increasing number of users of the BSCB web resources and the e-learning module. It further demonstrates that the Board's efforts to communicate effectively about CSE have been sustained across 2016-2017. It is disappointing that there has been a decrease in referrals relating to males over the course of the year when compared to 2015-2016 and it will be important for BSCB to re-visit local training to ensure the specific vulnerabilities of males is addressed.

A multi-agency CSE audit was carried out and the findings from this provided assurance to BSCB that agencies work well together to respond to the needs of CSE victims and where possible are creative in delivering support. In last year's annual report it was recognised that the availability of post-abuse therapeutic help for children who have experienced CSE was a gap. In the short-term the CCG have provided some funding to spot-purchase therapy and in the longer-term this requirement has been integrated within the revised CAMHS specification and tender which will take place in 2017-2018

Where we can improve

Disruption activity has been a challenge over the course of 2016-2017, due primarily to demands placed on GMP resources over the last year. This is currently being scrutinised and will be a focus for the CSE Steering Group in 2017-2018. This work will also consider how we can better work with probation partners for those offenders who may be currently on licence or due for release into the community. A further focus for 2017-2018 will be the development of 'complex safeguarding' arrangements across Greater Manchester; this covers not only CSE, but also includes Child Trafficking, FGM, Prevent, Criminal Exploitation of children etc. and in particular how these are likely to impact on our local arrangements and services.

What is 'Missing' from Home and Care?

A missing child is one whose whereabouts cannot be established; where the circumstances are out of character, or the context suggests the child may be the subject of crime or at risk of harm to themselves or another.

How will we know we're making a difference in Bolton?

Track and reduce the number of children who are reported as missing from home or care in Bolton

Reduce the number of children going missing on repeat occasions

Be assured that when children are missing and return they receive the right help and support

Be assured that interventions are provided to help children reduce risk when they are missing

448 children were reported as missing in 2016-2017 accounting for 1417 missing episodes. This is a 1% decrease in children reported as missing but an 11% increase in missing episodes when compared with 2015-2016. June, September and March were peak months

Slightly more girls than boys were reported as missing; 53% to 47%; 66% of children are reported missing from home, 13% missing from a care placement; 15% are children placed in Bolton by other Local Authorities

87% of children were offered a return interview; this is a 26% increase on 2015-2016 and a 46% increase on 2014-2015. In 2015-2016 91% of return interviews offered were taken-up. The quality of return interviews is audited regularly.

Six workshops were delivered to ninety-four social care staff. The sessions focused on increasing awareness of statutory responsibilities and further improve responses to children; recent audits have evidenced improvements in practice and staff understanding

The majority of children who were reported missing were in their teenage years, with 74% being aged 13-17 years old; 16% aged 11-12 and 10% aged 10 or under

The majority of children who are missing return within a short period of time; 73% of children returned the same day, 13% between 24 and 48 hours and 5% within a week. The top three reasons for missing are Contact with Family/Friends, Peer Pressure and Emotional Health

Sexual Exploitation and Missing (SEAM) arrangements are well established in Bolton. In the year SEAM ensured co-ordinated responses and action plans were in place for 95 children at risk; 66 girls and 29 boys. This is a 9% decrease on the previous year

Strategy meetings are held when the criteria are met and Early Help processes are being used more effectively to address lower risk missing concerns Case information is analysed to understand the 'pushes and pulls' that influence children who go missing.

In Practice; John's Story

John was regularly reported missing and following each episode RUNA completed return interviews. During this time the RUNA worker developed a good relationship with John and his family. Stranger danger work was completed during return interviews and while completing this work wider concerns about housing, John's mum's wellbeing and school were identified and shared with SEAM. As a result of the SEAM intervention, actions were put in place to improve housing conditions and provide additional support to the family.

In Practice; Louisa's Story

Ten-year-old girl Louisa was referred to SEAM as she had several missing from home episodes. The Safeguarding in Education Social Worker liaised with the school to request further information. School highlighted concerns about Louisa's presentation and sexualised behaviour. The school information was fed back at SEAM and shared with the other professionals working with her. The school continued to carry out direct work with Louisa and during these interventions she disclosed the reason she was going missing was because of her caring responsibilities at home. During a missing from home episode Louisa further disclosed to her friend's parents that she was being physically chastised by her mother. This resulted in her and her siblings being accommodated. A strategy meeting was convened and the Safeguarding in Education Social Worker attended and was able to effectively share information both from school and the SEAM meeting.

This case has led to the Safeguarding in Education Team developing their training offer to include missing as an element within their package.

Effectiveness of Arrangements

Since 2013-2014 there have been significant developments in collating, tracking and analysing the profile of children missing from home or care in Bolton. Over the last year we can see that the focus on improving the quality and quantity of return interviews is having an impact. There is now a better understanding of the reasons why children are missing and what is needed to help them at an individual and at a strategic level; John's case study is one example of how return interviews can improve a range of issues for a child and lead to positive outcomes. The Board is also assured that information about missing children and their potential vulnerability is consistently recorded within Children's Social Care systems and is available to social workers to inform their responses and interventions; this is a significant step forward. The renewal and re-development of the Service Level Agreement with our local missing provider, RUNA, is delivering positive outcomes. provided an opportunity to ensure all children have an opportunity to talk about their reasons for going missing, share anything that happened during the missing episode, identify any associates they were with during the missing and find out what might stop them from going missing in the future. RUNA also collect info from parents, carers and other professionals where appropriate and this provides a fuller understanding of the circumstances relating to the missing episode. Through this, consistency of information gathering, recording and sharing has improved. Any interventions offered to the child or family can be informed by the return interview and the information can be used if a child goes missing again to identify possible locations or associates to help find them.

Where we can improve

The Board recognises that over the past few years' significant efforts have been made to improve local multi-agency responses to safeguard children who are missing and these are effective. In order to strengthen this further the Board is supporting the development and implementation of a Missing from Home, Care and Education Strategy over 2017-2018. The Board would encourage all partners to contribute to the strategy, consider the implications for their setting and support effective implementation. The Board will ensure that as arrangements for LSCB's transfer to multi-agency partnerships this strategy will form a key part of work moving forward.

Domestic Abuse and Violence (DAV)

In 2015-2016 BSCB committed to work with the DAV partnership to undertake a multi-agency audit of MARAC cases involving children and seek assurance that this potentially vulnerable group of children are safe. In autumn 2016 BSCB and the DAV partnership sampled 10 MARAC cases to seek assurance that children living with high risk domestic abuse, who are not receiving services and support from social care, have their needs met, are safe and their wellbeing is promoted. This audit brought together statutory services including health and education partners, as well local Domestic Abuse and Violence services commissioned by the DAV partnership. The audit provided a window on current local practice and assured both partnerships that: -

- The services supporting the adult victim implement actions that indirectly safeguard children i.e. supporting applications for restraining orders, child arrangement orders, adult safety planning etc. and evidence of some safety planning undertaken directly with children
- When families move across geographical boundaries information is shared pro-actively agency to agency and MARAC to MARAC
- Information and concerns about children is known and is discussed with parents
- In the cases sampled there was a consensus that cases were being managed at the right level, thresholds were understood and applied with consistency

At the same time the audit identified areas for practice development, including: -

- Where a practitioner is making a MARAC referral, they will check whether an Early Help Assessment is in place and where a Lead Professional is identified they are notified of the referral; where no Early Help is in place the need for Early Help should be considered
- All MARAC agency champions should ensure that section on Early Help in the MARAC referral form is completed fully
- Early Help is integrated in the MARAC agenda, discussed within the MARAC meeting and where required a Lead Professional is agreed to undertake Early Help

In Practice; Practitioners View of Audit

"I found the audit day to be an excellent learning experience. In particular the clarity provided regarding the Early Help process was something that I was able to return and disseminate to all staff. As a result, we are better equipped at providing the correct information on the MARAC referral, and in making referrals to social care; which was another issue that was discussed at the workshop. Also, when attending the MARAC there is much more emphasis upon the children involved and the action plans will reflect this."

In Practice; Carla's Story

Play and Youth Services supported Carla, a 15-year-old girl, to attend a local girl's event. The event showcased a theatre production called "Black Eyes and Cottage Pies". The drama highlights issues of abusive teenage relationships, sexuality, adult domestic abuse, consent, sexting and the power of positive peer relationships.

On the day, Carla had been receiving text messages from her 17-year-old boyfriend. He was behaving very negatively towards her because she had gone out and wasn't able to see him. When the Carla and her worker sat down to watch the production, some of the same issues that she was experiencing were being highlighted in the drama.

Whilst watching the production, Carla turned to her worker and said "It's me!" This gave the worker the opportunity to discuss the issues and helped Carla identify that some of the behaviour that her boyfriend was demonstrating towards her was wrong and controlling. Carla was then able to reflect on what needed to change in her relationship and was helped to this with the support of her worker.

In Practice; Developing Bolton's FGM Training Offer

Bolton Solidarity Community Association, BSCA, is a self-help voluntary organisation that has been set up to tackle and reduce the problems facing new emerging communities in Bolton. One of these is tackling FGM. BSCA contacted the Board in 2016-2017 asking for support in developing a local FGM training pack to deliver to schools then eventually to the wider workforce. BSCA met with the Board's Training Coordinator and a member of the Safeguarding in Education Team (SET) to discuss the safeguarding aspects; ensuring the messages in the training were consistent with local and national processes. BSCA used this knowledge to further develop their package.

To quality assure the training, BSCA delivered a mock session to the Training Coordinator and the SET Lead; constructive feedback was provided and the training further enhanced. A pilot session was delivered to school staff in January 2017. This was well received by those attending. This training is now available to schools for a small fee. It is our aim to promote this across the partnership in 2017-2018 training.

In Practice; Responding to FGM

Astur, 5 and Iman, 7 attend a local Bolton primary school. They are from a high-risk country where FGM is widely practiced. When the dad contacted them to say that the children would not be attending the last week of the summer term as they were going abroad, school became concerned. A referral was made to Children's Services and a strategy meeting was convened to consider the risks. A social work assessment is completed to determine the risk level. The assessment establishes family is under pressure from other within the wider community and that while the parents do not agree with FGM, they felt unable to protect the children if the procedure is arranged by 'elders' or other family members such as grandparents. It is determined that there is a risk and in order to protect the children the local authority applies for an FGM Prevention Order. The local authority asks the court to direct that the parents must relinquish the children's passports. to further reduce the risk.

What is FGM?

Female Genital Mutilation (FGM), also known as cutting or female circumcision occurs when a female's genitals are deliberately cut, injured or changed, but where there's no medical reason for this to be done. FGM is usually carried out on young girls between infancy and the age of 15, most commonly before puberty starts. It is illegal in the UK and is recognised as a form of child abuse. It is a criminal offence to:

- Perform FGM (including taking a child abroad for FGM)
- Help a girl perform FGM on herself in or outside the UK
- Help anyone perform FGM in the UK
- Help anyone perform FGM outside the UK on a UK national or resident
- Fail to protect a girl for whom you are responsible from FGM

Anyone who performs FGM can face up to 14 years in prison. Anyone found guilty of failing to protect a girl from FGM can face up to seven years in prison.

How are we making a difference in Bolton?

Bolton continues to take a stance against FGM; this is particularly important in the context of Bolton's changing population. Activity to increase awareness has taken place across Bolton with a particular focus on education and health practitioners, as well as the wider public. BSCB encourages workers to complete the Home Office e-learning package and to date 737 clicks have been made to the site; this is a 238% increase on last year.

As a consequence of this work, 48 referrals for FGM were made in respect of child and 43 of these led to a FGM strategy meeting, a significant increase on the previous year's figure of 11. This is the highest number recorded since data reporting began in 2013-2014. 48% of FGM referrals were made by health partners, 27% from education and 6% respectively from the police with the remaining percentage made up of other sources. In addition to this 12 FGM prevention orders were successfully applied for between April 2016 and March 2017.

This provides assurance to the Board that partners, including the voluntary and faith sector, are working well together to identify and respond to children

What is LADO?

The Local Authority Designated Officer (LADO) is responsible for ensuring that any allegations made against those working with children are responded to and investigated appropriately. The criteria for referral to the LADO are applied when information indicates that a person who works with children may have: -

- Behaved in a way that has harmed, or may have harmed, a child
- Possibly committed a criminal offence against, or related to, a child
- 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

The LADO is involved from the initial phase of the allegation through to its conclusion.

How will we know we're making a difference in Bolton?

LADO referrals will remain constant year on year

Evidence that organisations seek LADO advice and support

Investigations will be carried out proportionately and completed in a timely manner - 80% of cases should be resolved within one month, 90% within three months

Meetings will be well attended; Police and Children's Services will ensure 100% attendance when invited

In 2016-2017 the total number of LADO referrals was 264, a 26% increase on the previous year and a 24% increase on 2015-2016. 57 professional strategy meetings were held - a 10% increase on the previous year but lower than 2015-2016 figure of 72

Education settings, including Early years, continue to make the most referrals; this is in line with regional and national data. 105 referrals were made to LADO by such settings, a 7% increase on 2015-2016 and a 46% increase on 2014-2015

203 cases were dealt with at initial consideration stages and required only a single agency response following LADO assessment. This is an increase of 31% on the previous year and a 51% increase since 2015

Police attended 93% of meetings; a 2% increase on last year while children's services have attended 91% of meetings; an 8% increase on the same time last year. 75% of cases were resolved within one month and a total of 89% in three months

Effectiveness of Arrangements

What has worked well?

Over the last year there has been learning from LADO cases in respect of decision making processes and subject access requests. BSCB has worked alongside the LADO to review and further develop local processes to take account of the learning. In 2017-2018 a revised policy will be published. Attendance at meetings by police and children's services continues to be consistently good; on occasions where services are not able to attend this is challenged and the LADO ensure the information is available. Awareness of the LADO and the managing allegations process is well embedded across Bolton as demonstrated by the year-on–year increases in contacts and referrals. The increase in the LADO training offer and re-development of the LADO flowchart has clearly

What would be better?

Given the increasing demands on the LADO resource, exploring the viability of commissioning an information management system would be beneficial. This may offer a system with less duplication and reduce time taken to record cases, produce reports, respond to Freedom of Information requests etc. Whilst the timescales for resolving LADO matters continues to improve it is important that where there is delay this continues to routinely monitored and reported to BSCB for action. The primary reasons for delay relate to on-going criminal investigations.

What is Safeguarding Children Training?
BSCB delivers an annual multi-agency training programme. The aim of the programme is to develop the workforce's skills and knowledge in recognising and responding to a range of safeguarding and child protection issues.

How are we making a difference in Bolton?

It is our aim in Bolton that 95% of delegates attend their session and 95% of sessions are delivered. In 2016-2017 949 training places were available with 772 delegates attending their session; this equates to an 88% attendance rate. It is important to understand the reasons as to why practitioners do not attend as this helps to inform future delivery. In 2015-2016 31% of delegates who did not attend cited workload or staffing issues as the primary reason, while a further 26% stated annual leave or sickness prevented their attendance.

86% of planned training sessions were delivered. The lower attendance rate was reported to BSCB in Quarter 2 when average attendance over the first six months of 2015-2016 was 84.5%. In Quarter 3 and 4 this increased to 90.5%. While lower than our expected target it does evidence that BSCB members responded when the issue was identified. It also indicates a need for the Training Group to revisit and refresh training needs analysis.

The Keeping Children Safe: Level 1 e-learning package continues to be well used. 2636 practitioners registered and completed the package this year. A proportion of the practitioners have completed the package have done so after face to face training to consolidate their learning. This is good practice and promoted within the training. The education sector are the biggest users of the e-learning resource with 61%, the next biggest is early years with 17%. Use by the health economy, community and voluntary sector and adult services is surprisingly low. In 2016-2017 it will be important to promote this resource to provide additional support to single agency training. There are also plans in the coming year to add e-learning modules on Private Fostering and Child Death Overview Panel.

Delegate evaluations are positive with the majority of delegates agreeing or strongly agreeing that courses meet their objectives. In 2016-2017 the Training Group are introducing a scoring matrix to further improve reporting on training experiences and inform service development. One of the on-going challenges is to capture and evidence the long-term impact and influence on practice from attending training. Due to the inconsistency in administrators in 2015-2016, the 3-month training impact questionnaires have either not been sent out or recorded, consequently for 2015-2016 there is limited data. This will gap be addressed during 2017-2018.

"Better understanding of the Investigation and allegations processes. Also, a better understanding as to how I can embed proper strategies into our organisation that will help prevent abuse and strengthen safeguarding."

"Really good to hear from people working in lead roles and an independent reviewing officer; in the past (not in Bolton) Level 3 training was delivered by a trainer who wasn't doing the job and therefore could not relate their own experiences"

"Better understanding of the Investigation and allegations processes. Also, a better understanding as to how I can embed proper strategies into our organisation that will help prevent abuse and strengthen safeguarding."
"Great trainer very committed to subject area, thank you"

Fully understand the process of referral and my responsibilities and would now be able to review our own documentation process of ongoing concerns and make contact with the team if I have concerns/need advice".
"Excellent - thank you for answering all my questions your combined knowledge and experience is admirable"

Elective Home Education

The responsibility for a child's education rests with their parents. In England education is compulsory, but attending school is not. Parents chose to electively home educate (EHE) for a range of reasons including dissatisfaction with the mainstream system, ideological beliefs or concerns that their children are not safe within a school environment. On occasion a few parents opt out of education to avoid the involvement of statutory childcare services. BSCB wished to understand the underlying reasons for EHE in Bolton and to be assured that any potentially vulnerable children are safeguarded.

From the report provided by Bolton's EHE officer it identified that during the academic year 2016-2017 251 students had a period of Elective Home Education. At year end March 2017, 58% of children were aged 11 or over. The primary reasons for opting to electively home educate were religious or cultural grounds, dissatisfaction with the education system and philosophical or ideological. Like many Local Authorities, Bolton offers at least one home visit per year to parents to discuss their child's education. While parents are not legally required to give access to their home nor are they compelled to respond to such requests it is encouraging that in Bolton the majority of parents take up this offer.

The EHE officer has attended relevant safeguarding children training courses and should it become apparent that the child or family is in need of additional support or there are concerns about the safety or welfare of the child action will be taken.

One area for development in 2016-2017 is evaluating our current responses and pathways to support children who may have particular needs and are electively home educated. The Board are keen to understand how support to respond to their needs is provided when schools are no longer providing early help.

What is Private Fostering?

Many people don't realise that if a child is under 16 and cared for by friends, neighbours or extended family for more than 28 days the law requires that the local authority be notified. 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 teenagers living with the family of a boyfriend or girlfriend, children living with a friend's family as a result of separation, divorce or problems at home and children sent to this country for education or health care by birth parents living overseas.

How are we making a difference in Bolton?

At the end of 2016-2017 there were 11 privately fostered children in Bolton. It is likely, as it is across England, that this figure is does not truly reflect the full picture in Bolton. At the end of March 2015, the last nationally published data, there were 1560 privately fostered in England. This is equivalent to 1.4 in every 10000; in Bolton the rate is slightly higher at 1.6 per 10000. BSCB has developed and utilised a range of publicity and training materials to increase workers' and the general public's knowledge of Private Fostering. This has included web articles and poster campaigns. The responses to these have been good. Looking over time at the profile of private fostering arrangements there appear to be no discernible patterns in terms of age of the child or the number at any given time. In 2016-2017 BSCB completed an audit of current private fostering arrangements in the area which included seeking the experiences of children themselves. While the audit identified that there are improvements to be made in complying fully with the local processes, it did provide assurance to Board members that children are living in arrangements that feel safe, stable and secure to them, they are happy and their carers give them the opportunity to achieve by ensuring they attend school.

What is Learning and Improvement?

Working Together 2015 encourages LSCBs to take opportunities to reflect on local practice by reviewing a range of childcare cases and not simply focusing on those that meet the threshold for a Serious Case Review. In Bolton we do this through the work of the Learning and Improvement Group. 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.

How are we making a difference in Bolton?

In 2016-2017 the group reviewed 6 cases, two of which met the threshold for a Serious Case Review which are in progress. Of the six deaths, 4 were linked to young people who died by their own hand and the remaining two deaths were infants.
The Board also published a Serious Case Review in summer 2016 which focused on learning from the death of a young person who took their own life. The findings from this report include: -

- Despite the family's social history, poor school attendance was continually perceived as being the 'problem' within this family, rather than it being considered as a symptom of what was happening in the young person's life
- Persistent failure to send children to school is a clear sign of neglect and every effort should be taken to work with parents to address this issue
- There is a mismatch between available resources and the needs of young people who need access to mental health services but who do not or cannot meet the criteria for CAMHS support
- A lack of knowledge among professionals about the evidence base related to risk indicators for adolescent suicide could leave them ill equipped to discuss and/ or recognise signs and respond accordingly

The theme of young people taking their own lives is one which has emerged in Bolton in the period 2014-2016. Board members recognised this as a concerning possible trend and in response commissioned an independent person to conduct a thematic review. The first phase of the review was an analysis of the factors within the children's lives. The findings were shared with Board members who, as a consequence have commissioned a second phase to seek the experiences and challenges faced by children and practitioners. This will report findings during 2017-2018. To ensure learning points is shared BSCB has produced a series of learning briefs which practitioners are encouraged to read, reflect on and implement within their own practice. Additionally themes identified from reviews contribute the scope and standards for future multi-agency audits.

In Practice; Learning from Others, 'True for Us'

As part of its commitment to learning, the Learning and Improvement Group not only considers local cases for review but also those from other areas. One example of this in 2016-2017 is where the group challenged the DAV partnership to consider the lessons from the 'Lucy' SCR commissioned by Gloucestershire's LSCB, and evaluate our local service and practice against the findings.
A workshop was held with attendees from a range of agencies who worked/had involvement with adolescents, including specialist DAV services. Prior to the workshop attendees were asked to review the learning in the report and consider:-

- Whether our agencies were equipped and had the necessary structures in place to support adequately a case like Lucy's
- Identify any gaps in provision and how these gaps could be addressed

Through group discussions, a significant amount of good practice was identified but those attending recognised that there were opportunities for further development. An action plan was developed with lead agencies identified to progress areas of work.
Participants stated that they found the reflective process really helpful and enabled a greater understanding and recognition of local strengths and assured that good practice is in place. One of the key actions identified was the current format of the Young People's MARAC Referral Form. This has been amended locally to incorporate additional lines of enquiry and so enable the practitioner to attain as much information as possible about the young person. Agencies are more mindful of the need to probe further when working with young people, to keep them engaged and make them feel that they are being supported. Progress against the learning will be reported to the learning and Improvement Group.

What is CDOP?

The Child Death Overview Panels (CDOP) is a multi-disciplinary group of the Local Safeguarding Children Board. The CDOP reviews the deaths of all children under the age of 18 years old who normally reside within the geographical boundaries of that CDOP. There are four CDOP's across Greater Manchester, three of which are 'tri-partite' such as Bolton, Salford and Wigan (BSW) with one CDOP covering the area of Manchester City Council. This summary provides information on the child deaths which have occurred in 2016-2017 known as 'notifications' but the main focus is on cases concluded by the CDOP during 2016-2017 referred to as 'closed' and any trends which can be identified during that period or through analysis of cases from previous years. It is important to recognise that not all notifications received in the year are concluded with in that 12-month period. Notifications received later in the year require information to be gathered which means they will be considered in the next 12-month period. Equally some cases may result in coroner inquests, police investigations and in some cases Serious Case Reviews. The timescales of these investigations mean there will inevitably be significant periods between the notification to CDOP and the case being discussed and closed by CDOP. Please note that the data reported in the following section relates to all child deaths across Bolton, Salford and Wigan unless otherwise stated.

Key Learning Points

- There were a total of 72 childhood deaths notified to the CDOP in 2016/17; of these, the panel concluded 25 (34.7%) and closed 68 cases, 87% within 12 months of the death taking place. 58% of notified and 55% of closed cases were children under 1 year of age; this is a continued downward trend since 2013 and for the first time both percentages are below the average for Greater Manchester.
- In 2016/17 there were 5 SUDI cases (1 in Bolton, 3 in Salford and 1 in Wigan) while across Greater Manchester there were 26 cases; common features in these cases were that parents smoked, or had been co-sleeping with their child in bed or on a settee
- There were 5 incidents of sudden deaths of Adolescents in the CDOP area (4 in Bolton and 1 in Wigan) where neither illness nor third party involvement was a factor. A recently-published national piece of research into suicides by young people, and the Independent Review completed by BSCB, all highlight key areas of improvement required in terms of young people's access to support services relating to emotional wellbeing
- 34% of the closed cases were identified by the Panel as having modifiable factors. In 2013/14 it was 17%. This has been replicated in the GM figures with slight year on year rises in percentage terms to 32.5% in 2016/17 from 24% in 2014/15. There is no definitive explanation for this rise in modifiable cases. A possible explanation may be that as the CDOP process continues to improve a higher level of information is collected from a wider range of agencies, thus providing more detail for panels to consider
- Bolton, Salford and Wigan have all produced action plans to target resources in these areas and prioritise work in line with local requirements. The action plans and resultant work around the Sector Led Improvement (SLI) is relatively new and will no doubt continue to develop in the years ahead. It is important that the SLI continues to be a priority in order to reduce the number of children who die before their first birthday. Children under the age of one are the most vulnerable to childhood deaths by a considerable margin both in GM and nationally and this is an ongoing trend, and additional consideration is needed about how to improve outcomes for this group; an action plan to reduce child deaths in infants under 1year has previously been recommended and should be a priority
- The high rate of deaths attributable to chromosomal or congenital abnormalities means that there is a need to review the provision of genetical counselling services across GM to ensure that there is adequate capacity to meet demand and to spread good practice
- Health inequalities in child deaths remain a concern. The BME population remains at increased risk of childhood mortality and although the proportion of deaths in the most deprived group appears to have fallen this year that is out of keeping with the trend for the last five years; an action plan to reduce deaths in disadvantaged groups has been previously suggested
- As in previous years, smoking remains a key modifiable factor for child deaths across GM. This has been recognised in the Greater Manchester Population Health Plan which calls for a single GM evidence-based pathway for stopping smoking in pregnancy which will require CCG commissioners, LA commissioners and maternity service providers to work together

BSCB BUSINESS PLAN PROGRESS 2016-2017

BP 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 in the area of the authority.	• **All** primary schools have confirmed commitment; Encompass went live as planned on 10 October 2016 and schools are returning a monthly impact report, the impact reports will be evaluated in April 2017 and a report provided to BSCB in May 2017 • The news section of BSCB Website has provided information about changes to FGM legislation and the mandatory duty to report known cases of FGM • BSCB is supporting a local voluntary group to develop their training offer and deliver awareness raising and interventions where FGM is suspected to be a risk to children; as part of BSCB's performance report the number of FGM strategy meetings and referrals has been reported to BSCB and is included in the annual report. Greater Manchester FGM Pathways have been developed and promoted via BSCB Website • The Domestic Abuse and Violence Handbook has been updated and is available for download ; the resource has been accessed 726 times in 2016-2017 this is a 56% increase on the previous year's figure; version 3 of the handbook is in development and will be launched in 2017 • Greater Manchester Safeguarding Policies have been accessed on 1447 occasions from BSCB's website since their launch in Bolton in November 2014 – 241 times more than in 2015-2016	**G**
1.2	Promote and support the on-going development of a safe and effective multi-agency workforce	• At year end 2014-2015 BSCB training courses had a 93% attendance rate; in 2015-2016 this had decreased to 88% with 89% of courses taking place; in 2016-2017 95% of delegates attended their course while 95% of planned course took place – this is in line with the Boards target • Quarterly reports are provided to BSCB by the LADO; over the last 3 years the number of allegations referred to the Local Authority Designated Officer (LADO) has remained reasonably static • The vast majority of allegations were referrals from Education, Social Care and the Police; referrals from Health services and the voluntary sector remain low; work continues to increase awareness with these partners • An issue was raised with the LADO relating to the timeliness of criminal investigations; this was subsequently discussed with the BSCB Independent Chair and action is underway to address this matter with the police • Section 11 audit has been completed in 2016-2017 and supported by a workforce survey; results of both provide assurance that partners have embedded safeguarding within their organisations	**G**

BP Ref	Core Objective	Evidence To Support RAG Rating and Outcomes Met	RAG Rate
1.3	Ensure the voice of children and their families develops local safeguarding priorities, processes and services	• Work is underway with Manchester Metropolitan University to evaluate the use and impact of the Board's 'My Conference Pack' a tool that has been developed to ensure the child's experiences and views inform the child protection process – this findings from this report will be shared with Board member in 2017-2018 • The views and experiences of Privately Fostered Children in Bolton has been completed and the findings shared with BSCB • Themes from Missing from Home return interviews are embedded within the Board's performance report and are scrutinised by the CSE and Missing Steering Group to inform further developments	G
1.4	Communicate to the public and partners the need to keep children safe and promote their welfare	• Worried about a Child Leaflets in process of being updated • Monthly articles are posted on the BSCB website highlighting research, new developments and resources from BSCB • CSE/Missing summit held in April 2016 with over 120 delegates in attendance; range of presentations and inputs delivered to increase knowledge and awareness of missing • Requirements for Mandatory Reporting of FGM continue to be publicised • Parents CSE awareness event piloted at a local secondary school in June 2016 • Foster carers training three times per year with an average of 19 attendees per session	G
1.5	Participate in the planning of services for children in Bolton	• BSCB agendas and minutes reflect discussions and safeguarding children implications of organisational changes, e.g. Changes to Safeguarding arrangements across NHS England and CCG's, development of Multi-agency Hub, Greater Manchester Devolution implications etc. • BSCB chair has met with working group Chairs to review membership and effectiveness of current sub-groups; issues identified by the sub-group chairs are being progressed by the independent chair • BSCB officer chairs and regularly attends the Greater Manchester LSCB Business Managers quarterly meeting • BSCB officer attends the Greater Manchester Safeguarding Partnership and minutes and issues arising are discussed at BSCB meetings • BSCB and Bolton Community Safety partnership have worked together to evaluate and report on local arrangements to safeguard children who are living with domestic abuse and violence • BSCB has ensured early learning from the thematic suicide review has been shared with CCG commissioners to inform the tender for re-commissioned CAMHS service • Bolton is also represented on a number of other regional forums and designated professional networks	G

BP Ref	Core Objective	Evidence To Support RAG Rating and Outcomes Met	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	• Learning from reviews has been shared with BSCB and the wider public via the website • One serious case review has been published and learning briefs developed; feedback and awareness sessions highlighting the learning have been held; the action plan has been completed and signed off by BSCB • CDOP annual report presented to BSCB and the findings endorsed; there is a programme of updates on action to respond to the findings; transfer of key actions was agreed with Bolton's Health and Well-being Board	G
1.7	Monitor and evaluate the effectiveness of what is done locally to safeguard and promote the welfare of children	• BSCB routinely receive the quarterly report and this has been further developed to include a supporting narrative document which includes identification of action required – this captures and reports on both quantative and qualitative data • Work is under way with GMP Bolton Division and Children Services to further develop routine reporting on Domestic Abuse • Two audits multi-agency audits were completed in partnership with Community Safety to evaluate and report on local arrangements to safeguard children who are living with domestic abuse and violence; one focused on the use of Early Help while the other considered the effective of responses where there is an allocated social worker – both audits evidence good practice as well as areas for further development; this audit will be repeated in 2017-2018 with a focus on how the lessons learned have been responded to • BSCB continues to use learning from inspection in other areas to learn and develop locally; a recent example is evaluating current CSE and Missing interventions/services against the findings from Time to Listen	G
2.1	Seek assurance that there are co-ordinated responses in Bolton to young people at risk of radicalisation	• BSCB Chair has met with Bolton Council Chief Executive on this matter and a presentation to BSCB is scheduled for July 2017 • Independent Chair assured that local Channel/Prevent processes are established, understood across the partnership and used effectively to provide co-ordinated and timely responses to children	G

BP Ref	Core Objective	Evidence To Support RAG Rating and Outcomes Met	RAG Rate
2.2	Respond to statutory guidance relating to 'Out of School Education Settings' registration and inspection	• This work was planned following to respond to the findings from the government consultation on 'Out-of-school education settings: registration and inspection' which closed on 11 January 2016; to date no statutory guidance has been issued and the government website states that the consultation responses are being analysed • BSCB has ensured local setting are aware of the proposed guidance • No further work can be progressed	**G**
2.3	Review and revise current responses to neglect in Bolton	• Neglect Task and Finish group has been established to develop a neglect strategy and action plan – a draft strategy has been developed • Audit tool in development and audit planned • A Neglect practitioner survey has been completed to understand workforce challenges in tackling neglect • Training reviewed and updated; however further work is required on completion of the Neglect Strategy with a particular emphasis on prevention • This work will continue into 2017-2018	**A**
2.4	Strengthen partnership with Bolton's community and voluntary sector	• Representative have been identified for the Safeguarding Executive, Early Help and CSE/Missing Steering Group as agreed • BSCB Chair has met with Bolton Together BSCB representative to further develop relationships	**G**

Appendix 2 – BSCB Members

SAFEGUARDING BOARD MEMBERS 2016-2017	
CHAIR	**DEPUTY**
Mike Tarver (to July 2017) Independent Chair Bolton Safeguarding Children Board Westhoughton Town Hall Market Street Bolton BL5 3AW 01204 337479 mike.tarver@bolton.gov.uk	Head of Community Housing Services Bolton Council 1 Silverwell Lane Bolton BL1 1QN boltonsafeguardingchildren@bolton.gov.uk
John Brimley (from July 2017) Bolton Safeguarding Children Board Westhoughton Town Hall Market Street Bolton BL5 3AW 01204 337479 john.brimley@bolton.gov.uk	

COUNCILLOR	
EXECUTIVE MEMBER	**DEPUTY**
Councillor Ann Cunliffe 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	Named Nurse Bolton NHS Foundation Trust Minerva Road Farnworth Bolton BL4 0JR

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
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

LOCAL AUTHORITY	
DEPARTMENT OF PLACE	
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

LOCAL AUTHORITY	
DEPARTMENT OF PEOPLE	
CHILDREN AND ADULT 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
PUBLIC HEALTH	
MEMBER	**DEPUTY**
Public Health Consultant Le Mans Crescent Bolton BL1 1UA	N/a

EDUCATION REPRESENTATION	
MEMBER	**DEPUTY**
Special Schools Head Teacher - Ladywood Special School Masefield Road Little Lever Bolton BL3 1NG	n/a
Head Teacher Sharples School Hill Cot Road Astley Bridge Bolton BL1 8SN	n/a
Primary Schools to December 2016 Head Teacher St John's Kearsley Church Road Kearsley Bolton BL4 8AP	Head Teacher Mytham Primary School Mytham Road Little Lever Bolton BL3 1JG
Primary Schools From January 2017 Head Teacher St Joseph's RC Primary School Shepherd Cross Street Bolton BL1 3EJ	

GREATER MANCHESTER POLICE	
MEMBER	**DEPUTY**
Bolton Divisional Superintendent Bolton Divisional Headquarters Greater Manchester Police 10 Scholey Street Bolton BL2 1HX	Detective Chief Inspector Bolton Divisional Headquarters Greater Manchester Police 10 Scholey Street Bolton BL2 1HX

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	N/a

FAITH GROUPS	
MEMBER	**DEPUTY**
Chair Bolton Council of Mosques 1 Vicarage Street Bolton BL3 5LE	N/a

VOLUNTARY SECTOR	
MEMBER	**DEPUTY**
Chair Bolton Together	N/a

LAY MEMBERS	
Mrs Elsie Rigby c/o Bolton Safeguarding Children Board Westhoughton Town Hall Market Street Bolton BL5 3AW 01204 337479	Mrs Carol Burrows c/o Bolton Safeguarding Children Board Westhoughton Town Hall Market Street Bolton BL5 3AW 01204 337479