KEEPING CHILDREN SAFE IN BOLTON 2023-2024

'In Bolton we want to give all our children the best possible start in life, so that they have every chance to succeed, be safe and be happy'

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Welcome and Introduction

Welcome to Bolton Safeguarding Children Partnership's Annual Report. This report covers the period from 1 April 2023 to 31 March 2024.

Local organisations and agencies that work with children and families have a shared role to play when it comes to safeguarding children in Bolton. The responsibility for joining-up local safeguarding arrangements rests with the three safeguarding partners - Bolton Council, Greater Manchester Integrated Care Partnership and Greater Manchester Police.

The safeguarding partners have a shared and equal duty to make arrangements to work together to safeguard and promote the welfare of all children in a local area. Through this annual report, we shine a light on some of the partnership's key priority areas, the activity that has been undertaken, the difference it is making, and any action needed to further strengthen local safeguarding arrangements. The report will also give oversight of the resources the partners have access to, the contribution that individual member organisations are making and our focus for 2024-2025

As the strategic safeguarding partners, there is a commitment to offer challenge not only to ourselves but to our partnership system and seek ongoing assurance that our safeguarding arrangements are as safe as practicable, that our workforce feels supported and confident and that children are listened to.

We recognise that it is the commitment, dedication, care and passion our practitioners give to children and their families on a daily that is the beating heart of our arrangements and personifies the 'Bolton Family'.

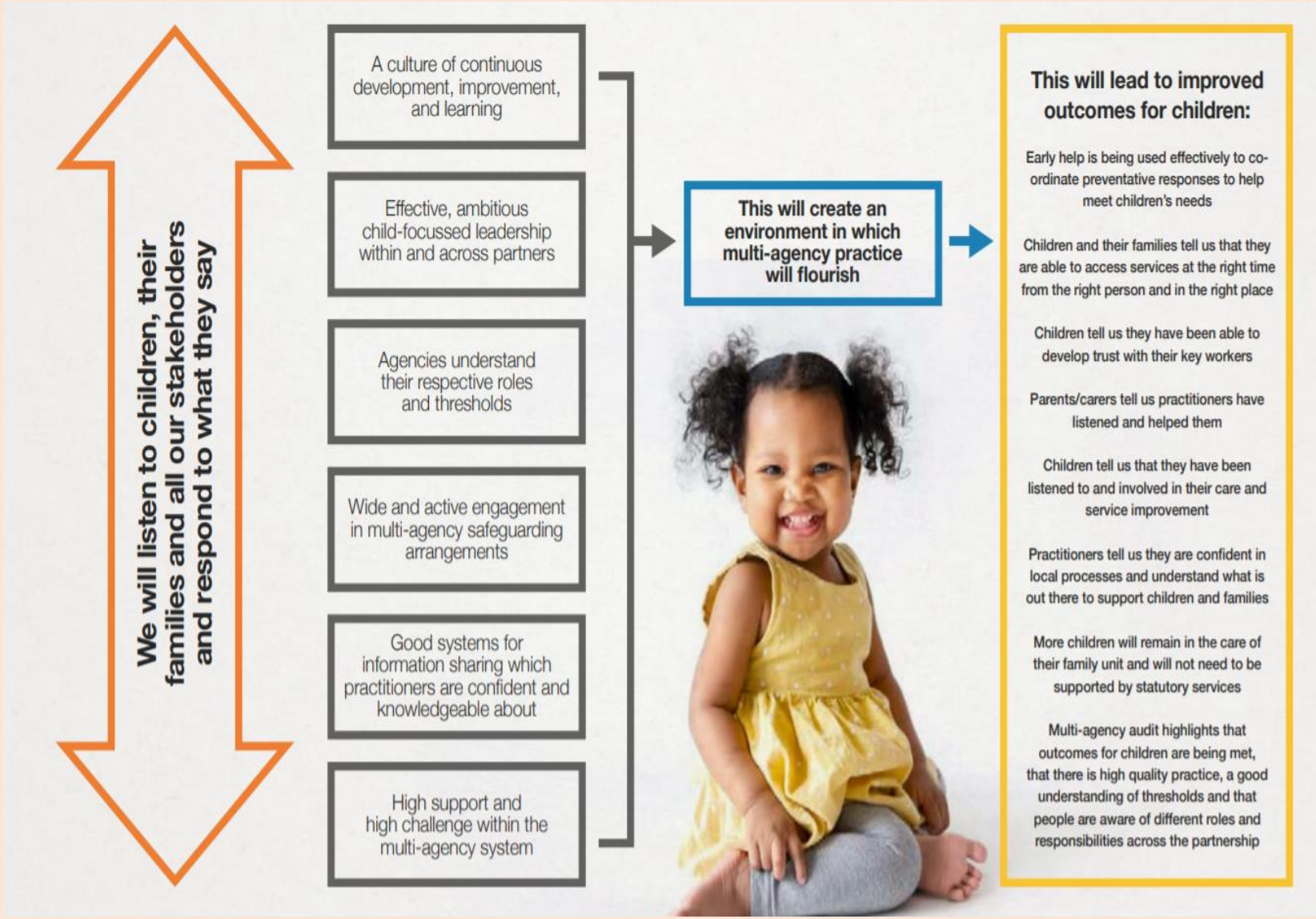
Thank you

This report provides an assessment of:

Our Vision and Purpose

In Bolton we want to give all our children the best possible start in life, so that they have every chance to succeed, be safe and happy.

We have retained a single vision and purpose for the past few years to ensure we fully embed and sustain what is important. In addition to this core vision, we will continuously provide or seek assurance about the impact and effectiveness of local safeguarding arrangements, as well as lead co-ordinated activity to address agreed priorities.



Our Children

Number of children in Bolton aged 0-17

72,458

(June 22)

Percentage of population who are children

Bolton
22.9%
England
20.8% *(June 22)*

Primary pupils eligible for free school meals

Bolton
24.7%
England
24%
(Academic Year 22/23)

Secondary pupils eligible for free school meals

Bolton
26.9%
England
22.7%
(Academic Year 22/23)

Number of young people in Bolton aged 16-17

8005

(June 22)

Number of young people that are not in education, employment or training
336 *(Academic Year 22/23)*

Percentage of young people that are not in education, employment or training
4.4% *(Academic Year 22/23)*

Percentage of children in low income families

Bolton
33.7%
England
19.9% *(March 24)*

Numbers of children classed as BME
(Census 2021)

Bolton
42.3%
England
26.6%

Number of children in primary education
31,257 *(Feb 24)*

Number of children in secondary education
22,206 *(Feb 24)*

Number of children with an Education, Health and Care Plan (EHCP)

2778

Number of children in our care

574

(April 24)

Number of children supported through early help

3,000

(February 24)

Number of children subject to child protection planning

353

(April 24)

Percentage of children's two year take up

66.3%

(2023)

Percentage of children reaching Good Level Development

63.8%

(2023)

Data correct at time of publication

Children's Lived Experience

When Ellie was 9 years old, she lived with her mother, her older sister and younger sister. For several years different practitioners and family members had been worried about Ellie and her sisters. Sharing concerns about the children's safety and highlighting a need of support for the family. A lot of the concerns were about domestic abuse and substance misuse within the family home.

This year an incident took place where the children had not attended school one morning, Ellie called school and said they would not be in and then put her mother on the phone. During the call it was suspected Ellie's mother was heavily under the influence of alcohol. Being concerned for the children, the Designated Safeguarding Lead (DSL) went to the family home to check on the children's safety. Upon arriving at the property, the DSL was able to see blood on the door, the door handle, and the steps outside the property. The DSL knocked on the door several times however the children did not come downstairs. Concern grew for the safety of the children and the DSL called the police and children services; it was assessed that it was not safe for Ellie and her sisters to remain with their mother. Ellie's wider family made arrangements for her and her siblings to be cared for by family members.

As part of the plan to support Ellie, she received 1-1 therapeutic support from a local Domestic Abuse charity. Ellie presented as being quiet and reserved. She was aware of why the support was taking place and on one occasion asked,

"*I know that you are here because of my mum, I don't like talking about those things, do I have to talk about that?*".

This was an important conversation for Ellie to have with her trusted adult as she was able to set the boundaries of what she wanted to discuss during the support. For Ellie to feel comfortable in her one-to-one sessions it was particularly important that her worker listened too, respected and understood her needs for support to take place successfully.

As the 1-1 sessions progressed, Ellie grew in confidence and developed her skills and knowledge in how to keep safe, healthy and unhealthy behaviours, recognising strong feelings and emotions, coping strategies, changing family, circle of control and positive affirmation. Ellie engaged well with her worker and built up a trusting relationship with her. Ellie shared

"I love the sessions that we do together, they are fun, and I learn a lot of new things"

At end of the intervention, Ellie was better equipped to keep herself safe through the creation of her own personalised safety plan, able to recognise her own feelings and emotions and implement healthy coping strategies to cope with these emotions. She has identified her trusted adults and can identify when she may need to share her worries with them.

Partnership Priorities

This section of the annual report summarises the action the statutory safeguarding partners have taken to progress our priority areas, what we have learned and what is needed next.

Tackling Neglect

Why this Priority?

The impact for a child of living with persistent neglect cannot be underestimated. It is well documented that children who are neglected over a long period of time will have their physical and emotional development restricted. Children who are living with neglect are likely to experience difficulties:-

- Establishing and maintaining healthy relationships both in the short and long-term
- Reaching their full educational potential and being able to move on to education, employment or training
- Developing confidence in themselves and their abilities
- Developing good emotional health and strategies to cope with challenges in their life

Understanding the impact of current approaches to tackling neglect was chosen as a priority as in previous years (2019-2022) a local strategy and supporting resources had been developed and delivered across the partnership. Local data indicated that the strategy had made some impact. Key measures, such as 'Neglect as a Factor in Local Authority Assessments' and 'Children Subject to a Child Protection Plan for the Category of Neglect' had both decreased between 2021 and 2023. In 2023, Neglect was recorded as a factor in 14% of assessments completed by Childrens Social Care (600 of 4157) compared with 19% in 2021 (742 of 3978). Neglect as the primary reason for a child being the subject of a child protection decreased slightly from 39% in 2021 (159 of 412 plans at year end for neglect) to 38% in 2023(144 of 379 plans at year end for neglect).

However, while improvement was noted, the statutory partners, in the context of a 'cost of living crises' viewed it as essential to gain assurance about the impact and effectiveness of local responses to tackling neglect from the perspective of children's lived experiences.

"You have to put up a pretence. You cover up your feelings"

"You get the mickey taken out of you, but you blame yourself, not your parents"

Tackling Neglect

What did we do?

The statutory partners commissioned an independent scrutineer to review the experiences of five children from three families. The scrutineer was asked to explore to what extent the identification and response to 'early' neglect indicators are effective across the partnership.

The children were identified as they had all experienced different types of significant neglect yet were relatively unknown to services.

What did we learn?

The scrutiny identified areas of strength and development, and it is impossible to include full detail in the annual report, however key points were:-

- The BSCP threshold document was considered an accessible resource that enabled the identification of level of need for individual children. A shared understanding and application of level of need is fundamental to the response to neglect and screening and assessment tools will aid the identification of level of need in cases of neglect.
- The local neglect strategy is comprehensive and there is a recognition that protocols and guidance for practitioners will by themselves be insufficient. It was evident through practitioner engagement sessions that not everyone was aware of the strategic approach and supporting resources. Stronger strategic leadership is needed.
- The workforce is committed and knowledgeable however perceived barriers to information sharing got in the way of offering help earlier. Challenges were also identified in respect of local early help arrangements and in particular the transition arrangements between children social care and universal services.

What Next?

- We will use the learning from the scrutiny to work alongside practitioners and system leaders to ensure our local resources and pathways are effective in supporting the earlier identification and response to child neglect.
- We will work with early help strategic leads to address the challenges highlighted in the report.
- We will work alongside children, parents and carers with lived experience to seek their insights into what works and the help and support they feel is needed.

Child Exploitation

Why this Priority?

For a significant number of years, leaders and practitioners in Bolton have worked together to improve and implement effective approaches to Child Exploitation. The work delivered across the partnership has sought to provide help at the earliest opportunities to avoid harm and reduce risk to children . While there have been many successes within this work, additional risks and threats continue to emerge. In particular, the risks to children from 'County Lines',, Modern Slavery and Trafficking and online harms The terms 'contextual' or 'complex safeguarding are often used to describe such threats.

It is important that Bolton is fully prepared for this threat and has strong partnership plans in place to ensure children are protected, practitioners are responsive to the threat and swift action is taken to pursue and prosecute those responsible.

Working with our partners it is our aim to further improve our understanding of this issue locally and seek assurance that:-

- Children are aware of and informed of the risks and methods of criminal exploitation
- Practitioners recognise and identify children vulnerable to criminal exploitation
- A co-ordinated and consistent multi-agency approach to divert, disrupt and protect children at risk of criminal exploitation is in place
- The work undertaken in this priority will contribute to Bolton's wider response to complex/contextual safeguarding.

Good use of resources to address online harm and exploitation

Finding from Greater Manchester Complex safeguarding Peer Review

May 2023

Children at risk of sexual and criminal exploitation receive an effective response from the dedicated complex safeguarding team, helping to keep children safer. Assessments are thorough, identify external harm and support a strengths-based approach

Inspection of Bolton local authority children's services, September 2023

Child Exploitation

What did we do?

- Implemented a revised intelligence led approach to identify and disrupt exploitation offenders
- An audit of six children currently identified as being at risk or being exploited to evaluate current practice
- Used the findings to agree improvement priorities

What did we learn?

- There is a strong, multi-agency response to children who are at risk of exploitation that includes good engagement with community groups and the voluntary sector
- Practitioners listen to children, reflect on their lived experience and aim to offer help and support in response to what children say
- Evidence in some instances where the role of the exploitation worker is blurred with that of the allocated social worker thus impacting on the effectiveness of building a trusting relationship with the child
- Case recording does not always accurately reflect the level of activity and direct wok being delivered by the exploitation team to keep the child safe

What Next?

- We will review our current exploitation training offer to ensure it addresses the learning from the audits and further strengthens frontline practice
- We will review our data and intelligence arrangements, identifying any gaps and opportunities to improve out strategic response
- We will review our local pathways for help and support for those children at risk of, or experiencing exploitation and seeking further assurance that these pathways lead to effective help and support for children

Scrutiny and Assurance Highlights

This section of the annual report summarises the focused scrutiny and assurance the partners have taken to seek assurance on key safeguarding arrangements.

Revision of Scrutiny Arrangements

During 2023/4, BSCP further developed its scrutiny and assurance functions utilising specialist support from an Independent Scrutineer.

Led by a multi-agency task and finish group, a *scrutiny and assurance plan* was created detailing activity to be undertaken to gain assurance about the effectiveness of safeguarding arrangements in the local area. Alongside this a partnership scorecard and 'safeguarding effectiveness' report was developed.

The plan, scorecard and narrative provides assurance from each agency about their current performance and any areas to bring to the attention of the safeguarding partnership. The system is now embedded and working well, managed by a new Safeguarding Effectiveness Group.

The impact of this has been a much greater multi-agency understanding of safeguarding across the local area from which the Safeguarding Effectiveness Group and the safeguarding partnership have been able to generate improvements.

Examples of activity undertaken in the 2023-2024, some of which are highlighted in this report, include:-

-A serious youth violence audit in conjunction with the Community Safety Partnership

-Scrutiny of Looked After Children living in Bolton from other Local Authority Areas

-Children with Disabilities in Residential Settings

Children With Disabilities

In October 2022 the National Child Safeguarding Practice Review Panel published its findings into a review of how and why a significant number of children with disabilities and complex needs came to suffer very serious abuse and neglect whilst living in three privately provided residential settings in the Doncaster area. The report highlighted three areas for urgent action, two of required local action, the third tasked to Ofsted:-

- **Action 1** stipulated that '*Quality and Safety Reviews are completed for all children with complex needs and disabilities currently living within placements with the same registrations (i.e., residential specialist schools registered as children's homes) to ensure they are in safe, quality placements*'

- **Action 2** to seek assurance that '*the host authority LADO for each individual establishment reviews all information on any LADO referrals, complaints and concerns over the last 3 years relating to the workforce in such establishments to ensure these have been appropriately actioned and the LADO should then contact any local authorities who currently have children placed in the establishments in their area if there are any outstanding enquiries being carried out regarding staff employed in the home'.*

In Bolton, it was identified that five residential settings met the criteria for the urgent action. A review team consisting of a Quality and Improvement Officer, the allocated social worker and an Independent Reviewing Officer undertook visits to each setting and completed assurance on the following themes:-

- Workforce, Safer Recruitment and Contract Arrangements
- Childrens Communication and Positive Behaviour Plans
- Medication and Health Records
- School Attendance and Progress
- Family Contact
- Safeguarding and Physical Interventions
- DOLS Arrangements

Children With Disabilities

The findings from the review were presented to BSCP and demonstrated:-

- **Workforce, Safer Recruitment and Contract Arrangements** – All five providers followed safe practice around recruitment, there were dedicated and experienced staff in post to meet the needs of young people and the contractual arrangements in place.
- **Childrens Communication and Positive Behaviour Plans** – All providers evidenced good practice in this area and there were no concerns. Communication was key across all areas of children's placements and linked heavily into individualised behaviour management plans.
- **Medication and Health Records** – During the visits, all but one provider evidenced safe practice in this area. Reviewers identified medication being incorrectly stored in the setting. When discussed, staff were unaware of what the medication was and there were no written records detailing its purpose. In response, immediate action was agreed with the provider, who responded positively. As a follow-up the provider completed an internal investigation and have put implemented further control measures.
- **School Attendance and Progress** – All providers evidenced tracking attendance well and all young people have high levels of engagement and achievement within their curriculums.
- **DOLS Arrangements** – All providers evidenced good practice in this area and arrangements were effective.
- **Family Contact** – All providers evidenced good practice in this area, and this was a particular strength across provisions and there is evidence of strong contact and relationships between staff and families. Physical family visits were frequent, and technology assisted virtual visits were employed to further bridge the geographical hurdles of this type of setting. All visits are recorded and supervised by staff, who often adapt their own rotas to facilitate the visits with their key children.
- **Safeguarding and Physical Interventions** – All providers evidenced good practice in this area. Training and reporting mechanisms were strong across both areas. A particular strength were the opportunities for joint learning across the residential and education provision when incidents occur and a desire for improvement which spans both provisions.

Evidence was provided that for children placed in these settings safeguarding arrangements are in place with no urgent concerns identified. It was agreed that an annual assurance of safeguarding arrangements for children with disabilities both living in Bolton and in placements outside the borough would be undertaken. While BSCP members agreed this review provided a good level of assurance, it would be further strengthened if future review teams included a health representative.

Operation Encompass

Operation Encompass

Operation Encompass is a long-standing proven police and education information sharing arrangement enabling immediate support to be given to children experiencing domestic abuse. In Bolton the arrangements were initially introduced as good practice in 2018 and in May 2024 Royal Assent was granted to The Victims and Prisoners Act. The new Act placed Operation Encompass into Law and puts a statutory obligation on police forces to share Operation Encompass notifications with schools.

For Encompass to deliver good outcomes for children, we need:-

- Timely information sharing
- Information to be accurate, consistent and of a good quality
- Effective responses from those receiving the information

Schools and colleges receive Operation Encompass notifications when there is a Domestic Abuse incident in a property where a child resides. On a termly basis schools and colleges in Bolton are asked to submit data to the Safeguarding in Education Team (SET) regarding the number of notifications received and the actions they have taken to safeguard children in their setting. Currently the data submission is voluntary, and we continue to work with education settings to encourage their completion. The insights provided from the returns help the safeguarding partnership to identify practice themes and emerging challenges, as well as good practice.

Encompass in Practice

Child E moved to Bolton when they were nine years old with their mother and father. English was an additional language for all the family members. While attending primary school the family received early help owing to a difficult parental separation and father's substance misuse.

As the child transitioned to secondary school, the secondary school became the lead professional. The school continued to support with child with weekly check-ins and liaison with mother. The child settled well into school and the early help plan was ended. However, it was agreed 'check-ins' would continue.

Towards the end of their first year at secondary school, an 'Encompass Notification' was received by the school detailing physical violence from father towards mother which Child E had witnessed. In response, the school quickly identified the child was not in school and undertook a home visit. Child E was located at home and brought to school. His mother had attended at the police station to provide a witness statement. Practical and emotional support was provided by pastoral staff to Child E and the school engaged a local Domestic Abuse Service, Fortalice, to work directly with the child. Arrangements were put in place to support this work, taking into account the child's language needs. Mother has also engaged with support services. Child E is now thriving in school and has developed trusting relationships with the pastoral team

Operation Encompass

Impact and Effectiveness of Encompass

In Summer 2023 a round table scrutiny session was facilitated by BSCP with Education Leads and Greater Manchester Police to evaluate the impact and effectiveness of current arrangements for children. During the session it was identified;-

- **Encompass Notifications are delayed**; notifications are not consistently being made by 9am the day after the incident.
- **Notifications Not Received**; there is a concern from education partners that not only are Encompass notifications delayed but that some notifications are not being made at all, again impacting negatively on how settings can support children and offer help earlier.
- **Inconsistent Information Sharing**: information about Domestic Abuse Incidents can range from one or two lines in an email to a full description of the incident recorded on a pro forma.
- **Alignment of Domestic Abuse Processes;** since the launch of Operation Encompass a number of new Domestic Abuse processes have been introduced in the local area, such as the 'DAV Daily Triage Meeting' and schools felt further clarification is needed to strengthen their understanding of the different processes, the roles and responsibilities and the link to safeguarding arrangements.

In response to the challenges, those at the round table session identified:-

- GMP Child Protection Unit will notify schools of domestic abuse incidents on a daily basis, and this will be in addition to the existing process. This should enable the partnership to get a 'true' sense of the timeliness of Encompass Notifications. Schools will be asked to track these for the agreed period and report on any Encompass notifications they do not receive or are delayed. Briefings for frontline GMP officers about Encompass will be routinely undertaken to ensure their understanding. Since the implementation of this approach, 100% of notifications are now reported as being sent and received by schools.
- awareness of roles and responsibilities within the process.
- As a number of schools in Bolton have similar names it was agreed to explore the viability of including 'what3words' into the current list of Encompass School contacts.

Practice Development 2024-2025

In addition to progressing the challenges from the round table session, it will be important in the coming year to:-

- Ensure compliance with any national guidance published relating to the implementation of Encompass and update local Encompass Protocol
- Review the current Encompass Scorecard with stakeholders and develop insights into the challenges for settings returning data
- Work collaboratively to further strengthen and develop Encompass quality assurance arrangements, with a focus on evaluating outcomes from the arrangements

Child Protection Arrangements

- Between April and June 2023, the safeguarding partnership became aware of a potentially significant increase in the number of children becoming the subject of a child protection plan. In the first three months of 2023-2024, it was noted that 168 children were the subject of an Initial Child Protection Conference (ICPC), which was a significant rise when compared to the same period in 2022-2023, where 65 children were the subject of an ICPC. Alongside this, by the end of June 2023, 456 children were subject to a Child Protection Plan (CPP) in comparison to 286 at the same time the previous year, a 59% increase. Projecting forward the indicators were that this number was likely to rise further.
- In response to this increasing demand the partnership undertook a 'spotlight' to explore potential drivers behind the increase and to consider any relevant action. On reviewing the available data partners identified the following contributing factors:-
    - **Poverty and Cost-of-living Crisis**; research has shown that child poverty has risen significantly in the last decade, and this is without taking into account the current economic pressures facing more families. In 2019, Bolton was ranked the 34th most deprived local authority in the country out of 317. In 2021/2022 41.6% (30,586) of children in Bolton were in poverty. It is recognised that changes in the economic conditions of family life alone, without changing any other factors, impact on rates of abuse and neglect. Increases in income reduce rates of Child Abuse and Neglect significantly, while economic shocks increase Child Abuse and Neglect unless families are protected by welfare benefits. It is therefore essential that when further strengthening our responses to Abuse and Neglect, our strategic response addresses the impact of income, employment and housing conditions on families and children to prevent child abuse and neglect. **Partners are asked to ensure these factors are actively addressed in assessment, supervision sessions, case conference and court reports.**
    - **Right help at the Right Time**; local safeguarding reviews and other assurance activity has identified that early help arrangements are not always being used effectively to prevent children and family's needs from escalating, particularly where need relates to neglect. Equally when child protection plans end, the arrangements for sustaining change or addressing ongoing needs in a family (usually referred to as 'step-down arrangements') are not always clear. In the short-term, the partnership has re-issued local 'step-down guidance' and for the longer term shared the learning and challenges with the Children and Young People's Board and Early Help Steering Group for a response.
    - **The Right Services Engaged in the Child Protection Plan**; for child protection arrangements to be effective there needs to be full engagement by all partners, including those supporting adult needs. The child protection spotlight identified gaps in attendance by key adult agencies, particularly those delivering substance misuse and mental health support. These issues have been raised with the commissioners and providers to provide assurances about future contributions from these services to these key safeguarding arrangements.
- It is of note, that by year end 2023-2024, the number of children subject to a plan had reduced to 332 and consistent with previous years. Child Protection Arrangements will be subject to an annual review, and this is scheduled in the partnership's 'Scrutiny and Assurance Annual Plan'.

Child Protection Arrangements

To further support effective local child protection practice, the partnership developed and launched local ‘child protection standards’ in October 2023. They put in place an agreed set of expectations for our work with children and families, not only identifying what and when key actions need to be taken but also ‘how’ in practice this can be achieved. The standards covered:-

- Effective Partnership Working
- Engaging and Supporting Children and their Families
- Effective Strategy Discussions
- Effective Conferences
- Effective Planning
- Effective Core Groups
- Managing and Supervising in Child Protection

The partnership sought practitioner feedback about this new resource, they told us:-

Makes it clear - expectations of all parties. Gives a reference point for all agencies.

Really good document to ensure everyone is doing their role

Managing and Supervising in Child Protection - Good that it is a specific area of focus as often supervision can be overlooked/not prioritised for some professionals working with Child Protection cases

Missing Children

Children are missing if their whereabouts cannot be established and the circumstances are out of character or the context suggests they may be subject of crime or at risk of harm to themselves or another. Children can go missing or run away for a variety of reasons. It is important that we have robust and consistent 'missing' arrangements in place to safeguard individual children and to support a strategic response to emerging themes or needs

In 2023/24, 612 children were reported missing for 1951 individual missing episodes, (some children had repeat episodes) This is an increase on the previous year of 107 individual children reported missing and 261 more episodes. In the previous year, (2022/23), 505 children were reported missing, for a total of 1690 individual episodes. Both years show October as having high rates of missing reports.

116 children (19%) were identified as 'Child in Need' with an allocated social worker. A further 49 children or 8% of the overall number of children reported missing were the subject of a child protection plan. This is lower than may be expected. As these children are generally living at home with parents or other family members, missing episodes may be under-reported as parents/carers do not want to draw the attention of police and other services. 159 children reported missing, were Looked After by Bolton Local Authority at the time of the missing report, which equates to 26% of the overall figure.

79 children 'looked after' by other local authority areas and who are living in Bolton, were reported missing for a total of 425 individual episodes. These children had multiple missing episodes. Arrangements are in place for notifying the responsible Local Authority. What we know is that generally, this group of children tend to return to their home authority or to places where they have former connections. Bolton police attend strategy meetings for these young people where needed, which significant resource implications.

It is evident that in 2023-2024 there has been overall increases in children being reported as missing. 47% of the children are receiving help and support from universal services, with the remaining 53% having an allocated social worker at the time of the report. Some if the increase aligns to improvements in reporting arrangements and data capture across the system, therefore it will be essential in 2024-2025 that the partnership evaluate trends over time, better understand the impact of strategies to reduce repeat missing episodes and better understand the impact on local services and safeguarding arrangements where children are living in Bolton but the responsibility of another Local Authority

Missing Children

Return interviews

When a child is found, they must be offered an independent return interview. Independent return interviews provide an opportunity to uncover information that can help protect children from the risk of going missing again, from risks they may have been exposed to while missing or from risk factors in their home. The interview should be carried out within 72 hours of the child returning to their home or care setting. In Bolton RUNA, an independent charity, are commissioned to provide this service and this is offered to all relevant children.

Reasons for not offering return interviews include, children admitted to hospital following a missing episode, children taken to custody, young children or non-verbal children (though RUNA do try with picture prompts and other tools where possible) or children moving to different placements following a missing episode.

For all those successfully offered, 64% were accepted and completed. Reasons for refusal included no consent given by parents who considered that the missing episode was not serious, and they didn't want RUNA to see their child, young people declining the offer or other practitioners involved spoke with the child instead.

Impact of Independent Return Interviews

A practitioner from RUNA met with Isabelle (12) and her brother Jamie (8) after they were reported missing together. At the initial return interviews, which were carried out separately, Isabelle and Jamie both shared that they were trying to get to their grandparents' house. They walked a significant distance over several hours, arriving safely at their grandparents' house. Isabelle has recognised learning difficulties and receives one to one teaching support in school.

Isabelle was reported missing on several further occasions, and each time had been attempting to walk to see her grandad. During the second return interview, Isabelle became tearful and would not verbally communicate. The RUNA staff member sat with her for a significant period, and asked Isabelle if she would prefer to share her feelings using pictures and words, rather than speaking. Isabelle engaged with this, and the RUNA practitioner used 'Three Houses' tool to gather her thoughts, feelings, and worries. Isabelle drew a picture of her immediate family to reflect that this is what makes her happy, writing the names of each family member; mum, brother and two sisters. She then wrote using words that she is sad, "when I'm on my own," and that she is worried, "when I'm on my own and people be mean to me."

This enabled the practitioners to ask deeper questions about those feelings and they understood from Isabelle that she is often left on her own in the family home and that worries her. The information from this return interview, alongside information from other sources, built a picture of Isabelle's lived experience and provided clear proof of the harm she was suffering at home. Having access to an independent person provides a safe space for children to talk freely about why they went missing, which they may not ordinarily do with other practitioners or adults in their life.

Learning from Reviews

This section of the annual report summaries the reviews completed in the last year, the learning identified, and action taken in response.

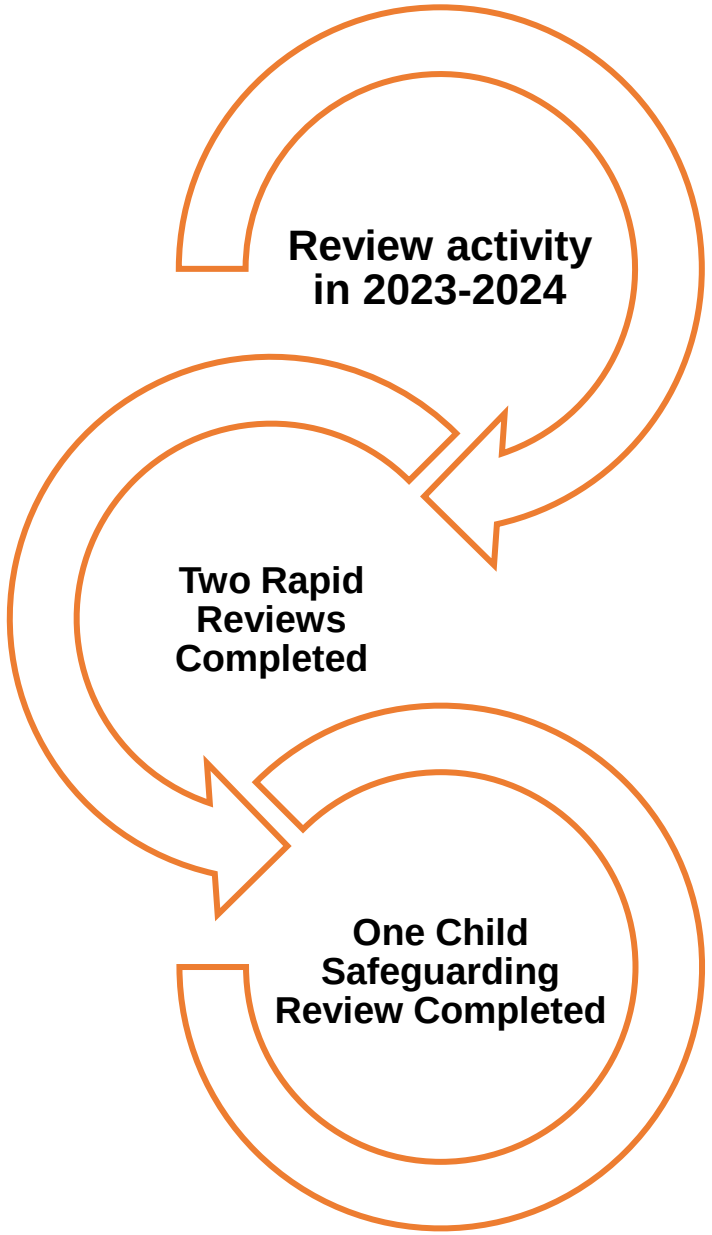
Learning from Reviews

Safeguarding partners must make arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area. A serious child safeguarding case is one in which abuse or neglect of a child is known or suspected and the child has died or been seriously harmed. Learning from local and national child safeguarding practice reviews forms part of the partnership quality assurance framework.

Carrying out learning reviews enables local partners to understand not only what happened but also why things happened as they did. They provide opportunities to reflect on whether or not different systemic approaches or actions are likely to reduce the probability of serious incidents recurring. In developing their case review arrangements, the safeguarding partnership aims to ensure:-

- Robust and transparent arrangements are in place to identify and review serious child safeguarding cases
- Timely and effective Rapid Reviews are completed and where required Child Safeguarding Practice Reviews are commissioned
- Learning from reviews leads to improved safeguarding arrangements

Progresss against individual and multi-agency actions identified following a review are monitored via the Child Safeguarding Practice Review Group. A quarterly report is provided to the partnership's Safeguarding Effectiveness Group for further scrutiny and challenge.



Learning from Reviews

When any review is completed, the partnership collate learning themes into a ‘Partnership Learning Log’. This builds a picture over time of recurrent themes as well as evidence of good practice. The diagram below highlights our key themes for 2023-2024.

Many of the local findings mirror national learning. To address some of the ‘stubborn challenges and strengthen local arrangements, the safeguarding partnership:-

- Launched local child protection standards to promote consistently good practice, in 2024-2025 we will be exploring practitioner awareness and application in practice
- Piloting ‘Muti-agency Supervision Arrangements’ to enable practitioners to use information in a reflective session where issues are complex, in 2024-2025 we will undertake an evaluation of the pilot
- Revised and relaunched local escalation processes; this still remains a challenge area and is a theme for further scrutiny in the partnership’s 2024-2025 ‘Section 11’ safeguarding self-assessment
- Shared recurrent Early Help themes with the Early Help Steering Group and Strategic Lead and in 2024-2025 will be undertaking a spotlight on Early Help arrangements

Rapid Review – Child H

Child H was aged five years at the time of the review and lived with their mother and two siblings. They were of White British heritage. The review was carried out as Child H died of a health-related condition and criminal investigations indicated medical neglect was suspected as a factor in the child's death. In the days before their collapse, Child H had been admitted to hospital to stabilise their health condition. At the time of death, Child H was being cared for by a 15-year-old babysitter. Mother's whereabouts were unknown, and it took a long time for mother to respond to calls from the babysitter. Child H was receiving help from universal services.

What worked well in practice

- Timely information sharing with the GP following hospital admissions and consultant appointments
- Effective medical responses to Child H's urgent care needs and follow-up to engage with mother
- GP was proactive in following-up missed appointments or other contacts with mother and offered a flexible approach to engage mother and meet her in Child H's care

Learning from Reviews – Child H

What did we learn

- Health and Education each held evidence which demonstrated a lack of compliance and potential ambivalence by mother to the seriousness of Child H's medical needs. However, neither agency appeared to view this through a lens of possible medical neglect
- Health practitioners have a key role in safeguarding children; however, they are operating in a complex landscape with different providers and different IT systems that do not easily connect to enable a 'whole family' approach
- Mother presented as credible to the practitioners who worked with her; however, the review has shown this was not the case and at times mother lied. There are many reasons why parents are not truthful and in the context of daily practice it can be very difficult for practitioners to identify deceit

Responding to Learning

- The partnership is already working on strengthening approaches to neglect and, as part of this will be facilitating a multi-agency Neglect Summit in 2024 with practitioners and leaders to share current research and local learning and seek their contributions to our strategic approach
- The complexity of the health economy and fragmented IT systems is not new learning, but within this review we have asked the National Panel to reflect on this as a national challenge; we are looking at what is possible locally
- An organisational preparedness to accept that parents may potentially be deceitful and for this to be accepted and anticipated and for leaders to create the conditions for their practitioners to explore this either in supervision or other methods

Learning from Reviews – Child O

Rapid Review – Child O
Child O is an adolescent of White British heritage. Child O disclosed they had experienced persistent and continuous sexual abuse from their mother's partner from the age of seven, until their disclosure. Given the significant period over which the abuse was reported to have taken place, the safeguarding partners asked organisations to review their involvement with Child O from when the abuse is began to the full disclosure. The key question the statutory partners wished to explore was whether there were opportunities to have acted sooner and prevented sexual abuse to Child O. In particular, whether there were any missed indicators either in Child O's presentation or in the history of the adult abuser.

What worked well in practice

- The tenacity of Child O's primary school when they were concerned about the care arrangements and their use of the Child Sex Offender Disclosure Scheme
- The largely effective multi-agency working and child protection investigation following disclosure; agency records demonstrate a high level of co-ordination, partnership working and support to Child O and their family through a very difficult time

What did we learn

- The transient nature of some adults makes it difficult for practitioners to access relevant historical information, particularly when a significant period has passed, and when organisations, experience significant structural change
- The use of written agreements as a tool to manage risk is potentially flawed, with little research about their efficacy
- The challenges facing practitioners in enabling children to disclose harm, and the challenges for children to tell their story

Responding to learning

- To review current research and best practice to support practitioners and their managers create the conditions to enable children to talk about the harm they may be experiencing and to look be yond reliance on children making direct disclosures
- To explore the use of written agreements across the partnership and their efficacy in practice

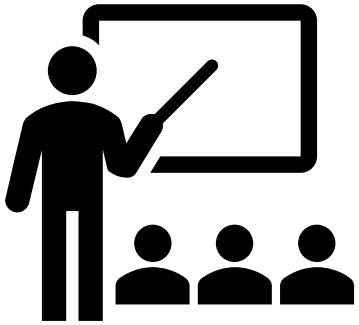
A Confident Workforce

This section of the annual report summaries the impact and effectiveness of the partnerships multi-agency training arrangements.

Confident and Knowledgeable Workforce

What are the arrangements for safeguarding children training?

- The various iterations of Working Together to Safeguard Children have consistently identified Multi-agency Training as a key part of local arrangements to keep children safe and there is a requirement for the statutory safeguarding partners to provide sufficient resources to develop and commission a training offer that meets the needs of local practitioners and promotes good practice in keeping children safe
- Multi-agency training provides a unique opportunity for practitioners from sometime diverse backgrounds to develop a shared understanding of the tasks, processes, principles, roles and responsibilities outlined in national guidance and local arrangements for safeguarding children and promoting their welfare. This training offer is designed to complement single agency safeguarding children training and not replace it
- In Bolton, a Multi-agency training co-ordinator and administrative support are employed as part of the partnership business unit. It is their role to work collaboratively with partners to develop, commission and deliver a comprehensive safeguarding programme , as well as report on the quality and impact of training on practice
- The contents for the annual training programme are identified in the following ways:-
    - Learning from local and national reviews and audits
    - Practitioner and Organisational feedback
    - Partnership priorities
    - New and emerging safeguarding issues

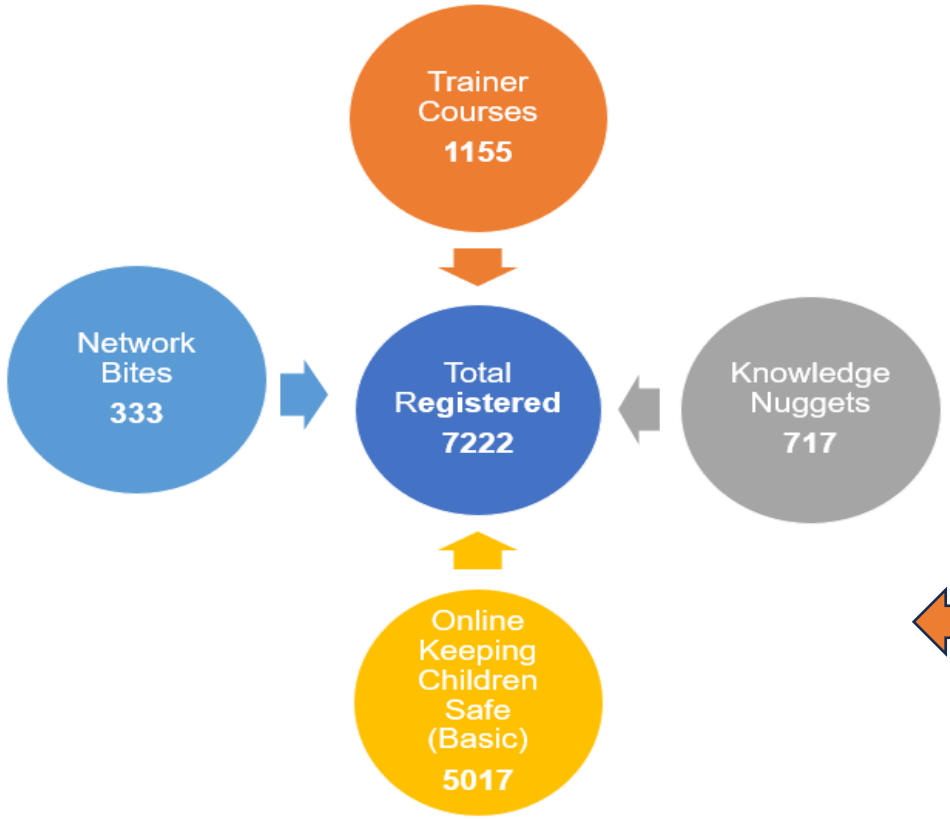


- The cost for the annual programme, including the cost of venues, commissioned training, on-line platform, a full-time Multi-agency Training Co-ordinator and part-time administrator is £79,967.44. This equates to £11.07 per registered delegate

Confident and Knowledgeable Workforce

How much workforce development is taking place in Bolton?

Diagram 1 provides a broad overview of workforce development activity in 2023-2024; the training is delivered using professional expertise from within the Bolton Family practitioner network, from commissioned sector experts or using online platforms.



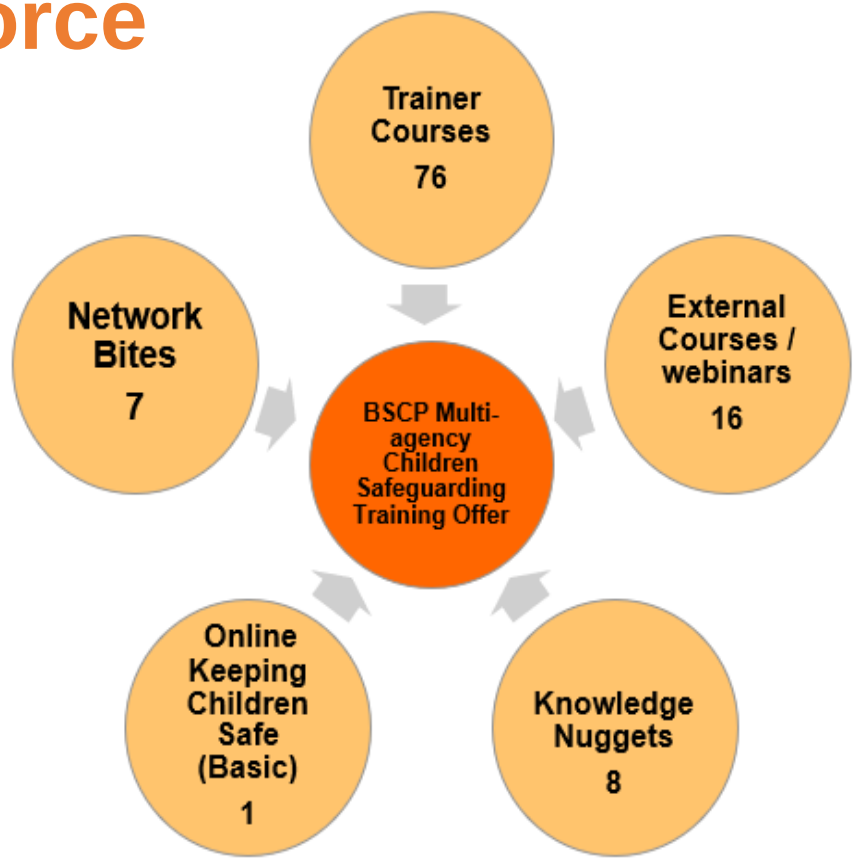


Diagram 2 shows the total number of registrations for safeguarding courses and then broken down to its component elements. It is a strength that the offer attracts such high numbers of delegates

Confident and Knowledgeable Workforce

What is our data telling us about our workforce development offer?

There has been an increase in the number of face-to-face training session being delivered in 2023-2024 (114) compared to the previous year (76); an increase 38. This reflects the return to ‘business as usual’ as recovery from the Covid 19 pandemic continued and in response to practitioner feedback to have opportunities to network with colleagues from other agencies.

There has been a reduction in the number of external courses and webinars. These courses cover ‘niche’ practice areas or are commissioned initially as ‘one-offs’ to address new and emerging safeguarding issues. The reduction is partly due to a return to ‘face-to-face’ delivery, some of the webinars becoming core courses in the annual programme and in response to declining numbers for some of the repeat sessions. Topics covered in the sessions included harmful gambling, complex trauma and ‘dogs and children’.

In 2022-2023 the partners wanted to reduce the number of delegates failing to attend courses and increase our attendance rate overall to 85%. This has not been achieved despite the introduction and application of a non-attendance policy. The attendance rate for this year was 76%. There are many factors that prevent delegates from attending training. One of the key challenges is to tackle cultural attitudes towards training and development as a luxury rather than an essential and to enable managers and supervisors to prioritise this for their practitioners.

A further ambition from the previous year was to maintain our high course evaluation rate at a minimum of 95% rating as excellent or good. In 2023-2024 99% of delegates rated the partnerships training offer as excellent or good; 70% rated it excellent. 92% of delegates reported the training would lead to changes in their practice, 60% stating there would be many or significant changes to strengthen their practice.

Confident and Knowledgeable Workforce

What do delegates say about the training?

Children Dealing with Bereavement

…work with a more informed knowledge on how children understand grief, process their grief and I will be able to help them in an age-appropriate manner.

Keeping Children Safe (Advanced) Refresher

Outstanding knowledgeable presenters who can impart knowledge to attendees in a friendly impactful way using a number of techniques which all gel to make the course which helps participants remember facts.

Reducing the Risk of Harm When Using CSE Resources (Boys and Men)

(I will) be able to introduce CSE resources appropriately and not be afraid to use them where they are suitable and could have the positive outcomes discussed.

What next for 2024-2025?

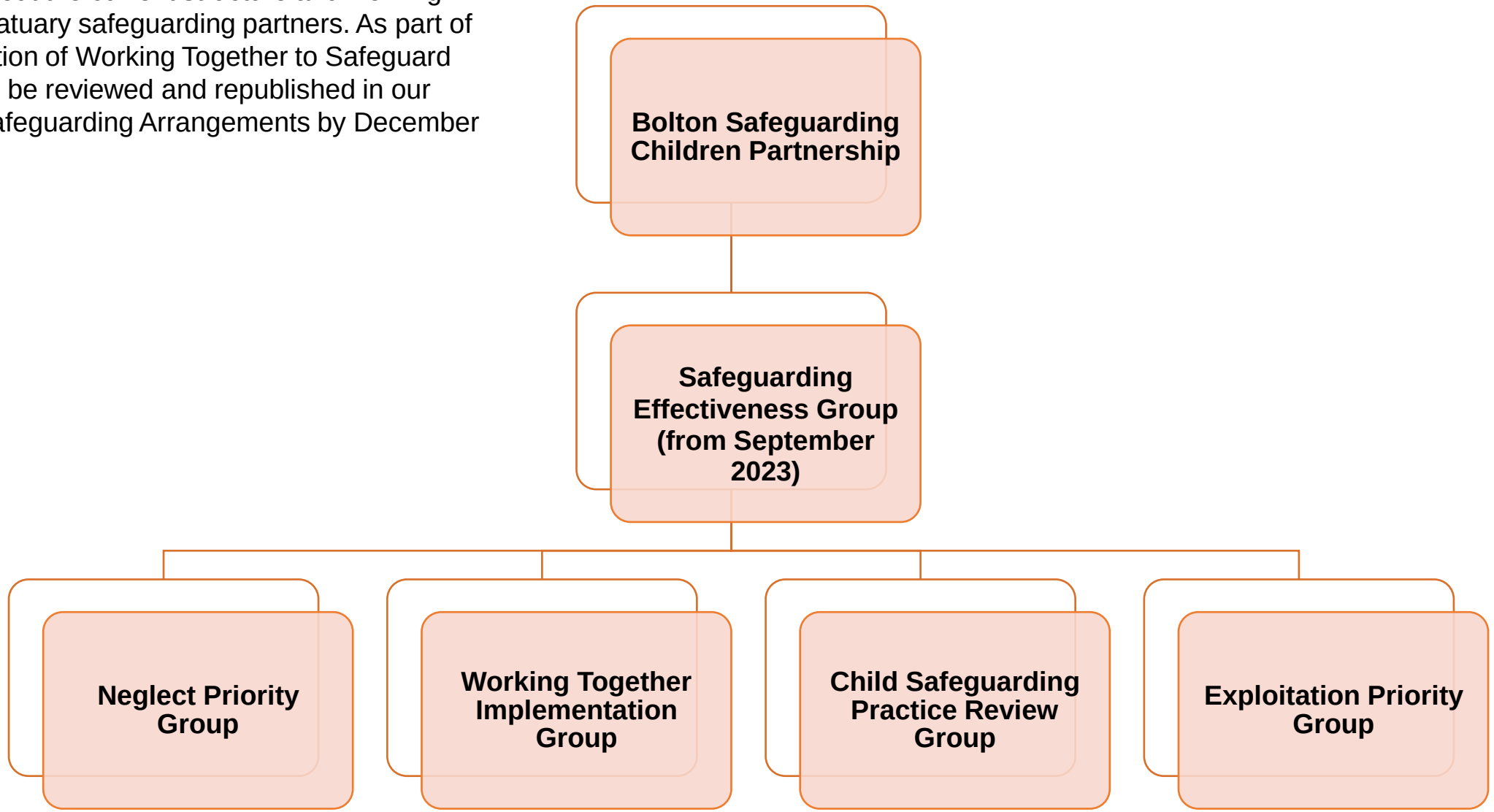
- Continue to transfer the learning from reviews e.g., Animal welfare, use of Nitrous Oxide, harmful gambling, information sharing, curious questions etc.
- With partners identify gaps within the programme and seek opportunities to address emerging workforce development needs.
- To test the reach of the Framework For Action (thresholds).
- To further develop knowledge checks and seek opportunities to evaluate training transfer.
- Increase awareness, access and take-up of the training offer using social media e.g. development of a partnership Facebook page.
- Maintain high course evaluation and impact rates, achieving a minimum of 95% of delegates rating courses as good or excellent.

Partnership Structure and Resources

This section of the annual report sets out the contributions and expenditure of partners to the multi-agency safeguarding arrangements.

Partnership Structure

The diagram below sets out the current structure and working groups supporting the statuary safeguarding partners. As part of the planned implementation of Working Together to Safeguard Children 2023, these will be reviewed and republished in our revised Multi-Agency Safeguarding Arrangements by December 2024.



Partnership Resources

The tables below sets out the income and key expenditure for the partnership over the last twelve months. The staffing costs include the partnership Business Manager, Multi-agency training lead, Local Authority Designated Officer and an administrator. All other expenditure is as detailed.

Partner	Income 2023-2024
Local Authority	143,500
NHS Greater Manchester Integrated Care Board	90,998
Greater Manchester Police (via Greater Manchester Combined Authority)	17,296
Education	60,900
Strengthening Multi-agency Leadership (one-off grant from DfE to support Working Together 2023 Implementation)	47,300
Total Income 2023-2024	359,994

Expenditure	Cost 2023-2024
BSCP Staffing	198,019
Independent Scrutiny (including costs for case reviews)	47,937
Safeguarding Arrangements (including partnership admin costs)	65,699
Multi-agency Training Programme (staffing costs excluded)	6,810
Child Death Overview Arrangements	19,560
Subscriptions	1,642
Room Hire	1,809
ICT Costs	3,377
To reserves	15,141
Total Expenditure 2023-2024	359,994

Partners Safeguarding Highlights

This section of the annual report shines a light on how members of Bolton Safeguarding Children Partnership contribute to safeguarding arrangements in Bolton.

Partner's Safeguarding Highlights

Probation Service

- Neglect Strategy and Resource pack has been shared with teams to improve understanding and recognition of child neglect
- Regional Case Audits are undertaken to check that safeguarding matters are addressed, and these audits are discussed with the practitioners and follow up actions monitored; these audit identify wider learning to be implemented and the local quality development officer tailors Bolton's training to respond to learning needs
- Accessing timely information from partners can be a barrier for the service in some safeguarding children; for the coming year developing holistic ways of working with people on probation that includes the wider family network and ensuring that any safeguarding needs are addressed within that network

Public Health

- A Community of Practice event in September 2023 looking at Sudden Unexplained Deaths in infants (SUDI) using national research and analysis of local child death review data, we presented the risk factors for SUDI and introduced a 'continuum of risk' model to colleagues and partners. The session explored the research to discuss how behavioural insights can be used to support behaviour change through personalised practices with vulnerable families.
- Understanding the challenges and implications of the cost-of-living crisis and the extent to which it adversely affects children and families with the potential for children's basic needs not being met; this is in the context of the reduced funding to commission services and the challenge facing universal services under pressure to provide a quality preventative offer

Safeguarding in Education Team

- Neglect, Exploitation and thresholds are included in training that is delivered to the education sector with knowledge nuggets being shared across the education sector
- Two schools have held Exploitation events for parents to raise awareness; Safeguarding in Education Social Worker and partner agencies were also involved which included RUNA, Police, Complex Safeguarding Team, I- Thrive, Health; following the Exploitation event a parent came forward for support therefore without the event this might not have happened
- Partners in education are worried about the increasing number of children, some of whom are living in complex circumstances, who are electively home educated; the challenges of delivering effective early help, particularly where the needs are related to parents or carers with the key challenge areas being Domestic Abuse, Mental Health and Neglect

Partner's Safeguarding Highlights

NHS Bolton Foundation Trust

- Safeguarding Partnership developments and activity are reported to the Trust's Safeguarding Committee and Divisional Safeguarding Committees
- The trust have actively supported partnership priorities including the neglect audit and development of local tools
- Child Exploitation Peer Review looked at the experiences of four children and the health interventions. The feedback about health services provided to the young people was very positive; an action from the Peer Review was to ensure there is supervision in complex or escalating cases
- The trust have noted emerging issues for young people including knife crime and youth violence, as well as arrangements for children with complex needs where there is family or placement breakdown

Bolton Together

- Bolton Together bid for Million Hours Lottery funding during the last financial year to deliver the One Life Project. The funding was awarded, and the project will begin in June 2024. This will enable additional youth hours to deliver work in specific areas of Bolton over 15 months, this will work alongside the delivery of awareness-raising workshops in schools on what exploitation is and the signs to be alert to
- The Neglect Strategy and toolkit has been shared widely with our members via partnership meetings and our provider 'Padlets'. All I-Thrive and Family Hub providers deliver support to families at a prevention level and highlight any concerns as soon as possible concerning neglect, supporting the family with practical help and support and signposting where possible, and escalating as a Safeguarding concern where required
- A key focus for the year ahead for the partnership to consider are the additional needs and vulnerabilities for children with Special Education Needs and Disability

Children's Social Care

- Neglect toolkit promoted across the service with managers encouraged to use in reflective supervision
- Partnership threshold document and resources included in training and induction across the service to support consistent understanding and application of thresholds; where the threshold for Targeted Early Help or statutory social work intervention is not met practitioners are guided and supported
- Reviewed and relaunched 'step-down' arrangements from social care in response to learning from local reviews; this is designed to ensure children and their families receive support to maintain positive change and reduce the likelihood of further intervention from statutory social work services
- The work to support the partnership from an early help perspective, remains a challenge; the Early Help Training has been in high demand, but this has not necessarily translated into an increase partner Early Help Assessments to offer co-ordinated preventative support to children. This remains a challenge area for the coming twelve months

Integrated Care Board Arrangements – NHS Greater Manchester Safeguarding Partnership

Overview

NHS Greater Manchester (GM) has continued to discharge our statutory safeguarding duties throughout 2023-24 in relation to safeguarding babies, children, young people and adults at risk. The NHS GM Chief Nurse holds the statutory accountability for safeguarding and is supported by the Deputy Chief Nurse and Associate Director of Safeguarding. Statutory safeguarding responsibilities are delegated to the Associate Director of Quality in each of the GM localities and delivery of the statutory functions are undertaken by the locality Designated Teams.
NHS GM is able to demonstrate that there are appropriate safeguarding governance systems in place for discharging their statutory safeguarding duties and functions in line with the following key legislation:

- Care Act 2014
- Children Act 1989 and 2004,
- Children and Social Work Act 2017
- Working together to Safeguard Children 2023

The NHS England (NHSE) Safeguarding Accountability and Assurance Framework (SAAF 2024) provides the strategic framework for ensuring strategic system oversight of safeguarding priorities. Assurance and oversight of these duties is maintained via the NHS GM.
NHSE requires the ICB to submit an annual response to the requirements of the Safeguarding Assurance & Accountability Framework (SAAF) to provide assurance of its arrangements. An overview of our detailed activity will be provided in the annual NHS GM Safeguarding Report 2023-24 to be published in quarter 2 of this financial year 2024-25 which will be accessed via our website. As part of the SAAF process the ICB must ensure that health services across the system have effective safeguarding arrangements in place.

Governance

The NHS GM safeguarding governance structure has supported an integrated model for the delivery of the safeguarding functions with the opportunity for continuing system change throughout 2023-24 and has ensured and promoted system oversight. Safeguarding is embedded within the overarching NHS GM quality governance structure.

Integrated Care Board Arrangements – NHS Greater Manchester Safeguarding Partnership

The Quality Committee receives safeguarding updates covering the ICB's approach to delivering safeguarding statutory functions, changes in the NHS Safeguarding Accountability and Assurance Framework 2024 (SAAF) and aspects of learning from safeguarding reviews and the ICB system response. The ICB accountabilities for safeguarding are noted by the committee which recognises the need for delivery and collaboration across the ten Places. The Quality Committee is sighted on any emerging themes and risks including the required actions to improve and strengthen arrangements.

Safeguarding Delivery Functions

The delivery of statutory safeguarding functions is undertaken via an integrated system wide safeguarding model aligned to the statutory functions and priority work areas within the SAAF (2024). This has promoted the opportunity for transformation across the ICS footprint and supported integrated working. National, regional and local reviews and independent inquiry recommendations are incorporated within the safeguarding delivery plan and form part of our system assurance.

Safeguarding Assurance

NHS GM has a statutory responsibility for ensuring safe systems of care are delivered and to ensure that all health providers with whom they commission, discharge their functions regarding safeguarding and the promotion of welfare of children, young people and adults at risk. Effective safeguarding arrangements are in place to ensure oversight of provider safeguarding assurance via the annual 2023-24 Greater Manchester Safeguarding Children, Young People and Adults at Risk – Contractual Standards which provide the safeguarding audit framework used to monitor all NHS and Non-NHS providers of health care. The statutory assurance processes set out in the SAAF (2022, 2024) have been adhered too.

Safeguarding Partnerships and Boards

NHS GM has maintained the CCG statutory duties across the GM Safeguarding Children Partnerships as one of the equal and joint statutory partners (Local Authority, ICBs and Chief Officer of police) and as a statutory partner for the GM Adult Safeguarding Boards. Full representation has been maintained at Safeguarding Children's Partnerships, Safeguarding Adult's Boards, and associated subgroup meetings, to fulfil and discharge both commissioning and statutory safeguarding responsibilities. This has enabled the ICB to work with its partners to ensure learning from local and national child death and safeguarding reviews has influenced and strengthened practice.

The locality area annual reports set out how NHS GM will work together with other agencies to safeguard and promote the welfare of children and adults in GM.

NHS Greater Manchester Safeguarding Partnership – Bolton Highlights

- Active contributor and critical friend as a member of the neglect thematic review panel; learning from the review was cascaded to primary care via their safeguarding annual event
- Promote the BSCP priorities via the NHS GM Bolton Safeguarding Health Collaborative and support effective communication between this forum and the partnership
- Active members of the exploitation and serious youth violence group providing a health perspective in these important areas of safeguarding activity
- Oversite of health provider contribution and have worked to further raise the profile of safeguarding with children commissioners
- Influencing best practice within health providers, for example the influence of specialist safeguarding roles within health providers, to ensure best health outcomes for children
- Ensuring effective safeguarding arrangements in place to ensure oversight of health provider safeguarding assurance via the annual 2023-24 Greater Manchester Safeguarding Children, Young People and Adults at Risk – Contractual Standards, the partnership themes are reflected in this tool
- NHS Greater Manchester safeguarding priorities are child neglect, child sexual exploitation and abuse and domestic abuse and impact to children and these align with and support BSCP's priorities and assurance activity

Independent Scrutineer

This section of the annual report shares the perspectives of the Independent Scrutineer on the impact and effectiveness of safeguarding arrangements in Bolton.

Independent Scrutineer

As Bolton's independent scrutineer and former independent chair of the children's safeguarding partnership I want to recognise the hard work and contribution our partners make giving children the best possible start in life, so that they have every chance to succeed, be safe and happy. Working together across our complex systems will only be effective if partners are truly committed to joint leadership and develop a culture of collaboration and shared accountability.

During the past 12 months I have seen how the partnership has progressed and developed, there are strong foundations, and evidence of effective joint working, and this is making a positive difference. The annual report provides an insight of the great work that takes place every day to keep children safe and achieve better outcomes. A lot has been done but there is more to do.

Annual Report

The annual report is well presented and contains key information on elements of independent scrutiny, multi-agency training offer and other aspects of safeguarding arrangements. It does provide insight into a range of activities linked to key priorities. It outlines the priorities for 2024/25, however the link between the work of the Safeguarding Effectiveness Group and the Statutory Partner leaders could be stronger in articulating how and why the priorities have been set. The future development of the BSCP Business Unit will be key making this happen.

Leadership

The three statutory partnership leads are appropriately senior enough to make strategic and operational decisions and engage and influence other relevant partners. I have found each of the named leads to be collaborative and they fully understand the importance of working together to safeguard children. They all have good relationships and support each other on key challenges. There are opportunities however to ensure the statutory partners come together formally to agree key strategic priorities and identify system risks. The creation of a Safeguarding business Unit with a clear role would enable this to happen.

It would be remis not to highlight the negative impact of frequent changes in senior leaders. This has been a key theme within Great Manchester Police and the developing structures of the Integrated Care Board (ICB). Although individuals have committed to partnership working, short tenors and constant change reduces strategic stability and continuity of the Partnership Executive and potentially safeguarding children.

Independent Scrutineer

BSCP Statutory Functions

BSCP is able to fulfil its statutory functions in accordance with Working Together Statutory Guidance. There is good multi agency engagement at all levels with strong leadership. For this to continue, senior partnership leaders to ensure appropriate budgets are sufficient and appropriate to deliver statutory duties and deliver on agreed priorities. The reliance on the current business unit structure is not sustainable and a risk to partnership having capacity to fulfil its statutory function in the future.

Voice of the Child and Family

Although there is evidence of how the voice of the child influences our approach through effective engagement. We could be stronger to demonstrate that the child is always central to our thinking and doing. I would like to see this further developed and included in the work of BSCP as we develop our understanding of Safeguarding Effectiveness processes. This must be central to our ambitions

Governance

BSCP has a number of governance meetings that inform the partnership and agenda linked to key priorities. Subgroup structures are relevant but are too reliant to the skills and experience of the BSCP Business Manager. Going forward I would like to see more ownership from partner organisations to lead and influence the outcomes of the subgroup work. The capacity and resilience of the Business Unit is limited due to its very ‘lean’ structure. In my view the structure is disproportionate to the level of risk and demand. This has been a long-term issue within BSCP, highlighted in previous peer reviews, however it remains a challenge and creates risk to the effectiveness of the partnership.

Strategic Alignment

There are very clear overlaps and interdependencies between Bolton’s Safeguarding Children, Safeguarding Adults and the priorities associated with Be Safe – Community Safety Partnership. Each of the strategic boards function in isolation with little alignment or joined up thinking. I am pleased that this has been recognised and the creating of a Partnership Alignment Group has been established. This will support system leaders to create a culture of shared accountability, challenge and priority setting across a much wider landscape. An additional opportunity should be pursued to align the work of the Integrated Health and Care agenda through effective connections, influence and leadership of the Locality Board.

Independent Scrutineer

Inspection and Review

I am keen to ensure the learning from external inspections and reviews of key safeguarding themes are recognised and more importantly embedded into operational practice. The Inspection of Bolton Local Authority Children's Services by Ofsted is a good example with an overall effectiveness rating of GOOD. This should be celebrated but we shouldn't be complacent.

There are areas that require development and there is a need to share and understand areas of good practice to maintain levels of good performance. I would like to see the partnership develop a more proactive role to seek assurance that the collective learning is implemented effectively and sustained.
I believe that we can align the outcome of inspections and peer reviews to enable better outcomes for children. This is a leadership challenge.

Assurance

The partnership is on a development journey from doing lots of 'activity' type functions to strengthening its assurance function. This report reflects the amount of activity and tasks undertaken throughout the year. The system and its partners are working hard delivering services to meet high levels of demand and complexity. The development of a Safeguarding Effectiveness Framework (SEG) has supported the shift needed to understand in impact of what we do, and if it makes a difference. This work must continue to ensure the partnership has an evidence base for making decisions, risks and priorities.

The partnership needs to be confident to challenge and seek assurance, I see early signs of this happening in governance meeting and operational practice. A good example of this has been the work of the Child Exploitation group who are developing new ways of working to increase the understanding of the threat and the wider system responses. Developing an Intelligence led approach to how the partnership does business is a here and now opportunity.

Early Help

The partnership has a significant and important role to play to improve and challenge Bolton's Early Help Offer. Some of the areas requiring improvement were identified in the ILACS inspection report. Other strategic and operational challenges have been highlighted by front line practitioners, partners and system leaders. The Early Help offer should provide children and families with the support they need to avoid further escalation into crisis situations. I would like to see the partnership support the changes needed to improve the offer and offer challenge to all statutory partners and relevant agencies where needed to drive improvement.

Independent Scrutineer

Conclusion

Safeguarding arrangements and the level of scrutiny in BSCP is strong. The partnerships ambition to develop stronger assurance and an intelligence led approach to delivering business is to be commended. Multi agency partnership working is very active and well led. The continued collaborative commitment, vision and focus will increase the effectiveness of the partnership.

I will ensure that Independent scrutiny drives continuous improvement providing assurance that Bolton's safeguarding arrangements are working effectively for children, families and practitioners.

Neil Smith
BSCP Independent Scrutineer

Priorities 2024-2025

This section of the annual report highlights the priorities for 2024-2025.

Priorities 2024-2025

It can be seen from the 2023-2024 safeguarding partnership annual report that progress has been made in understanding what works well in local safeguarding arrangements, where improvement is needed and how the partnership is leading improvement and/or offering challenge across the system.

Moving into 2024-2025 will present further challenge to all. The statutory safeguarding partners recognise through their work on reviews, audits and stakeholder engagement that keeping children safe is as complex as ever. The impact of the cost-of-living crisis on local families continues, coupled with the complexity of family life, and the increasing demand for help and support across the continuum of need and funding all add to this challenging landscape. There is also a need to acknowledge that all partners in the safeguarding system are experiencing difficulties in recruiting and retaining their workforce, and ensuring they have the right skills, knowledge and support to keep children safe .

It is within this context that the priorities for 2024-2025 are set as follows:-

- **Priority 1 Implementation of Working Together**; In December 2023, the government published their revisions to Working Together to Safeguard Children and launched the Social Care National Framework; both documents set out a strong ambition to further strengthen and develop local safeguarding arrangements and it is essential that as a partnership we use this opportunity to review our current arrangements and identify what local reforms are needed to comply with statutory guidance and achieve better outcomes for children.
- **Priority 2 Tackling Child Neglect**; Neglect continues to be an area of challenge and while some improvements have been evidenced, more is needed to ensure that we recognise the early signs and respond using a family focused approach. Reforms to local early help models will support this, as will the implementation of family hubs and we need to ensure that these initiatives are developed using the learning and intelligence held by the safeguarding partnership
- **Priority 3 Exploitation and Extra-familial Harm**; The risks from Extra-familial harm are dynamic and while we have worked hard in Bolton to continually strengthen and improve our arrangements to safeguard children at risk from harm outside their home environment, in 2024-2025 there is a need to focus on the impact and effectiveness of local arrangements not only to keep children safe, but to also target those who perpetrate this abuse

For further information about the arrangements, share your experiences of safeguarding in Bolton, give your views on the report or get involved in the work we do, contact: -
Phone: **01204 337479**

Email: **boltonsafeguardingchildren@bolton.gov.uk**

Website: https://www.boltonsafeguardingchildren.org.uk/

This document is available in alternative formats, please contact 01204 337974 to request a copy.

Are you worried about a child?

If you're worried about the safety and wellbeing of a child, it's important to take action.

To discuss your concerns, contact a member of our team on 01204 331500 or visit https://www.boltonsafeguardingchildren.org.uk/worried-child .