



**Bolton Safeguarding Children Partnership**

## **KEEPING CHILDREN SAFE IN BOLTON IN 2022**

**‘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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**Bolton Safeguarding Children Partners**

# Welcome and Introduction

Welcome to Bolton Safeguarding Children Partnership's Annual Report for 2022.

The work of the safeguarding partners and its relevant agencies in Bolton is wide-ranging. 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 further action needed to further strengthen local safeguarding arrangements.

The report aims to provide key stakeholders, including members of the public and the wider community, with a level of assurance and accountability about the impact and effectiveness of local safeguarding arrangements in Bolton. 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 support and that children are listened to.

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

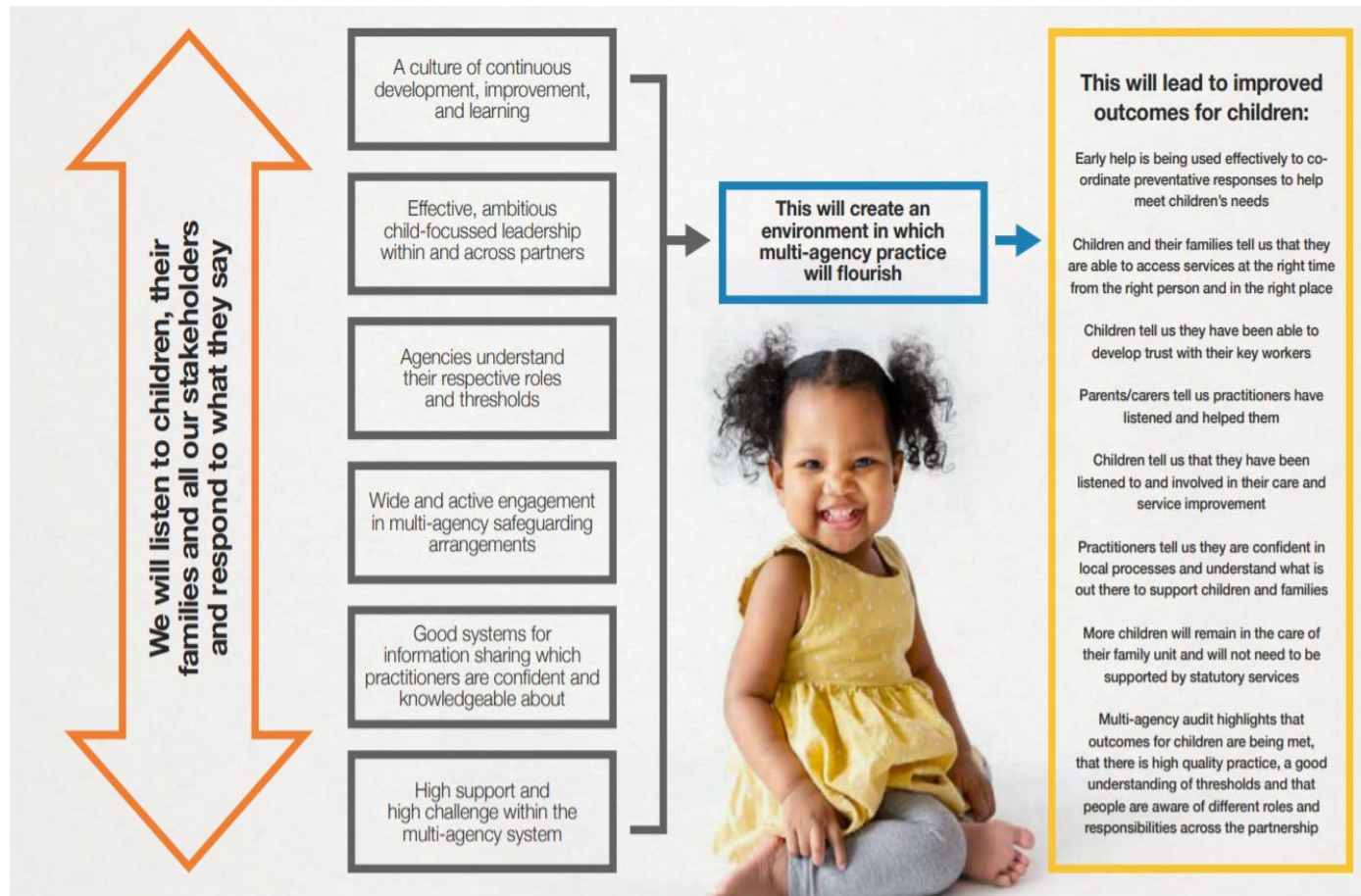
Thank you





# 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



## Bolton Safeguarding Children Partnership

- 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, Bolton Clinical Commissioning Group (now 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
- The partners must publish a yearly report to bring transparency for children, families and all practitioners about the activity undertaken
- This annual report aims to provide a level of assurance and accountability to all our stakeholders about the impact and effectiveness of priority safeguarding arrangements



# Our Children

Number of children in Bolton aged 0-17

**71,391**



Percentage of population who are children

*Bolton*  
**24.1%**  
*England*  
**20.8%**



Primary pupils eligible for free school meals

*Bolton*  
**24.4%**  
*England*  
**23.1%**

Secondary pupils eligible for free school meals

*Bolton*  
**25.1%**  
*England*  
**20.9%**

Number of young people in Bolton aged 16-17

**7,869**

Number of young people that are not in education, employment or training

**278**

Percentage of young people that are not in education, employment or training

**3.8%**



Percentage of children in low income families

*Bolton*  
**31.5%**  
*England*  
**18.7%**



Numbers of children classed as BME

*Bolton*  
**29.5%**  
*England*  
**24.6%**

Number of domestic abuse and violence incidents recorded as having a child present

**3,359**

Number of domestic abuse and violence incidents – incidents per 10,000 children

**487**



Number of children with an Open Child In Need (CIN) Referral

**2,291**

Number of children who have an open early help plan

**4,539**

Number of children who are on a child protection plan

**349**

Number of children who are looked after in Bolton

**556**



Number of children with Special Educational Needs

**2,132**

# What Children Tell Us

Listening to the views of children, through Youth Voice, supports the safeguarding partners to not only improve their services but to enable children identify their own solutions. BSCP aims to meet at least twice a year to work alongside children on the safeguarding issues that are important to them. A great example of this collaborative approach has been the creation and development of '[Be Kind to My Mind](#)'. This was a project that grew from children's passion to tackle the stigma of mental health to become a core foundation of Bolton's approach to provide earlier and preventative mental health support services.

## WORKING TOGETHER ON BEREAVEMENT AND LOSS

During the pandemic, responding to children's experiences of loss and bereavement emerged as a key theme and led to the creation of a bereavement support service under the 'Be Kind to My Mind' banner and delivered as part of [Bolton Lads and Girls Club I-Thrive Offer](#). Working with children post pandemic, one of our youth MP's shared his personal experiences with BSCP and proposed his solutions. One of these was to create a young person's bereavement café. Through his passion and commitment he worked with practitioners and others to launch the sessions. Below is Emily'

### Emily's Story – In Her Own Words

"Hi I'm Emily, I am 15 years old and I am a part of the bereavement café, currently I am in year 11 at high school. When I was 9 years old, my mum was diagnosed with terminal cancer. After 2 years she unfortunately died from it. I think some of my earliest memories without my mum, was climbing into her bed when my dad was working. However, when my mum died in year 7 it felt as if the world had stopped. The support I received was slim to none. I was even told that there wasn't anything the school could do after I reached out. I often felt alone and isolated as none of my friends went through what I went through. Earlier this year Youth MP...made contact with the bereavement cafe, as he was interested in extending the bereavement café to young people. I was a part of this steering group of young people where we discussed what we wanted to get out of the youth bereavement café. The Youth Bereavement café has made it easier to realise that I am not alone, even though I still have bad days, its not as difficult"

# What Children Tell Us

In 2022 BSCP supported children to develop and launch 'Be Kind to My Mind Champions'. Working with Youth Voice, youth groups, education practitioners and others a session was held to scope the role, identify what was needed to make it happen and gain commitment to roll this out across secondary schools in Bolton. 'Be Kind to My Mind Champion's Packs have been created and will be rolled out in the coming year.

Children have told us that the campaign and resources :-

- Help children to easily access services to help with their mental health
- Help children to signpost friends and support them in accessing mental health support
- Bring together the services that support in Bolton and sharing good practice

In 2022-2023 BSCP will continue to work collaboratively with children on their RESPECT ME campaign. This is a coproduced youth led Domestic Abuse Social Media Campaign, which will sit alongside a school-based session young people have developed on the subject of violence against women and girls. This will have a particular focus on public sexual harassment, gender-based abuse and promoting healthy relationships. BSCP will provide access to sector experts to finalise the resources, work with education partners to engage with the resource and create, with children, their success measures.

We asked children two key questions about working with BSCP, they told us...

## **What do you think of the safeguarding partnership in Bolton?**

"As young people we appreciate the support and interaction we have with the BSCP, it's great to know that we are being listened to and our views are acted upon. We especially like it when professionals come back to our groups to share any feedback or progression they have made."

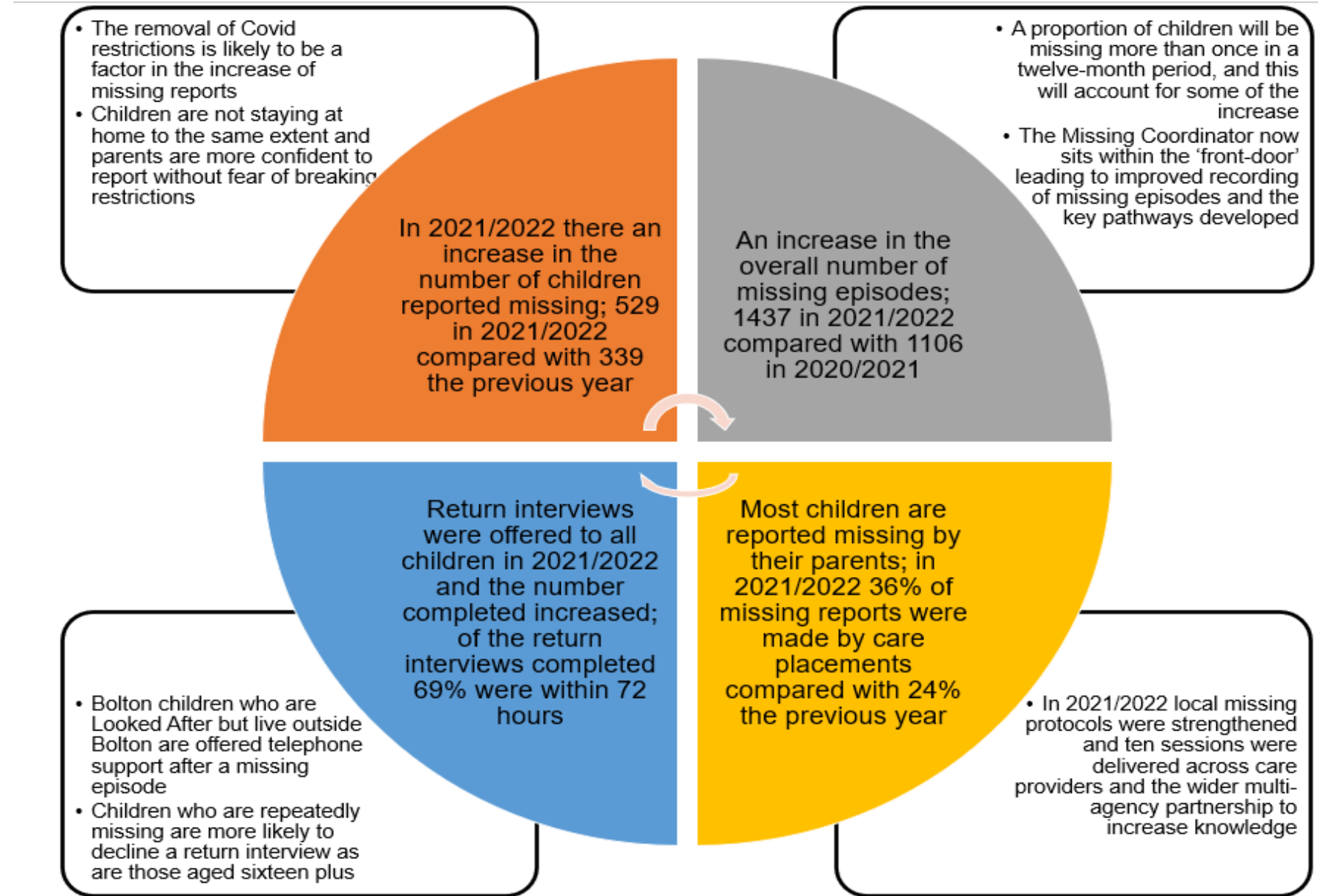
## **What impact does the relationship between Bolton youth voice and the safeguarding partnership have?**

"We feel that the meetings held between BSCP and Bolton youth voice are a great platform for young people and professionals to connect and discuss key issues. It enables professionals to get a real insight into problems young people face, but equally gives young people the perspective of time frames and the work that goes into making important changes for young people."



# Children Missing from Home

- 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
- This section of our annual report sets out some of the key data, what is working well and what can be improved





# Children Missing from Home

The Missing from Home Coordinator has led the partnership response to strengthening and further developing local arrangements to safeguard children who are missing. Over the last year their work has included:-

Briefing social workers and their managers on the requirements of statutory guidance and how these are met in Bolton, and this has resulted in improving their understanding and application of local processes

Developing a 'Foster Carer Missing Protocol' in collaboration with the Fostering Service and rolling this out to foster carers; this has not only improved foster carer's understanding of local processes but is also a likely factor in the increased number of children being reported from a care placement

Attending Missing Strategy Meetings ensuring children's views are presented from return interviews, identifying emerging threats or risks linked to locations or individuals and as an independent voice, hold partners to account for decision making and planning for children

Working with the commissioned provider for return interviews to strengthen the quality of information recorded and developing techniques to improve engagement with children in the service

Facilitating a qualitative audit of thirty-five children who had two or more missing episodes to evaluate practice in response to missing episodes

## What's working well in practice...

- 91% of children in the audit accessed a return interview meaning their voices were heard
- 75% of strategy meetings were held within timescale resulting in timely responses to respond to any harms
- Information is gathered from a range of sources including parents, carers and partner agencies to ensure a holistic understating of the child's needs and protective factors

## What's can be better...

- Practitioners ensure that they make full use of the information gathered from the return interview
- All missing strategy meetings are held within the five-day timescale
- Ensure clear goals are identified to address the underlying causes of missing episodes and include these in any other care plans for the child

# The Difference 'Effective Children Missing from Home Arrangements Make'

Kayla\* had a return interview from the local service following her first missing episode. The return interview gave Kayla and her mum the space to talk to the practitioner about what was going on and why Kayla had gone missing.

Mum was struggling with a Kayla's three month old brother, the loss of her job and trying to complete a course at college. Mum was able to talk about how things were getting on top of her, and felt that she was not coping.

Mum recognised she was taking things out on her family and needed some help. The practitioner mediated between Kayla and her mum and worked with them to develop their communication plan. Kayla's also had a better understanding the difficulties that her mum was experiencing. There have been no further missing episodes.

\*Details have been changed to protect the identity of children and their families



# Complex Safeguarding

Complex Safeguarding is a term used to describe a range of safeguarding issues that children face from outside their family home, in particular those related to criminality and exploitation. As children grow and develop they become more independent of their families, the risks that they face change. For some young people the relationships they form in their neighbourhoods, schools and online can feature violence and abuse outside of, or in addition to their experiences within their families.

During 2020 Bolton further developed its response to this challenging issue by creating a fully dedicated 'complex safeguarding team' and co-locating key police and social care practitioners. In 2022, following a Greater Manchester peer audit in 2021, the safeguarding partners undertook further scrutiny and assurance of these local arrangements. This section of the annual report highlights our key findings and response to continue to strengthen local practice in this area.

## Working Well in Complex Safeguarding

Timely identification of exploitation as a risk and appropriate referrals to the Complex Safeguarding Team (CST)

The right partners are actively involved in developing the CST assessment and there is good attendance at multi-agency meetings

Practitioners understand the complex lives that some children experience and the push/pull factors that make them vulnerable to exploitation

Children's lived experience is clear and considered  
Children are able to develop trusting relationships with key adults who support them

There is flexibility and creativity in the way practitioners engage and work with children

Plans are regularly reviewed and evaluated for progress and impact in reducing risk of harm

There is evidence of management oversight and there is consistency of practitioners

## Requires Strengthening

Ensure that key partners are notified of CST referrals, in particular health colleagues

Improve our use and analysis of data about children, including a better understanding of their health needs

Contingency plans in the Complex Safeguarding Team to manage the impact of staff absence as this can delay support to children

Peer mapping and association maps are underdeveloped; these are important as they support the identification of key people in a child's life

Push/pull factors are identified but the impact of these on current and future risk for children is not always fully explored

Promote language that recognises and is sensitive to children's trauma experiences

Children should not be discharged or access denied to services because they are not taken to appointment

When support from statutory services ends, including CST, it is important to identify who will continue to be a source of support to the child to sustain changes



# Complex Safeguarding

All those who contributed to the scrutiny and assurance have developed their single agency improvement plans. The partnership also identified a number of themes that required a collaborative approach to further strengthen arrangements for safeguarding children :-

- A skilled and knowledgeable workforce who can identify and respond to harm from exploitation at the earliest opportunities
- Effective processes when children need help to keep them safe from exploitation
- Effective practice to identify and disrupt those who exploit children

It is from this evidence base that BSCP have identified their complex safeguarding priorities. Progress against these priorities, as well as seeking assurance from partners on the difference their single agency improvement plans are making, will be evaluated in 2023.

## Complex Safeguarding Priorities

Revise and update the Complex Safeguarding Operating Protocol reflecting learning from BSCP scrutiny and assurance
--

Review and further develop current exploitation screening and assessment tools for use across the partnership
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Further develop the local workforce development offer training from awareness raising through to advanced level incorporating themes identified from BSCP scrutiny and assurance
--

Strengthen the complex safeguarding partnership performance framework
---

Report on the impact and effectiveness of revised disruption arrangements to BSCP
---

Track and review the impact of partners single agency responses to CST audit learning
---

Revise and update the partnership exploitation strategy
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# Tackling Neglect

The experience of neglect during childhood can have significant, long-lasting and pervasive consequences, affecting all aspects of a child's development and their lives into adulthood. It is the most common type of abuse experienced by children and it is increasing in Bolton. Tackling neglect has been a priority for the partnership in 2021, supported by a Neglect Strategy. The strategy had three key aims:-

- Strategic commitment and oversight
- Development of skills and knowledge of workforce
- Helping earlier

This section of the report provides an overview of the progress made and where challenges remain, particularly in the context of an emerging 'cost of living' crisis.

## Over the last twelve months the partnership have:-



- As stated, challenge was offered to Bolton's Children and Young People Board in 2022 as partnership reviews and audits highlighted:-
- As a system there is poor understanding of the prevalence of neglect in Bolton
  - Gaps in sharing information and failing to use information effectively to understand risk
  - Early help is often not being used effectively or not at all when there are indicators of neglectful care
  - A need to strengthen identification and analysis of family ACES and poverty in assessment and intervention

# Tackling Neglect

We know that 2023 is likely to present further challenges to children and their families as the impact of the cost of living crisis fully emerges. The indicators suggest that those families who previously may have 'just' managed may well now struggle to meet the basic needs of their children, and may, through no direct fault, require additional support from services to prevent harm coming to their children. Equally there is the potential that more young people might be at risk of grooming and exploitation given mounting financial pressures.

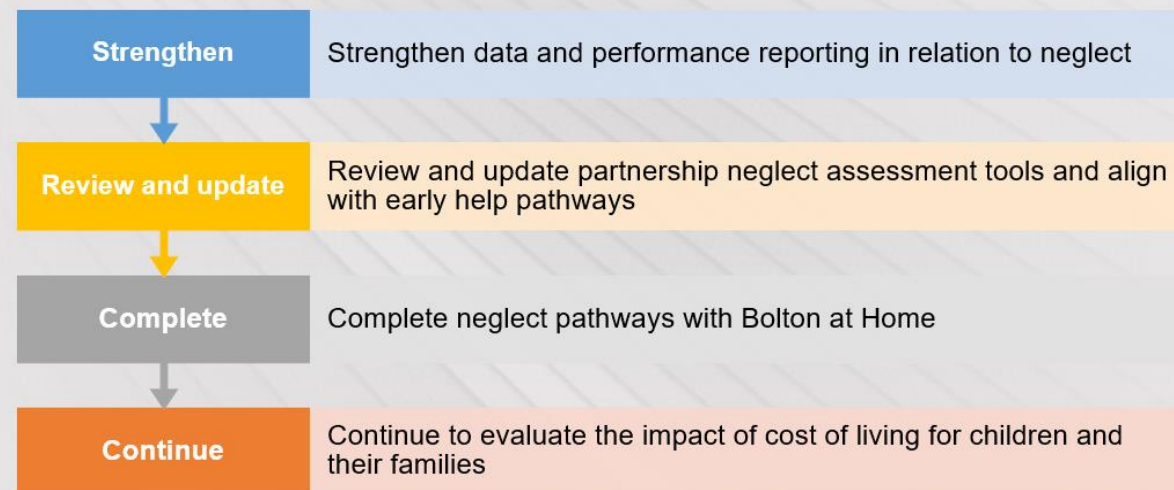
With this in mind, the partnership has responded by working with the 'cost of living' group to give advice and support when creating warm spaces; warm spaces are places where people can gather for free for warmth, refreshments and advice. We have worked with the group to create a 'warm spaces' safeguarding checklist. This means that those leading the warm space remain alert to their responsibilities to safeguard and promote the welfare of children, at the earliest opportunities.

We are also working with Bolton at Home, the largest, local registered social landlord (RSL), to create their neglect pathway. This will support practitioners across their services from UCAN centres to repair's teams to be confident in recognising neglectful care and taking appropriate, timely action. The aim is for this work to be completed and launched in 2023 and to use this model to work with other RSL's in Bolton.

## One young person's 'cost of living' experience

"The greatest impact was on my education. It isn't just missing a meal or feeling hungry during the day, it's the worry of how your sister's school trip will be paid for, or how you haven't seen your mum or dad eat a proper meal in days - all going through your head in a lesson. It creates anxiety and when combined with the stress of school, this explains the impact on educational attainment for children living in poverty."

## For 2023, the focus for neglect will be:-





# Safeguarding Thresholds

There are many reasons for having safeguarding thresholds in place, including helping children and families access help and support at the earliest opportunities and supporting practitioners to provide consistency in their responses. In mid 2021 the partnership launched its revised threshold document, [The Framework for Action](#) and throughout 2022 the partnership have been working with organisation to embed the revised model into their system and processes. We have also sought the views of practitioners in terms of their awareness and use of thresholds document and response to implementation of the revised safeguarding arrangements.

## What's the partnership have done...

- Four partnership briefing sessions with over 400 practitioners, managers and leaders attending from a range of statutory, voluntary and community organisations working with children and adults in Bolton
- Created and launched a single agency training resources for delivery by designated safeguarding leads
- Challenged partners to report to the partnership the work they have completed to embed the arrangements
- Practitioner survey and feedback on the effectiveness of the model

## What practitioners told us is strong...

- *"I think that it's a great tool and the training has made me realise how useful it is. As a teacher this training gave me the opportunity to do that, and I then went home and read it again."*
- *"Very informative and forward-thinking information to take forward in my practice"*
- *Only recently become part of the Safeguarding Team...you have really made things much clearer ...I now feel my confidence in this has dramatically improved.*

## What's practitioner say could be improved...

- Mindfulness about use of jargon and abbreviations for people unfamiliar with this area.
- Further clarification about early help as the number of different roles and sub teams within early help is slightly confusing
- More webinars like this just to keep the knowledge sharp especially if there are any slight changes

# Safeguarding Thresholds

## How Organisations have responded...

- A local large voluntary organisation are working to embed the language from the Framework for Action into daily practice; they have integrated the revisions into training and will be holding workshops with their staff and volunteers
- Bolton Clinical Commissioning Group have held briefing sessions with GPs and include updates in GP newsletter and update the GP safeguarding pathway
- Start Well have attended briefings and worked with private nurseries and other early years providers to ensure continual updates as staffing can change quickly in this sector; they also recognise that some providers are much more confident and competent because they are more familiar with the processes because of the communities they are servicing and the families.

## How Organisations have responded...

- In education the Framework for Action has been well received and the Safeguarding in Education Team have supported embedding the new model within all training, briefing sessions and their termly newsletter
- Probation leaders have briefed their staff on the key changes and worked with social care to further strengthen relationships and referral processes
- Education and Inclusion Service have ensured their staff attend partnership briefings then followed these up with small group single agency de-brief sessions, they have delivered additional briefings in whole team meetings

Over the last year the partnership has continued to focus and embed the thresholds across all aspects of its delivery. However as the workforce continues to change and evolve, and as the national responses to the [Star and Arthur Child Safeguarding Practice Review](#) and the [Independent Review of Children's Social Care](#) there will be a need to actively review our Framework for Action to ensure it remains relevant, fit for purpose and most importantly effective in supporting practitioners to provide children and their families with the right help at the right time from the right people.

# A Safe Workforce

Abuse and neglect can occur within the workplace. It is essential there are clear, consistent and timely arrangements in place to respond to any allegation of abuse made against practitioners working with children. All agencies that work directly with children should have procedures in place for identifying and responding to allegations against staff or volunteers. These should be compliant with the partnership's '[Managing Allegations of Abuse Made Against Adults Who Work with Children and Young People](#)'.

The processes are followed where it is alleged one or more of the following criteria are met, i.e. that a person working with children has:-

- 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 or children in a way that indicates that they may pose a risk of harm to children
- Behaved or may have behaved in a way that indicates they may be unsuitable to work with children

This process is managed in Bolton by the Local Authority Designated Officer (LADO) and it is their role to:-

Provide advice and guidance to employers and voluntary organisations

Liaise with the police, children's social care, other local authorities, and relevant agencies

Manage the allegation process, including chairing the allegation meetings and monitor the progress of the allegation to ensure that it is dealt with as quickly as possible, consistent with a thorough and fair process

Participate in the Bolton Safeguarding Partnership Workforce Development programme



# A Safe Workforce

In 2021/2022 a permanent LADO was appointed and they have promoted awareness across the partnership of their role, the criteria for referral and the local process

Meetings have continued to be held online and this has been beneficial as attendance has been consistently high, enabled agency's from outside the Bolton boundary to attend and be active participants

As expected, when services resumed direct delivery with children there was a noticeable increase in referrals to LADO; 144 in 2021/2022 compared with 89 the previous year

55% of referrals to LADO are resolved with advice, guidance and single agency actions; the remaining 45% required either a multi-agency consideration meeting or a LADO strategy meeting

Working Together 2018 does not indicate any time frame for the conclusion of LADO enquiries. However it is reasonable to expect that these are resolved as quickly as possible to avoid undue stress for all involved. The North West regional LADO group have agreed consistent timeframes to benchmark performance.

74% of LADO enquiries are concluded within three months. Ongoing police investigations and/or agency disciplinary processes are the main reasons as to why enquires go beyond three months.

## **LADO ACHIEVEMENTS**

- Created and implemented a managing allegations information and recording system to support improved record keeping, tracking and reporting in impact from managing allegations arrangements
- Delivered briefing sessions across the multi-agency workforce and to targeted services to increase awareness and strengthen knowledge of managing allegations arrangements, hence the impact of referrals mirroring pre-pandemic levels
- Worked with Bolton Council of Mosques to host a multi-faith event attended by representatives from agencies who work with children to further develop relationships between the faith and statutory sector
- Safer recruitment and managing allegations training to a range of organisations, including Bolton CVS, Bolton University (trainee teachers), headteacher forums, Bolton Wanderers and Bolton Together
- Developed and rolled out a Managing Allegations 'knowledge nugget' for use at practitioner inductions, team meetings as a brief overview of the LADO role and process

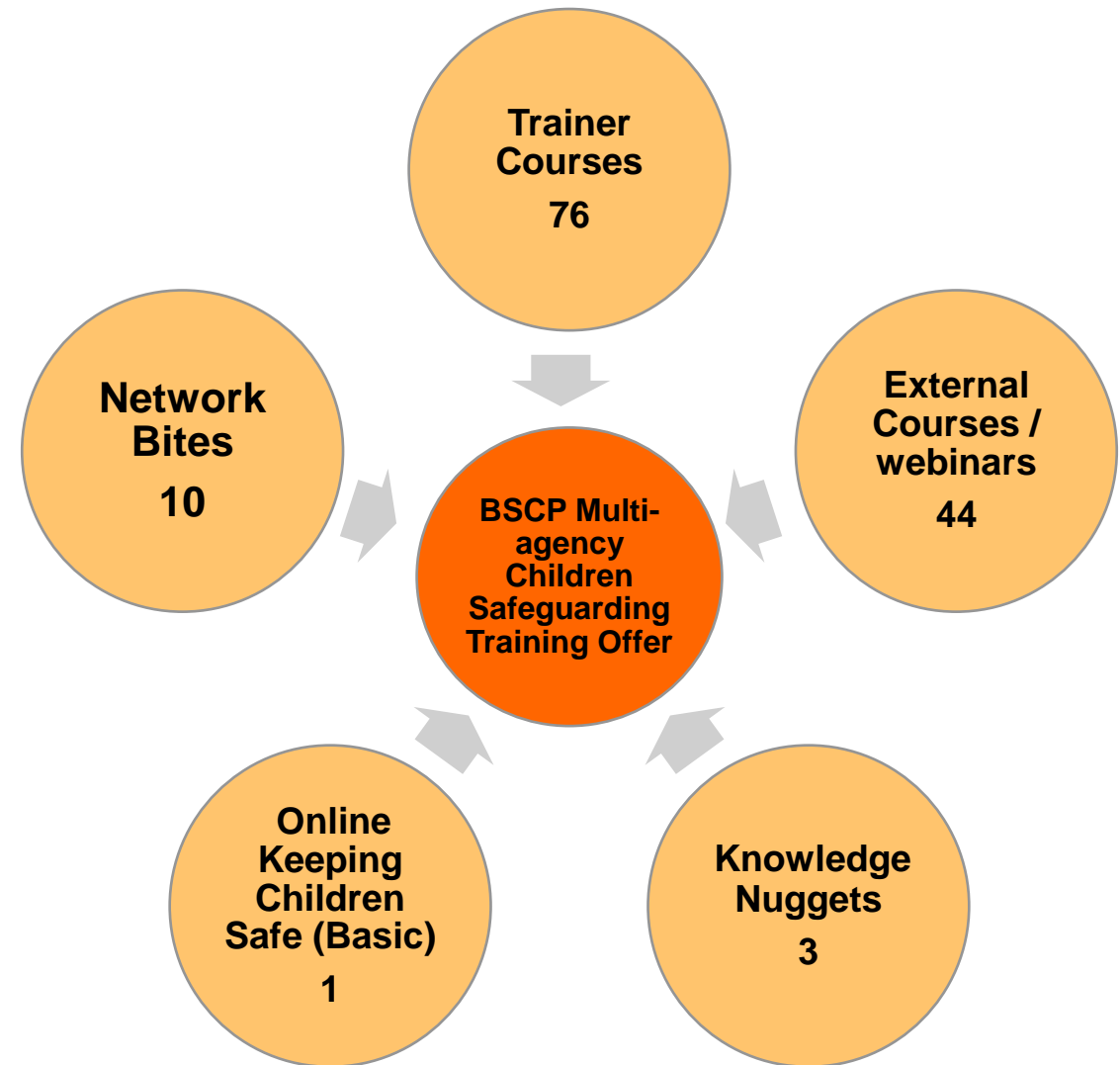
## **LADO DEVELOPMENT AREAS**

- Promoting Safer Recruitment within the Children's Social Care workforce.
- Work with regional colleagues to develop and implement an information campaign to increase awareness of safeguarding arrangements for out of school activities/clubs; working with this sector to ensure consistent standards in safeguarding
- Continuing to develop relationships with the faith sector, including training for Madrassa teachers
- Continuing to develop the Managing Allegations information and recording system to ensure accurate and timely contribution to BSCP

# **A Safer Workforce for 2023**

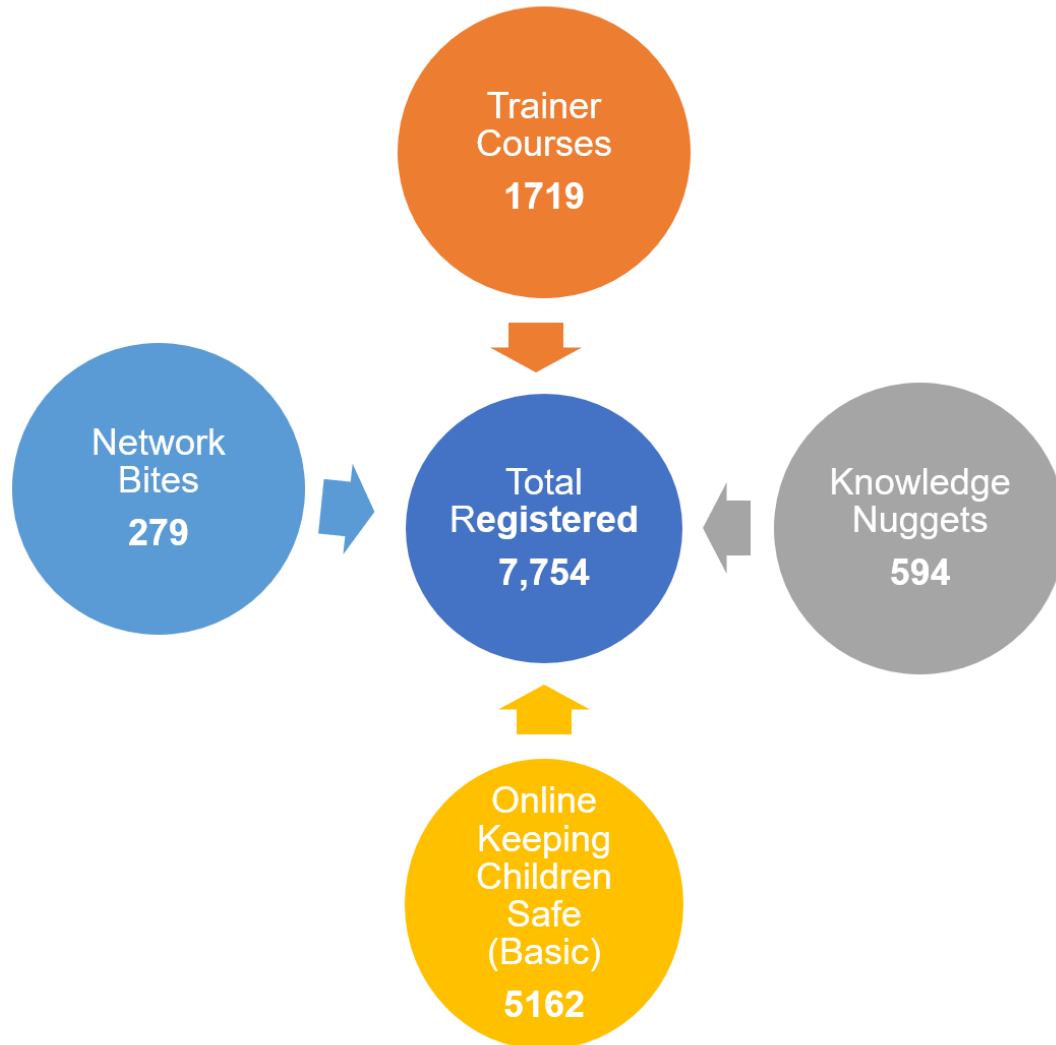
# Workforce Development

- The partnership delivers an extensive training offer and in the last year has expanded the delivery methods to reflect training needs during and post Covid-19 pandemic
- Within the offer there has been a focus on developing and delivering awareness and knowledge in relation to the partnership's priority areas of Neglect, Complex Safeguarding, Safeguarding Thresholds and Processes and Domestic Abuse and Violence
- The diagram provides a broad overview of partnership training activity in across the year-2022; the training is delivered using professional expertise from within the Bolton Family practitioner network, from commissioned sector experts or using online platforms
- New for 2022-2022 was the introduction of 'Knowledge Nuggets' – these are short online videos designed to increase awareness on the specific theme and for use in team meetings, personal development and/or as part of induction into safeguarding arrangements
- 'Network Bites', monthly online webinars, have continued to be an effective method to promote the range of services supporting children and their families in Bolton





# Workforce Development



- The diagram shows the total number of registrations for training and the broken down to its component elements. It is a strength that the training offer attracts such high numbers of delegates
- There has been a slight decline in attendance when compared to 2020-2021; it is suggested that 2020-2021 experienced particularly high attendance as practitioners' usual roles were limited by the pandemic, and this gave time to complete and engage in more training opportunities
- Of the 1719 delegates who registered to attend one of the partnerships training courses, 1328 (74%) attended. Non-attendance is often notified at the last owing to work commitments; all those who do not attend receive a follow-up contact and those who repeatedly book and do not attend are advised that should they fail to attend in future their access to the resource will be impacted
- 99% of the partnership's training is rated as good (24%) or excellent (74%)

# Workforce Development

Analysing the impact of training is inextricably linked to evaluation and audit. Positive impact in the change of behaviour and practice is the most desired outcome of training yet the least able to have commentary or be evidenced beyond the individual's **reaction** to training. In-depth analysis would require significant use of research methods and long-term analysis at several levels including individual, supervisor and the individual organisation, which is not possible within the current resources of the partnership. What we do currently capture are delegates reactions to the training and how they will perceive it will improve their practice. Below are a selection of the reaction statements from a sample of courses:-

## **Child Bereavement**

*"The importance for carers to be honest and not shy away from using the word death. A reminder of the need for honesty alongside nurture and warmth for the process of grieving to take place."*

*"I have learned about Loss oriented and restoration oriented - really liked this concept - very helpful"*

## **Co-ordinated Approach to Children who go Missing**

*"I feel more informed about protocol and understanding the system"*

*"Have new information on outside agencies that have changed over the last years during lockdown."*

## **Domestic Abuse: Children Affected by Domestic Abuse**

*"Different perspectives and using a GP surgery for meetings so it looks less suspicious"*

*"Considerations for safety planning and lesser-known indicators of Domestic abuse and children"*



# Workforce Development

For 2022-2023 the priorities for the multi-agency training resource will be to:-

- Reduce the number of delegates failing to attend courses and increase our attendance rate overall to 85%
- Maintain our high course evaluation rate achieving a minimum of 95% rating as excellent or good
- Further develop our evaluation approach by introducing six month 'follow-up' contacts with delegates to explore knowledge retention and identify to what extent training has supported their practice

# 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. Following the publication of Working Together to Safeguard Children 2018, the partnership revised its practice review guidance 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

In the reporting period the partnership completed four Rapid Reviews and published two completed Child Safeguarding Practice Reviews. The learning from these reviews are summarised in this section.



# Learning from Reviews

## Rapid Review – Child G

Child G was aged 16 years at the time of the review. Child G's family are of Asian heritage and practice the Muslim faith. Child G was exposed to significant Adverse Childhood Experiences (ACEs) whilst in the care of his parents including allegations of sexual grooming. Whilst in foster care he experienced a significant decline in his mental health and was sectioned under the Mental Health Act. On discharge from hospital a few months later he moved to a residential placement. He remained in this home for around five months with a repeat mental in-patient admission during this time. The placement ended suddenly because of significant concerns regarding the care and safety being provided in this home. Another young person, Child L, also lived in the house and they too were subject of a Rapid Review. The learning below is collated from both Rapid Reviews.

### What's worked well in practice...

- Good pastoral care from both children's school, responsive and flexible to their unique needs
- The Local Authority responded swiftly and collaboratively to secure a placement for both children following the closure of their home
- Practitioners worked hard to try and put in place strategies to reduce and manage impact from both children's complex needs
- Both children received good support from their respective GP practice

### What could be better...

- Opportunities for earlier and better co-ordinated multi-agency early help were missed
- On discharge from hospital there was no evidence of multi-agency meetings to review the complex care plans for either child
- There was a range of health services involved but at times the health offer lacked coordination
- Early case formulation for looked after children in order to support practitioners provide consistent trauma care

### Responding to learning...

- Children's services have briefed practitioners and managers to ensure they understand and make timely use of CAMHS consultations and case formulations
- BSCP have shared the learning from the review to support the development of ACE aware/ trauma informed practice
- Childrens Social Care and Childrens Mental Health services are reviewing their arrangements and protocols to ensure effective planning and joint working

# Learning from Reviews

## Child Safeguarding Practice Thematic Review

A Rapid Review was completed in March 2020 in relation to a young infant who suffered serious non-accidental injuries and it was agreed a Local Child Safeguarding Practice Review would be commissioned. The impact of Covid-19 meant there were delays in taking this forward. In the interim period further, Rapid Reviews identified similar challenges for safeguarding practice, and it was agreed to take a thematic approach to this CSPR. The purpose of this review was to explore local practice in relation to three themes: -

- Effective child protection practice; exploring practitioners' knowledge, understanding and confidence in applying local child protection systems and processes, including reflection on escalation and challenge
- Understanding Families; exploring how the system supports assessment and analysis of early life trauma on parents and parenting capacity and its impact on relationships within the family network
- Understanding the lived experiences of the child; in what ways practitioners can better understand and reflect how children see and understand their world when living in a risky environment

The Child Safeguarding Practice Review was published in June 202

## Practitioners told us that it works that practice works well as....

- They can easily access support from the 'front door' of Children's Social Care
- They have an existing rapport and relationship with parents and the skills and confidence to 'hold the difficult conversations'
- They can access to good supervision and time to reflect on how interventions are improving outcomes for the child and their family

## It can be improved by...

- Having local arrangements that support information sharing at the earliest opportunity and feeling confident they understanding information Sharing guidance
- Taking opportunities to better understand a parent's life story, their individual needs and how this may impact on parenting; this enables the right 'adult services' to get involved
- Understanding a family's financial situation
- Staying connected with other practitioners during; having opportunities to meet as a multi-agency group to develop practice and access system expertise
- Agreeing practice standards for child protection to support and promote consistency and confidence across the multi-agency system
- Using the network of practitioners around a child and their more effectively to gain insight into the child's world

# Learning from Reviews; Strengthening System Practice

## **Partnership Information Sharing Project**

One of the key outputs from reviews is to identify persistent or stubborn challenges that inhibit local practice. For Bolton, as it is nationally, a lack of timely information sharing has been a recurrent theme, particularly when practitioners are working together within early help arrangements. Through our work we established that it is routine practice to only use consent as the legal gateway to share information when there are emerging worries about a child or their family. When consent is not given, this then prevents partners from sharing information early to build a comprehensive and holistic picture of a child's needs.

In response a Partnership Information Sharing Project Group was established. Led by our CCG Statutory Partner the group have worked with Information Governance leads in police, health and the local authority to:-

- Review and update the partnership Information Sharing Agreement and associated documents including privacy notice and Data Protection Impact Assessment
- Develop an Information Sharing and Safeguarding Training pack for delivery across the workforce
- Liaise with the National Safeguarding Panel about our proposals to seek their views

The key objective is to create the right conditions to support practitioners be confident in understanding and using the information processing conditions, which allow them to store, and share, the information that they need to carry out their safeguarding role. In 2023 the focus will be on launching and implementing this new approach and leading to culture change in early information sharing across the workforce.

# Summary and Priorities 2023

It can be seen from the 2022 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 2023 will present further challenge to all. The statutory safeguarding partners recognise through their work on reviews, audits and stakeholder engagement that the safeguarding landscape is as complex as ever. The impact of new threats such as the emerging cost of living crisis, as well as a deeper understanding of the full legacy of Covid-19 are adding to this. There is also a need to acknowledge that all partners are experiencing challenges in recruiting and retaining their workforce, increased demand and pressure on resources. There will also be a need to respond to national requirements from national reviews.

It is within this context that the priorities for 2023 are set.



**To launch and implement revised arrangements for information sharing in Bolton**



**To review and evaluate safeguarding arrangements**



**To evaluate the impact of the partnership threshold document**



**To track the impact of learning from partnership audit and reviews**





## 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.

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](mailto:boltonsafeguardingchildren@bolton.gov.uk)**