Manchester City Council
Report for Resolution

Report to: Children and Young People Scrutiny Committee – 10 October 2017

Subject: Annual Report of Manchester Safeguarding Children Board April 2016 – March 2017

Report of: Strategic Director of Children's Services
Julia Stephens-Row, Independent Chair of Manchester Safeguarding Children Board

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Summary

This is a covering report providing an overview of Manchester Safeguarding Childrens Board Annual Report which is for the period from April 2016 - March 2017. This document reports on the work of the partnership.

Recommendations

The Committee is asked to:

a) Note the publication of the Manchester Safeguarding Childrens Board (MSCB) Annual report 2016 – 2017

b) To promote the importance of safeguarding of children and young people across MCC and in the services that are commissioned ensuring that safeguarding is at the heart of all that is delivered.

Wards Affected: All

Contact Officers:

Name: Julia Stephens-Row
Position: Independent Chair of Manchester Safeguarding Children's Board
Telephone: 07449310295
Email: j.stephens-row@manchester.gov.uk

Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

http://www.manchestersafeguardingboards.co.uk/wp-content/uploads/2016/06/MSCB-Annual-Report-2014_15-Published-230316.pdf

http://www.manchestersafeguardingboards.co.uk/wp-content/uploads/2016/10/2016-10-04-annual-report-with-photos-Version-2.pdf

https://www.manchestersafeguardingboards.co.uk/

https://www.manchestersafeguardingboards.co.uk/wp-content/uploads/2016/06/2017-09-28-MSCB-Annual-Report-2016_17-PUBLISHED-v2.pdf

1.0 Introduction

1.1 The Manchester Safeguarding Childrens Board (MSCB) annual report covers the period from April 2016 - March 2017. This report demonstrates the significant amount of work undertaken across a range of organisations and in partnership to safeguard children and young people in Manchester.

1.2 This report contains a variety of information detailing the work of the partners and some of key pieces of work undertaken by the MSCB. It also provides information on the work of the various sub groups which report to the Board, three of which are integrated with the Adults Safeguarding Board.

2.0 Background

Safeguarding Children's Boards are in place across the country and have a legal duty "to co ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area and to ensure the effectiveness of what is done by each such persons or body for those purposes".

Monitoring and evaluating the effectiveness of what is undertaken by the Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve is an important function of the Safeguarding Board. In addition to the various assurance activities carried out throughout the year, such as Section 11 and multi-agency case audits, each Board partner has submitted an assurance statement setting out main developments around safeguarding and work that is ongoing in their agency. **Appendix 1** to this Annual Report sets out the work partners have undertaken during 2016/2017 to ensure that children and young people are safeguarded and to contribute to how this work has contributed to meeting the priorities of the Board.

2.1 Business Priorities

At the beginning of each financial year the MSCB develop a Business Plan setting out its priorities for the coming year. The Annual Report summarises the progress that has been made against these priorities.

Our Priority was: The Board is assured that partners are working together to safeguard children.

The Board and its subgroups have during 2016/17 reorganised our structure and changed how we operate in order to: (i) better focus our work on our key safeguarding priorities; (ii) widen engagement of different partners across the city; and (iii) promote a culture of reflective practice across the partnership.

Our Priority was: Increased awareness in the community and across agencies:

(i) To ensure that children in need of protection are identified and referred appropriately and (ii) To increase awareness of strategies, actions and support that can work to prevent children at risk from significant harm.

The Board has worked hard over 2016/17 to increase awareness of safeguarding risks and guidance for protecting children and young people. In particular, the Board focused on: (i) producing high quality information, guidance, strategies - improving the range of material available to support practitioners, children and families; and (ii) improving the communication and engagement channels so that people can readily access the right information - including an overhauled website and a number of high profile campaigns that took place in the city over the year.

Our Priority was: Ensuring that all partners have a clear understanding of the Serious Case Review referral and decision making process; and that processes for sharing learning and ensuring actions are followed through are in place and monitored:

The Board has embedded improved and robust arrangements for SCR processes, ensuring reviews are effective and timely, and that the learning from reviews is leading to changes in how partners fulfil their safeguarding duties.

Our Priority was: Providing scrutiny and assurance, including regular reporting on the safeguarding performance of partner agencies against the Boards' agreed priorities; ensuring the effectiveness of what is done by Board

The Board scrutinises safeguarding effectiveness in a number of ways including: partner organisations' self-assessments; multi-agency audits of individual cases, which provide a more detailed view of current practice and issues at the frontline; reports on safeguarding effectiveness relating to the Board's key priorities; and the Board's annual assessment of organisations' effectiveness and the follow-up work undertaken in response.

Our Priority was: Developing MSCB Engagement and Support Early Help and understanding of Levels of Need:

Improved reporting around MASH and Early Help during 2016/2017 has enabled the Board to target where improvements can be made and work to embed this has begun (and is continuing into 2017/2018

Our Priority was:

(i) Ensuring the effectiveness of thematic strategies and support in the operational delivery of complex safeguarding and:

(ii) Ensuring that the focus of the impact of Domestic Violence and Abuse on children and young people is enhanced and is in line with the Domestic Violence and Abuse Strategy, with an emphasis on understanding and responding to underlying causes

There has been an improved focus and specific resources have been identified to support the delivery. For example, refreshing the Child Sexual Exploitation and Missing from Care, Home and Education strategies, the training of Early Help staff to recognise and support families were Domestic Abuse is present and Honour Based Violence and Forced Marriage training is planned

Our Priority was: Developing the Neglect Strategy, including using the learning from SCRs where neglect is a significant factor and integrating that learning into the multi-agency training programme.

In May 2016 the Board held a workshop to explore the prevalence of Neglect. As a result a Neglect strategy has been developed and implementation supported by a new assessment tool is taking place.

Our Priority was: Development of a framework to ensure that safeguarding learning and development activity equips the partnership to meet its safeguarding responsibilities; assurance that partners access multi-agency Learning and Development opportunities; and that evaluation of the impact of multi-agency training on practice is carried out. A multi-agency learning and development strategy has been completed. An impact evaluation tool is being used to drive continuous improvement. Almost 1500 practitioners attended face to face training and over 4000 learners completed a range of e-learning modules/

Our Priority was: Assurance that the Child Death Overview Panel (CDOP) are effectively collating child death information and identifying trends and that data is collected and reported in line with statutory requirements.

CDOP have continued to strengthen and consolidate data reporting processes and an analysis of trends is reported to the Board on an annual basis.

Our Priority was: Strategic Relationships - Ensuring the Board is informed of and is involved in planning across partner boards.

Details of the work undertaken to work towards achieving these priorities is contained within the annual report.

2.2 Challenges and Improvement

In addition to the areas identified as priorities in the 2016/2017 Business Plan which are summarised above, other areas of challenge and concern have been identified and addressed by the Board. Some of these are highlighted as follows:

Ensuring consistent attendance at multi-agency Child Protection Case Conferences and Strategy Meetings throughout the partnership Attendance data and existing processes were considered at MSCB and a number of improvements were agreed to both engagement procedures and, where necessary, to partners participation

Children Missing from Education: concerns regarding timescales for children taking up a new school place - a new dataset has been developed by Education to improve identification of any delays and to inform future monitoring;

Need for improved understanding by social workers of educational aspects of autistic spectrum disorder – the need for improved understanding has been progressed between Education and Children's Social Care and reflected in changes to training of social workers in the City;

Transitions – concerns had been raised that existing provision did not cover a range of possible transition points. This has been progressed by Children's Social Care, Adult's Social Care and the Clinical Commissioning Group, and arrangements have been put in place to secure assurance that safeguarding arrangements are in place during transitions

Non-Contact Sex Crimes – following a concern raised by a VCS partner regarding appropriate interagency responses to non-contact sex crimes as a consequence of sexting and indecent explicit image exchange, assurance was sought via Education and Safeguarding in Schools

Child Protection Information Sharing (CP-IS) – Children's Services and Health agencies have been working together to implement CP-IS system during this report year with a view to it being live in the Autumn of 2017

Abusive Head Trauma (AHT) – in March 2017 MSCB considered and agreed a proposal to endorse an innovative new abusive head trauma prevention campaign. Abusive Head Trauma (AHT), also known as Shaken Baby Syndrome, is a devastating form of child abuse often resulting in catastrophic injuries

2.3 Improvement Journey

A programme of improvement has been implemented to target areas for improvement identified through the Ofsted Inspection of Children's Services and of MSCB in 2014. MSCB partnership actions to contribute to the improvement programme have been agreed both through MSCB Leadership Group and through the Board.

Over the last year I consider that there is evidence of stronger multi-agency partnership working which is learning to accept positive challenge and use this to bring improvements in services for children and young people. The review of Board membership has ensured that the right strategic representatives are engaged across partner organisations and so we are more effective at cascading messages across the partnership. The MSCB Leadership group provides a good sounding board and an opportunity for subgroup chairs to meet together, monitor the business plan and make recommendations to the Board.

We have reviewed the impact of the Early Help offer, evaluating its effectiveness in terms of partner agency contributions and the impact on social care contacts and referrals.

We have strengthened our Serious Case Review process, ensuring that cases are appropriately reviewed in a timely and consistent manner; we are also improving the way in which we monitor improvements which have been made in response to SCR recommendations, to make sure that the review results in positive changes to practice; we are developing a rolling programme of learning events, to ensure that frontline practitioners also get the opportunity to benefit from SCR learning. Our training offer is comprehensive, is valued by attendees and we are working hard to ensure that we can measure the impact that multi-agency training is having.

For MSCB, all improvement plan actions have been completed. Visits to other LSCBs to learn from good practice as well and involvement in a Peer Review exercise in July 2017 have also taken place.

2.4 Priorities for MSCB 17/18

Towards the end of the 2016/2017 period, MSCB began the process of planning its vision and priorities for the 2017/2018 year. As part of this preparation, the Board felt very strongly that the views of children and young people should be sought and a short questionnaire was set up on the Safeguarding Boards website and promoted through both the Board and through individual agencies. Some focus groups were also held by partners with young people to gather views.

In early April, a Visioning and Priority Setting Event was held and partners came together to review what progress had been made during the year and identify what challenges remain on our improvement journey. There was also an opportunity to consider the factors, legislative, financial and others - that will have an impact in the forthcoming year.

The responses from the survey of young people were shared at that event and partners were able to analyse the findings and use them to help inform a picture of what the next year should bring for MSCB in terms of priorities. The priorities identified for 2017/18 are:

- Engagement and Involvement – listening and learning; hearing the voice of children
- Complex Safeguarding – Domestic Violence and Abuse; Female Genital Mutilation; Sexual Exploitation; Radicalisation; Missing; Organised Crime; Trafficking & Modern Slavery; So-called Honour Based Violence
- Transitions – Moving from child to adulthood in a safe and positive way
- Neglect – Ensuring the basic needs of every child are met.

3.0 Conclusion

The work and reach of the MSCB, as evidenced in this report is considerable, however there is much more to do if as a partnership we are to achieve the vision of the MSCB that ***Every child and young person in Manchester should be able to grow up safe; free from abuse, neglect or crime; so***

allowing them to enjoy a happy and healthy childhood and fulfil their potential.

Manchester Safeguarding Children Board

Annual Report 2016/17

"Every child and young person in Manchester should be able to grow up safe; free from abuse, neglect or crime; so allowing them to enjoy a happy and healthy childhood and fulfil their potential."

MSCB
MANCHESTER SAFEGUARDING CHILDREN BOARD

Published: September 2017

Remember Our Humanity – by '*The Group*'

Our lives can be like a rollercoaster.
Torment or the greatest opportunity.
We get given transience when all we want is stability.
This artificial family could mean belonging, could mean insecurity – we remain unaware.
Resilience is the buzzword in the lottery of care.

Finding safety in new roots.
Finding trust in new life's branches.
But what happens when the bough breaks?
Where does the cradle fall?
So many eyes, but nobody sees
The externally monitored remain invisible internally
Blind and blinkered for red tape and dotted lines
Can't spy the forest for the trees – too many unaware
Overcrowding gets you lost in the lottery of care.

Stigma predicts failure
Vulture like she circles
Expectant of damage and inability –
What news for our equality?
We hope. We demand. We strive
That you see past our vulnerability,
see beyond old case notes, scrawled files – you must be aware
individuals we remain in the lottery of care.

Now we stand. We stand together.
Not numbers in the bingo.
Not scratched out gamblers' cards.
Our lives are not a lottery.
Care is no betting game.
Remember our humanity
And see all people free from shame.

The poem above was written by 'The Group', Manchester's Children in Care Council. 'The Group' by sharing their own care experience and representing the voice of other looked after young people bring influence and challenge aimed at recognising strengths and improving practice and service to young people. A young person with Care Leaver experience shared this with the board in October 2016.

Foreword

I took up the role as the Chair of the Manchester Safeguarding Children Board (MSCB) in July 2016 and I would like to thank the partners, many of who have been working on this agenda for some time, for demonstrating over the last year their enhanced emphasis on ensuring that safeguarding children and young people is at the forefront of their work.

This annual report contains a range of information detailing the work of partners and some key pieces of work undertaken by the MSCB; including case audits, training and strategies that have been adopted, including Neglect, Missing from Care and Home and Education. We have provided an overview of the performance and effectiveness of the safeguarding system as a whole, the challenges that we are facing and information about the steps we are taking to address them.

There are seven subgroups of the MSCB, which drive forward the work of the board and I am grateful to all those who chair and sit on these groups. Three of these subgroups Complex Safeguarding, Learning and Development and Communications and Engagement are joint with the Adults Safeguarding Board, demonstrating the overlapping agendas. This has been further evidenced by the development of our shared business plan and priorities for 2017/18 of Communication and Engagement; Neglect; Transitions and Complex Safeguarding.

As a Board we need to do more to give a voice to and engage with children, young people and their families. As part of 'Our City Our Say' we have made a start by canvassing the views of young people when we were setting our priorities for this coming year; and we have started to get a sense of how partners capture the voice of the child as part of this year's self-assessment; however we need to do more to capture the impact of this.

Looking forward, following legislation that Local Safeguarding Boards are to be replaced, we need to be planning how the multi-agency safeguarding arrangements are to be established in the future. It will be vital to ensure that developing these new arrangements does not cause any instability and that we are creative and embrace the new opportunities whilst keeping the safeguarding of children and young people at the forefront of this change.

The vision of the Manchester Safeguarding Children Board is that "Every child and young person in Manchester should be able to grow up safe; free from abuse, neglect or crime; so allowing them to enjoy a happy and healthy childhood and fulfil their potential". This supports the Manchester Vision for children and young people and the principles of 'Our Manchester'. I am committed to leading the Board to achieve this vision and keeping safeguarding at the heart of everything that we do.

Julia Stephens-Row
Independent Chair of Manchester Safeguarding Adults and Children Boards
August 2017

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This Annual Report should be read in conjunction with the Supplement containing Partnership Reports.

1. Executive Summary

April 2016 to end of March 2017, the period covered by this Annual Report, has been a busy and productive period for the Manchester Safeguarding Children Board (MSCB). Progress has been made against all priorities set out at the beginning of the year in the 2016/17 Business Plan and the Board has identified and addressed areas of challenge relating to individual and multi-agency safeguarding arrangements. The Board have progressed a number of Serious Case Reviews.

Manchester has a large and growing child population, currently estimated to be 126,000 children and young people (aged 0-18). The population is growing by around 2% per year, in part fuelled by new arrivals; 2016/17 saw 3,648 school age children arriving in the city.

It is also a very diverse population with 49% of children and young people under 18 being from an ethnic minority background. The 2016 school census recorded over 190 languages being spoken in the city's schools; and the percentage of pupils recorded with English as an additional language rose from 23.5% in 2005 to 38.5% in 2016.

Despite strong economic growth over the last ten years, improvements in education and housing, and a falling number of children growing up in poverty, there remain a number of key risks to the welfare of children and young people in our city. There are still areas of intense deprivation, where outcomes are poor and daily life is a struggle:

- 66% of households with children are classified as having one or more element of deprivation;
- On the Income Deprivation Affecting Children Index, Manchester is ranked fifth, making it much more deprived on this index than the other Greater Manchester districts;
- Child poverty (defined as a household with children under 16 where income is less than 60% of the UK median) levels are falling but remain high at 35.5%.

Health outcomes for children and young people are generally poor across the city, particularly oral health and obesity:

- 41% of children aged five years in Manchester had one or more decayed, missing or filled teeth compared with 28% nationally;
- One in four reception class children in Manchester were categorised as overweight or obese; 40.3% Year 6 children were overweight or obese in Manchester.

Manchester's Joint Strategic Needs Assessment provides a comprehensive overview of the health issues affecting children and parents.

There are more specific areas of concern where children and young people are in need of safeguarding support and protection. These areas are where the MSCB focuses much of its work.

The Annual Report 2016/17 summarises the work of the Board during that period and offers an analysis of progress against priorities that were identified in the 2015/16 Annual Report and safeguarding practice and arrangements in Manchester. 2016/17 has seen the introduction of a Manchester Safeguarding Boards Complaints Procedure implemented as part of our Improvement Programme and we are pleased to report that no complaints have been received during the time period.

Monitoring and evaluating the effectiveness of what is done by the local authority and their Board partners individually and collectively to safeguard and promote the welfare of children, and advising them on ways to improve, is an important function of the MSCB. In addition to the various assurance activities carried out throughout the year, such as Section 11 and multi-agency case audits, each Board partner has submitted an assurance statement setting out their main developments around safeguarding and work that is ongoing in their agency.

A supplement to this Annual Report sets out the work partners have done during 2016/17 to ensure that children and young people are safeguarded and to contribute to the shared priorities of the Board.

2. Statutory Framework for the MSCB

Section 14 of the Children Act 2004 and Working Together to Safeguard Children 2015 sets out the statutory objectives and functions for an LSCB as follows:

1. To coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
2. To ensure the effectiveness of what is done by each such person or body for those purposes.

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out that the functions of the LSCB, in relation to the above objectives under section 14 of the Children Act 2004, are as follows:

(a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

(i) the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;

(ii) training of persons who work with children or in services affecting the safety and welfare of children;

(iii) recruitment and supervision of persons who work with children;

(iv) investigation of allegations concerning persons who work with children;
(v) safety and welfare of children who are privately fostered;
(vi) cooperation with neighbouring children's services authorities and their Board partners;
(b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;
(c) monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;
(d) participating in the planning of services for children in the area of the authority; and
(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

Regulation 5 (2) which relates to the LSCB Serious Case Reviews function and regulation 6 which relates to the LSCB Child Death functions are covered in chapter 4 of the guidance. Regulation 5 (3) provides that an LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

In order to fulfil its statutory function under regulation 5 a LSCB should use data and, as a minimum, should:

- assess the effectiveness of the help being provided to children and families, including early help;
- assess whether LSCB partners are fulfilling their statutory obligations set out in chapter 2 of this guidance;
- quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned; and
- monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

In 2015/16 the government issued additional guidance to all LSCBs in respect of radicalisation and extremism which needs to be recognised as a safeguarding issue and should be included in the quality assurance work undertaken by the Board.

Additionally the government contacted all LSCB Chairs and the Chief Executives of local councils in 2015 following publication of the independent Alexis Jay Report into Child Sexual Exploitation (CSE) in Rotherham (2013/16) reinforcing the importance of ensuring robust responses to CSE.

3. Voice of the Child

The MSCB is committed to listening to the voice of the child and improving engagement with children and young people in all aspects of its work.

This has included measures to involve children and young people in the business of Board meetings where appropriate and of value to children and young people. For instance, at a Board meeting when a report on looked after children was being considered a representative of 'The Group' (Manchester's Children in Care Council) was invited to attend the meeting and take part in the discussions. The young person also shared a poem written by The Group: *Remember our Humanity* which is reproduced at the front of this annual report. The MSCB has made a commitment to keep in mind the spirit of what is expressed in this poem when conducting all its business.

A Communications and Engagement subgroup has been established and a revised Communications and Engagement Strategy agreed, putting engagement at the heart of the work of the MSCB.

All reports coming to the Board and all subgroup progress reports now require information to be included to demonstrate how the work being described will impact on the lives of children and young people. The Board has also increased its number of Lay Members from one three to bring a more 'grass roots' perspective to the work on safeguarding children; to 'think as a member of the public'; and to play a part in the oversight and scrutiny of decisions and policies made by the Board. Each Lay Member has been allocated a link Board Member to support their participation in the work of the Board.

As part of the MSCB's revised Section 11 arrangements, partners are asked to provide assurance on how they are ensuring the voice of the child, parents and staff is incorporated into their safeguarding arrangements.

Towards the end of 2016/17, the MSCB began planning and developing its vision and priorities for 2017/18. As part of this work, an online survey of children and young people was created on the Manchester Safeguarding Boards website to seek their views on what made them feel safe and unsafe. The responses from this survey were then shared with Board members and the wider partnership at our Visioning Event and have directly fed into the priority setting process for 2017/18.

The MSCB has provided a consultative scrutiny role during the development and launch of the Children's Services 'Our City Our Say' Strategy aimed at strengthening the voice and influence of children and young people in Manchester. Board members were invited to feed into the consultation process for the strategy and the draft document was brought to MSCB for scrutiny and sign-off. The aims of the

strategy are that children and young people are involved in the decisions that affect them; that we focus on the rights, needs and wishes of children and young people; that we share decision making powers with them; that we provide good quality opportunities for children and young people so they can get involved in their communities and develop life skills; and that Manchester is a good place and a safe place for children and young people to grow up in.

Practice examples:

- As part of the continued development of the Pennine Acute Trust (PAT) Children and Young People (CYP) Participation and Engagement Strategy, the CYP Engagement Group are establishing links with different school councils and groups, community groups and established groups for children with chronic illness. This allows the Trust to update CYP on developments within the Trust, include CYP on interview panels and comment on particular areas of work of the Trust.
- With colleagues from the University of Huddersfield, PAT and the children from Pike Fold Community School designed a two hour 'Getting it Right' radio show that was broadcast on 15 February 2017 via Roch Valley Radio.
- Children in private foster care placements now receive improved advocacy services via Coram Voice, who deliver this service on behalf of the local authority.

4. Progress against our Business Priorities

At the beginning of 2016/17 the MSCB developed a Business Plan setting out its priorities for the coming year. This section of the Annual Report summarises the progress we have made against our priorities.

4.1 Our Priority was: the Board is assured that partners are working together to safeguard children.

The Board and its subgroups have, during 2016/17, reorganised their structure and changed how we operate in order to: (i) better focus our work on our key safeguarding priorities; (ii) widen engagement of different partners across the city; and (iii) promote a culture of reflective practice across the partnership.

We have:

- Reviewed the Board structure and refreshed the terms of reference for each subgroup in order to ensure there is clarity of purpose and that the work of the subgroups is aligned to Board priorities and focussed on delivery of them. Subgroups are now chaired by a range of agencies including Health, Police, Voluntary Sector and Children's Services.
- Replaced the former Executive with a refreshed Leadership Group that is leading and driving forward the Board's work. Importantly, each subgroup Chair now attends this group and is supported and held to account for the work of their subgroup and the delivery of Board Priorities.
- Ensured regular subgroup reports to the Leadership Group and Board are now built into the monitoring cycle and are focussed on *'What is working well? What is the subgroup are worried about? What needs to happen? Next Steps and What is the impact of the subgroup work?*' This approach is ensuring there is a strong focus on partnership working and most importantly its impact on safeguarding practice and arrangements.
- Put in place a Business Plan that defines what the Board intends to do to seek assurance and improve safeguarding for children across the City. The Business Plan gives the Board and its partners an improved sense of purpose and direction in relation to what needs to be done and why it is important. A risk register is in place to manage any risks relating to the delivery of the Board business plan, the nature of the risk and how we might mitigate against it. The Business Plan and Risk Register are overseen by the Leadership Group.
- Developed a Challenge and Impact Log so we can better understand and analyse challenges presented in relation to safeguarding practice and arrangements; the required response; and

the evidence of the impact this has had on practice and arrangements. Self-assessment activities were undertaken, including: a desk-top review; one to one interviews with key partners; and an online survey of the wider partnership.

- Actively pursued wider engagement in the Board and its work with the Voluntary and Community Sector (VCS), schools and Lay Members. This was important because the Board needs to be representative of the children's workforce in order to ensure there is wider understanding, influence and impact on the wider safeguarding system. We have achieved improved schools contribution and we have successfully recruited Lay Members. Representation from the VCS has been inconsistent and we will continue to focus on this during 2017/18.
- Integrated the Manchester Safeguarding Children Board and Manchester Safeguarding Adults Board (MSAB) business unit.
- Brought together the Complex Safeguarding subgroups and Learning Development subgroups; and created a joint Communications and Engagement subgroup. This has enabled us to have a greater focus and impact on cross-cutting safeguarding issues affecting children and adults in Manchester. Alongside this, there have been joint events focusing on Domestic Violence and Abuse; Prevent; Serious Case Reviews (SCRs); Safeguarding Adult Reviews (SARs); and learning from Domestic Homicide Reviews.
- Secured Partner contributions to ensure the Board's funding arrangements can deliver on plans and priorities.

Practice Examples:

- Education has a wide range of communication with schools and other partners, including quality assurance visits, ongoing projects, circular letters, network meetings, head teacher briefings, governor briefings. Over the past year, with the input of the Independent Schools MSCB representative, there has been a focus on improving engagement with independent schools around safeguarding.
- The Strategic Housing Access Manager represents social housing registered providers on the MSCB and messages from the Board are relayed to the registered providers via the Safeguarding Champion for each provider.
- Greater Manchester Mental Health Trust Foundation routinely shares information with a range of health professionals including GPs, Health Visitors, School Nurses and Midwives to ensure the best outcomes for children and young people.

4.2 Our Priority was: increased awareness in the community and across agencies.

(i) To ensure that children in need of protection are identified and referred appropriately; and

(ii) To increase awareness of strategies, actions and support that can work to prevent children at risk from significant harm.

The Board has worked hard over 2016/17 to increase awareness of safeguarding risks and guidance for protecting children and young people. In particular, the Board focused on producing high quality information, guidance, and strategies by improving the range of material available to support practitioners, children and families; and improving the communication and engagement channels we use, so that people can readily access the right information. This work has included a new website and a number of high profile campaigns which took place over the year.

Our work has encompassed:

- The development of an integrated Manchester Safeguarding Boards website, which has been successfully launched and promoted. The website is now easier to navigate and search; it has dedicated areas for the different groups who may use it i.e. children and young people; families and friends; and practitioners, including volunteers; and provides a range of advice and guidance.
- The website provides clear information about all safeguarding matters including what abuse is and what you should do if you are worried about a child or young person. It incorporates a Learning Hub (with links to Face to Face and Online Training resources, information on Learning from Practice and Communications and Engagement). There is also a Resource Hub providing guidance on the Multi-agency Levels of Need and Response Framework, access to a range of MSCB business documents and forms, as well as a resource for General Practitioners. The site is also a gateway to the full range of policies and procedures of both Manchester City Council and the Greater Manchester Safeguarding Partnership, of which MSCB is a member. The site will continue to be developed throughout 2017/18 to make it an even better resource and there are further plans for a member's only section for more sensitive information.
- We have refreshed the Manchester Safeguarding Children Board Safeguarding Standard to which all providers and commissioners of services for children and young people in Manchester are expected to adhere.
- A series of easy read 7 minute briefings have been introduced and circulated to board members and the wider workforce. Topics have included: Female Genital Mutilation (FGM) including Mandatory Reporting Requirements and 'Claire's Law' Domestic Violence Disclosure Scheme.

- The Board participated in the development of the Our City Our Say Strategy which is aimed at strengthening the voice and influence of children and young people in the city around four themes:
    - Decision Making;
    - Choices and Rights;
    - Improving Services; and
    - Shaping Communities.
- Our Communications and Engagement Strategy has been produced, agreed and implementation started.

Our focus going forward will be to build on these resources and embed their use across the partnership as valuable tools for learning and communication.

Practice Examples:

- The Healthy Schools Team launched the 'I Matter' curriculum in October 2016. This is a preventative safeguarding resource which aims to develop young people's knowledge, skills and attributes to identify and manage risk to keep themselves and others safe. School staff and over 500 students were involved in the pilot.
- Following an external review of safeguarding provision, University Hospital South Manchester (UHSM) made a commitment to further improvements. This has led to the introduction of a new Head of Nursing for Safeguarding post to support the leadership of safeguarding across the Trust.
- Greater Manchester Mental Health Trust (GMMHT) have tapped into their experiences of adult services to highlight the importance of effective communications by practitioners in affecting the perceptions of users. When things are explained as a routine part of planning care to benefit the individual and their wider family, information is generally received positively.

4.3 Our Priority was: ensuring that all partners have a clear understanding of the Serious Case Review referral and decision making process; and that processes for sharing learning and ensuring actions are followed through are in place and monitored.

The Board has embedded improved and robust arrangements for the Serious Case Review (SCR) process; ensuring reviews are effective and timely, and that the learning from reviews is leading to

changes in how partners fulfil their safeguarding duties. Section 6.7 summarises the particular issues from the individual reviews progressed during the year.

We have:

- Refreshed the Serious Case Review Referral Form and screening thus supporting timely referrals; improved information sharing and analysis of practice; informed decision making; and aiding the commissioning of reviews.
- Put a Learning and Improvement Framework in place which has been shared across local organisations who work with children and families. The purpose of the framework is to enable organisations to be clear about their responsibilities; to learn from experience and improve services as a result. Continuous development and improvement in safeguarding practice and services remains a central part of our work.
- Invested considerable time and effort in improving arrangements for commissioning Serious Case Reviews in order to ensure that there is clarity about the required review model; commissioning is consistent with the agreed 'MSCB/MSAB Manchester approach'; that the appointed lead reviewer has the experience and knowledge required for the particular review; and that there is improved transparency about our expectations.
- A joint SCR/SAR (Safeguarding Adults Review) workshop for Board members and the wider partnership, attended by approximately 55 partners, was held in September 2016 and provided both an overview of the SCR and SAR process and a briefing on producing chronologies and use of the *Chronolator* software utilised by the MSB Business Unit.
- Serious Case Reviews are now robustly tracked via a tracker that maps out each stage of the process and the progress being made.
- Meeting timetables are aligned to allow sufficient capacity for consideration of draft and final version reviews and agreeing next steps.

Practice Examples:

- SCR learning is shared with the Housing Safeguarding Champions and at the Connecting People work stream of the Manchester Housing Providers Partnership (MHPP) where particular focus is given to housing and its role.

- UHSM have incorporated initial learning from SCRs that they are involved with into training delivery to ensure practice is improved.

- The CCG Designated Safeguarding Team ensures that they have key findings and learning from children and adult reviews are shared with primary care and the CCG. The learning from the

reviews informs the operational plan for the coming year in terms of priorities.

- Pennine Acute Trust disseminate learning from SCRs via bulletins. This year this has included: awareness of caring responsibilities; the heightened risk that can present where mental health problems, alcohol and substance misuse and domestic abuse combine.

4.4 Our Priority was: providing scrutiny and assurance, including regular reporting on the safeguarding performance of partner agencies against the Boards' agreed priorities; ensuring the effectiveness of what is done by Board.

The Board scrutinises safeguarding effectiveness in a number of ways including: partner organisations' self-assessments (Section 175 audits); multi-agency audits of individual cases, which provide a more detailed view of current practice and issues at the frontline; reports on safeguarding effectiveness relating to the Board's key priorities; and the Board's annual assessment of organisations' effectiveness and the follow-up work undertaken in response.

We have:

- Completed Section 11 audits and held challenge sessions led by the Independent Chair and with the involvement of all partners. The findings of this are explored further in Section 6-8 Safeguarding Assurance.
- Undertaken Section 175 audits in 110 (61%) of schools and the findings and action plans shared; these will be monitored by the Quality Assurance and Performance Improvement (QAPI) subgroup. This is explored further in Section 6-8 - Safeguarding Assurance.
- Continued the rolling multi-agency Case File Audit Programme in a timely manner, with four audits taking place and individual and multi-agency learning and actions being shared and tracked by the QAPI subgroup. During the period April 2016 to March 2017, the following multi-agency audits were completed:
    - MASH and Early Help
    - Looked After Children Missing From Home
    - Child Protection and Core Groups
    - Child Sexual Exploitation.
    - Further information on the findings of the multi-agency Case File Audit Programme can be found in Section 6-8 - Safeguarding Assurance.

- Regular reporting expectations and increased scrutiny on strategic areas of high importance– such as Early Help, Domestic Violence and Abuse, Neglect, Child Protection Conferences and Strategy Meetings. The Board has also been able to act promptly in responding to areas of concern that have presented such as reported increases in use of 'Spice' and the potential increase in vulnerable asylum seekers.

Practice examples:

- The Public Health Team works with partners to identify learning from the audit programme to inform and improve practice. This includes ensuring that providers of commissioned services are aware of the findings and implement recommendations during formal quarterly performance monitoring meetings.

- Following inspection in 2016, safeguarding provision for 16 and 17 year olds at UHSM was identified as a potential concern. Since then, the safeguarding children's team have developed a 'snap shot' training package and completed a 'voice of the child' audit with 16 and 17 year olds. A thematic conference was held in September 2016 which was well attended by partner agencies and addressed issues such as Child Sexual Exploitation, emotional difficulties faced by young people and capacity to consent to treatment.

4.5 Our Priority was: developing MSCB engagement and supporting Early Help and the understanding of Levels of Need.

Improved reporting around MASH and Early Help during 2016/17 has enabled the Board to target where improvements can be made and work to embed this has begun (and is continuing into 2017/18).

We have:

- Recommended that the multi-agency design and delivery MASH Task and Finish Group report progress and recommendations to MSCB.
- Agreed a recommendation to review the referral pathway for domestic violence and abuse so that it aligns better with Early Help; and that a 'consultation line' for professionals be provided by the MASH.
- Agreed a recommendation that Early Help Hubs coordinate problem solving sessions for cases which are stuck or potentially escalating.

- Analysed the issues around the need to increase agencies understanding of the levels of need and agreed a refreshed multi-agency referral form that better reflects the levels of need and requires agencies to provide information on early help interventions that have been offered.
- Forged better links between the work of the Manchester Children's Board and the MSCB, including attendance at the Children's Board by the Independent Chair and six monthly progress reports on the work of the Children's Board being timetabled in the MSCB work Plan. The MSCB also provided input and scrutiny of the Children and Young People's Plan 2016-2010.
- Increased reporting and scrutiny of MASH and Early Help by ensuring that partners are made aware of current data, trends and challenges and can explore how best they can make improvements in their own agencies to embed Early Help and make sure that the right services are made available to children and young people at the right time.
- Included Early Help data on the MSCB Performance Scorecard. Improvements in the use of data is providing a greater understanding of take up by agencies and allowing progress to be measured.

Practice Examples:

- There are now specialist Greater Manchester Police officers embedded within each Early Help Hub to maximise partnership working opportunities, and early help is now included in the training programme for new recruits and within refresher training for all front line staff.

- The Clinical Commissioning Group (CCG) Safeguarding Team completed a scoping exercise to map out the provision of health services across the city to support the Levels of Need and Response Framework. Subsequently, a new delivery model was developed and implemented to ensure that health provision meets the needs of the MASH and Early Help Hubs.

- CMFT has established an Early Help subgroup within the Trust to raise the profile of the early help agenda and improve strategic and operational working. There is representation from community, acute and midwifery services.

- A multi-agency approach to Early Help has been embedded over three sites in the City in the form of the Early Help Hubs. The service is well embedded and a session with partners is planned to reflect on its progress from a multi-agency perspective.

4.6 Our Priority was:

(i) ensuring the effectiveness of thematic strategies and support in the operational delivery of complex safeguarding; and

(ii) ensuring that the focus of the impact of Domestic Violence and Abuse on children and young people is enhanced and is in line with the MSB Domestic Violence and Abuse Strategy with an emphasis on understanding and responding to underlying causes.

MSCB had two separate priorities on Domestic Violence & Abuse and Complex Safeguarding in 2016/17. These incorporated the wider vulnerabilities such as Honour Based Violence and Female Genital Mutilation (FGM) that are covered by the Manchester Delivering Differently Domestic Violence and Abuse Strategy 2016 - 2020. As some of the vulnerabilities around complex safeguarding and domestic violence and abuse are cross-cutting, progress on both priorities has been summarised below.

Manchester has higher rates of domestic violence and abuse compared to other core cities. A total of 3,308 victim-based crimes reported across the city between April 2013 and March 2014 were flagged as domestic abuse – an increase of 7.3% on the previous year. Domestic violence and abuse is also prevalent in child protection work, being a factor in around 40% of Child and Family Assessments according to Manchester's Joint Strategic Needs Assessment (JSNA). Nationally, research demonstrates the serious risks children face; for example 62% of children living in domestic abuse households are directly harmed; and a quarter of children in high risk households are under three years old.

Through the work of the MSB Domestic Violence and Abuse Strategy, launched in early 2016, and the accompanying JSNA Topic Report, Manchester now has a much better understanding of the prevalence of domestic abuse, the key points from research and the priorities for safeguarding going forward.

The focus and work of the MSCB over 2016/17 has been to support:

- Raising awareness of the prevalence of Domestic Violence and Abuse (DVA). As part of this, the MSCB and MSAB held a joint workshop in June 2016 that focused on increasing awareness, exploring prevalence and patterns across the city and agreeing next steps.
- Training of 230 Early Help Hub staff in a new curriculum for domestic violence and abuse.
- Ensuring domestic violence and abuse interventions are part of the new Family Resource Intervention Framework for key-workers in Early Help.
- Adult Safeguarding in Manchester City Council (MCC) to fund two additional Independent Domestic Violence Advisor (IDVA) posts in the North and South Manchester hospitals to ensure a consistent DVA response in all three midwifery units in the city.

- The joint funding by MCC and the Police and Crime Commissioner of a Lesbian Gay Bisexual and Transgender (LBGT) IDVA post covering the Greater Manchester area.
- The Black Minority and Ethnic complex needs worker post within the Saheli project.
- Extension of the Early Help and prevention project working with families who wish to remain in a relationship.
- The successful bid to the Department for Communities and Local Government (DCLG) from the Violence Against Women and Girls funding to deliver a specific LGBT Domestic Violence & Abuse dispersed project, linking in with Brighton and Hove and the London Tri borough.
- Honour Based Abuse and Forced Marriage training to be delivered to 360 staff.
- An IDVA role based in the new Adult MASH to carry out a duty function on behalf of the wider IDVA service which works with children and adults.
- The MSCB/MSAB Best Practice Plan agreed in February 2017, so ensuring that all partners operate a shared and consistent approach.
- Sharing and embedding learning on domestic violence and abuse. Domestic Homicide Reviews (DHRs) are now routinely built into the MSCB Work plan, thus ensuring that learning from DHRs is shared and understood by partners and that actions the MSCB can contribute to are carried out.
- Scrutiny of the progress made by the Domestic Violence and Abuse Forum, which was set up to take forward the priorities set out in the strategy. The Forum updates the MSCB at least twice a year. Partners are demonstrating a high commitment to contributing to this work

Complex safeguarding refers to a number of different risks:

1. Child Sexual Exploitation (CSE)
2. Children missing from home, care or education
3. Gangs and violence
4. Modern Slavery and trafficking
5. Radicalism and extremism
6. Female Genital Mutilation (FGM)
7. Honour Based Violence and Forced Marriage.

Historically these risks have tended to be addressed individually, but they are increasingly intertwined and there is work ongoing to understand the interrelation further, as well as develop new models to tackle complex safeguarding. The MSCB and its partners have changed their approach accordingly, with a number of developments taken forward over 2016/17.

- The Complex Safeguarding subgroup was refreshed to coordinate work around the above areas, following a clear work plan. The group has been integrated since January 2017 and serves both

the MSCB and MSAB, promoting a more joined-up and 'think family' orientated approach and greater strategic oversight of commonality across this work. The subgroup has been providing updates after each meeting to the MSCB Leadership Group and MSAB Executive Group, who in turn include them in their reports to the two Boards. Strategic documents and guidance relating to the seven strands are scrutinised by the group before being escalated to the Boards for sign-off.

- The group is progressing with the various elements of its work plan, receiving updates on the high level actions from designated leads in the group for each strand of work. Group members are engaged with the agenda and are actively contributing to the discussion and planning. This includes development of strategy, review of policy and guidance, commissioning training and delivery of a progress and impact report. The plan also considers a number of cross cutting themes such as communication and engagement, learning and development and quality assurance and practice which ensure a link across to the other subgroups serving the Board.
- An exercise to map current CSE provision has been carried out as well as work to establish a CSE dataset within the Complex Safeguarding 'Dashboard' to help monitor how prevalent the issue is and how well interventions are tackling it. The MSB CSE Strategy has been refreshed and sets out how professionals will work with young people, communities and professionals to tackle CSE across four thematic pathways:
    - Alert and Empower;
    - Support and Protect;
    - Disrupt and Enforce;
    - Monitor and Improve.
- A range of resources for practitioners and volunteers on CSE is available on the MSB website.
- A Review of the MSB Missing From Care Home and Education Strategy has been carried out and now has a focus on:
    - Prevention: how we reduce the number of children and young people who go missing and ensure that children and young people understand the risks;
    - Protection: how we will reduce the risk of harm to those children and young people who do go missing, and consider any wider safeguarding risks (e.g. drawing the links between missing and wider complex safeguarding issues); and
    - Provision: how we will provide children, young people who go missing and their families and carers with high quality, response, support and guidance.

- For Vulnerability and Organised Crime, there has been a review of partners' presence in the Community Safety Partnership Strategy Action Plan held by the Serious and Organised Crime Executive; and progress and impact monitoring against the Action Plan is being carried out.
- Honour Based Violence and Abuse - Manchester accepts the Home Office definition of domestic violence and abuse which is any incident or pattern of incidents of controlling, coercive threatening behaviour, violence or abuse between those over age 16 who are or have been intimate partners or family members. This definition also includes so-called honour based violence & abuse, FGM and forced marriage, and are covered by the Manchester Delivering Differently Domestic Violence and Abuse Strategy 2016 outlined above. A range of resources on forced marriage is available on the website for both practitioners and for .families and the community.
- Specialist advice, training and support will be offered to all professionals in order for risk assessment, referrals and support to be successfully managed. By having such awareness raising strategies in place, services can go the extra mile to ensure their service is accessible and inclusive to all. Plans are being rolled out to deliver honour based violence & abuse and forced marriage training to 360 staff. Manchester has developed and produced FGM Practice Guidance for Staff and a FGM Task and Finish Group is working to align the Manchester Action Plan to the Greater Manchester Strategy.
- Modern Slavery and Violence - there has been a review of Greater Manchester Modern Slavery Strategy and a raft of actions to improve awareness and to *Prevent, Protect, and Pursue.*
- Radicalism and Extremism - work is ongoing to monitor progress against delivery of the Prevent Strategy which includes preventative work in schools. It also includes participation in the Greater Manchester Channel Peer Review where a group of independent peer reviewers assess a random selection of Channel cases in relation to a number of lines of enquiry including: leadership, partnership working, information sharing, referrals, processes, vulnerability assessments, quality of decision making and impact of interventions and support to individuals.
- Manchester is also part of the Greater Manchester Safeguarding Partnership Review of MSCB/MSAB Working Together to Safeguard Children and Adults from Domestic Violence and Abuse.

Practice Examples:

- As part of a multi-agency Safeguarding Conference organised by UHSM, to ensure that they views of young people were considered through the day, a young person's drama group delivered a compelling play with the key theme being exploitation and grooming.

- CMFT worked closely with the police in operations at Manchester Airport in summer 2016 to raise awareness of FGM and provide advice to passengers travelling to and from countries where FGM is prevalent. CMFT also work closely with voluntary organisations such as Afruca to raise awareness about communities and cultural issues.

- Christie NHS Foundation Trust have held targeted campaigns to raise awareness of complex safeguarding issues and information is displayed throughout the organisation. Safeguarding Champions have been key in raising awareness of these issues and have successfully identified patients who are at risk.

- The CMFT Domestic Violence/FGM Subgroup meets quarterly and its terms of reference reflect key priority areas identified in NICE 2014 Domestic Violence and Abuse guidelines. The group work plan ensures that national and local learning, policy and practice area reviewed and developed to influence frontline practice in CMFT.

- Greater Manchester Police is committed to the implementation of Operation Compass, a reporting mechanism to share fast time information to schools about domestic incidents. This enables a greater understanding of the child's situation immediately following the report of a domestic abuse matter

- Funding is in place to train all 92 GP practices by the end of 2017/18 - with only 17 practices left to train. The IRIS programme ensures that GPs new to the city are trained, that practices which have a lower referral rate than expected are provided with extra support to ensure that survivors of domestic abuse receive the same 'gold standard' of response whichever GP or practice nurse they visit across the city.

- MCC Children's Social Care have commissioned and are planning the roll out of the Safe and Together programme, complementing Signs of Safety and other strengths based models.

4.7 Our Priority was: developing the Neglect Strategy, including using the learning from SCRs where neglect is a significant factor and integrating that learning into the multi-agency training programme.

Identifying and preventing risk of neglect is a key priority for Manchester. The Joint Strategic Needs Assessment report on neglect shows that 41% of Looked After Children in Manchester had neglect identified as a factor; 57% of children on a Child Protection Plan are on the plan for a primary reason of neglect; and 76% had neglect recorded as a factor. The percentage for our statistical neighbours was 36.6%. In addition, 18% of Children in Need on 31st March 2016 had neglect recorded as a factor.

In May 2016, the Board held a workshop to explore the prevalence of Neglect in the city further, the impact on children and to consider what we are doing well, what we need to do differently and our next steps. It concluded that arrangements at the time were not sufficient - the Neglect Strategy was outdated and was not effectively underpinning work on the ground. Furthermore the Board could not be assured that the daily lived experience of children experiencing neglect in the city was understood.

In response, the Board set up a multi-agency Task and Finish Group to develop an improved approach for identifying, preventing and tackling neglect. Two key deliverables came out of this which are now guiding practice.

We have:

- Developed a new Neglect Strategy for Children, Young People and Families 2017-2019 (published June 2017), which sets out the context in Manchester, what research tells us about the impact of neglect on children and the required priority actions.
- Linked the strategy to the JSNA Topic Report on Neglect which provides further detail on the prevalence (national and local) of Neglect and a summary of the key research.

Practice examples:

- CMFT used the learning from SCRs where Neglect is a significant factor, identifying themes and integrating that learning into the Trust's single agency training.

- Christie NHS Foundation Trust have introduced the graded care profile as a risk assessment tool after it was adopted by MSCB and have ensured that neglect is an integral part of all safeguarding training and that their safeguarding policy provides clear advice to workers on actions to take if neglect is suspected.

- The Signs of Safety approach is now embedded into Greater Manchester Police officer training

and staff are advised to take positive action where neglect is suspected or reported and this is then escalated to supervisor officers to ensure appropriate action can be taken in each individual case.

- Youth Justice have increased their engagement with families, parents and carers in recognition that the dynamics within the home are linked to the reasons why young people sometimes behave badly in the community. Parental neglect is a recognised feature and Youth Justice are working with early help colleagues to develop the skills of the workforce to engage parents in supporting young people in the criminal justice system.

4.8 Our Priority was: development of a framework to ensure that safeguarding learning and development activity equips the partnership to meet its safeguarding responsibilities; gives assurance that partners access multi-agency learning and development opportunities; and that evaluation of the impact of multi-agency training on practice is carried out.

We have:

- Put in place a multi-agency Learning and Development Strategy. This helps the Board ensure that learning is child focussed so that the voice of the child and the child's welfare remain paramount and training promotes the importance of understanding the child's daily life experience. Training is underpinned by the values contained within Working Together and is regularly reviewed and evaluated to ensure that it meets the agreed learning outcomes and has a positive impact on practice.
- Added an electronic evaluation tool to the MSB training website and an impact evaluation tool for face to face training is being used to drive continuous development and improvement in learning and development.
- Developed plans in relation to how learning from Serious Case Reviews (SCRs) will be disseminated and improve safeguarding practice and services. There were no SCRs published in this reporting year; however there has been a strong focus on ensuring early learning from SCRs is actioned at the earliest opportunity. For example, a SCR involving a concealed pregnancy - whilst still ongoing - has led to targeted and general awareness raising of the Greater Manchester Safeguarding Partnership guidance on concealed and hidden pregnancy.

- Agreed a revised and comprehensive Quality Assurance Strategy at the Learning and Development subgroup in March 2017. To achieve the MSB Standard, all child and adult safeguarding training should:
    - Be founded by and relate clearly to a robust evidence base, supported by the principles and guidance set out in "Working Together to Safeguard Children"; Care Act Statutory Guidance 2016 in relation to adults; and current legislation and Greater Manchester and local authority policies and procedures for safeguarding;
    - Reflect that the welfare of the child/vulnerable adult is paramount;
    - Encompass anti-oppressive practice and challenge discrimination on any grounds;
    - Validate inter-agency working and reach a wide inter-agency audience;
    - Promote best practice and personal development;
    - Accommodate adult learning styles;
    - Respond to local needs and be subject to evaluation and review;
    - Incorporate the six principles of adults safeguarding;
    - Been informed by Making Safeguarding Personal and the need to recognise and incorporate whole family approach.
- Seen an increase in the number of practitioners attending multi-agency training; 1,478 practitioners attended 63 face to face safeguarding training courses in 2016/17.

Practice examples:

- Cheshire and Greater Manchester Community Rehabilitation Company (CGM CRC) staff all complete an extensive induction and training process to equip them with the skills to deliver the 'Interchange Model'. Additional practice and development training includes mandatory safeguarding training, including child sexual exploitation and female genital mutilation.

- North West Ambulance Service is fully engaged with the SCR, SAR and DHR process and staff attend Child Death Overview Panel meetings when requested. Advanced and senior paramedics attend learning reviews and feedback to the Safeguarding Team. Support is always provided to staff attending reviews and feedback sought as soon as possible to enable learning to be captured and to follow up any actions that the service needs to carry out.

- Cafcass child exploitation and diversity ambassadors/champions collate learning from inside and outside the organisation and promote it to colleagues. The Cafcass Research Programme supports the work of external researchers and undertakes internal research projects each year.

This year, this has included: domestic abuse in contact applications, trafficking, radicalisation and high conflict cases.

4.9 Our Priority was: assurance that the Child Death Overview Panel (CDOP) are effectively collating child death information and identifying trends and that data is collected and reported in line with statutory requirements.

This year CDOP have continued to strengthen and consolidate data reporting processes however, issues regarding data completeness and quality remain. CDOP have also been working closely with the Chairs of the other Greater Manchester (GM) CDOPs, as well as with the GM Safeguarding Partnership.

Manchester has contributed to a shared GM database since 2012/13 to look at patterns and trends over the whole GM footprint.

- CDOP holds regular quarterly meetings and has introduced improved data collection tools. Manchester and Greater Manchester data, including analysis of trends, is reported to the Board annually and made available to the wider partnership.

Further information on the work of CDOP and headline findings from this year's annual report are available in Section 6.

4.10 Our Priority was: strategic relationships - ensuring the Board is informed of and is involved in planning across partner boards.

The Independent Chair of the MSCB is also the Chair of Manchester Safeguarding Adults Board (MSAB) and this ensures cross cutting safeguarding matters are kept high on the agenda.

Regular joint MSCB/MSAB workshops are timetabled and consider cross-cutting issues. During 2016/17 the Boards have comes together to:

- Consider:
    - Domestic Violence and Abuse (June 2016);
    - PREVENT (June 2016)
    - SCR/SAR Overview and Chronology/Chronolator Software Briefing (Sept 2016);
    - Domestic Homicide Workshop (Nov 2016).

- Establish joint subgroups for Learning and Development, Communications and Engagement and Complex Safeguarding. This is enabling the Boards to have a more holistic view and greater impact on safeguarding practice across cross cutting themes.

The work of both Boards is supported by an integrated Business Unit, managed and led by an Integrated Safeguarding Boards Manager.

- Each Board is supported by a dedicated Board Coordinator;
- The Boards are further supported by a number of integrated posts: Policy & Performance Officer, Communications & Engagement Manager, Learning & Development Officer, Child Death Overview Panel (CDOP) Officer and four Business Support Officers.

The Independent Chair of MSCB is also a member of the Children's Board, the Children's Improvement Board and presents an annual report to the Manchester Health and Wellbeing Board.

- Regular reports and updates on the work of the Children's Board and the Children's Improvement Board have been scheduled into the MSCB Forward Plan. The MSCB was able to provide feedback on the development of the key strategic plan of the Children's Board, the Children and Young People's Plan, ensuring that partners across the city have a shared understanding and are working together coherently to ensure a safe, happy, healthy and successful future for children and young people in the City.
- Improvements to links with the Community Safety Partnership (CSP), including Domestic Homicide Reviews (DHRs), are now being regularly considered at the MSCB to ensure cross-cutting links are made. It has been agreed that the CSP will act as the coordinating lead across the Boards for domestic violence and abuse to ensure that there is clarity across governance arrangements of the Boards in keeping with the Community Safety Strategy.
- MSCB involvement in the development of a Suicide Prevention Plan, led by Manchester Public Health and involving partners from across the public, community, voluntary and business sectors, recognises that everyone has a role to play in suicide prevention. The Plan is based on the *Living Works* model for suicide-safer communities - an internationally respected approach based on evidence from suicide prevention strategies from around the world.

4.11 Further Areas of Challenge and Improvement

In addition to the areas identified as priorities in the 2016/17 Business Plan summarised above, other areas of challenge and concern have been identified and addressed by the Board.

Ensuring consistent attendance at **multi-agency Child Protection Case Conferences and Strategy Meetings** throughout the partnership. Attendance data and existing processes were considered and a number of improvements were agreed to both engagement procedures and, where necessary, to partners participation. The MSCB has been assured that improvements have been made and progress will be further monitored by QAPI.

Children Missing from Education - concerns regarding timescales for children taking up a new school place - a new dataset has been developed by Education to improve identification of any delays and to inform future monitoring.

The need for improved understanding by social workers of the educational aspects of **autistic spectrum disorder** has been progressed between Education and Children's Social Care and reflected in changes to the training of social workers in the City.

Transitions – concerns had been raised that the existing provision did not cover a range of possible transition points. This has been progressed by Children's Social Care, Adult's Social Care and the Clinical Commissioning Group; and arrangements have been put in place to gain assurance that safeguarding arrangements are in place during transition. Going forward, we will be seeking to develop a Transitions Strategy that ensures an individual's engagement with services as they transition is consistent, seamless and safe; and that no one 'slips through the net'.

Non-Contact Sex Crimes – following a concern raised by a VCS partner regarding appropriate inter-agency responses to non-contact sex crimes as a consequence of **sexting and indecent explicit image exchange**, assurance was sought via Education and Safeguarding in Schools. Proposed actions include: awareness raising via the MSB website; production of a briefing to disseminate across the partnership; and a guide for parents on identifying the language that might indicate risky behaviours is being considered.

Child Protection Information Sharing (CP-IS) – Children's Services and Health agencies have been working together to implement CP-IS system during the reporting year with a view to it being live in the autumn of 2017. When CP-IS is implemented information about children who are looked after or those subject to a Child Protection Plan will be shared with unscheduled health care settings i.e. Accident and Emergency Departments, Walk in Centres and North West Ambulance Service. Sharing of such information will ensure unscheduled health care settings are alerted to the status of the children

attending and will trigger a notification back to the Children's Services system, thus improving safeguarding.

Abusive Head Trauma (AHT) – in March 2017 the MSCB considered and agreed a proposal to endorse an innovative abusive head trauma prevention campaign. Abusive Head Trauma (AHT), also known as Shaken Baby Syndrome, is a devastating form of child abuse often resulting in catastrophic injuries. One in 14 cases is fatal before hospital discharge and half of severely injured survivors will die before 21 years of age. The prevention messages relating to AHT are aligned with the public health levels of prevention which are:

- ***Primary*** (preventing a problem before it starts) targeted through school based education, via post-natal checks, at GP six-week check-ups, via public health awareness raising campaigns and community education and via fatherhood and parent summits and 'cafes';
- ***Secondary*** (intervening at the early stages of an emerging problem); and
- ***Tertiary*** (intervening when harm has occurred to prevent further harm and limit damage).
- Each have a range of ways of reiteration of the message through identifying stressors and improving recognition and referral;
- A further level which could be described as ***supportive*** helps support those families affected by AHT and foster a culture where education comes from within communities.

Greater Manchester Police: Safeguarding Investigations Vulnerability - in 2015 Greater Manchester Police developed a Target Operating Model (TOM) and a shared vision and model for the future on delivery of services. Investigative and safeguarding capabilities will be delivered as part of an integrated team at all levels (previously these had sat separately) and GMP will invest in their workforce to improve their ability to safeguard. A review has been underway in 2016/17 to establish how best to deliver these principles and the review is taking place in three phases, one of which will concentrate on development of the TOM for crime investigation and safeguarding. MSCB have provided feedback and scrutiny of the work as it develops and will continue to do so as the review is concluded and the changes implemented.

School Nurse and School Health Services – in order to gain assurance about impact and capacity, MSCB have provided input and scrutiny on the roll out of a new specification for school nurse services via reports and updates reported to the Board by the commissioner and commissioned service that is delivering the provision.

5. The Manchester Context - What do we know about children in Manchester?

5.1 Population

Manchester is the sixth largest city in the United Kingdom and the largest borough within Greater Manchester. The city is densely populated, with a population density of 49 persons per hectare, which is almost nine times the average for the North West region. Manchester's population in 2016 was estimated at 541,263. It is believed that changes in the methodology used by the Office for National Statistics in recent years may have resulted in under counting of recent population figures; and work carried out by Manchester City Council believes that 548,775 is a more accurate figure. The number of people living in the city is growing rapidly and the city is becoming younger and more diverse. There were 4,571 more births than deaths in the 12 month period up to June 2016. Migration (internal and international) and other changes accounted for a net increase of 6,400 residents in the 12 month period to the end of June 2016. Manchester's growth of 2.1% for the year to mid-2016 is higher than that seen nationally, with England estimated to have grown by 0.9%.

Analysis of Manchester residents by age band shows that Manchester has a younger population than the wider area of Greater Manchester and nationally; with higher proportions of under-fives and 15 to 39 year olds. Conversely, Manchester has much lower proportions of older residents.

Manchester has made real progress over the past decade, including improvements in education and housing, better access to jobs, falling numbers of children growing up in poverty, and reducing numbers of young people not in employment, education or training. Despite periods of economic growth and reductions in deprivation during the last few years, there continues to be significant and persistently high levels of deprivation and worklessness in the city. The Index of Multiple Deprivation (IMD) 2015 ranks Manchester as England's fifth most deprived local authority (rank of average scores). This indicates that Manchester has improved relatively from the fourth most deprived local authority (rank of average scores) in IMD 2010. However, Manchester has been ranked as first in the proportion of Lower Super Output Areas (LSOAs) that are in the most deprived 10% nationally in the Health Deprivation and Disability domain (ref. 2015 Indices of Deprivation (F1)).

The most commonly used national definition of child poverty is 'a household with children under 16 where income is less than 60% of the UK median'. The latest figures indicate that, between 2007 and 2014, the overall proportion of children living in poverty in Manchester fell from 44.6% to 35.5%. However, Manchester still has one of the highest rates of child poverty by local authority area. Of those living in

poverty, the vast majority (69.4%) are living in out-of-work poverty; whereas 13.6% are living in in-work poverty and 16.2% are classed as other poor. The 35.5% figure equates to 36,255 children under 16 living in poverty out of a total number of 101,845. The Institute for Fiscal Studies has also predicted that the number of children living in poverty will rise sharply by 2020, in part due to planned benefit reforms affecting families with children.

Since January 2016, the Council and its partners have been working to refresh the Manchester Family Poverty Strategy, which will sit under Our Manchester and work towards the ambition to create 'a progressive and equitable city'. The current economic and fiscal environment presents significant challenges for Manchester and as a city it has recognised the need to focus its efforts both in investment in growth and reducing dependency through early intervention and integrated delivery and commissioning.

5.2 Children and Young People in Manchester

Population by age range of children and young people in Manchester											
Age:	**3**	**4**	**11**	**15**	**16**	**17**	**0-4**	**0-7**	**0-12**	**0-15**	**0-17**
Pop:	**7652**	**7842**	**5974**	**5378**	**5521**	**5750**	**6811**	**60812**	**92,374**	**108,554**	**119,825**

Children and young people aged 0-17 represent 22% of the total population.

On the Income Deprivation Affecting Children index, Manchester is ranked fifth; making Manchester much more deprived on this index than the other Greater Manchester districts. The next most deprived neighbour is Salford (30th) followed by Rochdale (41st). By contrast, Stockport is at 180th and Trafford at 198th with both districts falling into the least deprived half of the country's ranking (ref. 2015 Indices of Deprivation - children (F2a)).

Manchester has a proud history of being a diverse and welcoming population. Migration changes (internal, international and a small amount of 'other') to mid-2016 indicate a net increase of 6400 residents. Black and minority ethnic (BME) residents make up 33.4% of Manchester's population as a whole and the proportion of children and young people from a BME background is far higher. It is estimated that 61.4% of school children are from a BME group, a slight raise on the previous years' figure of 59.3%. Many communities are long-established in the city, but there are also significant numbers of new residents and a changing richness in Manchester's diversity (ref. 2011 Ethnic Groups profile (A17)).

The City Council produces an annual report (ref. 2015 Profile of Children (A11)) which gives a detailed summary of Manchester's children aged 0-16, using ONS mid-year and census statistics. The reports look at the higher than predicted number of children aged 0 to 16 in Manchester and details some of the key characteristics of children living in specific areas around the city. The report also considers the impact the increase in numbers could have on children's social wellbeing, education and services provision. It is noted that the growth in Manchester's child population has not been equally spread across the age groups; the number of children aged 0 to 4 has risen substantially.

The Public Health England (ref: Child Health Profile (March 2016) provides a snapshot of child health in Manchester. Children and young people under the age of 20 years make up 25.4% of the population of Manchester; some 59.3% of school children are from a minority ethnic group. The health and wellbeing of children in Manchester is generally worse than the England average. The infant mortality rate is similar to and the child mortality rate is worse than the England average.

5.3 Levels of Need

How do we determine the vulnerability and needs of children and young people who live and study in Manchester?

The Multi Agency Decisions Framework defines the levels of need across all services operating outside universal provision. This framework describes the varying levels of need and gives detailed guidance to partners when assessing a child's level of need and considering what other services are available to support families when children and young people have needs within the categories falling short of statutory intervention.

The Framework seeks to improve support to families by promoting an approach whereby needs are responded to and met at the lowest possible level to avoid difficulties escalating into crisis and by intervention from the least number of practitioners as possible. There are however some children, for example those at risk of significant harm with immediate need for protection, who need an immediate statutory intervention without going up through each level.

Universal Services (Level 1)

Universal services are those which are available to all children for example: Early Years and Play Outreach Services, Schools and School Nursing, Health Visiting, GPs and Midwives. At level 1 most children's needs are being met by parents, carers, communities and universal services.

Early Help Services (Level 2-4)

Early Help Services encompass three levels of service:

- Level 2 - child, young person or family, who can be sufficiently supported by a single agency Early Help Assessment (EHA) and response; or by signposting to an additional agency.
- Level 3 - child, young person or family who would benefit from a coordinated programme of support from more than one agency using the EHA and a Team around the Child/Family meeting.
- Level 4 - child, young person or family who requires intensive and coordinated support for complex issues via Targeted Services / Early Help Hubs and where support at Level 3 has not improved outcomes.

Manchester's Early Help Strategy outlines how all partner agencies will work together to support children, young people and their families. The emphasis is on working 'with' rather than 'doing to'.

Specialist Intervention (Level 5)

A child or young person at risk of, or suffering significant harm, due to compromised parenting; or whose needs requires acute services or care away from their home. These children will receive a Statutory/Specialist Assessment.

These levels are not exhaustive and many factors such as going missing from home and living in households where there is domestic violence and abuse, substance misuse and/or parents who are mentally ill can place children at increased risk of harm from abuse and/or neglect.

5.4 Children in need of support and protection

What do we know about the children and young people in Manchester who have been identified by the local authority and other agencies, as in need of support, statutory or protection?

Headline figures from our partners tell us the following.

5.4.1 Referrals to Children's Services

The rate of **referrals to Children's Services** (981 per 10,000) has remained at approximately equal to that recorded in 2015/16 (970). The rate of referrals is significantly above the national (532), regional (584), Core City (606) and statistical neighbour (700) averages for 2015/16. The rate of referrals which are **Repeat Referrals** within the 12 month period is very similar to last year at 25.7%. The percentage of **Referrals leading to Assessment** is 92.5% this year, compared to 76.6% in the previous year. 83% of **Referrals were completed to timescale**. The rate of **Children in Need** per 10,000 of the 0-17 age population is 443 (compared to 424 last year).

During the last quarter of 2016/17, the number of **contacts** received by children's services has averaged at 2,715 per month. The number of these **contacts that progressed to referral,** whereby the offer of early help has been in place, has averaged 9.8%; the percentage that are stepped down to early help has also averaged out at approximately 9.1% per month. This would suggest that there are a significant proportion of contacts made which are not appropriate for any level of intervention.

The percentage of **re-referrals** has remained static at 25% for the last quarter of 2016/17, but also prior to that. The percentage of referrals and re-referrals that progress beyond assessment is not increasing despite the increase in contacts being made; a significant number of assessments lead to no further action being taken (74% in February).

5.4.2 Looked After Children

The rate of **children looked after** by the Council has decreased over the past five years despite an increase in 2014. Despite this reduction the rate of children looked after in Manchester in 2017 (100 per 10,000) is still above the national (60), regional (82), Core City (79) and statistical neighbour (93) averages for 2016. There were 1,291 **Looked After Children** (LAC) at the end of March 2015, which has reduced further to 1,170 at the end of March 2017. The percentage of **children ceasing to be LAC through adoption** fell from 18% in 2015/16, to 15% in 2016/17, but remains approximately in line with the most recent national and statistical neighbour comparators and above the level reported in previous years. The percentage of **LAC who have Unaccompanied Asylum Seeking Children (UASC**) status is 3.5%, compared to 2.1% the previous year.

5.4.3 Child Protection Plans

The number of children and young people made subject to a **Child Protection Plan (CPP)** (year to date figure) is 71, compared to 38 last year. **The rate of children subject to CPPs** per 10,000 population is 79.2, compared to 71.6 last year. The total number of CPPs stands at 945 compared to 840 last year. 1.5% of **CPPs have been open for a period of time of two years or more**, a reduction on last years' figure of 4.6%. The % of children becoming subject to a **Child Protection Plan for reasons of Neglect** is 59%, compared to 57% last year.

5.4.4 Early Help

A total of 3302 **Early Help Assessments for Families** have been completed in 2016/17, compared to 1615 in the previous year. The number of **Early Help Assessments for Children** is 8249 (comparative figures for the previous year not available). There were 6048 Early Help Assessments open at a point in time, compared to 3665 in the previous year, which is encouraging news.

It is evident from data and reported findings that the Early Help offer has increased, the percentage of work progressing from MASH to statutory intervention remains within the 35-40% mark, but the volume of contacts received to the department remains high. Alongside this, the re-referral rate has remained static at 25% for over six months. This suggests that the demand for social work intervention from partners within Manchester remains high, therefore consideration needs to be given to strengthening partners understanding of the level of need framework.

To ensure decision making at the front door is thorough and robust, there is a need for partners who have provided families with an offer of early help to evidence this within the referrals that are sent. Although data recorded states the number of early help assessments completed by partner agencies, these have not routinely been included in referrals. This was considered at MSCB in April/May 2017 and agreement was made that referrals going forward should now include this information. Further embedding of the Signs of Safety Approach - a 'strengths based' approach - is also a key part of this work.

5.4.5 Domestic Violence and Abuse

The number of **domestic violence notifications from the police where a child is recorded as living at the address** is 5420 (compared to 5407 last year). The number of **domestic violence notifications to Children's Social Care that led to led to a referra**l is 639 (compared to 273 last year). The number of **repeat domestic violence call outs by police** to an address where a child is recorded as living is 1306 (compared to 1229 last year).

5.4.6 Missing from Home/Missing from Care

The number of children classified **Missing from Home** is 1589 (an increase on last year's figure of 1414) with the number of **Missing from Home Incidents** standing at 4590. The number of children who have been classified as **Missing from Care** is 304 (compared to 272 last year); with the number of **Missing from Care Incidents** standing at 2254 (compared to 1923 last year). The total number of Independent Return Interviews (IRI) completed has risen to 2172 from 591 last year.

5.4.7 Children with a disability

The percentage of **Children in Need with a disability** is 6.8% (the same as last year) and the number of **disabled children subject to a Child Protection Plan** (rate per 10,000) is 0.9.

5.4.8 Child Sexual Exploitation (CSE)

Between June and September 2016, Greater Manchester Police (GMP) compiled a local profile of CSE in Manchester. The profile showed that in 2015:

- A total of 490 individuals were referred to Protect.

- Of these, 199 were also listed as CSE victims by GMP and half had at least one missing from home episode recorded.
- 253 individuals were recorded on the social care system as being referred; of these:
    - 87% of referrals were girls
    - the age range of referrals was 13 to 16 years
    - the most common month of birth for children and young people referred was August - this suggests that more work may be needed to identify whether younger children in a year group are more vulnerable to CSE
    - 27% of children and young people have been the subject of at least one care episode
    - 40% of the children and young people were linked to a Troubled Family record.
    - There were high numbers of children and young people who were classed as subject to abuse and neglect or living with family dysfunction.
    - 179 children and young people were identified by acute hospital staff as having been sexually exploited.
    - A further 166 children and young people were identified by a community service under the category of sexual abuse/CSE.

The Phoenix Protect Team, Manchester's multi-agency **Child Sexual Exploitation** (CSE) team, support over 100 young people at any one time; referrals remain at around 25 per month and 40% of the work carried out by the Team is preventative. Reporting and monitoring of the cases within Protect is facilitated by the team. These figures are the young people known to Protect and do not reflect the valuable awareness work with young people carried out by the Protect Team, NSPCC, Children's Society and universal services.

5.4.9 Front Line Support

There are 214 Full Time Equivalent (FTE) **Social Workers** (compared to 206 last year); 147 FTE **Health Visitors**; 46 FTE **School Nurses**. There is a vacancy rate of 44 Social Workers, 8 Health Visitors and 13 School Nurses. The average caseload of Social Workers is 21.2, compared to 23.8 in 2015/16.

5.5 Education

At the end of March 2017, of the 180 schools in Manchester, of those inspected 40 schools were judged to be **outstanding**, 113 **good**, 17 **require improvement** and 7 **inadequate**. This compares to the 31 Manchester schools inspected by Ofsted during March 2016 to February 2017; of which 3 were judged to be outstanding, 17 good, 11 requiring improvement and 0 inadequate.

In 2017 improvements have been sustained in terms of the percentage of **children completing the Early Years Foundation Stage** successfully achieving a Good Level of Development (GLD). Phonics outcomes

have improved on previous years as have the **reading, writing and maths outcomes at KS1**. Interim **KS2 outcomes** indicate that the percentage of pupils will again be in line with national outcomes for achievement and above the national averages for progress measures. In **2016 GCSE attainment** measures improved in relation to national measures with progress measures being at the national average. It is anticipated that this will be maintained in 2017 but provisional results are not yet published. 2017 provisional **A level results** show improving outcomes especially at the higher grades and with more students gaining passes at A*_E than seen nationally. The most recent data relating to pupil attendance shows primary school attendance in line with national averages and attendance at secondary school is better than that seen nationally.

5.6 Health

The Manchester Children and Young People's Joint Strategic Needs Assessment (JSNA) has been produced in recognition of the fact that improving the health outcomes of children and young people in Manchester requires a multi-agency approach to the collation, analysis, presentation and publication of data, research and intelligence relating to the health and wellbeing of children, young people and families across the city.

Giving every child the best start is crucial to reducing health inequalities across the life course. What happens before and during pregnancy, in the early years and during childhood has lifelong effects on many aspects of health and wellbeing in adulthood from obesity, heart disease, mental health, educational achievement and economic status.

5.6.1 Preconception and Pregnancy

Smoking is the single most modifiable risk during pregnancy and can lead to range of adverse outcomes. Manchester is likely to have a higher **number of mothers who smoke during pregnancy** because there are a higher number of young mothers; national data estimates the smoking rates amongst young mothers to be as high as 57%. The percentage of women **smoking at the time of delivery** in Manchester is 12.5% (compared to 12% for England).

Low Birth Weight (LBW) is a major determinant of mortality, morbidity and disability in infancy and childhood and can have a long term impact on later health outcomes. Around 7.6% of births in Manchester were low weight, and this is highest in the North of the city. 68.1% of mothers in Manchester initially **breastfed** their baby, compared to 73.9% in England.

The **life expectancy** of children born in Manchester is poorer than for the North West region and England, with boys expected to live to 75.5 and girls to 80.0 (compared to 79.4 and 83.1 nationally).

5.6.2 Oral Health and Healthy Weight

Poor **oral health** among children is linked to early life, upbringing and wider health issues. 41% of children aged 5 years in Manchester had one or more decayed, missing or filled teeth compared with 28% nationally. Manchester had a rate of 12.4 admissions for teeth extractions per 10,000 population aged 0-19 years, compared to 16.7% in Greater Manchester.

One in four (25.8%) reception class children in Manchester were categorised as **overweight or obese** compared to 22.5% for England. 40.3% Year 6 children were overweight or obese in Manchester compared to 33.5% nationally.

5.6.3 Alcohol and Drugs

There are an estimated 27,000 **alcohol or drug dependent adults** in the city, meaning that a lot of children and young people are potentially affected by parental alcohol and drug abuse.

Alcohol specific stays in hospital for under 18 year olds at 55.4 per 100,000 population was significantly worse in Manchester than for England as a whole.

5.6.4 Teenage Pregnancies and Sexual Health

Manchester had a rate of 36.5 **pregnancies per 1,000 girls aged under 18** in 2013. This is an improvement on previous figures, but still higher than national rates.

Young people accounted for almost two thirds of **chlamydia** and over half of cases of gonorrhoea and genital warts. Chlamydia, the most common STI, has a diagnosis rate of 2006 per 100,000 population aged 15-24 in Manchester, which is close to the England rate of 2016.

5.6.5 Mental Health

115 children aged 0-17 were admitted to hospital for **mental health conditions**, which at 101.9 per 100,000 population is similar to the rates in England as a whole.

Further population data can be found in the 2015 Profile of Children (A11) .

The Public Health team coordinate the stand alone Joint Strategic Needs Assessment (JSNA) for children and young people in Manchester. There is a safeguarding section within this and it can be found on the JSNA website at www.manchester.gov.uk/joint strategic needs assessment

5.7 Young People who offend or are at Risk of Offending

Research and findings from the Youth Justice Board indicates that children and young people from more deprived backgrounds are more likely to find themselves within the criminal justice system.

The numbers of First Time Entrants (FTE) in Manchester between October 2014 and September 2015 is 234; this is lower than the previous 12 month period, continuing the recent downward trend and is now in line with national trends.

The cohort of young offenders has changed considerably in the last decade and is comprised of young offenders whose characteristics mean they are more likely to reoffend than those in preceding cohorts.

Although there are fewer children and young people coming into the formal criminal justice process, those that do tend to be more prolific and committing more serious (usually violent) crimes.

6. Statutory Reporting

During 2016/2017 the Board received a number of annual reports in relation to key multi-agency services as follow:

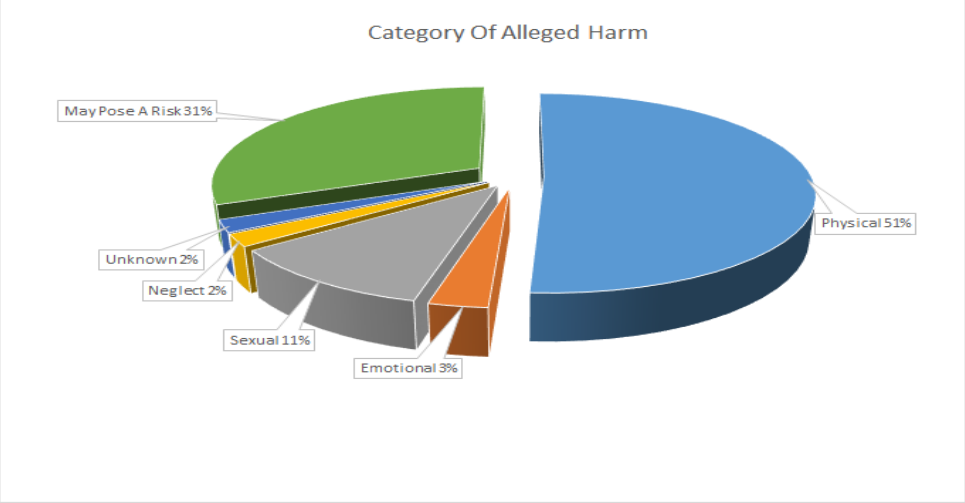
6.1 LADO - Management of Allegations against Adults who work with Children

The LADO Annual Report: *Management of Allegations against Adults who work with Children 2015/16* was considered by the MSCB in October 2016. The report summarised data for the period April 2015 to end of March 2016.

Table 6.1: Total number of allegations against adults who work with children during 2015/2016					
Total Referrals	Q1	Q2	Q3	Q4	Total
Allegation	45	38	65	56	204

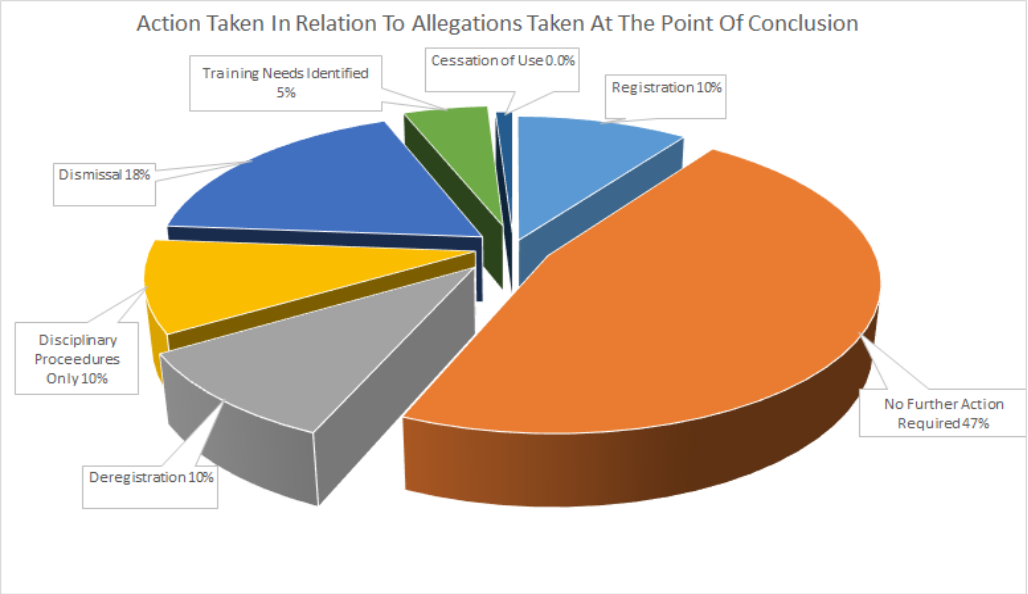
The data shows that while Manchester has a significant higher population of 0-19 year olds it receives comparatively fewer contacts relating to allegations against adults who work with children when compared to neighbouring authorities who have much smaller populations of 0-19 year olds.

Diagram 6.2: categories of alleged harm reported



Compared with data for the previous year, there has been a shift in the categories. 'May Pose a Risk' has declined to 31% from 44%; it whilst 'Physical Harm' has risen to 51% from 42%; 2014/15 did not record any allegations under Emotional Abuse or Neglect compared to 3% in this period.

Diagram 6.3: Action taken in relation to allegations



Service achievements during the course of the year include:

- The majority of cases are concluded within three months and no case has exceeded 12 months. There is evidence of the Designated Officer (DO) having robust oversight and follow up of cases to avoid drift.
- A new referral form and process was implemented from 1st April 2016; the new referral form and process can be found on the MSB website at https://www.manchestersafeguardingboards.co.uk/resource/lado/. This is a significant change and it is anticipated it will take some time to fully embed as the means of referring allegations against people who work with children and will require reinforcement by all managers across the partnership.
- A protected workflow has been developed on Manchester City Council's Integrated Children's System (MiCare). This will improve recording of allegations and provide us with the ability for oversight and tracking of cases and improved ability in relation to data analysis.
- Feedback in relation to how well the Designated Officer has fulfilled their responsibilities has been positive. The Designated Officer is highly regarded across the partnership and their advice, guidance and support has been valued. In particular colleagues have valued their ability to provide a timely response.

Manchester continues to have a valued, respected and deliver effective services for managing allegations against adults who work with children.

The increasing demands on the DO have not compromised the quality of service given in relation to allegations against professionals that are made. That said the increased demand has prevented the DO from delivering briefings in relation to: managing allegations and the role; what to do when you have a concern about someone working with children; and the developments that would improve the multi-agency response.

There have been some positive changes over the last 12 months which will ensure consistency in relation to the referral process and evidence clearly the allegations which are being made to the DO. The protected work flow in the Children's Information System (MiCare) will enable the service to more robustly track cases and enable the Designated Officer to record their actions, demonstrating more transparency and accountability.

In 2017/18 we need to ensure we have a better understanding of the Children's Workforce in Manchester and deliver a robust, diverse training package to be assured that when it is necessary for a referral to be made to the Designated Officer this is achieved in a timely manner, and professionals fully understand their role in the process.

6.2 Private Fostering

The MSCB considered a mid-way monitoring update in October 2016 which reported that Manchester's rate of Private Fostering Arrangements had reduced by 10 cases since January 2016, bringing the total of children and young people who are privately fostered to 24, as of October 2016; notwithstanding 14 new notifications within the period, of which only 4 remained in private fostering arrangements. This is attributable to children and young people living within private fostering arrangements for short periods before they return home or reach 16 years of age. The overall number of children who are privately fostered has increased since then, with a total of 34 children and young people being in such placements as of July 2017.

Table 6.2a: Private Fostering Data from 2015

Ages	3	4	7	8	10	11	12	13	14	15	16
Number	1	2	1	3	1	3	5	2	4	6	5

Table 6.2b: Private Fostering Data to October 2016

Ages	7	8	9	10	11	12	13	14	15
Number	1	2	1	0	4	2	2	4	8

Previously a number of regulatory compliance issues had been highlighted across the cohort of privately fostered children and young people, and there were a number of outstanding DBS checks on household members over the age of 16 years. All carers and the relevant members of their households now hold a current DBS Certificate, or are awaiting new Disclosure Barring Service checks to be processed, which will mean that all DBS checks are, or will shortly be, current and valid. Other improvements made include:

- Improvements to the timeliness of visits, which as of October 2016 showed that all children and young people who are privately fostered having been visited in the previous four weeks;
- Data cleansing and regular weekly analysis by service managers and the strategic lead for social work;
- Measures to improve the quality of interventions;
- A rolling programme of briefings and mandatory training for all new social work appointments;
- Improved advocacy services via Coram Voice who deliver this service on behalf of the local authority;
- Improved Post 16 support via Leaving Care Services;
- Raising awareness, via a programme of communication activities, including Manchester's Private Fostering Week which took place in November 2016; a learning and development circle session which took place within Locality Fora to identify any learning and to promote and raise awareness of children and young people who are privately fostered.

6.3 Child Death Overview Panel (CDOP)

In October 2016 the MSCB considered the following statutory CDOP reports:

- CDOP Annual Report 2015/16;
- Greater Manchester CDOP Annual Report 2015/16; and
- CDOP and Greater Manchester Sudden Unexpected Death of a Child Rapid Response Report 2015/16.

Between the 1st April 2016 and 31st March 2017 there were a total of 73 child deaths reported to the Manchester Child Death Overview Panel (CDOP). In comparison to previous years, 2016/17 shows an increase in the number of child death notifications reported to CDOP.

MSCB Annual Report 2016/17

Between the 1st April 2016 and 31st March 2017 the CDOP discussed and closed a total of 64 child deaths. Of the 64 cases closed, 44 (69 %) of these deaths occurred between 1st April 2016 and 31st March 2017. 20 (31 %) of these cases were historical child deaths where the death occurred prior to the 1st April 2016.

Due to the CDOP review process, there is a time lapse between a death being reported to CDOP and the case being closed by CDOP. The CDOP will not review any case which is subject to investigations until all have concluded and the reports are submitted to the panel. This is to ensure that the CDOP has the appropriate level of information to categorise the death and identify any potentially modifiable factors which may have contributed to the death.

The annual report and the annual submission to the Department for Education (DfE) includes information from the 64 cases closed where the death occurred in 2014/15, 2015/16 and 2016/17.

Of the 64 cases closed, 37 (58 %) of these were neonatal deaths (< 28 days of life). A further 11 (17%) died under the age of one, highlighting children under one year of age as the most vulnerable age group. The majority of cases closed were of English/Welsh/Scottish/Northern Irish/British heritage which accounted for 19 (30 %) of the total 64 cases.

27 % (17) of cases were categorised as having modifiable factors in the review, with the majority of these deaths occurring in the neonatal period. There was a higher proportion of male deaths recorded as having modifiable factors (10) in comparison to females (6).

The majority of deaths were categorised as a perinatal/neonatal event accounting for 45 % (29) of the 64 cases closed. This group also had the largest number of modifiable factors identified in the review. Of the 29 perinatal/neonatal deaths, 38 % (11) had modifiable factors.

Another large percentage of deaths were categorised as chromosomal, genetic and congenital anomalies which accounted for 17 (26 %) of the total 64 cases closed. Cases categorised as perinatal/neonatal event and sudden unexpected, unexplained death were identified has having the highest number of modifiable factors. This is to be expected as there may be one of more risk factors identified antenatally or postnatally which may have contributed to the death of the child.

There was a number of potential risk factors identified in cases categorised as have modifiable factors which included:

- Factors in relation to service provision, complications of caesarean section delivery, vulnerable baby discharged home
- Maternal obesity, high BMI 30+

- Parental substance misuse
- Parental smoking
- Maternal smoking in pregnancy
- IVF treatment provided abroad – numerous eggs implanted
- Factors in the parenting capacity, child and/or siblings subject to Child Protection Plans
- Language barriers that may increase the child's vulnerability
- Late presentation to health setting
- Parental mental health issues
- Parental difficulties in the care of children with complex needs
- Consanguineous relationships (siblings that have the same inherited autosomal recessive disorder and/or death of a sibling due to the same inherited condition)
- Unbooked pregnancy, Mother received no antenatal care.

The CDOP continues to provide anonymised information to support the University of Manchester National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Each year the NCISH produces an annual report which assesses the progress on safety in mental health care across the UK. It provides the latest figures on tragic events, suicides, homicides and sudden deaths and highlights the priorities for safer services.

The CDOP continues to collate information regarding bereavement support offered to families via services and voluntary organisations. The Greater Manchester CDOP has identified inconsistencies across the region in relation to the services available to bereaved families depending on the area in which the family reside. The Greater Manchester CDOP are working with Child Bereavement UK to address these issues with the aim of adopting a consistent approach.

Manchester has established a Suicide Post-vention Pathway Group whose aim is to map out the roles and responsibilities for agencies e.g. pastoral support role, family role, Winston's Wish, CAMHS, Children's Services, Police, Coroner, Schools and Paediatricians. The outcome is to develop a clear pathway for services to follow when supporting families bereaved by suicide. The membership is made up of various multi-agency professionals from services such as the Police, Coroner's Office, Rapid Response Team, CAHMS, CDOP, Voluntary Bereavement Groups, Health, Education etc. The group wishes to establish a consistent approach across Manchester to support families bereaved by suicide and identify a lead professional working with the family to provide support. The group is in the process of producing information which can be provided to parents to inform them of the various bereavement services available and how to contact them.

6.4 Safeguarding Learning and Development

The MSCB has provided a thorough and varied training offer throughout 2016/17.

6.4.1 Face to Face Training Courses

Attendance

In 2016/17 a total of 1472 trainees attended face to face training courses, on a total of 61 training courses. In 2015/16 a total of 1394 trainees attended 59 training courses.

The small increase in attendance is healthy despite three courses being cancelled and three courses being withdrawn from the training programme. **Introduction to Case Conference and Core Groups** was withdrawn temporarily pending Signs of Safety changes; **Safeguarding Children from Abroad** was withdrawn due to unavailability of trainers; and **Child and Young Persons Development** was withdrawn due to staff changes.

The decision to increase the frequency of the Introduction to Safeguarding has proved very successful with 11 courses delivered over the year and a total of 345 attendees. This is a statutory course that needs to be completed every three years for anyone who works with children and is in very high demand.

Three training courses were cancelled in 2016/17 which is an improvement on last year when eight training courses were cancelled. The reduction in cancelled courses is mainly due to a more robust and larger training pool and for some courses back up trainers being available to ensure course went ahead.

Non-Attendance

This has increased slightly in 2016/17 with a non-attendance rate of 16.6% (244 trainees did not attend) compared to a non-attendance rate of 15% in 2015/16 (253 trainees did not attend). Non-attendance remains a cause for concern and needs addressing by all agencies. Multi-agency training is an integral part of improving safeguarding knowledge, confidence and networking and it is disappointing that non-attendance has increased this year.

5.4.2 New Courses added to the 2016/17 Training Programme

- **Management of Allegations against Adults who work with Children** (manager only course) - proved very popular with 60 professionals attending over two courses and over 14 organisations represented.

- **Female Genital Mutilation Event -** two full day events were delivered by the National FGM centre and Olive Branch Theatre Company and 98 professionals attended over the two courses; a Manchester perspective was also provided by one of our partners in CMFT.
- **Train the Trainer Course (2 days) on Domestic Violence and Abuse -** delivered by Manchester Women's Aid and Independent Choices to twelve members of the training pool to increase the numbers able to deliver this course and increase resilience.

5.4.3 Training Feedback

Training feedback is received from three routes: 1. Online Feedback; 2. Impact Evaluation Survey; 3. MSB Action Plans.

- **Online Feedback** - Trainee feedback is provided anonymously online immediately after training and this is assessed by the training coordinator initially and then sent to trainers for their comments. Where appropriate courses are amended or updated to achieve maximum impact and learning. The number of trainees who provide feedback is high with the majority of courses achieving over 70% trainee feedback.

  Overall feedback is very high with the majority of trainees commenting that multi-agency networking is one of the most important parts of the training. Trainers value feedback and are keen to ensure that their training is relevant and accessible. The only negative comments can be around the length of the course as being too short or too long, or when ICT fails at the training venue.

- **Impact Evaluation** - Two training courses were impact evaluated in retrospect for the 2015/16 training programme: Managing Risky Business - two day managers' course (delivered on 20th and 21st October 2015) and Multi-agency Investigation into Child Abuse - two day course (delivered 17th and 18th February 2016).

  Multi-agency attendance, impact on practice and outcomes for children were some of the factors that are measured and assessed as part of the survey. All of the outcomes measured in the surveys confirm that learning outcomes are achieved, confidence levels increased and satisfaction with training are high. Both reports, including recommendations, were approved by the Learning and Development Subgroup.

  In the 2016/17 training programme the Neglect course (delivered 1.3.17) and Parental Mental Health course (delivered 14.3.17) were selected for Impact Evaluation as these met Board priorities and themes from Manchester Serious Case Reviews. All trainees have been contacted/interviewed and the reports are in progress.

- **MSB Action Plans** – All face to face training courses have MSB Action Plans uploaded onto the training website alongside the pre-course training materials and trainees are advised to print these off and complete at the end of the training course. All MSB training courses have housekeeping slides inserted into the PowerPoints which once again remind trainees that they need to complete these Action Plans for their own development and to discuss with their line managers to reflect on their practice and further development.

A huge thank you needs to be recorded to the fantastic partnership, skills, knowledge and enthusiasm of the training pool. They are the reason that Manchester has such a comprehensive training programme that benefits children and families in Manchester.

6.4.4 Online Learning

A total of 4020 learners completed online modules through our partner Virtual College which is an increase from 2015/16 when 3,471 courses were completed. Over 50 children and adults safeguarding online courses are now available; Adults Safeguarding courses were added to the online learning programme on 20th November 2016.

A total of 41 courses were accessed by learners, which is a slight increase on last year (39 courses were accessed) and 51 agencies or partner organisations accessed courses. A full Virtual College report is included in the Annual Training Report.

98% of learners would recommend the course to other people. When asked "*How satisfied were you that the course gave you the information that you needed to know?*" 3529 out of 4020 assessed that they were satisfied or very satisfied; 98 assessed that they were partly satisfied; with 10 assessing that they were not at all satisfied with most comments stating it was too much information, or too lengthy "*It was obvious to the point of being patronising*".

Impact Evaluation of Online Learning

414 out of 4020 learners completed a three month post course evaluation, which is approximately 10% of those who completed courses. Questions and responses included in the survey include:

1. **"Participation in this e-learning course has supported me to make measurable improvements to my work practice**" 319 of those who completed the Impact Evaluation Agreed or Strongly Agreed; comments included "learn better at my own pace" and "it does not matter how much we know. We can always learn. Reminders are good too". 86 learners assessed that they neither Agreed nor Disagreed, and many of these responses were from back office workers who did not have direct contact with children. A total of 5 learners either Disagreed or Strongly

Disagreed, comments stated the course was “long winded” or a refresher and therefore no additional learning was achieved.

2. **“Overall, how satisfied were you that the course gave you the information that you needed to know?** 372 assessed that they were either satisfied or very satisfied; and 22 recorded that they were either partly satisfied or not at all satisfied; comments mentioned that they were completing the module as a refresher or that e-learning did not suit their learning style.

6.4.5 Quality Assurance Strategy

A revised and comprehensive Quality Assurance Strategy was agreed by the Learning and Development Subgroup in March 2017. The strategy offers a comprehensive service on a three year programme and will award a Gold, Silver or Bronze level dependent on the criterion being met. To achieve the MSB Standard, all child and adult safeguarding training should:

- Be founded by and relate clearly to a robust evidence base, supported by the principles and guidance set out in “Working Together to Safeguard Children"; Care Act Statutory Guidance 2016 in relation to adults; and current legislation and Greater Manchester and local authority policies and procedures for safeguarding;
- Reflect that the welfare of the child/vulnerable adult is paramount;
- Encompass anti-oppressive practice and challenge discrimination on any grounds;
- Validate inter-agency working and reach a wide inter-agency audience;
- Promote best practice and personal development;
- Accommodate adult learning styles;
- Respond to local needs and be subject to evaluation and review;
- Incorporate the six principles of adults safeguarding;
- Been informed by Making Safeguarding Personal and the need to recognise and incorporate whole family approach.

6.5 Statutory Inspections and Reports

The Board have considered the safeguarding implications arising from statutory inspections of partner agencies that have taken place during the year and any safeguarding actions that are required, which this year has included Pennine Acute Trust and The Christie. In addition, the Quality Assurance and Performance Improvement (QAPI) subgroup receive updates on any school inspections where safeguarding issues have been raised. Where improvements concerning safeguarding issues were required, monitoring of progress has been built into the MSCB work plan, with regular updates aimed at seeking assurance on progress coming to Board.

The Board have also considered the Clinical Commissioning Group (CCG) Annual Report 2016 and the CCG Looked After Children Annual Report 2016.

6.6 MSCB Improvement Journey

A programme of improvement has been implemented to target areas for improvement identified through the Ofsted Inspection of the MSCB and MCC Children's Services in 2014. Children's Services, MSCB partnership actions to contribute to the improvement programme have been agreed both through the MSCB Leadership Group and through the Board. For the MSCB all improvement plan actions have been completed.

6.7 Serious Case Reviews (SCR)

There has been significant SCR activity during 2016/17.

A total of ten cases have been screened by the SCR Subgroup, four of which were recommended as meeting the criteria for conducting a SCR; all of the recommendations were agreed by the Independent Chair.

Nine SCR cases have been active during April 2016 to end of March 2017.

Two cases that were on hold pending parallel legal proceedings have resumed following completion of legal proceedings and it is anticipated these will be going to Board in late 2017 or early 2018. Two reviews that started during 2016/17 are in progress.

Serious Case Review reports are published on the MSCB website and/or through the NSPCC SCR repository.

A number of emerging themes have been identified by the Board

- Seeing and hearing the child
- Disguised compliance
- Rule of optimism
- Lack of professional curiosity
- Multi-agency working and information sharing
- Use of Escalation policy

The learning from the reviews is being shared across the partnership through: a planned SCR learning programme; specific events e.g. a planned conference on professional curiosity and disguised compliance; integration of case studies into appropriate MSCB training courses; promotion of the Escalation policy across the partnership.

6.8 Safeguarding Assurance

Monitoring and evaluating the effectiveness of what is done by the local authority and their Board partners to safeguard and promote the welfare of children and advising them on ways to improve is an important function of the Safeguarding Board. There are a number of ways that this is carried out.

See also 7.3.4 Quality Assurance & Performance Improvement subgroup

6.8.1 Section 175 Schools safeguarding self-assessment

Schools and colleges are expected to complete an annual self-assessment to demonstrate that they are complying with the key standards in relation to safeguarding children. To support this process, a proforma was circulated in February 2016 to all maintained schools (including academies and free schools) in the city. This was accompanied by a letter jointly signed by the MCC Director of Education & Skills and by the Independent Chair of MSCB. This was based on the revised guidance and the first time that schools had been asked to share their self-assessment with the local authority and the MSCB.

From the 180 maintained schools, academies and free schools in the LA, 110 audits were returned, a 61% return rate. In addition, although they were not specifically targeted, there were returns from two Post 16 colleges and from two independent schools.

The completed self-assessments provided a detailed picture of safeguarding practice in Manchester schools. Many schools have commented that they found the process to be useful, especially to identify any gaps and to support plans to address these. For the MCC Directorate of Education & Skills the analysis has highlighted areas of good practice and also areas in which schools could benefit from further guidance and training. These have been taken account of e.g. in the agenda of Designated Safeguarding Leads networks and actions for the Manchester Schools Alliance (MSA) Strategic Safeguarding Group.

Education & Skills also uses a variety of other information sources to contribute to intelligence on the effectiveness of safeguarding arrangements in schools. This includes the annual Quality Assurance Professional visits; analysis of the Safeguarding in Education Team's Schools Engagement Dashboard;

school's participation in local authority run networks and training opportunities; school's participation in multi-agency working; and feedback from partners.

Ofsted reports from 2015/16 are very positive, with 100% of the maintained schools, academies and free schools which were inspected over this period being judged effective in their safeguarding arrangements. This is less secure in the Independent sector, in which two schools were judged to not meet the Independent Schools Standards in this area.

6.8.2 Assurance Statements from Partners

In addition to the various assurance activities carried out throughout the year, each Board partner has submitted an assurance statement setting out its main developments around safeguarding. **Appendix 1** to this Executive Summary sets out the work partners have done during 2016/17 to ensure that children and young people are safeguarded and to contribute to the shared priorities of the Board.

7. MSCB Board and Subgroups

7.1 MSCB

During 2016/17 the MSCB full Board met at least every eight weeks for standard business meetings. In addition, extraordinary meetings were convened whenever necessary to consider finalised Serious Case Review findings, or those from other Reviews such as Domestic Homicide Reviews. Meetings that had a joint MSCB and MSAB component and workshop sessions were also regularly conducted.

All members are routinely asked to prioritise attendance, or where this is not possible, to arrange suitable deputies. The Board receives at each meeting a report on the work of the Leadership Group and all of the Subgroups and are asked to consider if they approve of and are satisfied with the work that is being done to further the priorities of the Board. All meetings of the Board (and all Subgroups) are facilitated by the MSB Business Unit.

Board priorities during 2016/17 were captured in the 2016/17 MSCB Business Plan; risks were monitored through the 2016/17 Risk Log. A number of agencies achieved 100% attendance at Board meetings, however this was not consistently the case across all agencies. Enquiries are made with agencies who are experiencing problems in achieving high attendance rates and the overall number of agencies achieving 100% attendance has increased from 2015/16.

7.2 MSCB Leadership Group

Since the 2015/16 MSCB Annual Report, which reported on the MSCB Executive, there has been a review and refresh of the group resulting in some changes to its operation and remit. The membership has been amended to ensure better representation by other Subgroup Chairs and appropriate senior level representation by agencies. As part of this refresh the Executive changed its name to Leadership Group and began to meet every 6-8 weeks. The Leadership Group updates and monitors the MSCB Business Plan, Risk Register and Challenge and Impact Log. It also monitors the MSCB Performance and Finance Reports. Progress of other MSCB and joint subgroups is reported at every Leadership Group meeting; this includes an assessment on '*what's working well, areas for development and impact on children and young people*'.

7.3 MSCB Subgroups

MSCB revised its governance structure in 2016/17. In addition to the Leadership Group, the MSCB has a number of other subgroups on a standing basis (see diagram in Appendix 1) and also commissions 'task

and finish' groups as required to carry out specific tasks relating to a specific issue or concern, for example the development of the MSCB Neglect Strategy. A brief summary of the remit and work of each subgroup is provided below.

7.3.1 Safeguarding Practice Development Group (SPDG) and Local Safeguarding Fora

The aim of the subgroup is to act as a connection between the MSCB and front-line practitioners, to ensure that the Board is aware of current practice issues, good practice and areas of improvement.

The SPDG met five times during the year, chaired variously by the MSCB Independent Chair, the Interim MSB Business Manager and then the Assistant Director Children's Services, Barnardo's (now the permanent Chair for this subgroup); with multi-agency membership from across the MSCB. The SPDG and Fora provide an effective line of communication between the Board and front-line workers. SPDG directs the work of the three Local Safeguarding Fora.

The three Local Safeguarding Fora (North, Central and South) each met four times through the year; they were chaired by a senior manager from MCC or Health and membership included a range of MSCB partners.

Headlines from the subgroups:

- Offers a forum for raising the profile of, and understanding of, safeguarding issues across a broad practitioner base.
- Provides a good vehicle for feeding-up live practice issues and challenges encountered by front-line practitioners across partner agencies.
- Dissemination of information relating to priority work streams; in particular Signs of Safety, Neglect Strategy, Levels of Need, etc.
- Means to identify and share resources to enable a better understanding of safeguarding.
- Channel to report to the MSCB any challenges/ practice issues that arise.
- At the end of the reporting period the SPDG and Fora members reviewed their terms of reference and activities and an Action Plan for 2017/18 took shape.

7.3.2 Complex Safeguarding Subgroup

The remit of the Complex Safeguarding subgroup is to consider thematic strategies/plans, developments (statutory/practice) and provide a challenge and support role within the context of operational delivery in the following work streams:

- Child Sexual Exploitation /Missing from home, care and education
- Gangs and violence

- Modern Slavery and Trafficking
- Radicalisation and extremism
- Domestic Violence & Abuse / Female Genital Mutilation/ Honour based violence (combined strategy).

In addition, the role of the group is to:

- Facilitate improved communication and information sharing between professionals including understanding of key terms, definitions and thresholds for actions, acting as a forum for developing effective multi-agency working practice and relationships.
- Provide reassurance to both Boards, ensuring that services are delivered in ways that safeguard and promotes the welfare of children, young people and vulnerable adults.
- To consider and address relevant Serious Case Review recommendations.
- To support the development of information/education programmes for children, young people and vulnerable adults; parents and carers; and the wider community; for use in by all agencies.
- To support engagement with local communities to raise awareness of key issues; how they affect individuals and the wider community; and how to report concerns.

The group meets quarterly and there is a broad representation from across the partnership. During its first year it has established a work plan addressing all the work streams under this agenda.

7.3.3 Serious Case Review Subgroup

The Serious Case Review (SCR) subgroup processes and considers referrals in instances when a child dies and abuse or neglect may have been a factor; or a child is harmed and there may be concerns about the way in which agencies worked together. The subgroup decide whether the criteria for a SCR (as laid down in Working Together 2015) have been met and makes a recommendation to the Chair of MSCB. In addition to determining recommendations about SCRs, the group closely examines all cases presented for other learning opportunities, and commissions a range of other learning reviews.

During 2016/17, the SCR subgroup have screened ten cases to assess whether SCR criteria was met, or whether another type of Learning Review would be appropriate. Of these four were found to meet SCR criteria and six were recommended for either learning review activities or other action as appropriate. The full list of SCR activity during 2016/17 can be found at Section 6.7.

7.3.4 Quality Assurance and Performance Improvement (QAPI) subgroup

The remit of the QAPI subgroup is to oversee the quality assurance of safeguarding practice and drive up performance improvement; and to seek assurance that Board partners are complying with statutory safeguarding requirements.

This includes:

- Coordinating an annual programme of multi-agency case file audits
- Developing and maintaining a quarterly multi-agency dataset
- Coordinating an annual Section 11 Safeguarding Self-Assessment
- Considering safeguarding concerns that arise from single agency audits & inspections

Multi-agency case file audit programme 2016/17

During the period April 2016 to March 2017 the following audits were completed:

- MASH and Early Help
- Looked After Children Missing From Home
- Child Protection and Core Groups
- Child Sexual Exploitation (CSE).

The themes for the audits were decided by the QAPI subgroup based on issues that had arisen in SCRs, and with guidance from the QAPI subgroup Chair. The in-depth multi-agency case file audit was a new method of auditing for MSCB which started in January 2015 and this is the third year of a continual rolling programme. An Audit Team Member is identified from each of the partner agencies and they are expected to operate independently on behalf of the MSCB to complete an in depth questionnaire for five randomly selected cases using an Ofsted style grading of Inadequate, Requires Improvement, Good and Outstanding. This can result in up to 30-40 case files being examined in detail for each audit. Instances of both good and poor practice are fed back to practitioners within their agency. The audit team meets to compare findings and to agree on an overall score for each case. Multi-agency recommendations are made based on the findings of the audit and these are monitored by the QAPI subgroup. An overview report is written and presented to the MSCB and then circulated widely to the partnership workforce.

Recommendations arising from the multi-agency case file audits broadly fall into the following areas:

- Recording / information sharing and communication / partnership involvement
- Maintaining focus on the child and acting on the child's wishes and feelings
- Specific recommendations relating to the Missing from Home process
- Further quality assurance activity.

Specific actions have taken place to make improvements in these areas, for example:

- a multi-agency learning circle was convened in order to identify ways that communications and methods of recording for core groups could be improved and the methods have been shared and adopted by partner agencies
- the Signs of Safety approach continues to be promoted and embedded across the partnership as an effective method of seeking, recording and acting on the child's wishes and feelings
- the multi-agency Missing from Home Strategy has been revised to incorporate the audit recommendations which will lead to a better understanding for all partners on how to meet the needs of vulnerable children
- the same areas are repeatedly tested in each multi-agency case file audit and more recent audits have evidenced some improvements in safeguarding practice when compared with earlier audits.
-

MSCB Performance Scorecard (quarterly multi-agency dataset)

Partners are asked to contribute to a quarterly dataset which is based on the agreed North West set of Performance Indicators for LSCBs. Contributions from partners comprise data, an assessment of "what good looks like" and how the stats compare, plus a written analysis or commentary. Any issues that become apparent from scrutinising the scorecard, e.g. gaps in data or commentary, are raised as a "red flag" to the full MSCB Board. Issues that have been raised as a “red flag” during 2016/17 include concerns around Children Missing Education; and a lack of data available for GMP Safe & Well checks.

Section 11 Safeguarding Self-Assessment

A Section 11 Self-Assessment based on a revised Greater Manchester template was sent to all Board partners for completion. The GM template is now a much shorter document with questions based around three themes:

- A culture of safeguarding children in the organisation
- A safe organisation
- Voice of the child, parents and staff.

Partners are asked to “RAG” rate their organisation as follows:

Red - Standard not met (action required)
Amber - Standard partially met (action required)
Green - Standard fully met (no further action required).

Actions to address any gaps were specified and each thematic area ends with an overall evaluation of how well the agency meets the standard. Partners were required to submit an action plan which detailed how they would address any areas that had been rated as Amber or Red.

Partners were then invited to a challenge session with the MSCB Independent Chair and Board Business Unit representatives during April and May 2016 on an individual basis to discuss any issues highlighted by the Section 11 self-assessment process, as well as any general Board engagement issues. A report of findings was presented to Board members in June 2016. The following areas were identified as common themes to be taken forward by MSCB:

- The gaps in provision and a lack of strategic oversight of safeguarding for young people aged 16 - 19 years
- How to share learning and examples of good practice between agencies
- How the Board can make the best use of available data.

All partners were then required to submit an updated Action Plan in September 2016 detailing the actions they had taken to address any shortfalls.

7.3.5 Child Death Overview Panel

The Child Death Overview Panel (CDOP) reviews all the deaths of Manchester children aged under 18 years of age. The CDOP is a multi-agency group that meets four times per year with representatives from local NHS hospitals, Health Visitors, Children's Social Care, Housing and GMP.

The Panel is chaired by a Consultant in Public Health and is facilitated by the MSB CDOP Officer. The subgroup met quarterly and meetings are well attended by representatives from the NHS, Children's Social Care, Strategic Housing, GMP, Coroner's Officer, SUDC Children's lead for Greater Manchester, Family Nurse Partnership, CAMHS and the Paediatric Critical Care Network.

Year on year the quality of data provided by agencies improves which supports the CDOP when analysing information and identify emerging trends. The CDOP continues to work closely with the Chairs of the other Greater Manchester (GM) CDOPs and the GM Safeguarding Partnership; also contributing to the North West Child Death Overview Panel Annual Report which started in 2013/14.

The national review of LSCBs, SCRs and CDOPs undertaken by Alan Wood recommended that the responsibility for CDOPs moves from the Department for Education (DfE) to the Department of Health (DoH). NHS England held a number of national stakeholder events to gather information from CDOPs regarding their current arrangements. Work remains ongoing and The Department of Health are in the

process of reviewing the current guidance set out in Working Together 2015 and CDOP lines of accountability.

For further information on the work of CDOP during 2016/17 and a summary of the CDOP Annual Reports, please see 6.3 of this document.

7.3.6 Learning and Development Subgroup

The primary purpose of the subgroup is to assure the delivery of high quality multi-agency training for safeguarding children that reflects local and national priorities.

The core function of the Learning and Development subgroup is to develop a framework which will enable the MSCB and MSAB to carry out its responsibilities to ensure that safeguarding learning and development activity equips the organisation, its staff and partners to meet the standards outlined in Manchester's safeguarding children and adults' policy and procedures.

- To ensure the workforce is effective in safeguarding children, young people and adults at risk of or experiencing abuse and neglect.
- Ensuring provision of high quality multiagency safeguarding learning and development.
- Enable and promote Safeguarding learning and development across partners and providers.
- Ensuring staff are competent to respond to safeguarding concerns (at a level consistent with their role) via the provision of high quality cross sector training.
- Review the implementation of the Multi-Agency Training Strategy for safeguarding children, young people and adults at risk of or experiencing abuse or neglect to ensure it is fit for purpose.

The subgroup met four times in the year and was chaired by the Head of Safeguarding, Pennine Acute Hospital Trust with support from the MSB Business Unit. Membership includes Adults Services; Cafcass; Barnardo's; Manchester CCGs; Education; Early Years; National Probation Service; CRC; MMHSCT; Manchester Youth Justice; CMFT; UHSM; MCC Strategic Housing; Early Help.

A full report of the MSCB training offer, rates of take up and accreditation, feedback and key developments around learning and development is included in Section 6 of this Annual Report.

7.3.7 Communications & Engagement Subgroup

The MSB Communications & Engagement subgroup was formed in April 2016 and operates on behalf of both MSCB and Manchester Safeguarding Adults Board (MSAB). The Subgroup is chaired by a Manchester Safeguarding Boards partner from Greater Manchester Police and supported by the MSB Communications Manager. Membership is made up of communications representatives from the partners of the Boards.

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The group is responsible for:

- oversight of the communication strategies of the two Boards;
- oversight of the development and maintenance of the MSB website and social media;
- advising both boards on national, regional and local opportunities to promote safeguarding and encourage public and professional awareness;
- leading on the implementation of campaigns and educational programmes to support safeguarding and to develop preventative strategies;
- work with partners to actively promote awareness of the needs of vulnerable children and adults.

A key function of the group is the development and delivery of the MSB Communications Strategy and action plan to take into account the duties of the boards, as well as the aims and objectives from business plans and risk registers.

Other activities of the subgroup during 2016/17 has included:

- Publication of e-Bulletins – this will continue on a regular basis.
- The replacement of the MSCB website by a joint MSB website https://www.manchestersafeguardingboards.co.uk/ which launched in January 2017 following an intensive development programme. This improved website will provide both Boards with:
    - an independent platform for sharing learning from local SARs, SCRs, DHRs, Reviews etc. and national research;
    - likewise for sharing news, updates and information of interest across the partnerships;
    - one place to promote multi-agency learning and development e.g. by linking to e-learning and other platforms and sources;
    - a single reference source for professionals and voluntary workers to access MSAB/MSCB policies and procedures alongside other key documents;
    - information that is 'owned' in terms of commitment by the multi-agency safeguarding boards and their partners;
    - a protected area accessible only by partners;
    - signposting to useful and appropriate information for the children, young people and adults of Manchester and their parents and carers;
    - similarly signposting for businesses, the wider community and members of the public;
- Development of 7 minute briefings.
- Maintenance of MSB (incorporating MSAB and MSCB) branding.

- Ongoing network of support to the MSB Communications Manager.

7.3.8 Greater Manchester Safeguarding Policies consortium

The MSCB is part of a consortium of Greater Manchester Local Safeguarding Children Boards – the Greater Manchester Safeguarding Partnership (GMSP).

All ten Boards jointly commission a single set of online safeguarding procedures. These are updated twice per year to ensure they are kept in line with current practice and statutory requirements. More information about the GMSP can be found on the website www.gmsafeguardingchildren.co.uk and the procedures can be found at greatermanchesterscb.proceduresonline.com

8. Finance

The income and expenditure sheet (refer to Appendix 2) shows that the combined income to the MSCB for 2016/17 was £556,585. This was a combination of funding from:

Manchester City Council	£441,019
Other Partners (as detailed in summary)	£ 92,316
Total Spend equated to	£476,996

9. Challenges and Future Priorities

Towards the end of the 2016/17 period, the MSCB began the process of planning its vision and priorities for the 2017/18 year. As part of this preparation, the Board felt very strongly that the views of children and young people should be sought and a short Survey Monkey questionnaire was set up on the MSB website and promoted through both the Board and individual agencies. Some focus groups were also held by partners to gather views.

Amongst the feedback, children and young people told us that being safe meant: being looked after/having adult supervision/having someone you can trust; avoiding strangers and danger; being safe both in and out of the home; being free from different types of abuse; environmental factors and freedom of speech.

Things that did not make children and young people feel safe included: abuse towards themselves or others; having no one to trust or talk to; bullying/hate crime/peer pressure/hate crime; drugs and alcohol; unlit areas/walking alone and arguments and shouting.

When asked what three areas the Board should work on most in terms of hearing the voice of children and young people, the themes of communication, trust building and further advice/information were identified.

In early April, a Visioning and Priority Setting Event was held and partners came together to review what progress had been made during the year and identify what challenges remain on our improvement journey. There was also an opportunity to consider the factors - legislative, financial and others - that will have an impact in the forthcoming year.

The responses from the survey of young people were shared at that event and partners were able to analyse the findings and use them to help inform a picture of what the next year should bring for MSCB in terms of priorities.

Further work through Leadership resulted in the Board being able to identify its key strategic priorities for 2017/18. The 2017/18 Business Plan will now be implemented and reported upon in the MSCB 2017/18 Annual Report.

MSCB Annual Report 2016/17

June 2017

MSAB
MANCHESTER SAFEGUARDING ADULTS BOARD

SHARED STRATEGIC PLAN 2017/18

MSCB
MANCHESTER SAFEGUARDING CHILDREN BOARD

MSAB Vision:

Ensuring every citizen in Manchester is able to live in safety, free from abuse and neglect. Everyone who lives and works in the City has a role to play.

MSCB Vision:

Every child and young person in Manchester should be able to grow up safe, free from abuse, neglect or crime; so allowing them to enjoy a happy and health childhood and fulfil their potential.

MSAB Objectives:

- To provide effective leadership, governance and partnership working to safeguard people
- To listen to, support and empower people
- To promote and raise awareness of safeguarding
- To be assured that vulnerable people are being safeguarded
- To implement and monitor changes to ensure abuse or neglect does not happen again to others

MSCB Objectives:

- To be assured services for children and young people are targeted, responsive and efficient
- To do all we can to help children and young people lead happy, healthy and productive lives
- To learn from SCRs and other reviews and listen to the views of children and young people
- To ensure we have processes to audit our work and to measure its effectiveness and impact
- To demonstrate collective leadership across the Board and subgroups

Our overarching strategic priority:

- To be assured that safeguarding is effective across Manchester

Achieving our thematic priorities for 2017/18:

- Mental health, learning disability and substance abuse are key considerations across all of our priorities
- We will support and challenge our partners against each priority
- Strong and effective governance and accountability are fundamental to assurance

Our key functions:

- Learning and Development (including reviews and investigations)
- Quality Assurance & Performance Improvement
- Communication & Engagement
- Standards, Policy & Practice

ENGAGEMENT and INVOLVEMENT

Listening & learning; hearing the voice of children & adults; Making Safeguarding Personal

We will:

- Listen to the views of children and adults
- Make sure their voices are heard and are at the centre of what we do
- Put children and adults in control of decisions about their care and support
- Be proactive in making children and adults aware of emerging issues and how we'll deal with them.

What will change?

- We will know what children and adults think and take account of it when we make plans
- We will know those views are taken account of when agencies set up and make changes to services.

COMPLEX SAFEGUARDING

Domestic Violence & Abuse, FGM, Sexual Exploitation, Radicalisation, Missing, Organised Crime, Trafficking & Modern Slavery, So-called Honour Based Violence

We will:

- Ensure that the complex safeguarding issues listed are tackled effectively and that adults & children at risk are protected
- Seek assurance from Community Safety partners that safeguarding issues are considered throughout the response to domestic violence and abuse
- Work with housing providers, the voluntary sector & communities to raise awareness of complex safeguarding issues and how to tackle them.

What will change?

- We will be assured that adults & children at risk are effectively and consistently protected from harm, or supported it if it does occur.

TRANSITIONS

Moving from child to adulthood in a safe and positive way

We will:

- Agree a clear, commonly understood definition of transitions, as it relates to our member agencies and services
- Map and understand all the points where individuals transitioning from child to adulthood may need and engage with care, support and safeguarding provision
- Facilitate the development of a Transitions Strategy that ensures individuals' engagement with services as they transition is consistent, seamless and safe; no-one 'slips through the net'.

What will change?

- We will be assured that individuals who need care & support benefit from a simple, effective and safe response as they make the change from child to adulthood.

NEGLECT

Ensuring the basic needs of every child are met

We will:

- Ensure that practitioners are equipped with the tools to recognise, assess and prevent neglect of children
- Communicate and embed the neglect strategy across partner organisations
- Seek assurance that early help is sought where there is a risk of abuse

What will change?

- We will be assured that children at risk of neglect will be safeguarded and protected.

NEGLECT

Adults at risk of self-neglect, wilful neglect or neglect by omission are safeguarded and supported

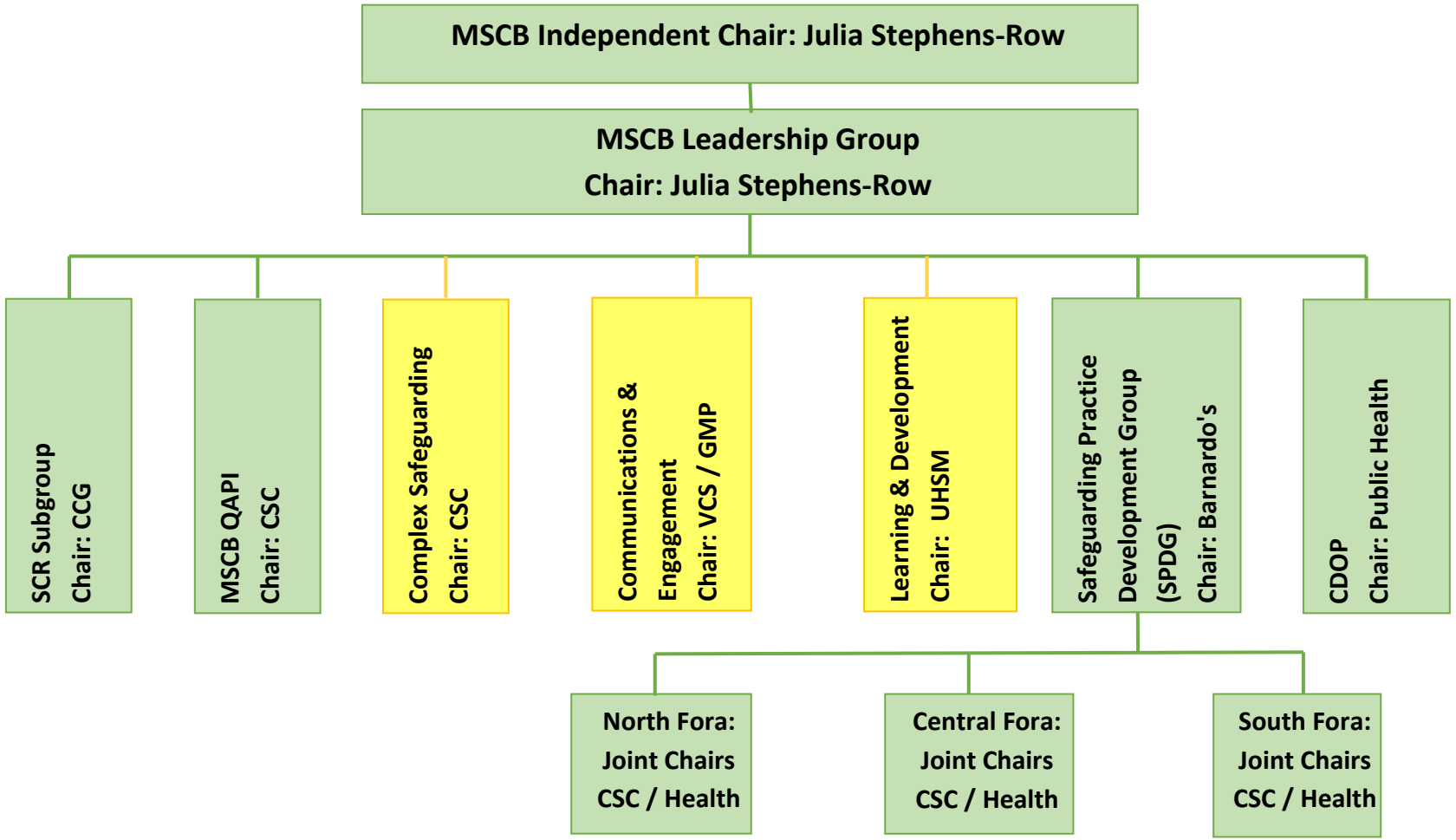
We will:

- Work with partners to assure ourselves that wilful neglect or neglect by omission is recognised and addressed
- Seek assurance that there is an effective multi-agency response to the issue of hoarding
- Seek assurance that there are appropriate responses in place for those at risk of self-neglect

What will change?

- We will have greater understanding that adults at risk of neglect are being safeguarded

Appendix 1: MSCB Structure April 2016 - March 2017



Appendix 2: MSCB Financial Statement 2016/17

Manchester Safeguarding Children Board - Budget and Expenditure 2016/17			
Cost Elements	**Annual Budget**	**Actual Spend**	**Variance**
* **Employees**	**348,604.00**	**388,376.12**	**39,772.12**
* **Premises**	**37,700.00**	**6,233.95**	**(31,466.05)**
* **Transport**	**3,000.00**	**951.07**	**(2,048.93)**
* **Supplies & Services**	**165,040.00**	**198,468.16**	**33,428.16**
* **Internal Charges**	**141.74**	**(166,221.66)**	**(166,363.40)**
** **Revenue Expenditure**	**554,485.74**	**427,807.64**	**(126,678.10)**
Miscellaneous Income		**(2,639.55)**	**(2,639.55)**
MCC Safeguarding	(94,500.00)	(94,500.00)	
MCC Education	(71,000.00)	(71,000.00)	
MCC Housing	(9,450.00)	(9,450.00)	
MCC Additional Income	(56,339.00)		56,339.00
MCC Budget Contribution	(209,730.74)	(209,730.44)	0.30
MCC Adult Income			
Total Contribution from MCC	**(441,019.74)**	**(384,680.44)**	**56,339.30**
NHS	(52,400.00)	(52,400.00)	
Probation	(7,500.00)	(7,500.00)	7,500.00
Cafcass	(550.00)	(550.00)	
Greater Manchester Police	(31,866.00)	(31,866.00)	
Total	**(92,316.00)**	**(92,316.00)**	
Total Revenue Income	**(533,335.74)**	**(476,996.44)**	**56,339.30**
Over/Underspend	**21,150.00**	**(51,828.35)**	**(30,678.35)**

Appendix 3: Glossary

GLOSSARY	
BMI	Body Mass Index
CA	Children Act (1989)
Cafcass	Children and Family Court Advisory and Support Service
CAMHS	Child and Adolescent mental health service
CCGs	Clinical Commissioning Groups
CDOP	Child Death Overview Panel
CMFT	Central Manchester Foundation Trust
CQC	Care Quality Commission
CRC	Community Rehabilitation Company
CSC	Children's Social Care
CSE	Child Sexual Exploitation
CSP	Community Safety Partnership
CYP	children and young people
DBS	Disclosure and Barring Service
DfE	Department for Education
DoH	Department of Health
EHA	Early Help Assessment
FGM	Female Genital Mutilation
FNP	Family Nurse Partnership
GMFRS	GM Fire and Rescue Service
GMP	Greater Manchester Police
GP	General Practitioner

GLOSSARY	
HWBB	Health & Wellbeing Board
IDVA	Independent Domestic Violence Advisor
IRIS	Identification and Referral to Improve Safety
LAC	Looked After Children
LADO	Local Authority Designated Officer
LSCB	Local Safeguarding Children Board
Macc	Manchester Alliance Community Care
MASH	Multi-agency Safeguarding Hub
MCC	Manchester City Council
MFH	missing from home
MSAB	Manchester Safeguarding Adults Board
MSCB	Manchester Safeguarding Children Board
PRU	Pupil Referral Unit
SCR	Serious Case Review

This report was circulated for comment to Board members and finalised on 28th September 2017.

It will be presented to the Manchester Health and Wellbeing Board, the Manchester Safeguarding Adults Board (MSAB), Manchester City Council's Scrutiny committee and the Clinical Commissioning Group.

It will be sent to the Chief Executive or equivalent of all member agencies, including the Police and Crime Commissioner.

The full published MSCB Annual Report 2016/17 can be found on our website
www.manchestersafeguardingboards.co.uk
Or contact the MSB Business Unit: Tel: 0161 234 3330 or email mscb@manchester.gov.uk