MANCHESTER SAFEGUARDING CHILDREN BOARD

2017/2018 Annual Report

"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"

Published: September 2018

This Annual Report was endorsed by the Manchester Safeguarding Children Board on 6th September 2018.

The report is produced by Manchester Safeguarding Children Board (MSCB). It reports on matters relating to 2017/18.

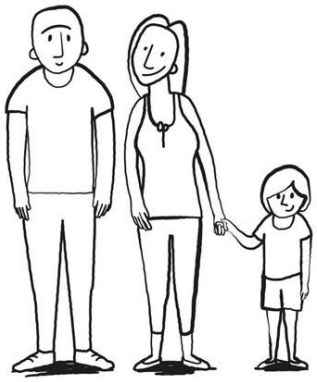
The purpose of the Annual Report, as stated in Working Together to Safeguarding Children 2015, is to provide a rigorous and transparent assessment of the performance and effectiveness of local safeguarding arrangements for children. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action.

The report includes lessons from reviews undertaken within the reporting period.

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

If you have any comments about the Boards work or wish to find out more you can contact MSCB: - Manchester Safeguarding Children Board on 0161 234 3330 or email: manchestersafeguardingboards@manchester.gov.uk

Large print, interpretations, text only and audio formats of this publication can be produced on request. Please call on 0161 234 3330



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1. Chair Foreword

Welcome to the Manchester Safeguarding Children's Board (MSCB) Annual Report for 2017/18. This annual report provides local people with an account of the MSCB's work over the past year to improve the safeguarding and wellbeing of children and young people across the city of Manchester.

The report reflects the activity of the MSCB and its sub groups against the agreed priorities for 2017/18. It is important to note that four of the subgroups are shared with the Manchester Safeguarding Adults Board which demonstrates the Think Family approach we take and the overlapping agendas of the two Boards. For the first time we were able to have a shared strategic plan across the two Boards with separate business plans ensuring that the focus on Children's Safeguarding or Adult Safeguarding is not diluted.

This report contains information on the Serious Case Reviews undertaken, strategies developed, training delivered and findings from audits. This year we had a particular emphasis on challenge and considering the impact of our activity and The Voice of the Child was a particular priority of the annual self-assessment carried out by each agency.

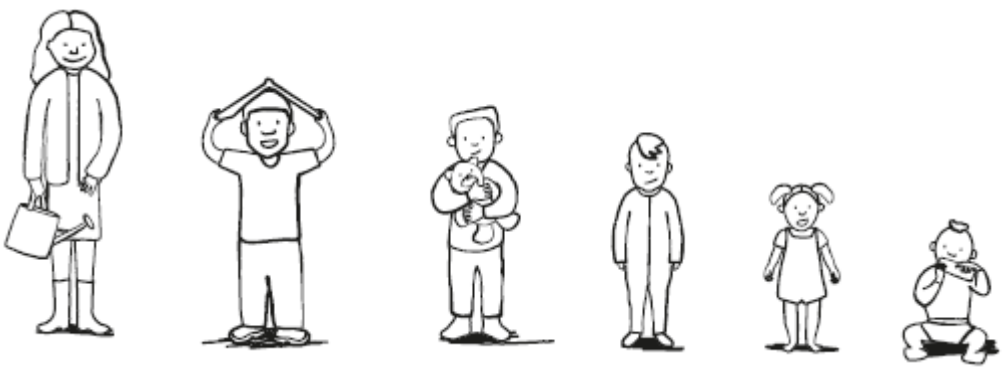
The vision of the Manchester Safeguarding Children Board was reviewed as part of the Annual planning process and was changed to 'Every Child in Manchester is Safe, Happy, Healthy and Successful. To achieve this, we will: Be child-centred, listen to and respond to children and young people, focus on strengths and resilience and take early action', to reflect the Our Manchester Strategy and is now consistent with the vision for the Children's Board. A focus for the Board has been to work more closely with the other key partnerships and the work of the MSCB contributed to the improvement journey for Children's services. It was pleasing to see the work of all the partnerships being recognised when Ofsted reported in December 2017.

Looking forward, legislation came into effect in July 2018 and Local Safeguarding Boards are to be replaced with new multi-agency safeguarding arrangements which have to be established by September 2019 at the latest. Until these new arrangements are in place the statutory requirements for the MSCB remain and it will be vital to ensure that the transition arrangements are robust to ensure that the safeguarding of children and young people remain at the heart of what is developed in the future. Early discussions are taking place in which the MSCB is actively engaged.

Finally, I would like to thank the many partner agencies for their hard work and dedication during a time of huge demand and whose commitment and motivation helps deliver our shared priorities.

J. B. Stephens-Row

Julia Stephens-Row
Independent Chair of Manchester Safeguarding Adults and Children Boards
August 2018



2. Executive Summary

The Board focuses on specific areas where children and young people are in need of help and protection.

This report details the progress we have made against our safeguarding priorities set early in 2017 in the 2017/18 Business Plan, along with the areas identified as future challenges relating to individual and multi-agency safeguarding arrangements and is put together along with contribution from partners and subgroups and includes information regarding the progress of the Board over the last year.

An important function of the Board is to monitor and evaluate the effectiveness of what is done by all Board safeguarding partners both individually and collectively to safeguard and promote the welfare of children, including advising them on ways to improve.

The Board meets regularly and is supported by a number of subgroups, detailed later within this report.

The 2017/18 priorities were set at a joint Board event (with the MSAB) in April 2017.

We chose four main priorities:

1. Engagement and Involvement
2. Complex Safeguarding
3. Transitions
4. Neglect

During the 2017/18 period, a number of statutory reports were received, including the annual report of the Child Death Overview panel, the annual Private Fostering report, which highlighted the Manchester Private Fostering Week, which took place in July 2017 ensuring that the Local Authority complied with the duty of care placed upon them to promote and raise awareness of children and young people who are privately fostered and an imminent targeted communications campaign aimed to do this. The report from the Local Authority Designated Officer (on the management of allegations against adults who work with children) was also considered, providing assurance of the safeguarding work ongoing. The report highlighted that during the reporting year there had been significant activity aimed at raising awareness about the management of allegations and increasing demands on the Designated Officer, with an increase in allegation referrals from 204 to 319. In addition the Designated Officer responded to advice and guidance contacts and providing information about adults who have worked in Manchester in the past as part of historic abuse enquiries.

The Board screened 12 Serious Case Reviews (SCR) during 2017/18, eight were found to meet SCR criteria and reviews are underway; one was found not to meet SCR criteria and a Learning Review was conducted and three were found not to meet SCR criteria and required no further action. These are summarised in Section 8.

The "*Trust Your Instinct*" Campaign was launched. This campaign is aimed at all members of society, from members of the public to safeguarding practitioners. Further details about the campaign can be found on our website at: **www.manchestersafeguardingboards.co.uk/trust-your-instinct**

Manchester Safeguarding Children Board partners worked together to develop a Neglect Strategy 2017/19 which was launched and introduced the Graded Care Profile 2 (GCP2) Neglect assessment tool. The primary purpose of this Strategy is to set out the strategic direction and priorities which outline how partners will work together to offer a coherent, effective and well-co-ordinated multi-agency response to cases where neglect is an issue.

The Voice of the Child was a specific focus of the 2017 Section 11 Safeguarding Self-Assessment, which incorporated an additional voice of the child section, requiring all partner agencies to assess how well their own agency takes account of the views and wishes of children and young people.

The Interboard Protocol was launched in July 2017. This protocol outlines the co-operative relationship between the Manchester Children's Board, (MCB), the Manchester Community Safety Partnership (MCSP), the Manchester

Health and Wellbeing Board (MHWB), the Manchester Safeguarding Adults Board (MSAB) and the Manchester Safeguarding Children Board (MSCB) in their joint determination to safeguard and promote the health and wellbeing of children, young people and adults in Manchester. The aim of this protocol is to ensure that there are core principles which underpin how the five Boards and other partnership forums operate.

3. About Manchester

Population statistics in Manchester were last collected in 2016 and showed a population of 541,000, with 22.2% of those being children and young people aged between 0-18 years and 28.5% being from an ethnic minority group. The estimated population for Manchester in 2020 is 563,000.

The percentage of school pupils from minority ethnic groups in Manchester in 2017 was 62.6% compared to the England average of 31% and the percentage of school children with social, emotional and mental health needs was 2.7% compared to the England average of 2.3%.

Child poverty is a concern in Manchester - the most commonly used definition of child poverty is a household with children under 16 where income is less than 60% of the UK median.

The latest figures show that, between 2007 and 2014, the overall proportion of children living in poverty in Manchester fell from 44.6% to 35.6%. 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 35.6% figure equates to 36,255 children under 16 living in poverty out of a total number of 101,845. It is predicted that the number of children living in poverty will rise sharply by 2020.

Manchester's State of the City report provides further data and statistics for Manchester: **www.manchester.gov.uk/state_of_the_city_report_2017**

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

Population Health

The Manchester Population Health Plan is the City's overarching plan for reducing health inequalities and improving health outcomes for our residents which will reduce safeguarding risks in the population. Much of 2017/18 was spent developing the plan and consulting with a wide range of stakeholders. The plan can be found here: **www.manchester.gov.uk/health_and_wellbeing/public_health**

The Plan, with five priority areas for action, has been developed in partnership with a wide range of stakeholders and is an integral component of the refreshed Locality Plan, "Our Healthier Manchester".

At Population Health we recognise that in addressing the safeguarding needs of children we need to address a complex range of factors throughout an individuals' lifetime such as parenting capacity, development/educational issues, housing, employment and income, social integration and support, drug and alcohol misuse, and issues related to service provision or uptake.

The decision to introduce compulsory relationships education in primary schools and relationships and sex education (RSE) in all secondary schools is a welcome move that we support locally. Comprehensive, high quality, age appropriate RSE is known to be a protective factor for children and young people, supporting them to keep themselves safe. 'Growing and Changing Together' and the 'I Matter' curricula developed by the Healthy Schools Team are already in use in many of the city's schools and extended delivery by schools to all their students will be a positive contribution both to preventative work and to improving public health outcomes. Population Health

will be working with a range of partners to ensure that schools, parents and children and young people are aware that this is now compulsory.

4. Statutory Framework and how we deliver

The Children's Act 2004 requires all Local Authority areas to establish a Local Safeguarding Children Board (LSCB). LSCBs are inter agency partnerships with statutory responsibility to coordinate local safeguarding arrangements which promote the welfare of children and make sure they are working effectively. Manchester Safeguarding Children Board includes representation from the Local Authority, Greater Manchester Police, Health Services, Housing, Probation and the Voluntary sector.

The functions of the LSCB are set out in Working Together to Safeguard Children 2015 (now revised to Working Together 2018) **www.manchestersafeguardingboards.co.uk/working-together**

Our statutory functions and objectives are 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;
- ensure the effectiveness of what is done by each such person or body for those purposes
- develop policies and procedures for safeguarding and promoting the welfare of children in the area of the authority
- raise awareness within communities of the need to safeguard and promote the welfare of children, how this can best be done, and encourage them to do so;
- monitor and evaluate 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 advise them on ways to improve
- participate in the planning of services for children in the area of the authority
- undertake Serious Case Reviews and advise the authority and their Board partners on lessons to be learned.

Manchester Safeguarding Children Board meets every two months and focuses on a range of activity including how we are implementing our Business Plan, the priorities within it and the impact our action is making towards safeguarding outcomes for children. Board members are required to commit to 80% attendance at meetings over the year. Those members who do not meet this attendance rate are contacted by the Independent Chair. A full list of membership as of March 2018 can be found at Appendix 1.

The Board has statutory responsibility for completing Serious Case Reviews (SCRs) by overseeing the screening, conduct and publication of SCRs and other learning reviews. This work is supported by the Serious Case Review Subgroup, Learning from Reviews Subgroup, Learning and Development Subgroup and Safeguarding Practice Development and Fora Subgroup.

Other subgroups that support the Board are the Quality Assurance and Performance Improvement Subgroup (QAPI), Communications and Engagement Subgroup and the Complex Safeguarding Subgroup.

The MSCB Leadership Group manages the Board's business, co-ordinating the work programme and overseeing key business functions on behalf of the Board. This includes overseeing the risk register and the budget, and performance. The Group also, where necessary, commissions groups to look at specific pieces of work in greater depth.

The Governance Structure for Manchester Safeguarding Board can be found at Appendix 2.

The Board is supported by the Manchester Safeguarding Boards Business Unit (MSB BU)

The Board support for the MSCB has been through significant change in the last year. There was one member of staff who was dedicated to supporting the MSCB and also leading on Serious Case Reviews. This has now been changed to having one member of staff supporting both Boards and one member of staff leading on Serious Case Reviews and Safeguarding Adult Reviews. The changes were brought about as each of the previous roles had a number of overlaps and the changes seem to be working well. It will be important to monitor the workload requirements of both roles. In addition, there is now a permanent MSB integrated Board Manager which has ensured greater continuity and consistency across the work of the board support team

Future challenges: -

The team are focusing on mapping the current systems in Manchester to ensure that they are appropriate. Moving forward, part of this system review will link in to the wider GM strategy and build a more collaborative working arrangements including the system of selecting and nominating reviewers for SCRs

It is also intended to recruit to a temporary project officer role who will support the implementation of the Neglect Strategy which is one of the board priorities and assist with the development of the web based services for practitioners thus supporting the embedding of learning in to practice.

It should be noted that as a result of the legislative changes introduced through the Children and Social Work Act 2017, the Government sent out consultation in October 2017 detailing revisions to the current Working Together Statutory Guidance. Following this, the Government proposes to update and replace the current statutory guidance as 'Working Together to Safeguard Children 2018.'

This signifies an interesting year ahead as the changes include replacing Safeguarding Children Boards with new safeguarding partnership arrangements.

5. Our Priorities for 2017/18

The 2017/18 MSB Business and Strategic Plan was set out by the Board in April 2017, detailing priorities and actions for the forthcoming year. The 2017/18 strategic plan can be found at Appendix 3. We chose four main priority areas:

Engagement and Involvement - Listening & learning; hearing the voice of children

We will:

- listen to the views of children
- make sure their voices are heard and are at the centre of what we do
- put children in control of decisions about their care and support
- be proactive in making children aware of emerging issues and how we'll deal with them

We have:

- Undertaken Voice of the Child self-assessments within Section 11 audit
- Embedded the Voice of the Child in our multi-agency audits
- Developed our website to have an area for children
- Engaged children in the development of our board priorities

What will change?

- we will know what children 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 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.

We have:

- Supported the Integration of Protect and Integrated Gang Management Unit (IGMU) services in preparation for Complex Safeguarding Hub
- delivered a series of awareness multi-agency awareness raising events regarding modern slavery and trafficking and developed a Manchester Modern Slavery and Trafficking Strategy
- Heard from Community Safety Partners who provide the Complex Subgroup with thematic updates re Domestic Violence & Abuse, Female Genital Mutilation etc, raising any concerns to the Board.

What will change?

- We will be assured that 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'.

We have:

- held a multi-agency transitions workshop with further actions to continue into 2018/19, seeking to highlight challenges faced by children in transition arrangements and consider what needs to happen to develop and improve multi-agency practice.

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.

We have:

- Launched the Neglect Strategy and held neglect briefings across the City
- Contributed to work on a Greater Manchester Campaign aimed at raising awareness of neglect
- Launched Graded Care Profile2 – an evidence based neglect assessment toolkit that will assist professionals to identify the root cause of neglect and target those areas that will have the greatest impact.
- Started to develop a multi-agency dataset aimed at measuring impact.

What will change?

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

6. What have we done?

Neglect Strategy

Manchester Safeguarding Children Board partners worked together to develop a Neglect Strategy 2017/19 that was accepted by the board in March 2017. Later in May 2017 the Graded Care Profile 2 (GCP2) was accepted as our chosen Neglect assessment tool.

The primary purpose of the Neglect Strategy is to set out the strategic direction and priorities and outlines how partners will work together to offer a coherent, effective and well-co-ordinated multi-agency response to cases where neglect is an issue.

This Neglect Strategy seeks to ensure our children and families workforce is able to identify and recognise neglect in families across universal and specialist services in order to ensure an effective multi-agency response is provided at the earliest opportunity to improve outcomes for children, young people and their families and reduce the impact of neglect and the risk of an escalation of concerns at the earliest opportunity. An integral part of the strategy is the importance of early identification and engagement of families including effective early help assessment and the development and delivery of a clear action plan.

GCP2 is an assessment tool that helps professionals to measure the quality of care being given to a child and helps them to spot anything that is putting that child at risk of harm. It is important we find children who are at risk of harm as early as possible so we can get them the right help and support at the right time and reduce the risk of escalation. The NSPCC have been engaged in supporting our implementation of GCP2 - we recognise this is at least a three year implementation programme.

The percentage of children subject to a Child Protection Plan under the category of neglect is the lowest it has been in three years. This year it has reduced from 54.8% in Quarter 1 to 45.7% in Quarter 4. It is below the national average of 47.8% which is positive, but still higher than core cities and statistical neighbours. The Graded Care Profile 2 is now being rolled out across Manchester and it is expected that there will be increase in referrals as this assessment tool is rolled out practitioners over the next 12 months.

The Neglect Strategy has not been fully embedded by all agencies and as a result, the Board intends to fund a temporary project officer to drive the project forward. This task will then be undertaken by resources within the Business Unit once the temporary officer position concludes. The embedding and implementation of this strategy and toolkit remains a priority for the Board as we move into 2018/19.

Voice of the Child

We are committed to listening to the voice of the child and improving engagement with children and young people in all aspects of our work. Considering the voice of the child was an integral part of our work during 2017/18.

All reports coming to the Board and subgroups continue to detail information as to how the work described will impact the lives of children and young people. The Board also has three lay members who attend at Board and other subgroups to provide a grass roots perspective to our work. Their attendance and contribution is highly valued.

The Section 11 Safeguarding Self-Assessment in 2017 incorporated an additional voice of the child section which required all partner agencies to assess how well their own agency takes account of the views and wishes of children and young people.

In the separate Voice of the Child self-assessment section, agencies were asked to give themselves a "RAG" (Red / Amber / Green) rating for the following five questions:

1. Developing a culture of listening supported by a strategy of participation
2. Providing inclusive structures for a range of children's voices to be heard
3. Participation by young people is acknowledged and rewarded
4. Develop staff skills in listening and responding to children
5. Measure & record the impact of participation

There were 21 self-assessments submitted in total. None of the agencies rated themselves as Red for Question 1. Two agencies rated themselves as Red for Question 2 and one agency rated themselves as Red for Questions 3, 4 and 5. The question where the most number of agencies (9) rated themselves as Green was Question 3. This was closely followed by Questions 1, 4 and 5 (8 agencies). However there were noticeably less Green scores overall in the separate Voice of the Child section than there were in the main Section 11 self-Assessment survey - for example the number of agencies rating themselves as Green in the first two sections of the Section 11 self-assessment which relate to 1) A Culture of Safeguarding and 2) A Safe Organisation was between 16 and 21. The highest score (21), which represents the total number of agencies that submitted a Section 11 self-assessment, was for the question that relates to safe recruitment procedures.

This shows that the MSCB as a whole is far more confident in matters that relate to policy and procedure than they are in matters that relate to taking account of the views and wishes of children and young people. The Voice of the Child audit in 2017 gave individual agencies the chance to benchmark how well they were performing and an opportunity to identify areas that can be improved on.

What are we doing about Child Sexual Exploitation (CSE)

Manchester Phoenix Protect Service is a co-located multi agency team consisting of social workers, police officers, early help, health and voluntary sector staff. The team work to safeguard young people who have been identified as being at risk of child sexual exploitation (CSE) and to disrupt and prosecute offenders of CSE. They work collectively and hold daily risk briefings as this facilitates information sharing, triage, joint working and decision making in respect of referrals, and new intelligence.

There were 174 referrals received for CSE in 2017/18; this is lower than in 2016/17 when referrals were 218. The lower figure reflects the screening and conversations undertaken by the team to identify the most vulnerable children and thus ensuring a key focus on those children who are suffering or likely to suffer significant harm through sexual exploitation. There was a peak in referrals in June 2017 reflecting a heightened focus following the commencement of Operation Diamond, a complex child sexual exploitation investigation which resulted in a number of referrals to both children and adult social care services.

A number of convictions were secured in 2017/18 including a female convicted of grooming and trafficking a 14 year old boy who was sentenced to 3.5 years in custody; two males were convicted of grooming and two offenders were convicted of fraud offences following complex safeguarding investigations. A male was convicted for breach of a sexual harm prevention order; this was imposed in relation to previous CSE offences.

Links between sexual exploitation and young people going missing as a key risk factor are well recognised. In 2017/18 it was agreed that the Protect social workers would complete the Independent Return Interviews (IRIs) where a young person had gone missing and is already receiving an intervention from Protect. This has been successful in increasing the completion of IRIs but more importantly ensuring that learning and the views of children and young people have informed care planning and trigger plans.

A Senior Specialist CSE Nurse has been co–located with the Protect multi-agency team for four years and the team are supported by a range of services and have a co–located Young People's worker from Barnardo's whose focus is therapeutic interventions. Other support is provided from key partners such as the Children's Society, Factory Youth Zone and Manchester Young Lives.

The dedicated Early Help Interventions Team co–located within Protect now work across all areas of exploitation, but have retained a specialism of working in a whole family way and focus on support and parenting interventions as well as direct work with children and young people. The team have supported 34 families and 68 children and young people and the average length of intervention is eight and a half months. The team have a strong retention rate; only seven families did not complete their intervention.

Complex Safeguarding

We know there are strong links between criminal exploitation and sexual exploitation and links between young people who go missing and being exploited. To improve our safeguarding response, it makes sense to reconfigure our partnership response in a more coherent and coordinated way and bring together a range of services including Voluntary and Community Services (VCS) partners who are responding to complex safeguarding and exploitation.

Throughout 2017/18 we have been developing our plans to implement a complex safeguarding hub, which is expected to be fully functioning by September 2018.

In preparation, the work of the Integrated Gang Management Unit (IGMU) was absorbed within the wider work of the Phoenix Protect team in October 2017. This has proved to be a successful approach, with workers having a mixed caseload of CSE and exploitation cases and has enabled the service to test out this approach as they work towards fully implementing the complex safeguarding hub. A team manager retains a thematic lead for organised crime and exploitation and has been instrumental in undertaking mapping with youth justice, social care and voluntary sector partners, to identify young people and their associates involved in both organised crime and the victims of criminal exploitation. From April 2017 to March 2018 a total of 49 referrals were made in relation to gangs and the emerging area of criminal exploitation.

Children missing from home and care

During 2017/18 there were 1515 children missing from home and 3505 missing from home incidents. There were 1173 missing from care incidents and 229 children missing from care. This number has reduced from the last period 2016/17 and it is noted that two individuals (4%) were missing on more than 12 occasions account for 39 (17%) incidents.

Due to a successful Missing From Home Panel, the number of Missing From Home episodes have significantly reduced for children in Local Authority Care.

The safe and well check process is now being delivered successfully across Manchester by Missing teams. Young people are engaging and able to share their views more easily.

7. Serious Case Reviews and Lessons Learned

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1)(e) and (2) set out an LSCB's function in relation to serious case reviews, namely: 5(1)(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned. (2) For the purposes of paragraph (1) (e) a serious case is one where: (a) abuse or neglect of a child is known or suspected; and (b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Cases meeting SCR criteria		
SCRs conducted and concluded; reviews published in 2017/18	3 cases	SCR H1, SCR I1, SCR K1
SCRs screened in 2017/18 and found to meet SCR criteria; reviews are underway	8 cases	SCR N1, SCR O1, SCR P1, SCR Q1, SCR R1, SCR S1, SCR T1, SCR U1
SCRs concluded during 2017/18 which will not be published	2 cases	SCR E1, SCR J1
Out of Area SCRs where MSCB has participated or contributed information	2 cases	Manchester has contributed to two SCRs being conducted in other areas: Trafford and Blackpool

Cases not meeting SCR criteria		
Learning Review undertaken	1 case	N/A
No review action required (case does not meet SCR criteria and no further action required)	3 cases	N/A

Published Reviews: Key Findings and Learning

SCR H1 (published December 2017) www.manchestersafeguardingboards.co.uk/serious-case-reviews	
Key Themes: Physical Abuse, Neglect SCR H1 concerns a 14 year old who was the eldest of five siblings. During the time covered by this SCR, there were ongoing concerns about the emotional and physical wellbeing of the eldest child, neglect of all the children and worries about the involvement of an unknown male in family life. In July 2015, mother was admitted to hospital suffering from acute psychosis and was detained in hospital under Section 2 of the Mental Health Act. The children were left in the care of the presumed father (of the three youngest children). After a few days, the eldest child alleged to police that their stepfather had raped them and he was arrested.	**Key Findings and Learning** Overall the review has highlighted the complexity of working long-term with a mother and her five children, who had been voluntarily accommodated by the local authority and subject to child protection plans for neglect, stepped down, and then the cycle repeating itself. The review identified the need to improve the multi-agency response to working with children and families, in particular; with families who are perceived as 'difficult to engage' and where there is a long history of poor parenting and neglect. ● safeguarding systems are too focused on the efficiency with which cases are progressed; this impacts particularly upon neglect cases which have over-prioritised practical support at the expense of gaining an understanding of root cause ● a combination of pressure to process cases through the system and limited available resource means that child protection plans in Manchester are being created with insufficient consideration of how well a service might meet individual needs ● when services are configured separately for adults and children there is a danger that the impact of risk within the family is not fully understood, which can potentially leave children and adults vulnerable ● beyond the superficial labels used for demographic data collection, when professionals feel uncomfortable asking about and further do not recognise the importance of a person's background, culture and belief system; children and families' needs may remain unmet ● local authority management systems are insufficiently challenging of the custom and practice of social workers not to seek or systematically record informed parental consent for s20 accommodation, potentially leaving the support needs of parent's unseen and making case-drift more likely ● over-concern about the risks rather than benefits of information sharing is resulting in professionals being unsighted as to safeguarding risks to children.
Learning Activities A learning event for practitioners and professionals was held on **15.9.2017** to disseminate the findings and learning from this review. Learning Packs for practitioners include a Learning Report, 7 Minute Briefing and Power Point Presentation and are available on the MSB website.	All of the identified actions associated with the Child H1 SCR recommendations are complete. A well-attended multi-agency Professional Curiosity conference has been held where techniques for holding difficult conversations were discussed. The MSCB agreed to commission Graded Care Profile 2 as the assessment tool for Neglect. An implementation programme has been developed and a multi-agency / multi threshold Board established. Neglect Strategy and Levels of Need briefings have been held across the city.

<table>
<tr><th colspan="2">SCR I1 (published December 2017) www.manchestersafeguardingboards.co.uk/serious-case-reviews</th></tr>
<tr><td><u>Key Theme: Neglect</u>
Child I1 was the youngest of a sibling group of three. The children had specific health needs and were removed from poor living conditions after a deterioration in the home environment following Child in Need (CIN and Child Protection Plan (CPP) interventions.
Child I1 and siblings experienced significant harm through neglect over a long period:
● the involvement of agencies during the period of time under review was in response to concerns about poor home conditions
● there was concern about parents not meeting the significant health needs of the children.</td><td>Key Findings and Learning
Key findings from this review identified:
● poor communication between agencies
● poor recording
● loss of focus on the voice of the child and their daily lived experience
● focus on task-completion rather than on on-going assessment of impact of the work being done
● lack of recognition of the importance of chronologies to show the context of previous history
● lack of challenge; and
● a lack of healthy scepticism amongst the professionals working on the case.

The voice of the child – professionals must focus on the daily lived experience of the child; consider specific disabilities and complex needs; and avoid emphasis on parents' perspective.
Assessments - interventions in neglect cases must be informed by multi-agency assessment based on clear understanding of history, with a combined multi-agency chronology as an essential tool.
Multi-agency working – agencies must work closely together to share information, especially where there is concern about disguised compliance. Multi-agency groups need to provide appropriate challenge.</td></tr>
<tr><td><u>Learning Activities</u>
A Learning Event for practitioners and professionals was held on 28.11.2017 to disseminate the findings and learning from this review.

Learning Packs for practitioners include a Learning Report, 7 Minute Briefing and Power Point Presentation and are available on the MSB website.</td><td>With regard to the recommendations from this report, the MSCB has agreed to commission Graded Care Profile 2 as the assessment tool for Neglect. Implementation programme has been developed. Neglect Strategy and Levels of Need briefings have been held across the city. Multi-agency Neglect audits are now part of the annual audit programmes. All multi-agency neglect audits consider how well chronologies are being used and the impact they are having on assessment and planning.</td></tr>
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SCR K1 (published December 2017) www.manchestersafeguardingboards.co.uk/serious-case-reviews	
Key Theme: Neglect Child K1 was three years old when they died following an asthma attack in June 2016. At the time, Child K1 had been diagnosed with brittle asthma and was on a Child Protection plan for neglect. Various services raised concerns & provided support in relation to Child K1's presentation & home environment - professionals had provided care in line with guidance but did not adequately take into account the safeguarding concerns (i.e. the impact of smoking and poor home environment) and the need to further escalate the case.	**Key Findings and Learning** The findings listed below deal with the impact on the management of Child K1's care: ● professionals provided care in line with nationally agreed guidance, however this did not adequately take into account the safeguarding concerns (i.e. the impact of smoking and poor home environment) and the need to further escalate the case. ● health professionals have a lead role to play in ensuring that professionals working with a specific family have a better understanding around the concept of when care is/is not good enough for a child who has a chronic illness or disability and how this should inform case planning ● neglect is a recognised category of abuse, however in this case the professional understanding was not sufficiently sophisticated as to the kind of behaviours that constitute neglect and their impact on children with chronic health conditions. **Further, the review concluded that:** the incidence of childhood asthma in Manchester is the highest in the country, an unsurprising statistic when one considers the social and economic deprivation and the high incidence of smoking. It is therefore important to consider the impact of this on both families and the services providing support when caring for children with asthma and concerns in relation to possible neglect.
Learning Activities A Learning Event for practitioners and professionals was held on **16.3.2018** to disseminate the findings and learning from this review. Learning Packs for practitioners include a Learning Report, 7 Minute Briefing and Power Point Presentation and are available on the MSB website.	The learning from this review regarding the impact of environmental tobacco smoke and the link to safeguarding has been passed to the National Institute for Health and Care Excellence (NICE) to be incorporated in future revisions of their Asthma Guidance. Work is currently underway to improve communication links between GP surgeries and the Safeguarding Improvement Unit in respect of Child Protection Conferences.

Learning Reviews

In addition to the statutory reviews that have been published or are underway, the MSCB also conducted a multi-agency learning review as outlined in the North West Learning and Improvement Framework, greatermanchesterscb.proceduresonline.com/nw_learn_imp_framework.html
and conducted by the MCC Lead for Children's Safeguarding. The review concentrated on 'Fabricated and Induced Illness' which the NHS defines as: 'Fabricated or induced illness (FII) is a rare form of child abuse. It occurs when a parent or carer, usually the child's biological mother, exaggerates or deliberately causes symptoms of illness in the child.'

The review considered a range of key practice episodes with the involvement of a range of agencies and was able to identify what had worked well and what were areas of improvement. The review recommended a range of actions including:

- a review of multi-agency training regarding fabricated and induced illness
- access to a central contact point for professionals to discuss concerns about FII
- easier access to full health chronologies when there is a concern

- a review of school nursing to ensure safeguarding needs are met
- improvement to Early Help meetings, minuting and action plans
- dissemination of learning around FII to school safeguarding leads.

8. Progress against our Business Priorities

We asked our subgroups to provide updates as to how they have contributed to these priorities, what has worked well and any future challenges. The subgroups discussed these and responded accordingly.

Extracts from the Subgroups responses are detailed below and full responses are can be found on the MSB website here: www.manchestersafeguardingboards.co.uk/mscb

Child Death Overview Panel (CDOP)

Purpose of the group - To review the deaths of all children aged 0 – 17 years (excluding stillbirths and legal terminations of pregnancy) normally resident in the City of Manchester to identify lessons learnt or issues of concern and make recommendations on effective inter-agency working to safeguard and promote the welfare of children. This multidisciplinary panel conducts a comprehensive review, with the aim to better understand how and why children in Manchester die and use the findings to recommend actions to prevent deaths and improve the health and safety of our children.

There was a total of 60 child deaths notifications reported to CDOP in 2017/2018, the CDOP discussed and closed a total of 62 cases. 25 (40%) infants were neonatal deaths (babies who died under 28 days of life). A further 16 (25%) died before their first birthday (28 - 364 days), highlighting infants under the age of 1 as the most vulnerable age group, accounting for 66% of the cases closed. The CDOP identified a number of modifiable factors which may have contributed to vulnerability, ill-health or death of the child in 21 (34%) cases. The largest number of deaths were categorised as a 'perinatal/neonatal event' (20, 32%) and 'chromosomal, genetic and congenital anomalies' (19, 30%). A further 6 (10%) deaths were categorised as 'sudden unexpected, unexplained death' where the pathological cause of death remains unascertained. An overview of the emerging themes, trends and modifiable factors are documented in the 2017/2018 CDOP Annual Report which is published each Autumn on the MSB website - www.manchestersafeguardingboards.co.uk/child-death-overview-panel-information-practitioners

Areas of future development: the CDOP aims to raise awareness of the emerging themes in child deaths and contributing risk factors as part of an MSB training event for frontline practitioners. The purpose of the event will be to disseminate learning and raise awareness of organisations that practitioners can signpost families to for additional support. The aim will be to provide frontline practitioners with information and advice to build professional knowledge and confidence when having difficult conversations regarding subjects such as bereavement, safe sleeping arrangements, smoking or obesity.

Practice Example - Neglect:
The CDOP requests information from partner agencies regarding the child, family and other household members to identify any issues in parenting capacity, such as poor parenting/supervision and child abuse/neglect. The panel analyses relevant family and environment factors which may have contributed to vulnerability, ill-health or death of the child. A number of these cases are also subject to Coronial investigations, criminal proceedings and Serious Case Reviews which the panel consider to assess how neglect contributed to the death and document recommendations to prevent future death.

Serious Case Review (SCR) Subgroup

The primary purpose of the SCR subgroup is to screen incoming referrals to assess whether they meet SCR criteria or not, and to recommend to the Independent Chair whether a SCR should be conducted. If SCR criteria is not met, the SCR subgroup can also recommend another type of learning review or activity, including single agency reviews. The SCR subgroup also monitors the progress of SCRs and considers first drafts of completed reviews, providing feedback to the independent reviewer prior to the review being considered by Board.

Once reviews are completed and signed off by the Board, Learning & Development subgroup are charged with conducting case specific learning events and publication of learning materials, and Learning from Reviews subgroup are charged with monitoring any actions agreed as a result of the review findings.

Areas of Future Development - the SCR subgroup recognise that Board members need to nominate appropriate representatives to review panels who can provide strategic analysis of historic and current policies and procedures and enact change in their agencies where required. Panel members need to identify appropriate SMART actions for their agencies in response to learning coming out of reviews for the Board to consider when the Review is concluded; and be able to cascade learning within agencies as it emerges through the review process. It is intended that some work around role profiles for review panel members will help to address this, and there has also been some trial work on identifying a partner representative on the panel as acting in a Lead Professional role.

- the volume of referrals and SCRs/other type reviews (where referrals do not meet criteria) remains high which is a challenge for the subgroup, for agencies and for the Business Unit
- the subgroup would like to have a greater understanding of Coroner's timescales for cause of death, and in particular, toxicology results.

Practice Example - Engagement and Involvement:

In screening and monitoring the conducting of SCRs, the voice of the child has been identified as a key learning theme emerging from a number of reviews and this has been reflected and highlighted in completed reviews. Specific areas where this has been noted includes: help seeking behaviour in children – where a child has taken action to seek help, such as making and attending a GP appointment, and this has not been adequately recognised as a need for greater intervention or has not been adequately responded to; the need for training to support staff to manage 'difficult conversations' with family members, sometimes compounded by reluctance to talk to a parent who is seen as 'challenging'; the importance of hearing the voice of the child – not only hearing but listening and responding; the need for development of awareness of non-verbal communication and ensuring there is confirmed parent/carer consent around Section 20 voluntary care orders, and that the parent/carer giving consent has full capability to give consent, and the importance of recording such consent.

Safeguarding Practice Development Group (SPDG and Fora)

The purpose of this group is to support the strategic priorities of the Board by gathering practice evidence, information and articulating practice challenges.

Areas of future development:

- Children with Disabilities team (CWD) to be invited to join Fora and share information ensure
- new arrangements for Leaving Care Service to be shared as they unfold
- adult safeguarding members recruited to shape transitions services
- continue to grow membership generally
- consider how communication in between meetings can be improved

Practice Example - What has worked well?

-good multi-agency learning arena which includes information and experience sharing
-opportunities to share learning from reviews
-having three Fora Chairs for each area who manage the discussions
-having an action plan and core agenda has benefited the arrangements.

Quality Assurance and Performance Improvement Subgroup (QAPI)

This subgroup has responsibility for the quality assurance of multi-agency safeguarding arrangements via the multi-agency case file audit programme, the multi-agency performance dataset; the annual Section 11 Safeguarding Self-Assessment and single agency audit reports.

Four themed multi-agency safeguarding case file audits have been undertaken in this period - Domestic Violence & Abuse, Looked After Children, Neglect and Pre Birth Assessments - which has resulted in the close scrutiny of approximately 100 agency records in total and the findings together with recommendations for improved multi-agency working have been reported back to the Board.

A Section 11 Peer Challenge Event based on the Section 11 Self Assessments that had been submitted by Board members was held in September 2017. This event was well-attended by partners and provided a forum for challenge between partners as well as sharing good practice and identifying opportunities for working better together to improve outcomes for children and young people.

Areas of future development: continue to strengthen and evidence the impact for children of the work of the QAPI subgroup and get more direct involvement from children & young people. Review the content of the quarterly multi-agency dataset to focus more clearly on Board objectives. Implementation of a practitioner survey to give us a view as to how well the frontline staff understand the requirements of Section 11, the Board priorities and how well learning from audit and reviews is being implemented.

Practice Example - Neglect: the QAPI subgroup has undertaken a multi-agency case file audit on the theme of neglect and the findings have been reported to the Board. One of the key themes arising from this audit was the importance of all agencies maintaining an up to date chronology on the child's record which can evidence the impact of living with neglect over a period of time.

The QAPI subgroup is developing a multi-agency dataset to support the implementation of the Neglect Strategy. This has proved to be more challenging than anticipated in terms of sourcing relevant useful data from across all agencies that is not linked to statutory safeguarding procedures.

Learning from Reviews Subgroup (LfR)

This subgroup has the responsibility for monitoring the implementation of recommendations and actions arising from completed Serious Case Reviews (SCR), Safeguarding Adult Reviews (SAR), other Learning Reviews and also specific recommendations for MSCB or MSAB arising from Domestic Homicide Reviews (DHR).

Areas of future development: this is a new subgroup that was formed in September 2017 and it has taken several months to set the parameters of how the group will operate. For example: as the group evolved it became clear that membership needed to be extended to include Adult Social Care, Probation and a representative for Domestic Violence & Abuse. The Terms of Reference had to be amended and agreed and a permanent Chair and Deputy needed to be secured. There have been issues with the quality of action plans arising from reviews which makes it difficult to monitor the implementation of actions, this has been fed back to the Board and plans are in place to address the problem of actions not being SMART. The subgroup is still in development in terms of being

able to evidence changes in practice arising from learning from Serious Case Reviews (SCR). As the subgroup becomes embedded there will be an opportunity for future development in terms of thematic analysis of learning that will inform the Boards' Business Plan.

Communication and Engagement Subgroup

This subgroup has the responsibility for facilitating the development and dissemination of accessible information in a variety of formats to raise awareness about safeguarding children and adults; targeting a range of stakeholders including citizens, professionals, service users and carers.

This subgroup was formed to:

- maximise communication and engagement opportunities between MSB partners and external stakeholders
- provide a forum to share communication and engagement expertise.

The subgroup will:

- act in a consultative capacity for the MSCB on communication and engagement activities
- allocate or respond to the work of other MSB subgroups
- offer support and advice to the planning and development of communication and engagement activities
- develop the MSB Communications and Engagement Strategy on behalf of the Boards

Areas of future development:

- development of 7 minute briefings has been ongoing
- campaign outputs to be developed
- planning for future campaigns
- measuring impact of communications work

In keeping with revised MSB Business Plan the long term priorities will be:

1. (Child) Neglect Strategy – MSCB
2. Modern Slavery Strategy – MSAB & MSCB

Practice example – what has worked well?

- the MSCB website was replaced by a new MSB website www.manchestersafeguardingboards.co.uk in January 2017; the website was then remodelled and all content refreshed in June / July 2017. Website analytics for 1.4.17 to 31.3.18 show the website had 31,602 users.
- marketing and communications activity for 2017/18 focused on MSB materials such as Trust Your Instinct and the national campaigns such as the DfE Child Abuse campaign.
- in June 2017 the MSB Twitter feed @McrSafeguarding was launched to support the integrated MSB website.

Learning and Development Subgroup (L&D)

This subgroup has the responsibility for supporting, analysing and assessing the delivery and impact on practice of a targeted multi-agency training programme that incorporates learning from SCRs and other reviews.

MSB Training website - the updated training website was launched in Summer 2017 and is proving popular and easier to access (mobile device friendly). The Impact Evaluation Questionnaire has been embedded into the training website alongside an improved reporting tool and automated back office features.

Impact Evaluation (IE) Reports (Face to Face Training) – two IE reports for 2016/17 (Neglect and Parental Mental Health and Safeguarding Children) are completed, report and recommendations are pending L&D Subgroup approval. Two IE reports for 2017/18 have been completed, pending L&D Subgroup approval (Awareness of Domestic Violence and Abuse); one using data collected via a telephone survey and one using the online Impact Evaluation Questionnaire. These reports will be compared and considered by the L&D Subgroup for future reporting purposes.

Impact Evaluation of Online Training – a total of 434 module feedback was provided which represents 8.7% of completed course modules; this is a slight decrease from last year when 10% provided feedback. When asked if participation in the e-learning supported them to make measurable improvements to their work practice 78% agreed. Over 86% assessed their confidence in applying the learning to their practice had improved since completing the training.

Engagement and Involvement: the MSB L&D subgroup arranged and facilitated a half day conference titled Professional Curiosity - Confidence and Challenge – this event focused on the children's workforce and included a keynote presentation from Professor Harry Ferguson (social work academic), group workshops and question and answer session. The event was well received and 165 professionals attended from across partner agencies.

A revised and improved learning from reviews procedure was agreed during 2017/18, in total six SCR events were delivered with 192 professionals attending. In 2015/16 there were no SCR learning events. These events were delivered by members of the relevant panels, with the presentations being developed by the independent chairs of the reviews. This ensured that the key themes from each event were identified and learning shared with those in attendance.

Complex Safeguarding: the learning and development programme delivered by the MSB includes a classroom based training programme incorporating courses on Awareness of Domestic Violence and Abuse, Forced Marriage and Honour Based Violence, Child Sexual Exploitation and Missing From Home or Care.

In addition to the classroom based sessions, online training is available through our contract with Virtual College and include courses on Understanding Pathways to Extremism and the Prevent Programme, Introduction to Female Genital Mutilation, Forced Marriage, Spirit Possession and Honour Based Violence, Basic Awareness of Child and Adult Sexual Exploitation and Trafficking, Exploitation and Modern Slavery. The MSB facilitated a CSE Champions training course in August 2017.

Neglect: during 2017/18, the Learning and Development subgroup have supported the implementation of the MSB Children's Neglect Strategy by arranging and facilitating three Neglect Strategy and Multi-Agency Levels of Need and Response Framework events. The events were well received and in total 174 professionals from across the partnership attended.

The Graded Care Profile 2 (Neglect Tool) training commenced with the initial focus being on the staff that support children and families within the pilot area of North Manchester. The Learning and Development Co-ordinators arranged and supported the facilitation of two NSPCC train the trainer sessions which were attended by 35 professionals.

Areas of Future Development:

Training delivery - the training pool that has delivered many different training sessions has reduced in number during the year due to professionals changing job roles. This will be a focus for development during 2018/19.

Training programme development – the following are areas that have been identified that require further training course development:

- safeguarding children with a disability
- children and young persons development
- young people transitioning into adulthood themed courses
- Neglect training (children and family focus).

Complex Safeguarding Subgroup

The purpose of this Subgroup is to receive thematic strategies/plans, research/policy developments (statutory/practice) and provide a challenge and support role within the context of strategic and operational delivery in the seven strands of complex safeguarding: Child Sexual Exploitation (CSE); Missing from home, care & education; Radicalisation & extremism; Vulnerability and Organised Crime; Modern Slavery and Violence; and Domestic Violence and Abuse, including Female Genital Mutilation (FGM), Honour based abuse and Forced Marriage. A work plan focussing on actions for all 7 strands of Complex Safeguarding was set for 17/18 - through this, actions and activities were tracked and supported. The work plan evolved constantly as work was completed and actions achieved. Thematic priorities were discussed at every meeting, on a rolling basis.

What has worked well?

Sexual Exploitation – there has been increased joined up working, with the 'Think Family' approach being better utilised, with better agency involvement and intelligence sharing from all areas.

Protect (Manchester CSE Team) has developed into a multi-agency HUB with a future challenge for this as it becomes part of the Complex Safeguarding Hub, there is also better recognition that 'CSE' doesn't stop at 17 and recognition of the connection with Adult Sexual Exploitation – vulnerability surrounds both.

Training is commissioned by independent providers and there has been improved work at schools, although there is still more to do to help young people recognise their own vulnerabilities.

Missing from Home – there has been a successful Missing From Home Panel and the number of Missing From Home episodes have significantly reduced for children in Local Authority Care. Frequency of missing episodes is reducing and Independent Return Interviews (IRI) quality is improving. The timeliness of IRIs is improving, with approximately 80% being completed within 72hours. Links are now being made between Missing From Home and Criminal Exploitation. There is good youth engagement via Unity Radio Project.

Radicalisation and Extremism – A Prevent self-assessment of compliance against the statutory duty was undertaken during this year and action plan for areas of development established e.g. Prevent training and our Channel Panel arrangements. The Home Office will now deliver it's national Prevent Peer Review process in Manchester between 11-13 September 2018 to:

- assess compliance against the statutory Prevent duty through an evidence based approach to delivery (not an inspection)
- identity practical actions to improve outcomes and productivity of Prevent across the partnership
- enable good practice and learning to be shared across all areas in the country

Radicalisation and Extremism - Manchester's Channel Cases Peer Review was delivered in March 2017 and from this an action plan for improvement developed. The action plan set out a number of actions to strengthen the process for making referrals and the multi-agency support offered to vulnerable people. The action plan has been

delivered but will now need to be reviewed in light of the changes proposed through the Home Office's GM Dovetail pilot, which aims to go live in Oct 2018 and will see the transfer of Channel functions from the police to local authorities.

Vulnerability and Organised Crime – with regards to Criminal Exploitation, we have finalised a Manchester definition, policy statement, formulated a multi-agency response and commissioned a piece of analytical work.

There are crossovers between Organised Crime and Vulnerability and will certainly be a future challenge in terms of risk and demand.

Modern Slavery and Violence – A Modern Day Slavery and Trafficking subgroup has been setup to work towards a Manchester Modern Day Slavery and Trafficking Strategy, utilising workshops and frontline practitioners. Three awareness days were held by Stop The Traffik and the Strategy was launched in April 2018 alongside workshops and a train the trainer training schedule.

The Independent Child Trafficking Advocate (ICTA) scheme was launched, with Manchester having some of the highest referral figures to the service.

Domestic Violence and Abuse, including Female Genital Mutilation and 'so called Honour Based Violence'

FGM – during this period we commissioned voluntary sector groups to develop health and peer mentors in the community and deliver a Zero tolerance event and held a GM event for faith leaders to sign anti FGM pledge.

HBV - 7 minute briefing developed to raise awareness across the partnership. We extended opening hours to the community language domestic abuse helpline and commissioned Independent Choices to deliver community events and drop in sessions for awareness and support

DVA - MSB DVA policy reviewed. There has been a successful implementation of Safe and Together and a commitment for DVA specialist to be involved in all SAR/SCR's as part of the panels. Continued funding has been secured for 18/19 for Midwifery support service and IRIS funding secured to expand the programme. Funding for an LGBT IDVA post was also secured on a GM level for 2 years.

There has also been good partnership working and commitment across the DVA sector and other partner agencies.

<u>Areas of Future Development:</u>

Sexual Exploitation – there needs to be ongoing awareness raising in communities. We need to ensure the implementation of Making Safeguarding Personal for children. More work needs to go into having difficult conversations, identifying the risks of social media, understanding perpetrators and interventions and recognising the transition impact of CSE on adults.

Missing From Care – there is more to do in exploring the correlation between Missing From Education (MFE) and Missing From Home (MFH) – Children MFH and Care are not always seen within 72 hours and this could improve. We need a better focus on hot spot areas and outreach and intervention. A further challenge is transitions for young people going into independent living and we need to review our response to our out of area Local Authority children in care and those placed in the city from outside.

Domestic Violence & Abuse – The roll out of Safe & Together across Children's Social Care will be a priority moving forward, this will also include partner agencies. We also plan to develop an MSB FGM training offer and implement learning from DHR's.

Modern Slavery and Trafficking – A future challenge will be the launch and implementation of Manchester Modern Day Slavery and Trafficking Strategy by agencies across Manchester. We also need to ensure that Duty to notify and National Referral Mechanism (NRM) referrals are maintained. Any potential changes to the Independent Child Trafficking Advocate (ICTA) scheme may present challenges as it may move to focussing only on children trafficked into UK rather than within the UK also. We will continue to work with AFRUCA to support

Community Champions work raising awareness of Modern Day Slavery and Exploitation, including referral pathways and how to get help. This is expected to run between July 18 – July 19.

Radicalisation and Extremism - Social media and the internet – fake news and propaganda, radicalisation, effective and credible counter narratives continues to be a challenge. Some areas / agencies have lower Channel referrals and we need to understand why. We need to continue work to remove the stigma and fear of making referrals and develop confidence in people to make Channel referrals, some of this is through the refreshed training and local case studies. We will continue to support people to hold difficult conversations to develop critical thinking and resilience and improve information sharing between agencies to better understand risk as well as vulnerabilities. The roll out of GM Dovetail pilot will present challenges, along with the proposed pilot Multi Agency Centres.

9. What our partners say:

We also asked our partner agencies what they have done to support our priorities and asked them what has worked well and what their future challenges are. Extracts regarding the priorities are detailed here. Full responses are can be found here on the MSB website: **www.manchestersafeguardingboards.co.uk/mscb**

Engagement and Involvement – Practice Examples

Manchester City Council Children's Services - The service has hosted bi-monthly staff engagement sessions and bi monthly management sessions. These fora provide an opportunity for the service to come together to discuss key aspects of development of services to protect children. Sessions always contain a briefing on service development. This is an opportunity to connect staff withe work of the Board and of the service. The Children's and Education services Directorate has seven priorities one of which is to use the voice of children more systematically in influencing service. Our audits suggest we are improving in relation to capturing the voice of the child and listening to the their wishes and feelings, but work here is inconsistent, in the coming year we will improve our consistency. Building on our Signs of Safety model we aim to improve our understanding and commitment to the wishes and feelings of children whilst balancing our role in protecting children and promoting their development. We have some examples of Our children influencing service design particularly in the leaving care service. Our children frequently manage the agenda of the Corporate Parenting panel, providing an opportunity for influence with senior officers and elected members of the Council. We are committed to doing more of this work. We have re commissioned our children's rights service and now have an opt out advocacy service for children attending child protection conferences. We continue to support the change group which is made up of a number of our children (care leavers) who aim to influence the work of the Council in supporting our children.

Youth Justice Service - A key priority for the Youth Justice Service is to strengthen levels of engagement with those young people referred by the police and courts. Research into the effectiveness of Manchester Youth Justice Service shows that when we do engage a young person successfully and they complete their court ordered supervision, they are 7 times less likely to come back again. All children and young people are asked to complete self-assessments at the outset and to give their views on the service throughout their contact with us. There are 'Participation Champions' in each team who have been trained by Manchester Metropolitan University and they are leading the development of interactive sessions with groups of young people who will advise on changes and improvements needed within the Service and design new information leaflets for those coming into the service.

Manchester Health Care and Commissioning (MHCC) - MHCC have continued to demonstrate our commitment to safeguarding in 2017/2018. The Designated Doctor, Nurse and Head of Safeguarding are active members of all Manchester SCRs and learning reviews. The Designated Team strive to ensure the voice of the child and "think family" approach are considered in all reviews and learning's. The recommendations about the Voice of the Child and Think Family have been noted as strong themes in many of the SCRs findings. The CCG Safeguarding Team promotes and delivers the learning from SCRs in various formats across the health economy. This forms part of the CCG assurance process and ensures that lessons learnt are embedded within training.

Throughout 2017/2018 the Designated Team have continued to provide highly specialised clinical advice and expert knowledge to peers, other professionals; advanced level practitioners and agencies within the geographical area on all safeguarding concerns. The team operate a robust supervision model for all Named professionals across the Manchester health economy and ensure that the child is always central in all practice and ensure their daily lived practice and voice is paramount.

Pennine Acute Hospital Trust (PAHT) - Through involvement into care planning and risk assessments 'Voice of the Child' and evidencing this in the child's notes. This process is on the safeguarding team's audit to plan to ensure Divisions are compliant and are engaging and involving children in their care.

CASE STUDY – Youth Justice Service - When 'David' first came to the Youth Justice Service he had many difficulties in different areas of his life - his difficulty in forming and maintaining positive relationships, his lack of educational progress, one year out of education. He was described as 'highly oppositional' and at times 'controlling'. When angry, he was unable to express what was wrong and would remain in this state for several hours or go missing from home. His parents were not available to care for him so David had been placed in care over 10 years previously. His carers described how 'persistent lying' made it difficult for others to relate to him and he rarely smiled and had periods of self-harming. David was convicted of a serious, imprisonable offence and was placed by the court on a Youth Referral Order. Shortly after this, both his care and school placements broke down. He refused to engage with CAMHs and the Clinical Psychologist stated "knowing this child's history, it is hard to expect an alternative trajectory other than forensic services"(Prison).

David was viewed by his school as high risk and the Youth Justice Service assessed him as low risk. His Youth Justice Officer recognised the challenge of engaging in any meaningful way with him so discussed his details with the Drama Therapist that has been commissioned to work in Youth Justice with those children who are the most disengaged.

The Drama Therapists use high quality interventions including art, music, dance and drama with a focus on providing a safe environment for the child to relax and build a trusting relationship. For those young people who have faced trauma in their early lives, this has proved to be a more effective way to get to know them rather than conventional approaches.

In David's case, there was a direct correlation between his increased emotional well-being through the therapy and his ability to engage in positive relationships with others, and eventually, in learning activities in the classroom. His academic achievements exceeded all expectations and included 100% Attendance over two terms, good engagement in school lessons, identified creative skills helped him to engage in school curriculum, with his music teacher, is currently making a rap album with a social skills focus, in English and Maths, completed levels 1 and 2 in two terms and his aspirations have changed and he is now seeking a college placement.

Complex Safeguarding – Practice Examples

Greater Manchester Police - The City of Manchester Division is committed to establishing a new integrated partnership operating model to reduce the risk of harm and to improve the protection and safeguarding of children, young people and adults with complex safeguarding needs at risk of exploitation. This will be achieved through effective information sharing, joint working, integrated interventions and support and protective practices. The Complex Safeguarding Hub will be based at Greenheys Police Station and will focus on the following strands of exploitation: Sexual Exploitation, Modern Slavery, Criminal Exploitation, Organised Crime Groups / Serious Youth Violence

Education - Implementation of the Prevent Duty and Counter Extremism continues to be a major focus. Schools have strongly supported the approach to Prevent in Manchester which sits very firmly within mainstream safeguarding arrangements, with a range of programmes for staff, children and for parents. This is reflected by the MCC Model Safeguarding Policy for schools (annually updated) and the section 175 Safeguarding Self Evaluation Framework. The Prevent Duty is part of, and embedded within, the policy and the SEF. Tracking of schools' responses from the Prevent SEF (Sept 15) and the Safeguarding SEF (March 16 and 17) shows impact in a rise in confidence in the delivery of the Prevent Duty particularly in relation to building resilience of young people.

Education is represented on the Domestic Abuse Forum and has worked to raise awareness of partners of training and resources that are available including 'Safe and Together' and Adverse Childhood Experiences (ACEs). A number of schools are involved in the pilot project for the latter. Others have volunteered to take a lead on 'Safe and Together'.

A key development over the past year has been to improve information sharing between the police and schools/Early Years settings, through school representation on the district MARACs and the roll out Operation Encompass from September 2017. This has supported awareness of schools and Early Years settings of children who have suffered from domestic abuse and improved the offer of Early Help and appropriate interventions.

Manchester Foundation Trust - Key messages regarding priority areas have been shared across all divisions which includes Complex Safeguarding. Key priority areas established in 2017/18 are CSE (Child Sexual Exploitation), DV&A (Domestic Violence and Abuse), FGM (Female Genital Mutilation), Early Help.
Domestic Abuse, Female Genital Mutilation and Child Sexual Exploitation sub-groups are well established within MFT which link with Manchester and Greater Manchester and national policy and strategy.
Priority for 18/19 is to embed the Complex Safeguarding agenda across MFT.
Safeguarding workplans for all hospitals/MCS/MLCO include the child wishes and views in all safeguarding decisions.
Safeguarding Children champions are in place across all frontline areas.

Greater Manchester Mental Health - GMMH continues to improve awareness and understanding of complex safeguarding issues that are impacting on children: Child Sexual Exploitation (CSE), Serious and Organised Crimes and Gangs, Modern Slavery, sham marriages, Female Genital Mutilation (FGM) and Radicalisation and Extremism by providing staff with a whole range of resources.

We are committed to having arrangements in place to ensure effective training of its entire staff, which includes complex safeguarding themes within its Safeguarding Training packages.

A key focus for GGMH is to continue to promote an awareness and understanding of the safeguards in relation to Domestic Violence and Abuse (DVA) and we recognise the important role of training in working towards the elimination of domestic abuse. Both can improve service provision to women and children experiencing domestic

abuse and impact on the prevention of abuse through conveying strong and unequivocal messages about its unacceptability.

Transitions – Practice Examples

The Christie - Teenage and Young adult cancer services, key workers continue to support during the transition from children to adult services providing continuity and consistency , empowering young people to take control of their care.

Strategic Housing - Strategic Housing work in partnership with Barnardos Leaving Care Service and Manchester Move in managing a Band 1 for social housing panel. 15 young people have been housed into social tenancies via this panel since last June. Registered Providers are aware of, and use, the Escalation Policy where they feel other agencies are not responding appropriately.

National Probation Service (NPS) - The NPS second two probation officers to Manchester Youth Justice Service (YJS), who have dedicated responsibilities in coordinating transitions of young offenders supervised by Manchester YJS to the NPS and the Community Rehabilitation Company (CRC). The NPS has developed a 18-24 hub for offenders released on licences and increased the use of Intensive Community Orders for this cohort of offenders to ensure services and interventions are tailored to meet young offenders needs and designed to improve compliance and reduce re-offending. The NPS has focused on improving practitioners understanding of their responsibilities with regard to care leavers in response to recent changes to government guidelines. At a local level, a care leaver protocols are being developed to ensure that care leavers are appropriately identified when they come into contact with the Criminal Justice System or transitioning to the NPS and are offered the appropriate support as a care leaver.

PAT - Policy on management of 17 to 18 year olds is in place and the children and young people are given a choice in regards to where they want to be admitted e.g. children's or adult ward. There is a flow chart on adult and children's wards in regards to managing transitions. However, with Safeguarding Boards support more work needs to be done in regards to managing transitions from child to adult around CSE/Trafficking/County Lines/Modern Slavery/Prevent (Complex Safeguarding) and the organisation support this through safeguarding level 3 i.e. raise awareness of complex safeguarding.

CASE STUDY – Manchester Health Care and Commissioning (MHCC) - the Designated Team provides strategic support and advice for staff working across the health economy when management of individual cases is causing concern. One example of this is the case of a young person aged 17 who has autism, severe learning difficulties and is non-verbal. The work around this young person is multi-faceted and has required oversight at a strategic level to ensure the right engagement and services are in place. The benefit of the MHCC safeguarding team is the "think family" approach which has facilitated a whole age approach to care. The team is supporting staff to escalate concerns to ensure that the young person's wishes and feelings are represented and that there is a safe and smooth transition to adult services.

Neglect – Practice Examples

Education - Schools play a major part in the identification of children who may be suffering from Neglect and are the main initiators of Early Help Assessments. The MSCB multi-agency audits evidence a positive contribution and highlight good practice from an Education perspective in terms of picking up on Neglect and DVA, as well as wider safeguarding concerns.

There are examples of schools providing timely and appropriate support to the child and family in the audits, as well as being noted in Child Protection Strategy meetings and conferences. Excellent partnership working and Early Help provided by schools is also highlighted in a number of Ofsted reports published over the past year eg free access to Breakfast Clubs and linking families into Housing and Benefits.

Officers from Education teams and school staff are amongst the NSPCC Graded Care Profile 2 champions and have supported the delivery of multi-agency training sessions.

GMFRS - Both through Safe and Well delivery and also post- fire reassurance work, GMFRS staff have identified and reported many cases of neglect to local social services staff. All front line staff are equipped with the necessary knowledge and skills and access to the resources required to make appropriate referrals and to ensure the immediate safety of the individual(s) concerned.

CASE STUDY - Strategic Housing - Example of a case study from Wythenshawe Community Housing Group:

Mother, 1 adult son and 1 child under 10

Neglect – Child

WCHG were notified by GMP over the Police communications radio that there was a kitchen fire in a first floor cottage flat. When GMP arrived at the property the fire had been put out by GMFRS and had been caused by burning food. The handle had fallen off the kitchen door and trapped them in the living room and unable to turn off the oven. The property was found to be in a very poor condition, there was evidence of hoarding, animal waste all over the floor and no obvious signs of a clean living space or clear beds for the family to sleep in.

Both GMFRS and GMP were concerned for the family remaining in the property in that condition and asked WCHG if we could relocate the family temporarily whilst it was cleaned but the mother did not want to leave the property. GMP took the child into custody and placed him/her in the care of another relative and told the mother that he/she would not be returned until the property had been cleaned up. The mother had been caring for an elderly relative who had just recently passed away, was working full-time whilst looking after a child and everything had got too much for her.

An 'if in doubt shout' referral was done and the Safeguarding team contacted the assigned social worker and arranged a meeting with them and the tenant. We offered to support the tenant in clearing the property, help her to get back on her feet and the tenant agreed. Our teams arranged for a contractor to clean the bathroom and for a skip to be delivered so that the family could start clearing the rubbish out of the property. Once cleared a new kitchen and bathroom was installed and repairs were made to walls and internal doors. The Social Worker also arranged for replacement furniture. We arranged for the tenant's benefits to be reviewed and a HB claim was completed. The adult son was encouraged to make a claim for Job Seekers Allowance, his confidence was boosted and he attended a number of courses. The family now have a clean and safe home and feel grateful for the support that they received.

10. Budget

The Manchester Safeguarding Adults and Childrens Board budget was combined for 17/18. The total budget during that period was: £ **707,019.74**

A full breakdown of the budget can be found at Appendix 4.

11. Future Challenges and Priorities

The MSCB reviewed its objectives and priorities from March to June 2017 and for the first time developed a shared strategic plan along with the MSAB. Each of the Boards have their own vision and objectives however the overarching strategic priority to be assured that safeguarding is effective across Manchester is shared, as are the thematic priorities, key functions and the four specific priorities of engagement and involvement, complex safeguarding, transitions and neglect.

It has been agreed that because work on this shared plan and specific priorities only really started in September 2017 that these would be carried forward into the financial year April 2018 - March 2019. The details are set out in the plan on a page which can be found at Appendix 5.

After careful consideration it was decided that the previous thematic priorities of mental health, learning disabilities and substance abuse, which are much wider than safeguarding, are more appropriately addressed through other arrangements for example the Health and Wellbeing Board. It remains important however for the Board to ensure that safeguarding issues in relation to these areas are appropriately considered.

The Board has a detailed business plan to which each of the subgroups contribute to ensure that work is progressed. Other groups are established as necessary for example a locality group has been established in the North to oversee the implementation of the neglect strategy. Similar groups will be established as the roll out continues in 2018/19.

This report has demonstrated the progress made thus far on the priorities, however as indicated a number of challenges still remain. These include neglect and complex safeguarding. In order to mitigate the risk around neglect, a neglect strategy and toolkit has been developed and communication and engagement across the partnership is supported by briefings, events and workshops. There is still much work to do to raise the profile of neglect and for agencies to embed this.

In order to mitigate the risk around complex safeguarding, information on new initiatives is shared via the MSB website - including key messages, new policies and seven minute briefings on new research etc. The Board also works to ensure the focus of the impact of Domestic Violence & Abuse (DV&A) on Children and Young People is enhanced and is in line with the DV&A Strategy, with emphasis on understanding and responding to underlying causes.

The number and complexity of Serious Case Reviews presents both a challenge in terms of resources required to complete these very complex pieces of work; and also in terms of ensuring the learning across such a large number of agencies is shared and embedded changes in practice are made and sustained.

Improvements still need to be made regarding attendance at strategy meetings and engagement in child protection planning.

A system wide challenge is the number of children and young people and families who are needing support and contact from a range of services thereby supporting an Early Help approach not provided by all agencies and there are many referrals received by social care that require no further action. A piece of work is planned which is looking at the 'front door', which will focus on timely interventions being provided that are focussed on the most vulnerable children and families and reducing the number of children looked after.

An area for future consideration is the changes being made to move from Safeguarding Children's Boards to Multi-Agency Safeguarding Partnership arrangements. Whilst these do not have to be established until September 2019 at the latest, joint planning has started to take place to ensure that the close working between the two current Boards remains whilst ensuring that the future arrangements are fit for purpose. Working Together July 2018 is very clear that a child centred approach is fundamental to safeguarding and promoting the welfare of every child. It seeks to emphasise that effective safeguarding is achieved by every individual and agency playing their full part.

12. Glossary

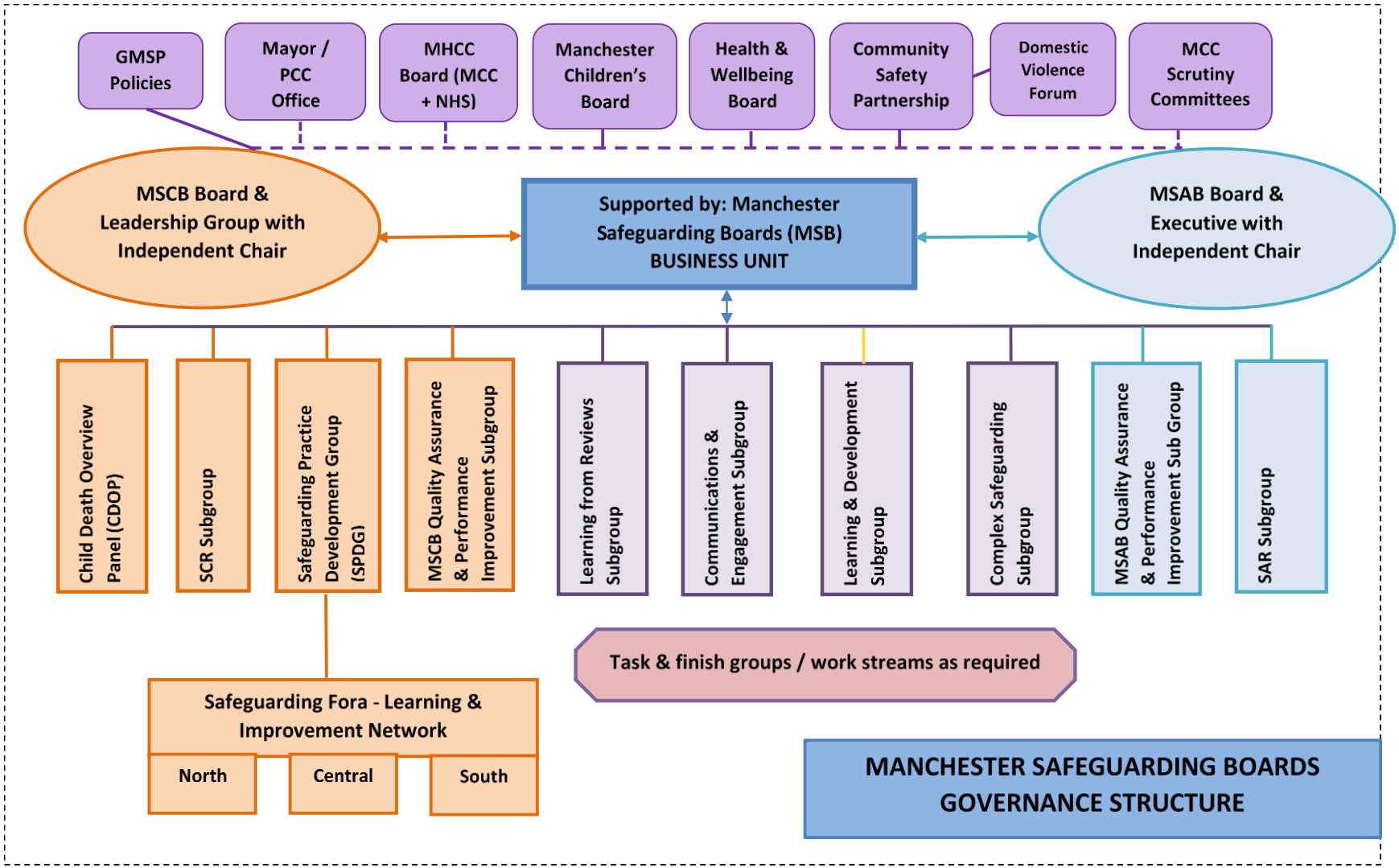
GLOSSARY			
CAFCASS	Children and Family Court Advisory and Support Service	**DfE**	Department for Education
CAMHS	Child and Adolescent Mental Health Service	**DoH**	Department of Health
CCGs	Clinical Commissioning Groups	**EHA**	Early Help Assessment
CDOP	Child Death Overview Panel	**FGM**	Female Genital Mutilation
CMFT	Central Manchester Foundation Trust	**GMFRS**	GM Fire and Rescue Service
CQC	Care Quality Commission	**GMP**	Greater Manchester Police
CRC	Community Rehabilitation Company	**GP**	General Practitioner
CSC	Children's Social Care	**HWBB**	Health & Wellbeing Board
CSE	Child Sexual Exploitation	**IDVA**	Independent Domestic Violence Advisor
CSP	Community Safety Partnership	**IRIS**	Identification and Referral to Improve Safety
LAC	Looked After Children	**MFH**	Missing From Home
LADO	Local Authority Designated Officer	**MSAB**	Manchester Safeguarding Adults Board
LSCB	Local Safeguarding Children Board	**MSCB**	Manchester Safeguarding Children Board
MACC	Manchester Alliance Community Care	**PRU**	Pupil Referral Unit
MASH	Multi-Agency Safeguarding Hub	**SCR**	Serious Case Review
MCC	Manchester City Council		

13. Appendices

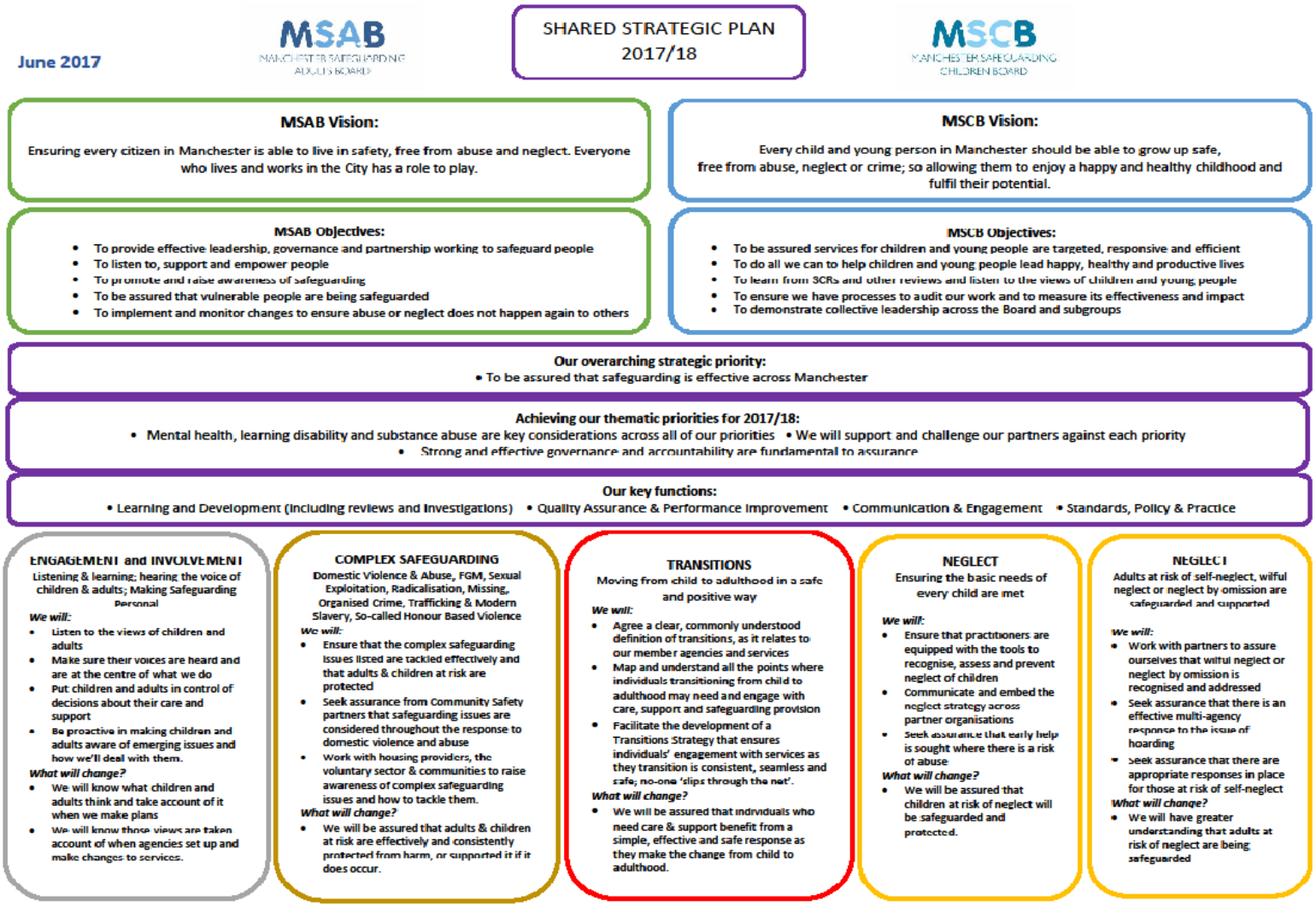
Appendix 1

MSCB MEMBERSHIP LIST 2017/18 AS AT MARCH 2018	
Barnardos	Manchester City Council Education
Children and Family Court Advisory and Support Service (CAFCASS)	Manchester City Council Population Health and Wellbeing Team
Career Connect	Manchester Communications Academy (MCA)
Central Manchester Foundation Trust (CMFT) (Joined with University Hospital of South Manchester (UHSM) to become Manchester Foundation Trust (MFT) on 01/10/17.)	Manchester Grammar School
Clinical Commissioning Group (CCG)	National Probation Service (NPS)
Community Rehabilitation Company (CRC)	NHS England
Greater Manchester Fire and Rescue Service (GMFRS)	North West Ambulance Service (NWAS)
Greater Manchester Mental Health NHS Foundation Trust (GMMH)	Pennine Acute NHS Trust (PAHT)
Greater Manchester Police (GMP)	The Christie NHS Foundation Trust
Manchester Alliance for Community Care (MACC)	University Hospital of South Manchester (UHSM) (Joined with Central Manchester Foundation Trust (CMFT) to become Manchester Foundation Trust (MFT) on 01/10/17.)
Manchester City Council Childrens Services (MCC)	Youth Justice

Appendix 2


GMSP Policies
Mayor / PCC Office
MHCC Board (MCC + NHS)
Manchester Children's Board
Health & Wellbeing Board
Community Safety Partnership
Domestic Violence Forum
MCC Scrutiny Committees
MSCB Board & Leadership Group with Independent Chair
Supported by: Manchester Safeguarding Boards (MSB) BUSINESS UNIT
MSAB Board & Executive with Independent Chair
Child Death Overview Panel (CDOP)
SCR Subgroup
Safeguarding Practice Development Group (SPDG)
MSCB Quality Assurance & Performance Improvement Subgroup
Learning from Reviews Subgroup
Communications & Engagement Subgroup
Learning & Development Subgroup
Complex Safeguarding Subgroup
MSAB Quality Assurance & Performance Improvement Sub Group
SAR Subgroup
Task & finish groups / work streams as required
Safeguarding Fora - Learning & Improvement Network
North
Central
South
MANCHESTER SAFEGUARDING BOARDS GOVERNANCE STRUCTURE

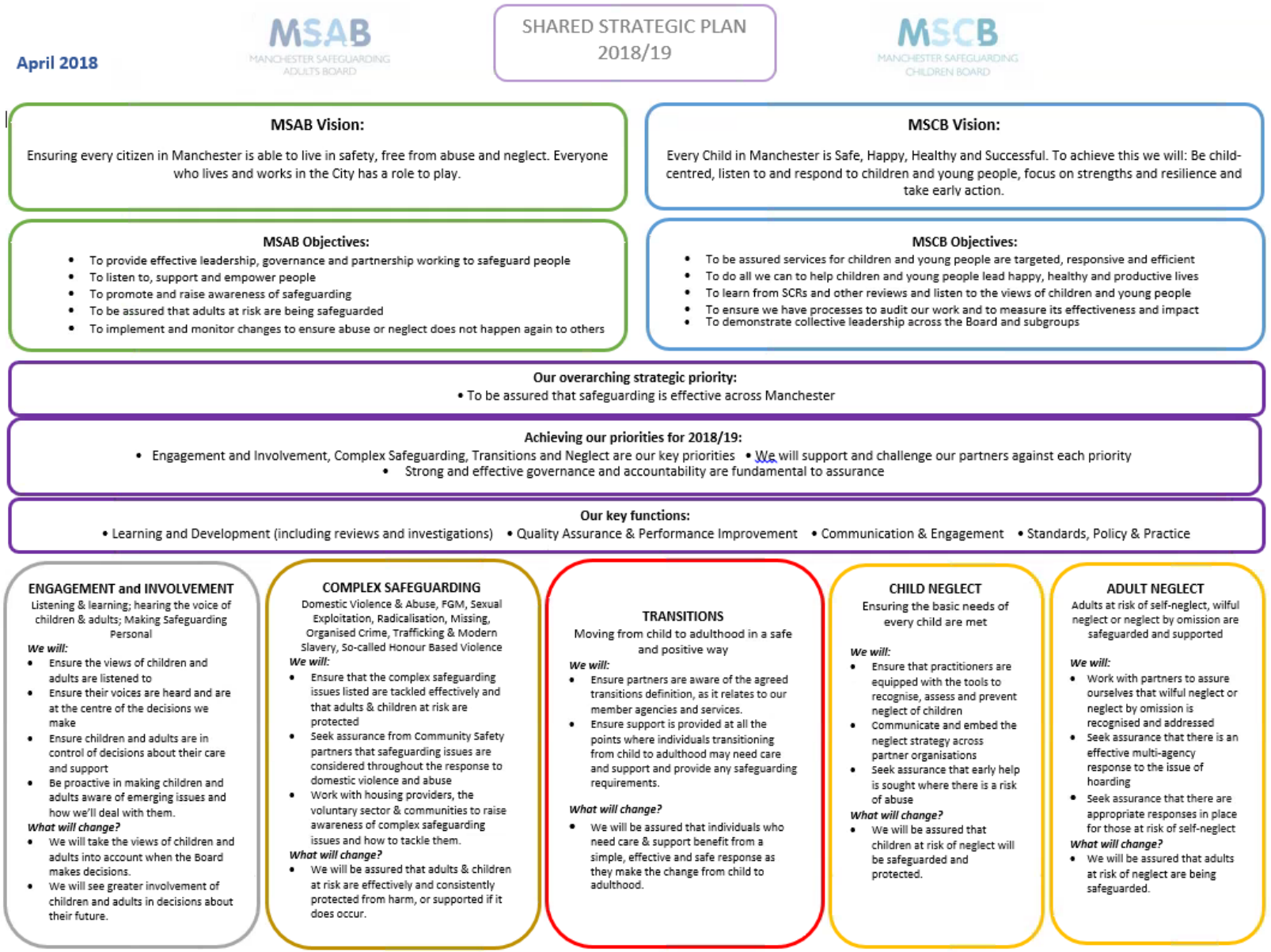
Appendix 3


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 healthy 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 if it if 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 4

Manchester Safeguarding Boards For the 12 Months ending 31.03.2018			
Cost Elements	**Annual Budget**	**Actual YTD**	**Var.YTD**
PAY Costs			
Total Pay Costs	**441,470.00**	**442,189.63**	**719.63**
Non-Pay			
* **Premises**	**7,000.00**	**1,659.20**	**-5,340.80**
* **Transport**	**2,300.00**	**2,615.94**	**315.94**
* **Supplies & Services**	**148,849.74**	**179,310.47**	**30,460.73**
* **Third Party Payments**	**101,000.00**	**0.00**	**-101,000.00**
* **Internal Charges**	**6,400.00**	**13,613.92**	**7,213.92**
* **Onwards Internal Trading**	**0.00**	**1,138.58**	**1,138.58**
Non-Pay Expenditure Childrens	**265,549.74**	**198,338.11**	**-67,211.63**
TOTAL EXPENDITURE Board	**707,019.74**	**640,527.74**	**-66,492.00**
INCOME			
Miscellaneous Income	**0.00**	**-50.00**	**-50.00**
MCC Education	-71,000.00	-71,000.00	0.00
MCC Housing	-9,450.00	-9,450.00	0.00
MCC Other	94,500.00	0.00	-94,500.00
Total Contribution from MCC	**-174,950.00**	**-80,450.00**	**94,500.00**
National Probaton Service		-4,381.86	-4,381.86
NHS	-52,400.00	-52,400.00	0.00
Cafcass	-550.00	0.00	550.00
GMCA(GM Police)	-38,800.00	-64,282.00	-25,482.00
External Income	**-91,750.00**	**-121,063.86**	**-29,313.86**
Interest	**0.00**	**96.31**	**96.31**
Contribution from MCC General Fund	-440,319.74	-440,319.74	**0.00**
Total Revenue Income	**-707,019.74**	**-641,787.29**	**65,232.45**
Over/Underspend	**0.00**	**-1,259.55**	**-1,259.55**

Appendix 5


April 2018
MSAB
MANCHESTER SAFEGUARDING ADULTS BOARD
SHARED STRATEGIC PLAN 2018/19
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 in Manchester is Safe, Happy, Healthy and Successful. To achieve this we will: Be child-centred, listen to and respond to children and young people, focus on strengths and resilience and take early action.
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 adults at risk 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 priorities for 2018/19:
Engagement and Involvement, Complex Safeguarding, Transitions and Neglect are our key 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:
Ensure the views of children and adults are listened to
Ensure their voices are heard and are at the centre of the decisions we make
Ensure children and adults are 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 take the views of children and adults into account when the Board makes decisions.
We will see greater involvement of children and adults in decisions about their future.
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 if it does occur.
TRANSITIONS
Moving from child to adulthood in a safe and positive way
We will:
Ensure partners are aware of the agreed transitions definition, as it relates to our member agencies and services.
Ensure support is provided at all the points where individuals transitioning from child to adulthood may need care and support and provide any safeguarding requirements.
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.
CHILD 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.
ADULT 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 be assured that adults at risk of neglect are being safeguarded.