Manchester Health and Wellbeing Board
Report for Resolution

Report to: Manchester Health and Wellbeing Board – 30th October 2019

Subject: Annual reports of the Manchester Safeguarding Children and Adults Boards

Report of: Julia Stephens-Row, Former Independent Chair of the Manchester Safeguarding Boards, Strategic Director of Children and Education, Executive Director of Adult Services

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Summary

Attached to this report are the Annual reports of the Manchester Safeguarding Adults Board and the Manchester Safeguarding Children's Board covering the period from April 2018 to March 2019. There is a statutory requirement to produce these annual reports and to share them with Strategic leaders including the Leader and Chief Executive of Manchester City Council; the Police and Crime Commissioner and the Chief Constable; and the Health and Wellbeing Board. The reports were considered by Health and Children and Young Peoples Scrutiny committees on 3rd and 4th September. An extract of the minutes from these meetings are included in the report. The MHCC Board will consider the reports on 27th November.

These documents report on the work of the partnership. Information regarding trends and issues arising from Serious Case Reviews and Safeguarding Adults Reviews is also included.

Recommendations

The Board is asked to:

1. Note the annual reports of the two safeguarding boards.

2. Request that each constituent member promote the importance of safeguarding across their organisation. Ensuring that safeguarding is at the heart of all commissioned and delivered services; with particular emphasis on learning from reviews and changing policies and practices accordingly.

Health and Wellbeing Strategy priority	**Summary of contribution to the strategy**
Getting the youngest people in our communities off to the best start	Ensuring children and young people are safeguarded supports this priority
Educating, informing and involving the community in improving their own health and wellbeing	Ensuring that safeguarding is everyone's business and empowerment and making safeguarding personal supports this priority.

Moving more health provision into the community	
Providing the best treatment we can to people in the right place at the right time	
Turning round the lives of troubled families	Ensuring that safeguarding issues are addressed and professionals provided with the tools to have difficult conversations to work effectively supports this priority.
Improving people's mental health and wellbeing	Mental health linked to safeguarding is a new priority for the partnership this year.
Bringing people into employment and leading productive lives	
Enabling older people to keep well and live independently in their community	Improving awareness of self-neglect helps with this priority

Links to the Manchester Health and Social Care Locality Plan

The three pillars to deliver the Manchester Health and Social Care Locality Plan	**Summary of Contribution or link to the Plan**
A single commissioning system ensuring the efficient commissioning of health and care services on a city wide basis with a single line of accountability for the delivery of services	
'One Team' delivering integrated and accessible out of hospital community based health, primary and social care services	
A 'Single Manchester Hospital Service' delivering consistent and complementary arrangements for the delivery of acute services achieving a fully aligned hospital model for the city	

Lead board member:
Councillor Craig - Executive Member for Adults Health and Wellbeing

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Background documents (available for public inspection):

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

Links to both reports can be found on the Manchester Safeguarding Partnership website here:

https://www.manchestersafeguardingpartnership.co.uk/resource/msab-annual-reports/
https://www.manchestersafeguardingpartnership.co.uk/resource/mscb/

Introduction

1. The Manchester Safeguarding Boards annual reports covers the period from April 2018 - March 2019. These reports demonstrate the significant amount of work undertaken across a range of organisations and in partnership to safeguard Adults and Children in Manchester.

These reports contain a variety of information detailing the work of the partners and some of key pieces of work undertaken by the Manchester Safeguarding Adults Board (MSAB) and Manchester Safeguarding Children Board (MSCB). They also provide information on the work of the various sub groups which report to the Boards, four of which are integrated across both Boards.

Safeguarding Adults and Children's Boards are a statutory requirement and are in place across the country. Their role is to co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and to seek assurance. The Boards have a role in monitoring and evaluating the effectiveness of what is undertaken by the Board partners individually and collectively and advising them on ways to improve is an important function of the Safeguarding Boards. In addition to the various assurance activities carried out throughout the year, such as self-assessments and multi-agency case audits, each Board partner has provided an assurance statement setting out the work they have undertaken to meet the Board priorities and the safeguarding work that is ongoing in their agencies.

2.0 Background

2.1 These reports detail the progress we have made around all of our priorities set out in the 2018/19 Business Plan, along with the areas identified as future challenges. It is put together along with contribution from partners and sub groups and includes information regarding the progress of the Board over the last year.

2.2 The Boards meet regularly and are supported by a number of subgroups, detailed in the report.

2.3 Business Priorities

The Boards have joint priorities and rolled forward the priorities from 2017/18 into 2018/19.

- Engagement and Involvement – listening and learning, hearing the voice of adults, and making safeguarding personal.
- Complex Safeguarding - Domestic Violence and Abuse; Female Genital Mutilation; Sexual Exploitation; Radicalisation; Missing from care; Organised Crime; Trafficking and Modern Slavery; Honour Based Violence
- Transitions – moving from child to adulthood in a safe and positive way
- Neglect - safeguarding and supporting adults at risk of wilful neglect, acts of omission and self-neglect.

These themes whilst shared across both Boards have ‘adult’ and ‘child’ specific pieces of work which are being delivered. Details of the activities undertaken to work

towards achieving these priorities is contained within the annual reports supported by some case studies.

2.4 Key activities in 2018/19 included the publication of one safeguarding adult review and five serious case reviews; launched a Modern Slavery and Human Trafficking strategy; held a Complex Safeguarding Conference; and received regular updates on the Domestic Violence and Abuse strategy.

With regard to the Adult Board we held a half day event with a focus on having difficult conversations in the context of Making Safeguarding Personal and developed a Self-Neglect and Hoarding strategy.

With regard to the Children Board we have established a multi-agency Neglect strategy implementation group and Graded Care Profile 2 - our chosen Neglect assessment tool which continues to be implemented across agencies. We have, along with Children's Social Care commissioned a review of the Front door arrangements with a focus on increasing conversations between professionals and Early Help and reducing the unnecessary referrals that do not require social work intervention. The new ways of working were introduced in March 2019 and are proving very successful. In October 2018 a conference took place focusing on raising awareness of potential risks which contribute to the vulnerability, ill health or death across the city embedding learning from reviews of child deaths that take place.

2.5 Nearly 1400 people have attended face to face learning events and nearly 5,000 e learning courses have been completed by both adults and children's workforces.

2.6 The Boards held joint meetings in January and March 2019 in order to agree the priorities for 2019/20. These have been determined to be Adverse Childhood Experiences; Complex Safeguarding; Transitions; Neglect and Mental Health.

2.7 **Future Challenges and Improvement**

In addition to the areas identified as priorities in the 2019/ 2020 Business Plan which are summarised above, other areas of challenge have been identified as follows:

2.8 There is still a need to ensure that Making Safeguarding Personal is embedded and that the Safeguarding partnership has a greater understanding of the issues faced by citizens. A task and finish group is in place looking at how to promote Making Safeguarding Personal and there is a specific area on the new business plan regarding hearing the voice of citizens in terms of Safeguarding.

2.9 A further challenge to the system is the number of adults who need care and support and as safeguarding awareness is increased, this is likely to have a knock on effect.

2.10 There is still a need to increase the awareness of the MSCB Neglect Strategy or familiarity of the tools to identify neglect. This should be aided by the multi-agency Neglect implementation steering group and the refresh of the existing strategy which will be promoted widely.

2.11 There is a need to review the Levels of Need framework to make it more accessible to practitioners and consistent with Signs of Safety and the iThrive framework used in mental health. A subgroup has been set up to develop this further.

2.12 The number of serious case reviews and safeguarding adults reviews which are to be completed 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 to make sure that changes in practice are made and sustained. Further detail on this is later in the report.

2.13 Following a legislative change there was a requirement for the Local Safeguarding Children Board to be replaced. Manchester now has a new multi-agency safeguarding partnership which has also brought the Children and Adults Boards together. As required the three statutory partners of the Local Authority, Police and the Clinical Commissioning Group published their plan at the end of June 2019 and have been in a transitional period until end of September. The development of one board for children and adults reflects the direction of travel over the last two to three years. However retaining two separate executive groups for Adults and Children ensures that the focus on single issues is not lost.

3.0 Extract of minutes from Health Scrutiny Committee 3rd September 2019

3.1 “The Committee considered the report of the Executive Director of Adult Services and the former Independent Chair of Manchester Safeguarding Adults Board. It provided Members with an overview of the work of the Board for the period from April 2018 - March 2019.

3.2 The Independent Chair of Manchester Safeguarding Adults Board referred to the main points of the report which were: -

- Noting the priorities of the Board that were rolled forward from 2017/18 into 2018/19;
- Noting the key activities described in 2018/19; and
- Future challenges and improvement.

3.3 The Executive Director of Adult Services paid tribute to the former Independent Chair of the Manchester Safeguarding Adults Board for her commitment and diligence in safeguarding adults in Manchester.

3.4 The Executive Director of Adult Services stated that in recognition of the reconfiguration of services in Manchester new safeguarding arrangements were due to be announced in September and information on these would be shared with the Health Scrutiny Committee.

3.5 A Member commented that the use of the word ‘customer’ in the context of Domestic Violence was inappropriate. The Independent Chair of Manchester

Safeguarding Adults Board acknowledged this comment and stated that this would be corrected prior to the reports formal publication.

3.6 A Member commented that the report referred to the Learning from Reviews Subgroup and noted that it stated 'It had been a challenge to secure regular and consistent attendance from all agencies and the subgroup had three different Chairs which had led to some inconsistency and slow progress at times.' and asked what was being done to address this. The Independent Chair of Manchester Safeguarding Adults Board informed the Committee that the new Chair of the Subgroup was addressing this issue and Learning from Reviews would continue within the new arrangements. She said this would be aligned with the Learning and Improvement Subgroup, and she was confident that this new arrangement would improve this situation.

3.7 The Executive Director of Adult Services commented that the new safeguarding arrangements would strengthen learning reviews and ensure that the right action was taken at the right time by the right partner.

3.8 In response to a question regarding the number of, and costs of legal challenges and how this was monitored and reported, the Independent Chair of Manchester Safeguarding Adults Board stated that it was not the role of the Board to consider any legal challenge and responsibility for that rested with the relevant partner. She further stated that the Board were satisfied with the approach taken to The Deprivation of Liberty Safeguards (DoLS). The Executive Director of Adult Services informed Members that she met with legal officers on a monthly basis to review and monitor any challenges.

3.9 The Executive Director of Adult Services responded to a comment from the Chair who noted that the membership list of the Board was predominantly statutory health providers and there appeared to be little or no representation from the Voluntary and Community Sector, and asked if this was typical. She advised that the levels of representation would be reviewed and workshops around this had been delivered with the intention to include both statutory and non-statutory bodies represented on the Board. She further stated that the recently appointed Director of Homelessness would be joining the Board.

3.10 Decisions

The Board: -

1. Note the publication of the Manchester Safeguarding Adults Board Annual report 2018–2019.

2. Recommend that the word customer is removed and replaced with a more appropriate term when referring to Domestic Violence. "

4.0 Extract of minutes from Children and Young People Scrutiny Committee 4th September 2019

4.1 Some of the key points and themes that arose from the Committee's discussions were:

- That this was a good, comprehensive report;
- To ask whether there had been any prosecutions in Manchester in relation to Female Genital Mutilation (FGM);
- Work to address neglect and child obesity;
- The importance of partnership working, particularly in relation to tackling "county lines" (where vulnerable young people from the city were exploited by criminal gangs to transport and sell drugs in other areas), given the way this crossed borders into other local authority and police areas;
- The importance of consistent, effective training for teachers and other professionals on recognising signs of neglect or other safeguarding concerns; and
- The work of the Local Authority Designated Officer (LADO), who managed allegations against adults who worked with children.

4.2 Julia Stephens-Row informed Members that there had only been one successful prosecution for FGM in the country, which had not been in Manchester. She reported that she had attended a conference on FGM where the North West Chief Crown Prosecutor had outlined the challenges in pursuing prosecutions for FGM but that she had been reassured that the Crown Prosecution Service would pursue prosecutions as necessary. She advised Members that, in her view, the key focus of work in this area, was to encourage women and girls to come forward and ensure that they were supported and protected.

4.3 Julia Stephens-Row reported that the MSCB had refreshed the Neglect Strategy and was continuing to fully roll-out the use of the neglect tool, which had already been used in a number of cases. She informed Members about a range of work to address child obesity, primarily lead by the Population Health Team. She advised Members that this included a refresh of the Obesity Strategy which linked into the MSCB's Neglect Strategy. The Strategic Head of Early Help reported that early intervention was the best approach to tackling obesity so, in addition to learning from serious cases, work was taking place to reduce obesity through the Early Help Offer.

4.4 Julia Stephens-Row reported that work to address county lines required good links between organisations across the country as young people were being moved across borders. The Strategic Head of Early Help informed Members about the 'Trapped' campaign against child criminal exploitation and outlined some of the work taking place to address this problem through policies, training and complex safeguarding operations. She reported that it had been recognised that young people going missing from home was a significant risk factor so the established processes for dealing with children who went missing from home were now being used to enable early identification and intervention. The Executive Member for Children and Schools recommended that the 'Trapped' video be circulated to Members of the Committee, to which the Chair agreed.

4.5 The Strategic Director of Children and Education Services informed Members about the work of the Education Safeguarding Team and how they worked with clusters of schools. He offered to provide further information on this in a future

report. The Executive Member for Children and Education Services commented that partnership working and a change of culture were central to a lot of the issues raised during this item and suggested that, when the Committee received future reports on locality working and safeguarding arrangements, officers should include more information on these aspects.

4.6 Julia Stephens-Row reported that work had been done to raise the profile of the LADO role, although some organisations were better than others at referring cases. She informed Members that the LADO provided advice to organisations on dealing with allegations and that not all cases progressed to investigations.

4.7 The Executive Member for Children and Schools and the Chair thanked Julia Stephens-Row for her work as the Independent Chair of the MSCB.

4.8 Decisions

1. To note the publication of the Manchester Safeguarding Children Board (MSCB) Annual report 2018–2019.

2. To recognise the need to promote the importance of safeguarding of children and young people across the Council and in the services that are commissioned ensuring that safeguarding is at the heart of all that is delivered.

3. To request that the 'Trapped' video be circulated to Members of the Board.

4. To request that an extract of the minutes for this item be provided to the Health and Wellbeing Board when they discuss this report."

5. Trends and themes from Serious Case Reviews and Safeguarding Adults Reviews

5.1 Both annual reports refer to the Serious Case Reviews and the Safeguarding Adults Reviews which have been published in the last year. Reference is also made to the recommendations and learning from these reviews. A small piece of analysis undertaken looking at the period April 2015 - June 2019 has provided some useful information which can be summarised as follows. The numbers are quite small and this needs to be borne in mind when drawing too many conclusions.

5.2 With regard to Serious Case Reviews the number of referrals has started to show a reduction from 12 in 2015/16 to 9 in 2018/19. However not all of these then become a serious case review; there will be some cases where no further action is taken; and some where a learning review, which is a more focused piece of work takes place. In 2015/16 5 Serious Case Reviews were commenced and no learning reviews, compared to 2018/19 with 3 Serious Case Reviews being commenced and 5 learning reviews. In 2015/16 the referrals were for neglect (4), physical abuse (4), sexual abuse (3) and emotional abuse (1). Of these those that progressed to a Serious Case Review the categories were neglect (3), physical abuse (1) and sexual abuse (1).

5.3 In 2018/19 the referrals were spread across all the categories including neglect, physical abuse, abusive head trauma, sexual abuse, emotional abuse, and suicide. Of those that progressed to a Serious Case Review the categories were emotional abuse(1), sexual abuse (1) and abusive head trauma (1). Up to the end of June 2019 4 referrals have been made, 1 of which has resulted in a Serious Case Review being started in the category of physical abuse.

5.4 A tentative conclusion that can be drawn is that there is a greater awareness of neglect although it is recognised that there is much more to do. In addition the reduction in referrals, if it continues for the remainder of the year, it may indicate practice improvements and early interventions are having an impact on reducing the overall number of referrals for Serious Case Reviews.

5.5 With regard to Safeguarding Adult Reviews (SAR) the picture is very different, showing a significant increase in referrals from 5 in 2015/16 to 28 in 2018/19.

5.6 The figures were similar in 2016/17 (5), and 2017/18 (7). In 2015/16 of the 5 referrals 3 led to an SAR and, 1 learning review and 1 was a single agency review, compared to 2018/19 where 28 referrals led to 5 SAR's, 8 learning reviews and 1 single agency review.

5.7 In 2015/16 the referrals were in the categories of self-neglect (1) and neglect / acts of omission (4). The SARs which were carried out were all in the category of neglect /acts of omission. In 2018/19 the referrals were in the categories of self-neglect (9); self-neglect with homelessness / rough sleeping as an issue (10); neglect/ acts of omission (3); physical abuse (2) and suicide / attempt suicide (4).

5.8 The SARs which were carried out were in the category of neglect/ acts of omission (1); self-neglect (4). Learning reviews in the categories of suicide / attempt (1) and self-neglect (1) and self-neglect with homelessness / rough sleeping (10). Up to the end of June 2019 4 referrals have been made, 1 of which has resulted in a Safeguarding Adult Review being started in the category of self-neglect.

5.9 The spike in referrals for reasons of self-neglect and homelessness in 2018/19 correlates to the publication of the Government Rough Sleeping Strategy in August 2018, which recommends that "a Safeguarding Adult Review takes place when a person who sleeps rough dies or is seriously harmed as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult." A learning review has been commissioned using a national expert in this field which is shortly due to be completed the findings of which will be shared widely to ensure that any necessary changes in practice are communicated.

5.10 A further reason for the increase in referrals has been the overall raising of awareness of safeguarding in the past four years. There has also been a considerable amount of work done by the MSAB to raise awareness about the issue of self-neglect within the 2018/19 period which is likely to account for the increase in self-neglect referrals overall.

5.11 The main learning areas from both SCR's and SAR's are in relation to the need to improve multi agency working; change or promote awareness of policies and procedures; training; and development of professional expertise. More specific details are contained within the annual reports.

6.0 Recommendations

6.1 The Board is asked to:

1. Note the annual reports of the two safeguarding boards.

2. Request that each constituent member promote the importance of safeguarding across their organisation. Ensuring that safeguarding is at the heart of all commissioned and delivered services; with particular emphasis on learning from reviews and changing policies and practices accordingly.