Manchester Safeguarding Children Board

Children's Services Peer Challenge: Child Sexual Exploitation

14th – 17th May 2019

Feedback Report

1. Executive Summary

There is strong leadership and political support to respond to children who have been exploited and those at risk of child sexual exploitation (CSE). Elected Members, Senior Leaders and Managers provide visible and aspirational leadership through their engagement with staff and involvement in scrutiny, reporting and briefings on CSE. There are robust assurance arrangements in place with good sharing of information and risks, including identification of high-profile cases and areas for improvement.

Manchester have reviewed the current safeguarding partnership arrangements and decided to streamline these into a single children and adults board under their new Multi-Agency Safeguarding Arrangements from September 2019. This will provide an important opportunity to provide robust and focused scrutiny and challenge, address performance gaps and mature quality assurance arrangements across the partnership. An initial priority is to ensure effective transition into adult support and services for vulnerable young people.

There is a positive culture and good staff morale. There has been investment in recruitment, retention and succession which has resulted in a significant increase in permanent staff as well as the steadfast commitment to manageable caseloads to support practice. Co-location of social workers, police, community safety, health, early help staff and missing from home teams in the Complex Safeguarding Hub (CSH) has enhanced joint and joined up work for children, young people and families who require support for child sexual exploitation.

There is a drive for 'enabling and delivering excellence' across the Council for the whole city population. The Council is aware that previously, signals of deteriorating performance were missed and has worked to ensure well defined and supported lines of accountability and robust assurance routines are in place. There is a clear recognition that systems leadership and productive partnerships on behalf of children are fundamental to effectiveness and sustained improvement.

There is effective partnership working in Manchester. This is supported by a clear governance structure and good information sharing at a strategic and operational level. CSE multi-agency meetings and panels ensure that there is partnership input at all levels of involvement. Multi-agency working across statutory and voluntary and community organisations is supporting early intervention and prevention through to statutory intervention, as well as diversion and prosecution. However, not all CSE cases held outside the CSH are included in the data and performance information, so there is not a full picture of the extent of CSE.

There is a good understanding of child sexual exploitation and a focus on keeping children and young people safe. There is support for the whole family, using a strengths and relationship-based model. The peer team were impressed by the workers interviewed. There are examples of good practice: regular visits, trusting relationships, intelligence and mapping leading to disruption and prosecution, joint plans across locality and CSH teams, assessments, direct work and multi-agency interventions, which are leading to many positive outcomes, including keeping children and young people safe.

There are practice areas which require further improvement so that best practice becomes consistent for all children. These include: better use of risk and analysis; consistent

approach to evidence informed direct work; focus on interventions leading to better outcomes and impact; consistent approach to case recording, including supervision and multi-agency involvement; balancing 'child led' practice with keeping children safe; evidencing the voice of the child, consistent use of thresholds into CSH and effectiveness of 'scoring'. There are too many professionals involved with some young people and roles and responsibilities are not always clear; the locality teams do not sufficiently 'own' the lead oversight role for CSE. Internal referral processes lead to delay in accessing specialist CSE services. The current system, MiCare does not support effective social work practice, although Manchester is moving to using Liquid Logic imminently (July 2019).

There is a commitment to developing performance information and quality assurance arrangements to better evidence impact and outcomes for children. The current performance dashboards would benefit from a contextual summary which draws together both metrics and commentary to enable better understanding of performance data. There could be more focus on evidencing outcomes and impact. There is a positive response to audit, however it would be helpful in developing and growing the audit framework to consider ways to improve understanding of expected standards of performance, the associated entitlement to support and supervision as well as providing guidance to ensure staff fully understand and adhere to these standards.

Listening to the voice and views of the child, and improving engagement with children and young people, is a development area across the partnership as is evaluation of multi-agency impact. An early priority for the new multi-agency safeguarding arrangements will be to ensure oversight and scrutiny of multi-agency auditing and to agree a robust evaluation strategy to assess the effectiveness of the joint work overall.

There are dedicated resources supporting child sexual exploitation services, including additional permanent staff in the CSH. There is additional funding for the post of Clinical Psychologist, but the sustainability of this funding should be addressed before the funding ends in March 2020. There are additional resources through partnerships with Schools/Education, Health, Police and the Voluntary and Community Sector. The Health and Police resources within the Complex Safeguarding Hub would benefit from review to ensure that they are in line with the growing demands on the service. There is some training for CSE, but there is no CSE-specific training and development programme, either internal to the Council or across the partnership.

An important and essential resource is the commitment by the Council and partner agencies to concerted and unified action to improve the lives and life-chances for children, young people and families who require support due to child sexual exploitation.

Summary of the Peer Challenge approach

The Peer Team

Peer challenges are delivered by experienced peers. The make-up of the peer team reflected your requirements and the focus of the peer challenge. Peers were selected on the basis of their relevant experience and expertise and agreed with you.

The peers who delivered the peer challenge at Manchester were:

- Rose Durban, Lead Peer and Independent Consultant

- Carol Drummond, Head of Safeguarding and Designated Nurse for Children in South Tyneside CCG
- Sue Lingard, Head of Service for CSE, Leaving Care and UASC in Oxfordshire
- Reg Hooke, Independent Consultant Police
- Viv Murray, LGA Peer Challenge Manager

In addition to the above, three associate peers (Viv Murray, Tracey Newcomb and Mick McGlynn) undertook a review of case records and interviews with relevant social workers.

Scope and focus

The agreed focus of this peer challenge was child sexual exploitation (CSE): the effectiveness of current Complex Safeguarding Hub (CSH) multi-agency working arrangements to respond to children at risk of exploitation and those being exploited.

In doing so, the peer challenge team considered:

1. Leadership and management, including governance structure and accountability
2. Partnerships
3. Effective practice and impact on outcomes for children and families
4. Use of quality assurance and performance, including local intelligence around children who go missing, return home interviews and how intelligence is used to disrupt activity
5. Resources and capacity

The Complex Safeguarding Hub work to a broader definition of child exploitation (for example, criminal exploitation and gangs) but the focus of this review has been on child sexual exploitation. The peer team have focused on current practice (within the last twelve months) and whether current CSE arrangements are keeping children safe.

The peer challenge process

The fundamental aim of each peer challenge is to help councils and their partners reflect on and improve the impact of services for children and young people. It is important to remember that a peer challenge is not an inspection; it provides a critical friend approach to challenge the council and their partners in assessing their strengths and identifying their own areas for improvement. By its nature, the peer challenge is a snapshot in time. The team appreciate that some of the feedback reinforced issues you are already addressing and progressing.

The main elements of the peer challenge were:

- A review of data and key documentation.
- A review of case records – there was an in-depth look at a sample of **33** cases where child sexual exploitation was identified. This work was carried out between 16th and 18th April 2019, in advance of the main peer challenge visit (during which we also undertook a 'light touch' review of a small number of additional case records).
- On-site work over four days (from 14th to 17th May 2019) including individual interviews, focus groups and practice observations of panels and meetings, visits to the CSH, observations of intelligence information sharing meetings and a meeting with a young person.

The documentary evidence provided to the team was used to guide its focus in assisting Manchester with its ongoing improvement. The case records review helped to inform the peer team's findings in relation to frontline practice; a summary report on the case records review has been provided separately to ensure the confidentiality of potentially sensitive and personal information. However, it should be recognised that the team were only able to consider a relatively small number of cases and the peer challenge is not a substitute for council and partners' own quality assurance processes.

2. Feedback

2.1 Leadership and Management

There is strong leadership and political support to respond to children at risk of child sexual exploitation (CSE) and those who have been exploited in Manchester. Elected Members, Senior Leaders and Managers provide visible and aspirational leadership through their engagement with staff, involvement in scrutiny and in receiving regular reports and briefings on CSE. Meetings with the Lead Member and Chief Executive evidenced that there are robust assurance arrangements in place with good sharing of information and risks, including identification of high-profile cases and areas for improvement. There is a process of escalation so that the most high-risk young people, including high risk missing from home are known to the DCS, Chief Executive and Lead Member. There is a good knowledge and understanding of the history of the service and its direction, together with support for sustaining improvements and commitment to additional resources. There are good working relationships across strategic and political leadership.

The CSE service benefits from a strong committed leadership team whose strategic approach supports the principles and behaviours of Manchester Children and Education Services:

> *Principles: "Place children and young people at the centre of everything we do; Listen to and respond to children and young people; Focus on strengths and building resilience; Better lives for children and Early Action and Integration.*
>
> *Behaviours: Trust and Work Together; Own it and not afraid to try something new; We listen; Proud and Passionate about Manchester and Leadership and Management – walking the walk"*

The peer team found that there is a pride and passion in Manchester from the frontline to the most senior leaders and across partnerships to make a difference for vulnerable children and young people. We heard statements such as "it's really good working here and things are improving", "leaders are there for us and we see them around" and "it's really changed for the better around here". The DCS and senior management team are visible, trusted and approachable and meet regularly with different groups of staff.

Governance of CSE is supported through the Complex Safeguarding Executive Partnership (chaired by the Director of Children's Services), LSCB Complex Safeguarding Sub-group, LSCB Complex Safeguarding Delivery Groups, a Complex Safeguarding Annual Report and reports to Children and Young People's Scrutiny and

Lead Member portfolio. There is good multi-agency representation on boards and an expectation that information will be cascaded across agencies. There are links to other local authorities through the Greater Manchester Partnership, where there is sharing of policies, procedures, resources and good practice.

Manchester has reviewed the current safeguarding partnership arrangements and decided to streamline these into a single children and adults board under their new Multi-Agency Safeguarding Arrangements from September 2019 onwards. This is a challenge in terms of bringing children and adult agenda's together. However, it is an opportunity to address current challenges, including multi-agency robust and focused scrutiny and challenge (including more focus on CSE), address performance gaps and embed quality assurance arrangements across the partnership. An important initial priority is to ensure effective transition into adult support and services for vulnerable young people.

There is a positive culture and good staff morale. The peer team noted how proud staff are to work in Manchester and how positive they are about the support they receive from management. Whilst the peer team did not focus on the history or previous CSE team, it became evident through talking to people that this positive culture and improved morale across the partnership has developed from a change in leadership style and improved sharing of information as well as the strong support for relationship focused practice. Staff appreciate and benefit from the investment in recruitment, retention and succession which has resulted in a significant increase in permanent staff as well as the steadfast commitment to manageable caseloads to support practice.

Co-location of social workers, police, community safety, health, early help staff and missing from home teams in the CSH has greatly enhanced joint and joined up work for children and young people and families who require support for child sexual exploitation. The CSH, located on police premises, is also co-located with the police proactive commitment to tackling organised crime, enhancing further the efficiency and effectiveness of partnership responses to CSE, in terms of the broader exploitation agenda and prosecutions. The police approach is strongly victim focused, with operations prioritising the protection of the vulnerable.

There is a drive to 'enabling and delivering excellence' across the Council for the whole city population. Strategic leaders take seriously their key leadership role across the council and in working with other local agencies, particularly Police and Health to improve outcomes for children, young people and families. This is built on a deep and contemporary knowledge and understanding of children's services including child exploitation services. The Council is acutely aware that previously signals of deteriorating performance were missed and has worked to ensure well defined and supported lines of accountability and robust assurance routines are in place. There is a clear recognition that systems leadership and productive partnerships on behalf of children are fundamental to effectiveness and sustained improvement. At a strategic level these are providing a firm base for the developing locality working including the 'team around the school' approach and informing decisions about resourcing and deployment.

Manchester is thoughtful about sustainable resources. This is evident across the partnership with recognition of the inter-dependencies of any resourcing decisions on

behalf of children. There are no plans to reduce resources into CSE support and services and there is good political support to sustaining resources. However, the sustainability of the single health post in the CSH should be considered. It is important that the wider health workforce also take full responsibility for CSE and jointly work together for those young people requiring CSE support.

Manchester is well placed to accelerate progress and impact, and develop a robust evaluation strategy to assess effectiveness.

2.2 Productive Partnerships

There is effective and productive partnership working in Manchester. The co-location of the multi-agency CSH team is good practice and is seen positively by all those involved. There is good joint working between the CSH and Police Neighbourhood Teams in tackling CSE hotspots and supporting families. The co-location of Police Excalibur and Challenger teams has led to more joint operations and intelligence sharing and has strengthened the positive culture of partnership working. The Community Safety Team is well integrated, including: Police, Licensing, Community Safety Specialists and specific operations. This has supported effective prevention, protection and interventions, including disruption activities and prosecutions. The seconded Probation officers provide smooth transition of young people into and out of the Probation Service.

There is a positive commitment to information sharing at all levels, although there should be more consideration as to how strictly consent to share information is used at the front line and in panels and meetings. There are daily intelligence meetings of all partners in the CSH, which address immediate risk and actions but not all case files contain a record of these meetings. Mapping is used to link young people and groups of alleged perpetrators and there are a range of CSE multi-agency meetings and panels. This ensures that there is partnership input at all levels of involvement. Observation of the Gold group evidenced good leadership and partnership engagement as well as being victim focused, with effective information exchange leading to clear actions for children, young people and families. The Missing from Home (MFH) Panel evidences a good multi-agency commitment and thorough tracking of young people. However, it is not always evident from the case files what added value these meetings bring.

There is good support from Schools and Education Services and the Voluntary and Community Sector in offering early intervention and prevention services. A broad range of services for children, young people and families is available to support child sexual exploitation, including clinical and therapeutic services. Schools offer support through the curriculum and additional support to individual children. There is good support around sexual health and prevention from health professionals.

Partners are now well placed to accelerate the impact of their work and achieve continuing improvements through a strategic approach to joint commissioning of services and support. This can be achieved by a review of the existing service support into the CSH with a clear understanding of impact and outcomes for young people and their families whilst jointly developing a sustainable plan. The plan should encompass the Psychology post which is currently within the Hub.

Arrangements for transition to Adult Services are at an early stage and terms of reference for the Transition Group need to be agreed. Transitions to adult services are not effective or timely for many young people. For some vulnerable and traumatised young people, there are delays in accessing services such as Child and Adolescent Mental Health Services (CAMHS) and substance misuse services. A more 'trauma informed' approach should be considered across agencies. There is not enough focus on addressing the impact of exclusions and reduced timetables for some young people who are subject to exploitation, or consideration of risks to young people missing from school.

2.3 Effective Practice

No cases were referred to management for immediate action. Many of the cases reviewed were complex and already had senior management oversight. Cases reviewed evidenced an understanding of child sexual exploitation and a focus on keeping children and young people safe. There is good multi-agency commitment and response to improving practice

The peer team were impressed with workers interviewed. They knew the cases and young people well. Workers presented as caring and concerned but also professional and analytical. We heard about good examples where workers are champions for young people and challenge practice and services on their behalf. However, this was more apparent in discussions and not always evident in the case file. Caseloads are manageable and there is access to training and development. The impact of smaller caseloads is that there is more time to reflect on cases and undertake direct work. There is a positive culture in the CSH and a positive approach to learning. The team work well together and there is good integrated support and sharing of information. This is particularly evident in high risk cases and joint operations and there is evidence of disruption and prosecutions as a result of good joint work.

Staff informed the peer team that they receive regular and good supervision and that there is management oversight, including senior management oversight. There is supervision on case files, but the quality is variable and it is not always easy to find supervision notes on the system. Reflective supervision is not evident and this is an important gap for all workers and particularly so for newly qualified workers. In some cases there are gaps in recording of management oversight. There is also no evidence of joint supervision, which would be useful learning in terms of clarity of roles, responsibilities, case direction and management oversight.

There are regular visits to children, young people and families and generally cases are compliant in terms of statutory requirements and procedures. The quality of case recording is mixed, and it is not always easy to find the CSH case records. There is a recent improvement in the quality of case recording, but this needs to be consistent across all cases. Direct work is not always recorded on the case file. Impact chronologies are good but were only found on approximately 50% of the cases reviewed. There are no case summaries on case files. MFH procedures are followed and there is evidence of actions taken, including strategy discussions. MFH concerns are evident in referrals and assessments. Not all recording of MFH return interviews detail actions or note follow up. Multi-agency involvement is not always evident from the case file.

Some good practice was seen but not consistently. There are good examples of multi-agency interventions and positive outcomes. Many cases evidenced appropriate planning, assessments, interventions, direct work, good intelligence sharing and mapping, trusting relationships and frequent visits. There are examples of keeping young people safe through legal interventions or placements. Direct work, where used effectively, leads to a good understanding of exploitation and risk and positive outcomes in keeping young people safe. In many cases children and young people have positive outcomes, but case files do not routinely evidence this.

Cases are hard to work through and it is difficult to find critical information or follow the 'journey' of the young person. There are a number of cases which have been closed and re-opened within a short period. Thresholds into the CSH team are not always clear or consistently used and there is not always a clear rationale on the case file as to why the case has or has not met the 'threshold' for the CSH team. It is not always easy to determine the levels of risks from the case file, and risks are not always supported by explicit statements. Vague terms such as "disclosed concerning information" or "is associating with unsuitable peers" are not sufficient to determine levels of risks, thresholds and interventions. There should be a more consistent approach to how risks are defined and supported by professional judgement. The application of risk indicators is already noted as a priority for the management of CSH.

There are some good assessments, particularly more recent ones, but this is not consistent. Good CSH assessments contain historical information, details of risks and resilience and use of analysis. However, analysis needs to be strengthened in assessments to help understand risks, including consideration of history and understanding this in the context of what is happening now. More emphasis is needed on the rationale for inventions and the linkage with outcomes. There should be more on wider family involvement, including fathers or stepfathers. The voice, wishes and feelings of the young people in informing and shaping their plans need to be strengthened. Input from health and other key professionals is not always evident. Not all assessments detail historical intervention, linking this to resilience or capacity to change. It is not clear what the advantage is of having separate assessments for CSE and Child and Family Assessments, this is often confusing.

The quality of plans and reviews is variable in terms of quality and timeliness. There is one 'child's' plan across the locality and CSE team. There are some good plans which contain relevant actions commensurate with risk/need with actions and timescales as well as an update on progress. Due to the nature of the CSE work, many cases are crisis led and it is difficult to keep plans current. There is not enough use of contingency planning or sequencing of actions, which would help address management of those complex cases. There is use of a 'Safety Plan' which can replace a child protection plan, but it is early days and it has not yet been evaluated. There is good multi-agency attendance at reviews and in some cases the IRO minutes were written for the child/young person, which is good practice. Frequency of reviews and updating of plans does not always reflect the complexity and levels of risk.

CSE assessments contain scoring but this is not always consistent with the levels of risk or agreed by the case reviewers. In some cases scoring was described as optimistic and not taking into consideration all risk factors or parents' ability to protect. Some cases are closed prematurely due to low scores, only to be re-opened within a short period following

escalation of concerns. Some cases are closed before there is a sustained period of change. Other cases contain inconsistent scoring, not linked to the content of the assessment and in some cases challenged by other professionals, including IROs. The reliability of scoring requires evaluation in terms of accuracy, consistency and added value.

The approach to working with young people is child centred in terms of work being 'child led', working to young person's timescales, consideration of trauma and taking time to build a trusting relationship. The safety of young people is central to case planning and interventions. Children and young people are listened to and their wishes and feelings considered, although this is not always evident in case files. Staff in the CSH were able to articulate their aim of building a trusting relationship with the young person but did not always explain that this is to safeguard and reduce risk, and not an end in itself. There is a balance between 'child led' practice and keeping children safe. In some cases, we would question whether action should have been taken earlier, even though this was not the wish of the young person. Where such decisions are made, the case file should evidence that there has been consideration of risks and the application of professional judgement and professional authority. The voice of the young person is not always evident in the case file. It was also difficult to see the daily lived experience of some children and young people.

There is a good response to individual needs, through input from a range of professionals, but in too many cases there are too many professionals. This can result in too much activity, which is not always co-ordinated or purposeful, leading to too many visits to the young person and different 'strands' of work. One young person commented that she "struggles to engage with too many people". It is difficult in some cases to determine the different roles and responsibilities of the locality and CSH social workers. It is not always clear who has overall case management responsibility, leading to the assumption that the locality teams do not sufficiently 'own' the lead oversight role. The early help worker having different line management to the hub social worker and the fieldwork social worker adds a further complication to current CSH lines of accountability.

The initial response to CSE concerns is mostly appropriate and timely. The Multi-Agency Safeguarding Hub (MASH) identifies CSE risk and consults by phone with the CSH team in a timely manner. However, MASH does not routinely record these discussions or the rationale for decisions. There is evidence in some cases of immediate action to protect young people. This is not the case for all young people and there are delays in accessing specialist CSE work. This is due to cases requiring a Locality Child and Family Assessment and referral to CSH before allocation. It is not clear why there is a need for an internal referral for CSE cases. These issues should be addressed through the review of the MASH arrangements.

The current integrated children's system, MiCare, does not support effective social work practice and the CSH team do not have a consistent approach to how they use MiCare. An immediate action should be to complete a case summary on all case files as well as an impact chronology. Manchester will be moving to Liquid Logic in July 2019; effective migration will be essential. Management are clear that the transfer to Liquid Logic is not seen as the means of improving practice but as a supporting contribution to ongoing work on practice improvements.

2.4 Quality Assurance and Performance

The Council recognises and is committed to developing performance information and quality assurance arrangements to better evidence impact and outcomes for children. At the present time not all CSE cases held outside the CSH are included in the data and performance information seen, so there is not a full picture of the extent of CSE. The current performance dashboards – general and specific for complex safeguarding - would benefit from a contextual summary which draws together both metrics and commentary to enable a response to the key questions of: 'how well?' and 'what difference?' It will be important, particularly in relation to the work of the CSH, to track and evaluate:

- What impact are we having on (this group of) children?
    - How do we move from encouraging signs and some evidence of practice improvement to systematically and reliably good practice?
- How well are agencies working together to improve outcome for children?
    - What are the key issues and are we trying to address them with pace?
- What does the latest information tell us about our capacity to improve?
    - What has improved?
    - What would strengthen it further?
    - Can we sustain it?
- What next?
    - Who will do what, by when?
    - What impact do we expect, by when, as a result?

As part of this, early important actions will be to track progress, impact and outcomes of all children who are assessed as being or at risk of sexual exploitation, identify a subset of key indicators that are tracked regularly over time and be clear about the inter-relationships between those indicators. The outcomes of audit, including multi-agency audits, should be consistently used to share learning and drive changes in frontline practice so that monitoring and auditing become part of an iterative, action-orientated and practice-focused feedback cycle. This will help form an overall picture of how effectively the complex safeguarding hub is performing, informed by a clear understanding of risk, need, cost and demand.

The current Quality Assurance framework has an understandable focus on audits as a main workstream. Staff and managers are committed to developing their practice and positive about and understand the audit routines. However, it would be helpful in growing and developing this framework to consider ways to improve understanding of expected standards of performance and the associated entitlement to support and supervision, as well as providing guidance to ensure staff fully understand and adhere to these standards. The scope of the current audit tool is minimal, and a future tool would benefit from more emphasis on evidence of analysis, impact and outcomes.

Across the partnership, listening to the voice and views of the child and improving engagement with children and young people is a development area as is evaluation of multi-agency impact. Multi-agency performance dashboards to inform and shape policy and practice in relation to complex safeguarding are at an early stage and should be a key priority for the new safeguarding arrangements. Although multi-agency audits do take place there have been no recent ones looking at CSE or complex safeguarding.

CSE is an element in the range of multi-agency training provision offered by the Board but there is no current face-to-face training with a specific CSE focus.

Staff in the CSH are enthusiastic about working in an innovative environment in a context of rapidly evolving practice, knowledge and expertise, where learning and development is supported and encouraged. It will be important to both sustain this enthusiasm for learning whilst rooting it in impact that is linked to better outcomes for children so that practice is evidence informed and nuanced to local need. Staff would benefit from a focus on developing their critical analysis skills particularly in relation to assessment, including impact chronologies, planning and evaluation. In reviewing and maturing the framework it is now timely to have a focus on the:

- Range of soft and hard information used to obtain a better understanding of the quality and effectiveness of frontline and management practice
- Quality of case recording so that it effectively reflects the quality of work undertaken. What evidence of analysis do you expect to see and how will you know if this is then supporting direct work with children and families?
- Frequency and quality of reflective supervision and ensure that this is recorded to give an accurate account of discussions, decisions and the subsequent follow up impact
- Routine of auditing frontline practice to deliver the essential qualitative evidence by analysis which includes: identifying themes; addressing gaps; sharing learning and follow up on impact

There needs to be clarity about how the Principal Social Worker arrangements add value, insight and improvement to quality assurance work so that there is assurance that frontline practice is safe and effective. This work should be connected to and augmented by multi-agency audit learning. An early priority for the new safeguarding arrangements will be to ensure oversight and scrutiny of the development and embedding of multi-agency auditing and to agree a robust evaluation strategy to assess the effectiveness of the joint work overall.

There are plans to bring together a group of young people so that they can learn from each other, share experiences and build resilience. It would be helpful if this was seen as a priority as this would enhance the voice of the child/young person as well as their role in evaluation and performance management.

2.5 Resources and Capacity

The dedicated multi-agency CSH came into operation on 1st October 2018. Most members of the team are new, and many are newly qualified. The team are permanent staff and additional resources have supported the growth in terms of numbers of staff within the team. The CSH has a wider remit than the previous Protect team, in that it covers wider exploitation, including criminal exploitation, gangs and Missing from Home and Care. Child sexual exploitation takes up just under 50% of the team resources.
Staff and managers spoke about the increased work around child criminal exploitation, which is reflected nationally. An early partnership challenge will be how to ensure that a focus on CSE is also maintained by all agencies. The service will also need to consider supporting care leavers up to the age of 25 years and unaccompanied asylum seekers.

The service supports children, young people and their families. The model is a restorative strength-based response to the complex needs of children and families. There is good co-ordination, mapping and strong oversight of complex safeguarding operations. There is good use of the resources in developing the team around the school approach and individual mapping and help for schools. The early help service supports families in a 'whole family' approach to complex safeguarding. The ACT model is resourced so that workers can have smaller caseloads and focus on complex cases and intensive support and relationship building. The ACT model is new to the team, so impact and effectiveness of this model is not yet tested in Manchester. The telephone consultation role of the service is seen positively by those who use it. There is a dedicated Missing from Home team, including resources from the Police. Additional MFH services are provided from the Voluntary Sector.

There is additional funding for one year for a part-time post of Clinical Psychologist. The peer team heard very positive feedback on the effectiveness of this post in relation to individual support to workers and impact on reflective practice. Evaluation of the impact of this post should be considered so that sustainable funding can be identified before the funding ends in March 2020.

Schools add value and resources to the early intervention agenda by embedding learning about CSE into the curriculum as well as supporting individual children and young people. Schools offer a range of early interventions such as: harmful and coercive relationships, self-esteem, skills for life, resilience, social media and support through use of DVD's and performing artists. It is not clear how well this work is tracked, evaluated and measured in terms of impact and outcomes. Manchester is part of the Adverse Childhood Experiences pilot.

Partnership resources need more consideration in terms of joint commissioning of services/support and in additional resources for Health and Police. The Specialist Nurse in the CSH is picking up the role of School Nurse shortfall with individual young people. The resourcing of this service should be considered through the appropriate governance forum. The Police have retained their resources, but these have not grown in line with increased responsibilities and workloads, including individual cases and wider operations for victims and perpetrators.

As stated earlier, there is no specific training and development programme for CSE, either internal to the Council or across the wider partnership. There is some training, but this is not based on a training needs analysis, prioritised for key staff groups or aligned to practice improvement. Multi-agency training is mostly e-learning and the development of broader methods of multi-agency learning should be considered as a priority under the proposed new safeguarding arrangements. One of the challenges outlined by the manager of the CSH team is to "ensure the wider workforce is informed and recognise new and emerging practice in relation to CSE and complex safeguarding". There is openness to learning and development across the partnership and the time is right to capitalise on this. Consideration should be given to updated mandatory CSE training being expected of all workers across the partnership who work with children, with more specialist training targeted at those holding specific roles and responsibilities. There is additional resource in the form of Social Work Consultants and this resource could be usefully aligned to future Principal Social Worker arrangements and linked into the developing Quality Assurance Framework.

An important and essential resource is the commitment by the Council and partner agencies to concerted and unified action to improve the lives and life-chances for children, young people and families who require support for child sexual exploitation.

3. Next steps

The Local Government Association would be happy to discuss how we could help you further through the LGA's Principal Adviser Claire Hogan (email claire.hogan@local.gov.uk or tel. 07766 250347) and Linda Clegg, Children's Improvement Adviser (email lindaclegg0@gmail.com or tel. 07545 787882).

The peer team would like to thank colleagues in Manchester for their assistance in planning and delivering the peer challenge and for their engagement and openness to learning during the process.