MANCHESTER SAFEGUARDING CHILDREN BOARD

2018/19 Annual Report

"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."

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This Annual Report was endorsed at a meeting of the Manchester Safeguarding Children Board and Adults Joint Board on 15th July 2019

The report is produced by Manchester Safeguarding Children Board (MSCB). It reports on matters relating to 2018/19.

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 of Manchester City Council, 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 Board's work or wish to find out more you can contact the Manchester Safeguarding Children Board on tele: 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's Foreword

Welcome to the Manchester Safeguarding Children's Board (MSCB) Annual Report for 2018/2019. This annual report provides local people with an account of the MSCB's work from April 2018 until March 2019 to improve the safeguarding and wellbeing of children and young people across the city of Manchester.

In 2017 we developed a strategic plan and priorities which was undertaken jointly with the Manchester Safeguarding Adults Board. This has rolled forward into 2018/19. This report provides an update of the work that has taken place through the MSCB and its sub groups to support the delivery of the strategic plan and priorities. It is important to note that a number of the subgroups are shared with the Manchester Safeguarding Adults Board and we have held several meetings whereby the areas in common to the two Boards could be explored.

This report contains information on the Serious Case Reviews undertaken, strategies developed, training delivered and findings from audits. This has included the launching of the modern slavery and human trafficking strategy; a complex safeguarding conference exploring the different aspects of complex safeguarding and the sharing of information on the new complex safeguarding hub; and the sharing of communications tools to highlight different aspects of neglect.

This will be the last annual report of the Manchester Safeguarding Children's Board as legislation requires that new multi-agency safeguarding arrangements have to be established by September 2019. Arrangements are in place to ensure that there is a smooth transition. The development of one board for children and adults reflects the direction of travel over the last two to three years of an ever more joined up agenda however retaining two separate "executive groups " for Adults and Children ensures that the focus on single issues is not lost.

Finally I would like to thank the many partner agencies for their hard work and dedication, particularly to those who are directly involved in the work of the Board, helping to achieve our overarching vision and priorities. The focus across the system is to ensure that children and young people are safeguarded and those working within it adequately supported to deliver high quality services. Safeguarding is a very difficult and challenging area and I have been impressed by the commitment and dedication of colleagues and I wish them well in the future.

Julia Stephens-Row
Independent Chair of Manchester Safeguarding Adults and Children Boards
June 2019

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 around all of our priorities set out in the 2018/19 Business Plan and in safeguarding prevention so as to keep children safe from harm, along with the areas identified as future challenges relating to multi-agency safeguarding arrangements. 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.

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 in this report.

The 2018/19 priorities were as follows:

1. Engagement and Involvement
2. Complex Safeguarding
3. Transitions
4. Neglect (children) and self-neglect (adults)

Key activities in 2018/19 include:

- During the period 2018/19, MSCB published 5 Serious Case Reviews: SCR F1 / G1 / L1 / M1 and N1. These are summarised in Section 7.

- The MSB Manchester Modern Slavery and Human Trafficking Strategy (2018-2020) was launched in May 2018, alongside three launch events held in in the localities to promote the strategy. The impact of this strategy is due for review but an early review shows evidence of improvement in awareness and responses to Modern Slavery and Human Trafficking both within the workforce and our community.

- In February 2019, the Manchester Safeguarding Board (MSB) held its first Complex Safeguarding Conference – 'New Thinking and Best Practice in Relation to Complex Safeguarding'. The conference was delivered to over 100 front line practitioners and their managers from both children's and adult's backgrounds. Speakers included the University of Bedfordshire on Contextual Safeguarding, a presentation from an exploitation and trauma consultant regarding Child Sexual Exploitation (CSE) and Adult Sexual Exploitation (ASE) and background information regarding the work of the Complex Safeguarding Hub. This was followed by six afternoon workshops from the Children's Society (Disrupting Exploitation), Youth Justice (Mapping Exercise), GM Dovetail Team (Radicalisation and Prevent), AFRUCA (Modern Slavery and Human Trafficking), Independent Child Trafficking Advocacy Service (ICTA) and Deconstructing Vulnerability and Consent. Feedback on the conference was widely positive and shows an appetite for similar training opportunities.

- The MSB has implemented a multi-agency steering group to ensure the neglect strategy and our tool – Graded Care Profile 2 (GCP2) is embedded in across all agencies. We have trained 16 multi-agency staff in GCP2 so they can go out and train their own staff and so far, 93 multi-agency staff have now been trained in GCP2. A neglect communications strategy and toolkit has also been launched.

- Protecting Vulnerable Babies and Preventing Child Deaths Conference in October 2018 took place to embed the learning from child deaths within Manchester.

The Board has not received any complaints during the 18/19 period.

3. About Manchester

In recent years, Manchester has experienced significant population and economic growth and a vastly improved physical infrastructure. The population of the City has increased by nearly a third since 2001 and local forecasts indicate that this growth is likely to continue in the future. By 2028, there are forecast to be over 662,000 people living in the city, up from 503,000 at the time of the 2011 Census.
The population of Manchester has some particular characteristics that set it apart from other major cities outside of London (the so called 'Core Cities' group of authorities comprising Birmingham, Bristol, Leeds, Liverpool, Newcastle-upon-Tyne, Nottingham and Sheffield). Compared with these cities, Manchester has a higher than average proportion of younger working age adults and a smaller, but more vulnerable, population of older people. The scale of population growth in Manchester has also outstripped that of other major cities. Between the 2001 and 2011 Census Manchester experienced the highest rate of population growth of any local authority in England.

Manchester has a long history of being multi-ethnic and multicultural city and migration into and out of the city (both to/from other parts of the UK and internationally) continues to be the major driver of population change in Manchester.

Manchester also has one of the highest rates of child poverty in England with around 27% of children under the age of 16 living in poverty. This equates to roughly 29,500 children aged under 16 living in poverty in Manchester. Levels of fuel poverty in Manchester are also significantly higher than the England average.

Manchester's State of the City report provides further data and statistics for Manchester and can be found at https://secure.manchester.gov.uk/info/200088/statistics_and_intelligence/7353/state_of_the_city_report_2018/1

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.

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 and further details can be found on our website at **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 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 the Safeguarding Practice Development Group and its three Safeguarding Fora.

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 'task and finish' 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).

5. Our Priorities for 2018/19

The 2018/19 MSAB Business and Strategic Plan sets out priorities and actions for 2018/19. The 2018/19 strategic plan can be found at Appendix 3.

We chose four main priority areas, listed below along with progress against our intentions:

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

We will:	We have:
• 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 will deal with them	• 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 and young people • Engaged children and young people 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

PRACTICE EXAMPLE:

Manchester Youth Justice *- Youth Justice workers listen carefully to all children and young people and ensure that they are interviewed away from parents and carers as part of any assessment process. We ask young people to give their views on our service through a self-assessment form which is integral to the Youth Justice assessment and planning framework and is completed every time an assessment is completed and reviewed. This allows us to report on the collated views of the young people we work with. We use this information to improve the way we engage with young people and improve effectiveness.*

Complex Safeguarding - Domestic Violence & Abuse, Female Genital Mutilation (FGM), Sexual Exploitation, Radicalisation, Missing, Organised Crime, Trafficking & Modern Slavery, So-called Honour Based Violence

We will:	We have:
• 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	• Supported the development of the Complex Safeguarding Hub • Delivered a series of awareness multi-agency awareness raising events including a Complex Safeguarding Conference in February 2019. • Developed a series of seven minute briefings including Criminal Exploitation and Coercion and Control. • 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

PRACTICE EXAMPLE:

Complex Safeguarding - Domestic Violence & Abuse, Female Genital Mutilation (FGM), Sexual Exploitation, Radicalisation, Missing, Organised Crime, Trafficking & Modern Slavery, So-called Honour Based Violence

Greater Manchester Police (GMP) *- Complex Safeguarding is a term used to describe criminal activity - often organised - involving vulnerable people, where there is exploitation and can include child sexual exploitation; modern slavery and trafficking; violent extremism or honour based abuse.*

Working with our partners, we have launched the Complex Safeguarding Hub, located at Greenheys Police Station. The Hub will change the way public services understand and respond to complex safeguarding risks. We will improve our ability to protect children and safeguard adults, and will reduce the impact of repeated abuse on children, adults, and families.

Transitions - moving from childhood to adulthood in a safe and positive way

We will:	We have:
• 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'	• Been given assurance from the Transitions Planning Team that all relevant partner agencies are working together to achieve smooth transition from childhood to adulthood. • A multi-agency Transitions Board has been established, which first met in March 2019.

What will change?

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

PRACTICE EXAMPLE:

Children's Social Care (CSC) *- Children's Social Care and Adults Social Care worked together so that an appropriate and experienced adult provider could be identified for a young person who was living in a family home, where younger siblings were frightened of him. A positive move took place out of the family home prior to his 18th birthday and the young person now engages in 1:1 sessions with support staff. The work of the Transitions Team will continue to aim towards smooth transition for those who need it.*

Neglect - ensuring the basic needs of every child are met

We will:	We have:
• 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	• Implemented a multi-agency steering group to ensure the neglect strategy and our tool – Graded Care Profile 2 (GCP2) is embedded in across all agencies. • Trained 16 multi-agency staff in GCP2 so they can go out and train their own staff. • 93 multi-agency staff have now been trained in GCP2. • Launched the MSCB Neglect Communications package https://www.manchestersafeguardingboards.co.uk/resource/neglect-campaign-materials-information-for-all/ • Developed obesity safeguarding tools for practitioners to identify safeguarding concerns in relation to obese children and work together to protect the child and other support to the family

What will change?

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

PRACTICE EXAMPLE:

***Education** - The Neglect Strategy has been highlighted to Education staff and to partners through circular letters, the Safeguarding Newsletter and networks.*
Education staff from the Safeguarding in Education and Education Casework Teams have been part of the pilot group and the team delivering training on Grade Care Profile 2.
Schools are involved in the North pilot of Graded Care Profile 2
Awareness of the signs of Neglect is incorporated into all Safeguarding training delivered by Education teams, and highlighted particularly to staff who work directly with children and families.

6. What have we done?

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.

Prior to the Board reviewing and setting our priorities for 2018/19, we asked children and young people what they wanted us to focus on via a Survey Monkey survey and the results of the Manchester Youth Council Make Your Mark Survey 2018 were also considered.

Every MSCB multi-agency audit contains questions regarding Voice of the Child, for example:
'Is there sufficient evidence of the Voice of the Child and the child's wishes and feelings in the assessment?' and 'If the child has communication difficulties is there evidence that alternative methods have been used to capture the child's wishes and feelings? Please explain the methods.'

The MSB multi-agency Section 11 self-assessment audit also asks agencies to assess what standards they meet regarding Voice of The Child by the following measures:

1) A culture of listening to children and taking account of their wishes and feelings both in individual decisions and development of services
2) A culture of listening to parents/public and taking account of their wishes and feelings both in individual decisions and development of services
3) A culture of listening to staff and taking account of their wishes and feelings both in individual decisions and development of services

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.

Neglect

The Manchester Safeguarding Children Board Neglect Strategy 2017-19 and the Graded Care Profile 2 (GCP2) - our chosen Neglect assessment tool, continues to be implemented across all agencies.

The Neglect Strategy sets 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.

A multi-agency Neglect Strategy Implementation Steering Group has been set up to ensure this continues to be driven forward. The group includes strategic leads from Children's Social Care, Police and Health services and will continue to meet to ensure full roll out of the MSCB Neglect Strategy across all partners.

The MSCB Neglect communications strategy and toolkit has been devised and published and is available here: https://www.manchestersafeguardingboards.co.uk/resource/neglect-campaign-materials-information-for-all/

The MSCB Neglect Strategy is due for review in April 2019 and this will be completed by the Implementation Steering Group, along with input from leads from the MSCB and Leadership Group.

Complex Safeguarding Conference

In February 2019, the Manchester Safeguarding Board held its first Complex Safeguarding Conference – 'New Thinking and Best Practice in Relation to Complex Safeguarding'.

The conference was aimed at front line practitioners and their managers from both children's and adult's backgrounds.

Over one hundred practitioners attended the conference, which included a speaker from the University of Bedfordshire on Contextual Safeguarding, a presentation from an exploitation and trauma consultant regarding CSE and ASE and background information regarding the work of the Complex Safeguarding Hub.

This was followed by six afternoon workshops from the Children's Society (Disrupting Exploitation), Youth Justice (Mapping Exercise), GM Dovetail Team (Radicalisation and Prevent), AFRUCA (Modern Slavery and Human Trafficking), Independent Child Trafficking Advocacy Service (ICTA) and Deconstructing Vulnerability and Consent.

66 people provided feedback regarding the conference – which included the below:

'I have come away from the course feeling a lot more confidence about challenging such issues professionally. I could relate a lot of the content of the course to my work at the current time which helped me to understand what is or could be going on around a couple of my families. I will be tackling such issues very differently following this meeting, for example, making sure the context to any safeguarding issue if considered and mapped out as appropriate. I would like to be able to shadow the complex safeguarding hub in order to help me understand more of how they operate.'

'All parts were very useful and relevant for me in my practice. I have delivered safeguarding children training within my agency (health) today and been able to refer to some of the information shared in the conference. Many parts were really useful: the presentation on contextual safeguarding made me really think and I enjoyed and benefitted from the workshops I attended on Afruca's current campaign to raise awareness of modern slavery and from Channel/ Operation Dovetail.'

Child Sexual Exploitation (CSE)

Child Sexual Exploitation forms part of the Complex Safeguarding Hub which was officially launched in October 2018, where the Achieving Change Together (ACT) model has been successfully implemented, clinical psychology support is also available under the Trusted Relationships Project and therapeutic intervention is delivered by dedicated mental health practitioners.

Following the identification of a gap as regards to the amount of identified cases of CSE and ASE held for boys and young men the Sexual Exploitation Group commissioned some training from Survivors Manchester to train a range of partners engaged in work on sexual exploitation. This was arranged by the Manchester safeguarding Board and funded by the Community Safety Partnership and took place on 19th March 2019. The evaluations were positive and there is scope to consider further sessions for partnership workers.

The MSCB has also commissioned The Local Government Association (LGA) to complete a peer review of our response to CSE, which will commence in April 2019.

Disrupting Exploitation Programme

The Children's Society Disrupting Exploitation programme is funded by The National Lottery Community Fund for three years in Greater Manchester, London and Birmingham. The programme commenced in October 2018 and is focussed on driving long-term, sustainable systems change that better responds to exploitation and provides the best possible outcomes for young people.

In Greater Manchester the team are focussing on disrupting Child Criminal Exploitation and recognise that this is a complex safeguarding issue that cannot be tackled in isolation and that it is also difficult to address solely by working with young people on an individual basis.
The programme therefore allows the team to work systemically and contextually, in partnership with professionals, young people and the community to challenge and adapt the 'systems' that we work in to ensure they are set up in the best way to effectively safeguard young people.
The systems change work consists of completing 'tasks' which fall under four different categories;

- Contextual
- Culture and training
- Policy and practice
- Information and intelligence

The Disrupting Exploitation Team are in the process of developing approaches to understand and respond to young people who are in debt due to their exploitation, ensuring young people's experience is recognised and understood by professionals to improve safeguarding responses, and ensuring children and young people's needs are met in school, in order to reduce school exclusions and are also completing investigative work around good practise and innovations to how we capture and improve 'intelligence' to support safeguarding interventions as well as community responses to Anti-Social Behaviour across several local authorities.

The team also work directly with young people 'at risk' of exploitation providing an early intervention approach. Wythenshawe was identified as the first pilot area, and the team have been working intensively with young people in this area since January 2019. In March 2019, this expanded to reach to North Manchester due to additional funding received through Early Intervention Youth Fund (EIYF). This allowed the team to work with young people at escalating risk of exploitation who were not meeting thresholds for complex safeguarding.

The project workers have a reduced caseload due to working intensively with young people and to allow capacity for 'systems change tasks'. The team have worked with a combined number of nine young people so far.
For more information please contact ManchesterDE@childrenssociety.org.uk

Private Fostering

The oversight of private fostering arrangements has increased significantly with monthly reports to all children's services managers and cyclical independent audit activity. Close scrutiny is paid to progressing legal permanence for this cohort of children and a number have now secure legal permanence within the private fostering arrangement by virtue of a private law order.
The Private Fostering Team has been in development and is expected to launch in April 2019 and will comprise of two full time social workers and one team manager. This will mean that all children who are privately fostered in Manchester are supported and monitored by one centralised team, which will ensure that the children and their private foster carers receive a quality and consistent service from Manchester City Council as well as ensuring that the monitoring and quality assurance of all practice is consistent.

Timeliness of Private Fostering visits has previously been a concern within Manchester Children's Services, however it is expected that the creation of the Private Fostering Team this should be improved. All Children who are privately fostered will receive visits within statutory timeframes and more as necessary which will be discussed in a case by case basis between the social worker and team manager.
There is a duty placed on the Local Authority, introduced by The Children Act 2004, to promote public awareness within their communities of the notification requirement. In order to fulfil this duty Manchester is set to launch a redeveloped communications strategy reaching out to staff across agencies, partners, residents and the general public. There also continues to be half day briefings being delivered as part of the Safeguarding Board multi-agency training programme. In addition, within the Level 3 safeguarding training an awareness of private fostering is incorporated, highlighting the vulnerability of privately fostered children and the duties of professionals when they are made aware of children who are privately fostered. Practice standards and expectations are part of the induction programme for all new social workers joining the Manchester social work service.

Designated Officer

The Designated Officer role is to manage allegations against adults who work with children. The role is pivotal in ensuring that children are safeguarded from adults in positions of trust, who may pose a risk to them. During the reporting year, there has been significant work coming into the Designated Officer Service. 275 referrals have been received.

Source of Referrals	**Number of Referrals**
Social Care	108
Education	79
Police	37
Early Years	19
Health	9
Other	6
Sports / Leisure	5
Ofsted	4
Transport	3
Voluntary Organisations	3
Faith Groups	2

The Designated Officers continue to respond to a high volume of contacts from employers seeking advice and guidance. Out of the 275 referrals received, 180 were not progressed to a Designated Officer meeting but were a given a combination of advice and guidance as they did not meet the criteria as outlined in Working Together. The Designated Officers also have increasing involvement with Subject Access Requests (SAR), responding to requests from the Disclosure and Barring Service (DBS) asking for information about allegations and outcomes, Freedom of Information requests (FOI) and providing information about adults who have worked in Manchester in the past as part of historical abuse enquiries, for example, the Independent Inquiry into Child Sexual Abuse (IICSA).

The high volume of work means that there is limited capacity for the Designated Officer to develop initiatives across other teams and services e.g. Safe After School. The Designated Officer does however, regularly attend the North West Designated Officer regional forum and contributes to regional and national learning in respect of the Designated Officer role. It is hoped that a combination of the new electronic system - Liquid Logic and the Designated Officer contacts being processed via the MASH will provide a more consistent approach to referrals that come to the Designated Officer.

Front Door Arrangements

The MSCB and Children's Social Care (CSC) have commissioned Professor David Thorpe to review our Front Door Arrangements and look at new ways of working. The aim is to reduce referrals to CSC and promote collaboration and partnership working at a local level, with a focus on embedding Early Help as everyone's business.

Research undertaken by Professor Thorpe, showed that many referrals could have been resolved with a telephone call or further work such as an early help offer that does not require a social worker.

Following on from this, Professor Thorpe offered training to MASH staff and from the last week of March 2019, all referrals into the Multi Agency Safeguarding Hub must be made by a telephone call. Partners then have the opportunity to discuss the case with a social worker who can provide advice and agree with the caller the right response and resources.

The impact will be monitored by scrutiny of weekly data, weekly referral meetings and audit. Feedback will also be gained from families and partners. Early indications are that this is working well - where people have had conversations, they have felt that it was positive and a reduced number of cases being passed to a social worker for further action. Some areas for further focus have also been highlighted, which include out of hours contact.

'I rang up gave some details and could speak to a MASH social worker straight away and was told what would happen next, then I was updated on the case progress. This was my first experience of the new way of working and I found it much better than the previous way'

Health Achievements

MHCC Safeguarding Children's Designated Team are undertaking an ICPC improvement programme with the 82 GP practices in Manchester to better the quality and return rate of Child Protection reports for conference. A user friendly electronic ICPC GP report template has been designed highlighting essential GP information required, and includes a signs of safety approach. A quarter of practices have so far been visited and advised how to improve report quality. GP's have shown a strong desire to support the programme. A deep dive audit will be undertaken to review changes as the programme progresses. Long term it is planned that findings will be shared with social care to improve information sharing from primary care further.

The ICON programme supports new parents with key messages about coping with crying and keeping infants safe from harm associated with shaking. This is through strength based conversations at key touch points with Health Visitors, midwives and early years outreach workers.
The programme was piloted in South Manchester during 2018 and the evaluation findings were presented to the MSCB in January 2019.
The programme is now being extended city wide and resources and communications are being enhanced. The plan is for training for all midwives and health visitors to start in July 2019.

The Population Health and Wellbeing Team within Manchester Health and Care Commissioning (MHCC) have led the development of the collaborative Reducing Infant Mortality Strategy which plans to take action to address the rise in Manchester's infant mortality rate. The strategy reflects the relationship between the causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions.

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.

An SCR is not an investigation intended to attribute blame, but rather to identify strengths and weaknesses of the safeguarding systems.

During the period 2018/19, MSCB published 5 Serious Case Reviews: SCR F1 / G1 / L1 / M1 and N1. The Board screened 8 Serious Case Reviews; 3 were found to meet SCR criteria and reviews are underway; 4 were found not to meet SCR criteria and a Learning Review was conducted and 1 was found not to meet SCR criteria and required no further action.

Published Reviews:

Full reports and learning packs can be found on our website at:
www.manchestersafeguardingboards.co.uk/serious-case-reviews

SCR F1: Published May 2018

Child F1 was thirteen years old when they died from a heart condition exacerbated by morbid obesity in April 2014. Child F1 had been obese for many years.

SCR G1: Published May 2018

Child G1 suffered injuries caused by adults who should have been nurturing and caring and who deliberately, over a long period, put barriers in the way of services which should have intervened to provide protection.

SCR L1: Published May 2018

Child L1 was born prematurely. Whilst pregnant with L1, mother disclosed her husband physically assaulted her and the sibling of L1. She later denied making the allegation. Following concerns over a mark on the abdomen of L1, both children were considered to be children in need (CiN). L1 sustained significant head injuries consistent with being severely shaken.

SCR M1: Published August 2018

M1 suffered a non-accidental injury and there was evidence of ineffective care planning, monitoring, supervision and oversight of multi-agency care planning and assessment processes.

SCR N1: Published November 2018

Child N1 was three years old at the time of death in March 2017. Child N1 was found unresponsive in the bath; the cause of death remains unascertained.

An analysis has been completed of the top four most common themes in Serious Case Reviews and Safeguarding Adult Reviews recommendations and these are as follows:

1. Multi-agency working:

- Child Protection medicals
- Health staff being present at multi agency meetings or providing info if not present
- GP involvement in child protection process
- Partner engagement in strategy discussions / Improved strategy discussions
- Partner info for assessment (housing)
- Continuity of healthcare for LAC & notification to GP of change of placement
- All relevant services involved in CP conference / planning
- Think family / joined up approach
- Involvement of faith & community groups
- Information sharing (data protection)
- More joined up working / silo working

2. Policies and procedures

- New issues

- Child / young person not brought to appointments by parents / carers
- Challenging behaviour
- Neglect strategy
- Asthma management and smoking guidance
- Domestic Violence – retraction of allegations
- Multi agency referral process for Adults
- Obesity and neglect

- Raising awareness of existing policies

- Escalation / Challenge
- Concealed pregnancy awareness
- Sudden Unexplained Death in Childhood guidance
- Shared understanding of legislation

3. Training

- Professional curiosity & difficult conversations:

- Hidden males / Transgender and sexuality / Self-neglect / Smoking / Obesity

-Specific Training:

- Neglect and Graded Care profile / Risk management in legal planning

4. Professional expertise

- Importance of engaging the father in all assessments and decision making
- Identification of young carers
- Identification of risks from males in households, mobile isolated families, immigration status and BME
- Waiting list management of psychological therapy referrals
- Expertise in working with children with disabilities and complex needs to ensure that their views, needs and daily lived experience are fully understood
- Practice issues highlighted with reference to completion of domestic abuse section of contact screening (child) form.
- Paediatric consultants being provided with insufficient information about safeguarding concerns ahead of child protection medicals in order to consider what action to take.
- Understanding that all professionals need to be aware of children not being brought for health appointments and safeguarding issues that maybe linked to this.

8. Progress from our Subgroups

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 56 child death notifications reported to the Manchester Child Death Overview Panel (CDOP) from 1st April 2018 to 31st March 2019. Owing to the CDOP review process, there is a time lapse between a death being reported and the case being discussed and closed at panel. This depends heavily upon the circumstances leading to death and the death being subject to investigations.

There was a total of 47 cases discussed and closed by the CDOP from 1st April 2018 to 31st March 2019. For deaths that occurred during April 2018 – March 2019, it would appear that there has been an increase in the number of cases subject to coronial investigations, criminal proceedings and other reviews such as Serious Case Reviews. Depending on the circumstances leading to death and the nature of the death, this impacts on the number of cases closed by the CDOP. To undertake a comprehensive review of the death, the CDOP will not review a case until all investigations have concluded and the necessary reports have been submitted to panel for consideration. Cases that are subject to investigations may remain open for a number of years thus impacting on the timescale of which the CDOP closes the case.

In line with statutory guidance, the CDOP has a requirement to produce a local annual report. Detailed statistical analysis is performed to provide an overview of the potential risk factors that are likely to contribute to Manchester's child death rate and suggest action that could be taken to address this. The 2018/2019 Manchester CDOP Annual Report is due for publication in November 2019 and will be made available via the MSB website.

The CDOP continues to publish the quarterly newsletter/poster containing seasonal messages. The newsletter is aimed at parents, carers and the general public to raise awareness of trends in child deaths and provides advice and information regarding services available to families with the aim of preventing future deaths of children and young people.

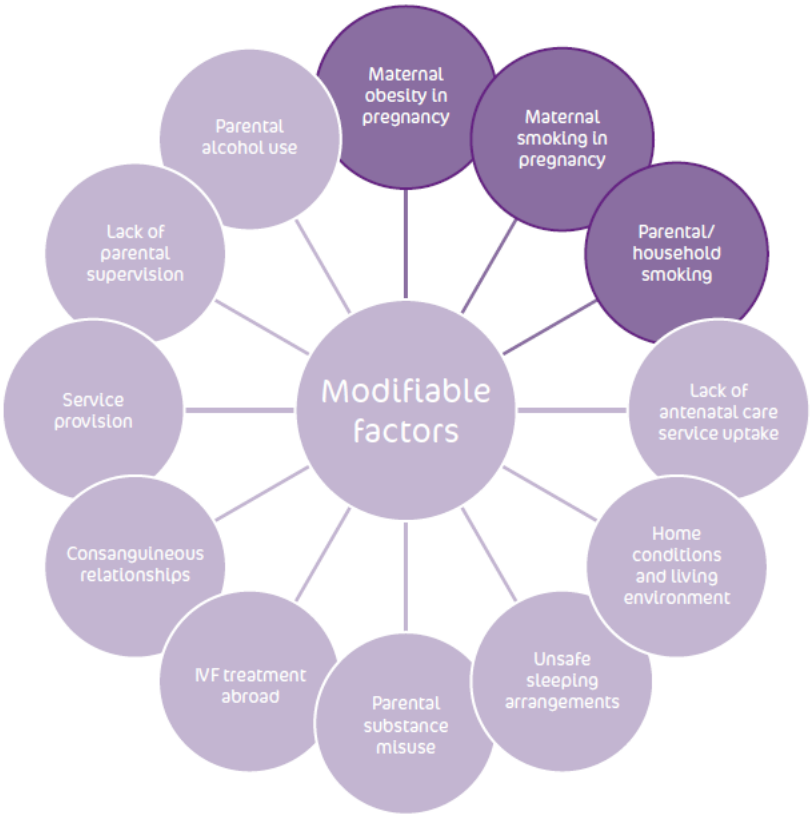
Following the 2017/2018 CDOP recommendation for the MSCB to develop a training event to disseminate CDOP themes and learning, the MSB delivered the Protecting Vulnerable Babies and Preventing Child Death Conference in October 2018, to coincide with Baby Loss Awareness Week. There was a total of 90 multi-agency professionals in attendance with a range of frontline practitioners and senior managers such as GPs, Social Workers, Health Visitors, Midwives, Clinical Psychologists, Nursery Managers, Detective Inspectors etc. The event included presentations from Dr Elizabeth Dierckx, Greater Manchester Sudden and Unexpected Death in Childhood (SUDC) Lead and Dr Juliet Court, Consultant Paediatrician Community Child Health. The aim of the event was to raise awareness of the CDOPs key modifiable factors and potential risks which contribute to the vulnerability, ill-health or death of children across the City. Participants were able to demonstrate impact and provided positive comments such as:

"Having been on the course, I was able to intervene when I witnessed a baby sleeping in an unsafe place whilst out visiting a family on my case load. I felt informed enough and confident enough to address the issue immediately. I was able to work with other agencies to help inform and support the family with their knowledge and subsequent improvement to this particular vulnerable baby's safe sleeping"

"I fed back at our team meeting some of the information from this course, I made a file from the slides and gave my colleagues leaflets. Our team was very interested in this. I have since, with families with new-borns, been able

to relay the information and I have recognised through my visits when there are worries in safer sleeping and been able to challenge and record this."

The Population Health and Wellbeing Team within Manchester Health and Care Commissioning (MHCC) have led the development of the collaborative Reducing Infant Mortality Strategy which plans to take action to address the rise in Manchester's infant mortality rate. The strategy reflects the relationship between the causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions. Reducing the infant mortality rate is a key priority within Manchester's Population Health Plan and encompasses the CDOPs key modifiable factors and contributing risk factors that increase the vulnerability of mother and baby both ante-natally and postnatally:



Three launch events were held across the City (North, South and Central) from 11th – 13th March 2019 to coincide with The Lullaby Trust Safer Sleep Week. The launches had a range of speakers with Councillor Garry Bridges, Councillor Sarah Judge and Barry Gillespie, CDOP Chair, opening the events which were well attended by 150 multi-agency practitioners. The strategy has been agreed by the Children and Young Peoples Scrutiny Committee, Health and Wellbeing Board and MSCB. It is a 5-year strategy from 2019 - 2024 and the steering group will continue to meet to discuss the implementation of the strategy and the delivery of the priority themes, objectives and actions.

An overview of the emerging themes, trends and modifiable factors are documented in the 2018/2019 CDOP Annual Report which is published each autumn on the MSB website at www.manchestersafeguardingboards.co.uk/child-death-overview-panel-information-practitioners

Serious Case Review Subgroup (SCRSG)

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.

The subgroup continues to be well attended, is responsive and has robust systems in place for agencies referring/screening new cases within timescales. There is a good level of discussion and challenge from partner agencies when screening cases.

The group is able to consider and contribute to cross-area reviews (including recently those from Trafford and Blackpool, Rochdale and Tameside) as well as cross/border links for specific reviews (Stoke on Trent, Stockport, Sussex).

Rapid Review pack and process work well and although national requirements for timetable is challenging, the SCRSG have successfully met the timescales for the first three rapid reviews.

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.

During 2018/19 the group has continued to evolve and grow, with a wide range of practitioners and services around the table.

The group have disseminated learning from a range of SCR and DHR's that have been published by the MSB over the period. Learning from the reviews has been demonstrated by examples of good practice identified by members from within their locality and reported back to the group.

An MSB priority area is discussed at each SPDG meeting and the subsequent Foras, meaning that MSB priorities remain a focus and ensuring that up to date information, learning and challenges are shared.

The group has also identified local trends and upcoming risks which has been further discussed at SPDG, with learning being and providing an excellent multi agency learning arena.

The group intends to work on evidencing impact as we move forward into the new reporting period

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.

The MSCB QAPI Subgroup have been able to evidence improvements in Children Missing Education (CME) and an increased number of responses to the Schools Safeguarding Self Evaluation as a direct result of QAPI scrutiny and challenge.

There was a good response to the Section 11 Safeguarding Self-Assessment – a total of 45 separate responses were received, including from 18 individual Registered Housing Providers and three Public Health commissioned organisations.

Two multi-agency case file audits were undertaken in the period. One was on the theme of Pre-Birth Assessments, and one was on the theme of Children with Disabilities (CWD) on a Child Protection plan for Neglect. The findings from the CWD & Neglect audit have shown evidence of improved safeguarding practice across the partnership, specifically around professional challenge and escalation, use of Signs of Safety, and recording of the Voice of the Child.

The multi-agency quarterly performance dataset had some missing data in the latter two quarters due to childrens social care being unable to commit to supplying the requested Performance Indicators due to competing demands on their resources. Some subgroup members feel that the dataset in its present form is too large and needs to be refined and refreshed. This will be reviewed during the next period as we move into the new arrangements.

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).

The group has made some progress this year on the backlog of recommendations from previous reviews and a substantial amount of the actions on the Tracker have been marked as Green or Complete.

Some progress has been made in terms of thematic analysis of SCR recommendations which has been used to inform the MSB Business Plan.

A representative for Domestic Violence & Abuse is now part of the group which has proved very useful.

As a result of outcomes from SCR findings around abusive head trauma, the Manchester ICON Steering Group was established in March 2018. The ICON programme supports new parents with key messages about coping with crying and keeping infants safe from harm associated with shaking. This is through strength based conversations at key touch points. The steering group has tested the ICON approach through a pilot in South Manchester which has demonstrated that the programme is effective in getting across key messages to carers and can be easily implemented within our local health care system. The evaluation findings were presented to MSCB in January 2019 and the model was endorsed. The programme is now being extended city wide and resources and communications are being enhanced. The plan is for training for all Midwives, Health Visitors and GPs to start in quarter 2 of 2019/2010 with the view of expanding the programme to reach all agencies.

It has been a challenge to secure regular and consistent attendance from all agencies and the subgroup has had three different Chairs which has led to some inconsistency and slow progress at times

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.

In 2018/19 the group the Communication and Engagement focussed on three priorities – MSCB Neglect, Modern Slavery and Trafficking, MSAB service user engagement.

The group successfully launched the MSCB Neglect Communications materials, in collaboration with Cheshire East LSCB, which includes social media messages along with a toolkit for use.

The toolkit is designed to:

- Raise awareness of Neglect
- Promote the Neglect campaign
- Help agencies across Manchester create their own campaign by utilising our materials. They will need to be able to localise the materials.

The campaign key messages are:

1. What is neglect?
2. How do we spot it?
3. Who do I contact for help?
4. Where do I find more information (who do I contact)?

With regards to Modern Slavery and trafficking, the group have promoted the Manchester Modern slavery and Human Trafficking Strategy, including twitter updates and featuring the Modern Slavery seven minute briefing on the 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 Face to Face Training Courses

A total of 1397 people attended face to face learning events in 2018/19 which is a decrease on the previous year (1612). (This data is based on both adults and children's courses)

Several new courses were added to the training programme :- GCP2, Awareness of Signs of Safety, Working with Male Survivors of sexual abuse and sexual exploitation (commissioned), and Safeguarding Children in whom illness is fabricated or induced. In addition to 2 x DHR events, 5 x SCR events and a non-SCR Multi Agency Concise Review on Fabricated and Induced Illness event. Large learning events included:- Complex Safeguarding Conference and Protecting Vulnerable Babies and Preventing Child Deaths.

Attendance and Non-attendance on Face to Face Training by Agency

The largest number of attendees were from Manchester City Council Children's Services and the NHS. The spread of agencies and job roles attending training remains good. Non-attendance has increased slightly this year to 16.3% up from 15.3% last year and may be linked to the reduced business support as maintenance and reminders for courses was reduced.

Post Course Feedback from face to face MSB courses

Attendees provide immediate post course feedback by completing a short online survey. The survey includes asking them to assess if learning outcomes were achieved and to outline any part of the course that was useful as well as any recommendations for improvement. The majority of courses achieve a response rate of at least 70% or higher. Trainee feedback is used to regularly update and amend courses and trainee satisfaction levels are also high.

Impact Evaluation of face to face Training

The Learning & Development sub group selected 3 learning events to be impact evaluated for 2018/19 – 1) Graded Care Profile2, 2) Safeguarding Adults Conference 3) Awareness of Signs of Safety. All 3 reports will be considered by L&D.

Overall, feedback for all of the learning events was positive, with many examples of improved impact on practice. However, the response rate on all IE surveys was less than 50% despite several reminders being sent to attendees to complete the survey.

Online Learning

The MSB has retained its contract with the online learning provider Virtual College which includes access to over 50 children and adult safeguarding training courses via a self-registration portal.

Online learning remains a popular and accessible source of safeguarding training. In 2018/19 a total of 5452 courses were accessed and 4,822 e-learning courses were completed, which is a slight decrease from 2017/18 when 5475 courses were accessed and 4924 were completed. The course completion rate was 88% compared to 90% in 2017/18.

The above data relates to both adults and children's training courses.

Impact Evaluation of Online Learning

A total of 569 online learners responded to an impact evaluation survey which equates to 12% of all completed courses. The largest agency response rate was from Education/Schools and Nurseries which reflects that they are also the largest users of online courses.

Online learning remains a popular option for agencies and practitioners and satisfaction rates appear high. However, the impact evaluation questionnaire reminders are sent manually and due to reduced business support in the business unit this may have contributed to a low response rate. It may also be worth considering reducing the number of questions on the survey to improve a response rate.

Conclusion

MSB learning events remain very popular and in high demand with most face to face courses having waiting lists. Courses are regularly reviewed and learning is embedded into training where requested and appropriate. Work is ongoing to ensure we recruit multi-agency subject specialists to join and deliver face to face training and review our online courses to ensure they match our priorities for 2019-20.

Complex Safeguarding Subgroup

The purpose of this group 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 following stands of Complex Safeguarding: Modern Day Slavery and Trafficking; Child Sexual Exploitation (CSE) and Adult Sexual Exploitation (ASE); Domestic Violence and Abuse, including Female Genital Mutilation and so called Honour Based Violence; Vulnerability and organised Crime; Radicalisation and Extremism and Missing from home, care & education.

A work plan focussing on actions for the strands of Complex Safeguarding was set for 2018/19 - 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.

Modern Day Slavery and Trafficking - The MSB Manchester Modern Slavery and Human Trafficking Strategy (2018-2020) was launched in May 2018, alongside three launch events held in in the localities to promote the strategy.

The Modern Slavery and Human Trafficking Subgroup continues to meet regularly to ensure communication and implementation of the strategy.

A joint project has been established with AFRUCA (Africans Unite Against Child Abuse) to establish 25 community champions and to run a joint campaign on exploitation.

Sexual Exploitation – Child Sexual Exploitation forms part of the Complex Safeguarding Hub which was officially launched in October 2018.

The MSCB commissioned The LGA to complete a peer review of our response to CSE, which will commence in April 2019.

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

Domestic Violence and Abuse- Greater Manchester Police and Council colleagues have continued and further rolled-out Operation Encompass across the city, including to PRUs and Early Years settings. Over 500 notifications were received by schools during Autumn and Spring terms of 2018-19. Numerous instances have been recorded in which the information shared has helped schools put a range of overt and silent support measures in place for pupils affected by domestic abuse in their household

Further progress has been made on the roll-out and embedding of the Safe and Together approach to working with families where domestic abuse is an issue, training over 100 staff in the approach and recently piloting a further related training package for staff on working with perpetrators

Colleagues in Community Safety have developed, promoted and launched, in conjunction with the MSB, a programme of learning from Domestic Homicide Reviews, along with related packages of learning materials and publications

Funding has been secured for continued provision of the Lesbian Gay Bisexual and Transsexual (LGBT) Emergency Accommodation Project, and the LGBT Independent Domestic Violence Advocate (IDVA) service, both of which have proved to be successful and highly regarded by those who have accessed them over the past two years.

Female Genital Mutilation (FGM)

Awareness raising of FGM has significantly increased during 18/19 with events in November, December and February with increased recognition at a local, Greater Manchester (GM) and National level.

These events have showcased the wide ranging work being done by NESTAC (New Step for African Community – a non-profit organisation), AFRUCA and other local organisations to raise awareness and provide support to victims. Grant awards have enabled the extension of working with women in the community to deliver the peer mentor and health advocate programme.

This work has also supported the Guardian project which provides direct support to girls and young women directly affected or at risk of FGM.

Forced Marriage/Honour Based Violence and Abuse (FM / HBVA)
Colleagues in Manchester have been working collaboratively with their counterparts across GM on development of a co-ordinated multi-agency action plan to deliver work under each of the four key themes of the 'So called' Honour Based Violence and Abuse Strategy.

The HBVA grant programme has enabled funding for Independent Choices to extend their Domestic Abuse helpline hours and for the delivery of community outreach to provide one to one support at the earliest opportunity. Work on HBVA has a focus on younger people, includes work with schools colleges and universities and involves participation in a community radio programme.

This work has also delivered drop in sessions in the localities and a conference focusing on coercion and control.

Missing From Home, Care and Education

The Missing from Home Operational Group has been meeting bi-monthly over the last 12 months. The partners have worked together to ensure a more focussed approach to Manchester Missing by creating an Impact Map for the Manchester Missing Strategy.

This detailed: Rationale; Inputs; Activities; Outputs; Intended Outcomes and Intended Impacts and allowed the group to identify not only the good work being done in the City to support missing young people but also to identify the gaps.

Meetings also included performance updates from commissioned services and feedback on service audits across both missing teams, as well as information sharing and partner updates.

Gaps still remain in the link with Missing and Education, however this is acknowledged and we are working to review this.

Vulnerability and Organised crime

A seven minute briefing was developed about Criminal Exploitation.

Criminal Exploitation now an element of the multi-agency Complex Safeguarding Hub, where several successful proactive targeted operations are currently ongoing.

Radicalisation and Extremism

Successful development and launch of the Home Office GM Dovetail Pilot, with Manchester as the GM Hub (shifting key functions of Channel from Police to the Local Authority)

Delivery of six Prevent / Channel workshops to social care staff (approx. 80 staff)

A refresh of the Manchester Channel Panel was completed.

Home Office funding was secured for 2019/20 to deliver Mock Channel Panels in the community to raise confidence in reporting concerns.

9. Budget

The Manchester Safeguarding Adults and Children Board budget is combined for 18/19. The total budget during that period was £ **740,148.58**. A full breakdown of the budget can be found at Appendix 5.

10. Future Challenges and Priorities

The MSCB held a joint Board meeting with the MSAB in January and March 2019 in order to agree priorities for 2019/20.

Decisions were made by reviewing the 2018/19 business plan and gaps identified within, data collated by the QAPI subgroups and information from the themes and learning gained from our SCR and SARs. Responses to the MSB Priorities Service User Survey was also used to assist in the process.

It was agreed that the MSCB vision would remain the same:

"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."

The 18/19 overarching strategic priority *'To be assured that safeguarding is effective across Manchester',* was changed to *'To support agencies and seek assurance that safeguarding is effective across Manchester'*.

The following priorities were agreed for 2019/20

Priority Areas

- Adverse Childhood Experiences (ACEs)
- Complex Safeguarding
- Transitions
- Neglect – Child and self and wilful neglect for adults
- Mental Health

It was also agreed that there would be underpinning principles, which include – 'Think Family', Communication, Engagement and Involvement including Voice of the Adult and Child and Making Safeguarding Personal (MSP), alongside early recognition and intervention and prevention and protection (of neglect – physical, sexual, emotional and financial abuse and DV&A)

The Joint Strategic Plan for 2019/20 can be found at **Appendix 4.**

The MSCB and MSAB also agreed that there would be one joint slim lined business plan, with priorities having aligned strategic leads who will report back to relevant Boards.

This report has demonstrated the progress made thus far on the priorities for 2018/19 and referenced the priorities for 2019/20. However as indicated a number of challenges still remain. The risk register for MSCB highlights a lack of awareness of the Neglect strategy, or familiarity with tools to identify neglect, impairs partners from early and supportive identification of safeguarding need, and awareness of levels of need across partnership is limited or not fully embedded, resulting in inappropriate levels of intervention.

Regarding neglect, a multi-agency Neglect Strategy Implementation Steering Group has been established to ensure this continues to be driven forward and to design and track a robust implementation plan. The neglect strategy will be refreshed for 19/20 to include additional identifying factors such as obesity.

With regard to the Levels of Need concerns, the MSB Levels of Need Framework will be reviewed at a newly established multi agency Working Group to review adapting the iThrive model for the Levels of Need Framework.

Whilst the number of referrals for Serious Case Reviews, which are now called Rapid Reviews has reduced. There are still a number of Serious Case Reviews to be completed. This 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 ensure that changes in practice are made and sustained.

As referred to in the last annual report there is a system wide challenge as to the number of children and young people and families who are needing support and contact from a range of services. As referred to in section 6, a piece of work has taken place from September 2018 to March 2019, looking at the front door arrangements. This has resulted in changes to referral processes and an increase in professional conversations which has shown early signs of a reduction in the need for social work assessments. The challenge is to ensure that the focus on locality working and early interventions continues to take place and that intensive casework services are focussed on the most vulnerable children and families and reducing the number of children looked after.

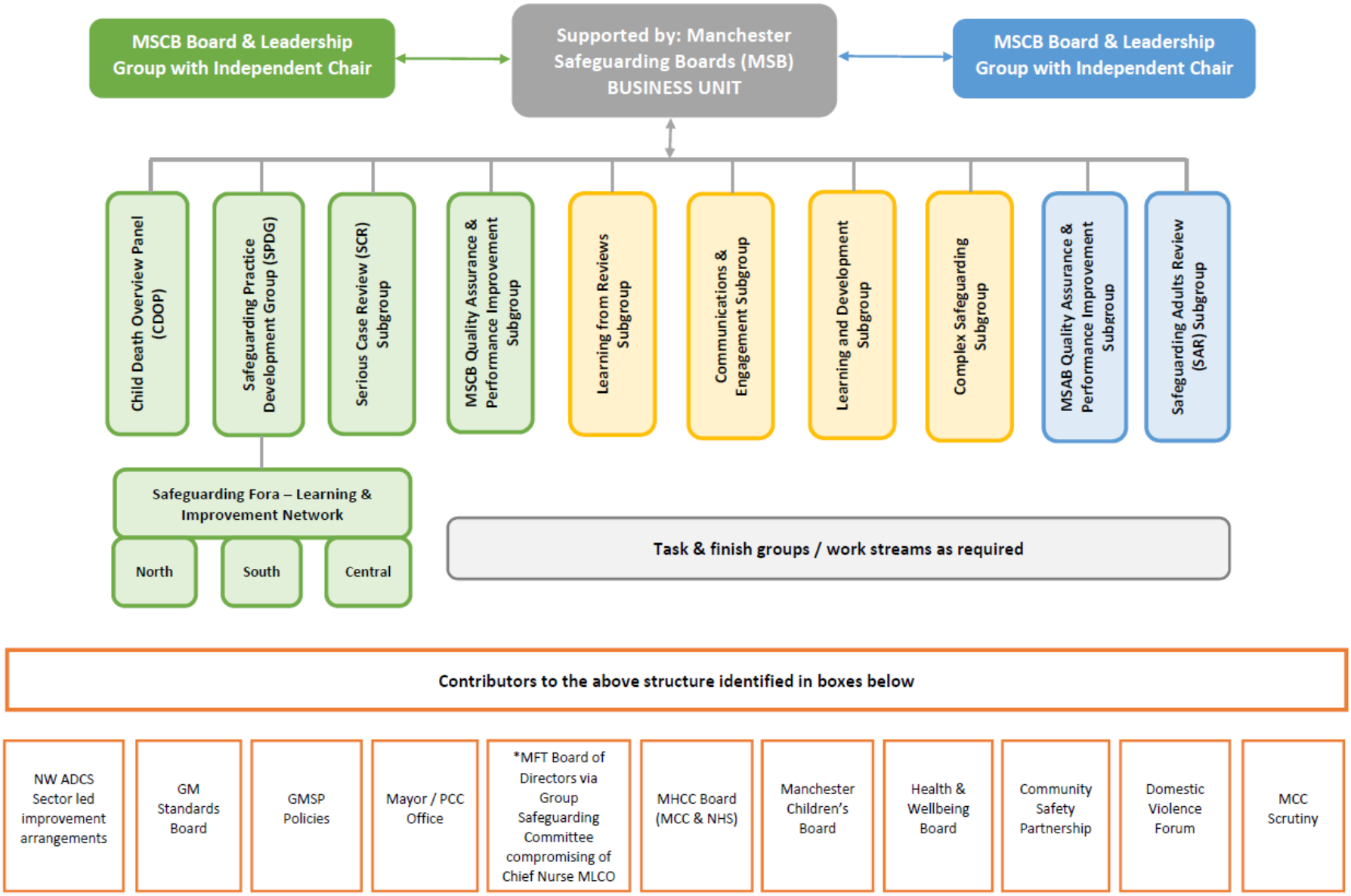
By September 2019 the MSCB will be replaced by one joint partnership board with adults, supported by two "executive" groups focusing on Adults and Children's issues and joint sub groups. It is intended to retain the Safeguarding children's sub group which will focus on the Child Safeguarding referrals and Rapid Reviews. 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. These new arrangements are building on the achievements over the last few years of the MSCB and the strengthened partnership needs to ensure that the focus on safeguarding children in Manchester continues.

11. Appendices

Appendix 1

MSCB MEMBERSHIP LIST 2018/19 AS AT MARCH 2019	
Barnardo's	Manchester Health and Care Commissioning Population Health and Wellbeing Team
Children and Family Court Advisory and Support Service (CAFCASS)	Manchester City Council Community Safety Partnership
Career Connect	Manchester Grammar School
Cheshire and Greater Manchester Community Rehabilitation Company (CRC)	Manchester Local Care Organisation (MLCO)
Clinical Commissioning Group (CCG)	National Probation Service (NPS)
Greater Manchester Fire and Rescue Service (GMFRS)	NHS England
Greater Manchester Mental Health NHS Foundation Trust (GMMH)	North West Ambulance Service (NWAS)
Greater Manchester Police (GMP)	Northern Care Alliance (formerly Pennine Acute NHS Trust)
Manchester Alliance for Community Care (MACC)	The Christie NHS Foundation Trust
Manchester City Council Children's Services	The Manchester College
Manchester City Council Education	Manchester Foundation Trust (MFT)
Manchester City Council Elected Member Portfolio Holder	Youth Justice

Appendix 2 – Governance Structure



Appendix 3

April 2018

SHARED STRATEGIC PLAN 2018/19

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:

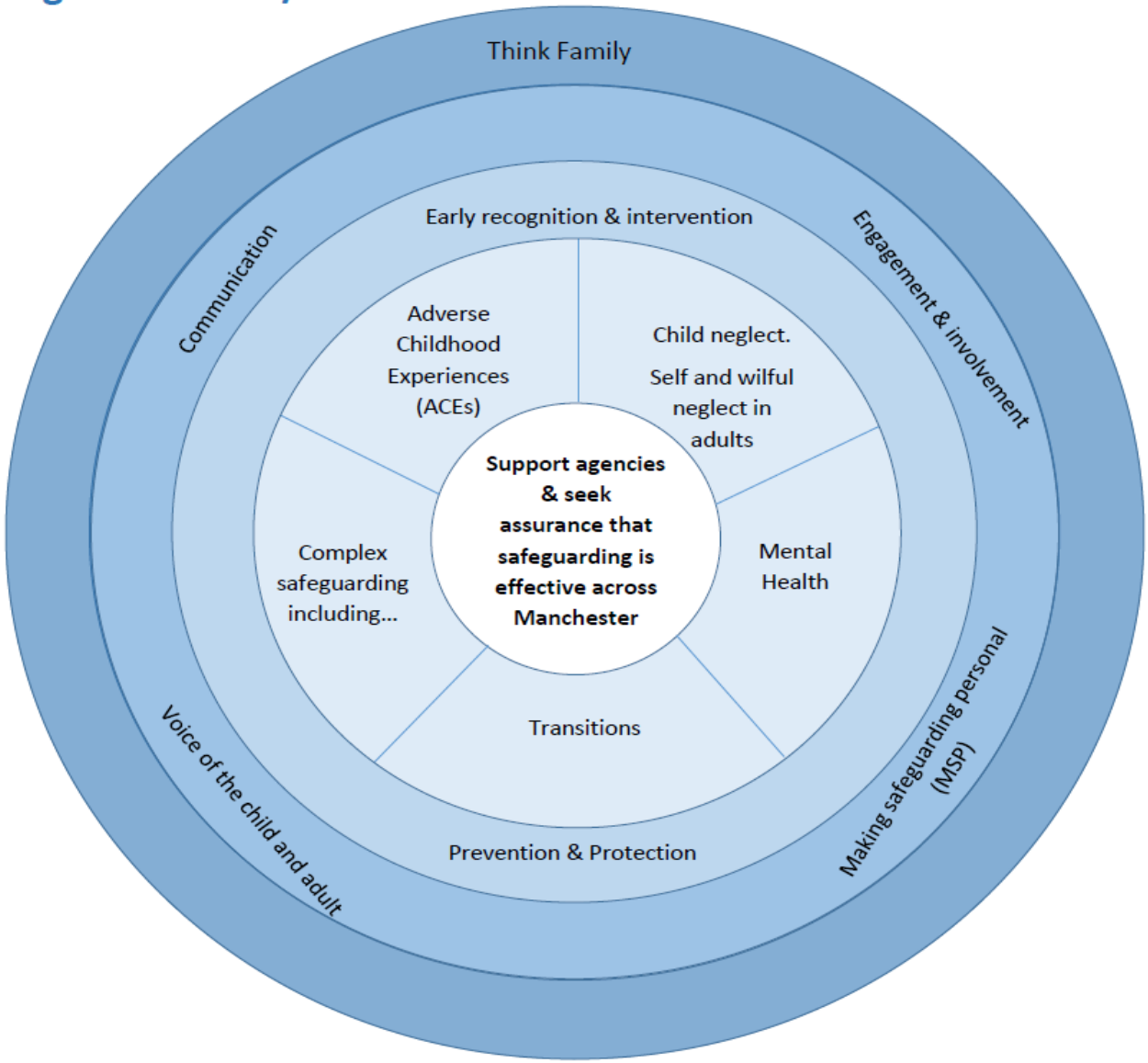
- Work with partners to assure ourselves that wilful neglect or neglect by omission is recognised and addressed
- Seek assurance that there is an effective multi-agency response to the issue of hoarding
- Seek assurance that there are appropriate responses in place for those at risk of self-neglect

What will change?

- We will be assured that adults at risk of neglect are being safeguarded.

Appendix 4

MSB Joint Strategic Plan 2019/20



Appendix 5

MSB Combined Budget - April 2018 – March 2019.

For the 12 Months ending 31.03.2019

	Manchester Safeguarding Boards			
Cost Elements	Annual Budget	Budget to Date	Actual YTD	Var.YTD
PAY Costs				
Total Pay Costs	475,028.84	475,028.84	420,644.08	-54,384.76
Non-Pay				
* Premises	7,000.00	7,000.00	12,832.68	5,832.68
* Transport	2,300.00	2,300.00	1,911.53	-388.47
* Supplies & Services	148,419.74	148,419.74	219,842.94	71,423.20
* Third Party Payments	101,000.00	101,000.00	0.00	-101,000.00
* Internal Charges	6,400.00	6,400.00	17,402.32	11,002.32
* Onwards Internal Trading	0.00	0.00	-366.00	-366.00
Non-Pay Expenditure Childrens	265,119.74	265,119.74	251,623.47	-13,496.27
TOTAL EXPENDITURE Board	740,148.58	740,148.58	672,267.55	-67,881.03
INCOME				
Miscellaneous Income	0.00	0.00	0.00	0.00
Total Contribution from MCC	-174,735.00	-174,735.00	-80,450.00	94,285.00
External Income	-91,750.00	-91,750.00	-122,662.86	-30,912.86
Interest	0.00	0.00	126.54	126.54
Contribution from MCC General Fund	-473,663.58	-473,663.58	-473,663.58	0.00
Total Revenue Income	-740,148.58	-740,148.58	-676,649.90	63,498.68
Over/Underspend	0.00	0.00	-4,382.35	-4,382.35

Note Reserves are £68,704