MANCHESTER SAFEGUARDING CHILDREN BOARD

Annual Report

2012-2013

MANCHESTER SAFEGUARDING CHILDREN BOARD
ANNUAL REPORT

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1. Welcome / Executive Summary– Ian Rush, Independent Chair of Manchester SCB

This is the annual report covering the work of the Manchester Local Safeguarding Children Board covering the 12 months from April 2012 to March 2013. The report summarises the activities of the board during this period, the achievements and improvements we have made (and the evidence we have used to substantiate this) and the key challenges we see from the safeguarding in relation to children, young people and families in the coming 12 months. Overall, the test of this report is how well it demonstrates an accurate view on our part about the safeguarding system in Manchester; whether we are focusing on the right priorities, accurately identifying and addressing areas which need improvement, and recognising things we have improved, without overstating these achievements to ensure they are maintained.

This Report is split into 6 sections:

- Governance and accountability
- Assessment and thresholds
- Performance reporting and quality assurance
- Learning and improvement framework
- Key safeguarding risk areas
- Early Help.

Also included are detailed appendices of key information and data referred to in the report.

Manchester is a major European and world city, and its achievements and profile are widely recognised. Like all major cities however, Manchester has significant safeguarding challenges and these are wide-ranging. Part of the board's role is to ensure that the professionals (and volunteers) working with children, young people and families (we estimate the total children's workforce in Manchester numbers over 20,000 people) are sufficiently aware and alert to safeguarding concerns where they encounter them, and know what actions to take ***to keep children and young people safe,*** **and** when to involve specialist safeguarding services within Manchester City Council, the NHS and Greater Manchester Police to ensure that children and young people are protected.

What follows is a summary of what we feel are on-going features of the safeguarding system in Manchester, achievements and particular challenges the board needs to focus on in the next 12 months and beyond.

Key features of the last 12 months (2012/13)

- Continued high volumes of safeguarding alerts and referrals reported by all services;

- The numbers of children and young people on safeguarding plans (i.e. those we feel are at the highest levels of risk) rose by 12%, in keeping with regional and national trends;
- Neglect remains, in volume terms, the single biggest challenge in relation to safeguarding children in Manchester – 56% of children on safeguarding plans have neglect cited as the primary area of concern;
- CSE continues to be a major focus; the number of identified cases are rising but increase is in keeping national trends;
- Paradoxically the numbers of children identified at risk of (non-CSE) related sexual abuse are lower than we would expect;
- Significant changes in relation to the vetting of staff and volunteers working with children.

Areas where we feel we can evidence some progress:

- Overall, despite the increasing pressures faced by all our partner agencies, the performance data we collect and analyse to assess how well the system is working remains broadly static – there is no noticeable deterioration in any area. This is an achievement by all agencies;
- The number of MCAFs is increasing; a 75% increase noted during the 12 months being reviewed, with better evidence being collected about the positive impact on families and improvements in the way these assessments are being undertaken;
- The continued delivery of high-quality training on relevant subjects, and the increasing use of e-learning to reach a wider number of staff;
- Progress in obtaining and using the views of young people and children as a source of reference in all safeguarding work e.g. the Voice Box for the production and use of "Zoe's story"; the development of the "Ambassadors Group", a group of young people who have shaped our online risks and sexting strategies are now an official subcommittee of MSCB;
- Better use of learning from serious case reviews and learning reviews, as evidenced by reference to these by frontline staff;
- have strengthened the representation and perspective on young people's and children's views coming to the board through the recruitment of a new lay member with a specific background and remit in this area, and with the creation of our "ambassadors group";
- Reductions in child deaths which we feel are linked to the Greater Manchester CDOP "safer sleeping" campaigns.

Areas which need continued emphasis and/or improvement in the coming 12 months:

- Neglect and CSE remain high on-going priorities for the board;
- We will identify the reasons and develop a better understanding for the comparatively low numbers of non-CSE related sexual assault cases;
- The safer staffing work-stream of the MSCB needs reinvigorating to ensure we effect improved monitoring of vetting and barring given the significant changes in guidance and legislation;

- The reduction in private fostering notifications, despite continued efforts, needs to be improved with better linkage, where appropriate, with partners initiatives in Greater Manchester;
- Our work in relation to forced marriage is fragmented and needs a coherent strategy and revised awareness raising initiatives within the children's workforce;
- Continued close attention to the interface between the child protection and domestic abuse systems;
- The Early Help offer in Manchester needs further development and the board will quality assure this and play its part in driving progress;
- The boards multi-agency case audit work, as a key source of assurance, needs to increase; this has been impacted on by the number of SCRs and learning reviews initiated (although some of these have contained case audits within them);
- Better linkage between child protection, domestic violence and troubled families work-streams to ensure that there is effective communication and case management, and best use of resources;
- Improvements taking place within MCC Children's Services to reduce the number of handovers of cases between social workers will be closely monitored by the board;
- Improvements already taking place at MCC Children's Services "front door", and its interface with other partner agencies will continue to be closely monitored, in particular to ensure that there is a consistent and agreed understanding about levels of need and thresholds across all agencies;
- The continuing workforce challenges facing a number of our partners, particularly in relation to recruitment and retention of social workers and health visitors, will be closely monitored by the board;
- MSCB will remain highly vigilant in relation to gang-related activity and its link with safeguarding, particularly in relation to young people;
- MSCB now has firm links with the Community Safety Partnership's PVE (prevention of violent extremism) and this will be developed further;
- MSCB will continue close oversight of work in Manchester relating to trafficked children and young people and unaccompanied asylum seekers;
- The Board's previous initiatives for ensuring appropriate support to vulnerable teenagers who are homeless and risk of exploitation will be reviewed;
- We have remodelled our business plan and process in accordance with new safeguarding guidance (Working Together 2013) issued in April 2013; we need to continue to improve this and link it to ensure we are prepared for the new inspection framework for safeguarding by Ofsted, which will include enhanced inspections of LSCBs performance;
- Continued review of the way in which the MSCB links with schools, including free and academy schools, and the way in which their own internal safeguarding performance is reported to governing bodies and externally (which includes MSCB);

- To maintaining our strong and effective links with the executive and other designated safeguarding leads in the NHS as its own reform programme continues;
- MSCB will maintain a strong and active role within the Greater Manchester Safeguarding Partnership to facilitate closer working with our other GM partners, particularly but not exclusively in relation to CSE;
- We need to maintain close oversight and scrutiny of Manchester City Council's reform programme to ensure it maintains its focus and prioritising of safeguarding;
- Maintaining a continuing and close monitoring of the impact of resource reductions across all public services in Manchester to ensure that potential risks through organisational transitions are being properly assessed and effectively managed.

This annual report ideally needs to be read in conjunction with the MSCB Business Plan 2013–15.

There is, necessarily, a lot of technical information and data in this report as we are required to produce this. But I hope reading this report gives you assurance that the safeguarding of children and young people in Manchester remains the highest priority.

Ian Rush

Ian Rush, Chair, Manchester Safeguarding Children Board

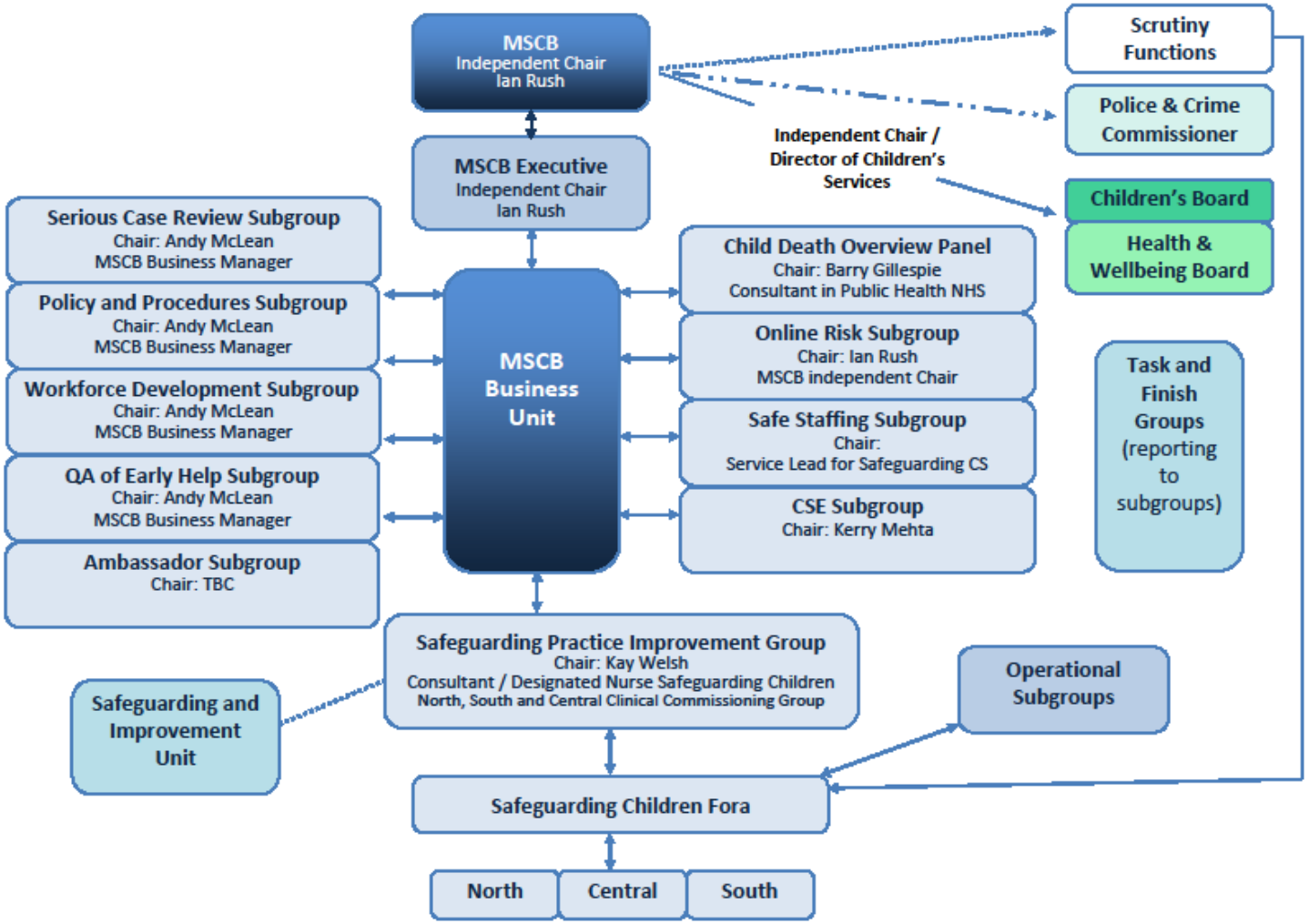
2. MSCB Structure and Governance

2.1 MSCB Board Members

Ian Rush	Independent Chair, MSCB
June Ackers	Manchester City Council, Legal
Lynn Agnew	Greater Manchester West Mental Health Trust[1]
Sue Ward or Jill Alexander	Central Manchester Foundation Trust
Christine Carroll	The Manchester College
Juliet Court	NHS Manchester
Karen Dolton	Family, Health and Well Being Directorate
Jane Dewar	Connexions
Delia Edwards	Manchester IDVA[2] Service
Lydia Fleuty	Manchester Drug and Alcohol Strategy Team
Steve Foster	The Manchester Grammar School
Mel Godfrey	Manchester City Council Housing
Gillian Clayton	Manchester Children's Services
Bob Barr	Greater Manchester Fire and Rescue Service
Paul Jackson / Jill Varndell	NSPCC
Stephen James	Directorate for Adults, Health and Wellbeing
Phil Owen	Greater Manchester Police
Pauline John	Manchester Mental Health and Social Care Trust
Graham Johnston / Paul Leahy	HMP Manchester
Sarah Khalil / Edith Attoh	Domestic Abuse Coordinator Manchester
C'llor Afzal Khan	Executive Member, Manchester City Council
Tim Kyle	Greater Manchester Probation Trust
Mike Livingstone	Manchester Children's Services
Kate MacDonald	Young People's Support Foundation
Marie McLaughlin	Youth Offending Service
Andy McLean	MSCB
Lynn Perry	Barnardos
Eleanor Roaf / Barry Gillespie	Public Health
Nicola Shanahan	Manchester Alliance for Community Care
Suzanne Smith	Pennine Acute Hospitals Trust
Jane Sykes	The Christie NHS Foundation Trust
Helen Thompson	UHSM[3] NHS Foundation Trust
Kay Welsh	NHS Manchester
Stephen Dean / Ruth Thompson / Dominic Hyland / Clare Ronals	GP Consortium
Mark Whittaker / Craig Harris	Clinical Commissioning Group
Amanda Thain	Head Teacher Representative

[1] This trust no longer attends from March 2013
[2] Independent Domestic Violence Advice
[3] University Hospital South Manchester

2.2 MSCB Governance Framework



Manchester Safeguarding Children Board Vision

'*Every child and young person in Manchester should be able to grow up safe from maltreatment, neglect, accidental injury / death, bullying and discrimination, fear of crime, crime and anti-social behaviour.'* (MSCB Business Plan 2013 - 2015)

MSCB's overarching purpose is to ensure that the safeguarding system in Manchester is working effectively and improving, based on evidence presented to the board.

Independence

MSCB is the key public protection partnerships in Manchester. It has a wide-ranging membership and senior level of representation from all appropriate agencies. MSCB is independent and ultimately accountable to its member organisations, central government and the citizens of Manchester. The board has a strong working relationship with the Manchester Children's Trust Board and the Manchester Health and Well-Being Board. The independent chair of the MSCB is a member of both of these bodies. Our work, performance and impact is scrutinised periodically by Ofsted and Manchester City Council's Young People's and Children's Scrutiny Committee.

MSCB Board

The MSCB Board meets every month with all members expected to attend. The Board receives reports on MSCB business from its subgroups and task and finish groups, as well as updates on the progress of the work contained in the MSCB Business Plan. (See Appendix 1 for Board member attendance).

MSCB Executive

The MSCB Executive members are:

- MSCB Independent Chair (Chair of Executive)
- Business Manager, MSCB
- Head of Safeguarding, Children's Services
- Strategic Lead for Children, Children's Services
- Safeguarding Manager, Education, Children's Services
- Consultant/Designated Nurse, North, South and Central Clinical Commissioning Group
- Assistant Director Children's Services, Barnardos
- GMP Superintendent, Crime Operations.

MSCB Subgroups

Safeguarding Practice Improvement Group (SPIG)

SPIG aims to achieve better outcomes for children in Manchester by improving multi-agency practice.

SPIG is chaired by the senior designated nurse (safeguarding), central Manchester CCG, with multi-agency membership from MSCB. SPIG directs the work of the five (now three) safeguarding district fora, membership of which includes MSCB partners. SPIG is very well attended and has a strong active membership. SPIG provides an effective line of communication between the board and front line workers.

Policies and Procedures Subgroup

The Policies and Procedures subgroup review, develops and improves practice guidance. It links closely to the work of the Manchester Adult Safeguarding Board.

The group is chaired by the MSCB Business and Performance Manager and includes membership from Children's Social Care, NHS, Education, Connexions, Probation, YOS and the voluntary sector.

Serious Case Review Subgroup

The Serious Case Review subgroup looks at cases when a child dies and abuse or neglect may have been a factor, or a child is harmed and there may be concerns about the way in which agencies worked together. The subgroup decides whether the criteria for a SCR (as laid down in Working Together 2013) have been met and make a recommendation to the Chair of MSCB. In addition to determining recommendations about SCR, the group closely examine all cases presented for other learning opportunities, and commissions a range of other learning reviews.

The group is chaired by the MSCB Business and Performance Manager and membership includes Greater Manchester Police, Health, Children's Social Care, Education and NSPCC. Their function includes establishing terms of reference and scope for all SCRs and for quality assuring the Overview Report and Action Plan before these are presented to the Board. The group performs a similar role in relation to learning reviews.

Where cases do not meet the criteria for a SCR but it is felt there are important issues to address, the group can undertake single or multi-agency Management Reviews and make recommendations to the Independent Chair of MSCB and other subgroups.

Please also see the Serious Case Review section on P. 16.

Workforce Development Subgroup

The Workforce Development subgroup ensures that the MSCB training programme, including delivery, is effective. It makes representations and recommendations to the MSCB about relevant children's workforce issues. It also has a role in ensuring that partner agency safeguarding training is being delivered effectively and is proportionate to the size of the children's workforce in Manchester.

The group is chaired by the Business and Performance Manager and has increased membership which now includes Children's Services, NHS, Connexions, GMP, Adult Safeguarding, Manchester Mental Health and Social Care Trust and MACC.

Child Death Overview Panel

The Child Death Overview Panel (CDOP) reviews the deaths of all Manchester children and young people to identify themes.

The Panel is chaired by a Consultant in Public Health. It reviews around 15 deaths at each meeting. Sixty to eighty child deaths are reported each year in Manchester. Over half of these deaths are babies under the age of one.
The subgroup meets quarterly and is well attended by representatives from NHS, Children's Social Care, Housing, Probation, Connexions, Rapid Response, Eclypse, YOT, GMP, Sure Start and Education.

Online Risk Subgroup

The Online Risk subgroup considers how online and communications technology affects child welfare in Manchester, and directs the work on the E-safety strategy.

The group is chaired by Ian Rush, the independent chair of MSCB, and meets quarterly. Membership includes Children's Services, GMP, Education, Libraries, Connexions, MACC, Sure Start, NHS, City Learning Centres, YOS.

Safe Staffing Subgroup

The Safe Staffing subgroup develops guidance and sets standards of practice to ensure that staffing and recruitment within partner agencies is safe and effective.

The group is chaired by Children's Social Care and membership includes representatives from NHS, Greater Manchester Police, Connexions and the MSCB Local Area Designated Officer (LADO).

Child Sexual Exploitation Subgroup

The CSE subgroup ensures that the boards CSE strategy is effectively being carried out at an operational level, and advises the board on key CSE issues.

The group is chaired by the Children's Services Area Safeguarding Manager with the lead for CSE. Membership includes Children's Social Care, the Safeguarding Improvement Unit,

Looked After Children Service, Education, NHS (Safeguarding Children's Team Lead), Connexions, Advanced Childcare / IFA rep, Protect, GMP, Eclypse, YOS, Barnardo's Leaving Care Service, The Children's Society, Young Person's Support Foundation and Brook.

Early Help Subgroup

A further subgroup of the MSCB has been set up in the year under review and tasked with quality assuring all early help activity to ensure that those at risk receive appropriate support at the right time, following the ratification of Manchester's Early Help Strategy.

2.3 Summary

Ensuring that the MSCB Board and associated governance framework remains fit for purpose against a changing national and regional context is a key priority for the MSCB Business Plan 2013-2015.

The MSCB's current business plan came to the end of its designated period of operation in mid-2013; a substantially revised plan has replaced it. The MSCB business plan needs to be considered in conjunction with this annual report.

As part of the MSCB Business Plan 2013-2015, MSCB will also present regular reports on the work of MSCB to MCC YPCOS and the Greater Manchester Police and Crime Commissioner.

Following the publication of Working Together 2013, the governance and accountability processes of the MSCB have been reviewed. Work to strengthen accountability has taken place and will continue under the direction of the board.

Lay membership

During the last twelve months, MSCB has secured a lay representative who has a specific remit to strengthen the boards representation of the voice of the child and young people as a central theme in our work and in safeguarding practice in the city.

Policies and Procedures

Over the past twelve months, the MSCB has reviewed and published a number of policies including:

- The Manchester Safeguarding Standard has been reviewed and remains operational;
- The MSCB Safeguarding Disabled Children Guidance was reviewed & published Jan 2013 as a result of a recommendation from the CR1 case review;
- The MSCB Safeguarding and Gangs guidance was updated and published in March 2013, this is now a joint MSCB / MSAB protocol;
- A new joint MSCB / MSAB Domestic Abuse protocol and referral form was finalised and published in January 2013;
- New practice guidance was finalised and published in November 2012 as result of alcohol themed multi-agency audit;

- The escalation policy was extracted from the core safeguarding procedures and published as stand alone item in October 2012 as a result of a recommendation from a case review;
- A new Protect flowchart was published in January 2013;
- Revised Safe Sleeping Guidance was published in February 2013:.
- MSCB contributed to the Combined Greater Manchester LSCBs online safeguarding procedures; these were launched in February 2013.

Regular review of the Manchester Safeguarding Standard and underpinning policies and procedures, alongside the implementation of a framework for effective partnership working remains a priority on the MSCB Business Plan 2013-2015.

Early help

Working Together 2013 emphasises the role of MSCB, under regulation 5 of the Local Safeguarding Children Board Regulations 2006, to 'assess the effectiveness of the help being provided to children and families, including '**early help**'.

Accordingly, a new subgroup of the MSCB has been created and tasked with quality assuring all early help activity to ensure that those at risk receive appropriate support at the right time, following the ratification of Manchester's Early Help Strategy, which is currently being finalised. As part of the remit of this subgroup, scrutiny of the effective delivery of the MCAF is a key and on-going objective.

A further priority for 2013-14 is to improve the linkage of the troubled families work streams commissioned by MCC and its partners from the Manchester Investment Fund with the work of the Board.

Views of Children and Young People and their Families

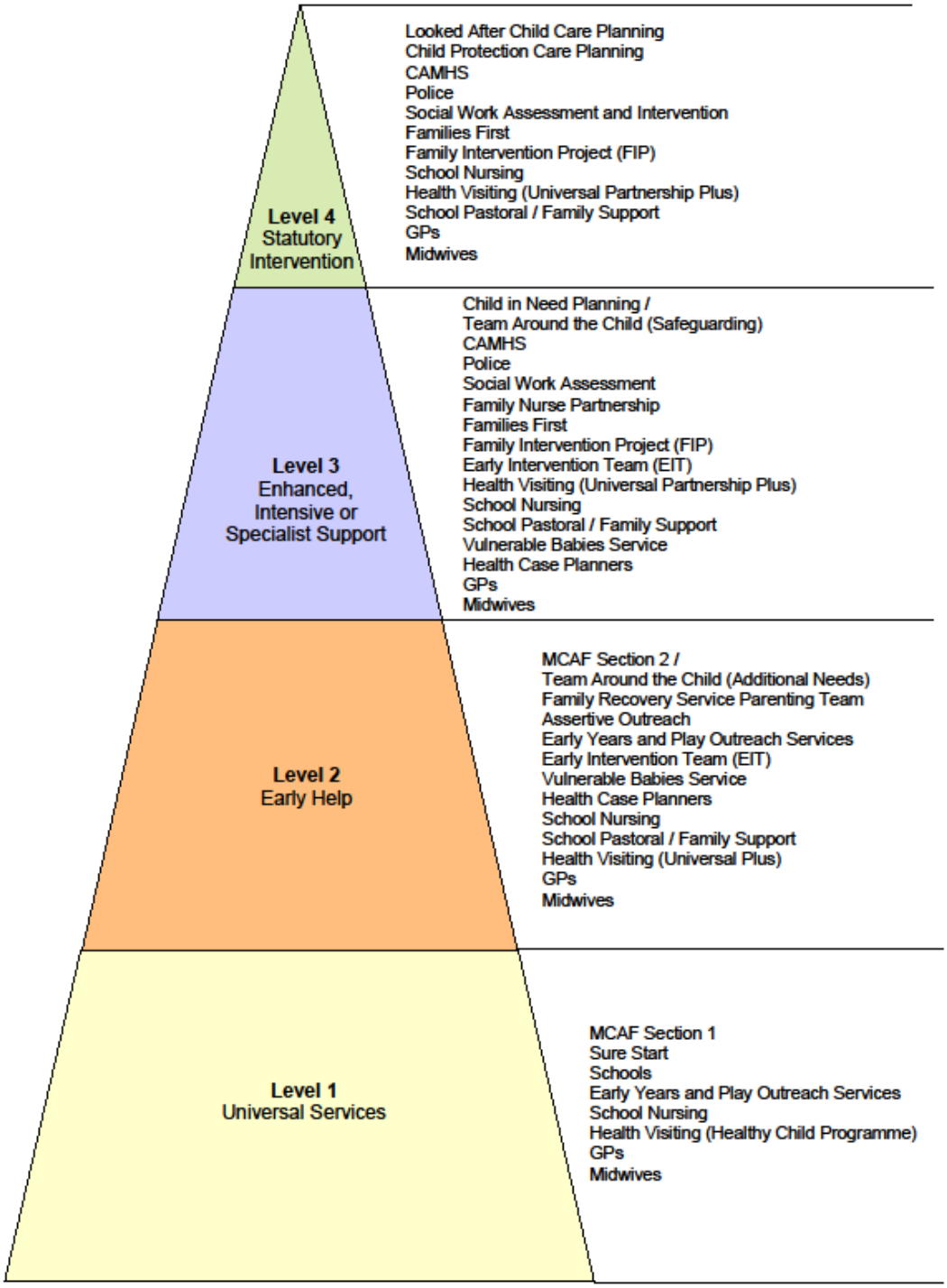
Over the past year, MSCB has undertaken a range of actions to elicit the views of children and young people. Mechanisms for this are embedded into all review processes (including serious case reviews, critical incident reviews and thematic reviews).

In addition, the views and opinions of young people are sought during the production and review of training materials and resources, e.g. work carried out by members of the Online Risk Subgroup around the dangers of young people sharing self-generated indecent images. Consultation with a group of young people enabled an educational resource to be circulated to schools and further work completed with Healthy Schools and Brook presented findings around the attitudes of young people in Manchester to the issue.

3.0 Assessment and Thresholds

Over the last twelve months, MSCB has revised child safeguarding thresholds and following this a new 'Threshold Document' defining levels of need across all services operating outside universal provision is being launched in October 2013.

This threshold framework describes the varying levels of need (as shown in the diagram below) and gives detailed guidance to partners when assessing a child's level of need and considering what other services are available to support families when children and young people have needs within the 3 categories falling short of statutory intervention.

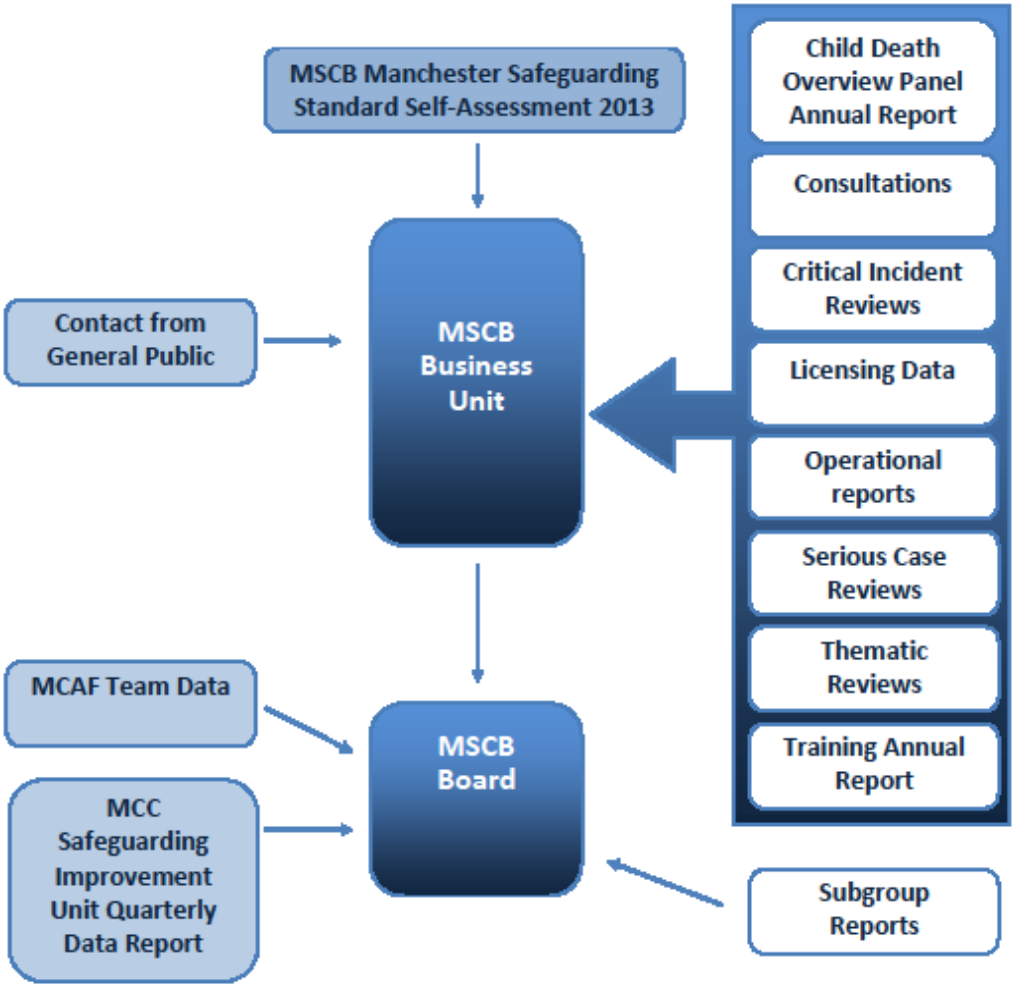


Level 3 Enhanced or Specialist Support - This is available for children, young people and their families who have needs or requirements that are complex and require assistance and support from more than one agency. These needs might be triggered by incidents such as parental mental health crisis, bereavement, change, family separation. This intervention can be long term and specialised, for example, assisting with a child that has disabilities.
Level 2 Targeted Services / Early Help are focused on supporting families in communities where it is known there are high levels of deprivation and other general needs. Many families can have a situation where they need level 2 support at some point in their lives. Targeted services are provided locally through schools, Children's Centres, voluntary agencies and through other initiatives. They provide early support, parenting and life skills and help families access ongoing training, education and employment. The aim of targeted services is to provide a more localised response to assist the general community in feeling more secure and improve the overall well-being of the community.
Level 1 Universal services are provided for all children and young people throughout Manchester, aged 0-18 years (and 0-19 for children who have a disability). Most families use only the universal or every day services available to all families such as health centres, schools, children's centres, general practitioners, hospitals. All children and parents/carers are helped to access and use these universal services.

4. Performance Reporting and Quality Assurance

MSCB must ensure the effectiveness of safeguarding practice, and its internal managerial and supervisory oversight, by each body represented on the Board.

In order to do this, MSCB receives and analyses information in a number of forms, both qualitative and quantitative.



The information gathered includes single-agency reports, multi-agency reviews and self-audit reporting.

MSCB Manchester Safeguarding Standard Self-Assessment 2013

Section 11 of the Children Act 2004, places a duty on organisations to safeguard and promote the welfare of children and young people. In response to this, the Manchester Safeguarding Standard was created by Manchester Safeguarding Children Board (MSCB) and Manchester Adult Safeguarding Board (MSAB). The

document ratified by both Boards, sets out the minimum safeguarding standards expected of all providers and commissioners of services for adults at risk and children in Manchester.

Each year, MSCB requires that agencies represented on the Board circulate an online self- assessment against the standard to front-line professionals. The data collected is then analysed by the MSCB Business Unit.

This year, the self-assessment has included additional questions on Child Sexual Exploitation and the Manchester Common Assessment Framework (MCAF). Information was received back from front-line professionals from 18 of the 23 agencies represented on MSCB although a decrease was seen in the number of returned assessments. A more detailed analysis of the results is being, however despite the summary figures displaying roughly the same level of adherence to the standards as reported last period, there is a very slight decrease generally across all areas but more marked within the area of online risk and agencies taking the views of children and their families into account.
A summary of the 2013 results is provided as Appendix 4.

Quarterly Data report on Safeguarding Activity

The MSCB Board receives quarterly reports on safeguarding activity prepared and presented by the Safeguarding Improvement Unit at Manchester Children's Services. A summary of the safeguarding performance is included as Appendix 3.

MCAF Team Data

All MCAFs instigated across Manchester are registered with the MCAF team at Manchester City Council. The resulting data is shared with the MSCB Quality Assurance of Early Help Subgroup. A summary of the data for 2012–2013 is included in Appendix 3.

Individual Case and Thematic Reviews

Serious Case Reviews and Critical Incident Reviews are undertaken in response to reports into the subgroups of the MSCB. For more information see the Learning and Improvement Section.

Child Death Overview Panel

Every death of a child under the age of 18 resident within Manchester is reviewed by the Child Death Overview Panel (CDOP). The CDOP provides information back to the MSCB Board by:

- Making recommendations to the Board, where a child death reveals actions that could be taken to avoid further deaths;
- Reporting back on any identified themes or trends in local data;
- Where there is suspicion that neglect or abuse may have been a factor in a child's death, the CDOP will refer the case to the MSCB Chair to consider whether a serious case review is necessary;

- The CDOP also produces an annual report which is available from the MSCB website[4]. The report for the period 2012–2013 is expected to be published in November this year.

For more information on CDOP see section 5.2.

Consultations

Consultation with professionals and the children and young people of Manchester remains embedded within MSCB business.
The North, Central and South forums facilitate wider communication with the workforce and allow consultation and also concerns to be raised by the workforce directly to MSCB.

Consultation with families and young people is highly prioritised where possible within all case review processes and is regarded as an essential part of ensuring that focus is placed not only on the child but also on ensuring that children's voices are heard. An example of this is seen in 'Learning with Zoe'. (see Key Safeguarding Areas for more information)

MSCB maintains close working relationships with Manchester Voicebox to allow consultation with young people through school councils across Manchester. This has been utilised successfully over this period to enable the 'Online Risk and Sexting' Campaign that is on-going (see Key Safeguarding Areas for more information)
Work is progressing to foster closer relationships with Manchester Youth Council, House of Manchester and other Manchester-wide Youth forum.

Training Annual Report

The training annual report from MSCB highlights the continuing success of the MSCB training programme.
The courses remain in high demand and participant feedback confirms the quality of teaching and learning on offer. (see training section below)

Licensing Data

As the responsible authority for matters relating to the protection of children from harm under the Licensing Act 2003, the MSCB must be notified of and evaluate all license variations and new applications for the sale and supply of alcohol and public entertainment.

In 2012-2013 there were 465 applications, 162 of which were for new licences. Of the new applications considered, a written response was made to those which warranted additional conditions to achieve the 'protection of children from harm' objective; in 2011/12 this occurred in 30% of applications.

There are no applications from this time period 'awaiting risk analysis'.

[4] www.manchesterscb.org.uk

5. Learning and Improvement Framework

5.1 Learning Reviews

Reviews are not ends in themselves; their purpose is to identify improvements which are needed and to consolidate good practice. MSCB continues to develop appropriate systems for reviewing cases in order to extract learning and to translate this into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.

There is a requirement to describe the impact of SCRs and other reviews in LSCB annual reports and to sustain improvement through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for children.

The Serious Case Review Subgroup of the MSCB looks at cases where a child dies and abuse or neglect may be a factor, or where a child is harmed and there may be concerns about the way in which agencies have worked together. If the criteria for a Serious Case Review (SCR) is met (as laid down in Working Together 2013), the group will make a recommendation to the Chair of MSCB. If cases do not meet the criteria but the group feel that valuable learning can be gained from the case, a number of 'lighter touch' review methods can be employed.

During 2012-2013 MSCB considered **8** cases and commissioned **3** SCRs. The completed SCRs have all been published in full.

Serious Case Reviews

This year the reviews of two completed serious cases (at the time of writing) have been published.
Findings from these reviews highlight that parental mental health remains a risk factor, with the need for professionals to have the confidence not only to challenge medical assessments and outcomes but also to work with parents who are hostile or difficult to engage.

Recognising and responding appropriately to domestic abuse continues to be identified as a theme as does the need for good assessment to underpin work with families. The need to listen to children and also engage with fathers was also emphasised. This suggests a need for greater guidance and challenge to staff from first line managers who are accountable for the quality of assessments completed within their span of management.

New learning identified and analysed closely within one of the SCRs was that of the impact of parental bereavement on agency response. Action plans for both individual agencies and multiagency learning continue to progress, monitored by the business unit at MSCB.

In line with current government policy, all SCRs completed by MSCB have been published in full. Further information on specific SCRs can be obtained by contacting the MSCB Business Unit.

Critical Incident and Multi-agency Learning Reviews

In addition to serious case reviews, a critical incident review has been completed. The learning has been disseminated and progress on action is being monitored. Learning from a further critical incident review commissioned during the period is due to be reported on. At the end of the period, two multi-agency learning reviews are being undertaken. On referral to the SCR subgroup, the cases did not reach the necessary threshold for a recommendation for an SCR to be made. Nevertheless, the subgroup felt that reviewing the cases offered an opportunity to extract valuable learning. The findings of these will be reported to the MSCB in due course.

As outlined below, a rapid appraisal case carried out by CDOP last year instigated a thematic review of children experiencing neglect where disability is a factor; the significant amount of learning extracted from the review has been circulated to the multi-agency workforce and has informed changes to the training offered by MSCB.

5.2 Child Death Overview Panel

MSCB is responsible for ensuring that a review of each death of a child resident in the Manchester is undertaken by a Child Death Overview Panel (CDOP).
The CDOP meets quarterly and is chaired by a public health official; during 2012/13, the chair of the panel changed jobs, and a new chair (also a public health consultant) has been appointed. Case management and administration is undertaken by the CDOP manager who underpins and supports the CDOP process.

Cases are referred into the CDOP by the Coroner, the Rapid Response Team and the Hospitals. The CDOP manager is then responsible for tracking down and collating information from professionals, and where appropriate the family, on all factors pertaining to the child who has died.
Once prepared, each individual case is discussed, whether or not the death was avoidable is determined and actions decided upon by the CDOP.
The CDOP is also responsible for agreeing local procedures for responding to sudden unexpected deaths and cooperating with regional and national initiatives to identify lessons on the prevention of child deaths.

This year the CDOP has been notified of 51 deaths and has completed reviews on 56 cases.
CDOP continues to see recurrent themes and risk factors in the cases it reviews; these are discussed more fully in the Summary Report 2008-2012 produced by the outgoing chair earlier this year. Issues such as smoking (both in the home and in pregnancy), co-sleeping, overheating and parental drug or alcohol use are seen in almost all of the sudden unexpected deaths of infants and reducing the prevalence of these would undoubtedly have an impact.

Many of CDOP's findings are echoed in the case reviews undertaken this period; the need for more consistency in the bereavement services across Greater Manchester is supported as is the focus needed on critical risks posed by domestic abuse, parental mental health and neglect.

One such case was referred for consideration for a serious case review; although not meeting the threshold for an SCR, the case underwent a review as a 'Rapid Appraisal' led by the Chair of CDOP.
The learning distilled from this exercise instigated more intense scrutiny on the additional risk where disability is additional to neglect, culminating in the MSCB commissioning an independent consultant to undertake a thematic review of neglect with a key focus on disability.

CDOP continues to collaborate with regional and national initiatives. Data supplied from from Manchester has contributed to national appreciation of several issues identified in the statistical release[5] from the Department for Education this summer; these include the need to remove potential language barriers when summoning emergency services, and the increasing concern surrounding child / young person suicide.
Closer to home, the CDOP continues to work towards the creation of a Greater Manchester database of child deaths. The rationale for this is to provide a bigger cohort for improved and strong evidence about key themes across GM.

The CDOP annual report will be published in November this year.

5.3 Training

Standard Programme

During 2012/13, 53 courses were delivered by MSCB as part of the standard training programme resulting in 230 members of the workforce completing the Level 1 – Introduction to Safeguarding Children Course, and an additional 1001 places allocated to all other courses.

The programme remains consistently linked and adaptable to the learning distilled from local reviews and national developments; all courses on offer through the training programme are reviewed and updated regularly. For example this period significant modifications have included: changes to the Introduction to Safeguarding Children and the Child and Young Person Development Course in response to the findings within the Child V SCR; changes to the Parental Mental Health and Safeguarding Children course following the publication of the SCR of Child U; and courses including Safeguarding Children with a disability and Neglect following a critical incident and thematic review.
Adaptions to courses have been informed by national reports and updates such as the Rochdale Review[6] and the Children's Commissioner Inquiry[7] (for example Child Sexual Exploitation).

[5] Child Death Reviews: Year Ending 31/3/2013 SFR 26/2013 available from the Department for Education
[6] Rochdale Safeguarding Children Board (2012) Review of Multi-agency Responses to the Sexual

E-Learning

On-line training is rapidly developing as the most popular method of undertaking basic safeguarding children training with the MSCB. This year, 1687 members of the workforce have completed the "Awareness of Child Abuse & Neglect" e-learning course. Further developments to enable more front-line workers to access MSCB learning online are planned in the coming 12 months.

Briefings

MSCB also facilitates planned shorter 'briefing' courses on both Private Fostering and Online Risks (formally E-safety).
The lower than expected uptake of places on the Private Fostering briefings during 2012 – 2013 are being addressed. (see also section on PF).

The integration of learning from both local and national case reviews will always form an integral part of MSCB training courses. In addition to the designated training course running 3 times per year on 'learning from Serious Case Reviews, from the latter half of the 2012-2013 period, the MSCB trainer has produced a presentation or briefing pack after each critical incident or SCR. These packs include an annotated power point for use by designated training leads in each member agency of the multi-agency workforce and have been widely circulated by the board.

In 2012–2013 the following presentation/ briefing packs have been produced and circulated:

- Critical Incident Review – CR1
- SCR – Child V.

In addition a small briefing event was held for those involved with Child V delivered by the Author of the SCR report on behalf of MSCB and the 'Learning from Zoe' events (see Troubled Teen Section).

In relation to a recommendation from CR1, MSCB commissioned G-map to deliver a course entitled: "Basic Awareness Training: Young people who sexually abuse others". G-map is a multi-agency initiative to develop services in the UK for young people who have exhibited sexually abusive behaviours.

As outlined above, the annual report for MSCB training highlights the continuing good evidence of impact of the training programme, as evidenced by managers in partner agencies and feedback from staff receiving training.

A priority for 2013/14 is to develop improved evidence about the longer-term impact of training; an evaluation study has already been completed on the impact of neglect training.

Exploitation of Children. Rochdale: RSCB.

[7] Berelowitz, B. Firmin, C. Edwards, G & Gulyurtlu, S. (2012) I thought I was the only one. The only one in the world. London: Children's commissioner.

MSCB training has shown to be cost-effective, making important efficiencies in 2012-2013. This needs to continue in the year ahead in order to be able to meet the on-going demand for the current courses, in addition to funding new courses under development.

In the 2013 – 2014 programme it is hoped that a new course entitled 'Hidden Sentence' will be piloted in response to a national initiative and learning from the MSCB report MM1. The course will be run with assistance from Greater Manchester Probation Service. A new course called 'Risky Business' will be finalised and available for managers and/or supervisors.

Finally it is envisaged there will be a greater emphasis on learning in relation to sexual abuse and sexually harmful behaviour; the MSCB plans to commission specialist training in this area.

6. Key Safeguarding Areas

6.1 Safer Systems

MSCB is committed to ensuring that systems that are used to protect children in Manchester and help professionals to manage risk in a safer and smarter way.

It is estimated that the current children's workforce in Manchester consists of over 20,000 people. It is exceedingly important, highlighted by the recent high profile cases and public concern around the suitability of some professionals who have worked with children, that both recruitment and investigation into allegations are handled appropriately.

The last year has seen changes to recruitment process and requirements with the move from CRB checks to the new Disclosure and Barring System. MSCB has reviewed current systems and worked with all partners to raise awareness of the requirements whilst being mindful of the need to monitor any effect of the new system; MSCB is therefore working to strengthen oversight of safer recruitment processes.

Raising awareness campaigns

Work continues on engaging with both professionals and young people and producing materials and opportunities to raise awareness of both risk and where to find help in times of need.

One area of focus over the past period has been that of 'online risk'.
The decision to undertake a campaign aimed at raising both awareness and discussion around sexting was made at the end of last year based on two pieces of research released by the NSPCC, backed by frontline professionals' observations and an appreciation that 'sexting' was a much more complex issue than many professionals had at first anticipated. The campaign was joint working between MSCB, Brook and Healthy Schools and comprised of a number of stages.

The initial stage of the campaign, which was completed in February 2013, included a 'Mock Trial' in conjunction with Healthy Schools and the Child Exploitation and Online Protection Centre (CEOP).
The 'mock trial', developed from a training programme with young people on this subject in Australia, was held in February in conjunction with the Child Exploitation and Online Protection Centre. The preliminary work and the day itself served as an initial opportunity to gather CYP opinion around the issue, in addition to the production of a DVD resource that has now been circulated to schools. The feedback from the CYP who attended the event was extremely positive (this has been captured as short video interviews with the CYP who played the defence and prosecution counsel at the event), with pupils reporting that the event had made them see sexting in a new light, recognising the full implications and consequences in a way they had not formally appreciated. The CYP recommended

that the activity be used in schools with secondary pupils to help educate in a more effective and less didactic way than a traditional 'lesson'.

On the back of this, research was carried out to further inform our work going forward. Over 471 completed questionnaires from young people aged between 12 – 18 years across Manchester were returned. Alongside the quantitative element, qualitative focus groups were also held in a number of Manchester schools. This has culminated in a citywide strategy to tackle sexting called "Rise up Manchester", launched in June 2013 and fronted by Manchester young people.

6.2 Neglect

Neglect continues to be one of the biggest challenges to safeguarding children in Manchester and remains the main category of need both for Child Protection Plans and Looked after Children; neglect being a factor in 56% of Child Protection Plans at any one time. Ensuring an effective multi-agency response to neglect remains MSCB's highest priorities.

A multi-agency neglect summit was held for managers in November 2012 to begin to develop a strategy for a consistent approach for tackling neglect.
Actions agreed included the need for a new approach in Manchester based on the 'lived experience of the child'. The MSCB has commissioned Professor Jan Horwarth (University of Sheffield) to work alongside a multi-agency group developing this process. The new approach will then be piloted with a cohort of cases later in 2013 with an evaluative report due in 2014.

In addition, as already reported, a thematic review of children experiencing neglect where disability is a factor has been undertaken by the MSCB, the learning from which along with a critical incident review has been circulated, via staff briefings and the creation of a learning pack, to large numbers of frontline staff throughout the partnership.

Work continues on the impact of the presence of other themes including alcohol, domestic violence, mental health, parental behaviour and child sexual exploitation (CSE) where neglect is identified. MSCB continues to distil and disseminate SCR learning and update training and awareness briefings in response to developing intelligence.
Neglect will be included as an active work-stream in the MSCB Business Plan 2013 – 2015. Included within this is a need to improve the connectivity between work-streams tackling neglect in the city and the very significant initiatives to work with troubled families.

6.3 Private Fostering

The priority for 2012-13 was to increase the number of notifications of private fostering placements in Manchester. This has not been met, and reflects falling numbers of notifications across Greater Manchester despite continuing targeted activities and efforts in this area. A review and refresh of the private fostering strategy in Manchester is taking place at the time of writing of this report.

6.4 Teenagers at Risk

Tackling this difficult area of work remains an on-going priority for MSCB. Specific plans include work in this area include improving methods of consultation with children and young people; missing from home protocols and maintaining a high level of vigilance in relation to CSE; rates of self-harm; and gang-related safeguarding issues. There are a number of separate but connected work-streams commissioned by MSCB in relation to young people; CSE, missing children, trafficking, children and young people arriving in Manchester as unaccompanied asylum seekers; vulnerable young people who do not have stable accommodation and support; young people involved in or at risk from gang-related activity; young people at risk of involvement in radical extremist activity. The board has revised the organisation of these work-streams to make them more effective and facilitate a more streamlined reporting on activities and achievements to the board.

The cross flow of information from these forums into MSCB acknowledges the links between MFH, CSE, Gangs and Trafficked children and will reinforce the Board's oversight and scrutiny.

Manchester continues to have a representative on HM Youth Offending Institution Hindley safeguarding group which is a subgroup of Wigan Safeguarding Children Board. Manchester City Council continue to report regularly to the board and invite close scrutiny and challenge on their looked after children strategy.

"Learning from Zoe"

In October 2011 MSCB commissioned a Case Review using the SCIE Learning Together Systems Methodology, a new way of undertaking serious case reviews put forward by central government. The subject of the review was Zoe (pseudonym), a fourteen year old female in a situation of escalating risk of harm, and who was removed from home under police powers of protection. She had been subject to a Child Protection Plan under the category of neglect and professionals were concerned about frequent episodes of being missing from home, vulnerability to child sexual exploitation, possible gang association, fragile mental health and self-harm and frequent use of cannabis and alcohol.

To summarise the findings of the review, although Zoe had been known to a number of agencies, collective efforts to help her had fallen short of what could have been achieved and what she herself had been asking for. Some of the themes identified in other reviews both inside and outside Manchester were present in this case. The MSCB were keen to try and find a different way of using the learning from this kind of case to drive better improvement in helping teenagers like Zoe with high levels of need.

Professionals, who had worked directly with Zoe, and their managers, took part in conversations with the Lead Reviewers and members of the Review Team. Zoe herself also took part in the conversations. Analysis of these conversations and relevant documentation revealed several 'Key Practice Episodes' from which key findings were

distilled. The final report was presented to the MSCB at the Board meeting of 10 May 2012, and is obtainable from MSCB on request.

As part of a creative response to the findings, the MSCB Executive Committee agreed to arrange a number of consultation events for the purposes of:

- Sharing the findings with a representative sample of the workforce across the City of Manchester;
- Seeking their ideas on how to respond to the findings and improve practice when dealing with 'Troubled Teenagers';
- Highlighting the differences in the current SCR process and the proposed 'Systems Analysis Approach';
- The development of a meaningful multi-agency strategy for dealing with 'Troubled Teenagers'.

7. Early Help

What is 'early help'

Early help is defined in Working Together 2013 as 'providing support as soon as a problem emerges, at any point in a child's life, from the foundation years through to the teenage years' identifying this as more effective in promoting the welfare of children than reacting later.

The need for MSCB to assess this 'early help' being provided to children and their families in Manchester is part of the statutory function of an LSCB. In addition there is a requirement that MSCB publish a document that details the threshold for responding to child need. This should document the process for the early help assessment, the MCAF, and the type and level of early help services to be provided.

Manchester Common Assessment Framework

The Manchester Common Assessment Framework (MCAF) is a key part of Manchester's Offer of Early Help. It is an important tool in delivering frontline services. It is a shared approach used to assess the needs of children and young people and decide how these should be met.

MCAF promotes more effective, earlier identification of additional needs, particularly in universal services. It is intended to provide a simple process for a holistic assessment of a child's needs and strengths, taking account of the role of parents, carers and environmental factors on their development.

The MCAF Team have been in place since October 2011. Further information on MCAF can be found online at www.manchester.gov.uk/mcaf.

This year, there has been an upturn in the number of MCAFs carried out across Manchester, with the number in period rising from **472** in **2011-2012** to **898** in **2012-2013**. For more details please see appendix 3.

Once the Early Help Strategy is finalised, the recently formed Quality Assurance of Early Help subgroup will give oversight. At the present time, figures are reported quarterly directly to the Board.

Whilst awaiting the strategy, representatives of the MSCB Early Help Quality Assurance sub group have reviewed 15 spot samples, three from each of the five SRF Areas and covered the period September to November 2012. The group used the draft Early Help QA Tool Kit to complete this work.

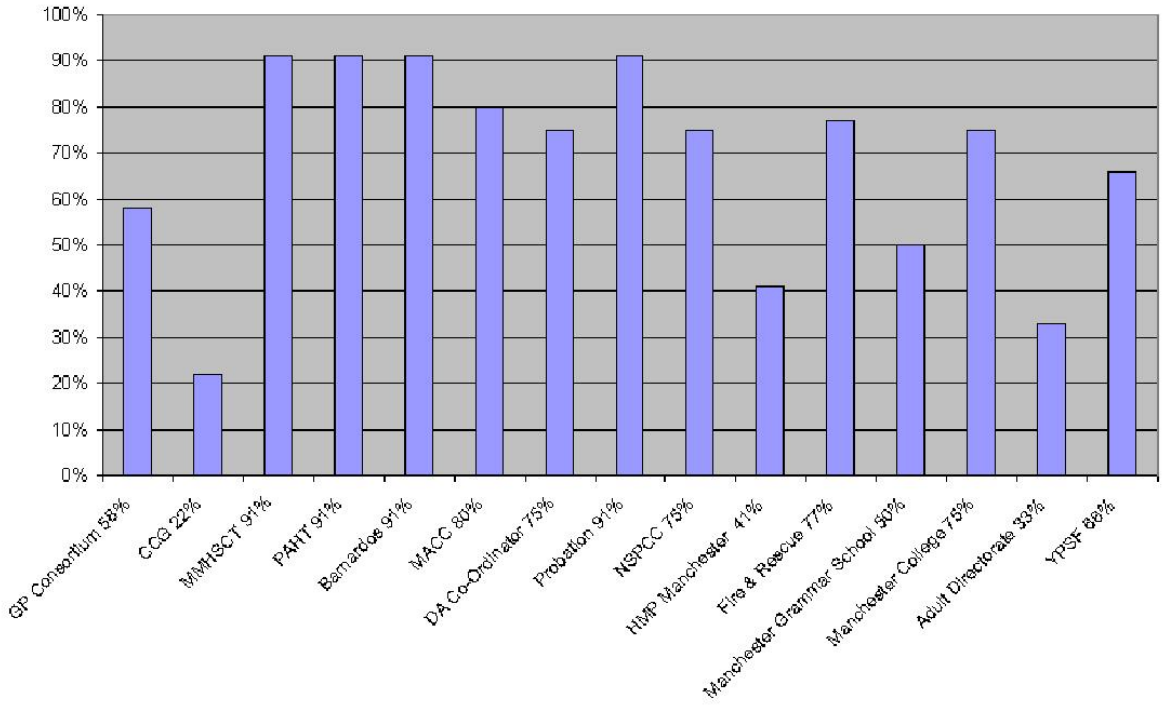
The majority of the MCAF's that were looked at by the QA group were not at the time closed with some of the information from Section 3 and 4 missing. This meant that the

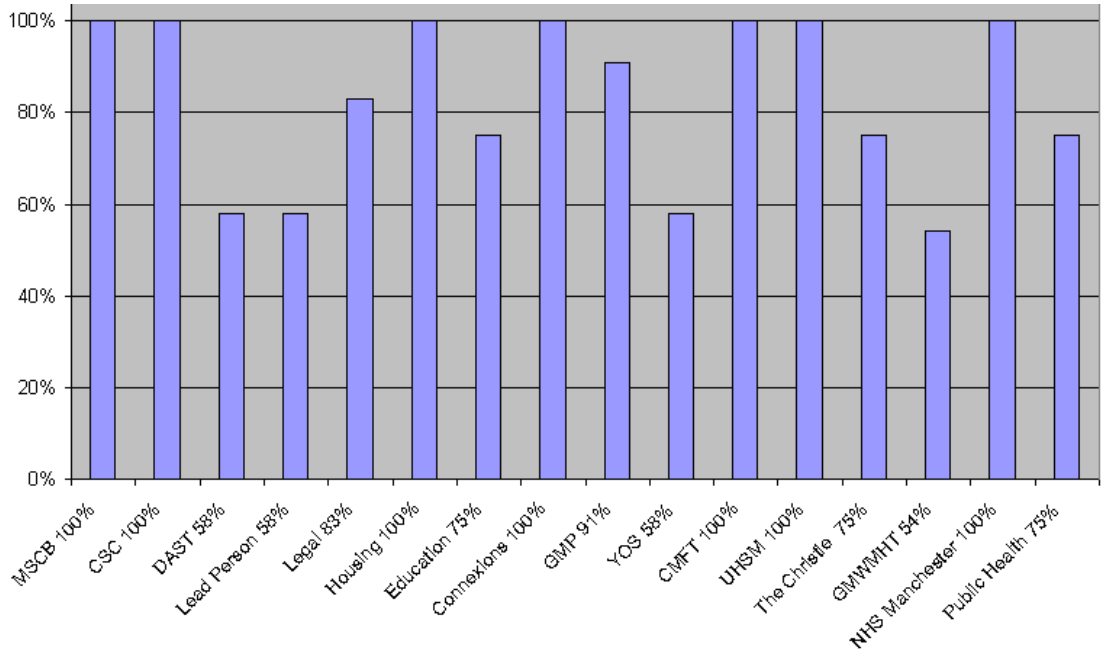
comparison of information was limited as the quality of the process was difficult to ascertain. Though the majority of the 15 MCAFs looked at had the main information needed for registration it was clear that there were some areas of improvement needed when it comes to information being documented.

Appendices

Appendix 1 – Agency Attendance at MSCB Board Meetings

The following graphs show agency attendance at MSCB meetings 2012-2013. Meetings take place monthly, target attendance for MSCB meetings, including subgroups and other groups is 100% for the member agency, through use of designated substitutes only where necessary. Poor attendance is addressed through the MSCB Executive Committee.





Appendix 2 – Manchester Safeguarding Children Board Budget 2012-2013

	Budget	Actual to Q4	Variance to budget
Staffing			
Business and Performance Manager	47,836	46,042	-1,794
Policy and Performance Officer (0.7fte)	25,143	25,290	147
Managing Allegations Manager (LADO)	47,836	49,688	1,852
Managing Allegations Manager (LADO) - Admin (0.5fte)	9,865	0	-9,865
MSCB Administrator x 2	46,164	34,405	-11,759
Multi Agency Training Administrator (30hrs pw)	16,911	15,762	-1,149
Independent Chair Safeguarding Board	30,000	12,525	-17,475
Media and Communications Manager (0.5 fte)	21,166	21,299	133
Multi Agency trainer	36,667	37,067	400
CDOP Process Manager	36,667	32,703	-3,964
Independent Consultants - Serious Case reviews	30,000	55,917	25,917
Independent Consultants - General	10,000	5,010	-4,990
Training for staff/CPD	2,000	239	-1,761
Sub-total staffing costs	**360,255**	**335,947**	**-24,308**
Multi Agency Training Costs	37,500	23,329	-14,171
Promotional Events	5,000		-5,000
Stationery	1,000	568	-432
Information Strategy	5,000	0	-5,000
E-Safety	5,000	10,085	5,085
Printing	5,000	2,666	-2,334
Mobile Phones	1,500	994	-506
Legal Advice	10,000	10,000	0
Misc	14,200	7,643	-6,557
Sub-total other costs	**84,200**	**55,286**	**-28,914**
Sub-total all costs	**444,455**	**391,233**	**-53,222**
Income			
Manchester Children's Services (Social Care)	94,500	94,500	0
Manchester Children's Services (Education)	69,300	69,300	0
Manchester Adult Social Care	0		0
Health	50,400	50,400	0
GMP	31,866	31,866	0
Probation	15,000	15,000	0
Connexions (Better Choices)	12,800	12,800	0
Housing	9,450	9,450	0
YOS	15,750	15,750	0
Cafcass	550	550	0
CDOP	112,100	112,100	0
Sub-total income	**411,716**	**411,716**	**0**
Net costs/(income)	**32,739**	**-20,483**	**-53,222**

Appendix 3 – Safeguarding Performance Data

According to the latest population estimates (Census2011) there are over 97,400 children under the age of 16 living in the City of Manchester (NB this figure does not take account of young people aged 16 and 17. The safeguarding figures that follow apply to children up to the age of 18).
The following data includes the last 2 year's figures, where available, for comparative purposes.

Initial Child Protection Conference (ICPC)

The table below shows the Initial Child Protection Conference figures for Manchester for the last three years.

	1st Apr 2010 to 31st Mar 2011	1st Apr 2011to 31st Mar 2012	1st Apr 2012 to 31st Mar 2013
Number of ICPCs held following a Strategy Discussion	898	922	874
Number of ICPCs held within timescale	357	513	618
% ICPCs held within timescale	39.8%	55.6%	70.1%

Where concerns about a child's welfare are substantiated and the agencies most involved judge that a child may continue to suffer, or be at risk of suffering significant harm, an initial child protection conference should be convened. The purpose of the conference is to draw together the information that has been obtained and to make judgements on whether the child is at continuing risk of significant harm and whether he or she therefore requires a child protection plan to be put in place. It is set out in the interagency guidance "Working Together to Safeguard Children (2013)" that an initial child protection conference should take place within 15 working days of the strategy discussion which decided whether s.47 enquiries should be initiated. The conference will result in a decision on whether the child will become the subject of a child protection plan or not.

Improving the percentage of initial child protection conferences was an identified priority with an action plan in place during 2012-2013.
Over the period 1,345 s47 enquiries were undertaken in Manchester resulting in 874 ICPCs. Of these, 70.1% were held within timescale, an increase of 14.5%. The percentage of ICPCs held within timescale therefore continues to improve.

Child Protection Plans (CPP)

The tables below show the relevant Child Protection Plan data for Manchester for the last three years.

	1st Apr 2010 to 31st Mar 2011	1st Apr 2011 to 31st Mar 2012	1st April 2012 to 31st Mar 2013
No. of children and young people who became subject to CPP within the period	837	843	884
Percentage of children and young people ceasing to have a plan, the number which lasted two years or more	7.5%	4.9%	5.4%
Percentage of children and young people on CPPs that began during the period that were subject to a second or subsequent time	16.7%	18.7%	14.9%
CPP reviews completed on timescale	99.1%	99.7%	98.2[8]

Manchester has seen an increase in the number of children on child protection plans of 105. This increase in child protection plans is in line with the national picture. The recent Association of Directors of Children's Services (ADCS) Safeguarding Pressures Report[9] released in October 2012 cites a 7.9% increase in Child Protection (CP) plans nationally, although distinct variations in regions are reported.
One area of concern is the slight drop of 1.5% in the number of child protection plans in Manchester reviewed within timescale.

8 From the Children In Need return

[9] Available from http://www.adcs.org.uk/news/safeguarding-pressures.html

Child Protection Plans - Age and Gender

	31st Mar 2011	31st Mar 2012	31st Mar 2013
Number on a CPP	707	631	736
Main category of abuse recorded as reason for CPP	Neglect (445) 63.0%	Neglect (383) 60.7%	Neglect (424) 57.6%
Gender Male Female Unborn Unknown	 345 351 11	 311 316 4	 376 355 5
Ages	Under 1 = 47 1-4 = 210 5-9 = 194 10-15 = 210 16 + = 46	Unborn = 10 Under 1 = 55 1-4 = 172 5-9 = 163 10-15 = 188 16 + = 43	Unborn = 5 Under 1 = 62 1-4 = 222 5-9 = 195 10-15 = 206 16+ = 46

The table below shows a breakdown of the categories of abuse recorded as the reason for the 736 child protection plans in existence in Manchester on 31st March 2013

Category of Abuse	Number
Neglect	424 (57.6%)
Emotional Abuse	239 (32.5%)
Physical abuse	42 (5.7%)
Sexual abuse	29 (3.9%)
Multiple categories	2 (0.3%)

The table below shows the ethnicity breakdown for children and young people on a child protection plan as of the 31st March 2013.

Table 1a - Ethnicity of children and young people on a CPP – March 31st 2013	
Bangladeshi	8
Indian	7
Any other Asian background	11
Pakistani	59
African	15
Caribbean	22
Any other Black background	42
Any other Mixed background	27
White and Asian	16
White and Black African	13
White and Black Caribbean	42
Information not yet obtained	23
Any other ethnic group	13
White British	414
White Irish	7
Traveller of Irish Heritage	1
Any other White background	12
Gypsy/Roma	4
Total	736

Looked After Children

	1st Apr 2010 to 31st Mar 2011	1st Apr 2011 to 31st Mar 2012	1st Apr 2012 to 31st Mar 2013
Number of children and young people becoming LAC during the period	553	414	514
Number of LAC 31st March 2010, 2011 & 2012	1,391 (inc. UASC)	1,311 (inc 39 UASC)	1,302 (inc 22 UASC)
3 or more placements	147 (10.6%)	137 (10.5%)	168 (12.9%)
Stability of placement	67.3%	63.7%	63.1%[10]

UASC = Unaccompanied asylum seeking child

[10] from the submitted 903 return

In Manchester there was a increase of 100 in the number of children and young people becoming LAC during the year but 9 less young people being looked after at the year end snapshot.

There has been an increase in the number of LAC who have had 3 or more placements, from last year, but the stability of placement figure remains almost static - this is defined as those children under 16 years on the 31st March who have been looked after continually for 2.5 years, the percentage who have been in the same placement for at least two years.

Gender breakdown

The table below shows breakdown by gender for looked after children on the 31st March 2011, 2012 and 2013.

Table 2 – Gender	31st Mar 2011	31st Mar 2012	31st Mar 2013
Male	763	712	712 (54.7%)
Female	628	599	590 (45.4%)

Category of Need

The following table gives a breakdown of category of need for looked after children on the 31st March 2013.

Table 3 - Category of need for children looked after at 31st March 2013			
	Number	Proportion	% change on previous year
Abuse or neglect	831	63.8%	-4.2%
Disability	40	3.1%	+0.3%
Parental illness or disability	74	5.7%	-0.6%
Family in acute stress	103	7.9%	+1.7%
Family dysfunction	143	11.0%	+2.8%
Socially unacceptable behaviour	47	3.6%	+0.9%
Low income	7	0.5%	+0.3%
Absent parenting	57	4.4%	-1.3%
TOTAL:	1302		

Ethnicity

The following tables give a breakdown of ethnicity for looked after children on the 31st March 2013.

Table 4 - Ethnic origin of children looked after at 31st March 2013				
	Number	Proportion	% Change	SSDA 903 ETHNIC ORIGIN CODE
White	833	64.0%	-0.8%	WBRI,WIRI,WOTH,WIRT,WROM
Mixed	198	15.2%	-1.3%	MWBC,MWBA,MWAS,MOTH
Asian or Asian British	66	5.1%	+1.0%	AIND,APKN,ABAN,AOTH
Black or Black British	168	12.9%	+2.5%	BCRB,BAFR,BOTH
Other ethnic groups	37	2.8%	-1.3%	CHNE,OOTH,REFU,NOBT
TOTAL:	1302			

Age

The following tables give a breakdown of ages for looked after children on the 31st March 2013.

Table 5 – LAC age at 31st March 2013			
AGE	Number	Proportion	% Change
Under 1:	57	4.3%	-0.1%
1 - 4:	214	16.4%	-0.4%
5 - 9:	276	21.2%	+0.8%
10 - 15:	484	37.2%	-1.2%
16 - 17:	271	20.8%	+0.9%
18 & over and placed in a community home:			
TOTAL	1302		

Private Fostering

The definition of a privately fostered child is - a child under the age of 16 (under 18, if disabled) who is cared for, or proposed to be cared for, and provided with accommodation by someone other than a parent, a person who is not a parent but has Parental Responsibility, a close relative, ie. aunt/uncle/step-parent/grand-parent/sibling but not a cousin or great aunt/uncle, and who is cared for and accommodated by that person for 28 days or more, or the period of actual fostering is less than 28 days but the private foster carer intends to foster him/her for more than 28 days. A child is not privately fostered if the person caring for him/her had done so for a period of less than 28 days and does not intend to do so for any longer period. The arrangement is seen as private fostering if it meets the criteria above whether for reward (monetary or otherwise) or not.

Manchester City Council has a duty to be notified about private fostering arrangements in their area and satisfy themselves that the welfare of privately fostered children is being safeguarded and promoted. In Manchester each privately fostered child who has been assessed must be notified to the Child In Need Coordinator who has the thematic lead for Private Fostering and can provide advice and guidance in relation to Private Fostering Arrangements.

The table below shows the number of children privately fostered during the periods 2011-2012 and 2012 - 2013.

	1st Apr 2011 to 31st Mar 2012	**1st Apr 2012 to 31st Mar 2013**
Number PF as of 31st March 2010, 2011 and 2012	28	24
Number of PF within the periods (April 2009 – March 2010, April 2010 - March 2011 and April 2011 - March 2012	All PF opened/ceased during the year = 72 (ie includes PF continuing from previous year	All PF opened/ceased during the year = 65 (27 started and 38 ceased)

Manchester Common Assessment Framework (MCAF)

The Manchester Common Assessment Framework (MCAF) is a key part of Manchester's Offer of Early Help. It is an important tool in delivering frontline services. It is a shared approach used to assess the needs of children and young people and decide how these should be met.

MCAF promotes more effective, earlier identification of additional needs, particularly in universal services. It is intended to provide a simple process for a holistic assessment of a child's needs and strengths, taking account of the role of parents, carers and environmental factors on their development.

Everyone working with a family has a role to play in ensuring children and young people receive Early Help, with families feeling a part of the inclusive process.

The MCAF Team have been in place since October 2011. Information on MCAF can be found on www.manchester.gov.uk/mcaf

	1 Apr 2011 to 31 Mar 2012	1 Apr 2012 to 31st Mar 2013
Number of CAFs carried out within the periods	472*.	898

The snapshot data shown above shows a significant increase in the number of CAF assessments undertaken in Manchester of 190%

CAF Agency	Number of MCAFs undertaken 1st Apr 2012 – 31st Mar 2013	Proportion
ADSERV	3	0.3%
CF	9	1.0%
CONNEX	55	6.1%
EDSUPP	10	1.1%
EY	97	10.8%
HOUS	5	0.6%
NHS	295	32.9%
NHS – Unborn babies	127	14.1%
OTHER	14	1.6%
PRU	1	0.1%
SCHOOL	231	25.7%
SOCCAR	8	0.9%
VS	36	4.0%
(blank)	7	0.8%
Grand Total	898	

Number of CAFs by Ethnicity	2012 – 2013
AAF African Asian	1
ABA – Bangladeshi	7
AIN- Indian	8
AOP- Other Pakistani	20
APK – Kasmiri Pakistani	12
BAO- Other Black African	6
BLB- Black Caribbean	13
BLF- Black African	9
BLG – Any other Black Background	15
BNI – Nigerian	8
BSO - Somali	3
CHE – Chinese	1
MBA - White/Black African	7
MOT - Any other Mixed Background	24
MWA – White/Asian	14
MWB – White/Black Caribbean	10
NOT – Info not obtained	4
OAF – Afghanistan	2
OAR – Arab	1
OEO – Another Ethnic Group	6
OIR –Iranian	1
OOE – Other Ethnic Group	4
REF – Refused	10
WEU – White European	4
WHA – any other white background	7
WHB – British	294
WHR – Irish	1
WOW – Other white	1
WRO – Roma Gypsy	1
(blank)	277
Total	771

The above information does not include the ethnicity of unborn babies (n = 127).

Appendix 4 – Manchester Safeguarding Standard Self-Assessment 2013

Individual agency compliance with the Manchester Safeguarding Standard is reviewed by requiring front line professionals to self-assess using an online questionnaire.

The table below shows the responses from the assessments carried out in 2012 and 2013.

	Assessment held in 2012	Assessment held in 2013
Total number of responses	264	171
Number of agencies responding	21 of a possible 27	18 of a possible 23
Percentage of responders having direct contact with CYP	95.1%	94.7%
Responders who strongly agree / agree that their service takes account of the need to safeguard and promote the welfare of CYP	100%	99.3%
Responders who strongly agree / agree that their service is informed by the views of CYP and families	99.2%	89.5%
Responders who strongly agree / agree that their service has a safeguarding policy / statement of responsibility	99.6	96.7
Responders who strongly agree / agree that their service's Senior Management Team are committed to importance of safeguarding and promoting welfare of CYP	100%	97.3%
Responders who know who their safeguarding lead is	91.7%	90.8%
Responders who strongly agree / agree that their service has a clear line of accountability	97.7%	97.7%
Responders who strongly agree / agree that their service ensures training attendance	96.6%	94.2%
Responders who strongly agree / agree that their agencies require all staff attend at least 3 yearly safeguarding refresher training	90.2%	90.2%
Responders who strongly agree / agree that their service operates safe recruitment practices including CRB / adherence to ISA regulations	98.9%	97.4%
Responders who strongly agree / agree that their organisation is able to identity and assess risk to CYP accessing the service	97.3%	94.8%
Responders who strongly agree / agree that their service has procedures in place to seek advice for complex issues or where concerns may need to be escalated	98.8%	97.3%
Responders who strongly agree / agree that they are aware how to make a referral to Children's Social Care	98.9%	96.7%

	Assessment held in 2012	Assessment held in 2013
Responders who strongly agree / agree that their service has systems in place to keep a written account of any actions/ observations/conversations that they have concerning a child's welfare	98.9%	96.1%
Responders who are confident in their understanding and recognition of CSE		Yes 88.2%
Responders who know how to recognise and deal with a private fostering case		Yes 69.3%
Responders who have been involved in MCAF in the last 12 months		Yes 57.2%
Responders who know how to register an MCAF		Yes 75.2%
Responders whose service has policies that make reference to e-safety where appropriate	Yes 85.9	76.3%
Responders whose service produces an acceptable use policy for staff	88.5%	75.2%
Responders whose service produces an acceptable use policy for CYP	77.1%	64.7%
Responders whose service ensures staff receive e-safety awareness training as a minimum	70.1%	63.8%
Responders whose service maintains a log of e-safety incidents	71.5%	63.8%
Responders whose service has a named person responsible for e-safety on site	64%	57.3%

Appendix 5 – Manchester Safeguarding Assessment

Introduction

Manchester Safeguarding Children Board (MSCB) and Manchester Adult Safeguarding Board (MSAB) expect all providers and commissioners of services for adults at risk and children in Manchester to adhere to this safeguarding standard.
This represents the minimum standards expected.

The MSCB and MSAB will quality assure against this standard using a number of tools including:

- Annual self-assessment for all MSCB and MSAB member agencies and other key stakeholders;
- Single agency audit information;
- Quality review of the Multi Agency Risk Assessment Conference (MARAC);
- MSCB and MSAB multi-agency audit information;
- Inspection/declarations and audits that organisations are subject to;
- Serious Case Review recommendations - evidence of practice improvement;
- Domestic Homicide Review recommendations – evidence of practice improvement.

OBJECTIVES:

1. Safeguarding practice with both adults at risk and children will:
    - reflect best practice nationally;
    - incorporate learning from Serious Case Reviews locally;
    - be regularly audited and evaluated;
    - be informed by MSAB and MSCB policies and procedures;
    - ensure that the safety of children is always considered by practitioners working with adults at risk, particularly where domestic abuse, mental health or drug and alcohol abuse are known to be a factor;
    - ensure that the safety of adults at risk is considered by practitioners working with children.
2. The MSCB and MSAB can be assured of the effectiveness of safeguarding practice across Manchester and identify where there are issues that need addressing, using their authority to ensure this happens where needed.
3. Commissioners apply a consistent safeguarding standard to their commissioning activity.
4. Organisations monitor and assess the effectiveness of their safeguarding practice across Manchester and identify where there are issues that need addressing.
5. Managers feel confident and competent in their roles and responsibilities.
6. Individual practitioners receive appropriate training and support to allow them to practice in a competent and confident manner.

OUTCOME:

By adopting this standard across providers and commissioners of services in

Manchester, the MSCB and MSAB will be assured that the quality of multi-agency practice with adults and children is regularly assessed and monitored, and that processes are in place to improve the effectiveness of safeguarding arrangements for adults and children in the city within the context of the individual, the family and the community.

THE STANDARD

1. Children, young people and adults at risk are at the centre of practice

    - Services are accessible, well publicised, ensure confidentiality and are available in an environment that is sensitive to the needs of adults at risk and children.
    - All services and settings take account of the views of children, young people, and adult service users, in the decisions about and delivery of services.
    - All services ensure that racial heritage, language, religious beliefs, sexuality, gender and disability are taken into account – for example by the use of interpreters or by making adjustments to enable access for disabled people.
    - All services take into account the service user's wishes and feelings and balance this against their rights and need to be safeguarded.
    - All adult services consider if there are risks to children from adults perpetrating domestic abuse; with mental health problems; misusing drugs and alcohol; or at risk of homelessness.
    - All children's services to consider if adults are at risk.

2. Safeguarding Lead

    - Each organisation has an identified lead person for safeguarding adults at risk and children. This person should be suitably trained and skilled to carry out this role on behalf of their organisation.
    - Each organisation should have a named lead person responsible for e-safety.
    - Every service/project that works with service users should identify a suitable experienced and knowledgeable safeguarding link person.

3. Safer Staffing

    - Each organisation/service operates safe recruitment practices including CRB checks and adherence to Independent Safeguarding Authority Regulations where appropriate, to support robust systems for checking references, employment gaps and signed declaration of criminal convictions.
    - MSCB procedure for managing allegations against people who work with children and families is adopted where the service users fall into that category.
    - Each organisation adopts the Government Office for the English Regions Guidance for Staff Conduct (Guidance for Safer Working Practice for Adults).