Tameside Safeguarding Children Board

TAMESIDE SAFEGUARDING CHILDREN BOARD (TSCB) ANNUAL REPORT 2016/17

September 2017

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FOREWORD

This has been a particularly full and challenging year both locally and nationally. Tameside Safeguarding Children Board has worked hard to fulfil its responsibilities in the face of many different events and circumstances in Tameside. We cannot lose sight of the bigger threats to our children that come with austerity and the national picture. Like it or not, levels of poverty and deprivation are high and even with the significant efforts of all agencies that make up the Board, there still is much work to be done. The inspectors have been here and challenged services to strengthen their efforts to provide a safer Tameside and an comprehensive improvement plan is in place and gaining momentum.

We have commissioned and learned from several reviews that involved injury, trauma and occasionally, the death of a child in Tameside. The great national threats to children such as neglect, child sexual exploitation, domestic abuse, poverty, issues of mental health, inadequate housing, radicalisation and so many more are, sadly present in our community as well.

We will never eradicate child abuse but we will strive to reduce its impact to the best of our skill and determination and the professionalism of all partners on the Board is testament to this. In extremely challenging times and under huge pressure, all members of the Board work to deliver the best service they can.

We have a comprehensive business plan and fully support all the improvement work being undertaken. Our aims are many and varied but all would agree that improving the voice of young people, listening more to those we represent and finding better, more modern ways of communicating with the people of Tameside are high on the priority list.

There are so many subject areas that come the way of the Board and extra areas of responsibility from predecessor Boards in past decades include increased awareness of subjects such as radicalisation, the huge numbers involved in Child Sexual Exploitation and Missing, Self-Harm and Suicide, Neglect, the vital area of Early Help, Female Genital Mutilation, Anti-Slavery initiatives, the importance of the voice of the child and online safety and communication requirements. With over 50% of all child abuse cases having some component of domestic abuse, the Boards involvement in the wider Domestic Abuse Strategy is critical as well as supporting the Domestic Abuse Steering Group.

All the key agencies represented on the Board deserve recognition for the level of work and effort the deliver but I must also mention the staff of the Board for their dedicated service. Their management, administration, training organisation, quality assurance and general support is invaluable and has to be thanked.

The future organisation and structure of Local Safeguarding Boards is being examined and legislation is changing. At this time no guidelines from Government have arrived but, whatever the future arrangements look like, safeguarding Tameside's children will still be the highest priority.

The coming year looks to have many challenges and the Board will participate, with all partners, in continuing to make the children of Tameside safer.

David Niven – Independent Chair of Tameside Safeguarding Children Board

Tameside Safeguarding Children Board

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EXECUTIVE SUMMARY

In September 2016 Tameside Safeguarding Children Board was judged to 'require improvement' by OFSTED. The Board has continued to deliver the good work that was already in place and implemented a number of changes in response to the recommendations that were made.

The Board has a training programme that reflects the changing needs of the children's workforce, is well attended, receives positive feedback and impacts on practice. Learning from case reviews is widely communicated via 7 minute briefings, specific learning events and safeguarding practice updates. It is leading to improvements in policy and practice such as the Self-Harm Referral Pathway, Greater Manchester Police Custody Protocol for Children and Joint Housing and Children Social Care Protocol for Homelessness. It has agreed a revised multi-agency dataset which will be used from April 2017 and in February 2017 implemented an audit schedule as part of a new Quality Assurance and Performance Management Strategic Framework. That increased auditing activity will mean that the quality of practice and the effectiveness of service provision can be more carefully monitored and scrutinised.

Domestic Abuse, self-harm, demand placed on services by the number of children placed in Tameside from Out of Borough and Neglect continue to be key challenges that need to be addressed. Our 3 year strategy (2015-18) and the strategic priorities within it therefore remain correct. They are Domestic Abuse, Child Sexual Exploitation, Neglect and Emotional Health and Well-Being. The previous Early Help priority is now incorporated into a wider Threshold Management priority that looks at the application of Thresholds across the 4 levels of need and not just at Early Help at Level 2. The focus on Early Help continues to be a key part of the work because the Board recognises that if we get our Early Help offer working properly we can reduce demand on the Children's Hub and ensure that they are only having to deal with appropriate referrals which could in turn improve the quality of their assessments and improved decision making. All of that work is being taken forward via the Threshold Management Sub-Group. There is still no system in place to centrally record all Early Help activity which means that the Board cannot be assured that children and families are receiving the support they need at the earliest opportunity. The recruitment of CAF Advisors will help to address this priority issue.

In March 2017 Tameside Safeguarding Children Board removed the Business Group from its organisational structure so that the Strategic Board could have greater management oversight and accountability for the work plans linked to its strategic priorities. However the Board's ability to question and challenge the effectiveness of partners safeguarding arrangements is not as robust as it could be. The Board needs to be quicker to direct and oversee changes that are required as a result of the challenges and recommendations that are presented to them and members need to be held to account when that doesn't happen. Strengthening those safeguarding arrangement will be re-considered in line with the recommendations from the Wood Review in 2017/18. Proposals for the future safeguarding arrangements will be submitted to the Board in late 2017 ready for implementation in 2018.

1. WHAT IS TAMESIDE SAFEGUARDING CHILDREN BOARD?

Tameside Safeguarding Children Board is made up of statutory partner agencies including the Local Authority, Health, Police, Education, Probation and the Voluntary and Community Sector. They all have a legal responsibility to safeguard children through their day to day work. We want to make sure that children and young people that are in Tameside are protected from harm and feel safe and cared for.

1.1 LEGAL FRAMEWORK

Tameside Safeguarding Children Board and all other Local Safeguarding Children Boards are established in accordance with The Children Act 2004 (Section 13).

Tameside Safeguarding Children Board reflects the core functions of The Local Safeguarding Children Boards Regulations 2006 and is governed by Working Together to Safeguard Children 2015 which sets out how organisations and individuals should work together to safeguard and promote the welfare of children and young people.

1.2 ROLES AND RESPONSIBLITIES

The role of LSCBs are to coordinate, monitor and support what is done by each person or body represented on the LSCB for the purposes of safeguarding and promoting the welfare of children in the area of the authority. TSCB should ensure the effectiveness of what is done by each such person or body for that purpose.

LSCB responsibilities as set out in chapter three of Working Together to Safeguard Children (2015) include:

1. developing policies and procedures for safeguarding and promoting the welfare of children
2. communicating the need to safeguard and promote the welfare of children, raising awareness of good practice and encouraging staff and services to carry out their safeguarding responsibilities to the best of their ability
3. monitoring and evaluating the effectiveness of what is done by Board partners individually and collectively to safeguard children
4. participating in the planning of services for children in the area
5. conducting reviews of serious cases and advising Board partners on the lessons to be learned

The guidance also sets out the requirements for this Annual Report stating that it should;

1. Assess the effectiveness of child safeguarding and the promotion of the welfare of children in Tameside
2. Provide a rigorous and transparent assessment of the performance and effectiveness of local safeguarding arrangements.
3. Identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action.
4. Include lessons from reviews undertaken within the reporting period.
5. List the financial contributions made to the LSCB by partner agencies and details of what the LSCB has spent, including Child Death Reviews, Serious Case Reviews and other specific expenditure such as learning events or training.

The report is a public document published on the TSCB website for members of the public to find out what the LSCB has achieved during 2016-2017. It is submitted to the Chief Executive of the Local Authority, Leader of the Council, the Local Police and Crime Commissioner and the Chair of the Children's Trust, Health and Wellbeing Board, Community Safety Partnership and Adult Safeguarding Board.

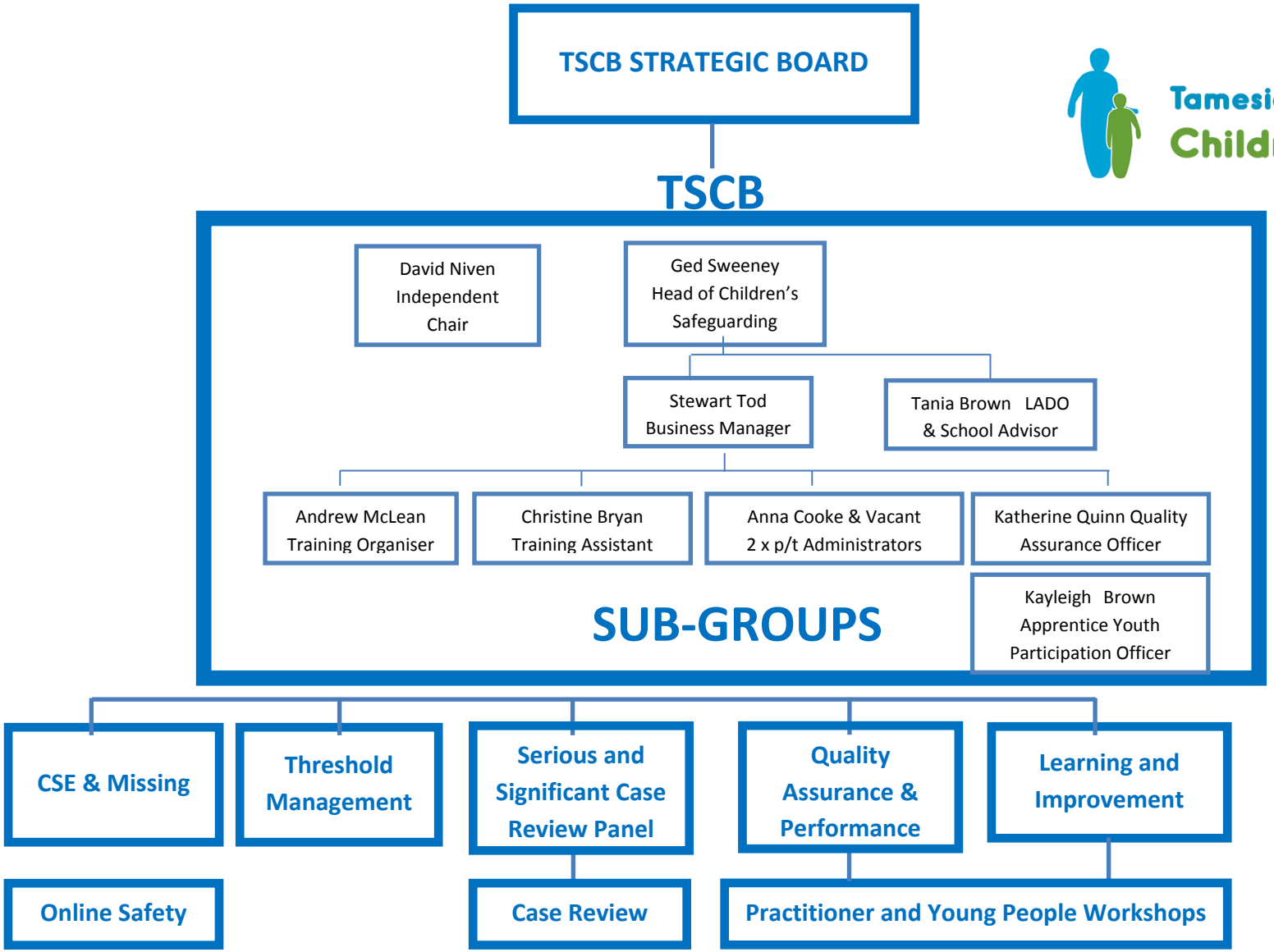
1.3 TSCB STRUCTURE AND GOVERNANCE

In order to achieve its roles and responsibilities the Board has a three tiered structure.

1. The Strategic Board – meets every 2 months and sets the strategic direction for the Board, agrees priorities and monitors effectiveness of both single agency and the collective arrangements. The group monitors and reviews the implementation of the Business Plan via progress/annual reports from TSCB Sub Groups, TSCB Task and Finish Group and Strategic Partnerships.

2. Sub Groups – carry out the ongoing core functions of the Board as well as time limited actions or projects linked to the agreed strategic priorities or emerging safeguarding themes. Sub-Groups cover the areas of, Quality Assurance and Performance Management, Serious and Significant Case Reviews, Child Sexual Exploitation, Threshold Management, Communications (Learning and Improvement Activity Group) and Child Deaths (Child Death Overview Panel). Sub groups Chairs brief the Strategic Board every 2 months and report formally via an annual report.

3. TSCB Staff – Individual staff members carry out additional responsibilities in relation to training and development, policies and procedures, quality assurance, youth participation and communication. They are informed of any new learning and improvement requirements through the existing sub-groups, with any recommendations agreed in advance by the Strategic Board. (Refer to Learning and Improvement Framework for further details). They also consult and report back into those same structures in order to agree any new areas of work that they will lead on or support.



Tameside Safeguarding Children Board

TSCB re-structured in March 2017 in response to the OFSTED Inspection and judgement. It removed the Business Group from its organisational structure in order that the Strategic Board could be better informed of the challenges raised via the sub-group work plans, and have greater management oversight and accountability for those plans.

During 2016/17 the Business Group had raised a number of challenges, for example in relation to the Public Service Hub and Early Help provision, but was unable to implement changes or improvements quickly enough. Reporting directly to the Strategic Board will ensure a more effective response to any identified gaps in service provision or areas for improvement.

TSCB also established a Threshold Management Sub-Group in February 2017 to monitor the application of Threshold's across the 4 levels of need. Its primary focus in early 2017 was to revise the Threshold Guidance and promote the early support and intervention via the Common Assessment Framework (CAF) process.

1.4 TSCB Team

During 2016/17 the Board had a fully staffed team comprising of a Business Manager, Quality Assurance Officer, Training Organiser, Training Assistant and Board Administrator. In addition the Board has an Independent Chair for 3 days a month.

1.5 Key Roles

The Board is comprised of statutory partner agencies, identified in Working Together (2015), and by key appointments and professionals. They include;

- Independent Chair – The Board is led by an Independent Chair who can hold all agencies to account. It is the responsibility of the Chief Executive (Head of Paid Service) of Tameside Metropolitan Borough Council to appoint or remove the Chair with the agreement of a panel including Board partners and lay members. The Chief Executive, drawing on other Local Safeguarding Children Board partners and, where appropriate, the Lead Member will hold the Chair to account for the effective working of the Board.

- Partner Agencies – All partner agencies in Tameside are committed to ensuring the effective operation of Tameside Safeguarding Children Board. Members of the Board, hold a senior management and strategic role and are able to speak for their organisation with authority, commit their organisation on policy and practice matters and hold their organisation to account.

- Local Authority – Tameside Council is responsible for establishing a Local Safeguarding Children Board in their area and ensuring that it is run effectively. The Director of Children's Service is held to account for the effective working of the Board by the Chief Executive of Tameside Council and challenged where appropriate by the Lead Member. The Lead Member is a 'participating observer' of the Local Safeguarding Children Board and regularly attends Board meetings.

- Designated Professionals – The Local Safeguarding Children Board includes on its Board, appropriate expertise and advice from, frontline professionals from all the relevant sectors. This

includes a designated doctor and nurse, the Director of Public Health, Principal Child and Family Social Worker, Legal Advisor and the voluntary and community sector.

- Local Authority Designated Officer – The role of the Local Authority Designated Officer is to oversee investigations into allegations of child abuse by professionals who work with children and young people and to investigate behaviour which may place children at risk. The aim of the role is to promote an effective, consistent and proportionate response by employers, police and child protection agencies. The role is financed by Tameside Safeguarding Children Board.

- Lay Member – The role of the lay member is to help to make links between the Local Safeguarding Children Board and community groups, support stronger public engagement in local child safety issues and an improved public understanding of the LSCB's child protection work.

All Board members are required to sign a membership agreement which sets out their roles and responsibilities in accordance with Working Together to Safeguard Children, 2015. A full list of Board members and advisors is available at Appendix A for information.

2. FINANCIAL MANAGEMENT

Tameside Safeguarding Children Board has always been well supported by monetary contributions from both statutory and non-statutory partners and for the last 6 years the Board has been in a position to carry a reserve into the new financial year. This reserve has been maintained in order to finance unexpected commitments including the costs of Serious Case Reviews. At the end of 2016/17, Tameside Safeguarding Children Board carried forward £127,996.

TSCB has a charging policy for non-attendance on TSCB Training Courses and for private profit making organisations. This created a small revenue of £7,394 during 2016/17.

3. DELIVERY OF THE STATUTORY LSCB RESPONSIBILITIES

The 3 tiered structure of the TSCB ensures that the statutory responsibilities are delivered and that clear and robust reporting and governance arrangements are in place. This section identifies how the TSCB Sub-Groups and TSCB staff have delivered against each of the statutory responsibilities.

3.1 Policies and Procedures

The TSCB Business Manager with support from the Strategic Board and its members has responsibility for ensuring that;

- The policies and procedures of the Board are compliant with statutory and regulatory requirements and are updated within the context of the Greater Manchester initiative on safeguarding procedures.

- All relevant professionals have access to current policies and procedures and that their practice is compliant as to their requirements.
- Professionals and other relevant audiences are alerted to changes to policies and procedures.
- Policies and procedures are implemented in practice and to evaluate the impact on service delivery and outcomes for children and families.

Tameside continues to contribute towards the Greater Manchester Safeguarding Procedures. The TSCB Business Manager regularly attends the Tri-X meetings to review and update those procedures and liaises locally with partner agencies on any proposed changes. The GM Safeguarding Procedures are promoted in all training and learning events and in the TSCB e-bulletin where practitioners are also encouraged to sign up for email alerts to inform them of any changes to procedures.

During 2016 a number of updates have been made to the 'Domestic Abuse and Violence Policy' and 'Female Genital Mutilation (FGM) Multi-Agency Protocol'. A Tameside self-harm referral pathway has been added to the 'Young People and Self-Harm' chapter of the Greater Manchester Safeguarding Procedures following learning from a Tameside Serious Case Review. All local and multi-agency policies and procedures are included on the Local Assessment and Guidance section of the TSCB website. Additional CAF guidance was added in June 2016 to supplement the CAF Training as part of the TSCB Training Programme.

3.2 Communication and Raising Awareness of Safeguarding Issues

A Learning and Improvement Activity Group was established in 2015 to enhance communication and raise awareness of safeguarding issues. The primary focus of the group is to coordinate the delivery of the TSCB Training Programme and evaluate the impact of learning on practice.

The following objectives are identified within the Learning and Improvement workplan and form part of the groups terms of reference;

- To develop a range of communication methods so that the above learning can be disseminated.
- To actively involve practitioners in the development of communication materials.
- To encourage managers and practitioners to disseminate communication materials throughout their respective service.
- To ensure the effective communication of safeguarding responsibilities to the public and professional community.
- To raise awareness of the need to safeguard children and promote their welfare by ensuring that people in Tameside understand how the arrangements for safeguarding work and how they can contribute to these objectives.
- To have oversight of the TSCB website and all TSCB publications.

During 2016/17 a total of 55 Multi-Agency training courses were delivered covering 23 different topics associated with safeguarding children. Additional training courses were delivered in response to increased or new demand which the Learning and Improvement Activity carefully monitors and responds too.

A new 'Modern Slavery and Human Trafficking' course was commissioned in January 2017, as a result of a request from Greater Manchester Police (Phoenix Tameside), who were investigating a number of trafficking cases and requested that the Multi-Agency workforce in Tameside, including representatives of the Crown Prosecution Service, were educated about the issue. This course was received well, evaluations were positive and the course will be delivered again as part of the 2017/18 training programme. An additional 'Graded Care Profile Workshop' was commissioned and incorporated into the existing neglect course in March 2017 in response to feedback from course participants and in light of the need to increase the use of the Graded Care Profile prior to statutory social care interventions. Again the course was well received, evaluations were positive and the two topics remain combined in the current training year.

TSCB also deliver regular safeguarding practice updates on current and emerging themes. 6 Multi-Agency Safeguarding Practice Updates were delivered during 2016/17. Three involved the learning from Child 'Q', 'R' and 'S' case reviews, which were shared with the attendees. Seven minute briefings associated with these reviews have all been disseminated to the Multi-Agency workforce

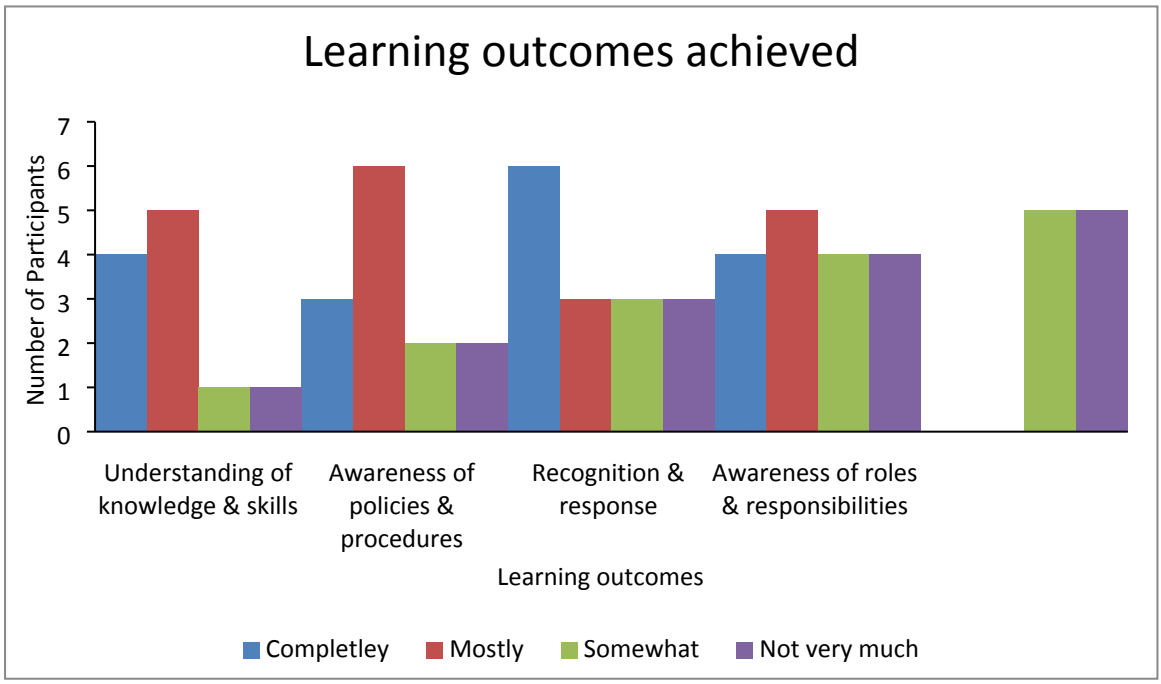
and are published on the TSCB website. The remaining three Practice Updates dealt with, Mental Capacity, Equality Legislation and engaging with the Public Service Hub; Fabricated and Induced Illness and Substance Misuse and the impact on children.

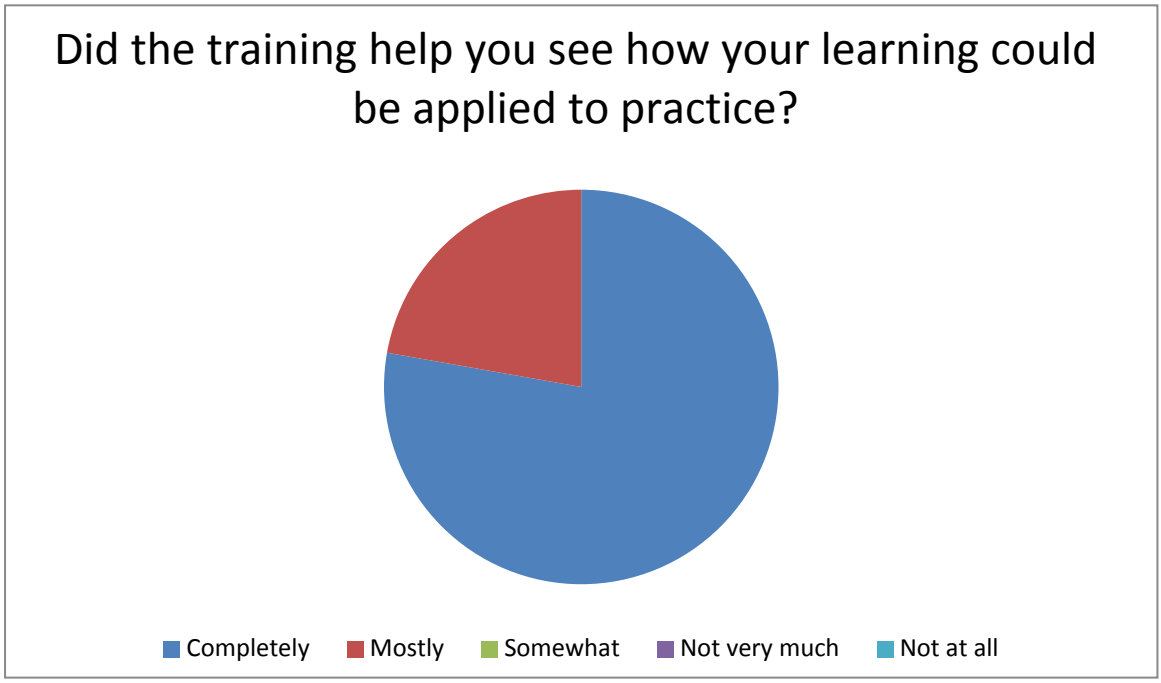
Overall a total of 1,273 Multi-Agency learners attended the training courses or learning event delivered by TSCB. Representation from Education, Local Authority and Health is very good at 36.5%, 20% and 10% respectively. However, attendance at training from the Police and Probation is poor.

A system of pre and end of course evaluation was implemented in 2016/17 whereby learners self-assessed the learning they brought to the beginning of a course and upon conclusion completed a further evaluation to measure their acquired learning. Measures were also included to capture the achievement of learning outcomes and intended changes in practice at conclusion.

All of the evaluations reflect an average increase in acquired learning as the result of attending the course from little or moderate learning to good or significant learning. All courses demonstrate a high percentage of 'learning outcomes achieved' and 'intended changes to practice' declared as shown in the charts below.

Chart 1 & 2





3.3 Monitoring and Evaluating Effectiveness

The Quality Assurance and Performance Management (QAPM) Sub-Group fulfil the Boards responsibilities in relation to monitoring and evaluating the effectiveness of safeguarding practice. Its purpose is to provide objective scrutiny of multi-agency safeguarding performance in order to consider the effectiveness of partner agencies in promoting the welfare of children.

The following objectives are identified and form part of the quality assurance framework;

- To provide objective scrutiny and challenge of multi-agency safeguarding performance by scrutinising and analysing agency data in relation to the Board's safeguarding priorities
- To consider the effectiveness of partner agencies to safeguard and promote the welfare of children via multi-agency thematic safeguarding audits and Section 11 audits.
- To ensure the Voice of the Child is integral to safeguarding activity and that this drives service improvement

A new Strategic Quality Assurance and Performance Management Framework was produced in January 2017 in response to the OFSTED report and recommendations.

As of quarter 1 2017/18 TSCB will use a revised dataset which has been developed in partnership with key agencies that work with children and young people in Tameside. The dataset has been developed to reflect the Board priorities, as well as information about key points of the child's journey through services.

The number of cases sampled as part of the multi-agency audit and the number of themes audited each year has doubled. During 2016/17, TSCB completed audits on Domestic Abuse, Strategy

Meetings, Pre-birth Assessments and Child Sexual Abuse and will oversee the delivery of action plans to improve practice in 2017/18.

The conclusion of the Child Sexual Abuse audit crossed-over into the 2017/18 period. In addition, the decision was taken to tailor the audit template to include theme specific questions, and to focus on key areas such as the application of thresholds and clear planning to manage risk. Learning and recommendations are reported back to Strategic Board and developed into action plans that are overseen by the Quality Assurance and Performance Management Sub-Group. The work itself is disseminated out to relevant partnerships such as the Domestic Abuse Steering Group or alternatively short life task and finish groups are created, via the Learning and Improvement Sub-Group, to deliver against specific actions. For example, the Pre-Birth audit has led to a revised Pre-Birth Protocol between the Maternity Unit and Children Social Care.

A Single Agency auditing schedule was implemented as a means of tracking actions which had been completed from Serious Case Reviews and was then extended to include actions from Multi-Agency audits. Single agency reviews on the use of the GMP Custody Protocol, and the Voice of the Child within Health assessment and reviews for example have shown that changes to policies and procedures, revised as a result of case review activity, have been implemented in practice.

The Section 11 audit was issued in April 2016 and adopted the Greater Manchester Template. This format focused on 3 keys areas; a culture of safeguarding children in the organisation, a safe organisation, and the voice of the child, staff and community. Agencies showed a good level of compliance to safeguarding with some exceptions from those agencies whose primary client group is not children.

There was a variable response to how the voice of the child was captured and enabled participation of children and young people in a way which lead to changes to service delivery; for those agencies demonstrating good mechanisms by which to capture the voice of the child, there still remains a gap in terms of how views and opinions are then acted on in a meaningful way. This therefore requires further improvement during 2017/18 and is one of the reasons why TSCB has approved the recruitment of an Apprentice Youth Participation Officer to gather service user feedback direct from the children and young people that have received support.

3.4 Participating in the Planning of Services

The TSCB Business Manager with support from the Strategic Board and its members has responsibility for ensuring that;

- Links to relevant partnerships are developed to ensure that safeguarding and promoting the welfare of children is central to the design and delivery of services
- Governance arrangements are well established so that the above partnerships report progress against the Board's strategic priorities to the Board on a cyclical basis

- Board members are equipped with the up to date safeguarding knowledge they require in order to scrutinise, challenge and add value to other Board partners safeguarding practice when reported to the Board via their Annual Reports
- A Safeguarding Youth Forum is established that will inform the strategic priorities and delivery of the Board's work.

TSCB Board Members are representatives or leads on a range of other partnership Boards. They include;

- Health and Well-Being Board
- Adult Safeguarding Partnership Board
- Transformation Board
- Family Justice Board
- Corporate Parenting Panel
- Child Death Overview Panel
- Youth Justice Board
- Educational Attainment Board
- Domestic Abuse Steering Group

Annual reports are scheduled to be reported to the TSCB throughout the year as part of their Forward Planner. The TSCB Report template was updated so that partners would have to outline what good performance or outcomes would look like and then demonstrate how they are performing in comparison to those. A development day in March 2017 reminded Board Members of their statutory roles and responsibilities and examined how each member contributed to that. However, Board Members are not routinely attending or contributing toward safeguarding training which means that their safeguarding knowledge is not kept up to date. The regular turnover of Board Membership also means that attendance and representation from some partners is inconsistent.

The Board's ability to question and challenge the effectiveness of partners safeguarding arrangements is not as robust as it could be and needs to be enhanced when the Board considers its future direction as a result of the Wood Review 2016 and Children and Social Work Act 2017.

Although the Safeguarding Youth Forum created in 2015 only met for a 9 month period its work and suggestions have continued to inform service planning throughout 2016/17. An Online Safety Group was established to promote online safety messages across schools and to parents and pupils. A Safer Social Networking Activity Pack was also piloted in New Charter Academy with Year 10 and 11 pupils successfully delivering presentations to Year 7 and 8 pupils. This work has continued to be rolled out across other schools. During 2016 TSCB has met with the coordinator of the Youth Council to establish formal links to that group and to other Youth Forums so that young people are involved in the design of training and service user feedback.

An Apprentice Youth Participation Officer will be recruited in 2017 to consult directly with children and young people about their experiences of being involved with a variety of services.

3.5 Conducting Reviews of Serious Cases

The Serious and Significant Case Panel (SSCP) fulfil the Boards responsibilities in relation to conducting reviews of serious cases;

The terms of reference for that group state that its purpose is to undertake reviews of serious cases and advise the authority and Board partners on lessons to be learned.

The following objectives are identified and form part of the SSCP work plan;

- To receive referrals of Serious and Significant Incidents from professionals/agencies, gather relevant information and decide whether they meet the criteria for a case review and make recommendations to the Board Chair.
- To consider, in the light of each case, the scope of the review process and to draw up clear terms of reference, identifying any specific expertise needed within the Overview Panel including nomination for independent Chair and Author.
- To develop and oversee the delivery of action plans as a result of the findings and recommendation of case reviews and their overview reports.
- To provide the Quality Assurance and Performance Management Sub-Group with key actions that have been completed and need to be reviewed via quality assurance activities to ensure that they have been embedded in practice and are supporting improved outcomes.
- To provide the Learning and Improvement Activity Group with relevant multi-agency learning and actions that need to be communicated across the workforce to ensure that changes to practice are embedded.

During 2016/17 SSCP considered 3 referrals. One of those was as a result of a child death and lead to a Serious Incident Notification but after careful consideration was not suitable for a case review. One referral (Child U) resulted in a Serious Case Review and another (Child T), in a multi-agency critical review. The National Serious Case Review Panel agreed with all 3 of the TSCBs decisions.

In early 2016/17 the Panel was overseeing the delivery of the action plans from Child M and N Serious Case Review. In addition it had to devise action plans to address each of the recommendations from the case reviews for Child Q and R that had been signed off at the Strategic Board in March 2016 and Child S that was signed off in June 2016.

The Serious and Significant Case Panel has overseen the implementation of some significant improvements including a re-launch of the family CAF, a revised Children's Needs Framework, training for schools on record keeping, Governor training on exclusions, a new GMP Custody Policy for Children, revised Child in Need Procedures, a Joint Children Social Care and Housing Protocol for homeless 16/17 year olds, and self-harm referral pathway.

All actions from the Child M and N case reviews were signed off as complete in May 2016, and for Child S in March 2017, with evidence of completion closely scrutinised by the panel. Some of the actions from the Q and R reports are still to be completed despite the intention for these to be

signed off in November of last year. Some of those are large pieces of work requiring complete process or system re-designs and are therefore warranted. For example, a revised Learning Disability Pathway will be presented to the SSCP in June 2017 and will lead to significant changes to the way midwifery services, health visitors and learning disability team support parents with a learning difficulty.

A revised schedule of multi-agency audits now ensure that actions delivered as a result of case review activity are monitored to ensure they are properly embedded in practice and that the process works. In 2016/17 audits have been undertaken on the pre-birth assessment protocol and strategy meetings and further improvements have been made as a result. In addition the Board requests that partner agencies provide reassurance that improvements have been made via the submission of single agency audits. For example Greater Manchester Police have submitted evidence that the custody protocol is being adhered to and Tameside and Glossop Integrated NHS Care Foundation Trust have demonstrated how the Voice of the Child is captured by School Nurses at Review Meetings.

Learning from case review is widely communicated through a variety of channels. Practitioner Feedback events and Safeguarding Practice Updates have been routinely delivered after all case reviews over the past 2 years. In addition 7 minute briefings are disseminated via Strategic Board Members and the learning and implications to professional practice is discussed within team meetings. The Learning and Improvement Activity Group are regularly requested to update training content and materials in response to learning from case reviews.

4. Local Demographics and Needs

Tameside is a small authority compared to other Local Authority areas both nationally and regionally. However, it faces considerable challenges linked to poverty and deprivation, health and well-being and crime.

Tameside's has an overall population of 220,597 with a youth population aged 0-19 of 53,847 which is 24% of the total.

Table 1: Tameside's Youth Population 0-19

	Mid-2013 Tameside Population		
	Males	**Females**	**Persons**
0-4	7,514	7,319	14,833
5-9	6,765	6,561	13,326
10-14	6,254	6,065	12,319
15-19	6,922	6,447	13,369

The breakdown of Tameside's population by ethnic group is shown below. The largest ethnic groups within Tameside are the South-Asian ethnicities Indian, Pakistani, and Bangladeshi accounting for 1.7, 2.2 and 2% of the Tameside population respectively. The overall white British population is considerably higher in Tameside at 88.5% compared to the English average of 79.8%.

Table 2: Population Breakdown by Ethnicity in England, the North-West and Tameside

	England (%)	North-West (%)	Tameside (%)
White: English/Welsh/Scottish/Northern Irish/British	79.8	87.1	88.5
White: Irish	1	0.9	0.7
White: Gypsy or Irish Traveller	0.1	0.1	0
White: Other White	4.6	2.1	1.7
Mixed/multiple ethnic group: White and Black Caribbean	0.8	0.6	0.6
Mixed/multiple ethnic group: White and Black African	0.3	0.3	0.2
Mixed/multiple ethnic group: White and Asian	0.6	0.4	0.4
Mixed/multiple ethnic group: Other Mixed	0.5	0.3	0.2
Asian/Asian British: Indian	2.6	1.5	1.7
Asian/Asian British: Pakistani	2.1	2.7	2.2
Asian/Asian British: Bangladeshi	0.8	0.7	2
Asian/Asian British: Chinese	0.7	0.7	0.4
Asian/Asian British: Other Asian	1.5	0.7	0.3
Black/African/Caribbean/Black British: African	1.8	0.8	0.5
Black/African/Caribbean/Black British: Caribbean	1.1	0.3	0.2
Black/African/Caribbean/Black British: Other Black	0.5	0.2	0.1
Other ethnic group: Arab	0.4	0.3	0.1
Other ethnic group: Any other ethnic group	0.6	0.3	0.1

Source: NOMIS, 2015

Tameside is the **41st** most deprived area in England out of 326 local authorities.

Average house prices in Tameside are significantly below the regional average, £133,586 compared to £149,421 (January 2017) and is therefore an attractive area for other local authorities to place their looked after children. In March 2017 Tameside had 380 other Local Authority children placed in Tameside which has put additional demand on Tameside schools and health services.

22 children out of every 100 are living in poverty and 52 are not school ready at the age of 5. However, school performance compares favourably to national averages. In 2016, **63.5%** of pupils gained Grade C or above in English and Maths GCSEs compared to 59.3 across all schools in England. **55%** of pupils achieved the expected standard at Key Stage 2 in Reading, Writing and Maths compared to 53% in England.

Tameside has a history of high levels of domestic violence. In 2014/15 the rate of domestic violence was 30.1/1000 population, this equates to approximately 2,357 reported numbers of domestic violence incidents; compared to 22.1/1000 (England) and 23.5/1000 (NW). In 2016/17 the number of A&E attendances recorded as Domestic Violence was 851. 373 MARAC referrals were discussed in 2016/17 and 251 of those (67%) featured children. This is a higher proportion compared to Greater Manchester average of 61% (Source: GMP Child Safeguarding Performance Monitoring Tool 2016/17).

The number of current adults in drug treatment is 725 and in alcohol treatment 293. Of the adults in treatment services, 21% have children living with them, this equates to a total of 535 children living with parents in treatment for drug or alcohol abuse. There are approximately a further 544 children, who don't live with their parents because of drug and alcohol issues.

In 2015/16 there were 2,874 live births (13.0/1000 population), this is higher than both the England and North West average but similar to the rest of Greater Manchester. Of these births, 24% were to women under 25 years. Approximately 50% of all births occur in the 20% most deprived quintile. Children born in more deprived areas have worse outcomes than their more affluent peers.

The chart below illustrates the level of mental health and wellbeing for children and young people in Tameside. It illustrates that outcomes for mental health are generally worse than the England average, which is similar to overall health and wellbeing outcomes for our children.

Chart 3: Children's and Young People's Mental Health and Wellbeing

Data quality: Significant concerns ● *some concerns* ● *Robust* ●

Compared with benchmark ● Lower ● Similar ● Higher ○ Not Compared

Indicator	Period	Tameside			Combined authorities	England	England		
		Recent Trend	Count	Value	Value	Value	Lowest	Range	Highest
Estimated prevalence of mental health disorders in children and young people: % population aged 5-16	2014	-	3,089	9.9%*	9.7%*	9.3%*	7.1%		11.0%
Estimated prevalence of emotional disorders: % population aged 5-16	2014	-	1,185	3.8%*	3.7%*	3.6%*	2.8%		4.3%
Estimated prevalence of conduct disorders: % population aged 5-16	2014	-	1,898	6.1%*	6.0%*	5.6%*	4.0%		6.9%
Estimated prevalence of hyperkinetic disorders: % population aged 5-16	2014	-	520	1.7%*	1.6%*	1.5%*	1.1%		1.9%
Prevalence of potential eating disorders among young people: Estimated number of 16 - 24 year olds	2013	-	3,183	3,183*	-	*	-	-	-
Prevalence of ADHD among young people: Estimated number of 16 - 24 year olds	2013	-	3,349	3,349*	-	*	-	-	-
Children who require Tier 3 CAMHS: estimated number of children <17	2012	-	900	900	-	-	-	-	-
Children who require Tier 4 CAMHS: estimated number of children <17	2012	-	40	40	-	-	-	-	-

Mental health problems affect about 1 in 10 children and young people. They include depression, anxiety and conduct disorder, and are often a direct response to what is happening in their lives.

For Tameside there is a worrying issue of children and young people self-harming. In 2015/16, 237 (473.1/100,000) children aged 10-24 years were admitted because of self-harm. Although it has decreased from previous years, the rate of self-harming in children is a concern.

People self-harm for different reasons. For example;

- deal with strong emotions like anger or sadness,
- punish yourself for things you think you've done wrong,
- make yourself feel normal, or
- distract yourself from feelings

(Source: Joint Strategic Needs Assessment 2017/18)

5. Children's Hub

5.1 Number of Contacts and Referrals

A total of 13,205 contacts were received in 2016/2017, a 14% reduction compared to 15,367 in 2015/2016. However, the conversion of contact to referrals has increased from 1,471 (9%) to 3,487 (40%). The conversion rate has improved over the course of the year from 27% in Quarter 2, 44% in Quarter 3 and 69% in Quarter 4.

(Source: Whole Service Data Booklet June 2017)

What difference has it made?

The data could be interpreted in 2 ways. Firstly it may be that more children in need of protection are being appropriately referred to the Children's Hub resulting in the case being accepted by the Duty Social Work Team. Secondly, the Threshold's for Children Social Care intervention could have been too high prior to the OFSTED Inspection in September 2016 and since then the Thresholds have lowered. This means that more children are now being triaged and risk assessed for Children's Social Care intervention. The national rate of referral per 10k in 2015/16 was 532 and Tameside was significantly below that at 302. During the whole of 2016/17 that only increased to 347 but the increased activity during quarter 3 and quarter 4, taken on its own, would bring the Tameside average in line with the national average. This early indication shows that contacts are now being appropriately considered at the point of referral and that conversion rate will need to be carefully monitored during 2017/18 to ensure that it remains in line with the national average.

What needs to happen next?

The appropriate, and consistent, application of Threshold's needs to be carefully monitored by TSCB. Work to enhance partners understanding of the Threshold Guidance, and crucially of their role in applying it, needs to be completed.

5.2 Decision Making

Of all the contacts received approximately 50% have a decision made within 24hrs. During 2016/17 all contacts to the Children's Hub had to be made by telephone. Supporting assessments, such as the Common Assessment Framework or Graded Care Profile (to evidence that the Threshold for Children Social Care was met) would not be routinely submitted because there has been no system to submit written information. As such there could be a lack of evidence upon which to support referrals which in turn would make the decision harder to make. In 2017/18 a new written referral form will have to be submitted along with any supporting evidence and this will help to speed up and stengthen the decision making process.

What difference has it made?

Accepting referrals with incomplete information will mean that the Duty Social Work teams have to start their investigations based on limited information. As a result it will take longer to gather that information and there is an increased likelihood that their decision to progress the referral on to assessment could be the wrong one, either because it does or does not need an assessment.

What needs to happen next?

There is a need for partner agencies to demonstrate that the Threshold Guidance has been used to assess the risk of harm to a child prior to contacting the Children's Hub. If it is safe to do so an assessment of need, and attempts to intervene early, should be undertaken prior to contact with the Children's Hub. The introduction of a written referral form will help to ensure that this happens.

5.3 Assessment

2,728 assessments were completed throughout the year compared to the England comparator at 3,761. However, in the last quarter 1,237 assessments were completed thereby showing an increase in activity above the national average. During 2016/17 an average of 91% of cases accepted as a referral led to a child and family assessment.

The majority of cases that are accepted as a referral will therefore result in an assessment. This is linked to the fact that there is often a lack of supporting evidence at the point of referral, as noted above. Without that supporting information a Child and Family Assessment has to be completed because otherwise it's not possible to determine whether or not there is a risk of harm to the child. Therefore where referrals have increased in quarter 3 and 4 the number of assessments has also risen, leading to an increase in demand to complete assessments on time. Tameside's performance

levels in 2016/17 was 70% and therefore behind the national average of 83.4%. Timeliness of assessments is an area which requires sustained improvement.

(Source: Whole Service Data Booklet June 2017)

What difference has it made?

Children Social Care are undertaking assessments to ensure that children at risk of harm receive the support that they need. It is reassuring that Children Social Care are investigating and assessing cases but some of those could have potentially been assessed and addressed at Level 2 of the Threshold of Need and won't have required a statutory assessment. This is creating additional work on an already strained resource and, in some cases, resulting in poor quality assessments that don't for example consider all relevant historical information or the views of the child.

What needs to happen next?

It may be possible to reduce the demand placed on Children Social Care if partner agencies complete assessments and work together to offer coordinated support at an earlier stage. Reducing demand and providing supporting evidence will help to improve the quality and consistency of Child and Family assessments and to improve the timeliness of those assessments. Further work will be done to promote the use of the Common Assessment Framework and other assessments like the Graded Care Profile across the partnership so that assessment is a shared responsibility that is continued across the thresholds of need.

5.4 Outcome and Progression

404 children became the subject of a Child Protection Plan during 2016/17, 15% of all those that were assessed. A further 857 (31.5%) were placed on a Child in Need Plan, had their CP or CIN plan continued or were placed into accommodation or continued with their care plan. Approximately 1,283 (47%) received other (non-Children Social Care) interventions and just 29 (1%) received no further action.

(Source: Whole Data Service Booklet April 2017)

What difference has it made?

Children's Social Care provide interventions in nearly half of all cases that they assess and the other half receive other actions, although the nature of these is not stipulated in the data. A wide range of interventions are therefore in place to ensure that children do receive support. It is unclear from the data available whether all of these cases require a Child and Family assessment or could have been assessed and supported at an earlier stage. With the absence of the Early Help data it is unclear if children and families are getting the right support, at the right level and at the right time.

What needs to happen next?

Once the Early Help data is available the Board should monitor any correlation between an increase in early help activity and the level of demand at the front door.

The Board could consider whether it would be appropriate, with the introduction of the Signs of Safety Model in 2017/18, to introduce an outcome focused performance management framework that shows what has been achieved when a case has been closed.

6. Child Protection Activity

The number of all open Child in Need cases has roughly doubled from 1379 in quarter 1 to 2753 in quarter 4 and there are 110 more children on Child Protection Plans at the end of the year than there were at the beginning. The number of Looked After Children has increased by 73 over the same period. Additional staff have been recruited to manage demand but the increased workload overall means that individual caseloads have not dropped to the target of 20 cases per worker.

What difference has it made?

More children at risk of harm and in need of protection are being placed on Child Protection Plans or being placed in care. However, the timeliness and quality of that activity is suffering as a result of the increased demand.

The percentage of assessments completed within 45 days in 2016/17 remains similar to the year end in 2015/16, at roughly 70%. The timeliness of Initial Child Protection Conferences has dropped from 86.9% in quarter 1 to 69.3% in quarter 4, although approximately 90% of child protection reviews are held on time. The timeliness of LAC reviews has also dropped from 84.3% in quarter 1 to 64.2% in quarter 4. Auditing activity, both by Children Services and TSCB, has also indicated that the quality of assessments and action plans is inconsistent and sometimes of poor quality.

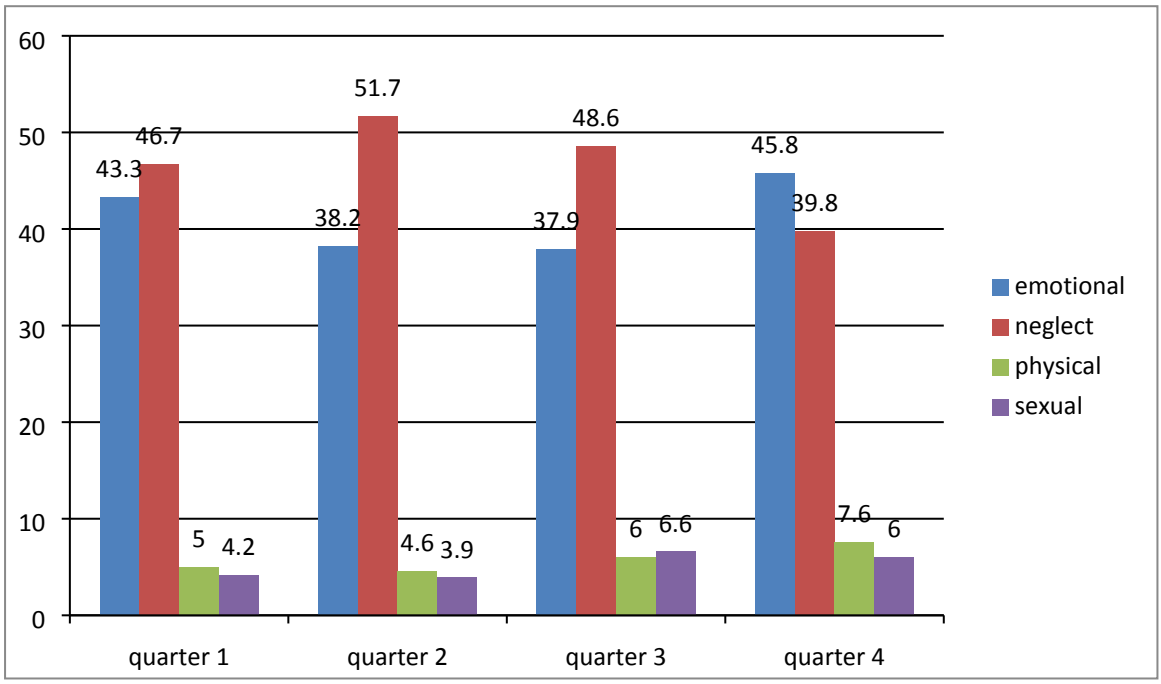
What needs to happen next?

Children Social Care need to manage demand, in terms of individual caseloads, better. Steps have already been taken to recruit additional staff to help reduce those caseloads and there has been some improvement. However, caseloads will not reduce to the target level if the number of referrals accepted, assessments completed and children in need cases allocated all continue to increase. Managing demand at the front door is key and further work has to be done across the wider partnership to ensure that appropriate contacts are made to the Children's Hub so that Children's Social Care only accept it as a referral when there is evidence that the Thresholds for statutory intervention are met and where partner agencies have already, in the majority of cases, provided early help.

7. Child Protection by Category of Abuse

The child protection abuse categories for 2016/17 are displayed below:

Chart 4: Child Abuse Categories 2016/17



Quarter 4 saw the number of cases at child protection level due to emotional abuse increase again to almost 46%, and neglect cases drop slightly to 39%. Both physical and emotional abuse has remained fairly steady. A trend can be observed throughout the year where, during quarters 2 and 3, neglect became more prominent than emotional abuse, but this has reverted to the historical trend of emotional abuse remaining the most common.

It has continued to be difficult to accurately and reliably measure the level of Child Sexual Exploitation, Domestic Abuse, FGM and Prevent incidents and activity due to problems with inputting information on to, and extracting information from, different I.T. and performance management systems. Alternative ways of gathering the data will be sought by the Board and the relevant partner agencies will be tasked with providing it.

These particular issues had been raised in the quarterly performance reports presented to the Business Group and Strategic Board and logged in the Challenge Audit and Progression log but remain unresolved. The absence of good quality data that could provide reassurance about the effectiveness of service provision was clearly noted in the OFSTED Report. A CSE Systems Review due to be reported to Strategic Board in July 2017 will make recommendations about the best way to gather CSE data. New 'assessment factors' will be recorded from the beginning of 2017/18 including for example risk factors such as Domestic Abuse, Substance Use and Mental Health. More robust data collection methods for FGM and Prevent will also need to be established in 2017/18.

8. Youth Justice

During the period October 2015 to September 2016 the number of First Time Entrant's (FTE's) has risen by 8% in Tameside. This is against the national and North West trend. Greater Manchester

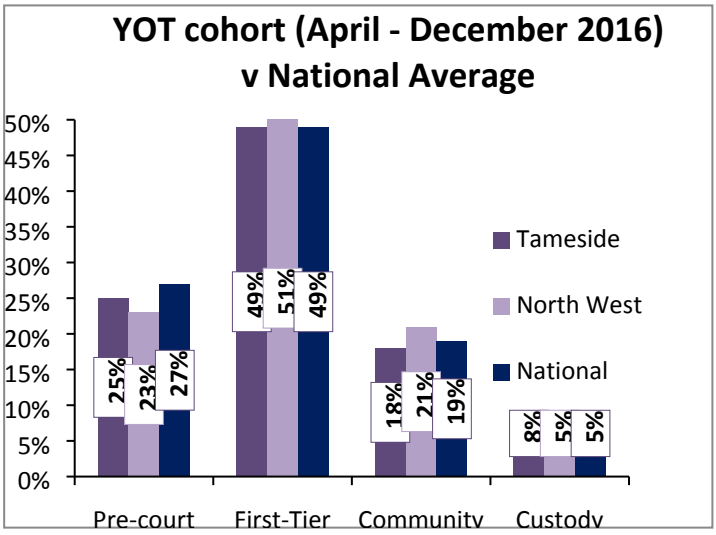
YOTs show a decrease of 1% indicating a regional slowdown in the decrease of FTE rates. It is difficult to attribute this to any single factor but clearly this is something that is concerning and needs to be closely monitored.

The table and chart below suggests that in Tameside young people are more likely to be dealt with outside of the court arena, compared to other areas in the North West and the National picture.

Table 3

Type	Local	North West	National
Pre-court	**29**	**924**	**7441**
First-Tier	**58**	**2107**	**13,150**
Community	**21**	**865**	**5220**
Custody	**9**	**217**	**1300**
TOTAL	**117**	**4113**	**27,111**
% Pre-court	**25%**	**23%**	**27%**
% First-Tier	**49%**	**51%**	**49%**
%Community	**18%**	**21%**	**19%**
%Custody	**8%**	**5%**	**5%**

Chart 5



Tameside YOT continues to offer credible and robust alternatives to custodial remands and sentences where and when required and appropriate. This is predominately, but not exclusively, via the use of Intensive Supervision and Surveillance (ISS) (Bail or YRO requirement) as well as Bail Support and Supervision and other flexible and creative solutions (e.g. Intensive Referral Order).

As part of the devolution work, the OPCC agreed to fund a safeguarding social worker post based in Wetherby Youth Offending Insitute (YOI) to work specifically with GM young people. This worker acts as a specific point of contact for GM YOT staff and provides the strategic leads with a monthly report that contains information about the use of restraint, incidents of violence, self-harm, adjudications and ACCT activity. The YOT also internally tracks safeguarding incidents for Tameside young people and a summary of these can be viewed below:

- Since September 2016 there have been 20 recorded incidents in the secure estate; 12 in HMYOI Wetherby; 6 in Rainsbrook STC and 2 in a Local Authority Childrens Home (LASCH)
- The 20 incidents involved 7 young people, with one young person being involved in 5 of the recorded cases
- There were 6 occasions when Tameside young people had been restrained and 14 incidents of violence (7 where the young person was considered to be the victim and 7 where they made allegations against other trainees and staff)
- 3 LADO referrals were made following allegations by young people

All children in custody are seen a minimum of once a month by YOT staff but additional visits are made to ensure the safety of the young people following a safeguarding incident.

(Source: Youth Offending Team Annual Report, May 2017)

9. TSCB STRATEGIC PRIORITIES 2015 - 2018

The Board's Strategy and Business Plan have been revised for 2017/18 so that each TSCB sub-group or other strategic partnership monitor, and provide the Board with assurances on, the effectiveness of service delivery. This was in direct response to one the OFSTED recommendation that said the Board should;

"Undertake an urgent review of Tameside Safeguarding Children Board (TSCB) priorities and update its business plan to include concerns about frontline practice and service delivery at all levels of need, and ensure that an evaluation of the impact of safeguarding practice upon children's well-being and safety is undertaken and included in the board's annual report."

The five strategic priorities set by Tameside Local Safeguarding Children Board for 2015-2018 were as follows:

1. Domestic Abuse
2. Child Sexual Exploitation
3. Self-Harm & Suicide
4. Early Help
5. Neglect

In response to the OFSTED Inspection findings the Early Help priority was amended to Threshold Management to incorporate close monitoring on the application of Thresholds and Levels of Need. The other strategic priorities remain the same but with a greater focus on monitoring the effectiveness of service provision through performance data. Work plans against each of the Strategic Priorities for 2017/18 can be found in Appendix C. The following section reports on the work of the Board and its partners against its strategic priorities in 2016/17.

9.1 Domestic Abuse

Education and awareness programmes were piloted to 14 schools in 2016/17. To embed the success of this delivery the project is identifying Domestic abuse champions within each school. The implementation of Operation Encompass was piloted in Stalybridge schools, and will be rolled out across Tameside in phases, commencing in Ashton.

Operation STRIVE is now a well-established approach to Standard risk cases in Tameside. All cases are triaged jointly by a PCSO and Bridges Keyworker within the Integrated Neighbourhood Service (INS), with a range of partners responding depending on the need. This includes escalation to Children's Services where appropriate. The PCSOs and Bridges Keyworkers work from both the Children's Hub and Integrated Neighbourhood Services teams and ensure communication between

both and enable a step up/ step down approach to cases. During 2017/18 partners hope to design a new approach to medium risk cases which mirrors the standard risk approach.

Bridges have established and trained a network of volunteer peer mentors to support the home visit. This ensures victims receive good quality follow up support services. Bridges also appointed a Young Person's Independent Domestic Violence Advocate and a Children's Independent Domestic Violence Advocate in mid-2016/17 to strengthen the Children's and Young Persons team to provide dedicated support to children and young people. (Source: Domestic Abuse Progress Report, Business Group, December 2016)

What difference has it made?

Quarterly data in relation to Domestic Abuse is currently restricted to Multi-Agency Risk Assessment Conference (MARAC) data and on the performance of the commissioned service, Bridges. Data on domestic abuse incidents reported to the Police is available periodically and retrospectively. TSCB will be seeking assurance from the Domestic Abuse Steering Group on the effectiveness of service provision for those standard and medium risk cases and in relation to the developments highlighted above. In addition OFSTED highlighted concerns in relation to the timeliness of notifications from Greater Manchester Police to Children's Social Care and to the timeliness of the response. A report to TSCB in March highlighted improvements to the process. A daily report is produced which gives the numbers of domestic abuse referrals received. In conjunction with this a further report, also daily, identifies how many children's referrals are managed within 24 hours. The two reports combined give an overview which reassures that the notification process is working. Evidence was provided to show that there was no batching of high numbers arriving at social care and provided reassurance that the revised process was effective.

(Source: Domestic Abuse Report, Strategic Board, March 2017)

What needs to happen next?

The Domestic Abuse Steering group, which maintains oversight of the notifications, is aware that in some instances there is an unsatisfactory amount of time between the incident date and notification being sent which will require further improvement. The Board will seek assurance on this from the Domestic Abuse Steering Group.

9.2 Child Sexual Exploitation (CSE) and Missing from Home (MFH)

The CSE and Missing Sub-Group has continued its work from 2015/16 to raise the awareness and understanding of CSE across Tameside. Members of Phoenix Tameside (the local CSE Team) and a Local Authority Policy and Communications Officer has been instrumental in coordinating the CSE Weeks of Action with Phoenix Tameside and was praised by the GM Project Phoenix Manager as "amongst the best practice of its kind".

The CSE Sub-Group established a Safe and Healthy Relationship Task and Finish Group which;

- Secured joint funding from Public Health and New Charter Housing for the Barnardo's CSE 'Real Love Rocks' and 'Love or Lies' resource.
- Delivered Barnardos training to 54 out of 76 primary schools, 12 out of 15 secondary schools, 4 out of 5 special schools and both Pupil Referral Units

The roll out of the resource pack has enabled schools to deliver CSE Awareness sessions to their pupils from September 2016. An audit on the use and success of those resources will be undertaken in December 2017.

In 2015/16 TSCB Safeguarding Youth Forum identified social media use as a safeguarding concern that underpinned several of the TSCB Strategic Priorities. The TSCB Quality Assurance Officer subsequently attended SNAPP (Safer Social Networking Activity Practice) training and promoted this resource to schools.

New Charter Academy Year 10 pupils presented messages regarding Safer Social Networking to Year 7 and 8 pupils in their school and attended Strategic Board in June 2016 to inform partner agencies of their work. 80% of pupils reported that they felt safe using the internet as a result of the training. An Online Safety Working Group established in September 2016 to take this work forward has helped to roll this out to other schools and to promote messages regarding online safety to parents and professionals.

In February 2017 a reporter from local radio stations, Key 103 and Revolution Radio, came to interview pupils/teachers and film part of a SSNAP session. A series of parent workshops have also been held across Tameside Libraries.

What difference did it make?

Phoenix Tameside continues to support victims of CSE and deliver a range of disruption and enforcement activity. 199 referrals were made to the Phoenix Tameside during 2016/17. All referrals should receive a risk assessment and subsequent intervention depending on the level of risk. However, continued problems in recording, and reporting on, data means that the effectiveness of the service provision cannot be given from the Children's Social Care system. This has, in part, led to an Independent CSE Systems Review being commissioned by TSCB in February 2017.

During 2016/17 328 enforcement visits have been undertaken and 43 abduction notices issued. Young People have reported to Phoenix Tameside that having an abduction notice means that they can use it as a reason to stay away from an individual whereas without it they would have been persuaded, or coerced, to meet with them.

There have been 13 CSE related convictions in 2016/17 compared to 8 in 2015/16. A new 'Modern Slavery and Human Trafficking' course was commissioned in January 2017, as a result of a request from Greater Manchester Police (Phoenix Tameside), who were investigating a number of trafficking cases and requested that the Multi-Agency workforce in Tameside, including representatives of the Crown

Prosecution Service, were educated about the issue. This course was received well, evaluations were positive and the course was delivered again in the current training year. It is probable that the course will become a regular feature of the training programme.

Off the Record Counselling Services received 12 months funding from the Greater Manchester Police and Crime Commissioner to deliver 1-2-1 counselling sessions to victims of CSE. Additional funding will allow the project to continue into 2017/18 and a dedicated counselling room will be made available within Phoenix Tameside.

A Missing Panel meets fortnightly to share information, identify CSE concerns and ensure a multi-agency response to children who go missing from home and care. The Group works to the Greater Manchester Missing from Home Procedure but the local procedure (created in January 2016) will be revised when there is a change in provider for return interviews in April 2017.

What needs to happen next?

The findings and recommendations from the Independent CSE Systems Review will be reported to the Strategic Board in June 2017. A revised CSE strategy will be written following that which will consider the operational procedures, multi-agency responsibilities, strategic oversight and monitoring arrangements. A new CSE dataset will be a critical part of those developments so that TSCB can be assured that service provision is effective.

9.3 Self-Harm & Suicide

Over the past 3 years TSCB has been involved in 5 case reviews (G, M, N, S & T) where a child has died from suicide or misadventure. There has been strong cross representation between TSCB and the Transformation Board from early 2015 and in 2016 this led to a Tameside Self-Harm Referral Pathway being devised and added to the Greater Manchester Safeguarding Procedures and to a training ladder for professionals including 5 e-learning modules and an accredited Mental Health First Aid course. A new Emotional Health and Well Being Pathway has been established too. Previous gatekeeping arrangements that meant referrals had to go via G.P.s have been removed and any service can ring a duty number for consultation and advice or make a referral. Referrals are screened every day by a multi-agency panel at a Single Point of Entry (SPOE) meeting and if the criteria for 'Healthy Young Minds' is not met then other service provision will be considered and cases signposted as appropriate.

What difference did it make& what needs to happen next?

The Child T case review presented to Strategic Board in March 2017 still highlighted a lack of awareness regarding the Emotional Health and Well Being referral pathway and therefore the Board priority for the following year must be to promote awareness and understanding. The Board will also need reassurance on the use and effectiveness of that referral pathway and any subsequent service provision.

9.4 Early Help

The lack of Early Help data had been repeatedly challenged by TSCB throughout 2015/16. The TSCB Business Group was slow to address that challenge and the issue was recognised in the OFSTED Inspection in September 2016.

The number of CAFs completed by partner agencies is still not routinely recorded or collected by either their own agencies or via a central database/system. As a result Tameside cannot be assured of the level, or effectiveness, of its early help activity in the Borough. This is a significant gap and one that places additional pressure on the Children's Hub as cases are inappropriately referred to that service as a child protection concern. TSCB together with Children Services began work on implementing a new process in June 2017 and that will be supported by a new CAF Team from quarter 2 of 2017/18.

In March 2017 Tameside Safeguarding Children Board requested data from partner agencies on the number of Common Assessment Framework (CAF) and Graded Care Profile (GCP) assessments they had completed from January to December 2016. The data was requested as part of the TSCB Improvement Plan to establish a baseline level of Early Help activity offered across the Borough and to determine whether assessments were being completed appropriately at Level 2 of the Threshold Guidance. Services were asked to state how many assessments had been completed each month over the 12 month period. They were also asked to respond with a nil return or if their service didn't have a system for recording the information. The following responses were returned;

Table 4: Common Assessment Framework and Graded Care Profile assessments completed January 2016 to January 2017

Service	Total No. of CAFs	Total No. of GCPs
Greater Manchester Police	Nil	Nil
Community Rehabilitation Company	No system to record	No system to record
National Probation Service	Nil	Nil
Health (Acute)	No system to record	No system to record
Health (Community)	202	No system to record
Adult Services	Nil	Nil
Bridges (Domestic Abuse Service)	Nil	Nil
Lifeline (Drug and Alcohol Service)	2	Nil
Local Authority Early Help Service	208	12
Total	410	12

Each school returned data on the number of open CAFs rather than the number of CAFs and GCPs completed. Averages for the year have been calculated as follows.

Table 5: Common Assessment Framework and Graded Care Profile assessments completed by Education settings January 2016 to January 2017

School Setting	Average No. of Open CAFs
Primary Schools	216 (3 per school per month)
Secondary Schools	120 (8 per school per month)
Specialist Schools	30 (6 per school per month)

The baseline CAF and GCP data indicates that partner agencies do not have a clear process or easily accessible system for completing and/or collating CAFs and GCPs and that there is an urgent need to implement such a process and system.

What needs to happen next?

Children Services will recruit a team of CAF Advisors to support practitioners to complete, and follow the process of, the Common Assessment Framework. All agencies will be asked to identify a CAF Champion who will promote, and monitor, the use of the CAF within their own agency. TSCB will work with the CAF team and CAF Champions to keep a central record of all CAF activity which will include the outcomes achieved through that process.

TSCB has established a Threshold Management Sub-Group which met for the first time in February 2017. That group will be responsible for revising and promoting the Threshold Guidance and enhancing services understanding of the Thresholds and Levels of Need so that children and families get the right support at the right time through the appropriate and consistent application of Thresholds.

9.5 Neglect

Graded Care Profile Training and Neglect Training has been part of the TSCB Training Programme for several years. Tameside practitioners therefore should have the confidence and skills to identify, assess and respond to neglect at an early stage, including at Level 2 of the Threshold Guidance, before it needs to escalate to Child in Need or Child Protection.

Approximately 40% of all child protection cases are as a result of neglect. The majority of those should be referred to the Children's Hub with a CAF and / or Graded Care Profile already completed and available as supporting evidence but the current referral pathway does not promote that way of working.

What difference has it made?

The figures gathered by TSCB as part of the baseline measure for CAF and the Graded Care Profile (GCP) show that partner agencies are not using the Graded Care Profile and that even within the

Local Authority Early Help Service it is not being well used. However, the proportion of child protection cases categorised as neglect indicates that safeguarding concerns in relation to neglect are being made. As a result children suffering from neglect are being identified and receiving statutory support but the lack of Graded Care Profiles completed suggests that those children are not receiving the targeted support that they need at the earliest opportunity.

What needs to happen next?

The Neglect and Graded Care Profile training will be combined and delivered as 1 training course in 2017/18 and will therefore help to promote the message that all neglect cases should have a Graded Care Profile. A Safeguarding Practice Update and Conference on Neglect will also highlight the need to tackle neglect at an earlier stage of the Thresholds. Children Services may also need to consider how they can reinforce the message to complete a Graded Care Profile before referring in to the Children Hub as well otherwise there could be an over reliance or expectation that this is a Children Social Care responsibility.

TSCB need to reflect on the current governance arrangements of the Neglect Strategy. There is no separate Neglect Sub-Group or Implementation Group and no lead agency responsible for delivering the Neglect Strategy. Previously attempts to coordinate the delivery of the Neglect Strategy have relied upon the efforts of the TSCB Team as there has been a lack of strategic leadership or direction on the issue. There is also a Greater Manchester Neglect Group and any local governance arrangements need to fit with the work of that group too.

10. SPECIFIC RESPONSIBILITIES UNDER WORKING TOGETHER (2015)

10.1 Local Authority Designated Officer

The Local Authority Designated Officer (LADO) task is to oversee investigations into allegations of child abuse by professionals working with children and young people or behaviour which may place children at risk. It includes the chairing of inter-agency Professional Abuse Strategy Meetings (PASMs) on behalf of the Tameside Safeguarding Children Board and being available for advice and consultation.

Allegations against professionals working with children are varied. Many arise within the context of behaviour management, there are a small number of very serious allegations and there are others involving professional boundaries. They come to light through a variety of sources, most frequently children and parents who may complain to the agency concerned or contact the police.

Professional Abuse Strategy Meetings (PASMs)

Professional Abuse Strategy Meetings are convened in agreement with referring and employing agencies and investigators. The criteria is usually the existence of a clear and documented allegation against an individual which raises the possibility of significant harm to a child or children. Strategy Meetings are also held when there is a need for a formally agreed inter-agency strategy for dealing with the case. Complaints to the police have generally required PASMs.

Consultations

Consultations concern matters that do not require co-ordinated inter-agency action. These have increased year on year which indicates that the awareness raising has been effective.

Strategy Meetings are not convened in these cases because of one or more of the following;

- all appropriate action would have already been taken,
- only one agency was involved,
- or the evidence of risk to children was very weak.

The majority of the advice sought during a consultation is around low level parental complaints or allegations made by a child in relation to professional boundaries. This includes incidents whereby a member of staff has made inappropriate verbal comments to a child, given children lifts in vehicles without permission, contacted a child through social media or given gifts. Cases would always be stepped up to a PASM if the need for a multi-agency meeting was evidenced.

Analysis (All Referrals)

Table 6 - Breakdown of Referrals:

Year	PASMs	Consultations	Total
2008/09	41	21	62
2009/10	24	20	44
2010/11	36	35	71
2011/12	13	48	61
2012/13	25	49	74
2013/14	31	67	98
2014/15	22	106	128
2015/16	26	120	146
2016/17	23	136	159

Employing Agencies referred to LADO

As with previous years the majority of referrals have concerned professionals with the greatest and most regular direct exposure to children i.e. school staff, foster carers, residential workers and early year's services.

Table 7 - Agencies Contacting LADO for advice or to refer cases

Agency	Number of contacts
Health	3
Education	36
Early Years	16
Other LADO	0
Residential	31
Children's social care	40
Police	7

OFSTED	5
Other	21

(Other includes agencies such as parents, MPs, HR, NSPCC)

Table 8 - Breakdown of Employing Agencies discussed

Agency	2013/14	2014/15	2015/16	2016/17
Health	10	7	7	6
Education	26	46	55	50
Early Years	11	24	16	21
Residential	14	17	22	37
Children's social care			3	1
Police	4		1	2
Foster carers	16	14	18	20
Other	17	20	4	23

Breakdown of Categories of the cases which progressed to an initial consideration/strategy meeting (PASM). These are the cases where it is agreed with the employer that their employee may have:

- Behaved *in a way that has harmed, or may have harmed a child;*
- *Possibly committed a criminal offence against, or related to a child; or*
- *Behaved towards a child or children in a way that indicates they may pose a risk of harm to children*

If from the information received the threshold for harm has been met, a criminal act has taken place, or the person's behaviour indicates that he/she is unsuitable to work with children or young people, liaison with key agencies to organise an Initial Consideration Meeting will take place.

In any case where a child has possibly been harmed consultation takes place with the Police. The LADO has reported that this has been much easier this year due to the fact that the Police Public Protection Unit have had a Detective Constable permanently placed in the Children's Hub. This has made contact much easier and meant the LADO has been able to get advice and a decision from the Police as to whether they need to be involved much quicker. This in turn has helped agencies in dealing with allegations in a much more timely fashion.

The 23 cases which progressed to an initial consideration meeting where in respect of the following agencies:

Social care -1
Police -1
Foster carers – 9
Education – 2
Residential care workers – 5
Early Years – 2
Health – 1
Other – 2 (sports)

The cases were in respect of the categories of abuse:

3 – Neglect
13- Physical Abuse
3 – Sexual Abuse
2 – Emotional Abuse
2 – Risk of Harm

The police have been involved in, and investigated, 11 of the cases. No further police action was taken in 8 of the cases, 2 were charged with offences and 1 case is still under review by the CPS.

10.2 Child Death Overview Panel (CDOP)

Child Death Overview Panels (CDOPs) are a multi-disciplinary sub-group of Local Safeguarding Children Boards that work across Local Authority boundaries based on population numbers. The CDOP reviews the deaths of all children aged from birth to under the age of 18 years old (excluding still births and planned terminations carried out under the law) who normally reside within the geographical boundaries of that CDOP.

Tameside shares a tripartite arrangement with Stockport and Trafford. In 2016/17 there were 63 child deaths (notifications) to CDOP. 47 cases were closed by the panel. It is not possible for all notifications received in 2016/17 (1st April to the end of March) to be dealt with in that 12 month period. Over the past 4 years Tameside has had an even share, a third, of all of the CDOP cases across the 3 areas.

In closed cases the CDOP has seen an increase of deaths under the age of 1 in percentage terms from 55% in 2014/15, to 73% in 2015/16 and 77% in 2016/17. The consistent features in these deaths remain prematurity where the infant is too under developed to survive or because of severe life limiting conditions when the child is at its most vulnerable. Common themes in premature births are parental smoking and to a lesser extent drug and alcohol abuse.

The data collection process and analysis around CDOP has continued to develop both locally and across Greater Manchester. This has resulted in the production of a Greater Manchester CDOP annual report which is able to analyse trends using larger numbers. The GM report will be published in September 2017 but in general terms the consistent issues will continue to be deaths in children under 1 year. These deaths have consistent themes around prematurity, parental smoking (particularly by mother), low birth weight and life limiting conditions when the child is at its most vulnerable.

As a result of previous CDOP annual reports Greater Manchester CDOPs and Public Health have initiated a sector led improvement plan across the North West targeting infant mortality rates. Since this work started in 2015 all areas in Greater Manchester and 21 out of the 23 areas have provided information on their work to tackle infant mortality rates. In line with previous GM CDOP recommendations a joint regional conference looking at the consistent themes highlighted above will be held in November 2017.

Tameside Safeguarding Children Board

APPENDIX A

TSCB Membership 2016/17

Agency	Name	Title	TSCB Role
	David Niven	Independent Chair	Independent Chair
TMBC	Steven Pleasant	Chief Executive	Member
TMBC - People	Stephanie Butterworth	Executive Director	Member
TMBC - People	Dominic Tumelty	Assistant Executive Director	Member
TMBC - Stronger Communities	Emma Varnham	Assistant Executive Director	Member
Education	Bob Berry	Assistant Executive Director	Member
Primary Schools	Carolyn Divers	Head Teacher	Member
Colleges	Leon Dowd	Vice Principal	Member
Pupil Referral Unit	Maureen Bretell	Principal	Member
Community Rehabilitation Company	Donna Meade	Community Director	Member
National Probation Service (NPS)	Richard Moses	Head of Stockport and Tameside NPS	Member
CAFCASS	Michelle Evans	Service Manager	Member
Community and Voluntary Action Tameside	Ben Gilchrist	Chief Executive	Member
Pennine Care NHS Foundation Trust	Mark Stan Boaler	Service Director	Member
Public Health	Angela Hardman	Director of Public Health	Member
NHS England	Linda Buckley		Member
NHS Tameside and Glossop Clinical Commissioning Group	Michelle Walsh	Director of Nursing and Quality	Member
Tameside Hospital	Pauline Jones	Chief Nurse	Member
Greater Manchester Police	Dean Howard	Super Intendent	Member
NHS Tameside and Glossop CCG	Christina Greenhough	CCG clinical lead and GP	Member
TMBC Elected Member	Peter Robinson	Councillor	Observer
Children's Services	Ged Sweeney	Head of Service - Safeguarding	Sub Group Chair and Member
Greater Manchester Police	Robert Cousen	Detective Chief Inspector	Sub Group Chair and Member
NHS Tameside and Glossop CCG	Munera Khan	Designated Doctor Safeguarding	Sub Group Chair and Advisor
NHS Tameside and Glossop CCG	Hazel Chamberlain	Lead Designated Nurse Safeguarding	Sub Group Chair and Advisor
TMBC Legal Services	Alison Robertson	Principal Solicitor	Advisor
	Cathy Wilde	Volunteer	Lay Member
Tameside Safeguarding Children Board (TSCB)	Stewart Tod	TSCB Business Manager	Advisor

Tameside Safeguarding Children Board

APPENDIX B

TSCB FINANCIAL SUMMARY 2016/17

INCOME/CONTRIBUTIONS 2016/17	
Tameside Council contribution	£123,330
School/Academies	£88,246
Clinical Commissioning Group	£134,700
Other contributions inc. Police, New Charter, NPS, CRC & CAFCASS	£20,937
Training Charges & Contributions	£7,394
Total Contributions 2016/17	**£374,607**

EXPENDITURE 2016/17		
Account Code Description	**Budget 2016/17**	**Actual Spend 2016/17**
Staffing costs	£191,400	-£188,504
TSCB General	£153,624	-£146,157
Training Strategy	£26,000	-£21,528
Serious Case Review	£21,000	-£18,409
TOTAL EXPENDITURE	**£392,024**	**-£374,598**

FINANCIAL RESERVE 2016/17	
Headings	**2016/17**
Funds from 1 April 2016	£127,987
Total Expenditure in excess of income	-£9
Balance in Reserve 31/03/17	**£127,996**

Tameside Safeguarding Children Board

APPENDIX C

TSCB STRATEGIC PRIORITIES 2017/18

Strategic Priority 1: DOMESTIC ABUSE

1.1 To monitor the effectiveness of partner agencies identification and response to Domestic Abuse

1.2 To develop and deliver an educational awareness programme to universal services

1.3 To continue to deliver multi-agency training on the 'whole family approach to Domestic Abuse' and to evaluate its impact

1.4 To explore and develop ways to tackle domestic abuse at an earlier stage

To assist with monitoring actions are "RAG rated" with commitments assessed as RED, AMBER or GREEN.

RED: There is a significant risk that the action/s will not be completed within the timeframe of the business plan.

ACTION REQUIRED : Sub-Group Chair to raise to the Strategic Board

AMBER: A potential problem has been identified and actions may not be fully achieved

ACTION REQUIRED: Sub-Group Chair to raise to the Strategic Board

GREEN: Actions on target to succeed.

ACTION REQUIRED: None

OBJECTIVES	RATIONALE	BY WHOM	TIME SCALE	RAG STATUS	PROGRESS
1.1 To regularly seek assurance from the DA steering group that working processes are safeguarding children	The Domestic Abuse Steering Group to continue to lead the development and ensure feedback to TSCB	Domestic Abuse Steering Group	3x a year Mar, July & Nov 17		
1.2 Better Futures deliver training in Schools	Children and young people are aware of the risks related to Domestic Abuse	Domestic Abuse Steering Group	December 2017		
1.3 To continue to deliver the 'Whole Family Approach to Domestic Abuse'	Practitioners have the knowledge and skills to provide advice and support to victims, perpetrators and families	Learning and Improvement Sub-Group	Annual TSCB Training Programme		
1.4 To roll out 'Operation Encompass'	Vulnerabilities of children and young people affected by Domestic Abuse are addressed	TSCB	Begin March 2017		

Strategic Priority 2: Child Sexual Exploitation

2.1 Evaluate the effectiveness of the CSE System and Strategy

2.2To ensure that a tiered package of support is available for victims of CSE

2.3 To increase awareness of CSE amongst children and young people, parents and community

2.4 To revise the local Missing from Home Protocol that reflects the response to missing children who are known to be at risk of CSE

To assist with monitoring actions are "RAG rated" with commitments assessed as RED, AMBER or GREEN.

RED: There is a significant risk that the action/s will not be completed within the timeframe of the business plan.

ACTION REQUIRED : Sub-Group Chair to raise to the Strategic Board

AMBER: A potential problem has been identified and actions may not be fully achieved

ACTION REQUIRED: Sub-Group Chair to raise to the Strategic Board

GREEN: Actions on target to succeed.

ACTION REQUIRED: None

OBJECTIVES	RATIONALE	BY WHOM	TIME SCALE	RAG STATUS	PROGRESS
2.1 Complete CSE Systems	Children at risk of CSE are protected from	Independent	June 2017		

Review and revise CSE Strategy inc. support for victims of CSE	harm and provided with the appropriate level of support. Perpetrators are disrupted or prosecuted	Reviewer			
2.2 Develop multi-agency CSE dataset	Board is assured of the sufficiency of the CSE System and Strategy	CSE Sub-Group	Q2 Data available Oct 2017		
2.2 Determine most appropriate and tiered model of support for victims of CSE and develop service specification	Victims of CSE access support that is suitable to their needs	CSE Sub-Group	June 2017		
2.3 Promote online safety to pupils and parents	Pupils and parents know how to keep themselves safe online and know where to go to for help and advice	CSE Sub-Group	March 2018		
2.3 Participate in the GM CSE Awareness Days and other methods of communication	Community members are aware of CSE, help keep others safe and report any concerns	CSE Sub-Group	x2 per year		
2.3 Undertake Training Needs Analysis of Children's Disability Services and Phoenix Team	Practitioners have the knowledge and skills to support children with disabilities that are at risk of CSE	CSE Sub-Group	October 2017		

2.4 Revise local missing from home policy Promote policy via communication channels & CSE Training	Children at risk of CSE who go missing receive a swift response	Missing from Home Operational Group	November 2017		

Strategic Priority 3: SELF-HARM

3.1 Work with Strategic Partners to develop and implement the Transformation Plan

3.2 Develop and deliver a package of self-harm and suicide training and support

To assist with monitoring actions are "RAG rated" with commitments assessed as RED, AMBER or GREEN.

RED: There is a significant risk that the action/s will not be completed within the timeframe of the business plan.

ACTION REQUIRED : Sub-Group Chair to raise to the Strategic Board

AMBER: A potential problem has been identified and actions may not be fully achieved

ACTION REQUIRED: Sub-Group Chair to raise to the Strategic Board

GREEN: Actions on target to succeed.

ACTION REQUIRED: None

OBJECTIVES	RATIONALE	BY WHOM	TIME SCALE	RAG STATUS	PROGRESS
3.1 Board Partners are part of the Transformation Board and the delivery of its work streams	A holistic multi-agency approach to children and young peoples' mental health and well-being is developed	Transformation Board	Part of a 5 year plan to 2020		
3.2 Develop & deliver a self-harm and suicide training package	Practitioners can identify self-harm and provide, or refer to, the appropriate level of service required	MindED	x5 courses during 2017/18		

Strategic Priority 4: THRESHOLD MANAGEMENT

4.1 Promote an improved understanding and consistent application of the threshold criteria.

4.2 Support practitioners to identify and respond to need and/or risk at the earliest opportunity, inc. Early Help & Neglect

4.3 Develop a performance management system that will monitor the responsiveness of the Hub and the consistent application of Thresholds

To assist with monitoring actions are "RAG rated" with commitments assessed as RED, AMBER or GREEN.

RED: There is a significant risk that the action/s will not be completed within the timeframe of the business plan.

ACTION REQUIRED : Sub-Group Chair to raise to the Strategic Board

AMBER: A potential problem has been identified and actions may not be fully achieved

ACTION REQUIRED: Sub-Group Chair to raise to the Strategic Board

GREEN: Actions on target to succeed.

ACTION REQUIRED: None

OBJECTIVES	DESIRED OUTCOME	TIME SCALE	RESPONSIBILITY	RAG STATUS	PROGRESS
TBA by Threshold Management Sub-Group once established	TBA by Threshold Management Sub-Group once established	TBA by Threshold Management Sub-Group once established			

Strategic Priority 5: NEGLECT

5.1 To improve the awareness and understanding of neglect (including the threshold for access to agencies)

5.2 To improve the recognition and assessment of children and young people living in neglectful situations

5.3 Developing and sustaining an agreed, early multi-agency response to neglect

To assist with monitoring actions are "RAG rated" with commitments assessed as RED, AMBER or GREEN.

RED: There is a significant risk that the action/s will not be completed within the timeframe of the business plan.

ACTION REQUIRED : Sub-Group Chair to raise to the Strategic Board

AMBER: A potential problem has been identified and actions may not be fully achieved

ACTION REQUIRED: Sub-Group Chair to raise to the Strategic Board

GREEN: Actions on target to succeed.

ACTION REQUIRED: None

OBJECTIVES	DESIRED OUTCOME	BY WHOM	TIME SCALE	RAG STATUS	PROGRESS
5.1 Agencies collate baseline measure and undertake Training Needs Analysis in relation to the use of CAF, identification of Neglect within the CAF and subsequent use of the GCP	Partnership is aware of current level of activity or put systems in place to measure that activity and report training needs to Learning Improvement Sub-Group	QAPM Sub-Group	March 2017		
5.1 Promote use of Graded Care Profile amongst all universal services at the Level 2 of the Threshold Guidance (Neglect)	Launch event raises awareness and sets expectations around the consistent application of thresholds	Threshold Management Sub Group	June 2017		
5.1 & 5.2 Review relevant training course materials and revise according to identified need from objective above	Training of staff means that services intervene earlier (Level 2) to address the problems of Neglect and prevent them escalating to CIN/CP	Learning and Improvement Sub-Group	April 2017		
5.2 Draft development of a new multi-agency dataset including CAF, GCP, Relevant upgrades made to ICS for CAF, GCP	Level of Early Help offer and specifically work to tackle Neglect is accurately measured	Task and Finish Data Group	April 2017		

5.3 Collate service user feedback from those on CP, CIN & CAF for reasons of Neglect (cross ref 3.1)	Service user feedback identifies good practice and areas for improvement which influences service planning	QAPM Sub-Group	May 17 Strategic Board		
5.3 Agree multi-agency requirements for assessing Neglect and accessing Children's Hub	Earlier multi-agency intervention to address Neglect Consistent application of Thresholds for the purposes of Neglect	Threshold Management Sub-Group	April 2017		