Tameside Safeguarding Children Board

TAMESIDE SAFEGUARDING CHILDREN BOARD (TSCB) ANNUAL REPORT 2017/18

October 2018

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CHAIRS FOREWORD

2017-18 has been a challenging year for the Strategic Board with the requirement to progress the improvements identified through the 2016-17 Ofsted Inspection. In 2018-19 we will look to refresh the Business and Improvement Plan and consider the other actions that need to be undertaken to strengthen the work of the partnership and the effective working of the Strategic Board.

Changes were put in place in the last quarter of 2017-18 to review and refresh the business processes that underpin the work of the board which included subgroup report to the board, reframing the agenda to ensure that strategic developments and assurance were seen as key functions; starting each meeting with a presentation from partners on how they capture the voice of a child and the changes they are making. We will continue this through 2018-19. We have also started to consider at the end of each meeting how effective we had been and if the right issues are being considered. It is anticipated that this will encourage partners to be more effective in their role of scrutiny and challenge and for them to consider their own assurance processes.

Challenges will continue into 2018 – 19 as we continue to support the improvement journey in Tameside and start to move to the new Safeguarding Arrangements as determined in Working Together 2018. Tameside has been successful in its bid to be an early adopter of these new arrangements.

As you read through the pages of this report you will gain an insight into the work of the Board, how we audit, review, learn and invest in partnerships with the ultimate aim of improving the lives of our children. There is no doubt that there is much to celebrate in our work, but much more that we can do. We are committed to continuous improvement and strive to improve the lives of children who are neglected or in need of early help, those who live with the toxic trio of parental domestic abuse, substance misuse or poor mental health and those who are at risk of child sexual exploitation. We are determined to tackle these issues from every possible angle, to improve practice, to better engage with children and communities and to build stronger partnerships.

To conclude, I would like to thank members of the Board, across the partnership of our voluntary, community and statutory services and all the frontline practitioners and managers for their commitment, hard work and effort in keeping children and young people

safe in Tameside. We will continue to seek out what we can do better, to support the community we serve and ensure that children and young people are safer as a result.

Gill Frame, Interim Independent Chair, Tameside Safeguarding Children Board

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EXECUTIVE SUMMARY

Tameside Safeguarding Children Board has continued to develop and deliver programmes against its 2015-18 strategic priorities. Continual improvement to service design and delivery, the piloting and roll out of innovative work streams and preparations for new Multi-Agency Safeguarding Arrangements have all underpinned the Boards activities in 2017/18.

Of particular note have been the early phases of development on a number of initiatives that will form the bedrock of Tameside's safeguarding arrangements in the future. They include an Integrated Neighbourhood Model, a Signs of Safety approach, and the Voice of the Child. Tameside's confidence in its progress, readiness and commitment against these work programmes are such that it has applied, and been successful in its bid, to the Department for Education to be an Early Adopter of the new multi-agency safeguarding arrangements.

A new Strategic Framework 'Smarter, Stronger, Sooner, Safer' has been developed and outlines Tameside's integrated approach to improving outcomes for children, young people and their families through early help. A system to monitor the level of Early Help activity and support to enhance that activity has been implemented from July 2017. The level of Early Help activity is reassuring but the information collated also shows that more targeted support is required in certain settings. A Team Around approach, piloted as a core part of the Integrated Neighbourhood Model, will help to provide the support that services need to deliver early help.

Tameside Youth Council revised the content and created the final design of the Voice of the Child Strategy. They launched the strategy at a high profile event, organised and hosted, by young people at Tameside College in March 2018. The strategy sets out Tameside's commitment to hearing the voices of all children and young people in Tameside. Children and young people have identified 15 statements of expectation which will be the basis of future Voice of the Child training that the Board has commissioned as part of the TSCB Training Programme in 2018/19.

A dedicated social work team manager is now based at Ashton Police station to oversee all Domestic Violence notifications on a daily basis. Greater Manchester Police reported at the end of 2017/18 that there were no outstanding queues and referrals are addressed within the Children Hub in 24 hours. The Domestic Abuse Steering Group will continue to closely monitor the timeliness and response to Domestic Violence Notifications.

Tameside Safeguarding Children Board commissioned a CSE Systems Review and a Serious Case Review for Child U that was completed in July 2017. A series of recommendations were subsequently actioned including a revised CSE Joint Working and Missings Protocol which has clarified and improved the referral, allocation, assessment and case management processes. Further work in 2018/19 will ensure that any remaining recommendations are implemented such as reviewing the need for a Parenting Worker and the role of the Health Practitioner that supports the Phoenix Team.

TSCB ran a Safeguarding Practice Update on Neglect in April and a Conference in November 2017 which contributed to a body of ongoing work to encourage and promote the use of standardised

assessment tools for neglect, namely the Graded Care Profile. Whilst much has been done to raise awareness of Neglect and provide the tools to tackle it the impact in practice is yet to be realised. The Board have been advised that a stronger strategic position regarding the use of the Graded Care Profile across the partnership, and across Levels 2-4 of the Thresholds, would help to further encourage the use of the Graded Care Profile. The Board will seek assurance from partners that they are effectively identifying and responding to Neglect and review its strategic position in 2018/19.

The Boards Quality Assurance and Performance Management group has developed a new performance indicator set to oversee the performance of key agencies that work with children and young people. Data is now being collated more routinely but receiving exception reports with meaningful narrative and actions is proving more challenging and will have to be addressed in 2018/19. Members of the Quality Assurance and Performance Management group have conducted a number of multi-agency audits including; self-harm, neglect, early help and sexual abuse during 2017/18. Those audits have produced a series of recommendations for agencies to improve practice within their services. Partner agencies need to provide greater assurance that their internal auditing processes are evidencing that learning from case review and audit activity is being embedded in practice.

The Boards Serious and Significant Case Panel has continued to deliver the actions from the Child R, S and T case reviews, all of which are now complete. This has meant that a pre-birth assessment protocol has been developed including a learning disability pathway to ensure joined up assessments and intelligence are identifying and meeting the needs of vulnerable and at risk parents, multi-agency training on chronologies has been delivered to partner agencies, learning disability resources have been promoted and parental responsibility guidance has been disseminated to all schools.

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 from 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 2017-2018. 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.

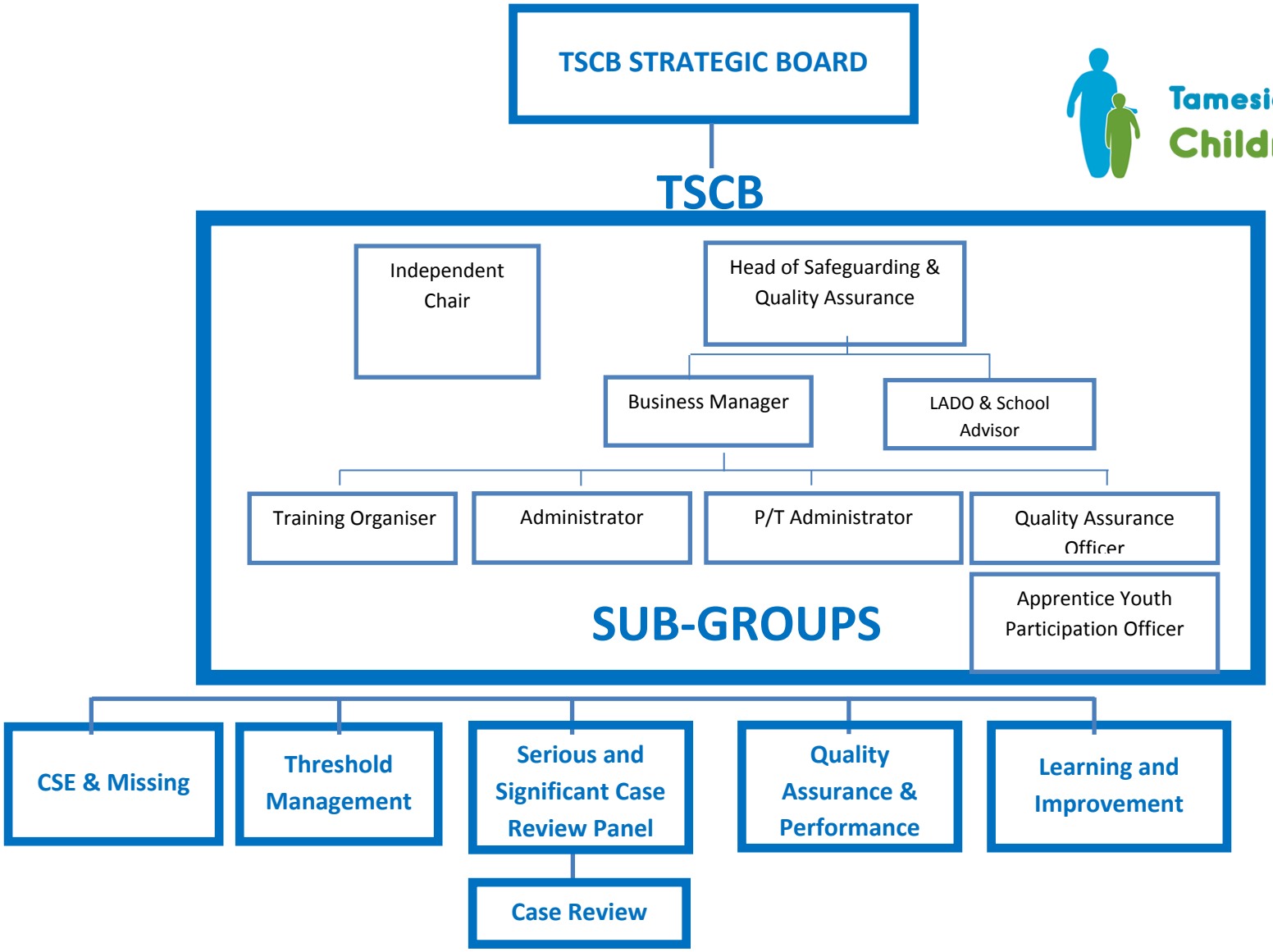
1.3 TSCB STRUCTURE AND GOVERNANCE

In 2017/18 the Board had a three tiered structure to enable it to carry out its statutory functions;

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

1.4 TSCB Team

During 2017/18 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.

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 during 2017/18 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 7 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 2017/18, Tameside Safeguarding Children Board carried forward £102,996.

3. ACHIEVEMENTS AND DEVELOPMENTS 2017/18

3.1 Early Help Model & Thresholds

A new Strategic Framework 'Smarter, Stronger, Sooner, Safer' has been developed and outlines Tameside's integrated approach to improving outcomes for children, young people and their families through early help. It provides a guide to the workforce on the vision, principles, model, priorities and enablers of early help that will impact on children and families lives. The Early Help Strategic Group that developed the Strategy has become a Starting Well Sub-Group of the Health and Well-Being Board showing the group has the strategic impetus and direction required to deliver a quality Early Help offer.

A Threshold Management Sub-Group revised, launched and monitored the implementation of Tameside's Threshold Guidance during 2017. Revised guidance was published in June 2017 to ensure that all partners understood their responsibilities in relation to providing early help and to fulfil their safeguarding duties. The proportion of referrals from the Children's Hub has changed with information and advice given increasing from 31% (2017) to 56% (2018) whilst referrals to social care has reduced from 47% (2017) to 35% (2018).

There has been a clear and consistent message that all partners must do more to intervene early to prevent problems escalating to the point where statutory intervention is required. Additional support has been provided to enhance the early help offer through the Common Assessment Framework and in 2018/19 further work to reduce demand on Children Social Care will be developed with the roll out of Early Help Panels closely aligned to an Integrated Neighbourhood Model.

3.2 Integrated Neighbourhood Model

Tameside are developing an Integrated Neighbourhood Model through which joint working between partner agencies on the ground will be strengthened. The model will provide a governance structure which engages all of the partners including every single school. This will be done both through Neighbourhood Learning Circles which engage partners three times per year, and through introducing a Team Around the School model in which multi-agency safeguarding partners proactively meet in each school to discuss children of concern. In this way every school will be fully integrated in our local safeguarding arrangements, being held to account for their performance and being able to raise issues of concern.

3.3 Voice of the Child

Tameside Safeguarding Children Board has worked closely with the Youth Council and Voluntary and Community Sector to consult with children and young people and create a Voice of the Child Strategy. The Youth Council took control of the final consultation phase, revised the content and created the final design of the Strategy. They launched the strategy at a high profile event, organised and hosted, by young people at Tameside College in March 2018. The strategy sets out Tameside's commitment to hearing the voices of all children and young people in Tameside. Children and young people have identified 15 statements of expectation which will be the basis of future Voice of the Child training as part of the TSCB Training Programme in 2018/19. The training will be delivered by members of the Youth Council twice a year.

In 2018/19 Tameside will build on this work and develop a Youth Forum Network that can connect the existing forums together and give them a stronger collective voice on issues that are important to them. The proposal is to feed their ideas and issues up to the Neighbourhood Learning Circles for action via the Integrated Neighbourhood Model.

3.4 Signs of Safety

Tameside Children Social Care has adopted Signs of Safety as its chosen model of practice. Signs of Safety is a relationship and strengths based practice model which enables practitioners to work collaboratively with families to produce assessments and plans; focussing on their own strengths and resources. The approach moves away from the professional adopting the position of expert towards a more constructive culture where 'the work is done together'. A project lead will be appointed to implement the Signs of Safety Model and Tameside Safeguarding Children Board will have responsibility for ensuring that all partners adopt the model across all levels of the Threshold.

4. TSCB STRATEGIC PRIORITIES 2015 - 2018

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

The following section reports on the work of the Board and its partners against its strategic priorities in 2017/18.

4.1 Domestic Abuse

A dedicated social work team manager is now based at Ashton Police station to oversee all Domestic Violence notifications on a daily basis. Greater Manchester Police reported in Quarter 4 that there were no outstanding queues and referrals are addressed within the Children Hub in 24 hours. The

Domestic Abuse Steering Group will continue to closely monitor the timeliness and response to Domestic Violence Notifications.

Tameside and Glossop Integrated Care NHS Trust have recruited and trained 36 Domestic Abuse Champion with the aim of having a Champion in every department of the Trust. Posters have been in place across the organisation to promote who the Champions are. The initiative has led to several members of staff receiving support after approaching champions in their clinical areas and subsequent referrals to Bridges and MARAC demonstrating are better at identifying and responding to concerns about Domestic Abuse.

TMBC and GMP have been completing a phased roll out Operation Encompass for Standard Risk incidents across all schools in the borough. The purpose of the operation is to notify schools of any Domestic Abuse incidents that have occurred where one of their pupils has been present and may have witnessed the incident. It allows the school to provide better pastoral care and support and help the child settle into the school day rather than sanction them for being late or for poor behaviour. A successful pilot in the Stalybridge cluster has now been rolled out into the Ashton schools. Feedback from schools where it has been rolled out has been extremely positive and a roll out across the remaining schools is planned during 2018/19.

What difference has it made?

TSCB Performance Scorecard reported to the March Strategic Board an increase in the number of repeat referrals to MARAC and an increase in the number of cases involving children during Q3. MARAC consider high risk Domestic Abuse cases and ensure a robust safety plan in place. This prompted a request for assurance from the Domestic Abuse Partnership about the effectiveness of the MARAC process to safeguarding children.

Across Greater Manchester an average of 60% of all MARAC referrals feature children. Tameside is consistently above that at approximately 70% but in quarter 3 jumps to 94%. In addition Tameside has a greater proportion of repeat referrals to MARAC which in quarter 3 was 43% compared to 25% across Greater Manchester.

The MARAC Coordinator presented comparator data over the past 3 years to the Strategic Board and explained how the number of expected cases is worked out based on population size by 'SafeLives', a Government funded project. The number of repeat referrals and the number of cases involving children is in line with the expected numbers and also the national average. Tameside's figures are consistent, and while there is an overall increase, Tameside are recognised as having an effective MARAC with other areas looking to adopt our model. The Chairing at MARAC is strong and members give adequate time to consider each case. Referrals to MARAC now include coercive control, harassment and stalking which may result in more referrals and a spike in the numbers next year.

What needs to happen next?

The Domestic Abuse Steering Group has identified from their performance management information that there has been a lack of referrals from Alcohol Services to the Bridges Domestic Abuse Service

during 2017/18. They have committed 2 members of staff from Bridges to attend the Alcohol Services team meeting to raise awareness of their service and how to refer appropriately to ensure that providers of commissioned alcohol services are aware of the links with domestic abuse and know how to access support. Similarly, there have been a small number of referrals from a range of services to MARAC.

Table 1: MARAC Referrals by Source

BY REFERRER														
Area	Tameside													
Year and Quarter	Secondary Care/ Acute trust	GMP	IDVA	Children's Social Care	Primary Care	Education	Mental Health	Probation	Housing	Voluntary Sector	Substance Abuse	Adult Social Care	MASH	Other
2017-18 Q1	2	43.5	13	7	4	0	1.5	1	4	1	0	0	0	3
2017-18 Q2	3	58.5	8	12	9	0	0	2	2	8.5	0	0	0	5
2017-18 Q3	4	41.5	5	2	3	2	0	0	3	4.5	0	0	0	4
2017-18 Q4	3.5	52	14.5	8.5	5.5	0	1	2	0	1	1	0	0	4
Grand Total	**12.5**	**195.5**	**40.5**	**29.5**	**21.5**	**2**	**2.5**	**5**	**9**	**15**	**1**	**0**	**0**	**16**

Tameside Safeguarding Children Board will need to ask the Domestic Abuse Steering Group for assurance that services training needs in relation to Domestic Abuse are being met. Changes to the Domestic Abuse Training as part of the Training Programme for 2018/19 have already been made in response to feedback from course trainers and participants. Promotion of those courses to a more targeted audience may be required so that those most in need of the training are receiving it.

Whilst the work outlined above highlights the excellent examples of joint partnership work there is other specialist support that is currently at risk. As of March 2018 funding for 2 posts, the Children's and the Young Person's Independent Domestic Violence Advocate was only secured until September 2018. Demand for the service far outstrips supply with 28 children and young people accessing outreach support in Quarter 3 and 213 on the waiting list for 1:1 support.

Tameside has a low number of FGM referrals or flags identified within Children Social Care. In addition Project Choice; that is based in Oldham but provide support across the 10 Greater Manchester Boroughs in relation to Forced Marriage, Honour Based Violence and FGM; has received no referrals from Tameside. Tameside Safeguarding Children Board had subsequently identified the need for FGM Training and this will be provided by Project Choice as part of the TSCB Training Programme in 2018/19.

4.2 Child Sexual Exploitation (CSE)

Tameside Safeguarding Children Board commissioned a CSE Systems Review that was completed in July 2017. An independent reviewer was appointed to undertake the review and make recommendations to the Board on the efficacy of the current system and whether changes or modifications may be required to improve the system and more importantly outcomes for young people affected by CSE. The review noted that Greater Manchester Police problem profile of CSE in Tameside was not unique amongst other areas of Greater Manchester. It indicated that CSE crime locally is primarily made up of one-to-one and/or internet based contacts with no evidence of links to serious organised crime or gangs. However it acknowledged that there is no room for complacency regarding the threat of links to organised crime groups.

A series of recommendations were subsequently actioned and implemented. A revised CSE Joint Working Protocol and Missings Protocol has been developed which clarifies the referral, allocation, assessment and case management processes.

All referrals are now received via the Children's Hub and screened and allocated to the area teams. If CSE is identified as a contributing factor the allocated Social Worker will make a referral to the Phoenix Team. Typically there are 30 young people open to the Phoenix Team at any one time. At the end of March 2018 there were 7 high risk cases, 19 medium risk and 1 low risk. The majority of CSE victims are white female aged 12 to 15yrs, living in a family home and having frequent missing from home episodes. Offenders are white male, aged 19 to 24yr old lone offenders. At present the majority of investigations start online and follow the older Boyfriend / Girlfriend Model.

Each referral is discussed at the weekly multi agency governance meeting where the decision is made whether the threshold is met to open to the Phoenix Team. If a Child in Need or Child Protection case is allocated to the Phoenix Team then it will be co-worked between the area team Social Worker and the CSE Social Worker to ensure that the specialist intervention is separate from the child protection process. The CSE Social Worker will complete the CSE risk assessment tool to determine the level of risk and the intervention required. The assessments are reviewed on a three monthly basis or following any significant event.

What difference has it made?

A CSE and Missing from Home Panel was implemented in October 2017 which has improved multi-agency sharing of information on missing from home episodes and the link to CSE. This has provided a more robust mechanism of assessing and responding to the needs of children that are reported missing from home and are at risk of CSE. Barnardo's Missing from Home return visits have seen an increase in meaningful and detailed information/intelligence being gathered and shared. This has had a direct result in missing from home children being located quicker and therefore safeguarded sooner, thus reducing the risk of CSE.

Off the Record Counselling Services continue to deliver first class 1-2-1 counselling sessions to victims of CSE. A dedicated counselling room provision has been provided within Phoenix Tameside, ensuring children have a safe welcoming environment when meeting with any representative from Phoenix Tameside. Positive feedback has been received from victims of CSE and families who have utilised the facility. Young People have said that it is important for a worker to build a positive trusting relationship, listen and not judge, to be consistent and persistent and honest. Feedback from young people indicates that they feel involved and informed in the work that is done to support and protect them.

The Phoenix Team have successfully implemented a range of disruption tactics to stop or deter potential offenders. 150 Joint Enforcement Visits to licensed premises and food takeaways have been completed compared to 68 in the previous year. 37 abduction notices have been served compared to 9 in the previous year. In addition there have been 13 CSE related convictions during 2017/18 compared to 3 in the previous year.

Tameside hosted a very successful launch of the It's Not Okay week of action, which called on parents to 'keep switched on' to their children's online and offline activities and raised awareness of steps they could take to help protect them from CSE. The SSNAP team from Great Academy Ashton delivered online safety training to parents on a Surviving Teenagers course at Greenside Children's Centre. Tameside also produced a very powerful case study of a Tameside mother whose son was abused after being groomed online. Both the launch and the case study achieved wide coverage both locally, regionally and even nationally. The Phoenix team also ran various engagement activities across the borough throughout the week including at Tameside Hospital, school sports events, youth clubs and Stalybridge Carnival. Youth workers made CSE their theme for the week while carrying out outreach and intervention work in the community and many schools shared the campaign information on their websites and social media themes.

A dedicated CSE page has been added to the Tameside's Service Information Directory to more effectively signpost parents, carers, young people and professionals to CSE support groups and resources. This facility has helped reduce some of the demand on Phoenix Tameside and the Tameside Children's Hub by providing advice, guidance and information on how to access early help.

What needs to happen next?

The Achieving Change Together (ACT) Programme piloted in Rochdale and Wigan will be rolled out across Greater Manchester. It will tackle Complex Safeguarding encompassing CSE, Criminal Exploitation, Modern Slavery and Trafficking. Each Local Authority will have to determine its operational response and resource in order to implement the programme. In Tameside discussions have already taken place about the need to provide transitional support for vulnerable young people up to the age of 25 as a minimum. Tameside Safeguarding Children Board will need to identify a Complex Safeguarding Lead and determine how it wants to progress this work so that it can benefit from the offer of support from the GM Complex Safeguarding Group.

4.3 Self-Harm & Suicide

Tameside and Glossop has invested in new early intervention and prevention services as well as expanding capacity within its Healthy Young Minds service to ensure that children and young people receive the right level of support in a timely manner; aid recovery and prevent escalation to specialist services. The specialist workforce has increased from 23.7 FTE in 2014/15 to 32.5 FTE in 2016/17 (a 37% increase on base line year). Both public and third sector services have been uplifted, providing accessible services in meeting need and an array of new pathways have been developed and implemented for children and young people with mild and moderate mental health issues.

Healthy Young Minds (CAMHS) has been working to improve the support available between referral and first appointment through the development of a waiting times initiative, which includes embedding Third sector providers within the core offer. In addition a new, user friendly, interactive and informative website has been launched. Work on the website has included reviewing and including a range of applications for young people, self-help information and links to social media such as Twitter. The website has a range of quality assured self-help information, links to local and national resources NHS applications approved by young people.

What difference has it made?

Accessible expert knowledge of children and young people's mental health has been placed across the system; particularly placing them where children and young people are deemed most vulnerable such as in the LAC Team and Youth Offending Service. A pathway for families with high needs, such as those within the child protection system and care leavers has been established. Work with NHSE and the Department for Education to pilot and test the CAMHS school link model has provided training within 14 schools and ensuring a named practitioner for each of the schools that has a mental health lead (champion) within its setting. In addition all GPs have a named Consultant to improve communication and access between Primary Care and Healthy Young Minds.

There has been investment in the development of a local training ladder and a programme of e-learning and face to face training. The training ladder is hosted by Tameside Safeguarding Children's Board and a core part of its Training Programme.

What needs to happen next?

Healthy Young Minds needs to develop stronger links to Children Social Care and ensure that they are part of the Single Point of Entry meetings. Based on feedback from young people about access and referral routes to the service it has committed to reviewing the possibility of a self-referral option. There are, however security and confidentiality issues that need to be carefully considered as part of this.

4.4 Early Help

A network of CAF Champions across schools and other partner agencies have been identified and supported to implement the Common Assessment Framework process within their service. A team of CAF Advisors provide regular advice and guidance to those CAF Champions and services. Tameside Safeguarding Children Board has devised a system for recording the level of CAF Activity on a quarterly basis and the CAF Team has implemented a Quality Assurance Framework.

What difference has it made?

Approximately 250 CAFs are being initiated or completed by all partner agencies each quarter. From quarter 3 there has been over 800 multi-agency meetings a quarter to implement and review action plans in order to provide a coordinated package of support to families. Crucially over 100 CAFs a quarter are being closed because the families needs have been met and stepped back down to universal services. The number of CAFs closed due to non-engagement has reduced by almost 75% since the CAF Advisors have been in post suggesting that more families are willing to accept support. Cases are also being stepped up to Children Social Care but in quarter 4 the number of CAFs escalated to CSC reduced by almost 50%. This could be for a number of reasons such as a better understanding and application of Thresholds, or CAF Advisor support strengthening the CAF process. The trend will need to be closely monitored and understood in 2018/19.

What needs to happen next?

While there have been significant improvements to the Common Assessment Process there are still some services that are either unable to provide information on their level of Early Help Activity or provide nil returns. Tameside Safeguarding Children Board and the CAF Team will continue to use the quarterly returns to target those services in need of additional support and training.

CAF Advisors are also auditing the quality of CAF and have completed 47 Audits in Quarter 4 of which 24% were assessed as good, 72% requires improvement and 4% inadequate. They have found that during 2017/18 the number of good CAFs has increased by 3%, the number requiring improvement has increased by 26% (this is from a large amount of Inadequate) and the number of inadequate CAFs have reduced by 29%. The CAF Advisors will continue to work with CAF Champions and Lead Professionals to improve the quality of the CAFs so that more families have their support needs identified and met as early as possible.

4.5 Neglect

TSCB ran a Safeguarding Practice Update on Neglect in April 2017 which was attended by over 40 professionals and a TSCB Conference in October 2017 attended by over 100 professionals. The practice update and conference contributed to a body of ongoing work to encourage and promote the use of standardised assessment tools for neglect, namely the Graded Care Profile.

What difference has it made?

Between July and September 2017 just 0.5% of Child in Need cases had a Graded Care Profile, and 2.5% of Child Protection cases where neglect was identified. Following the conference, in Quarter 3 the figures rose to 2.1% of all Child in Need Neglect cases and 7.6% of Child Protection Neglect cases which is a promising increase but still only a small proportion of all cases.

What needs to happen next?

The Board have been advised that a stronger strategic position regarding the use of the Graded Care Profile across the partnership, and across Levels 2-4 of the Thresholds, would help to further encourage the use of the Graded Care Profile. However, there has been a big push to promote and support the uptake of the Common Assessment Framework and to improve the quality of assessments in Children's Social Care during 2017/18. The Board has also acknowledged that all partner agencies, and not just Children's Social Care, have an equal responsibility for identifying and responding to Neglect at the earliest opportunity.

Wherever possible, early assessment tools and processes such as the Common Assessment Framework and the Graded Care Profile should be used to address the issues associated with Neglect in order to avoid the need to escalate safeguarding concerns up to the Children's Hub.

In recognition of this Board members agreed to undertake a Neglect Assurance Exercise and were asked to provide evidence to show how they have implemented the Neglect Strategy. The following 3 questions were asked;

1. How is your organisation assuring itself that the Neglect Strategy is embedded within the organisation?

2. How is your organisation quality assuring the use of the Graded Care Profile?

3. How is your organisation quality assuring their assessment, planning and supervision processes to ensure that staff are identifying and responding to Neglect in a robust manner?

Partner agencies noted that while there is good evidence of awareness raising and training there is insufficient assurance that it has impacted on front line practice and led to improved service delivery for families. Partners agreed at the Strategic Board meeting in March 2018 that the responses did not provide the required assurances and agreed to repeat the exercise for the Strategic Board meeting in September 2018. While Tameside Safeguarding Children Board acknowledges it is not able to assure itself that their response to Neglect is effective it does demonstrate a willingness to provide strong challenge of each individual partner agency, and the collective partnership, response in an open and transparent way.

5. 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.

5.1 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.

5.2 Communication and Raising Awareness of Safeguarding Issues

A Learning and Improvement Activity Group is responsible for communicating, and raising 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 2017/18 a total of 48 Multi-Agency Learning Events were delivered including 42 Courses on the Multi-Agency Training Programme, covering 21 different topics associated with safeguarding children, 4 themed Safeguarding Practice Updates, a 'Voice of the Child Strategy Launch Event' and a 'Tackling Childhood Neglect Conference'.

Two new courses were commissioned; Multi-Agency Practice Development Programme, which provides an opportunity for multi-agency partners to consider their contribution to Tameside's improvement journey and specifically addresses the principles of effective assessment, weak analysis of history, risk and parenting capacity and children's wishes and feelings not consistently informing plans. Domestic Abuse; Analysing the Impact, which provides a more in depth examination of the impact on children, impact of trauma and safety planning for survivors and children.

The Safeguarding Practice Updates dealt with themes of Neglect, Thresholds, Mental Health of Young People, through a joint learning event with Oldham and Engaging Resistant Males in Assessments. The Update involving neglect was a precursor to a 'Tackling Childhood Neglect Conference', which reinforced the 'Neglect Strategy', promoted use of Tameside's Graded Care Profile and the importance of acquiring and analysing the 'daily lived experience of children and their families'.

Overall a total of 1,093 Multi-Agency learners attended the Multi-Agency Learning events delivered by TSCB. Between them, representatives from Education, Local Authority and Health take up the majority of places on offer, with an improving take up rate from the Police & Probation, which has previously been poor. In addition to the events attended, 303 active Multi-Agency e-learning licences were issued to consolidate learning for the foundation course, domestic abuse, neglect and Early Help (CAF).

Pre & end of course evaluation:
Part of the update to the electronic booking system involved learners completing pre and end of course evaluation through their electronic individual learner account. Learners self-assessed the level of their existing knowledge at the time of applying for a course and upon conclusion completed a further evaluation to measure their acquired learning. Across all courses delivered during the period there was an average increase of 34% in the level of knowledge from 'little' or 'moderate' at the time of application to 'good' or 'significant' at the end of course.

Impact evaluation:
A system to monitor and evaluate the effectiveness of multi-agency training on practice has continued to be utilised. A post course survey designed to determine the impact of the **Child Sexual Exploitation Course** revealed qualitative data suggesting the course had been useful to participants with evidence of increased understanding, awareness and confidence. Some practitioners were able to link their learning to improved outcomes for young people which included protecting a child who had been sexually abused by her father and one-to-one work with 3 vulnerable young girls. Some participants had also worked with other family members to offer support and guidance. Several had gone on to provide training, information and advice to other relevant parties both in the workforce and in the community. Spreading the word and disseminating information increases the likelihood of vulnerable young people finding suitable help. The system of impact evaluation based on the 'Kirkpatrick Model' has proven to be a valid and reliable model and needs to be developed to cover more courses on the programme. This will be a priority for the current year and a further course, **Safeguarding Children where there is Neglect (including the Graded Care Profile)**, is subject of the system at the time of writing.

5.3 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

QAPM has developed a new key performance indicator set to oversee the performance of key agencies that work with children and young people.

QAPM members have conducted a number of multi-agency audits including; self-harm, neglect, early help and sexual abuse. These audits produced a series of recommendations for agencies to improve practice within their services. For example Children Social Care has provided assurance that the Child in Need procedures are now being applied and audited more robustly, Information Sharing guidance has been reviewed and multi-agency chronology guidance has been developed, and Children's Social Care are now attending the Healthy Young Minds Single Point of Entry meetings. There is a need to make practitioners more aware of the necessity of gaining consent to share information when providing additional support outside of a statutory framework such as the CAF. It is also important for practitioners to give greater consideration to historical information in order to understand the root causes of a child's presenting issues so that they can be tackled in the most effective manner.

QAPM faces challenges around evaluating the effectiveness of partners safeguarding practice, ensuring actions impact on frontline practice and ensuring actions from audits have been implemented by individual agencies.

2018/19 sees an opportunity for QAPM to improve its effectiveness during the transition between the current Tameside Safeguarding Children Board to the new Partnership arrangements.

5.4 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 strategic 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

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

- Family Justice Board
- Corporate Parenting Panel
- Child Death Overview Panel
- Youth Justice Board
- Educational Attainment Board
- Emotional Health and Well-Being 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.

5.5 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 2017/18 the SSCP considered 2 referrals of which neither met the criteria for a case review. The National Serious Case Review Panel agreed with all of the TSCBs decisions.

The final report for Child U was completed in July 2017 and the Panel has focused its efforts on delivering the learning and recommendations from that review and the CSE Systems Review. They included a separation of the Children Social Care and Phoenix roles so that the CSC Social Worker

managed the Child Protection or Child in Need process while the Phoenix Social Worker provided the specialist support required. A revised CSE Joint Working Protocol and Missings Protocol has been developed which clarifies the referral, allocation, assessment and case management processes. An online directory of support services for those at risk of CSE and a network of CSE Champions have been created to ensure that risks are identified and dealt with at the earliest opportunity.

The Serious and Significant Case Panel has continued to deliver the actions from the Child R, S and T case reviews, all of which are now complete. This has meant that a pre-birth assessment protocol has been developed including a learning disability pathway to ensure joined up assessments and intelligence are identifying and meeting the needs of vulnerable and at risk parents, multi-agency training on chronologies has been delivered to partner agencies, learning disability resources have been promoted and parental responsibility guidance has been disseminated to all schools. 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 few 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.

6. Local Demographics and Needs

6.1 Tameside's Population

Tameside is one of ten Local Authorities based in Greater Manchester. Tameside's 0-17 year old estimated population is 49,645 (Office National Statistics, 2018). This is 7.8% of the Greater Manchester's 0-17 year old population.

Table 2: Tameside's population by age band 0 to 24.

	0to4	5to10	11to16	17	0to17	18to19	20to24
Tameside	14,664	17,424	15,073	2,484	49,645	4,843	12572

Source: Office National Statistics, 2018

The ethnic diversity of Tameside's population has changed. The proportion of Tameside who classified from a BME as increased from 7.4% (2001) to 15.8% (2011).

In 2017, 2875 live births were recorded within Tameside geographical boundaries. The number of births to 15-17 year olds is higher in Tameside 26 per 1,000 compared to England 19 per 1,000.

6.2 Deprivation within Tameside

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

The average house price in Tameside as increased from £136,400 (June 2017) to £144,200 (June 2018). However, it is still well below the national house price is £245,076 (June 2018)

Data from: https://www.gov.uk/government/publications/uk-house-price-index-england-june-2018/uk-house-price-index-england-june-2018

6.3 Children receiving social services support

The number of children with a child protection plan and LAC status continues to increase in Tameside. The rate per 10,000, suggest Tameside is an outlier in Greater Manchester, Statistical Neighbours and Nationally. The Improvement Plan was revised towards the end of 2017 and include detailed plan to address this trend with several actions in place including development and implementation of Strengthening Families Child Protection Conference process and Signs of Safety model of practice. This is beginning to be effective and the number of Children on Protection Plans is reducing. We are also now beginning to see stability and reduction in the number of Children Looked After through our Edge of Care and Early Help work to ensure that children only become looked after when necessary and there is an active permanency plans for those children.

We are seeing more LAC being placed over 20 miles away from home and outside of Tameside geographical boundaries. However, we see 374 LAC being placed within Tameside geographical boundaries from other local authorities. We have developed a new sufficiency strategy and increased capacity in our placement commissioning team to strengthen procurement and commissioning arrangements so that we maximise the use of available placements within the borough. We have also launched the residential provider forum to strengthen opportunities for Tameside children to be looked after in Tameside.

(ii) Table 3: Child Protection Plan

	2014/15	2015/16	2016/17	2017/18
Number of children on CP plan	212.0	220.0	370.0	473.0
Rate per 10,000 on CP plan	44.0	45.0	76.0	94.0

(iii)Table 4: Looked After Children (LAC)

	2014/15	2015/16	2016/17	2017/18
Looked After Children (No.)	417	423	509	625
Looked After Children (Rate)	85	87	105	127

	2014/15	2015/16	2016/17	2017/18
Looked After Children Placed 20+ miles out from their home (out of Tameside)	4%	6.1%	8.40%	10.10%
Looked After Children placed inside geographical boundaries from other LAs			380	374

The number of LAC placed in residential settings has reached over 100 for the first time.

	2014/15	2015/16	2016/17	2017/18
LAC placed in residential settings	63	53	75	108
LAC in Fostering	289	299	360	424

6.4 Injuries to Children

It is important to understand of rate of injuries to children to judge whether we are safeguarding children well.

Hospital admissions caused by injuries in children (0-14 years) was 635 per 10,000 (2016/17). This was rated as significantly worse than England by Public Health England (https://fingertips.phe.org.uk). As part of Tameside's Healthy Child programme staff routinely cover child safety as part of routine developmental reviews and Emergency Department staff regularly cover prevention when children attend with injuries.

Hospital admissions as a result of self-harm (10-24 years)was 181 per 10,000 (2016/17). This was rated as significantly worse than England by Public Health England (https://fingertips.phe.org.uk). Healthy Young Minds Tameside and Glossop has revised its care pathway and this will be introduced from April 2018. The pathway is informed by a number of psychological theories to ensure that the service supports children and young people and their networks at the various stages of their emotional development and needs. Children are being routinely and appropriately referred for support when they present acutely at Tameside Hospital.

7. Children's Hub

7.1 Number of Contacts and Referrals

Tameside's Hub recorded 13,587 contacts in 2017/18. This was similar to the number of contacts received in 2016/17 (13,205).

The number of referrals has increased from 3,487 (2016/17) to 4,481 (2017/18). The conversion rate from contact to referral is 33%. Rates of referrals per 10,000 are higher in Tameside compared to Statistical neighbours and England.

(Source: Whole Service Data Booklet June 2018)

There has been a peak in the conversion of contact to referrals in 2017/18 compared to 2016/17. The Ofsted inspection back in September 2016, noted that there was inconsistency's in the threshold application across the partnership and work has been undertaken to address this, which may be an influencing factor within the increased conversation rate. The other factors that has contributed to the increase rate is that services are increasingly effective at identifying higher level need within the community therefore a greater percentage of contacts are of higher level of need, which may include higher levels of identification of Domestic Violence given we have the Team manager based at Ashton Police Station for the purpose of triage with police. There is lower tolerance of risk with greater scrutiny being placed on marginal level of need contacts and therefore referrals increasingly are made to CSC.

We have commenced the implementation of a MASH in Tameside and partner agencies are keen to buy in to this way of working. We have also strengthened our Early Help offer to ensure that our families receive the right support at the right level.

7.2 Assessment

Once the referral to social care has been made it is important to undertake an effective assessment of the child and families needs.

The number of child and family assessments reported in 2017/18 was 5515. The proportion of assessments completed within 45 days has improved from 70% (2016/17) to 82% (2017/18).

(Source: Whole Service Data Booklet June 2018)

Tameside is performing above statistical neighbours' performance. In response to the increase in contacts and referrals, and in line with the Improvement Plan, we have increased the capacity within the Duty Teams. We have further strengthened management oversight in respect to allocation and direction; inclusive of internal 10 day reviews which led to improved quality and timeliness of assessments.

8. SPECIFIC RESPONSIBILITIES UNDER WORKING TOGETHER (2015)

8.1 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
2014/15	22	106	128
2015/16	26	120	146
2016/17	23	136	159
2017/18	29	160	189

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	46
Early Years	21
Other LADO	0
Children's social care	46
Police	14
OFSTED	8
Other	51

(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	2017/18
Health	10	7	7	6	6
Education	26	46	55	50	60
Early Years	11	24	16	21	35
Residential	14	17	22	37	40

Children's social care			**3**	**1**	**6**
Police	**4**		**1**	**2**	**2**
Foster carers	**16**	**14**	**18**	**20**	**16**
Other	**17**	**20**	**4**	**23**	**24**

The rise in referrals in education, early years and residential care settings is due to the LADO work promoting their role and developing good working relationships with managers in those settings.

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 29 cases which progressed to an initial consideration meeting were in respect of the following agencies:

Foster carers – 4
Education – 7
Residential care workers – 3
Early Years – 4
Health – 2
Other – 9 including faith group, voluntary sector etc.

The cases were in respect of the categories of abuse:

1– Neglect
10- Physical abuse
10 – Sexual abuse
1 – Emotional abuse
7 – Risk of harm

8.2 <u>Child Death Overview Panel (CDOP)</u>

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. There were a total of 47 childhood deaths notified to the CDOP in 2017/18. Since 2007/8 there have now been a total of 614 child deaths across the 3 areas with year on year variations. When the numbers of deaths 2007-2018 across the CDOP are compared to the total under 18 population across the 3 areas of the CDOP the split is Stockport 37.5%, Tameside 29.5% and Trafford 33%.

Cases can only be closed when all other processes such as Inquests, criminal investigations and Serious Case Reviews have concluded. In closed cases over the previous 3 years 2014-2017 saw an increase year on year in deaths under the age of 1 from 55% to 77%. In 2017/18 there was a slight drop to 66% of deaths being children under the age of 1. There continues to be a significant proportion of these children being 27 days old or less. In Stockport 66% of the deaths under 1 year of age were 27 days old or less. In Tameside this figure was 89% and in Trafford it was 92%. This is an average for 2017/18 across the CDOP of 82%. This percentage has increased year on year from 37% in 2014/15. 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, high maternal BMI (30+) and to a lesser extent drug and alcohol abuse.

Since 2009 both Tameside and Trafford have a higher percentage of deaths in the BME population than might be expected when set against the population percentages.

In 2017/18 the CDOP identified 1 SUDI case which was in Tameside. Across GM as a whole there were 19 cases and although there has been a reduction in the number of SUDI cases in the percentages have remained fairly consistent between 7-10% of total closed cases. In the local case the modifiable factors were around parental smoking and co-sleeping. In 2016/17 each area had 1 case of SUDI although none involved co-sleeping. The common features across GM were that parents smoked and/or had been co-sleeping with their child in bed or on a settee. Research shows that the North West and Wales have the highest rate of sudden unexplained deaths in England and Wales.

In 2017/18 a total of 58 cases were closed by the panel. Of those, 27 (47%) were identified as having modifiable factors. This is higher than in previous years and is also higher than the average for Greater Manchester (40%). In 2016/17 the figure for the CDOP area was lower than in previous years at 21%.

Where modifiable factors are identified consistent features are smoking by mothers in pregnancy, high maternal BMI or smoking by parents where the infant is vulnerable due to age or medical condition.

Tameside Safeguarding Children Board

APPENDIX A

TSCB Membership 2017/18

Agency	Name	Title	TSCB Role
	Gill Frame	Independent Chair	Independent Chair
TMBC/T&G CCG	Steven Pleasant	Chief Executive	Member
TMBC - People	James Thomas	Executive Director	Member
TMBC - People	Gani Martins	Assistant Executive Director	Member
TMBC - Stronger Communities	Emma Varnam	Assistant Executive Director	Member
Education	Bob Berry	Assistant Executive Director	Member
Secondary Schools	Alan Harrison	Head Teacher	Member
Colleges	Leon Dowd	Vice Principal	Member
Community Rehabilitation Company	Beverley Cogan 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	Interim Delivery Improvement Director	Member
NHS Tameside and Glossop Clinical Commissioning Group	Gill Gibson	Director of Safeguarding and Quality Assurance	Member
Tameside Hospital	Pauline Jones	Chief Nurse	Member
Greater Manchester Police	Jane Higham	Super Intendent	Member
NHS Tameside and Glossop CCG	Christina Greenhough	CCG clinical lead and GP	Member
TMBC Councillor	Jim Fitzpatrick	Lead Member for Children and Families	Observer
Children's Services	Ged Sweeney	Head of Service - Safeguarding	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
Tameside Safeguarding Children Board (TSCB)	Stewart Tod	TSCB Business Manager	Advisor

Tameside Safeguarding Children Board

APPENDIX B TSCB Membership Attendance 2017/18

Key:	
	75% attendance and above (Expectation)
	Between 50% and 74% attendance
	49% attendance and below

Agency	Title	TSCB Role	Agency Attendance	Named person attendance
Independent Chair	Independent Chair	Independent Chair	100%	100%
TMBC	Chief Executive	Member	50%	50%
TMBC - People	Executive Director	Member	67%	67%
TMBC - People	Assistant Executive Director	Member	50%	100%
TMBC - Stronger Communities	Assistant Executive Director	Member	17%	17%
Education	Assistant Executive Director	Member	100%	100%
Secondary Schools	Head Teacher	Member	50%	100%
Colleges	Vice Principal	Member	50%	50%
Community Rehabilitation Company	Community Director	Member	17%	17%
National Probation	Head of Stockport and Tameside NPS	Member	67%	0%

Service (NPS)				
CAFCASS	Service Manager	Member	67%	17%
Community and Voluntary Action Tameside	Chief Executive	Member	33%	0%
Pennine Care NHS Foundation Trust	Service Director	Member	33%	0%
Public Health	Director of Public Health	Member	83%	0%
NHS England	Interim Delivery Improvement Director	Member	0%	0%
NHS Tameside and Glossop Clinical Commissioning Group	Director of Safeguarding and Quality Assurance	Member	100%	100%
Tameside Hospital	Chief Nurse	Member	83%	17%
Greater Manchester Police	Super Intendant	Member	100%	75%
TMBC Councillor	Lead Member for Children and Families	Observer	50%	40%
Children's Services	Head of Service - Safeguarding	Sub Group Chair and	100%	100%

		Member		
NHS Tameside and Glossop CCG	Designated Doctor Safeguarding	Sub Group Chair and Advisor	100%	100%
NHS Tameside & Glossop CCG	Lead Designated Nurse Safeguarding	Sub Group Chair and Advisor	100%	100%
TMBC Legal Services	Principal Solicitor	Advisor	33%	33%
Tameside Safeguarding Children Board (TSCB)	TSCB Business Manager	Advisor	83%	83%

Tameside Safeguarding Children Board

APPENDIX C

TSCB FINANCIAL SUMMARY 2017/18

INCOME/CONTRIBUTIONS 2017/18	
Tameside Council contribution	£123,330
School/Academies	£82,735
Clinical Commissioning Group	£134,700
Other contributions inc. Police, New Charter, NPS, CRC & CAFCASS	£16,240
Training Charges & Contributions	£11,820
Total Contributions 2017/18	**£368,825**

Account Code Description	Actual Spend 2017/18
Staffing costs	-£187,570
TSCB General	-£172,975
Training Strategy	-£12,890
Serious Case Review	-£20,370
TOTAL EXPENDITURE	**-£393,805**

FINANCIAL RESERVE 2017/18	
Headings	**2017/18**
Funds from 1 April 2017	£127,98
Total Expenditure in excess of income	-£24,991
Balance in Reserve 31/03/18	**£102,996**

Tameside Safeguarding Children Board

APPENDIX D

TSCB BUSINESS & IMPROVEMENT PLAN 2018/19

1. BUSINESS PLANNING & DEVELOPMENT

OFSTED RECOMMENDATION

* Urgently review the Board priorities and update its business plan to include concerns about front line practice and service deliver at all level
* Include in the Board's annual report an evaluation of the impact of safeguarding practice upon children's wellbeing and safety
* Establish effective links with the corporate parenting strategic group and family justice board

Objective	Difference it will make	Timescale	Responsibility	Direction of Travel	Comments
1.1 Establish governance arrangements of strategic partnerships and align safeguarding agendas	Accountable Strategic Partnerships work together to ensure the effectiveness of safeguarding arrangements	Aug-18	DCS		
1.2 Produce TSCB Annual Report	Impact of safeguarding practice and Board activity is evaluated. Priority and emerging themes are identified and addressed via TSCB Business Plan	Sep-18	TSCB Strategic Board		
2. ENABLING EFFECTIVE SERVICE DELIVERY					
Objective	**Difference it will make**	**Timescale**	**Responsibility**	**Direction of Travel**	**Comments**
2.1 Implement recommendations from the CSE Systems Review	Children at risk of CSE are protected from harm and provided with the appropriate level of support. Perpetrators are disrupted or prosecuted.	Jul-18	CSE & Missing Sub-Group		
2.2 Deliver TSCB Training Programme	Children's workforce have the	Mar-19	LIAG		

2018/19 in accordance with the identified needs of the multi-agency workforce	confidence and knowledge to identify and respond safeguarding concerns				
2.3 Undertake regular case reviews and identify areas for improvement	Lessons are learned from case reviews and lead to improved practice	Mar-19	SSCP		
2.4 Develop and revise safeguarding policies as required	Children's Workforce have the guidance and processes they need to safeguard children effectively	Mar-19	GM Tri-X Group		
2.5 Communicate learning and good practice to partner agencies	Lessons learned lead to improved practice	Mar-19	LIAG		
2.6 Develop a Multi-Agency Practitioner Forum	Children's Workforce propose and develop solution to improve frontline practice	Aug-19	QAPM		

3. ENSURING COMPLIANCE AND QUALITY

OFSTED RECOMMENDATION

*Establish a programme of sufficient multi-agency and single-agency audits

* Evaluate the application of thresholds

* Improve understanding and informed challenge underpinned by the development of an integrated multi-agency dataset

Objective	**Difference it will make**	**Timescale**	**Responsibility**	**Direction of Travel**	**Comments**
3.1 Deliver an agreed Multi-Agency Audit schedule	Multi-agency safeguarding practice is effective or areas for improvement are identified	Mar-19	QAPM		
3.2 Deliver an agreed single-agency audit schedule	Single-agency safeguarding practice is effective or areas for improvement are identified	Mar-19	QAPM		

3.3 Agree new format and reporting mechanism for multi-agency dataset	Effectiveness of service delivery against Board priorities, Hub and Duty arrangements are monitored. Consistent application of Thresholds means children receive the support they need when they need it	Apr-19	QAPM		
3.4 To regularly seek assurance from strategic partnerships that their work is addressing strategic priorities and safeguarding children effectively	Safeguarding arrangements and practices are scrutinised and continually improved	Mar-19	TSCB Strategic Board		
4. CAPTURING THE VOICE OF THE CHILD					
OFSTED RECOMMENDATION *Re-establish effective methods of ensuring the views of children influence the service planning needed to deliver TSCB priorities and plans					
Objective	**Difference it will make**	**Timescale**	**Responsibility**	**Direction of Travel**	**Comments**
4.1 Develop and deliver the Voice of the Child Strategy	Partner agencies implement the 'Statement of Expectations'	Mar-19	TSCB Strategic Board		
4.2 Build regular service user feedback sessions into performance management framework and quarterly reports	Children and parent/carers feedback their experiences of service provision and inform future planning and service improvement	May-18	QAPM		
4.3 Collate evidence of partners gathering, and responding to, the views of children via the S.11 audit	Partner agencies routinely gather feedback from children and use it to improve service delivery	Jul-18	QAPM		
5. RESPONSE TO STRATEGIC PRIORITIES AND EMERGING NEED					
Objective	**Difference it will make**	**Timescale**	**Responsibility**	**Direction of Travel**	**Comments**
5.1 TSCB will ensure the Neglect Strategy is embedded into frontline practice	Neglect is identified at the earliest opportunity and responded to at the appropriate level of the Threshold	Jul-18	Board Members		

	Guidance				
5.2 TSCB support the implementation of the Early Help Strategy	Families receive the support that they need at the earliest opportunity	Dec-18	Via the Early Help Strategy Group		
5.3 TSCB and Strategic Partners develop and implement a governance structure for Complex Safeguarding	Tameside has a clear service response and reporting mechanism for all elements of Complex Safeguarding	Sep-18	DCS		
5.4 Review transitional arrangements from Children to Adult Service provision	Vulnerable adults 18-25 receive the continued support they need	Nov-18	TSCB & TASPB		