Oldham
Local Safeguarding Children Board

OLDHAM LOCAL SAFEGUARDING CHILDREN BOARD ANNUAL REPORT

2017-18

This Annual Report is a public document.

It can be accessed on the website of Oldham Local Safeguarding Children Board:

https://www.oldham.gov.uk/lscb/info/1/about_the_board

Approved by Oldham LSCB on 25 October 2018

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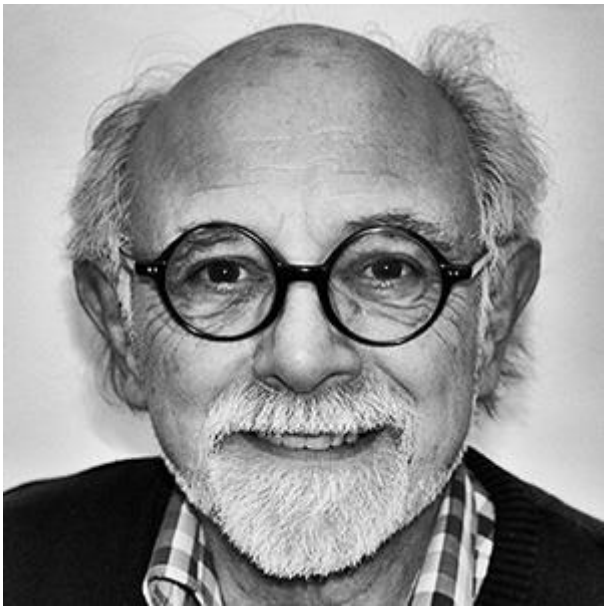
Foreword



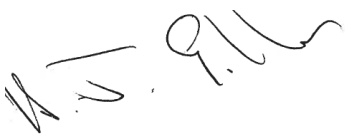
Welcome to the 2017-18 annual report from the Oldham Local Safeguarding Children Board. The report overviews the activities of the Partnership over the 12 month period and also marks the end of the three year business strategy of the Board which has been progressed since 2015. Both aspects merit comment.

With respect to the 12 month period, clearly the Partnership has been fully occupied progressing a range of key and current safeguarding issues, reaching into the diverse communities in Oldham to communicate the message of the importance of safeguarding children. The reach of the Partnership now clearly extends far beyond the traditional focus of protecting children within intra-familial settings and is exceedingly active in what is termed contextual safeguarding - ie in issues relating to sexual exploitation, peer on peer abuse and the engagement in criminal activity. The ability of the Partnership to be agile in its response to emerging forms of child exploitation will be an important dimension of effective practice in the future

A key characteristic of the partnership's work over the past 12 months has been its ability and willingness to challenge current practice and transparently evaluate its effectiveness. In several critical areas this has led to the Partnership determining that change is required and has put in place processes to change and improve on present performance. On issues such as assessment of safeguarding need, learning from serious case reviews, children missing education and children whose needs will endure through the transition to adulthood work is now on-going to seek significant improvements in performance.

With respect to the impact of the board's three year strategy, clearly the Partnership has matured over time and now has a major role in shaping the safeguarding agenda of its constituent agencies. The changes introduced to the structure of the Board by the strategy – the Executive and the various sub-groups of the Board – have enabled the Board's business priorities to be discharged more effectively and to review and revise safeguarding priorities as new needs emerge.

As the report comments, the future shape of the governance of safeguarding children in Oldham will be the subject of a review during the business year 2018-19. We do not as yet know what that structure will look like or how it will discharge its responsibilities. The current Partners, however, are commited to transparent and participative partnership working across their membership and the continuation of working relationships which effectively safeguard the children and young people of Oldham.



Dr Henri Giller

Independent Chair of Oldham Local Safeguarding Children Board

1 Purpose of the annual report

The purpose of the annual report is to evaluate the effectiveness of the safeguarding arrangements for children and young people in Oldham. This report, which covers the period from April 2017 to March 2018, sets out the effectiveness of the Local Safeguarding Children Board (LSCB) in carrying out its statutory core functions and the progress made against its three year strategy (2015-2018).

Working Together to Safeguard Children 2015 states that,

"The Chair must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area…..The report should provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action. The report should include lessons from reviews undertaken within the reporting period…..The report should be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner and the Chair of the health and well-being board."

1.1 LSCB Statutory Responsibilities

Section 14 of the Children Act 2004 sets out the objectives of LSCBs, which are:

(a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and

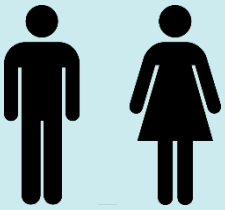
(b) to ensure the effectiveness of what is done by each such person or body for those purposes.

1.2 Oldham LSCB

The Board effectively executes its role by working in partnership with both statutory and non-statutory organisations, all of whom have a role to play in safeguarding children and young people. The Board delivers the following core functions, in addition to key priorities that are identified within the three yearly strategic plan and reviewed on an annual basis:

- Policy and Procedures
- Serious Case Reviews
- Audit and Scrutiny
- Multi Agency Training
- Managing allegations against professionals
- Private Fostering

2 Oldham's Context

If Oldham had 100 Children and Young People	
51 would be boys, **49** would be girls 	**56** would be White British and Irish. **19** would be Pakistani Asian and **14** would be Bangladeshi Asian. **1** child would be Black, at least one of whom would be Black African.
4 would be Children in Need. Less than **1** would be Looked After and less than **1** would be subject to a Child Protection Plan	Less than **1** would be at risk of Child Sexual Exploitation.
27 would be living in poverty, even before any housing costs are taken into consideration.	**20** would be living in workless households.
15 would have a special educational need. **3** would have an Education, Health and Care plan, most probably for Speech, Language and Communications Needs.	**18** would be eligible for free school meals 
Out of 10 children in reception, ***1*** would be obese and ***2*** would be overweight. Out of 10 children in Year 6, ***2*** would be obese and ***3*** would be overweight.	Out of 5 five year olds, ***1*** would have one or more decayed, filled or missing teeth.

3 National and Regional Context

Working Together and new safeguarding arrangements

Following Alan's Wood review of Local Safeguarding Children's Boards (May 2016), the Children and Social Work Act 2017 includes the following recommendations arising from the review:

- A new model of accountability for safeguarding children, placing equitable responsibility on three safeguarding partners: Local Authority, Police and Health. This including a duty on these partners to work together and with any relevant agencies identified with a role in safeguarding and promoting the welfare of children
- A new system of local and national reviews which will replace Serious Case Reviews
- Transfer of responsibility for child death policy from Department for Education to Department of Health.

Oldham LSCB took part in the national consultation in relation to the new Working Together guidance, which is due to be published in Spring 2018 and have started discussions locally and across Greater Manchester about the new safeguarding arrangements for Oldham.

The proposed arrangements and subsequent implementation will be a key focus for the Board in 2018/19.

Police and Crime Plan

In May 2017 Greater Manchester elected Andy Burnham as the Mayor with responsibility for the work of the Greater Manchester Combined Authority (GMCA). The Mayor also supports the work deputy mayor for policing and crime who in June 2017 was announced as Baroness Beverley Hughes.

Following the broadcast of the "Three Girls" documentary in July 2017 which documented the story of child sexual exploitation in Rochdale the Mayor's office commissioned an independent review into Greater Manchester's response to Child Sexual Exploitation. Oldham LSCB is involved in this assurance exercise alongside other Greater Manchester LSCBs.

The Police and Crime Plan, "Standing Together" was launched in March 2018 and identifies three key priorities: 1. Keeping people safe, 2. Reducing harm and offending and 3. Strengthening communities and places. Priority 1 identifies safeguarding children as a key area of focus for 2018, and specifically transitions, complex safeguarding, missing children, female genital mutilation and so called honour based abuse.

All of these areas are echoed as priority areas for Oldham LSCB over the next three years.

4 LSCB Core Business

4.1 Policies and procedures

Oldham LSCB continues to support the development and revision of Greater Manchester Safeguarding policy and procedures which are reviewed by the Greater Manchester policy and procedures subgroup three times per year. These can be accessed via the LSCB website. The chair of Oldham's policy and procedures subgroup along with the LSCB business manager are members of the Greater Manchester subgroup ensuring that professionals in Oldham are instrumental in the refresh of policies and procedures. Oldham's policy and procedures subgroup has also agreed to lead on the review of the Greater Manchester pre-birth assessment policy following learning obtained locally from Serious Case Reviews.

Within Working Together 2015 it states that,

"Local authorities, with their partners, should develop and publish local protocols for assessment. A local protocol should set out clear arrangements for how cases will be managed once a child is referred into local authority children's social care and be consistent with the requirements of this statutory guidance."

The policy and procedures subgroup of the LSCB lead on the refresh on Oldham's local assessment protocol during 2017-18 ensuring that the document offers clarity for both practitioners and members of the public. The refreshed document is available on the LSCB website.

A key area for improvement identified within a number of serious case reviews and multi-agency audits has been a lack of professional challenge and escalation from partner agencies. In order to strengthen this partner responsibility the group updated and recirculated the escalation policy, tightening the timescales and providing clarity about the requirements at each stage of an escalation. This is being supported by the development of multi-agency training which is being developed by the Board's training subgroup. In order to evaluate the impact of the refreshed policy and newly developed training the Board manager has created an escalations spreadsheet which will allow the LSCB Executive Board to review the number and type of escalations being raised by agencies in Oldham.

Following the completion of the Thematic Review by the Serious Case Review Subgroup (more detail of which can be found in Section 4.2.1) it was noted that

recurrently assessments lacked professional curiosity and were not holistic in their approach. As a result the group developed a recommendation for the Board that a multi-agency model of assessment needed to be explored. The policy and procedures subgroup agreed to lead on this piece of work which coincided with Children's Social Care's exploration of a new social work model. An options analysis of different models was presented to the group by the Principle Social Worker and Signs of Safety was

agreed as the preferred model. The group are supporting the introduction of Signs of Safety to ensure that there is multi agency buy in from an early stage.

What impact has this work had?

- There has been a notable increase in the number of escalations from partner agencies, all of which have been resolved before requiring the Board's intervention.
- An escalation relating to Fabricated or Induced Illness lead to a review of local procedures by Children's Social Care and Clinical Commissioning Group.
- The multi-agency approach to the introduction of Signs of Safety will ensure that partners are fully engaged in this approach leading better co-ordinated, more holistic responses to children and families.

4.2 Learning and Improvement

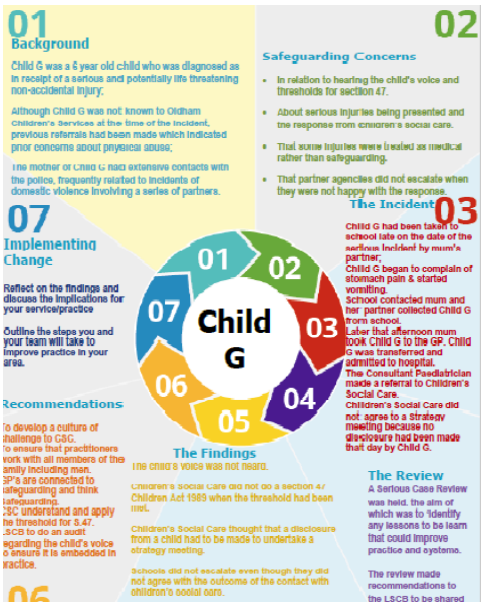
This is a key function of the LSCB and Oldham perform this statutory duty in the following ways:

- Serious Case Reviews
- Multi Agency Concise Reviews
- Multi Agency Training
- Child Death Reviews (Child Death Overview Panel)

4.2.1 Serious Case Reviews

During 2017-18 Oldham LSCB published two Serious Case Reviews on Child G and Child H. Both reports can be found on the LSCB website.

Child G

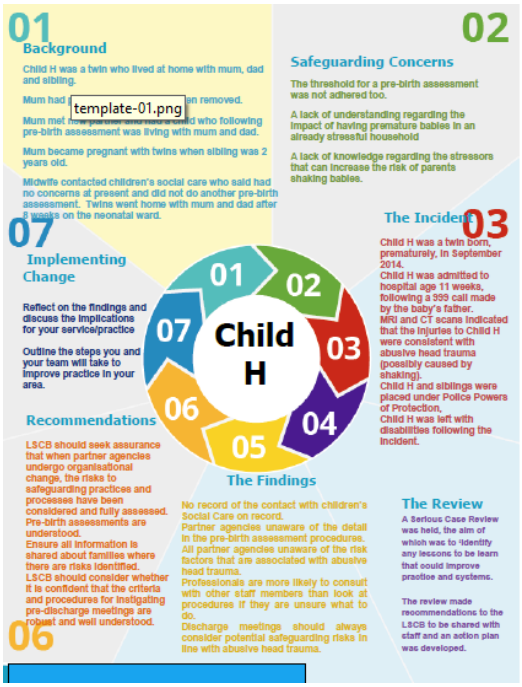


The review into Child G found that his voice was unheard by a range of professionals and that the threshold criteria for Section 47 was not applied. This meant that a comprehensive assessment, considering other agency information, historical risk factors and the male within the family home, was not completed. The review noted that information wasn't shared appropriately between health and social care colleagues leading to safeguarding concerns not being followed up. The reviewer did find that the paediatrician pursued the referral until she received a satisfactory outcome however also noted that other agencies failed to challenge or escalate their concerns relating to Children's Social Care decision making.

The recommendations arising from the review into Child G resulted in the following actions:

- An audit was undertaken into the application of thresholds by Children's Social Care, which found that from 83 cases audited at random only one was deemed to have been closed early when it was clear that the threshold for assessment had been met. A further 7% of the cases that had been identified as requiring further assessment could have been stepped down to Early Help at the front door meaning that the right support would have been offered to the family at an earlier stage. Training has been provided to staff in the Multi Agency Safeguarding Hub (MASH) and ongoing audits of thresholds continue to be undertaken by the Service Manager.
- A section has been added to the LSCB's multi agency case evaluation template to ensure that the voice of the child is audited during the Board's audit work.
- Training has been provided to GPs and Pennine Acute professionals to reflect on the need to share information appropriately, follow up on safeguarding concerns and to take definitive action where concerns remain unresolved.
- Multi Agency training has been updated to reinforce the need for professionals to consider males within the family when undertaking an assessment.
- The Board's escalation policy has been reviewed and relaunched amongst professionals. The Board manager has introduced a process to monitor escalations and report directly into the LSCB Executive Board regarding emerging themes.
- Multiagency workshops on Voice of the child and lived experience have been delivered.

Child H



The review into Child H found that there was a lack of understanding amongst professionals about the stressors that can increase the risk of parents shaking their babies, particularly within an already stressful household. Pre-birth assessments procedures were not followed despite the fact the threshold had been met and the reviewed identified that the procedures were not fully understood by professionals.

Practitioners admitted that they would often consult colleagues if they were unsure of a procedure rather than accessing the Greater Manchester Policies and Procedures, resulting in incorrect or out of date guidance being provided.

The incident took place during a period of significant organisational change for Children's Social Care which had resulted in a number of contacts in relation to this case not being recorded on the case management system meaning that historical information was not considered in professional's decision making.

Finally there reviewer noted that a pre-discharge meeting was not held prior to the child being returned home which meant that the only plan in place was a referral to neo-natal outreach services.

As a result of the recommendations arising from this case:

- Workshops and audits have been undertaken to improve the knowledge and application of pre-birth assessment procedures.
- All agencies have been asked to provide assurance that staff are signed up to receive notifications relating to GM policy and procedures.
- An appropriate system has been established for Health and Social Care to record if a child has been subject to a child protection plan previously

- The LSCB continued to receive regular updates relating to the implementation of the Multi Agency Safeguarding Hub (MASH) in order to ensure that any implications for safeguarding were able to be considered in a multi-agency forum.
- Partner agencies will now submit reports to the LSCB when undergoing any organisational change that may impact on safeguarding arrangements and practice.
- Special Circumstances Forms have been reviewed and confirmed to be robust in terms of highlighting the need for early help processes
- The Importance of discharge planning & SCR findings has been fed back to Midwifery, Neonates & Paediatric staff and Lessons Learned Bulletin circulated
- The Board has received a presentation from the Assistant Director of nursing and agreed to support a pilot project relating to Abusive Head Trauma alongside other Greater Manchester LSCBs.

What impact has this work had?

- ❖ Evidence from the multi-agency case evaluations has indicated that agency's reflections of the child's voice is improving.
- ❖ There has been an increase in the number of escalations being raised by professionals evidencing improved challenge across the partnership
- ❖ Development of safeguarding supervision across Midwifery and Neonatal teams

A workshop to cascade the learning from both reviews was held in April 2017.

Thematic action plan

The Serious Case Review subgroup also undertook a thematic review of six previous serious case reviews, two multi agency concise reviews and two multi agency case evaluations in order to identify recurrent learning themes and recommendations. The group highlighted the following themes that were consistent in most, if not all of the above documents:

1. **Domestic Abuse:** Six of the eight reviews had domestic abuse as a significant feature. Presenting issues related to information sharing and management of notifications of domestic abuse; unclear and inconsistent pathways for the multiagency management of domestic abuse. The SCR subgroup identified the need to develop a clear pathway for children and families experiencing domestic abuse.
2. **Voice of the child**: In all cases the child's voice and lived experience was not strong. Failing to incorporate and triangulate all information available in a meaningful way to meet the needs of children. The SCR subgroup identified the

need to strengthen the voice of the child and their lived experience in assessments in order to develop plans that recognise and meet their needs.

3. **Application of thresholds**: Several cases identified inappropriate application of thresholds at the "front door" to social care, followed by lack of challenge and appropriate escalation from partner agencies. The SCR subgroup identified the need to confirm appropriated thresholds are being applied to referrals and all agencies are confident to challenge and escalate concerns if they feel thresholds are not being applied correctly.
4. **Vulnerabilities in pregnancy:** In four out of the six Serious Case Reviews babies under one year of age sustained serious non accidental injuries. The SCR panel identified that vulnerabilities during pregnancy are not being fully recognised in order to plan to reduce risk of harm to the baby when born.
5. **Professional curiosity:** Assessments lacked professional curiosity, thereby missing information on household members and wider community issues, and consequently did not always recognise escalating risk. The SCR panel identified that new approaches and contributions to holistic assessments is needed.
6. **Workforce competency:** The review identified on occasions the skills/competency of the workforce did not always match the complexity and needs of the families they worked with. The SCR panel identified that there needs to be competency and supervision frameworks to support frontline practitioners.

The review led to the development of the thematic review action plan which is overseen by the LSCB Executive Board. Actions have been tasked to relevant subgroups of the Board.

4.2.2 Multi Agency Concise Reviews

The Board also concluded two Multi Agency Concise Reviews which were commissioned following two serious incidents of peer on peer violence.

Both reviews were undertaken independently but identified significant similarities in relation to the perpetrators in these cases. These included a history of domestic abuse, an association with criminality either within the family or the community, displays of harmful attitudes and behaviours and a disturbed school history including multiple exclusions.

One of the reviews identified that whilst parents were aware of some of the behaviours; their influence over the children's behaviour was eclipsed by the influence of their peers. Furthermore reviewers noted that, in the case of the victim who was bullied over a two year period, his behaviour wasn't attributed to being the response to being bullied.

These two reviews were instrumental in Oldham's consideration of the multi-agency understanding and response to Contextual Safeguarding and led to the introduction of

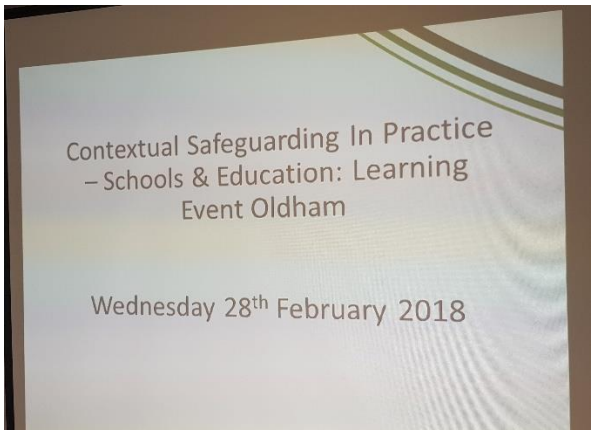
a peer on peer abuse task group to support the implementation of the reviews' recommendations.

As a result of the reviews the following work has been undertaken:

- Mandatory Board member training relating to Contextual Safeguarding was delivered by Dr Carlene Firmin from the University of Bedfordshire
- Missing from Education guidance has been reviewed to ensure that bullying is a consideration when undertaking an assessment regarding truancy and disengagement with education
- Mapping exercise has been undertaken to identify services for troubled teens
- A peer on peer pathway has been developed to support the identification and information sharing of young people involved in peer on peer abuse and to ensure that any assessments of this kind of abuse consider the contextual factors associated with it.
- Development of a domestic abuse training framework for professionals to ensure that staff are receiving the right level of training for the function and level of involvement

As a result of the work that Oldham LSCB has been undertaking in this area of Safeguarding the Board were asked to host the Contextual Safeguarding Network's "Contextual Safeguarding in Schools" conference in February 2018 which was a launch of the Network's "Beyond Referrals" toolkit. The event was well attended by Oldham schools, academies and colleges as well as professionals from other local and national organisations.

Following on from this event three schools within Oldham agreed to pilot the Harmful Sexual Behaviours audit tool, supported by the LSCB team.



What impact has this work had?

- ❖ Agencies have an greater understanding of peer on peer abuse
- ❖ A clearer pathway for agencies to address concerns relating to contextual safeguarding at the earliest opportunity

4.2.3 Multi Agency training

The multi-agency training calendar is refreshed on an annual basis by the training subgroup of the Board. The calendar is underpinned by learning from reviews and case evaluations and continues to offer a diverse menu of safeguarding topics to support practitioners in achieving excellent practice.

During 2017-18 the LSCB delivered extensive training to 1040 professionals across a range of statutory and voluntary sector organisations. Feedback from training courses indicates that the training is very highly regarded and appears to provide clear evidence of learning transfer which is reflected in practice and outcomes for children and families. The training subgroup has developed qualitative means of evaluating the impact of training which will be applied to three courses, chosen by the subgroup each year. The group have piloted the process with the "Domestic Violence and the impact on children" course, from which there is evidence from both practitioners and managers that the course built confidence and knowledge amongst front line practitioners, improved engagement with victims and families and improved referral pathways into specialist services.

Comments from evaluators included:

"There is clear evidence that attending this training has helped to enhance peoples working practice, clients have benefited from participants referring vulnerable children and victims onto appropriate services, and these include children social care and the IDVA service post course attendance."

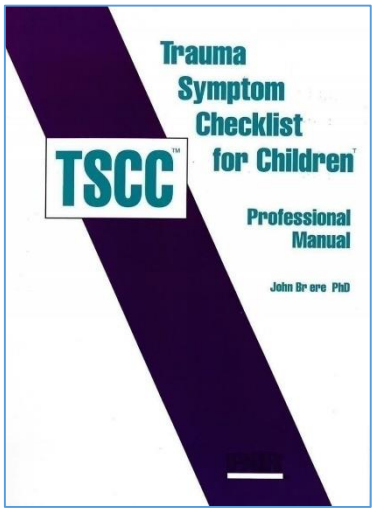
"Children have benefited by people using appropriate tools/techniques to hear and support them. This has led to two disclosures and subsequent appropriate referrals."

During 2017-18 the subgroup introduced short briefing sessions to complement the courses already available. The briefing sessions, which are between one to two hours in length are intended to pick up on emerging themes from audits and reviews, providing a targeted input to a larger number of professionals. The first of the briefings focused on the "Voice of the Child" was delivered in December 2017 and repeated in February 2018. Four sessions in total were delivered to over 150 professionals from a range of partner agencies. A second briefing relating to "Improving the life chances of looked after children" is planned for May 2018.

The LSCB training consultant has begun to develop training frameworks in order to ensure that professionals are able to access the correct level of training for their job requirements. The first framework will focus on Domestic Abuse and will signpost professionals to the courses within the Multi Agency calendar that have been identified as required to support their specific professional development. It is also intended to

develop similar frameworks relating to neglect, peer on peer violence and engagement with families.

The training subgroup are leading on a pilot project of the Trauma Symptoms Checklist for Children (TSCC).



The Trauma Symptoms Checklist for Children (TSCC) developed by ***Briere, 1996*** is a 54-item self-report scale intended for use in assessing trauma related symptoms and has six clinical scales (anxiety, depression, anger, post-traumatic stress, dissociation sexual concerns).

The checklist is designed to be used with children and young people who have experienced traumatic events, including childhood physical and sexual abuse, victimisation by peers (i.e. physical and sexual assault), major losses, the witnessing of violence done to others and natural disasters.

The child is presented with a list of thoughts, feelings and behaviours and is asked to mark how often each thing happens to him/her. Items are rated on a 4 point scale (from 0-never to 3 almost all the time).

Analysed by a clinical psychologist the outcome of the checklist provides professionals with a tailored approach in which to work with and engage a child or young person.

The training subgroup successfully led on a pilot of the TSCC which saw professionals from Children's Social Care, Healthy Young Minds and Youth Justice Service trained to undertake the TSCC with children and young people aged between 8 and 12 years of age who had experienced high levels of trauma.

During the pilot 33 children and young people (10 girls and 23 boys) completed the TSCC.

All staff who undertook the training and completed TSCCs with children and young people unanimously agreed that using a standardised tool helped them to better understand the children's experiences of trauma or distress. The tool enabled them to better advocate for children and by doing this the child's lived experience /voice was heard and validated.

Staff reported an increase in confidence attributed to using the tool and some felt the checklist influenced decision making. This resulted in more appropriate services/ responses and smarter planning being offered.

As supervision is a key element in staff development, effective practice and reflection, staff reported that the use of the TSCC enabled them to have a stronger focus on the direct work they were undertaking with children and young people. It enabled cohesive dialogue focused on the child's needs and provided a positive outcome in terms of next steps and appropriate interventions .This coupled with the clinical supervision received provided a framework for professional challenge and development.

Following a presentation to the LSCB in September 2017 partners agreed to a further roll out of the TSCC once discussions had taken place with commissioning colleagues

to understand the current therapeutic offer to children and young people in order to ensure that services can meet assessed needs and there is capacity to meet demand.

What impact has this work had?

- Improved means of engagement with children and young people
- Greater understanding of children's needs in relation to trauma
- Improved supervision and management oversight with these cases

4.2.4 Training for schools and education establishments

In addition to accessing the Multi Agency training calendar, maintained schools, academy and college staff also accessed:

- Four Designated Safeguarding Lead (DSL) sessions
- Whole School Training – 42 sessions across 36 schools and academies
- Three Governor Safeguarding Training sessions

The LSCB also delivers safeguarding sessions to pupils in primary, secondary and further education establishments on topics including consent, radicalisation and online safety.

During 2017-18 the LSCB training officer delivered:

	Primary	Secondary	Further education
Online safety	2640	1350	5750
Radicalisation	625	2775	2500
Sexual consent	-	2850	5750

Utilising funding from the Community Safety Partnership the Training Officer also worked alongside a local third sector organisation, Keeping Our Girls Safe (KOGS) to provide follow up support to pupils after a consent assembly had been delivered. The impact of this will be evaluated during summer 2018.

4.2.5 Child Death Reviews (CDOP)

Oldham continues to work under a tripartite arrangement with Rochdale and Bury to undertake child death reviews.

In Bury, Oldham and Rochdale (BRO) in 2016/17, a total of 69 child deaths were notified and 71 cases were closed across the tripartite. Of these, 22 child deaths notified and 31 cases closed were from Oldham. For the tripartite, this is a 39% increase of the total number of cases closed compared to 2016/17. The number of cases closed is not reflective of the date of death. Cases cannot be closed to CDOP

until all other investigations e.g. Criminal/Coronial/Serious Case Review are concluded.

For Bury, Rochdale and Oldham, 46% of cases closed in 2017/18 included modifiable factors. For Oldham, 35% of cases closed included modifiable factors.

Consanguinity is a recurring theme in a number of deaths across the tripartite. For Oldham, 23% of 31 cases closed showed consanguinity as a feature. This is considerably higher than Rochdale (8% of 26 cases closed) and Bury (14% of 11 cases closed).

In terms of ethnicity, 42% of cases closed in Oldham were White British. 55% of cases closed were BME and 3% of cases were not known.

Within the Greater Manchester CDOP Annual Report, smoking in the household/pregnancy is analysed in depth and it is likely that this will be addressed in the local report. The table below shows the number of cases where smoking is identified as a factor that may have or did contribute to the deaths of infants under 1 year old.

Local Authority	Smoking identified as a factor that may have or did contribute to the death (2 & 3)	Smoking at time of delivery %
Bury	22%	11.6
Oldham	18%	13.3
Rochdale	29%	16.3

Rates of obesity are rising nationally and across GM and so data regarding maternal BMI continue to be gathered from all CDOP's. Again, this is analysed within the Greater Manchester Annual Report for CDOP's and will likely be analysed in local reports. For Oldham, the table below shows the breakdown of maternal BMI categories for cases closed.

BMI Category	Number	Percentage
Underweight (>18.5)	4	13%
Healthy (18.5-24.9)	9	29%
Overweight (25-29.9)	6	19%
Obese (30-39.9)	5	16%
BMI Not Input	7	23%

All trends are explored further through the Greater Manchester Annual Report which will be available on the LSCB website.

Genetic Counselling pilot project

In order to address Child Death concerns as a result of consanguinity Oldham receives services from Manchester Regional Genetics Service, which is clinical in nature rather than delivered within communities. As such, the provision of additional community focused support was identified as having the potential to improve access to services and outcomes in Oldham. A need for additional resource was identified in Oldham because of its high population of families from South Asian Heritage, in particular of Pakistani origin where there is a tradition of consanguineous marriage.

The pilot project, which ran from January 2016 to March 2018, was designed to provide a genetic counselling service for at risk families in Oldham, training and development for health and social care professionals to provide advice and information to clients. It also sought to increase the uptake of universal services and raise knowledge in communities affected by consanguinity about the associated risks, including the adoption of available communication tools for professionals working with affected families and communities.

An evaluation of the project in November 2017 highlighted:

- Increase in referrals between April 2016 and June 2017;
    - 36 families referred into the outreach service through community agencies
    - 12 families referred into the genetics counselling service
- Almost 100% attendance reported at the genetics counselling service, previously those not attending appointments (DNAs) could be as high as 50% - the improvement is attributed to the introduction of a telephone support and reminder system.
- Eighteen training sessions delivered to front line staff totalling 177 people trained.
- 143 multi-agency partners working to improve awareness.
- Twenty four families receiving ongoing support post genetic counselling (this includes families rolled over from previous year).
- Outreach is targeted in areas with populations at high risk of inherited illness. Fortnightly drop-ins are established in Werneth and Glodwick Primary Care Centres which consist of 13 GP practices and community services situated within the South Asian Community.

The evaluation noted that there still remain some sensitivity within the local community and work is needed with key community leaders to enlist their support to reassure the community that this service is not a challenge to tradition or religious beliefs or cultural practices.

The Interim Director of Public Health has concluded that eighteen months is not a long enough period of time to quantify the benefits from this type of outreach service, however a clear need has been identified, and the service has demonstrated its ability to respond to this need and achieve some positive outcomes. Further funding has been identified to continue with the project.

4.3 Audit and Challenge

4.3.1 Multi Agency Case Evaluations

The LSCB revised and strengthened its case audit process by adopting the methodology used in the Joint Area Targeted Inspection (JTAI) framework to assess thematic areas of multi-agency safeguarding practice.

During 2017-18 the Audit and Scrutiny subgroup of the Board undertook multi agency case evaluations into Children living with neglect and Children at risk of Child Sexual Exploitation (CSE). Under each theme 20 cases were identified from Children's Social Care child level data and cross referenced with agency information to identify seven cases with the most multi agency involvement. The seven cases under each theme were then subject to full case evaluation and scrutiny by the Board's audit and scrutiny panel.

Children living with neglect

The case evaluation highlighted the following themes:

- There were missed opportunities to use the neglect toolkit
- Poor historical practice and application of thresholds by Children's Social Care
- Need for more effective multi agency information sharing
- Inconsistent use of pre-proceedings protocol (Public Law Outline)
- Weak scrutiny and challenge by Independent Reviewing Officers (IRO) in the main although evidence that this is beginning to improve
- Lack of partner agency challenge
- Handover processes at the point of step down to Early Help requires clarity in terms of responsibilities.

Following the evaluation the Audit and Scrutiny panel the following work has been undertaken:

- Development of the Signs of Safety proposal to support a common approach to sharing information
- Development of a seven minute briefing regarding the neglect toolkit including a link to the multi-agency training for neglect
- Delivery of four multi agency briefing sessions relating to voice of the child
- Dispute resolution protocol has been written by the Safeguarding Unit and distributed across the service area
- All IRO's, Team managers, Service managers and Heads of Service within Children's Social Care have been trained by the QA Service Manager
- Training session has been developed by the North West LSCB trainers group on professional challenge. This will be added to the LSCB training calendar for 2018-19.

Children at risk of Child Sexual Exploitation (CSE)

The case evaluation highlighted the following themes:

- Majority of cases were rated as good or outstanding in respect of the child's voice
- Social workers need to be clear that case responsibility sits with them and not with specialist teams such as Phoenix
- Weaknesses in planning and assessment, in particular the lack of an overarching plan for the child
- Lack of rigour in the CIN process
- Arrangements for children who became missing from education and their subsequent vulnerabilities were not challenged
- Issues relating to differing perceptions of risk between boys and girls
- One of the cases evaluated was subsequently referred to the Serious Case Review panel and is currently the subject of a review.

As a result of the evaluation the following work has been undertaken:

- The establishment of a Safeguarding and Wellbeing in Education subgroup of the LSCB to progress this agenda, in particular the safeguarding concerns in relation to children missing from education
- Commission of a specialist CSE nurse to work across the health economy
- Review of the Children's Social Care element of the Phoenix team and the development of a CSE action plan
- A review of CSE training to ensure that it reflects the risks associated with boys as well as girls

Both evaluations were subject to independent review by a commissioned external person. The reviewer noted that the Multi Agency Case Evaluation process had demonstrated its ability to reach valid judgements in relation to the quality and impact of multi-agency working and was successful due to engagement and commitment from a wide range of agencies to the process.

The new approach to case audits has been positively received by agencies and is being replicated by other Boards in the Greater Manchester area.

What impact has this had?

- Recognition of the gap in service provision for children and young people at risk of Child Criminal Exploitation ("County Lines")
- Devised a risk screening tool for Child Criminal Exploitation - the only area in Greater Manchester to have done so and possibly only one in the country
- Recognised and addressed a gap relating to dedicated CSE nurse based within the Phoenix Team
- Introduced an escalation policy for Phoenix decision making to ensure management oversight
- Good evidence of multi-agency working and escalation in relation to children at risk of exploitation
- Introduced a dedicated Missing from Home officer who is based in the Phoenix Team to further the link between Missing from Home / Missing from Education and CSE
- Improved identification of young people at risk of CSE in Primary Care
- Improvement in capturing the child's voice
- Increase in escalations within Children Social Care from Safeguarding Unit

4.3.2 Section 11 Audit

The LSCB undertakes Section 11 audits with agencies every two years in order to measure their compliance with Section 11 duties under the Children's Act 2004.

Whilst the most recent audits began with agencies in 2016, timeliness of completions was slow with most agencies finalising their audits in November 2017. Fourteen agencies completed the Section 11 audit during this period and analysis of their responses indicated that the top three strengths were:

- Organisations have written policies, and where applicable a procedure, for safeguarding and protecting children that is accessible to all staff
- There are clear procedures for recording and reporting concerns or suspicions of abuse of children which all staff are aware of. All have access to a copy of 'what to do if you are worried a child is being abused' (DfES, 2015)
- There is clear guidance on how to respond to a disclosure of abuse from children, which includes a confidentiality policy and procedure

The top three areas for improvement included:

- Employees involved in the recruitment of staff to work with children have received training as part of a 'safer recruitment 'training programme

- All staff who work with children receive regular refresher safeguarding training at least once every 3 years
- Outcomes and findings from reviews & inspections are disseminated to appropriate staff and volunteers

The three areas requiring improvement are being addressed by the Training subgroup and the Serious Case Review subgroup respectively.

The Audit and Scrutiny subgroup of the Board also considered a request from educational establishments to revise the Section 11 audit tool for them to bring it in line with requirements under Keeping Children Safe in Education 2015. The Safeguarding lead for education worked with five schools (maintained, academies and independent) to trial a new audit for schools. The response was positive and the new audit tool will be rolled out to all education establishments in 2018-19.

Oldham Safeguarding Snapshot 2017/18

58802 children live in Oldham

25% of total population

27.2% of children are living in poverty (before housing costs)

11,111 are living in families in receipt of Child Tax Credit or Universal Credit (all dependent children under 20)

Approximately ***17.6%*** of children in receipt of free school meals

81% of Oldham pupils in good or outstanding schools

33 Children and young people open to the Phoenix Team, the CSE system

838 incidents of children and young people going missing from care

4470 referrals of which **835** were re-referrals

4691 assessments completed

34.4 days - average timelines of assessments

560 children with a child protection plan as of March 2018

1802 open children in need cases as of March 2018

256 Child in Need cases with a disability as of March 2018

553 children and young people looked after as of March 2018

1547 children identified with a risk of domestic violence within the household

22.5 rate of domestic abuse incidents recorded by the police per 1,000 population

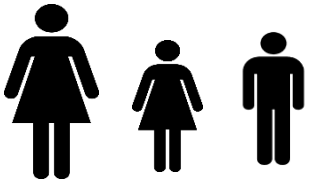
244 allegations against staff working with children and young people

5 private fostering arrangements as of March 2018

47.7% of 5 year olds have one or more decayed, missing or filled teeth

183 admitted to hospital for an extraction of one or more teeth

29.9% of households are single parent families



A key priority for the Board during 2017-18 was the development of performance data to ensure that it was reflective of partnership activity. Significant work has been undertaken to identify and gather key performance data from other agencies in particular Police, Health and Education.

By the end of quarter four the data set was updated to include indicators relating to schools absenteeism and exclusions, Multi Agency Risk Assessment Conferences (MARAC) information, Children involved in the Criminal Justice System including those who are looked after and Mental Health admissions broken down by reason for admission.

A review of the Early Help indicators was also undertaken and a revised set of indicators was agreed that would be more indicative of volume of work undertaken.

Deep dives

In addition to the revised data set the Performance Management subgroup introduced a deep dive process to allow further scrutiny to be given to areas of performance that were causing concern. The first of these deep dives focused on the timeliness of Initial Child Protection Conferences.

In April 2017 the timeliness of Initial Child Protection Conferences dropped to 7.7% that were convened within the statutory timescales. This was attributed to an increase in the number of cases requiring a S47 assessment and subsequent capacity issues within the Safeguarding Unit. The Board sought immediate reassurance from the Executive Director of Children Services (DCS) about the measures being put in place by Children's Social Care.

Daily performance meetings were introduced, led by the Director for Children's Social Care and Early Help and attended by Heads of Service, Service Managers and Performance officers. Investment was made into the Safeguarding Unit to increase the capacity and robust processes were embedded to ensure conferences were progressed.

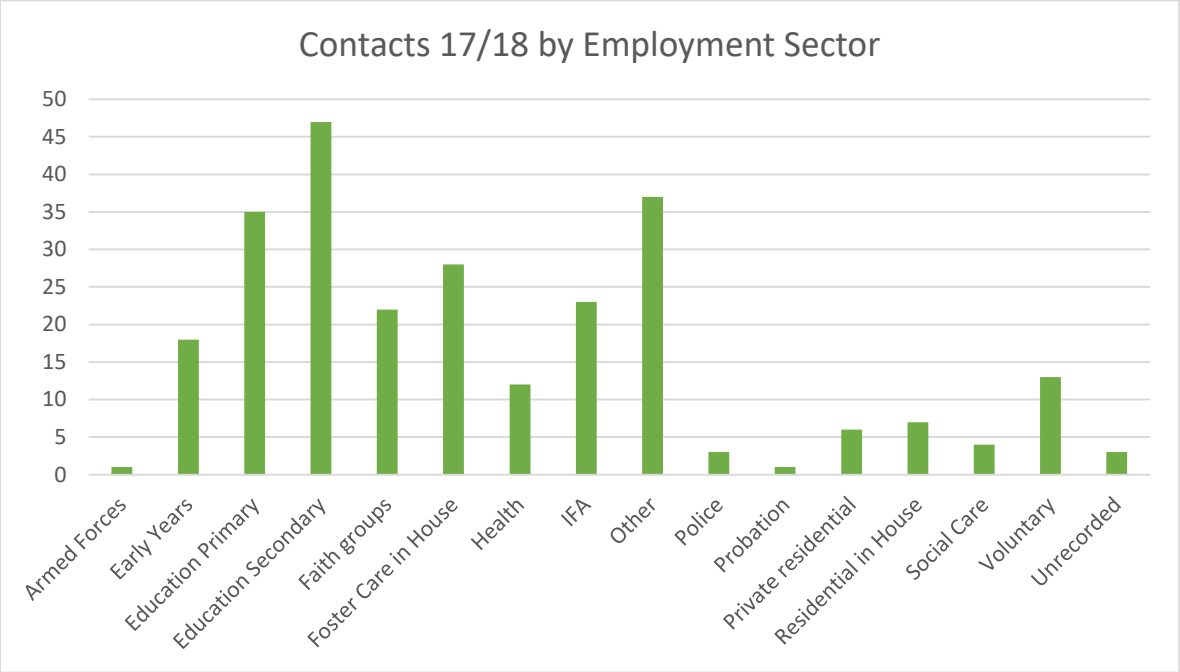
As a result of the measures taken rapid improvement was seen and by the end of Quarter 1 timeliness was up to 42.3% and had improved further to 86.5% by the end of Quarter 2. Between Quarter 2 and Quarter 4 the rate of ICPC held in time remain consistent between 86.5% and 84%.

The second deep dive is planned for 2018-19 focusing on children missing from education data including children who are electively home educated, following the concerns highlighted in the two Multi Agency Concise Reviews into peer on peer abuse and the Multi Agency Case Evaluation into children at risk of CSE.

4.5 Allegations against Professionals

There were 277 allegations in the 17/18 period with 112 of these leading to an Allegations Management Meeting (AMM).

The Local Authority Designated Officer (LADO) noted that this is the first year where a spread across employment sections has been evident suggesting that the role of the LADO is much better understood compared to previous years.



The majority of allegations continue to relate to physical harm (40%) or risk of harm (38%) however this year also saw an increase in emotional harm and neglect being referred to the LADO.

The LADO consistently received referrals relating to mosques and madrassas. In an attempt to reduce these incidents of physical harm the LSCB worked closely with Oldham Mosque Council to provide two training sessions for both male and female madrassa teachers covering safeguarding and dealing with challenging behaviours. On 29 March the teachers were invited to attend a celebration event during which they were presented with a certificate from the Mayor of Oldham for the completion of their training.

4.6 Private Fostering

During 2017/2018 there were five cases open as Private Fostering. One of these cases closed due to a move out of borough. Most of the children were known to Children's Social Care prior to being privately fostered. Three below the age of seven, two children aged 14 plus.

The private fostering subgroup met during this period however there was a delay in the action plan being progressed following the nominated Social Care lead leaving the authority and a new lead being identified.

First Choice Homes Oldham developed a training presentation for use with staff to ensure that they were fully aware of Private Fostering and how to notify it to the Local Authority. Similarly Private Fostering awareness was included in all Whole School and Designated Safeguarding Lead training delivered during this period.

The corporate version of the Children in Care Council/Youth Service's YouTube video about Private Fostering was re-produced and placed on the LSCB website

(https://www.oldham.gov.uk/lscb/info/14/parents_and_carers).

4.7 Communications

A refresh of the LSCB website was agreed as it was noted that professionals find it difficult to navigate and as a result don't often use it to access safeguarding information as evidenced during the Serious Case Review for Child H.

A web designer has been commissioned and the website is currently being redesigned in consultation with the Youth Council and Children in Care Council.

5 Are we making a difference?

This section outlines the progress made against the Board's priority areas for 2017-18.

5.1 Missing From Home and Child Sexual Exploitation

Oldham's shared key strategic priorities for 2017-2018 in this thematic area were:

- Prevention;
- Safeguarding;
- Bringing offenders to justice;
- Scrutiny and Governance of Services;
- Identifying emerging trends and issues.

Profile and data analysis

In 2017/2018, the specialist CSE Phoenix team and/or Multi Agency Safeguarding Hub (MASH) received 113 referrals concerning 103 young people. 32 of the 103 young people who were referred to MASH/the Phoenix Team in this period, had been known to the Phoenix Team before; the re-referral rate was therefore, 31%. Further work is required to understand the reasons behind why almost a third of the young people for whom there were concerns about CSE, have been involved with the Phoenix Team previously.

The majority of the referrals to the MASH/Phoenix Team, in respect of CSE concerns, were made by social workers (52), equating to 46% of all referrals. The Police Service were the second highest referrer, accounting for 13% of all new referrals in this period.

When exploring why referrals from a number of partner agencies are low, it is suggested that informative, relative and up to date daily governance ensures timely information sharing between the Police Service and the Phoenix Team, enabling the ability to recognise and respond to concerns about potential CSE, at the earliest opportunity.

The majority of young people referred to the MASH, or directly to the Phoenix Team, in 2017/2018 are White British (68%), which is reflective of the current demographic of Oldham. Similarly, the majority of young people within this group of children are female (87% during 2017/2018); there continues to be concerns that the sexual exploitation of young males remains unreported. However it should be noted that Oldham has a higher percentage of open cases that are male compared to most other phoenix teams, as a direct result of having a dedicated male family support worker.

During 2017/2018, there were referrals in respect of children as young as 10 years and 11 years old being vulnerable to CSE; although the majority of the young people

referred to the MASH/directly to the Phoenix Team for CSE concerns this year have been between 13 and 17 years old, accounting for 86% of referrals. It is evident from the content of many referrals received in respect of younger children that earlier and easier access to smart phones poses a serious risk of them being exploited online, via social media or by the use of various apps.

The majority of young people for whom there were concerns about CSE lived at home (72%). Of the young people who were deemed, by the referrer, vulnerable to exploitation, 12% were subject to child protection plans, and 12% were subject to child in need plans; 6% were subject to Child and Family Assessments. 28% of children were looked after by Oldham Council. The highest cohort of children who repeatedly go missing however, are looked after children.

Peers and associates were identified as a risk factor in 18% of all young people for whom there were CSE concerns in 2017/2018, either in terms of their associations with other vulnerable young people, or risky associates. Substance misuse was a concern in 22% of cases, either in terms of alcohol misuse, drug misuse, or both, and mental health a significant concern in 13% of all cases. 20% of the young people Phoenix worked with alleged having been sexually assaulted either during this period, or historically.

45% of all young people for whom there were concerns about CSE during the 2017/2018 period had been missing from home/care, and for the majority of these young people, these missing episodes were multiple. There is further work to be done in respect of young people who go missing, certainly in respect of the requirement to understand their lives and intervene at the earliest opportunity, in order to prevent escalation.

Partnership activity during 2017-18:

The Phoenix team has:

- Spoken to all hotels in respect of being alert to the indicators of CSE in customers using their hotel;
- Approached all takeaways during the week of action in 2017 with leaflets given in respect of CSE;
- Maintained good links with licensing and all taxi ranks in Oldham have been approached in relation to being alert to the indicators of CSE;
- Attended two Foster Carer Forums, both in March 2017 and March 2018;
- Attended one interfaith forum, where information in respect of CSE was delivered to thirty Imams;
- Met with Neighbourhood Police Officers in respect of indicators of CSE;
- Attended two Home Watch meetings, in order to educate the wider community about the signs of CSE to be alert to;

- Reached out to pharmacies, who may well have contact with young people seeking emergency contraception, however only one pharmacy opted to participate in CSE training;

- Provided refresher training to the majority of social work teams, with only the After Care Service remaining outstanding;

- Provided training to the Army Cadets, Air Cadets, Sea Cadets and the Boys Brigade;

- Delivered CSE and Missing from Home training to fourteen local children's residential homes.

Keeping Our Girls Safe (KOGS) is a registered charity, established in 2011, working with children and young people to educate them about unhealthy relationships, child sexual exploitation (CSE), grooming and risks; to empower them to have confidence and self-esteem; and inspire them to make positive life choices (www.kogs.org.uk). In the period between 01.04.2017 and 31.03.2018, KOGS had referrals for 136 young people. This number was made up of six 12-week group programmes, two ongoing group programmes, and 25 one-to-one therapeutic interventions. There is currently no similar intervention for young males.

The Youth Justice Service have worked with 24 cases whereby there has been a risk of CSE identified, following which they would make a referral directly to the MASH, unless the Phoenix Team are already involved with the young person. In terms of themes identified by this service, they have noted a significant reduction over recent years in relation to young people known to the Phoenix Team (females in particular) entering the Criminal Justice System, which is positive; however, those that have come through recently have been for serious violent offences as opposed to petty low level offences which has been their experience previously.

Between 01.04.2017 and 31.03.2018, the National Probation Service worked with a total of six offenders who are flagged as CSE perpetrators. Three of these are alleged perpetrators and work has been undertaken following Police intelligence in each of these instances re concerns pertaining to CSE, one individual having been issues with an abduction notice. One of these 3 is known for sexual offences against and adult female, the other two are known for non-sexual offending (violence, driving and acquisitive matters). There is no evidence of engagement in organised criminality within these cases. 1-1 work has focused on risks associated with CSE. In terms of ethnicity, four self-identify as Asian males (1 Bangladeshi; 1 Pakistani; 2 British); the other 2 are white males. 1 is subject to potential deportation. They vary in age from 20-65, with no significant pattern to this, nor - with the exception of 2 a pattern to the way in which they have groomed their victims. All victims in these instances were white British teenage girls (12-15 years).

It has been difficult for the National Probation Service to identify themes, and consider these to be significant, with such a small sample. However, given the very specific definition of CSE, the National Probation Service will be undertaking a review of all cases of sexual offending against children to see if they fit the definition but have not been flagged; once this has occurred, the National Probation Service would be more confident with any localised patterns.

It is becoming increasingly more frequent that younger children are engaging in inappropriate image sharing due to their access to smart phones; training has been provided to primary schools via the LSCB (see 4.2.4).

During the 2017/2018 period, it was identified that the work undertaken in respect of missing from home/care, was reactive, rather than pro-active, and there was insufficient capacity within the Phoenix Team to ensure that Tier 1, Tier 2 and Strategy Meetings were being held within appropriate timeframes, that missing episodes were being recorded appropriately, and that there was a clear analysis of the information collated from the Police Service and from Positive Steps in terms of young people who go missing, enabling identification of themes. As such, a business plan was proposed, and agreed; there is now a Senior Practitioner within the Phoenix Team responsible for missing from home/care, and the Police Service are sourcing a PSCO for this work too. The scope of this practitioner will include children missing from education, and will consider children who are electively home educated; this was highlighted as a vulnerability within the CSE Multi Agency Case Evaluation.

In addition, it was identified that the Local Authority did not have a strategy or a service to respond to County Lines, which is often closely linked with missing episodes and potentially, CSE; similarly, there was no assessment tool or dedicated practitioner to undertake assessments of young people possibly engaged in County Lines. As such, the risks were not being formally identified and responded to, to reduce the risk of escalation into further exploitation and the criminal justice system. As such, this was included within the business proposal, and will form part of the role for the Senior Practitioner, who is now in post.

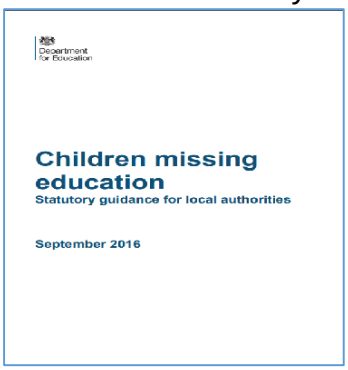
During 2017/2018, the Phoenix Team took ten young people who were difficult to engage, on a residential trip which included numerous outdoor activities; some very positive relationships were built between the young people, the Police personnel and the Social Care personnel, and a similar excursion is planned for July 2018.

What impact has this work had?

- There is clear evidence of Phoenix Team personnel (both Social Care and Police Service staff) having formed excellent relationships with the young people they work with, and that young people benefit from having a stable and consistent professional support network in their lives.
- Increased awareness of the indicators of CSE, particularly regarding the vulnerability of young males

5.2 Missing from Education

Following an update of the Statutory DfE guidance relating to children missing education, a local protocol was drafted that sought to define children missing from education and clearly outline the responsibilities of schools and other education establishments when responding to absences and behaviour management. The ongoing implementation of this guidance is being overseen by the new Safeguarding and Wellbeing in Education Partnership which has clear links to the Behaviour and Attendance Partnership, thus ensuring that any safeguarding concerns arising from children being missing from education are appropriately addressed.


Department for Education

Children missing education

Statutory guidance for local authorities

September 2016

Further work is underway with the Local Authority's inclusion team to support the implementation of the Inclusion policy and to work with schools to consider any wider safeguarding implications of exclusions, part-time tables and elective home education.

5.3 Peer on Peer abuse

This task group was established to support the multi-agency concise reviews into the two incidents of peer on peer violence and to lead on the implementation of any recommendations arising from the reviews. See 4.2.2 for details. Ongoing work relating to peer on peer violence has been incorporated into the action plan for the Safeguarding and Wellbeing in Education Partnership, where appropriate.

5.4 Domestic Abuse

Responsibility for domestic abuse is devolved from the LSCB to the Domestic Violence Partnership (DVP), whose governance lies with the Community Safety Partnership.

Secondary reporting into the LSCB occurs via the LSCB Executive Board on a bi-monthly basis by the chair of the DVP.

During 2017-18 the DV strategy, “Changing Hearts and Minds” was refreshed and identified seven key priorities:

- Protecting children and young people from harm
- Early help, intervention and support
- Developing healthy relationships
- So called honour based violence and abuse, forced marriage and female genital mutilation
- Exploitation (CSE, human trafficking, modern slavery and sham marriages)
- The impact of DV on health and wellbeing
- Training, governance and collaborative working

Domestic abuse continues to be a significant factor in families known to social care with 2506 notifications being made to social care by police for incidents of domestic abuse where a child is living in the home. The number of repeat incidents, however has seen a decrease from 41 repeat addresses to 15 (reduction of 63.4%) and a decrease in incidents at those addresses from 96 to 37 (reduction of 61.4%).

The implementation of Operation Encompass, a project that seeks to inform schools when an incident of domestic abuse has taken place so that appropriate support can be offered to any children involved, has been a key priority for the DVP during 17-18. Schools are welcoming of the project however issues relating to the most effective means of delivery had resulted in some delays. This has now been resolved and the project is expected to be rolled out fully during the 18-19 year.

A mapping exercise has begun to understand the support offer to victims, children and perpetrators across Oldham. This was a key recommendation arising from the LSCB’s Thematic Review. The Victim’s Services Co-ordinator from GMP is leading this piece of work on behalf of the partnership.

The original Operation STRIVE pilot in Oldham was not formally commissioned for 17/18 as the Police Innovation funding period expired, however the local delivery continued with a committed police resource, pending a decision from the GM Mayor’s Office about the future model of working, with the Officer working in partnership with colleagues from other services within the MASH. In addition the referrals to INSPIRE following the Victims Champion Network model continued, complimented by funding for the Community Connectors Project from the Community Safety Fund.

Following the GM evaluation of STRIVE the GM Mayor’s Office committed funding for a three year period, with a potential further funding extension, in order to rollout a single cluster model for the future delivery of STRIVE based upon the learning from the successful volunteer re-visit model adopted in Trafford. A single GM provider is being commissioned and Oldham will be in the 2nd rollout cluster.

5.5 Transitions

The focus of the Transitions subgroup during 17-18 was to provide reassurance to the Board that the transitions arrangements for the following three areas of business were robust and effective:

- Youth Justice
- Substance Misuse
- Mental Health

The group found that arrangements were robust and that services were clear about their responsibilities with regard to safeguarding and processes to be taken if safeguarding was identified as an issue in day to day practice. It was noted that the response from the After Care Team was to be commended with the flexibility and young person focus with their work and the fact that they work hard to ensure a wraparound approach to young people that present to them. The Positive Steps Oldham model with its range of services aims to bolster this.

However there were major concerns and vulnerabilities resting with young people not connected with services that tend to present in crisis. It can be difficult to effectively engage and support young people who do not have a framework of support around them and to generally have the need to react in crisis. A wide range of issues is likely to confront them and in the absence of effective housing, family or structure within an education or training placement, their vulnerability to offending, substance misuse and mental health difficulties are far greater. Linked to that is a theme that the preventative arm of services have been reduced in recent years which can impact upon early identification and intervention to support or deflect the presenting issues.

Furthermore work is needed and ongoing regarding children and young people with a disability. It is to be hoped that this will also bring a focus upon young people with a diagnosis of autism.

The recommendations arising from the subgroup's review will be fed into existing work plans for health and social care transitions groups with regular reporting being presented to the LSCB.

5.6 Early Help

Oldham's Early Help offer commenced in 2015 with delivery being shared across the Local Authority and Positive Step Oldham.

A review of the current all age offer was undertaken by Red Quadrant in May 2017 and found that:

- It's a good model in terms of aspiration, design and (for the most part) performance. There appears to be increasing demand for work with single adults or childless households. Some service improvements can be made which will enhance delivery
- There are known financial risks from 18/19 onwards relating to ongoing education contributions and whether or not to continue to deliver health checks and smoking cessation as part of the offer. The current cost of the service is around £3 million. Highlighted lack of partner contribution in spite of positive impact across a number of issues benefitting Oldham as a whole.
- Since the Early Help offer commenced the landscape has changed with the development of the Thriving Communities approach and the roll out of place based working as well as the proposal to establish a Wellness Service. This presents opportunities to expand Oldham's Early Help approach
- The 'two provider' model may no longer be the best option as services have evolved

The reviewers were highly impressed with the Positive Steps delivery and recognised effective resource management with evidence of good use of volunteers and VCS partners.

In order to address the findings from the review a new Early Help and MASH subgroup has been introduced. It is proposed that services will remain the same for the 2018-19 year whilst a wider review is undertaken to establish a revised Early Help vision for Oldham.

6.Future priorities for 2018-19

In addition to the Board's focus on the development and implementation of new safeguarding arrangements by September 2019 the following areas have been identified by Board members as the key strategic business aims over the next three years:

1. Excellent practice is the norm across all practitioners in Oldham
2. Partner agencies hold one another to account effectively
3. There is early identification of new safeguarding issues
4. Learning is promoted and embedded
5. Information is shared effectively
6. The public feel confident that children are protected

The Safeguarding priorities for 2018-2021 will be:

Domestic Abuse:

To have a competent and confident workforce who are able to recognise and appropriately respond to the needs of children affected by domestic abuse. This will be led by a clear domestic violence and abuse strategy that is fully reflective of children's safeguarding priorities.

Complex and Contextual Safeguarding:

To have a clear understanding of the scale of complex and contextual safeguarding within Oldham, with a clear multi- agency response to raising awareness with children and young people, assessing their needs and providing appropriate support

Children missing from education including elective home education:

All children in Oldham are accessing suitable education and where children are electively home educated that this provision is of a suitable standard.

Child's lived experience

To be confident that all professionals recognise and fully reflect the child's lived experience, including those who are non- verbal and that all children and young people have the opportunity to be involved in the work of the board and its partners

Transitions:

To have a clear transitions process from children's services to adult services that ensures that that agencies work together to develop a transition plan that begins at an early stage, involves the young person and their family/carers and ensures that appropriate safeguarding information is shared.

Understanding the impact of trauma on children and young people:

To have professionals appropriately trained to utilise a continuum of tools including the ACES toolkit and the TSCC in order to fully assess the impact of trauma on children and young people and to commission appropriate support to meet the needs identified.

Appendices

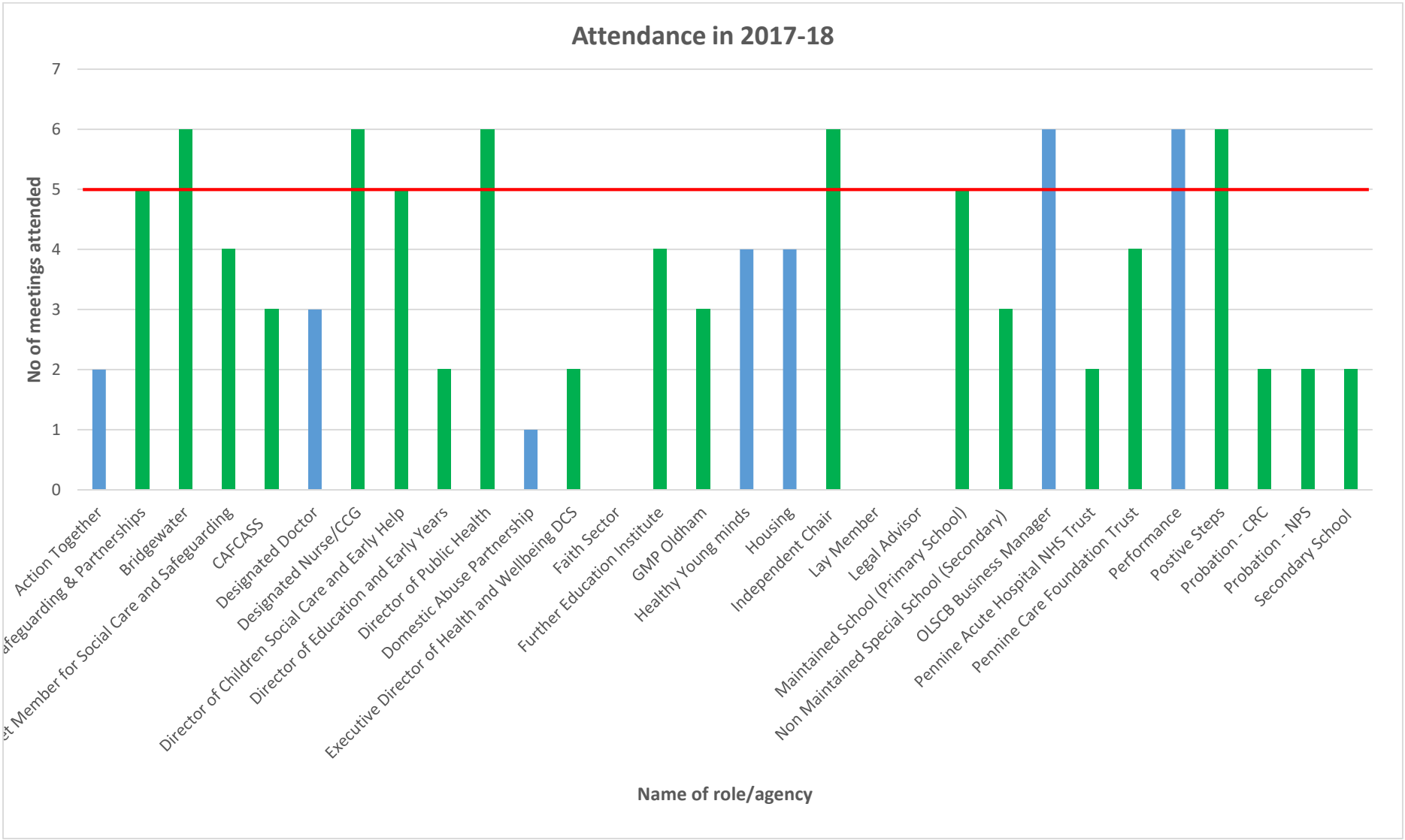
1. Governance and Accountability

1.1 Membership

Role	Agency	Membership
Independent Chair		
Cabinet Member for Social Care and Safeguarding	Oldham Council	Full member
Executive Director for Health and Wellbeing (DCS)	Oldham Council	Full member
Director of Children's Social Care and Early Help	Oldham Council	Full member
Director of Education and Early Years	Oldham Council	Full member
Head teacher	Primary school	Full member
Director of Community Health Services	Pennine Care NHS Foundation Trust	Full member
Executive /Designated Nurse	Oldham CCG	Full member
Superintendent	GMP	Full member
Assistant Director of Safeguarding and Partnerships	Oldham Council	Full member
Imam	Oldham Inter-faith forum	Full member
Service Manager	CAFCASS	Full member
Head teacher	Non maintained special school	Full member
Director of Public Heath	Oldham Council	Full member
Associate Directorate Manager	Healthy Young Minds	Full member
Women and Children's divisional nurse director	Pennine Acute Hospitals NHS Trust	Full member
Public Heath Manager	Oldham Council	Full member
Associate Director for safeguarding	Bridgewater Community Health NHS Foundation Trust	Full member
Head teacher	Secondary school	Full member
Assistant Chief Executive	National Probation Service (NPS)	Full member
Chief Executive	Positive Steps	Full member
Community Director	Community Rehabilitation Company (CRC)	Full member

Deputy Principle	Oldham College	Full member
Lay member		Full member
Lay member		Full member
Designated Doctor	Pennine Care NHS Trust	Advisory member
Oldham Housing Investment Partnership Manager	Oldham Housing Investment Partnership	Advisory member
Domestic Abuse Partnership chair	GMP	Advisory member
Legal Advisor	Oldham Council	Advisory member
Chief Executive	Action Together	Advisory member
LSCB Business Manager	Oldham Council	Advisory member

1.2 Member attendance

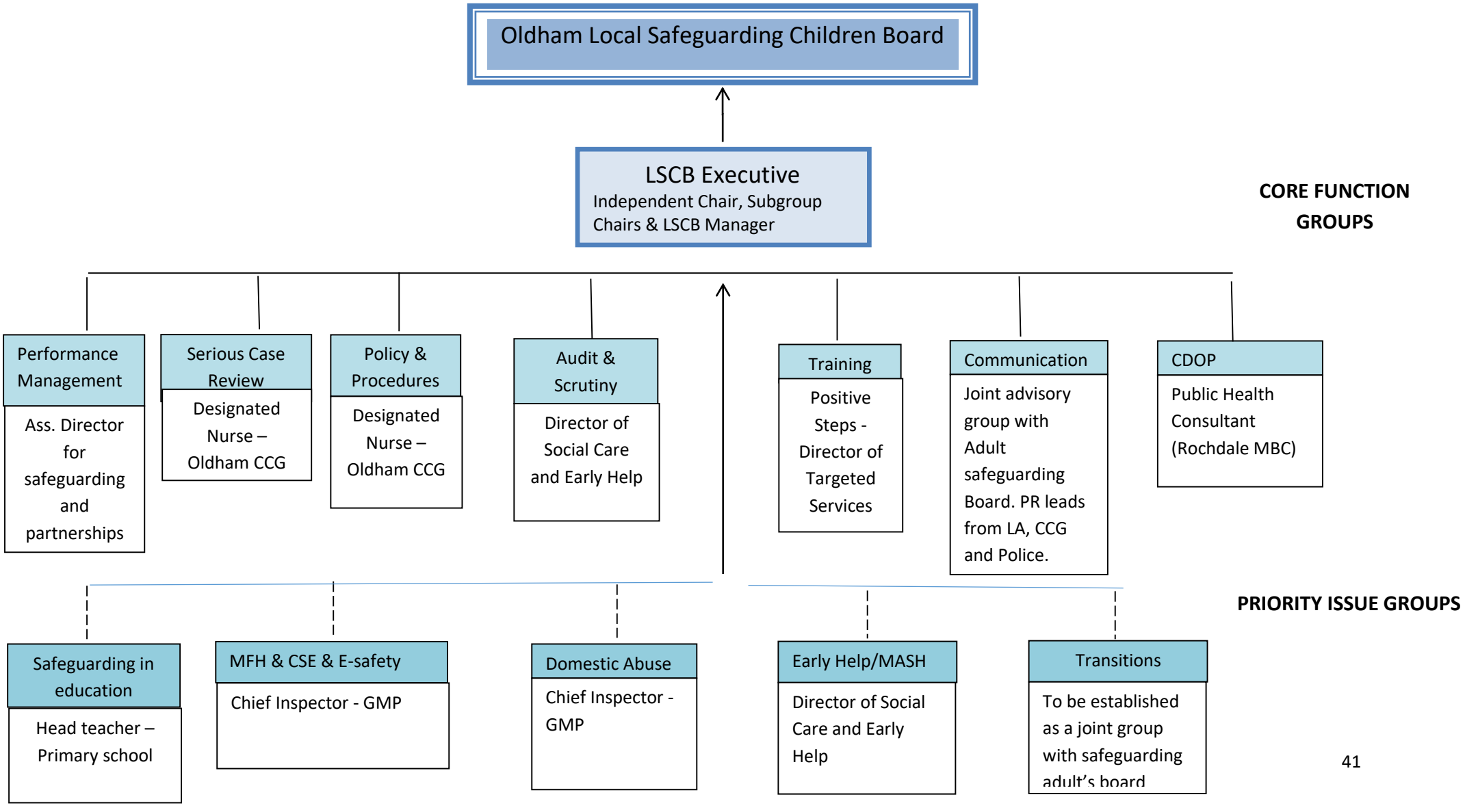


Core members of the Board are indicated in green on the above chart. Those in blue are advisory members. The agreed attendance target for core members is 85% (as indicated by the red line). As the chart indicates only 40% of core members attended for the target number of meetings. In May 2018 the Independent Chair of the Board wrote to all members to ask them to reflect on their present position and, if necessary, take measures to ensure that their agency would be able to meet the requirements of Board participation for the next business year 2018-19.

The position of lay members was advertised on two occasions with little interest. Further work is to be done during 2018-19 period to identify a lay member for the Board.

At the time of writing the report there has been a notably improvement in attendance. Furthermore a new lay member has been invited to join the Board. The lay member will also represent the local faith communities via links with Oldham Interfaith forum.

1.3 Structure



1.4 Budget 2017-18

2017/18 Outturn	
Expenditure	
Description	**Amount (£)**
Employee Costs	221,416
Room Hire	2,060
Transport and Travel	1,038
Supplies and Services	39,632
Support Services	98,750
Total Expenditure	**362,897**
Income	
Description	**Amount (£)**
CDOP	14,921
Cheshire & Greater Manchester CRC	1,944
Children & Family Court Advisory & Support Service	505
Community safety grant	15,000
Designated Schools Grant	110,000
Greater Manchester Combined Authority	12,900
Greater Manchester Police	12,900
NHS	56,890
Positive Steps	5,050
Probation Service	1,345
Traded service income	58,901
Oldham Council Contribution	72,541
Total Income	**362,897**