Annual Report 2015-2016

Sandwell Safeguarding Children Board (SSCB)

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Contents

1. Foreword by the Independent Chair

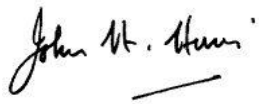
This is my third and final Annual Report as the Independent Chair of Sandwell Safeguarding Children Board (SSCB). The report is published at a time of considerable change, both locally and nationally. The report covers the period April 2015 - July 2016, and is intended to provide a baseline position for partner agencies locally to respond to the challenges ahead.

Within Sandwell, there remain significant concerns about the effectiveness of the local authority's Children's Services. A report by the DfE's Commissioner in June 2016 recommended that the responsibility for Children's Services should be transferred to an Executive Commissioner or a Voluntary Trust. The Commissioner's findings reflect the concerns identified by the SSCB through its commissioned reviews, audits and performance reports. A final decision about the future organisation of the local authority's Children's Services is awaited from the Secretary of State. Whatever the outcome in respect of the local authority's Children's Services, there will be a key role for partner agencies to work collaboratively to drive further improvement in safeguarding.

In May 2016 the government published its response to the review of the role of LSCBs undertaken for the Department for Education by Alan Wood. Whilst committing to retaining systematic mult-agency arrangements for safeguarding children, the government has stated that there will no longer be a requirement for each local authority area to have an LSCB although there is a discretion for local partnerships to do so where the LSCB is working well.

A recent peer review of the SSCB has found that the SSCB is now meeting its statutory requirements (having been judged inadequate by OFSTED in February 2015) and is providing authoritative and constructive challenge to the local authority and partner agencies.

I am proud of the work of the SSCB over the past year and would like to thank Board members and professionals in all the partner agencies for their contribution. We now have in place a good multi-agency partnership that will enable us to respond to the challenges ahead in Sandwell



John Harris - Independent Chair

2. Introduction

2.1 This is the annual report for Sandwell Safeguarding Children Board (SSCB). It covers the reporting period between April 2015 and July 2016 and evaluates the work and impact of the Board relating to its identified priority areas of work.

2.2 With respect to the role of the Local Safeguarding Children Board (LSCB) in monitoring and evaluating the local impact of safeguarding arrangements, each LSCB is required to produce and publish an Annual Report on the effectiveness of safeguarding in the local area. Section 14A of the Children Act 2004 (as amended by the Apprenticeships, Skills, Children and Learning Act 2009) requires that at least once in every 12-month period, a Local Safeguarding Children Board must prepare and publish a report about safeguarding and promoting the welfare of children in its local area.

2.3 In accordance with Working Together 2015, the report should:

- provide a rigorous and transparent assessment of the performance and effectiveness of local services
- identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action
- include lessons from serious case reviews, child death reviews and any other relevant reviews undertaken within the reporting period
- report on the outcome of assessments undertaken on the effectiveness of Board partners' responses to child sexual exploitation
- include an analysis of how the LSCB partners have used their data to promote service improvement for vulnerable children and families, including in respect of sexual abuse
- include appropriate data on children missing from care, and how the LSCB is addressing the issue.
- list the contributions made to SSCB by partner agencies and details of what SSCB has spent, including on Child Death Reviews, Serious Case Reviews and other specific expenditure such as learning events or training.

2.4 The annual report will be submitted to the Chief Executive and Leader of the local authority, as accountability for the safety and welfare of children must start with the most senior strategic local leaders. It will also be sent to the local Police and Crime Commissioner and the chair of the Health and Well Being Board.

3. Local Background and Context

3.1 Sandwell is located to the west of Birmingham and shares its borders with Birmingham, Dudley, Wolverhampton and Walsall. Sandwell is a metropolitan borough with six towns; Oldbury, Rowley Regis, Smethwick, Tipton, Wednesbury and West Bromwich and is one of seven local authorities that make up the West Midlands conurbation.

3.2 Approximately 76,867 children and young people under the age of 18 years live in Sandwell. This is 25% of the total population in the area.

3.3 Approximately 30% of the local authority's children are living in poverty.

3.4 The proportion of pupils in the borough eligible for free school meals is above the national average with 22% in primary schools and 22% in secondary schools - the national averages are 17% and 15% respectively.

3.5 Children and young people from minority ethnic groups account for 41% of all children living in the area, compared with 22% in the country as a whole. The largest minority ethnic groups of children and young people in the area are Indian and Pakistani.

3.6 The proportion of pupils with English as an additional language is above the national figures with 31% in primary schools and 26% in secondary schools. This compares with national averages of 19% and 14% respectively.

3.7 Sandwell has experienced an increase in economic migrants, with the majority arriving from Poland; this group increased from 208 individuals in 2001 to 5,673 in 2011. In 2011, people born in EU accession countries accounted for 2.6% of the usual resident population of Sandwell. There have also been additions to the established communities, including the number of individuals born in India increasing by 4,556 to 15,190 and in Pakistan increasing by 1,722 to 5,295.

3.8 The local authority does not operate any children's homes.

4. The Local Safeguarding Children Board

4.1 As detailed in the SSCB 2014-15 annual report, the Board's Strategic Review in September 2014 acknowledged that the Board was not meeting statutory duties and a ten-point improvement plan was put into place as a result. OFSTED reviewed the SSCB shortly after (in February 2015) and whilst acknowledging progress made, judged the SSCB to be *'inadequate'*. OFSTED's judgement looked at progress since the previous inspection in 2013, when the SSCB was first identified as inadequate.

4.2 In response to the OFSTED Review of SSCB the Board prepared and implemented a detailed Improvement Plan which was aligned to the 2015-16 Business Plan. The plan was monitored through the Board's Chairs' Group with good progress made in all aspects of it. For further details see: http://www.sandwelllscb.org.uk/wp-content/uploads/2016/08/10b-SSCB-Improvement-Action-Plan-May-2016.pdf

4.3 A Peer Diagnostic Review of the SSCB undertaken by the Local Government Association in June-July 2016 found that the Board was now meeting its statutory duties and was providing authoritative and constructive challenge to the local authority and partner agencies.

"It was evident to the peer team that the SSCB has made huge progress since the last OFSTED inspection and that it is now fulfilling its statutory requirements... overall the SSCB has improved greatly the way it works, bringing together key partners, the development of policy and key guidance and its focus on specific safeguarding issues"

LGA Peer Diagnostic Review - Executive Summary Report

4.4 The Peer Diagnostic Review identified the need for the Board to evaluate its impact on multi-agency practice as a key next step and considered that there was good capacity for further improvement in the Board's work

"The SSCB is now at the start of the next phase of its development and as stated, all the basic building blocks are now in place, including a clear and focussed Business Plan, based on identified priorities to progress the work of the SSCB"

LGA Peer Diagnostic Review - Executive Summary Report

4.5 The full Peer Diagnostic Review report is available at http://www.sandwelllscb.org.uk/wp-content/uploads/2016/08/LGA-Diagnostic-and-Peer-Review-of-SSCB.pdf

Governance & Accountability Arrangements

4.6 In order to provide effective scrutiny, SSCB is an Independent Board which is not subordinate to or subsumed within any other local structures in Sandwell. Joint working arrangements with the other strategic partnerships in Sandwell are set out in a Sandwell Partnership Protocol.

4.7 The SSCB worked closely with the various performance improvement arrangements directed by the Secretary of State in respect of the local authority's Children's Services. This included providing reports and challenge for the Performance Accountability Board, liaison with the two Commissioners appointed to work with Sandwell, and contribution to the Children's Services Development Board. In their reports to the Secretary of State in November 2015 and May 2016 the Commissioners commended the work and contribution of the SSCB, particularly in setting an agenda for improvement with the local authority and partner agencies. The contribution of the Board was noted in the Peer Diagnostic Review:

"The SSCB has made a significant contribution to the work of the local authority and partners locally to ensure more consistent understanding and application of thresholds; improving engagement in early help, and in responding to CSE."

LGA Peer Diagnostic Review - Executive Summary Report

4.8 Much of the work of the LSCB is conducted through subgroups, and by its central support team. The Chairs' Group has the responsibility for monitoring and coordinating the work of the LSCB, agreeing and overseeing the Business Plan, and driving forward improvements in multi-agency safeguarding practice. See Appendix 1 for the 2015-16 SSCB Structure Chart.

4.9 Task and finish groups are convened as required in order to undertake specific pieces of work. These groups are well supported by LSCB members.

4.10 SSCB met 7 times during April 2015 - July 2016, in April, June, August, October, and February, May and July 2016. An extraordinary

meeting also took place in December 2015 to receive the findings from a Serious Case Review.

4.11 Attendance at the Board meetings throughout the year has been variable as illustrated in the table below. Regularity of attendance at the Board meetings is an area of work that the Board will be taking forward with partners during 2016-17. It is important to note that the Safeguarding Board's primary school representative stepped down during the year which contributed to their low attendance figure. The attendance figure of the young people is based on attendance since becoming members of SSCB in May 2016.

Figure 1: SSCB Membership Attendance April 2015 - July 2016

Agency	Attendance Level (%)
Sandwell MBC - Adult Social Care	71%
Sandwell MBC - Children's Social Care	100%
Birmingham Community Healthcare NHS Trust	86%
Birmingham & Solihull Black Country Team	86%
Black Country Partnership Foundation Trust	57%
Sandwell & West Birmingham CCG	100%
Sandwell & West Birmingham Hospital NHS Trust	86%
Academy	71%
College	71%
Primary School	14%
Special School	43%
CAFCASS	29%
Dudley & Sandwell Community Rehabilitation Company	43%
Dudley & Sandwell National Probation Service	43%
West Midlands Police - Local Policing Unit	67%
West Midlands Police - Public Protection Unit	86%

Lay Member(s)	71%
Young People	100%
Voluntary Sector	86%

4.12 The work of SSCB and the Business Unit cannot be achieved without a dedicated budget. Working Together 2015 states that all SSCB member organisations must provide SSCB with reliable resources (including finance) that enable it to be strong and effective. SSCB continues to be well-funded. During 2015-2016, SSCB received funding of £398,196 provided by:

Funding Source	Budget (£)
Sandwell Council	213,400
Sandwell and West Birmingham CCG	162,100
West Midlands Police	19,146
Community Rehabilitation Company	1500
National Probation Service	1500
CAFCASS	550
Total	£398, 196

4.13 SSCB is grateful to Sandwell Council for provision of Board secretarial support; communication and press office support and data support, and to partners who chair SSCB sub groups and enable their staff to attend sub group meetings and task and finish groups.

Board Development

4.14 There have been a number of important Board developments in the past year: recruitment of new Lay Members; improving the engagement of young people in the work of the Board; and activities to improve the engagement with faith communities. Board members have also prepared reviews of their individual contribution to the work of the Board and have been given the opportunity to learn about frontline safeguarding issues in other agencies through *'Walk the Floor'* visits. A number of these developments are considered further below.

Community (Lay members)

4.15 Lay members operate as full members of the LSCB, participating as appropriate on the Board itself and on relevant sub-groups. Their role is to provide a community voice at the SSCB, help to make links between the SSCB and community groups, support stronger public engagement in local child protection and safeguarding matters and an improved public understanding of safeguarding and the work of SSCB generally.

4.16 Following a successful recruitment process in March 2015, two lay members joined the Board who have played a substantial role in challenging the Board and making a positive contribution to its work.

I (Sharon Wilson) became a lay member of Sandwell Safeguarding Children Board in May 2015. My passion is child care and family support. I have worked in this field for thirty years as a nanny, in nurseries, family centres, a local college and currently as a Recruitment Consultant, specialising in child care/early years. I am dedicated to providing the best outcomes for children and their families.

I joined the Board at a challenging time, just as the Ofsted report was published, which had raised a number of concerns about the Board's effectiveness. Consequently, the Ofsted report was the main focus of my first meeting. I was encouraged by the fundamental commitment to improving the lives of children in Sandwell within the team, which gave me confidence that we will succeed. I also quickly felt at ease contributing to the meeting by the friendly, welcoming attitude of the group. Members were receptive to new ideas and shared thoughts openly, challenging practices objectively. An Improvement Plan was formulated in response to the report this has been a working document over the year.

Having attended full board meetings and chairs group meetings, I find them well-structured and focussed, with a clear agenda that allows each member to contribute. Actions are agreed and followed up, with reports provided at each meeting. Initiatives are in place to facilitate a more active involvement of children and young people in the decision making process.

I am pleased to say that during my time as a board member there has been a significant increase in the involvement of young people and we now have two young people on our board. There is full agreement within the Board that the key to all of our actions is the 'impact on children'. We are looking to further improve the process of measuring this through enhanced data collation and refreshing the Early Help Offer, which is well underway.

Earlier in the year, Alan Wood undertook a national review of Local Safeguarding Boards which I was part of, meeting him in Birmingham on 24th February 2016, sharing my thoughts, views and opinions as a lay member. As we look forward to 2016-17, the board will be commissioning a Diagnostic and Peer Review from the LGA. As a result of both of these reviews, I anticipate that we will scrutinise our practices further to ensure that we remain focussed on the children and families we are there to help.

I am confident that as a board we are in a position to improve practice across the partnerships, increase our links with the local community and make a real difference to the children in Sandwell. As a lay member I do not represent an agency and therefore, I give an independent view away from the constraints and jargon of each organisation involved. I look forward to continuing and developing my role in the future.

I (Leeanne O'Donohue) feel well embedded into my role as a lay member with SSCB having been in post since May 2015. I feel very passionate about my involvement and the safeguarding of children and young people in the Borough.

I am a qualified art psychotherapist and have worked with children and young people for many years. I am currently a front line practitioner in a primary school working as a Pastoral Lead and Attendance Officer and have previously worked as a Learning Mentor. I have been overwhelmed by the extent and breadth of work that SSCB encompasses and have experienced the dynamic impetus and drive that is present at board level. The board continue to work hard in responding to key priorities following Ofsted review.

I was pleased to attend a Joint Board Development Day with the Adult Safeguarding Board in April 2016. The element around modern slavery was

particularly interesting though shocking. The Annual Conference of the SSCB on 5 July 2016 was the first that I had attended and I was impressed by the size and representation at this event. The itinerary for the day was thought provoking and informative. I was particularly interested in a group of young people speaking about internet and social media usage and the safeguarding risks involved. Their breadth of knowledge on the subject was astounding; their presentations had a huge impact on me as a parent. I feel very strongly that astute young people like these should have opportunity to educate our young people in Sandwell schools as they are both accessible and hold current information in this ever developing field.

I feel that young people and their views are an essential element in the work of the Board and in its promotion to others and following on from the young people's Board "takeover", am pleased to see the addition of two young people to the Board and very much look forward to meeting them.

I was also pleased to contribute to the LGA Diagnostic and Peer Review which took place in June 2016. I met a member of the peer review team and was able to share my views upon the current position of the Board. The implementation of the Peer Review gives a clear message that SSCB is constantly striving to improve, addressing any areas for improvement in a transparent way.

I have attended many training days recently through SSCB including Neglect, Trio of Vulnerabilities, MARAC, and feel that the training programme is excellent; the highlight of these being Zoe Lodrick speaking on The Psychology of CSE. Zoe is a very engaging and memorable speaker who communicates so well on the distressing subject of child sexual exploitation. The learning and development subgroup continue to improve training available to Sandwell practitioners.

Engagement with and Participation of Children and Young People

4.17 As detailed in the 2014-15 Annual Report, SSCB used the SHAPE programme to engage with young people.

4.18 The second Child's Voice Conference was held at Bethel Convention Centre on 30 November 2015 with attendance of children and young people across the Borough. The outcomes from the conference, along with a survey completed by young people (resulting in 563 responses) and subsequent activity to develop *'pledges'* was presented to the SHAPE Youth Forum in January 2016 and an Annual Report was presented in May 2016 with positive feedback. The Annual Report can be accessed from the SSCB website at: http://www.sandwelllscb.org.uk/wp-content/uploads/2016/09/22062016-Cabinet-SHAPE-annual-report.pdf

4.19 This programme, which is led by Sandwell MBC, with extensive involvement from partner organisations (including the community and voluntary sector), has enabled SSCB to understand the safeguarding issues that are important to children and young people.

4.20 On 25th February 2016, a group of young people took part in a *'takeover day'* of SSCB. Takeover is a fun, hugely successful and exciting engagement project which sees organisations across England opening their doors to children and young people to take over adult roles.

4.21 Teenagers from Q3 Academy, Holly Lodge School, Sandwell's Looked after Young People's Board, the SHAPE Youth Forum and Sandwell Youth Parliament, spent the afternoon not only presenting to Board members, but also leading them through a series of interactive exercises.

4.22 The initiative encouraged SSCB to hear their views and enabled the young people to gain an insight into the work of the Safeguarding Board, whilst also providing members with a fresh perspective about their work.

Front row left to right: Charlotte Wright, Ieasha Hamrahi, Jamie Priddey, Sasha Bunn, Eloise Duce, Chelsea Thompson. Back row left to right: Rizwana Arif, Priya Kumari, Edwin Boateng, Gurmaad Omer, Sara Banares, Keisha Eaton, Lydia Bradbury, David Nemec

"The young people engaged board members, challenged them, and stretched their thinking. They were a great credit to themselves and the schools and colleges they represented."

John Harris, SSCB Independent Chair

4.23 Building on this work, the Safeguarding Children Board has benefitted from having the perspective of two young people - Chelsea Thompson and Ieasha Hamrahi - who became Board members in May 2016.

4.24 Ieasha subsequently played an integral part during the Board's multiagency annual conference on 5 July 2016 which she hosted with a great deal of confidence and skill. Influenced by a Serious Case Review (SCR) undertaken during the year coupled with several other cases brought to the attention of SSCB (which will be taken forward during 2016-17 in the form of a Lessons Learned Review), the Conference explored the theme of exploitation of older young people and looked at key dimensions to adolescent risk and resilience, including the ways in which choice and behaviour can play a role in both.

4.25 Keynote speakers from Research in Practice and The Children's Society challenged the thinking of delegates and encouraged them to focus on *what we know* rather than be constrained by a child protection system that may not be working effectively enough for many older young people. They were complemented throughout the day by a number of young people who ensured that their voice ran through the conference.

A group of Year 9 students from Wodensborough Ormiston Academy (Jay Hall, Bradley Greenaway, Lucas Peterkin, Paige Rumbold and William Shaw) shared their knowledge and expertise on the dangers of the internet and what young people and their parents can do to keep safe. Two young people from the Children's Society also facilitated an interactive session with delegates about a young person's perspective on professionals and CSE.

"At first I was nervous but once I was presenting, I felt like my normal self. I also felt proud because I was representing the school in a good way. Also, because not many people had heard of Snap Chat, I see myself as a good opinion leader."

Lucas Peterkin, Wodensborough Ormiston Academy

4.26 Delegates also heard about Project 12 - a Personal, Social, Health and Education programme being rolled out across Sandwell by DECCA - as well as being able to listen directly from a victim of FGM as she bravely recounted her very personal experience of this form of abuse. In addition, a presentation about the learning from a recent SCR (GS) was delivered and supplemented not only by an activity

that asked agencies to consider their strengths and areas of development in supporting older young people, but also by the powerful delivery of GS's experience in her own words (using the voice of an actor).

Faith Communities

4.27 The Board has commenced work to improve engagement with faith, culture and emerging communities. Whilst there was a proposal to set up a Faith and Culture sub group during 2015-16, this work was in fact taken forward in the form of a Community Faith-Based Establishment (CFBE) task and finish group, chaired by the Local Authority Designated Officer (LADO).

4.28 The group, which has met on a bi-monthly basis since January 2016, focuses on safeguarding and promoting the welfare of children from faith groups and culturally diverse communities in Sandwell.

4.29 In order to progress the pace of work the LADO has linked in with neighboring LADOs on how strategies should and could be developed with community members. The LADO has also engaged with the Inclusive Muslim Action Network (IMAN) and other community members to discuss the crucial role CBFEs have to the safeguarding agenda.

4.30 Processes are now in place to ensure that a strategy discussion with Police is undertaken when any unregulated agency comes to light where alleged abuse has taken place. This is managed via a Position of Trust (POT) screening process or progressed to a POT coordination meeting.

4.31 In January 2016 the 'Protecting the rights of children and adults at risk of abuse – a guide to Child Protection and Adult Safeguarding for Faith Based Establishment' was launched which is aimed at gaining consistency across CFBE practice.

4.32 Looking forward, further work needs to take place to ensure that key information - including the names of committee members and key contact details - is captured whenever the Police visit an unregulated agency/organisation. This will enable the continued development of a directory of resources and identify a network of support that could be tapped into.

4.33 It should be noted that the Sandwell Partnership has commenced a complementary piece of work involving a mapping exercise to create a database on CFBE and highlighting the support services on migrant communities.

4.34 CFBEs also need to be encouraged to take on the guidance and tools that are now available in developing standards of competency, practice and policy within their organisations.

Further Development of the Board

4.35 Partners will need to give further consideration to the membership and structure of the SSCB in the light of a finding from the Peer Diagnostic Review that the membership of the Board is too large and that there are possibly too many sub-groups. A review of the Board's membership and organizational structure will also need to take into account the response to the Wood Review of LSCBs from partners in the region and in Sandwell.

5. Performance and Effectiveness of Local Arrangements

Sandwell MBC: Children's Services

5.1 In March 2010 the Secretary of State issued an improvement notice to the Council for the purpose of securing 'adequate' performance of children's services. The improvement notice followed an 'inadequate' rating in the January 2010 safeguarding and looked after children inspection. In October 2013 the secretary of State issued a statutory direction to the council following 'inadequate' inspection reports for arrangements for the protection of children (April 2013) and for services for looked after children (August 2013). In July 2014 a second statutory direction was issued as the Secretary of State considered that the service remained 'inadequate'. The action taken did not, however, result in service improvement to an adequate standard and performance in respect of child protection has remained 'inadequate' as detailed in OFSTED's inspection report of 5 June 2015.

5.2 During the reporting period SSCB and Children's Social Care jointly commissioned three external audits to provide an independent perspective in respect of key areas of safeguarding risk. Not only did these audits examine specific issues around Thresholds, Early Help and Child Sexual Exploitation (CSE), but they also signaled that the SSCB could provide authoritative and constructive challenge to enable the Local Authority and partners to reflect upon key issues of substance identified in OFSTED's inspection of Children's Service's.

5.3 One of the recommendations from the SSCB's external review of the understanding and application of thresholds (June 2015) was that a more detailed review of early help should be undertaken. The same external team carried out a review of early help in October 2015 and the findings were considered as part of a development workshop with the Early Help/MASH Board on 24th November 2015. This workshop also considered findings from a review of the capacity in the MASH, which had been a recommendation from the external review of thresholds.

5.4 The Early Help/MASH Board subsequently prepared an action plan in response to the recommendations from this review that was incorporated into the local authority's Improvement Plan

5.5 The CSE Assurance Review was commissioned in response to key issues identified in the OFSTED inspection report. The review took

place between August and October 2015, with the final report submitted on November 8th 2015. The review included interviews with senior leaders and practitioners across partner agencies, practice observations, and an audit of representative sample of 20 CSE cases. The findings were reported against SSCB's ten key CSE assurance questions:

1. How well does Sandwell understand the nature and scale of CSE?
2. How reliable is the data?
3. How effective is preventative work with children and families?
4. How far are services providing timely, appropriate and effective support to victims and those at risk?
5. How far do partner agencies have the capability and capacity to respond to CSE?
6. How effective is work in disrupting and prosecuting perpetrators?
7. How effective is information sharing?
8. How effective is multi-agency training for responding to CSE?
9. How effective are quality assurance arrangements?
10. How effective is the strategic leadership of Sandwell's response to CSE?

5.6 The report found evidence of strong commitment from all partner agencies to tackle CSE, with some evidence of progress. Nevertheless, there were improvements required across all ten of the areas for assurance. The CSE Strategy and Action Plan were subsequently reviewed and updated in response to the findings and recommendations from the review.

5.7 Having considered the 2015 Ofsted report and the findings of a subsequent independent diagnostic report commissioned by the DfE and undertaken by Malcolm Newsam towards the end of 2015, the Secretary of State found that the Council's delivery of children's services, particularly in relation to child protection, continued to be inadequate.

5.8 Consequently, the Secretary of State appointed Eleanor Brazil as Commissioner for Children's Services in Sandwell to take the following steps:

a.) To direct and support the improvement of children's social care

b.) To review the Council's leadership and management capacity and capability to drive forward the changes necessary to achieve the required standard

c.) To make a recommendation to the Secretary of State as to whether alternative delivery arrangements are the most effective way of securing and sustaining improvement.

5.9 In response to this, the initial Improvement Plan 2015-2016 was reviewed to identify actions completed and outcomes achieved and this was shared with Ofsted. A new version of the Improvement Plan was subsequently developed for 2016/17 taking forward remaining actions and incorporating lessons from the DfE Review (Malcom Newsom) and the work of the Children's Commissioner. The plan focusses on five key themes:

a.) Continue to Improve Our Response to CSE

b.) Effective Governance Arrangements

c.) Partnership Working

d.) Improving the Quality of Practice

e.) Develop and Inspire the Workforce

5.10 The plan is managed within the Service to ensure speed of improvement and links in with other improvement activity including the CAMHS Transformation Plan, SSCB Improvement Plan and Early Help Strategy. The Commissioner has also established a Children and Families Service Development Board which works with partners to ensure that the activity is achieving the right outcomes for families and on time.

5.11 In her report to the Secretary of State in May 2016 the Children's Commissioner identified continuing concerns about the quality of social work practice, with findings similar to those identified through the external reviews of thresholds, early help and CSE that had been commissioned by the SSCB. She considered that the local authority did not have the capacity on its own to manage the scale and pace of improvement required. The Commissioner identified two options for future delivery arrangements in Children's Services: appointment of an Executive Commissioner with an improvement team; or the creation of an independent Trust with full council involvement. At the time of publication of this report the Secretary of State had not determined which of these options to take forward. The SSCB is well placed to support improvement under either option. Early resolution of the preferred option will be beneficial to enable the council and partners to drive forward the improvement that is urgently required.

Health Services

5.12 Health professionals are in a strong position to identify welfare needs or safeguarding concerns regarding individual children and, where appropriate, provide support. This includes understanding risk factors, communicating effectively with children and families, liaising with other agencies, assessing needs and capacity, responding to those needs and contributing to multi-agency assessments and reviews.

5.13 A wide range of health professionals have a critical role to play in safeguarding and promoting the welfare of children including: GPs, primary care professionals, paediatricians, nurses, health visitors, midwives, school nurses, those working in maternity, child and adolescent mental health, adult mental health, alcohol and drug services, unscheduled and emergency care settings and secondary and tertiary care.

5.14 Sandwell & West Birmingham Clinical Commissioning Group, as a commissioner of provider services, has provided good leadership to the safeguarding children agenda across the health community. The designated professionals and CCG Chief Officer (Quality) are members of the LSCB and make a significant contribution to the work of the Board and its subgroups (with the latter being the Vice Chair of SSCB).

5.15 The Safeguarding Board's Health Forum brings together professionals across the health community to discuss matters relating to safeguarding, and acts as a conduit between the LSCB and health services. The Health Forum provides a valuable opportunity for the local health providers to discuss a common response to safeguarding across 'health'. Arrangements such as this help provide both discussion and co-ordination and are greatly helping the work of the SSCB and its direct impact on services.

5.16 Health and adult social care services in England are independently regulated by the Care Quality Commission (CQC), which ensures that the Essential Standards for quality and safety are met and in particular Outcome 7 - Safeguarding people who use services from abuse. The CQC inspects how NHS providers are meeting this standard through the acute hospital, Community and mental health trust and primary care inspection programmes.

5.17 Following the review in August 2014 of safeguarding and looked after children by the CQC recommendations for health services were put

into a SMART action plan for each organisation. Compliance has been monitored by the health forum, with robust peer challenge and progress reports submitted to the SSCB via the Chairs Group.

5.18 The CQC recommendations included the need for Sandwell & West Birmingham NHS Trust to ensure that staff in the emergency department assessing adults who attend for treatment are fully supported to identify risks of hidden harm to children through the provision of appropriate trigger questions on attendance cards, and that completion is subject to effective operational monitoring. To this end prompts are being added to the adult card via IT (Patient First) to consider whether the adult has 'child caring responsibilities' particularly if attending due to one or more of the trio of vulnerabilities.

5.19 In addition, closer working with General Practitioners (GPs) was recommended to ensure all health information known about a Looked After Child informs initial and review health assessments. A new process was subsequently developed but audit activity identified that GP's response to requests for health information was poor (31.2% for 2014/15). In response to the poor returns, the Designated Nurse for LAC delivered training to GPs at the GP Safeguarding Forum in January 2016. This was reinforced with a new LAC page on the CCG intranet page. The Designated Nurse for LAC is also in discussion with Named Professional for Primary Care to create a new process for GPs to share records when a child initially becomes looked after. Discussions are also underway about the health professional for a child to liaise directly with the GP prior to undertaking risk health assessments.

5.20 SSCB will be requesting a formal report from the Health Forum during 2016-17 about progress since the CQC Review in 2014.

Emotional Wellbeing and Mental Health

5.21 NHS England released the Future in Mind report in March 2015 which provided 50+ recommendations of how organisations across Health, Education and Social Care need to work together to improve emotional wellbeing and mental health of children and young people. Additional funding (£1.01m) from NHS England was made available; as such in August 2015 all CCG's were tasked with submitting transformation plans to NHS England that proposed how they aim to transform services.

5.22 Sandwell developed a Transformation Programme Board that consisted of key stakeholders including senior representatives from Health: NHS England and CCG the Local Authority: Education, Social Care, and Public Health. Sandwell submitted its Transformation Plan in October 2015 and was fully assured with an 88% assurance rating. Sandwell's plan focuses on a comprehensive transformation of CAMHS locally, including:

- Early Intervention
- The provision of outreach mental health services
- The delivery of a full range of psycho social therapeutic interventions based on the young person's need
- Timely access
- Moving to a 0-25 service,
- Moving away from the traditional tiered model of care, adopting the 'Thrive model' (see below)

Thrive Model

5.23 By the end of the reporting period, progress was being made in almost all service areas including:

- Increased access to provision

- Improved outcomes monitoring
- Young people being instrumental in the design and development of services
- Consistent approach to referral triage
- Quality standards rolled out across organisations

Looking Ahead to 2016-17

5.24 Since the start of the National Programme for Child and Adolescent Mental Health Services, significant progress has been made in Sandwell although there is still work to do including the following:

- Whilst access to the crisis team has significantly improved further work is required. Monitoring in this area also needs to be strengthened as it is currently inconsistent.
- Similarly, there is a need for more consistency in respect of early interventions and the response from education
- Additional clinical psychology input has been funded to support children and young people with Autism Spectrum Disorder (ASD) which will be closely monitored over the coming year.
- Work will continue in developing specific *Place of Safety* facilities for young people (although interim arrangements have been put in place)
- With respect to the Increasing Access to Psychological Therapies (IAPT), the Sandwell Partnership is currently looking to support 42 training places. The East Midlands Learning Collaborative have amended entry requirements which may cause issues for trainer access as the requirements are for clinical staff only to be trained. The issues are in the process of being reviewed.
- It is anticipated that the Eating Disorder Service will be fully operational by October 2016
- Sandwell Children's Services, Public Health and Sandwell and West Birmingham CCG have commissioned nine Primary Mental Health CAMHs Workers (PMHCWs) to provide additional support to the partnership and act as a link between tier ¾ and tier ½ when appropriate. Six of the workers have been located in the multi-agency teams. The remaining capacity is focused on the key areas of CSE/missing, Looked after Children and YOS. The programme is currently funded for 2-3 years and will be evaluated during this time to assess impact and support long term funding decisions

Education and Schools

5.25 SSCB has taken purposeful action to improve its engagement with schools and colleges. The Board established an Education Advisory Group (EAG) that held its first meeting in February 2015. The objective of the group is to improve understanding, recognition and response to education related safeguarding issues across school and college settings in Sandwell, ensuring the timely dissemination of information and engagement with partners about safeguarding.

5.26 During the year the EAG has been integral in reviewing the changes to Sandwell's Early Help system with the overall consensus being:

- School and Early Help communication has improved with the changed systems
- Access to day to day phone support and advice had reduced the need to take all issues to COG meetings.
- Less cases having to go to COGs meant COG meetings were not overly subscribed with school raised issues
- Lead professional role often requires external support and advice
- Social Care attendance at COG meetings has improved but more frequent representation was required. Similarly, the EAG felt that Health attendance at COGs required improving

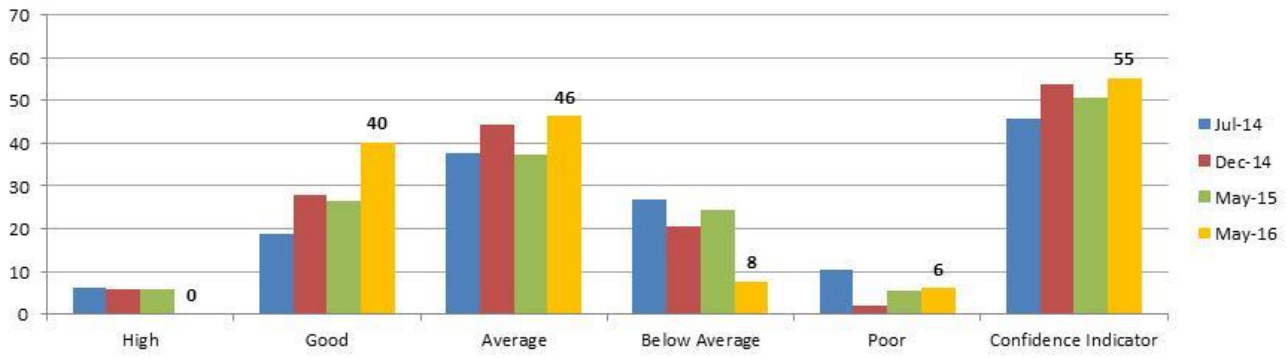
5.27 A further key activity of the EAG focused on the PREVENT agenda. Having been sighted on the proposed schedule of training from the PREVENT Coordinator, members felt that a faster roll out of WRAP training was required and that links to Learning Community groups could ensure that train the trainer events and subsequent school training could be accelerated. This will be reviewed in the coming year.

5.28 During the reporting period the EAG has given consideration to a number of DfE documents including online safety and the consultation on Keeping Children Safe in Education to which a collective response in agreement with the proposed changes and updating of the DfE guidance was submitted.

5.29 The group has also reviewed questions from previous school safeguarding surveys in light of comments made through the Head Teacher Joint Executive group. This has resulted in additional questions being added to the survey relating to the social and emotional support offered to young people; LAC; CME, DV and PREVENT training. The latest survey indicated the schools

confidence in Safeguarding systems had increased significantly since the last survey. A further review of messages to schools and young people in respect of child sexual abuse and exploitation was also undertaken which provided a good starting point for the development of curriculum materials.

Safeguarding and child protection procedures are improving in Sandwell



The data from the recent school survey demonstrates that schools feel child protection and safeguarding procedures have been steadily improving since July 2014 and there is an overall increase since the last survey

Note: The confidence score is the average of the ratings given by schools for each of the questions

Ranked summary of responses

Rating	Area	Av +	Conf.	Trajectory
High	Undertaking and understanding of PREVENT training	*93%*	82%	-
Good	Undertaking and understanding of CSE training	*90%*	74%	-
Good	Domestic violence notifications	*88%*	65%	-
Good	MASH speed and effectiveness	*91%*	63%	↑
Good	Children Missing Education support effectiveness	*83%*	60%	-
Average	LADO responsiveness and support	*86%*	59%	-
Average	Improvement in safeguarding and child protection	*87%*	55%	↑
Average	Health visitor support	*77%*	52%	-
Average	School nursing arrangements	*75%*	52%	↑
Average	Effectiveness of COGs in identifying and	*73%*	51%	↑

	providing support			
Average	Communication with COG teams to support working	*76%*	47%	-
Average	MASH communication (outcome of referrals)	*68%*	47%	↑
Average	Social worker response to support safeguarding in schools	*70%*	46%	↑
Below	Receipt of current, up to date, minutes (CIN, LAC, Core)	*61%*	43%	-
Below	Consistency of Social Worker case support	*58%*	42%	-
Poor	Accessibility of CAMHS support	*29%*	25%	↑
Poor	Mental Health counselling support	*22%*	22%	-

Note: The 'AV +' column represents the proportion of schools who rated the service as average or better

Threshold for ratings

Rating	Confidence range
High	**75 – 100**
Good	**60 – 75**
Average	**45 – 60**
Below	**25 – 45**
Poor	**0 – 25**

5.30 During the reporting period, the LSCB completed its 2014-15 academic year s175 audit and recommenced the audit for the 2015-16 academic year. The s175 online audit tool enables the Board to receive assurance that school governing bodies, local education authorities and further education institutions had arrangements in place to safeguard and promote the welfare of children.

5.31 As part of its scrutiny and assurance role the Safeguarding Board scheduled a number of 'assurance panels' with a cross section of schools in order to further discuss individual submissions and seek clarity over safeguarding arrangements. The assurance panels - which have been well received - also provided an opportunity for schools to showcase and evidence the work they were undertaking. The action plans resulting from the assurance panel meetings are monitored by the Quality of Practice and Performance Subgroup.

Looking Ahead to 2016-17

5.32 Develop an EAG action plan in line with SSCB business plan

5.33 Whilst the response rate to the 2014-15 and 2015-16 s.175 audits were good the diagnostic and peer review of the Board highlighted the need to ensure that there is a full response rate to the Section 175 exercise. This is an area that the EAG will be integral to during the 2016-17 academic year.

5.34 Ensure compliance with the statutory guidance on safeguarding, Keeping Children Safe in Education, when it comes in to force from 5 September 2016

5.35 Review uptake of PREVENT training available to schools

5.36 Monitor development of Lead Professionals Network meetings

Criminal Justice and Public Protection

West Midlands Police (WMP)

5.37 Protecting children is one of the most important tasks the police undertake. Only the police can investigate suspected crimes, arrest perpetrators and monitor sex offenders. Police officers have the power to take a child who is in danger into a place of safety, or to seek an order to restrict an offender's contact with children. The police service also has a significant role working with other agencies to ensure the child's protection and well-being, longer term

5.38 WMP is a statutory member of the LSCB, and its officers (both from the Public Protection Unit (PPU) and the Local Policing Unit (LPU)) play an active role in the Board, the Chairs' Group and its sub-groups.

5.39 West Midlands Police have actively supported the implementation of Multi Agency Safeguarding Hubs across all 7 Local Authority areas during 2015 - 2016, dedicating a Child Abuse trained Detective Sergeant and Detective Constable to each, supported by their Child Abuse and Domestic Abuse Teams based at West Bromwich Police Station.

5.40 In the summer of 2015, West Midlands Police was subject to 3 separate HMIC Inspections focused on vulnerability, these being:

- HMIC Child Abuse Re-Inspection (previous inspection in June 2014) - July 2015
- FGM, Forced Marriage and Honor Based Violence (HBV) - October 2015
    - The Force was one of only three Forces (from a total of 43 nationally) declared to be good at dealing with Forced Marriage and HBV. This accurately reflected the investment the Force had made in these areas. Both areas are of concern for the Sandwell area where both crimes are an issue for some minorities within the Borough.
- HMIC Vulnerability Inspection

5.41 All were published in December 2015 and are available on the HMIC website at: http://www.justiceinspectorates.gov.uk/hmic/peel-assessments/peel-2015/west-midlands/other-reports/

5.42 As a result of the recommendations from the inspection, the Force has significantly invested in raising awareness across all areas and all specialisms with particular focus on the management and supervision of investigations and in the recognition, identification and assessment of risk to children.

5.43 These issues and the Force responsibility to capture the voice of the child and ensure actions and decision making focus on achieving the best outcomes for children have been driven through a Child Abuse Action Plan, which is overseen by the nominated Child Abuse lead for the Force, Detective Superintendent Paul Drover under the leadership of the Force Public Protection lead, ACC Carl Foulkes.

5.44 During this period, the Force has invested heavily in a structured learning and development training plan for all areas of vulnerability. This programme has now been delivered to the vast majority of operational 'front-line' police officers and supervisors.

5.45 All dedicated child abuse investigators are either experienced, trained detectives or are working towards detective status on the nationally accredited Initial Crime Investigators Development Programme (ICIDP).

5.46 All Child Abuse Investigation Team (CAIT) officers attend the Serious Child Abuse Investigations Development Programme (SCADIP) and for supervisors the responding to child death course.

5.47 All local policing officers and child abuse specialists have received specific training on key areas of child abuse, including ensuring that the "Voice of the Child" is captured and put at the heart of decision making. This helps to ensure that:

- children impacted by domestic incidents are identified and referred for joint agency discussion and appropriate response
- appropriate processes used to capture evidence from children are utilised
- specially trained officers are deployed
- indicators of CSE are identified and referrals made accordingly

5.48 There is a regime of monthly dip sampling of Domestic Abuse incidents and Voice of the Child is one of the areas reviewed. A presentation on this subject has been disseminated by Detective Insp Mick Spellman internally to Police colleagues and also to partners. The presentation is available upon request.

Child Abuse and Safeguarding Governance Arrangements

5.49 Following a review of investigative structures and processes across the Force area introduced in June 2014, there are now 153 constables dedicated to local Child abuse investigations across the Force, made up of 7 CAIT teams each covering a local authority area, including Sandwell.

5.50 These are supported by a central Online Child Sexual Exploitation Team the central CSE team and a central referral unit into which all referrals from partners regarding potential child protection issues are received and initially assessed before being forwarded to local CAIT for further action / strategy discussion and section 47 activity (joint agency response with children's services)

5.51 Each CAIT is managed by a dedicated, trained child abuse Detective inspective who oversees specialist trained Sergeants and Constables who work in three teams, covering the Borough seven days per week from 0800 to 2200hrs, supported by the Local Policing Unit teams. A Detective Chief Inspector from the Force Public Protection Unit oversees the teams and also sits as part of the senior leadership team with overall responsibility for Child Abuse investigations.

5.52 Detective Superintendent Paul Drover is the Force Child Abuse lead, with ACC Carl Foulkes being the overall Command Team lead for the Public Protection Unit, incorporating all Child and Domestic Abuse and Sexual Offence matters.

5.53 Local CAITs manage all investigations into sexual abuse of a child under 18, all neglect, physical and emotional abuse of a child under 18 whether the offender is inter familial, in a position of trust or someone with responsibility for the child, as well as all HBV, FGM, Forced Marriage on a child under 18 and all SUDC's.

5.54 West Midlands have developed clear and detailed operating principles for every team and officer working within Child Abuse which are accessible on the Force intranet page.

5.55 There is a trained child abuse manager on duty between 8x4 every week day and on call from 4pm each night and at weekends. Standard operating principles have been developed determining the roles and responsibilities of all officers within child abuse, including on call functions.

5.56 The Public Protection Unit holds a daily management meeting at 0830 hrs every day of the week where critical, serious and complex incidents and investigations are discussed, senior management oversight is ensured and any requirement for additional support or consideration is managed.

5.57 This is supported by a local daily management meeting held on each LPU at 9am each day and monthly tasking meetings which specifically focus on trends, themes and emerging issues around vulnerability and risk. At 0945hrs the Force holds a Force Level management meeting, which both LPU and PPU feed into.

Key Achievements in 2015-2016

5.58 An internal cross discipline 'Improvement Board' (held monthly, chaired by Assistant Chief Constable Foulkes) has been introduced overseeing an agreed improvement plan bringing together all HMIC recommendations and the Force's own internally identified issues requiring additional focus.

5.59 The plan is set out under the following headings:

- **Prepare:** Providing strong leadership, effective systems whist working with partners to reduce vulnerability, the prevalence of hidden crimes and the harmful impact of missing episodes
- **Prevent:** Raising awareness of all aspects of hidden crime and vulnerability amongst the work force, partners, young people, parents, carers and potential perpetrators in order to identify risk quicker and prevent incidents/repeat incidents of harm including missing episodes
- **Protect:** Safeguarding vulnerable people and support victims and those professionals who seek to reduce instances concerning all forms of abuse including missing episodes
- **Pursue:** Disrupting, arresting and prosecuting offenders, ensuring a victim/child-centred approach at all times

5.60 The HMIC Child Abuse re-inspection identified that 1 recommendation had already been fully achieved and a further 7 recommendations partially achieved. The Force is continuing to drive forward efforts to achieve all of the outstanding recommendations via their Improvement and Crime Governance structures.

5.61 As referenced above, West Midlands Police have actively supported the implementation of Multi Agency Hubs across all 7 Local Authority areas during 2015 – 2016, dedicating a Child Abuse trained Detective

Sergeant and Detective Constable to each and being active members of the Operational and Strategic groups overseeing the implementation and effectiveness of the MASH

5.62 Throughout 2015 and 2016, West Midlands Police delivered Operation Sentinel - a Force wide initiative with an internal and external focus on Child Abuse, raising awareness and enhancing services to children at risk.

5.63 In February 2016 a Force wide Child Abuse monthly audit programme was implemented, including learning lessons and sharing of good practice which are discussed at monthly Child Abuse managers forums, chaired by the dedicated Child Abuse lead for the Force. The forum identifies good practice, shares learning and embeds consistency across all Local Authority areas as well as developing effective networks and relationships across all CAITs.

5.64 In addition, a Vulnerability specific tasking meeting chaired by the Local Policing Chief Inspector, Martin Hurcomb, has been introduced, which includes a specific focus on preventing children from becoming at risk of CSE, protecting victims of CSE and bringing CSE perpetrators to justice. This meeting is a multi–discipline meeting with colleagues from the PPU, neighbourhood officers, partnership team staff, West Midlands Police intelligence department and response functions to ensure a fully joined up and focused response to vulnerability, including inter familial abuse and CSE from the local police.

West Midlands Police Key Challenges in 2015-2016

5.65 The increase in incidents (crime and non-crime child abuse investigations) that have been managed by Sandwell Child Abuse Investigation Team (CAIT) has continued to rise (reflecting a national increase in reported crimes of this type).

5.66 There has been a 24% increase in recorded Crimes against Children for Sandwell compared to the previous year April 2014 to March 2015 and a 24% increase for the Force.

5.67 The volume of Crimes against Children in Sandwell over the year was 1730 crimes, reflecting 12% of the Force total volume which is consistent with the 12% in the previous year April 2014 to March 2015

5.68 Child Sexual Exploitation cases are continuing to increase with the Home office raising CSE as a national threat; the on-going focus and benefits of the work commissioned by Preventing Violence against Vulnerable People Board and the embedding of the regional framework for CSE has resulted in in the early identification of both victims and offenders. There remains a dedicated CSE Police officer working alongside the CSE team within Sandwell MASH. In Sandwell there were 170 reports, reflecting 10% of the Force total. This showed an increase from 81 reports the previous year. It is believed that rather than reflecting increased exploitation this rise indicates a great willingness to report and recognise CSE as a crime.

5.69 The CAIT teams continue to manage CSE investigations. As a Borough the Force are beginning to understand the problem but it is suggested that the Force still have some way to go in fully understanding the problem. The Force are improving in this area. A trial is due to take place in September 2016 involving a Sandwell victim where a number of offenders have been charged with 23 CSE related crimes. The Borough has continued to develop an effective Young People at risk of Sexual Exploitation forum (YPSE). This involves the commitment of partner agencies to understanding and responding to CSE in the Borough. This is chaired by the Police and is linked to the Missing Operational Group, given the overlap between Children missing and Children at risk of CSE. Both PPU and LPU are represented at these meetings. The LPU also chair and facilitate a CSE coordination Group which addresses the issue of CSE, supported by the Police Intelligence Department.

5.70 The number of resources within West Midlands Police has greatly reduced in recent years and there remains a need to explore new ways of working in response to a more sustainable model. West Midlands Police will continue to look at ways to transform services and drive efficiencies through the WMP2020 programme (a programme running in the Force supported by Accenture Business Consultants), which will form a vital element of a medium term financial strategy.

Looking Ahead to 2016-2017

5.71 West Midlands Police published its Strategic Assessment for 2016/17 in January 2016, full details of which can be found at: https://www.west-midlands.police.uk/docs/keeping-you-safe/about-us/public-facing-strategic-assessment.pdf%20

5.72 The assessment emphasises the need to maintain the current priorities of reducing violence and investing in intervention strategies. However, it also highlights the need to change the way in which the Police work with partners.

5.73 It is recognized that it is no longer enough for the Police to simply lock up criminals and alternative ways must be found to work collaboratively with partners in order to understand and provide interventions to prevent young people especially from becoming victims and committing crime.

5.74 There is growing awareness that there is a big overlap in the effect of serious issues such as Adverse Childhood Experiences (ACE), homelessness, drug and alcohol misuse, poor mental health and offending behaviours for people experiencing them. The Force has recently commenced a piece of work which seeks to create a profile of neglect in Sandwell.

5.75 Serious issues such as these rarely happen in isolation and the focus during 2016-2017 is to prevent people from becoming victims or offenders of crime and identify and work with partners to provide appropriate interventions at the right time to reduce the harm caused to the community.

West Midlands Police internal reporting systems

5.76 As referenced above, West Midlands Police has developed a structured internal reporting, auditing and incident flagging programme which includes daily management meetings to review all incidents from the previous 24 hours and ensure an effective response.

5.77 Monthly tasking meetings focus on vulnerability to identify any emerging themes, issues and risks, including a PPU specific operational oversight meeting which reviews all major investigations and focusses on high risk offenders and locations, supported by a bi-monthly Service Improvement Meeting attended by all Child Abuse managers who conducts thematic 'deep dive' reviews and a quarterly performance meeting chaired by ACC Foulkes and attended by all PPU Senior Managers which discusses departmental priorities, challenges and opportunities across the Child, Domestic and Sexual Abuse arenas.

Staffordshire and West Midlands (SWM) Probation Trust

5.78 Probation Trusts are subject to 'section 11' duties. They are primarily responsible for providing reports for courts and working with adult offenders both in the community and in the transition from custody to community to reduce their reoffending. They are, therefore, well placed to identify offenders who pose a risk of harm to children as well as children who may be at heightened risk of involvement in (or exposure to) criminal or anti-social behaviour and of other poor outcomes due to the offending behaviour of their parent/carer(s).

5.79 During the reporting period, SSCB sought assurances from the National Probation Service (NPS) and Community Rehabilitation Company (CRC) in response to the SSCB Annual Report 2014-15, which had identified a number of areas of focus

5.80 The Board's key concerns were in three areas: (a) the impact of organisational changes in these agencies on their ability to engage fully in local child protection arrangements; (b) supervision, training and management oversight; (c) engagement in local child protection processes and the LSCB. The reports provided the Board assurance that these partner agencies could meet the required expectations. The subsequent Section 11 Scrutiny Panels provided an opportunity to test out the issues in further depth.

Sandwell Youth Offending Service (YOS)

5.81 Sandwell Youth Offending Service (YOS) is a multi-agency team responsible for the supervision of children and young people subject to pre-court interventions and statutory court disposals. The YOS is also responsible for the provision of persons to act as Appropriate Adults to safeguard the interests of children and young persons detained or questioned by police officers, hence are significant in ensuring the safety and welfare of children in particular circumstances. Since the opening of the Super Custody Police block in Smethwick during 2015-16, the office hours Appropriate Adult cover has been completed on a rota basis with Dudley and Walsall boroughs.

5.82 If young people commit an offence which is suitable for a pre-court resolution, the YOS has an Out of Court Disposal (OOCD) process which was designed and implemented with Police, and seeks to divert from formal court proceedings where appropriate. If a young person reoffends and is sentenced at Court, the YOS work with the young person to complete the Order.

5.83 In terms of statutory work, the YOS continues to work towards progress against its three key performance indicators of Reducing First time Entrants, Reducing Reoffending and Reducing the Use of Custody. The YOS is currently implementing a new assessment system 'ASSET+' which has been developed by the Youth Justice Board.

5.84 There are a number of significant challenges which require ongoing consideration and evolution of service; particularly around the diverse and challenging nature of the current cohort and a particularly difficult financial situation with reduced funding in a number of funding streams. Youth Offending is under a national review commissioned by the Government. The Charlie Taylor Review is due to be published in the summer and may have significant implications for Youth Justice Delivery. There is a risk around maintaining standards in an already reduced service which will need to be mitigated when new national guidance is received.

5.85 There will also need to be consideration of the potential for more regional collaboration as Youth Justice forms part of the long term plan of development of the West Midlands Combined Authority. Sandwell Magistrates Court closes in September 2016 and so regional Court cover is likely to form the focus of collaboration in the short term.

5.86 Whilst waiting for the results of the Government review, the YOS takes its own development seriously and learning from thematic inspections routinely informs the YOS Management Boards' agenda. In addition the YOS seeks to learn from other areas and has visited Ealing YOS, and have approached Bracknell Forest and Gloucester to understand their models which are considered good practice.

5.87 Regarding the Child's voice, the YOS gained over 40 responses to a HMIP e-survey, and a collated report of comments has been received which will be submitted to YOS/TYS Management Board for analysis and inform service delivery improvements

5.88 DECCA deliver harm reduction educational work around substance misuse in mainstream schools as part of their universal offer. The team also deliver harm reduction educational work using a structured model within non mainstream settings, and direct treatment with those young people identified as having alcohol and/or drug related issues.

5.89 The Prevent duty has become a requirement since July 2nd 2015 which placed a duty on Local Authorities and Education to engage with the Prevent Agenda. Prevent is part of the Government's Counter Terrorism Strategy with three overriding objectives, which are: (a) response to the ideological challenge of terrorism and the threats faced from those who promote it; (b) prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support; (c) work with sectors and institutions where there are risks of radicalisation which need to be addressed.

5.90 Sandwell has been engaging with the Prevent Agenda for a number of years and is designated as a supported area by the Home Office with an expectation of having a strategy, delivery plan and Channel arrangements in place. Channel is a multi-agency approach to protect people at risk from radicalization. The overall coordination of the Prevent Agenda now sits within the Community Safety Team, but the YOS continue to fund a specialist post for interventions on this area of work and are involved in the coordination of the Channel forum

5.91 With regard to Child Sexual Exploitation, the YOS and DECCA undertake screening on cases and have representation at multi-agency meetings for cases demonstrating CSE concerns. Staff are aware that they need to be proactive in the response to this complex issue.

5.92 The YOS has representation on the FGM working group and is raising awareness of this issue

5.93 The SSCB targets for 16/17 will be to ensure continuity of service delivery in a challenging climate nationally for Youth Justice Services.

Third Sector

5.94 Third sector organisations in Sandwell make an important contribution to safeguarding in Sandwell. As well as there being VCS representation on the Board itself (from Sandwell Womens Aid (SWA), Barnardos and Krunch), there is involvement in board sub-groups as active members although this is an area that needs strengthening in order to increase VCS participation in safeguarding initiatives.

5.95 Sandwell Womens Aid (SWA), Barnardos and Krunch all provide services that support SSCB's key safeguarding priorities. An overview of the contributions from Barnardos and SWA is provided below.

Sandwell Women's Aid

5.96 Sandwell Women's Aid (SWA) is an independent charity operating across the Black Country specialising in supporting both adult and child victims of abuse; this includes victims of domestic abuse, rape and sexual violence, modern slavery and child sexual exploitation. SWA supports over 10,000 victims each year offering sensitive, trauma informed, evidence based interventions and counselling to help victims cope and recover. From humble beginnings 30 years ago SWA has developed a range of services that has responded to the changing needs of victims; to achieve this SWA has worked successfully with local, regional and national partners to ensure that victims of abuse get the right help and support.

5.97 In June 2014 the SSCB agreed to allocate development funding for innovative safeguarding projects. Following a formal bidding process against published criteria two projects were taken forward: the IRIS Project (led by Sandwell and West Birmingham Clinical Commissioning Group partnering with Sandwell Women's Aid), and 'Think Family, Act Early' led by Sandwell Women's Aid supporting child victims of domestic abuse alongside adult support. Both projects focus on tackling aspects of domestic abuse.

5.98 The 'Think Family, Act Early' project relates to piloting support services for 6-10 year olds who are direct/ indirect victims of domestic abuse. Developing the right model was vital from the outset and use of existing assessments (Barnardo's Screening Tool and SMBC Thresholds) provided a common approach to risk identification and

needs assessment. Children are referred into the service via Domestic Abuse Advocates and local schools. Dedicated Young People's Advocates (YPAs) provide age-appropriate interventions which include one to one support for individual children, group work with families and children. This enables each child to have a voice and be heard, for the YPA to understand family dynamics and facilitate peer support within a group setting.

5.99 Awareness and information dissemination are essential, preventative work targeting children and young people must be seen as a long term priority. Schools are therefore an essential conduit to reach children and their parents. As part of the pilot, a mapping of local need was undertaken and work was targeted to schools in Smethwick, West Bromwich and Oldbury.

5.100 The pilot delivered awareness and education sessions around healthy and unhealthy relationships, gender equality, and unhealthy secrets targeted at years 5 and 6. Safeguarding and domestic abuse awareness has also been delivered to children, teaching staff and mentors.

5.101 Whilst local schools have engaged with the pilot positively, as there is no imperative for schools to include work on healthy relationships in their curriculum, it is therefore important that there is a commitment to a consistent awareness-raising and education programme in schools targeting both child and parent.

Barnardos

5.102 Barnardo's delivered West Bromwich North Childrens Centre, Barnardo's Sandwell Family Support Service, Black Country BASE, Sandwell ABC (Awards in the Black Country playscheme) and BALANCE family support on behalf of Sandwell MBC during 2015-2016.

5.103 West Bromwich North Childrens Centre cluster comprises of Hillside Childrens Centre and Great Barr and Hamstead Childrens centre with a satellite base at The Brambles in Yew Tree. The centres offer a range of activity including:- Early years sessions, Family Support, Community development and outreach work and work with a number of key partners from Health, Welfare support, Information/Advice/Guidance and Education. Barnardo's deliver early intervention services for children 0-5 and their families on behalf of Sandwell MBC. The Children's centre family support teams are all operating within Sandwell's Early help model and acts as lead

professionals in the co-ordination of care pathways designed to safeguard and support children.

5.104 The Sandwell Family Support Service is an early intervention support service for Families in Sandwell that delivers early intervention, CAF and outreach engagement in direct work with families. Using a range of evidenced based parenting support models and therapeutic & practical support for families, the service delivered on behalf of Sandwell MBC works within COGs and multi-agency partnerships within Early Help to deliver a responsive and flexible approach. Acting as lead professionals, family support workers are central to offering family support to enable families to support and safeguard their children.

5.105 Sandwell ABC delivered a holiday play scheme on behalf of the borough for children with mild to moderate Disabilities

5.106 Black Country BASE (Barnardo's Against Sexual Exploitation) offers specialist CSE services in Sandwell and operate as part of Sandwell's CSE co-located multiagency team in delivering safe, effective and co-ordinated care pathways across the Borough. Using evidenced based practice, the service provides Missing/Return interviews for children who go missing from home with an independent and outreach approach, a high level CSE therapeutic support model for children/YP at high risk or who have been victims of CSE and some educative family support work for families. Training is also delivered on behalf of the SSCB to ensure the care pathways operating locally are embedded into evidenced based training programmes. All CSE provision works within National and Regional guidance with reporting into the local systems of YPSEM operational and strategic subgroups.

5.107 Since January 2015 the BALANCE Volunteer Family Support Service has been working in collaboration with Sandwell Children's Social Care Management teams to provide additional support to families who have Child in Need or Child Protection plans in place. This approach is designed to offer a level of outreach, engagement and support to families who may need additional resource to enable them to safeguard and support the well-being and development of their children. Using volunteers this service is an innovative approach to providing cost effective, tenacious services aimed at improving outcomes for families around resilience, engagement and access. This service ended in March 2016.

6. Learning and Improvement

6.1 Working Together (2015) sets out the requirement that LSCBs "should maintain a local learning and improvement framework which is shared across local organisations who work with children and families. This framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result"

6.2 The Board's current Learning and Improvement Framework was developed by the Board's Improvement Partner in early 2015. The Framework will be refreshed during the early part of 2016-17 in order that Partner agencies and all local organisations who work with children and families further endorse and embed it into their organisational and workforce learning and development policies.

6.3 The framework covers the full range of reviews and audits aimed at driving improvements to safeguard and promote the welfare of children.

Serious Case Review Subcommittee

6.4 During the reporting period the SCR Subcommittee met seven times in April, June, July, October 2015, and February, April and June 2016. During this time the SCR subcommittee ensured that reviews were undertaken appropriately, not only for cases which met statutory criteria, but also for other cases where it was felt that useful learning into the way organisations worked together to safeguard and protect the welfare of children could be identified. This year the subcommittee has disseminated learning through single agency briefings, SSCB training, published reports, learning notes and newsletters. Recommendations from a published serious case review this year have linked the subcommittee with the SSCB audit programme.

6.5 The experienced chair of the SCR Subcommittee, Eileen Welch, stepped down from the role in July 2015 and the Independent Chair of the SSCB undertook the role for the remainder of the year. A new chair for the subcommittee will take up the role in 2016-17.

Key Subgroup Activity and Achievements

6.6 A Serious Case Review relating to the neglect of a child, who had moved into Sandwell with his family from a neighbouring Local Authority, was published in January 2016.

6.7 The SCR was undertaken using the SILP (Significant Incident Learning Process) methodology and was completed within a six-month timeframe. SILP is a learning model which engages frontline staff and their managers in reviewing cases, focussing on why those involved acted in a certain way. It follows a systems methodology and highlights what is working well and patterns of good practice.

6.8 This SCR analysed the events leading up to his third removal into the care of the local authority and explained the reasons why key agencies failed to intervene and protect him from significant harm.

6.9 The report highlighted the importance of effective information sharing and joint working when a case transfers from one local authority to another. In this case the lack of an effective handover of the case increased the vulnerability and risk of harm for the child. Crucially the voice of the child was not heard. Some professionals did not visit the child and when a disclosure was made, and his views were disregarded. Overall, the review concluded that the key partner agencies 'failed to get the basics right'.

6.10 Lessons learnt from this review were:

- Ensuring compliance with the West Midlands regional cross border protocol. An audit was undertaken by the Quality of Practice & Performance Subgroup in November 2015. Recommendations from this audit were translated into an action plan to progress this area of learning further.

- The importance of recording prior interventions, accurate family histories and chronologies. Although similar to previous lessons identified from local and national SCRs, the importance of case recording cannot be underestimated. For this reason the audit tool utilised by SSCB was amended to ensure that future multiagency audits undertaken take into consideration the quality of case recording.

- Ensuring that training commissioned by schools is consistent with local practice models which have been approved by SSCB. Using SSCBs Learning Improvement Framework, the s175 audit

undertaken across the Education Sector specifically enquired about the training commissioned by schools. During the accompanying s175 assurance panels this resulted in recommendations being made to schools to align their policies with SSCB practice models. In addition, the Learning and Development Subgroup positively engaged with those independent providers commissioned by schools with whom concerns had been identified. Further assurance work was undertaken during 2015-16 by the Education Advisory Group resulting in an increased awareness of multi-agency safeguarding training.

6.11 Following liaison with the national panel of independent experts on Serious Case Reviews a Serious Case Review relating to sexual exploitation of a looked after child was commissioned and carried out.

6.12 The methodology for the review encompasses the traditional individual management reporting as well as the SCIE systems model which encourages agencies to come together to share information, share any learning and draw out the key practice issues.

6.13 The SCR is due for publication during 2016-17. An action plan has been developed in conjunction with strategic members from representative agencies. Practitioner notes have also been designed and disseminated to ensure learning is circulated in a timely manner.

This SCR was themed into 4 main learning areas

a.) Listening to the voice of the child and embedding culture and relationships
b.) Multi-agency approach and response to CSE
c.) The Effectiveness of Health Interventions
d.) Care Planning, placements and transition

6.14 Lessons learnt from this review were:

a.) A multi–agency group to provide governance, monitoring and assurance for all missing episodes (including missing from care, school and home) and the links with CSE should be established urgently.
b.) The Corporate Parenting Board should ensure there is a review of the quality of foster care and the support and training carers receive against the regulatory framework.
c.) Social care and health commissioners should agree referral pathways and access for targeted services, for those looked after

children who have been identified at initial assessment and have been placed out of the Authority and also for looked after children and young people who have been sexually exploited.

d.) SSCB working with partners should ensure there is a clear and transparent process in place to ensure all health information is transferred over to receiving Health Trusts and Clinical Commissioning Groups when children are placed out of borough.

6.15 The SSCBs Significant Safeguarding Incident Notification process resulted in the submission of five cases during the year to the SSCB Business Unit.

- One of these cases led to the commissioned SCR as detailed above;
- One case was a Birmingham case and was passed to Birmingham Safeguarding Children Board;
- Two cases led to a lessons learned review
- One has led to a table top review is being carried out by health.

6.16 Dissemination of learning has been a focus point during the reporting period.

- The SSCB newsletter is routinely used to ensure learning from case file audits, local serious case reviews, learning reviews, key national serious case reviews and child death reviews reaches frontline practitioners. The newsletter also details forthcoming training offered by SSCB.
- SSCB multi-agency 'Learning Lessons from Serious Case Reviews' training has taken place on 16th June 2015, 4th November 2015, 16th March 2016 to a multiagency audience in order to inform frontline practice

6.17 In addition to multiagency 'Learning Lessons from Serious Case Review' training, single agency briefings have also been undertaken with the following:

- Designated Safeguarding Professionals (DSPs) in schools on 10th February 2016 (x80 delegates)
- Private, Voluntary and Independent (PVI) Sector on 9th March 2016 (x200 delegates across Early Years and Day Nursery Managers)
- Health Visitors, FNP and Students
- Smethwick cluster of schools (x20 delegates)

Looking Ahead to 2016-17

6.18 The Board will be publishing the SCR that was commissioned during the year as well as any specific learning from table top and lessons learned reviews. The subcommittee will ensure that its work informs the Board's Learning and Improvement Framework and will work closely with the Board's other sub-groups.

Child Death Overview Panel

6.19 An underlying principle of Child Death Overviews is to undertake a comprehensive and multi-disciplinary paper-based review of all child deaths up to the age of 18 years (excluding babies who are stillborn and planned terminations of pregnancy carried out within the law) normally resident in the Local Safeguarding Children Board's area. This is known as the Child Death Review Process. 2015-2016 was the eighth year of this data collection

6.20 During the reporting period CDOP met a total of 15 times and also convened 2 extraordinary meetings in order to decrease the amount of outstanding deaths requiring review.

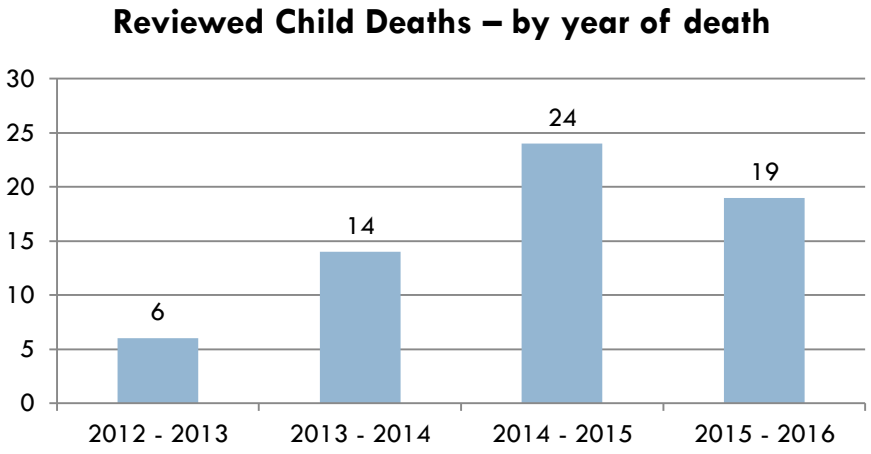
Key CDOP Activity and Achievements

6.21 In the year ending 31st March 2016 there were a total of 44 reported child deaths in Sandwell. Of these, 15 were deemed unexpected. Working Together 2015, Chapter 5 guidance gives the definition of an unexpected child death as: 'the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death'

6.22 Four of the unexpected deaths that occurred in the 1 month to 1 year age group were all co-sleeping sudden infant deaths

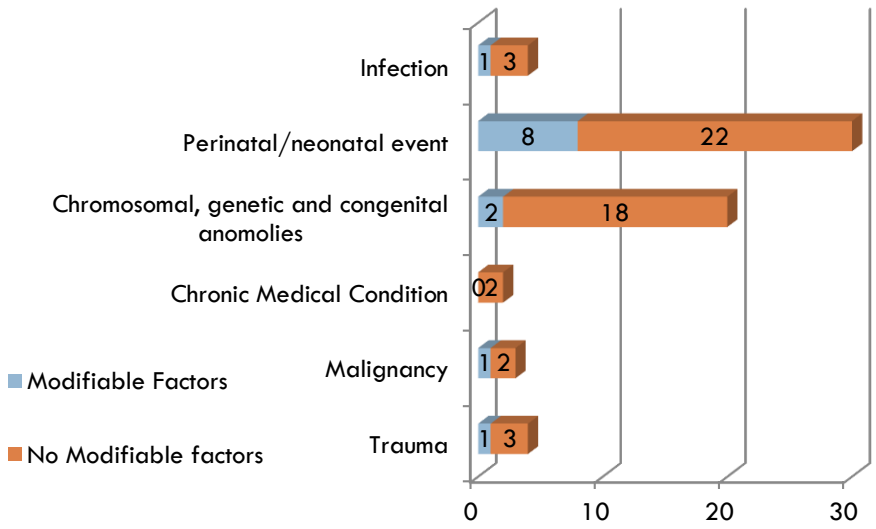
6.23 Of the 44 deaths reported in 2015-16, 25 were male (57%) and 19 were female (43%) which continues to reflect the global trend in a higher percentage of male deaths.

6.24 By the end of March 2016 CDOP had reviewed a total of 63 child deaths between 2012–2016 as illustrated below:



6.25 In 13 of the deaths reviewed between 1 April 2015 and 31 March 2016 modifiable factors were identified by panel members. These factors included maternal smoking as well as smoking in the household, co-sleeping and consanguinity. The learning from these deaths is disseminated in a variety of ways by short report briefings following each CDOP and bespoke briefings to frontline practitioners.

6.26 During this time the main cause of reviewed deaths was in the neonatal death category which is in line with national reviews. Nationally in this category 81% of deaths reviewed have modifiable factors. Similarly in Sandwell, 71% have modifiable factors.



6.27 The primary function of CDOP is to learn from the child deaths reviewed and the three main campaigns - Dog, Duck and Cat, Safer Sleeping and Shaken Baby - have continued throughout 2015-16.

Safer Sleeping - New materials were commissioned this year to reflect the Sandwell message of not sleeping in bed at all with baby. These messages have also now been portrayed pictorially to overcome any language or literacy issues. The campaign continues to be endorsed by the Lullaby Trust.

Shaken Baby - Sandwell & West Birmingham CCG agreed to fund the continuation of the shaken baby campaign bibs in 2015–2016 following a successful funding application from CDOP.

Dog Duck and Cat - The official launch of The World of Dog, Duck and Cat took place on Wednesday 3rd February at Oldbury Library. This event was supported by Cllr. Simon Hackett and a local primary school who enjoyed a morning of stories and activities presented by Bookstart

Looking Ahead to 2016-17

6.28 **Baby Box Launch:** Following discussions between Kerris Percival from the Family Nurse Partnership on behalf of CDOP, and a representative of the Baby Box Company, a decision has been made that they will adopt Sandwell as one of their UK starter sites. Baby Boxes will be launched in Sandwell in October 2016 for women booked at City Hospital.

6.29 Sandwell Public Health will be working with CDOP on a number of initiatives during 2016–2017 around healthy pregnancies, specifically maternal smoking, and will provide regular updates to the Panel members. These include:

- A new antenatal education module that will form part of the Changes Parenting Programme to be delivered within the community over the next 2 years
- Public Health 'healthy pregnancy' magazine covering topics highlighted at CDOP around smoking in pregnancy, safe sleeping and car seat safety
- Programmes with Sandwell and West Birmingham CCG to reduce infant mortality
- Working with colleagues on the ante natal pathway to ensure CO2 monitoring is carried out consistently and referred on appropriately

6.30 Despite a Sandwell-wide safer sleep campaign, CDOP is concerned at the increasing number of co-sleeping/bed sharing deaths being reported. An in-depth audit is planned for 2016–2017. This will take into consideration

- Co-sleeping/bed sharing deaths reported into CDOP from 2014-2015 and 2015-2016
- Co-sleeping/bed sharing deaths reported into CDOP's nationally

6.31 The audit will consider demographic information, and will examine if there are any common themes to highlight local trends.

6.32 The World of Dog, Duck and Cat will in 2016:

- Devise a Dog, Duck and Cat Accident & Emergency Prevention Programme for use by parents, carers and guardians
- Devise a Dog, Duck and Cat Accident & Emergency Prevention Programme for use by schools and organisations
- Launch the new books 'I Love My Car Seat' and 'What's in My Mouth' and then distribute
- Roll out new resources
- Redevelop 'The World of Dog, Duck and Cat' website to allow resources to be accessed online due to lack of funding for printing resources.

Learning and Development (L&D) Subgroup

6.33 SSCB has a statutory responsibility to ensure that appropriate training on safeguarding and promoting welfare for children and young people is provided in Sandwell in order to meet local needs.

6.34 The L&D sub group met 15 times between 1st April 2015 to 31st July 2016. During October 2015 membership was refreshed with the appointment of a new subgroup Chair, Vice Chair and L&D coordinator. The new chairing arrangements were due to a reshuffle of chairing arrangements for some subgroups following various chairs either stepping down or leaving the borough.

6.35 The subgroup was presented with a number of challenges during the year including representatives not attending meetings or there being no representation from some agencies (most notably the voluntary sector). This was addressed by way of a membership refresh and providing challenge to those not attending meetings on a regular basis. Impact evaluations remained an ongoing challenge as delegates were not always proactive in responding to an online survey to capture key information. Similarly, the parallel dip–sampling of 25% of attendees and their managers for each course has not proved very effective and requires strengthening (see paragraph 6.40).

Key subgroup activity and achievements during 2015-2016

6.36 Sandwell's learning and development chair and coordinator have been involved in the feasibility and implementation planning of delivering training courses across the four Black County LSCB's (Sandwell, Dudley, Wolverhampton and Walsall). Sandwell's L & D Chair has taken on the role of Chairing the task and finish group to drive this project forward during 2016-17. The project started in September 2015 with the objectives of making available a broader range of safeguarding across the multiagency workforce; enabling better cross border networking; and long term cost efficiencies.

6.37 In order to meet the target date of 1st April 2016 for the commencement of the delivery of amalgamated training across the Black Country, a training needs analysis was completed to inform a new amalgamated training catalogue. The four LSCBs have taken a lead responsibility in terms of writing, coordinating and administering up to 4 courses each.

6.38 Course content of SSCBs training offer during 2015-16 has been influenced by identified need from external reviews, practitioner demand, findings from audits, learning from SCR's and DHR's. In order

to accomplish this Tutor briefings were introduced and routinely circulated to trainers with information taken from SSCBs various assurance activities to thread through training (see Appendix 2). This enabled an ongoing channel of communication for consistency of key messages and helped to ensure that training was reflective of current learning and informed practice.

6.39 During the year the subgroup implemented a peer assessed quality assurance process to ensure high quality training and training delivery across all courses, both commissioned and delivered by in house trainers.

6.40 The evaluation process of the training courses was also strengthened during the year. In addition to on the day evaluations, 100% of delegates are now contacted 3 months post training to complete an online survey. In parallel to this, 25% of delegates and their line managers are contacted to complete an impact evaluation. This process was implemented for the courses run during Q3 for which the subgroup produced an impact report for the Board. Whilst the response rates have been limited they have nevertheless demonstrated that the learning offer is impacting front line practice. Looking forward to 2016-17, it is hoped that data captured through audit will complement the impact evaluations i.e. if delegates report that they have a better understanding of referral routes the data should identify a reduction in inappropriate referrals in to MASH

6.41 Links were established with the Strategic Prevent Coordinator to deliver (Workshop to Raise Awareness of Prevent) WRAP training and to complete a WRAP train the trainer event to increase capacity and deliver training across the borough. Having these trainers also aided single agency training.

6.42 SSCBs 'Training Pool' was strengthened during the year with good representation from across the partnership. The pool of trainers deliver training in a wide range of subjects and share their knowledge from frontline practice to enhance the training delivered. Having a Training Pool has resulted in cost savings as the subgroup are not commissioning as many external trainers. The Training Pool will also support the Black Country Programme.

6.43 As part of the refreshed training offer the 'Safeguarding Children & Young People Module 1' face to face course was replaced with online training (Artemis) and/ or a list of approved trainers that could be individually commissioned by services to support single agency training.

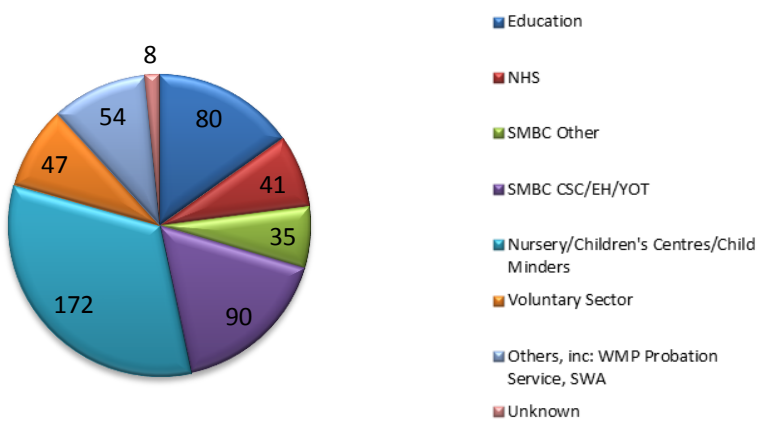
This will result in a considerable cost saving during 2016-17 of approx. £3760.

6.44 Domestic Violence and Abuse (DVA) training was delivered through DASP with a total of 266 officers attending DVA levels 1 and 2; Forced Marriage/ Honor Based Violence (HBV) /FGM; Sexual Violence; Domestic Abuse and Access to Public Funds and Services training during the reporting period.

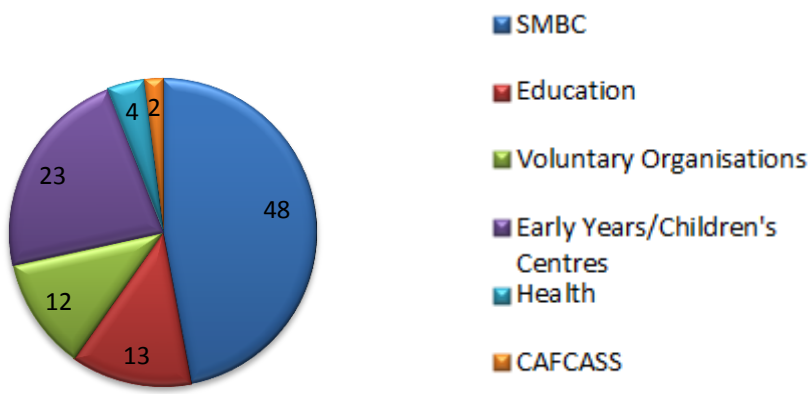
2015-16 Attendance and Non-attendance figures

6.45 SSCBs 2015-16 training offer commenced in September 2015 until March 2016. Detailed below are the attendance and non-attendance figures by service area

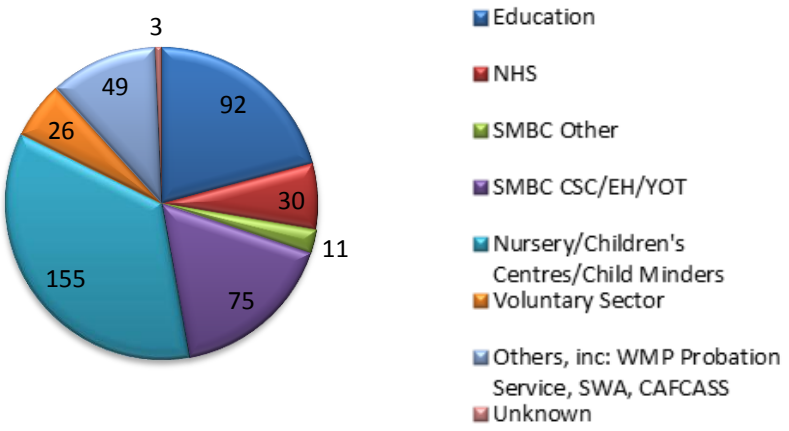
Q3 2015-16 Attendance Figures



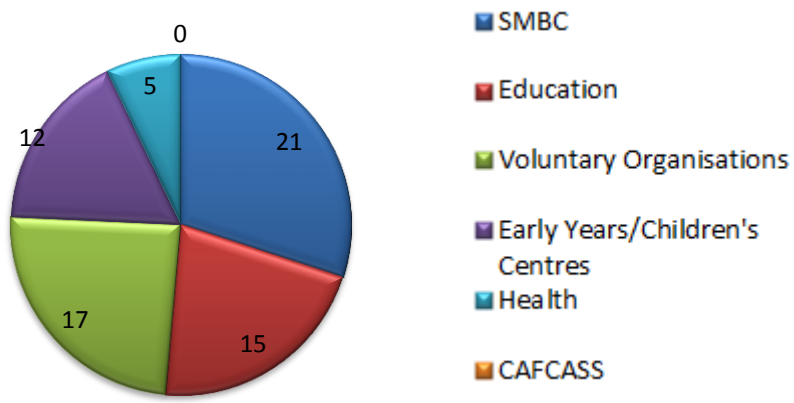
Q3 2015-16 Non-attendance Figures



Q4 2015-16 Attendance Figures



Q4 2015-16 Non-attendance Figures



6.46 Based on the above charts it can be seen that a total of 968 delegates were trained between September 2015 and March 2016 (although it should be noted that the same delegate could have attended multiple courses). Conversely, 171 delegates did not attend training that they had booked on. In order to mitigate this, the Learning & Development Subgroup introduced a non-attendance charging policy in April 2016 at a rate of £30 per delegate (in line with the agreed Black Country LSCB rate). On this basis, SSCB would have generate an income of £5130 had the policy been introduced in September 2015. An additional £1290 would have been generated from those 43 delegates who did not cancel at least 48 hours prior to the course taking place.

Looking Ahead to 2016-17

6.47 Implementation of a new work plan focusing on key priorities from the SSCB Business Plan. This will enable the work of the group to be monitored more effectively and provide oversight of effectiveness of meeting timescales and targets.

6.48 Using the income generated from non-attendance to enable further development of courses to meet need and SSCB's priorities

6.49 Bite Size sessions for CSE and Missing, Thresholds, SCR, Trafficking and Modern Day Slavery and Signs of Safety (SoS), to be developed and offered to the children's workforce. These sessions will be delivered within the 6 towns to enable easy access for local practitioners and will focus on practice issues/ concerns.

6.50 Fully integrated Black Country programme with delivery of five courses over 42 sessions.

6.51 Exploration of bringing together the four Black Country learning and development subgroups as one group and also the coordination of training administration from one central point. At present there is one coordinator in each area operating various booking systems. From September 2016 it is envisaged that there will be a single online booking system for all of the regional courses offered.

6.52 A consultation learning event to be scheduled in order to inform the 2017/18 learning catalogue and to also consider impact on the workforce of the courses delivered during 2016-17.

6.53 To work with SHAPE to ensure the voice of the child is reflected within courses.

Policy& Procedures Subgroup

6.54 The Policies and Procedures sub-group is responsible for ensuring that all reasonable steps are taken to promote effective multi-agency working through the implementation and oversight of all safeguarding procedures. The subgroup coordinates the development of new local policies, procedures and guidance for safeguarding and promoting the welfare of children and young people in Sandwell. In addition the subgroup's remit includes the analysis of the implications of national multi-agency policies, procedures, guidance or research findings in terms of the need to develop any additional local policy, procedures or guidance.

6.55 The subgroup met a total of 4 times in June, September and December of 2015 and February of 2016. During this time the work of the subgroup continued to focus on ensuring that SSCB policies were accurate and reflective of current practice.

6.56 In parallel to this, regional work was commenced following a successful project proposal submission to the DfE on behalf of the West Midlands Metropolitan Authorities Safeguarding Children Boards for funding to develop regional safeguarding procedures. The LSCB Chairs from the wider West Midlands area subsequently agreed that there would be benefits in broadening the project beyond the West Midlands metropolitan area to include all 14 LSCBs in the wider West Midlands (including Herefordshire, Shropshire, Staffordshire, Stoke-on-Trent, Telford & Wrekin, Warwickshire and Worcestershire in addition to Birmingham, Coventry, Dudley, Sandwell, Solihull, Walsall and Wolverhampton).

6.57 A three level approach that has worked well in other areas of the country was proposed:

1. Level A - Core Child Protection Procedures
2. Level B - Regional Guidance Procedures
3. Level C - Area Specific Information

6.58 By the end of the reporting period:

- the draft 'Level A Core Procedures' had been developed by Dr Zoe Cookson, the consultant funded to led the project until March 2016, and had been scrutinised by staff and partners from a large number of LSCBs across the area. Many were happy to take the procedures for formal sign off, acknowledging the fact that some minor changes may still be made.

- the Task and Finish Group had:
  - agreed the proposed contents of the 'Level B' Guidance
  - agreed a minimum content for Level C;
  - recommended establishing a 'Regional Safeguarding Procedures Group' accountable to the regional LSCB Chairs;
  - developed terms of reference for the proposed regional group
  - developed a draft service specification for the electronic hosting of region-wide safeguarding procedures
  - developed an update schedule for the three different levels of the Procedures

Looking Ahead to 2016-17

6.59 Sandwell will lead the regional procedures task and finish group in order to drive forward the project

6.60 In light of regional development the work of the Policy and Procedures Subgroup will be phased down. This may involve reframing some of the functional responsibilities of the Board into the work plan of a single subgroup.

Health Forum

6.61 The Health Forum Subgroup brings together Named and Designated professionals and those with lead responsibility for safeguarding children across the health economy both in commissioning and provider organisations. The forum monitors and provides assurance to the SSCB that there are effective safeguarding arrangements in place within Sandwell health organisations minimising any disconnect across the health economy. A key role is monitoring the implementation of health specific recommendations and actions following inspections/reviews from Regulatory Bodies and internal inquires. Progress reports in relation to those recommendations and actions are submitted to the appropriate bodies.

6.62 Membership includes representation from Sandwell & West Birmingham NHS Trust, Black Country Partnership NHS FT, Birmingham Community Healthcare Trust, IRIS, Public Health and Sandwell & West Birmingham CCG. These organisations provide health services such as School Health Nursing, Health Visiting, Midwifery, Acute Medicine (including ED), Mental Health services (children and adult), Adult Drug services and various other services. Commissioners of the services are also members of the forum.

6.63 The Forum is very well attended and meetings take place bi-monthly. There have been a total of seven meetings between April 15 and March 16. In addition there is also an established health CSE group to support in the delivery of CSE strategy which is aligned to the SSCB key priorities.

6.64 A key deficit within the membership is the absence of a health forum coordinator following the previous post holder moving positions. This places a significant increase on the workload for the Chair.

Key Subgroup activity and achievements

6.65 In early 2015 the Health Forum refreshed the TOR and membership, to align the work plan with the Board priorities.

6.66 The Health Forum agreed an action plan to address the concerns reported that health professionals were not taking on the Lead Professional Role when required. This culminated in a Lead Professional Conference targeted at health professionals. The event was very successful, evaluated well and identified training needs/resource issues required to support practitioners to fulfil the role.

6.67 Following a Significant Safeguarding Incident Notification Form (SSINF) submitted to the Board from a partner agency where concerns had been raised about possible safeguarding issues in relation to Health Services involvement the a subject's care, a Table Top Review was convened under the auspices of the SSCB Health Forum. During the review good practice was identified, particularly from community children's nursing, health visitors and the nursery nurse. It concluded that the incident could not have been predicted or prevented, however there was learning identified. A number of health recommendations were agreed and an action plan developed. Progress against the action plan was monitored by the Health Forum and progress reported to the SCR subgroup.

6.68 A task & finish group was established, for health partner organisations to develop a 'health action plan' in response to the CSE strategy. The CSE Task & Finish Group mapped CSE training undertaken by staff groups across the represented health organisations and arranged for additional training to be delivered by the CSE coordinator.

6.69 In February 2016, the group coordinated a CSE awareness/training event targeted at front line health professionals. People were asked to become "superheroes for CSE" In addition Sandwell & West Birmingham CCG commissioned through the group a short CSE film aimed at raising awareness in primary care and "what to do". This was premiered at the event and has subsequently received national recognition. It will be used widely as a training tool across health and other agencies.

6.70 The group have a comprehensive work plan and has subsequently become an established Health CSE group reporting directly via the Chairs group to the SSCB

6.71 A Peer to Peer audit has been conducted following the CQC Key Lines of Enquiry which look at how health services work together and evidence the "voice of the child". Findings were shared with the SSCB Quality of Practice.& Performance Subgroup An action plan was created and implemented and monitored by the Health Forum.

6.72 The Health Forum has addressed issues that had been highlighted with the Child Protection flagging systems in place across the health economy. All practitioners now have the correct access rights to view flagging and the safeguarding node within the health electronic record; SystmOne. There has also been progress with the alert system within the EMIS electronic health records used by some Sandwell GP

practices; with alert instruction being produced and circulated to allow this function.

6.73 Serious Case review 'health' actions have been monitored and updates submitted to the Chair of SCR.

6.74 Following the review in August 2014 of safeguarding and looked after children by the Care Quality Commission (CQC) recommendations for health services were put into a SMART action plan for each organisation. Compliance has been monitored by the health forum, with robust peer challenge and progress reports submitted to the SSCB via the Chairs Group.

6.75 The Health Forum agreed to work with the QPP Subgroup to review and revise the health dataset presented to the Board. This will provide accurate and outcome focused data for the Board to evaluate the health economy's commitment and progress against protecting and promoting the welfare of children.

Looking ahead to 2016-17

6.76 Health Forum members have completed a scope 'capturing the voice of the child' within their organisations with a view to collating the health economy methods, share best practice and identify gaps. This work will be progressed in the forthcoming year.

6.77 The Health Forum will continue to progress the SSCB business plan

6.78 Potential risks that the Health Forum will need to mitigate against include a lack of business support/ coordinator and 'gaps' in health service provision or support; specifically within the MASH and CSE

7. Performance Management and Quality Assurance

7.1 SSCB should use data and other performance information to assess the effectiveness of the help being provided to children and families, including early help; whether partners are fulfilling their statutory obligations; and quality assuring practice, including through joint audits of case files involving practitioners and identifying lessons to be learned.

7.2 The lead for this aspect of the Board's work is through the Quality of Practice and Performance (QPP) Sub Group. During the reporting period the Subgroup met a total of 11 times in April, June, July, September, October, November 2015 and January, February, April, June and July 2016.

7.3 Alongside the three Board commissioned audits, the work undertaken by the QPP Subgroup during this time included the coordination and delivery of four multi-agency audits in respect of Domestic Abuse (April 2015); Cross Border Compliance (November 2015), Looked after Children (February 2016) and Neglect (June 2016). Performance reports and an agreed data set were also routinely submitted to SSCB.

7.4 The Peer Diagnostic Review commissioned by the Board included an *'audit validation exercise'* that examined how SSCB uses multi-agency case audit to assess and improve the quality of practice; how well audit reports are used by SSCB and partners; and what action is taken in response to audit reports.

7.5 Whilst the audit validation exercise acknowledged that the audit tool utilised for audits contained good elements, overall it was found to lack impact with a focus on process rather than on quality of practice and outcomes. This was an area of development that the QPP Subgroup had already recognised and corrected for the audit on neglect. Additionally, the diagnostic and peer review found that audit reports and recommendations missed clear practice issues with little evidence from the reporting process of learning being fed down the line to frontline teams and practitioners.

7.6 An evaluative report of the Board's assurance activities undertaken during 2015-16 encompassing the work of the QPP Subgroup as well as the Board's wider work is included as Appendix 3

Key subgroup activity and achievements during 2015-16

7.7 In addition to sub group meetings and the multi-agency audits a full Section 11 (Children Act 2004) audit was undertaken to assess whether agencies were fulfilling their statutory obligations as set out in Chapter 2 of Working Together 2015. All partners completed their respective audits and submitted supporting evidence demonstrating improved outcomes for children, young people and their families as a result of the arrangements. The submissions were supplemented by a series of *'Scrutiny Panels'* during which partners were held to account for their submissions. Between September 2015 and July 2016 scrutiny panels had taken place with all organisations that had completed a Section 11 audit.

7.8 Findings from the audit activity included:

- A clear line of accountability across the partnership, with a senior board level lead taking leadership responsibility for the organisation's safeguarding arrangements.
- Clear whistleblowing procedures, safer recruitment practices and a culture that enables issues about safeguarding and promoting the welfare of children to be addressed
- The need for further work to evidence a culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services
- Good assurances that staff across the partnership are aware of arrangements for identifying and supporting families who may require early help
- A lack of evidence to support that all relevant agencies undertake the role of lead professional on a regular basis.
- Appropriate supervision and support for staff, and safeguarding training taking place within organisations

7.9 The supplementary scrutiny panels that took place sought further assurances under key themes. A summary of the key findings are detailed below:

- Communication:
  - Evidence of the dissemination of SCR recommendations and the impact on practice
  - Evidence of clear pathways, responsibilities and handover between key agencies
- Voice of the Child
  - Both from organisations and the services they commission

- Workforce Development:
  - Assurance that relevant staff within organisations attend CSE, Neglect and Multi-Agency Threshold training as appropriate;
  - For agencies to ensure staff undertake DASH risk assessment training and MARAC training to ensure staff are aware of the support available for victims

7.10 The Subgroup also relaunched the Section 175/157 (Education Act 2002) audit across the education sector in September 2015. The submissions were similarly supplemented with a series of *'Assurance Panels'* (commencing in January 2016) during which schools were held to account for their submissions. By July 2016 a total of 8 Section 175 panels had taken place.

7.11 The SSCB was presented with comprehensive and regular information within an agreed dataset during the year. This performance data (with commentary from the contributing partner agencies and the QPP Subgroup) increasingly included information regarding all agencies which enabled the Board to focus in particular on a number of key aspects of performance.

7.12 A significant piece of work has been the review and development of the current Quality Assurance Framework (QAF) introduced during the year. The QAF is intended to be the single framework for performance across the partnership.

7.13 The multi-agency audit programme during the reporting period was more directly linked to the Board's priorities and four multiagency audits (Domestic Abuse; Cross Border Compliance, Looked after Children and Neglect) were undertaken with a further audit in respect of CSE and Missing being undertaken in September 2016.

Looking Ahead to 2016-17

7.14 During the reporting period there was a tendency to include too much information in the data set and performance reports. With this in mind, the QPP Subgroup will refine this information and ensure that it provides a clear and focused message to enable improved analysis, monitoring and challenge. This will better enable SSCB to consider how best to link data to the Business Plan to help identify priorities and performance. This was also the view of the Peer Diagnostic Review team.

7.15 Whilst the current version of the QAF can be considered to be more 'user-friendly', it will nevertheless be necessary to refresh it further during 2016-17 in order for SSCB to assure itself and evidence that the QAF is embedded across the partnership

7.16 Further work is required in order to reviewing the approach to multi-agency audits, their impact and dissemination of learning.

7.17 Despite the extensive improvement work of SSCB there remains an absence of a clear line between SSCB and front line practice across all agencies. With this in mind there is a need to take more advantage of the quality assurance role of Independent Reviewing Officers in order to help capture what is happening *'on the ground'* and to improve service practice and learning.

7.18 The focus of multi-agency audits will be around risks for the child or the strengths for the child/family rather than being 'process-orientated' as was the case during 2015-16. Case workers will now be involved during the audit of the case file and the case sample size will be reduced in order for the focus to be on 'quality' rather than 'quantity'

7.19 During 2015-16 there was little evidence from the reporting process and recommendations of learning being fed down the line to frontline teams and practitioners. This will be an area of focus for the QPP Subgroup during 2016-17.

7.20 The QPP Subgroup will focus on ensuring that learning from audits are used to better identify priorities that will improve multi–agency professional practice with children and families. Additionally learning from audits will routinely inform the Board's training priorities and content.

7.21 For 2016-2017, along with ensuring audits are linked to the board's priorities, the QPP Subgroup will be ensuring concerns highlighted through the Board's performance information are reflected within the audit programme.

7.22 The QPP Subgroup will also maintain oversight of the programme of single agency audits and findings emerging from them.

7.23 The work of the QPP Subgroup will continue to be strengthened and enhanced by ensuring that all of the agencies attend the meeting and contribute to the process. This will give greater clarity about each

other's roles and ensure that the audits and performance data can be effectively scrutinised.

7.24 The Board will be carrying out Section 11 Audits on a biennial basis therefore the next audit will take place during 2017-18. All challenges highlighted to agencies during the scrutiny panel process will be monitored during 2016-2017 (year two of the 2015 – 2017 Section 11 process).

8. Key Safeguarding Areas

Understanding and Application of Thresholds

8.1 SSCB has continued to keep under review the extent to which there is consistent understanding and application of thresholds by practitioners in partner agencies. The Board's external review of thresholds in 2015 and the audits undertaken by Malcolm Newsam (the first Children's Commissioner appointed by the Secretary of State) highlighted key weaknesses in the identification and assessment of risk.

8.2 Partner agencies have continued to support, and have confidence in, the Sandwell Multi Agency Safeguarding Hub (MASH). The Board's external review in 2015 highlighted that the MASH was under significant resource pressure.

8.3 In the light of these concerns, the SSCB has overseen revisions to the Sandwell Thresholds Document (with associated *'refresh'* training) and the operational arrangements for the MASH. These have been designed to ensure a more effective multi-agency response to changing risk and need, with casework held at the appropriate level in the system.

8.4 The Board will be commissioning a further review of the understanding and application of thresholds (including MASH arrangements) in 2016/17. Key areas of focus for the Board will be:

- Are risks identified and thresholds applied correctly?
- How effective is decision-making?
- To what extent are cases dealt with in a timely way?
- To what extent is information shared appropriately and securely?
- How effective is management oversight?
- How effective is multi-agency cooperation under the MASH arrangements?
- To what extent are cases referred to appropriate agencies?
- To what extent do the MASH arrangements add value to the quality of safeguarding (compared with, for example, a social work duty arrangement)?

Early Help and Targeted Support

8.5 Activity within early help and targeted support during 2015-16 was informed by the review of Early Help that was commissioned by SSCB (following the recommendations made in the external review of thresholds). The review contained 11 recommendations, for both the local authority and partner agencies. The recommendations covered areas such as Information Sharing, the format of Team Around the Family (TAF) Plans, Performance Management and the accountability of each agency in ensuring that they are compliant with standards of practice.

8.6 These recommendations were instrumental in the decision to ask the Sandwell Council of Voluntary Organisations (SCVO) to take a lead in refreshing the partnership Early Help Strategy and in re-branding the COG Teams as *'targeted support'*. This has led to a greater appreciation that 'early help' is not a service but a concept.

8.7 Progress as a result of the Early Help Review include the following:

- Locality COG Teams now have a clearer role with a focus upon targeted support
- There is an agreed set of indicators to inform locality score cards
- Partners are better equipped to undertake the Lead Professional role, with more focused training
- TAF Plans are aligned to Child in Need Plans and incorporate the Signs of Safety methodology
- SSCB partners are clear about their accountability in terms of their role relating to early help assessments and the Lead Professional role
- Arrangements within COG Teams (supervision, weekly COG Meetings, etc.) are now embedded.

8.8 Locality COG Teams have been re-defined as 'Targeted Support' to emphasise that case work undertaken by Targeted Family Support Workers is 'targeted' rather than early help (as per the SSCB Threshold Document 'windscreen wiper' diagram). COG Teams continue to be managed by a COG Manager who have a role that includes supporting partner agencies in terms of the development of effective early help arrangements and the operation of thresholds.

8.9 The revised Early Help Strategy (due for publication during 2016-17) will place a much greater emphasis upon the role of universal

providers, the voluntary sector, schools and other agencies as the providers of early help support.

8.10 Locality based Targeted Family Support Teams based in COGs continued to work closely with various universal services (including schools, health, police, neighbourhoods) and commissioned support services, such as Children's Centres, Barnardo's Family Support, Action for Children and Options for Life, together providing a continuum of support across age groups and levels of need.

Key Activity and Preventive Success

8.11 In terms of locality based target family support teams based in COGs, headline activity for the 12 months to the end of July 2016 was as follows:

- COG Teams have worked with 1278 families and 2681 children.
- The average duration of a Team Around the Family (TAF) Plan was 14.5 weeks.
- Of the 1278 families (2681 children) worked with 110 families (242 children) have subsequently been escalated to Children's Social Care for statutory support or as Children in Need.
- Of those families stepped down to universal or universal plus support following intervention by COG Teams, 36 families (63 children) have been stepped back up to locality family support in COG Teams. This provides an overall 'success rate' of 88.6% of families that have not been stepped back up to the COG for targeted family support or escalated to Children's Social Care.

8.12 **Outcome Star and Troubled Families:** Outcome Star is a shared approach to measure and evidence progress for families. It is an evidence based tool that is used to demonstrate significant and sustainable change to support Payment By results Claims as part of the Troubled Families Programme.

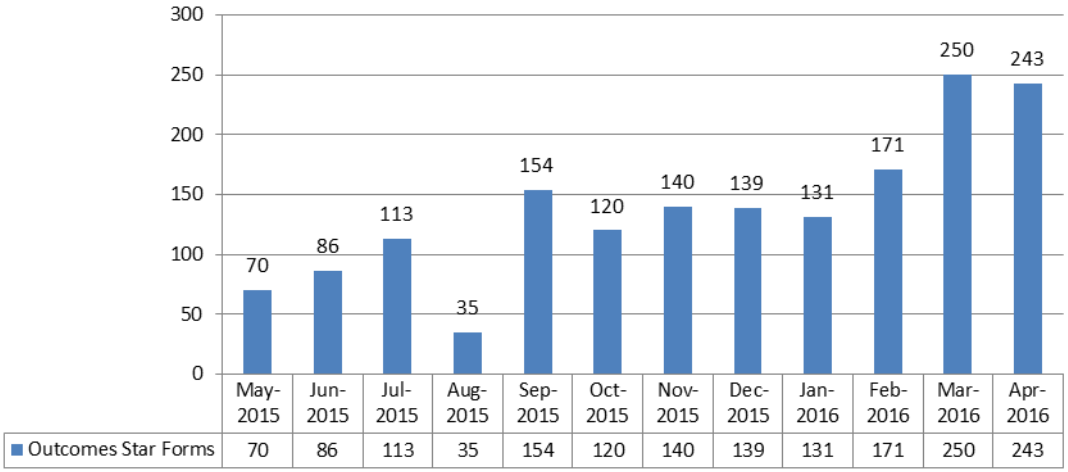
8.13 Multiagency training on Outcome Star commenced on 16th February 2015 with the initial 25 sessions being delivered by trainers from 'Triangle Consulting'. From April onwards the training was delivered by internal and partner licensed trainers who had undertaken two days Licensed Trainer Training and been assessed and verified as competent to train by Triangle Consulting. There were 10 Licensed Trainers Trained. This has subsequently been streamlined to ensure consistency and there are now 3 Licensed Trainers, one of whom is responsible for quality assurance.

8.14 The Early Help Assessment has evolved to correlate to the domains of Outcome Star, and for those agencies that are trained, it is a requirement that they complete an Outcome Star as part of their assessment.

8.15 Outcome Star is also embedded into Sandwell's localised parenting programme; 'Changes', and is used by Family Support Staff across schools and Children's Centres.

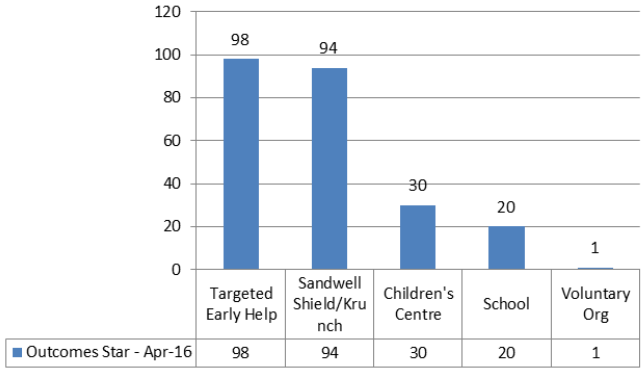
8.16 Of Family Stars completed by locality based family support teams based in COG, 9 out of ten aspects show positive improvement. Of completed My Stars 7 out of 8 aspects show positive increase. Greatest increases were in the following areas: Family Routine. Boundaries and Behaviour. Your Well-being. Feelings and Behaviour.

8.17 The following chart summarises the gradual increase in the use of Outcome Star forms



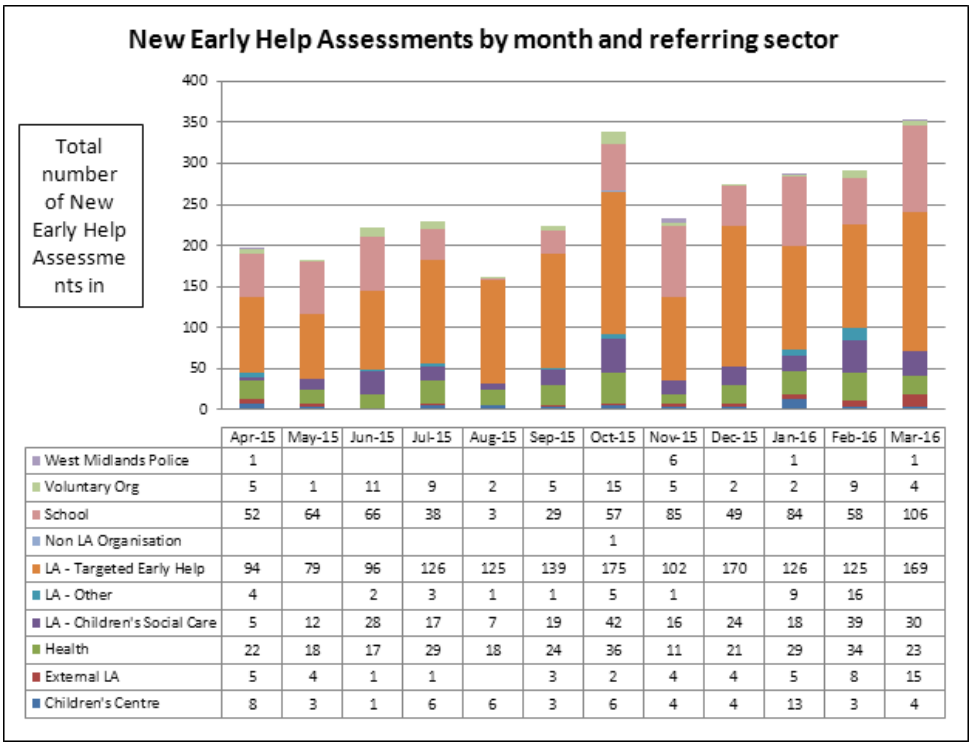
	May-2015	Jun-2015	Jul-2015	Aug-2015	Sep-2015	Oct-2015	Nov-2015	Dec-2015	Jan-2016	Feb-2016	Mar-2016	Apr-2016
Outcomes Star Forms	70	86	113	35	154	120	140	139	131	171	250	243

8.18 The following chart provides a breakdown of Outcome Star forms by agency as at April 2016.

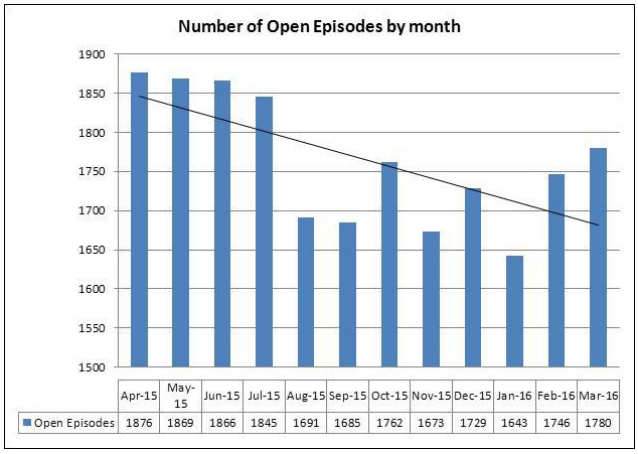


	Targeted Early Help	Sandwell Shield/Krunch	Children's Centre	School	Voluntary Org
Outcomes Star - Apr-16	98	94	30	20	1

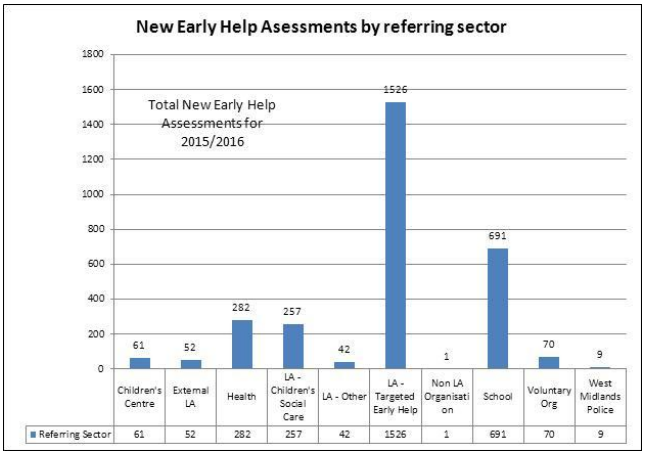
8.19 The following charts provide a breakdown of Early Help assessments by referring sector as well as the number of open episodes by month.



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
West Midlands Police	1							6		1		1
Voluntary Org	5	1	11	9	2	5	15	5	2	2	9	4
School	52	64	66	38	3	29	57	85	49	84	58	106
Non LA Organisation							1					
LA - Targeted Early Help	94	79	96	126	125	139	175	102	170	126	125	169
LA - Other	4		2	3	1	1	5	1		9	16	
LA - Children's Social Care	5	12	28	17	7	19	42	16	24	18	39	30
Health	22	18	17	29	18	24	36	11	21	29	34	23
External LA	5	4	1	1		3	2	4	4	5	8	15
Children's Centre	8	3	1	6	6	3	6	4	4	13	3	4



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Open Episodes	1876	1869	1866	1845	1691	1685	1762	1673	1729	1643	1746	1780



	Children's Centre	External LA	Health	LA - Children's Social Care	LA - Other	LA - Targeted Early Help	Non LA Organisation	School	Voluntary Org	West Midlands Police
Referring Sector	61	52	282	257	42	1526	1	691	70	9

Challenges for Early Help in 2016-17

- Sustaining the range of support and partnership working in current climate of reducing resources and budgets
- Promoting a clear early help offer so that Lead Professionals are able to identify the range of services available to families
- Making sure that information and advice is available to children, young people and families
- Ensuring clear understanding of thresholds and responsibilities across the partnership
- Defining the clarity of the role of Targeted Services and Universal Services
- Gathering information and intelligence for localities to understand the services available
- Agencies taking responsibility for using the Early Help System (ECAF) as an effective tool for information sharing and coordination of TAF meetings
- Changes to the 'Front Door' following the Lean Review recommendations about MASH, which includes the creating of a single access point
- Embedding Troubled Families so that we achieve outcomes with families.
- Implementing Signs of Safety approach to processes in early help

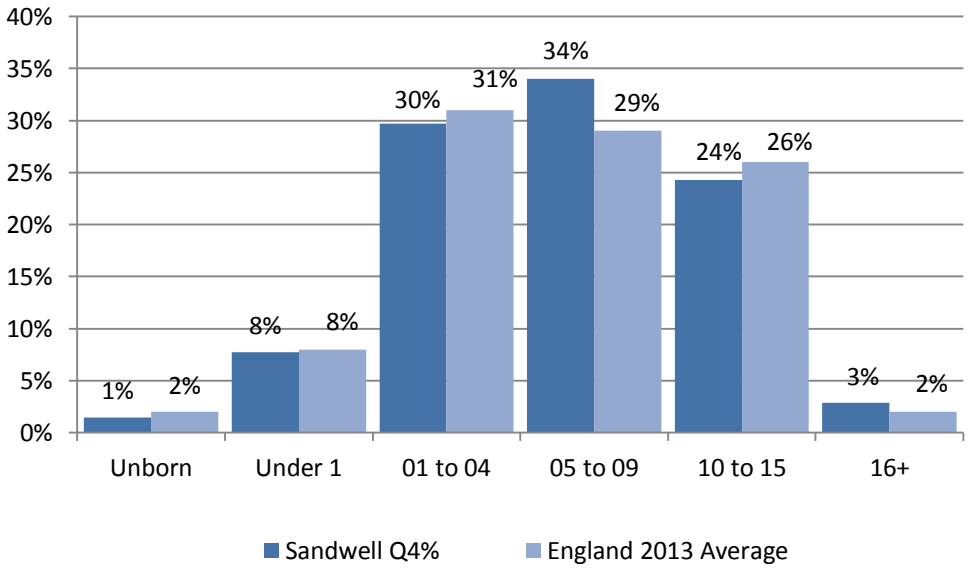
Child Protection

8.20 Over the past twelve months there has been some improvement in the quality of child protection work but from a very low base. There continue to be key weaknesses in the quality and consistency of practice, particularly the identification of risk, quality of assessment, care planning and case recording. A more focused Improvement Plan, streamlining of the MASH arrangements and the systematic implementation of the *'Signs of Safety'* practice model are important building blocks for further improvement.

8.21 During the summer months of 2015 there had been an increase in contact and referrals coming into the service resulting in the service and partners struggling to achieve performance targets, therefore in late 2015 a review was requested by the service to help find solutions to cope with the excess demand. The review team concentrated their time within the Social Care team, Partners and the Early Help Desk within the MASH. Single Assessment Team 1 and 2 and the Multi Agency Enquiry Team were also reviewed. The initial part of the review focused on the flow of work when it first arrived in the MASH. The review team quickly identified a process change that resulted in quicker decision making with work on contacts being completed in a timelier manner than previously. The review stage in early 2016 focused on spending time with the individual teams looking at their processes and the quality of their work. Key recommendations were put to CFSMT and CSDB and are now being taken forward by the service; these include recommendations around Front Door Access, Quality of Assessment, Training, Information Sharing, Governance, Organisational Changes, Decision Making and Process Changes.

8.22 As of the 31st March 2016 there were 350 children subject to a child protection plan in Sandwell. This figure is significantly below the 2015 Statistical Neighbour Average of 447. During the course of 2015-16 there has been a steady increase in the number of children starting plans and ending them within three months – increasing from a rolling twelve month average of 64 in April 2015 to 149 March 2016. This has led to an increase in the overall numbers starting and ending plans during the year.

Category	Sandwell Q4 2015-16	Sandwell Q4 %	England 2015 Average
Neglect	158	45%	45%
Emotional Abuse	168	48%	36%
Physical Abuse	15	4%	7%
Sexual Abuse	8	2%	5%
Multiple Category	1	0%	7%
Total	350	100%	100%



8.23 Throughout the last two years there has been a focus on performance and the meeting of the national Key Performance Indicators for Child Protection. The communication of performance information continues, with managers receiving weekly performance information at a team and worker level and a culture of exception reporting to Senior Management is now embedded. During the course of the last two financial years an average of 95% of children visited every six weeks much higher than the 2013/14 average of 84%. There has also been a focus in relation to improving the timeliness of holding child protection conferences throughout the year and significant progress was made. E.g. the timeliness of Initial Child

Protection Conferences (ICPCs) has increased significantly during the last two years with over 90% held within 15 working days. This mirrored a large reduction in the caseloads of Independent Reviewing Officer's (IRO's).

Next Steps

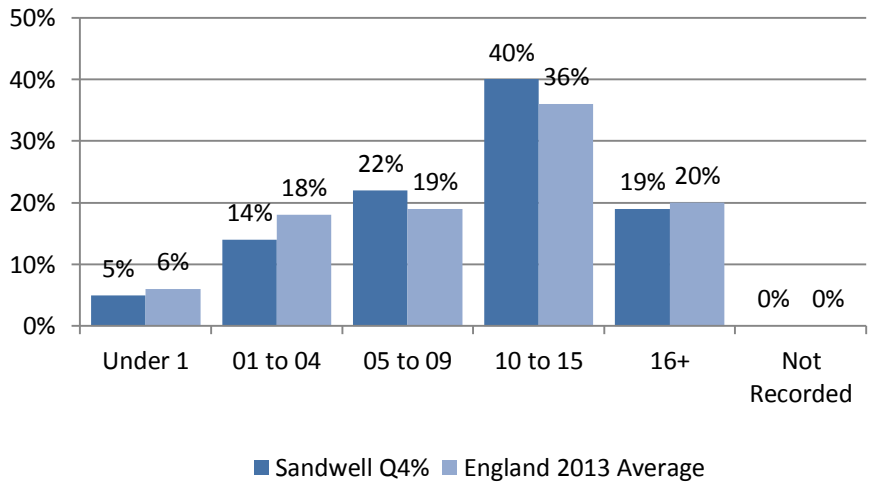
- Implementing the 'Signs of Safety' practice model across children's services
- Embed outcome focused templates across the service.
- Participation officer to move to the Quality Development Unit to ensure that the child's voice is incorporated throughout both the LAC and CP planning
- Care management case discussion panel to regularly review all children subject to a child protection plan for more than 9 months
- Increase the number of note takers for Core Groups and CIN reviews.

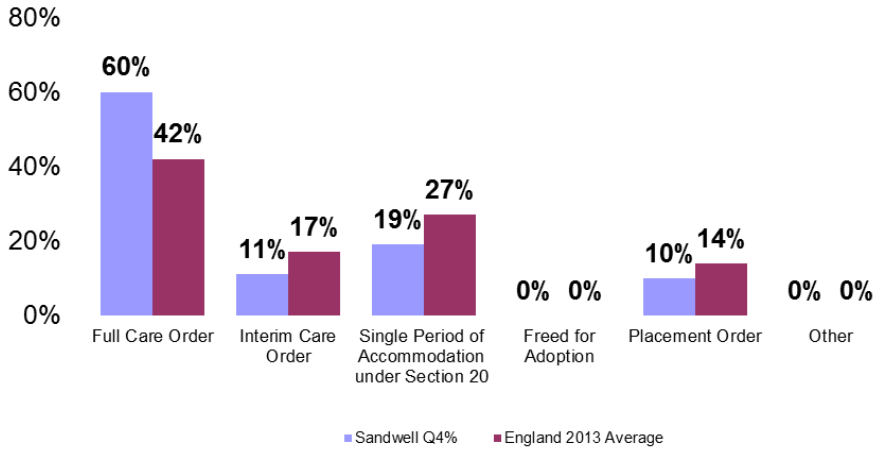
Looked After Children

8.24 Performance indicators against Looked After Children are closely monitored across Care Management and the LAC Service to ensure that all children have a Plan in place, are visited in statutory timescales and are seen alone. Performance in all of these indicators has shown improvement during the course of the year. Closer monitoring is now being undertaken to ensure that all children have a Permanency Plan at second review and Pathway Plans are in place ahead of transition to the Leaving Care Service

8.25 As of the 31st March 2016 there were 533 Looked After Children in Sandwell and at 68.5 Sandwell's rate per 10,000 sits in between the England (60) and SN (89.6) averages. During the course of the year 236 children became looked after and 226 ended care. This works out to an average of 19 becoming looked after and 18 ceasing care per month. LAC numbers have remained very consistent during the last year which is a result of the strengthening of the edge of care provision and safeguarding work (using PLO more effectively) across the service e.g. Family Group Conferencing, MST and Early Help Services which assist in the prevention the escalation of problems. A breakdown of the LAC population is shown below:

8.26 Evidence from a Serious Case Review and other case review information suggests the need for a more coordinated response to the needs of a small number of teenagers with complex needs and challenging behaviour.




80%
60%
40%
20%
0%
60%
42%
11%
17%
19%
27%
0%
0%
10%
14%
0%
0%
Full Care Order
Interim Care Order
Single Period of Accommodation under Section 20
Freed for Adoption
Placement Order
Other
Sandwell Q4%
England 2013 Average

Child Sexual Exploitation

8.27 SSCB established its initial CSE strategy in June 2014, based on the Local Standards in the regional framework. Progress against the strategy continues to be monitored by the Young People Sexual Exploitation (YPSE) and Missing (MOG) Sub-Groups and overseen by the strategic group CMOG.

8.28 In response to key issues identified in the OFSTED inspection report, an external assurance audit was undertaken between August and October 2015, with the final report submitted on 8th November 2015. The review included interviews with senior leaders and practitioners across partner agencies, practice observations, and an audit of representative sample of 20 CSE cases. The findings were reported against SSCB's ten key CSE assurance questions.

8.29 Alongside the 18 recommendations made, the report found evidence of strong commitment from all partner agencies to tackle CSE, with some evidence of progress. Nevertheless, there were improvements required across all ten of the areas for assurance. The CSE Strategy and Action Plan were subsequently reviewed and updated in response to the findings and recommendations from the review. The action plan is monitored by CMOG.

8.30 Effective multi agency arrangements to tackle CSE continue to be developed. Since the last annual report progress has been made by all partners in tackling CSE however there is a lot more to do.

8.31 The integrated, multi-disciplinary CSE team has increased. A Barnardos worker, who undertakes all missing from home or care interviews, is in post and a Primary Mental Health Worker is due to start in July 2016.

8.32 An electronic workspace to identify children who are at risk of CSE and have missing episodes has been developed. This enables more effective oversight of CSE and missing cases and also assists in the development of a more comprehensive 'problem profile'.

8.33 The importance of sharing information and data is recognised in terms of tackling CSE and other forms of exploitation. The use of the FIB (Force Intelligence Bureau) form is being embedded with all partners which also contributes to a more comprehensive problem profile and assists with the ongoing agenda around disruption.

8.34 The improved focus on CSE is assisting in the early identification of victims and offenders.

8.35 There continues to be a specific programme of work with taxi companies, hotels and fast food outlets to increase awareness and target hotspot locations identified through emerging intelligence. In addition there is an increased focus on perpetrators and locations to ensure that disruption activities could be coordinated to increase effectiveness.

8.36 During the reporting period, Sandwell continued its participation as one of three local authorities nationally (along with Oxfordshire and Brighton and Hove) in the 'See Me Hear Me' pilot project - an innovative approach to addressing CSE developed by the Office of the Childrens Commissioner (OCC).

8.37 The 'See Me, Hear Me' (SMHM) Framework was developed by the OCC in the light of findings set out in the OCC report 'If Only Someone Had Listened' - OCC Inquiry into Child Sexual Exploitation in Gangs and Groups', (November 2013). Based on the evidence about effective arrangements for tackling CSE, the SMHM Framework sets out operating principles, functions and processes that, in combination, will assist in safeguarding children and young people from CSE.

8.38 The OCC subsequently established a pilot project with a small number of partner local authority areas to support the implementation of the SMHM Framework in practice; to evaluate the efficacy of the model and the impact it achieves for children; and to recommend ways in which the SMHM 'approach' might be developed effectively in other localities, drawing on the learning from the pilot. The University of Sussex worked as the research partner for the project during the year (and continues to do so). They assisted the local authority areas in the pilot to formulate a key focus for the implementation of the SMHM framework, and will be evaluating the project outcomes during 2016-17.

8.39 During the year, Sandwell also continued to be part of the regional network, contributing to the West Midlands problem profile and to the development of wider cross border links and activity. The Black Country local authorities (Sandwell, Wolverhampton, Dudley and Walsall) are also working closely together in the following areas:

- Hotels and bed and breakfast establishments
- Fostering and residential units

- Placement of young people across borders
- Information sharing and planning
- Therapeutic support / interventions to both children and perpetrators
- Transition across children's and adults services
- Taxi and licensing activity
- E safety

Next Steps

- Review and update the CSE strategy working within the West Midlands Metropolitan Area Regional Framework
- Ensure the use and understanding of the CSE screening tool is embedded by partner agencies
- Continue to develop the engagement of young people and parents/carers in service development and feedback on current services
- Develop the mapping of services that support young people at risk of CSE across Sandwell and the Black Country.
- Enhance the problem profiling of trafficked children

Signs of Safety

8.40 During 2015/16 Children's Social Care adopted Signs of Safety as its preferred model and approach to social work practice. During the reporting period a total of 366 Children's Services staff received 2 days of training (which launched in November 2015) regarding the approach. 5 workers, managers and senior managers have undertaken a 5 day residential course during September 2015 with a further 20 scheduled to be trained during April and May 2016. Those that attend the 5 day course are the Practice Leads for implementation of the approach.

8.41 A Signs of Safety Project Manager was appointed in January 2016 and she has been responsible for the implementation plan. During Jan to March 2016 Signs of Safety was started in 9 teams, MASH and the Local Authority's 8 Care Management Teams.

8.42 The service has concentrated on embedding Signs of Safety Group Supervisions that concentrate on Case Mapping and on its use in CIN and CP Core Group Meetings. It has also been fully implemented in MASH discussions.

8.43 Signs of Safety is at the early stages with the service but this will grow over the coming year with everyone in the service trained during the remainder of 2016 and all parts of the service using Signs of Safety by March 2017. Partner agencies have had the opportunity to attend briefings and this has been disseminated through SSCB and during the remainder of 2016 it is envisaged that multi-agency Signs of Safety training will be available through the SSCB Learning and Development Subgroup.

Domestic Abuse

8.44 The Domestic Abuse Strategic Partnership (DASP) has worked hard in the last year to consolidate and further strengthen the collective response to domestic violence and abuse. Each year, thousands of children live in households in Sandwell where domestic violence and abuse (DVA) occurs. DASP has sought to increase reporting of DVA, so that victims and their children can access the support they need at the earliest opportunity in order to prevent further harm and reduce the risk of homicide

8.45 Reports of DVA to the police have been increasing locally, regionally and nationally. During 2015-16, there were 6539 DVA crimes/incidents in Sandwell reported to the police. This is a 13% increase compared to 2014-15 and a 34% increase compared to 2012-13. The majority of adult victims were female and the majority of perpetrators were male. Approximately 66% of those cases were screened by the multi-agency Domestic Abuse Screening Team in the MASH (Multi-Agency Safeguarding Hub). Between April 2015 and March 2016, 3724 DVA cases of families with children were screened by that team. The richness of information shared has enabled partners to gain a better understanding of the complexities of domestic violence and abuse and put in place appropriate risk assessment for both adult and child. Interventions from Sandwell Women's Aid (SWA), Children's Social Care or Early Help were then offered to those families, depending on the level of risk identified. The number of high risk cases of DVA increased slightly from 450 in 2014-15 to 460 in 2015-16. There were 613 children living in those households. All of these cases were considered by the MARAC (Multi Agency Risk Assessment Conference) and a safety plan put in place to reduce the risk to the victims and their families.

8.46 The Delivery Plan for 2015-16 consolidated a number of actions which started in the previous year. Sandwell Council provided funding for SWA to support victims of domestic abuse and sexual abuse, including support to families with children. Additional Domestic Abuse Advocates (DAAs) were recruited in early 2015 to work with the six Community Operating Groups across the borough. The DAAs provide support to victims and their families in localities and work with other agencies to provide an effective community coordinated response to DVA at a local level.

8.47 Work with young victims, both male and female, continued to grow with funds from the Safer Sandwell Partnership, the Police & Crime

Commissioner and Sandwell Children Safeguarding Board (SSCB). A project working with boys who are living in families where there is domestic abuse has been undertaken by SWA. The project aimed to improve their ability to manage emotions, sense of safety, behaviour and feelings of wellbeing. The 8 week programme ran alongside SWA's specialist support for parents (most often mothers), offering an integrated, whole family approach to tackling domestic abuse. Another project delivered by SWA was the "Think Family, Act Early" pilot. Children and adults were keen to engage with this work, and demand for support for children from the Young People's Advocate (YPA) has been high with 93 children receiving one to one support and parallel support for 61 non-abusive adults/parents. Feedback from children and young people included the following comments:

"Doing work around domestic abuse made me understand more about what my mum went through and why we had to leave. Emotional abuse is like bullying, hard to prove and must be really hard to have it from someone you're meant to love" Child in refuge

"The most important thing I learned was that I don't have to keep a devastating secret, I can tell an adult"

"I learnt that you can trust people, but you have to be careful who you trust"

8.48 SWA continues to provide emergency accommodation to women fleeing domestic abuse through refuges, safe houses, specialist provision for BME women and floating support. During the year Sandwell MBC and SWA were successful in securing funding from central government to provide extra refuge places and dispersed accommodation for victims of domestic abuse. 9 new bed spaces of medium/low risk accommodation were provided. This enabled a smoother transition of women from high risk to medium risk accommodation, enabling high risk/high need accommodation to be used by more families in real crisis and enable families for example on child protection plans to be kept together with their mothers in a more supportive environment.

8.49 A successful domestic abuse awareness raising event, "Faces of domestic abuse - perspectives on victims, children and perpetrators" took place on 10th March 2016. The event attracted 166 professionals from a range of disciplines targeted at agencies working with children, young people and families. The event incorporated the Sandwell launch of the West Midlands DVA

standards (WM domestic violence and abuse standards | Sandwell Council) which DASP worked with regional partners in the West Midlands to develop. The standards are for all statutory organisations and specialist agencies and aim to provide a framework for these organisations to develop their professional practice, improve services, shape future services and deliver the right response across all settings and sectors.

8.50 The standards formed the basis of the event and were incorporated into a performance which enabled professionals to identify with the complexities within families and challenged existing approaches to ensure better outcomes for children and families. DASP worked with SWA who brought in the skills of a professional actor telling the life story of a real character of Sandwell whose own life experience depicted experiences of intergenerational violence and abuse and that this continued with current risks to her daughter who was currently being exploited. This powerful emotional performance left the audience with the challenge of a fresh approach to supporting individuals and families.

8.51 Presentations were also heard from Tracey Brown from Fry Housing Trust on Sandwell's Brighter Futures voluntary perpetrator programme which started in October 2015 and from Sara Ward from SWA on children and domestic abuse. In addition, Adrian Scarrott, the Chair of DASP, gave the audience an overview of the work of the DASP. The event was very ably compered by Eileen Welch from the Children Safeguarding Team in Sandwell & West Birmingham Clinical Commissioning Group. Excellent feedback was received from delegates including the following comments:

"The actress and her performance were both moving and informative. Brilliant"

"Excellent update bringing all services and agencies together, making domestic abuse everybody's business"

8.52 The work of all the DASP sub-groups has continued during the year. A key development this year has been the commissioning of a voluntary perpetrator programme on a 2 year pilot basis. Fry Housing Trust has been funded by Sandwell Council to deliver a behaviour change programme with DVA perpetrators. Group work and 1-2-1 programmes started in October 2015. Referrals to the programme can be made by partner agencies or by perpetrators themselves. Parallel support to victims is funded by Safer Sandwell Partnership

and delivered by SWA and children are referred for support to SMBC Children's Services. The programme is being evaluated by the University of Birmingham, the findings of which will inform and shape future work with domestic abuse perpetrators on a local and regional level.

8.53 Other key developments have been regarding the response of the health sector to domestic abuse. Whilst GPs and health professionals are well placed to identify domestic abuse at an early point and direct victims and perpetrators for help and support, they need further training and support to undertake this role. Sandwell & West Birmingham Clinical Commissioning Group secured funding from the SSCB for a pilot IRIS project (Identification and Referral to Improve Safety) in GP surgeries in 2015-16. IRIS is a general practice domestic violence training, support and referral programme for primary care staff. It is targeted prevention for female patients aged 16 and above experiencing current or former domestic abuse from a partner, ex-partner or adult family member. IRIS provides care pathways for all patients living with abuse as well as information and signposting for male victims and for perpetrators. Approximately 20 GP surgeries were identified to work as part of the pilot and training has taken place with those surgeries during the pilot period. The University of Birmingham produced a positive evaluation of the IRIS pilot. This captured very powerful feedback from survivors regarding the value and importance of this work as articulated in the following comments:

"Participant: I was going through a lot of domestic violence from my husband… he was on the verge of murdering me. I went to my GP and told him what was happening and he referred me…

Interviewer: Why did you feel the need to say something?

Participant: Because he left the gas on in the house and he was going to kill me and enough was enough."

Another person said:

"Thank goodness I told the doctor because I would have gone through another 15 years - I am sure of pure Hell - we are going to move and that is down to your information and your programme of support."

8.54 Since the implementation of the IRIS pilot, there has been an increase in the number of victims referred for support to Sandwell Women's Aid (SWA) and MARAC from the IRIS GPs. In 2015-16, 49

out of 62 GP referrals to SWA were from IRIS GPs. 2 GPs made referrals of high risk victims to MARAC, both of those being from IRIS GPs. Sandwell & West Birmingham CCG are due to consider the findings of the evaluation and future funding for this project in April 2016.

8.55 During the year, SWA and Sandwell & West Birmingham Hospitals Trust (SWBH) also secured funding to enhance the response to DVA in Accident & Emergency Services and refer victims of domestic abuse for appropriate support. This work began in Sandwell Hospital and City Hospital in November 2015. By 31st March 2016, there were 62 referrals to SWA from A&E since the A&E DVA project started. 2 out of the total of 3 MARAC referrals from A&E in 2015-16 have been since the A&E project commenced. There were no MARAC referrals from SWBH in 2014-15.

8.56 Work to address female genital mutilation (FGM) has also been undertaken in the last year. The West Midlands Police and Crime Panel undertook a review of FGM in the West Midlands and made a number of recommendations to ensure consistency in dealing with FGM; encourage reporting and provide support to girls and women who are victims and potential victims. Sandwell has been proactive in work to deliver action against these recommendations. Training on FGM has been delivered to over 100 officers across a number of agencies during the year and further training will be delivered over the next year. Advice and guidance has also been issued to teaching and social care staff on the mandatory requirement to report FGM. A multi-agency policy on FGM has been agreed which includes information and guidance on how child and adult cases of FGM should be dealt with. A problem profile on FGM will be commissioned in the forthcoming months to build on work undertaken last year and further improve our collective understanding of the scale and nature of the risk of this hidden crime in Sandwell in order to target work with specific communities.

8.57 During the year, two Domestic Homicide Reviews (DHRs) were published and these can be accessed at www.sandwell.gov.uk/domesticabuse. The DHR Standing Panel has worked to ensure that all the recommendations from these DHRs were implemented and lessons learnt from DHRs were included within the DASP training programme.

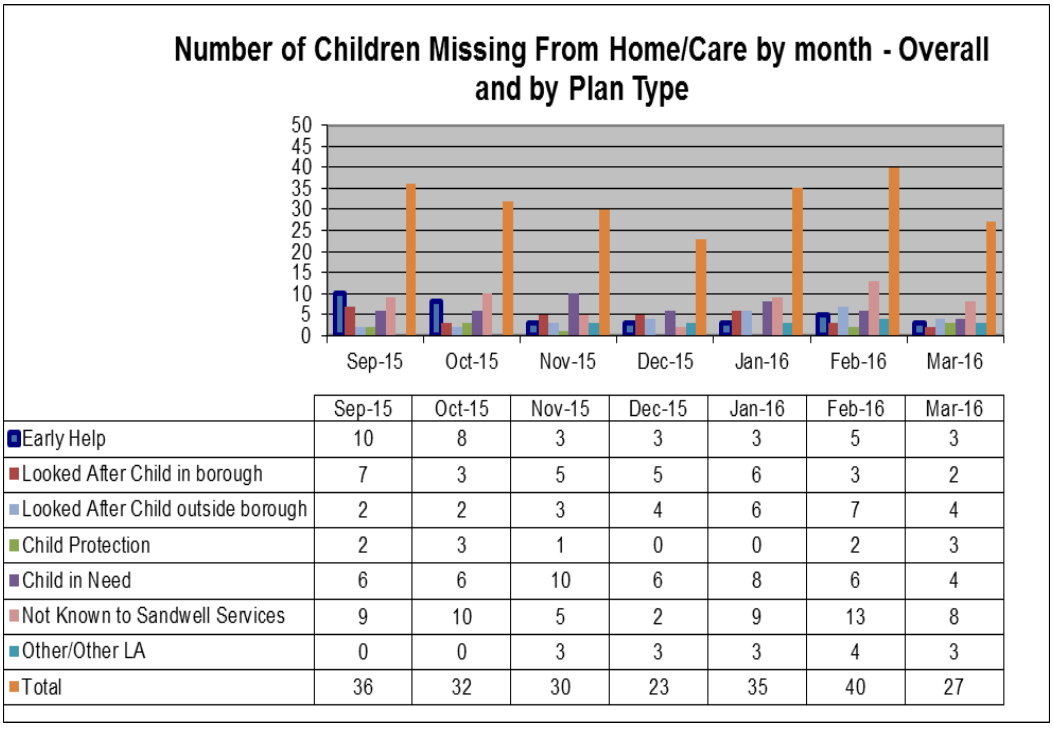
8.58 DASP priorities are:

- Spot victims of domestic abuse earlier, especially working with NHS & Clinical Commissioning Group.
- Strengthen MARAC (Multi Agency Risk Assessment Conference)
- Ensure support to victims of all forms of domestic abuse is made more visible and more locally accessible
- Develop victim services and provide support to vulnerable people harmed by DVA including female genital mutilation (FGM), “honour” based violence (HBV) and forced marriage (FM)
- Target perpetrators of Domestic Violence & Abuse; Forced Marriage; Honour Based Violence and Female Genital Mutilation
- Learn from Domestic Homicide Reviews how to improve practice and reduce risks and threats to victims
- Commission and implement a voluntary behaviour change programme for DVA perpetrators
- Raise awareness of domestic abuse (including FGM) through campaign

Children Missing from Home, Care and Education

8.59 The local authority and partner agencies have taken action during the year to strengthen the arrangements for monitoring and responding to children missing from home and care. Missing children data is tracked weekly, with cross-referencing information about missing children with information about children at risk of CSE. A new scorecard has been developed since September 2015, through the Missing Operational Group (MOG) and this is reported to the local CMOG.

8.60 Children missing from home and care are known to be at greater risk of significant harm, including CSE. The chart below shows the children missing data from September 2015- March 2016 in Sandwell (ECAF workspace designed and went live on 1 September 2015 to ascertain stringent data collection and processes for Missing and CSE agenda). Over the seven month period there were 361 missing episodes involving 144 children, with 39 children missing on more than three occasions of which 19 were Looked After Children.



	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Early Help	10	8	3	3	3	5	3
Looked After Child in borough	7	3	5	5	6	3	2
Looked After Child outside borough	2	2	3	4	6	7	4
Child Protection	2	3	1	0	0	2	3
Child in Need	6	6	10	6	8	6	4
Not Known to Sandwell Services	9	10	5	2	9	13	8
Other/Other LA	0	0	3	3	3	4	3
Total	36	32	30	23	35	40	27

*please note individual children could go missing in different months hence the higher figure in the graph of 223 missing children instead of the 144 total above

8.61 Return to home interviews are undertaken by Barnardos with the aims of assessing the level of risk and understanding the reasons why a child ran away. There is a need to ensure that return to home interviews take place in a timely way, that they are recorded on children's social care and targeted services files, and that they are considered as part of a wider analysis of themes and patterns in relation to CSE.

8.62 The MOG reviews the effectiveness of the systems agencies use in gaining and transferring information to ensure the safeguarding and support for children who are missing from home, care and education. This includes improvements in the way data is recorded and shared by police, partners and through council services. It also tracks the information received from the admissions service and schools/academies regarding Children Missing Education and Children Missing from Education.

Next Steps

8.63 SSCB will consider data and qualitative information about children missing from home and care through its quarterly performance report, and will request impact reports to assess the extent to which partner agencies are responding in an effective way to children who are missing. The Board will focus in particular on the following key issues:

- How good is our data and analysis about missing children, particularly the soft intelligence gathered from return to home interviews?
- How effective is our assessment of risk in relation to missing children?
- What improvements are needed in our systems and processes?
- How effective is our care and support for missing children, particularly those who are repeatedly missing?
- How far do partner agencies demonstrate the capacity to respond to the needs of missing children?

Elective Home Educated (EHE) Children

8.64 Education is a fundamental right for every child and Sandwell Metropolitan Borough Council (SMBC) recognises that parents have the right to choose to educate their child at home rather than at school. This is known as "Elective Home Education" (EHE) or Education Otherwise (otherwise than at school). It does not refer to children who have a home tutor provided by the Local Authority (LA) as a result of their being unable to attend school because of illness, exclusion or any other reason.

8.65 Parents are responsible for ensuring that their children receive a suitable education. SMBC have a duty to intervene if a child of compulsory school age in their area does not appear to be receiving a suitable education. By working together positively with home educating parents, recognising the rights and responsibilities of one another, the best outcome can be achieved for all concerned.

8.66 As at 31st March 2016 there were 181 active home education cases in Sandwell. During the 2015/16 academic year there were 249 active cases including 106 new referrals and 68 closed referrals. Of cases closed, 11 moved out of the area and 38 returned to education.

8.67 It is the Local Authority's policy to visit all new cases and offer an assessment, to ensure the children's educational needs are met. The Local Authority has no power of entry by law for home education and an assessment is not compulsory. As of the 31st March 2016, only 30 assessments had been completed at the request of home educating parents.

8.68 The EHE support teacher employed by SMBC works with the EHE community to develop relationships and offer advice and support as required. Community events continue to be organised in the hope of improving future levels of engagement.

8.69 The Sandwell EHE policy has been reviewed with the support of legal services. The local EHE community plus regional and national advocates were consulted and the new policy will go live during the first quarter of 2016-17.

Next Steps

- Where concerns arise, EHE officers will continue to work closely with social care and early help to identify and assess whether children are being suitably educated at home.
- Continue to promote concept of professional curiosity in relation to shared responsibility of all agencies working with children to identify children who are electively home educated or missing education.
- Recruit full time EHE support teacher to work with EHE and traveller communities. (It is recognised that travellers arriving in Sandwell are at risk of missing education).

Private Fostering

8.70 A private fostering arrangement is essentially one that is made privately (that is to say without the involvement of a local authority) for the care of a child under the age of16 (under 18, if disabled) by someone other than a parent or close relative, with the intention that it should last for 28 days or more. Private foster carers may be from the extended family such as a cousin or great aunt. However, a person who is a relative under the Children Act 1989 i.e. a grandparent, brother, sister, uncle or aunt (whether of full blood or half blood or by marriage) or step-parent will not be a private foster carer.

8.71 On 14 August 2015, the Government launched a one month public online consultation on a proposal to close down the annual private fostering data collected from local authorities as it provides only limited numerical information concerning children in private fostering arrangements and does not identify how many arrangements, or which types, are harmful. The data is therefore of little relevance in keeping children safe. The consultation proposed to instead gather information on private fostering through the addition of new questions to the existing annual children in need census which is completed by all local authorities to enable better identification of the types of arrangements posing most risk of harm to children. The consultation closed on 15 September 2015.

8.72 Respondents broadly supported the proposal and the Private Fostering data collection subsequently ceased.

8.73 This new data should help national and local Government identify the kind of abuse perpetrated against children privately fostered and whether there are any significant differences between the types of arrangement children are in. This insight can be used in future to support targeted action leading to better safeguarding and prioritisation of privately fostered children.

8.74 What has not changed is the duty on local authorities to satisfy themselves that the welfare of a child privately fostered within their area is satisfactorily safeguarded and promoted.

8.75 Nor does it change the way local authorities discharge their statutory duties in line with 'The Children (Private Arrangements for Fostering) Regulations 2005'. Local authorities will still be expected to collect appropriate data on private fostering arrangements to help monitor performance locally and support compliance

8.76 At the end of the reporting period Sandwell had 5 children who were in a privately fostered arrangement, with 5 children becoming privately fostered during 2015-16 and 9 children ceasing to being privately fostered in this period.

8.77 Private Fostering in Sandwell is currently held within the Permanency Team in CSC. During the reporting period there has been a drive to ensure that privately fostered children are adequately safeguarded. An example of this is that the Permanency Team routinely complete the CSE Screening Tool for children and young people to ensure that risks and safeguarding concerns are identified at the earliest opportunity and that these are included and worked within the child's plan.

8.78 In order for the Permanency Team's focus to remain on 'private fostering' and not become diluted with other risks and concerns, it is only where safeguarding or child protection concerns are identified that a joint working approach is taken between the Permanency Team and the Care Management Team with the latter focusing on the risks and the Permanency Team focusing on the Private Fostering.

8.79 An information Pack has been developed by the Permanency Team during the last 12 months, one for carers and one for children. The Information Packs include essential information about what to expect when visits are made by Social workers, what assistance is available e.g. how to claim benefits and find schools for children as well as other agencies and organisations that they can access.

8.80 Looking ahead to next year there are plans to further publicise private fostering by taking a more targeted approach in the form of making leaflets available at specific locations such as GP Practices and schools for example. A flowchart/ process map clarifying arrangements will also be developed and links into targeted services and COGs will be strengthened in order to firm up joint working.

Allegations Management

8.81 Between December 2015 and July 2016 the Sandwell LADO has been managing both the IRO service and the LADO service. The LADO represents the Quality Assurance and Safeguarding Unit on the SSCB subgroups for Policy and Procedures and SCR's. The LADO continues to manage and chair complex and politically sensitive meetings that may be in the public and/or media domain as we as the quarterly Position of Trust (POT) Partnership meetings with lead agencies.

8.82 The POT process is applicable in situations where a person who works with children is alleged to 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
- Behaved towards a child or children in a way that indicates he or she would pose a risk of harm if they work regularly or closely with children

8.83 This relates to a person's paid employment or voluntary activity and may involve concerns arising about the person's behaviour and issues of "suitability" to work with children.

8.84 In consideration of a concern or allegation, there are three main safeguarding strands:

- The investigation of any criminal offence;
- Whether a child protection investigation is required to safeguard the children or whether they are in need of support
- Any perceived need for disciplinary action in respect of an employee in relation to the allegation/s

8.85 Data for 2015-16 shows that there were 424 referrals to the LADO by way of the POT screening process, of which 80 met the criteria for an initial Position of Trust (POT) meeting. 49 Review POT meetings were also undertaken during the year.

8.86 The recording of data will be strengthened during 2016-17 as figures are often recorded manually which may compromises their integrity.

8.87 The table below provides a breakdown of the outcome of LADO intervention:

	Total	Total
Disciplinary	19	18%
Cessation of use?	22	20%
Unsubstantiated?	21	19%
Dismissal?	4	4%
Unfounded?	10	9%
Conviction?	1	1%
Criminal Investigation?	0	0%
Malicious?	1	1%
Referral to ISA?	0	0%
Training?	0	0%
Referral to other regulatory body?	1	1%
Resignation	1	1%
Suspension?	0	0%
Total	**80**	**100%**

8.88 Cessation of use for the purposes of the POT process means *'No Further Action'*. The unsubstantiated outcome is mostly related to faith based establishments as children have withdrawn their disclosures and/or changed their stories; however evidence clearly shows from their initial disclosure that their stories have been consistent and credible and supported by other children who may attend the same faith based establishment.

8.89 There continues to be a significant increase in the number of referrals received by the LADO Service. More cases are being dealt with at the screening point, but the time to resolve these has increase, between 8 to 10 weeks in most cases.

8.90 Initial POT Coordination meetings have reduced even further; previously on average there were 25 meetings a month – this has been reduced considerably to around 7 meetings a month. This reduction may be due to the fact that the LADO has grown in experience and knowledge in respect of their ability to carry out a robust risk analysis at the screening stage to decide whether the concern proceeds to a POT meeting. Information is also showing that agencies are also growing in confidence by being more aware of the LADO Service and its purpose – this is evidence for instance in the Section 175 and 157's produced for the Quality Assurance (scrutiny) panels in respect of schools and academies safeguarding procedures. Concern still remains that academies are not making referrals in the same way local authority schools and the reasons for this remain unclear.

Regional LADO Developments

8.91 The West Midlands Regional LADO Network (WMRLN) continues to provide support and communication network for LADO's across the West Midlands. At present this Network continues to be chaired by the Sandwell LADO. The work of LADO's is fed into the West Midlands Safeguarding Group; The Network has a Terms of Reference and an ongoing Work Plan ratified by the Regional Safeguarding Strategic Group.

National Conference

8.92 The main outcomes from the third National LADO Conference, held in Bristol in March 2016, were the development of national standards; a communication strategy with external partners; and a National LADO Network (NLN). The Sandwell LADO is currently the vice-chair for the NLN.

8.93 The next National LADO Conference will be led by the West Midlands region and is planned for March 2017. SSCB was the first LSCB to financially support this project. The National LADO Conference continues to be the only recognised forum that looks at the ongoing support and development of LADO's and their work.

Looking Ahead to 2016-17

8.94 The LADO will continue to lead on the Task and Finish group and continue to develop and coordinate the work needed to safeguard children within CFBE.

8.95 The LADO will be working with the IT Project Manager with a view to integrate the IT functions of the Managing Allegations process with the new Liquid Logic system.

8.96 The LADO will continue work to improve the understanding of procedures with Partners agencies in the creation of dedicated POT/LADO page on the SSCB website.

8.97 The LADO will continue to explore creative options to share learning and raising awareness e.g. communication strategy to schools/academies; newsletter.

9. Conclusion

9.1 The information and analysis in this report set out a baseline position in respect of the performance of the SSCB, the effectiveness of safeguarding arrangements in individual partner agencies, and the overall effectiveness of safeguarding in Sandwell. Arising from the analysis in this report and the Board's learning from assurance activity, there are a number of key issues to be addressed if improvements in safeguarding are to be realised in 2016/17:

For the SSCB

9.2 The Board needs to ensure that there is a stronger connection between its strategic activity and improved frontline practice in safeguarding. This applies particularly to the Board's audit and performance management activity.

For multi-agency partnership working

9.3 To ensure consistent and appropriate application of thresholds, professionals across partner agencies need to improve the assessment of changing need and risk. Crucial to this aspect are the improvement of information sharing and better casework recording.

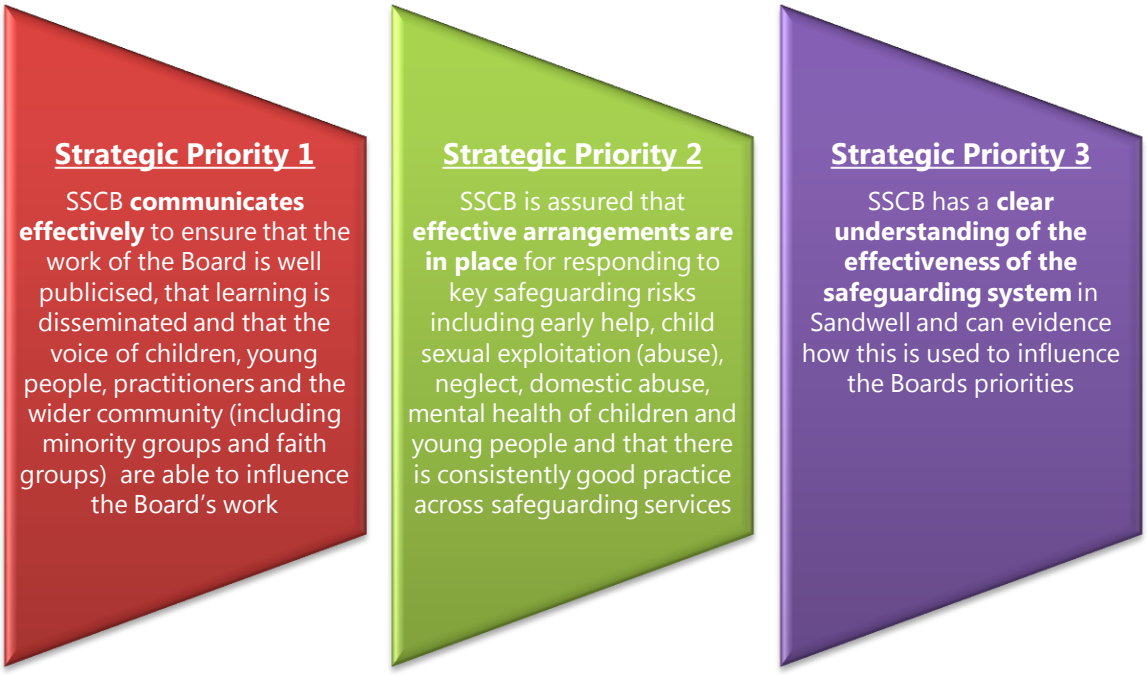
9.4 The quality of practice will be improved through the adoption of a shared practice model to inform assessment, planning, and engagement with children and families. It will be essential to implement *'Signs of Safety'* as a shared practice model, with effective training, supervision and support for professionals in the local authority and partner agencies.

For the Local Authority

9.5 With a revised and more focused Improvement Plan the local authority is gradually making progress to tackle the systemic weaknesses found by OFSTED in the inspection in February 2015. For that progress to be accelerated and sustained it is essential that there is now a swift resolution of the future service delivery arrangements for Children's Services. This will ensure greater clarity for service leaders and staff, for partner agencies, and for the role of the SSCB itself.

SSCB Business Plan 2016/17

9.6 The SSCB's Business Plan priorities for 2016/17 are intended to provide a cohesive framework for the Board and partner agencies to respond to these key issues:



Approval Process

9.7 A draft of this Annual Report was presented at a meeting of the Chairs' Group on 23 June 2016, and the final version including members' comments was approved by the Independent Chair on 7 September 2016. It is the responsibility of SSCB members to present the SSCB Annual Report to their individual Boards and Governing Bodies.

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Sources and verification

9.9 Content included in this report has been presented at SSCB meetings, or at other meetings attended by the Chair, Business Manager or Members. External documents are referenced throughout the report where relevant

Availability and accessibility

9.10 This Annual report is available on the SSCB website www.sandwelllsb.org.uk

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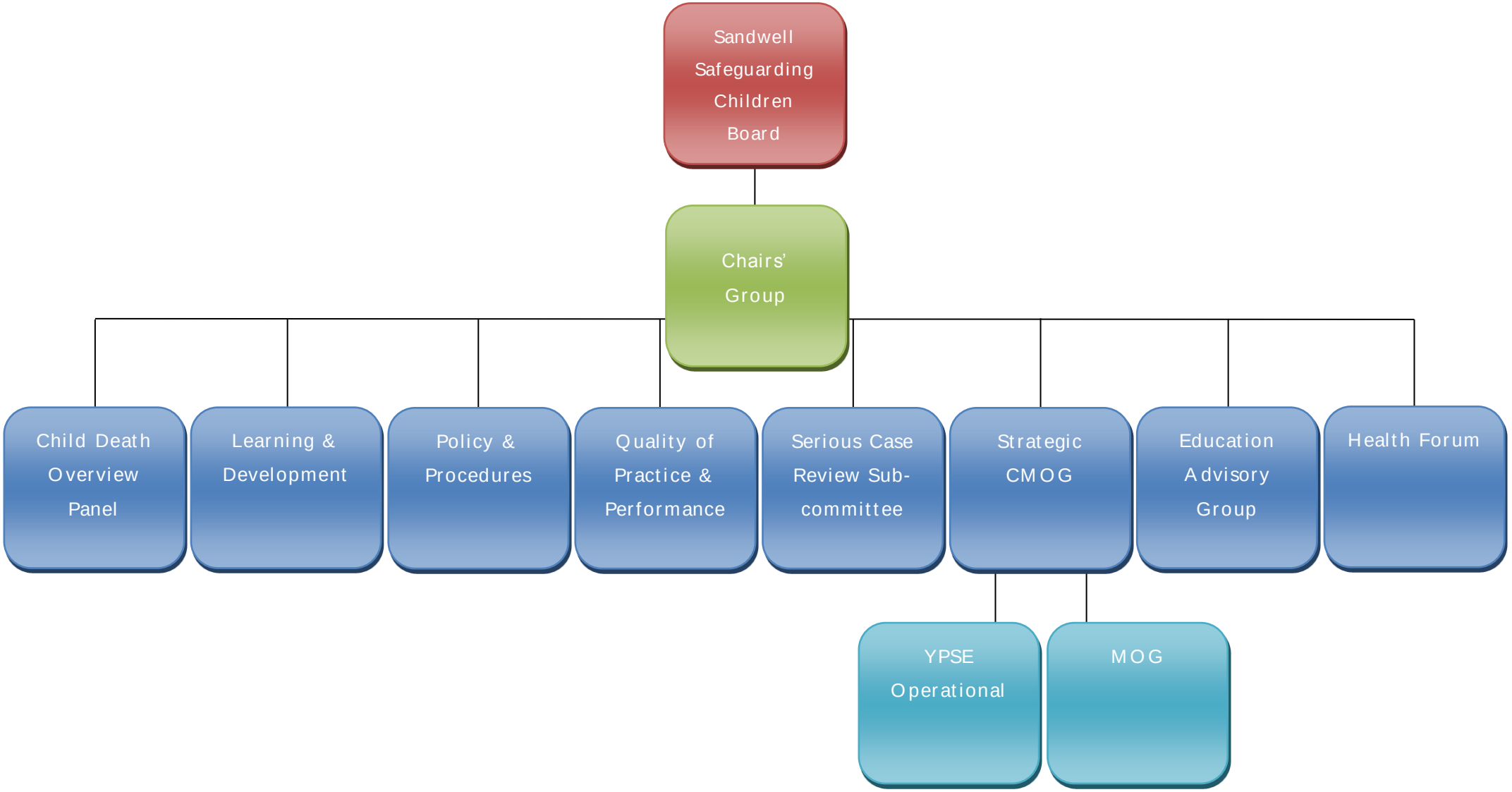
Appendix 1: 2015-2016 SSCB Structure



Appendix 2:

Learning & Development Subgroup Tutor Briefing – March 2016

Following a review of audits, SCRs and management reviews the Learning & Development Subgroup have collated important information to be shared in training delivered on behalf of SSCB. This information should be included in all training, however, as a guide we have highlighted some courses for each of the pieces of information where this MUST be included, please see table below

As recommended in the review of early help services and Working Together 2015 the following needs to be referenced in all training; failure of parents to allow consent to sharing information to be considered for 'step-up' where there is a perceived risk to the safety of a child. The Prevent Duty and FGM reporting duty should also be referenced throughout all training courses.

Information	Source	Relevant Courses
Suicide Prevention Care Pathway	GS SCR	Thresholds, Core Working Together, Trio of Vulnerabilities, Serious Case Reviews, Mental Health Training
Capture and share key statutory information for DA screening e.g. record of GP	DA Multi Agency Audit	MARAC/DASH/BST, Thresholds, all DA courses co-ordinated by DASP
Children Missing Education/Children Missing From Education - increasing vulnerability of children	FS management review	CSE, Core Working Together, Thresholds, children with mental health
West Midlands Police Intel form (FIB) and CSE Screening Tool	CSE assurance Review	CSE training, Thresholds
Chronologies and recording accurate	ES SCR, DA audit, Application of Thresholds	SoS Briefings, Neglect, Thresholds, Core Working

histories	Audit	Together
West Midlands Cross Border protocols, for all agencies not solely a CSC responsibility. Preventing cases getting lost, especially with transient families	ES SCR	Core Working Together, SCR
Policies and procedures to reflect key issues and concerns. e.g what happens about DNA's/handovers. Policies to be reviewed regularly taking into account SSCB information	SCR's, management reviews	All
Including fathers in assessments	Local/national SCR's	Thresholds, Core Working Together
Signs of Safety tool	Learning from SSCB Assurance Activities (2015 – 16)	All

Appendix 3: Learning from SSCB Assurance Activities (2015 – 16)

Author: Raj Bector, SSCB Business Manager

Date: May 2016

1. Introduction

1.1. A common area for development for LSCBs is that lessons from case file audits, local/ national serious case reviews, management reviews and child death reviews need to be built into a multi-agency programme for practice improvement.

1.2. The following report - drawn from an analysis undertaken by Sandwell Safeguarding Children Board (SSCB) Business Unit - encapsulates the key learning points emanating from the performance management and assurance activities undertaken by SSCB during 2015-16. Through this analysis a number of key themes have been identified. These have been organised under the following main categories:

1.3. Using these categories a number of proposed actions have been derived to inform the 2016-17 SSCB Business Plan which will be structured around the following key strategic priorities:

a.) **Strategic Priority 1:** SSCB **communicates effectively** to ensure that the work of the Board is well publicised, that learning is disseminated and that the voice of children, young people, practitioners and the wider community (including minority groups and faith groups) are able to influence the Board's work.

b.) **Strategic Priority 2:** SSCB is assured that **effective arrangements are in place** for responding to key safeguarding risks including early help, child sexual exploitation (abuse), neglect, domestic abuse, mental health of children and young people and that there is consistently good practice across safeguarding services.

c.) **Strategic Priority 3:** SSCB has a **clear understanding of the effectiveness of the safeguarding system** in Sandwell and can evidence how this is used to influence the Boards priorities

2. Assessment of Changing Need and Risk:

2.1. Concerns about the effective assessment of need and managing risk are repeatedly referred to throughout the assurance activities. The Ofsted inspection of services for children in need of help and protection, children looked after and care leavers (published in June 2015) commented that *"The application of thresholds is inconsistently, and at times, inappropriately, applied. This results in cases not being allocated for a social work assessment when appropriate and in cases remaining in early help when a social work intervention is required due to known and potential risk to children"*.

2.2. The Understanding and Application of Thresholds (commissioned by SSCB and SMBC in June 2015) confirmed the challenge that Early Help services faced in engaging with families on a voluntary level, particularly when cases stepped down from a statutory social intervention. It identified that cases sometimes drifted, and in some instances required re-escalation with little or no effective work having been undertaken in the interim period.

2.3. This was echoed in the Safeguarding Board's *'Walk the Floor'* initiative during which staff, whilst having a good understanding of thresholds, expressed frustration as to what the next steps should be if intervention was not effective. A primary school also school also highlighted an issue of a child being moved between a child in need plan, early help and child protection with no progress or improvement.

2.4. Managers of integrated targeted family support services (COGs, Family Solutions Team, Youth Service and Early Help Desk) had already identified engagement as a significant challenge. In response to this issue, Salford University School of Social Work were commissioned to develop an Integrated Services Training Programme for all staff, covering solution focused approaches, working with hard to engage families, risk analysis and a range of other practical approaches. Mixed feedback was received on the usefulness of this training.

2.5. The subsequent Early Help Review (September 2015) highlighted that Early Help staff across the partnership continued to report that it was more difficult to step cases up than step them down and that traffic appeared to be more one way than

the other (performance information at that time showed of 301 cases closed, 11% were step-ups and 23% step-downs). However, the introduction of Challenge Panels reviewed all open Targeted Early Help cases. This empowered workers in the COGs to challenge partner agencies over effective multi-agency working to prevent escalation and also social care colleagues over step ups which have been declined.

2.6. The reviewers undertaking the CSE Assurance Review (September 2015) found that of the 15 CSE cases audited 5 were considered to have risks higher than stated. However, they concluded that 14 cases were being managed in the right part of the system (Early Help or Children's Social Care). This was considered as positive and a significant change in findings since the publication of the Ofsted report.

2.7. During September 2015 SSCB commissioned the GS Serious Case Review (SCR). The SCR identified similar findings about the effective assessment of need and managing risk with a key conclusion being that *"…a multi- agency core assessment of needs and risks was never completed despite extensive agency involvement over many years…This meant that all information was not used to 'identify difficulties and risk factors as well as developing a picture of strengths and protective factors'".* The SCR went on to say that *"…the completion of a Core assessment should have included a suicide risk assessment with updates in response to changing circumstances, consistent with Sandwell's Safeguarding consistent with Sandwell's Safeguarding Board procedures 'Suicide Prevention Care Pathway for children and young people' (2014). Such an assessment would have identified the risk to GS and possibly served to mitigate future attempts by GS by exploring her personal history, personal functioning, verbal warning signs and trigger points".*

2.8. Responses to a workforce survey undertaken by the Safeguarding Board's Quality of Practice & Performance Subgroup during the year also elicited responses from front-line practitioners in respect of inconsistencies in the application of thresholds and improvements in Sandwell's Early Help offer.

Proposed Key Actions for 2016-17 SSCB Action Plan
1. **Strategic Priority 3:** Repeat an audit of the understanding and application of thresholds during the autumn of 2016 in order to ascertain the progress made since the June 2015 external audit.
2. **Strategic Priority 3:** Recommendation to Children's Social Care to undertake periodic Challenge Panels of all open Targeted Early Help cases and report back to SSCB accordingly.
3. **Strategic Priority 3:** SSCB 2016-17 audit schedule to incorporate audits that have a focus on assessment of changing risk and need.
4. **Strategic Priority 3:** SSCB Threshold Training to be refreshed in light of key learning from OFSTED review and external assurance activities
5. **Strategic Priority 3:** SSCB Threshold Document to be refreshed to reflect current practice in Sandwell.
6. **Strategic Priority 2:** Coordinate a Board development day during which members will work closely with frontline practitioners and undertake an audit.

3. Communication (including information sharing and recording):

3.1. Effective communication was a recurring theme in the assurance activities.

3.2. Despite the positive affirmation of improved **communication** and **information sharing**, the Domestic Abuse multiagency audit (undertaken in April 2015) highlighted the fact that GP details were not routinely shared at Barnardo's Screening meetings as well as the fact that domestic abuse notifications themselves were not routinely shared with school health nurses. In addition, the audit led to a specific recommendation to develop guidance for Children's Centres regarding the appropriate action to take following receipt of domestic abuse notifications - this has subsequently been developed and circulated to all Sandwell's children's centre.

3.3. Additionally, the FS Management Review explicitly recommended the review of the Local Authority's Children Missing Education protocol in conjunction with health services to ensure a robust sharing of information particularly around first entry to school to prevent children being at risk of missing education.

3.4. The FS Management Review also spoke more broadly about communication and recommended that the Board should consider **raising awareness** to increase third party reporting of children at risk of neglect.

3.5. The issue of *'raising awareness'* was also echoed in the CSE Assurance Review with the reviewers recommending the wider use across the workforce of the information sharing form that is to be used to submit intelligence to the West Midlands Force Intelligence Bureau (FIB). The form is now available on the Safeguarding Children Board's website and featured in the Board's Autumn 2015 Newsletter.

3.6. There was commonality across the assurance activities in respect of **information recording** with a key recommendation from the ES SCR (published in January 2016) being that a multi-agency case audit be undertaken to ensure that prior interventions, accurate family histories and chronologies are part of the records and inform risk assessments. Whilst a formal audit has not been undertaken, the Quality of Practice & Performance Subgroup has incorporated specific questions into its audit tool to ensure the capture of these crucial pieces of information with a view to then analysing the collated information.

3.7. Both the Review of the Understanding and Application of Thresholds and the Domestic Abuse multiagency audit also made similar recommendations about case responsible staff ensuring case files had fit for purpose updated chronologies, and accurate details of workers, involvement with the child and family and child names/DOB/GP & School.

3.8. The *'Compliance with West Midlands Cross Border Protocol'* audit (November 2015) similarly highlighted gaps in information recording, record keeping and a lack of robust chronologies/ recording. However the audit did also identify cases which benefited from having holistic chronologies and good analysis with the wishes/ feelings of the child/ parent/ carer included in the assessment.

3.9. The workforce survey undertaken during Q4 of 2015-16 also provided useful feedback to SSCB that a number of respondents were of the view that they had not received feedback from MARFs and that processes needed to be clear and consistent.

3.10. A similar point was also echoed in the findings from the Board's *'Walk the Floor'* initiative during which front-line practitioners within Children's Centres identified a lack of communication when cases are de-escalated.

3.11. The Serious Case Reviews and Management Reviews undertaken during 2015-16 resulted in a number of recommendations being made in respect of Policy & Procedures. These ranged from:

- ensuring that there is a clear policy and pathway for the handover from Health Visiting to School Nursing;
- ensuring that health providers in Sandwell review their DNA policy and making sure that it is being appropriately applied;
- developing multi-agency procedures and practice guidance for missed appointments;
- receiving assurance that Sandwell Local Authority Education have undertaken a review of the Children Missing Education protocol in conjunction with health services to ensure a robust sharing of information particularly around first entry to school to prevent children being at risk of missing;
- ensuring that single agency procedures include practice guidance for children who are subject to supervision orders;

3.12. A key area of focus during 2016-17 will therefore be to drive forward the development of local policies against a backdrop of potentially phasing down the work of the Policy & Procedures Subgroup in light of regional developmental work. This will need to be supplemented with a robust 'Communications Strategy' which clearly identifies what messages will be shared with which groups and how this will be done..

3.13. Whilst the Board has been routinely disseminating learning across the partnership from SCRs and audit activity through its quarterly newsletters, coupled with a rolling programme of multiagency 'learning from SCRs' training, which is supplemented with single agency briefings, there remains much work to be done in order to embed learning in a timely manner across the wider workforce.

3.14. This was a theme from SSCBs Section 11 audit activity (comprising the submission of an online audit supplemented by a series of *scrutiny panels* with each partner in respect of their submission) undertaken during the year. A key theme identified that whilst agencies provided assurance that learning was disseminated, there was little evidence of impact.

3.15. The Safeguarding Children Board's *Walking the Floor* initiative undertaken between January 2016 - March 2016 highlighted the need to do more to increase practitioner knowledge and understanding of the role of SSCB as well as the need for clearer communications from the Board and wider circulation of the Board's newsletter/ CDOP briefings. In addition, further clarity on the SSCB Serious Safeguarding Incident Notification Form (SSINF) was also identified as an area for improvement as well as broadening the range of information accessible on the SSCBs website. During the Section 11 audit activity the majority of organisations provided assurance that key staff were aware of the SSINF process. However, given that the majority of SSINFs to date have been submitted by Children's Social Care and Police it would seem logical that further work in this area is required.

3.16. The review of child deaths during 2015-16 identified several modifiable factors which led to the launch/ continuation of several campaigns. These included the:

a.) development of 'Dog, Duck and Cat' books around poisonous household substances, dog safety and water safety

b.) revision, production and distribution of Safer Sleeping bags and thermometers with the inclusion of messages around bed sharing and the use of more imagery to support with EAL (English as Additional Language)

3.17. Data was also provided to Public Health to support with campaigns around maternal smoking

3.18. Looking forward to 2016/17, CDOP will continue to respond in real time to the emerging issues raised through the collection and review of child death information through campaigns, briefings and dissemination of learning. In addition, a project funded through Sandwell & West Birmingham Clinical Commissioning Group regarding the use of 'Baby Boxes' with the most vulnerable mothers will be carefully evaluated and scrutinised for further distribution and profile raising both locally and nationally.

Proposed Key Actions for 2016-17 SSCB Action Plan
1. **Strategic Priority 1:** SSCB to actively promote the third party reporting of children at risk of neglect
2. **Strategic Priority 2:**SSCB Module 3 / Core *'Working Together'* Training to make explicit reference to the importance of cumulative chronologies and recording of accurate and timely information
3. **Strategic Priority 1:**SSCB to publicise the need to adhere to the West Midlands Cross Border Protocol
4. **Strategic Priority 2:** SSCB to request an assurance report in respect of feedback provided to agencies submitting MARFs
5. **Strategic Priority 1:** Develop a Communications process to better disseminate learning and policy development across the partnership
6. **Strategic Priority 2:** Drive forward the development of local policies in light of regional developments in respect of policies and procedures.
7. **Strategic Priority 1:** Develop and implement a communications strategy which clearly identifies what messages will be shared with which group and how this will be done.
8. **Strategic Priority 3:**CDOP to continue to respond in real time to the emerging issues raised through the collection and review of child death information through campaigns, briefings and dissemination of learning

4. Workforce Development:

4.1. Workforce development is the mechanism to equip staff (and volunteers) with skills and knowledge so that they can effectively deliver and improve services to children, young people and families.

4.2. Whilst there is sufficient regular, appropriate and purposeful multiagency training across and within disciplines it is important that learning from the Boards assurance activities are reflected in its training programme.

4.3. To this end, the Review of the Understanding and Application of Thresholds made some basic observations about case plans including the need for plans - LAC, CP or CiN - to be SMART with clear alternative plans if objectives are not met. Furthermore, the reviewers highlighted the importance for case assessments and plans to be child focused. This was echoed in a key finding from the Domestic Abuse audit which called for an increase in staff awareness about understanding and assessing a child's demeanour, ensuring that it is recorded in domestic abuse incidents.

4.4. The ES SCR was also clear in its conclusions about basic procedure stating that *"…there are few if any new findings from this SCR. The main finding is that agencies failed to get the basics right*. *The history of the case was 'lost' not just by one but by all the agencies when the family moved from one area to another, information was not recorded accurately, the outcomes of meetings were not recorded, professionals did not share information both within and between organisations, child protection procedures were not followed…"*

4.5. Similar recommendations about basic practice were made following the Review of Early Help Services which suggested that staff need to be reminded of Working Together guidance and that a failure of parents to allow consent to sharing information needed to be considered for *'step-up'* where there is a perceived risk to the safety of a child. It also recommended that Senior Family Support Workers should be provided with training in supervision as soon as possible.

4.6. The CSE Assurance Review highlighted the need to not only improve the consistency and quality of CSE casework but to also embed the use of the CSE Screening Tool across the partnership supported by a programme of training. In

order to be effective, the reviewers further recommended that data collection regarding the nature and scale of CSE in Sandwell should be used to inform a CSE training programme. This is a key activity that will need to be taken forward by the Safeguarding Board's Learning & Development Subgroup.

4.7. A finding from the FS Management Review focused on adopting a more targeted approach with Housing and Neighbourhood Officers in respect of Module 1 training. This was to equip those officers who complete home visits with the skill-set to identify and report child neglect. To this end the MASH Education Officer delivered a number of sessions across the housing sector about thresholds and was supported by colleagues who provided additional information about Early Help, Troubled Families agenda and CSE.

4.8. One of the key issues of substance arising from an analysis of SSCBs s175 audit with schools during the 2014-15 academic year (which spanned the 2015-16 financial year) related to the development of the Personal, Social, Health and Economic (PSHE) curriculum in respect of CSE and Extremism. Although the audit activity found that schools were increasing their awareness in CSE (demonstrated through the number of referrals being received), it was clear that a more targeted approach needed to be taken with specific schools in order to raise awareness further. This finding was reflected in the SSCB's CSE Strategy. Primary Schools in particular expressed concerns with regard to CSE being within the key stage 1 (ages 5 - 7) & key stage 2 (ages 7-11) curriculum. A consistent approach of how to manage disclosures made by children was also highlighted as a particular area of concern by schools during the s175 audit. This was addressed by making a West Midlands Police presentation that supports practitioners in managing disclosures available to schools.

4.9. The Section 175 audit also identified that a number of schools have either had specific training, or bespoke workshops for pupils, thereby increasing their awareness and engagement in respect of extremism/ radicalisation, this is not routinely being done across the sector. It is clear that a more targeted approach needs to be taken in order to raise awareness further. In light of the withdrawal by West Midlands Counter Terrorism Unit (CTU) of their Securities and Partnership Officers from the delivery of WRAP (Workshop to Raise Awareness of Prevent)

training, SSCBs Learning & Development Subgroup coordinated the delivery of a *'Train the Trainer'* program in November 2015 equipping twelve multiagency colleagues with the skills to now deliver WRAP training on behalf of SSCB. The Local Authorities Strategic Prevent Coordinator, who commenced employment in October 2015, has also supported a delivery plan where training and awareness has been prioritised accordance with the expectations set out in the Prevent Duty.

4.10. Both the external review of thresholds and the CSE assurance review made explicit reference to the need to strengthen staffing levels within the MASH/ MAET, CSE Service/ Team as well as COGs, not only in terms of capacity but also in terms of skill-mix. The external review of thresholds for example highlighted that *"…although the speed and professionalism of the decision-making by team managers in MASH was impressive, we concluded they were working at the edge of capacity"*. The reviewers also commented that *"…MAET is also under considerable pressure and one of the 2 Team Managers indicated that there had not been enough time to carry out routine supervision".*

4.11. In response to this, staffing levels within both MASH (1.5 x FTE) and MAET (1 x FTE) were strengthened during the summer of 2015. A review of the roles and responsibilities within COG teams has also resulted in each COG Manager now being supported by two Senior Targeted Family Support Workers who manage five Targeted Family Support Workers per COG. The role of the Early Help Social Worker (EHSW) has also been reviewed and refocused to complement the weekly COG Case Discussion Forums, providing consultancy type advice to schools, supporting risk assessment and operation of thresholds. Following the establishment of a new Single Assessment Team within Children's Social Care it is no longer necessary or appropriate for EHSWs to undertake Single Assessments.

4.12. Additionally, the appointment of a single Group Head for Targeted Services from September 2015 responsible for all 6 COG services is providing greater coherence to the development of the service in the future.

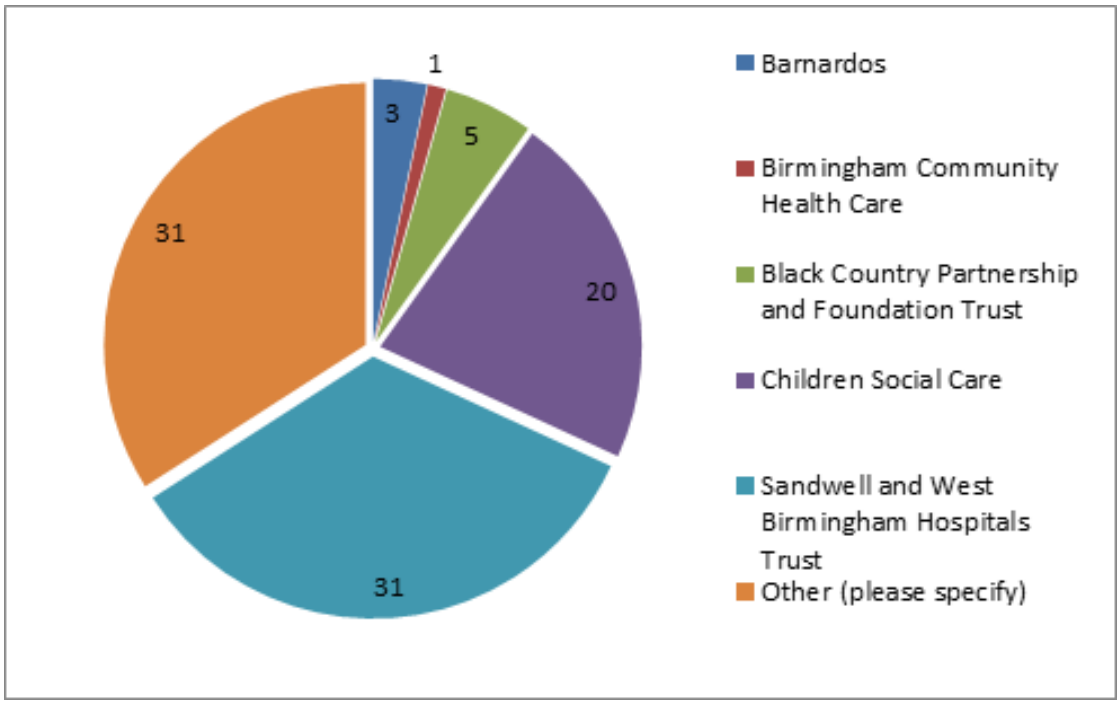
4.13. The Section 11 audit activity also highlighted *workforce development* as a theme with recommendations that relevant staff within organisations attend CSE and multi-agency threshold training as appropriate; undertake DASH risk assessment training

and MARAC training; complete on-line training on Domestic Violence and Abuse, Forced Marriage, Honour Based Violence and Female Genital Mutilation.

4.14. The CSE assurance review also recommended that the Board be sighted on progress of plans by West Midlands Police to develop dedicated capacity and capability to tackle CSE and confirm witness care arrangements for CSE victims.

4.15. It should be noted that during the year there have been a number of initiatives to strengthen practice with the appointment of a Principal Social worker team and the introduction of Signs and Safety and Outcome Star. Outcome Star (a suite of tools designed for supporting and measuring change in work with individuals and families) has been rolled out and over 600 professionals from across the multi-agency Early Help workforce have been trained in its use. 'Signs of Safety' has also recently been rolled out across the workforce in Children's Social Care. SSCB will be working with partners during 2016-17 to ensure that frontline practitioners within their respective agencies have an understanding of the Signs of Safety model.

4.16. A key component of the Board's Quality Assurance Framework is *'Workforce Engagement and Development'* and the survey undertaken during the year was specifically designed to proactively engage with the Partnership's workforce who work directly with children in Sandwell. The survey was live between 12th January 2016 - 12th February 2016 and a total of 91 responses were received from organisations as illustrated below.



4.17. Based on the limited number of responses the key issues highlighted by the survey results were as follows:

a.) Approximately 50% of respondents either agreed or strongly agreed that children were being effectively safeguarded in Sandwell. Conversely this means almost 50% do not have this view and communicated that high caseloads, being over-worked and thresholds being high as possible reasons for this.

b.) A similar split and similar reasons were also echoed in responses to the questions asking whether staff were able to spend enough time working with children and young people and whether current caseloads were manageable.

c.) 85% of respondents felt that they did receive regular supervision with the vast majority commenting that they also found the process effective.

d.) Three-quarters of respondents felt that their interventions had improved the safety and welfare of children. However, resource constraints and a reducing workforce were cited as potential reasons that weaken the effectiveness of interventions. This latter point was also identified in the 'Walk the Floor' initiative during which more capacity within services to attend the COG meetings, and within services to support families were highlighted as challenges facing practitioners.

Proposed Key Actions for 2016-17 SSCB Action Plan
1. **Strategic Priority 2:** EAG, in conjunction with the CSE Team, to identify and work with those schools that would benefit from a more targeted approach in order to raise awareness in respect of CSE.
2. **Strategic Priority 1:** L&D Subgroup to reflect the learning from assurance activities in both the 2016-17 training catalogue and the tutor briefings
3. **Strategic Priority 3:** SSCB to be sighted on progress of plans by West Midlands Police to develop dedicated capacity and capability to tackle CSE and confirm witness care arrangements for CSE victims
4. **Strategic Priority 1:** L&D Subgroup to incorporate Signs of Safety into the refreshed threshold training and supplement this with 'bite-sized' training

5. Performance Information & Quality:

5.1. A further recurring theme identified during 2015-16 related to performance information and quality.

5.2. The CSE Assurance Review questioned the reliability of data given that of the 20 cases that the reviewers explored, 5 (25%) were not in fact CSE cases. Discussions with staff about these cases indicated that the reason they were considered as CSE was due to the high emphasis placed on CSE. Reviewers considered that additional training may be needed in the recognition of CSE, distinguishing it from other types of need/ risk. Further issues were also raised about the reliability of available data.

5.3. In order to address this agreed information is now routinely provided to Strategic CMOG and SSCB. A monthly scorecard is produced by the Local Authority and quarterly information is supplied to SSCB which provides information on victims, perpetrators, locations and overarching themes.

5.4. It should be noted that 5 of the 15 cases audited were escalated to senior managers in terms of the quality of assessment, planning and effectiveness of safeguarding activity. Of note in terms of timeliness and effectiveness of support to victims is that three of these five cases had previously been audited by SMBC following the Ofsted inspection so in effect the cases were raised again for further enquiries.

5.5. In response to the CSE Assurance review, both SMBC and SSCB have implemented a cycle of audit of CSE cases to ensure risk has been identified and is being managed effectively. The Safeguarding Board are scheduled to undertake a multiagency audit focusing on multiagency intervention during 2016-17 and the Board's current Section 11 audit incorporates specific questions in respect of CSE. This will be further supplemented when SSCB develop arrangements during 2016-17 to scrutinise and challenge the partner agency CSE self-assessment process and any associated action plans that were produced as part of the CSE Assurance Review.

5.6. Both the external review of thresholds and the CSE assurance review made explicit reference to the need to undertake further audit work. With respect to the former, a review of Early Help was recommended and duly undertaken in August 2015. The latter highlighted the need for SSCB to commission regular audits of CSE risk

ratings, case plans and MASE meetings to ensure consistency and quality in the work. This will be taken forward by SSCB during 2016-17.

5.7. The Early Help Assurance Review made several recommendations about performance information and at the time of writing, a range of draft outcome-based performance indicators have been developed, drawing from the Troubled Family Indicators (TFI) criteria, by Children's Social Care. The indicators, which have yet to be signed off, will inform Locality Score Cards and local partnership working and will include data in respect of school attendance, school exclusions, educational attainment, anti-social behaviour and juvenile crime.

5.8. The Early Help Assurance review further recommended that Children's Services and the SSCB needed to have a clearer perspective on all agencies and schools' performance in terms of providing early support to children and families with non–compliant schools being an early priority for COG managers in ensuring a consistent Early Help offer from schools. With this in mind, consideration is being given to the governance arrangements and remit of the Early Help/MASH/MAET Board and whether it should become a formal subgroup of SSCB. This would better ensure that the monitoring of lead agencies is overseen at the Early Help/MASH/MAET Board with issues being directly escalated to SSCB.

5.9. The Section 11 audit activity also resulted in several recommendations in respect of performance information and quality. These included:

- Strengthening the Board's current data set further in order to enable SSCB to effectively scrutinise outcomes for children within the court system
- Seeking full engagement from partners in respect of their single agency audit programmes and outcomes.
- Seeking further assurance in respect of how agencies are taking forward the Prevent agenda by increasing staff awareness and engagement in respect of extremism/ radicalisation including identifying a Prevent Lead to coordinate this work
- Seeking further assurance in respect of how agencies are embedding CSE as a priority throughout their organisations

5.10. On a broader note, in September 2015 SSCB agreed a new Constitution which included a Board member role description and referenced an ongoing Board development programme. The development programme is part of the way in which

SSCB can assure itself that it functions well and can demonstrate its effectiveness. One element of the development programme is the completion of a Board member Annual review, the purposes of which are to:

a.) strengthen individual and collective responsibility
b.) clarify expectations of Board members
c.) learn from members' experiences to measure the Board's effectiveness
d.) improve communication and engagement
e.) provide an opportunity for open discussion between members and th
f.) Independent Chair on how to improve the Board's functioning
g.) maximise members' contributions
h.) identify areas for development
i.) model good practice and reflective learning

A recurring theme from the Board member review exercise focused on strengthening SSCB challenge. Whilst it was acknowledged that this was an improving area members commented on the need for more challenge to be made to the education agenda in terms of quality safeguarding practice and training. In addition there were comments that whilst the majority of challenge rightly comes to Social Care there is a need to replicate this with the same intensity for other partners.

Proposed Key Actions for 2016-17 SSCB Action Plan
1. **Strategic Priority 3:** SSCB to commission audits of CSE risk ratings, case plans and MASE meetings to ensure consistency and quality in the work.
2. **Strategic Priority 3:** SSCB develop arrangements during 2016-17 to scrutinise and challenge the partner agency CSE self-assessment process and any associated action plans that were produced as part of the CSE Assurance Review
3. **Strategic Priority 2:** Early Help/MASH/MAET Board to be reframed into a formal subgroup of SSCB
4. **Strategic Priority 1:** The SSCB CSE training offer to specifically distinguish CSE from other types of need/ risk.
5. **Strategic Priority 2:** SSCB to give consideration to resurrecting the use of a 'Challenge Log'

Appendix 4:

Jargon Buster

ACC	Assistant Chief Constable
ACE	Adverse Childhood Experiences
ASD	Autism Spectrum Disorder
CAIT	Child Abuse Investigation Team
CAMHS	Child and Adolescent Mental Health Services
CDOP	Child Death Overview Panel
CCG	Clinical Commissioning Group
CFSMT	Children and Families Senior Management Team
CIN	Children in Need
CME	Children Missing Education
CP	Child Protection
CRC	Community Rehabilitation Company
CSDB	Children's Services Development Board
CSE	Child Sexual Exploitation
DAAs	Domestic Abuse Advocates
DASP	Domestic Abuse Strategic Partnership
DECCA	Drug Education, Counselling and Confidential Advice
DHR	Domestic Homicide Review
DVA	Domestic Violence and Abuse
EHE	Elective Home Education
FGM	Female Genital Mutilation
FM	Forced Marriage
HBV	Honor Based Violence
IAPT	Increasing Access to Psychological Therapies
ICIDP	Initial Crime Investigators Development Programme
LPU	Local Policing Unit

LSCB	Local Safeguarding Children Board
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multiagency Safeguarding Hub
MBC	Metropolitan Borough Council
MOG	Missing Operational Group
NLN	National LADO Network
NPS	National Probation Service
OOCD	Out of Court Disposal
PMHCW	Primary Mental Health CAMHs Worker
POT	Position of Trust
PPU	Public Protection Unit
SCADIP	Serious Child Abuse Investigations Development Programme
SCR	Serious Case Review
SCVO	Sandwell Council of Voluntary Organisations (SCVO)
SMBC	Sandwell Metropolitan Borough Council
SoS	Signs of Safety
SSCB	Sandwell Safeguarding Children Board
SUDC	Sudden Unexpected Death in a Child
SWA	Sandwell Women's Aid
SWM	Staffordshire and West Midlands
TAF	Team Around the Family
WMRLN	West Midlands Regional LADO Network
WRAP	Workshop to Raise Awareness of Prevent
YOS	Youth Offending Service
YPA	Young People's Advocate
YPSEM	Young People at Risk of Sexual Exploitation