Sandwell Safeguarding Children Board

Annual Report 2016-2017

Sandwell Safeguarding Children Board (SSCB)

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August 2017	Raj Bector	2	Additional information provided by partners. Report further refined.
September 2017	Raj Bector	3	Final draft
September 2017	Raj Bector	4	Charts updated in Chapter 7

Contents

1. Foreword by SSCB Independent Chair, Audrey Williamson

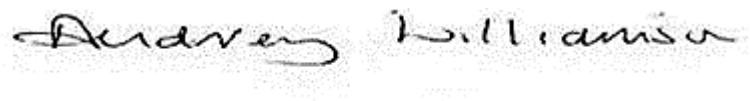
This is the Annual Report of Sandwell Safeguarding Children Board (SSCB) and covers the year ending 31 March 2017.

The work of the Board in recent years been characterised by continuous improvement and steady progress, coupled with growing partnership involvement and purpose.

This year has been challenging as John Harris, the previous independent chair left in August 2016 and I took up the post in June 2017. In the interim the deputy chair, Claire Parker, the senior Board representative from Sandwell and West Birmingham Clinical Commissioning Group (SWB CCG) covered the post on behalf of the Board. I would like to thank both John and Claire for their work. John led the Board through a positive peer review which provided clear evidence of improvement across the partnership while Claire maintained the improvement during a time when it was announced that Sandwell children's services would be delivered through the formation of a Trust. This report sets out the achievements during 2016-17 whilst also identifying the improvements that we must continue to address.

The Board is confident that whilst safeguarding arrangements in Sandwell are robust they can always be further strengthened. The challenge in the year ahead will be to regain momentum and maintain progress at a time of unprecedented pressures on public finances, and through a period of national policy changes (including to the focus and remit of safeguarding boards) without losing sight of what matters most: the safety and wellbeing of children in Sandwell. It is a challenge for which we are well equipped.

I would like to take this opportunity to thank all Board members for their work during last year and the safeguarding team which has provided strong support to the Board. Most importantly I would like to thank all those staff who work on a daily basis with vulnerable children and their families in a complex and challenging environment.



Audrey Williamson
SSCB Independent Chair

2. About the annual report

2.1 This is the annual report for Sandwell Safeguarding Children Board (SSCB). It covers the reporting period between April 2016 and March 2017 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.

2.3 The report highlights the progress made by the partnership over the last year and the challenges going forward. Contained within the report are the lessons that SSCB has identified through its Learning & Improvement Framework and Serious Case Reviews and the actions taken to improve child safeguarding and welfare as a result of this activity.

2.4 Also highlighted is the range and impact of the multi-agency safeguarding training delivered by SSCB.

2.5 The final section sets out the priorities going forward and the key message from the Independent Chair of SSCB to key people involved in the safeguarding of children.

2.6 In line with statutory requirements and best practice, 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. The Board

3.1 Governed by the statutory guidance in Working Together to Safeguard Children 2015 and the Local Safeguarding Children Board (LSCB) Regulations 2006, SSCB comprises senior leaders from a range of different organisations. The basic objective is defined with the Children Act 2004: ***to coordinate the safeguarding work of agencies and to ensure that this work is effective.***

Key Role and Relationships

3.2 The Independent Chair of SSCB is Audrey Williamson who commenced in the role on 1 June 2017. Supported by a Board Manager and a business unit, the Chair is tasked with ensuring the Board fulfils its statutory objectives and functions. Key to this is the facilitation of a working culture of transparency, challenge and improvement across all partners with regards to their safeguarding arrangements. Prior to Audrey's appointment, the Board was chaired on an interim basis by Claire Parker following the departure of the then Independent Chair, John Harris, in July 2016.

3.3 The Chair is accountable to the Chief Executive of Sandwell MBC. The Director of Children's Services for Sandwell is a member of SSCB and worked closely with the Chair on related safeguarding challenges during the reporting period. Whilst being unable to direct organisations, SSCB does have the power to influence and hold agencies to account for their role in safeguarding.

GOOD PRACTICE: In June 2016, the Chair commissioned a peer review from the Local Government Association (LGA) in order to validate progress since the Board's Strategic Review in September 2014. The peer team found 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"*

Partner Agencies

3.4 All partner agencies across Sandwell are committed to ensuring the effective operation of SSCB. Members of the Board hold a strategic role within their organisations and are able to speak with authority, commit to matters of policy and hold their organisation to account.

3.5 During 2016/17 the quality of performance data from partners was comprehensive enabling the Board to begin considering trends. Additionally, the interface with the schools sector in the Borough has improved with the Designated Safeguarding Practitioners (DSP) forum becoming more

embedded and robust during the year. The forum provides a good communication channel in ensuring the education sector in the Borough are kept abreast of key safeguarding initiatives and engaged in Board activity. This is augmented by the Board's Education Advisory Group (EAG)

GOOD PRACTICE: Tangible impact is seen through the engagement of schools in the Board's 2016/17 academic year Section 175 audit. 98% of schools have successfully completed their audit with the remaining 2% having populated at least 80%.

Designated Professionals

3.6 The Designated Doctor and Nurse take a strategic and professional lead on aspects of the health service contribution to safeguarding children. Designated professionals are a vital source of professional advice. Across the range of SSCB activities, these designated roles have continued to demonstrate their value during 2016/17.

GOOD PRACTICE: At a National Safeguarding Conference in 2015 safeguarding professionals were challenged to become 'superheroes' to combat CSE. In response to this, the Sandwell & West Birmingham CCG Safeguarding Team launched the Superhero Campaign. This included:

- The commissioning of a film called *'Know the signs'* for use in primary care settings from the organization '*Chatback'* who are a group of children in care and children of foster carers
- The development of a training resource pack in conjunction with the Children's Society to underpin the film
- The development of resources for use in a variety of settings to promote the campaign

Relationship with Other Boards

3.7 There is a clear expectation for LSCBs to be highly influential on strategic arrangements that directly influence and improve performance in the care and protection of children. There is also a clear expectation that this is achieved through robust arrangements with key strategic bodies across the partnership.

3.8 During 2016/17, engagement continued and was strengthened with the Safeguarding Adults Board (SSAB). A Joint Board Development Day was held in April 2016 where members of SSAB and SSCB - including Heads of Service, Senior Police representatives as well as Health Partners - looked at key safeguarding themes that impact on both adults with support needs and children in this area.

3.9 Joint working arrangements with the other strategic partnerships in Sandwell are set out in a Sandwell Partnership Protocol but this failed to gain traction during 2016-17 and will be revisited during 2017-18

76,867
children and young people under the age of 18live in Sandwell

120 children identified being at risk of CSE

99 incidents of children going missing from care (involving a total of 25 children)

29.6%
of children living in 'relative' poverty (of which 87% are unde 16 years old)

1488 Children in Need

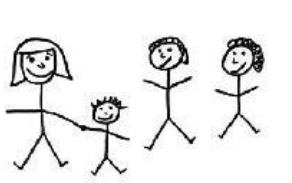
156 children in need with a disability

3,320
DVA cases of families with children screened by the MASHDA team

1282 referrals to CSC

17.4% were re-referrals to CSC within 12 months

22%
of primary & secondary children in receipt of free school meals (compared with 15% and 17% nationally)



417 children on CP plan as at March 2017

608 children looked after as of March 2017

17.2% children became subject of CPP for CP investigations, 2nd or subsequent times

4.1 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.

4.2 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.

4.3 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.

4.4 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.

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

Governance & Accountability Arrangements

4.6 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.

4.7 On 6 October 2016, the Secretary of State issued a Direction to the Council to set up a Trust to deliver Children's social care functions. A Children's Commissioner was appointed at the same time, and a dedicated project team was established to oversee the process.

4.8 The Trust - to be known as Sandwell Children's Social Care Trust - will be an operationally independent company, with responsibility for delivering children's social care services. Statutory accountability will remain with Sandwell council. Staff will TUPE transfer into the Trust, which will have its own distinct branding and accommodation. Staff are engaged in the process, and are actively shaping the look and feel of the new organisation.

4.9 Whilst a Chair of the Board of the Trust has been appointed the role of Chief Executive has yet to be appointed to.

Business Priorities and LGA Peer Review Actions

4.10 OFSTED reviewed the SSCB 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.

4.11 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 and Board priorities. The plan was monitored through the Board's Chairs' Group with good progress made in all aspects of it.

4.12 A Peer Diagnostic Review of the SSCB undertaken by the Local Government Association (LGA) between June and July 2016 found that the Board was meeting its statutory duties and was providing authoritative and constructive challenge to the local authority and partner agencies

4.13 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

4.14 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

4.15 Following a review of the Safeguarding Board's assurance activities during 2015/16, coupled with a Business Planning session following the peer review, the following refreshed strategic business priorities were identified for 2016-18:

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

4.16 The following section sets out the progress and identified challenges.

5. Summary of performance against 2016/17 strategic priorities

5.1 **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 the children, young people, practitioners and the wider community (including minority groups and faith groups) are able to influence the Board's work*

5.2 Whilst the LGA Peer Review commented on the *"…significant improvements in communication and presentation of SSCB business"* there was a concerted effort during the year to ensure that the work of the Board was well publicised.

- SSCB newsletters were routinely produced on a termly basis and circulated to all Board members (for wider circulation within their respective organisations) and across the Education Sector

- Learning notes were routinely produced for (serious) case reviews and multiagency audits undertaken during the year.

- The Board's annual conference, attended by 150 professionals from across the partnership, took place on 5 July 2016. Influenced by a Serious Case Review (SCR) undertaken during the year, coupled with several other cases brought to the attention of SSCB, 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. 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

- As the financial year ended the Board commissioned a safeguarding survey that was circulated across the multiagency partnership. Results indicated that almost two thirds of respondents do not routinely receive the learning notes from audits and SCRs. Communicating effectively therefore remains a continuing challenge for the Board.

- During the year the Board 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).

- 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 Community Based Faith Establishments (CFBEs) have to the safeguarding agenda.

- However, the Board is aware of the need to progress this work further and will be prioritising this during 2017-18

Further Development of the Board

- 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 Children and Social Work Act 2017 which sets out future arrangements for safeguarding children within localities.

5.3 **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*.

Child Sexual Exploitation

5.4 The purpose of the Strategic CMOG subgroup is to work collaboratively to address *identified* gaps in relation to identifying and preventing CSE and to have strategic insight into how the partnership are working to proactively pursue offenders and bring them to justice.

5.5 Strategic CMOG has responsibility for ensuring that the Child Sexual Exploitation (CSE) strategy is embedded and that partners work collaboratively to address CSE across the Sandwell footprint. The group oversees the work undertaken in both the Young People Sexually Exploited (YPSE) Group and the Missing Operational Group (MOG).

5.6 The subgroup has had delegated responsibility from the SSCB to ensure that actions and recommendations from both local and national reviews into CSE are implemented and embedded across Sandwell with the aim of improving recognition of CSE and outcomes for those affected by this crime.

5.7 In relation to *YPSE*, the Strategic CMOG group are provided with updates in relation to intelligence and disruption tactics being utilised across Sandwell. Whilst the techniques, tactics and activity is discussed at YPSE, it is the role of Strategic CMOG to have oversight of these implementations and to further progress any challenge or identified trend analysis; this will contribute to the local profiling of CSE across Sandwell.

5.8 The Subgroup met a total of five times during the reporting period in May, July, September, November and January 2017.

Key subgroup activity and achievements during 2016/ 2017

- Strategic CMOG subgroup was delegated the responsibility of ensuring that lessons learnt from various reviews and enquiries were embedded across Sandwell.

- The group had oversight of the Action Plan and CSE strategy that was agreed as a result of these and has implemented a variety of mechanisms in order to track progress being made against actions.

- Throughout 2016 there was emphasis placed on the continued training for frontline practitioners and professionals in the recognition of CSE and the referral routes for those deemed at risk. The training programme for CSE awareness has now been embedded into the 'Learning Catalogue' for the SSCB and the course is well attended and evaluated.

- Sandwell Local Authority also participated in a pilot project commissioned by the Children's Commissioner. The 'See Me Hear Me' Pilot included three Local Authority areas with evaluation of the project commissioned to Sussex University. This pilot used a foundation of embedding 7 key principles into the CSE work completed by the Authority and partner agencies. The project supported the existing framework and the methodologies in place and supported development of the CSE response across the partnership.

- Strategic CMOG have overseen the development of robust data collection and data reporting for the MOG which is subsequently analysed as part of the MOG meeting. Trends and themes highlighted as part of MOG are fed into Strategic CMOG for review and discussion regarding any actions or coordinated approaches required. Strategic CMOG provide direction for the MOG in terms of implementing diversionary tactics or engagement programmes in order to reduce the number of missing young people, or to reduce the risk that young people may be at in the community.

- The subgroup have addressed a number of barriers in effectively sharing information in order to safeguard young people either at risk of, or being exploited. This has included the introduction of effective flagging of victims on health systems, which allows health professionals to be aware of the potential for abuse and prompts them to ask questions relating to the young person's sexual health and wellbeing. This has proved advantageous for known victims.

- It has also overseen the development of the CSE specific area of the internal electronic file. This 'workspace' has been created within the Early Help system. The development of the 'workspace' has enabled accuracy of data and also contributed to effective multi agency working and information sharing.

- Strategic CMOG has overseen developments in YPSE whereby disruption and pursue tactics have improved, leading to more robust techniques being used as a multi-agency partnership, with intelligence gathering and submission increasing; resulting in enhanced profiling of offenders and activity. This has allowed the group to effectively coordinate responses and implement tactics in addressing problem areas and identifying both victims and offenders.

- Actions taken in order to increase professional curiosity and knowledge of vulnerability & risk factors has led to improved identifications of potential CSE and more informed referrals. There has also been an increase in the quality of information shared and submitted to the Police via the FIB form.

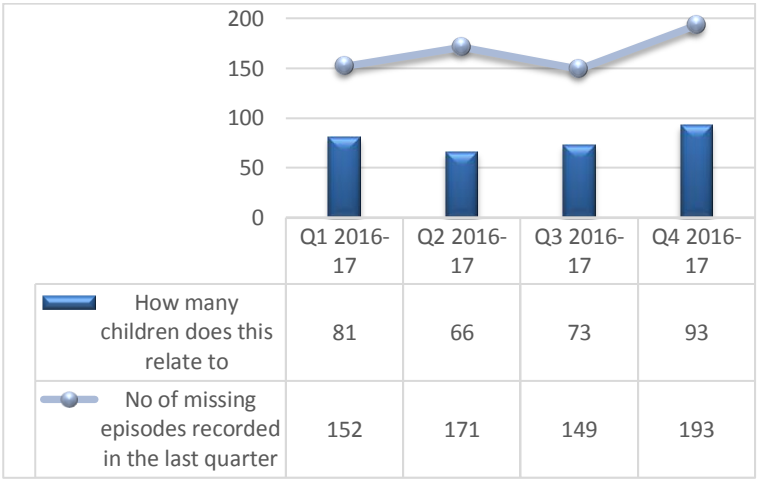
- Earlier identification of concerns will hopefully lead to improved outcomes for the child/young person as interventions can be implemented sooner in order to reduce their vulnerabilities and risk whilst increasing their resilience and awareness levels.

- It is envisaged that improved identification of victims will also lead to identification of offenders, thus allowing earlier opportunity to disrupt activity, pursue criminal behaviours and prosecute perpetrators.

- Improved information sharing has also had an impact on the ability to coordinate a borough wide response, communicating concerns and assigning actions to a variety of teams and professionals in order to manage and contain activity at early stages.

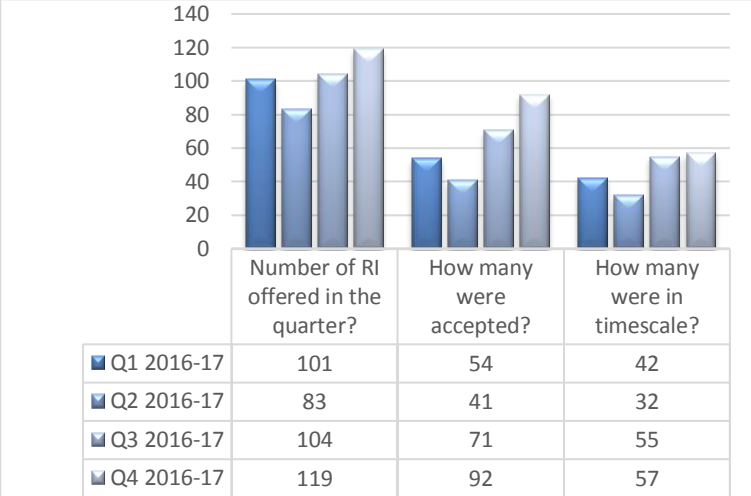
- The development of a robust dataset for CSE and missing has allowed Sandwell to utilise trend analysis in relation to 'push & pull' factors; to monitor the number of children & young people that are regularly missing and to implement earlier interventions in order to support the reduction of risk and/or risk taking behaviours.

2016/17 Missing Information



	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17
How many children does this relate to	81	66	73	93
No of missing episodes recorded in the last quarter	152	171	149	193

- There has been an increase in the return interviews being offered throughout the quarters with the highest amount of missing episodes in Q4 of 193



	Number of RI offered in the quarter?	How many were accepted?	How many were in timescale?
Q1 2016-17	101	54	42
Q2 2016-17	83	41	32
Q3 2016-17	104	71	55
Q4 2016-17	119	92	57

- There was also been an increase in the number of return interviews being accepted towards the end of the year.

Looking Ahead to 2017/18

- Strategic CMOG will be developing and launching the revised CSE Strategy in 2017, this will provide overall direction for the partnership as we move forward to enhance protection, prevention, pursuit and prosecution of CSE. The strategy will be accompanied by a SMART action plan, which will set out the responsibilities for the partnership in moving forward with the agenda. Strategic CMOG will retain oversight of the action plan and hold agencies and officers accountable for attainment and achievement against this.

- The group will also be seeking to ensure that both YPSE and MOG continue to be functional and that these forums are productive with regards to their actions and outcomes. This will be done through regular updates provided by both groups and by members of Strategic CMOG providing challenge and guidance where necessary.

- Strategic CMOG will continue to support the 'See Me Hear Me' Regional approach, workstreams and communication strategy by having oversight of the wider region profiling and ensuring that Sandwell (where appropriate and applicable) contribute to delivery of the frameworks objectives. This will include financial and operational contributions to support consistency and collaboration across the wider region.

Domestic Abuse

5.9 The Domestic Abuse Strategic Partnership (DASP) has continued to work hard to consolidate and further strengthen the collective response to domestic violence and abuse in Sandwell. 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.

5.10 Reports of DVA to the police have continued to increase year by year. During 2016-17, there were 6759 DVA crimes/incidents in Sandwell reported to the police. This is a 3% increase compared to 2015-16 and a 17% increase compared to 2014-15. The majority of adult victims were female and the majority of perpetrators were male. There were 3220 DVA cases of families with children screened by the MASH DA team during 2016-2017.

5.11 The number of high risk cases of DVA increased from 460 in 2015-16 to 468 in 2016-17. There were 498 children living in those households. These cases were considered by the Sandwell MARAC (Multi Agency Risk Assessment Conference) and a safety plan put in place to reduce the risk to the victims and their families.

5.12 An exercise to identify the outcomes achieved by Sandwell MARAC was also completed through work with *Safelives*, a national organisation working on domestic violence and abuse that help MARACs become more effective. This exercise found that victims (and their children) discussed at Sandwell MARAC had a 72% reduction in police call outs and 61% had a total cessation of police call outs after MARAC. There was also a significant reduction in the severity of incidents that police attended after victims had received support from MARAC. This correlates with data from the Accident and Emergency Advocacy pilot (detailed below), which shows a significant reduction in attendance at A&E by victims following intervention from MARAC agencies.

5.13 DASP have worked to improve the Sandwell MARAC over the last three years, to ensure that there is effective safeguarding of victims who are at highest risk. In recognition of the work undertaken, the Sandwell MBC Domestic Abuse Team and Sandwell Police Public Protection Unit Domestic Abuse Team received the West Midlands Police PPU Commanders Working in Partnership Award in September 2016. This award recognizes the collaborative work undertaken by the DASP to improve work to support high risk victims.

5.14 Black Country Women's Aid data shows that 2494 victims were supported by Sandwell IDVAs (Independent Domestic Violence Advisors) and DAAs (Domestic Abuse Advocates) during 2016/17.

5.15 The IRIS programme (Identification and Referral to Improve Safety) 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, and their children as well as information and signposting for male victims and for perpetrators. National and local IRIS evaluations found the programme has been invaluable in training GPs and other primary care staff in GP practices to recognise domestic abuse at the earliest opportunity and signpost victims to appropriate support services. There has been an increase in the number of victims identified by IRIS GP's and referred for appropriate support.

5.16 IRIS began as a 12-month pilot with 20 GP practices in April 2015 funded by the Sandwell Safeguarding Children Board. Funding has since been agreed by Sandwell and West Birmingham Clinical Commissioning Group (SWBCCG) and the Safer Sandwell Partnership (SSP) to continue this important work in 2016/17 and 2017/18.

5.17 The Accident & Emergency Advocacy Pilot is a two-year partnership project between Black Country Women's Aid (BCWA) and Sandwell & West Birmingham NHS Hospitals Trust which commenced in November 2015. The project is funded by the Hospitals' Charitable Trust. It aims to improve the early identification of, and response to, survivors of domestic violence and abuse (DVA) within A&E departments as well as strengthen the integration of the Trust within local strategic responses to DVA. Two IDVAs (Independent Domestic Violence Advisers) are placed in A&E, offering victims a crisis response and referral to ongoing support, such as refuge or community advocacy.

5.18 One of the key aims of the pilot was to increase the visibility of domestic abuse in A&E and the wider Trust to gain a picture of the true impact of DVA on health services in Sandwell and West Birmingham. During the reporting period Black Country Women's Aid (BCWA) carried out an analysis of all high risk DVA cases heard at MARAC in 2015-16, cross-referencing those discussed with A&E attendances to scope the scale of the issue and identify patterns. This study revealed that high risk victims of DVA are 'frequent flyers' in A&E departments. Key points from the data analysis found victims in the study were found to have attended without being recognised as a victim prior to their referral to MARAC. After specialist support from Women's Aid and other partners, victims' attendance at A&E decreased significantly. The project has supported 190 victims between November 2015 and March 2017.

5.19 There was a 13% increase in women accommodated into refuges in Sandwell during 2016-17 when compared to the previous year. There were also increases in the number of accompanied children (53%) accommodated in Sandwell refuges during 2016-17 when compared with the previous year.

5.20 51 perpetrators completed the Brighter Futures Domestic Violence Perpetrator programme by March 2017. An evaluation by the University of

Birmingham is underway, with early feedback indicating some positive outcomes.

5.21 Work to address female genital mutilation (FGM) has continued to be undertaken by the Sandwell Stopping FGM sub group of the DASP. This group have produced the Sandwell policy and procedures to address Female Genital Mutilation. The procedures provide professionals, practitioners and anyone working with adults, children and young people with an understanding of FGM and what action they should take to safeguard girls and women who they believe may be at risk or have already undergone FGM. The procedures were launched at the annual Safeguarding Children Board Conference (July 2016) by the chair of the SSFGM. Conference delegates (150 multi-agency professionals from across Sandwell) also heard directly from a survivor of FGM as she bravely recounted her very personal experience of this form of abuse. This further demonstrated Sandwell's commitment to raising awareness of FGM. The FGM policy is available at:

http://www.sandwell.gov.uk/downloads/file/24516/sandwell_policy_and_procedures_to_address_female_genital_mutilation

5.22 Sandwell's Domestic Abuse Strategic Partnership have worked with Sandwell Children's and Adult's Safeguarding Boards to coordinate all domestic abuse related training to ensure that gaps in training are identified and addressed and training is easily accessible. Training is available on a wide range of domestic abuse issues, including forced marriage, honour based abuse and FGM. The training plan is available at this link:

http://www.sandwell.gov.uk/downloads/file/22478/domestic_abuse_training_plan

5.23 An FGM primary schools resource pack and training, recognised as good practice by OFSTED, has been shared with school designated safeguarding leads for Smethwick. Work is underway to make this training and resource pack available to all schools in Sandwell.

5.24 A community health and information event to raise awareness of FGM with the community in Smethwick is being planned for summer 2017.

5.25 Sandwell DASP have worked alongside Sandwell Safeguarding Children Board to include questions on domestic violence and abuse in Section 11 audits which agencies are statutorily required to complete. The Section 175 audits which schools complete have also had questions included. Inclusion of the questions will ensure accountability by agencies, their executives and boards. The outcome of this work has resulted in a raised awareness and understanding within social care and schools.

5.26 DASP has refreshed Sandwell's Strategy to address domestic violence and abuse 2017-20. The strategic objectives are: Prevention; Provision; Protection; Partnership working

5.27 A detailed delivery plan has been developed to support implementation of the strategy.

Early Help

5.28 In December 2015, the SSCB commissioned the Strategic Lead for Children's Services for the Voluntary and Community Sector (VCS) in Sandwell, and SCVO (the VCS umbrella organisation in the borough), to facilitate a refresh of the Early Help Strategy focusing on how to improve early intervention work with children and families, in particular the Universal and Universal Plus offer.

5.29 Activity aimed at engaging and involving a wide range of strategic partners from all Sectors in this refresh process ran throughout the course of 2016/17 year. There was widespread support from all quarters to work towards an updated Strategy which addressed some of the recognised challenges of partnership working. Feedback from early consultation highlighted a significant commitment towards Early Help and some excellent practice by individual agencies but a lack of awareness of the 'big picture' of local provision and of genuinely 'joined-up' partnership working on the ground.

5.30 Partners strongly endorsed the overarching aims of the existing Strategy: *"…to ensure our children grow into happy and successful adults who can take good care of their own families…"; "… the earlier we can provide help for these children and families, the earlier they can thrive and enjoy success…"; " …if we can provide support which is effective and cost-efficient then we will be able to help more children and families"*.

5.31 Consultation activity began in April 2016 with a meeting of over 60 local strategic partners and delivery agencies, which was followed by a survey to gather responses from a further 80 children and family practitioners, seeking views on how to improve practice and strengthen joint working. Senior leads from the fire service, police, health, schools, childrens centres, neighbourhoods, youth offending team, social care, the voluntary sector and targeted services were also interviewed for their perspective on Early Help challenges and opportunities. Following this a series of four workshops were held involving a range of different agencies to work through and create a fresh Sandwell approach to early intervention. The discussions focused on reviewing the existing strategy, agreeing priorities and considering what needs to be done differently to deliver a broader and more cohesive partnership of local early help providers.

5.32 What emerged from this consultation was a new 2017-2019 Early Help Strategy, approved at the February 2017 meeting of SSCB with unanimous support from all partners. The new Strategy emphasises the need to focus on promoting and developing Universal and Universal Plus provision and is only concerned with how universal providers engage and interface with Targeted support rather than developing a strategy for targeted support itself. The Strategy also takes a tiered approach to how agencies engage and work

together avoiding a 'one size fits all' notion and developing a number of discrete cohorts of organisations committed to early help support. Individual local organisations are invited to sign up to the Strategy as formal members of a new Early Help Partnership by opting-in at one of a number of different levels, at a level of commitment that fits them best. These range from *'Active Communities'* (encourage active citizenship and engagement by community establishments, committing to the 'see something do something' approach), through 'bronze, silver and gold' Early Help Partner levels with each level determining an increasing commitment by the signatory organisation to universal provision and partnership working.

5.33 Through the development of an online 'Early Help' services portal and ongoing growth and co-ordination of the Early Help Partnership, these identified cohorts of organisations will be engaged in different ways, relative to their expertise, complexity and commitment, to work towards improved outcomes from children and families in Sandwell.

5.35 **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.*

5.36 Multi-agency case file audits are led by the Audit and Review Group. The multi-agency audits scrutinise areas of practice or are thematic. The audit reports are taken to the main board to enable challenge to be put in place. to ensure that all agencies are compliant with Working Together 2015. Through the audit process, improvements have been made to the audit tools, and the reporting

5.37 The QPP Subgroup lead Section 11 audits and all partner agencies were asked to provide assurance during the reporting period in respect of their 2015-16 submissions. The full Section 11 audit will recommence during 2017 and will be augmented by scrutiny sessions.

5.38 Performance reports are routinely presented to the Board supplemented by comprehensive performance data.

5.39 Membership of the board is robust, with partners who have sufficient seniority to hold their agencies to account. Attendance is good, membership is stable and there is a very strong commitment from members, including positive involvement of the lay members with close, highly effective working relationships, which ensure that progress is sustained.

5.40 Chapter 7 below sets out further work undertaken during the year in addressing this strategic priority.

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 refreshed its Learning and Improvement Framework during the early part of 2016-17 providing more clarity regarding how SSCB will review cases/ undertake audits and cascade learning across the wider workforce. The framework covers the full range of reviews and audits aimed at driving improvements to safeguard and promote the welfare of children.

Learning and Development (L&D) Subgroup

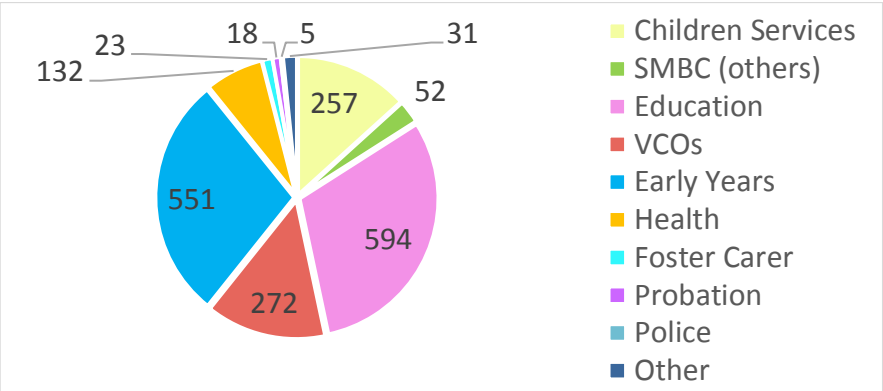
6.3 The board is committed to providing a comprehensive and effective training programme to professionals and volunteers across the borough of Sandwell.

6.4 The L&D subgroup met eight times between 1 April 2016 to 31 March 2017. and was presented with several challenges during the year including representatives not attending meetings or there being no representation from some agencies. This was addressed by providing challenge to those not attending on a regular basis and as a result some organisations have changed their representative.

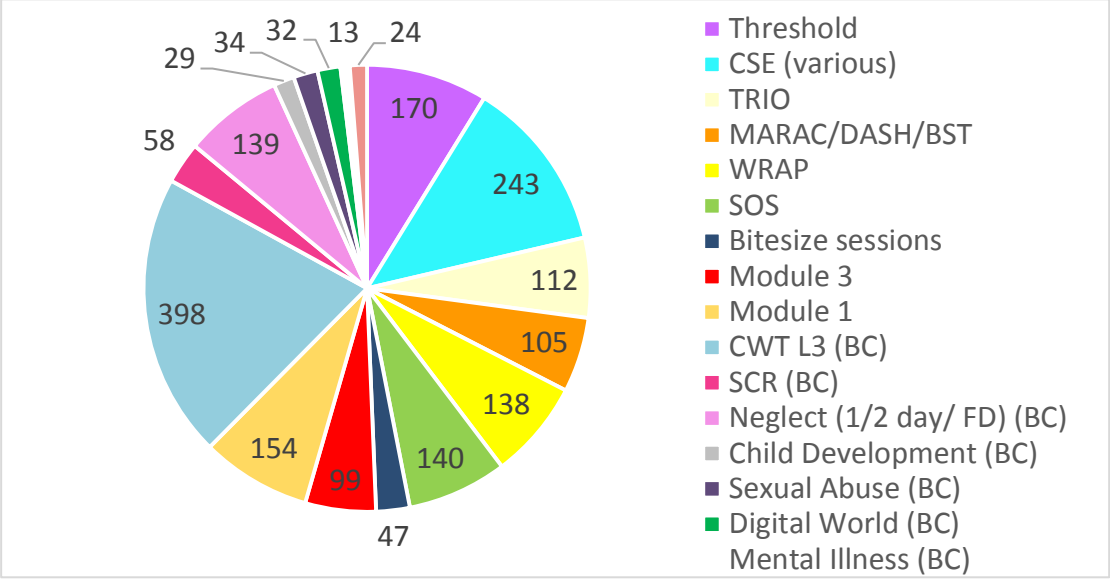
Key subgroup activity and achievements during 2015-2016

Training Courses

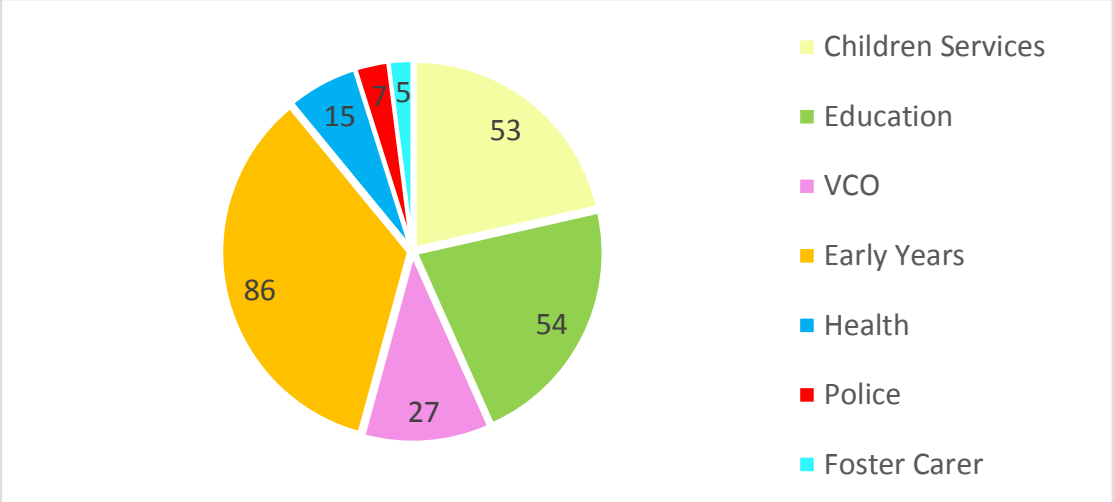
6.5 During 2016/17 1935 delegates from a wide range of agencies attended training sessions delivered by SSCB.



6.6 A breakdown of attendance by course is detailed below:



6.7 Conversely the chart below illustrates that 247 delegates did not attend training that they had booked on. The L&D subgroup implemented a non-attendance charging policy in April 2016.



6.8 During 2016/17 a total of £5,490.00 was generated as a result of the non-attendance charge.

Black Country Training Project

6.9 Progress was made in respect of the Black Country Training Project which started in September 2015 with the objectives of making available a broader range of safeguarding training across the regional multiagency workforce, enabling better cross border networking and long term cost efficiencies. During the year, Sandwell's L&D Chair chaired the regional task and finish group to drive the project forward.

6.10 The delivery of amalgamated training across the four Black Country LSCB's (Sandwell, Dudley, Wolverhampton and Walsall) commenced in June 2016. However, the project was presented with a range of challenges in respect of a shared IT booking system, training spaces not being used, and level of contribution from the participating LSCBs.

6.11 The year ended with Walsall LSCB stepping away from the project and the Chair of the task and finish stepping down having fulfilled her obligation of chairing the group for over a year. Sandwell will be undertaking a cost-benefit analysis during 2017/18 to assess the effectiveness of the project.

Course Content and Support

6.12 Course content of SSCBs training offer during 2016/17 has been influenced by identified need from external reviews, practitioner demand, findings from audits, learning from SCR's and DHR's. Tutor briefings continued to be circulated to trainers with information taken from SSCBs various assurance activities to thread through training. 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.

GOOD PRACTICE: The subgroup developed short workshop sessions (1.5 hours) to respond to demand in respect of thresholds, SCRs; Understanding the Voice of the Child; CSE; Trafficking and Signs of Safety. The L&D sub-group also co-commissioned an Independent Monitoring Review (IMR) training during Spring 2016 with 19 people from across the partnership receiving training.

6.13 The SSCB Training Pool continues to work well with good representation from across the partnership. Delegates have provided feedback that they enjoy having the training delivered by frontline practitioners sharing their knowledge. Training costs have reduced. The sub-group is currently considering reducing the remaining numbers of commissioned course.

Impact Evaluation

6.14 During the year the sub-group attempted to strengthen the impact evaluation process. In addition to the on the day evaluation, 100% of delegates were contacted three months post-training to complete an online Survey Monkey. In parallel, 25% of delegates and their line managers were contacted to complete a more detailed impact evaluation questionnaire. This process was mirrored for all Black country courses. However, despite attempts to increase the level of engagement, the online response rates have been limited. During the six months' period being reviewed (September 2016 - March 2017), 45 courses were evaluated across ten course topics, a total of 516 delegates were contacted, 78 responses were received. Similarly, the 25% dip-

sampling of delegates has proven to be a time-consuming task with very little return.

Looking Ahead to 2017/18

6.15 Over the forthcoming year the L&D Subgroup will:

- Use the income generated from non-attendance to organise *'Awarding Education and Training Level 3'* training via Dudley College to train some of the Training Pool Trainers.
- Undertake a cost-benefit analysis of the Black Country project to assess the effectiveness of the project.
- Cease the 25% dip-sampling exercise and commence a new project called the *'delegate journey'* with the University of Wolverhampton.
- Develop and deliver a new full day neglect course to respond to demand for more in-depth training
- Further explore how to improve the impact evaluation data analysis
- Undertake a Training Need Analysis (TNA) to inform the training catalogue.
- A Training Needs Analysis will be cascaded to capture more detailed information regarding what agencies sense they require concerning these themes
- Organise another *'Train the trainer'* session to continue to build capacity of the training pool with multi-agency practitioners.

Serious Case Review Subcommittee

6.16 The Serious Case Review Subcommittee carries out the statutory function around serious incident notifications, initiating Serious Case Reviews (SCRs) or local case reviews.

6.17 During the reporting period the SCR Subcommittee met seven times in April, June, September, November, December 2016, and January and March 2017. There was also an extra-ordinary meeting in February 2017 to discuss cases that had been presented to the subcommittee for consideration. 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. The subcommittee has disseminated learning through single agency briefings, SSCB training, published reports, learning notes and newsletters.

6.18 During the reporting period,

- one SCR was published by another Local Authority involving a child who had died in Sandwell;
- one SCR carried out during 2015-16 that involved sexual exploitation of a looked after child, concluded. With the agreement of the National Panel of Independent Experts on Serious Case Reviews, the SCR was not published in the best interest of the young person.
- One SCR commenced in March 2017 regarding a young child with significant injuries who was known to a number of agencies at the time these occurred and there was concern about how they had worked together to safeguard the child. This will conclude in September 2017.

6.19 Lessons learnt included:

- a failure to listen to the voice of children; persistent failure to recognise risk;
- lack of recognition of the long-term impact of neglect;
- poor inter-agency communication;
- the need to conside culture and relationships;
- the need to strengthen and develop the multi-agency approach response to CSE;
- the effectiveness of health interventions required improvement (particularly when children are placed out of borough);
- the need to ensure robust care planning, placements and transition for vulnerable young people.

6.20 These are common themes from SCRs and aspects of the cases have informed a number of the multi-agency SSCB training programmes. Learning notes have also been widely distributed to agencies to enable them to ensure

their working practices address these important points and that staff are aware of them.

6.21 A further Serious Case Review is due to commence in May 2017 regarding a young child who was found to have a toxic substance in the bloodstream which could not have happened accidentally. At the time, he was known to agencies.

6.22 In addition, five Significant Incidents were reported to the SCR Subcommittee which, after deliberation, did not result in a SCR. Instead, where considered appropriate Table-Top Reviews (TTRs), and in one case a combination of a TTR and a child death case discussion, were undertaken to elicit key learning. This learning included:

- the importance of a lead professional when a number of agencies are involved with a child, and information sharing
- transfer of information between schools at transition points (now addressed by a common protocol used by schools).
- the need for an independent interpreter when a parent/ carer has limited English skills. This would overcome an over-reliance on use of a family member as an interpreter.
- The importance of holistic assessments of the child and mother's needs.

6.23 The SCR subcommittee updated its Significant Safeguarding Incident Notification Process in early 2017, which will need to be embedded in practice during 2017/2018

6.24 Three cases were also discussed by the subcommittee which had been submitted the previous year, all having similar issues (adolescents who were looked after children with mental health and child sexual exploitation concerns). One of these had been the subject in a serious case review (see above). It was agreed to undertake a three-part independent review of these cases and the report regarding this was received in November 2016. Actions related to CSE and missing children, and coordination/ provision of looked after children and CAMHS services, particularly across district borders, were identified and will be monitored by the serious case review subcommittee.

6.25 Dissemination of learning has been an area of focus 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.
- Learning notes regarding individual cases are sent to SSCB members to disseminate and take appropriate action on in their organisations.
- Several multi-agency 'Learning Lessons from Serious Case Reviews' training sessions have taken place during the year, supplemented by

bitesize sessions. Staff from across the Black Country have attended this training as part of a regional training program.

- In addition to multiagency 'Learning Lessons from Serious Case Review' training, representatives from the subcommittee delivered to health colleagues during a conference entitled 'Voice of the Survivor' in March 2017

Looking Ahead to 2017/18

6.26 The Board will consider the findings from the two SCR's that were commissioned during the year as well as any specific learning from other 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 subgroups.

6.27 There will also be a poster campaign coordinated through the subcommittee on highlighted themes identified throughout the year. These include:

a.) CSE and Looked after Children
b.) Looked after Children and transitions
c.) Neglect
d.) Application of Thresholds
e.) Bullying
f.) Self-Harm
g.) Physical Abuse.

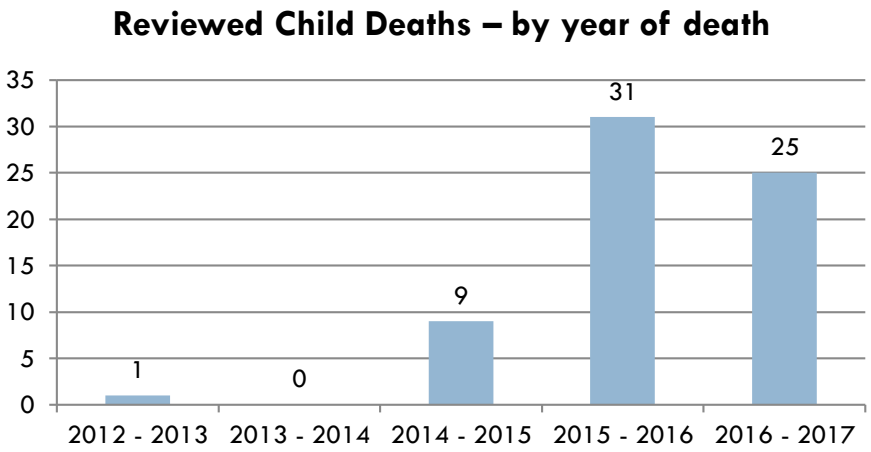
Child Death Overview Panel (CDOP)

6.28 During 2016/17, CDOP met a total of nine times and also convened one extraordinary meeting in order to decrease the amount of outstanding deaths requiring review.

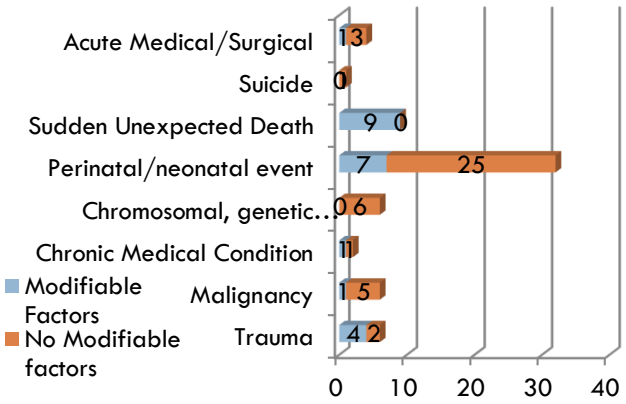
6.29 There was a total of 40 reported child deaths in Sandwell. Of these, 8 were deemed unexpected, and 32 expected. Two of the unexpected deaths that occurred in the 1 month to 1 year age group were sudden infant deaths, both due to unsafe sleeping environments.

6.30 Of the 40 deaths reported:

- 19 were male, 20 were female and one baby had indeterminate gender.
- 28 (70%) involved families living in the most deprived areas of Sandwell.
- 33 (82.5%) were under the age of 1 year. This represents a percentage increase from 2015/16 where this figure was 70% 2014/15 where this figure was 62.5%



6.31 In 22 of the deaths reviewed between 1 April 2016 and 31 March 2017 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. During this time the main cause of reviewed deaths was in the neonatal death category which is in line with national reviews.



6.32 The primary function of CDOP is to learn from the child deaths reviewed and the two main campaigns - Dog, Duck and Cat and Safer Sleeping - have been the focus in 2016-17.

GOOD PRACTICE: Families who have their baby at Sandwell and West Birmingham Hospitals NHS Trust were the first in the region to receive a Finnish-style Baby Box for their new-born to sleep in.

Midwives have handed out in excess of 1200 registration cards to women. (The cards are given out at 16 week contact and boxes can be collected from 24 weeks gestation).

By the end of the reporting period, 489 registered and completed programme had taken place. Baby Box tradition, which originates from Finland, has been credited with reducing the infant mortality rate in the country from 65 infant deaths per 1,000 births in 1938 to 2.26 per 1,000 births in 2015. The UK has some of highest rates of infant mortality in Europe, ranking 22nd out of the 50 European countries with 4.19 deaths per 1,000 births

GOOD PRACTICE: The Dog, Duck and Cat resources continue to be well received and are being used by Health Visitors, School Nurses, Libraries and Children's Centres.

Two new resources were developed and published in 2016 – 2017. *'I love my car seat'* and *'What's in my mouth'* are aimed at 0 - 5 year olds designed to be used for parents to share with children tackling car safety and choking.

Looking Ahead to 2017/18

6.33 Dog, Duck and cat stories will be merged into a combined booklet to amalgamate the three existing 0-5 stories and a new story that looks at Co-Sleeping. There will also be new information about road safety, burns and scalds and dog safety that we haven't previously had for the 0 – 5 age range to help support parents, carers and guardians to keep their child safe

6.34 The Family Nurse Partnership (FNP) will be replaced during 2017 – 2018 by Best Start. CDOP will be working closely to support families around safer sleeping and the baby box distribution.

6.35 Sandwell CDOP will be taking part in a second peer review with a neighbouring authority to ensure that decisions made during reviews around modifiable factors and allocation of specified grading is consistent,

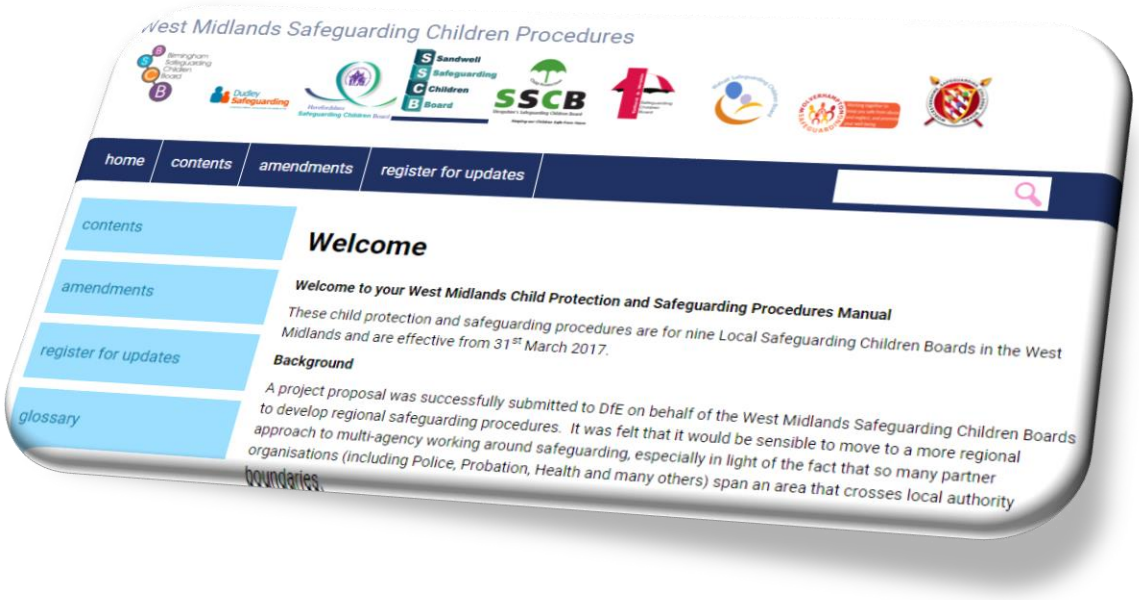
Policy & Procedures

6.36 By far the most significant achievement for the work relating to Policy and Procedures during 2016/17 was the successful implementation of the West Midlands Regional Safeguarding Procedures Project which went live on 31 March 2017.

6.37 SSCB, along with eight other participating LSCBs across the region, developed the regional procedures, procured a host/ platform for the procedures (http://westmidlands.procedures.org.uk/) and collaboratively launched the project. The initiative has provided policy consistency across Boards in the region, economies of scale (significantly reducing the cost of providing multi-agency procedures), and accessed regional expertise on policy development.

6.38 The functionality of the web site allows professionals to access procedures on three levels. Level 1 procedures are those that are overarching child protection procedures, Level 2 procedures are those agreed at a regional level, and Level 3 procedures are area specific, including referral guidance, local levels of need, and named contacts.

6.39 The Regional Safeguarding Procedures Group (RSPG) continues to meet regularly with SSCB representation. RSPG has a rolling programme in place to refresh and update the West Midlands procedures."



7. Scrutinising the effectiveness of safeguarding children

7.1 The Quality of Practice & Performance (QPP) Subgroup has developed and manages the Quality Assurance Framework (QAF) which provides the management information to the board to ensure safeguarding and child protection compliance.

7.2 During 2016/17 the subgroup met a total of nine times in April, June, July, September, November and December 2016 and January, February and March 2017.

Key Subgroup activity and achievements

Section 175/157 (Education Act 2002) Audit

7.3 The Subgroup relaunched the Section 175/157 audit across the education sector in September 2016. The question set was revised at the beginning of the academic year to reflect the changes in statutory guidance; Keeping Children Safe in Education 2016.

7.4 All submissions were analysed and a programme of feedback to schools was established involving the Quality and Governance Officer attending each locality Learning Community between January - July 2017. Feedback was supplemented with a series of 'Assurance Panels' (commencing in January 2017) where schools that had either completed less than 50% of their audit the previous year (2015-2016), or were an education provider that SSCB felt more assurance was required from, were held to account for their submissions.

Achievements

- Through the improved audit questions in relation to the new statutory guidance a better response rate was received from schools. A total of 98% of the schools/ academies had completed their respective audits.
- The questions for the assurance panel were revised to accommodate a signs of safety approach which ensured that QPP could gather what is working well along with areas of development.
- Providing direct feedback to schools closed the gap on quality assurance and supported a culture of continuous learning.

Actions Required

- The remaining schools left to complete the audit will be asked to provide assurance within three months that they are discharging their safeguarding function under S175/157 of Education Act 2002.

Section 11

7.5 SSCB partner agencies were asked to submit assurance on the recommendations from their Section 11 Scrutiny Panel held during

2015/2016 to evidence they were discharging their Statutory safeguarding function under Section 11 of the Children Act 2004. However, the responses were not found to be as robust as the previous year.

Achievements

- Although there has been limited assurance received from partners in relation to the section 11 Assurance request, QPP have been involved with the regionalisation of the Section 11 Audit.

Actions Required

- The Board has initiated the biennial Section 11 Audit which will take place during Quarter 1 of 2017/18

Performance Information

7.6 SSCB was presented with comprehensive and regular information within an agreed dataset during the year.

7.7 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 on a number of key aspects of performance.

Achievements

- During 2016-2017 there was a tendency to include too much information in the data set and performance reports. With this in mind, the QPP Subgroup have refined this information with a view to providing 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.
- The QPP Subgroup are now ensuring concerns highlighted through the Board's performance information are reflected within the multi- agency audit programme and aligned to the board's priorities.

Action Required

- More refined dataset reports will be presented to SSCB during 2017/18

Multi-Agency Audits

7.8 Four multi-agency audits in respect of Neglect (June 2016); CSE & Missing (September 2016), Domestic Abuse (November 2016) and Early Help and the role of Lead professional (February 2017) were coordinated during the year.

7.9 Learning notes for each audit were disseminated to the partnership and made available on the SSCB website

Achievements

- The Peer Diagnostic Review commissioned by the Board incorporated 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. 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. QPP has subsequently routinely disseminated learning across the partnership from audit activity through the Board's quarterly newsletters and learning notes. Additionally, all multi-agency audits since September 2016 onwards have been completed with the case practitioners.
- The focus of multi-agency audits during the year was on risks for the child and strengths for the child/family rather than being 'process-orientated' as was the case during 2015-16. The case sample size was also reduced in order for the focus to be on 'quality' rather than 'quantity'

Action required

- To further strengthen SSCB's monitoring and oversight of practice the latter half of the 2017-2018 audit programme will be strengthened to include how each audit will measure success and impact

Single-Agency Audits

7.10 During 2016-17 SSCB partner agencies were asked to submit their internal safeguarding audit schedules and the findings for the audits completed

Achievements

- At the end of the reporting period 10 of 13 agencies had responded with their audit schedule and provided evidence that they were implementing key learning from audits.

Action required

- To ensure there is a 100% response to the single agency audits which are then robustly scrutinised.

Looking Ahead to 2017/18

7.11 The work of the QPP Subgroup will continue to be strengthened and enhanced by ensuring all agencies attend meetings and meaningfully contribute. This will give greater clarity about each other's roles and ensure that the audits and performance data can be effectively scrutinised.

7.12 In response to the limited assurance received from partners in relation to the section 11 assurance request, in April 2017, SSCB initiated the biennial audit for 2017-2018

7.13 A key focus area will be for QPP to ensure there is a further improved response rate to 2017-2018 S175/157 Audit

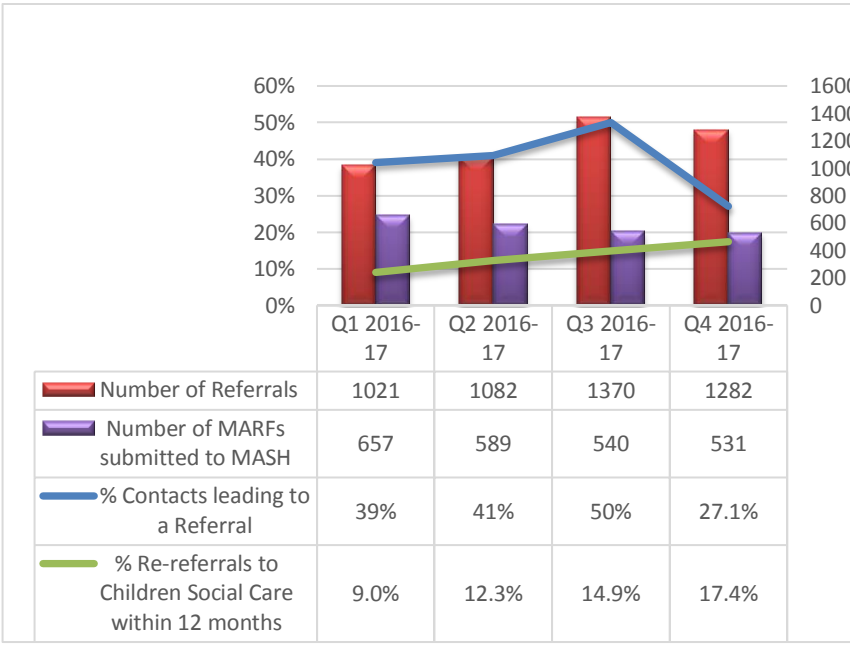
7.14 The QPP Subgroup will focus on ensuring that learning from audits are used to better identify priorities that will improve multi–agency professional practice with children and families. Additionally, learning from audits will routinely inform the Board's training priorities and content.

7.15 To further strengthen SSCB's monitoring and oversight of practice the 2017-2018 audit programme will be enhanced to reflect how each audit will measure success and what the impact of the audit is.

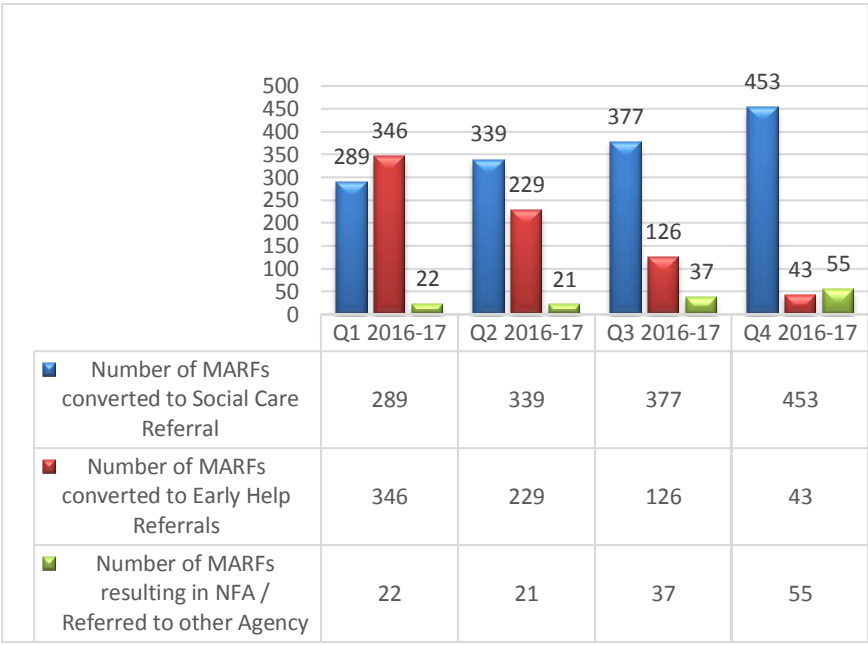
7.16 In order to proactively engage with staff who work directly with children in Sandwell, a survey was launched on 3 April 2017. This will be closely analysed that and the findings used to help inform frontline practice.

7.17 A further area of focus for the QPP subgroup will be to ensure that there is a 100% response to the single agency audits which are then robustly scrutinised

Contacts & Referrals



	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17
Number of Referrals	1021	1082	1370	1282
Number of MARFs submitted to MASH	657	589	540	531
% Contacts leading to a Referral	39%	41%	50%	27.1%
% Re-referrals to Children Social Care within 12 months	9.0%	12.3%	14.9%	17.4%

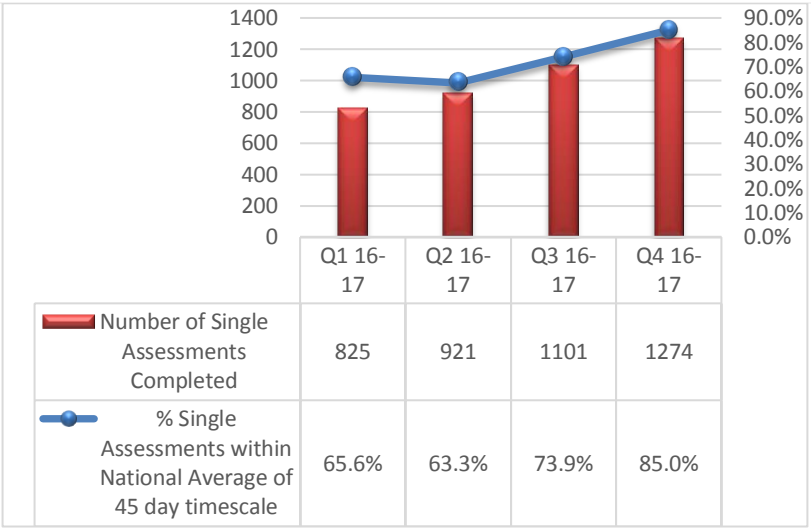


	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17
Number of MARFs converted to Social Care Referral	289	339	377	453
Number of MARFs converted to Early Help Referrals	346	229	126	43
Number of MARFs resulting in NFA / Referred to other Agency	22	21	37	55

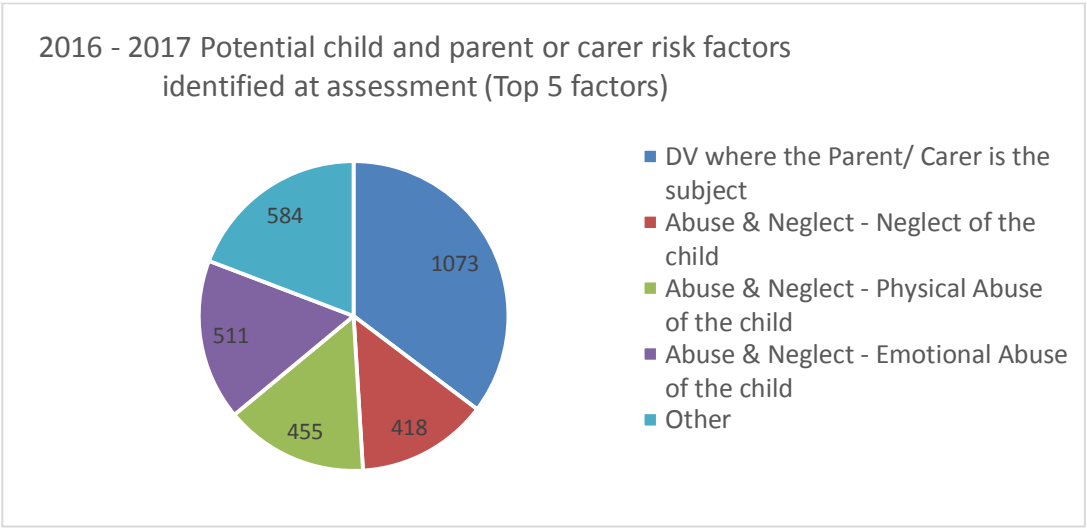
During the reporting period, there has been an increase in the percentage of Contacts leading to a social care referral. The total number of referrals to Children's Social Care during the year was 1021 Q1 and 1282 in Q4. These figures include the steady increase during the year of the number of MARFs being converted to Social Care Referrals. Whilst this is illustrative of the demand on Children's Social Care, it perhaps is also indicative of the positive changes in the thresholds at the front door of Childrens Social Care and more comprehensive referrals coming through.

Note: A new IT system was introduced during the beginning of 2017 which has impacted upon data collection, hence the reason why some information is missing from the above tables,

Single Assessments



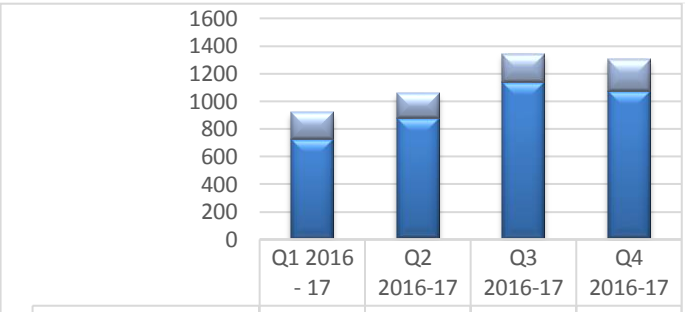
	Q1 16-17	Q2 16-17	Q3 16-17	Q4 16-17
Number of Single Assessments Completed	825	921	1101	1274
% Single Assessments within National Average of 45 day timescale	65.6%	63.3%	73.9%	85.0%



There has been an increase in the number of single assessments completed within the national average of 45 days.

Based on the risk factors identified at assessment it is clear that domestic abuse features frequently.

Neglect

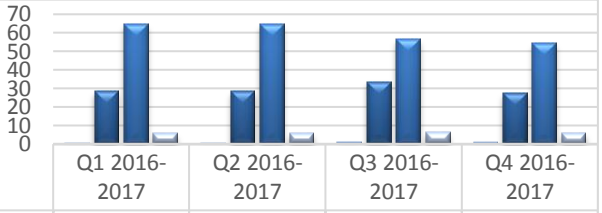


	Q1 2016 - 17	Q2 2016-17	Q3 2016-17	Q4 2016-17
No. of children on a CP plan under the category of neglect.	196	181	206	225
No. of referrals to children's social care with the presenting need of Neglect.	723	869	1135	1074
No. of referrals to early help with the presenting need of Neglect.	2	8	3	4

During 2016/17 there was a steady increase in referrals to Childrens Social Care with the presenting need of neglect. This trend has continued into Q1 of 2017/18 with a total of 1367 referrals which is significantly higher than Q1 of 2016/17. This could be indicative that children who are experiencing neglect are in the right part of the service and that there is increased awareness and understanding of the identification of neglect

In contrast, referrals to early help with the presenting need of neglect appear to be relatively low. This could be because neglect may be the secondary reason for involvement by Targeted Services

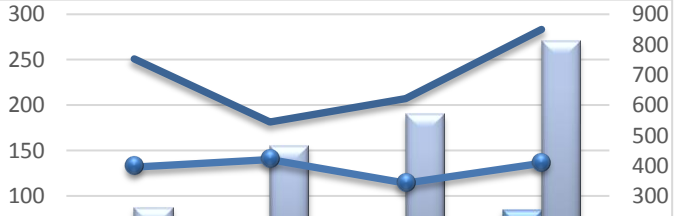
Care Proceedings



	Q1 2016-2017	Q2 2016-2017	Q3 2016-2017	Q4 2016-2017
Average Time taken to appoint a Guardian from receipt of application (days)	0.6	0.6	1.2	0.9
Average duration of section 31 care or supervision cases (in weeks).	28.5	28.5	33.7	27.5
Proportion of section 31 care or supervision cases which are completed within 26 weeks.	64.7	64.7	56.4	54.5
Average number of hearings in section 31 care or supervision cases.	5.6	5.6	6.3	5.9

By the end of the year, the average duration of Section 31 care or supervision cases was the lowest it had been during the reporting period at 27.5 weeks in Q4. The direction of travel is in line with the national 26 week timescale.

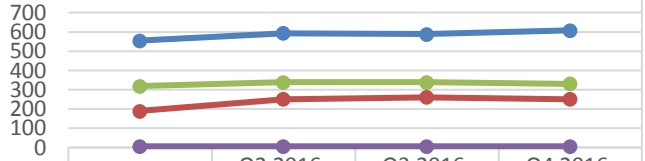
Early Help



	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17
No. of Early Help Cases referred to social care	64	63	55	85
No. of social care cases stepped down to Early Help.	87	155	190	271
No. of Repeat Early Help Referrals in the last 12 months	132	140	114	136
No. of Early Help Assessments completed in quarter	753	544	621	850

A total of 2768 assessments were completed over the reporting period in comparison to 2923 the previous year. This represents a decrease which, due to the increase in referrals, could be indicative of children being in the right part of the service. At the end of the reporting period 85 cases had been stepped up to Children's Social Care. This represents a decrease of 19 cases in comparison to the previous year.

Children Looked After



	Q1 2016-17	Q2 2016-2017	Q3 2016-2017	Q4 2016-2017
Number of CYP living in local area who are the responsibility of another Local Authority	190	250	260	250
Number of LAC in Sandwell	555	593	589	608
Number of CYP(LAC) living outside local area who are the responsibility of this Local Authority	319	339	339	331
Number of CYP in Private Fostering Arrangements	6	6	6	6

- The number of children living in Sandwell who are the responsibility of another Local Authority was 250 at the end of the reporting period.
- This represents 41% of Sandwell's total LAC population which at the end of the reporting period was 608 (which is in itself an increase from 533 at the end of 2015/16). The national average is 676. The 608 LAC children comprised 347 males and 261 females.
- The number of LAC living outside the borough settled at approximately 330.

Looking forward, there will be an increased focus on planning early permanence and moving children through the system (Adoption/ Special Guardian Orders/ Child Arrangement Orders). There will also be a focus on reunification and 'edge of care' service.

Private Fostering (PF)

7.18 Following a restructure during the year within the Looked after Children's Service, private fostering has transferred to the Fostering Team. Changes in personnel at a senior level and management capacity has limited progress. However, with the LAC restructure and repositioning of PF work into Fostering and with a stable staff group, further progress will be made.

7.19 During the reporting period a total of six privately fostered children were known to the Local Authority. Two become 16 years of age during the year and are therefore no longer considered to be privately fostered. One child became subject to a Special Guardianship Order in January 2017, hence is no longer privately fostered. One young person has been transferred to Birmingham and one young person is due to turn 16 in June 2017.

7.20 Whilst It is difficult to draw any significant conclusions or trends from current data due to the low level of numbers and reporting being in its infancy, it is noted that with an increase in management capacity and oversight in PF, in due time, we will be able to better identify areas of unmet needs and patterns or trends to be able to plan an internal communication strategy to support these children and families.

7.21 During the reporting period, some of the most significant needs have been in relation to ongoing medical health needs for a 6-year-old boy with severe physical disability, teenagers who are experiencing relationship breakdown in their families and risk of homelessness for Gypsy Roma children with parents who are overseas.

7.22 Two children have been supported to achieve permanency through Special Guardianship with their existing Carers in the past year.

7.23 Independent Quality Assurance Auditing of private fostering cases is yet to be undertaken, to ensure that all procedures are being followed correctly and children are being safeguarded and making good progress.

Looking Ahead to 2017/18

- There are plans to undertake a complete review of the communications strategy including a refocus on PF and repositioning of PF into the Fostering Team. Lead Officers will need to be identified from this team and a new strategic lead identified and the multi-agency steering group be re-established.
- Through the Safeguarding and Assessment Education Lead, it is planned that training is delivered to partner agencies which includes information on private fostering, and SSCB include private fostering in regularly held multi-agency training on safeguarding children.
- Better links will be established with Community Partners to promote private fostering responsibilities in tailored training sessions to parents, faith groups and the voluntary sector.

- Workshops will be delivered by the PF lead officers to other social work teams within children's services on Private Fostering and PF training is being considered and will be discussed with Sandwell's Learning and Development Service in formulating an annual training programme as part of ongoing training across Children's Services.

Elective Home Educated (EHE) Children

7.24 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.

7.25 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.

7.26 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.

7.27 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.

7.28 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.

7.29 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.

Looking Ahead to 2017/18

- 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 the 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 a 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).

Local Authority Designated Officer Role

7.30 There has been a significant increase in the number of referrals via the POT screening process to the LADO during 2016/17 with increased activity when schools return from holiday periods.

	2016-17	2015-16	2014-15	2013-14	2012-2013	2011-2012
Referrals	511	424	431	325	115	89

7.31 Those referrals progressing to a Position of Trust Coordination Meeting can be broken down into the following categories of abuse (although it should be noted that instances of inappropriate restraint or deception for example do not necessarily fall into these categories). Q: Can one referral have more than one category?

	Emotional Abuse	Neglect	Online Abuse	Physical Abuse	Sexual Abuse
2016-17	20	18	5	38	12
2015-16	19	5	1	37	12
2014-15	22	6	2	47	11

7.32 There is a continuing trend in data analysis, which clearly identifies physical abuse as the prevalent category of abuse. During the reporting period there appeared to be a rise in cases presenting with neglectful duty of care i.e. staff not following safeguarding procedures, not intervening when a child needs to be safeguarded, not informing their employer they are open to an investigation etc. It should also be noted that there is a slight increase in on-line abuse. These referrals are in relation to professionals contacting children via media sites and/or by phone, including sending of inappropriate images of self or making requests to do so.

Referrals concerning staff/volunteers according to employment sector

	2016-17		2015-16	
	No. of staff	**%**	**No. of staff**	**%**
Not recorded	**4**	**5**	**4**	**6**
LA Education	**28**	**35**	**23**	**35**
Private Provider	**11**	**14**	**2**	**3**
Social Care	**3**	**4**	**4**	**6**
LCC Foster Carers	**7**	**9**	**8**	**12**
Health	**1**	**1**	**2**	**3**
Private Residential Units	**5**	**6**	**0**	**0**
Child Minders	**1**	**1**	**1**	**2**
Other	**3**	**4**	**4**	**6**
Police	**3**	**4**	**1**	**2**
Faith Group	**9**	**11**	**5**	**8**
Voluntary Youth Agency	**0**	**0**	**1**	**2**
Probation	**0**	**0**	**1**	**2**
Agency Foster Carers	**0**	**0**	**7**	**11**
LA Leisure Services	**0**	**0**	**1**	**2**
Early Years	**6**	**7**	**1**	**2**
Total	**81**	**100**	**65**	**100**

7.33 The data identifies that staff are more likely to be referred to the LADO as being school staff. This is expected, as these are areas where there are high levels of interaction with children and where the issue of safeguarding awareness is highest which may subsequently result in a referral/ consultation to the LADO. However, the LADO highlighted concerns about a potential lack of engagement from Academies and has sought to build closer relationships by way of attending Joint Executive Group meetings (attended by Head Teachers from across the Education Sector).

7.34 What has been noticeable is an increase in the number of referrals made from Private Providers (identified as residential establishments) when

physical restraint has been the central issue, as well as Faith Groups (mosques and masjids).

Overall Outcomes

	2016-17	
	Figure	%
Disciplinary	32	53
Cessation of Use	5	8
Unsubstantiated	24	40
Dismissal	3	5
Unfounded	8	13
Conviction	3	5
Malicious	2	3
Acquittal	1	2
Referral to other regulatory body	3	5
Total	81	100

7.35 There has been an increase in the outcomes of *'disciplinary'* and *'unsubstantiated'*, primarily due to an improved approach in gaining risk analysis from all agencies and clearer recording at the end of the Position of Trust meetings. Cessation of use i.e. no further action has decreased considerably from last year and this is due to the right cases going through the POT process.

Looking Ahead to 2017/18

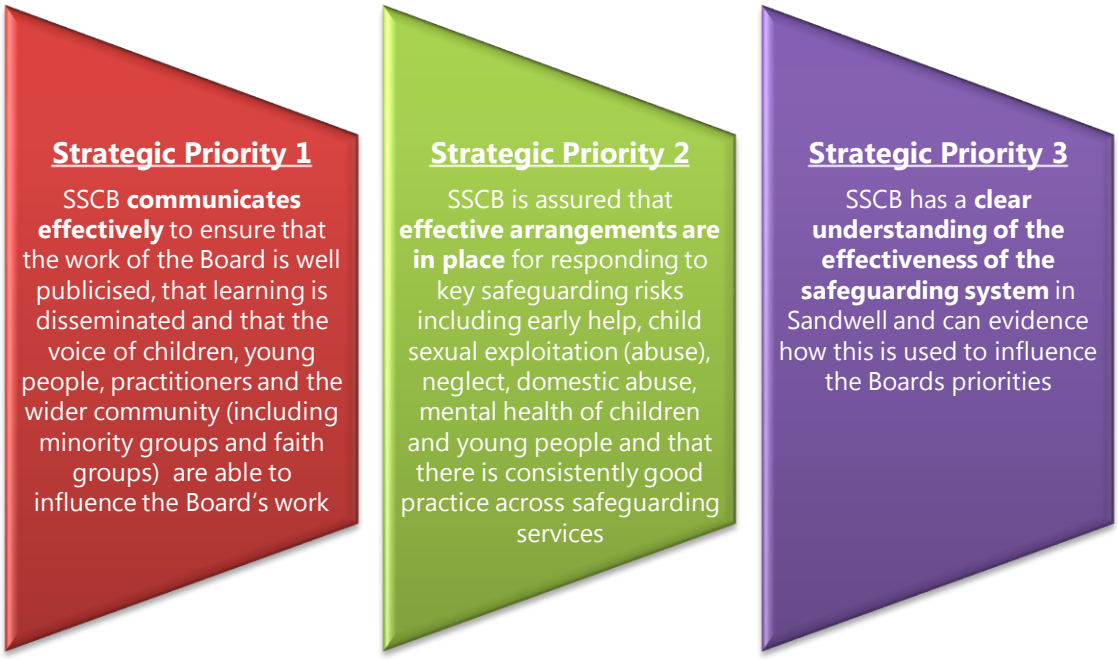
- A conference/ launch to safeguard children within CFBEs to take place. The principal aims will be to explore training opportunities that can be developed for CFBE staff and to explore the development of a 'network forum' (similar to that for designated safeguarding leads in school/academies.
- The LADO will continue to work with the IT Project Manager with a view to integrate the IT functions of the Managing Allegations process with the Local Authority's new Liquid Logic system.
- The LADO will continue to explore creative options to share learning and raising awareness e.g. specific guidance for head teachers/principals about their roles & responsibilities in relation to POT matters.

8. Looking Ahead to 2017/18

8.1 Through the work described in this annual report, we recognise there is still much to do.

8.2 In identifying the priorities Sandwell LSCB will take forward into 2017/18, the Board has considered the range of learning and information presented during the year and summarised in this annual report. We have looked in detail at the experience of individual children through Serious Case Reviews, local learning reviews, audits of multiagency work and listening to staff working every day with vulnerable children. This has improved our understanding of the need to focus on specific areas of work.

8.3 This has enabled us to conclude that we must retain our existing priorities:



8.4 We must however ensure a clearer focus on specific key areas of work.

8.5 High numbers of children who have a child protection plan have suffered from neglect in Sandwell. Based on the number of CP plans at the end of the year (417), it would appear that 54% (225) were under the category of neglect. This number has continued to rise in Q1 of 2017/18.

8.6 We know that neglect can have a long-term impact on the life chances of children experiencing neglect. As a result, we will prioritise our work in this area for the next 12 months as we want to make sure that all staff across the partnership recognise neglect and its impact on children and work with families at the earliest possible opportunity. Training to increase confidence

amongst staff and to equip them with the tools to assess and address features of neglect has to be a specific area of work.

8.7 In conjunction with Children's Social Care's seven improvement priorities (see appendix 1), the Board will also maintain a focus on a sustainable solution to the front door (priority 3) which will include improved working on the MARF and providing challenge in respect of whether children in need, children on a child protection and looked after children have an up-to-date plan focused on outcomes, and that children on caseload are visited at the required frequency by social workers (priority 7).

8.8 Whilst a detailed plan has been developed to drive forward the actions underneath the strategic priorities, detailed below is a 10-point plan to drive forward the immediate areas of development. This will be supplemented by the individual work plans of the SSCBs various subgroups. Monitoring of the plan will be undertaken by the Chairs' Group with updates being routinely provided to the Board.

Ref.	Action	SSCB Priority	Completion Date
1	Deliver a community engagement event to work more closely with Sandwell's diverse communities	Priority 1	Dec 2017
2	Develop a Safeguarding Board Communications Strategy	Priority 1	Mar 2018
3	Board members to undertake a *'Walk the Floor'* exercise to raise the visibility and influence of SSCB	Priority 1	Mar 2018
4	Be assured of the effectiveness of Sandwell's refreshed Early Help strategy	Priority 2	Mar 2018
5	Establish a time-limited neglect working group to improve how the partnership work with families who experience neglect	Priority 2	Mar 2018
6	Refresh the Safeguarding Board's threshold document	Priority 2	Dec 2017
7	Robustly scrutinise performance information relating to Initial Child Protection Conferences and Core Group meetings (following a recent SCR)	Priority 3	Mar 2018
8	Undertake a comprehensive Section 11 audit with returns being rigorously analysed and challenged	Priority 3	Dec 2017
9	Develop a plan to establish new safeguarding arrangements in preparation for the replacement of LSCBs	Priority 3	Mar 2017
10	Undertake purposeful consultation with children and young people in order to directly hear their voice (this will include a *'takeover session'* of the Board; working with the SHAPE Forum to understand the experiences of children who use services; eliciting the child's experience through the Board's audit work).	Priority 1 & 3	Mar 2018

9. Conclusion

9.1 This year, the Board would like to convey the following key messages. Many of these messages are the same messages as last year but this is because they remain important:

For children and young people

9.2 We are still listening and your voices are the most important of all voices. Whilst SSCB are trying to get better at listening to you, we are continuing to work on new ways of hearing you. Your wellbeing remains at the heart of our child protection systems. We want to hear from you about how services can be improved to ensure your wellbeing, to prevent you being harmed, and to protect you.

For the community

9.3 You are in the best place to know what is happening to children and young people and to report your concerns if you think something is happening. Protecting children is everybody's business. If you are worried about a child, contact the Children's Single Point of Contact (SPOC).

For Sandwell Safeguarding Children Board partners and organisations

9.4 The protection of children is paramount. How do decisions that your agency makes affect children and young people. You are required to assure this Board that you are discharging your safeguarding duties effectively and ensuring that services are commissioned for the most vulnerable children.

9.5 Are you making sure that the voices of all children and young people are informing the development of services? Take notice of the voices of vulnerable children. Listen and respond, particularly if they disclose abuse. Children and young children may not always verbalise their feelings. Be aware of other non-verbal ways they may indicate to you that they are distressed or worried.

9.6 Use your representative on our Board to make sure the voices of children and young people and front line practitioners are heard. Ensure your workforce is able to contribute to the provision of safeguarding training and to attend training courses and learning events. Know the priorities of the Board and take these into account. Share responsibility in the delivery of the Board's work.

Approval Process

9.7 A draft of this Annual Report was presented and approved at a meeting of the Safeguarding Board Children Board on 12 September 2017. 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:

Safeguarding assurances from partners

Sandwell MBC: Children's Services

1.1 Following the Ofsted inspection report in June 2015 the Council's Children's Social Care Services continued to be judged as 'inadequate'. An Improvement Notice was issued on 6 October 2016 and a Children's Commissioner appointed to oversee the improvements and a move of the service to a Children's Trust.

1.2 The priority for the Council during the reporting period has been to improve the compliance with statutory requirements and the quality of children's services work to ensure that the service is effective, safe and efficient as part of an improvement journey. The Council must show significant progress and sustainable improvement by the time of the next Ofsted inspection.

1.3 Therefore, in February 2017, the Council provided additional resources to increase the baseline number of Social Workers in core front line service teams, including the Safeguarding and Assessment Teams (SAATs), Care Management and Care Leaving Teams. Following Council agreement to fund the additional resource a major recruitment campaign was implemented. The local authority increased the social work establishment in line with a new staffing model agreed with the Children's Commissioner. This included an increase of ten team managers to maintain the appropriate levels of management oversight, including extra management capacity with the appointment of an Improvement Director and appointments of an additional Group Head (senior level). The additional interim Group Head has a focus on Looked After Children (LAC) services.

1.4 However, the Council has struggled in recent months to recruit the required number of social worker appointments to the service and this has meant that caseloads remain too high. Further resources have been made available to implement a volume agency recruitment programme to immediately address this. The plan is to increase the number of qualified social workers within the service to 184 which will result in manageable caseloads for staff and support the improvement activity within the service.

1.5 During February 2017, a new senior leadership team brought a clearer focus of improved compliance and improved quality of social work activity to the service. This has included setting and maintaining a higher level of pace and traction in the improvement work related to social work practice and management oversight. Moving on from the original improvement plan, the seven priorities outlined by the Commissioner are now embedded within the service and being used as the baseline for the improvement framework.

Sandwell's Seven Improvement Priorities:

Priority 1: Increase the social care workforce to ensure that caseloads are manageable across the service

Priority 2: Ensure that there is the required management capacity for appropriate oversight and direction of casework and that all staff have supervision at the required frequency.

Priority 3: Put in a sustainable solution to the front door to ensure that children and families receive timely assessments to the required quality.

Priority 4: Ensure all children in need, children on a child protection plan and looked after children have an up-to-date plan focussed on outcomes, and that children on caseload are visited at the required frequency by social workers.

Priority 5: Address the deficits in the provision of computer equipment, business support and accommodation so that social workers are appropriately supported in high quality practice.

Priority 6: Put in place effective communication systems which connect senior management with practice and ensure that staff concerns are swiftly addressed.

Priority 7: Strengthen the approach to attraction, recruitment and retention to make Sandwell Council an employer of choice within the region and reduce the over-dependence on agency and newly qualified staff.

1.6 Leadership, management and governance has been recognised to be key to the future success of the Children and Young Peoples Service improvement journey. The improvement plan now has a dedicated work-stream with clear priorities and actions; this will further build on the improvements to date.

1.7 The political and corporate leadership have been committed to wanting to ensure the successful delivery of the Sandwell Improvement Plan. As well as the increased resources for social work recruitment, additional corporate support in the form of project management time has been provided to deliver the change and improvement. At the same time the Council has continued to work closely with the Commissioner to develop the future Children's Trust arrangements.

1.8 The Council recognises the unique and fundamentally important role of middle managers. During the last year, the service has invested in the development of Team Managers, with a popular and effective Aspiring Managers course. The second cohort of Aspiring managers has been commissioned and started in May 2017. This has the dual benefits of informing the content of management training and supporting the development of the future service. The Council has successfully recruited extra team manager posts to support the increased number of social workers within the service.

1.9 Towards the end of the reporting period some improvement actions, against the seven priorities, have started to evidence a positive impact on performance across a range of service areas. The Corporate Parenting Board has been refreshed and is now better supported to ensure that it undertakes its role robustly and can provide effective support and challenge.

1.10 There is also evidence of improvements within the Single Point of Contact (SPOC), MASH, Safeguarding and Assessment Teams (SAAT), LAC, and Leaving Care. These changes are beginning to lay the foundation for sustainable improvement across the service. The senior management team are maintaining a strong focus across key indicators related to assessment timeliness, child protection and LAC plans and visiting. The response times and compliance with timescales in other areas such as complaints has also improved.

1.11 At the end of the reporting period there was a weakness within the service auditing and quality assurance activity and framework. However, the first quarter of the next reporting period (April – June 2017) has shown a significant improvement and the number of audits is now over 45 each month with 100% compliance. The auditing work is now linked to practice improvement activity and 'closing the loop' action tracking which can evidence the improvement impact of the work on children's outcomes.

1.12 It is acknowledged by the service that there is not yet a high degree of consistency across quality practice within the service. Improvements continue to be made but progress has been slower than required. This historical slow pace is a theme highlighted in the Ofsted monitoring visits during the last year. The service is not complacent and there remain several challenges that still need to be addressed. These issues primarily relate to the need to have a stable and skilled workforce which will be delivered by the increased numbers of social workers. The quality of social work practice will be improved through the consistency and rigour of practice management oversight which is now built into the practice improvement activity and greater emphasis on supervision and recording.

1.13 There have been several reoccurring improvement themes identified by the senior leadership team through recent practice improvement activity. Work is underway on these themes and the recently completed service self-assessment has provided evidence that the service is moving towards a Requires Improvement judgement. This work needs to be accelerated to deliver the priorities and actions to achieve the desired outcomes that have been agreed.

1.14 **Priorities to achieve outcomes**

- We will show that we are meeting our statutory duties to vulnerable children in need of support, protection and care.

- We will have the management capacity to provide appropriate oversight and direction to case work and staff supervision.
- We will have strong and robust individual and partnership responses to children in need of support, protection and care, including those at risk of CSE and who go missing
- We will have a communication system to connect senior leaders and staff, that supports the timely addressing of issues and concerns, keeps staff updated and informed and has a flexible feed-back loop.
- Performance management will be effective and underpinned by a strong quality assurance framework
- We will have a corporate response to address recruitment and retention issues, ensuring a skilled workforce with manageable caseloads
- Governance will be clearly understood by all, with clear accountabilities, roles and responsibilities which ensure effective challenge, scrutiny and feedback

1.15 **Actions to deliver priorities**

- Establish stronger strategic leadership within the council and across the partnership system that creates the conditions for strong partnership working and practice
- Establish strong communication system between the council, commissioner and leaders of the future Trust arrangements
- Maintain our recruitment activity to increase the number of suitably qualified and experienced social
- Review, consolidate and strengthen existing governance arrangements ensuring there is a growing culture of listening to the views of children and families providing constructive challenge.
- Appoint to and support the development of our leaders and managers
- Review and refresh existing quality assurance arrangements, including the role and effectiveness of audit
- Implement strengthened member development programme to support our role as corporate parents

Health Services

1.16 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.

1.17 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.

1.18 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

1.19 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.

1.20 As an NHS organisation and principal commissioner of local health services, Sandwell & West Birmingham Clinical Commissioning Group (SWB CCG) has specific responsibilities and duties in respect of safeguarding children (including looked after children).

1.21 All NHS bodies have a statutory duty to make arrangements to safeguard and promote the welfare of children under Section 11 of the Children Act 2004. NHS bodies are statutory members of the Local Safeguarding Children Boards under Section 13 of the 2004 Act. Following recent government NHS reforms and the passage of the Health and Social Care Bill, statutory responsibilities to safeguard children are now the responsibility of NHS England, CCGs and the NHS Commissioning Board. The NHS has proposed changing the current way of working within the NHS with 'The 5 Year Forward View'; these changes mean that the NHS needs to work differently. The Forward View sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health

1.22 The National NHS Commissioning Board has produced final guidance advice for CCGs and NHS England local teams on critical arrangements to secure children's and adult safeguarding within the updated version of the NHS Safeguarding and Accountability Assurance Framework (2015).

1.23 As the footprint of Sandwell & West Birmingham CCG (SWB CCG) covers both Sandwell and Birmingham Local Authorities assurance and activities are reported to both Sandwell and Birmingham Safeguarding Children Boards.

1.24 SWB CCG has robust governance arrangements in place. The Quality and Safety Committee of SWB CCG receives monthly safeguarding children reports. The function of this group is to ensure effective monitoring of safeguarding arrangements is reported through internal governance structures.

1.25 Evidence to support compliance with Section 11 is monitored by both Birmingham and Sandwell Safeguarding Children Boards (BSCB & SSCB). Reports are submitted to the BSCB & SSCB for audit and scrutiny and robustly challenged at scrutiny and peer review meetings. SWB CCG are compliant with section 11. There are a few areas that require strengthening and these are now included in the 2017/18 Safeguarding Children strategic plan.

1.26 The effectiveness of the safeguarding system is assured and regulated by a number of bodies and mechanisms. These include Provider internal assurance processes and Board accountability; LSCBs; external regulation and inspection- CQC; locally developed peer review and assurance processes; effective commissioning, procurement and contract monitoring. All provider services, including every General Practice, are required to comply with the Care Quality Commission Essential Standard for Quality and Safety which include safeguarding standards (standard 7).

1.27 Contracts and service specifications for Provider Trust services commissioned by the CCG include service standards, information requirements and key performance indicators (KPIs) for safeguarding; work is underway to strengthen these assurances.

1.28 The SWB CCG Safeguarding Children Unit is responsible for the development, monitoring and reviewing of safeguarding practice by all providers Trusts, services and independent contractors. In this capacity they provide professional leadership, expert advice and support to the named professionals in each provider organisation.

1.29 The CCG has continued to invest in the safeguarding agenda and this has been acknowledged and acclaimed by the Safeguarding Children Unit finalist status for HSJ Compassion in Care award 2016.

1.30 Working Together to Safeguard Children (2015) sets out statutory guidance on the responsibility of CCGs and NHS England to ensure that employees

and independent contractors have an awareness of how to recognise and respond to safeguarding concerns

1.31 Sandwell & West Birmingham CCG commissioned a trainer to deliver face to face level 3 safeguarding training to members in Primary Care with a key focus on child sexual exploitation (CSE), female genital mutilation (FGM) and domestic abuse (DA). The training was a scenario based session to encourage discussion.

1.32 The CCG facilitate and monitor Primary Care engagement with the ICPC process and have disseminated a GP Safeguarding Children Tool Kit to all member practices

1.33 The FGM mandatory reporting duty is a legal duty provided for in the FGM Act 2003 (as amended by the Serious Crime Act 2015).

1.34 Within Sandwell & West Birmingham work has been undertaken with NHS digital to identify member practices that have not yet registered with the clinical platform to ensure compliance of the mandatory recording duty. Sandwell & West Birmingham CCG now have a FGM policy. This policy covers both adults and children and provide professionals, practitioners and anyone working with adults, children and young people with an understanding of FGM and what action they should take to safeguard girls and women who they believe may be at risk or have already undergone FGM. An FGM information pack was distributed to all Sandwell & West Birmingham GP practices in July 2016 which included professional and legal responsibilities as well as signposting victims for support. It is anticipated that prompting awareness across member practices of FGM prior to the 'cutting season' commencing will remain an annual campaign. The pack included information on the mandatory responsibility of health professionals to report cases of FGM.

1.35 During October 2016, the CCG were able to resource a safeguarding lead nurse to contribute on behalf of primary care to the Mutiagency Risk Assessment Conference (MARAC) discussion. The benefit of have this 'voice' at this platform enables, primary care to share any information they feel is significant to ensure that an effective safety plan in put in place for the victims of high level abuse. The outcomes of the conference is shared with the GP practice, which then allows them to 'flag' records and enable a holistic assessment if the victim was to present at the surgery again for treatment.

1.36 The CCG have continued to fund the IRIS project in Sandwell. GP practices are provided with domestic abuse training and a dedicated advocate to support victims within their practice.

1.37 The Child Sexual Exploitation (CSE) Superhero campaign is an innovative project developed by SWB CCG in partnership with The Children's Society, and is fully endorsed by NHS England.

1.38 SWB CCG wanted to take the CSE Superhero Campaign further, thus creating a project to develop, educate and raise awareness of CSE amongst healthcare professionals and to provide them with an online learning tool and guidance resources to improve practise. It is known that disclosures are made by children to the lead professional in their life, and in many occasions this is a healthcare practitioner. The aim is equip healthcare professionals with the correct skills and training to be able to recognise the signs of CSE and better facilitate disclosures.

1.39 The campaign is hosted on the SWBCCG website, rolled out locally in Primary Care March/April 2017 and nationally in November 2017.

1.40 After the success of last year's Safeguarding Conference the SWB CCG Children's Safeguarding Unit hosted a conference on the 2nd March 2017 called 'Voice of the Survivor'. The conference was aimed at health professionals however there were a number of key partner agencies attending with 150 delegates confirmed. There were both national and local speakers; experts in their fields of practice. They discussed Modern Day Slavery, FGM, CSE, Child Sexual Abuse (CSA) and Lessons learnt from Serious Case Reviews. Delegates were also fortunate to hear the voice of 3 survivors sharing their experiences. They had been victims of FGM, CSE and CSA.

1.41 Sandwell and West Birmingham CCG worked with Sandwell CDOP and the Family Nurse partnership (FNP) in the plans to bring Finnish style Baby Boxes to Sandwell and West Birmingham. The CCG kick-started the projects with a grant of £2000 to initially provide a pilot study with vulnerable young families. This quickly progressed to the opportunity to work with Baby Box Company who agreed to use City Hospital Maternity Unit as one of their UK starter sites. It is hoped that this initiative, alongside the Safer Sleep campaigns, will help to reduce the number of sudden infant deaths in Sandwell and West Birmingham.

1.42 In January 2017 the SWBCCG Chair's award was presented to the safeguarding team for "having shown innovation, tenacity and courage in the work that they have done including the CSE superheroes, the work of the domestic abuse team in the IRIS project and the nationally recognised CSE video that worked with children and the police to develop a fantastic video".

Looking Ahead to 2017/18

1.43 The CCG will support the Modern Day Slavery agenda and ensure that a clear action plan is embedded within the CCG

1.44 Look to secure funding for embedding IRIS across all member GP Practices in a phased process.

1.45 The CSE agenda will remain a key focus with the dissemination of the CSE Superhero training toolkit both locally and nationally.

1.46 The GP safeguarding toolkit will be refreshed to include adult safeguarding; to support GP practices in their safeguarding arrangements.

1.47 The CCG will continue to support and contribute to the 17/18 SSCB Business Plan.

West Midlands Police (WMP)

1.48 West Midlands Police have actively engaged in the multi-agency work within the Borough. Following the retirement of a colleague who had worked within the MASH since its creation, the sergeants from within the investigation unit have worked in rotation to ensure the role is covered. A Detective Chief Inspector has continued to lead YPSE, with strong support from a Children's Services Group Head. The Group has worked well and now has a strong membership. A Detective Inspector has continued to work hard on CDOP as well as contributing to safeguarding training. A new CSE coordinator was also appointed during the reporting period.

1.49 During the year the Force has undergone some structural changes which now mean that Response Policing is now centrally managed. Sandwell retains a Neighbourhood structure with dedicated officers working and based in Sandwell. A new tasking process means that a Local Tactical Delivery Board meets one a month, usually a week after YPSE. The Board agrees to actions to ensure that perpetrators and locations are targeted by officers in an attempt to disrupt CSE activity in the Borough. The Board and YPSE is supported by the Intelligence Department.

1.50 Performance has been challenging throughout the year. There has been a 12% increase in overall crimes against children in the Borough, which is in line with the Force trajectory. Data shows that 23% of crimes result in a positive outcome (the vast majority of these involve charge / cautions etc). In many cases children do not want parents / carers charged and in many cases such an outcome would be inappropriate. In the autumn of 2016 the Force completed a Problem Profile of CSE. In Sandwell there are an estimated 146 children at risk of CSE, identified during the reporting period. There have been 39 PPOs over the year, involving 63 children.

Child Abuse and Safeguarding Governance Arrangements

1.51 The same governance arrangements are in place for Child Abuse in West Midlands Police with a new Chief Superintendent now leading this crucial area of work.

Key Achievements in 2016/17

1.52 An internal cross discipline 'Improvement Board' (held monthly, chaired by the Assistant Chief Constable) continues to oversee an agreed improvement plan bringing together all HMIC recommendations and our own internally identified issues requiring additional focus.

1.53 The Plan is set out under:

- **Prepare** - providing strong leadership, effective systems whilst 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 our 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

1.54 In February 2016 a force wide Child Abuse monthly audit programme was implemented, including learning the lessons and sharing of good practice which are discussed at the monthly Child Abuse managers forum, chaired by the dedicated Child Abuse lead for the force. This has continued throughout 2016/17.

Future Plans for 2016-2020

The PCC has published his Police and Crime Plan 2016-20. This is split into seven sections, the first section is entitled “Protecting from Harm.”

Sandwell Safeguarding Adults Board (SSAB)

1.55 The Sandwell Safeguarding Adults Board is a multi-agency partnership made up of statutory sector member organisations and other non-statutory partner agencies providing strategic leadership for adult safeguarding work and ensuring there is a consistent professional response to actual or suspected abuse. The remit of the board is not operational but one of coordination, quality assurance, planning, policy and development.

1.56 It contributes to the partnership's wider goals of improving the well-being of adults in the borough and promotes and develops campaigns, examples of which is the current campaign *'See Something, Do Something'*.

1.57 We continue to use our short film *'See Something, Do Something'* as a standard tool in all of our training which has also been adopted and used widely by our partners. This can also now be seen on our website: www.sandwellsab.org.uk. Detailed below is a quotation from a Lay Member of the Board: *"The use of campaigns helps everybody understand in a clear way what safeguarding means and what we are all trying to do"*

1.58 There are currently twelve agencies represented on the Board. It is agreed that the Care Quality Commission will attend and report on their activity at one board meeting a year. The board also has the support of a Cabinet member who attends meetings whenever possible and the previous post holder participated in various adult safeguarding events.

1.59 The Board is supported by a small business team of Officers and a Board Operations Manager. In addition to this, professional advisers and safeguarding leads assist in the delivery of the Board's business.

1.60 The Partnership accesses a large network of health and social care providers from statutory, voluntary and private sectors, to promote the welfare of adults at risk.

1.61 Throughout 2016-17 SSAB was represented on the West Midlands Editorial Group. The safeguarding policies and procedures of the group are used by all agencies and have been adopted by all 14 Safeguarding Adult Boards in the West Midlands region. All documentation has been reviewed and revised to reflect the new government legislation and guidance.

1.62 Regional guidance has been developed in the areas of Self Neglect, Safeguarding Adult Reviews and Positions of Trust. Work was undertaken to ensure that all the documents are both Care Act and Making Safeguarding Personal compliant. This is to secure a consistent approach to safeguarding adults across the West Midlands region. Sandwell has lead in partnership with West Midlands Fire Service and Neighbourhoods on the development of both local and regional guidance including the use of Clutter Images on best practice when responding to hoarding.

1.63 SSAB is well established and provides strategic leadership for adult safeguarding work and seeks to ensure there is a consistently high standard of professional response to situations where there is actual or suspected abuse.

1.64 The board also oversees the effectiveness of the arrangements made by individual agencies and the wider partnership to safeguard adults from abuse.

1.65 The board has four meetings a year and would aim to have annual development days. There are strong links with all key Boards locally enabling joint development of agenda's including Prevention of Violence and Exploitation.

1.66 A Joint Board Development Day was held 28.04.16, where Heads of Service, Senior Police representatives as well as Health Partners and others, all members of both Sandwell's Safeguarding Children Board and Sandwell Safeguarding Adult's Board were present at a local event (the first of its kind in Sandwell) to look at key Safeguarding themes that impact on both adults with support needs and children in this area.

1.67 The identified priority areas were: Modern Slavery, Prevent, Transition and Vulnerable Young Adults and the Crisis Mental Health Concordat.

1.68 The focus for future development days could be common areas of safeguarding with our partners and developing our understanding of new areas of abuse as identified in the Care Act, and developing our partnerships and joint working with Sandwell Safeguarding Children Board, the Health and Wellbeing Board and the Sandwell Safer Partnership Police and Crime Board.

1.69 Common of areas of work with SSCB include adults aged 18 plus with additional support needs and their transition to adulthood.

1.70 Key policies including Hoarding Guidance and Self Neglect Guidance can now be found on the SSAB website @ www.sandwellsab.org.uk

1.71 All current safeguarding forms can be downloaded using the link below: http://www.sandwell.gov.uk/downloads/download/1359/safeguarding_adults_forms_guidance_policies_and_procedures

Education and Schools

1.72 SSCB continues to take purposeful action to improve its engagement with schools and colleges. The Board established an Education Advisory Group (EAG) in February 2015 and this continues to meet 4 times a year. 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

1.73 During the year the EAG has been integral in reviewing the developments to Sandwell's social care system with the overall consensus being:

- The development of the Single Point of Contact has improved the pace with which cases are dealt with and responses given to schools on whether, or not, referrals meet the threshold for intervention.
- Access to day to day phone support and advice had reduced the need to take all issues to COG meetings.
- Communication systems, particularly considering feedback on individual cases, requires significant improvement so that schools are well placed to support families.
- Lead professional role often requires external support and advice and the Lead Practitioner meetings have been viewed as useful to improving the consistency and quality of work across the borough.
- Access to mental health services continues to be a concern with poor response rates and long waiting times
- The quality of social care workers support to families is viewed, at best as inconsistent, with the frequent changes in social workers for family cases cited as the main reason for poor performance.

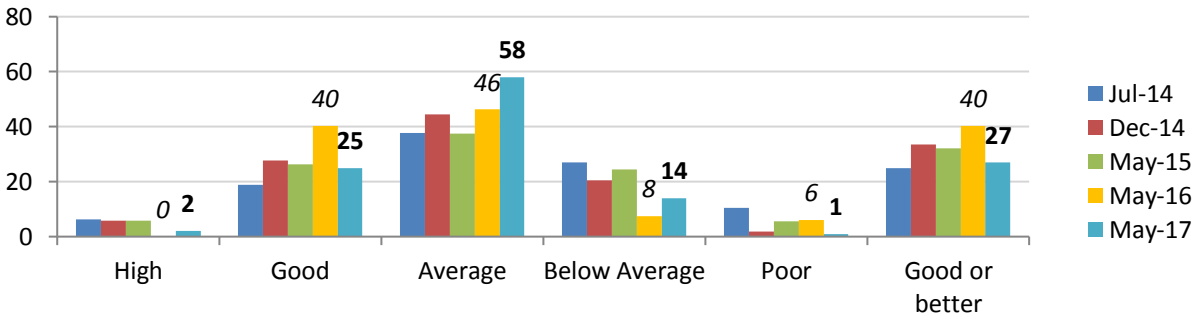
1.74 A further key activity of the EAG focused on the PREVENT agenda. EAG has continued to monitor uptake of WRAP training and will continue to monitor this in the coming year. The effectiveness of PREVENT training is rated highly by schools in the recent confidence survey

1.75 During the reporting period the EAG has monitored the completion of Section 157/175 audits and has linked this information with the Quality and Standards Performance Board so that intervention can take place should schools fail to be compliant with safeguarding expectations.

1.76 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 including how the development of the new Children's Trust could impact on the current levels of performance. The latest survey indicated that schools'

confidence in Safeguarding systems had fallen significantly since the last survey.

Schools' confidence in safeguarding and child protection procedures in Sandwell has fallen



The data from the recent school survey demonstrates that schools confidence in child protection and safeguarding procedures have fallen back after three years of slow but steady improvement in confidence

Ranked summary of responses

Rank	Area	Good+	Av+	Traj
1	Undertaking and understanding of PREVENT training	**88**	*96*	*+6*
2	Undertaking and understanding of CSE training	**85**	*94*	*+18*
3	Accessibility of safeguarding training	**84**	*94*	*NA*
4	PEPs: Quality, appropriateness and effectiveness	**49**	*80*	*NA*
5	Attendance and prosecution support	**49**	*74*	*-1*
6	Domestic violence notifications	**41**	*75*	*-17*
7	School nursing arrangements	**35**	*72*	*+4*
8	LADO responsiveness and support	**35**	*60*	*-8*
9	Effectiveness of COGs in identifying and providing support	**33**	*79*	*+1*
10	MASH/SPOC speed and effectiveness	**33**	*76*	*-24*
11	Communication with COG teams to support working	**33**	*71*	*+10*
12	Health visitor support	**30**	*52*	*-2*
13	Improvement in safeguarding and child protection	**27**	*84*	*-13*
14	Alternative Provision: Support quality	**24**	*46*	*NA*
15	Alternative Provision: Meeting pupil entitlements	**23**	*41*	*NA*
16	Admission/HTP information quality	**22**	*68*	*NA*
17	Trust development leading to improvement in safeguarding	**22**	*62*	*NA*
18	SPOC/MASH communication (outcome of referrals)	**21**	*55*	*-9*

19	Quality of LAC information for OOB children	**20**	*46*	*NA*
20	Receipt of current, up to date, minutes (CIN, LAC, Core)	**18**	*45*	*-4*
21	Social worker response to support safeguarding in schools	**14**	*58*	*-5*
22	Consistency of Social Worker case support	**11**	*57*	*-6*
23	Accessibility of CAMHS support	**11**	*29*	*+2*
24	Mental Health counselling support	**6**	*25*	*-2*

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

1.77 During the reporting period, the LSCB completed its 2015-16 academic year s175 audit and recommenced the audit for the 2016-17 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.

1.78 All submissions from 2015-16 were analysed and a programme of feedback to schools was established involving the Quality and Governance Officer attending each locality Learning Community. The feedback sessions were supplemented with a series of 'Assurance Panels' (commencing in January 2017) where schools that had either completed less than 50% of their audit the previous year (2015-2016), or were an education provider that SSCB felt more assurance was required from, were held to account for their submissions. By March 2017 a total of 6 Section 175 panels had taken place

Looking Ahead to 2017-18

1.79 Whilst the response rate to the s.175 audits were very 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.

1.80 Ensure compliance with the statutory guidance on safeguarding, Keeping Children Safe in Education, which came in to force from 5 September 2016

1.81 Review uptake of PREVENT training available to schools

1.82 Monitor development of Lead Professionals Network meetings

1.83 Completion of 2018 School Confidence Survey

Birmingham Community Healthcare NHS Foundation Trust (BCHC)

1.84 BCHC became a member of SSCB in July 2014, following the transition to BCHC of the Sandwell School Nursing service on the 1 April 2014. Since that time the Associate Director of Safeguarding has been a consistent member of the SSCB and the Sandwell Health Forum. BCHC actively participates in the SSCB Sub-groups and the associated work program.

Assurance and Governance Arrangements

- The Director of Nursing and Therapies is the Board Executive Lead for Safeguarding Children. Assurance and quality are demonstrated through a constant programme of review via the internal Committee structures. This includes the preparation and submission of monthly and quarterly reports to the Clinical Governance Committee. The established Safeguarding Children Subcommittee meeting has an annual work programme and audit programme that is monitored through the Clinical Governance Committee.
- The reporting schedule also includes quarterly reporting on the local implementation of recommendations from Serious Case Reviews, Independent Management Reviews and Domestic Homicide Reviews, compliance with Care Quality Commission (CQC) standards, safeguarding training and supervision.

Section 11 Compliance

- BCHC, in common with all health organisations, has a statutory responsibility to safeguard and promote the welfare of children under Section 11 of the Children Act (2004).
- The Section 11 audit provides evidence of the structure, systems and process in place to ensure that the statutory duties of Section 11 of the Children Act (2004) are being discharged by BCHC.
- During 2016/17 BCHC undertook the Section 11 audit for Sandwell Safeguarding Children Board, providing BCHC with assurance of compliance. The audit demonstrated that BCHC is compliant with all relevant aspects of the Section 11 audit and CQC Outcome 7.

School Nursing Service - Key Activities and Good Practice

- During 2016/17 Sandwell School Nursing Service has actively operationalised BCHC's safeguarding systems and processes. This has supported the School Nurses to effectively safeguard Sandwell Children. The Sandwell School Nurses have dedicated Named Nurse support which has resulted in the service having:
    - Access to advice and support from the Safeguarding Children Named Nurse team as part of the established on call system.

- The Named Nurse team provide support for School Nurses on completion of court reports. The team provide advice, training and quality assurance of the court reports.
- Regular 1:1 safeguarding supervision- the service is compliant with the BCHC safeguarding policy target of 90%. Compliance with safeguarding children training at level 1-3. All training meets the requirements of the intercollegiate guidance (2014).
- Access to the electronic caseload monitoring tool to upload monthly safeguarding activity.
- The Safeguarding Children Named Nurses have participated in SSCB training programmes.

Quality Assurance /Audit

- Single agency audits completed have included:
  - School Nurse attendance at child protection conference
  - The quality of multi-agency referral form audit
  - Record keeping audit- 10% sample of child protection cases
  - Quality of court report audits

Child Sexual Exploitation (CSE)

- BCHC is committed to tackling CSE through single and multiagency arrangements. The CSE Champions model has been introduced throughout the School Nursing Service. The model promotes awareness raising and advice for colleagues on CSE and the screening tools available to support early identification of young people at risk of CSE. School nurses are supported to attend the multi-agency sexual exploitation meetings to share information and agree actions to protect young people at risk.
- BCHC participates in regional arrangements for CSE, including linking into the strategic CSE sub group of Sandwell Safeguarding Children Board.

Areas for Development

- It is recognised that the involvement from School Nurses as Lead Practitioners within Sandwell's Early Help Strategy could be increased. As a response to this, bespoke training around the principles of Early Help and assessment, consistent with Sandwell approach, has been devised by the Named Nurse Team. The information will be cascaded to School Nurses through training and supervision.

Key areas of Focus 2017/18 will include;

- Maintain effective partnership arrangements throughout the development of Sandwell Children's Trust.
- Seek, Listen and Respond to the voice of the child, including children with special educational needs and/or disability, as a thread throughout all School Nurse Service delivery.
- Participate in multi-agency audits to develop practice.
- Embed Sandwell's refreshed Early Help Strategy into front line practice, promoting the Lead Practitioner role within school nursing.

Sandwell and West Birmingham NHS Trust

1.85 During the year the Emergency Department (ED) Advocacy Partnership Project with Black Country Women's Aid continues to prove to be a positive venture in increasing the visibility of domestic abuse in ED. We have seen an increase in Emergency Department Practitioner response, identification and onward referral to the Independent Domestic Violence Advisors (IDVA) based in Sandwell Hospital for victims of domestic violence and abuse (DVA).

1.86 During 2016/17 141 individuals have been identified as victims of DVA in ED; which brings the total number of referrals for support into the project from commencement to over 259 individuals. Analysis of preliminary data in October 2016 has shown that 41% of these individuals were previously unknown to any other services as DVA victims and were also found to be multiple attenders in ED; for a small number this equated to between 27-35 ED attendances over the year. In addition, interestingly data demonstrates that there is an increased number of victims being identified from Black and Minority Ethnic Groups which have previously not been represented in data identifying groups accessing domestic abuse services. Data shows that 77% of victims have accepted ongoing support following initial referral into the project.

1.87 We have seen a marked decrease in ED attendance for those high risk individuals following case discussion at Sandwell's Multi-agency Risk Assessment Conference at Sandwell MARAC and we now 'tag and flag 'DVA cases on Trust electronic patient records (EPR) to ensure these individuals are not invisible to services. This is also replicated in ED attendance for those individuals being referred into the ED IDVA service and ongoing support 1 year post launch of the project

1.88 Our Domestic Abuse Lead Nurse Team continues to contribute into the Multi-Agency Domestic Abuse Screening Process in MASH to ensure that information relating to risk is shared with health professionals involved with the victim and children in order to protect, safeguard and reduce the negative impact that DVA poses. The Team have delivered specific training to staff across the Trust on the Safe Lives (formerly CAADA/DASH Risk Assessment) and domestic abuse training forms part of our Safeguarding Children and Adult Safeguarding Mandatory Training requirements. A DVA leaflet has been designed and sent to all Trust employee's to raise the awareness of DVA.

1.89 Child Sexual Exploitation (CSE) remains a high priority for Sandwell & West Birmingham Hospitals NHS Trust (SWBHT); during the year we have delivered bespoke' bite-size' CSE training jointly with Barnardo's to ED, Paediatric Ward staff, front line community nurses and allied health professionals to raise the profile of CSE ensuring they are alert to the signs and triggers of CSE via our Quality Half Improvement Day (QIHD) sessions. We have good representation at Sandwell's CSE Health Group from the

paediatric areas including our Integrated Sexual Health Services, Safeguarding Team, ED; we work closely with all partners and in particular with Sandwell and West Birmingham CCG following the inception of the CSE Health Group and contribution to their hosting of the CSE Health Event held in March 2016.

1.90 We flag all children and young people who are known to Sandwell CSE Team as being at risk of CSE on our EPR systems which is particularly relevant for our ED staff. Audit has shown an improvement in ED practitioner response to a flag and contacting Children's Social Care to share information on ED attendance.

1.91 For 2017/18 we will continue to focus on DVA with a view to secure substantive funding for the project which was a result of SWBHT Charitable Funds and will cease in December 2017. We will continue to increase practitioner response to DVA across the whole Trust by continuing to provide expert DVA Nurse advice, support and training. We will continue to utilise our QIHD sessions to raise the profile of DVA and routine enquiry across all areas. Furthermore, to ensure SWBHT's staff remain accountable and responsible practitioners within the safeguarding children agenda we will continue to work with our Learning and Development Department to ensure we meet mandatory requirements in relation to Safeguarding Children Training to ensure we have a safe and accountable workforce to meet the needs of vulnerable children, young people and families.

Black Country Partnership Foundation Trust (BCPFT)

1.92 Black Country Partnership NHS Foundation Trust (BCPFT) has continued during the year to strengthen the 'Think Family' Approach across all of its services ensuring that both children and adult practitioners are fully engaged in the safeguarding children process, fully understanding their responsibilities in line with legislation and best practice.

1.93 To support the 'Think Family' approach safeguarding training has been reviewed to include a stronger focus on the practitioners responsibility to children, whether they are working with the child in a family or with the adult, and on the thresholds that must be considered for action when a safeguarding concern is identified.

1.94 The Trusts Named Nurse for Sandwell is now co-located at the Trusts headquarters building and within the Children and Adolescent Mental Health Service which has proven to be effective to outreach community/inpatient services and integrate safeguarding policies, procedures and safer practice.

1.95 The Trusts safeguarding audits completed during the year have identified good practice and practice improvement requirements. Audits have included a review of the quality or reports provided to child protection conferences, the LSCB required Section 11 audit, Journey of the Child, Child Protection Records, Voice of the Child and Child Sexual Exploitation.

1.96 The Trusts safeguarding children team continue to provide support and advice on a case by case basis and through focussed Child Protection Supervision where a practitioner is involved in a case where the child is on a child protection plan.

1.97 The named nurses for safeguarding adults and children have commenced a dynamic safeguarding forum which is designed to provide a refresher or introduction to a current safeguarding subject and allows time for questions and concerns to be addressed in an ad hoc, informal and proactive way. One of the sessions has focussed on domestic abuse and referral to MARAC as it had been identified that referrals from BCP to the MARAC were very low.

1.98 In order to provide more robust safeguarding assurance the quarterly performance and quality reporting to the commissioners of health services (Sandwell and West Birmingham CCG) has been updated and along with the required Key Performance Indicators outlines the ongoing work and development of the Trust in the safeguarding agenda.

1.99 The Trust is an active participant in the Safeguarding Board and its sub groups and has contributed to reports, audits and reviews in line with its statutory responsibilities of the Children Act 2004 and participated in a number of external quality reviews relating to safeguarding and completed any actions required to improve safeguarding by the organisation. The Trust

is committed to participating in such reviews and participated in the Joint SEND inspection late 2016/17

Priorities for 2017/18

- To strengthen attendance and participation in the LSCB and its associated sub groups to ensure consistency and improve effectiveness of the trusts response.
- To strengthen the Trusts process for sharing and embedding lessons learnt from Serious Case Reviews (SCRs), Significant Incident Learning Process (SILPs) and case file audits, CQC, Peer reviews etc. are shared with all staff, from strategic to frontline.
- To increase capacity to deliver safeguarding training through the 'train the trainer courses' and establish with the Trusts clinical 'Divisions' staff release plans to deliver the training.
- To devise and implement an agreed safeguarding audit plan including an audit of the quality of safeguarding supervision and supervision record keeping.
- To continuously review the Safeguarding Children Team structure to ensure it meets the demands of increasing safeguarding activity.
- To ensure current and emerging safeguarding themes - including Exploitation and Modern Slavery are embedded - within the organisation.
- To ensure any actions from reviews such as the SEND review are incorporated into the organisations work streams.

Staffordshire and West Midlands Community Rehabilitation Company (SWM CRC)

1.100 SWM CRC has embarked upon a significant period of organisational development in 2016/17. Since the company came under the ownership of the Reducing Reoffending Partnership, (RRP) a collaboration of Ingeus, Change Grow Live (CGL) and St Giles Trust, in February 2015, the CRC has worked in partnership to develop a new operating model for the delivery of probation services in Staffordshire and the West Midlands. This culminated in the publication of "Our Plan to Change Lives" our target operating model in November 2015 and the organisation is currently in the process of implementing the proposed changes across the area.

1.101 The CRC's role is to:

- Protect the public
- Reduce re-offending
- Enforce the punishment of offenders
- Uphold the interests of victims of crime
- Rehabilitate offenders to lead law-abiding lives

1.102 At any one time SWM CRC is responsible for the supervision of over 13000 adult offenders in the community and the caseload is made up of men and women over the age of 18. Offenders are sentenced by a Court to a single Community Sentence with one or more requirements. Courts are advised by the National Probation Service and CRCs implement the sentences of the courts where the offenders are identified as posing a medium or low risk of harm to potential victims. Whilst the CRC does not work directly with any person under the age of 18 we are in a unique position to undertake a full assessment of those adults we work with and identify any children who may be at risk.

1.103 Public protection and the CRC's responsibilities in relation to Safeguarding Children are at the heart of "Our Plan to Change Lives", our new operating model with the key objective being to maximise the effectiveness of our operational staff in supervising and changing the behaviour of our service users and working collaboratively with our key partners to manage risk. Some of the key elements that are relevant to our delivery of Safeguarding Children priorities are as follows:

- A Customer Service Centre function which will provide a single point of contact for service users and professionals.
- Newly designed estates that will provide modern facilities for the delivery of rehabilitative services.
- A focus upon evidence based practice and evaluation of key rehabilitative interventions with a focus on leading quality improvements and the implementation of best practice.

1.104 Throughout this period of change it is a key priority of the CRC to work collaborative with our partners necessary to manage risk of serious harm. Safeguarding arrangements within the CRC continue to be strong. To demonstrate our commitment, we set up a Public Protection Governance Group. This group develops and produces policy and has produced guidance on Safeguarding Children, and on risk which has been disseminated to all staff. The group also quality assures the safeguarding actions from all the Local Delivery Units and monitors progress. The groups focus has also been to; review the Probation Trust Domestic Abuse Strategy, developing a strategy on CSE and learning lessons and disseminating best practice on Domestic Homicide Reviews, Serious Further Offences and Serious Case Reviews.

1.105 The CRC has introduced has a New Performance Framework, which includes a focus on the prevalence of Home Visits in safeguarding cases.

1.106 Sandwell Practitioners have access to internal and multi-agency arrangements for safeguarding children.

1.107 Also as part of the restructure we have established a Service Excellence Team which will have improvements in safeguarding practice at its core and be responsible for implementing any recommendations from any internal and external inspections. The CRC will relaunch the Public Protection Framework with an emphasis on Safeguarding Children and Adults in autumn 2017. The Service Excellence Team is also working on making improvements to some of our processes such as MARAC to ensure we are working effectively to manage any risks.

1.108 Our Senior Partnership Manager is responsible for compiling the Section 11 audit for Regional Managers to assist in the completion of annual Safeguarding Children Section 11 self-assessments. It provides an organisational overview of our current level of compliance with the section 11 standards. It is refreshed every six months to ensure the information is up-to-date.

1.109 Regional Managers refer to this document and use the information contained in each section when completing local Section 11 self-assessments. Once completed, Regional Managers share their local Section 11 self-assessment with the Chair of our newly established Quality Improvement Group (QIG) so that any areas requiring improvement can be incorporated into the Section 11 Improvement Plan. The seven standards which the Senior Partnership Manager will provide information about are: Leadership and Accountability; Policies and Procedures; Recruitment and Selection; Staff Induction, Training & Development; Complaints, Allegations & Whistle-Blowing; Information Sharing, Communication & Confidentiality; Listening to Children and Young People.

Third Sector

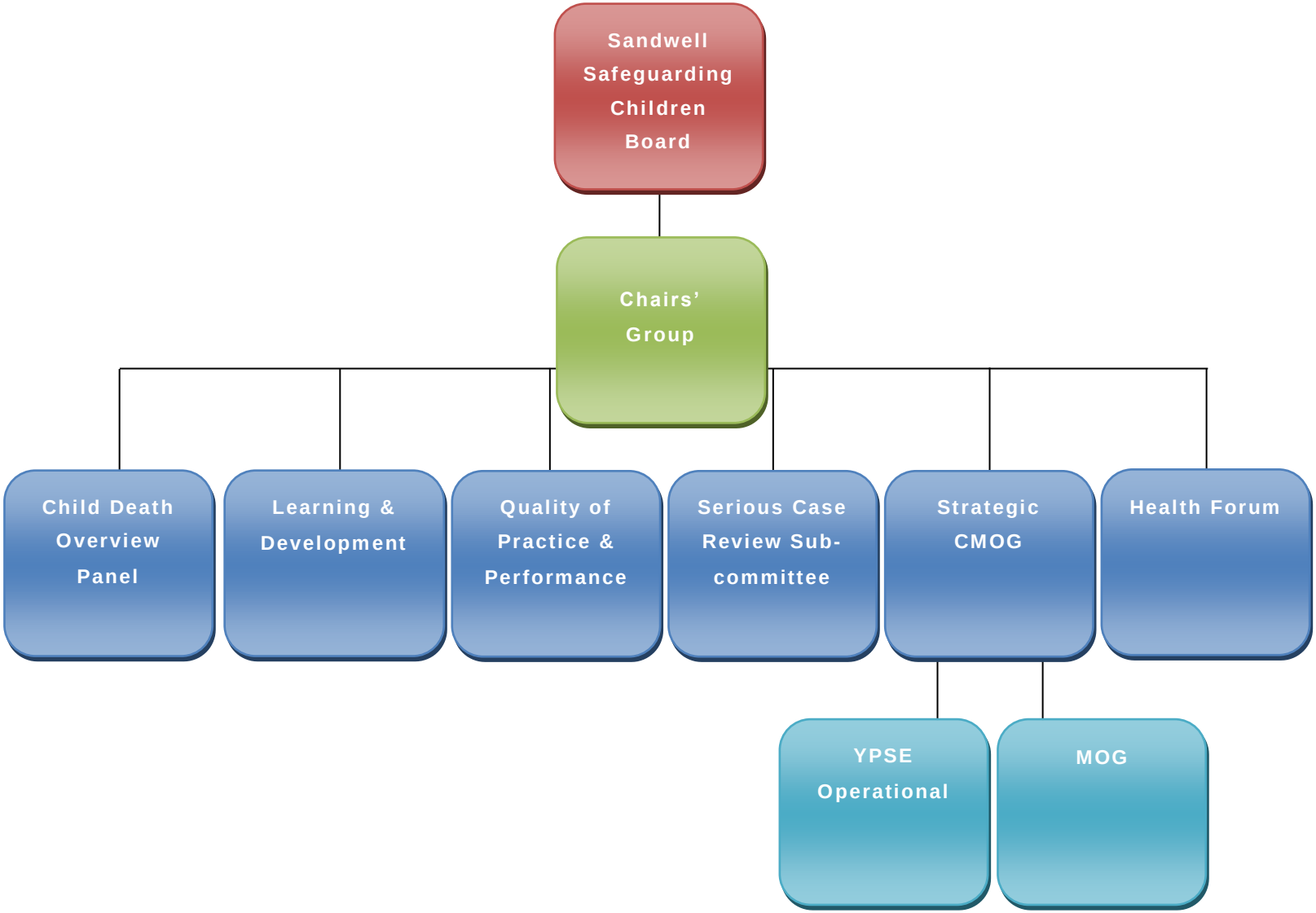
1.110 Third sector organisations in Sandwell make an important contribution to safeguarding in Sandwell. As well as there being VCS representation on the Board itself (from Black Country Women's Aid, Barnardos and Krunch), there is involvement in board sub-groups as active members although this is an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

1.111 An overview of the contributions from Barnardos is provided below.

Barnardos

- During the reporting period Barnardo's delivered Black Country BASE (Barnardo's Against Sexual Exploitation), Sandwell ABC (Awards in the Black Country play scheme) and Black Country Families Matter.
- Sandwell ABC delivered a holiday play scheme on behalf of the borough for children with mild to moderate Disabilities
- 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.
- Since January 2017 the Black Country Families Matter - funded by Big Lottery - provides additional support to families with an aim to increase employment, education and training for parents. This approach is designed to offer a level of outreach, engagement and support to families to reduce the barriers to employment/training such as mental health, child care and self-esteem. 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.
- Additionally, Barnardo's delivers the West Midlands Panel for the Protection of Trafficked children, offering consultation, advice and direct work into Children's Services across the Borough, as well as Prion Family Services for the Midlands on behalf of HMPPS. This prison located service is supported by outreach training and strategic work into Local Authorities around children affected by parental imprisonment and offending.

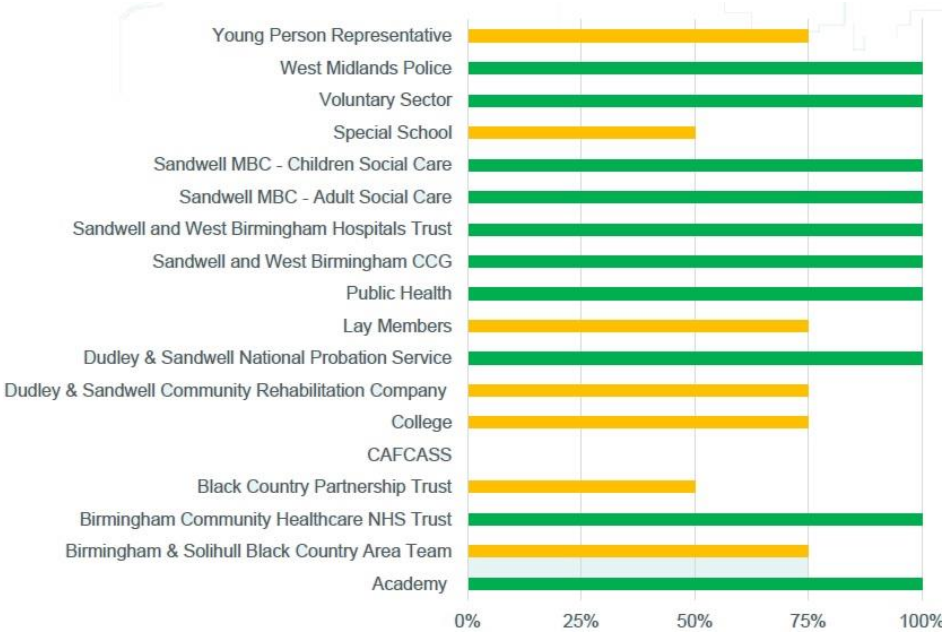
Appendix 2: 2016-2017 SSCB Structure



Appendix 3: Board attendance and financial arrangements

1.1 During 2016/17 there were four main board meetings (in May, July, October and February 2017), and five meetings of the subgroup Chairs. The main board had a membership made up of representatives from all statutory partners and others concerned with safeguarding children. Following the LGA Peer Review a business planning session was also held. The Local Authority, CCG and Police were always represented.

1.2 The Board have not benefitted from the input of a Primary School Representative during 2016-17 (although Primary Schools are represented on the Board's Education Advisory Refence Group). This will be addressed during 2017-18 along with clarification over the attendance of CAFCASS who did not attend during the year.



1.3 Partner agencies continued to contribute to the SSCB's budget for 2016/17, in addition to providing a variety of resources, such as staff time for training. Contributions totalled £376,842

Funding Source	Budget (£)
Sandwell Council	220,500
Sandwell and West Birmingham CCG	136,485
West Midlands Police	16,307
Community Rehabilitation Company	1500
National Probation Service	1500
CAFCASS	550
Total	£376, 842

1.4 From April 2016 charges were made for non-attendance at training events. This culminated in £5,490 worth of income to SSCB during the reporting period. It is anticipated that a regional safeguarding procedures project, involving ten Local Authority areas, will deliver cost savings during 2017/18.

Appendix 4: Jargon Buster

CAMHS	Child and Adolescent Mental Health Services
CDOP	Child Death Overview Panel
CCG	Clinical Commissioning Group
CFBE	Community Faith Based Establishment
CIN	Children in Need
CP	Child Protection
CPP	Child Protection Plan
CRC	Community Rehabilitation Company
CSE	Child Sexual Exploitation
DAAs	Domestic Abuse Advocates
DASP	Domestic Abuse Strategic Partnership
DHR	Domestic Homicide Review
DVA	Domestic Violence and Abuse
EHE	Elective Home Education
FGM	Female Genital Mutilation
LSCB	Local Safeguarding Children Board
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multiagency Safeguarding Hub
MBC	Metropolitan Borough Council
MOG	Missing Operational Group
POT	Position of Trust
PPU	Public Protection Unit
SCR	Serious Case Review
SMBC	Sandwell Metropolitan Borough Council
SSCB	Sandwell Safeguarding Children Board
SWM	Staffordshire and West Midlands
WRAP	Workshop to Raise Awareness of Prevent
YPSEM	Young People at Risk of Sexual Exploitation