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Sandwell Safeguarding Children Board (SSCB)

Sandwell Safeguarding Children Board

Annual Report 2017-2018

Document Control

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Author (s)	Raj Bector, Holly Bramley, Jaki Bateman
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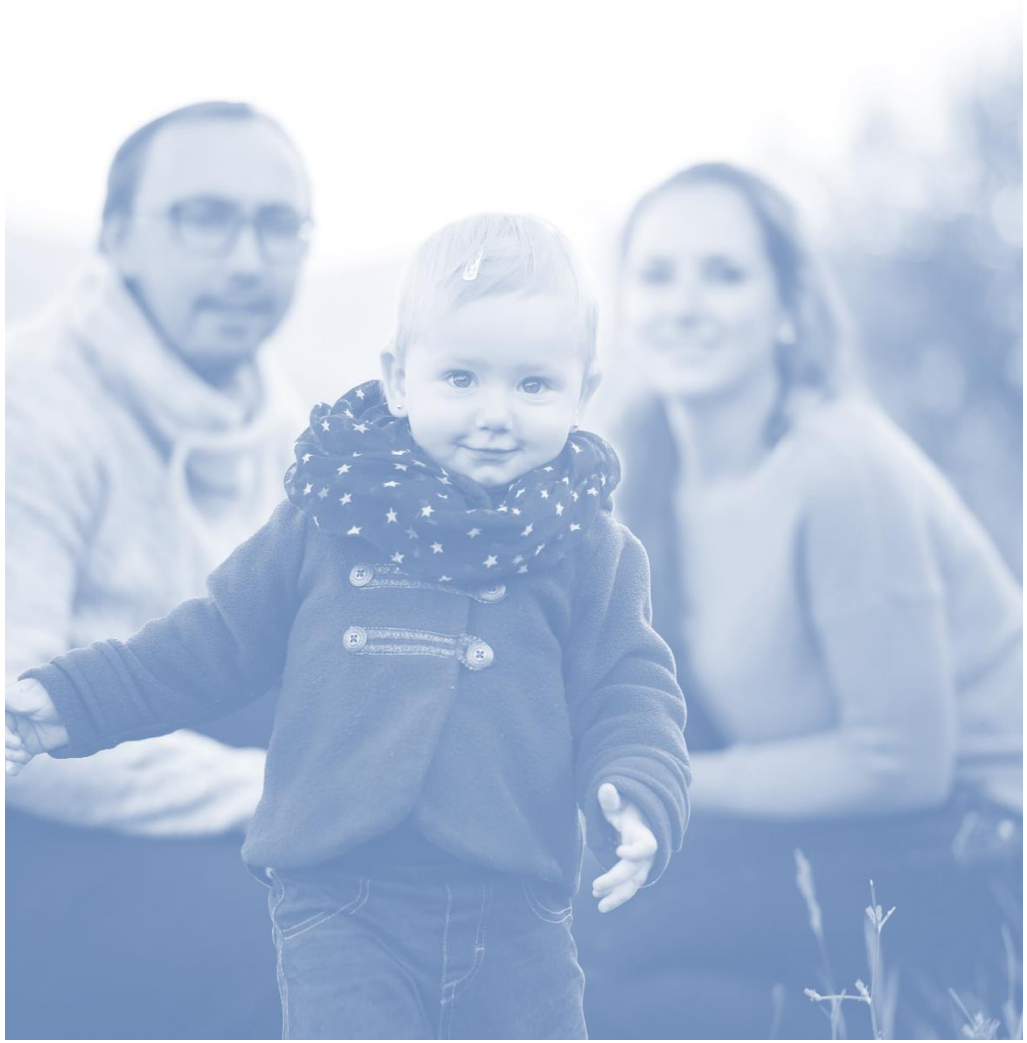
March 2018	Raj Bector	1	Initial version drafted
June 2018	Holly Bramley	2	Additional information provided by partners. Report further refined.
August 2018	Holly Bramley/Jaki Bateman	3	Report restructured and refined.
November 2018	Holly Bramley	4	Additional impact information provided by partners.

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 2018.

This report sets out areas we have worked on to safeguard children and young people during 2017-18 whilst also identifying the improvements that we must address to ensure Sandwell is a good and safe place for children to live and grow up in.

This has been a challenging year for the partnership in Sandwell. The Ofsted inspection which took place in November last year judged children's services to be inadequate and that Sandwell children were not being served well. The full report can be found here. Inspectors noted that the first point of contact for children, the Multi-Agency Safeguarding Hub (MASH), was a strength in Sandwell and risk assessment was robust. However, longer term support was not consistent, assessments of children's needs required improvement and should include children's wishes and feelings. Partner agencies must work together to improve and strengthen their work with families to ensure that clear and strong plans are in place to meet the needs of individual children.

Such work is not without challenge however and you will see in the report that demand for services, particularly childrens social care services has increased significantly. As we continue to improve and strengthen early help services some high-level intervention may not be required in the future. At the same time Sandwell also reflects the national picture of increasing numbers of children referred to children's social care services and more families requiring support at a time of austerity and decreasing resources. Sandwell has a growing young population and while this annual report demonstrates the commitment of all agencies and the hard work undertaken during the last twelve month this context must be recognised.

The partnership has experienced significant change in the last twelve months particularly as a new organisation, Sandwell Childrens Trust, was being established. Childrens services moved from the local authority to Sandwell Childrens Trust alongside a change of senior leadership to take the new organisation forward. Sandwell children's services have experienced a turnover of managers at all levels for a considerable period of time. This has made it difficult to establish strong and consistent relationships across the partnership, critical to good services. I am pleased that there is now a stable leadership team in place within the Childrens Trust and that the transition has been very positive. Good work is currently being undertaken to develop a strong and stable workforce.

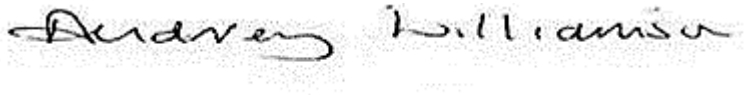
This year the partnership is focussing on the improvements needed to strengthen services. We have renewed our focus on child sexual exploitation, recognising the work required in this area. Alongside this we are improving our understanding of the broader area of child exploitation including criminal exploitation, known as "contextual safeguarding". This is an emerging issue concerning children who may be targeted outside the family by, for example gangs supplying drugs outside the local area. Nationally there is a growing understanding of the potential risks to vulnerable young people posed by such gangs. In Sandwell all key partners are committed to prioritising this area. Good collaboration is required to meet the challenge of this issue.

This coming year new multi-agency safeguarding arrangements will be put in place in Sandwell in line with government requirements. Locally the

three key partners; the local authority, the police and health through the clinical commissioning group, and in partnership with the new Childrens Trust will be leading and working towards implementing the new arrangements. This will offer a real opportunity to review and strengthen our current work and the establishment of the Trust is a good time to make the changes.

Looking forward there is no doubt that partners are committed to improving services to meet the needs of vulnerable children and young people. This needs to be translated into good and excellent services for children in Sandwell which have a positive impact. We need more good examples of how we make a difference in our work such as the good practice highlighted by children's services when protecting a 17 year old young person at risk of sexual exploitation. We also need to listen carefully to what children and young people are telling us.

Finally 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.



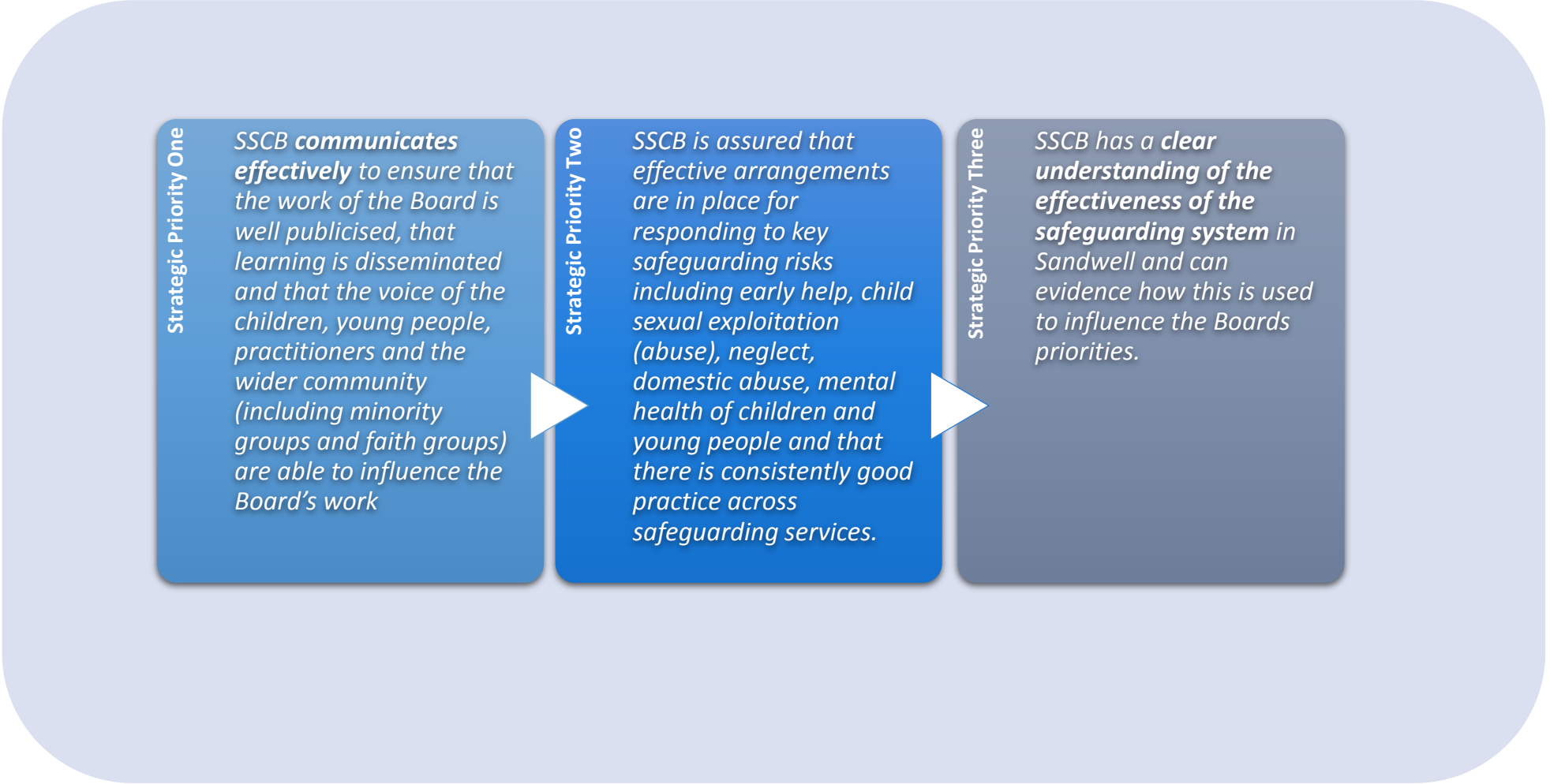
Audrey Williamson
SSCB Independent Chair

2. About the Annual Report

Local Safeguarding Children Board's (LSCB) are required to produce and publish an Annual Report on the effectiveness of safeguarding in the local area; monitoring and evaluating the local impact of safeguarding arrangements, as detailed in Working Together (2015).

This report for Sandwell Safeguarding Children Board (SSCB) covers the reporting period between April 2017 and March 2018. The report evaluates the work and impact of the Board relating to its identified priority areas and highlights the progress made by the partnership over the last year and the challenges going forward.

SSCB 2017/18 Priorities



3. 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

4. About Sandwell

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.

It is a Borough that faces significant challenges. Sandwell has high and widespread deprivation with increasing demands for council services. The Council has faced some difficult issues including significant change to the leadership team, continued austerity and protracted standards cases. The Council acknowledges that Children's social care services have been inadequate for far too long, with insufficient improvement. Despite this context there is an optimism that 2018-19 provides an opportunity for the Council to make progress and move forward, improve its reputation and build on its strengths and successes.

The Council has established a strong vision for the future of the Borough. This is articulated through the recently developed *'Vision 2030'*. There are good levels of awareness across the organisation and amongst external partners of the Vision which sets out ten strategic outcomes for the borough. There is now a need to ensure 'Vision 2030' drives and determines the Council's future role and purpose - as well as prioritisation, resource allocation and performance management - to improve outcomes for Sandwell's towns and communities. The Council now needs to progress the thinking, planning and practice at pace with partners in order to capitalise on the awareness, enthusiasm and high expectations it has generated through the stakeholder engagement undertaken to shape the Vision and ambitions.

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.

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.

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.

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

Safeguarding in context

79,853

children and young people under the age of 18 live in Sandwell. This is 25% of the total population in the area

122 children identified being at risk of CSE as at March 2018

187 incidents of children going missing from care (involving a total of 92 children)

Approximately **30%**

of the local authority's children are living in poverty

1973 Children in Need

246 children in need with a disability

5,244

DVA cases of families with children screened by the MASHDA team

747 children live in a 'high risk' of DVA household

6336 referrals to CSC

136 first time entrants to the YOS

154 YOS reoffenders

202 YP in custody

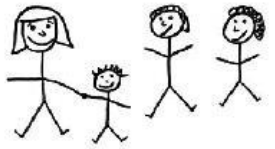
21%

of primary & secondary children in receipt of free school meals (compared with 15% and 13% nationally)

1938 children on an ECHP

832 children on CP plan as at March 2018

765 children looked after as of March 2018

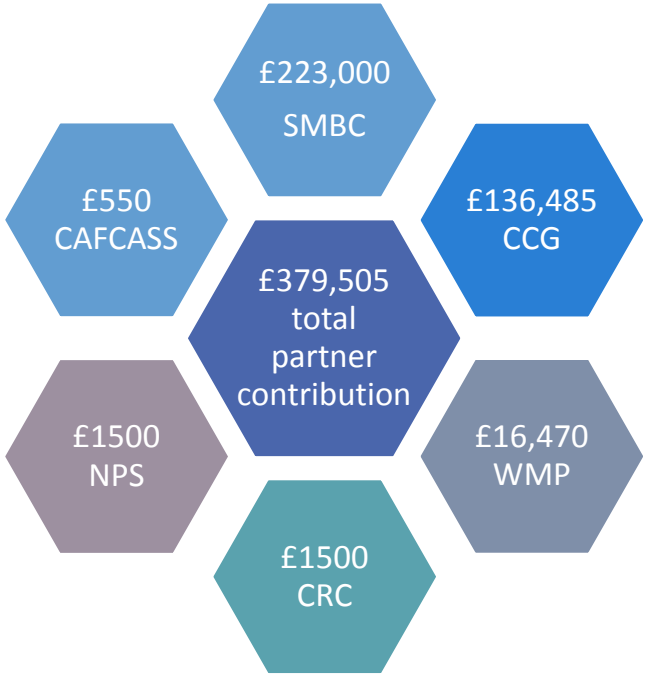


5. Board Finances and Meeting Attendance

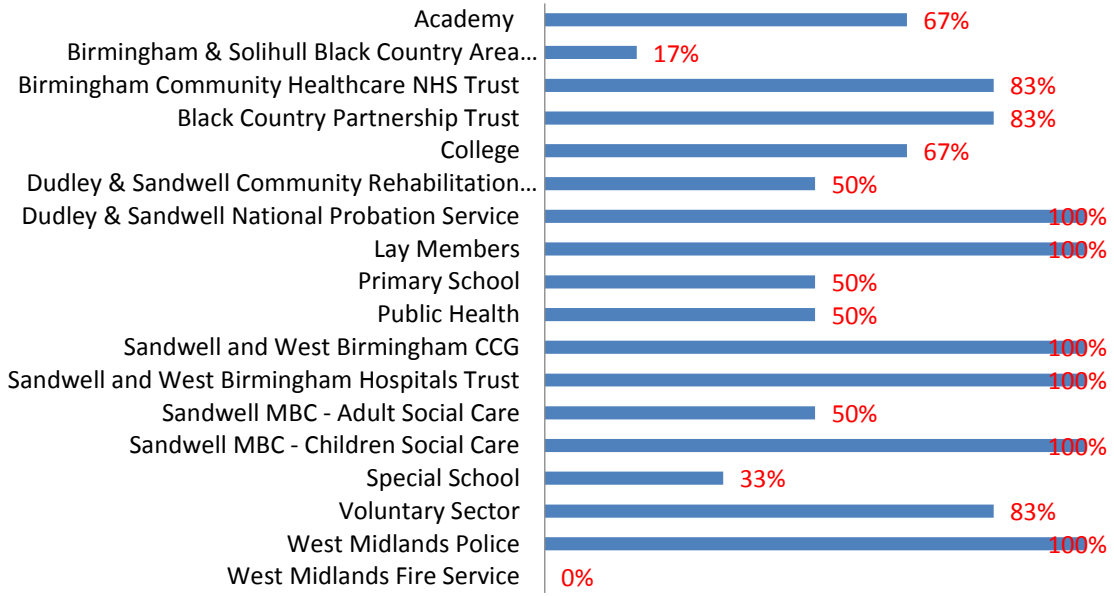
Having the right finances and resources is key for the partnerships success to meet its statutory obligations and have an impact on the delivery of Sandwell's children's safeguarding arrangements.

SSCB requires an annual budget to include the cost of training and development on a multi-agency basis and to enable it to carry out its agreed business plan objectives, which also includes the cost of Serious Case Reviews and other learning where necessary.

The 2017/18 budget is broken down by partner agency below:



2017/18 Attendance across six Board meetings

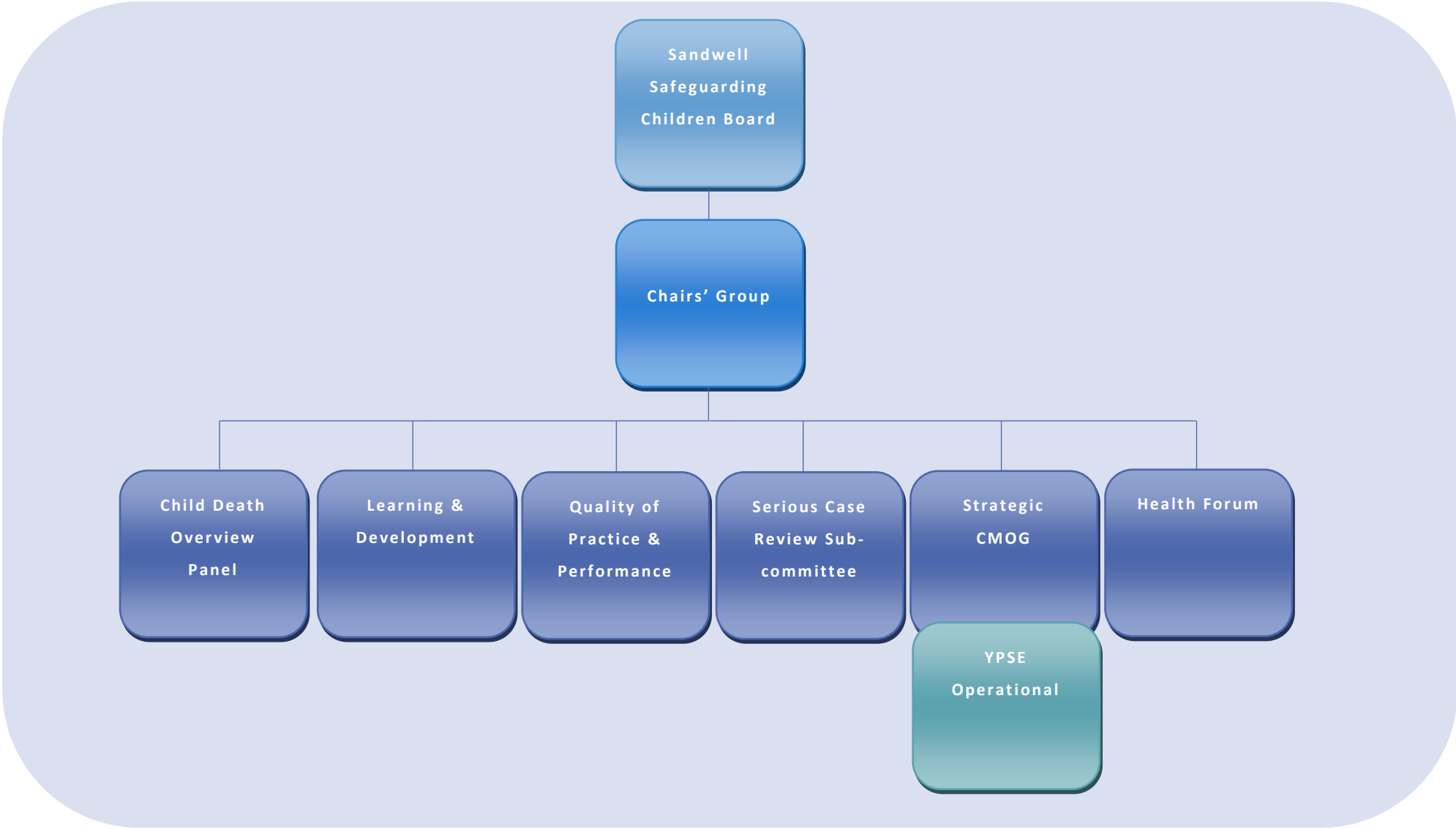


During 2017/18 there were five main board meetings (in May, July, September, December and March 2018), and an SCR-themed Board meeting in January 2018. These were supplemented with five meetings of the subgroup Chairs. The Board also undertook two development sessions (in July 2017 and February 2018).

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.

As detailed in the 2016/17 annual report, the Board now benefits from the input of a Primary School Representative. A decision was also made during the year that CAFCASS and WMFS would be invited to attend when required.

Board Structure



6. 2017 – 18 At a Glance

April 2017
Fourth SMBC Children's Social Care OFSTED monitoring visit: overall OFSTED indicated that progress remained too slow

June 2017
In response to the need to tackle CSE on a local and national level, the CCG has worked in partnership with The Children's Society and NHS England to develop the CSE Superhero Campaign

September 2017
Safer Sandwell Partnership Launch of the New Domestic Violence Perpetrator Programme

October 2017
SSCB launches new learning management system for booking and evaluation of training
SSCB launches updated multi-agency threshold/level of need document

December 2017
OFSTED Inspection begins

Children & Families Service Conference held, Getting to good: making a difference

Sandwell Safeguarding Children Board: HS Serious Case Review Learning Event

January 2018
Ofsted report published Children's services in Sandwell are judged inadequate.

March 2018
HMICFSR PEEL: Police effectiveness2017
An inspection of West Midlands Police March 2018
WMP police judged as requires improvement

7. Sandwell Children's Services Improvement Journey

Following several monitoring visits in November 2017 Ofsted carried out a single inspection of Sandwell's safeguarding arrangements.
The Ofsted inspection report was published in January 2018, Ofsted's judgement was that Sandwell Children's Services are inadequate.

Recommendations
The inspection report made 17 recommendations for CSC, ten of these recommendations were repeated from the 2015 ofsted inspection.
A link to the full Ofsted report can be found here.

Governance & Accountability Arrangements
Ofsted's re-inspection of services identified a number of areas that required urgent action to ensure that services for children improve. Sandwell LSCB needs to play a full role in ensuring that these improvements are implemented. We recognise that no single agency can achieve this on its own and the partnership as a whole must take responsibility to provide improved services to children.

This was recognised further in a Development Session in February 2018, where the Board looked at how the Ofsted findings mirrored the learning identified through audits, reviews and feedback from training.

Ofsted Findings	SSCB
For some children, the response to neglect is not timely	The neglect audit found a lack of purposeful work by managers in directing cases where there was evidence of drift and delay
Professionals sometimes have an over-optimistic view of parents' ability to change, and decisions are not taken soon enough to prevent further harm.	HS SCR identified that some professionals were over optimistic about the parenting ability of mum and dad
Referral information from other agencies is not always clear and sufficiently detailed	HS SCR reports that information sharing was at times poor and resulted in some professionals being unaware of the key issues

Discussions held about how to support with these recommendations will be captured in the 18/19 Board priorities.

During the reporting period work around the new Children's Trust, known as Sandwell Children's Trust, reached its peak in advance of the 'go live' date of 1 April 2018 with negotiations taking place on the contract that will govern the relationship between the Council and the Trust.

Whilst the Trust will be operationally independent from the Council in legal terms, it - and children and families in the Borough - will still be dependent upon services that will continue to be provided by the Council. Some of these services directly relate to children - children's centres, special educational needs services etc. - and some are support services, which the Council will continue to provide for the Trust under Service Level Agreements (SLAs) for things like legal services, payroll, insurance etc.

During the reporting period, the Trust made several appointments to its Executive Board as well as to the role of the Chief Executive.

The Board is well-positioned to support the Trust as it starts its journey to better safeguard Sandwell's children.

8. Summary of performance against strategic priorities

Strategic Priority One	*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*

Work Completed: There has continued to be a concerted effort during the year to ensure that the work of the Board was well publicised.

- SSCB newsletters were produced 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 supplemented by '7-minute briefings' for multiagency audits undertaken during the year
- During the year the Board improved engagement with faith, culture and emerging communities. In parallel to hosting a safeguarding event aimed solely at Sandwell's faith communities, the Board also developed a Community Engagement Group (CEG) with membership drawn from Sandwell's faith communities supported and key personnel from the multiagency partnership
- Partners will need to give consideration to the membership and organisational structure to take into account the Children and Social Work Act 2017 which sets out future arrangements for safeguarding children within localities.

Strategic Priority Two	*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

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 the Young People Sexually Exploited (YPSE) Group. Strategic CMOG group are provided with updates from YPSE 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.

Key activity during the year	Areas that worked well	Key focus for 18/19
• Training has been undertaken with CSC staff and key partners • Use of new FIB intelligence form (amended and extended version) • Changes in staffing and increase in County Lines referrals • CSE Development Plan in progress • Appointment of New Group Head and Operations Manager • Rise in referrals screened for YP who are at risk of, or who are experiencing criminal exploitation through association or involvement with gang and county lines	• Health professionals increased attendance at MASE meetings • Completion of NRM's and Conclusive Grounds being granted • Attendance at MASE – Parent, Child and agencies are well engaged in the process • YP engaging in prevention work 1-1 and agreeing to take part in 'informal interviews with Police' in order to gather intelligence – aiding pursue and disruption of offending activity • Early identification and support for children who are starting to go missing frequently via Barnardo's Missing Pilot and engagement with Early Help and Targeted Services • Measuring the impact of intervention and outcomes for YP involved in all areas of exploitation	• Strategic CMOG meetings to regularly take place to ensure timely response and interventions take place to CSE and missing incidents. • Strategic CMOG will continue to ensure that the Child Sexual Exploitation (CSE) strategy is embedded and that partners work collaboratively to address CSE across the Sandwell footprint. • Awareness raising work to continue with taxi drivers and the local landlords' association. This work will be further extended to include hotel staff and staff working in educational settings • Ensure the 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.

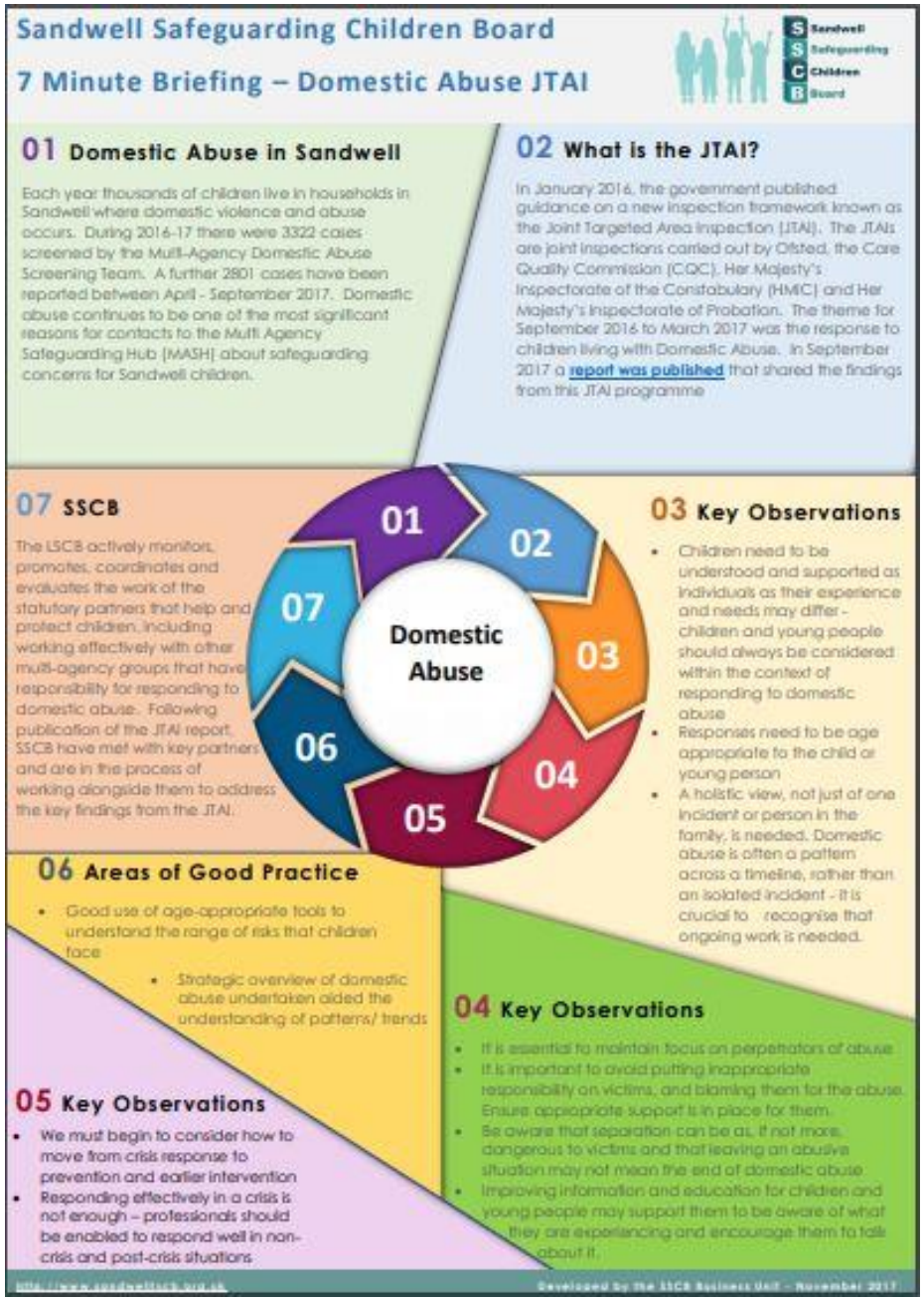
2017/18 Missing Information

	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18
Total no. of children at risk of CSE as at end of Quarter	136	149	193	122
Number of children assessed as "serious risk" of CSE during the quarter	1	1	9	4
Number of children assessed as "significant risk" of CSE during the quarter	26	9	43	33
Number of children assessed as "at risk" of CSE during the quarter	19	20	120	51
Number of children with identified risk factors or vulnerabilities who are awaiting a CSE risk assessment and classification	13	10	24	34
How many children have had a reduction in their risk level?	24	39	38	24

Domestic Abuse

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. Each year, thousands of children live in households in Sandwell where domestic violence and abuse (DVA) occurs. DASP has sought to increase reporting of DVA, so that victims and their children can access the support they need at the earliest opportunity in order to prevent further harm and reduce the risk of homicide.

Key activity during the year	Area's that worked well	Key focus for 18/19
• National and local IRIS (Identification and Referral to Improve Safety) evaluations found the programme has been invaluable in training GPs and other primary care staff to recognise DA 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. • A&E advocacy pilot has continued into its second and final year showing a significant reduction in attendance at A&E by victims following intervention from MARAC agencies • 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 policy also details action professionals should take to safeguard girls and women who they believe may be at risk or have already undergone FGM. The link to the document is here.	• The Sandwell Stopping FGM forum has active involvement from a wide range of community groups. These developments culminated in a Health and Wellbeing event in July, supported by numerous partners, providing an ideal opportunity to raise awareness of FGM and community support which was available. This event was attended by approximately 150 people • Victims (and their children) discussed at 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	• 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 • Offender Managers to be invited to core groups to ensure there is an appropriate focus and accountability placed on the perpetrator for the domestic abuse • The SSCB escalation policy to be used and / or use of the Independent Reviewing Officer in cases of drift and delay • The directory of resources for therapeutic services to be shared by emotional health and mental health group • A specialist therapeutic service to be commissioned for children who are witness of or a victim of domestic abuse



In September 2017, the government published a report on the findings from Joint Targeted Area Inspections (JTAI) of organisations' response to children living with domestic abuse. Following this, work was undertaken in Sandwell by a multi-agency task and finish group to review Sandwell's response against the JTAI report recommendations. This identified positive work being undertaken and also identified further work to be done, which will be overseen by the Domestic Abuse Strategic Partnership. The adjacent 7-minute briefing was produced which can be also found at: Joint Targeted Area Inspection (JTAI); Sandwell LSCB

Early Help

Sandwell's 2017-19 Early Help strategy is centred on building the capacity and resilience of the community and voluntary sector. This will be done by information sharing, training, signposting, representation at relevant boards and strategic meetings. The project also aims to effectively build stronger local infrastructure within neighbourhoods as well as developing an understanding of current delivery. It also aims to provide support in terms of capacity, ability and standard of provision.

Key activity during the year	Areas that worked well	Key focus for 18/19
• 77 frontline practitioners drawn from across the public and voluntary sectors in Sandwell gathered on Wednesday 28 February 2018 to launch the new partnership initiative aimed at improving access to support for local children, young people and families. • Mark Davis, SCVO's Chief Executive, launched a new online portal which providers of family support can use to advertise their services • The Sandwell Early Help Partnership is the culmination of many months of discussions between schools, health agencies, Sandwell Council, the police, fire and the voluntary sector. Discussions have focused on how to ensure families can find the support they need to improve their health, happiness and wellbeing and to address at the earliest stages challenges that growing up and family life can bring	• The VCS strategic lead has engaged with a wide range of agencies but especially those VCS organisations that are purely volunteer led so that an understanding of safeguarding procedures, effective signposting information, guidance and support can be given. This enables organisations to be confident in raising concerns when necessary.	• The Early Help partnership membership has been growing and current partner organisations have received a certificate stating that they are an Early Help partner organisation. A wide variety of bronze, silver and gold members that have engaged and signed up from schools, VCS, health and the Police. In order for the Early Help partnership to grow, further funding will need to be secured to enable capacity to be built so that more information of Early Help services can be gained; to provide network and training opportunities; as well as enabling the partnership to influence and shape the Early Help offer and processes across Sandwell. • VCS strategic lead, in partnership with SCVO, will develop and chair an Early Help Partnership board. The aim of the board would be to ensure that the Early Help Strategy is being implemented across all agencies as well as delivering against set targets • Development of the EH portal is ongoing to promote an awareness of local services across all agencies and the delivery of Early Help among children and their families

Strategic Priority Three	*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.*

Work Completed: Quality of Practice & Performance

Multi-agency case file audits are led by the Quality of Practice & Performance (QPP) Subgroup. The multi-agency audits scrutinise areas of practice or are thematic. During the year a total of three multiagency audits were undertaken in relation to neglect; children with disabilities and domestic abuse. In addition, a desktop exercise in respect of physical abuse was also undertaken. The audit reports are taken to the main board to enable challenge to be put in place.

The QPP Subgroup lead Section 11 audits and all partner agencies were asked to complete their respective audits during the reporting period. The S11 audit activity culminated in a successful challenge session in March 2018 when agencies were partnered up to undertake a peer challenge of each other's audit submission, facilitated by a member of the QPP Subgroup.

Performance reports are routinely presented to the Board supplemented by comprehensive performance data. During the year there was a conscious decision to focus the performance reports on specific assurance questions in order for focussed discussions to take place at Board.

The *Subgroup Activity, Scrutinising the effectiveness of safeguarding children section* below sets out further work undertaken during the year in addressing this strategic priority.

9. Subgroup Activity, Learning and Improvement

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"*

Child Death Overview Panel (CDOP)

An underlying principle of Child Death Overviews is to undertake a comprehensive and multi-disciplinary paper-based review of all child deaths up to the age of 18 years (excluding babies who are stillborn and planned terminations of pregnancy carried out within the law) normally resident in the Local Safeguarding Children Board's area. This is known as the Child Death Review Process. 2017-2018 was the tenth year of this data collection

During the reporting period CDOP met a total of 8 times and reviewed 38 deaths.

Key activity during the year	Areas that worked well	Key focus for 18/19
• In the year ending 31st March 2018 there were a total of 36 reported child deaths in Sandwell. Of these, 6 were deemed unexpected. Working Together 2015, Chapter 5 guidance gives the definition of an unexpected child death as: 'the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death' • Five of the unexpected deaths that occurred in the 0-1 year age group were all safer sleeping infant deaths • Of the 36 deaths reported in 2017-18, 18 were male and 17 were female. It was not possible to determine the gender on one death due to abnormalities.	• Following on from the Baby Box initiative, there were 371 new registrations from Jan 2018 – March 2018, where 47% of this total were first time parents. • Members from Sandwell CDOP supported a highly successful Conference in March 2018, *'Learning from Child Deaths'* with presentations around the new child death review guidance, an overview of the coroners processes locally and nationally and research on SUDI investigations. Two parents of bereaved children also recounted their story before delegates were asked to complete a table top activity • A new resource was developed in 2017-2018 to support with the safer sleeping campaign. *'Please Don't Fall Asleep with Me!'* tackles	• The Board will consider the findings from Safer Sleeping Awareness: Sandwell CDOP will be delivering joint training with the Lullaby Trust to frontline practitioners using anonymised case studies to support with the safer sleeping message • Joint Sandwell and Dudley CDOP arrangements: Arrangements are being put in place to support the new legislation and guidance around the number of child deaths needed to be reviewed on an annual basis. This means combining Sandwell and Dudley together to ensure an average of 60 deaths will be reviewed. • Sandwell Public Health will be working with CDOP on a number of initiatives during 2017 - 2018 around healthy pregnancies and childhood, and will provide regular

• 38 deaths were reviewed by the panel for deaths from 2015-2018 • In 10 of the deaths reviewed between 1 April 2017 and 31 March 2018 modifiable factors were identified by panel members. These factors included maternal smoking as well as smoking in the household, domestic abuse, unsafe sleeping practices, neglectful home conditions, disguised compliance and alcohol misuse. The learning from these deaths was disseminated in a variety of ways by short report briefings and bespoke training to frontline practitioners	the dangers of co-sleeping and sleeping on the sofa in conjunction with advice from the Lullaby Trust through the Dog Duck and Cat books  • The Dog, Duck and Cat (DDC) resources, brand and copyright, have now been moved from Sandwell MBC, and a charity created, The Dog, Duck and Cat Trust. The following are initial plans for the charity: ○ Secure funding ○ Develop fund raising opportunities ○ Develop new resources –looking at mental health, emotional well-being, bereavement, loss, domestic abuse, appropriate peer relationships, culture and diversity and 'how to' guides for parents to use with their children who are under 5 ○ Respond to need - The Trust will continue to provide resources to support the findings of CDOP	updates to the Panel members. Updates include: ○ The 'My Pregnancy Magazine' will be updated to include information on lifestyles and safer sleeping including the image which is currently on the bags given to new parents. The magazine will be distributed to all women during their booking appointment with their midwife. A new magazine for new parents covering the first two years is being developed and will be distributed to all new parents via the new born visit. ○ Concepts are currently being tested with pregnant women and midwives, with the aim of launching a new campaign ○ A literature review is currently being undertaken within Public Health with regards to SIDS, when completed a meeting with key stakeholders will be held to consider campaigns ○ Public Health will continue to work in conjunction with CDOP to ensure highlighted concerns are addresses on a wider scale

Learning and Development (L&D) Subgroup

During the reporting period, the L&D Sub group met ten times inclusive of three course review focus meetings. Reflecting on feedback from delegates, trainers, quality assessment through observations and changes to policy, practice and guidance the following training courses have been updated; Core working Together level three Safeguarding Children & Young People, Multi-agency Thresholds, and Serious Case Review Training.

During the 2017/ 18 training catalogue 1927 spaces were offered across 84 courses covering 12 topics. 1574 bookings were made, 1370 delegates attended training, 172 DNA's generated a potential income of £5160.

Key activity during the year	Areas that worked well	Key focus for 18/19
• Three new bitesize workshops have been launched as short training sessions to give an overview on specific topics; Trafficking and Modern-Day Slavery, Listening to the Voice of the child – dealing with disclosures and Child Sexual Exploitation and Missing • Training needs analysis (TNA) across all board partners conducted in August 2017 has informed the 2018/19 training catalogue TNA report is available on request • Sandwell exited the Black Country training project following consideration of key challenges faced when trying to establish regional arrangements • SSCB launched a new learning management system on 1 October 2017. The new system enables delegates to make bookings on courses, to complete post training evaluations immediately following the event and three months following to assess the impact of the training. • L&D Sub Group member Louise Harris volunteered to take over the role of Training Pool Chair. Louise has an L&D background and is going	• 2018 – 19 training catalogue launched in March 2018, this year the combined catalogue is inclusive of training provided by SSAB, SSCB, DASP and Safer Sandwell Partnership. The project was led by SSCB with the catalogue being designed and co-ordinated by the SSCB L&D co-ordinator • Quality assurance of training, combined with delegate feedback has led to course being updated/refreshed • Dedicated members of the training pool have offered the full training catalogue with positive feedback being received • Income generated through non-attendance charging funded seven members of the training pool to complete their Level 3 Award in Education and Training • Following feedback from delegates a level 2 neglect training course has been developed to provide more in-depth knowledge on the subject, this training was first offered in December 2017, feedback was positive with requests for the session to be a full day	• Work on impact evaluations needs to be the focus of the L&D sub group, an increase in the number of those who respond and the quality of the information received needs to improve if the impact is going to be assessed and reviewed • Sandwell has put together a proposal to re-establish joint training arrangements with Dudley; this should support Sandwell to deliver on some of the TNA requests made by partners • Following retirement of two of our main multi agency partners who deliver training a recruitment drive to increase capacity of the training pool will be in progressed Summer 2018 • New courses requested in the TNA that have been identified by the sub group as being a gap in the training offer will be commissioned

to drive forward the quality assurance of training and trainers. Offering one to one mentoring opportunities in addition to the regular training pool support meetings.	course not half day, this is currently being reviewed by the L&D group. • Work has started on assessing impact of training in following several different processes: ○ Online via the learning management system ○ In person; early years services and foster carers are being contacted in person via L&D sub group links	

Serious Case Review Subcommittee

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

During the reporting period, the SCR Subcommittee met seven times inclusive of two extra-ordinary meeting 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, the website and newsletters. The SCR subcommittee had a change of Chair in December 2017.

Key activity during the year	Areas that worked well	Key focus for 18/19
• Two serious case reviews were concluded in September and January. Both are subject to criminal proceedings and so will not be published until these are concluded. • A proportionate serious case review concerning a young person was finalised during this period and discussions are being held about the impact	• Learning notes were written and disseminated highlighting the following themes: • Consistent application of thresholds • Recognition, recording and monitoring of Neglect • Poor information sharing • Recording the voice of the child	• The Board will consider the findings from the SCR 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.

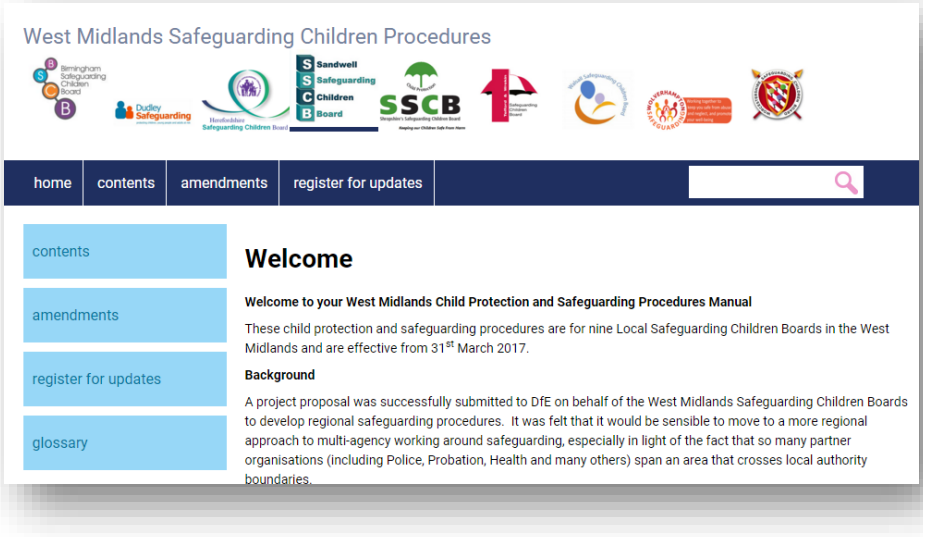
publishing this could have on the wellbeing of the young person concerned. • One SCR commenced in November 2017 following a child death. This is due to be concluded in June 2018 and learning disseminated widely to partner agencies • Eight Significant Incidents were reported resulting in one SCR, one Table Top Review, one in depth Child Death Review and four which did not meet the threshold for a multi-agency style review.	• Recognising, planning and understanding of Risk • Identification of CSE • Disguised compliance • Professional curiosity • Multi-agency attendance at meetings has meant robust discussions and challenge have led to clear decisions and actions • Learning from Serious Case Reviews has included local and regional cases.	• The subcommittee will consider the effects of legislative changes as a result of Working Together 2018 and manage any transitional arrangements to ensure incidents are consistently reviewed and assessed. • Briefing staff on the lessons learned from SCR's will continue to be a key activity in the coming year and work is in progress to develop the website to incorporate better information

Policy & Procedures

The first year of the West Midlands Regional Safeguarding Procedures Project was a success, achieving policy consistency across the participating LSCBs and economies of scale.

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.

The Regional Safeguarding Procedures Group (RSPG) continued to meet regularly during the reporting period. RSPG has a rolling programme in place to refresh and update the West Midlands procedures.



Subgroup Activity, Scrutinising the effectiveness of safeguarding children

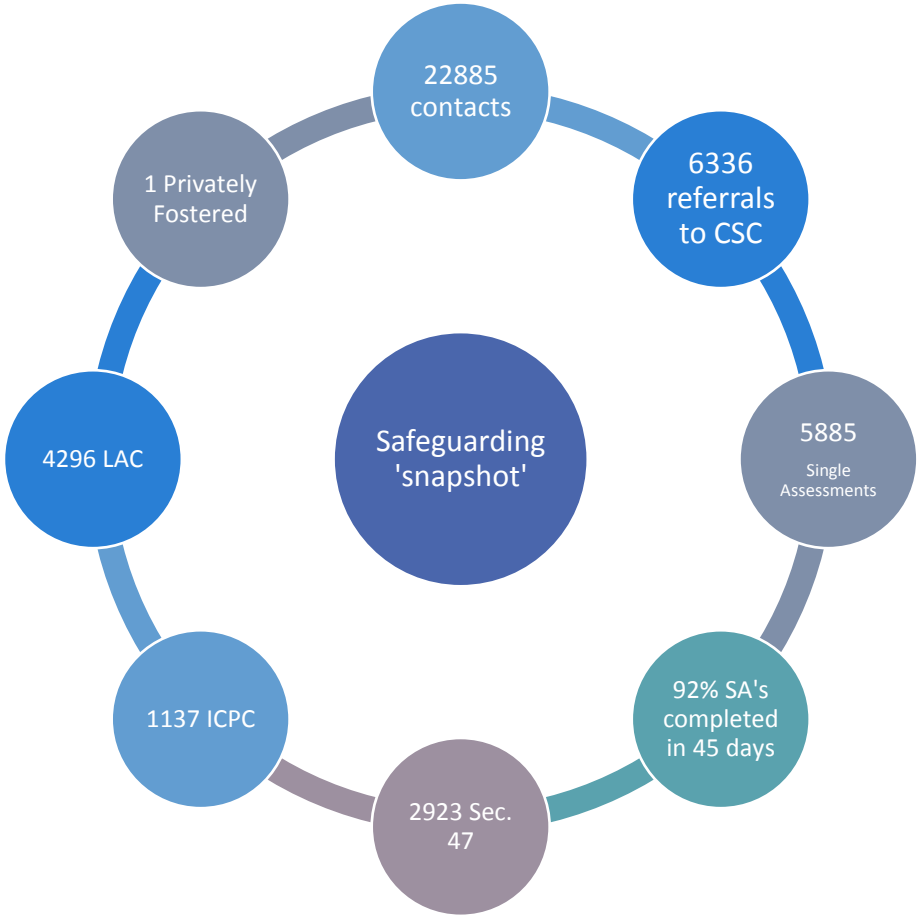
During the reporting period the Quality of Practice and Performance (QPP) sub group met a total of 7 times; May, July (annual review day), August, September, and November 2017, January and February 2018.

Key activity during the year	Areas that worked well	Key focus for 18/19
• Six 'Walk the Floor' visits took place by board members during January – March 2018, these were: - 31/1/2018 – WMFS visit The Priory Primary - 7/2/2018 – Sandwell and West Birmingham Hospitals visit Barnardos - 14/2/2018 – Barnardo's visit Q3 Academy - 12/3/2018 – The Meadows School visit West Midlands Police - 14/3/2018 – CCG visit Housing - 21/3/2018 – BCHC visit West Midlands Fire Service • Three multi-agency audits took place on Neglect (June 2017); Children with Disabilities (October 2017) and Domestic Abuse (February 2018). • 2017/18 Section 175/157 audit was launched across the education sector in September 2017, at the time of writing 93% are completed • A challenge session took place for the biennial Section 11 Audit in 20 March 2018 allowing agencies to scrutinise partnership information. Board members were paired up with another	• At the end of the reporting period 12 of 13 agencies had responded with their single agency audit and provided evidence that they were implementing key learning from audits. • 100% of Approved Off Site Education Provision completed a s157 Safeguarding Audit (19 in total) this is the first time this has been completed • All agencies signed up and completed their audit evidencing compliance with the SSCB section 11 process •	• The QPP Subgroup is well attended by partners who continue to strengthen and enhance the work of assessing the quality and impact of safeguarding practice across the partnership • A further review of the QAF will take place in early 2018-2019 to ensure intelligent data informs multi-agency discussions about the timeliness of assessments, plans, meetings and interventions • A key focus area will be for QPP to ensure all S175 submissions are analysed and a programme of feedback provided to Schools will commenced by the Quality and Governance Officer attending the Designation Safeguarding Forum in the Summer 2018 term. • The QPP sub group will consider the timeline for launching the regional S11 audit across the Sandwell partnership • The QPP Subgroup will focus on ensuring that learning from audits are used to better

agency and the S11 submission was reviewed and actions for next step were identified		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. • To proactively engage with the partnership's workforce, a further survey will be launched to staff across the partnership who work directly with children in Sandwell • A further area of focus for Quality of Practice and Performance sub group will be to ensure there is a 100% response to the single agency audits which are robustly scrutinised along with ensuring that there is evidence by the partnership of implementing key learning from audits.

10. Safeguarding at a glance

- Contacts to Single Point of Access (SPOC) – 22885 contacts were recorded between 01 April 2017 and 31 March 2018
- Referrals - there were 6336 recorded referrals between 01 April 2017 and 31 March 2018. An increase from the 4755 recorded the previous year
- 92% of the 5885 single assessments were completed within the national average of 45 working days
- No. of child protection investigations – 2923 Section 47 investigations were undertaken between 01 April 2017 and 31 March 2018. 1137 (39%) had an ICPC outcome.
- 4296 children recorded as LAC with 2748 placed within Sandwell and 1548 living outside of Sandwell but are the responsibility of this local area.
- Private fostering numbers – 1 as of 31 March 2018



Early Help Information

Contacts to Early Help	**2222**
Stepped up to Social Care	**323**
Stepped down from Social Care	**607**
Repeat referrals in last 12 months	**414**

11. Local Authority Designated Officer

The Local Authority Designated Officer (LADO) is responsible for the management and oversight of all investigations into allegations against those working with and who volunteer with children and is responsible for preparing the annual report to the Sandwell Local Safeguarding Children Board and establishing processes to disseminate learning throughout the children's partnership. In addition to the contribution included in this report the full LADO annual report can be found on the SSCB website.

Key activity during the year	Areas that worked well	Key focus for 18/19
• There was an increase of 51 referrals from last year to 562. An average of 47 referrals were received per month. This is indicative of a trend in a rise in referrals from the previous recording year when the average monthly figure was 43. • A significant proportion of allegations in Sandwell continue to come from Education with 40% of alleged perpetrators/Person of Concern working in this setting. • In July 2017, the LADO and the Chair of the Learning and Development sub-group for the SSCB, delivered level 1 Module Safeguarding training to C&FBE's and did a Train the Trainer on 25th September 2017. 28 participants attended. All members of the Polish community went on to deliver their training. • In comparison to last year, there has been an increase in the outcomes of 'disciplinary' and 'unsubstantiated', primarily due to an improved approach in multi-agency risk analysis from all agencies and clearer recording at the end of the Position of Trust meetings.	• Materials and guidance regarding handling allegations have been reviewed and updated to reflect current national guidance. • Specific Good Practice Guidance was provided to the Education sector in order to improve the management of allegations in their sector. Guidance document also available for staff who may be subject to a POT process. • The C&FBE's Safeguarding Launch was brought to fruition • The LADO has secured partnership working with the FA and the Premiership football and improvement made in sharing ideas in how Safeguarding of children in their sector can be improved eg mechanisms in place where the child's voice can be heard	• Develop and integrate the Managing Allegations process with the Liquid Logic system • Move the LADO referrals process through to the front door ie Access and created support document guidance outlining the new changes in process and procedures. • Review and update the Policy and Procedures in respect of the Management of Allegations against Employees and Volunteers in Sandwell. • Develop quality assurance framework In respect of the LADO work eg auditing the service, including learning from complaints and seeking feedback from POT Meetings. • National engagement with the Independent Inquiry into Sexual Abuse and support by LSCBs to do this.

Next Steps - we want children to tell us how well we are doing

Engagement with Partner agencies for example Education, Childrens Social Care, Foster care associations is good and ensures agencies implement robust safeguarding procedures, and are aware of information on the SSCB website regarding referring staff who may have harmed a child to the LADO service.

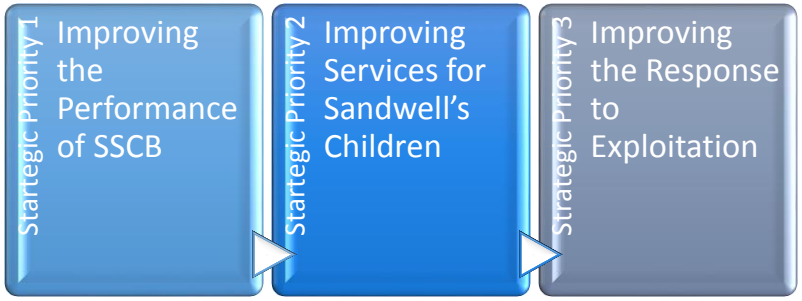
Sandwell LADO ensures good coordination and communication between lead agencies takes place when managing of allegations against those who work with children, including low level concerns. Data analysis of referrals and management of risk in Position of Trust meetings demonstrates the impact on children and their families in ensuring their allegations are heard and responded to in a timely manner.

12. Looking Ahead to 2018/19

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

The Ofsted re-inspection in November 2017 identified a number of areas that require urgent action to ensure that services for children improve. Sandwell LSCB needs to play a full role in ensuring that these improvements are implemented. We recognise that no single agency can achieve this on its own and the partnership as a whole must take responsibility to provide improved services to children.

In identifying the priorities Sandwell LSCB will take forward into 2018/19, 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. These pieces of information were central to the Board's developments session in February 2018 during which a number of potential priorities were discussed and debated. Following an iterative process with Board members, the 2018-2020 priorities have been identified as:



13. Conclusion

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

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

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), 0121 569 3100.

For Sandwell Safeguarding Children Board partners and organisations

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.

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.

Use your representative on our Board to make sure the voices of children and young people and frontline 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

A draft of this Annual Report was presented and approved at a meeting of the Safeguarding Board Children Board on 18 September 2018. 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

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

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

Contact Details

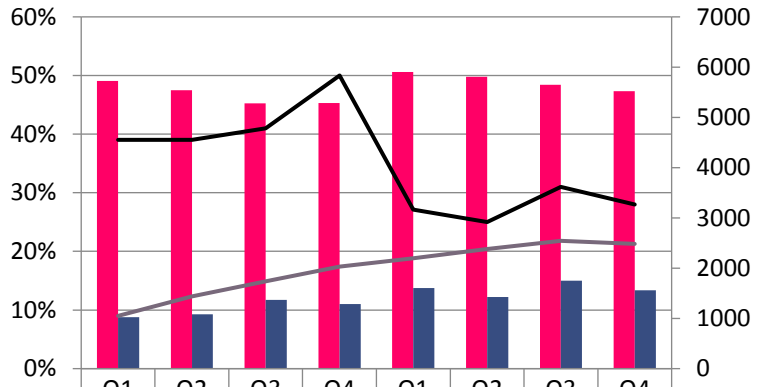
Sandwell Safeguarding Children Board (SSCB) Business Unit
Metsec Building
Broadwell Road
Oldbury
B69 4HE

Website: www.sandwelllscb.org.uk
Email: lscb_sandwell@sandwell.gov.uk
Telephone: 0121 569 4800

Appendix One: Safeguarding Assurance from Partners

Children's Services

Contacts and Referrals



	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-2018
Number of Contacts	5728	5540	5278	5285	5906	5810	5646	5523
Number of Referrals	1021	1082	1370	1282	1602	1426	1752	1556
% Contacts leading to a Referral	39%	39%	41%	50%	27%	25%	31%	28%
% Re-referrals to Children Social Care within 12 months	9.0%	12.3%	14.9%	17.4%	18.8%	20.4%	21.80%	21.3%

The reporting period saw 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 1602 in Q1 and 1556 in Q4. Whilst this represents a decrease during 2017/18, there has been an overall increase in the number of referrals compared to the previous year (4755 compared to 6336). Whilst this is illustrative of the demand on Children's Social Care, it perhaps is also indicative of the positive changes in the thresholds.

The Ofsted re-inspection during 2017 highlighted improvements that had been made. For example, Ofsted concluded that the multi-agency safeguarding hub (MASH) works effectively to assess risks and ensure that work is directed to the appropriate service level.

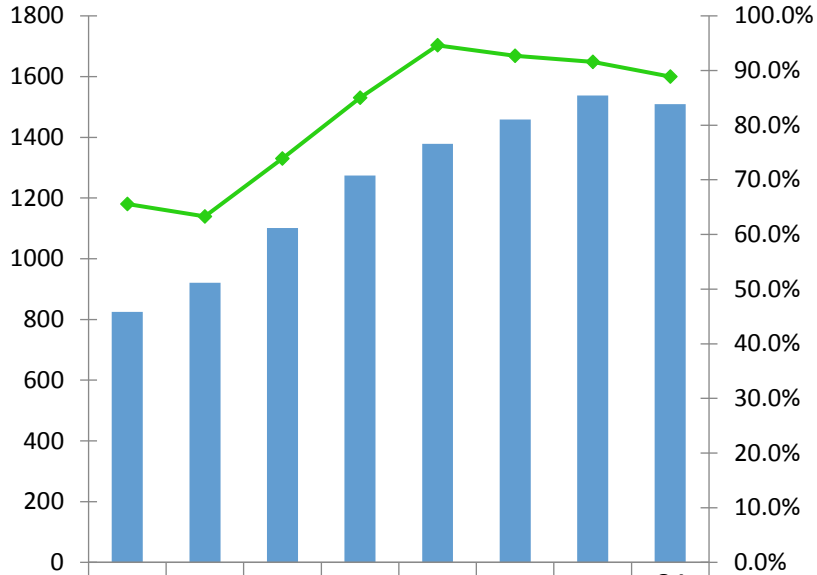
Additionally, Ofsted identified that the single point of contact (SPOC) manages the vast majority of contacts and referrals in a timely way. Staff in the MASH have a clear understanding of thresholds, and risk assessment is robust. This means that children receive a timely and proportionate response to presenting needs. However, referral information from other agencies is not always clear or sufficiently detailed. This will require further exploration during 2018/19.

Single Assessments

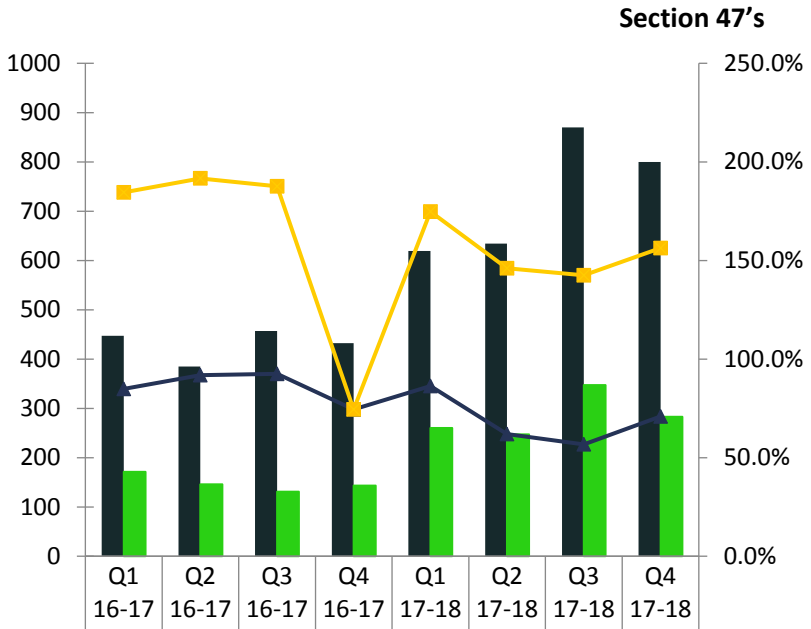
During the reporting period, there has been an increase in the number of Single Assessments completed from1379 in Q1 to 1509 in Q4. This increase reflects an overall increase in the number of assessments compared to the previous year (4121 during 2016/17 to 5915 during 2017/18).

The average timescale of Single Assessments being completed within the national average of 45 days has improved from 72% during 2016/17 to 92% during 2017/18.

Ofsted commented on the quality of the assessments stating that assessments are of poor quality and are not updated annually or when a child's circumstances change. Risk is identified, yet is not rigorously analysed, and children's historical information is insufficiently considered. Oftsed also found that assessments do not provide a sense of the child or an understanding of children's lived experiences, and therefore do not fully inform planning to achieve the best outcomes for children.



	Q1 16-17	Q2 16-17	Q3 16-17	Q4 16-17	Q1 17-18	Q2 17-18	Q3 17-18	Q4 17-2018
Number of Single Assessments Completed	825	921	1101	1274	1379	1459	1538	1509
% Single Assessments within National Average of 45 day timescale	65.6%	63.3%	73.9%	85.0%	94.6%	92.7%	91.6%	88.9%



	Q1 16-17	Q2 16-17	Q3 16-17	Q4 16-17	Q1 17-18	Q2 17-18	Q3 17-18	Q4 17-18
Number S47s	447	385	457	432	619	634	870	800
Number ICPCs	171	146	131	143	260	247	347	283
% RCPCs held within timescale	99.6%	99.8%	95.1%		88.5%	84.1%	85.7%	85.4%
ICPCs held within 15 working days	84.9%	91.8%	92.5%	74.4%	86.3%	61.9%	56.70%	70.8%

The number of Section 47s has increased from 1721 in the last reporting period to 2923 during 2017/18. This increase has meant that the number of ICPCS has also increased resulting in an increased number of children becoming subject to a CP Plan. This in turn, has had an impact on the timeliness of ICPCs and RCPCs as illustrated in the graph. The increased number of multiagency child protection meetings has impacted on all partner agencies. To address this, a multiagency working group has been established since January 2018 to consider and improve agency attendance and reporting to child protection meetings.

Ofsted commented that since June 2017, the number of children on child protection plans has risen by 71%. This dramatic rise has been analysed by the local authority and attributed to a number of factors: better recognition of risk; fewer children whose plans end after three months; and a better review of child in need cases which have been escalated to child protection. This rise means that, despite significant staff recruitment, social workers' caseloads remain high, and this has an impact on the quality of practice. Nationally numbers of children with a child protection plan have risen, however Sandwell remains an outlier and the Board will want assurance that proper systems including management oversight are in place to address this.

CSC practitioners have been engaged to have a heightened awareness when identifying children who are experiencing neglect; SSCB 7 minute briefings in relation to neglect have been communicated to practitioners. More children who are experiencing neglect are now being identified as needing safeguarding or are identified as being at risk. This is evidenced in the SSCB performance data and rise in numbers of children subject to CP Plans due to neglect. One child (8 years old) who has become a looked after child with an extended family member as a result of neglect commented that "My uncle is a millionaire as he has carpets and curtains".

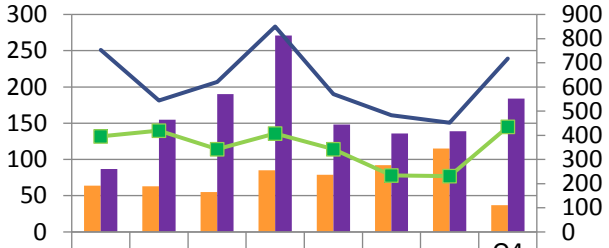
CSC practitioners have been engaged and have had the opportunity to attend SSCB multi-agency training regarding CSE. One child (17 years old) who was being sexually exploited and had become a looked after child was placed over 20 miles away from her home address. With support from the carer, SW and IRO she is no longer being exploited, is in college and learning, working part-time, and now has a healthy relationship where she is treated with respect.

Early Help

A total of 2222 assessments were completed over the reporting period in comparison to 2768 during the previous year. This represents a continued decrease since 2015/16 (when the figure stood at 2923). Similarly, there has been a small decrease in the number of repeat early help referrals in the last 12 months from 522 during 2016/17 to 414 during 2017/18.

At the end of the reporting period there had been an increase in the number of cases being stepped up (from 267 during 2016/17 to 323 during 2017/18) and a decrease in the number of cases being stepped-down (from703 during 2016/17 to 607 during 2017/18). The cumulative effect of this is that, along with the increased number of referrals, the pressures on the child protection system have been unprecedented.

Ofsted commented that there is a well-established early help offer recognising and assessing need effectively. Thresholds are now better understood by partners, but some variability in application remains. Early help services are offering many families appropriate intervention with a comprehensive range of services providing effective community-based and intensive support to children and their families.



	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-2018
No. of Early Help Cases stepped up to social care	64	63	55	85	79	92	115	37
No. of social care cases stepped down to Early Help	87	155	190	271	148	136	139	184
No. of Repeat Early Help Referrals in the last 12 months	132	140	114	136	114	78	77	145
No. of Early Help Assessments completed in quarter	753	544	621	850	570	483	452	717

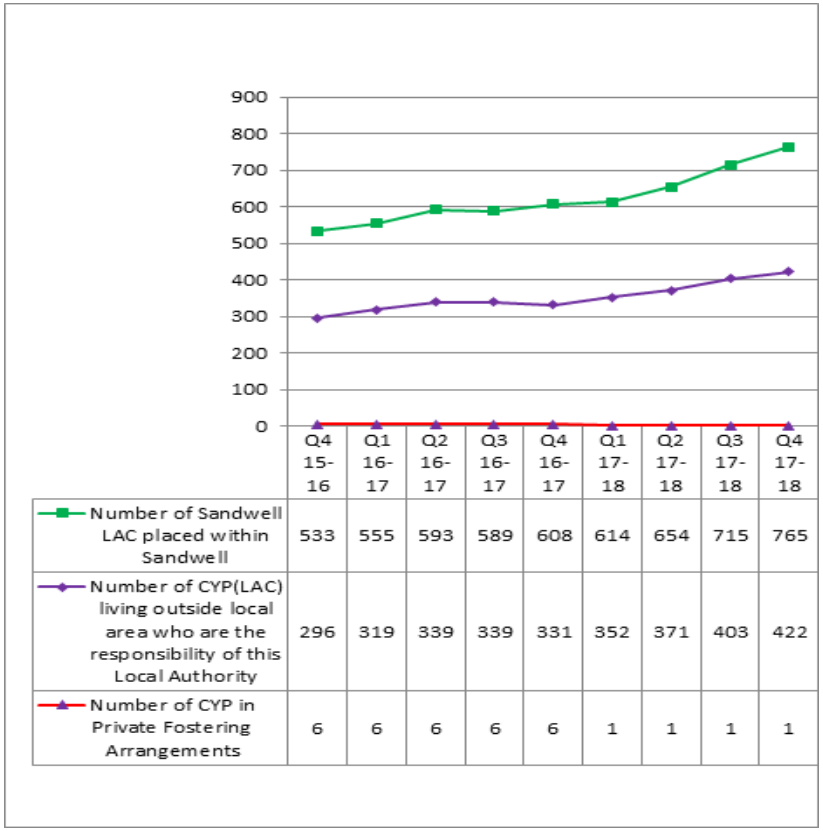
The VCS continues to effectively engage children and young people at a grassroots level.

The VCS has recently led on the Early Help refresh providing and facilitating workshops around how Early Help could become more effective, especially with networking and promoting Universal and Universal plus services.

The VCS established the Early Help Partnership meets regularly to see how resilience could be built at a lower level and to also gain a better understanding of localised services around the Early Help agenda.

The Early Help Portal – Sandwell Family Life has been launched and is being updated on a regular basis - https://www.sandwellfamilylife.info/ Over 150 Universal/Universal plus services are listed from a wide variety of agencies on the portal. There are also over 40 agencies signed up to the Early Help Process. The newly appointed Early Help Coordinator will enable the partnership to be further developed and build on achievements to date.

Looked After Children (LAC)



	Q4 15-16	Q1 16-17	Q2 16-17	Q3 16-17	Q4 16-17	Q1 17-18	Q2 17-18	Q3 17-18	Q4 17-18
Number of Sandwell LAC placed within Sandwell	533	555	593	589	608	614	654	715	765
Number of CYP(LAC) living outside local area who are the responsibility of this Local Authority	296	319	339	339	331	352	371	403	422
Number of CYP in Private Fostering Arrangements	6	6	6	6	6	1	1	1	1

The number of LAC has increased from last year. Those LAC that are placed in borough has exponentially increased from 2345 to 2748, and for children placed out of borough the increase has been from 1328 to 1548. The reasons for the increase in LAC is partly due to legacy cases being identified and matters being placed before the court, as well as some LAC being known to the service for a substantial period of time. Permanency planning for LAC is essential and the recently established permanence monitoring group aims to track all children looked after to ensure that plans for permanence are achieved in a timely manner. This is not yet well established, and will therefore be an area of focus during 2018/19.

Ofsted commented that the local authority is successful in placing a high percentage of children within 20 miles of their home address. They also found that children placed out of the local authority area are well supported and have good access to services and advice. However, disabled children featured heavily in those children placed out of borough. This will be taken forward during 2018/19.

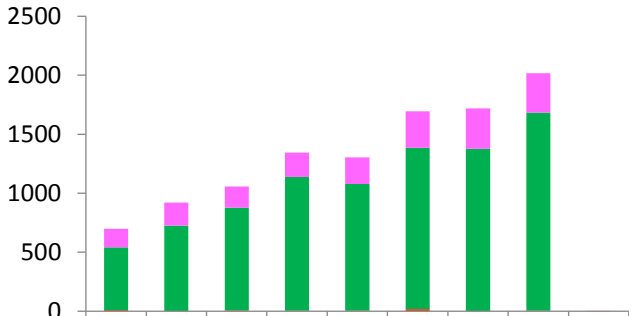
Ofsted also found that the use of voluntary arrangements is not always appropriate to children's circumstances when children become looked after voluntarily under section 20 of the Children Act 1989. For most children accommodated under section 20, there are shortfalls in planning. Many children have remained subject to these arrangements for too long, resulting in significant delay in securing them a permanent home either back with their families or in care.

Neglect

During 2017/18 there was an increase in referrals to Childrens Social Care with the presenting need of neglect. The number of referrals have increased from 3801 to 4421 (up to Q3); and those on a CP plan have increased from 808 to 985 (up to Q3). This could be indicative of some legacy cases where neglect was not identified whereas it now is, coupled with the heightened awareness of neglect across the partnership.

Early identification of neglect requires further work given that the referrals to early help with the presenting need of neglect continue to appear to be relatively low from 17 during 2016/17 to 27 during 2017/18. This could be because neglect may be the secondary reason for involvement by Targeted Services.

Ofsted found that for some children, the response to neglect (particularly in cases of long-term neglect) is not timely and, as a result, they have entered care later than they should have done. Neglect therefore remains a priority for the Board with consideration due to be given during 2018/19 to implementing the Graded Care Profile 2 across the multiagency partnership as a tool to help in assessing where neglect may be a feature.



	Q4 2015-16	Q1 2016 - 17	Q2 2016-17	Q3 2016-17	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-2018
No. of children on a CP plan under the category of neglect.	158	196	181	206	225	309	344	332	0
No. of referrals to children's social care with the presenting need of Neglect.	531	723	869	1135	1074	1367	1374	1680	0
No. of referrals to early help with the presenting need of Neglect.	11	2	8	3	4	19	2	5	1

Education and Schools

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 3 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.

Key activity during the year	Areas that worked well	Key focus for 18/19
• During the year the EAG has been integral in reviewing the developments to Sandwell's social care system. The EAG is currently completing the 5th annual confidence survey in Social Care systems. The focus this year will be on the significant changes in the system due to the development of the Children's Trust and how this impacts on the quality of front line delivery • Areas of focus for discussion have been:- - Effectiveness of Single Point of Contact - Access to safeguarding advice prior to referral - Communication systems - The lead professional role - Access to mental health services - Capacity of front line social workers	• The response from schools with regards to the section 175 audit has been high. Equally the inclusion of organisations not managed by the council in the audit been increased. • 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 • 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.	• Whilst the response rate to the s.175 audits was good but had fallen slightly from the previous year's response. The EAG will focus on ensuring that there is a full response rate to the Section 175 exercise. • Ensure compliance with the revised statutory guidance on safeguarding, Keeping Children Safe in Education • Monitor uptake of PREVENT training available to schools • Monitor development of Lead Professionals Network meetings an attendance • Monitor changes to Elective Home Education regulations and numbers of pupils who are EHE • Completion of 2018 School Confidence Survey • A focus on the referral rates from schools and the proportion which meet the threshold for further action.

100% of Sandwell schools have completed the section 175 audit

Education partners *coordinated a piece of work ensure all schools completed the Section 175 audit. This audit sets the compliance standards for keeping children safe whilst they are in education. The Designated Safeguarding Practitioners have worked with Schools to promote key safeguarding messages and any changes to the safeguarding system to practitioners at safeguarding forums and learning events. The Councils Education Advisory Board have supported the work to improve effectiveness and can report 100% compliance with the audits.*

The successful completion of the audits means that all Sandwell's Schools are aware of their responsibilities for keeping children safe in school but also what they know when to support families through asking for support with other partners or making a referral to the Sandwell Children's Trust.

Elective Home Educated (EHE) Children

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.

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.

Key activity during the year	Area's that worked well	Key focus for 18/19
• The Education, Skills and Employment Directorate appointed a new EHE advisory teacher in September 2016 to work with the EHE community; to develop relationships and offer advice and support as required. • Since her appointment, regular community events have been organised fulfilling our hopes of improving levels of engagement • As the numbers of children who are home educated have risen nationally, Sandwell has also	• During the local authority re-inspection, Ofsted noted (29/01/18): "*Sandwell has seen a sharp increase in the number of parents who elect to home educate their children. Increasingly, effective work with these parents has resulted in a significant increase in the number of families who now engage with the local authority and cooperate in monitoring how well their children are*	• In the academic year 2018/19 the attendance & prosecution service will continue to work closely with social care and early help to identify and assess whether children are being suitably educated at home. • The Service will further develop arrangements with local colleges and alternative education providers to ensure that EHE families continue to have access

seen year on increases in EHE numbers as demonstrated below (which represents the identified number of EHE children at any one time) **2013/14**: 249 **2014/15**: 256 **2015/16**: 322 **2016/17**: 476 **2017/18****: 394 ** February 2018	*progressing (from 30 out of 165 families in 2016, to 130 out of 262 families in 2017".* • Data to Feb 18 showed further ongoing improvements in engagement levels, with only 54 out of 293 (active cases) either declined or not assessed (historic) – this means 227 had some form of contact. All new EHE families receive / are offered an initial consultation visit so that they can make an informed decision about whether or not to proceed with the responsibility to home educate their child/ren.	to work experience and vocational learning opportunities where required. • The Service continues 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

Health Services

Sandwell & West Birmingham Clinical Commissioning Group (SWBCCG) continue to fulfil its statutory duties outlined in the Children Act 2004 and the Care Act 2014. The CCG employs the expertise of Designated Professionals for Safeguarding, Child Death, Looked after Children and Domestic Abuse. Compliance is assured via completion of the Local Safeguarding Children Board Section 11 audit tool and evidenced in NHSE Safeguarding Assurance Tool pilot. The CCG are fully engaged with the Sandwell and Birmingham Safeguarding Children and Adult Boards and are represented at Birmingham Safeguarding Children and Adults Boards through a memorandum of understanding with Birmingham CCG's.

The Designated Nurse for Safeguarding and Designated Nurse for Child Deaths, Chair the SSCB Health Forum and SSCB Child Death Overview Panel. The CCG Chief Officer for Quality continues to support the SSCB as Vice Chair of the Board.

The CCG Safeguarding team contribute to serious case reviews, domestic homicide reviews and safeguarding adult reviews in both Sandwell and Birmingham local authorities.

Key activity during the year	Areas that worked well	Key focus for 18/19
• Sandwell & West Birmingham CCG continue to deliver face to face safeguarding training to level	• SWBCCG continue to fund the existing 20 practices taking part in the Identification &	• Work to improve safeguarding knowledge and engagement in primary care has

3 practitioners in accordance with the Intercollegiate Document (2014). • The Named Professionals for Primary Care facilitate a GP safeguarding leads forum which provides updates on current topics relevant to practice, for example; PREVENT, child sexual exploitation (CSE), female genital mutilation (FGM), domestic violence and abuse. This is also a forum where GPs can share good practice and raise concerns, as well as be informed of new developments in safeguarding arrangements. • In March 2018 the CCG facilitated an FGM Conference for health practitioners and partners. • The CSE Superhero Campaign continues to be promoted nationally. In addition the team has joined with Sandwell College and NHSE to implement the Protective Behaviours Mentorship course for a cohort of students. We have also provided training sessions to the students on a range of topics including learning from child deaths (safer sleep/road safety/self-harm and suicide) CSE, FGM and Domestic violence. • In 2017/18 members of the CCG safeguarding team have presented at both Birmingham University to Masters Students and delivered Level 3 safeguarding training at the National Nursing in Practice Conference at the NEC. • Promoting the health and wellbeing of looked after children (LAC) remains a priority. • To ensure commissioning transparency and to support a seamless service the LAC team was transferred to the provider Trust. The CCG	Referral to Improve Safety (IRIS) project. In 2018 supplementary funding has been obtained from the Safer Sandwell Partnership Police and Crime Board so that IRIS can be further extended across another 22 practices in Sandwell taking the total number of practices in Sandwell to 38. • Dr Bradbury Jones was commissioned from Birmingham University to undertake the evaluation of the IRIS pilot. It demonstrates on a number of the levels the impact that IRIS has made to victims who have suffered from domestic abuse, some of the comments made by these survivors include: • *"I was going through a lot of domestic abuse from my husband…he was on the verge of murdering me. I went to my GP and told him what was happening and he referred me….."* • *"Thank goodness I told my doctor because I would have gone through another 15 years – I am sure of pure hell – we are going to move and that is down to your information and your programme of support"* • *"Without the question in the first place being asked I would never have thought there was so much help and support – me and my sons are now safe and well – thank you so much…"*	continued to be a priority area for the CCG safeguarding team • The safeguarding team continue to facilitate and monitor on a quarterly basis GP submission of reports for initial child protection conferences (ICPC's) and their attendance. • Reports are submitted to the CCG Quality and Safety Committee and there has been the addition of a key performance indicator (KPI) relating to ICPCs to the Primary Care Dashboard. • This will measure GP ICPC engagement on a monthly basis, and feed into wider quality performance indicators. • Communication is paramount to safeguarding; there has been a significant increase in engagement between primary care and the health visiting service over the last 12 months evidencing better communication between GP's and the health visiting service. GP's and HV's are clear on the methodology for safe, effective communication and frequency of formal meetings. • Learning from serious case reviews are shared across the organisation and a quarterly CCG safeguarding newsletter is disseminated. • In 2017/18 the designated doctor and lead professional for primary care gave a presentation on learning from SCR's to GPs

Designated Nurse and Doctor for LAC quality assure the health assessments for looked after children and are in the process of developing GP guidelines to improve response rate of GP summaries to inform health assessments. • The leaving care passport continues to be issued, and interviews are planned with care leavers to assess the effectiveness of the passport. The health passport is profiled on the local authority face book page. • A regional LAC health group has been established. The CCG Designated Nurse is chair and represents the Midlands region at the National NHSE forum.		within the CCG, at one of their protected learning events. In addition a separate, slightly different learning from SCRs presentation was delivered to the paediatric department at the Acute Trust • Embedding learning across the health economy will remain a focus for 2018/19 • Sandwell & West Birmingham is committed to a successful partnership arrangement under the new statutory guidance

Sandwell and West Birmingham Clinical Commissioning Group (SWBCCG) *have been instrumental in initiating the CSE Superhero Campaign. This project was developed in partnership with the Children's Society and is designed to raise awareness amongst healthcare professionals about Child Sexual Exploitation. SWBCCG funded and commissioned the "Know the Signs" Film produced by Chatback a group of looked after or birth children of foster carers. To accompany the film an online training video, a training toolkit and supporting resources were developed. In excess of 220 individuals have completed the training including nurses, GPs, safeguarding staff, practice managers, paediatricians, midwives, lecturers and college students. The feedback from the training has been overwhelmingly positive with 99% of participants reporting that they would recommend the training to others.*

99% of participants would recommend the "Know the signs" training to others

Birmingham Community Healthcare NHS Foundation Trust (BCHC)

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 Sub- Committee 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.

During 2017/18 BCHC refreshed the Section 11 audit, and engaged in a peer challenge session 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 as well as Outcome 7 of the Care Quality Commission framework, "Safeguarding People who use services from abuse."

Key activity during the year	Areas that worked well	Key focus for 18/19
• **Training:** BCHC has a structured safeguarding training programme that outlines roles and responsibilities and associated required levels of training. The training is evaluated in terms of measuring impact upon practice. Named Nurses have also participated in the delivery of Sandwell Safeguarding Children's Board multiagency training programmes. • **Supervision:** The School Nurses receive regular 1:1 safeguarding supervision in line with the BCHC safeguarding policy. The service consistently achieves 100% compliance with the agreed target. This is complimented by a schedule of group based supervision. All supervision is facilitated by a Named Nurse for Safeguarding Children. The model of supervision is underpinned by specialist training from NSPCC. • **Quality Assurance /Audit:** BCHC has a formal process of robustly monitoring audits and outcomes through the Safeguarding Children Sub Committee and the Clinical Governance Committee. Internal and partnership wide learning from serious case reviews, incidents and	• Formalised processes around Audit & Review are robustly monitored through the governance structure in BCHC • Safeguarding Supervision - as at April 2018, compliance with Safeguarding Supervision is maintained at 100% for Sandwell School Nursing Service. School Nurses are engaged in this process and offer positive feedback on the impact on practice and learning • Innovative styles of learning through capturing and responding to the child's voice. This is achieved through workshops focused on learning from patient stories, as part of a Commissioning for Quality and Innovation (CQUINN) initiative. The stories are presented across the Trust and discussed within the Safeguarding Children Sub Committee, recognising children as key partners in shaping services	• 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 • Disseminate learning from Serious Case Reviews, clarify implications on School Nurse practice and evaluate the impact of any changes.

audit is routinely disseminated across the workforce. This is further supported by an annual safeguarding audit programme. • **Partnerships:** As a member organisation of the Sandwell Safeguarding Children Board, BCHC demonstrates a commitment to partnership working that is supported at executive level. Through membership of the sub groups of the Board and contribution to the multi-agency training pool, the Safeguarding team is able to support Sandwell's School Nurse workforce to function pro-actively across Sandwell's partnership. The continual link to the Health Forum sub group allows for communication around the health function in Sandwell MASH ensuring a consistent approach to operational agreements. For example, in MASH and the application of an Early Help approach. • **Practice Development:** The Sandwell School Nurses have dedicated Named Nurse support which has maintained the service standard, ensuring that each School Nurse has access to; - A programme of role specific Safeguarding Training in line with requirements of the Intercollegiate Document- Safeguarding Children and Young People; roles and competencies for healthcare staff. (Royal College of Paediatrics and Child Health 2014). This includes bespoke training and workshops around CSE, Early Help and Patient Stories		

- Protected time for regular 1:1 Safeguarding Supervision - Access to advice and support from the Safeguarding Children Named Nurse team and Safeguarding Adult Team as part of the established on call system. - The Named Nurse team provide support for School Nurses on completion of court reports. This includes advice, case reflection, training and quality assurance of the court reports.		

Sandwell and West Birmingham Hospitals NHS Trust (SWBHT) is an integrated care organisation dedicated to improving the lives of 530,000 local people from across North-West Birmingham and towns within Sandwell. Safeguarding children remains a key priority for SWBHT and it fulfils its statutory obligations within Section 11 of the Children Act (2004) demonstrating a strong commitment to safeguarding children by our accountability and reporting structure. The Chief Nurse is the Executive Lead for Safeguarding Children and key member of Sandwell Safeguarding Children Board (SSCB) with a continued focus of appropriate representation at SSCB and its sub-groups. Assurance and quality is demonstrated through internal accountability structures and programme of review via internal committees. This includes quarterly reporting to Sandwell and West Birmingham Clinical Commissioning Review Meeting to demonstrate compliance and offer assurance in relation to safeguarding children and adults on how we, as a provider of services are improving outcomes and developing a culture of safeguarding.

Key activity during the year	**Areas that worked well**	**Key focus for 18/19**
• The joint Emergency Department (ED) Advocacy pilot with Black Country Women's Aid (BCWA) continues to demonstrate positive outcomes in increasing the visibility of domestic abuse in ED. Since the start of the project in November 2015 over 452 victims have been identified in ED. All have received a crisis response from the ED Independent Domestic Violence Advocate (IDVA), 62% have agreed to be referred on to BCWA	• The Trust have been involved in a number of Serious Case Reviews (SCR) during the year ensuring that staff access the learning events commissioned by SSCB and internally provide monthly reports to Clinical Governance on all the Serious Case Reviews, Independent Management Reviews and Domestic Homicide Reviews SWBHT are involved in.	• Continue to maintain effective partnerships and collaborative working in line with new legislation and statutory guidance • Secure substantive funding for the IDVA ED project, Without this the project will cease in July 2018 • Continue to maintain a focus on the 'voice of the child' and service delivery/response

community services. 55% of these individuals were previously unknown to any other services as victims of Domestic Violence and Abuse (DVA) and found to be multiple attenders in ED. In addition, a significant number of victims identified were from Black and Minority Ethnic groups which previously had not been representative in groups accessing domestic abuse services. • Outcomes are very positive for clients referred in this way to community services; with risk being reduced in 71% of cases either significantly or moderately; 84% of victims reported that their overall situation had improved; 80% felt safer; and 76% said that their overall emotional and physical wellbeing had improved. We have a current Domestic Abuse Policy which recommends routine enquiry in key areas. • In October 2017 the Looked after Children Service transferred over from Sandwell and West Birmingham Clinical Commissioning Group which has been a positive move enabling the safeguarding children team to work more cohesively to meet the needs of this vulnerable group. With continued good partnership working between health and the local authority looked after children team completion of review health assessments is currently at 93% for 2017/18. • The safeguarding children team continue to deliver Level 3 single agency safeguarding children training which has seen an increase in staff compliance to over 90%. There has been significant investment to develop an on-line Level	• Key learning points from SCR's are disseminated across the organisation via our communications department and are included in the case scenario session in Level 3 training. SWBHT have seen an increase in child protection supervision compliance with community staff to ensure there is safeguarding children expertise oversight provided by members of the safeguarding team. This continues to be monitored via internal key performance indicators.	• Maintain and continue to improve current supervision percentages. • Continue to monitor safeguarding children training compliance to ensure we have a skilled and informed workforce with regard to safeguarding children responsibilities

2 learning module for staff to access prior to the Level 3 session and a refresher record developed to record training accessed over a 3 year period in order to meet training requirements as outlined in the RCPCH Intercollegiate document. We have had a continued focus with department heads to improve compliance at all levels of training resulting in level 1 being over 98% and Level 2 over 90%. • SWBHT remain an active participant in Sandwell's CSE Health Group and 'flag' all children and young people known to Sandwell's CSE Team on our electronic patient record (EPR) which is particularly relevant for ED staff where children may present as victims of CSE. • SWBHT also successfully participated in SSCB Section 11 peer review challenge.		

'Client left stating that she does not feel suicidal as she now knows there's help and support for her'

Within the Health visiting Service the Signs of Safety assessment framework has been embedded into documentation. This has helped focus conversations with families and encouraged engagement with the plan of care.

Through increased training across community and acute paediatric services regarding thresholds we have seen an increase in submission of MARF's at an earlier stage and contact with the Safeguarding Children Team for advice and support.

The Domestic Abuse Nurse Team and IDVA's have developed posters which are displayed across key areas within the hospital advising both staff, patients and visitors that SWBHT is a 'Domestic Abuse Awareness Hospital' with contact numbers for support and advice for both staff and clients.

The team has also developed a Domestic Awareness Leaflet which has been attached to all staff within the organisation via their wage slips.

Through the work of the IDVA's in ED and in the hospital we have evidence of positive outcomes for victims referred into the project: 'Client left stating that she does not feel suicidal as she now knows there's help and support for her'

'Discussed DV and the effect on children even if they are not in the same room, which Client said she hadn't realised before'.

Black Country Partnership Foundation Trust (BCPFT)

Key activity during the year	Areas that worked well	Key focus for 18/19
• Black Country Partnership NHS Foundation Trust (BCPFT) has continued to strengthen the 'Think Family' Approach across all of its services by embedding joint development sessions between safeguarding adults and safeguarding children • To support the Think Family Approach the safeguarding named nurse for children and the safeguarding named nurse for adults are now co located for part of their working week to support collaborative working • Training has been further reviewed and refreshed to incorporate emerging safeguarding themes from national and local knowledge. • The Trust has completed 3 audits: Voice of the child, Did Not Attend (children not brought) and Record Keeping and participated in 4 SSCB audits relating to Domestic Abuse, Neglect, Early Help and Children with Disabilities. The Trust has completed the remaining actions relating to the previous Section 11 audit and has no outstanding actions. • 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	• Safeguarding supervision has increased during the year and support is now offered to staff working in Child and Adolescent Mental Health Services (CAMHs) and Early Interventions in Psychosis, a service for people from the age of fourteen. It has been noted that there has been earlier identification of cases and this has reduced delay and drift with plans and appropriate escalation and resolution where appropriate. • Quarterly reporting within the Trust and to commissioners has evolved during the year and will continue to do so in 2018/19. The reporting and assurance now includes information on the number of safeguarding children supervision sessions, training compliance, Section 11 action plan progress and completion, FGM and CSE identification and updates on progress relating to cases that are being externally reviewed by the SSCB.	• continuing to enhance the availability of trainers form the clinical divisions for safeguarding children training • checking that lessons learnt have been embedded into practice • facilitating learning on the importance of accessing the e-caf to improve information sharing and early identification of risk and appropriate intervention and intervention of risk and support • develop and deliver bespoke CSE training into CAMHS and Early Intervention in Psychosis • developing communication pathways between mental health services and health visitors/school nurses

completed any actions required to improve safeguarding by the organisation.		

Private Fostering

The duties of the Local Authority in response to Private Fostering have two components:

1. To assess the suitability of any private fostering arrangements and to provide ongoing monitoring and support to children who are privately fostered
2. To raise public and professional awareness of private fostering and the requirement for parents and carers to notify the LA of any such arrangements or intended arrangements.

For information on Private Fostering, please view the Sandwell MBC private fostering page:
http://www.sandwell.gov.uk/info/200219/children/1178/private_fostering

Sandwell Safeguarding Adults Board (SSAB)

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.

Key activity during the year	Areas that worked well	Key focus for 18/19
• Throughout 2017-18 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	• 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	• Key areas of focus include: - POVE agenda - Preparation for Adulthood - Learning & Development – particularly with relevance to the overlap between

Midlands region. All documentation has been reviewed and revised to reflect the new government legislation and guidance. • Regional guidance continues to be developed and updated 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. • The SSAB has signed up to the Partnership Protocol and continues to work in partnership with Sandwell Children's Trust, Health & Wellbeing Board and The Safer Sandwell Partnership to prevent and address issues of violence and exploitation in a collaborative manner. • A Work Plan is in development with a focus on all cross-cutting issues and increasing partners and stakeholders understanding of exploitation and its impact. • Violence and Exploitation has profound and damaging consequences for children exploited and those around them including families and communities. • There was joint participation in a Prevention of Violence and Exploitation Event 26.09.17 in which we used theatre performances to demonstrate exploitation and its impact and challenges in a range of scenarios.	Safeguarding Children Board, the Health and Wellbeing Board and the Sandwell Safer Partnership Police and Crime Board. • Common of areas of work with SSCB include adults aged 18 plus with additional support needs and their transition to adulthood. • Key policies including Hoarding Guidance, Self-Neglect Guidance and Safeguarding Adult Review Policy, guidance and referral form can now be found on the SSAB website @ www.sandwellsab.org.uk • Delivery of a joint Learning & Development catalogue.	learning from Safeguarding Children Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews. A greater focus on a joint Learning & Development offer

Staffordshire and West Midlands Community Rehabilitation Company (SWM CRC)

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

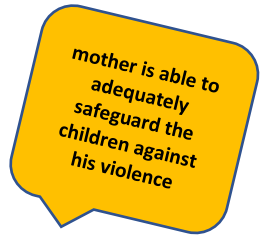
Criminal Justice case management is split across two agencies, Community Rehabilitation Companies and the National Probation Service. Community Rehabilitation Companies deal with low and medium risk cases and the delivery of all interventions bar Sex offender programmes. Interventions include accredited and non-accredited programmes and unpaid work. Both agencies work within custodial settings and have statutory responsibilities relating to safeguarding although both are adult facing service providers.

Key activity during the year	Areas that worked well	Key focus for 18/19
• Mandatory Prevent training was undertaken across all four areas raising the awareness of the prevent agenda and how this links into safeguarding approaches. • Aligned forced marriage and honour based violence champions were established across the four teams in the cluster. • In Sandwell CPNs were integrated into teams to specifically review Safeguarding. JTAI work was started and lead Managers were identified to work across this area. • A training review against current safeguarding training to identify current status of all staff and gaps	• Sandwell in particular have a strong Mash link ensuring a good information sharing protocol is observed. • As an adult facing service SWM CRC concentrate on partnership links to ensure safeguarding is managed although they would not necessarily be informed of any direct impact on children or young people. In Sandwell SWM CRC have strong links with both MARAC and domestic abuse partners including Mariposa in Sandwell. A specific example of this is as follows: • *Mr Bloggs was sentenced to a new Order for a Domestic Abuse offence in September 2017 witnessed by Children. His social worker made contact with a SWM CRC probation practitioner within a week to advise that the*	• Training, specifically on CSE • There are clear safeguarding policies in place. However, visibility of training has been a challenge and SWM CRC have had to revisit following IT systems incompatibility. Interim arrangements have been made to manually track this whilst new recording systems are set up.

	Children were already on CP plan and set up a three-way meeting at Probation within 7 days. As a result of this SWM CRC were able to prioritise SIADA (a domestic abuse intervention) and place him on a group within first 3 weeks of his Order. The Social worker has kept CRC probation informed inviting the practitioner to Core Groups and sharing the contact plan. At the first Conference review in January 2018 agencies agreed that although concerns about Mr Bloggs controlling behaviour remain, the relationship is ended and the mother is able to adequately safeguard the children against his violence and so they were removed from CP plan and placed on Child in Need	

*The **Staffordshire and West Midlands Community Rehabilitation Company (CRC)** have strong links with both MARAC and domestic abuse partners including Mariposa in Sandwell.*

An example of how these links have worked successfully is: Mr Bloggs was sentenced to a new Order for a Domestic Abuse offence in September 2017 witnessed by Children. His social worker made contact with our probation practitioner within a week to advise that the Children were already on CP plan and set up a three way meeting at Probation within 7 days. As a result of this we were able to prioritise SIADA (a domestic abuse intervention) and place him on a group within the first 3 weeks of his Order. The Social worker has kept CRC probation informed inviting the practitioner to Core Groups and sharing the contact plan. At the first Conference review in January 2018 agencies agreed that although concerns about Mr Bloggs controlling behaviour remain, the relationship is ended and the mother is able to adequately safeguard the children against his violence and so they were removed from CP plan and placed on Child in Need.



West Midlands Police

We know increasing Police attendance at conferences makes a difference to keeping children safe!

- The volume of Crimes against Children in Sandwell over the year was 12% of the Force total volume which is consistent with the previous year's 12% April 2016 to March 2017
- The total number of recorded Crimes against children in **Sandwell** separated into the geographical areas – the total being 2350, Force wide the figure was 19,328. Sandwell North statistically has the highest number of recorded Crime and Sandwell South the lowest over the last 12 months
- There has been an 21% increase in recorded Crime for **Sandwell** compared to the previous year April 2016 to March 2017 (1,949) and a 20% increase for the Force (16,164)
- There were 44 Police Protections in the Sandwell Borough between 1st April 2017 and 31st March 2018, involving 68 children
- There has been a difficulty faced in terms of successful prosecution during 2017 – 18. The annual outcome rate for Positive Outcomes in prosecution was 19.3% for **Sandwell** compared to the Force figure of 17.7%, this is a decrease on the previous year's figures of 23% for **Sandwell** and 19% for the Force.

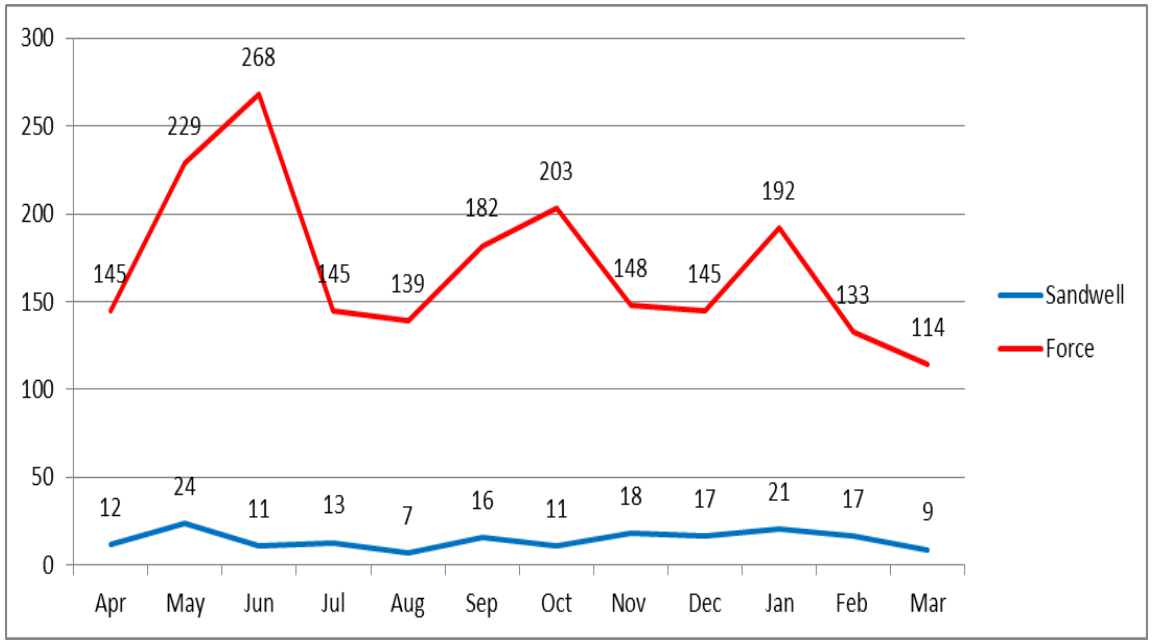
Offence as Recorded - Sandwell	% of Total SW Volume	Total Recorded
01103 - Cruelty/Neglect Child	25.6	602
00806 - ABH	17.1	401
03403 - Robbery Personal Property	8.3	194
10501 - Common Assault and Battery	7.7	181
00872 - Send communication/article conveying a threatening message	3.0	71
04400 - Theft Pedal Cycle	2.9	67
00891 - Malicious Wounding	2.6	62
04910 - Theft Other	2.6	60
02005 - Sexual Assault on F	2.1	49
02006 - Sexual Assault on F -13	1.4	34
12509 - Cause Intentional Harassment Alarm Distress	1.3	31
12511 - Fear or Provocation of Violence	1.3	30
01907 - Rape of F 13-15	1.2	29
01916 - Rape of F -13 by M	1.2	29
00501 - Wounding with intent GBH	1.1	27
01908 - Rape of F 16+	1.1	25
03404 - Assault with Intent to Rob Personal Property	1.0	23
03900 - TFTP	0.9	22
00821 - Dog Cause Injury, Public Place	0.9	20
01302 - Child Abduct by Other	0.9	20

← These are the most frequently reported offences against Children in the **Sandwell** area.

← Cruelty/Neglect by a parent or someone in care and control of the child is again the highest recorded crime and accounts for over a 1/4qtrof all offences against children.

← This is an increase on the 21% in the previous year April 2016 to March 2017.

Volume of CSE Reports



← The Red line shows the total number of Crime or Non-Crime records with a CSE "Special Interest Marker" Force wide – the **Blue** line shows the number for **Sandwell** .

← There were 2043 CSE reports Force wide this year, which is 7% higher than the 1902 in the previous year April 2016 to March 2017.

← The figures for **Sandwell** were 176 reports this year compared to 147 the previous year April 2016 to March 2017 a 20% increase.

← **Sandwell** accounts for 9% of all CSE reports across the Force area.

← The last quarter (January to March 2018) has seen reports for **Sandwell**, 2% higher than quarter 3 (October to December 2017) and 24% higher than in the same quarter in the previous year April 2016 to March 2017.

Safeguarding children from sexual exploitation is a key priority for the SSCB. ***West Midlands Police*** *have worked closely with partners on improving the multi-agency safeguarding response to this issue. The Police has an improved system for information about offenders and vulnerable children. The information held has enabled a more effective response to identifying risky locations and those individuals who set out to harm children. Information sharing to partners has improve, alongside an increase of Police attendance at case conferences – we know this makes a difference to keeping children safe.*

A lot of work has been undertaken to keep awareness raised and train staff across the children on CSE, Modern Day Slavery and Capturing the voice of the child.

Child Abuse Investigations

- Between April 2017 and March 2018 there were 1010 recorded Crimes across **Sandwell** investigated by WMP Specialist Public Protection Teams, this is a 22% increase from the previous year April 2016 to March 2017 figure of 825.
- The Force wide total for the same period was 8671, a 23% increase from the previous year April 2016 to March 2017 figure of 7068.
- The last quarter (January to March 2018) has seen reports for **Sandwell**, 4% higher than quarter 3 (October to December 2017) and 30% higher than the same quarter in the previous year April 2016 to March 2017.
- As at the 9th April 2018 we are still investigating 91 of those **Sandwell** Crimes which is 31% of the **Sandwell** total.
- These figures are for Crimes with a CA marker which means they were committed by a parent or someone in care or control of the child at the time.

Missing Children

- The police system for recording missing persons is Compact Misper Live.
- Between April 2017 and March 2018 1851 children were recorded as missing Force wide which resulted in 4982 separate missing reports being investigated due to repeat incidents.
- There were 836 missing reports from the **Sandwell** Borough, relating to 296 children which equates to 16% of the Force wide total missing children.