Annual Report 2018/2019

Report prepared and published pursuant to the statutory requirement under section 14A of the Children Act 2004

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1. FOREWARD

This is the Annual Report of Sandwell Safeguarding Children Board (SSCB) and covers the year ending 31 March 2019. As part of the statutory duties set out in working together 2015 the LSCB is required to produce an annual report of its effectiveness of child safeguarding arrangements in its area and the work undertake to promote the welfare of children.

This report sets out the achievements during 2018-19 performed against its agreed priorities, whilst also identifying the improvements that we must continue to address.

The work of the SSCB over the course of 2018/2019 has been focused on the following priorities:

The SSCB was chaired by Audrey Williamson until January 2019 and I would like to thank her for the commitment to Sandwell, driving forward strategic improvements in the way that partners work together to keep children safe. From the period of Audrey's departure to the end of March the SSCB was chaired by the Council's Executive Director of Children's Services, Lesley Hagger.

The introduction of Working Together 2018 meant that the organisation of Children's Safeguarding Boards were changed so that new Multi-Agency Safeguarding Arrangements (MASA) could be introduced. The SSCB was well-prepared to be able to implement these new Arrangements ahead of time, by 1st April 2019.

The Sandwell partners have had a 'can do' approach and have demonstrated that they stand firm in their commitment to work together to keep children safe, to keep staff across our organisations well-informed, supported and trained, and to ensure that our services improve.

Lesley Hagger,
Executive Director of Children's Services
Sandwell Metropolitan Borough Council

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 is the last report for the Sandwell Safeguarding Children Board (SSCB) and it covers the reporting period between April 2018 and March 2019. 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.

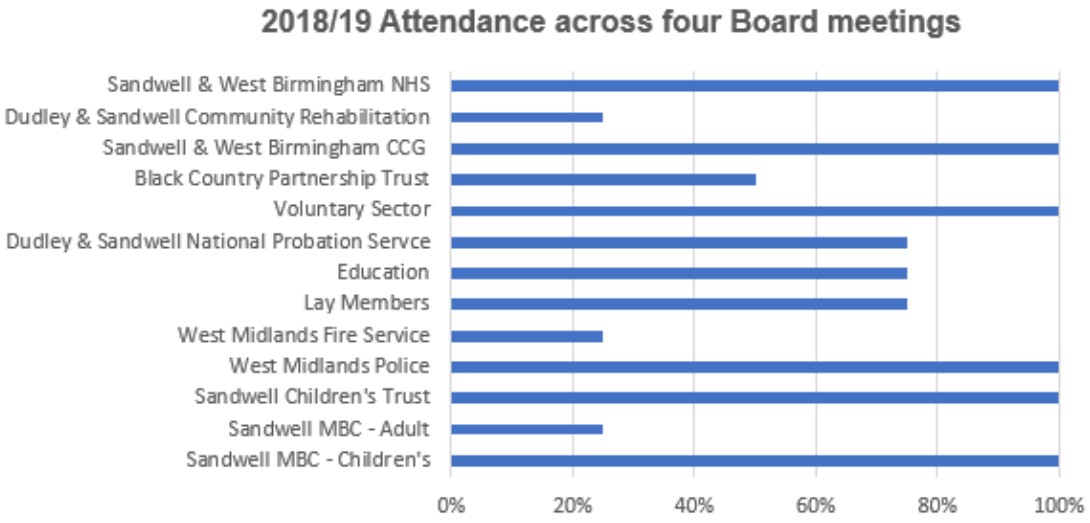
3. Membership and Attendance

SP 1

During 2018/19 there were four main board meetings (in June, September, December 2018 and February 2019). The main board had a membership made up of representatives from all statutory partners and others concerned with safeguarding children.

In addition the SSCB convened an extraordinary meeting of partners in to consult on the new multiagency safeguarding arrangements (MASA).

To assist further with the transition a meeting of Stakeholders (the Safeguarding Partners) met on four occasions to develop the MASA in August, January, November and December.



4. Key Roles and Relationships

Sandwell Safeguarding Children Board is the key statutory body overseeing multi-agency child safeguarding arrangements across Sandwell. The work of the Board is governed by statutory guidance Working Together to Safeguard Children 2015.

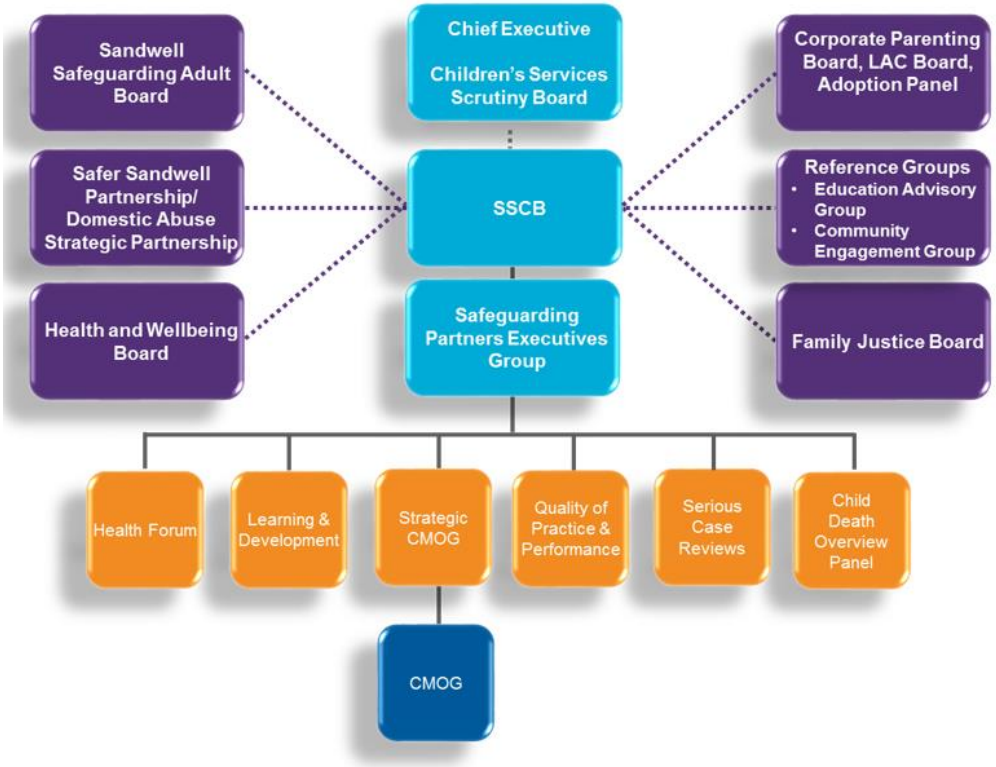
Section 14 of the Children Act 2004 sets out the statutory objectives of LSCBs which are:

- To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in their area; and
- To ensure the effectiveness of what is done by each such person or body for those purposes.

Sandwell SCB has an independent chair, lay member and senior /chief officer representation from a range of statutory and non-statutory agencies/organisations including the voluntary community sector. SSCB members are collectively responsible for the strategic oversight of the local safeguarding arrangement, whilst respectively holding to account their own agencies/organisations performance to lead, coordinate, challenge and monitor the delivery of operational safeguarding practice across Sandwell.

SP 2

5. Structure of Sandwell SCB 2018 - 2019



Summary of SSCB Operating Arrangements

a. Sandwell SSCB meet four times per year for core business meetings to discuss evidence of progress of the delivery of work undertaken against its key priorities by the sub-groups as detailed above. It works to ensure partners are fulfilling their statutory obligations in relation to safeguarding and promoting the welfare of children within their organisations.

b. Standing agenda items would be received from the Quality of Practice and Performance subgroup on performance data, audits and quality assurance activity to provide position statements and identify emerging issues risk and vulnerabilities.

c. Serious case review group would provide position statement on serious incidents reviews commissioned and opportunities for single and multiagency learning from review.

d. The learning and Development sub-group provides multiagency safeguarding training programme based on the needs of the local children's workforce.

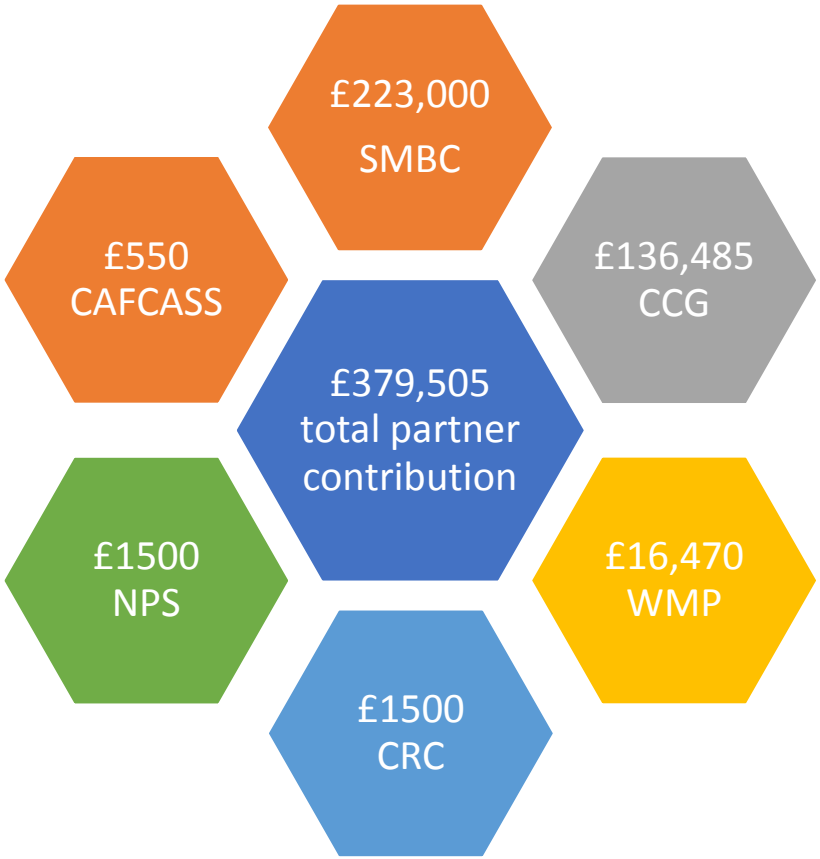
e. Child death overview panel provides the SSCB with data and learning arising from deaths of children and work closely with public health to reduce and prevent unexpected child deaths in Sandwell.

f. The Health Forum share information that is gathered from across the health provider network

g. Strategic and Operational CMOG are responsible for the strategic and operational delivery of the SSCB plans to protect children from the risks associated with child sexual exploitation and going missing. As this work evolved the remit of the work changed to include a wider scope of exploitative situation where children are vulnerable or at risk including county lines and gangs.

SP 3

6. Financing and Staffing 2018 – 2019



Staffing – The SSCB Business Manager left in May 2018, Safeguarding Officer - Quality left June 2018, Child Death coordinator and L&D coordinator took on additional responsibilities to cover the vacant posts.

A Business Support post that previously was not part of the team was recruited to and commenced in August 2018, the vacant Safeguarding Officer – Quality post was filled in September 2018.

There have been two serious case reviews in progress in 2018/19. The cost of serious case reviews amount to £20k and has been funded from the allocated budget. The SSCB has held funds in reserve accrued from a carry forward budget for SCRs from previous years. Three further SCRs were commissioned in 2018/2019, the cost for these reviews have not yet been allocated

The Independent Consultant was contracted in August to support Sandwell with its transition into the new local child safeguarding partnership and its multiagency safeguarding arrangement (MASA). The Independent Consultant also took on the interim Business Manager position from October until a permanent appointment is made.

SP 1

7. What Our Lay Member had to Say

I am encouraged by the fundamental commitment to improving the lives of children in Sandwell within the team. I am confident contributor, treated in a friendly, respectful manner by group members.

Working Together to Safeguard Children 2015 stipulates; 'lay members will operate as full members of the Local Safeguarding Children Board (LSCB), participating as appropriate on the Board itself and on relevant committees. Lay members should help to make links between the LSCB and community groups, support stronger public engagement in local child safety issues and an improved public understanding of the LSCB's child protection work'.

SP 1

Sandwell LSCB has the privilege of retaining an experienced lay member Sharon Wilson, who has worked tirelessly across Sandwell to raise awareness and understanding of safeguarding children in her own profession and as an ambassador for the SSCB within the community we serve. See below what Ms Wilson has to say about her role and the SSCB.

I am dedicated to providing the best outcomes for children and their families, my career and personal behaviour in all aspects of my life demonstrates this.

"I am lay member of the SSCB. My passion is child care and family support. I have worked in this field for thirty years as a nanny, in nurseries, as a nursery practitioner and manager, family centres, a local college and currently as a senior early year's recruitment consultant, specialising in safeguarding in each role.

I am dedicated to providing the best outcomes for children and their families, my career and personal behaviour in all aspects of my life demonstrates this.

I joined Sandwell Safeguarding Children's Board for the above reasons, seeing it as an opportunity to make a difference to children and families strategically as well as on a day to day practical level.

It was a challenging time for the Board as the Ofsted report had just been published (2015); it raised several concerns about the Board's effectiveness. Consequently, the Ofsted report was the main focus and an Improvement Plan was formulated in response to this. The Partnership Business Plan builds on the priorities and progress made since the Ofsted inspection in June 2015, continuing to deliver on its core function of promoting the safety and welfare of children in Sandwell.

I am also a committed member of the QPPA subgroup, having an input into the quality element of practice and performance.

During my time as a Lay Member I have seen a genuine desire of practitioners to do the best for the community in Sandwell.

As a lay member, I bring ground level experience to the discussions. Over the past 12 months I have attended the full board and QPPA meetings. I have also contributed to workshops, sharing front line

practitioners' experiences, comments and feelings, as well as those of children and their parents/carers.
I do not represent an agency; therefore, I give an independent view away from the constraints and jargon of each organisation involved.
I take my position seriously and use every opportunity in my personal and work life to promote and raise the profile of Sandwell Children's Safeguarding Partnership. I spend much of my work and personal time in Sandwell engaging with the community.
I mentor and support early years practitioners in my current employment, in terms of safeguarding policies and procedures, what to do and how to do it and empower them to feel confident in their roles and responsibilities when working with children and families. Another element of my role takes me into early years settings, nurseries, primary schools and children's centres in Sandwell. I promote Sandwell safeguarding arrangements and listen to practitioners, parents/carers and children and feed their comments, views and feelings back into the full board and QPPA meetings.
I have recently presented to a group of Level 3, 2nd year childcare students at Sandwell College, they are due to qualify as early years practitioners in July 2019. I dedicated some of the presentation to telling them about Sandwell Children's Safeguarding Partnership in order that they gain a good understanding in respect of the arrangements and their responsibilities within them.
It is crucial that front line staff in any organisation working with children, have the knowledge and confidence to be able to support children and families in the most appropriate way. I therefore share my experience wherever I can to promote this.
I am encouraged by the fundamental commitment to improving the lives of children in Sandwell within the team. I am confident contributor, treated in a friendly, respectful manner by group members.

There is full agreement within the new partnership that the key to all of our actions is the 'impact on children'. There have been positive changes in recent years, but these have not been quick enough to truly make a difference to many children and families in Sandwell.

With the new strong leadership and governance in place I believe there will be an improved co-ordination of services, resulting in an effectiveness in preventing harm and keeping children in Sandwell safe.

The development and focus of the one front door approach will mean that there will not be a delay in the appropriate services being identified and deployed with children and their families. I am confident that involving the whole family in the process will lead to better outcomes for all.

We need to be assured that all agencies involved in children's lives are engaged in safeguarding meetings and that all front-line staff are trained and skilled to be able to work effectively in partnership with children and families. This will mean that decisions about children's lives will be made within a multi-disciplinary team and without unnecessary delays.

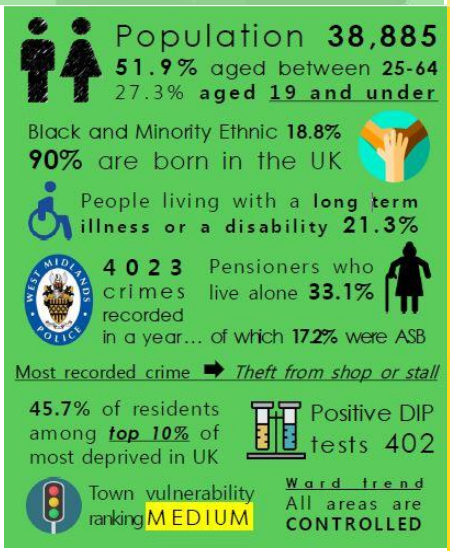
As a Lay Member I will continue to promote the partnership within my work and personal life, bringing relevant information/views shared by members of the public and practitioners to meetings, in order to become part of the decision-making process."

8. What Does Sandwell Look Like?

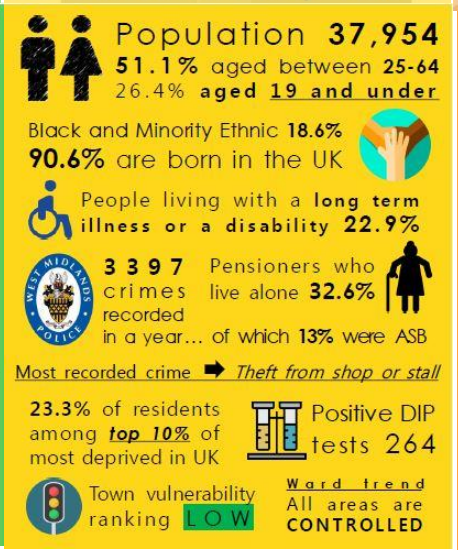
Sandwell is located to the west of Birmingham and shares its borders with Birmingham, Dudley, Wolverhampton and Walsall. Sandwell is a metropolitan borough with six towns; Oldbury, Rowley Regis, Smethwick, Tipton, Wednesbury and West Bromwich and is one of seven local authorities that make up the West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

Sandwell 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. Nonetheless Sandwell is up and coming, a vibrant multicultural town with lots of opportunity to move forward and build on its strengths and successes.

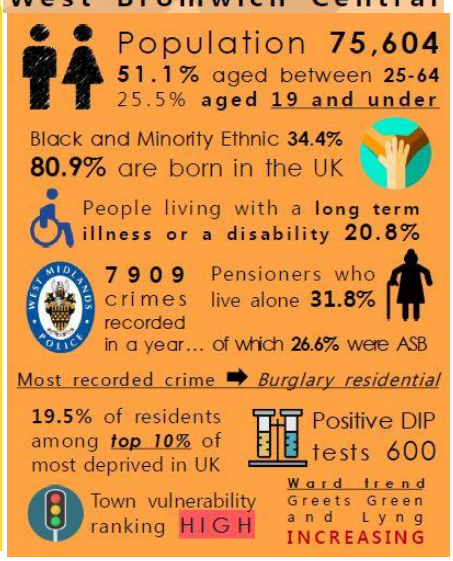
Princes End Tipton Green Great Bridge



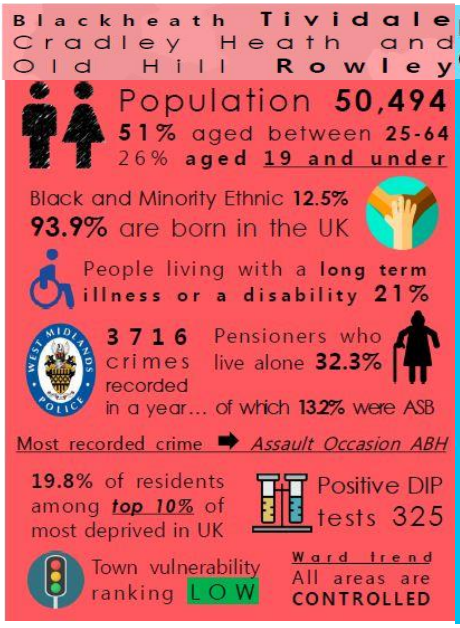
Wednesbury North Friar Park Wednesbury South



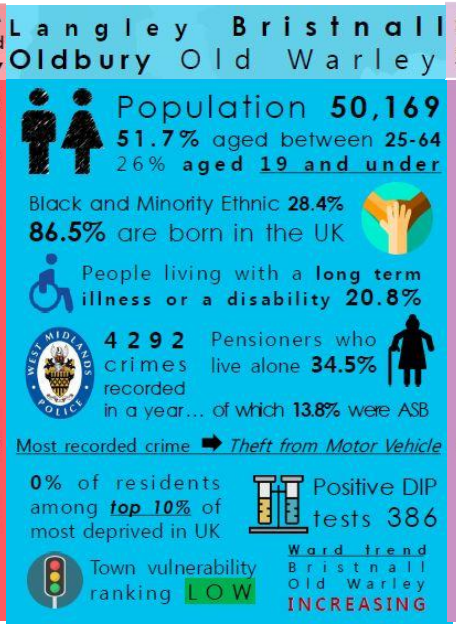
Greets Green and Lyng Newton Hateley Heath Great Barr with Yew Tree Charlemont with Grove Vale West Bromwich Central



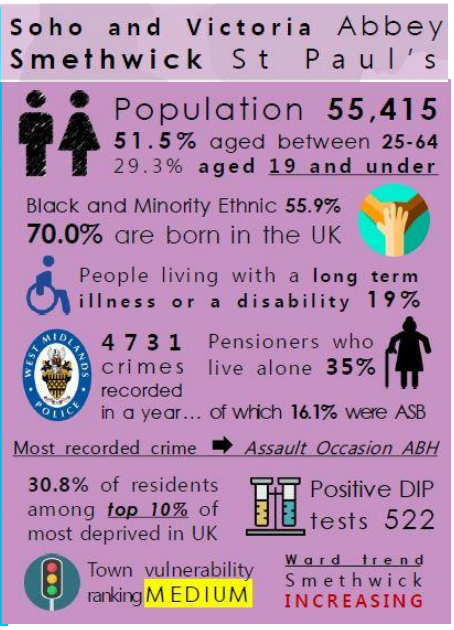
Blackheath Tividale Cradley Heath and Old Hill Rowley



Langley Bristnall Oldbury Old Warley



Soho and Victoria Abbey Smethwick St Paul's



Sandwell Safeguarding Children Board

9. Summary of Key Development

Early Help Partnership – Sandwell CVO and VCS

Why did we do it? How did we know there was a need to do it?

SCVO and VCS leads have led on the Early Help refresh over the last few years providing and facilitating workshops around how Early Help could become more effective, especially with networking and promoting Universal and Universal plus services.

It was identified that there was a lack of understanding of what universal services there are across Sandwell. Through various forums and networking events it was agreed that better intelligence and partnership working would improve the offer of services and support for children, young people and their families.

We established the Early Help Partnership and have met regularly to see how resilience could be built at a lower level to stop families needing more targeted support

SP 2

How much have we done in the last 12 months up to 31st March 2019?

Since March 2018 we have held an Early Help Partnership networking event in Smethwick and also West Bromwich.

The meeting in West Bromwich focused on bringing together local, grassroots level providers to network and discuss the issues and challenges their local community faces. We had 41 attendees:

- 60% Voluntary and Community Sector
- 20% Education
- 7% Sandwell Metropolitan Borough Council
- 7% Public Services
- 2% Other

The Early Help Partnership also held a borough-wide event engaging organisations, services and schools from across Sandwell. We had 45 attendees – over half from the voluntary and community sector and there was also a good representation from schools, Sandwell MBC and Sandwell Children's Trust.

The event enabled members to network, make new connections, share successes and discuss how we might overcome current challenges in supporting young people and families. Members then shared their thoughts on which areas of vulnerability were the greatest concern to them in their work, and where they could share best practice or effective agency working. Attendees were asked to indicate which group they thought presented greatest concern in their service delivery.

We continued to promote the Sandwell Family Life website. At our Partnerships and Possibilities event in November we had 180 services. At present we now have 405 services and activities listed on the website.

The Early Help Partnership steering group met regularly but our activity needed to greatly reduce due to uncertainty in regards to funding moving forward and out Early Help Coordinator moving on.

Impact - How well did we do it? - Is anyone better off? - How do we know they are better off?

The Early Help Partnership provided and will continue to provide:

- An opportunity to learn/share best practice
- An opportunity for networking and the development of cohesive joined-up services for children and families
- An increased knowledge of universal services by all local providers
- An increased number of local providers committed to collaborative working and sharing good practice
- An improved partnership practice by EH providers meaning more timely, appropriate and effective support for children & families
- An improved communication of ground level intelligence which would feed into strategic landscape and vice-versa
- Confidence to deliver Early Help in local communities
- An improved visibility of EH available and improved access to such support
- An increasing confidence of providers to provide higher quality & more effective support
- Understanding re. the role of ACEs, how if fits within EH and Targeted services and how the VCS and wider communities can engage with it

Areas for Development or Assurance Action

SCVO have recently appointed a new Partnership Co-ordinator who will be able to engage partners and also promote the Sandwell Family Life Portal as well as promote regular Early Help partnership events. We also plan to develop our social media following (@earlyhelpptr) to raise the profile of the partnership and will continue to send out our e-bulletins.

The Early Help Partnership will continue to promote usage of Sandwell Family Life website as well as share relevant holiday activities and support information for children, young people and families across Sandwell. We will also consider our next programme of events and activities. And will be seeking more places to promote the Sandwell Family Life site by poster, video and face-to-face meetings.

The Early Help Partnership is also in the process of ensuring that we effectively link with targeted services and the COG's.

Sandwell Children's Trust

The creation of the Sandwell Childrens Trust was deemed, "a crucial opportunity to improve the services that we offer to the most vulnerable children and families in Sandwell" by Jacqui Smith.

Why did we do it? How did we know there was a need to do it?

Sandwell Metropolitan Borough Council, which retains statutory responsibility for Children's Services in the borough, following an inadequate rated Ofsted inspection introduced an independent trust to run Sandwell's children's social care services.

The Trust was officially launched on Sunday 1st April 2018. Jacqui Smith is the Chair of the SCT Board and Frances Craven is the Chief Executive. The creation of the Sandwell Childrens Trust was deemed, "a crucial opportunity to improve the services that we offer to the most vulnerable children and families in Sandwell" by Jacqui Smith.

The approach to improvement in the first year of Sandwell Children's Trust has been one of **'Responding and Getting the Basics Right'.** This has been to:

- Ensuring stable leadership and robust management structures are in place
- Ensuring demand is understood and addressed through stabilising the workforce
- Ensuring governance is in place for improvement
- Ensuring frameworks are in place for Quality Assurance and Performance
- Ensuring partners are engaged on our improvement journey
- Ensuring there are clear minimum standards of practice and children are safe

The next stage for our improvement is **'Building on Strengths and Ensuring Impact'.**

How much have we done in the last 12 months up to 31st March 2019?

Key improvements relevant to the SCSP are:

- A stable and permanent senior leadership team (at Director Level and very soon Head of Service level) has and will foster organisational stability, making sustained improvement more likely.
- A clear performance dataset, regular reporting and governance cycle established to ensure that all staff are held to account for their performance.
- Review of the Front Door by Children's Services Advisors and subsequent implementation plans have ensured that thresholds in the front door are applied consistently and safely for children.

SP 2

- Additional capacity within the IRO / CP Chair service has been put into place to ensure that all children have the benefit of a comprehensive independent review of their situation not only at review points but in between.
- A review of the LADO function, improved performance dataset and subsequent changes made to process / procedure to ensure that our response to allegations are more robust and the LADO is held to account.
- A change in approach for children subject to Child Protection Plan that had led to a safe reduction in children subject to CP Plans for longer than 12 months.
- Directors resource panel is now in place that ensures, (amongst other things), that decisions for children coming into care are timely and appropriate.
- Implementation of the workforce strategy (12 reasons) has led to the recruitment of more qualified and experienced social workers than we have ever had.
- Minimum standards and revised processes and procedures for a wide range of our work has been developed to ensure that practitioners have a solid foundation for consistent practice.
- SCT's involvement in the Graded Care Profile rollout will ensure that social workers (in addition to all partners) will have a solid understanding of how to assess neglect within families and work with them to reduce this.
- Exploitation and Contextual Safeguarding strategic and operational arrangements are in place, which, in time, will ensure that our response to this complex area of work is as robust as it can be across the partnership.
- Review processes / procedures and practice guidance for MARAC and MAPPA.

SP 3

Impact- How well did we do it? - Is anyone better off? - How do we know they are better off?

As stated in the previous section, given the scale of improvement needed, impact is expected to be better seen in the coming 12-24 months. However, there are signs of improvement as follows:

Demand and Threshold

- The increased referral rate to SCT in 2017/18 has been maintained for 2018/19 and is 782.79 per 10,000 children.
- The average percentage of contacts that are accepted as referrals within 24 hours in 2018/19 is 75.5%, which is a slight improvement from the previous year (74%).
- The % of referrals that are re-referrals within the last 12 months has slightly increased over the course of this year (from 21.06% to 24.1%), but is in line with our comparators.
- The rate of S47 enquiries per 10,000 has reduced in the year 2018/19 to 295.24 from 339.00 the previous year.

- The percentage of S47 enquiries held within 15 working days has been consistently high at an average of 94.8% in 2018/19. This is an improvement from the previous year when this was 90%.
- Throughout the year 2018/19, the rate of children subject of a Child Protection Plan per 10,000 has reduced from 99.93 at the start of the year to 72.0 at the end of the year, a reduction of 214 Child Protection Cases.
- The rate of ICPC's per 10,000 has also reduced from 141.3 in the previous year to 108.95 this year.

This shows that we have continued to have to handle referrals at a rate far higher than our comparators. However, alongside dip sampling of assessments, S47's and ICPC's the above measures provide clear evidence that we are acting more confidently and consistently when applying thresholds for our services, and working in a more timely fashion.

Assessments

- The rate of assessments completed in 2018/19 was 669.2 per 10,000 children in Sandwell. This is in line with our statistical neighbours, but remains above the West Midlands and England Averages.
- Whilst there has been a dip mid-year, the percentage of Single Assessments completed within 45 working days is 81.3% on average. This is slightly below our comparators.
- On average in 2018/19, the percentage of children visited within 5 days of their assessment starting is 64.6%, which is a slight improvement on March 2018 (which was 64.3%).
- The percentage of open Single Assessments beyond 45 working days has significantly improved within the year, from 19.7% in May 2018 to as low as 3.6% in October 2018. Although the 2018/19 average is 10.1%, the latter half of the year average is 7.4%.

Whilst there is more to do in ensuring our assessments are completed in a more timely way, the data shows us that towards the latter half of the year 2018/19 backlogs were being addressed, and children were being visited more as part of their assessment. This provides a solid foundation for improved performance in 2019/20.

Child Protection Planning and Review

- The percentage of Review Child Protection Conferences held within timescale in 2018/19 was 88.8%, which is better performance than our statistical comparators and 13% higher than the previous year.
- The percentage of Child Protection Plans updated within the previous 6 months has reduced over the course of the year, from 94.3% to 85.7%.

- The average percentage of Children visited within local timescales is 78.2%, which is a slight improvement on 2017/18. However, this needs to improve further.
- On average over the course of the year, 18.1% of our children subject of a Child Protection Plan have been for over 12 months, (calculated as an average of month end percentages). This is slightly above all our comparators.
- On average over the course of the year, 0.76% of our children subject of a Child Protection Plan have been for over 2 years (calculated as an average of month end percentages), which is well below all our comparators.
- On average 18.62% of children made subject of a CP Plan had been previously subject of a CP Plan (calculated as an average of month end percentages). This is below all our comparators.

This information shows that whilst Social Workers can do more to review progress of their interventions in between Child Protection Conferences, when cases are reviewed formally, decisions are made in a more timely way and have led to purposeful interventions. This means re-referrals and repeat Child Protection Plans are reduced.

Children in Need

- The average percentage of Children visited within local timescales is 68.3%, which is an improvement on 2017/18 (62.7%).
- The percentage of Child in Need Plans updated within the previous 6 months has maintained over the course of the year at or around 85%, the average being 83.1%. This is an improvement from the previous year, which was 76.5%.
- Over the course of the year, activity has been in place to safely reduce the number of children in need open to SCT for longer than nine months. As a percentage of all Children in Need, this increased in year to 36.66% in July 2018. This has been reduced to 28.08 at the end of the year. There are no historic comparators in this measure.

Intervention through Children in Need plans need to be purposeful and time limited, and therefore reviewed regularly. We recognise that further improvements need to be made in this area.

Contextual Safeguarding / Exploitation

- The average number of children recorded as missing in Sandwell is 41.25, just under double it was in 2017/18. On average, 21.25 of this cohort are Looked After by Sandwell Children's Trust, which represents around 52% of all missing children. This compares with around 26% in 2017/18.
- Within 2018/19, the average percentage of Return Home Interviews undertaken within 72 hours is 65.2%.

- There has been a reduction over the year in children assessed at risk of Child Sexual Exploitation, moving from circa 100 children in April 2018 to between 40 and 50 towards the end of the year, with a higher percentage being assessed at high risk of CSE (moving from around 5% to 10-17% in December 2018 – March 2019). Figures have stabilised on recent months.

Whilst there is still further work to do to obtain a fuller dataset and understanding in this area, what is clear is that a more targeted approach is being taken that addresses the needs of the most vulnerable to CSE. More children are recorded as missing, which highlights that we are ensuring oversight in this cohort of children, and that we have a better understanding of those missing children who are Looked After.

Quality Assurance and Auditing

- In 2018/19, 634 Audits were completed, which gives a coverage of around 25% of our total cases. Over the course of 2018/19 the percentage of cases rated as Requires Improvement or Better has been variable, but has improved. On average, 60% of cases have been rated RI or better, but in the last Quarter of 2018/19 this average was 67.6%.

SP 2

Across the year, the QA dataset has expanded to include the outcome of various sections within the Audits, alongside the quality of the audits completed. This is a work in progress and meaningful data will be available over time. Nevertheless, this evidences that the quality of the work found in audits is gradually improving.

Areas for Development or Assurance Action

It is clear there is some way to go, but as stated earlier, the first 12 months of Sandwell Children's Trust is **'Responding and Getting the Basics Right'.** Amongst our strategic priorities in SCT, areas for development and further improvement in the next 12 months are:

- Building a strong Exploitation offer that effectively safeguards children at risk in the context of exploitation.
- Building an Edge of Care offer that safely prevents children from being placed in care and more effectively manages risk within families.
- Ensuring that safeguarding is as strong throughout the organisation as it is in our front door.
- Ensure that our practitioners have the tools to assess and intervene in the areas most prevalent within Sandwell, namely, Neglect, Alcohol and Drug misuse.

SP 3

Please see the table at Appendix 1 for all the improvement activity within SCT's first year of operation.

Education, Skills and Employment of Children in Sandwell

Why did we do it? How did we know there was a need to do it?

We want our Children's Services to be aspirational, we will ensure that children in Sandwell are safeguarded and that adverse childhood experiences are minimised.

Ambitions and priorities detailed in Children's Services business plan confirms the Education Skills, and Employment Directorate commitment to the 2030 Sandwell vision with specific contributions to ambitions 1, 3 and 4.

1. High aspirations
3. Skilled and talented workforce
4. High quality education

SP 1

For example, Attendance & Prosecutions Service outcomes can be summarised as **"reducing lost learning, safeguarding and improving life chances for children"** clearly demonstrating Service contribution the priorities above.

The attendance & prosecution service has achieved the above via consistent support to the Sandwell Children's Trust via its contribution to the success of the MASH partnership and the support provided to schools' "designated safeguarding leads" etc. Service commitment to raising aspirations is further confirmed by work undertaken in relation to education otherwise than at school i.e. the placement of young people with alternative providers and the significantly improved engagement of EHE families with the local authority.

Keeping Children Safe in Education – September 2018 requires a child centred and coordinated approach to safeguarding, requiring educators to provide a safe environment in which children can learn. (See also Working Together to Safeguard Children 2018).

How much have we done in the last 12 months up to 31st March 2019?

The Education & Skills Directorate makes a significant and a wide-ranging contribution to the Sandwell safeguarding agenda in a variety of service delivery areas. For example, the Education Advisory Group EAG) provides the link between the Sandwell Childrens' Trust, SSCB and Schools whilst "education representatives" based within the multi-agency safeguarding hub gather information and contribute to screening and strategy discussions.

Hub staff also notify schools of incidences of domestic abuse under the national banner of "Operation Encompass" (see below) support MARAC plus learning & development via training and half-termly forums for designated safeguarding leads.

Staff performing a variety of management and leadership functions within the Directorate also support the following:

- Individual Agency Reviews / Serious Case Reviews / Domestic Homicide Reviews and Child Death Overview Panel meetings etc
- Position of Trust meetings (% of total education PoTs)
- Audits and support to the quality, practice and performance sub-group

Specialist officers support early years, school age and post 16 children and young people plus those identified as belonging to certain vulnerable groups, including:

- SEND – special educational needs / disabilities
- Children Missing Education (not on roll)
- Children Missing from Education (part-time / alternative provision)
- Elective Home Educated
- Excluded or at risk of exclusion
- Child Employment & Entertainment Licensing
- Irregular / persistent absentees

- **Operation Encompass (launched in Sandwell in February 2019) is a National police and Education early intervention safeguarding partnership that supports children and young people exposed to Domestic Abuse. It aims to ensure Schools are notified in a timely manner of any Domestic Abuse incident where child/ren are present or registered at the address.**

- School feedback regarding Operation encompass

  Full info provided by the team via a launch event – including what to expect, letter for parents, scenario's etc. Really helpful that staff were asked for feedback after 3 months and review meeting was arranged to discuss progress/problems and look at good practice etc. Gives school insight into how notifications are collated and distributed etc. Also, great that 'Our Future' project from BCWA was included on the review meeting agenda.

On 28/11/2018 the DSL safeguarding forum was "handed over" to 4 young people from SHAPE to discuss what safeguarding means to them and how they feel about this. Issues covered included young people's perspectives on mental health, local challenges and contextual safeguarding etc.

Impact - How well did we do it? - Is anyone better off? - How do we know they are better off?

Feedback from schools' designated safeguarding leads include the following?

- The support we receive from education staff in the MASH is outstanding. We feel that because you have more experience

and knowledge of education, your responses and advice reflect this.

- The DSL forum is our safety net, there is always an opportunity to discuss our concerns and we feel they are genuinely heard. When concerns have been raised we always receive feedback about what the response was from the Trust etc.
- The Serious Case Review outcomes training I have attended this year has been very informative.
- MASH education staff able to contact the right managers to escalate/remedy issues …e.g. Quality and practice leads are notified where a gap has been identified in knowledge of new social workers.
- Timely receipt of notifications and agenda's for DSP meetings plus 'Safeguarding in Education Newsletter' provided includes latest guidance, research, resource lists, Police info. Etc. This helpful for school staff

Wide range of topics and speakers are arranged for DSP meetings – really useful for building practitioner knowledge and hearing from speakers working 'in the field. Topical issues are also addressed quickly. Meetings are well managed and schools appreciate being able to air concerns constructively/give scenario's which have caused them issues when managing safeguarding.

Areas for Development or Assurance Action?

The Learning and Development sub group is chaired by an education representative. This means they are ideally situated to respond to emerging issues and development needs including the following:

Safeguarding compliance visits for schools to support preparation and completion of s175 audits

Further development of the train the trainer - Graded Care Profile 2 programme sponsored by the NSPCC. **GCP2** is an assessment tool that supports practitioners to make a judgement about whether or not parental care is neglectful. The tool helps practitioners to measure the quality of care given to a child, and make it easier for professionals to spot when sub-optimal parenting is putting a child at risk of harm.

Sandwell and West Birmingham Clinical Commissioning Group (CCG)

Why did we do it? How did we know there was a need to do it?

Sandwell and West Birmingham Clinical Commissioning Group (CCG) Safeguarding Team is fulfilling its statutory duties in relation to safeguarding children and adults and in respect of all the services they commission.

Safeguarding which encompasses protecting people's health, wellbeing and human rights enabling them to be free from harm, abuse and neglect is implicit in all aspects of our work. Compliance is assured via completion of Section 11 audit tool and evidenced in NHS England Safeguarding Assurance Tool pilot.

The CCG as a key partner is fully engaged with the new multiagency arrangements with executive and designated representation at the strategic partnership meetings. The former SSCB health forum has completed a reformation; with revised terms of reference and governance to support communication and a health economy approach to meet health's statutory responsibilities under the new arrangements. The CCG is fulfilling its statutory responsibility as a Child Death Review Partner in accordance with the new legislation. We continue to actively demonstrate a commitment to safeguarding all children and adults within the community we serve.

SP 1

How much have we done in the last 12 months up to 31st March 2019?

Sandwell and West Birmingham CCG **deliver face-to-face safeguarding training to level 3 practitioners.** This training will enhance level 3 practitioners' knowledge in terms of contextual safeguarding. NHS England, The Royal College of General Practitioners (RCGP) and the National Society for the Prevention of Cruelty to Children (NSPCC) have developed a Safeguarding Children and Young People safeguarding toolkit for General Practice to help ensure that member practices safeguard the children and young people in their care. The Primary Care Safeguarding Lead has revised the self-assessment assurance tool to include adults at risk. This tool helps practices to consolidate and improve practice, and should be part of an on-going organisational development and risk assessment. The assurance toolkit has been presented at both Sandwell and Birmingham Local Medical Committees to secure endorsement throughout Sandwell and West Birmingham member practices.

Promoting the health and wellbeing of looked after children remains a priority. The CCG's Designated Nurse for Looked After Children has continued with the responsibility of chairing the Regional Looked After Children Nurse Forum, and represents Sandwell and West Birmingham CCG at the National Looked After Children Forum.

The Safeguarding Team have been instrumental in initiating the **CSE Superhero Campaign**. This is an innovative project developed by SWB CCG in partnership with the Children's Society and has been endorsed by NHS England. In excess of 220 individuals have completed the training including nurses, GPs, safeguarding staff, practice managers, paediatricians, midwives, lecturers and students from a variety of organisations including Birmingham Community Healthcare Trust, Sandwell and West Birmingham Hospitals Trust, Sandwell College, Solihull Metropolitan Borough Council and Black Country Partnership Foundation Trust. The feedback from the training has been overwhelmingly positive. 73% of respondents rated their knowledge of CSE after the training as very high; and 96% of respondents said their confidence in recognising the signs and symptoms after watching the film had increased. 90% of delegates who responded reported that the objectives of the training had been met and 99% said they would recommend the training to others.

SP 3

IRIS is a general practice-based domestic violence training, support and referral programme for primary care staff. It is a targeted intervention for female patients aged 16 and above experiencing current or former DVA from a partner, ex-partner or adult family member. IRIS provides care pathways for all patients living with abuse as well as information and signposting for male victims and for perpetrators.

Sandwell and West Birmingham CCG safeguarding team are in a unique position in that they provide a safeguarding nurse to represent GP information at **Sandwell's Multi Agency Risk Assessment Conference (MARAC)**. MARAC provides a forum for effective information sharing and partnership working to enhance the safety of high risk Domestic Abuse (DA) victims and their children; by devising a safety plan around the family.

The **LeDeR programme** was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives. The Black Country Steering Group was established in 2017 and includes; Sandwell and West Birmingham, Wolverhampton, Walsall and Dudley CCG. The aim of the group is to implement the local recommendations that are being identified following reviews.

The Health Forum (chaired by the CCG Designated Nurse) which was a subgroup of the LSCB has become a reference group to the SCSP with revised TOR and work plan aligned to the partnership's key priorities. It is now known as Sandwell Safeguarding Health Partnership.

Impact - How well did we do it? - Is anyone better off? - How do we know they are better off?

The Primary Care Safeguarding Lead has worked very closely with the Head of IT to embed safeguarding reports for Initial Child Protection Conferences within patient electronic health records to support engagement. The pilot of this template proved to be successful with positive feedback.

GP Feedback: ICPC pilot is much better than the previous system. It auto-populates the form and allows you to electronically send the

form back to safeguarding (along with recording the form in the notes). This has saved me quite a bit of time!

- Primary Care represented at the Multi Agency Risk Assessment Conference by the Lead Nurse for Safeguarding
- Further funding secured for to extend the IRIS Programme across member practices within the CCG at end of March 2019, 75% of member practices are engaged.
    - The Primary Care Safeguarding Lead has worked very closely with the Head of IT to embed safeguarding reports for Initial Child Protection Conferences within patient electronic health records to support engagement. The pilot of this template proved to be successful with positive feedback.
- GP Feedback: ICPC pilot is much better than the previous system. It auto-populates the form and allows you to electronically send the form back to safeguarding (along with recording the form in the notes). This has saved me quite a bit of time!
- Primary Care represented at the Multi Agency Risk Assessment Conference by the Lead Nurse for Safeguarding
- Further funding secured for to extend the IRIS Programme across member practices within the CCG At end of March 2019, 75% of member practices are engaged.
- Health representation within MASH provide quality information, robust analysis of risk and contribution to the decision making process to safeguard Sandwell's vulnerable children.

SP 2

- Modern Slavery local pathway has been developed to sign post health professionals, this has been acknowledged by WMASN as good practice.
- Superhero campaign endorsed by NHS England has been shared nationally
- CSE Protective Behaviour training facilitated at Sandwell College.
- The Designated Nurse for Safeguarding Children is a member of the National Working Group for CSE and CSA.
- Worked with Fixers to raise awareness of exploitation and knife crime with children and young people.

SP 3

- The CCG Designated Nurse for Child Death continues to Chair the joint Sandwell & Dudley Child Death Overview Panel (CDOP).Baby Box Scheme: This campaign, which was initiated by the CCG, and then taken up by baby Box Co., it continues to gain momentum.
- Safer Sleeping: The Dog, Duck and Cat Resources moved to a charitable Trust in 2017-18, whilst still working closely with Sandwell CDOP and the Designated Nurse for Child Death.

- A new resource called 'Please Don't Fall Asleep with Me' was developed to support with the safer sleeping campaign.
- This tackles the dangers of co-sleeping and sleeping on the sofa in conjunction with advice from the Lullaby Trust.

http://www.dogduckandcat.co.uk/stories-0-5/please-dont-fall-asleep-with-me/

- Training: The Designated Nurse for Child Death has delivered joint training with the Lullaby Trust to frontline practitioners using anonymised case studies to support the safer sleeping message.
- Training has also been delivered to Sandwell College Students on learning from child deaths to include issues around suicide, road traffic accidents and safer sleeping deaths.
- The Designated Nurse for LAC Chairs the Regional LAC Health Group and represents the Midlands Region at National Meetings and is sited in the Standard Approach Document.
- Development of GP Guidelines to improve response rate of GP summarised to inform health assessments.

Areas for Development or Assurance Action

The initiation and mobilisation of an effective Sandwell Safeguarding Health Partnership to support a health economy approach to safeguarding and promoting the welfare of children in Sandwell and delivery of the SSCB priorities.

Sandwell & West Birmingham NHS Trust

Why did we do it? How did we know there was a need to do it?

Sandwell and West Birmingham NHS Trust (SWBT) is a provider of both acute hospital and community services for the people of West Birmingham and across six towns in Sandwell, serving a population of around 500,000 people, and employing 5,912 staff. SWBT provides community and acute services in a range of settings; Adult and Paediatric Care including Emergency Care both general and Birmingham and Midland Eye Centre, Maternity and Neonatal Care.

Safeguarding children remains a key priority for SWBT which is demonstrated by a clear line of accountability and reporting structure in the provision of services designed to safeguard and promote the wellbeing of children from frontline through to our Chief Nurse as the Executive Lead for Safeguarding Children. Our dedicated Safeguarding Children Team with Lead and Named professionals support the workforce offering advice, support and training. We have a robust assurance and quality framework which is demonstrated through a programme of review via our internal committees.

SP 2

SWBT is fully involved with the emerging multi-agency safeguarding arrangements (MASA) with Chief Executive and Chief Nurse representation at senior partnership meetings. This includes the Safeguarding Children Lead Nurse being a key member of the revised Sandwell Health Forum now called Sandwell Safeguarding Health Partnership and Named professionals being represented at various sub-groups aligned to the new MASA.

SWBT is required statutorily to ensure we are compliant with Section 11 of the Children Act 2004 and the Care Quality Commission (Registration) Regulations 2009. This is demonstrated by submitting an up to date Section 11 audit and compliance with Care Quality Commission and audit recommendations following internal inspection, safeguarding children training and supervision; in addition to recommendations following domestic homicide reviews and serious case reviews

How much have we done in the last 12 months up to 31st March 2019?

We continue to embed the Child Protection Information Sharing Project (CP-IS) in our Emergency Departments (ED) and regular audit has demonstrated that staff are viewing the summary care record and making the appropriate referrals. This will be enhanced further once Sandwell Children's Trust goes live with CP-IS in April 2019. Our Associate Named Nurse will support staff within ED or the paediatric wards where they may have concerns. The safeguarding children team continue to offer advice and support to staff which has been enhanced by the introduction of a duty rota for advice calls

The team continue to deliver a rolling programme of Level 3 safeguarding children training mapped against the RCPCH Intercollegiate Document 2014. Compliance is monitored closely with monthly reports included in our Corporate Review meeting with the Chief Executive; compliance remains a challenge. Level 3 currently stands at 84%. Child protection supervision is delivered to health visitors on a three-monthly basis over the year this has remained constant at over 80%. Areas where this has remained on

an ad hoc basis are maternity and the paediatric ward areas due to staff vacancies. This position will be remedied in 2019/20 due to the appointment of safeguarding professionals in the team.

Our Looked after Children's Team has recently expanded due to the significant increase in children looked after in Sandwell with numbers now over 900. We have worked closely with the Children's Trust to improve communication and transfer of required paperwork to facilitate the statutory health assessment process to ensure the health needs of this vulnerable group are met. This has proved beneficial with our administrator sitting two days within Sandwell Children's trust looked after Children service and at year end we achieved 88% completion of review health assessments; which is above the national average of 85%.

SP 3

We deliver a programme of audit which includes for example the review of the Child Sexual Exploitation (CSE) flag we added to our patient records to ensure practitioners are intervening to support children at risk of CSE. Audit has demonstrated practitioners are making appropriate referrals and notifying social workers when children attend our ED. Further audits include quality and thematic review of completed MARF's and audit of maternity records to ensure identified concerns have been shared with key professionals.

The Emergency Department (ED) Domestic Abuse Advocacy Project (joint partnership with Black Country Women's Aid) continues to show positive outcomes by increasing awareness and visibility of domestic violence and abuse (DVA) in ED and across SWBT; in the last twelve months 220 individuals have been identified as victims of DVA, comparable to numbers for 2017/18 and brings the total figure since the project went live in November 2015 – July 2018 to over 490 victims being identified. Data continues to demonstrate that the project identifies victims who are unknown to services and from BAME groups.

We have been successful in securing part funding from Safer Sandwell Partnership and recurrent SWBT funding agreed by our Chief Executive and Chief Nurse.

Our domestic abuse lead nurses continue to work within MASH to share information with health professionals when there has been an incident of domestic abuse. The team have worked with the ED IDVA's across SWBT to raise awareness of domestic abuse with the introduction of routine enquiry in key areas such as sexual health and paediatric ward areas. The team work closely with the CCG MASH nurses with regard to strategy meetings in MASH and attendance at MARAC to share appropriate health information across the health economy.

SP 2

Impact - How well did we do it? - Is anyone better off? - How do we know they are better off?

The ED IDVA project continues to prove positive with 50% of victims of domestic violence and abuse (DVA) previously unknown to services. We have also found that more BAME and varied ages of victim engage through ED.

National data identifies pregnancy of increased risk of DVA. SafeLives found that around 30% of DVA begins during pregnancy;

the project has identified 33 pregnant victims through ED having reviewed data up until July 2018.

83% of referrals through to the ED IDVA in Sandwell engaged with support services and direct feedback from a client acknowledges that the crisis intervention offered in ED is positive:

'You have been so supportive and informative during one of the hardest times of my life. Having an independent body to speak to and your ongoing support since all this has happened has helped massively. I don't think I would have got through this so positively without you!'

Our Domestic Abuse Lead Nurses have successfully raised awareness across SWBT of domestic abuse and SWBT is promoted as a Domestic Aware Hospital

During the reporting period we have introduced a quarterly Safeguarding Children Newsletter which will share findings from serious case reviews, domestic homicide reviews and multi-agency audits in addition to highlighting key legislative changes and guidance updates.
We continue to deliver a programme of level 3 face to face safeguarding children training to improve frontline staff's knowledge of contextual safeguarding. Further training delivered by the safeguarding children team includes bespoke domestic abuse training and court report writing. We have also delivered specific safeguarding children topics such as CSE at SWBT Quality Improvement Half Days.
Health representation in MASH contributes to the risk assessment with partner agencies by sharing appropriate health information. In addition this facilitates timely information sharing within health.

Areas for Development or Assurance Action

1. Maintain effective multi-agency partnerships and representation with the emerging MASA arrangements.
2. Continue to monitor Looked after children processes jointly with Sandwell CT
3. Continue to embed CP-IS across unscheduled care settings
4. Continue to evaluate the IDVA project and audit routine enquiry compliance
5. Continue to review service delivery through a programme of audit, data capture and evaluation
6. Update level 3 Safeguarding children training in line with RCPH 2019
7. Embed a programme of formal supervision in Maternity and Paediatric areas

West Midlands Police

Why did we do it? How did we know there was a need to do it?

West Midlands Police (WMP) Vision is 'Preventing crime, protecting the public and helping those in need'. The 3 year Police and Crime Plan identifies a number of objectives to tackle crime related to children and young people including underreported and often hidden crimes, such as Child Sexual Abuse, Child Maltreatment, CSE, Modern Slavery and Trafficking and FGM. The force has invested in a dedicated and specialist Public Protection Unit that leads on all such investigations as well as Neighbourhood Policing Units who lead on early intervention, prevention and engagement. This includes a focus on intervening early to prevent future offending. WMP makes it clear to all staff that safeguarding is the responsibility of everybody.

How much have we done in the last 12 months up to 31st March 2019?

Our safeguarding priorities

WMP is involved in a wide variety of activity, throughout Sandwell and indeed the force area that is focused on the safety and welfare of children and young people. A selection of examples includes:

- We have developed an external communications campaign aimed at children and young people so that the police are seen as 'safe' and not to be 'feared'. Twitter, a rolling video for police buildings, school visits and blogs have been used. Examples include:

SP 2

  - **SEE ME HEAR ME** - We have been continuing to take a partnership approach to CSE communications through the regional See Me Hear Me Communications Group. Messaging has taken place throughout the year with highlights including targeting teachers, putting out 'Gaming with AJ', a male CSE product, and specific communications on CSE Day on 18 March.
  - **FGM conference** - Communications support was provided for the national FGM conference including running the social media account on the day and designing and producing temporary henna tattoos and broadcasting how the force is working with partners to end FGM.
  - **Knife crime** – WMP is currently running a major knife crime campaign encouraging parents to talk to children and supporting conversations in schools with a schools pack. Local officers continue to visit educational establishments to support this.

- WMP works closely with the elected Youth Commissioners who represent the Police Crime Commissioner (PCC) and are an essential part of the WMP and the PCC youth engagement strategy. They undertake project work and leadership training, looking at key areas of policing that affect young people. They meet regularly with their local NPU Commander and are involved in various consultations feeding back the voice of young people.

- Operation Sentinel is a long term police initiative that was implemented in 2013. Its aim is to 'make hidden suffering of children and vulnerable people everybody's business'. Feedback informs us that Sentinel is now embedded locally and nationally and is recognised as a brand in its own right in relation to hidden crime. The initiative is aimed at enhancing the service provided by WMP and its partners to victims across the force area, who remain hidden and silent for a number of reasons. These reasons can include mistrust of statutory agencies, fear for personal safety and the influence of family, cultural beliefs and behaviour.
    - In 2018 'Vulnerability in Volume Crime" was the theme. This aimed to ensure that frontline officers and staff were fully aware of issues relating to hidden harm when they are conducting their day to day duties. This afforded us the opportunity to identify issues at an early stage and uncover the true extent of harm which would otherwise be invisible. A training package was developed to up skill staff in this area.
- **FGM** - WMP continue to be actively involved with Operation Limelight, an initiative at Birmingham Airport which involves intercepting passengers on incoming and outgoing flights which are bound or returning from areas of the world where FGM is conducted. The operation has proved extremely informative for police, partners and the public with regard to prevention and raising awareness. WMP held a national 350 delegate, free multi-agency conference on 6th February 2019 on International Zero Tolerance Day for FGM where further awareness was raised in relation to Harmful Practices, Witchcraft and FGM.
- West Midlands Police maintains a collaborative focus on **Road Safety**, something that we know from young people in Walsall is an area of concern - Initiatives include:
    - WMP Roads Policing has launched a new force wide Community Speed-watch initiative, empowering members of the public to actively work with the police to reduce speeding and antisocial use of vehicles within areas of concern within their communities. This includes children.
    - WMP Road Harm Reduction Team, working in collaboration with West Midlands Fire Service (WMFS), continues to engage in Multi Agency Road Safety Operations, where WMFS staff examine and educate parents in the correct use of child safety seats.
    - The Child Safety Bridge continues to be toured around schools by officers from the Special Constabulary, educating children and their families in child seat and seatbelt laws.
    - CMPG has invested in 20 new VR headsets that will be used to educate young motorists on the dangers of fatal 4 driving offences, and is investing in a new

App. That will utilise Augmented Reality to project "Perry Bear" onto a tablet/phone in order to educate young people on safer crossing of the roads. This will be the first App of this type released nationally.

- WMP Roads Policing continues to support Operation Hercules, which is an operation aimed at reducing the anti-social use of vehicles by "boy racers" these events predominantly attract young people as both participants and spectators.

- WMP has a **comprehensive 3 year CSE strategy**. We are currently at the end of year 2. Learning and evolution of the strategy has led us to develop a broader exploitation strategy incorporating but not forgetting CSE. Some examples of progress are:

SP 3

  - The **Child Exploitation operational group (formerly CMOG)** within Sandwell is chaired by the Police and has overseen interventions for victims, offenders, and locations in Sandwell. This has expanded to include all forms of child exploitation and not just CSE and missing.

- **WMP's dedicated missing team** continues to evolve and work closer with partners. Learning from feedback the team is increasing its focus on early intervention and prevention.

WMP continues to support Barnardo's and the Panel for **the Protection of Trafficked Children** (OPCC funded). This has been further enhanced by the introduction of the West Midlands Independent Child Trafficking Advocacy resource. This is a Home Office Pilot, aimed at offering additional support for certain categories of Trafficked Children.

Performance analysis – measuring our progress

S.11 Audit - WMP has completed its annual return in line with the regional Section 11 audit tool. There are no outstanding actions.

Initial Child Protection Conferences -. The PCC is currently undertaking an audit of how the Force completes and delivers ICPC reports and attendance - This review commenced at the beginning of April 2019 and it is estimated that it will be completed in 3-6 months.

Feedback forms an important element of improving operational practice. WMP take part in both multi-agency and single agency audits. Dip sampling of investigations, team peer reviews and performance review within a monthly meeting with Inspectors ensures consistency of practice continues to drive improved performance. In addition, close relationships with CPS, independent scrutiny panels and structured partnership debriefs also contribute to internal reviews to improve practice and deliver a consistent service.

Learning - WMP has a dedicated investigative review team to manage and complete all aspects of work relating to statutory reviews including Serious Case Reviews & Child Safeguarding Practice Reviews . The Review Team maintain the strategic overview of all learning and focusing on key themes this is then

embedded throughout all strands of training delivered within WMP. This includes new recruit, promotion and investigative training. Furthermore, the head of PPU and Review Team supervision are core members of the Organisational Learning & Risk Board which maintains overall responsibility for governance and implementation of recommendations generated from statutory reviews.

Re-structure – In February 2019 the public protection unit restructured in order to better deal with an anticipated increase in demand. This saw the formation of MAET (multi agency enquiry teams) which saw police detectives embedded in local authority safeguarding hub in order to work directly alongside social worker for joint visits to children. A complex child abuse investigation team was also formed which has responsibility for the whole Black Country. This was followed by a recruitment campaign for child abuse officers within West Midlands Police and a number of new officers joining the department. This new structure will be reviewed in the new financial year 2019/20

Areas for Development or Assurance Action

<u>Looking ahead – challenges and focus for 2019/20</u>
Exploitation & Organised Crime - There is a desire to create a contextual safeguarding hub building on the CSE model to ensure a consistent partnership offer to all children. Like other partners WMP needs to develop a more holistic approach to Exploitation without losing its effectiveness and learning around CSE. Working with partners we hope to continue to develop a public health approach, with an emphasis on improving data collection and an effective means by which we can track the mitigation of risk.

Modern Slavery and Trafficking – The WMP Exploitation Strategy and Serious & Organised Crime Strategy is seeking to ensure that Modern Slavery is embedded within both and that the leadership and governance arrangements ensure that child victims or slavery and/or trafficking are recognised and treated with parity to other forms of exploitation.

Domestic Abuse in Sandwell - SMBC Domestic Abuse Team

Why did we do it? How did we know there was a need to do it?

Domestic abuse is a significant issue which has a momentous impact on children. There were over 7000 incidents of domestic abuse reported to police in Sandwell in 2018-19. There were 498 high risk cases of domestic abuse which were dealt with by MARAC (Multi Agency Risk Assessment Conference) in the same year. 663 children lived in those families. In 90% of cases of domestic abuse, children are in the same or the next room when an incident happens. Children directly witness 75% of abusive incidents. Even where children do not directly witness violence, living with coercive, controlling behaviour in the home can severely affect them. The impact of this early trauma can last a lifetime, and may include:

• Anxiety, fear and confusion which may lead to panic attacks, depression and self-harm;

• Anger and disruptive behaviour towards authority figures;

• Harm to physical, emotional, cognitive and social development leading to behaviour problems, poor academic achievement, illness, and depression;

• Increased risk of being taken into care or of becoming a victim of child abuse

Operation Encompass is a police – education partnership in which police provide notifications to schools when police have been called out to a child's home relating to domestic abuse. In order to support schools with work to support children who live in families where there is domestic abuse, Sandwell MBC worked with Black Country Women's Aid to secure Home Office funding for Our Future, school-based support for children. Our Future can help primary and secondary schools in Sandwell to build a response to domestic abuse, with support including:

• Advice for staff on supporting children ;

SP 2

• Direct one to one casework for children;

• Group support programmes delivered in school;

• Training for staff.

Our Future builds on BCWA's delivery of a range of groupwork programmes. For secondary students, TRAPPED is an awareness and resilience-building programme aimed at 11-18-year-olds; VIVA is run with boys and girls separately, focusing on self-esteem, safety and risk. For younger children, Helping Hands aims to help 5-8-year-olds recover from their experiences of domestic abuse and Inside Out focuses particularly on 8-11 year-olds, helping children to understand how they can control their actions. Themes covered include self-esteem, gender stereotypes, understanding safety/warning signs, secrets and surprises; the right to feel safe; feelings & emotions. More information on Our Future

FGM

It is difficult to estimate the no of girls and women who are at risk of FGM in Sandwell. Approximately 60,000 girls aged 0-14 were born in England and Wales to mothers who had undergone and approximately 10,000 girls aged under 15 who have migrated to England and Wales are likely to have undergone FGM. The greatest number of women and girls who were known to NHS services in the Midlands and East Region with FGM were in the West Midlands. Sandwell & West Birmingham Hospitals Trust was the 5th highest FGM reporting- Trust in England in 2017-18.

How much have we done in the last 12 months up to 31st March 2019?

Domestic abuse:

BCWA have worked with 597 children and young people in 2018-19 as follows:

- 170 children have completed the Inside Out programme
- 238 young people have completed the Trapped Programme
- 189 children & young people have been individually supported by an Advocate

FGM

The Sandwell Stopping FGM forum has produced an FGM lesson plan and resource pack for use in primary schools for teaching staff for year 5 & 6 and includes a pre-lesson parents session. This has been delivered to Designated Safeguarding Leads (DSLs) in Soho/Victoria. FGM literature for professionals and the public has also been produced.

Impact - How well did we do it? - Is anyone better off? - How do we know they are better off?

Domestic abuse:

Following Groupwork delivered at 8 Schools in Sandwell the following has been determined:

74.46% Enjoyed Sessions

5.37% Did not attend Sessions or did not respond

18.6% Thought session was OK

1.57% Disliked Session

Direct feedback from the children who attended Inside Out Groups include the following quotes:

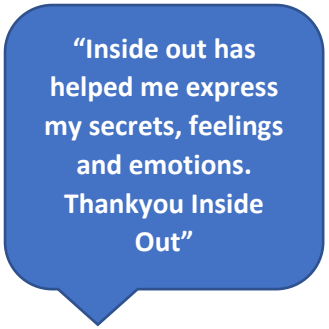
"It has helped me be more confident and face my fears and it has helped me control my anger"

"It has helped me be more confident and face my fears and it has helped me control my anger"

"They have readjusted my confidence and helped me control my emotions"

"Inside Out has helped me to be a better person, Have more self-esteem. Also taught me to be more self-aware about people around me"

"It helps me by calming me down, make me feel good by making me less stressed"



Areas for Development or Assurance Action

Domestic Abuse: More work will be undertaken to actively promote the Our Future programme to Sandwell schools in 2019-20. Sandwell Children's Trust are also seeking to commission a risk assessment tool to better identify the risks of domestic abuse to children and inform child protection and child in need plans.

FGM: Future plans will include the lesson plan being extended to Key Stage 2 and 3 pupils and all DSLs across Sandwell being trained to deliver this within all primary and secondary schools in Sandwell. In addition to the work undertaken within schools the SSFGM have highlighted the potential gaps within nursery school provision; to ensure staff are aware of FGM and how to respond appropriately. SSFGM is currently working with NHSE in supporting the development of an FGM feature film which highlights the complexities of safeguarding issues around FGM, Honour Based Abuse and Forced Marriage.

National Probation Service and Community Rehabilitation Companies

Why did we do it? How did we know there was a need to do it?

Probation Services case management is split across two agencies, Community Rehabilitation Companies (CRC) and the National Probation Service (NPS).

The 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.

The Reducing Reoffending Partnership is a ground breaking new partnership between St Giles Trust, Ingeus and CGL (formerly CRI), working together with Derbyshire, Leicestershire, Nottinghamshire and Rutland (DLNR) and Staffordshire West Midlands (SWM) Community Rehabilitation Companies. The Black Country Cluster is one of Staffordshire and West Midlands regions and covers Dudley, Walsall, Wolverhampton and Sandwell.

How much have we done in the last 12 months up to 31st March 2019?

- Refresher Safeguarding Training has been delivered to all Sandwell staff
- Modern Day Slavery Tier 2 Training has been delivered to all Sandwell staff
- GDPR briefings delivered to all Sandwell staff
- MARAC representation at each Sandwell MARAC meeting
- Continual promotion of multi-agency training available to Sandwell staff
- Introduced a Peer reflection audit (February 2019)
- Manager Case Audit resume

Impact - How well did we do it? - Is anyone better off? - How do we know they are better off?

The CRC is primarily responsible for working with adult Service Users (SU) both in the community and in the transition from custody to community to reduce reoffending and improve rehabilitation. Therefore, the contact that we have with children is limited. However, when will identify that a SU poses a risk to a child we will ensure:

- At the earliest opportunity check if the SU live with, have caring responsibilities for, are in regular contact with, or are seeking contact with children.
- If a SU is assessed as presenting a risk of serious harm to children working with partnership agencies to address and manage the risk

Areas for Development or Assurance Action

- Domestic Abuse internal training (April 2019)
- Further Safeguarding Training- New Working Together Arrangements (April 2019)
- Internal review to ensure that Risk Registers are accurate and reviewed timely by Practitioners.
- Embed Peer reflection audits

A good practice example of multi-agency working:
ST was sentenced on 27/03/2018 for offences related to the Prison Act- namely being in possession of prohibited devices whilst in prison. ST has a lengthy criminal history with the pattern of his offending consisting of multiple driving related offences, thefts, robbery and breaches. Upon his release he was requesting that he reside with his new partner in the Sandwell area but was unwilling to provide the address details for appropriate safeguarding checks to be completed. In addition, there remained Children Services involvement with TS's former partner and their children under Child in Need arrangements. The Case Manager and Walsall Social Worker worked well together pre-release, conducting a joint prison visit to ensure ST was aware of the assessments required regarding his contact with his children. 6 days prior to his release ST provided the proposed release address of his new partner. It was quickly established with close working between the Case Manager and the Sandwell MASH Manager that ST's new partner and her child were previously known to Sandwell Children Services. Due to the late notification of planned release address the Case Manager deemed TS's new partners address as unsuitable for release as there had not been enough time for Children Services to complete appropriate risk assessments. The Case Manager and MASH Manager ensured this was communicated to both TS and his partner and that assessments would be on going. Following release TS did not engage with his Case Manager as directed which resulted in swift recall action. The Case Manager communicated their actions to both the Walsall Social Worker and the Sandwell MASH Manager and they remain in contact to ensure all assessments and arrangement are in place for TS's future release.

SP 1

Quality of Practice and Performance (QPP)

The QPP Sub Group has the responsibility for seeking assurance from partner agencies relating to the quality and effectiveness of multi-agency working within Sandwell. WT 2015 identifies systematic multi-agency case auditing allows the SSCB to deliver on the best learning opportunities for front-line workers. The SSCB identified from its priorities and improvement /Business plan a programme of audits. The SSCB has a Quality Assurance Framework which details assurance activity, part of the work this year has been the re-development of the Quality Assurance Framework, Terms of Reference, and Workplan for 2019/20**. Outlined in the table below is the audit activity and outcomes from 2018-19 and the impact that this has had.**

Activity	Impact
Multi-Agency Audits:	
Child Protection – The multi-agency response to child protection in Sandwell – 23rd May 2018 **Early Help** – The multi-agency response to Targeted Services and the Lead Professional role – 24th September 2018 **Child Sexual Exploitation and Missing** – How effectively is risk being managed and reduced in the cases where CSE/Missing concerns have been identified? – 23rd November 2018 **Neglect** – How well do staff across the multi-agency partnership work together to support children at risk of, or currently experiencing, neglect? – 27th February 2019	For each of the audits a detailed report was circulated the member of the QPP along with recommendations for areas of improvement. For each audit a 7-Minute Briefing was disseminated to frontline practitioners identifying recommendations for practice improvement and next steps.
Section 175 Audit for Education Providers:	
Completed by all schools and academies in Sandwell through the Virtual College, this is a self-assessment tool to provide assurance to the SSCB that education providers in Sandwell are fully compliant with safeguarding policies and practices. All schools completed the Section 175, however, there were 5 schools who completed out of timescale or did not show as fully compliant who were asked to attend a challenge panel to provide assurance. 4 of the 5 schools attended the challenge panel and assured the SSCB of their safeguarding policies and practices. One school did not attend and has not communicated or assured the SSCB, this has been escalated to the Director of Education within the Local Authority.	All schools apart from one completed the Section 175 and showed full compliance, either through the self-reported tool or through attendance at the Challenge Panel. There were some examples of excellent practice within schools, and the audit identified some areas for improvement.
Table Top Review:	
A table top review was conducted in November 2018 into the case of 'Michael', who was identified as one of the most vulnerable children in Sandwell by the Improvement Board. All agencies that were	From the review, recommendations surrounding Criminal Exploitation and early childhood Neglect were

currently involved or had been involved with the case over the last 8 years were asked to provide chronologies of involvement and were invited to attend the review. The case was discussed in detail, several recommendations were identified for the case, as well as some overall learning. A detailed report was sent to the Improvement Board, and a 7-Minute Briefing with the overall recommendations was publicised through the SSCB, partner agencies, and put on the SSCB website.	fed into the Improvement Board. A 7 Minute Briefing was disseminated to frontline practitioners and is available on the SSCB Website.

2019-20 Areas of focus for QPP:

Multi-Agency Dataset
The QPP Sub Group is in the process of developing a multi-agency dataset of agreed Performance Indicators. This will be analysed on a quarterly basis to identify trends, areas of concerns, and areas of success.

JTAI Framework
A framework will be developed for responding to the potential for upcoming JTAI. This is so that agencies can assure themselves that they are prepared should a JTAI be called. The themes of the upcoming JTAI's are covered by the multi-agency audits for 2019/20.

Multi-Agency Audits:
Audits scheduled for 2019/20:

- Pre-Birth Assessments – 1st May 2019
- Children Living with Mental Health Issues – 3rd July 2019
- Exploitation (Review Audit) – 2nd October 2019

Neglect (Review Audit) – 14th January 2020

Collaborative Work

The Regional Safeguarding Procedures Group (RSPG) has successful reviewed developed and maintained the regional website to enable all practitioners to have access to a range of child safeguarding policies and procedures.

Sandwell is one of fourteen local authorities and LSCBs in the West Midlands, the SSCB works collaboratively with the other LSCBs within the region to ensure a joined approach to safeguarding. This is particularly important where agencies deliver services across, and are represented on, a number of LSCB areas and in agreeing a common approach and response to specific safeguarding and child protection issues.

Sandwell SCB is signed up to the West Midlands multiagency child protection procedures.

LSCB Business Managers and Chairs from across the west midlands meet 4 times per year to share and discuss specific issues, protocols and developments**.**

Sandwell Safeguarding Adults Board SSAB, Sandwell Adults and Childrens Services have worked in partnership with Children's service particularly the Children's disability team to enable effective planning for children and young people who may require a formal service post 18 to ensure they have effective support. The preparing for adulthood service has an agreed protocol and clear working together pathway to ensure young people with additional care and support needs are supported from 14 onwards.

We know there is a need to undertake this joint planning and preparation work based on the evidence provided both regionally within the West Midlands transition protocol locally with the preparing for adulthood pathway and local intelligence supported by commissioning colleagues that clearly identifies the predicted numbers of young people year on year who may, pending assessment, need an ongoing service.

Operational Practice:

The preparing for adulthood service continues to work with 225 children and young people between the ages of 14-25 preparing appropriate assessment information and sharing information with commissioners to ensure effective mapping of the needs of citizens are identified within the 'demographic planning meeting'.

Impact

The preparing for adulthood service has identified a scenario where working together and planning for the future went well. The service was asked to work with a young person who was looked after and was identified as having care and support needs. Whilst in foster care, planning was made with DH and his social worker for supported living to commence on his 18th birthday and he was enabled to have his own tenancy with, initially 24-hour support over 7 days. The young person was described as having behaviour that challenges others and he was initially described as being quite destructive of property.

This young person is now 19 years old, has low level support, particularly at meal times and preparing food, he is managing his tenancy well and is being supported to secure paid work opportunities. The young person has identified his own outcomes (to have his own home and have a job) and has clearly stated to his social worker that he does not need 'care' or 'looking after' he needs ''help with the things he needs help with''.

SSAB works closely under a formalised **4Boards arrangements** with the Statutory Boards in Sandwell. Each of the Boards are independent of each other but need to ensure that they take a whole family approach to setting their priorities and reporting performance where warranted

SP 1

The 4 Boards - The SSCB has worked closely with Sandwells other statutory boards – the Health and Well-being Board, Sandwell Adults Board and the Safer Sandwell and Police and Crime Partnership (SSPCP).

The 4 Statutory Boards each hold individual responsibility for their work to tackle the joint priority 'exploitation' in Sandwell.

Strategically the statutory 4 Boards Chair's group met four times during the reporting period and agreed a revised protocol for working together, a joint set of priorities including PoVE, engagement. communications and Learning and Development, and have agreed a joint engagement and communications strategy. The strategic 4 Boards group were instrumental in securing a PoVE Lead Officer post and have scheduled a 4 Board's and Chairs Development session to identify next steps.

Impact

The 4 Boards is now a robust arrangement with clear commitment from all parties. Systems are more robust, thinking is collaborative and joined up which in turn has created new opportunities.
The development session will address how we make a difference.

Areas for Development

There is a continued need for development in respect of promoting independence and enabling children and young people with care and support needs.

Local relationships are positive, and systems now better enable working together and effective information sharing.

Assurance action with reference to 4Boards work is to consider a robust assurance framework that demonstrates the partnership is working well and the impact is effective.

10. How Do We Learn and Improve?

Sandwell and Dudley Child Death Overview Panel

Child Death Overview Panel (CDOP)

SP 1

As stated in Chapter 5 of Working Together (2015):

The Local Safeguarding Children Board (LSCB) functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004. The LSCB is responsible for:

a) collecting and analysing information about each death with a view to identifying -

(i) any case giving rise to the need for a review mentioned in regulation 5(1)(e);

(ii) any matters of concern affecting the safety and welfare of children in the area of the authority;

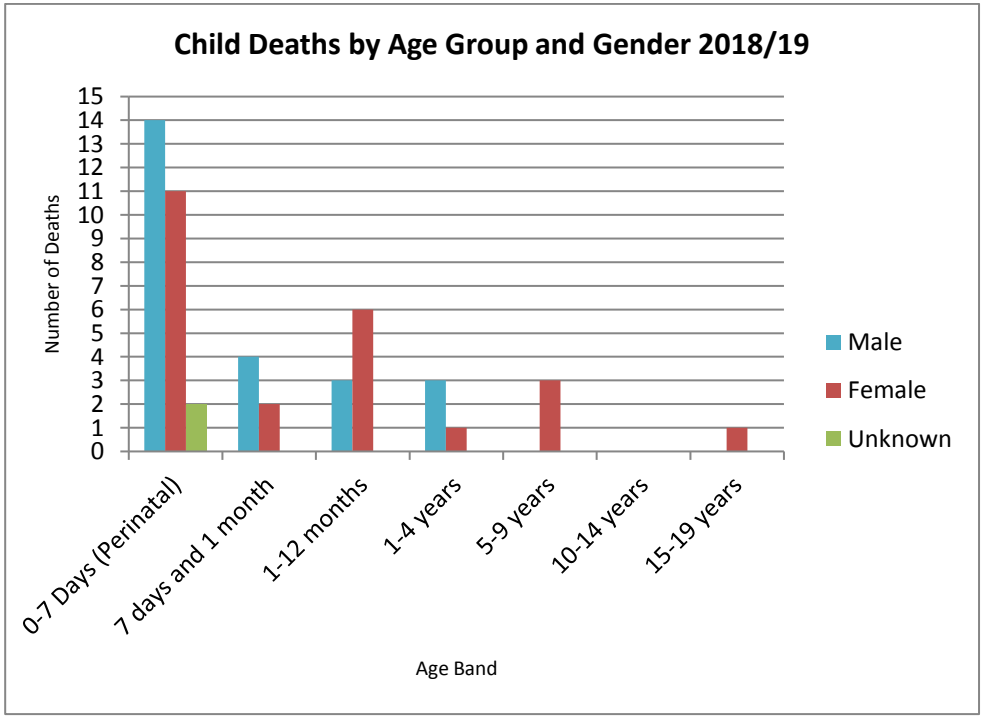
(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and

(b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

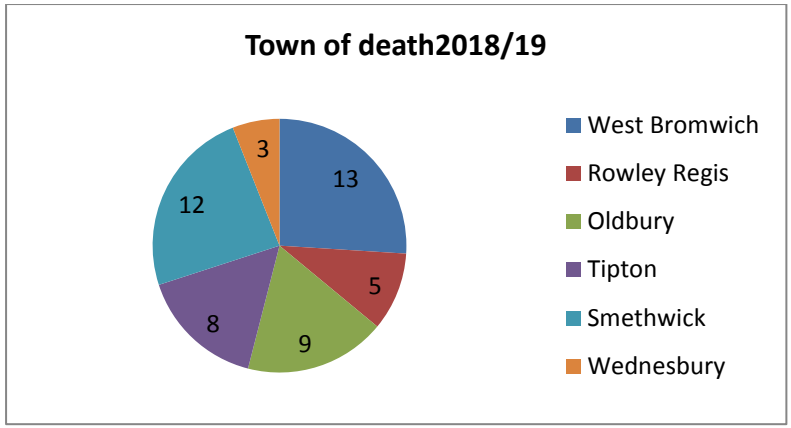
In Sandwell during the period 1st April 2018 to 31st March 2019 there were a total of 50 child deaths (compared to 36 in the previous year). Of these 50 deaths, 8 were classified as unexpected.

Of the 50 deaths reported in 2018/19, 24 were male and 24 were female. It was not possible to determine the gender of two deaths due to prematurity/abnormalities.

42 of the deaths in Sandwell (84%) occurred in the first year of life.

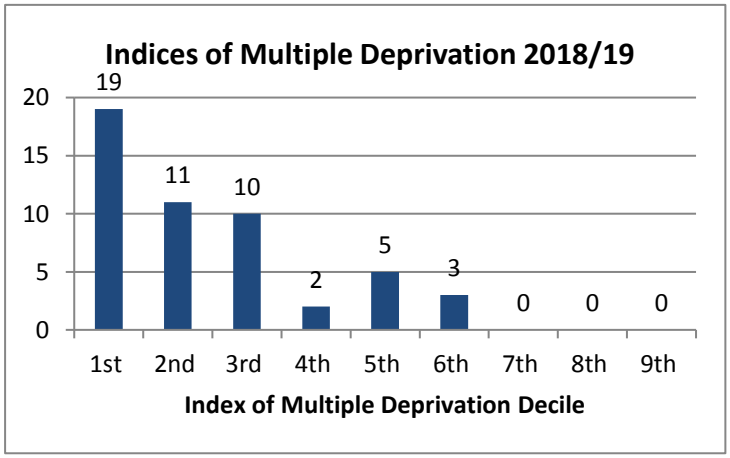


Sandwell Safeguarding Children Board



Sandwell Deaths – Deprivation

This is the third year that we have collected specific information based on the residential address of the child in relation to deprivation to further demonstrate the relationship between deprivation and child death. As with last year, and as expected most deaths have occurred in areas of greatest deprivation.



Impact

Modifiable factors are recorded at CDOP as well as any learning identified in reviews. This information is then shared through newsletters, briefings and bespoke training disseminated to practitioners via their agency representatives sitting on the child death overview panel.

A new resource called 'Duck's Fish' was developed to support bereavement resources for children. This resource tackles the difficult subject of explaining death to children in a sensitive and practical workbook.

http://www.dogduckandcat.co.uk/stories-4-plus/ducks-fish/

2019-20 Areas of focus for CDOP:

Reducing infant mortality in Sandwell remains a Public Health, Acute Hospital trust and CCG priority. 42 of the 50 deaths of Sandwell resident babies (84%) were under the age of 1 year. NHS England has published a new version of the **Saving Babies Lives** Care Bundle as part of its ongoing drive to reduce the rates of stillbirths, neonatal deaths, maternal death and brain injuries. CDOP will be working alongside the Child Death review Partners in 2019 – 2020 to support with strategies and campaigns to reduce infant mortality further. 2019-20 we will be a joint CDOP with Dudley under the new child death procedures.

For further reading see **CDOP Annual Report 2018/2019**

SP 1

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 as per Working Together (2015).

During the reporting period, the SCR Subcommittee reduced membership considerably to reflect the upcoming changes for Working Together (2018). The subcommittee met six 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 October 2018.

Five significant incident notifications were received in 2018 – 2019 by the serious case review subcommittee. Three of these were accepted as meeting the threshold for a serious case review, LS, MS and NS. These were tendered for and commissioned as per Working Together (2015). The remaining two were commissioned as Management Reviews.

The serious case review subcommittee came into the reporting period with four outstanding reviews that had been completed but were not able to be published as there were police proceedings outstanding. During 2018-2019, three of these were published following the conclusion of police proceedings.

Impact

- A review of the commissioned housing services in Sandwell has culminated in specific training assessments being carried out meaning that safeguarding concerns are responded to more effectively supporting staff and vulnerable children and families
- A protocol ensuring attendance at child protection/review meetings was reviewed, agreed by relevant agencies and implemented. This means that there is a shared ownership of commitment ensuring children are safeguarded appropriately in a coordinated way.
- Practitioner learning event held was attended by 80 practitioners who evaluated the event well at the end of the session particularly with regards to disguised compliance and professional curiosity
- A pre-birth network group to share information when there is cause for concern/need for additional support and coordinated response was proposed which will safeguard vulnerable mothers and babies.

Areas of focus for SCR Subcommittee

Working Together 2018 has removed Local Safeguarding Boards responsibility to identify, commission and monitor the outcomes from serious case reviews.

Instead, there is a duty placed upon safeguarding partners to:

Locally, safeguarding partners must make arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area. They must commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken. (Working Together 2018)

A new Rapid Review procedure has been proposed by Birmingham for an area wide process and will be adopted by Sandwell Children's Safeguarding Partnership in 2019 – 2020.

2019-20 The SCR subcommittee will be replaced by the Child Safeguarding Practice Review Group.

Local Authority Designated Officer (LADO)

Contextual Information – data is categorised into 3 different areas:

i) Information and Advice – previously known as the Position of Trust Screening process: This is contact via the referral by agency with the LADO which, after consideration, is deemed not to meet the definition of an allegation (as above). Examples could include the following although this is not an exhaustive list:

- the subject of the allegation/concern cannot be considered to be 'a person who works with children'
- there is no identifiable safeguarding children concern
- where the worker concerned cannot be identified
- the allegation/concern is more appropriately described as a practice issue and should be dealt with by the employer

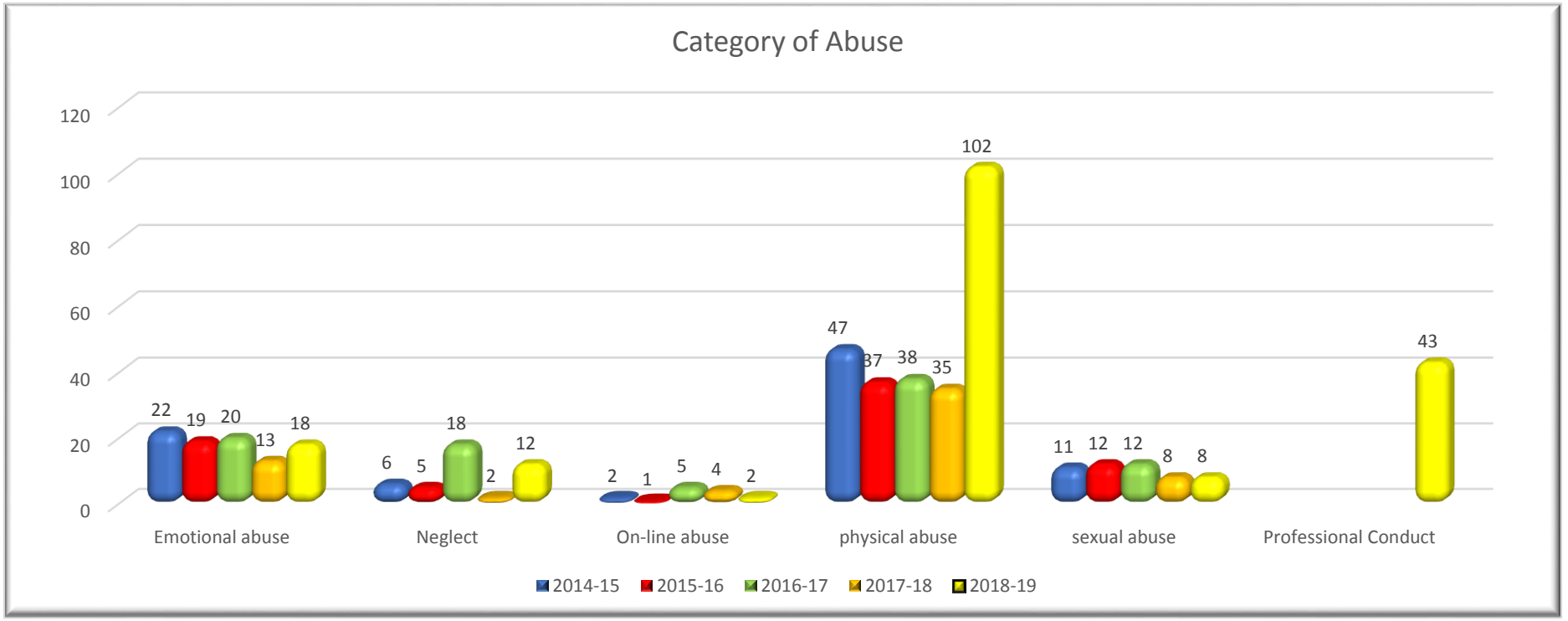
In response to these referrals, the POT Administrator will create the contact, the LADO will record a brief discussion and will consider asking significant safeguarding questions, dependent on the presenting situation and the outcome of the conversation. Records are made against the adult's name.

ii) Consultation with the LADO: This is where the referral does meet the definition of an allegation and therefore, for data purposes, is recorded as a consultation. The strategy required for dealing with a case at this level can be more complex when compared to escalating to a POT Coordination meeting as it requires the LADO actively manage the communications between agencies to its final conclusion.

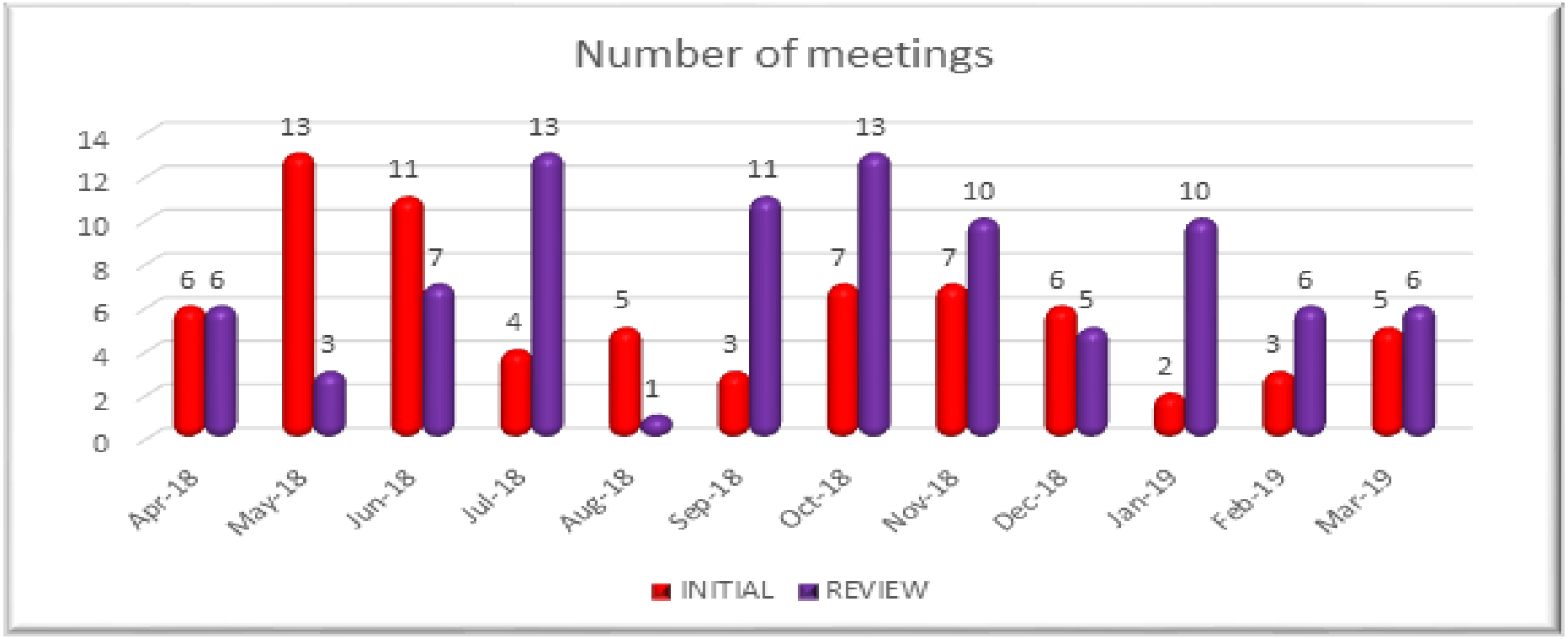
iii) Referral to LADO: The referral clearly meets the definition for LADO involvement as the Threshold has been met. All cases of a physical, sexual, emotional abuse or neglect (as defined by Working Together 2018) or serious concerns about the potential risk of harm a person may pose to children will be managed requiring a POT Coordination Meeting. There may be occasions where apparently less complex or serious cases are managed via a POT process where there may be a pattern of emerging harm/risk from the allegations/reported incidents being made or there is an additional complicating factor which requires active management by the LADO.

Referrals

The figure below of 483 outlines the number of referrals to the LADO Service during 2018-19 compared to 562 for 2017-18 with a reduction of 79 referrals and only 68 of those cases progressing to a POT meeting process in the previous year. The actual figure the new LADO system has picked up is 368 allegations against staff; the additional data of 115 are other contacts being made with the LADO and extensive work being carried out e.g. DBS and Ofsted request, parental complaints, access to records, freedom of information requests and so forth.



Breakdown of Agencies: in this reporting year a breakdown of agencies/organisations who refer and the role of the Employee/Volunteer cannot be given at this time as the system did not collect this information comprehensively. This has been rectified and should be captured in the next LADO report. However, Education sector remain the highest in submitting referrals.



The graph above shows the number of Initial POT Coordination meeting, in red, taking place on a monthly basis; over the reporting year there were 72 meetings. The highest figures peaking after school term breaks. The lowest points are when Education establishments are closed and/or the LADO is on leave. The number of POT Review meetings taking place in the reporting year were 91, (in purple). Altogether the LADO has managed 163 meetings with an average of 13.5 meetings a month. During the previous year 2017/18 – the LADO managed 130 meetings in total. There are however, approximately a dozen POT meetings managed via phone calls and emails due to the given capacity of the LADO and/or Administrator at any given time, unfortunately the new system is unable to capture POT meetings managed via this approach.

SP 1

11. Training and Development

219 hours of training and development was accessed

1524 bookings were made on the learning management system

60 multi agency training sessions were completed in the last 12 months on 11 different topics

190 delegates booked a space on the training but did not attend, an increase of 10% from the previous year

Delegates representing 35 different organisations have been able to network on the multi-agency training

1334 delegates have successfully completed training

Core training on the day feedback:

Multi-agency Threshold training

129 delegates attended threshold training across the year, 80% felt the training increased their subject knowledge. 100% felt training was excellent/good in its effectiveness.

- Following the training delegates identified Signs of Safety as a priority for their further professional development.
- Delegates identified the importance of using the threshold document when making referrals.
- Delegates said they'd check policies are current and up to date.
- Delegates felt more confident to raise issues through using the threshold document to support and evidence levels of concern.

Core Working Together (CWT) Refresher

CWT refresher was a new course for 2018 – 19 following TNA and evaluation feedback from delegates attending the full day session who only needed to access a short refresher course.

Of the 118 delegates who attended the sessions 65% recorded an increase in their knowledge, 28% felt their knowledge stayed the same.

97% felt the training was excellent/good in its effectiveness and they also found the trainers to be supportive and knowledgeable.

Core Working Together (CWT)

312 delegates attended 9 sessions 77% recorded an increase in their knowledge following the training session and 18% felt their knowledge stayed the same.

Trainer feedback

Following feedback from the trainers this course has been updated. Trainers found the '*case study too complicated – too much information to take in'*, this has now been simplified.

Trainers raised concerns on this and the full day Core Working Together that, *'Delegates have not consolidated their learning ie many attend and do CWT/refresher and have not done the basic training around Thresholds and Module 1 for Safeguarding'*

Delegate feedback:

Training is always well organised and runs smoothly. It's lovely to see that the team are not prescriptive in their delivery. The information we need to digest is cascaded, but colleagues are allowed to question, share experiences etc, so we all learn from each other. They cater to the needs of their audience. **Safeguarding Lead and Attendance Officer, Corngreaves & Timbertree Primary Academies**

Feedback from delegate impact evaluations (three months post CWT training)

How have YOUR systems/practice changed following the training?

I have acted on all gut feelings and become even more curious. All Cause for concerns have been passed on as I always did before, however my awareness and reporting of even the smallest details to relevant staff have had an impact for the children I come into contact with. The children have an increased confidence to approach me and come daily for reassurance and contact. I feel they are so happy to know they are listened to and understand we are here to help and support them.

Since the training how do you ensure that consent, the child's voice, information sharing is captured, is robust and meets statutory requirements?

Working 1:1 the child's voice is so important the children now always get chance to say what they would like to be done in order to help their situation and is recorded. Our SPTO pupil diary is filled in by adult.

Please give a brief anonymised example of where things have improved for a family following attendance on this session:

A child was either very often late or didn't attend. Curiosity of staff brought to light that mum had mental health issues and that the child was being kept at home to support her etc. Staff actually went to the child's home and saw mum. The child was then brought into school where breakfast etc was provided. Details emerged of dad being in prison.

The child had MARF, the child now comes to school regular and contact is often made with mum and all staff are aware of child's needs and now has 1:1 mentoring sessions in place weekly. Mum is aware our team from attendance officer, senior leaders, SENCO and mentor all have an input and are here to give support.

Please give a brief anonymised example of where things have improved for a family following attendance on this session:

1. *School have been monitoring a family for some time and built a relationship with mom. School suspected that the family had become homeless. Our Family First Advisor and DSL who are part of the safeguarding information sharing team, called in mom for a meeting. Mom disclosed that they had been evicted and were struggling to stay at a family members home. . School offered Early Help with moms consent. During the early help application, mom divulged information regarding her past and being in care and her own vulnerabilities. The early help referral was accepted for targeted support and the Family now have a worker who is supporting the family to gain appropriate benefits and housing. There is now good inter agency working with a team around the family to ensure the children are safe.*
2. *Due to good staff safeguarding training, office staff were able to identify that a new parent to school, was intoxicated and in distress when coming late to collect their child. The DSL was sent for immediately and through speaking to mom, was able to identify real concerns for moms and the child's safety. With moms consent, school rang the police and also submitted a MARF. A single assessment is now being completed and mental health needs and alcohol related concerns for mom have now have now been identified. Mom is now getting the support she needs and has been allocated a social worker. Mom is very grateful to school for making the referral and is working closely with school to improve the families situation*

12. Executive Summary

Throughout 2018/2019 Sandwell Safeguarding Children Board worked as required to coordinate and ensure the effectiveness of each partner agencies contribution to keep children safe through meeting the strategic objectives:

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

and

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

Summary of performance against strategic priorities

What worked well

- **Sandwell Partner agencies** have remained committed to the safeguarding agenda. The SSCB has held partners to account on a number of issues including:
    - Improving the multiagency response to children identified and at risk of CSE, Missing and Trafficked
    - Education & Skills Directorate has worked hard to make a significant and a wide-ranging contribution to the Sandwell safeguarding agenda in a variety of service delivery areas -particular efforts are noted in children's participation and their perspectives relating to domestic violence, local challenges and contextual safeguarding and mental health.

- **Quality of Practice –** The QPP has successfully completed its schedule on multiagency audits/reviews and received performance data from a range of partners. This has enabled the SSCB to receive, performance and quality assurance reports and scrutinise information and respond to exceptions arising. The outcome of all audits have been widely disseminated through 7 minute briefings which are published on the website and have informed the development/revision of training material on a range of safeguarding training courses with the aim of impacting on the quality of frontline practitioner approaches to children and families. The QPP have worked to redevelop the Multi-agency Quality Assurance Framework with additional focus on holding partner agencies to account through their own single agency assurance activity.

- **The SCR sub committee** has ensured that the SSCB met its statutory responsibilities as outlined in Chapter 4, Working together 2015 to undertake serious case reviews in cases which met the criteria and other learning reviews and ensured the board

partners undertook actions to learn and improve Multiagency learning from serious case reviews has enabled more robust approaches and developments to

- Sandwells housing services training and response to safeguarding
- Quaracy and attendance issues for child protection review meetings
- Increased awareness on engaging complex families where there is a perception of disguised compliance and applying professional curiosity
- Safeguarding children pre-birth

A new Rapid Review procedure has been proposed by Birmingham for an area wide process and will be adopted by Sandwell Children's Safeguarding Partnership in 2019 – 2020.

- **Sandwell CDOP** has responding effectively to the learning arising from children's deaths. The new resource 'Duck Fish' developed to explain death to bereaved children

- **The SSCB Multi-Agency Learning and Development Group** during 2018/19 revised its training catalogue for delivery of multi-agency training this included developments to support priority areas for enhanced multi-agency learning across the partnership in relation to Neglect and Exploitation. The Learning and Development Group have continue to work with partners on the training needs analysis and to bridge the gap between review / audit outcome , learning and practice delivery and the impact on children and families with partners.

- The SSCB has worked with the **Regional Safeguarding Policies Group** to ensure the childrens policies and safeguarding procedures were reviewed and uploaded to the SSCB website.

- **Successful work between adults and children services** to enable effective planning for children and young people who may require a formal service post 18 to ensure they have effective support.

- **The statutory 4 Boards Chair's group** have continued to join up thinking and priorities to keep children and vulnerable adults safe in Sandwell particular in preventing violence and exploitation.

What next

Following the Children Act 2017, from the end of September 2019 all LSCBs, in their current form, will no longer exist. The responsibility for the safeguarding arrangements will then sit with three named safeguarding partners, the local authority, the police and the local Clinical

Commissioning Group (CCG), in Sandwell we have also included the Sandwell Childrens Trust as a key safeguarding partner.

The new partnership plans were published in March 2019 and whilst there are some great opportunities to do things differently the new multiagency safeguarding arrangements does face some key challenges.

Extensive work has been undertaken to prepare Sandwell partners for the transition to the local child safeguarding partnerships and its new multiagency safeguarding arrangements (MASA)

The Sandwell Childrens Safeguarding partnership have agreed on the following priorities for 2019/2020

1. **SCSP is to ensure it delivers on its core functions and develops and maintains good governance, performance and quality assurance processes and to be assured of the effectiveness of its multi-agency safeguarding arrangements. This includes**
    a. **Completion of outstanding serious case reviews and replace new commission of serious child safeguarding incidents through the new arrangements for local child safeguarding practice reviews**
    b. **Transferring responsibilities for CDOP to child death partners and developing on arrangements through the Black Country CDOP.**
2. **SCSP s to be assured that there is a culture and continuous system of single and multi-agency learning and Improvement**
3. **SCSP to be assured that there is a robust system to respond to serious incidents, local child safeguarding practice reviews and reviews of child deaths.**
4. **SCSP is to be assured that 'Early Help' services are accessed and delivered effectively, and thresholds are understood and consistently applied.**
5. **Be assured that children and young people in dangerous settings have faster, easier access to safeguarding support**
6. **SCSP is to be assured that there is evidence to consistently demonstrate that children and young people are effectively safeguarded from the risks. Particular areas of work to target improvement include:**
    a. **Exploitation (CSE, Missing Children, Modern Slavery, Gangs, Domestic Violence)**
    b. **Neglect**

Sandwell Children's Safeguarding Partnership

Appendix 1 – Sandwell Childrens Trust - Improvement Milestones and Outcomes in 2018/19

Period	Milestones	Outputs
By July 2018	• Programme and performance governance cycle established • Review of the Front Door by Children's Services Advisors took place • Introduced additional management capacity in Operations Directorate • Revised communications approach with staff put into place • Leadership • Strengthened resources in the IRO service	• Workforce Strategy – '12 Reasons to work for Sandwell Children's Trust' • External and Internal Websites for SCT • Front Door Acton Plan • Quality Assurance Framework • Beyond Auditing Framework • Direct Work Toolkit • Revised Processes / Procedures and Practice Guidance for Assessments, PLO and Entry into Care • 10 Minimum Standards document for practitioners
By October 2018	• Social media and digital marketing used • Review of the LADO function • Child Protection Plans reduced • Cohort of children subject to CIN plans who did not require a statutory service were closed • Implementation of Directors Resource Panel • Began a systematic review of process, policy and practice guidance across the Trust. • Began a review and the implementation of the new Multi-Agency Safeguarding Arrangements • Staff Conference • Staff Survey	• Twitter and Instagram Handles • Communications Strategy • LADO action plan • Pre-proceedings and permanency action plan • SSCB revised Learning and Development Offer • Revised Processes / Procedures and Practice Guidance for Child Protection • Production of Performance Daily Dashboards for Care Management and LA • New front door action plan 'building' on previous

Period	Milestones	Outputs
	• More permanent and experienced social workers than ever before	
By January 2019	• Permanent Directors all in place • Full Organisational Review of management capacity completed • Review of Exploitation Strategic and Operational delivery in Sandwell • Participation confirmed in 'Frontline programme and consultant identified • 1st cohort of children whose Care Order required revoking were done so • Team Manager Impact Workshops • LSCB led programme to implement Graded Care Profile begun	• Revised Learning and Development Offer to all Staff (including practitioners) • Revised Processes / Procedures and Practice Guidance for Allegations, Front Door, Child Protection, MARAC and MAPPA • Participation strategy • Revised Policies for Adoption and Fostering • Revised Foster Carers Handbook • Long term matching process • IRO 'Coming into Care' Pack
By April 2019	• Appointment of Head of Service for Practice and Social Work Innovation • Strategic approach to Looked After Children group set up • SMBC brief review of early help provision with a view to creating a Sandwell Strategic Childrens Partnership • Launch of Exploitation Briefings • Staff Awards Evening • Launch of the Sandwell Children's Safeguarding Partnership • Voluntary Adoption Agency Inspected	• Exploitation action plan and Exploitation Hub • Safeguarding Unit Action Plan • CIN Action Plan • Revised Processes / Procedures and Practice Guidance for IRO Service, Fostering, SEND, and Looked After Children • Fostering performance dashboard • Launch of new Single Assessment • Local Offer for Care leavers

Period	Milestones	Outputs
	• Independent Fostering Agency Inspected • SEND Partnership Event and Inspection • RAA transfer of adoption functions	