Sandwell Safeguarding Children Board

Annual Report

April 2014 – March 2015

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To keep the children of Sandwell safe by ensuring that effective and meaningful arrangements are made, maintained and robustly monitored and that outcomes for children are as good as they can be and all partners play their part.

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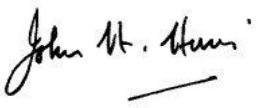
1. Foreword by the Independent Chair

This is the second annual report to be published since I was appointed as Independent Chair of Sandwell Safeguarding Children Board (SSCB) in July 2014. I would like to take this opportunity to thank Board members, partners and the SSCB Business Unit for their support.

The report provides an assessment of the performance and effectiveness of local services in safeguarding and promoting the welfare of children in Sandwell during 2014-15, as well as providing an account of the activities, development and impact of the Board in meeting its statutory responsibilities. It is intended to be read by both professionals and members of the public.

The past year has seen significant progress in improving safeguarding arrangements in Sandwell, with the Board itself beginning to deliver its own statutory responsibilities more effectively following a Strategic Review. A number of important foundations are in place across the partnership: a robust and cohesive safeguarding model based on Munro Review principles and incorporating systematic 'early help' services; strong commitment from partner agencies to prioritise safeguarding and work within the new service model (notably through the Sandwell Multi-Agency Safeguarding Hub). External inspections in the period have nevertheless identified continuing challenges for the local authority, police and health in terms of responding to changing needs and risks, quality and consistency of practice, and in responding to cross-cutting safeguarding issues such as child sexual exploitation. SSCB itself is being challenged to demonstrate that its activities are making a positive difference for children, young people and families. These challenges are addressed through a focused and robust SSCB Business Plan for 2015-17.

In this period of challenge and change, what has remained consistent is the determination of all who are engaged with Sandwell Safeguarding Children Board (SSCB) to make an impact; to continue to learn, develop and fulfil their responsibilities to the highest standard.



John Harris - Independent Chair

2. Introduction

2.1 This is the annual report for Sandwell Safeguarding Children Board (SSCB). It covers the reporting period between April 2014 and March 2015 and evaluates the work and impact of the Board relating to its identified priority areas of work.

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

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

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

2.4 In accordance with Working Together 2015, the annual report will be submitted to the Chief Executive and Leader of the local authority, as accountability for the safety and welfare of children must start with the most senior strategic local leaders. It will also be sent to the local Police and Crime Commissioner and the chair of the Health and Well Being Board.

3. Local Background and Context

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

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

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

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

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

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

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

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

4. The Local Safeguarding Children Board

4.1 The year commenced with the Council still under a Statutory Direction (received on 31 October 2013). The Statutory Direction is a legal instruction from the Secretary of State for Education to the council to improve failing services in children's social care.

4.2 In response to the requirements under the Statutory Direction, the Independent Chair led a strategic review of the effectiveness of SSCB in September 2014. The independent Chair's overall conclusion about the baseline position in September 2014 was that SSCB was not adequately fulfilling its statutory responsibilities for the following reasons:

- Insufficient evidence that the governance arrangements enable SSCB partners to assess whether they are fulfilling their statutory responsibilities to protect and care for children;
- The Board's prioritisation of key safeguarding issues and their incorporation into a delivery plan had been ineffective;
- The auditing of multi-agency practice was too limited to identify where improvement in safeguarding practice is required;
- The Board's Learning and Improvement Framework was underdeveloped;
- There was limited evidence of partner agencies holding one another to account for their contribution to the safety and protection of children
- The Board had not been effective in assessing the performance and effectiveness of local services and challenging the action being taken;
- The Board was not using its scrutiny role and statutory powers effectively to influence the work of statutory partnerships such as the Health and Well-Being Board

4.3 In response to the findings from the Strategic Review, the Independent Chair and Board agreed new Board priorities for 2014-17 as follows:

- **Strategic Priority 1:** Sandwell has an effective LSCB which meets its statutory responsibilities

- **Strategic Priority 2:** Sandwell has highly effective safeguarding systems and practice
- **Strategic Priority 3:** Sandwell has effective arrangements for identifying, understanding and responding to key safeguarding risks, including neglect, child sexual exploitation and early help.
- **Strategic Priority 4:** Sandwell LSCB is visible and influential, engaging with other key partnerships, frontline professionals, children and young people, parents and the wider community.

4.4 The Board identified ten key areas for development, which were incorporated into a new SSCB Business Plan with a view to securing rapid improvement such that, by March 2015, SSCB would be performing adequately, (although requiring further improvement) and discharging its statutory functions. The key areas for development are set out below.

	Key Area for Development	Strategic Priority
1.	Review the Board Membership, Structure and Constitution and improve the effectiveness of meetings, ensuring Board members understand their roles and have the necessary support to fulfil them effectively	Strategic Priority 1
2.	Ensure that young people are engaged effectively in the work of the Board and that the 'voice of young people' is evident in activities under the all the Board's strategic priorities	Strategic Priority 1 Strategic Priority 2 Strategic Priority 3 Strategic Priority 4
3.	Develop and implement a new Business Plan 2014-15, with appropriate arrangements for programme management and evaluation of impact	Strategic Priority 1
4.	Establish and further develop the SSCB Performance and Quality Assurance Framework so that the Board uses performance information and evidence from audits effectively to drive improvement in safeguarding	Strategic Priority 1 Strategic Priority 2
5.	Ensure that key safeguarding strategies are in place, with agencies playing their full part, and with evidence of impact	Strategic Priority 2 Strategic Priority 3
6.	Improve the Learning & Development Framework, particularly ensuring the link between learning from audit and case reviews, and changes to training, policy and procedures, and practice	Strategic Priority 1 Strategic Priority 2

7.	Ensure that the SSCB multi-agency training is of high quality, up-to-date, relevant and aligned with key priorities to improve the effectiveness of the workforce	Strategic Priority 2 Strategic Priority 3
8.	Ensure that SSCB meets specified 'criteria for readiness' to take over responsibility from the Children's Services Performance Accountability Board and is ready for inspection.	Strategic Priority 1 Strategic Priority 4
9.	Improve the Board's visibility and influence, particularly ensuring that it can maintain the learning culture across partner agencies once the Children's Services Performance Accountability Board has completed its work	Strategic Priority 1 Strategic Priority 4
10.	Prepare the Annual Report 2014/15, ensuring that it is evaluative and identifies clear improvement priorities	Strategic Priority 1 Strategic Priority 4

4.5 To support and challenge the Board in making the necessary improvements, iMPOWER (an external improvement partner) were commissioned to provide a programme of targeted improvement support over the period October 2014 - February 2015.

4.6 Following the Strategic Review the Board has been through a necessary and rapid period of development with good progress being made in taking forward the key areas for development.

4.7 This coincided with a review of the effectiveness of the safeguarding board by OFSTED which was undertaken between 27 January 2015 and 19 February 2015.

4.8 The inspection team recognised the rapid progress being made by the Board to meet its statutory functions, particularly in establishing a culture of challenge in which the safeguarding work of partner agencies is monitored and scrutinised. The inspection also confirmed that the priorities set in the SSCB Business Plan provided *'a clear route map for progress'*.

4.9 The Board accepted a key finding from OFSTED's review that the improvement of the LSCB since the last inspection had been too slow. Board members themselves recognised this in the Board's Strategic Review undertaken in September 2014.

4.10 As a result of the developmental work over the past year, the Board now has a good understanding of its current strengths and areas for improvement. Good progress has been made in responding to the five priorities for immediate action identified in OFSTED's review - all

of which were being actively addressed through the SSCB Business Plan.

- The Board has now initiated a Section 11 audit to assure itself that partner agencies are fulfilling their statutory safeguarding duties. These are scheduled to be submitted by partner agencies by the end of August 2015.
- An external review of the understanding and application of the LSCB threshold has been commissioned, reporting in May 2015.
- A revised strategy is being developed for Board approval in June 2015.

Governance & Accountability Arrangements

4.11 In order to provide effective scrutiny, SSCB is an Independent Board which is not subordinate to or subsumed within any other local structures in Sandwell. Joint working arrangements with the other strategic partnerships in Sandwell are set out in a Sandwell Partnership Protocol. The Sandwell Partnership Coordination Group meets quarterly to ensure that there is effective alignment of priorities and plans.

4.12 Much of the work of the LSCB is conducted through subgroups, and by its central support team. The Chairs' Group has the responsibility for monitoring and coordinating the work of the LSCB, agreeing and overseeing the Business Plan, and driving forward improvements in multi-agency safeguarding practice. Task and finish groups are convened as required in order to undertake specific pieces of work. These groups are well supported by LSCB members.

4.13 SSCB met 6 times during 2014-2015, in April, June, August, October, December 2014 and February 2015. An extraordinary meeting also took place in December 2014 to receive the findings from a Serious Case Review.

4.14 Attendance at the Board meetings throughout the year has been good as illustrated in the table below which demonstrates the commitment of partner agencies to the work of the safeguarding

[1] Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

board. It is important to note that attendance figures are based on the meetings that took place following an agency becoming a member of the Board. This accounts for those agencies that became members during the course of the year.

Figure 1: SSCB Membership Attendance 2014-2015

Agency	Attendance Level (%)
Sandwell MBC - Adult Social Care	83%
Sandwell MBC - Children's Social Care	100%
Birmingham Community Healthcare NHS Trust	100%
Birmingham & Solihull Black Country Team	50%
Black Country Partnership Foundation Trust	83%
Sandwell & West Birmingham CCG	100%
Sandwell & West Birmingham Hospital NHS Trust	100%
Academy	83%
College	67%
Primary School	50%
Special School	67%
CAFCASS	33%
Dudley & Sandwell Community Rehabilitation Company	83%
Dudley & Sandwell National Probation Service	67%
West Midlands Police - Local Policing Unit	100%
West Midlands Police - Public Protection Unit	100%
Lay Member(s)	67%
Voluntary Sector	67%

4.15 SSCB has been undertaking its work alongside the Performance Accountability Board (PAB), which was established by a direction

from the Secretary of State. In a period during which the Board was required to improve its effectiveness, and was reporting on its progress to the PAB, partner agencies agreed that the PAB itself would scrutinise key aspects of the performance of agencies in respect of safeguarding, recognising that the production of data and workflow reports for the Board would lead to unnecessary and unhelpful duplication. The Board has started to promote a culture of respectful challenge building on the work of the PAB, with partner agencies now expecting that their safeguarding work will be monitored and scrutinised. SSCB is now better placed to provide that monitoring and scrutiny function through its dataset and performance framework and the scheduled Section 11 audit for 2015-16.

4.16 The work of SSCB and the Business Unit cannot be achieved without a dedicated budget. Working Together 2015 states that all SSCB member organisations must provide SSCB with reliable resources (including finance) that enable it to be strong and effective. During 2014-2015, SSCB had funding of £243,800 provided by:

Funding Source	Budget (£)
Sandwell Council	148,100.00
Sandwell and West Birmingham CCG	76,000.00
West Midlands Police	16,100.00
Staffordshire and West Midlands (SWM) Probation Trust[2]	500.00
Community Rehabilitation Company	1250.00
National Probation Service	1250.00
CAFCASS	600
Total	**243,800.00**

The expenditure of SSCB during 2014-2015 was £317,152.84 (with additional funding being drawn from the 'reserve' that the Board had carried forward from the previous year). In addition to staffing costs, approximately £100,000 was used to strengthen the work of SSCB through the commissioning of an external

[2] Under the Government's Transforming Rehabilitation initiative the former SWM Probation Trust ceased to operate from 31st May 2014. To reflect Probation Services' contribution to the Sandwell Local Safeguarding Board for April & May 2014, the Trust paid an invoice for £500.

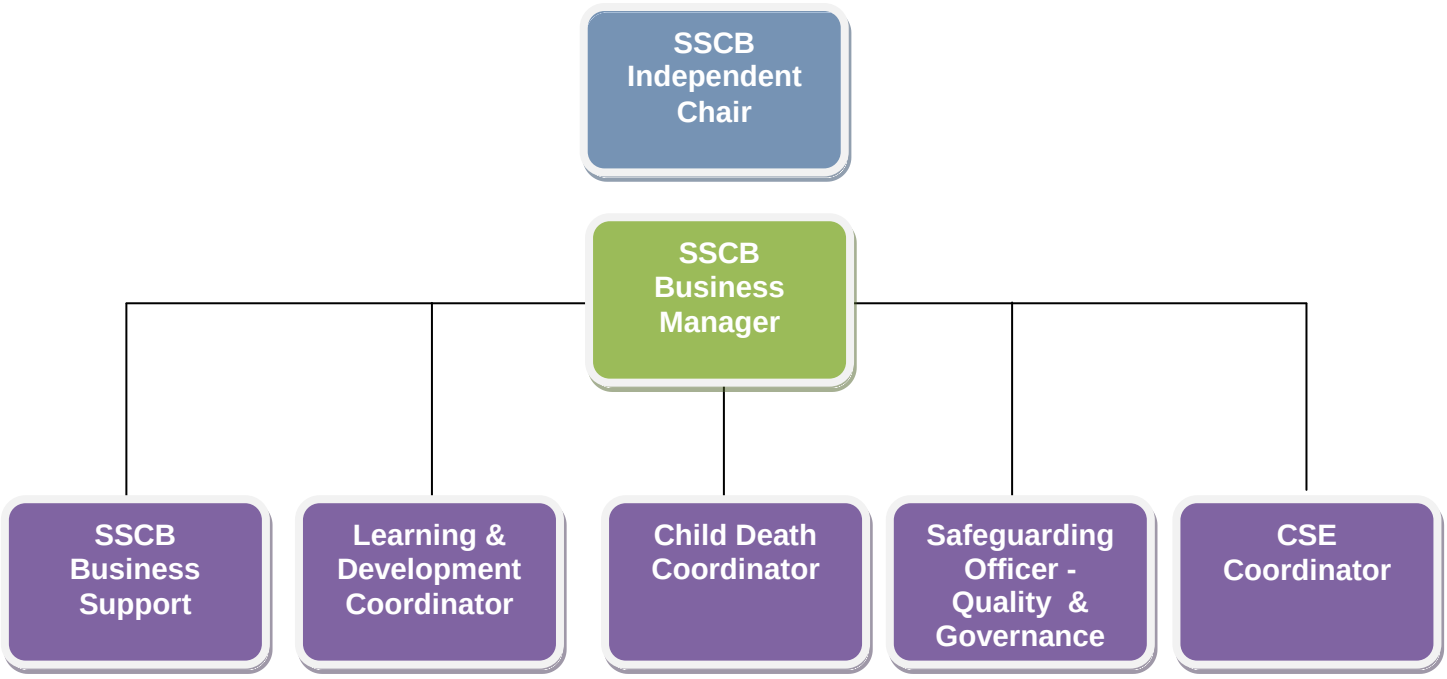
improvement partner. Further expenditure of £35,000 was incurred to undertake a SCR and two management reviews.

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

SSCB Business Unit Structure

4.18 As part of the Strategic Review, an established and appropriate staffing structure was agreed for the SSCB Business Unit. This is shown below.

Figure 2: SSCB Business Unit Structure (as at March 2015)



4.19 Action was taken during the year to add short-term capacity and mitigate against workforce pressures.

4.20 The Learning and Development Coordinator role was vacated in May 2014. An employee from the Local Authority was subsequently seconded to the role (for a period of one year) in June 2014. Processes are already underway to ensure that the post is filled on a permanent basis from June 2015.

4.21 The vacant Child Death Coordinator role was filled in May 2014 but was again vacated in October 2014. A period of recruitment then followed with a permanent employee commencing the role in February 2015.

4.22 An appointment was made to the role of CSE Coordinator in July 2014 with the successful applicant commencing the one year role in September 2014. As we enter 2015-2016, SSCB will be seeking to make the role permanent.

4.23 The vacant Safeguarding Officer for Quality & Governance role was filled in September 2014 with the successful applicant commencing the role in January 2015.

Community (Lay members)

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

4.25 SSCBs use of its lay members during the reporting period was underdeveloped, with lay members having very limited opportunity to develop their roles beyond attendance at the full Board meetings. A successful recruitment process was undertaken in March 2015 with two further lay members joining the Board. It is planned that the three lay members will provide stronger challenge to the Board and its sub-groups as well as playing a substantial role in connecting the Board with the wider community.

Engagement with and Participation of Children and Young People

4.26 SSCB continued its bespoke multiagency training to support the roll out of *'Communicrate'* to various teams of frontline practitioners. *Communicrates* are a toolkit developed by the Children's Involvement Team (Sheffield City Council) to support and enable creative direct work with children and young people in order to ensure they are listened to and have their views taken into account in any decision being made that affects their lives. The training was evaluated positively, with 100% of attendees agreeing that *Communicrates'* would better equip them to engage with children and young people. Impact evaluations several months after the training showed that

practitioners were seeking to elicit the voice of the child in more creative ways as a result of attending the training. Detailed below are some of the key impact evaluation comments:

- Rather than using a tick box, or ask questions that can be invasive, it has been achieved in a much more compassionate way, using the tools in communicrate, So I can be more child focussed rather than trying to get through a form - ***LAC Nurse commenting on the use of the communicrate during initial and review health assessments***
- I have added more children into my 1-1 sessions and have been able to deliver support without contacting agencies or having to make referrals in some cases. I have been able to use the resources to work with vulnerable children in different ways - ***Acting Head Teacher of a local junior school***
- I have used the worry tree, and good day, bad day and magic wand. These are my favourites and I do believe that the good day/bad day led to a child making a disclosure - ***School Nurse***

4.27 Overall, the influence and involvement of children and young people with the work of the LSCB continues to be limited. Looking ahead to 2015-16, SSCB has agreed that its work to engage with children and young people will be through the SHAPE programme. The name is constructed from the 5 key out-comes from the Every Child Matters initiative:

- Staying **Safe**
- Being **Healthy**
- Enjoying and **Achieving**
- Making a **Positive Contribution**
- **Economic** Wellbeing

4.28 This programme, which is led by Sandwell MBC, with extensive involvement from partner organisations (including the community and voluntary sector), will enable SSCB to understand the safeguarding issues that are important to children and young people and ensure that they are addressed through the SSCB Business Plan. It is intended to work directly with children and young people on the development of action plans and in evaluating their impact.

Faith Communities

4.29 The Board's engagement with the faith communities is an important area for development. During 2015-16 a 'Faith and Culture' Task and Finish Group will be established to develop and lead this area of work.

5. Performance and Effectiveness of Local Arrangements

Sandwell MBC: Children's Services

5.1 Over the past twelve months the local authority has made important progress in improving its arrangements for safeguarding children and promoting their welfare, having been found inadequate and subject to a direction notice by the Secretary of State for Education in 2013. A number of important foundations for sustainable improvement have been established, notably: a robust and cohesive service model based on Munro Review principles and incorporating systematic 'early help' services; strong commitment from partner agencies to prioritise safeguarding and work within the new service model (demonstrated in particular through the promotion of the SSBC threshold document and the operation of the Sandwell Multi-Agency Safeguarding Hub); an increasingly stable workforce; rapidly improving performance evident from key workflow data and audits of practice.

5.2 In spite of the progress that has been made there remain significant areas of weakness, as identified by OFSTED in its inspection of Sandwell Children's Services in January/February 2015. OFSTED found that services for children in need of help and protection continued to be inadequate, as was overall leadership and management.

5.3 The local authority, whilst not accepting aspects of OFSTED's findings, (and still pursuing a formal complaint), has identified seven key priorities within its Improvement Plan for 2015-17, as shown in the diagram below.

5.4 Arising from the inspection, SSCB will focus on two key issues of substance: the effective understanding and application of thresholds to enable an appropriate response to need and risk, and the effectiveness of arrangements for responding to CSE. SSCB will be commissioning external reviews to inform the local authority's improvement planning and will challenge progress through its performance and quality assurance work. The Board will challenge the effectiveness of partner organisations where their contribution to multi-agency safeguarding arrangements or service provision is not good enough.

Health Services

5.5 NHS organisations are subject to the 'section 11' duties set out in Working Together 2015. Health professionals are in a strong position to identify welfare needs or safeguarding concerns regarding individual children and, where appropriate, provide support. This includes understanding risk factors, communicating effectively with

children and families, liaising with other agencies, assessing needs and capacity, responding to those needs and contributing to multi-agency assessments and reviews.

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

5.7 Specific roles and responsibilities for Clinical Commissioning Groups and other NHS statutory bodies in relation to safeguarding are outlined in *"Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework"*, issued by NHS England in March 2013.

5.8 Sandwell & West Birmingham Clinical Commissioning Group, as a commissioner of provider services, has provided good leadership to the safeguarding children agenda across the health community. The designated professionals and CCG Chief Officer (Quality) are members of the LSCB and make a significant contribution to the work of the Board and its subgroups (with the latter taking on the role of interim Independent Chair of the Safeguarding Board between May - August 2014 before returning to the role of Vice Chair).

5.9 The Health Forum brings together professional across the health community to discuss matters relating to safeguarding, and acts as a conduit between the LSCB and health services. Health and adult social care services in England are independently regulated by the Care Quality Commission (CQC), which ensures that the Essential Standards for quality and safety are met and in particular Outcome 7 - Safeguarding people who use services from abuse. The CQC inspects how NHS providers are meeting this standard through the acute hospital, Community and mental health trust and primary care inspection programmes.

5.10 A review of the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within the NHS in Sandwell was undertaken by CQC between Monday 11th August 2014 and Friday 15th August 2014. The focus was on the experiences of looked after children and children and their families who receive safeguarding services; specifically the role of healthcare

providers and commissioners, the role of health care organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multiagency assessments and reviews. In addition the review reported on the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.

5.11 The final report concluded there were examples of good practice in all services reviewed and a strong infrastructure in the CCG to lead and oversee safeguarding and health support for looked after children. There were identified areas for development which were articulated in the form of recommendations for health providers and commissioners.

Areas of improvement and good practice	Areas for development
School Health Nurse service is proactive and has developed/implemented various methods of innovative practice and good practice methods. (i.e. established Twitter account to 'tweet' information/discussions regarding topics such as FGM/CSE/Forced Marriage)	*'Think family'* approach should be embedded across the health economy services
Family Nurse Partnership are providing good and effective care to pregnant teens, resulting in good health & wellbeing outcomes for children	More should be undertaken to capture the 'voice' of the child through assessments, documentation and meeting minutes
Health Visitor handovers are good. Good practice was evident in the majority of the cases reviewed.	Communication between agencies and services should be improved
There is good understanding of thresholds amongst practitioners from all agencies and services	Multi-disciplinary meetings should include all agencies/services working with the family to ensure that a clear picture is built
LAC health assessment completions and timescales are significantly improved	Completion of quality MARF's remains inconsistent. The services should ensure that practitioners clearly articulate their concerns regarding the child within the

	form
Development of the MASH is impressive	CP/CIN/EH plans should be recorded by all practitioners/services working with the child
Multi agency working (especially within the MASH) is much improved	GP engagement with the ICPC process remains an area for development
The development of strong infrastructure in the CCG to lead and oversee safeguarding and LAC is commendable	Information should be sought from other practitioners working with the child prior to completing an annual review health assessment.

5.12 The LSCB sought assurance from health services about their safeguarding arrangements by receiving a report on the findings from the CQC inspection. The action plan that was subsequently developed for Providers, Sandwell & West Birmingham CCG and NHS England is being monitored through the Health Forum.

5.13 Monitoring through the PAB has shown good engagement by NHS organisations to support the operating model for safeguarding in Sandwell. There has been a strong drive to reduce vacancies in key safeguarding roles, manage caseloads, provide effective supervision, and support multi-agency meetings. A key challenge over the next twelve months will be to extend and embed the Lead Professional role and contribution to early help assessments.

Child and Adolescent Mental Health Services (CAMHS)

5.14 The range and effectiveness of CAMHS was highlighted as an area of concern by SSCB in March 2014. The provision of CAMHS was subsequently reviewed by the Director of Public Health in September 2014, with a number of proposals for improving CAMHS as part of a wider commissioning strategy for children's emotional well-being and mental health.

5.15 Some progress has been made to improve joint planning through the establishment of a multi-agency 'co-production group'. Communication with schools has been more purposeful, with discussions about pathways that will enable schools to get speedier access to services.

5.16 At a practical level, a 'Well Net' directory for schools, has been developed, with individual schools listing the current services they have commissioned for improving emotional wellbeing for their

student population. The CCG has commissioned an Emergency response, assessment and treatment service to provide a mental health crisis service to young people presenting at A&E and providing targeted support in the community where appropriate. The CCG and SMBC are commissioning a 'point of access' service for a period of 12 months for referrals in to tier 2 and 3 provision. In spite of these developments, substantial concerns remain about the range of CAMHS services and their effectiveness. This will be a continuing area of scrutiny and challenge by SSCB in 2015-16.

Education and Schools

5.17 SSCB has taken purposeful action to improve its engagement with schools and colleges. The Board established an Education Advisory Group (EAG) and held its first meeting in February 2015. The objective of the group is to improve understanding, recognition and response to education related safeguarding issues across school and college settings in Sandwell, ensuring the timely dissemination of information and engagement with partners about safeguarding. During 2015-2016 the Safeguarding Board will use the EAG as a vehicle for further engagement with the education sector.

5.18 Section 175 of the Education Act 2002 places a duty on local authorities (in relation to their education functions and governing bodies of maintained schools and further education institutions, which include sixth-form colleges) to exercise their functions with a view to safeguarding and promoting the welfare of children who are pupils at a school, or who are students under 18 years of age attending further education institutions. The same duty applies to independent schools (which include Academies and free schools) by virtue of regulations made under section 157 of the same Act. Details of what this means are set out in Working Together 2015.

5.19 All maintained schools, academies, independent schools and Further Education colleges are required to complete an annual audit that culminates in an Annual Safeguarding Report to the Governing Body. The local authority monitors compliance.

5.20 During the reporting period, the LSCB launched its online audit tool in order to enable the Board to receive assurance that school governing bodies, local education authorities and further education institutions had arrangements in place to safeguard and promote the welfare of children. The tool was initially piloted with a small number of schools

in September 2014 before being widely rolled out. At the end of the reporting period 93% of the education sector had signed up to the tool. The Board will be taking action to ensure that all schools sign up to the audit tool and will challenge schools about its timely completion.

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

5.22 The key issues of substance for the SSCB arising from the audit activity included the following:

- Although schools are increasing their awareness and engagement in CSE (which is demonstrated through the number of referrals being received), it is clear that a more targeted approach needs to be taken with specific schools in order to raise awareness further. Primary Schools in particular expressed concerns with regard to CSE being within the key stage 1 (ages 5 - 7) & key stage 2 (ages 7-11) curriculum.
- Although a number of schools have either had specific training, or bespoke workshops for pupils, thereby increasing their awareness and engagement in respect of extremism/ radicalisation, this is not routinely being done across the sector. It is clear that a more targeted approach needs to be taken in order to raise awareness further.
- A consistent approach of how to manage disclosures made by children was highlighted as a particular area of concern by schools. This will be addressed by making available to schools a presentation developed by West Midlands Police that supports practitioners in managing disclosures.
- The growing number of private companies offering services to the education sector, such as training and safeguarding advice, has the potential to compromise the work of SSCB due to such training and advice not being consistent with the model of working in Sandwell. This finding mirrors a recommendation from Sandwell's recent ES Serious Case Review and is being addressed through the work of the Board's Learning & Development Subgroup and Education Advisory Group. A

programme of meetings specifically for Designated Safeguarding Leads will also be developed.

- Whilst schools are accepting of their role as Lead Professionals there was a consistent view that capacity issues - particularly in respect of the administrating and coordinating of meetings - often impacted upon this ability.

5.23 At the end of the reporting period assurance panels have taken place with several schools with further schools scheduled to participate during the first quarter of 2015-2016.

5.24 A full report, with proposed recommendations, will be provided to the Safeguarding Board during 2015-2016 that will bring together the key learning from the online submissions and the assurance panels

5.25 The OFSTED review specifically commented that "Engagement with schools has been strengthened through a new clearer structure to engage representatives of schools (primary, secondary, colleges and special) and a strengthened approach to S.175 audits providing greater challenge to schools".

5.26 Areas which will be monitored by SSCB during 2015-2016 include:

- Engagement of schools in early help arrangements
- Participation by schools in statutory child protection processes
- Practice in relation to children educated other than in school
- Efforts made to reduce the number of children absent or missing from education

Criminal Justice and Public Protection

West Midlands Police (WMP)

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

5.28 WMP is a statutory member of the LSCB, and its officers (both from the Public Protection Unit (PPU) and the Local Policing Unit (LPU)) play an active role in the Board, the Executive and its sub-groups. The Strategic YPSEM subgroup was chaired by the police until the

end of December 2014, the Operational YPSEM subgroup is co-chaired by the Police, and the Policy & Procedures subgroup is also chaired by the Police.

5.29 In June 2014, WMP were inspected by Her Majesty's Inspectors of Constabulary (HMIC) on child protection. This was part of a rolling programme of such inspections of all police forces in England and Wales. The inspection report was published on 28 October 2014 and is available at the following link:

5.30 The inspection team highlighted a number of areas of strength, including a strong commitment from the leadership team to child protection, with a clear plan for developing their child protection services; staff responsible for managing child abuse investigations were knowledgeable, committed and dedicated to providing good outcomes for children; the force has developed good relationships with partner agencies and local safeguarding children boards; and the force has introduced a series of mandatory training packages for officers and staff, which includes child protection and child sexual exploitation, honour-based violence and female genital mutilation

5.31 HMIC also identified a number of important weaknesses and areas for improvement including a weak response to difficult, complex or prolonged child protection cases; that heavy workloads meant staff in child abuse investigation teams were unable to manage their investigations effectively; a general lack of understanding of the extent of child sexual exploitation and inconsistent practice across the force area; that officers did not always understand when to refer child protection issues to other agencies or how to do it; and children were being unnecessarily detained in police custody overnight.

5.32 An action plan developed as consequence of the inspection was presented to the LSCB in December 2014. The LSCB challenged the police in relation to their practice with missing children, the detention of children and MARAC arrangements for responding to domestic violence where children are present. Further assurance in respect of the implementation of the action plan formed part of the June 2016 Board meeting.

5.33 During February 2015, along with the further 42 Police Forces, West Midlands Police took part in 'Phase one' of an HMIC inspection in relation to Forced Marriage, Honour Based Violence and Female Genital Mutilation. Phase two will commence between 22 June 2015 and 7 August 2015 during which time there will be an in-depth

inspection of a smaller number of forces following analysis of the information gained in phase one.

5.34 WMP has developed an extensive response to the protection of vulnerable people, building on the learning rom the 2013 Operation Sentinel. Since October 2014 WMP has extended its Sentinel activities, which now cover: domestic abuse; child sexual exploitation; human trafficking (which is now referred to as Modern Day Slavery); forced marriage; honour-based violence; and female genital mutilation; child abuse, serious sexual assault, rape; and prostitution. Sandwell specific activities/ successes are:

- Rolling programme of taxi enforcement/education operations in partnership with Council Licensing Department
- Briefing of and closer working between Police and Council Wardens and environmental Health
- Closer working relationship between Police, CSE borough lead and Care Homes on the Borough.
- Police Surgery's held at Raaj FM Radio Station.
- FGM inputs delivered to Health Care Professionals and Soho and Victoria Priority area leads. More briefings scheduled for May 2015 at Coneygre Centre.
- Joint operations with Hope for Justice re Modern Day Slavery
- Robust partnership offender management process adopted with regard nominals believed to be criminally active in Sentinel relevant themes.
- Restructuring of YPSEM panel.
- Part funding via Sentinel funding stream of bespoke training aid, the Trapped Programme, in partnership with Sandwell Womens Aid to go into the 17 secondary schools and 96 primary schools in the Borough, covering all aspects of vulnerability.
- Part funding also via Sentinel Funding Stream of further multi-agency event with regard domestic violence in partnership with DASP

5.35 At the end of the reporting period, Sentinel was being evaluated by West Midlands Police with a view to how it will continue to move forward.

5.36 In 2015-16 SSCB will focus in particular on the progress made by WMP in responding to the HMIC child protection inspection, the contribution of the police to Sandwell's revised CSE action plan.

Staffordshire and West Midlands (SWM) Probation Trust

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

5.38 SSCB did not request an assurance report from the Probation Trust this year. This was primarily due to the major changes to the delivery of probation services that took effect during 2014-2015. Under the Government's Transforming Rehabilitation initiative the former Probation Trust ceased to operate from 31st May 2014. Staffordshire and West Midlands Community Rehabilitation Company (CRC) was subsequently created in June 2014 and the Reducing Re-offending Partnership (RRP) was confirmed as the as the owner on 1st February 2015. SWM CRC remains the provider of probation services for low and medium risk offender.

5.39 Although NPS retain lead for both Multi-Agency Public Protection Arrangements (MAPPA) and Multi-Agency Safeguarding Hub (MASH arrangements), SWM CRC retain involvement with Multi-Agency Risk Assessment Conference (MARAC) and indications are that attendance at CP conference remain active.

5.40 Areas which will be monitored by SSCB during 2015-2016 include:

- The impact of the organisational changes on the ability of the Probation services to engage fully in local child protection arrangements;
- The level of supervision, training and management oversight available to staff in the new CRC;
- The engagement of both the NPS and the CRC in local child protection processes and the LSCB

Targeted Youth Support (TYS)

5.41 Sandwell Targeted Youth Support (TYS) is made up of a range of statutory and voluntary services for young people, committed to working with young people and their families to enable young people to fulfil their potential away from crime and anti-social behaviour. TYS staff have contributed fully to embedding the 'Early Help' offer, aiming

to provide effective support to families at the right time; thereby reducing the need for intensive services at a later stage. The Sandwell Early Help offer has been developed and is approaching a review following one year of implementation. TYS staff remain located in the Community Operating Groups but all COG staff are to have an expectation around ASB/Crime prevention in Job Descriptions to further attempt to reduce first time entrants in to the criminal justice system. The assessment tool being used is known as the Early Help System (formerly eCAF) but will incorporate elements of the 'Onset' assessment tool for crime/ASB cases

5.42 Sandwell Youth Offending Service (YOS) forms part of TYS and is a multi-agency team responsible for the supervision of children and young people subject to pre-court interventions and statutory court disposals and is therefore well placed to identify children known to relevant organisations as being most at risk of offending and to undertake work to prevent them offending. The YOS is also responsible for the provision of persons to act as Appropriate Adults to safeguard the interests of children and young persons detained or questioned by police officers, hence are significant in ensuring the safety and welfare of children in particular circumstances.

5.43 Should young people go on to commit offences, the YOS has an Out of Court Disposal (OOCD) process which was designed and implemented with Police, and seeks to divert from formal court proceedings where appropriate. An independent academic report on the impact of this process concluded it to be statistically significant in improving reoffending outcomes when compared to the YOS previous systems, with 87% of young people in the OOCD cohort not reoffending.

5.44 In terms of statutory work, the YOS has made steady progress towards its three key performance indicators of Reducing First time Entrants, Reducing Reoffending and Reducing the Use of Custody. However there are a number of significant challenges which require ongoing consideration and evolution of service; particularly around the diverse and challenging nature of the current cohort. The Police Custody Superblock (opening December 2015) and the current consultation on the potential closure of Sandwell Magistrates Court are likely to impact on the wellbeing of children and the YOS is monitoring via the YOS/TYS Management Board.

5.45 Learning from thematic inspections routinely informs the YOS/TYS Management Boards' agenda. A recent example is the work being

undertaken by YOS on a 'girls health check' for female young offenders to improve practice for this cohort. The YOS is also hoping to access Speech and Language Therapist support on a two day a week basis in the near future (subject to funding) in an attempt to better engage with a complex cohort of young people and ensure paperwork is young person friendly.

5.46 Capturing the child's voice continues to be improved. Recently the YOS has encouraged young people to complete a HMIP survey to capture service user voice. Over 40 responses were submitted to HMIP and a collated report of comments has been received which will be submitted to YOS/TYS Management Board for analysis and inform service delivery improvements. Feedback was anonymous, but 87% stated that the YOS service was good or very good and 92% stated that they had been treated fairly.

5.47 Looking ahead to 2015-16, the Prevent duty will become a requirement on July 2nd 2015 and this will place a duty on Local Authorities and Education to engage with the Prevent Agenda. Prevent is part of the Government's Counter Terrorism Strategy with three overriding objectives, which are: response to the ideological challenge of terrorism and the threats faced from those who promote it; prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support; work with sectors and institutions where there are risks of radicalisation which we need to address

5.48 Sandwell has been engaging with the Prevent Agenda for a number of years with good practice noted regionally in the form of an award from the West Midlands Counter Terrorism Unit. Sandwell is designated as a supported area by the Home office with an expectation of having a strategy, delivery plan and Channel arrangements in place. Channel is a multi-agency approach to protect people at risk from radicalization

5.49 DECCA deliver harm reduction educational work around substance misuse in mainstream schools as part of their universal offer. The team also deliver harm reduction educational work using a structured model within non mainstream settings, and direct treatment with those young people identified as having alcohol and/or drug related issues. DECCA in all these ways have managed to deliver substance misuse messages to approximately 15,000 young people

5.50 SSCB will have the following areas of focus for TYS and the YOS in 2015-16:

- Numbers of young people held overnight in police custody;
- The rising number of young people who are being convicted of sexual offences, and the services that are available to them.

Third Sector

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

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

Sandwell Women's Aid

5.53 SWA (Sandwell Women's Aid) is an independent, West Bromwich based charity which has been supporting victims of domestic abuse and sexual violence in the Black Country for the last 25 years. SWA offer sensitive and holistic support services which help victims of abuse to escape from violence cope with trauma and move on with their lives. Over the years they have grown from a small refuge provider to a diverse organisation which supports over 2000 women, children and men across the Black Country every year.

5.54 During the reporting period SWA won the **One to Watch: Most Improved Organisation** award and **Highly Commended** overall runner-up at the first national Investors in People Awards3.

5.55 A successful bid to SSCB during the year will enable the Identification and Referral to Improve Safety (IRIS) model to be introduced into GP Surgeries in Sandwell during 2015-16. IRIS is an evidence based

[3] The Awards celebrated the best workplaces, bosses and businesses in the UK, and the competition was stiff with over 550 nominees

training, support and referral programme for GP teams, enabling them to respond effectively to domestic violence and abuse. Practices will also have streamlined and simple referral pathway for their patients to a named advocate educator, reducing time required from GPs and practices to respond to disclosures and related issues.

5.56 SWA will continue to provide the regional Human Trafficking Service for the West Midlands for a further 3 years, after successfully re-tendering for the contract earlier this year. SWA has offered refuge and support to victims of international human trafficking since 2011, supporting victims referred through the NRM (National Referral Mechanism) as a sub-contractor of the Salvation Army, which administers the national service on behalf of the Ministry of Justice. Last year SWA supported 99 people who had been trafficked from across the world for sexual exploitation and forced labour, reflecting a growing demand as more victims of trafficking come forward. SWA is extending its refuge provision with a brand new refuge in Sandwell

Barnardos

5.57 Barnardo's delivered West Bromwich North Childrens centre, Barnardo's Sandwell Family Support Service, Black Country BASE, Sandwell ABC (Awards in the Black Country) and BALANCE family support on behalf of Sandwell MBC during 2014-2015.

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

5.59 The Sandwell Family Support Service is an early intervention support service for Families in Sandwell that delivers early intervention, CAF and outreach engagement in direct work with families. Using a range of evidenced based parenting support models and therapeutic & practical support for families, the service delivered on behalf of Sandwell MBC works within COGs and multi-agency partnerships

within Early Help to deliver a responsive and flexible approach. Acting as lead professionals, family support workers are central to offering family support to enable families to support and safeguard their children.

5.60 Sandwell ABC works within Sandwell schools to support children and young people with identified disabilities. Using an Awards based approach of Adventure Service Challenge and Duke of Edinburgh schemes, this service encourages opportunity, growth and self-esteem for children with a range of learning difficulties and disabilities. Future funding for this service remains uncertain.

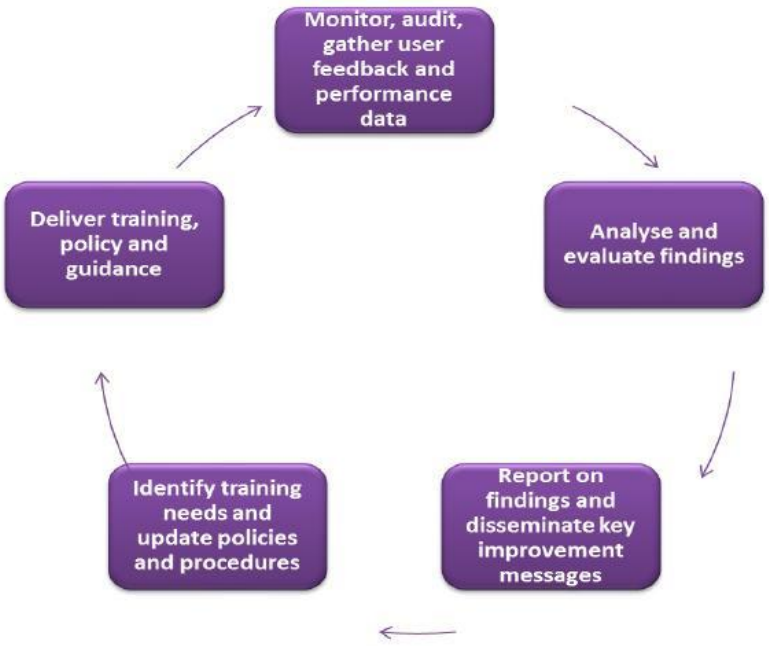
5.61 Black Country BASE (Barnardos Against Sexual Exploitation) offers specialist CSE services in Sandwell and operate as part of Sandwell's CSE co-located multiagency team in delivering safe, effective and co-ordinated care pathways across the Borough. Using evidenced based practice, the service provides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

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

6. Learning and Improvement

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

6.2 In January 2015, as part of the improvement work with iMPOWER, SSCB agreed a new Learning and Improvement Framework. See the figure below.



The Board's previous framework was not fit for purpose and did not enable the Board to draw together learning from case reviews and audits to inform training, policies and procedures, and practice improvement. The full implementation of the new Learning and Improvement Framework is a key priority in 2015/16. In the meantime, the Board has drawn on learning from the work of the relevant sub-groups in the review period to inform Business Plan priorities.

Serious Case Review Subcommittee

6.3 During 2014-2015 the SCR Subcommittee met six times in April, June, September, November 2014, and January and March 2015. During this time the SCR subcommittee ensured that reviews were undertaken

appropriately, not only for cases which met statutory criteria, but also for other cases where it was felt that useful learning into the way organisations worked together to safeguard and protect the welfare of children could be identified. Although the sub-committee has disseminated learning from case reviews through briefings and published material, there has not been sufficient connection with the Board's training activity, its work on policies and procedures and its audit programme.

Key Subgroup Activity and Achievements

6.4 Following liaison with the national panel of independent experts on Serious Case Reviews a Serious Case Review relating to the neglect of a child, who had moved into Sandwell with his family from a neighbouring Local Authority, was commissioned.

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

6.6 At the time of writing the SCR has yet to be published due to an ongoing criminal investigation. However, lessons learnt include:

- Ensuring compliance with the West Midlands regional cross border protocol. Using SSCBs Learning Improvement Framework an audit will be undertaken by the Quality of Practice & Performance Subgroup during 2015-16 to progress this area of learning

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

- Ensuring that training commissioned by schools is consistent with local practice models which have been approved by SSCB. Using SSCBs Learning Improvement Framework, the s175 audit undertaken across the Education Sector specifically enquired about the training commissioned by schools. During the accompanying s175 assurance panels this resulted in

recommendations being made to schools to align their policies with SSCB practice models. In addition, the Learning and Development Subgroup positively engaged with those independent providers commissioned by schools with whom concerns had been identified. Further assurance work will be undertaken during 2015-16 by the Education Advisory Group.

6.7 Two Management Reviews were also completed during the reporting period. These are undertaken when it is felt that the threshold for a SCR has not been met but there are nevertheless important lessons to be learnt. Lessons learnt include:

- The need for a clear policy and pathway for the handover from health Visiting to School Nursing
- Developing a neglect training programme and raising the profile of SSCB's Neglect Policy & Practice Guidance
- SSCB seeking further assurance that thresholds are being correctly applied and that children are receiving services that address risk and needs.

6.8 The SSCBs Significant Safeguarding Incident Notification process resulted in the submission of four cases during the year to the SSCB Business Unit. Whilst one case was felt to be an inappropriate submission (as there were no significant safeguarding concerns about a child) the following action was taken in respect of the other three:

- One case was re-directed to the SSCB Escalation and Resolution Protocol
- One case was re-directed to Sandwell Safeguarding Adults Board (who have subsequently commissioned a SCR)
- A Table Top Review (TTR) was undertaken by Health

6.9 Learning was disseminated to professionals and managers directly involved in cases reviewed. There has also been training of some specific staff groups such as housing officers and health visitors.

Looking Ahead to 2015-16

6.10 The SCR Subcommittee will be publishing the SCR that was undertaken as well as the Management Review. The sub-committee will ensure that its work informs the priorities in the Board's Learning and

Improvement Framework, working closely with the Board's other sub-groups.

Child Death Overview Panel

6.11 An underlying principle of Child Death Overviews is to undertake a comprehensive and multi-disciplinary paper-based review of all child deaths up to the age of 18 years (excluding babies who are stillborn and planned terminations of pregnancy carried out within the law) normally resident in the Local Safeguarding Children Board's area. This is known as the Child Death Review Process. 2014-2015 was the seventh year of this data collection

6.12 During 2014-2015 CDOP met a total of 10 times in April, May, June, July, August (Extraordinary meeting), September, November, December 2014 and January and March 2015. During this time CDOP continued to function alongside SCR (Serious Case Review) Sub-Committee, allowing for consistent and relevant panel membership.

Key CDOP Activity and Achievements

6.13 In the year ending 31st March 2015 there were a total of 40 reported child deaths in Sandwell. 45% of child deaths recorded in 2014-15 occurred in the first month of life, with a total of 65% occurring in the first year of life. Child deaths of children over the age of 10 years accounted for 10% of the total. Nine deaths in 2014-2015 were sudden and unexpected.

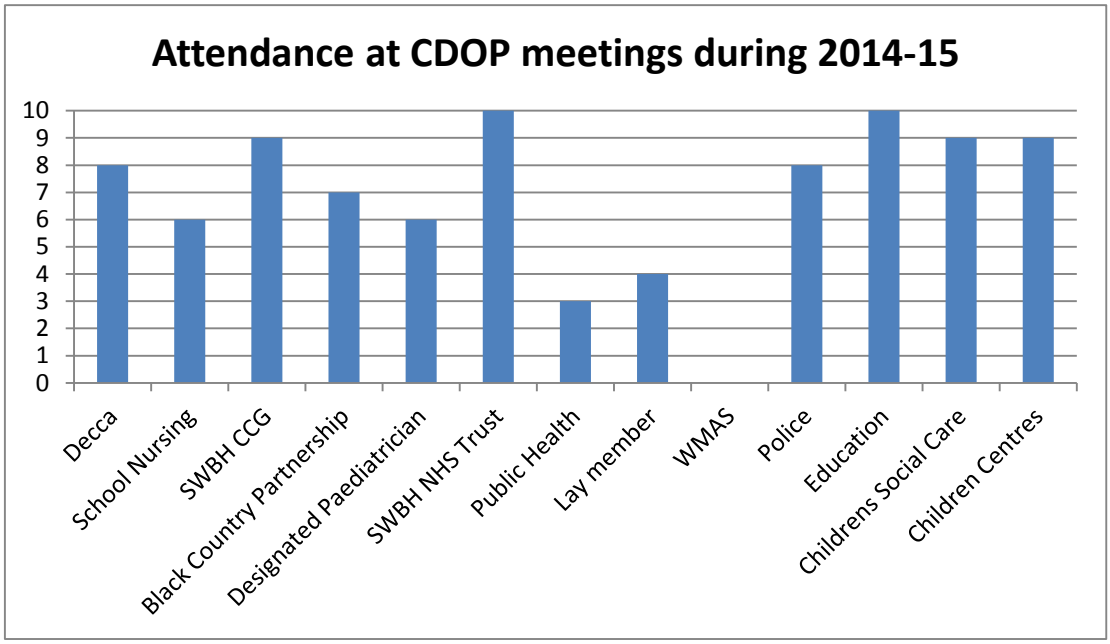
6.14 Factors identified in these unexpected deaths included: babies co-sleeping with an adult and other small children, accidental choking, sudden infant death and road traffic collisions.

6.15 CDOP reviewed a total of 29 child deaths. 62% of the deaths reviewed occurred between 2010-2013,which illustrates that there can still be a significant delay in completing the child death review process owing to the need to wait for the outcome of other processes such as Serious Case Reviews, criminal investigations and/or post mortem examinations.

6.16 In 7 of the deaths reviewed during 2014-15 modifiable factors were identified by panel members. These factors included maternal smoking and substance misuse, Suicide and self-harm (with a possible link to CSE in one death), Complications from a medical procedure (2 deaths), post-surgical infection (1 death), and recognition of pertussis in a baby under the age of 8 weeks (1 death). The learning from these deaths is

disseminated in a variety of ways by short report briefings following each CDOP and bespoke briefings to frontline practitioners.

6.17 Working Together 2015 requires the panel reviewing child deaths to be drawn from a variety of organisations represented on the LSCB. Key findings from attendance at review meetings audit 2014-2015 are illustrated in the chart below.



6.18 Working Together 2015 specifically requests that a professional from public health should attend meetings. It was noted that during the second half of the year, this agency was not represented at meetings. This was challenged by the chair of the panel resulting in a permanent representative from public health regularly attending meetings.

6.19 West Midlands Ambulance Service are still not able to attend meetings due to capacity issues, but regularly update the panel with required information and will be visiting as a guest speaker in the year 2015-2016.

6.20 The Coroner's office has also been approached to send a representative and have responded positively.

6.21 The primary function of CDOP is to learn from the child deaths reviewed and it should be noted that its two main campaigns – Safer Sleep and Shaken Baby continued throughout the last year.

- **Safer Sleeping** - this campaign has now been running since 2010 and continues to be well received. Every Sandwell family with a new baby receives a promotional bag and room thermometer at the Health Visitor's primary visit at 10 – 14 days after the birth. These materials reflect the advice that families are given from both Health Visitors and Midwives, based on the Lullaby Trust guidelines on safer sleeping. Unfortunately there were three deaths at the close of 2014-15 where a baby had been co-sleeping with an adult and other children and this was considered a significant factor in their deaths. As a response to this Sandwell CDOP issued a briefing to all front line practitioners that attended the SSCBs annual conference on 30th April 2015 informing them of these deaths and reminding them of the need to discuss the risks with families and signpost them to the Lullaby Trust advice. The briefing was also circulated to CDOP members with a request for further dissemination within their respective agencies.

- **Shaken Baby** - this was a campaign launched in 2013, following the death of a baby in Sandwell, and subsequent SCR. This campaign was also well received by families in Sandwell, with Health Visitors giving new parents a promotional bib and having a discussion with families about their support networks and the dangers of shaking an infant. Although this was intended to be a time-limited campaign it was so popular with families and practitioners, further funding was obtained in 2014 to continue.

- **Suicide Prevention Pathway** - following the tragic deaths of 2 teenagers in Sandwell a pathway and toolkit was developed by a multiagency working group to assist practitioners in Sandwell to identify behaviours that may lead to self-harm and suicide. ASIST training was commissioned by Public health, supported by the LSCB and was delivered to a range of front line practitioners by Birmingham Mind. The pathway is available to download from the LSCB website.

- Following the successful CDOP peer review that was conducted with Shropshire and Telford and Wrekin CDOPs in 2013-2014 a poster presentation was accepted and presented at the Annual BASPCAN Conference to be held in Edinburgh in April 2015.

Look Ahead to 2015-16

6.22 The 'In There First' (ITF) Programme is designed to deliver safety messages to ensure harm is reduced and young people don't put

themselves at risk. Essentially we 'get in their first' and give safety messages to young people and their parents/carers. These resources can be used in a range of settings but ideally we want them to be used by parents/carers and their children at home. We as professionals may introduce them in a range of settings but it is vital the stories are disseminated so the learning can take place in the home. The programme materials were piloted in 2014-15 and will be launched to coincide with Child safety Week in June 2015.

Learning and Development (L&D) Subgroup

6.23 The subgroup commissions and facilitates multi-agency training to complement single agency training and support partner agencies in meeting their statutory responsibilities with regards to safeguarding children. The Training Catalogue is driven by the priorities of the Board, training needs passed on to the L&D sub group by other SSCB sub groups and feedback from learners.

6.24 During May 2014 membership was refreshed with the appointment of a new subgroup Chair, Vice Chair and L&D Coordinator (seconded to the role for a year following the departure of the previous post-holder in May 2014). This was followed by an increase in the frequency of meetings from bi-monthly to monthly to strengthen the processes around learning and development.

Key Subgroup Activity and Achievements

6.25 The training year began with a new training policy and strategy. The aim was to focus on the quality of training and the development of learners through training and education. Throughout the summer of 2014, the structure and content of training sessions and the skill set used to deliver them by internal and external tutors was considered in detail. The objective was for learners to acquire knowledge and skills for use in their current job. In a facilitated session, the participants were guided through a process involving the development and analysis of ideas, solving problems and/ or making a decision. Tutors were encouraged to use group work to embed knowledge and learners had previously requested greater use of case studies to illustrate practical application of local and national policies, procedures and context in order to achieve greater understanding.

6.26 There was recognition that partner agencies should be involved in training delivery and all courses should have the local Sandwell context in terms of referral routes. The L&D Subgroup launched the 'Training Pool' comprising a group of safeguarding leads in Sandwell from across

the multiagency partnership who were keen to develop their skills to deliver training on behalf of the SSCB. Two 'Train the Trainer' courses were offered during the year resulting in 16 Trainers co delivering or preparing to deliver SSCB courses. In addition, a stand-alone 'Train the Trainer' Neglect course was also delivered by Child & Family Training.

6.27 The year began with a basic training plan to support the L&D Subgroup priorities of Thresholds, Neglect, CSE, Domestic Abuse and Emerging Issues. The training offer included Safeguarding Modules 1 & 3, Threshold Training, CSE and Domestic Abuse. The training catalogue however quickly expanded with the SSCB offering 'Understanding Extremism' – including 'PREVENT'. A total of 34 training sessions took place up to March 31st 2015. During this time, 1050 places were offered with 830 (79%) places being booked through Learning Pool (SSCB Booking Agent). Of this figure, 96 delegates (12%) did not attend on the day and 82 (10%) attended without booking but were accommodated.

6.28 During the reporting period, the L&D Subgroup commissioned some innovative and bespoke training from leading national & local providers due to the availability of extra funding by the Board. Child & Family Training (Neglect), Barnardo's (CSE) and Loudmouth (CSE) have all delivered bespoke training during the year for SSCB. This extra funding also enabled the group to initiate a new and exciting learning intervention to launch the new Domestic Abuse (DA) & CSE training offer and supporting resources. This culminated in the SSCB DA and CSE Launch Event, 'Love Hurts', on 5th March 2015 at the Bethel Convention Centre, West Bromwich. The event was produced in conjunction with the Domestic Abuse Strategic Partnership (DASP) for 200 delegates to raise awareness of domestic abuse and child sexual exploitation in Sandwell. It brought forward the voice of victims and encouraged professionals who work with children and their families in Sandwell to reflect on their practice. Over 81% of delegates rated the event as 'excellent' with numerous requests to repeat the event based on the evaluation feedback.

6.29 The sub-group has sought to strengthen its evaluation of the training programme and its impact. Evaluation of the content, design and methods is now built into course design. Feedback from evaluations and online surveys has helped the subgroup improve the quality and effectiveness of courses and instruction. "On the day" evaluations have been instigated, providing tutors and the L&D subgroup with immediate feedback. This resulted in an increase of 81% in evaluation completion from 17% in 2013-14 to over 98% in 2014-15. The Training Needs

Analysis illustrates that 96% of learners rated SSCB courses 4/5 or 5/5 in meeting course objectives. The active use of feedback has enabled the SSCB training catalogue to become a 'live' document which is added to or amended throughout the year in response to feedback from learners and any emerging issues. This has enabled the subgroup to keep the training focused, current and relevant.

6.30 During the reporting period training participants were strongly encouraged to participate in impact evaluations in order to assess the changes that could be attributed to the training course. These are ideally completed 3 months after attending. The response rate has been poor, with the result that the sub-group has been unable to assess the impact of its training programme in improving practice.

Looking Ahead to 2015-16

6.31 Key areas of work that the L&D Subgroup will be taking forward during 2015-16 include:

- Reflecting on last year's learning and commissioning a new catalogue based on reflecting the Boards priorities/ needs of other sub groups and comments from our learners.
- Rolling out the 2015-16 training catalogue before August 2015 in order to allow delegates sufficient time to attend courses during September/ October
- Repeating the 'Train the Trainer' course to attract new members to the Learning Pool.
- Commissioning Sandwell Women's Aid to extend their training offer (in respond to delegate demand) to deliver bespoke courses on MARAC/DASH & BST and DA & equality from April 2015.
- Commissioning Child & Family Training to deliver full and half day courses on Neglect, in May, June and July 2015.
- Using the new learning and improvement framework to ensure that the quality and impact of training is assessed and that training available clearly reflects priorities identified by the LSCB.

Policy& Procedures Subgroup

6.32 The Policies and Procedures sub-group is responsible for ensuring that all reasonable steps are taken to promote effective multi-agency working through the implementation and oversight of all safeguarding

procedures. The subgroup coordinates the development of new local policies, procedures and guidance for safeguarding and promoting the welfare of children and young people in Sandwell. In addition the subgroup's remit includes the analysis of the implications of national multi-agency policies, procedures, guidance or research findings in terms of the need to develop any additional local policy, procedures or guidance.

6.33 As detailed in the SSCB 2013-14 annual report, following a hiatus in the operation of the Policy & Procedures subgroup during 2013-2014, the group met a total of 5 times in July and August of 2014 and January, February, March of 2015. During this time the work of the subgroup was refocused in order to ensure that SSCB policies were current and relevant. This involved allocating the various policies and procedures to colleagues and other subgroups (e.g. the Education Advisory Group) in order to determine their suitability, accuracy and need. This was then followed by overseeing the process to make the necessary amendments to those policies that were considered to be a priority to SSCB.

Looking Ahead to 2015-16

6.34 Key areas of work that the Policy and Procedures Subgroup will be taking forward during 2015-16 include:

- The creation of a Policy Development Protocol in order to provide guidance to those developing multi-agency policies and procedures for use across Sandwell
- The development of a Female Genital Mutilation multiagency policy
- The development of a Pre-birth Protocol
- Communication across the partnership of any new policy developments/ amendments.
- Ensuring actions from SCRs and Management Reviews relating to Policy and Procedures are addressed

Health Forum

6.35 The Health Forum Subgroup brings together Named and Designated professionals and those with lead responsibility for safeguarding children across the health economy. This allows the group to monitor and provide assurance to the SSCB that there are effective

safeguarding arrangements in place within Sandwell health organisations, as well as minimising any disconnect across the health economy by bringing together a range of health clinicians, professionals and commissioners. The Forum has responsibility for monitoring the implementation of health specific recommendations and actions following inspections/reviews from Regulatory Bodies. Progress reports in relation to those recommendations and actions are submitted to the appropriate bodies.

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

6.37 The Forum is very well attended and meetings currently take place bi-monthly. There are also established task & finish groups to support in the delivery of the Forums action plan which is aligned to the SSCB key priorities.

Key Subgroup activity and achievements

- The Health Forum has supported SSCB L&D in the implementation of threshold document across the health economy and promoted appropriate referrals to MASH from health professionals.
- Bespoke training to frontline health practitioners on application of thresholds and quality of MARF's has been provided to community and acute staff, including ED and a neighbouring acute trust.
- All health staff have been invited to the MASH to observe thresholds being applied. The Forum coordinated a response to address the deficit in health service provision within the MASH for responding to domestic abuse.
- A process has been agreed with Child Health Department to trace children whose whereabouts were previously unknown and forward the records to the appropriate authority.
- The 'Safeguarding Node' within the SWBHT electronic health record system has been implemented. It allows for the sharing of safeguarding

information pertaining to both adults and children across users of SystmOne (electronic health records).

- A single point of contact has been established to receive and distribute invitations to health professionals to Initial Child Protection Conferences (ICPCs). This arrangement now provides a more coordination of performance information GP contribution to ICPCs and timely circulation of reports to conferences.

- The Faltering Growth and Neglect policies have been embedded across the health economy in response to SCR recommendations.

- The Forum has established a task & finish group to ensure that health actions from the SSCB CSE Strategy are implemented and embedded. The group will scope activity and resource within the health economy in order to identify gaps within service provision. The actions plans developed by the group will support and compliment the National/Regional CSE Strategy.

- The Forum has agreed to conduct peer to peer reviews using CQC 'lines of enquiry' to audit multi-disciplinary working. This will identify areas for development within practice and across services and allow for the forum membership to develop an action plan to address issues arising.

- The Subgroup has developed a newsletter which is shared with the Chairs Group following each meeting. The newsletter provides highlights of the group's activity since the previous meeting and informs of key dates or events for the Board to be aware of.

- Members have agreed an action plan to address health's contribution to the lead professional role. Significant progress against the plan is being made and a Workshop has been arranged for health professionals to work with the Early Help Team in addressing barriers and increasing health's uptake of the role.

Looking ahead to 2015-16

- Review draft overview health specific recommendations from SCR/Domestic Homicide Reviews (DHR) to ensure they are appropriate and SMART

- Develop a common approach across the health economy, for SCR/DHR recommendation implementation to provide quality and consistency

- Identify and undertake health audits which may be service specific

- to share with Learning & Development subgroup any training needs identified from audits.
- Ensure outcomes of audits are communicated across the subgroups and to the board
- identify themes for audits and work in partnership with health providers and subgroups to improve data quality and outcomes for children
- To receive & review health components of multi-agency audits, to respond to health actions, agreeing monitoring and implementation process(s).
- Review and contribute to the scoping of the Voice of the Child and identify any gaps and develop any action plans required
- Develop a dataset to capture Health deficits of children entering the care system and comparison at annual review. This will identify improved outcomes for the LAC cohort, whist also highlighting gaps in services for this vulnerable group.

7. Performance Management and Quality Assurance

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

7.2 The lead for this aspect of the Board's work is through the Quality of Practice and Performance Sub Group. During 2014-2015 the Subgroup met a total of 6 times in May, June, July, October 2014 and January and February 2015. The sub-group has put in place the necessary foundations for the Board to undertake its performance management and quality assurance function.

7.3 A multiagency Quality Assurance Framework (QAF) and dataset has been agreed by SSCB. The QAF is intended to be the single framework for performance across the partnership. The Board's dataset incorporates the national requirements and prescribed local information set out in the Department for Education's LSCB Performance Framework requirements, together with multiagency data which reflects the priority development areas in the SSCB Business Plan.

7.4 A more extensive programme of multi-agency case file audits has been established. Multiagency audits were undertaken on the Voice of the Child (April 2014); Section 31 thresholds (July 2014); Quality of Care Plans (October 2014); and Early Help Interventions (December 2014), and Neglect (February 2015). The quality of the audits themselves has gradually improved and there is now a more formal process by which the learning from audits informs policies and procedures, training and practice improvement. The multi-agency audit programme for 2015-16 will be linked more directly to the Board's priorities (e.g. responding to CSE), recommendations from case reviews, and areas concern highlighted through the Board's performance information.

7.5 In respect of the Section 11 Audit to assess whether agencies are fulfilling their statutory obligations as set out in Chapter two of Working Together 2015, the Board did not carry out such an audit in 2014-15. This was because the SSCB completed a full Section 11 Audit in 2012-13. This was followed by a series of SSCB 'Scrutiny panels' during 2013-14 to review the Section 11 audits of a number of the

partner agencies. The last of these panels took place in March 2014. The Board will be carrying out a further Section 11 Audit during 2015-16. The Board will also be scrutinising in more detail the audit activity in single agencies and any learning points arising.

Looking ahead to 2015-16

- The work of the QPP sub- group will be strengthened and enhanced by ensuring that all of the agencies attend the meeting and contribute to the process. This will give greater clarity about each other's roles and ensure that the audits and performance data can be effectively scrutinised.
- In an effort to ensure that learning from previous audits has been disseminated and had an impact, the QPP group will need to revisit key areas and do repeat audits. If concerns are not addressed, the QPP group will need to look at what action it can take to ensure there is compliance with the findings.
- The Board is required to ensure that the voice of the child and their parents is reflected in the work that all agencies do. The QPP sub-group is therefore looking at ways that we can capture this information and engage with families to ensure that the findings are addressed and help to shape future practice.

8. Key Safeguarding Areas

Child Sexual Exploitation

8.1 SSCB established its initial CSE strategy in June 2014, based on the Local Standards in the regional framework. Progress against the strategy was monitored by the Young People Sexual Exploitation and Missing (YPSEM) Sub-Group and the Chairs' Group.

8.2 SSCB undertook an assurance audit on CSE in September 2014 to scope responses to children and to proactively learn lessons for how the wider partnership was dealing with CSE in the borough. In response to this challenge the following actions were undertaken:

- The Local Authority established an integrated, multi-disciplinary CSE team located in the MASH. Additional capacity was identified and this team was launched in December 2014;
- The screening of all children and young people (aged 10-17) open, at that time, to children's social care and integrated early help services. In addition all those referred to children's services since this audit are also screened resulting in over 1000 screenings having taken place since November 2014;
- The completion of a risk assessment, using the National Working Group (NWG) risk assessment tool, for all children or young people whose screening identified them as being at potential high risk of CSE;
- The implementation of the integrated CSE team, alongside a CSE Coordinator to provide more specialist support in responding to CSE, increase awareness and understanding and provide tracking of all open cases;
- A specific programme of work with taxi companies, hotels and fast food outlets to increase awareness and target hotspot locations identified through the screening undertaken;
- The re-focusing of the governance for CSE in Sandwell to better respond to emerging intelligence, improve the interventions with victims of CSE, and ensure a more coordinated response to missing children who are also at risk of CSE;

- Increased focus on perpetrators and locations to ensure that disruption activities could be coordinated to increase effectiveness.

8.3 The OFSTED inspection in 2015 provided an external perspective on the effectiveness of the response to CSE in Sandwell. The inspection report concluded that:

- *The arrangements for the management of children who are missing and at risk of child sexual exploitation are poor… The local authority and its partners do not fully understand the scale and prevalence of child sexual exploitation in Sandwell.*

This criticism arose in large part from a concern that the needs and risks in relation to CSE cases were not always being held at the right level, with work with some children at high risk of CSE being supported inappropriately and ineffectively in early help.

In respect of SSCB[4], OFSTED found that:

- *The LSCB has not assured itself that children at risk of CSE in Sandwell are identified by agencies or that they are receiving appropriate services. It has not provided sufficiently timely or strong leadership despite having a longstanding link to Young People at risk of Sexual Exploitation and Missing group (YPSEM). The LSCB is in the process of revising and updating its CSE strategy but that work is not yet complete.*

Next Steps

- Complete the revision of the Sandwell CSE strategy, drawing on learning nationally, and working within the West Midlands Metropolitan Area Regional Framework
- Revise the guidance, processes, and referral pathway for managing CSE cases
- Commission an external assurance audit of CSE cases to inform improvement in work to support victims and tackle perpetrators
- Participate in the pilot project with the Office of the Children's Commissioner and Sussex University to implement and

[4] ibid. paragraph 169.

evaluate the See Me, Hear Me framework of Local Standards as a supporting framework for the Sandwell CSE strategy

Early Help

8.4 The year April 2014 to March 2015 saw the development of foundations for effective multi-agency early help support in Sandwell, building on the successes of the previous year. The new 'Early Help' service went live in June 2014 Early Help strategy during the with the creation of the locality COG Teams. Underpinned by a vision of multi-agency integrated working, each COG Team included a COG Manager, an Early Help Social Worker, Intensive Family Support Worker, Targeted Youth Support Worker, Early Help Coordinator and Business Support. The role of the Family Solutions Team was also expanded to include Family Group Conferencing, preventing family breakdown and encouraging families to create their own solutions.

8.5 From the beginning COG Teams have worked closely with various universal services (including schools, health, police, neighbourhoods) and commissioned support services, such as, Children's Centres, Barnardo's Family Support, Action for Children and Options for Life, working together to provide a continuum of support across age groups and levels of need. The core process is that work is channelled through the Early Help Desk (including completed Early Help Assessments, 'green' MARFs and domestic violence reports that are screened as requiring an early help response) to the COG locality, where a coordinated response can be put into place.

8.6 Essential to the establishment of the 'Early Help' service new COG procedures were created including standards for effective case-work and the SSCB Thresholds Document updated to include Guidance on how to request early help support. The Early Help/MASH Board was established to drive forward multi-agency working - reporting to the SSCB as required. The Early Help service has been required to work closely with the SSCB partners regarding ongoing partnership training regarding early help assessments, the Lead Professional role and multi-agency working. They have also been required to work closely with agencies within children's services including youth justice teams, youth service and the 'prevent' agenda, developing the 'Troubled Families' approach across all casework.

8.7 Following the establishment of the service the COG Teams quickly became responsible for up to 1000 cases, with the early help (ecaf) system managing up to 2000 early help 'episodes' open across the

partnership at any one time. COG Managers set about building strong relationships with local partners, including through monthly COG Meetings. Over time these were reconfigured to focus upon the development of services, identifying gaps and commissioning needs and working with local communities to respond to need. In order to support partners to take on the role of Lead Professional, an Early Help Coordinator was placed in each COG to identify the appropriate Lead Professional and Team Around the Family (TAF) and chair the first TAF meeting. As partners grow more confident, the strategy has always been for the Early Help Coordinators to transition to direct work in 2015/2016.

8.8 As the service has embedded, practice within the Early Help Service has been subject to regular review and managers of the local authority's Integrated targeted family support services (COGs, FST, Youth Service and Early Help Desk) identified engagement as a key challenge for staff. As a result they have worked with Salford University School of Social Work to commission an Integrated Services Training Programme for all 120 staff, covering solution focused approaches, working with hard to engage families, risk analysis and a range of other practical approaches.

8.9 Senior managers have also recognised that two key aspects of measuring the effectiveness of early help work are 'service user views' and the use of clear 'outcome focussed plans'. In order to embed these into practice the early Help/MASH Board has subscribed to the Outcome Star system (My Start and Family Star), embedding the 'Star' into both ECAF and ICS. It is anticipated that by September 2015 over 600 practitioners from across the partnership will be trained in this approach.

8.10 By April 2014 work had been undertaken to:

- Secure partnership buy in to the Sandwell locality approach.
- Assess the level of early help support needs in Sandwell, across each locality area.
- Develop the on-line 'ecaf' case management system.
- Develop plans for locality based 'Community Operating Groups' (COGs).
- Provide partnership training on 'Integrated Working'.

- Establish and 'Early Help Desk' within MASH as an integral part of the threshold decision making and case allocation processes.

Next Steps

- Establish weekly COG Case discussion forums with partner agencies to support effective decision making from September 2015.
- Review the role of the Early Help Social Workers in ceasing to undertake Early Help assessments and utilising the Single Assessment process for open cases in Early Help to provide greater confidence about the operation of thresholds between early help and social care.
- Appoint a Team Manager and review capacity on the Early Help Desk.
- Complete the Salford University training to all 120 Integrated Services staff and evaluate to consider further roll-out.
- Continue to develop multi-agency membership of COG Teams, to include Domestic Violence Advocates and Primary Mental Health Workers.
- Roll out and embed Outcome Star to support outcome focused plans and service user engagement.
- Undertake -commissioning work, regarding Children's Centres and other targeted support to ensure sufficient capacity.
- Further embed the Troubled Families Initiative approach within all casework.
- Review role of the Early Help Coordinator and begin transition to direct work.

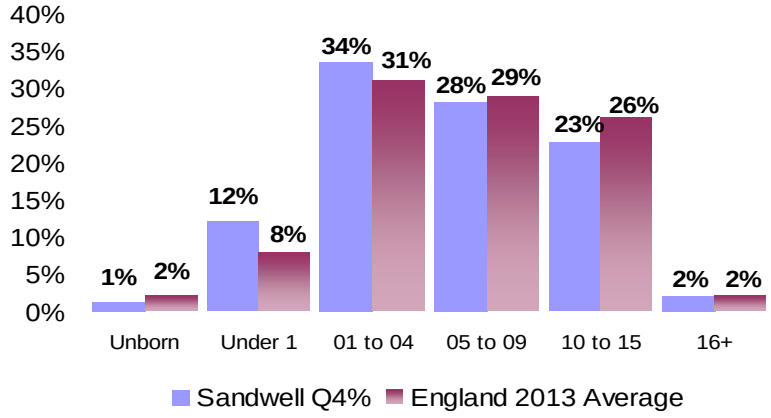
Child Protection

8.11 Sandwell Children's services continue to improve their child protection with a view to ensuring that all children are adequately protected and that children, young people and their families receive the right help and protection at the earliest opportunity. The MASH and MAET front door services have continued to be embedded throughout the year and have built

a strong culture of collaborative, multi-agency working, professional challenge and ensured that thought is given to the context and analysis of the shared information and outcome for each child.

8.12 The effectiveness of the front door has been regularly reviewed e.g. senior management have analysed information regarding referral and demand at the front door and created new MASH criteria and procedures to strengthen management decision making and oversight. Multi-agency auditing within the MASH has also informed regular challenge from partner agencies, ensured consistency of decision making, assisted us to identify resource across the partnership and to address capacity issues in July/August 2014.

8.13 As of the 31st March 2015 there were 321 children subject to a child protection plan in Sandwell. 338 Children were made subject to a plan throughout the year and 387 children were removed from being subject to a plan. This figure remains significantly below our statistical neighbours and slightly below the England average. The reduction of children and young people subject to a CP plan is a direct result of increased expenditure on Early Help and a greater focus on ensuring that preventative services are available which safeguard children such as domestic abuse services. The breakdown of children subject to a child protection plan is shown below:



Category	Sandwell Q4	Sandwell Q4 %	England 2013 Average
Neglect	127	40%	41%
Emotional Abuse	150	47%	32%
Physical Abuse	21	7%	12%
Sexual Abuse	22	7%	5%
Multiple Category	1	0%	11%
Total	321	100%	100%

8.14 Throughout the year there was a focus on performance and the meeting of the national Key Performance Indicators for Child Protection. The communication of performance information was redeveloped, with managers receiving weekly performance information at a team and worker level and a culture of exception reporting to Senior Management was created. There was also a large focus on the timeliness of child protection proceedings throughout the year and significant progress was made. E.g. the timeliness of ICPCs has increased significantly since previous year with 90.2% held within 15 working days since 1st April 2014 (last year 61.6%). This mirrored a large reduction in the caseloads of Independent Reviewing Officer's (IRO's).

8.15 Throughout the year, the service has implemented the Public Law Outline (PLO) process which focuses heaving on working with families in the widest context to maximise outcomes for young people. This has improved timeliness in court proceedings, reduced the amount of time that children spend subject to child protection plans and created more permanency for children.

8.16 The planned removal of agency staff and introduction of permanent workers throughout the year created some instability within the service; however this clearly began to have a positive impact on the quality of practice in child protection cases. Children and young people will have less changes of social worker, which enables families to build relationships and progress, preventing drift and delay. With performance standards now being met, the service can focus on ensuring that the correct thresholds are being applied and improving the quality of practice and management oversight.

An example of this is that the service has introduced a pilot programme of minute takers for core groups to improve the quality of minutes and increase the accountability of all partners to progress outcomes in a timely way.

Next Steps

- An independent review of thresholds at the front door to provide assurance that these are correct.
- Implementing the 'Signs of Safety' practice model across children's services
- Embed outcome focused templates across the service.
- Participation officer to move to the Quality Development Unit to ensure that the child's voice is heard across all of safeguarding.
- Care management panel to review all cases subject to a child protection plan for more than 2 years.
- Increase the number of minute takers for Core Groups and CIN reviews.

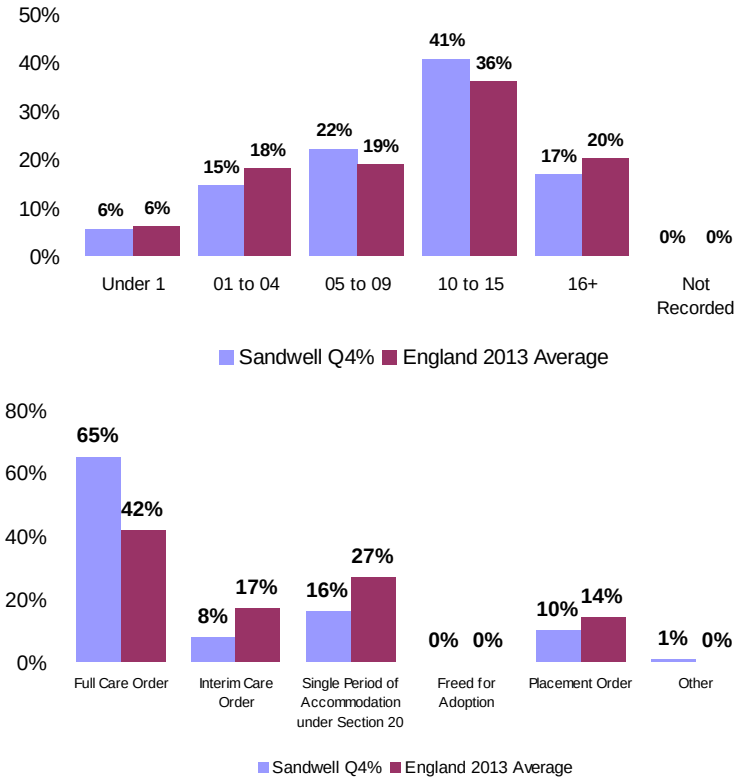
Looked After Children (LAC)

8.17 The delivery of services for Looked after Children within Sandwell has undergone significant change within the past year in order to provide better quality services to children, young people and their families. A service restructure took place on the 1st November 2015 which increased the number of Team Managers in the LAC teams to enable a greater focus on quality of supervision, build on compliance with minimum standards and see real development in the quality of work carried out by practitioners.

8.18 The restructure also split the Fostering and Adoption Teams and a Permanency Team was created to work alongside the teams to support the child's journey into permanence. Work in the adoption team was also rationalised to further reduce the number of handovers for children. Key strengths of the work carried out by these services were recognised by OFSTED in the inspection in March 2015. The service was recognised as "not yet good" and was given a "Requires Improvement" grading.

8.19 As of the 31st March 2015 there were 540 Looked After Children in Sandwell and during the year 164 children and young people became looked after and 183 young people ceased to be looked after. This has been a continuously

reducing number from a peak of 621 in November 2013 and is a result of the strengthening of safeguarding work across the organisation e.g. Family Group Conferencing and Early Help Services which prevent the escalation of problems. A breakdown of the LAC population is shown below:



8.20 Prior to and post the restructuring of service delivery, there was a focus on the 'voice of the child' throughout the year, with the Looked After Children's Board being re-launched and providing a strong vehicle for young people to participate, the creation of a child's voice file for every Looked After Child in Sandwell and young people actively being involved in chairing their own LAC reviews where appropriate. The child's voice will continue to be active focus for LAC services in the forthcoming year.

Next Steps

- The service will continue to focus on improving the quality of practice and improving permanence.

- Create plans to ensure that all Looked After Children have good quality life story work carried out with them.
- Permanency Planning to be incorporated into Legal Planning Meeting's and LAC reviews.
- Multi-agency meetings to be held in between LAC reviews to prevent drift and delay.
- Focus on working with foster carers to start the Special Guardianship Order (SGO) process and create permanency for children and young people.
- Develop Multi-systemic Therapy Services (MST) to prevent teenagers from entering the care system.

Domestic Abuse

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

8.22 During 2014-15, there were 5765 DVA crimes/incidents in Sandwell reported to the police. This is a 12% increase compared to 2013-14. The majority of adult victims were female and the majority of perpetrators were male. Approximately 65% of those cases were screened by the multi-agency Domestic Abuse Screening Team in the MASH (Multi-Agency Safeguarding Hub). Between May 2014 and March 2015, 3363 DVA cases of families with children were screened by that team. The richness of information shared has enabled partners to gain a better understanding of the complexities of domestic violence and abuse and put in place appropriate risk assessment for both adult and child. Interventions from Sandwell Women's Aid, Children's Social Care or Early Help were then offered to those families, depending on the level of risk identified. The number of high risk cases of DVA increased significantly from 286 in 2013-14 to 450 in 2014-15. All of these cases were considered by the MARAC (Multi Agency Risk Assessment Conference) and a safety plan put in place to reduce the risk to the victims and their families.

8.23 A new Delivery Plan for 2014-15 contained a number of actions which have been successfully delivered. Sandwell Council provided funding for SWA to support victims of domestic abuse and sexual abuse, including support to families with children. Additional Domestic Abuse Advocates (DAAs) were recruited in early 2015 to work with the six Community Operating Groups across the borough. The DAAs provide support to victims and their families in localities and work with other agencies to provide an effective community coordinated response to DVA at a local level.

8.24 Work with young victims, both male and female, continues to grow with funds from the Safer Sandwell Partnership and Police & Crime Commissioner. These has enabled direct support to young victims and the continued delivery of the "TRAPPED", teenage relationship abuse programme targeted at year 9 pupils at secondary schools and a pilot targeting year 5 and 6 in primary schools. This is as a result of a growing recognition of not only the impact of domestic abuse amongst young people but young people as direct victims of abuse in their experiences of early relationships. The programme integrates issues such as domestic abuse, rape and sexual violence, exploitation, substance misuse, gang culture and challenges gender attitudes. During the year, 13 secondary schools; 6 pupil referral units; 5 alternative education provision (including NEET); 1 college and 16 primary schools engaged with the programme with over 100 teaching and pastoral staff being trained to deliver the programme as part of the sustainability plan. The education programme has been delivered to approximately 3654 children and young people in Sandwell in the last year with 2254 secondary aged children and 1400 primary aged children.

8.25 SWA continues to provide emergency accommodation to women fleeing domestic abuse through refuges, safe houses, specialist provision for BME women and floating support. During the year DASP identified a need for support to eastern European women and SWA responded by identifying external funds to appoint an eastern European advocate to work across services including accommodation services. In addition to the DASP funding, SWA have attracted external funding from other sources to enhance and complement the SMBC-funded provision with a provision for single women.

8.26 DASP and SSCB recognised the need to integrate issues in order to address them effectively across the partnership and have worked jointly together to integrate issues such as Domestic Abuse and Child Sexual Exploitation. A successful event on 5th March 2015 attracted over 250 professionals from a range of disciplines targeted at agencies working with children, young people and families. This multi faceted presentation enabled professionals to identify with the complexities within families and challenged existing approaches to ensure better outcomes for children and families.

8.27 The work of all the DASP sub-groups has continued during 2014-15. A key development this year has been the commissioning of a voluntary perpetrator programme on a 2 year pilot basis. Fry Housing Trust has been funded by Sandwell Council to deliver a behaviour change programme with DVA perpetrators and this will start in September 2015. Referrals to the programme can be made by partner agencies or by perpetrators themselves. Parallel support to victims will be funded by Safer Sandwell Partnership and delivered by SWA. The programme will be evaluated by the University of Birmingham.

8.28 SWA and Sandwell & West Birmingham Hospitals Trust have also secured funding to enhance the response to DVA in Accident & Emergency Services and refer victims of domestic abuse for appropriate support. Preparations are underway for work to begin in Sandwell Hospital and City Hospital in early autumn 2015.

8.29 DASP has also worked with regional partners in the West Midlands to develop minimum DVA standards for all statutory organisations and specialist agencies. They aim to provide a framework for these organisations to develop their professional practice, improve services, shape future services and deliver the right response across all settings and sectors. The DASP has also been working with the SSCB to incorporate appropriate questions on DVA into the Section 11 audit which agencies are statutorily required to complete. In Sandwell, the Section 11 audit will be used to help monitor the implementation of DVA standards, once they have been agreed.

8.30 DASP priorities for the next year are:

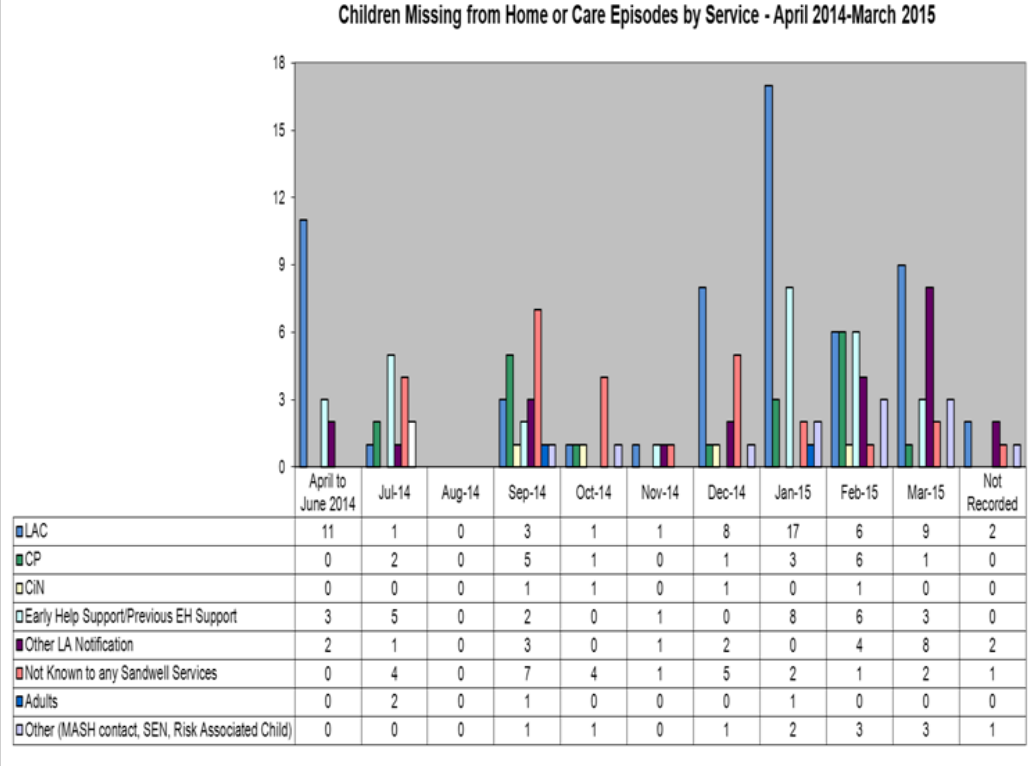
- Spot victims of domestic abuse earlier, especially working with NHS & Clinical Commissioning Group.
- Strengthen MARAC (Multi Agency Risk Assessment Conference)
- Ensure support to victims of all forms of domestic abuse is made more visible and more locally accessible
- Develop victim services and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

Female Genital Mutilation (FGM)

8.31 Work to address female genital mutilation has also been undertaken in the last year under the strategic lead of the DASP. Data analysis has indicated those areas of the borough where communities from FGM practicing countries live. This analysis has helped to target work to engage specific community organisations to consult and work sensitively with them to raise and promote awareness of FGM and reduce the risk of other girls and young women from having FGM. Letters have been sent to schools to raise awareness with head teachers and school staff, to alert them that the summer holidays are a time when girls are at risk of having FGM and advise them of what can be done and the support available. The DVA training plan and Artemis e-learning programme will include FGM. Further work in 2015-16 with local and regional organisations will be undertaken to strengthen the response to this issue.

Children Missing from Home and Care

8.32 Children missing from home and care are known to be at greater risk of significant harm, including CSE. The chart below shows the children missing data for 2014-15 in Sandwell. Over the year there were 176 missing episodes involving 97 children, with 27 children missing on more than one occasion.



	April to June 2014	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Not Recorded
LAC	11	1	0	3	1	1	8	17	6	9	2
CP	0	2	0	5	1	0	1	3	6	1	0
CiN	0	0	0	1	1	0	1	0	1	0	0
Early Help Support/Previous EH Support	3	5	0	2	0	1	0	8	6	3	0
Other LA Notification	2	1	0	3	0	1	2	0	4	8	2
Not Known to any Sandwell Services	0	4	0	7	4	1	5	2	1	2	1
Adults	0	2	0	1	0	0	0	1	0	0	0
Other (MASH contact, SEN, Risk Associated Child)	0	0	0	1	1	0	1	2	3	3	1

8.33 The local authority and partner agencies have taken action during the year to strengthen the arrangements for monitoring and responding to children missing from home and care. Missing children data is tracked weekly, with cross-referencing information about missing children with information about children at risk of CSE. Return to home interviews are undertaken by Barnardos with the aims of assessing the level of risk and understanding the reasons why a child ran away. There is a need to ensure that return to home interviews take place in a timely way, that they are recorded on children's social care files, and that they are considered as part of a wider analysis of themes and patterns in relation to CSE.

Planned changes to partner agency oversight of children missing through a local CMOG should improve management oversight of children missing.

Next Steps

- SSCB will consider data about children missing from home and care through its quarterly performance report, and will commission external audits to assess the extent to which partner agencies are responding in an effective way to children who are missing.

Elective Home Educated (EHE) Children

8.34 The responsibility for a child's education rests with their parents. In England, education is compulsory, but schooling is not and parents are not required to register or seek approval in order to educate their children at home. The parents' legal duty is set out in Section 7 of the Education Act 1996: "The parent of every child of compulsory school age shall cause him to receive efficient full-time education suitable –

(a) to his age, ability and aptitude, and
(b) to any special educational needs he may have, either by regular attendance at

8.35 The "otherwise" option includes home education with parents/ carers taking responsibility to provide education without recourse to a school or local authority; in short, education is compulsory, school is not.

8.36 Home educated children must receive full time education from the start date of what would be the school term following their fifth birthday, if they were in school. Compulsory education continues until the last Friday in June, of Year 11, i.e. any child, who is aged 16 between September and 31st August, is of compulsory school age until the last Friday of June in that year.

8.37 In the 2014/2015 academic year as of the 31st March 2015 there were 141 active home education cases in Sandwell, with 81 new referrals and 77 closed referrals. Of cases closed, 2 were lost pupils, 7 moved out of the area and 61 returned to education.

8.38 It is the Local Authority's policy to visit each of these cases and offer an assessment, to ensure the children's educational needs are met. The Local Authority has no power of entry by law for home education and an assessment is not compulsory. As of the 31st March 2015, only 38 of 141 had a completed assessment.

Next Steps

- The attendance officer will continue to work closely with both social care and early help to assess whether children are being adequately educated at home.
- Review of all children who are EHE in order to obtain reason for non-attendance in mainstream schooling.

Private Fostering

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

8.40 In the year ending 31st March 2015 the DFE return data of notifications by local authorities of children in private fostering arrangements shows that the national average was 10.4 children per authority and the West Midlands figure was 10 children per authority. Sandwell had 11 children subject to PFA in the year ending March 2015 which is slightly higher than some neighbouring authorities such as Walsall (8 children) and Dudley (8 children) whereas Birmingham was understandably higher at 33 children.

8.41 The last report to the SSCB of report of 24th October 2013 explained that Private Fostering was initially located in Care Management and then came across to the Adoption Support Team from April 2014. After that point the Adoption Team Manager had oversight of Private Fostering, the Social Workers within the Adoption Team were undertaking assessments, doing Regulation 8 visits and providing support

to carers. A restructure of Fostering and Adoption in Children's Services took place during the summer of 2014 and as from October 2014, Private Fostering cases moved to be managed in the newly created Permanency Support Team

8.42 It was apparent from subsequent audit activity undertaken by the Local Authority that a lack of management oversight and scrutiny of Private Fostering cases within the Adoption service prior to October 2014 resulted in some Private Fostering Assessments not progressing in a timely way or being completed in timescale. There were also recognised gaps in recording on case files on some of these cases which have been addressed with the managers and workers concerned.

8.43 Following this audit activity, a decision was made by senior management to reallocate Private Fostering cases to an experienced worker in the Permanency Team who has progressed and completed all outstanding assessments and ensured that Regulation 8 visits to the child in placement have been completed within the statutory timescales. Safeguarding reassurance was also requested by senior management on individual cases, which have been audited in depth by the Principal Social Worker, along with a review of all open Private Fostering cases to ensure that regular visits are being undertaken to the child and that any safeguarding issues have been addressed

Next Steps

- All private fostering situations to be considered by the Multi-agency Safeguarding Hub (MASH) to ensure that information sharing takes place regarding families.
- Review Private Fostering processes to ensure that all children and young people are correctly identified, assessed and supported in a timely way.
- Work with the SSCB to raise awareness regarding Private Fostering.

Allegations Management

8.44 Referrals to the Local Authority Designated Officer (LADO) have increased significantly over the past four years. Data for 2014-15 shows that there were 431 contacts with the LADO, of which 80 met the criteria for a LADO strategy meeting. The majority of contacts have been from education settings, with

physical abuse the most likely category for referral. The table below shows the overall outcome of referrals in 2014-15:

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

Where allegations require the intervention of the LADO this is timely and effective.

Next Steps

- SSCB will initiate work with faith groups to ensure that they understand their safeguarding responsibilities.

9. Conclusion

9.1 In spite of important progress in the past twelve months substantial challenges remain for the local authority, individual partner organisations, and for the overall effectiveness of safeguarding in Sandwell. In terms of improving the effectiveness of local arrangements, there are four key issues of substance to be tackled as a partnership in the next twelve months:

- To ensure that there is shared understanding and consistent application of the SSCB thresholds so that children's needs and risks are responded to in a timely way and at the right level;
- To significantly improve the response to CSE;
- To ensure that all partners contribute to systematic and effective early help arrangements, with professionals from across partner agencies accepting the lead professional role and completing early help assessments;
- To promote a culture of shared learning from case reviews and multi-agency audits.

9.2 There is a substantial challenge for the SSCB itself to ensure that it meets its statutory responsibilities and makes a difference to the outcomes for children, young people and families.

Approval Process

9.3 A draft of this Annual Report was presented at a SSCB meeting on 27th August 2015, and the final version including members' comments was approved on 24th September 2015. It is the responsibility of SSCB members to present the SSCB Annual Report to their individual Boards and Governing Bodies.

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Sources and verification

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

Availability and accessibility

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

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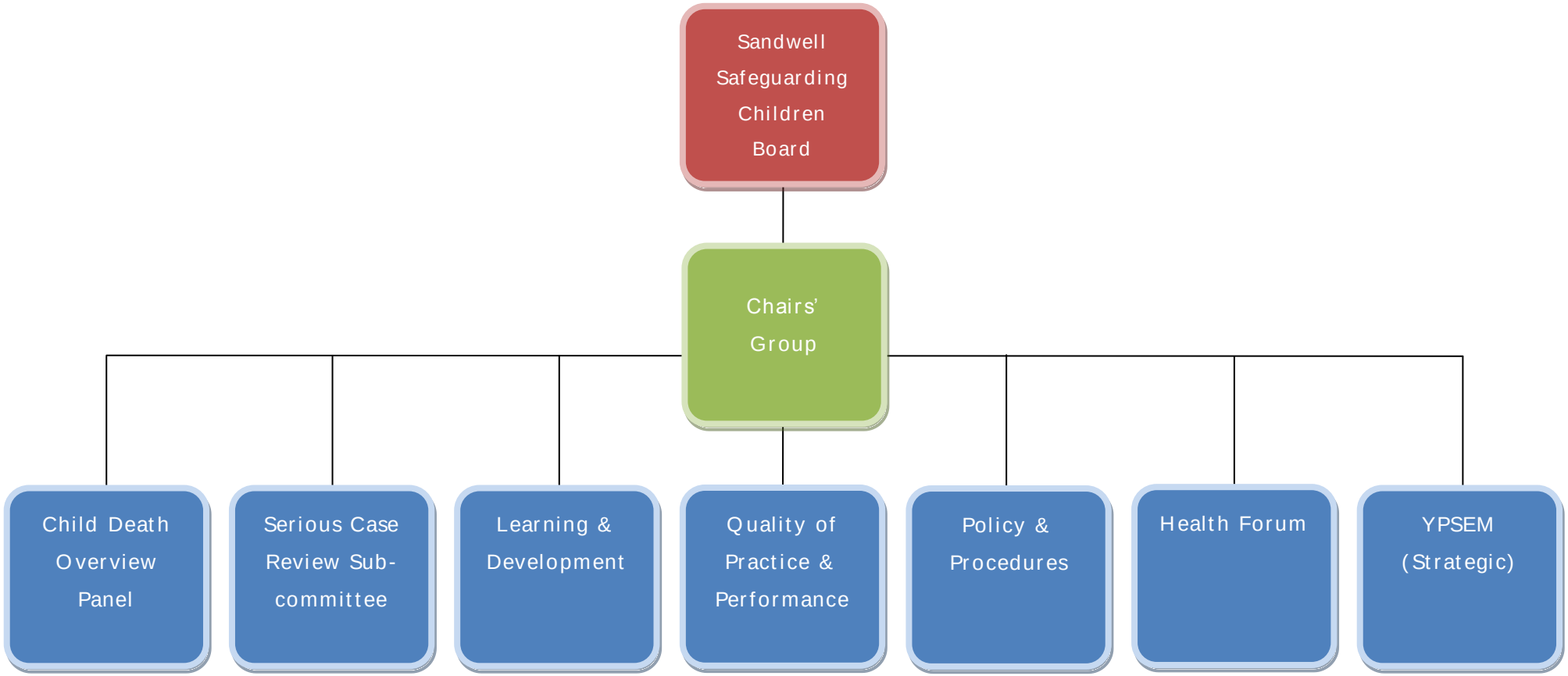
Appendix 1: 2014-2015 SSCB Structure



Appendix 2:

Jargon Buster

CAMHS	Child and Adolescent Mental Health Services
CDOP	Child Death Overview Panel
CCG	Clinical Commissioning Group
CRC	Community Rehabilitation Company
CSE	Child Sexual Exploitation
DASP	Domestic Abuse Strategic Partnership
DHR	Domestic Homicide Review
HWB	Health and Wellbeing Board
ICPC	Initial Child Protection Conference
ITF	In There First
LSCB	Local Safeguarding Children Board
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MBC	Metropolitan Borough Council
NPS	National Probation Service
SCR	Serious Case Review
SMBC	Sandwell Metropolitan Borough Council
SSAB	Sandwell Safeguarding Adult Board
SSCB	Sandwell Safeguarding Children Board
SSP	Safer Sandwell Partnership
SWA	Sandwell Women's Aid
SWM	Staffordshire and West Midlands
YPSEM	Young People at Risk of Sexual Exploitation and Missing