# Working Together to Safeguard Children 2022 -2023 Annual Report-

## Demonstrating the inter-agency activities to safeguard and promote the welfare of Sandwell's children.

Sandwell Children's **Safeguarding** Partnership


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# FOREWORD: LESLEY HAGGER, INDEPENDENT CHAIR, SANDWELL CHILDREN'S SAFEGUARDING PARTNERSHIP.

Welcome to the Sandwell Children's Safeguarding Partnership's Annual Report for the year April 2022 to March 2023. In this report you will hear about the work that has taken place to strengthen, improve and evidence our joined-up and effective safeguarding practice; you will see the results of the important work carried out by our Independent Scrutineer; and you will also read about the priorities for our future work.

Statutory safeguarding partners in Sandwell have continued to work closely together with an ambition to provide visible and significant leadership across the Borough to safeguard Sandwell's children and young people. The Partnership has continued to benefit from representation and involvement from other relevant partners such as our schools, the voluntary and community sector, and faith organisations, all of which are key providers of support to children, young people, and their families.

Our two key priorities, neglect and exploitation, have continued to drive the work of the Partnership, with the inclusion during the year of a third area of focus: Early Help.The development and publication of a robust quality assurance framework during the year has helped the Partnership to deepen its understanding of safeguarding activity in Sandwell and take actions to respond to those findings and improve our ways of working.

At the start of the year, we began to distribute a newsletter following each Partnership meeting, so that the widest possible number of agencies and individuals can be kept in touch with the work of the Partnership. Feedback has indicated that this has been a useful way of communicating key messages and securing feedback and involvement from the widest range of practitioners and organisations. A range of other resources were published including a new website for all practitioners, sandwellearlyhelp.info, an updated multi-agency child exploitation strategy, and multi-agency 'Was Not Brought' guidance to support all practitioners working with children who may not be attending health appointments, home visits or school.

May 2022 saw the Ofsted ILACS inspection in Sandwell. Whilst this is primarily an inspection of children's social care services, there were important messages for all agencies regarding the application of thresholds when referring to children's social care to ensure children and families receive the right service. As a result, the Partnership published its updated Threshold Guidance in June 2022, which was supported by a series of workshops to support agencies with their understanding and use of the guidance. Messaging was further strengthened later in the year to reflect the shared responsibilities that all agencies have to keep children safe even once a Multi-Agency Request Form has been submitted. However, this is an area that still needs significant improvement and will continue to be a high priority of focus next year.

One of the most insightful meetings that took place during the year was the Take-Over Day, when young people 'took-over' the Partnership meeting. Young people told us about their concerns around gangs, knife crime, 'what next?' after school/college, drug use and bullying in schools. A range of actions were progressed including the Bullying Awareness training course for education staff that became over-subscribed as a result.

The Partnership has continued to engage with regional and national work, including having a better understanding of equality, diversity, and inclusion in safeguarding with a view to addressing disproportionality and creating a better understanding of the rich and diverse community that is Sandwell.

The biggest challenge in a report such as this is being able to demonstrate the difference that the Partnership's activities have made, and asking the question: are children safer as a result? There is a great deal of evidence in this Annual Report, although the more questions we ask, the more we find that needs to be done, and in a nutshell that is the core purpose of the Partnership – to ask the right questions, to bring analysis to the answers, and then collectively to make improvements to the system to protect our children and young people. I hope that this Annual Report provides a comprehensive overview of child safeguarding in Sandwell and that you can see and share the commitment to continuous improvement.

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# 1. INTRODUCTION

Local Children's Safeguarding Partnerships (LCSPs) are in place in each local authority area having responsibility for ensuring that children of all ages and abilities get the help, support and protection they need to keep them safe from abuse and harm. The legislation which orders the existence of LCSPs stems from the Children and Social Work Act 2017 which places a duty on key statutory agencies to work together with other agencies in the local areas and agree local Multi Agency Safeguarding Arrangements (MASA) for the purposes of safeguarding and promoting the welfare of children.

**What is Safeguarding?**

For the purposes of this report, the remit and focus for safeguarding is about the actions taken to promote the welfare of children and protect them from harm. Safeguarding in Sandwell is everyone's responsibility, and every single person who comes into contact with children and families has a role to play.

Child Protection is part of safeguarding and refers to the activity undertaken to protect children suffering from, or at risk of, significant harm (Working Together to Safeguard Children 2018).

From the above distinct areas mentioned, the SCSP describes the above to all partners as:

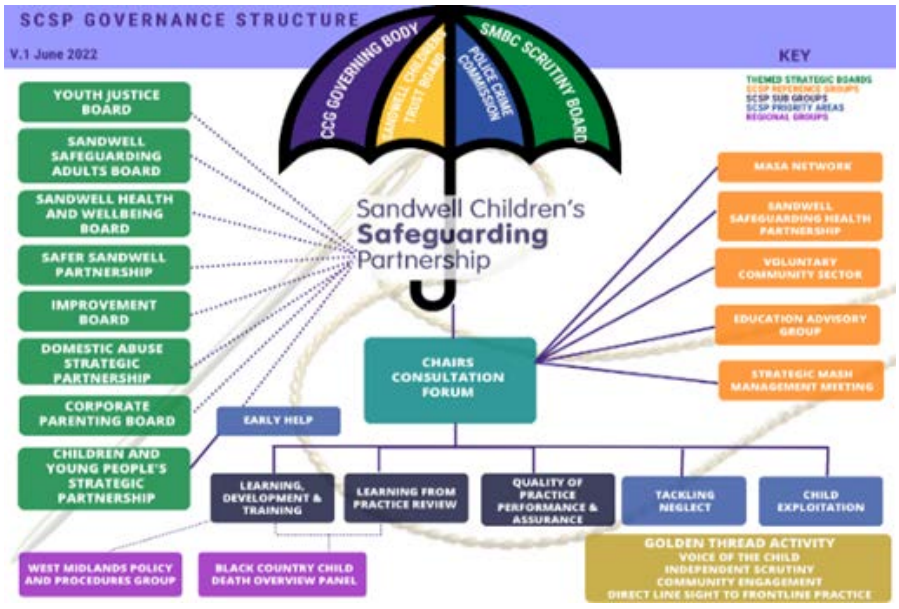
- The actions that we must all take to promote the welfare of children and protect them from harm.
- Adhering to the multi-agency systems, processes and arrangements in place to ensure that all children in Sandwell can be protected from abuse and maltreatment.
- Abiding with the agreed robust structures and pathways for preventing harm to children's health or development.
- Utilising the available provisions to ensure children of all ages, from all backgrounds and abilities have equal opportunities to grow up within provisions of safe and effective care.
- Being proactive, skilled and confident to recognise the early signs that children are in need of help, support and/or protection and take action to enable all children and young people to have the best possible outcomes.

**The SCSP Structure**

Sandwell Children's Safeguarding Partnership (SCSP) was established in April 2019 to ensure effective arrangements for 'Safeguarding' as is described above. The leadership functions sit within the auspices of 4 Statutory Safeguarding Partners, namely:

- Sandwell Metropolitan Borough Council (SMBC)
- West Midlands Police (WMP)
- NHS Black Country Integrated Care Board (ICB) (formerly CCG); and
- Sandwell Children's Trust (SCT) as a 4th partner, hosting the provision of Children's Social Care services in Sandwell.

These agencies as named, working in collaboration with other agencies, have agreed the local structures and MASA required to respond to the local safeguarding needs of the child population in Sandwell.




The Safeguarding Leads have statutory responsibilities for setting the priorities for the SCSP, agreeing its budget, contributions and resources. Its prime role is to ensure robust local multi agency arrangements exist to safeguard and promote the welfare of all children in Sandwell, particularly those at the greatest need of help and/or protection from the actions or inaction of other people.

The SCSP has a 3-tiered structure comprising of the SCSP main board where all four Strategic Leads join together on a bi-monthly basis to include Professional Advisors, a Local Council Member and named relevant partners from Education and Sandwell Community and Voluntary Organisations (SCVO). An Independent Scrutineer as is named in Statutory guidance attends this 'top-tier', where meetings are led/facilitated by an Independent Chair.

In addition to routine meetings, four extraordinary/exceptions meetings were arranged during the reporting year 22/23 to include the four safeguarding leads, the 'Independent Chair' and Business Manager only.
In addition to the meetings alluded to above, the SCSP Chair, Independent Scrutineer and Business Manager meet on a bi-monthly basis to consider on-going strategic safeguarding priorities and operational matters arising that may impact on the delivery of effective multi agency working, and therefore to be directed to the SCSP agenda for further deliberation.

The SCSP Chair and Business Manager represented the SCSP at a 5+ allied board of partnerships, including the Safeguarding Adult Board, Community Safety Partnership, Health and Wellbeing Board, Children and Families Strategic Partnership and the Domestic Abuse Strategic Partnership, bringing to the attention of the SCSP any safeguarding initiatives undertaken by these bodies as well as any issues emergent in other portfolio areas.

The SCSP reviews its structure each year, with the most recent being in January 2022 when the governance and reporting processes of the reference and subgroups were refreshed and reinforced to ensure a clear line of sight and improved monitoring of effective delivery of its core functions and priorities.
The SCSP expects all organisations named,(and those who are not named in the structure however do come in to contact and/or provide services to children and families in the line of their duties) to cooperate with the local MASA[1] and act as a 'Relevant Partner' to collaborate with the SCSP, particularly as they may have duties under section 10 and/or section 11 of the Children Act 2004. A list of relevant agencies is set out in: The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018

The structure illustrated aids the SCSP to organise its Multi Agency Safeguarding Arrangements (MASA) to support and enable local organisations and agencies to work together in a system whereby:

- Children are safeguarded, and their welfare promoted.
- Partner organisations and agencies collaborate, share, and co-own the vision for how to achieve improved outcomes for vulnerable children.
- Organisations and agencies challenge appropriately and hold one another to account effectively.
- There is early identification and analysis of new safeguarding issues and emerging threats.
- Learning is promoted and embedded in a way that local services for children and families can become more reflective and implement changes to practice.
- Information is shared effectively to facilitate more accurate and timely decision making for children and families.

**SCSP Vision and Priorities for 2022 / 2023**

The 2021 SCSP MASA as publicised articulates the collective vision and priority areas of focus for three years with the flexibility to add and amend the delivery plans on a yearly basis.

The SCSP vision born from consultation with the workforce and feedback from children and young people living in Sandwell underpins the MASA and as such is identifiable across all agencies who have individually and collectively committed to:

"Our vision is for all children to be safe at home and in their communities, where they are loved, cared for and have the stability to grow healthily and to achieve their ambition"

[1] https://www.sandwellcsp.org.uk/wp-content/uploads/2021/08/2021_07_21-Revised-MASA-2-years-on.pdf

The value statements hinging 'our vision are as follows: -


**22-23 Priorities for the SCSP**

- **Neglect**
- **Exploitation,**
- **Early Help (from 2021)**

Additional areas identified and elevated as themed areas for improvement during 2022 –23 include:

- Focus on Front Door, Early Help and the responsibilities of agencies.
- Refreshing and strengthening the threshold guidance.
- Under 1s and injuries in non-mobile babies: this includes activities to increase awareness of the role of Sandwell Unborn Baby Network (SUBN) in identifying concerns 'early' and applying appropriate preventative support.
- Creating a culturally competent workforce.
- Increased engagement with voluntary, community and faith-based organisations.
- Better engagement with fathers and significant others.
- Emotional wellbeing of children and young people.
- Responding to regional and national reviews.

The role and functions for LSCPs are further defined in the statutory guidance Working Together 2018, within which there is a requirement for safeguarding partners to publish a report at least once in every twelve-month period detailing the partnership activities undertaken during the year. At a local level, this means:

- What the SCSP have done during 22/23 because of the arrangements, including in relation to Child Safeguarding Practice Reviews, and how effective these arrangements have been in practice.
- The priorities for the report period and what activities took place to take forward these priorities.
- Evidence of the impact of the work of the safeguarding partners and relevant agencies, including training and the impact on practice for improved outcomes for children and families, from Early Help to children in care and care leavers.
- Any resulting improvements from activities (including from Rapid Reviews and Local or National Child Safeguarding Practice Reviews)
- The scrutiny arrangements in place and how successful they have been to support the MASA
- The role, visibility and voice of children and families in the safeguarding activities.

While the fundamental purpose of this report is to depict the work undertaken by the SCSP over the last 12 months, it is important to 'set the scene' and give a sense of Sandwell, the demographics, the population and the child population accessing and receiving services, including Multi-Agency Early Help and Statutory Social Care support over the reporting period.

# 2. SANDWELL CHILD POPULATION

Sandwell is an urban area lying in the centre of the West Midlands conurbation, made up of six small urban towns.

The population of Sandwell is 328,450 people (The Office for National Statistics 2019), of which approximately 82,995 are children and young people under the age of 18 years. This is 25.1% of the total population in the area. Sandwell is ranked 12th in the most deprived Local Authorities out of the 317 in England (Indices of Deprivation IoD, 2019, Rank of Average Score).


Sandwell is an ethnically diverse borough, with children and young people from minority ethnic groups accounting for 49% of all children compared with 26.2% in England (0-17 years). The largest minority ethnic groups of children and young people in the area are of Indian origin (8,246) and Pakistani origin (5,917). 57.1% of school children are from minority ethnic groups.

The Public Health England (PHE) Child Health Profile (March 2020) stated the Health and Wellbeing of children in Sandwell is worse than the majority of other areas in England particularly in terms of infant mortality, teenage pregnancy and child obesity.

25.5% of children aged 16 years were recorded as living in poverty (2016), 2.7% of school pupils had social, emotional and mental health needs (2018) and 4.3% of young people aged 16 to 18 were not in education, employment and training.

The proportion of children entitled to free school meals in primary school is 26.3% (the national average is 21.6%); in secondary schools it is 27.6% (the national average is 18.9%). The proportion of children and young people with English as an additional language in primary school is 32.4% (the national average is 20.9%); in secondary schools it is 29.2% (the national average is 17.2%).

From what is known and stated above in respect of the child population in Sandwell, it would be expected that children and young people receiving support from services would be higher than that of many other local authority areas across England.

29,729 Total Contacts, with 4194 Referrals to MASH

625 open to Strengthening Families
367 Multi-Agency Early Help Assessments

802 Children in Care

68 First Time Entrants into Youth Justice

4048 Early Help Assessments completed

1574 Child Abuse Crimes

641 Children in Need

**82,995 Children and Young People under 18**

Sandwell Children's Safeguarding Partnership

862 re-referrals to MASH

47% Initial Health Assessments completed in timescale

72.1% Early Help Success Rate

339 Children on Child Protection Plans

1678 Missing Episodes

89.7% Care Plans in Timescale

6.7% subject to second or subsequent Child Protection Plan

**Contacts and Referrals**

- 29,563 contacts were received to SCT Front Door from 1st April 2022 through to 31st March 2023.
- 10,581 of those contacts were received from Police, making up 36% of the total, with Education contacting 4,489 times at 15.2% of the total.
- 7,010 (23.7%) of the 29,563 contacts had an outcome of action for SCT
- 4,194 referrals were received by SCT, with 850 of those from Education (20.3%) and 1,436 from Police (34.2%). This is an average of 350 referrals per month.
- 3,613 of the 4,194 referrals went to Single Assessment, with a conversion rate of 86.1%.

**Domestic Abuse Contacts**

- 4,798 Domestic Abuse contacts were received by SCT totalling 16.2% of the contacts received. This is slightly lower than the previous end of year position which was 16.9%.
- Of the 4,798 Domestic Abuse contacts received, 4,783 of those were from Police (99.7%). Nearly half of the contacts that are made to SCT from Police are in relation to Domestic Abuse (45.2%).

**Missing Children and Episodes**

- 1053 young people had a missing episode within the 2022-2023 year. There were 1678 missing episodes in total, meaning that on average children went missing for 1.6 episodes each. Given the number of children and young people in Sandwell, there were on average 87 children missing each month at an average rate of 10 children in every 10,000 going missing for a period of time.
- 87% of children that went missing received a 'return home interview' to discuss why they went missing, where they had been and to advise of the risks of going missing. 82% of these were completed within 72 hours of the young person returning home.

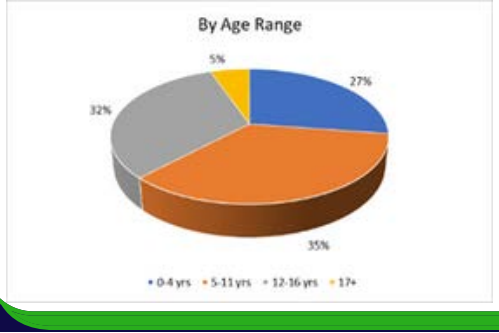
**Child Exploitation and Child Sexual Exploitation**

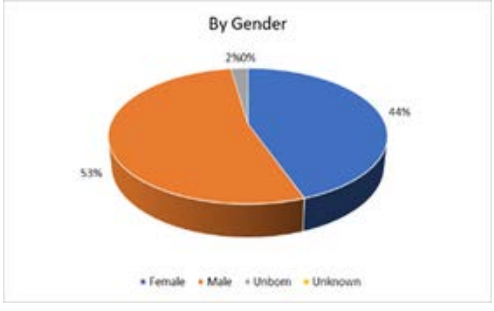
- 50 children were assessed as being at risk of Child Exploitation by the end of March 2023.
- None were assessed as 'low risk,' 39 (78%) were assessed as 'medium risk' and 9 (18%) were assessed as 'high risk'.
- Of the 50 children at risk of Child Exploitation, 13 were assessed as at risk of Child Sexual Exploitation (26%).

| Contact to Referral/Met Threshold for EH | Q1 2022 - 2023 | Q2 2022 - 2023 | Q3 2022 - 2023 | Q4 2022 - 2023 |
|---|---|---|---|---|
| Total Contacts | 7496 | 7072 | 7233 | 7925 |
| Met Threshold for EH | 2338 | 2330 | 2060 | 1872 |
| % Met Threshold for EH | 31.2% | 32.9% | 28.5% | 23.6% |

**Children in Need**

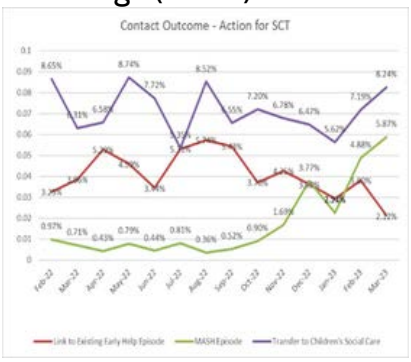
- At the end of March 2022 there were 641 young people on a Child in Need Plan. This is a rate of 81 young people in every 10,000 in Sandwell - around 2.5 full classrooms of children.
- 16.5% of the young people on a Child in Need Plan have been so for 9 months or longer.
- 341 (53%) are male, 285 (44%) are female, with 15 (2%) unborn.
- 67 young people (10.5%) were identified as having a disability.
- 50% were White British, 18% from a Mixed ethnic origin, 19% were Asian or Asian British, 9% were Black or Black British and 5% were from Other Ethnic backgrounds.
- 175 of the 641 are under 4 years old - 27%.
- 24 of the 641 are between 5 and 11 years old - 35%.

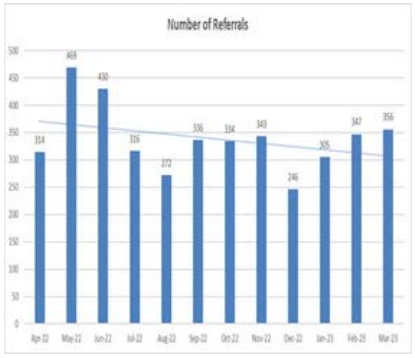



**Re-Referrals**

·967 (23%) of the 4,194 referrals received by SCT Front Door over the reporting period were re-referrals. This is above the West Midlands average (19.1%), the Statistical Neighbour average (20.4%) and the England average (21.5%).



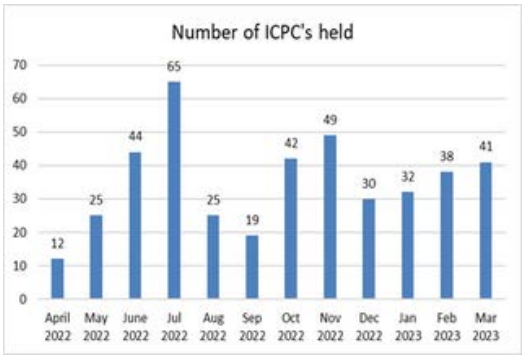


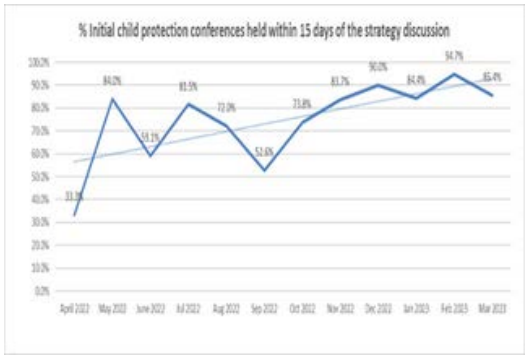
**Police Protection Orders**

·Police issued 84 Protection orders over 2022-2023 that involved 130 young people.

**Initial Child Protection Conferences (ICPC)**

- 422 ICPCs were held in the year 2022-2023 and on average 78% of these were held within 15 working days of the Strategy Discussion. This is below the West Midlands average (85%), below the England average (83%) and also the Statistical Neighbour average (80.5%).
- 82.5% of ICPCs that were held by SCT resulted in a Child Protection Plan.



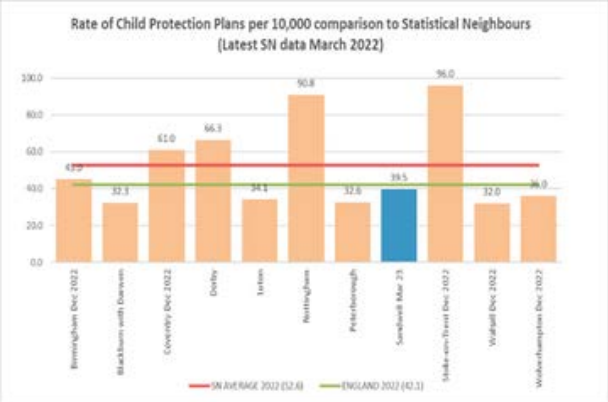

**Single Assessments**

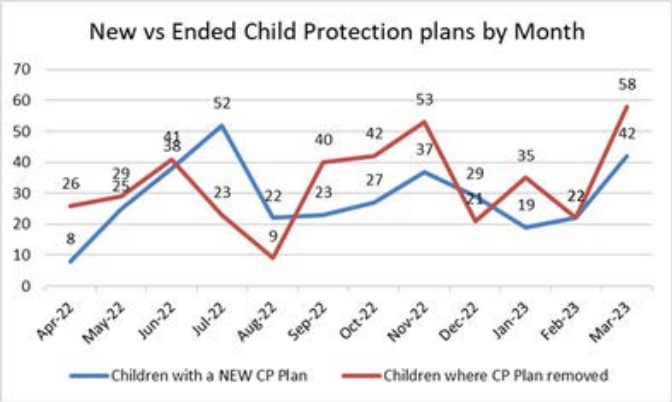
- 4,244 Single Assessments were completed by SCT over the course of the 2022-2023 year. 3,034 of these were completed within 45 workings days (65.3%).
- 3,221 new assessments were completed, with 2,467 of these completed within 45 working days (67.8%).
- 2,377 initial visits as part of the assessment were completed within 5 working days of the assessment commencing (56%).
- Over the year, 2,583 of the 4,244 assessments (61%) concluded that there was either no further action required, that it could be stepped down to Early Help, or a referral was made to another agency that was not social services.

**Child Protection Plans**

- At the end of March 2023 there were 339 young people on a Child Protection Plan. This is a rate of 39 young people in every 10,000 in Sandwell. This is below the England average of 42.1 young people and below the Statistical Neighbour average of 52.6.
- Over the course of 2022-2023, 344 young people started a Child Protection Plan whilst 399 were removed from Child Protection Plans (deficit of 55 young people).
- 70% of these young people have been on a Child Protection Plan for less than 9 months, with 4.7% being on a plan for longer than 2 years (16 young people).
- 106 (31%) of these young people have previously been on a Child Protection Plan.
- On average 93% of the visits made to young people during 22/23 were within timescale (20 working days).

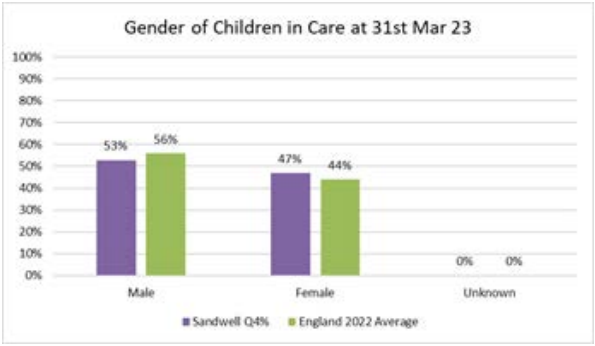
- In March 2023, 82% of young people on Child Protection Plans had their plan updated within timescale (6 months).
- 54% of the young people are male whilst 43% are female. 3% are unborn



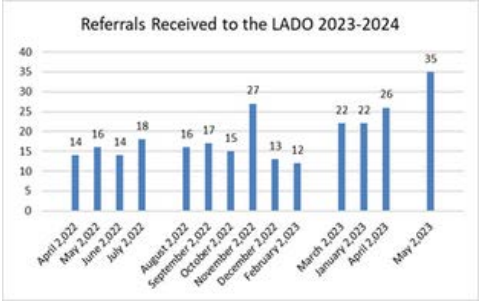




**Children in Care**

- At the end of the year 2022-2023 there were 802 Children in Care in Sandwell. That equates to 94 children in every 10,000 in Sandwell. This was below the Statistical Neighbour average of 97.6 and above the England average of 70.
- 53% of the young people were male, with 47% female.
- 53% were White British, 25% from a Mixed ethnic origin, 9% were Asian or Asian British, 10% were Black or Black British and 3% were from Other Ethnic backgrounds.
- 63% were between the ages of 5 and 15 years old.
- 39% were in external foster placements, 17% in internal foster placements, 19% placed with connected carers and 11% placed at home with parents. The remaining 16% were in various other placement types.
- 81% of the children in care were assessed as at risk of abuse or neglect.
- 96.7% of children in care had their review health assessments completed within the past 12 months.
- On average, 90% of children in care aged 0-15 years old had their care planning completed within timescale, with 91% of them having a single or multiple track plan of permanence at their first LAC review.
- 94% of children in care had a Personal Education Plan (PEP) completed.




**LADO Referrals**




Through the LADO, Sandwell complies with the statutory duty and manages allegations for people in 'positions of trust'. The LADO is responsible for managing all child protection allegations made against staff and volunteers who work with children and young people in Sandwell. This includes Council/SCT staff, staff from partner agencies and volunteers. Reports on the activity of the LADO are received annually by members of the SCSP to ensure a full oversight of this important aspect of the safeguarding systems. The table above illustrates new referrals received by the LADO by month during the report period.

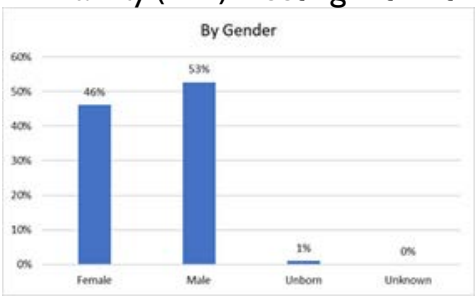
**Private Fostering Arrangements**

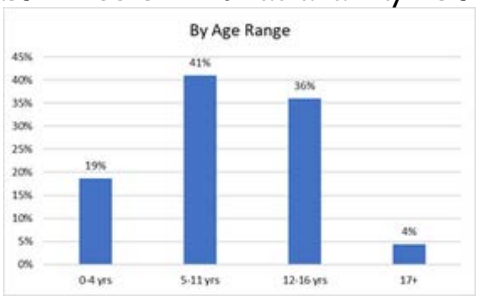
At the end of 22/23, the annual report for Private Fostering Arrangements as presented to the SCSP recorded that there were 13 children who are subject to private fostering arrangements in Sandwell during the period. This is an increase of 4 from the previous year's (21/22) report which highlighted 9 children who were subject to these arrangements.

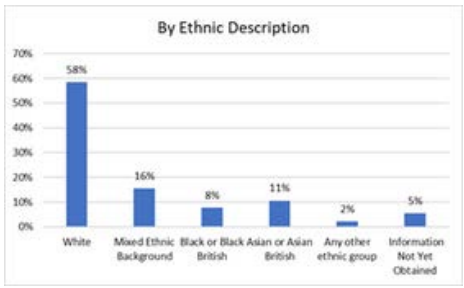
- A&E Admittance of Young People
- 26 young people were seen in A&E in Sandwell for Alcohol misuse.
- 186 young people were seen in A&E in Sandwell for Overdose.
- 42 young people were seen in A&E in Sandwell for Self-Harm
- 50 young people were seen in A&E in Sandwell as a Victim of Assault

**Strengthening Families and Multi-Agency Early Help**

- ·At the end of 2022-2023 there were 1017 young people open to Multi Agency Early Help and Strengthening Families Service.
- 53% of those were Male, 46% Female & 1% Unborn.
- 58% were White British, 11% Asian or Asian British, 16% from a Mixed Ethnic Group, 8% Black or Black British, 2% were from Other Ethnic Backgrounds and 5% Information not Obtained.
- 19% were between the ages of 0-4, 41% between 5-11, 36% between 12-16 and 4% were 17 years+.
- Of the young people open to Strengthening Families on 31 March 2023, 97% had a Team Around the Family (TAF) Meeting within the last 12 weeks. 94% had a family visit within the last two weeks




**Child Death during 22/23**

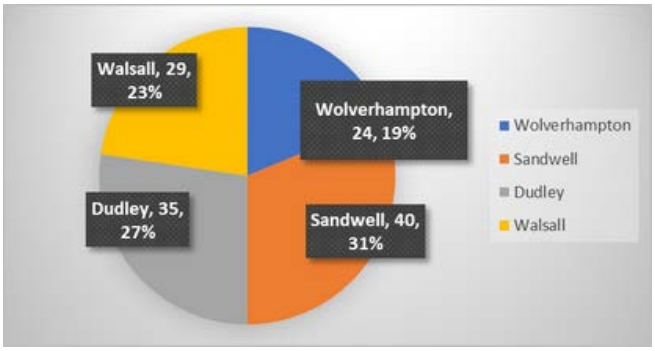
Sandwell is a member of the Black Country Child Death Overview Panel (BC CDOP) as an inter-agency forum set up to conduct reviews for Child Death across the Black Country local authority areas (Sandwell, Dudley, Walsall and Wolverhampton).

The Child Death Overview Panel has a remit to provide scrutiny of a child's death for the purpose of: -

(a) identifying any matters of concern affecting the safety and welfare of children relating to the death or deaths,

(b) to consider any actions or recommendations that can be taken based on a death (or a pattern of deaths) to identify trends that require a multidisciplinary response.

**Deaths Notified in 2022-23**




During 22/23 there were 128 child deaths notified across the Black Country. Chart 1 (left), provides a breakdown by area, with Chart 2 below showing a 4-year comparison across the Black Country areas since April 2019.

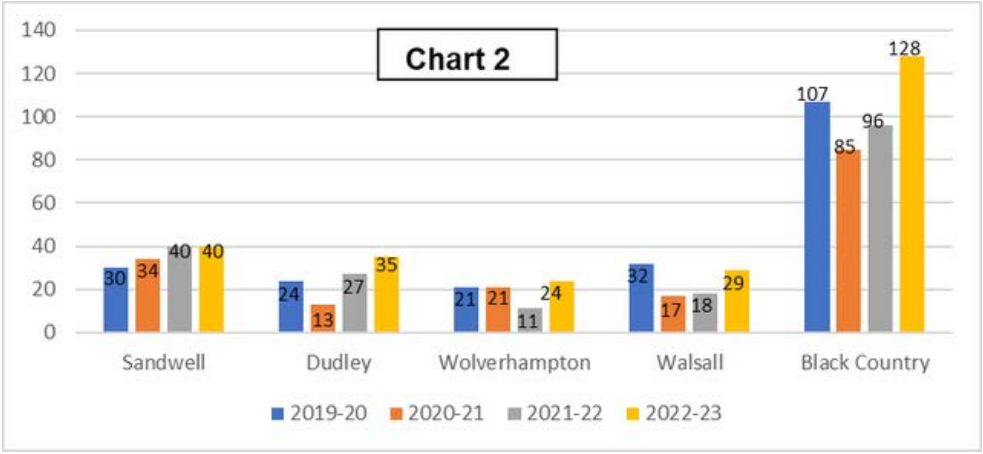



Chart 2 above shows that in the 3 years preceding 2022-23, Sandwell saw a year on year increase in the number of child deaths however the total for 2022-23 has remained the same as the previous year.


Chart 3 presents Sandwell specific data and shows that deaths in babies aged under 28 days have remained the same as the previous year, whereas there has been a decrease in the number of deaths in the 1-4 years and 10-14 years age ranges. Deaths in the 5-9 age range have risen by 3, and deaths in adolescents between the ages of 15-17 years have risen by 1.

Of the 128 deaths notified across the Black Country in 2022-23, 62 have required further scrutiny via a Joint Agency Response (JAR) meeting, 10 of which were attributed to Sandwell child deaths. From these 10 JAR meetings, 1 was referred to the SLPR subgroup and led to a Local Child Safeguarding Practice Review.

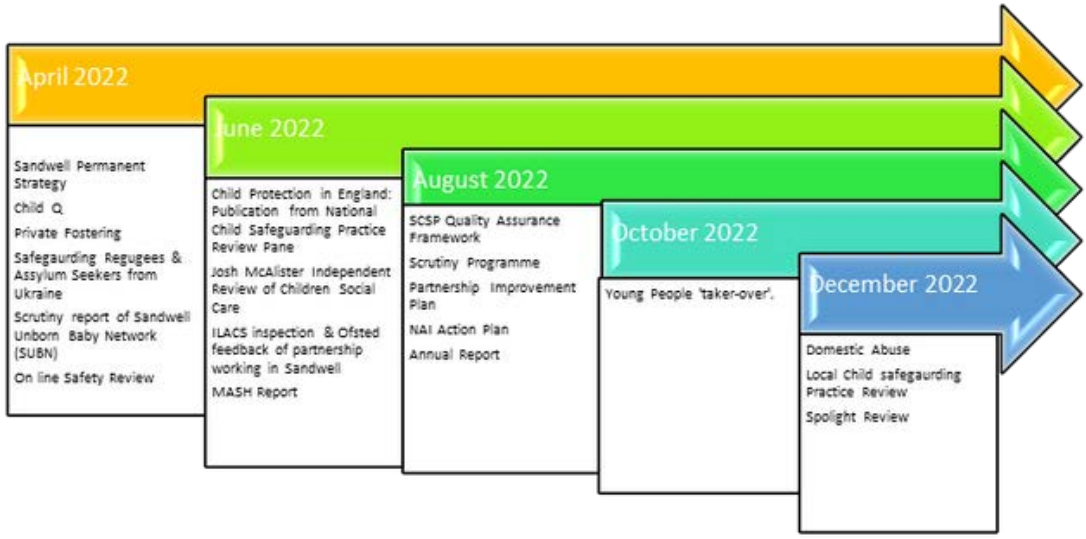
**The Structural Arrangements delivering the Safeguarding Functions during 22/23**
The SCSP have a number of operational subgroups which focus on particular aspects of its work. Each group operates to a bespoke terms of reference with multi-agency memberships as pooled from nominated representatives from key agencies, as well as relevant partners from Education and third sector organisations. Members of each group have been specifically selected for having a particular knowledge that links them to the subgroup theme. Delivery plans are agreed annually with the SCSP receiving programme updates at each meeting.

In addition to the SCSP multi agency subgroups, there are three single agency safeguarding reference groups that have been established. Sandwell Safeguarding Health Partnership formed by ICB for all the 'Health' economy, including commissioners and provider care services, and two reference groups created by the Local Authority for Education and the voluntary, community and faith-based organisations. These reference groups have a remit for transporting safeguarding messages, monitoring the effectiveness of single agency actions and providing reports and assurance to the SCSP on compliance and effectiveness.

Throughout this year's report there are links to YouTube audio form interviews facilitated by young people with each Safeguarding Partner, Sub and Reference group Chair, as well as the Independent Chair. At the start of the next section the Independent Chair shares her reflections on the effectiveness of the year's activities and any improvement work identified.

Leading into the details of activities undertaken across each tier of the SCSP structure to deliver the core functions, strategic priorities and elevated themes, the next section starts with an account from the Independent Chair Lesley Hagger responding to a series of questions when interviewed by young people. This will be followed by accounts taken from two of the four Statutory Safeguarding Partners outlining their role and what each have done to own, lead and drive forward the MASA over the period.

**Activities undertaken to deliver the SCSP MASA during 22/23**
The Independent Chair facilitates the SCSP meetings revolving the agenda to constantly seek assurance on quality and compliance with Working Together to Safeguard Children 2018.
Much of the activities are delivered via subgroups that have been established to concentrate on the core functions and the agreed priority areas. In addition, across the period, the SCSP have covered a wide span of safeguarding themes, some of which are
captured here:



Here the **Independent Chair Lesley Hagger** talks to young people about her role which is followed by a detailed account of the progress made against the themes identified and elevated for improvement during 22/23 from the previous year's annual report.

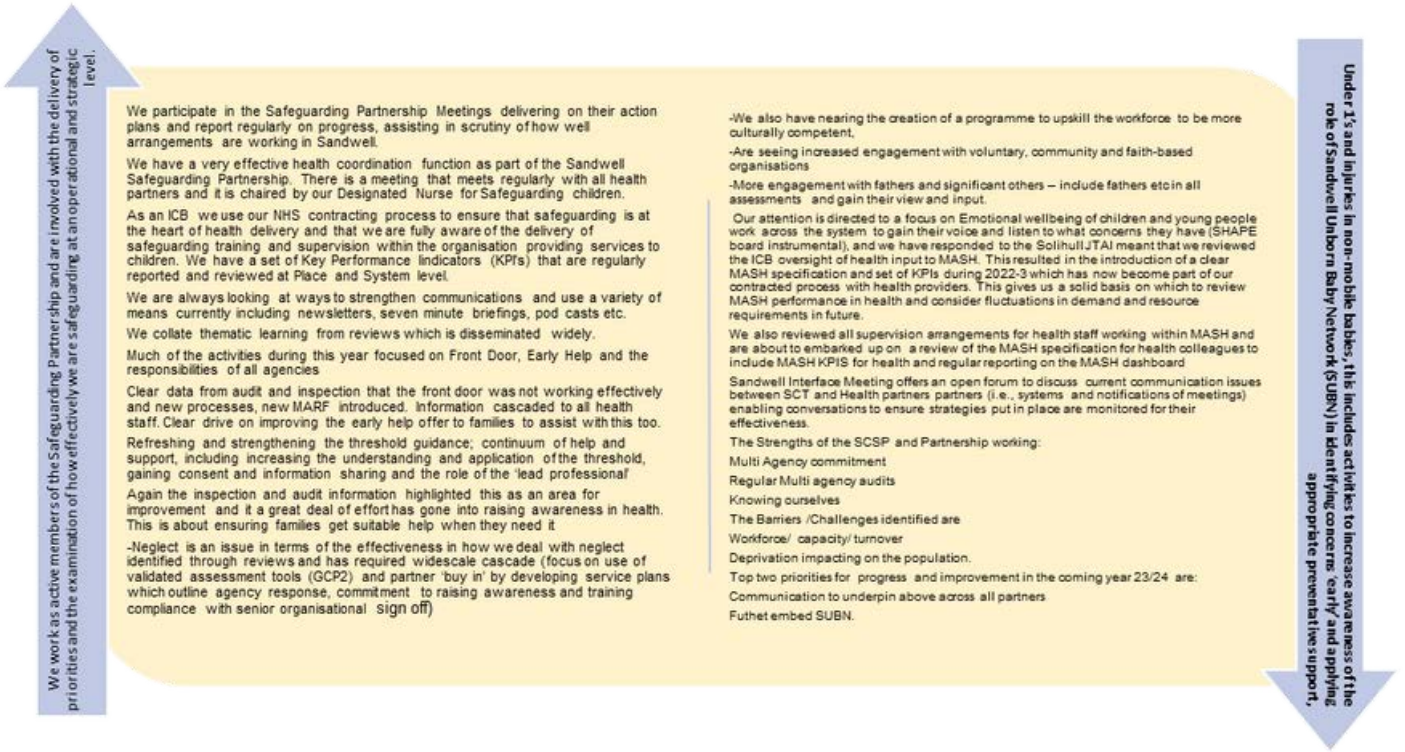


In addition to the narrative provided by the Independent Chair above, statutory partners have also been quizzed by young people as to how they have each delivered their leadership functions to safeguard children during the year. We have included the responses from the following two agency leads in this section of the report.

**Sandwell Metropolitan Borough Council** (SMBC) Membership on SCSP is delegated to the Director of Children Services, Michael Jarrett. Here https://youtu.be/v3mHXOm6d-g Michael talks to young people about his role as a Statutory Partner and one of the leading members of the SCSP, followed by additional narrative below.


**The NHS Black Country Integrated Care Board** (ICB, formerly CCG) representative for SCSP is delegated to Maria Kilcoyne, the Associated Director for Safeguarding and Partnerships.

Here https://youtu.be/3vHxrKdtBHI, you can listen to Maria's response to questions posed to her by young people. Maria has also provided additional commentary as captured below.



The sections to follow in this year's report covers the activities undertaken to deliver the MASA. The report will include the progress of each subgroup, as well as an overview of the work undertaken by reference groups focusing on wellbeing and safeguarding, from early interventions by universal services through to the ever more specialised services and sometimes statutory provision.

## Sandwell Learning from Practice Reviews Subgroup

Working Together 2018 requires the safeguarding partners to make arrangements to review serious child safeguarding cases and others where there may be learning in order to prevent or reduce the likelihood of recurrence of similar incidents.
Sandwell Children's Trust is duty-bound to notify the Department for Education and OFSTED, and by extension the National Child Safeguarding Practice Review Panel (NCSPRP) if it knows or suspects a child has died or been seriously harmed, and abuse or neglect is known or suspected. The SLPR subgroup (SLPR) carries out reviews of the cases that are notified to NCSPRP and other safeguarding cases where there has been multiagency involvement which could support learning.

In the year April 2022 to end of March 2023, SLPR have undertaken the following:

| | |
|---|---|
| 3 | Notifications were made to the NCSPRP in 2022/23 |
| 4 | Cases were directed to Sandwell Learning from Practice Reviews Group (SLPR) in 2022/2023 by partners for consideration |
| 3 | Local Child Safeguarding Practice Reviews (LCSPR) are waiting publication (due to ongoing Police investigations) |
| 2 | Of the 3 notifications to the NCSPRP, 2 were progressesd to a LCSPR following a Rapid Review meeting during 22/2023. See a brief coverage from each child's story as follows: |

**Child 1** – a young person over the age of 16 who sustained serious injuries in an assault in spring 2022. A Serious Incident notification was made to the regulators within the specified timescale and the RR panel met on day 10 after receiving the referral. The decision of RRP was to initiate a Local Child Safeguarding Practice Review, which the National Panel agreed with. Key learning themes identified included how information is used/analysed to inform assessments and plans, co-ordination of support by multiple agencies, how to successfully engage young people involved in criminal activity/exploitation and the transition between Children's and Adults' services. The LSCPR was ratified in February 2023 and remains embargoed due to competing parallel proceedings.

**Child 3** – a child with complex additional needs under the age of 8 who died suddenly in winter 2022. A Serious Incident notification was made to regulators within the specified timescale and the RR Panel met on day 9. The decision of the RRP was to initiate a thematic LCSPR which the National Panel agreed with. The key themes were the stubborn practice challenges when intervening in cases of persistent neglect, and how to safeguard children at risk of or experiencing neglect who also have complex needs. The LCSPR remains in progress as of 31/3/23 and is expected to complete in winter 2023

**Child 2** – a baby under the age of 6 months who received serious non-accidental injuries in summer 2022. A Serious Incident notification was made to regulators although there were conflicting views on whether the injuries were inflicted or had a medical cause. The decision of the Rapid Review Panel (RRP) was that the threshold for a LCSPR was not met, however identified areas of learning for the Health economy and requested a Tabletop Review. The National Panel concurred with this decision and the Tabletop Review was held in January 2023. Key learning focussed on use of routine questions during antenatal care, working with families who speak EAL and communication between midwifery and health visiting services.

Rapid Review meetings are held within 15 days of the incident coming to the attention of the safeguarding partners. They gather facts about the case, identify whether any immediate action is required to secure the child's safety, whether there is immediate learning, and whether a local or national Child Safeguarding Practice Review (CSPR) is warranted.
For each review undertaken there are detailed action plans created and undertaken to address the identified need. These are monitored quarterly within the SLPR meetings and regular reports on progress are made to the SCSP. It is the view of the SCSP that LCSPRs are not published until all due processes are concluded to ensure there is no conflict or influence on other statutory parallel investigations.

More about the work of this group can be heard via this link: https://youtu.be/t5gPzMgnCNc, where young people speak to the former SLPR subgroup Chair Dez Lambert about how SLPR ensures that serious and challenging themes are tackled by systematic formal processes and how these feed into professional practice, training and reflection to better safeguard children in Sandwell.

**Delivering the SLPR Mandate Between April 22 to March 23**

## Strengths

- Good core membership, attendance and engagement at SLPR and Rapid Reviews
- Positive feedback from National Panel on quality of Rapid Reviews
- Emerging learning from this group underpins and informs actions taken across whole SCSP – themes can be mapped to activities of all subgroups
- Clear processes in place from initial incident through to publication – always subject to continual reflection and updating
- Spotlight Review process
- Good liaison with National Panel

**WHAT DIFFERENCE DID WE MAKE?**

Tracking and assurance on implementation of recommendations/actions from reviews continually improves safeguarding systems, practice and processes. An example is a change within SCT on how concerns are logged on open children's cases – this is a result of learning from the VS CSPR.

## Barriers /Challenges

- Clarity on Chairing in 2023-24
- Embedding Serious Incident Notification process with partners
- Continuing to share learning in a dynamic way taking into account demands on time for practitioners
- Clarity on purpose and role of Joint Agency Review and Rapid Review processes when there has been a child death

**WHAT DIFFERENCE DID WE MAKE?**

Feedback on the quality of Rapid Review minutes continues to be positive from the National Panel – one was described as 'comprehensive and concise that was sensitive in the way it addressed the young person's experience' with a 'clear rationale' for decision making

**WHAT DIFFERENCE DID WE MAKE?**

Feedback from a staff member from a local primary school after attending the Learning from Practice Reviews training said the following had been done as a result of learning from a local CSPR: 'The school recognised that only teachers and senior leads were regularly updated on learning from reviews and safeguarding updates. All other staff received an annual update in September. It was felt that some staff didn't need all of the information but on reflection it is important that they have an understanding of how bad it can be, and it has been an eye opener for many. A slot at weekly team meetings to discuss safeguarding has now been added and all staff are now involved in team meetings. An audit has been completed with the school governor with responsibility for safeguarding and created an action plan. They now have a termly meeting to share and update on safeguarding information – this could be replicated across other schools as good practice.'

**WHAT DIFFERENCE DID WE MAKE?**

As a result of learning identified in the YS CSPR, the Domestic Abuse Strategic Partnership shared that the following work has been undertaken: secured funding to support children in the community, delivery of community events e.g. Coffee Mornings, development of a DA Matrix for professionals to use and the funding of two specialist posts (family support worker/resettlement worker) to support victims of DA and their children. Both workers provided a case study to show the impact of their work. A 'healthy relationships' programme for young men has also been funded, linking to the subtheme of working with male carers.

## Quality of Practice, Performance and Assurance (QPPA) Subgroup

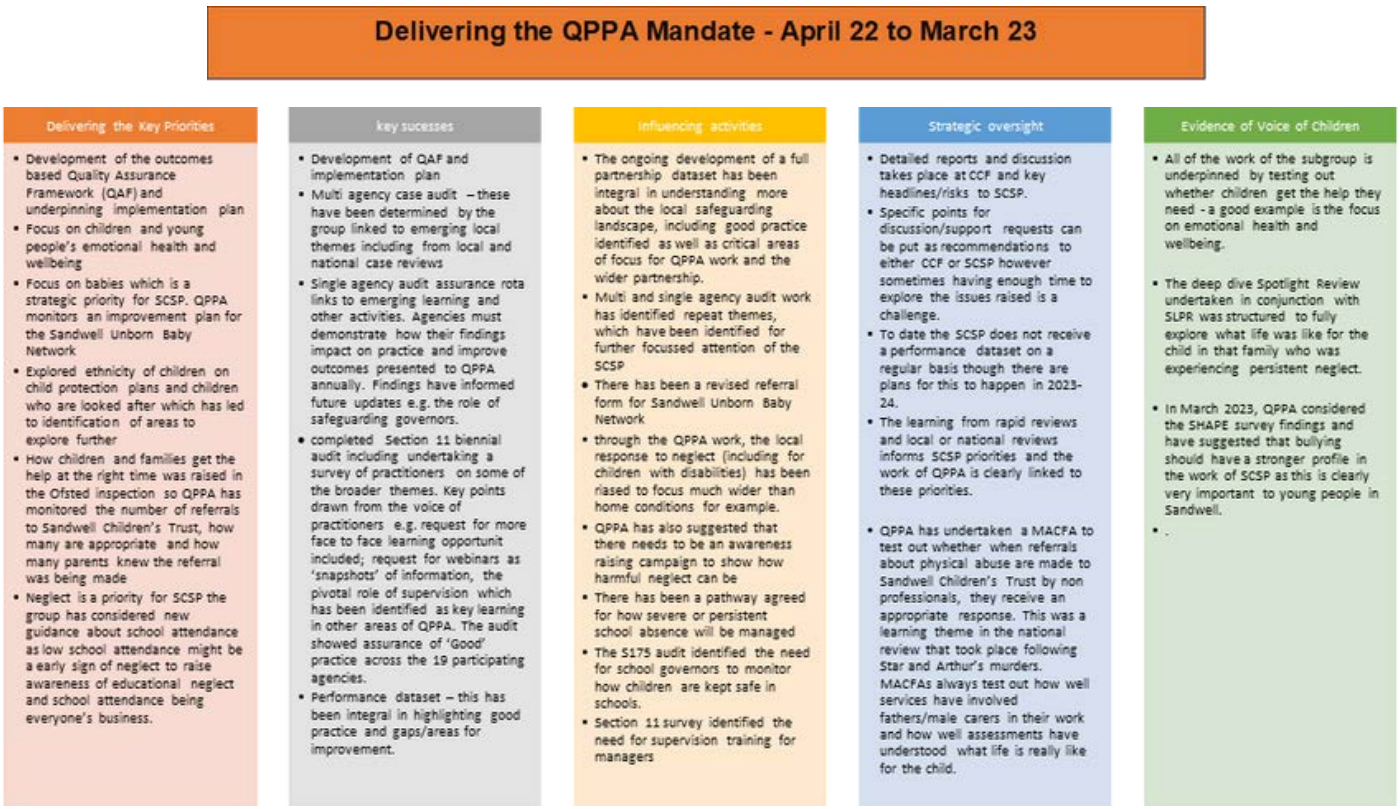
The QPPA Subgroup seeks to assure and contribute to the development of child safeguarding practice in line with national and local drivers and strategy. This is achieved by providing healthy challenge and holding professionals to account with respect to safeguarding children practice.

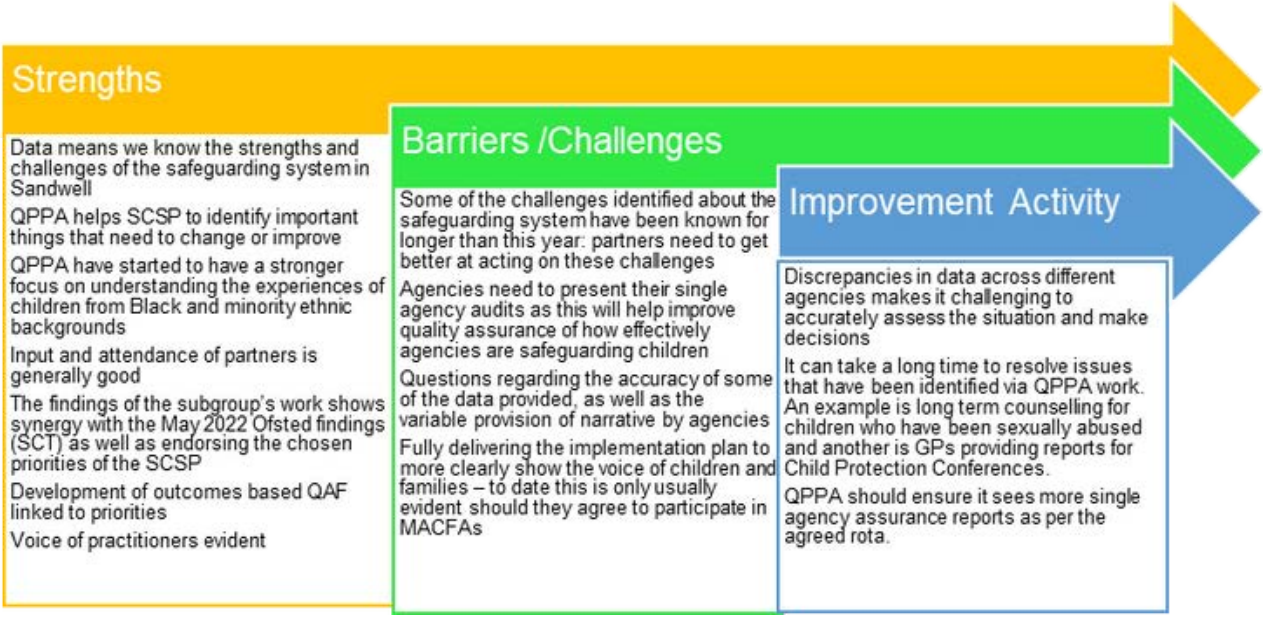
The group meets on a bi-monthly basis with membership representative of the wide range of agencies working with children and families across Sandwell. The group is chaired by the Independent Scrutineer which allows for objectivity and challenge and ensures the joining up of improvement activities. The group also has the support of a data analyst whose input is vital to support and aid with understanding how well services are keeping children safe.

As well as consistently monitoring and testing out the quality of practice and performance at the 'frontline', the group seeks assurance via single agency audits, as well as completing our own multi agency audits, which provides a real overview of good practice and areas for improvement and also tells us about the effectiveness of safeguarding arrangements in Sandwell.

Updates on the activity of the subgroup, including any risks/challenges, are reported to CCF with headlines being shared at the full SCSP Board meeting to evidence the partnership mandate being met.

The work of the subgroup is influenced by local, regional and national learning, and this year much of the activities have arisen from the findings and outcomes of scrutiny activities, areas for improvement as recommended from LCSPRs and national reviews including that following the murders of Arthur Labinjo-Hughes and Star Hobson.




## Learning and Development (L&D) Subgroup

The L&D subgroup has a membership drawn together from the full range of statutory and relevant partners who can drive practice improvement through their own organisations as a result of learning that has been identified not only from SLPR work and recommendations but from wider sources in research, or the work of national, regional or local bodies.

The group operates to a clear workplan and priorities which are devolved from the overarching SCSP Priorities and the aims and steer of the partnership keeps the agenda on track.

The Chair has a direct link to providers of Education, and also delivers from the SCSP training programme on behalf of the partnership and uses these contact points to hear first-hand some of the issues and challenges facing frontline practitioners which contribute to ensuring learning is influenced by the voice and skillset needs of the workforce.

The group is held to account through the Chairs Consultation Forum and the SCSP as well as the individual members within L&D who are committed and focused on our deliverables.

## Workforce Development activities addressing the key Strategic themed priorities and focus areas

| | | | | | | |
|---|---|---|---|---|---|---|
| **Focus on Front Door, Early Help and the responsibilities of all agencies**<br>Multi agency threshold training has been offered bi monthly covering processes as well as how to use thresholds.<br>Thresholds are threaded through CWT as well as the EH training offer.<br>EH training offer was increased in 22/23, including Lead Professional, Intro to Early Help, and EHM system training.<br>Early identification and intervention for children young people is threaded through all learning and development | Refreshing and strengthening the threshold guidance; continuum of help and support, including increasing the understanding and application of the threshold, gaining consent and information sharing and the role of the 'lead professional' Multi agency threshold training has been offered bi monthly covering processes as well as how to use thresholds | **Exploitation**<br>4 eLearning courses are offered covering different areas of exploitation, this is for level 1 awareness of these issues. A full day training session is also offered to partners. Some of these sessions were cancelled due to low take up. | **Neglect**<br>Level 1 neglect awareness eLearning was available throughout this reporting year<br>GCP2 training sessions were run regularly throughout 22/23 and take up of this training was high.<br>Due to the early identification and interventions around neglect being a concern across Sandwell a task and finish group was started to look at the training offer eLearning was reviewed as part of this, the group continue to move forward with other learning activities being reviewed in to 23/34. | **Domestic abuse**<br>This learning is developed/commissioned and delivered by the domestic abuse team within SMBC. In order to ensure that we are linking up with this team DA training coordinator is part of the L&D training pool and we share the PHEW booking system meaning training is all in one place for partners to book. | **Under 1's and injuries in non-mobile babies, this includes activities to increase awareness of the role of Sandwell Unborn Baby Network (SUBN) in identifying concerns 'early' and applying appropriate preventative support**<br>This is included within CWT when discussing learning from reviews, it is also threaded through the Multi agency threshold training via one of the activities delivered. SCSP website now has information about SUBN including the referral criteria and referral form | **Creating a culturally competent workforce**<br>This is a piece of work that has been commissioned, however we are awaiting the final practice guidance as well as training materials in order to roll this out,<br>**Better engagement with fathers and significant others**<br>Training is commissioned around working with fathers and male carers, 'Hidden Men' 120 spaces were made available to partners in 2022/23 |

### 22/23 Workplan deliverables

Guidance documents- impact as there is now clear guidance for partners as to what training is available and what they should be completing based on their job role

Governance documents- how L&D work as a group has been defined to ensure work plan is met, communication is taking place to and from partner agencies, correct representation on subgroup

Charging policy implemented and processes put in place

Commissioning of high quality trainers to deliver on some priority areas, such as hidden men, working with resistance, EH training offer.

Quality assurance (mystery shopper) completed on externally commissioned training.

Voice of the child to be more evident across our training and whilst we started working with SHAPE to progress this there are still areas of focus to be moved forward to the next year's workplan.

Impact is demonstrated through delegate feedback on evaluations

### Barriers /Challenges

Review of training offer, this started in 22/23 however due to change of L&D officer little progress was made. This has been carried over to 23/24 where all core training is being reviewed and redeveloped.

The majority of our courses were run to capacity

Impact evaluation has been difficult to capture, this as been the same for other L&D groups across the UK. This is being taken forward in 23/24 with a review of the evaluation process as a whole and to include case studies that evidence impact.

### Improvement Activity

The learning offer is regularly updated following any local or national reviews where partnership learning has been identified.

Briefing papers were published

Course review completed including neglect awareness to reflect learning from activities

Findings of SHAPE survey discussed training updated accordingly

Young peoples take over event of SCSP meeting, concerns and key points raised discussed and earning activities review. This has helped us to start to plan the next safeguarding today event.

We recognise there is more work to do around translating this in to training and the shaping of training during 23/24

The L&D subgroup have created a training guidance and expectations document in order to support professionals to identify what training they need to access based on their roles and safeguarding responsibilities. The training and expectations guidance document underpins the training programme. This is currently in its' infancy and will require wide dissemination across the partnership in the coming year.

Delivering of the SCSP training programme is undertaken via a combination of a locally well-established cross partnership training pool and external facilitators. All trainers have been selected for the specialist knowledge of the subject area, with the vital commodity of being to ensure all trainers are familiar with the local practice and MASA arrangements.

**Top 10 Courses delivered during 22/23**

| COURSE TITLE: | Available Spaces | Allocated Places | No shows |
|---|---|---|---|
| Core Working Together – (CWT) | 371 | 371 | 42 |
| Thresholds | 150 | 127 | 21 |
| Managing Allegations | 112 | 90 | 19 |
| Neglect (GCP2) | 135 | 121 | 17 |
| Exploitation | 60 | 39 | 9 |
| Intro to Early Help | 135 | 122 | 20 |
| Early Help & the Role of the Lead Professional | 120. | 113 | 23 |
| Hidden Men | 120 | 73 | 4 |
| Disguise Compliance: Working with Resistance- | 160 | 12 | 20 |
| Gender Identity - | 120 | 101 | 12 |

**What difference did training make on Practice?**
Feedback and evaluations from courses are routinely very positive, however this is collected in the days following a course rather than at a later stage to truly see the difference being made to practice. That said, records of knowledge tests prior to course attendance is in most cases averaging at 40% whereas post course measures show increases in knowledge scoring in the upper 90% for every course, with the widest margin being captured from Hidden Men training where the quality of the training was rated highly with 91.3% scoring it a 4 or 5 out of 5.Pre-session knowledge measures scored 23.91% and Post session at 97.83%.

| eLearning Modules Completed during 22/23 | |
|---|---|
| ICON: 'Babies cry, you can cope' | 285 |
| SCSP Learning from Serious Cases - When Will We Learn? | 39 |
| SCSP Module 1 - Childhood Regained: Child Sexual Exploitation Awareness | 109 |
| SCSP Module 2 - Childhood Regained: County Lines Awareness | 152 |
| SCSP Module 3 - Childhood Regained: Gangs Awareness | 84 |
| SCSP Module 4 Childhood Regained: Knife Crime | 86 |
| SCSP Neglect Awareness | 270 |
| SCSP Private Fostering Module. under review) | 15 |
| SCSP Refresher Level 3 Core Working Together to Safeguard Children and Young People- | 117 |

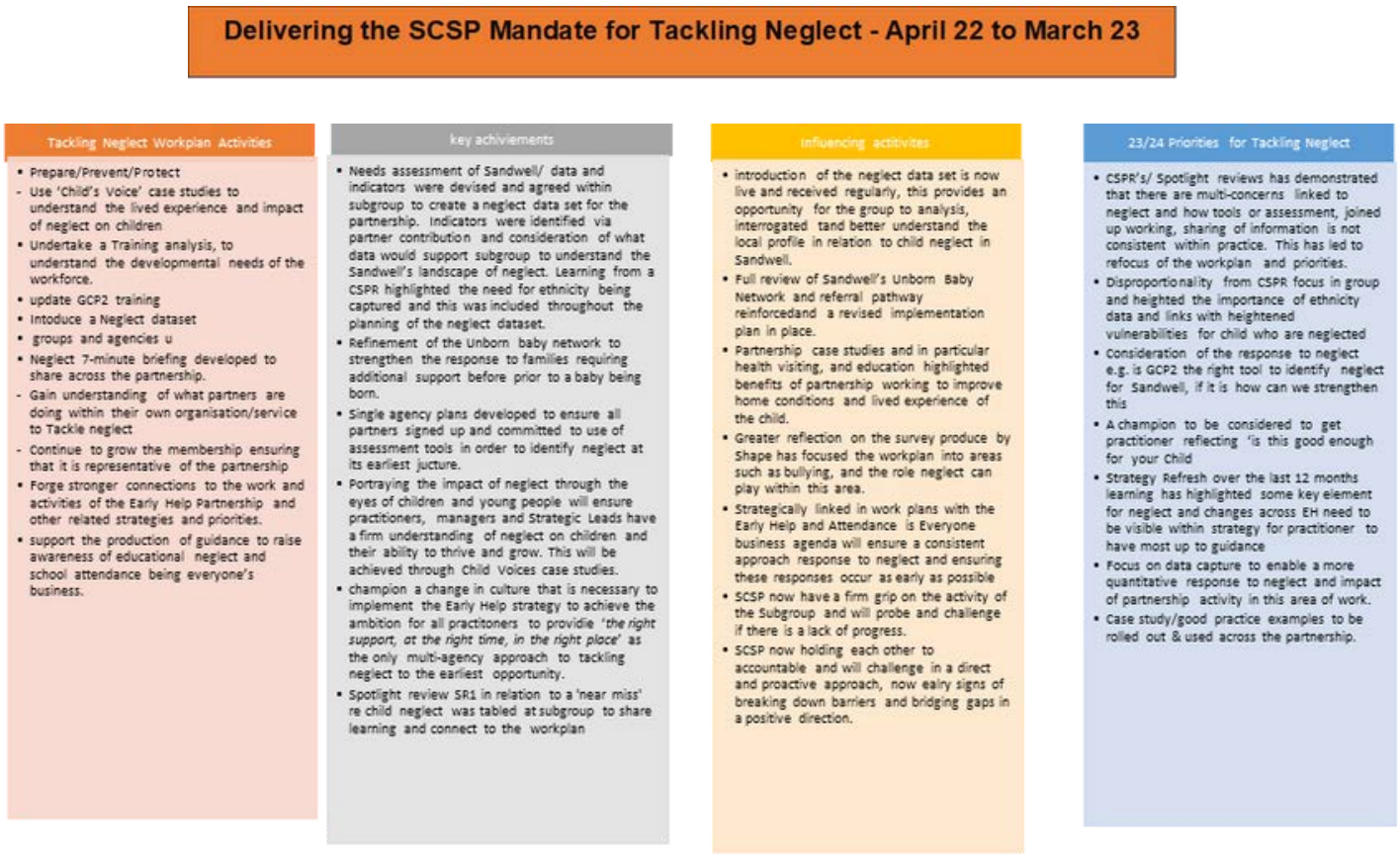
Hear more about the L&D group here https://youtu.be/sG0KL8bm8O8 from Lisa Harvey who talks to young people about her role as Chair and the activities of the subgroup.

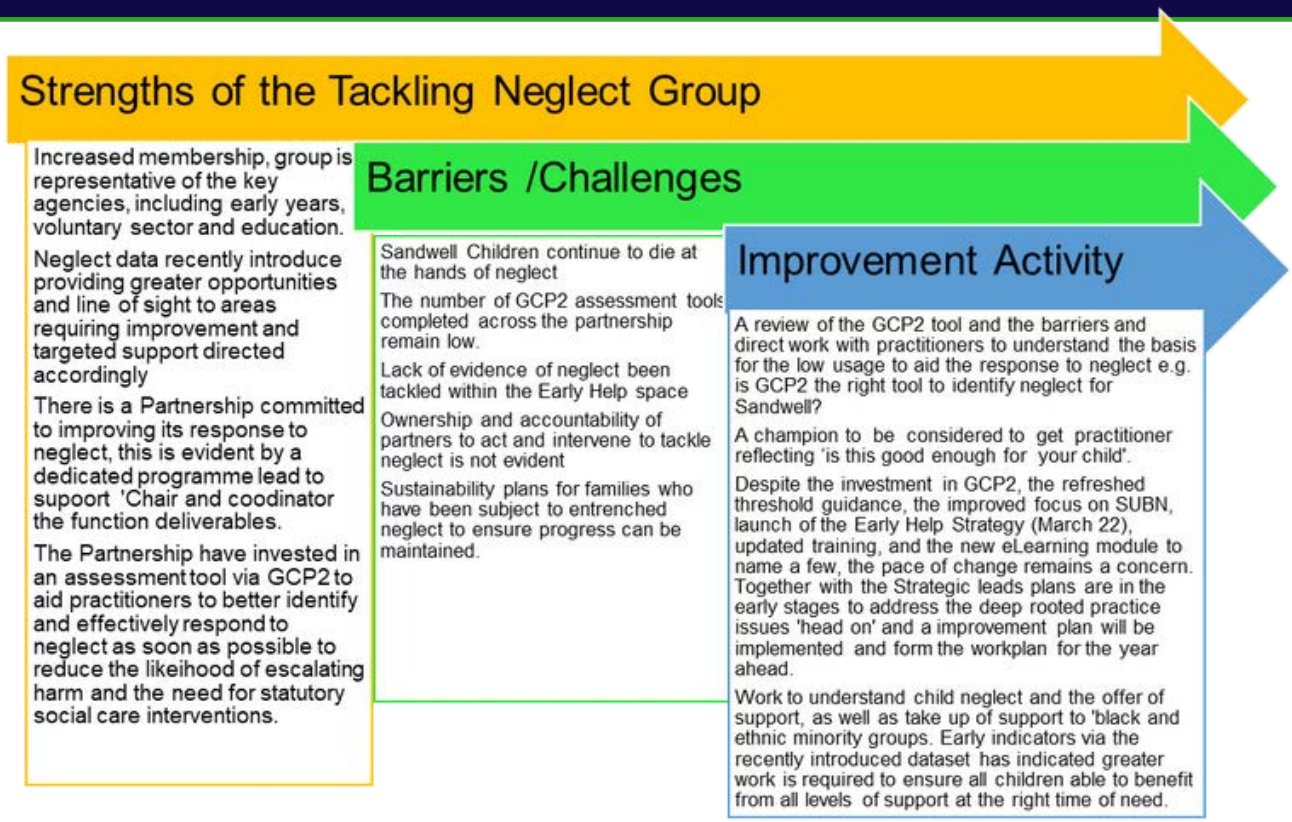
## Tackling Neglect Subgroup

The SCSP have identified Child Neglect as one of its' priority areas and in doing so have established a dedicated workstream via a subgroup consisting of a membership from across statutory and relevant agencies (including Education and the voluntary sector) to deliver on the mandated functions.

The year 22/23 has seen some changes within the membership - the most significant being the chairing arrangements for the group which up to November 22 was chaired by the Lead Nurse for Safeguarding (SWBNHS). However, following a resignation due to reduced working hours, the role of chairing was nominated to the Strategic Lead for Early Help and Partnerships based with SCT as of January 23.
The meetings of the Tackling Neglect subgroup have remained consistent, taking place on a bi-monthly basis, with set agenda items where progress is monitored against the delivery of the workplan.

The group operates within the parameter of the terms of reference which was reviewed by the group and approved by the SCSP in March 23.
Here https://youtu.be/5s-91ps7QFM, the former and current Tackling Neglect Chairs, along with the programme lead, are quizzed by young people about the work of the subgroup.



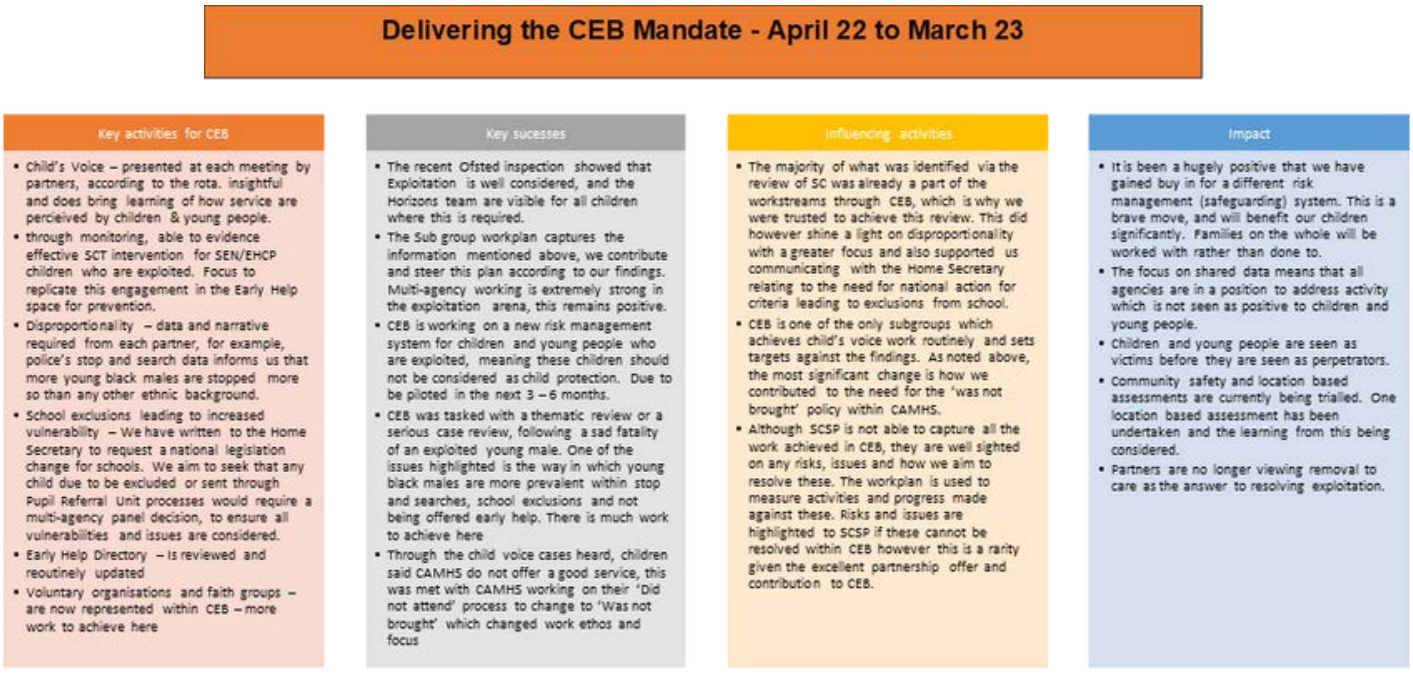


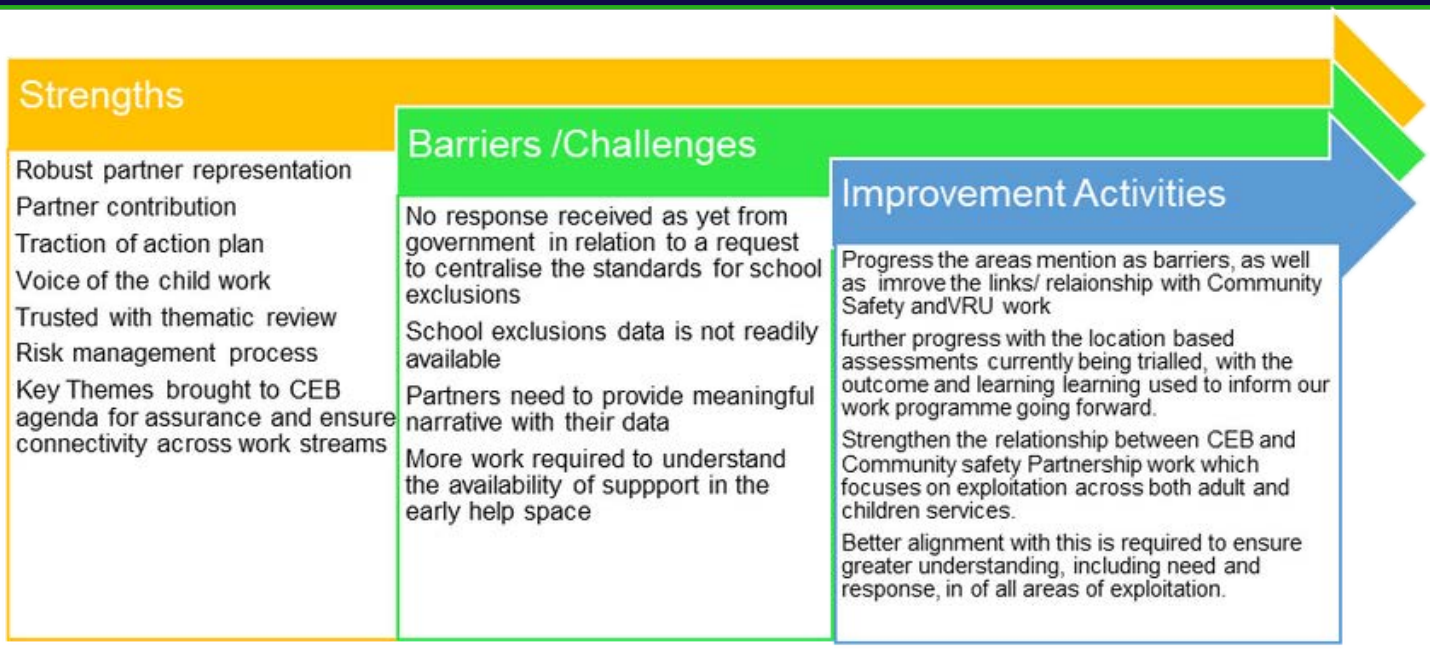

## Child Exploitation Board (CEB)

The SCSP has made a strategic commitment to tackle all forms of child exploitation and to respond effectively to emerging themes of abuse.

Through the nominated representatives from across statutory and relevant partners, there is a well-established and highly committed membership, with meetings taking place bi-monthly. Agenda items are agreed in advance and progress against the workplan is reviewed at each meeting. The Chair meets with the programme lead in between these meetings to consider new emerging themes resulting from local, regional and/or national research, reviews and initiatives. The Chair attends the Chairs Consultation Forum on a bi-monthly basis and is held to account for delivering the strategic ambitions of the SCSP, as well as to ensure there is the joining of all subgroup agendas and activities.

More about the work of CEB is captured here: https://youtu.be/zuawipSfWX4where Louise Wright, the chair of the group is questioned by young people about the work of CEB.






## Early Help

In 2021, following a challenge between partners in Sandwell, it became apparent that the threshold for statutory social care was not clearly understood or duly applied across the partnership. This was evident in the high numbers of inappropriate Multi-Agency Referral Forms (MARFs) being received at the SCT Front Door with little or no evidence of activities (Early Help) or support offered prior to seeking statutory interventions.

In line with Working Together to Safeguard Children 2018, local organisations and agencies should have in place effective ways to identify emerging problems and potential unmet needs of individual children and families. Local authorities are required to work with organisations and agencies to develop joined-up Early Help services based on a clear understanding of local needs. This requires all practitioners, including those in universal services and those providing services to adults with children, to understand their role in identifying emerging problems and to share information with other practitioners to support early identification and assessment.

As is mandated, SCSP have a published threshold document that was devised following consultation with all local agencies/organisations. This guidance sets out the local criteria for action in a way that is transparent, accessible and easily understood. It includes:

- the process for Early Help, multi-agency Early Help and assessment and the type and level of Early Help services to be provided
- the criteria, including the level of need, for when a concern should be referred to Sandwell Children's Trust for assessment, statutory support and intervention.

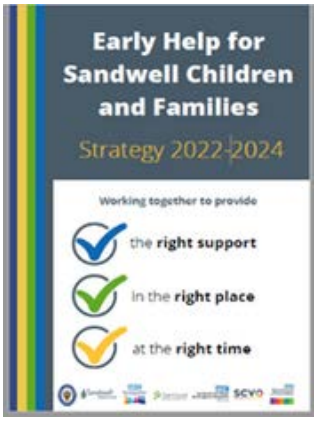
Sandwell have an established Early Help Partnership (EHP) which is overseen by the SCVO and chaired by the Chief Executive of a local voluntary sector organisation. The governance of this group aligns to the portfolio of the Children and Families Strategic Partnership within the local authority.

In response to the challenge posed by partners, the SCSP formally sought evidence of the impact of the work being undertaken by the EHP to strengthen the Early Help Offer, as well as the understanding and application of the threshold guidance to prevent inappropriate referrals and escalations for statutory social care services.

A review of the Early Help Offer started in 2021 and a new improvement plan was developed followed by the launch of a new Early Help Strategy and Implementation plan in 2022

The SCSP are well sighted on Early Help via quarterly data to the QPPA subgroup who uses data and intelligence to assess the effectiveness of the help being provided to children and families, including Early Help.

Throughout 22/23 the activities undertaken to improve Early Help in Sandwell have intensified, with weekly events undertaken to take forward Early Help as a priority, with some of the work and the evidence base behind the activities and interventions presented below.




**Key Actitivties & Achievements during 22/23**

- Promotion of Sandwell refreshed early help strategy in partnership meetings
- Devised an action plan to deliver early help driven forward by the Early Help Partnership
- Launch of the Targeted Early Help website to help practitioner look for local services, intervention and support. Refresh of the early help training offer in line with the new strategy
- Re-launch/refresh of Early Help Assessment (EHA) October 2022
- 4 on line workshops in October 2022 to understand the barriers to evidencing multi agency early help
- 5 briefings on new EHA attended by 235 practitioners/managers.
- Develop an early help data dashb oard
- Refresh of the early help training offer in line with the new strategy
- Complete a survey to beter understand why the BAME community are more reluctant to take up early help support.
- Imbedding of the Multi Agency Solution Panel (MASP), to consider threshold and ensure all early help intervention and support have been exhausted prior to escalation to CSC

**Have there been any resulting improvements from activities**

- Since the launch of the strategy there has been a 25% increase in the amount of multi-agency early help and a decline in the amount of children on CIN and Child Protection plan. Although the amount of families being supported via multi-agency early help has increased, we have not yet seen this reflect in the variety of professionals undertaking the Lead Professional role in the same way.
- The Strengthening Families Service, within SCT, and the Family Hubs practitioners continue to hold the majority of the Lead Professional role. It is encouraging to report that West Midlands Police have employed Early Help Police Officers as they see the value of ensuring children receive the right support at the right time and have undertaken the Lead Professional role within the last 12 months.
- The Early Help Partnership is inclusive of all partners and aims to achieve the action plan through collaboration. This level of ownership and accountability is required to ensure the Early help action plan is fully realised

**Impact of activities on children, families and professionals**

- Children and families are encouraged and supported to take interve ntion and support at the earliest opportunity from services they know and trust, to prevent needs escalating and inappropriate and intrusive involvement of CSC. Since the launch of the strategy there has be en a 25% increase in the amount of multi-agency early help and a decline in the amount of children on CIN and Child Protection plan. The Early Help Partnerships vision is to build strong resilient c ommunities who identify when support is required and have the relationships within the community to secure help and support from family, peers and community and voluntary organisation s and services

**What role has children and families' had in your planning and activities**

- The Early Help practitioner actively promote children and family feedback to help shape and develop the action plan and activities. This includes gathering feedback from individuals service, views from child and family's as part of practice reviews and involvement of formal forums such as S HAPE, the Care Leavers forum and Sandwell Parent of Disabled children. More work is now required to ensure coproduction.

**Where there has been little progress or things have not gone well, what lessons have been learnt,**

- The change in culture has been slower than anticipated, however having spoke to other LA's who are further in their early help journey then Sandwell, this is typical.
- The Early Help partnership have hold events to a diverse group of practitioners and managers from across the partnership to share key messages from Early help, this is to increase awareness of early he lp but also to encourage partnership accountability. This approach was useful but now more beep oke service by service conversations are re quired to support partners to deliver t heir early help responsibilities.
- The use of a shared partnership system rem ains an area to strengthen. The Early Help Module (EHM) in Sandwell has over a 1,000 users from across the partnership. Greater use of the system to evidence all support offer through a multi-agency approach is now required.

Throughout the coming year and beyond, the SCSP remain committed to monitoring the pace and progress of the improvement work being undertaken by the EHP and will continue to seek assurance that there are:

- Clear pathways so that thresholds are understood, consistently applied and that there is effective multi-agency working in responding to early identified needs
- Evidence of closing the gaps between Early Help and the MASH, establishing broad and consistent knowledge of what support is available to families at every stage of their journey
- There is a shared understanding of Early Help in Sandwell and the responsibility of every professional to support early, understand thresholds and work in partnership with families.
- Evidence of effective contributions to the multi-agency response, including early decision-making across Early Help, Child in Need and Child Protection.
-

Ultimately, SCSP need to be assured that all staff working with children and families in Sandwell are skilled to identify and respond to all parents/carers, including those who may have additional needs, to enable them to participate fully in any assessment process. Families should be offered early help services when issues affecting their parenting capacity are identified particularly in line with the Child Safeguarding Practice Review Panel publication: The Myth of Invisible Men.

## Community Safeguarding

One of the SCSP's statutory functions is to communicate to persons and bodies in Sandwell the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so.
The Voluntary and Community Sector services and organisations are named as 'relevant partners' within the SCSP structure and are represented at each meeting by a nominated lead from the umbrella organisation for Sandwell's Community Voluntary Organisations (SCVO).

Safeguarding communication to the sector is coordinated via the SCVO Safeguarding Reference group, however following a review in 2021 of the safeguarding needs and required support across the sector, it was evident that the quantity and quality of the sector was unknown. The report from SCVO to the SCSP prompted the recruitment of a dedicated post on a fixed-term basis to support the SCVO to better understand the size of the sector and, in doing so, to raise the profile of the SCSP, build sustainable links between the sector and the work of the partnership and respond to their Section 11 duties and responsibilities.

During the report period, 4 VCS Safeguarding Reference group meetings have taken place as planned just before the meetings of the SCSP to ensure information from the sector is reported in a timely manner. Equally, discussions and communications relevant for the sector, including safeguarding training, is circulated to community and faith-based organisations via email.

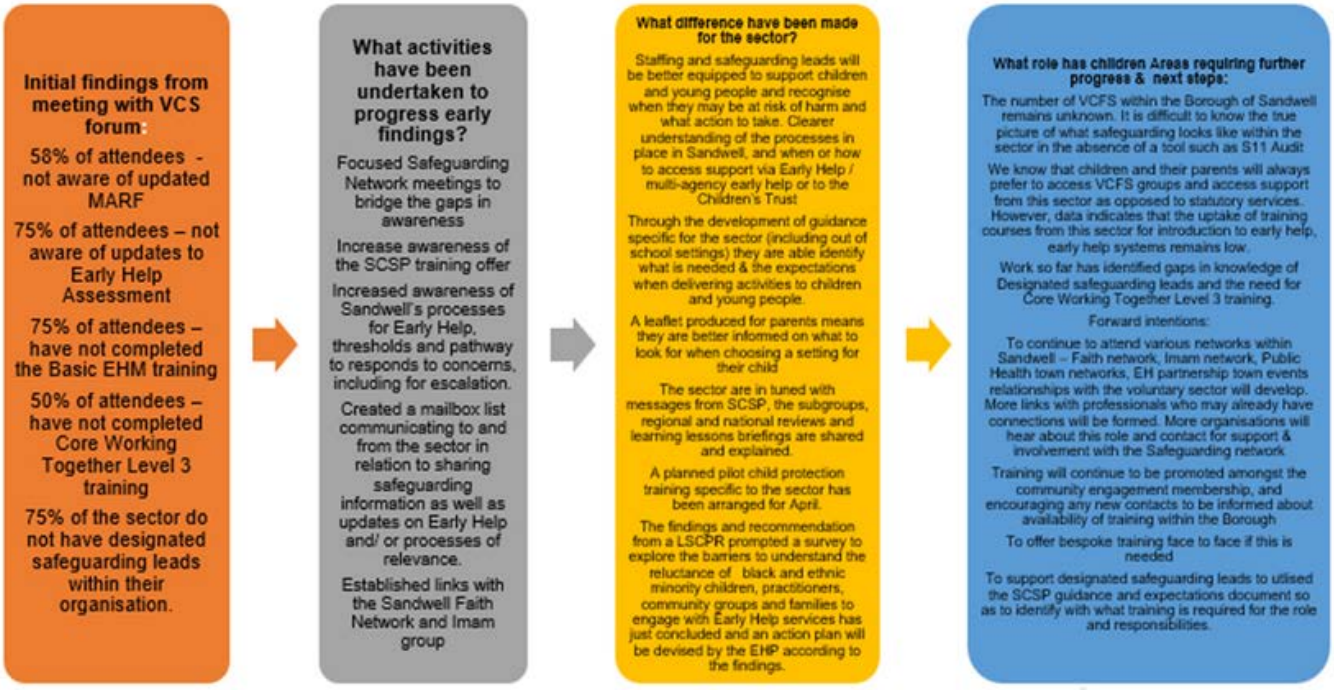
Hear more about the SCVO reference group and the work of the Safeguarding Community Engagement role here: https://youtu.be/ucJJEnvknmE, from Jon Grant who represents Sandwell's Community Sector and faith-based organisations.

To uplift the activities and improve the links to the VCS, the role of SCSP Community Engagement Safeguarding Officer commenced in August 2022 with a clear remit being to support SCVO in building better links and engagement with voluntary, community and faith-based organisations.

**Major Achievements Between Aug 22 to March 23**

| |
|---|
| Linking agencies within the voluntary sector with the Early Help Partnership meetings to increase the knowledge on processes for Early Help and social care support. |
| Linking agencies with the multi-agency learning and development offer via Sandwell Children's Safeguarding Partnership. |
| Raise the profile of the Children's Safeguarding Partnership and the MASA |
| Open the line of communication with all groups, including faith-based organisations, who have sought support from this role. |
| Connecting the community and voluntary sector with each other, building networks for sustained partnership working. |
| Formed a 'Sandwell Safeguarding Network' group in January 23, with membership represented from faith and voluntary sector organisations across the Borough. The meetings are held on a monthly basis. Membership has increased each month from 11 in January 23 up to 33 in March 23. |

## What does this mean to the target groups?




## When we really know we are making a difference

*"Thank you so much for the guidance with the policy. We have adapted and updated the policies based on your input and advice. The information was really helpful as well as the additional safeguarding map you have also provided. I can't thank you enough for taking the time out to support us with our policies. We are really grateful".*

*"I would just like to say that the Sandwell Safeguarding Network (SSN) that you have created is informative and opens other doors to working with different organisations and learning from each other. Well DONE YOU, great job for giving everyone round the table these opportunities to develop this forum".*

## Sandwell Safeguarding Health Partnership

Health is one of the 4 Statutory Partners with leading legislative responsibilities for safeguarding children and promoting their welfare in Sandwell. The Associate Director for Safeguarding and Partnerships NHS Black Country Integrated Care Board (ICB) represents the health economy who, along with the Designated Nurse, have delegated authority to:

- speak with authority on behalf of the wider health providers and commissioners
- take decisions on behalf of the representing organisation or agency and commit them on policy, resourcing and practice matters
- hold their own and representing agencies to account on how effectively they deliver their safeguarding functions, participate and implement the MASA.

Sandwell Safeguarding Health Partnership (SSHP) is chaired by the Designated Nurse for Safeguarding within the ICB and has the structures in place that bring the varying disciplines together on a bi-monthly basis to discuss and review safeguarding governance arrangements, monitor compliance and effectiveness of the safeguarding policies, processes and system. It includes consideration of new or revised statutory guidance, safeguarding risks and emerging themes or concerns, supports the assessment of need, risk and vulnerability and embeds learning from safeguarding reviews or inquiries in frontline practice.

The SSHP has representation from across the health economy including WMAS and is the conduit between the partnership and health services, providing a vehicle to escalate strategic issues.

**Strategic Priorities and Focus of activities during 22/ 23**

**Key Priotities for 22/23**

Early help, front door and MASH were a key focus for the SSHP. A health focus group was convened to review the EH system and processes, this fed into the wider multiagency EH workshops to improve practitioner engagement.

The review of Sandwell Unborn Baby Network led by health (SUBN)

Health monitoring tool for reviews.

ICON within health.

Following an independent review of SUBN and subsequent recommendations, an implementation group led by health was established to improve the efficacy of the SUBN. Health have taken lead responsibility for amending the TOR, chairing, and managing the referral process via a multiagency T&F group. The group has been relaunched and promoted across the partnership to raise awareness and improve referral rate.

**What progress have SSHP made?**

Improved health engagement with the early help agenda

Unborn babies needs identified

Learning from reviews improve frontline health practice

ICON training offered/promoted to all relevant health professionals to enable them to share the key messages with parents/carers and reduce the risk of abusive head trauma (shaken baby).

Learning from all reviews is included in the SSHP monitoring tool and SMART actions developed

**What difference have been made for the sector?**

Learning from reviews improves health systems and practice.

Contribution to the multiagency review of the MASH/Front door to improve effectiveness and safety of CYP

The SUBN will identify early need and coordinate support to improve the baby's outcomes

ICON messages will be delivered to all new parents/carers by midwives, health visitors and GP's at relevant touchpoints to support them in coping with a crying baby

**Areas to improve in the next 12 months**

Strengthened communication between SSHP and organisation internal safeguarding committees to assure wider reach.

Frontline practitioners are invited to meetings to share good practice, innovations and their experience of safeguarding systems.

increase Regularity of attendance across all health services

SCRUTINY - CHALLENGE - REVIEW - EVALUATE

I have attended the SCSP meetings and another meeting called Chairs Consultation Forum (CCF): this is because I chair the QPPA sub group

One of the key insightes was that neglect does not generate the same level of professional concern or response as other forms of abuse. The key findings and areas to be progressed by the partnership were identified as:

Use of evidence based assessment tools and frameworks (e.g. GCP2, hoarding tool, chronologies or their equivalent, cycle of change, motivational interviewing) – this will aid evidencing persistent neglect

- Develop awareness about harmful consequences of neglect including that neglect can kill
- Maximise the pivotal role of supervision across the system
- Progress to embed and establish role of Lead Professional
- Involvement of Housing providers in MASH decision making.

I have participated directly in 2 Rapid Reviews and also provided feedback on the findings and process of a Rapid Review that I was not invited to attend.

**Areas where scrutiny work has identified learning:**

In respect of leadership, I have identified the need for regular performance reporting to SCSP (this challenge was informed by the findings of an inspection undertaken in another West Midlands area.

In respect of practice I have identified the need to address the additional vulnerabilities of children with disabilities in the local response to neglect. Further I have reported to SCSP on SUBN and attended a meeting of partners on 11/5/22 to support and challenge the development of a plan to implement the findings of independent review of SUBN completed in June 21.

I have not completed any distinct pieces of scrutiny work other than the spotlight review that would have had recommendations in during the report year

IMPROVEMENT ACTIVITIES:

Improvement work in respect of the multi agency front door and a domestic abuse pilot were influenced by scrutiny work I completed the previous year

Another example is the ongoing work to improve the Sandwell Unborn Baby Network

There is a clear link between leadership and quality of practice and the Ofsted inspection (2022) provides evidence of progress that has been made over the years in Sandwell to improve safeguarding of children in the Borough

The Inspection also ialso identifies that there is a need for the partnership to focus its attention on children receiving the right help at the right time. This was reflected in the work I completed last year in respect of the front door which found that partners were over-reliant on MASH to determine the level of need for a child and a need to develop the culture of shared ownership for delivering interventions to improve the lives of children at early help level of need. My critical friend question to statutory partners would be for them to reflect on the extent they have and are promoting the cultural change required.

I provided challenge regarding the content of a CSPR (SD). The final report had not sufficiently addressed the key practice/system issue that emerged during the Rapid review that I attended which was the response provided to a young person who was involved in criminal activity and had a positive National Referral Mechanism status meaning it had been recognised that he was a victim of exploitation

I have also challenged the delay in notifying a serious child safeguarding incident ( case GN) and the need for Rapid Reviews to clearly set out the actions that need to be taken to address single and multi agency learning ( action plan). As a result of this challenge, RRs now routinely set out the actions to be taken and by whom.

There is a piece of work in progress regarding a national child safeguarding practice review ( which focused on safeguarding babies from physically abuse). This is remains work in progress. I am less clear how SCSP has used the learning from the national child safeguarding practice review on babies who die unexpectedly (SUDI)

The national review recommends a targeted approach rather than general safe sleep campaigns

CRITICAL FRIEND - IMPROVMENT GURU -

**IDENTIFIABLE IMOROVEMENT**

There is clear evidence that the local response to child exploitation has been informed by local and national learning.

There is also evidence that the Partnership is beginning to explore the impact of race and ethnicity ( and other social characteristics) on Sandwell children e.g. proportion of Black children being excluded from school

A Multi Agency panel has been established to oversee the assessment and safeguarding plans for unborn children for who there are concerns that they will be significantly harmed. This work also includes ensuring that fathers/men are included in assessments and plans.

**STRENGTHS IN PARTNERSHIP WORKING**

Clear priorities - informed by local and national learning.

Arrangements in place to engage with schools.

Investment in a role to provide safeguarding advice and guidance to the voluntary and community sector

-Adequate budget for partnership business support; including dedicated analyst capacity.

-CSPRs are published as per the requirements of statutory guidance – evidencing openness and accountability

**BARRIERS & CHALLENGES**

The need to develop a stronger culture of shared accountability for the identification of level of need; and for early help to become a way of working (rather than a service that is delivered by Strengthening Families

Understanding the systemic factors that impact on frontline practice and so avoiding an over-reliance on disseminating learning to front line practitioners as the actions taken to implement learning from Rapid Reviews, child safeguarding practice reviews and audits

SCSP line of sight to front line practice and the experiences of children and families.(Currently SCSP does not routinely receive performance reports)

Current arrangements do not secure engagement with/by Public Health and senior leaders (Board level) in health providers

**Scrutineer's Top 3 Improvements areas for SCSP during 23/24**

1.Clarifying the distinct role and responsibilities of the SCSP statutory partners/meeting versus CCF (to enable a stronger focus on leadership and governance)

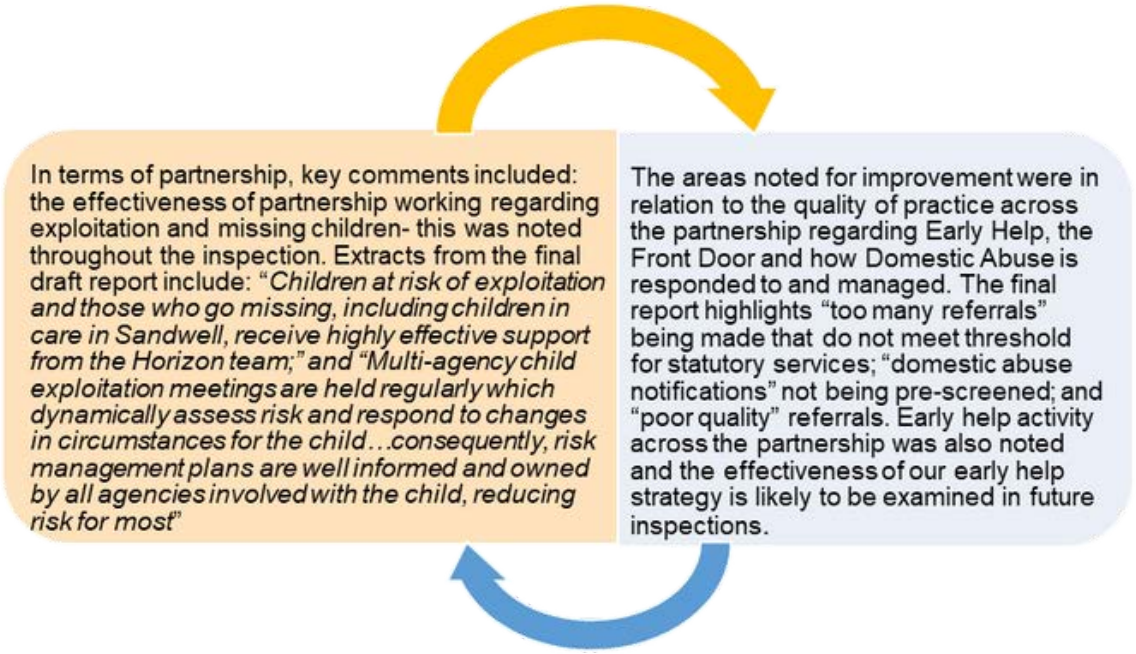
2.Enhanced arrangements to collectively agree the responses required to act on Rapid Review and Child Safeguarding Practice Review learning, plus monitoring of the actions taken.

3.Making the delivery of Early Help a whole system/all agency/every practitioner responsibility (whole family approach)

This year's annual report author has identified two areas termed as 'significant moments' and have deemed these to be highly relevant and 'a must' to be included in this report. These choices are based on the involvement, influences and impact on partnership working and safeguarding, and will be influential in shaping some of the activities of SCSP in the coming year.

## Ofsted Inspection May 2022

The first was the outcome of the Ofsted Inspection of Children's Social Care services delivered via Sandwell Children's Trust and the feedback which evaluated the quality and impact of services on children and families in Sandwell, as per the inspection framework. The inspection included all parts of the continuum of need- Early Help, Children in Need, Child Protection, Children in Care and Care Leavers. Leadership - both operational and strategic - across SCT, the council and wider partnership was also examined and graded.




Overall, and in the context of its history, the outcome of the inspection undertaken in May 2022 was positive for Sandwell's children and families with the judgement and grade awarded being 'Requires Improvement to be Good.' This came on the backend of having received 'inadequate' Ofsted grades from full Ofsted Inspections for over a decade prior to this visit.

The Chief Executive of Sandwell Children's Trust, Emma Taylor, is the 4th Statutory Partner leading the MASA as well as providing feedback to SCSP from the Ofsted Inspection of 2022 and monitoring the work arising from the Inspection for partnership improvements. https://youtu.be/fiYr4Q17HZg, Here Emma speaks to a group of young people about her role as a member of the SCSP.

## SHAPE Takeover October 2022

The second memorable and influential event of 22/23 is taken from the presence of young people during their takeover of the SCSP meeting in October 2022. The young people in attendance are members of Sandwell SHAPE, a programme attended by young people designed to listen to children and young people in Sandwell.

The SHAPE Programme organises events, opportunities and consults with young people across Sandwell throughout the year to ensure children and young people are listened to and able to engage in positive activities.
To manage the session, the young people delegated a Chair from their group who facilitated the conversations and focused the meeting on three distinct areas which were of most concern to them with a 'strong message' to members of the SCSP across the selected themes.

## WE NEED TRUSED ADULTS WHO WE HAVE CONFIDENCE IN AND CAN RELY ON

Young people defined *"A trusted adult is someone, we can go too, who knows us personally, who has been through all the different stages of our lives,"*

Sharing experiences, of having been through the care system, having lots of different social workers, NHS workers and midwives, managers, directors and lots of different corporate parents. young people asked - "*how a young person is expected to build a relationship when professionals are constantly changing job roles and leaving Sandwell*".

one young person shared not trusting anyone. having been in and out of the CAMHS service, with different people coming and going from their life constantly, seeing CAMHS for a couple of months, then they would assume them being better and be discharged from the service even though they were still struggling on a daily basis.

Another young person raised the issue of the waiting period to be allocated with a supposedly Trusted Adult, claiming that firstly it takes ages to get referred, then you are given just one hour per week for a 5-week period in total, which isn't simply long enough.

Another talk to members about the impact in having had 9 different social workers in an 8-year period whilst he was in care, while for another young person there were concerns about not being able to make contact with the Trusted Adult, and would oftn not hear from them for weeks at a time

The young chairperson summarised as "it takes a lot for a young person to open up and confide in a Trusted Adult. Young People just want consistency and do not want to keep on repeating their stories".

. ha queried if the passion is there, for the professional and are they making a difference?

## DO SOMETHING TO STPO BULLYING FROM HAPPENING

The second topic was around "**Bullying in Schools**".

The young people queried what support is out there for young people that have experienced bulling at school? Also, what training do teachers get so that they can offer the support to YP's via thier own experiences, training was not up to standard and only offered empty promises.

The young people highlighted that one of Sandwell's values is "Respect, Recognise and Respond to differences, and they questioned if the workforce were adhering to that value, because from their view, they are not.

Each young person shared snipits of their experiences of bullying, saying there isn't enough support for young people to combat bullying, and asked members "What is being done about bullying?"

Young people were shocked that members were unaware about the things that were going on, but felt that in schools nothing was being done, nothing has changed and bullying is becomin normal

Young People queried with members if school's policy's are strong enough to make the nescessary changes

Young People went as far as linking bullying as leading to young people committing suicide because they are scared to speak up because nothing is being done.

the young people talked about the anti-bullying programme and work covered including the anti-bullying roadshow. The feedback received from the 13 schools had been phenomenal, but the other schools sent their apologies and stated that bullying wasn't seen as a priority for their school.

members of the SCSP each made pledges to

## SUPPORT US IN ACHEVING OUR ASPIRATIONS - SUPPORT & INVEST IN US TO REACH OUR FULL POTENTIAL

Third theme was covered by 'Children in Care' and 'Ccare Leavers', who open the subject with, "what support is out there for young people that want to go to University or into Further Education?"

Each sharing their future aspirations, including wanting to go to University, the struggles being experienced which forces them to financially support themsleves.

they posed a question to members 'as "corporate parents" what support are they offering to care leavers

response from SCSP included:

there is a "Care Leavers" offer. which should be the best that it can be. The offer also needs to provide other options, whether that be university, college or apprenticeships. This was followed up with a recommendation to raise the issues at the next Corporate Parenting Group, which already have a good foundation in place within to be built upon.

From the takeover event, the young people received pledges frlom each member of the SCSP of things to happen /change as a result of their 'takeover'.

This starts with an action plan created to be approved and monitored by the young people.

This year's report for 22/23 covers the activities undertaken by SCSP because of the arrangements, including in relation to child safeguarding practice reviews. The report demonstrates a high volume of work covered over the period, with areas of particular strengths and features of effective partnership working. However, there are areas where there have been little or no progress made despite increased attention, resources and commitment of partners.

The 'themed' areas elevated for improved focus from the previous year's report for 21/22 and the activities undertaken to take forward the 'key themes' have been commented on throughout this report and are covered in some detail by the Independent Chair in section 4 of this report.

There is some evidence to demonstrate the impact of the work undertaken by the safeguarding partners and relevant agencies, including impact of training on practice for improved outcomes for children and families from Early Help to Children in Care and Care Leavers. However, it could be argued that on the balance of the volume of work referenced throughout this report, the evidence of impact is somewhat marginal.

In compiling this report using the areas noted from the guidance produced by the Child Safeguarding Practice Review Panel to craft and guide the contents, there are examples and accounts in some areas that would clearly evidence effective safeguarding interactions through the impact of our work in some sections.

There is now a line of sight in receiving data on school exclusions and from West Midlands Police about the local response to the stop and search of children since the publication of the SC LCSPR. However, we do not currently request data on strip searches which was suggested to be an area of increased concern after the publication of the Child Q LSCPR (City and Hackney, London).

A number of key guidance documents have been reviewed, including the threshold guidance which has been strengthened and updated, as well as other key documents to inform practice such as the Early Help Strategy (via the Early Help Partnership) and the Child Exploitation Strategy to name a few. Equally relevant to ensure and maintain clear focus on agreed subgroup deliverables, terms of reference for all sub and reference groups have been reviewed and updated during this reporting period.
The Multi-Agency Request Form (MARF) was reviewed and strengthened after a series of consultation events with leaders and practitioners. This was released directly to strategic leads by the Independent Chair with reinforced messages to ensure the practice expectations by which a request for statutory social care response will be met is articulated, understood and adhered to at all tiers of the workforce and across all safeguarding partners.

The scrutiny activity during the period included a review of the response to referrals received in MASH from non-professionals: this demonstrated and concluded that responses to referral from relatives/public etc are appropriately triaged. This was added to the scrutiny programme following the tragic murders of Arthur Labinjo-Hughes and Star Hobson.

In terms of the challenge made to partners in 2021 regarding the responsibilities for Early Help, though this theme has received huge investment and commitment from partners, there doesn't appear to be any tangible or sustainable improvements made. The feedback from scrutiny activities, the outcome of Rapid Reviews undertaken and feedback from the latest full Ofsted Inspection have all unravelled the same issues, with Ofsted citing 'inappropriate referrals, and little evidence of early help interventions.' This is by far the most urgent area for practice improvement for the SCSP to focus on going forward. Within the section that captures the work of all sub and reference groups, all have alluded to 'Early Help' as an area for improvement. With this, partners will need to consider what needs to be done differently to make the required improvements in the year ahead.

The Independent Scrutineer has made reference to feedback provided to safeguarding partners in 2021 that was also uncovered some 12 months later during the Ofsted Inspection in 2022, which raises a question as to how the SCSP responds to systems, performance and practice messages and recommendations for improvements. This does steer towards a need for leaders to review the existing structures and strategic arrangements to respond to recommendations, including a seamless line of sight to monitor progress and act in a timely manner.

Reference has already been made to the volume of activities undertaken during the reporting year versus the impact on practice, however this again does feature within the feedback received from the Scrutineer who cites the need for leaders to understand the systemic factors that impact on frontline practice and not rely solely on disseminating learning to front line practitioners as the action taken to implement learning from all types of reviews and audits. There is a need for leaders to develop a stronger culture of shared accountability and collectively 'own' their improvement activities via enhanced arrangements that place them at the forefront for driving the MASA. This will include revisiting and strengthening the existing structures and reaffirming the distinct roles and responsibilities of the SCSP statutory partners to enable a strong and responsive leadership.

Going forward into 23/24, the areas of focus remain unchanged from what was agreed in the previous year's (21/22) report. This is not due to making no traction, but more about allowing ample time for changes to be embedded to take effect to be able to evidence meaningful impact that can be attributed to the changes made.

- Early Help and Prevention - interventions through a range of cohesive and coordinated universal and specialist services at the earliest opportunity to ensure that needs are met. This has to go hand in hand with increasing the understanding and application of the threshold, gaining consent, information sharing and the role of the lead professional.
- Focus on the Front Door and MASH arrangements.
- Neglect – on every level from understanding to responding. This includes a review of the GCP2 standardised tool and agreed approach to support all practitioners in their responses to neglect. This is under-utilised and there is no evidence that this tool has improved or aided practitioners to tackle neglect in Sandwell since it was introduced in 2018. The GCP2 will need to be reviewed for its' suitability.
- Exploitation – a focus on early identification and implementation of tools and strategies to prevent escalation to statutory services and/or the risk of further harm
- Strengthen the connectivity from strategic leads to the frontline by developing a communication strategy to ensure there are effective engagement channels to reach entire workforces who, in their line of work, are in contact with children and families to ensure that safeguarding systems are robust and effective
- The voice and lived experiences of children and families accessing services needs to be strengthened. This extends to progressing the areas of most concern to young people in Sandwell and feedback received in the 'takeover' event referenced in this report
- A review of the leadership and governance structures which oversees and underpins the MASA. The SCSP needs to have a clearer line of sight and be better positioned to steer the MASA to be effective.

**Themed areas**

- Increase the profile and purpose of Sandwell Unborn Baby Network (SUBN) to assist in identifying concerns 'early' and applying appropriate preventative support
- The SC LCSPR sought to understand whether black and other ethnic groups are given equal/timely access to services, including and particularly Early Help support, for the purposes of reducing risks to and intervention for statutory interventions
- A focus on timely implementation of actions arising from reviews, including from MACFAs, Rapid Reviews and Child Safeguarding Practice Reviews
- Continue to build sustainable relationships with voluntary, community and faith-based organisations.

# 12. GLOSSARY OF TERMS

- **A&E** - Accident and Emergency
- **BC CDOP** – Black Country Child Death Overview Panel
- **CAMHS** – Child and Adolescent Mental Health Service
- **CCF** – Chairs Consultation Forum
- **CCG** – Clinical Commissioning Group
- **CEB** – Child Exploitation Board
- **CIN** – Child in Need
- **CSPR** – Child Safeguarding Practice Review
- **DA** – Domestic Abuse
- **DASP** – Domestic Abuse Strategic Partnership
- **EH** – Early Help
- **EHCP** – Education, Health and Care Plan
- **EHP** – Early Help Partnership
- **GCP2** – Graded Care Profile
- **GP** – General Practitioner
- **ICB** – NHS Black Country Integrated Care Board
- **ICON** – Infant Crying is OK – Never shake the baby
- **ICPC** – Initial Child Protection Conference
- **IoD** - Indices of Deprivation
- **JAR** – Joint Agency Response
- **JTAI** – Joint Target Area Inspection
- **L&D** – Learning and Development
- **LADO** – Local Authority Designated Officer
- **LCSP** – Local Children's Safeguarding Partnership
- **LCSPR** – Local Child Safeguarding Practice Review
- **MACFA**- Multi Agency Case File Audit
- **MARF** – Multi Agency Request Form (previously Multi Agency Referral Form)
- **MASA** – Multi Agency Safeguarding Arrangements
- **MASH** – Multi Agency Safeguarding Hub
- **NAI** – Non-Accidental Injury
- **NCSPRP** – National Child Safeguarding Practice Review Panel
- **OFSTED** – Office for Standards in Education, Childrens Services and Skills
- **PEP**- Personal Education Plan
- **QAF**- Quality Assurance Framework
- **QPPA** – Quality of Practice, Performance and Assurance
- **SCR** – Serious Case Review
- **SCSP** – Sandwell Children's Safeguarding Partnership
- **SCT** – Sandwell Children's Trust
- **SCVO** - Sandwell Community and Voluntary Organisations
- **SHAPE** – Children in Sandwell want to be: Safe, Healthy, to Achieve, and have Positive Experiences
- **SLPR** – Sandwell Learning from Practice Reviews
- **SSHP** – Sandwell Safeguarding Health Partnership
- **SUBN** – Sandwell Unborn Baby Network
- **SWBNHS** – Sandwell West Birmingham NHS
- **TAF** – Team Around the Family
- **TED** – Tell, Explain, Describe
- **TN** – Tackling Neglect
- **VCS** – Voluntary Community Sector
- **WMP** – West Midlands Police
- **WMAS** – West Midlands Ambulance Service

Statutory guidance requires the four statutory safeguarding partners (which for the period covered by this report are Local Authority Chief Executive, Sandwell Children Trust Chief Executive, Chief Constable of the local Police Force and Accountable Officer, Clinical Commissioning Group superseded by Chief Nurse, Integrated Care Board (with effect from July 2022) or their delegated representative) to make arrangements for independent scrutiny of the yearly report they are required to publish.

In my roles as Chairperson of Quality of Practice, Performance and Assurance (QPPA) group and Independent Scrutineer, I have contributed to the content of SCSP Annual Report 2022-23. The activity undertaken in my independent scrutineer capacity, along with my reflections on the strengths and barriers and challenges of the safeguarding partnership arrangements, are detailed at Page 34.The reader will note that the activity I have undertaken includes direct involvement in the arrangements to learn from serious child safeguarding cases and front-line practice as required by statutory guidance.

Based on my involvement in the safeguarding partnership arrangements, I consider that the report is an accurate representation of the work undertaken by partner agencies and associated accomplishments. Furthermore, I consider the safeguarding partnership to be self-aware and to use data and local and national learning to determine its priorities. The report details the 'stubborn' challenges that partner agencies have identified as adversely impacting upon the provision of help and support and/or the safety and wellbeing of children and young people in Sandwell.

The extent of these challenges is more understood than at the start of the reporting period; learning from the National Panel endorses the important role that leaders play in creating the conditions for good safeguarding practice and outcomes to flourish. The recognition of the need to do more to improve the effectiveness and evidence the impact of the work of the safeguarding partnership should be considered a reflection of the commitment of statutory partners to provide strong leadership.

The ambition of the safeguarding partnership is to create a strength based, preventive whole system approach to delivering help and support to children and families and the report concludes by setting out the direction of travel for 23-24. There is an emerging understanding of the experiences and outcomes for children from black and minority ethnic backgrounds and the differential experiences they have compared to their white counterparts. This data, along with other socio-economic data, will need to inform the work of the safeguarding partnership to tackle disadvantage and disparity that children and families experience in Sandwell.

The safeguarding partners recognise that to deliver their ambition there is a need to drive cultural and practice changes. The planned review of the structural arrangements of the safeguarding partnership will support this work. The forthcoming revisions to statutory guidance along with the Government response to the independent Review of Children's Social Care, the Child Safeguarding Practice Review Panel's inquiry into the murders Star Hobson and Arthur Labinjo-Hughes and the Competition and markets Authority's study of the children's social care market will also serve as enablers. The greatest enabler will of course be a shared and relentless focus on doing the very best for every child in the borough.

A final, but very important comment from me; in whatever role you have played, thank you for your contribution to safeguarding children and young people during 2022-23.

Very best wishes
Liz Murphy
Independent Scrutineer, Sandwell Children Safeguarding Partnership