Sandwell Children's Safeguarding Partnership

Working Together to Safeguard Children 2021 -2022 Annual Report

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

Version Control			
Number	**Date**	**By Who**	**Reason**
V1	Oct 2020	Holly Bramley & Gillian Ming	Annual Compliance Report
V.2	Oct. 2021	Holly Bramley & Gillian Ming	Annual Compliance Report
V.3	Dec 2022	Gillian Ming	Annual Compliance Report

Foreword: Lesley Hagger, Independent Chair, Sandwell Children's Safeguarding Partnership.

Welcome to the Annual Report of Sandwell Children's Safeguarding Partnership covering the period between 1st April 2021 and 31st March 2022.

The Partnership is very proud that the framework for this report has been led by young people. This involved young people meeting with members of the Partnership and asking them various questions about their role in keeping children safe in Sandwell. Whilst the young people had undertaken some intensive sessions to prepare their questions, the members of the Partnership were not aware of what they would be asked, and the responses that you will see in the embedded video clips were not rehearsed. On behalf of the Partnership, I would like to thank the young people that were involved for their insightful questions and for holding us to account for their wellbeing and safety. Thanks also go to Sandwell SHAPE for supporting the young people through the process.

This Annual Report reflects a period when Sandwell, along with the rest of the world, was emerging from the Coronavirus pandemic. Ensuring the safety of children during the pandemic became more complicated and complex, and emerging from the pandemic highlighted how difficult life had been for many young people. Partners in Sandwell continued to work together effectively in sometimes seemingly impossible circumstances but with a determination to ensure that children and young people were a priority for all agencies. This, combined with our learning from tragic national child safeguarding cases, has led to the inclusion of children's 'voices' as a feature of all sub-committee meetings, so partners can hear and respond to what children are telling us, and embed this into their individual and organisational learning and understanding.

Intelligence and data from this period influenced the Partnership to include a third key priority for 'early help' alongside the key priorities for neglect and exploitation. Our annual conference, in June 2021, focused on our 'neglect' priority. This also reflected themes from Local Child Safeguarding Practice Reviews which highlighted the need for increased visibility and focus on males involved in children's lives, and on our cultural competence when working with Sandwell's diverse communities.

During the year, the Partnership reinstated its 'Chair Consultation Forum' as the executive group to support the delivery of the decisions made by the Partnership and drive innovation and pace in the dissemination of learning and practice developments. An increased focus on understanding what difference the Partnership is making and using the work of the Independent Scrutineer to examine effectiveness and to highlight good practice as well as development needs has helped the Partnership to have a greater focus on understanding the impact of its collective work.

Keeping children safe is truly everyone's responsibility and the Partnership would like to extend its thanks to each person, organisation, community, and business that worked hard to keep children safe and to respond to their needs during 2021/22. The Partnership has set out clear actions for 2022/23, recognising that these are part of that wider safeguarding environment in Sandwell and looking forward to continuing to be held to account by children, young people, families and the wider community for their delivery.

Lesley Hagger
Independent Chair, SCSP

Content Page

1. Introduction

The Children and Social Work Act 2017 and Working Together 2018 introduced new flexible arrangements for safeguarding children. The agencies and organisations from each local authority area named in legislation to lead the local multi-agency safeguarding arrangements (MASA) have collectively agreed to be known as Sandwell Children's Safeguarding Partnership (SCSP), have formalised and published the MASA for the area which came into effect as of April 2019.
The SCSP MASA, have a fundamental purpose, to support and enable all local organisations and agencies to work together in a system where:

- 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.

Who are the members of the Sandwell Children's Safeguarding Partnership – (SCSP)
The SCSP is made up of the leading Statutory agencies known as:

- Sandwell Metropolitan Borough Council (SMBC)
- West Midlands Police (WMP)
- NHS Black Country Integrated Care Board (ICB) (former CCG)
- Sandwell Children's Trust (SCT) for the provision of Children Social Care;
  as well representatives from other organisations listed in legislation as 'Relevant Partners'*, and in Sandwell, includes:
- Sandwell Community and Voluntary Organisations (SCVO)
- Education
- Other attendees as regular representatives of the SCSP include:
  - The Independent Chair
  - Independent Scrutineer – as named in Statutory guidance
  - Professional Advisors,
  - Local Council Member,
  - Lay-Person, and
  - Business Support - as required via Statutory guidance

* Relevant agencies are those organisations and agencies whose involvement the safeguarding partners consider is required to safeguard and promote the welfare of local children. The SCSP expect organisations and agencies who are not named to cooperate with the MASA and collaborate with the safeguarding partners 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

As well as publishing the MASA, the SCSP have shared the local MASA with all partners, relevant agencies, and others expected to work within the formalised safeguarding arrangements for the area.

Mandated to local safeguarding structures, is the role of an 'Independent Scrutineer', this role exists to provide assurance in judging the effectiveness of multi-agency arrangements to safeguard and promote the welfare of children. In Sandwell, this role quality assures our arrangements and the processes in place for responding to serious child safeguarding incidents.

This independent role in Sandwell is aligned to our wider quality assurance processes and provides objective scrutiny, acts as a constructive critical friend and promotes reflection to drive continuous improvement.

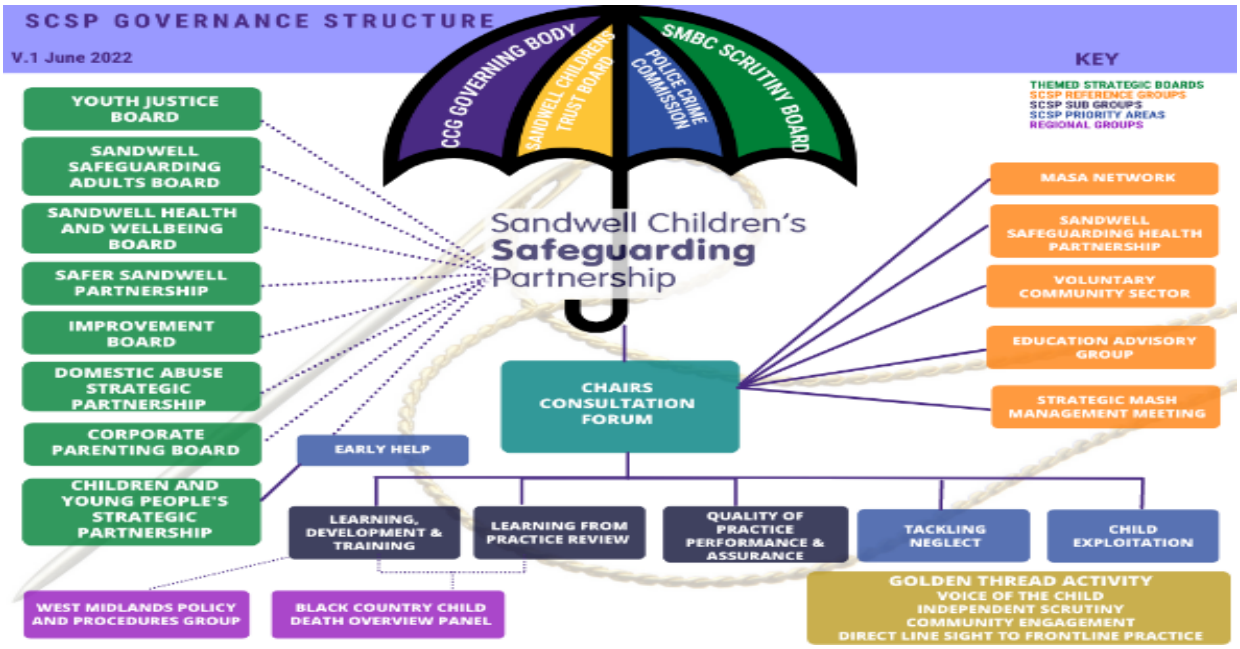
This annual report for 21-22 will focus on the activities planned and delivered over the 12month period as a result of the MASA, including reporting the approaches taken in response to serious safeguarding incidents as well as undertaking local child safeguarding practice reviews, and how effective these arrangements have been in practice.

In addition, this annual report will include:

- evidence of the impact of the work of the safeguarding partners and relevant agencies, including training, on outcomes for children and families from Early Help: https://westmidlands.procedures.org.uk/page/glossary?azid=E to Looked after children: https://westmidlands.procedures.org.uk/page/glossary?azid=L and care leavers
- an analysis of any areas where there has been little or no evidence of progress on agreed priorities
- record of decisions and actions taken by the partners in the reporting period (or planned to be taken) to implement the recommendations of any local and national child safeguarding practice reviews, including any resulting improvements
- ways in which the SCSP have sought and utilised feedback from children and families to inform their work and influence service provision.
- a reflection from the independent scrutineer on the effectiveness and delivery against our MASA, and how our arrangements are working for children and families as well as for practitioners, and how well as safeguarding partners we are providing strong leadership.

More information about the formalised arrangements underpinning the work of Sandwell Children's Safeguarding Partnership can be found on the SCSP website.

The SCSP reviewed and refined the structure below at its Development Day in January 2022 to ensure full and effective delivery of its 'core functions, priorities and have a line of sight to other local 'Boards' with connecting strands to our multi-agency safeguarding arrangements.



The SCSP meet on a bi-monthly basis, having 6 preschedule meetings for the reporting year 21/22, as well as convening a further 6 meetings, including extra-ordinary meetings to receive exception reports, emerging issues from a national perspective and arising and recovering from Covid 19 Pandemic, as well as its annual development event.

The SCSP also have within its refined structure direct links to other strategic partnerships/boards whose work is expected to include support /connectivity to children and families. This includes other public boards including Health and wellbeing boards, Adult Safeguarding Boards, the SCT Improvement Board, Community Safety Partnership, the Local Youth Justice Board linking to Violence Reduction Unit, Domestic

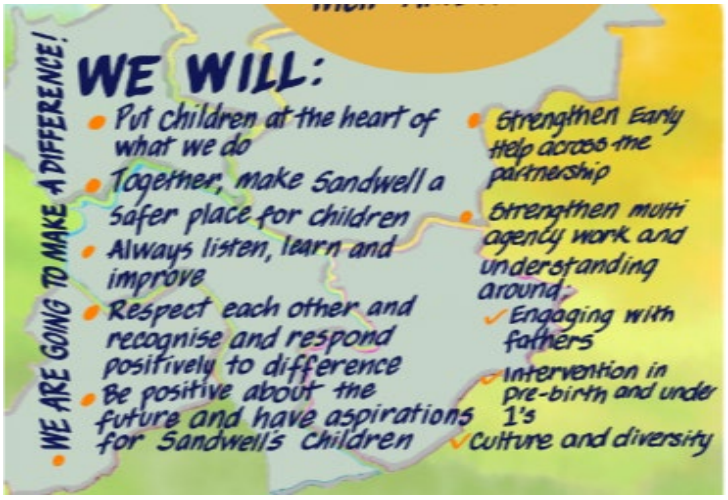
Abuse Strategic Partnership, Corporate Parenting Board, and the Children and Families Strategic Partnership.

Across Sandwell, the Safeguarding Partners have equal and joint responsibility for local safeguarding arrangements. With lead representatives of seniority from each statutory agency being accountable for any actions or decisions taken on behalf of their agency.

The representatives, or those with delegate authority to must be able to:

- speak with authority for the safeguarding partner they represent
- take decisions on behalf of their organisation or agency and commit them on policy, resourcing and practice matters
- hold their own organisation or agency to account on how effectively they participate and implement the local arrangements.

The SCSP have collectively agreed the following a set of values culminated in a mission statement which underpins its existence, commitment, and ambitions:



In addition to the mandated 'core functions to be delivered via all local safeguarding children's partnerships, the SCSP have agreed and added the following as themed areas as 'Key Priorities' for 2021 – 2022 these are:

- **Neglect,**
- **Exploitation, and**
- **Early Help – (from autumn 2021)** In 2021, following a challenge between partners in Sandwell, it became apparent that the threshold for statutory social care was not clearly understand or duly applied across the partnership, this was evident in the high numbers of inappropriate Multi-Agency Referral Forms (MARF) being received at the 'front-door' with little or no evidence of activities (Early Help) or support offered prior to seeking statutory interventions.

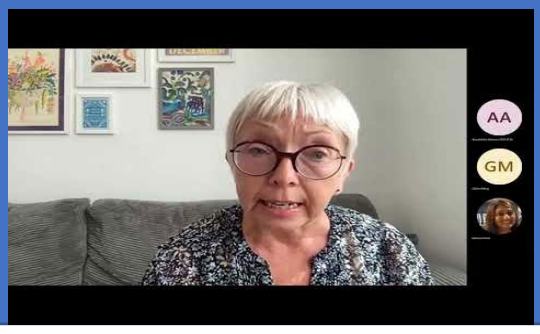
A further 2 themes areas following the outcome of learning from Local Child Safeguarding Practice Reviews (LSCPR) were heightened for increased focus, attention and improvement, these being:

- The visibility and voice of Father's, Men/Partners/significant others in our work with children,
- Increase our knowledge, understanding, confidence and cultural competence to work with children and families across the diverse communities in Sandwell,

As well as activities against the 'core' functions as defined by legislation, statutory guidance, and illustrated in the SCSP structure chart, the priority areas and elevated themes are the focus for this year's annual report.

Heading in to the next section a reminder from Lesley Hagger the SCSP Independent Chair responding to a question posed by a young person who asked 'why does the SCSP exist' -

Here's what Lesley said:



2. An Overview of Sandwell's the Child Population – Accessing and receiving Multi-Agency Help and Support during 21/22:

30,626 Total Contacts, with 4454 Referrals

625 Strengthening Families
367 Multi-Agency Early Help

844 Children in Care

55 Children at risk of Exploitation*

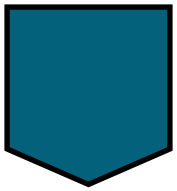
558 Children in Need

86,871 Children and Young People under 19

Sandwell Children's Safeguarding Partnership

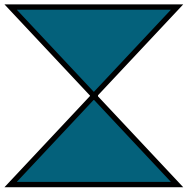
862 re-referrals

212 LADO Referrals

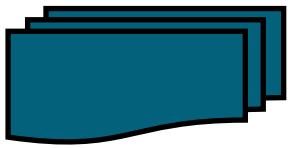


61 Children Police

409 Children on CP

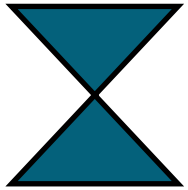


77% Assessments in



5179 Domestic Abuse contacts

365 young people seen in A&E



83% ICPC's in timescale

748 Children reported Missing

2. Understanding the Local context and the needs of the child population:

With 327,378 residents, Sandwell has the third largest population in the West Midlands Combined Authority area and is the 34th biggest local authority in Great Britain. It is predicted to grow faster than the West Midlands and the national average.

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

Sandwell is a Borough that has for many years faced significant challenges, having high and widespread deprivation with increasing pressures and demands for health and social care services. The outbreak of the Coronavirus pandemic in 2020 has exaggerated this and 2 years on, we continue to adapt to a changing landscape in relation to demand for services, impact on children, families, availability and resilience of the workforce.

Sandwell has a young and diverse population with more than 40% residents under the age of 30, compared to around 30% across the UK. Almost 40% of residents are from ethnic groups, making us more diverse than the regional and UK average of 18.8% and 14% respectively.

The needs of children and young people accessing services and support from 'Early Help, through to statutory social work interventions to help and protect during 21/22:

Education Attainment in Sandwell

With a third of the children in Sandwell being below school age and, although children do make progress when they are in school, this early underachievement has an impact throughout their school lives where attainment at both KS2 and KS4 are below the national average.

However, Sandwell performs below the national average on many indicators relating to children and young people.

- KS1 – at the end of 2022, Sandwell performed 6% below the National average for reading at 61%. Writing came in at 7% below the National average at 51%, Maths was 5% below the National average at 63%.
- KS2 – at the end of 2022, Sandwell performed 2% below National average for reading at 72%. Writing came in at 3% below the National average at 66%, Maths was 5% below the National average at 66%.
- KS4 – at the end of 2022, Sandwell performed 3% below National average for 9-4 English, and 9% below National average for 9-4 Maths.

Obesity in Sandwell's young people is measured at Reception Age (4 years old) and in Year 6 (10 years old).
12.8% of Reception age children in Sandwell are considered as obese or severely obese in comparison to the West Midlands average of 11.2%, whereas 28.5% of Year 6 aged young people are considered either obese or severely obese in comparison to the West Midlands average of 23.9%.

Towards the end of the reporting year, Sandwell received confirmation of being one of the 55 councils identified as an 'Education Investment Area' and one of 24 council's as a 'Priority Investment Area'. This sees the formation of Sandwell Partnership Board devising an action plan to be submitted to the DfE for ministerial approval in the coming financial year and will identify strategic priorities to focus on across the education sector.

In regard to teenage pregnancies, the latest data available indicates that there was 18 young people in Sandwell under the age of 16 years old that was pregnant. As at March 2022 none of the children and young people in care in Sandwell under the age of 16 years old were pregnant.

Contacts and Referrals:

- 30,626 contacts were received over the financial year and on average 85.1% of these were completed within one working day.
- 9,805 of those contacts were received from Police, making up 32% of the total, with Education contacting 5,010 times at 16.4% of the total.
- 5,510 (18%) of the 30,626 contacts had an outcome of action for Sandwell Childrens Trust.
- 4,454 referrals were received by SCT, with 1,147 of those from Education (25.8%) and 1,380 from Police (30.9%). This is an average of 372 referrals per month.
- 4,151 of the 4,454 referrals went to single assessment, with a conversion rate of 93.2%.

Domestic Abuse Contacts

- 5,179 Domestic Abuse contacts were received by SCT totalling 16.9% of the contacts received. This is a slightly lower position to the previous end of year position at 20.6%.
- Of the 5,179 DA contacts received, 5,167 of those were from Police (99.8%). Over half of the contacts that are made to SCT from Police are in relation to Domestic Abuse (53%).

A&E Admittance of Young People:

- 80 young people were seen in A&E in Sandwell for Alcohol misuse.
- 187 young people were seen in A&E in Sandwell for Overdose.
- 49 young people were seen in A&E in Sandwell for Self-Harm
- 49 young people were seen in A&E in Sandwell as a Victim of Assault

Missing Children and Episodes

- 748 individual young people had a missing episode within the 2021-2022 year. There was 1240 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 was on average 62 children missing each month at an average rate of 13 children in every 10,000 going missing for a period of time.
- 91.2% 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. 88% of these were completed within 72hrs of the young person returning home.

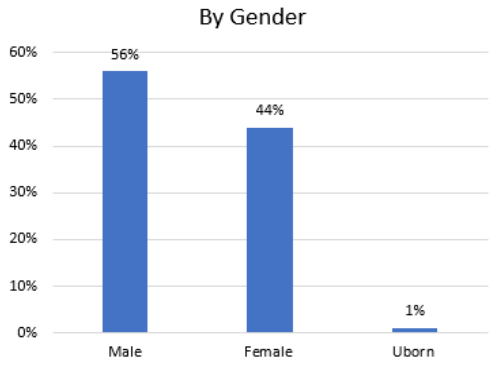
Child Exploitation and Child Sexual Exploitation

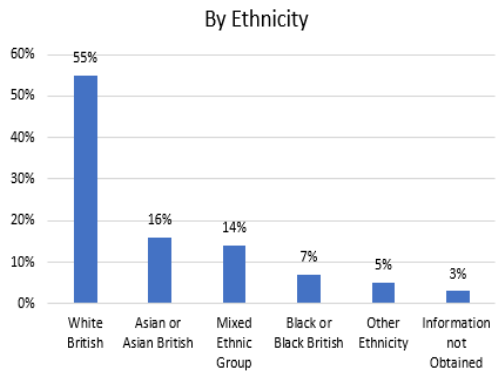
- *55 children were assessed as being at risk of Child Exploitation by the end of March 2022.
- None were assessed as "low risk", 34 (62%) were assessed as "medium risk" and 20 (36%) were assessed as "high risk".
- Of the 55 children at risk of Child Exploitation, 26 were assessed as at risk of Child Sexual Exploitation (47.3%). 20 of the 26 young people are female (77%).

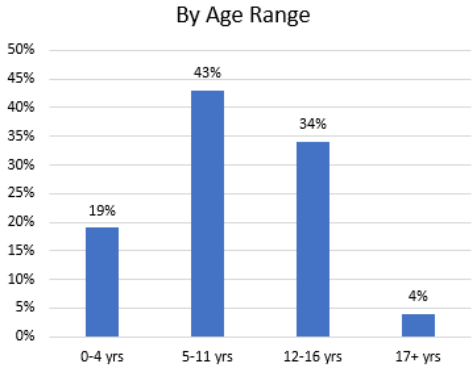
Strengthening Families and Multi-Agency Early Help

Contact to Referral/Met Threshold for EH	Q1 2021 - 2022	Q2 2021 - 2022	Q3 2021 - 2022	Q4 2021 - 2022
Total Contacts	7629	7409	7801	7641
Met Threshold for EH	2618	2140	2318	2405
% Met Threshold for EH	34.3%	28.9%	29.7%	31.5%

- At the end of 2021-2022 there were 992 young people open to Multi Agency Early Help and Strengthening Families Service.
- 56% of those were Male, 44% Female & 1% Unborn.
- 56% were White British, 16% Asian or Asian British, 14% from a Mixed Ethnic Group, 7% Black or Black British, 5% were from Other Ethnic Backgrounds, and 3% Information not Obtained.
- 19% were between the ages of 0-4, 43% between 5-11, 34% between 12-16 and 4% were 17 years+.
- Of the young people open to Strengthening Families as at 31 March 2022, 88% had a Team Around the Family (TAF) Meeting within the last 12 weeks. 91% had a family visit within the last two weeks.



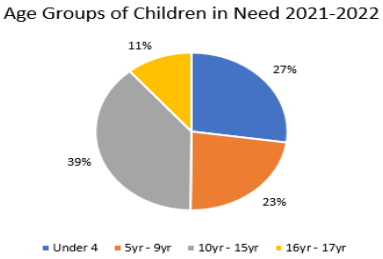


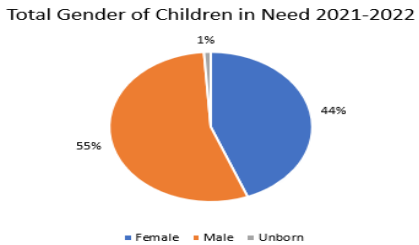


Children in Need

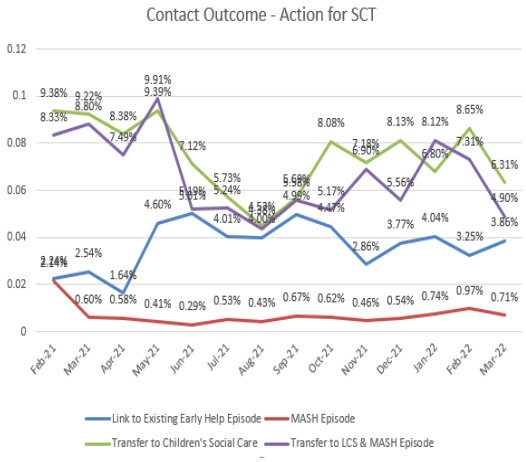
- At the end of March 2022 there was 558 young people on a Child in Need Plan. This is a rate of 67 young people in every 10,000 in Sandwell, that's around 2 full classrooms of children.
- 21.5% of the young people on a Child in Need Plan have been so for 9 months or longer.
- 306 (55%) are male, 246 (44%) are female, with 6 (1%) unborn.
- 59 young people (11%) are identified as having a disability.
- 52% were White British, 17% from a Mixed ethnic origin, 16% were Asian or Asian British, 11% were Black or Black British, 4% were from Other Ethnic backgrounds.
- 152 of the 558 are under 4 years old—27%.
- 128 of the 558 are between 5 years old and 9 years old—23%.

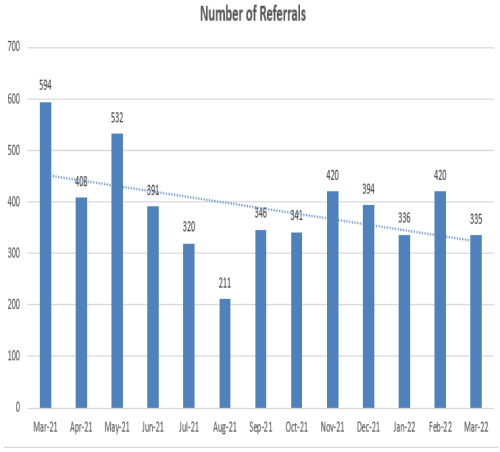
Re·

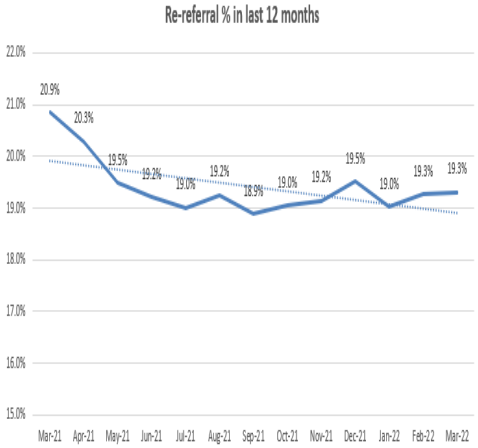




- 862 (19.3%) of the 4,454 referrals received over the 2021-2022 financial year were re-referrals. This is below the West Midlands average—20.4%, the Statistical Neighbour average—20.8% and the England average—22.7%.





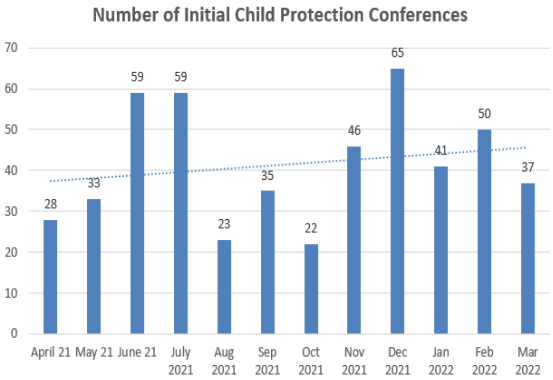


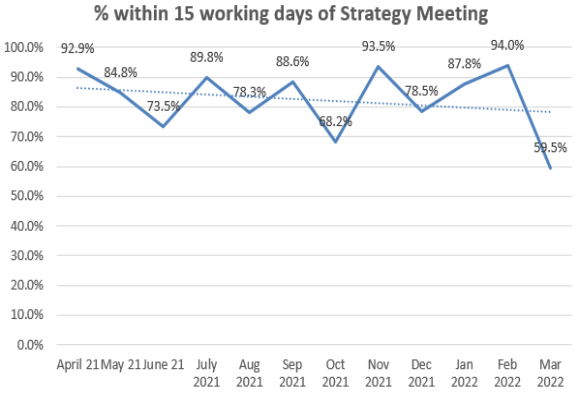
Police Protection:

- Police issued 42 Protection orders over 2021-2022 that involved 61 young people.

Initial Child Protection Conference (ICPC)

- 489 ICPCs were held in the year 2021-2022 and on average 83% of these were held within 15 working days of the Strategy Discussion. This is below the West Midlands average (85%), on par with the England average (83%) and above the Statistical Neighbour average (80.5%).
- 87% of ICPCs that are held by SCT result in a Child Protection Plan





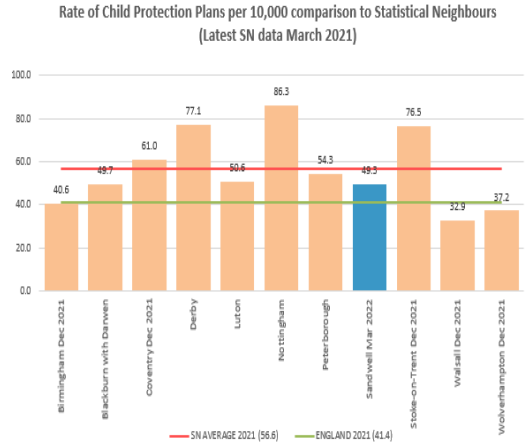
Single Assessments

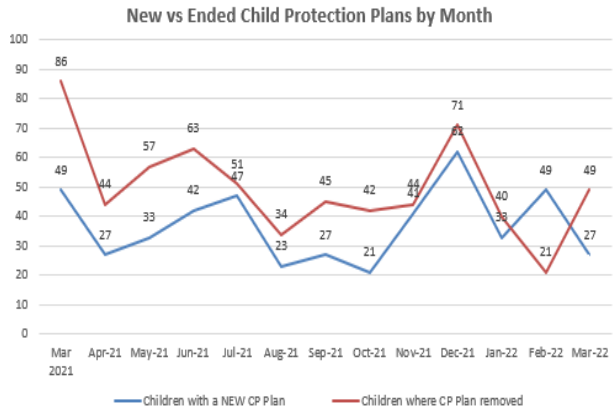
- 5,036 Single Assessments were completed by SCT over the course of the 2021-2022 year. 3,866 of these were completed within 45 workings days (76.8%). This is an average of 51 assessments for every 10,000 young people in Sandwell.
- 4,136 NEW assessments were completed, with 3,277 of these completed within 45 working days (79%).
- 3,634 initial visits as part of the assessment were completed within the 5 working days from the assessment commencing (72%).

- Over the year, 3327 of the 5,036 assessments (66%) 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:

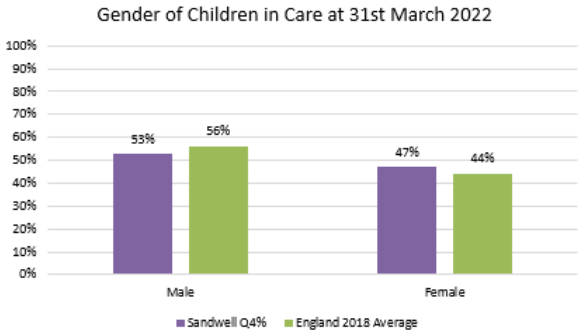
- At the end of March 2022 there was 409 young people on a Child Protection Plan. This is a rate of 49 young people in every 10,000 in Sandwell. This is above the England average of 41.4 young people but below the Statistical Neighbour average of 56.6.
- Over the course of 2021-2022, 432 young people started a Child Protection Plan whilst 561 were removed from Child Protection Plans (deficit 129 young people).
- 72% of these young people have been on a Child Protection Plan for less than 9 months, with only 2.4% being on a plan for longer than 2 years (10 young people).
- 132 (32%) of these young people have previously been on a Child Protection Plan.
- On average 91% of the young people were visited within timescale (20 working days).
- Over the course of the year 93% of young people on Child Protection Plans had their plan updated within timescale (6 months).
- 49% of the young people are male whilst 48% are female. 3% are unborn.





Children in Care

- At the end of the year 2021-2022 there was 844 Children in Care in Sandwell. That is 102 children in every 10,000 in Sandwell. This was about Statistical Neighbour average of 94 and above the England average of 67.
- 53% of those young people were male, with 47% female.
- 55% were White British, 25% from a Mixed ethnic origin, 9% were Asian or Asian British, 9% were Black or Black British, 2% were from Other Ethnic backgrounds.
- 61% were between the ages of 5 and 15 years old.
- 37% were in external foster placements, 16% internal foster placements, 18% placed with connected carers, 11% were placed at home with parents. The remaining 18% were in various other placement types.
- 79% of the children in care were assessed as at risk of Abuse or Neglect.



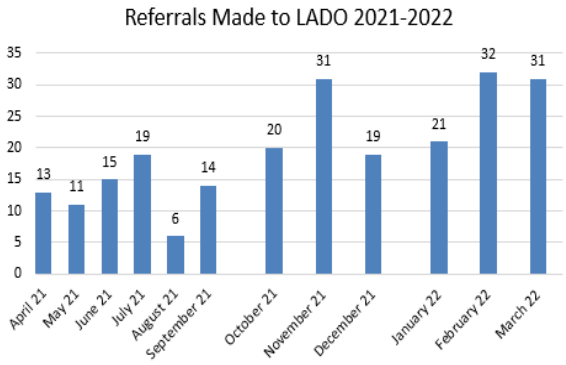
- 92% of children in care had their review health assessments completed within the past 12 months.
- On average, 91% of children in care aged 0-15 years old have their care planning

completed within timescale, with 92% of them having a single or multiple track plan of permanence at their first LAC review.

- 96% of children in care have a Personal Education Plan (PEP) completed.

LADO Referrals:

In line with legislation Sandwell, through the LADO 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 or partner agencies and volunteers. The table aside illustrates new referrals received by LADO by month during the report period.



Private Fostering Arrangements:

At the end of 21/22, there are 9 children who are subject to private fostering arrangements in Sandwell. This is a reduction of 6 from the previous year's (20/21) report which highlighted 15 children who were subject to these arrangements. The reasons for this decrease in number is varied, for example children leaving these arrangements if they have become Looked After or moved back out of the Sandwell area.

Child Deaths:

Sandwell is a member of the Black Country Death Overview Panel (BC CDOP) is an inter-agency forum for Child Death Reviews comprising of Sandwell, Dudley, Walsall and Wolverhampton.

The BC CDOP is a multi-agency panel set up to conduct independent scrutiny on behalf of the local Child Death Review partners to review all deaths of children normally resident in the Black Country, to learn lessons and share findings for the prevention of child deaths.

The Child Death Overview Panel review is intended to provide the final scrutiny over 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 2021 – 2022

96 deaths in total were notified across the Black Country between April 2021 – March 2022

Chart 1 below provides the breakdown for for each Black Country area is as follows:

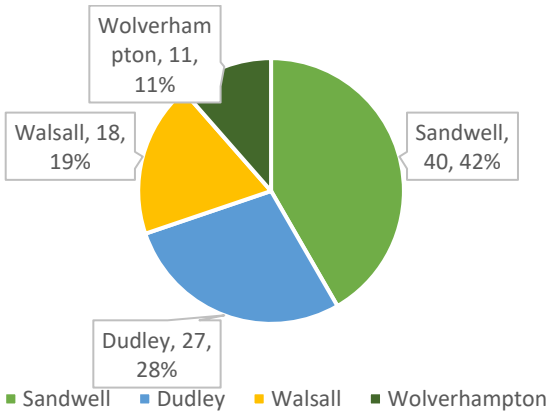
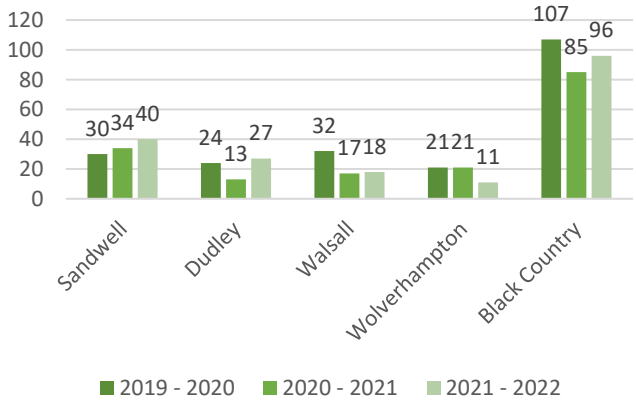


Chart 2 below shows a 3-year comparison since April 2019

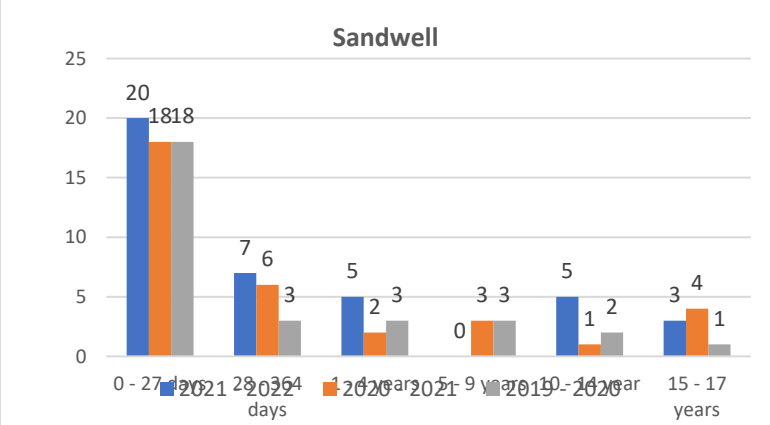


From chart 2 above, it is evident that Sandwell as seen as increase in Child Deaths year on year over the last 3 years, and in **Chart 3** below, by age, Sandwell child deaths have reduced in the 5 - 9 years and 15 - 17 years age groups. However, deaths have increased in all other age groups. The largest increase was in the 10 – 14year age group

Duties for Managing Unexpected Deaths in Children

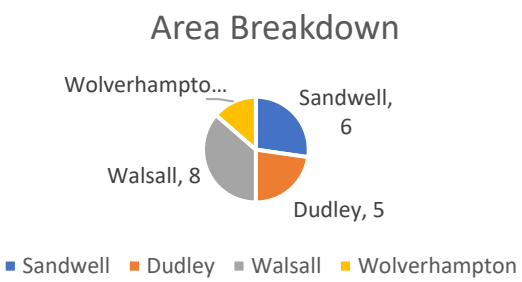
An unexpected death of a child means, cases where a death (or collapse leading to death) of a child, which was not reasonably expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent.
In such cases, there is a requirement to perform further investigations for all children who die where the cause is unknown. This process is referred to as a **Joint Agency Response**
A Joint Agency Response (JAR) is a coordinated multi-agency response which is triggered if a child's death: -

- is or could be due to external causes.
- is sudden and there is no immediately apparent cause (including SUDI/C).
- occurs in custody, or where the child was detained under the Mental Health Act,



- in the case of a stillbirth where no healthcare professional was in attendance; or
- where the initial circumstances raise any suspicions that the death may not have been natural – where abuse or neglect is known or suspected, in Sandwell, such deaths will also be referred to

SCT for a referral to Ofsted, DfE and National Safeguarding Practice Panel, and also to the SCSP for a Rapid Review via the relevant subgroup.



Figures in **Chart 4** (side) shows that out of the 96 deaths notified to the Black Country in 2021 – 2022, 22 were unexpected and required a Joint Agency Response (JAR), 6 of which were undertaken in Sandwell with 2 of the 6 referred for further scrutiny via Sandwell Learning from Practice Review subgroup.

For further information see the link to the Statutory and Operational Guidance and Working Arrangements for Child Death Overview Panels: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england . This sets out the key features of a good Child Death Review (CDR) process to be followed by all organisations involved with the process of child death reviews as of 1st April 2019.

3. SCSP Subgroups & Priority Groups

The SCSP have three subgroups that leads of its 'core functions', and two groups with a mandate to drive forward the identified priority areas of business. Each subgroup has a nominated chair and representatives from across the multi-agencies. In addition, in May 2021 the partnership reinstated its 'Chair Consultation Forum, as the executive group to drive both the decisions made by the SCSP and also drive innovation and pace in the dissemination of learning and practice developments.

Learning from Safeguarding Practice Reviews (SLPR) Subgroup

The Sandwell Learning from Practice & Review (SLPR) group, oversee the functions defined for responding to serious safeguarding incidents. This group meets on a bi-monthly basis and calls agencies in to the meeting to report on progressing recommendations and actions assigned.

The SCSP have formal arrangements to identify and review all serious child safeguarding cases which raise issues of importance and learning which can improve services and support to children and families in Sandwell. In these cases, independent reviews are completed, published and learning disseminated to all agencies and organisation.
Let's hear from the SLPR Subgroup DCI Dez Lambert as he describes what a CSPR is and why we do them:

- All serious incidents referred to the SCSP are reviewed against the qualifying criteria for a Rapid Review. Activities and compliance against this function for the reporting period are noted as:
- 2 Rapid Reviews during the year –
    - 1 progressed as thematic LCSPR facilitated via the 'Child Exploitation Board (CEB) due to the nature of the incident and the connectivity to exploitation;
    - 1 did not meet the threshold for further interrogation
- Published 4 LCSPRs from previous years, 2019/2020, each being delayed due to competing criminal proceedings;
- 4 further LCSPRs were ratified by SCSP during this period - all related incidents occurred in 2020 and at the height of the COVID pandemic.
- **National reviews: NAI in babies, JTAI**

Key learning themes taken from the LCSPRs during this period include recommendations that partners should:

- Ensure that the voice of the child or young person is heard, and their lived experience is captured appropriately by those working closely with them.
- Seek assurance about how agencies approach working with parents who have learning difficulties/disabilities.
- Improve communication between Adult and Children's Social Care services when a parent has, or is suspected to have, a mental health condition.
- Seek assurance about the quality of assessments and pre-birth procedures.
- Recognise and work within the appreciation of Sandwell being a multi-racial, multi-religious, multi-language and multi-cultural borough, therefore all our policies, procedures, practice and services should positively acknowledge, reflect and respect this fact, and position ourselves towards being a more culturally appropriate partnership where all Practitioners are:
    - Knowledgeable about cultural differences and their impact on attitude and behaviours;
    - Sensitive, understanding, non-judgmental and respectful in dealing with people whose culture is different from your own;
    - Being flexible and skilful in responding and adapting to different cultural contexts and circumstances.
- Routinely capture the voice of fathers/significant male carers and whole family view needs to be visible in assessments and records by frontline practitioners. This ensures a rounded and holistic view of the entire family to enable practitioners to make effective and informed decisions when safeguarding the child or young person including decisions based on risk.
- Ensure that partners work closely with agencies from other authorities when there are cross-border concerns in any safeguarding enquiry.

- Seek assurance that staff and agencies are able to effectively manage risk and that assessments of any kind are live documents which should be updated and triangulated with any significant event.
- Learning identified through reviews reinforces the rational for the priority areas and associating subthemes.

Some of the improvement work arising from national and local serious incidents, and safeguarding practice reviews:

- Development of training for SCT on unregulated placements, and a briefing for all partners to be aware of the basics and know where to go for further support
- Special Guardianship Order policy has been revised and led to targeted support for special guardians as it was recognised they did not receive enough financial and emotional support. Dedicated post developed during the pandemic to support special guardians and links special guardians and connected carers for a seamless approach. Funding secured to recruit workers to give direct support.
- Identified gap in provision for perpetrators of domestic abuse which was raised as a risk to SCSP and is now a key area of focus for action
- Draft cultural competence framework devised as a result of learning from reviews to be launched in 2022 -23

What did we learn from 'Practice Reviews during 21/22

Case 1: Learning from National & Local CSPR's:

Published January 2022 – Injury to a non-mobile baby also a sample case used to inform the National Review *('The Myths about invisible men'*) published by the National Safeguarding Practice Review Panel in September 21:

What happened?
RS was a 4-month-old baby living with their parents and older sibling when they received potentially life changing non-accidental injuries.
The learning from this local review together with the findings from the National Review was shared at a local event 'Safeguarding Today' in February 2022, this introduced and launched the 'ICON' eLearning module (see meaning of ICON in image below) a programme that will help to keep crying babies safe by providing coping strategies, including:

What is Abusive Head Trauma (AHT) Also known as Shaken Baby Syndrome:

- Catastrophic injuries:
  - Brain injuries
  - Bleeding
  - behind the eyes
  - Bony injuries

Our goal for ICON is to communicate to parents/carers that they can expect crying, prepare for it and cope with it
Our aim is to reduce the incidence of AHT triggered by crying

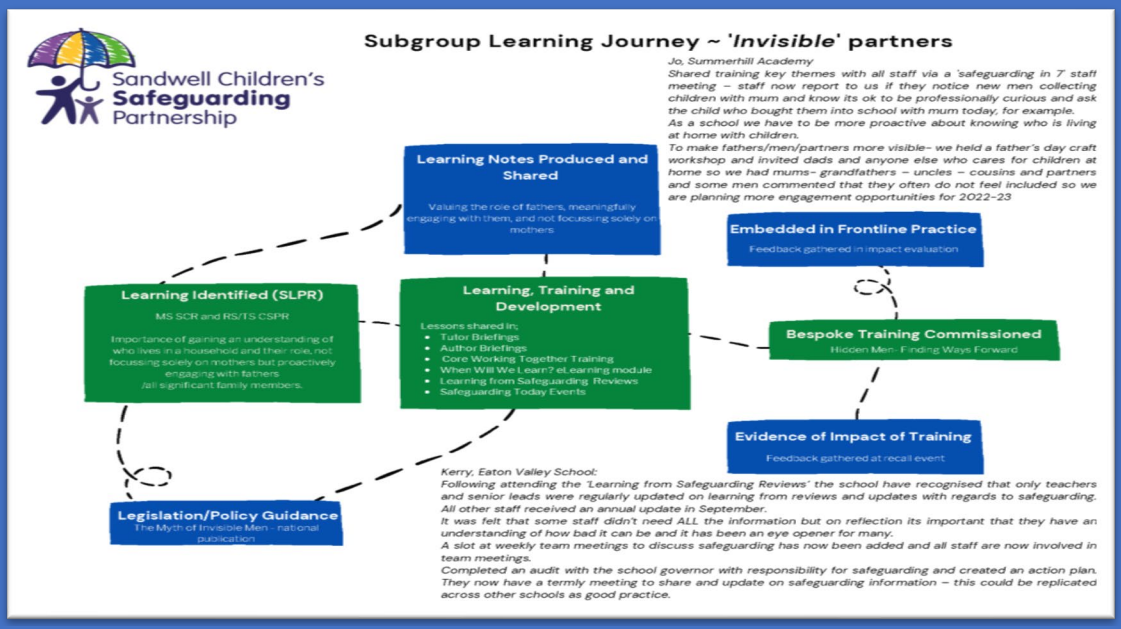
Facts about AHT;

- AHT is the most common cause of death or long-term disability in babies
- 24 out of 100, 000 hospital admissions for babies are due to abusive head trauma
- 200 children are killed or hurt annually in the UK, these figures underestimate the real numbers involved

Case 2: Using feedback to shape, influence & improve how we work together

Direct feedback from parents of children who have died/been seriously injured has shaped reviews and learning: Father of WS told the reviewer: ".. *"I was invisible to professionals who would direct all conversations towards mother, it was only when I insisted or initiated conversations that I was spoken to".* He went on to say … *"and this would always lead to some confrontations as it was thought I should either not be there or be silent and 'spoken' at when I am there.* The quote from father that really resonated with partners at all level and positions in Sandwell was his final statement; ***"Men don't matter, we're not there, looked past, not important"***. When it comes to children, and when we say something, it is suggested 'aggressive', it's like we can't win."

Case 3: Showcasing our Learning Journey



What difference did we make and where to next?

We made an impact by;
Providing a diverse safeguarding workforce with information so that they can reflect on their practice, identify changes and help to prevent the need for future reviews.
Acting on the wishes of family members affected by the incidents that resulted in a report by demonstrating our willingness to learn and prevent future incidents.
Changing our processes so that we can get learning out of the Partnership more quickly to relevant agencies so that we can improve the pace of change.

Independent Scrutineer's reflection on the SLPR rapid review process:

Rapid Reviews are conducted well by the 4 statutory partners and there is careful consideration of the need for a Child Safeguarding Practice Review (CSPR). In one case, a decision was made to complete a CSPR and in another, partners appropriately determined that there would be no additional new learning obtained from conducting a CSPR.

Areas for consideration by statutory partners by statutory partners in relation to Rapid Reviews are:

- *To what extent are the actions to address the learning set out in the Rapid Review?*
- *How is the implementation and impact of learning from Rapid Reviews reported to Executive leads and also how is it monitored?*

The Quality of Practice, Performance & Assurance (QPPA) Subgroup

The core functions of the Quality of Practice, Performance and Assurance Subgroup (QPPA) is to assess the quality of the work we undertake to safeguard children and promote their welfare, by analysing and understanding the impact of both single and multi-agency work in terms of its effectiveness in helping to keep children safe.

The QPPA's remit include robust and constructive challenge to partners and escalate areas of risk where there are concerns about performance or the outcomes being achieved for children and families are evident through the quality assurance process, and data intelligence. This results in consistently reviewing the safeguarding systems, structures, processes and practice in place to improve outcomes and the experiences of children across Sandwell for its effectiveness.

The group is responsible for providing assurance that local practice is compliant with west midlands policies and procedures, legislation and guidance; and undertakes multi-agency audits, quality assures single agency audits and assesses the quality of agencies arrangements in relation to the Section 11 duties arising from the Children Act 2004, with similar monitoring processes across the providers of education in relation to Section 175 of Education Act 2002, and uses the SCSP quality assurance framework to monitor, challenge and hold partners to 'account' for the effectiveness of their intra safeguarding arrangements.

Ultimately, QPPA is accountable to provide evidenced based assurance to the SCSP of regular and effective monitoring of the multi-agency front-line practices. We identify where improvements are required in the services that children and families receive, including the effectiveness of early help.

To facilitate this core function, the Chair of this subgroup is also the 'Independent Scrutineer' for the SCSP and meets regularly with the Independent Chair, Safeguarding Partners, other subgroups Chairs and Business Manager of the SCSP.

Key achievements from 2021-22 work activities:

- Through our MACFA: Identified gap in resources to support practice, and devised and published Core Groups: Best Practice Guidance on Effectiveness of Core Groups;
- From a DHR recommendation, produced a Local Multi Agency 'Was Not Brought Guidance;
- Created a Multi-Agency Case File Audit (MACFA) Guidance for Professionals to encourage inclusion a clear understanding of the expectations required of all partners;
- Explored varying approaches to undertake MACFA functions based on Signs of Safety and root cause analysis to clearly chart the journey of the child and show the impact of consistent relationship-based work on improving outcomes for children.
- Undertaken a full Section 11 – with 100% response rate from agencies returns.
- Sought assurance from education directorate in response to S175/157 self-assessments functions, identifying the need for 'Safeguarding Governors' to be aware/inclusive in the safeguarding requirements and responsibilities for schools.
- Developed outcomes based Multi -Agency Quality Assurance Framework (QAF).
- At the primary stages in establishing a multi-agency Performance dataset, which will be invaluable in improving the line of sight, scope of information available and provide us with the data and intelligence to assess the effectiveness of the help being provided to children and families, including early help

- Highlighted need for practice improvement and resources in response to children who have experienced child sexual abuse, and the lack of availability of counselling – signpost to the 'Thrive' Board for action
- Joining the scrutineering activities to that of QPPA, has seen the need for the creation of a Perinatal Mental Health Support Pathway to be developed, this is underway via task and finish group;
- The recent introduction of a rotating agenda item of 'Single Agency Assurance Reports tabled at each meeting – in response to recommendations from former SCR's LCSPR's and MACFA work.

QPPA have within its portfolio, a duty to undertaken MACFA's each year. Each MACFA event considers the effectiveness of multi-agency practice across a random sample of cases (minimum 4) against a chosen theme. MACFA's themes during 21/22 are:

Theme 1: Emotional Wellbeing and Mental Health of Children and Young People

What did we want to know?	Access to and the effectiveness of services to support/address children's emotional & mental health concerns - The impact of COVID on children's wellbeing and the ease of access and range of support.

Strengths Identified: • Evidence of improved outcomes in case sample; • Schools provide high level of practical and emotional support for families; • Range of support offered by specialist and voluntary services; • Value of advocacy; • Positive impact of COGs (Early Help).	• **Areas for Improvements**: • Clarity on EWMH pathway including services and thresholds; • Level of support offered when crisis happens outside of standard hours; • Access and availability of counselling and management of waiting lists; • Review of school nursing pathway to minimise delay and ensure holistic approach; • Robustness of response to children who are victims of sexual abuse.

Recommendations:

1) The SCSP to be assured that the mental health offer (including pathways, services, roles and responsibilities) at all tiers of the system is: clear and effectively promoted so that practitioners understand the eligibility criteria for accessing services, including to CAMHS, and can proactively identify the appropriate level of support for children and young people. This assurance should include monitoring of increased emotional health and wellbeing needs of children and young people which may have arisen as a result of the COVID-19 pandemic.

2)The SCSP to be assured that there is a range of commissioned services for children who have experienced trauma, including availability and responsiveness of counselling for children who have experienced sexual abuse, and that interventions are responsive according to the needs of the child.

Actions taken/progress made:

- Update the Multi Agency Threshold document to include guidance on emotional mental health and wellbeing needs of children and young people,
- Health partners have completed an audit of children attending acute settings in mental health crisis services with findings presented to QPPA for assurance,
- Shared findings with *'Thrive Board'* to undertake a further review and provide assurance of the EMWH offer including availability of counselling to victims of child sexual abuse

Theme 2: Understanding & meeting the needs of Children with Disabilities (CWD)

What did we want to know?	• The effectiveness of support to CWD, the impact of intervention in: meeting their needs, • capturing the voice, culture and identity as part of assessments, plans and direct work; • How well do practitioners understand/consider the holistic needs of CWD • Impact of COVID on timely access to support

Strengths Identified:	**Areas for Improvements:**
• Passion/knowledge of staff; • Positive impact of special schools and Early Years support; • Case samples received face to face appointments during lockdown • Community Nursing Team well sighted on needs and issues	• Availability of support and impact when panel decisions delayed; • Trauma of families being passed between services and there is little or no change in circumstances • Need for holistic whole family approach • Clearer multi agency working • Inappropriate unsafe housing • Availability of childcare/transport • Need for basic multi agency training on disabilities

RECOMMENDATIONS:

1. SCSP statutory partners to present the findings of this audit to the Children and Families Commissioning Partnership to highlight:
   (a) the lack of assurance in relation to the implementation of key learning arising from a local Child Safeguarding Practice Review completed in 2021;
   (b) The experience of children with disabilities and their families in receiving the right support, at the right time and according to their specific needs

2)The Chair of the Children and Families Commissioning Partnership to formally respond to SCSP in respect of timeliness and availability of support services to children with disabilities;

3) SCSP to gain assurance that a 'Think Family' approach to include considering the impact of the disability on wider family members and their individual needs (including fathers and siblings) is applied when working with children/families with disabilities.

Actions taken/progress made?

- The independent scrutineer presented the findings to the Children and Families Commissioning Partnership to highlight the lack of assurance following the audit, a recent LCSPR and the experience of CWD and their families in receiving/not receiving support
  - Further work planned to understand barriers to engaging/assessing CWD and planned future updates to L&D catalogue to reflect feedback

Theme 3: Working with Children Missing from Education

What did we want to know	How multi agency statutory plans address educational issues and how well this is monitored and progressed

STRENGTHS	AREAS FOR IMPROVEMENT
• Evidence of trusting working relationships • Tenacity and commitment of Horizons work • Evidence of appropriate use of National Referral Mechanism	• Impact of issues that begin to emerge in primary school on secondary attendance • Timely identification of a child needing EHCP • Oversight of EHCPs by private providers • Limited evidence of school nursing involvement if no physical health need • Need more vocational provision for CMFE • Improve the interface between CIN and MACE

RECOMMENDATIONS:

1) Safeguarding Partners to increase awareness across the workforce of the factors identified as impacting on children not attending education to aid practitioners to work collaboratively to meet the educational needs of this cohort of children;

2) Safeguarding Partners to increase awareness amongst education settings of the significance of issues that emerge in primary school on secondary school attendance and explore best practice in transitions between primary and secondary education settings to ensure children receive consistent support;

3) Safeguarding Partners to formally present the thematic learning in relation to the Emotional Wellbeing and Mental Health Pathway to the THRIVE Board with a request for assurance about the issues raised;

4) Safeguarding Partners to evaluate the work to date to improve the quality of multi-agency assessments and plans, including EHCPs linked to wider learning from Rapid Reviews and CSPRs, to identify what else is needed to support these critical areas of safeguarding practice;

5) Sandwell Children's Trust to provide assurance that the timeframes for completion of CIN assessments and frequency of CIN reviews is routinely monitored;

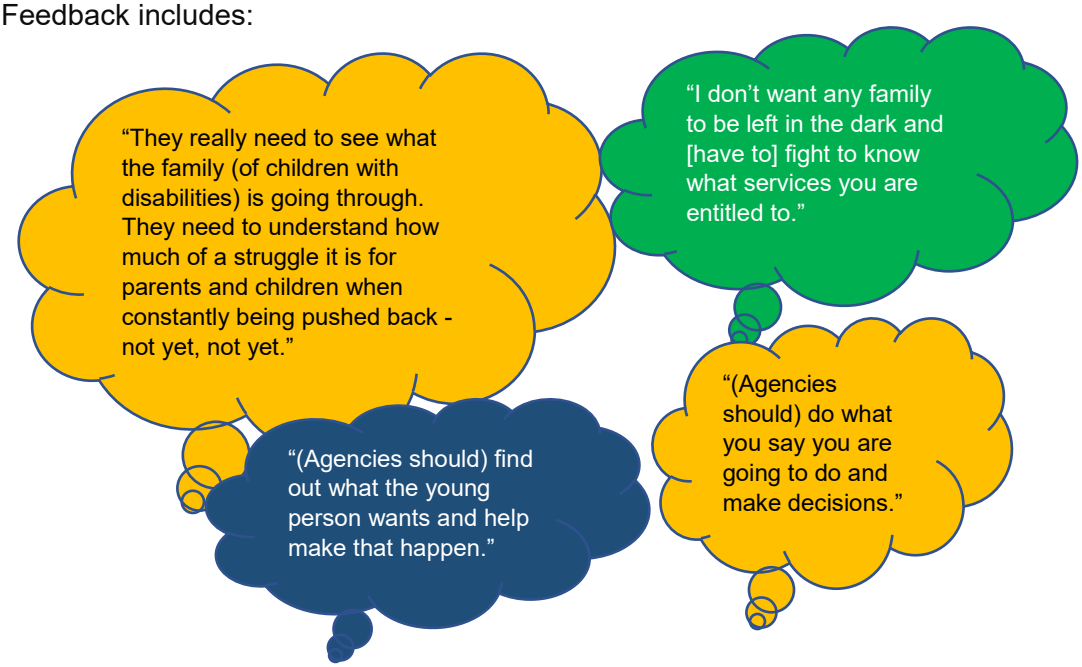
6)The SCSP to be assured that CIN and MACE processes work effectively together.

Actions Taken/progress made:

- Review and update L&D offer to ensure practitioners know how to complete good quality assessments and planned training to increase awareness of early intervention when issues emerge in primary schools (also linked to learning from SC CSPR)
- Single agency audit (SCT) on quality of assessments and plans
- Golden thread of safeguarding assessments included in updated Multi Agency Threshold Document and aligned to all training courses

MACFA's reach during this period extended and invited children, parents and families to comment on their experiences of interventions, and the impact of services received. This added contribution enabled partners to really understand the child and family's lived experiences and what has worked/needs to change.

Feedback includes:



QPPA work for 22/23 will include:

- Development of full partnership dataset enabling challenge, transparency and accountability via a clear line of sight on data from all partners. This will enable identification of good practice, gaps and where to target focussed multi agency activities.
- Implementation plan to launch aligned to QAF and enable partners to own and have accountability for all quality assurance activities
- Strengthen impact evidence across all multi agency activities to show the difference made as a result of actions taken, i.e. as a result of MACFA recommendations. Ensuring recommendations/actions are outcome focussed
- Seamless approach to inclusion of child/family in MACFAs and continuing inclusion of voice of practitioners
- Build on links between subgroup areas and other key reports via an annual programme of presentations e.g. CEB workplan/data, LADO annual report etc
- Surveys (e.g.) to ensure practitioners are receiving/know where to access/are using published items e.g. Core Group guidance.

The Learning & Development – L&D Subgroup

Supporting the SCSP in maintaining a skilled workforce to carry out the functions:

The L&D subgroup is responsible for the development and delivery of multi-agency safeguarding training across the children's workforce. The Subgroup undertakes a regular training needs analysis and evaluations of local training. It links with adult safeguarding training in relation to mental health, Prevent, Contextual Safeguarding and Domestic Abuse. The subgroup leads on Conferences and has a pool of practitioners who deliver most of our local safeguarding training.

The L&D group is Chaired by the MASH Education Officer, who also coordinates the safeguarding training for Education, provides support and oversees the operation of the DSL (Designated Safeguarding Lead) forums for our schools.

The Learning and Development Subgroup is responsible for the identification, planning, delivery and evaluation of training to ensure all those coming into contact/working with children in Sandwell are competent and up to date with current legislation and procedures to help them safeguard and promote the welfare of children effectively.

The subgroup ensures that policies and procedures are in place relating to training people who work with children and young people or in services affecting the safety and welfare of children. The group oversees the provision and evaluation of safeguarding training across the children's workforce. It also ensures that our learning and development activity takes account of developments in national and regional policy and practice, as well as relevant research, and implement recommendations from national, regional and local reviews, including safeguarding practice reviews, MACFA's, DHR's and SAR's where there are relevance to learning and development.

What we were most proud of in 21/22:

The SCSP Annual Conference in June 21 '*Is Neglect being Neglected?*'. Using evidence-intelligence to raise awareness on why neglect is a priority for SCSP, to provide relationship/strength-based approaches/strategies to tackle neglect together.
The conference was captured in visual minutes, as illustrated in the image below:

Other achievements from L&D during 2021-22

- ✓ Produced Training Guidance & Expectation document;
- ✓ Reinstated and extended the SCSP Training Pool;
- ✓ Facilitated two 'Safeguarding Children Today Events;
- ✓ Overseen and support the GCP2 Training;
- ✓ Extended our suite of eLearning programmes;
- ✓ Published, and monitored the reach of the SCSP Multi-Agency Training Programme;
- ✓ Enabled 111 courses to 2365 delegates on the following topics
- ✓ Early stages of implementing an training evaluation process

The SCSP introduced its Multi-agency Was Not Brought Guidance devised in response to learning from a Domestic Homicide Review and linked to the 'Tackling Neglect work; **Rethinking 'Did Not Attend'** video has been embedded in training,

Post Training Feedback from Delegates:

Spotlight on the impact of 'Core Working Together' training

CWT 18/01/2022: *The training has completely refreshed/recharged my knowledge around Safeguarding and provided me with more emphasis on improving good practice going forward.*

The training has enabled me to reflect on my practice.

One of the benefits, after I and my colleagues attended the training is that the college is reviewing cases a great deal more and on a wider basis, we have introduced weekly supervision by the DSL of our active cases and this is ensuring that safeguarding staff (including myself) are more confident in our judgements and we have a wider forum in which safeguarding staff can pose questions relating to cases within a safe environment.

I have personally found that my own recording of cases has improved greatly and has become more child centred in my approach. For example, I have recorded more on the impact on the child in my records including noting on what they want to happen next. This good practice is wider than myself and includes members of my team.

I do believe that I have become more confident to have faith in my own professional curiosity and this is something that I have expanded to all staff in my organisation by (I hope) giving them the confidence to follow their gut instinct. This is certainly something that I communicate in the staff training that I deliver.

Were there any barriers to implementing learning?

None however being new to Sandwell more of an overview of the system and meetings, process etc would have been helpful. Greater understanding of how things are done in Sandwell. No introduction becoming a new DSL. Was not aware of the EH training available. New to Sandwell programme/training would have been useful.

The above in respect of safeguarding induction for new staff was also identified as an area for improvement from the s11 activities undertaken by QPPA. L&D are currently undertaking work to address this issue and similar concerns raised that new staff need induction/introduction to training prior to attending the wider training offer as detailed in the SCSP Training Guidance and Expectations document.

Next steps for the L&D

- A key aim for the year ahead in order to support the networking function of training we have agreed to return to in-person events as soon as it is possible to do so, in a way that is equitable to all colleagues (i.e. does not exclude those who may still need to practice caution with social contact).
- We will produce our training plan setting out how we will deliver both multi-agency training and learning and development opportunities. This will include a range of methods, including commissioning subject experts, in-house/partner subject experts and experts by experience. Practice development will use methods, such as action learning sets, competency framework, a range or resources and practice tools and we will seek to speed up the dissemination of learning from reviews, including the full range of practice reviews, MACFA's and regional, and national publications using accessible methods, such as 7 minute briefings, animations, commissioned creative pieces, videos and TED talks (using visual platforms).
- We will undertake a Training needs analysis
- Maintain our training pool
- Monitor the impact of training on practice with a focus on 'Early Help', working with men and significant others, and implement our cultural competence framework.

The SCSP Priorities:

In addition to its 'core function, as covered to this point of the annual report, the SCSP and partner agencies have prioritised improvement in areas and on issues of greatest risk and concern to safeguarding as well as responding to emerging needs.
The themes below are identified as the strategic priority areas, each has formed the basis of some the partnership activities over the year.
The priority areas to follow are:

Priority 1: Contextual Safeguarding – via the Child Exploitation Board (CEB)
Priority 2: Tackling Neglect - via Tackling Neglect Subgroup
Priority 3: Early Help – via Early Help Partnership.

The Child Exploitation Board – CEB

Traditionally, the focus of children's safeguarding has been on risks to children which exist within a family context such as abuse or neglect. However, Contextual Safeguarding recognises that children as they grow in age spend increasing amounts of time outside the family and in other 'contexts. These are often outside of the influence of families but as we now know and must consider, can/does have an effect on them.

These are referred to as 'Extra Familial Risks' and can include youth violence, gangs, involvement in crime and county lines/trafficking and child sexual exploitation. Children may be vulnerable to abuse or exploitation in peer groups, the wider community, or online as well as by adults.

The overall purpose of the CEB is to have the strategic oversight of what is done by partners in Sandwell, individually and collectively, to safeguard and protect children at risk from all forms of exploitation.

CEB is Chaired by the Head of Service from SCT having a remit for Sandwell Horizons (the local CE team and has a multi-agency membership consisting of key representatives from partner agencies across Sandwell.

The fundamental work of this 'Board' is to develop Contextual Safeguarding Practice according to the following set of 6 principles:

1. **Recognise and Respond**: understand recognise and respond to young people's experiences of harm beyond their families (extra familial risk)
2. **Assess and Intervene**: Develop effective tools to identify, assess and intervene when extra familial risk and harm are suspected
3. **Expand our Vision**: expand our vision of the child protection framework and referral pathways to incorporate extra familial risks & harm
4. **Work in Partnership**: engaging with individuals and all agencies to reduce harm and increase welfare
5. **Capable and Competent Systems**: Ensure our systems are capable and competent to work contextually, looking for opportunities to develop shared resources and systems, particularly in the Early Help and Preventative areas as relevant
6. Monitor Outcomes: Monitor outcomes of success in relation to contextual, as well as individual change.

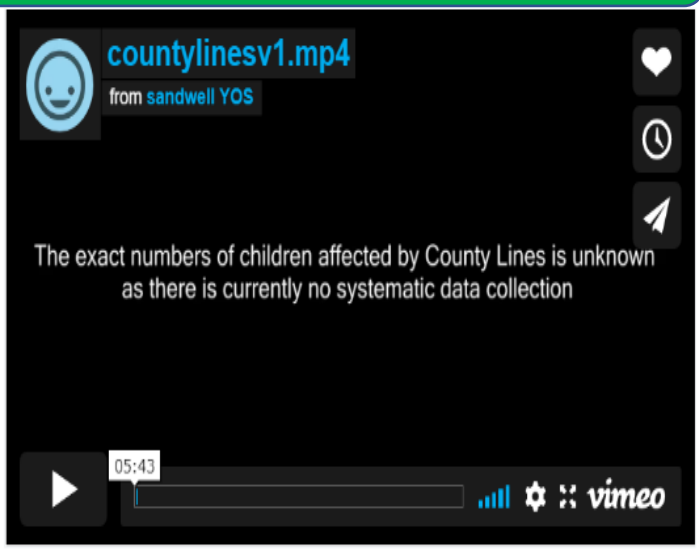
The planned work and activities of CEB for 21/22 was redefined mid-term in response to a serious safeguarding incident where the outcome of a Rapid Review determined that the line of enquiry to be explored by a Local Review aligns to existing/planned activities being undertaken to tackle criminal exploitation via this CEB group, and much of the work for the period, was by way of a focused systems-based analysis used as the format for producing a local 'thematic CSPR exploring:

- The disproportionality of cohorts involved in exploitation: this in particular needs to address how black children are seen and perceived by the youth justice and the safeguarding systems, particularly in the context of exploitation and gang activity
- A spotlight review of the cohort of children known to or at risk of exploitation linked to school exclusions, CME, and/or have an EHCP/SEND which will lead to raising awareness of more targeted interventions and strengthen processes.

The outcome and finding from the completed report present a number of recommendations for individual agencies, the SCSP and nationally for policy makers. The report once published will be available in the public domain, however in the meantime, actions are being progressed at a local level.

Some of the work, activities and discussion items at the CEB during 21/22

1. A summary of the activities undertaken during 'County lines week,
2. A podcast was undertaken with a young person who shared his experience of County Lines which is a powerful example of using the child voice and has been shared at both the CEB and the YJPB and is being used for training material across the partnership



Some of the activities, developments and progression by agencies across Sandwell as members of the CEB to enhance the wider understanding and response to 'Contextual Safeguarding'

The Youth Forum has become integral to the YJS in ensuring the young people have a voice in service delivery. It has become more established over the last year and the young people have had an active role in designing the new YJS website. They have been consulted in relation to content, layout and pictures used in the website have given invaluable feedback from a youth perspective. We have even had our new YJS logo created by a young person, with them working alongside an established artist to create a design that encapsulated the YJS ethos of being a creative service. The young person who designed the logo when asked why she chose a butterfly stated that "It's because when we come into the YJS we are all like caterpillars but by the time we leave, because of all the support we get, we have become butterflies".

SANDWELL YOUTH JUSTICE SERVICE
CREATIVITY & EXPRESSION

Changes in terminology used;

Sandwell Youth Justice Board Partnership is committed to the Child First principles. This was evidenced by the Boards decisions in August 2021 to change the name of the service from Sandwell Youth Offending Service to Sandwell Youth Justice Service in order to move away from the stigmatising language of "offending". This has led to the development of our "Getting to Know You" pack which is a 6-session relationship building tool which gets practitioners to understand the youth's lived experience through their eyes by completing creative sessions around identity, relationships, life story and, future dreams and aspirations.

No longer using '*hard to reach* young people because someone is reaching them to exploit them so that's about us and our practice not the young person being hard to reach'

Think 'Victim' not 'Perpetrator'

Here's what *Louise (Chair of CEB) have to say about the use of language*

Plans for 22- 23 will see CEB maintaining abreast of our current work, following through the lifespan of the existing workplan ending in March 23

In addition, will continue to monitor the actions and recommendations from the thematic LSCPR overseen by this 'Board'

Tackling Neglect Group

The most recent subgroup to be established in 2021, the 'Tackling Neglect subgroup' has a mandate to take forward the Neglect agenda for the SCSP, this includes:

- Implementing and reviewing the Neglect Strategy and guidance
- Improving awareness of neglect, the harm it causes and how to report and prevent neglect
- Improve the early recognition and identification of neglect across the Partnership
- Identify a clear pathway for support and intervention at the earliest stage
- Establish a collective understanding and threshold for intervention where neglect is a concern (i.e. referral pathways).
- Review and promote the agreed GCP2 Neglect toolkit and ensuring that supporting training is available
- Reviewing the reach and effectiveness of neglect training, including GCP2 across the partnership,
- Identify key learning and messages to be incorporated into the SCSP multi agency training programme.
- Analyse the impact and effectiveness of interventions to address neglect

To demonstrate the activities of this recently formed group, we will start by hearing from the Tackling Neglect Subgroup Chair – Jayne Clarke (Safeguarding Children Lead Sandwell & West Birmingham NHS Trust) as she talks a little about the position of Neglect in Sandwell.

Jayne, Tackling Neglect Subgroup Chair: "*We recognise that we are obviously not identifying it [neglect] soon enough so children are being left in that situation much longer than they should be. So, one of the key things we are doing is rolling out some training around the Graded Care Profile which is a well-researched assessment tool. We're making sure all our practitioners out there; that can be across your social workers, your housing people* so they've got an awareness of neglect, so that if you've got someone going into a home, it might be a housing person they can see things and think, 'well actually this doesn't look quite right', so that they've got the knowledge and awareness and can take it through to their safeguarding leads. We're doing a lot of work around that. We're starting to, this is very early days, look at some data – we're going back as early as when women are pregnant because if mum isn't accessing antenatal care, then you could say that that is neglect because that child's growing needs in the womb are not being met. Around the [Tackling Neglect] strategy we are raising awareness around the whole area. we have in Sandwell an unborn baby network which is particularly for that reason because what we have recognised* ***is the best way forward is that early help and early intervention,*** *not waiting until things are going wrong it's about offering every opportunity to families that they can with support actually put things right"*

Feedback from Tackling Neglect Training introduced during 2021

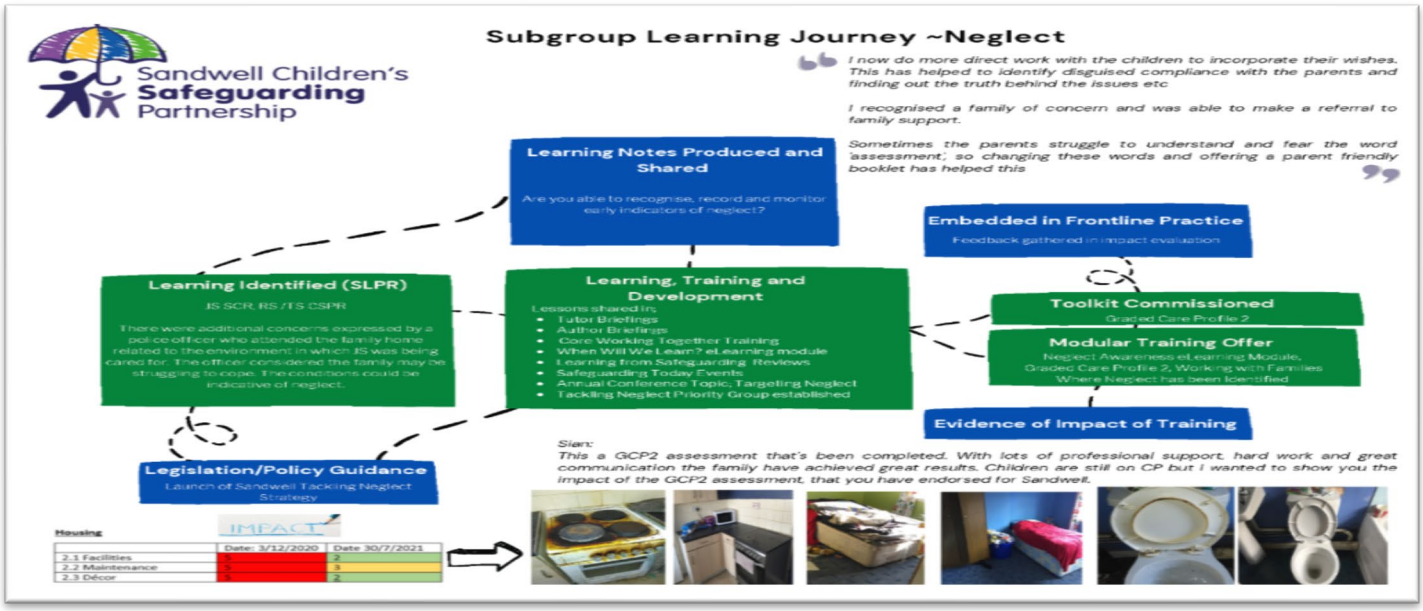
*350 neighbourhoods' employees have been trained in neglect and exploitation awareness.

Feedback received from delivering the neglect sessions was regarding staff already seeing properties where neglect could be a possibility but thought that was what Sandwell was like, following the training they now realised that they needed to report it in.

Staff also raised concerns with regards to reporting neglect and the tenants being aware that they had reported it, they were concerned for their own personal safety due the fact they have to return to properties to conduct work, we had this concern on numerous sessions. One gas engineer gave an example of a property he reported in where the female of the property was always in bed no matter what time of day he went round, the man living at the property had lots of large knives around – machetes & swords, drugs were lying on the coffee table, children were at the property. He had to return to the property after reporting it and the man at the property stated he was aware that the gas engineer had reported him, he stated this had now put him off reporting anything in again. (Trainers advised they would meet with the managers to discuss his concerns, they looked into it and it wasn't a children's social worker it was a housing officer who told the tenant, so the Business Manager over this area has gone back over confidentiality process with them and we have also told them to utilise the repair as a reason for going to do a visit, instead of stating a safeguarding concern had been raise, to go and complete a visit and explain to the tenant they are there to review the repair job, obviously then once they have access they can see for themselves)

Things that have changed since we delivered the sessions and now an audit of 9000 properties is taking place in regard to 'decent homes' review, our Housing Officers now have to complete more home visits, so we are expecting to have greater visibility of our properties, hence why we have such a large training programme coming up for everyone.

4672 individual referrals, 510 identified a form of neglect – 11%



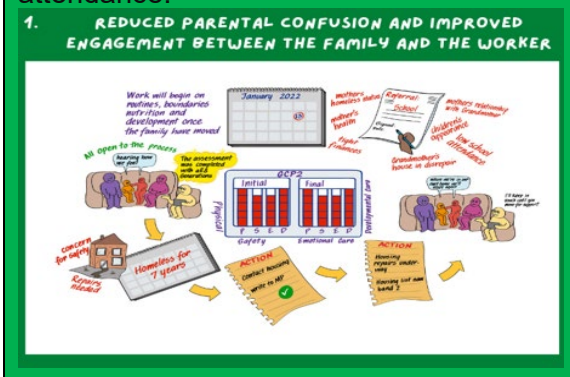
The Tackling Neglect subgroup closely monitors the impact of GCP2 – (the NSPCC founded assessment tool) used for effective engagement with children and families where 'neglect' is of primary concern

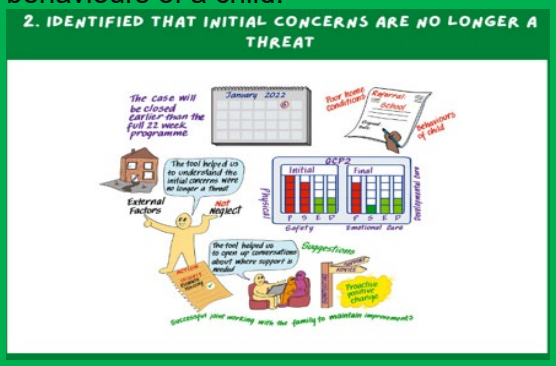
Some of the comments received from practitioners having used GCP2 includes:

- It gives a visual display of scores and progress being made which helps the family and professionals.
- It opens up conversations about how to make improvements.
- The tool was useful in breaking down areas of parenting makes it much clearer and not so overwhelming –
- easier to explain and talk about.
- It helped us to identify where support was most needed.
- It helped us to identify other areas of positive parenting and areas of concern
- Using the tool and parent friendly leaflet reduced potential confusion and improved engagement between the family and worker.
- It has helped parents understand how what they are doing has an impact on the children.
- It helps them see what they are doing well and where they need additional support.
- It helps us work together towards an end goal/ outcome.

The Tackling Neglect group review cases for evidence of the impact of GCP2 with families in Sandwell during 20/21

Click on the links below each image to hear more about the outcome of work with 6 families

<table>
<tr>
<td>Case 1: Referred from school because of missed medical appointments, deteriorating home conditions, and poor school attendance.
 

1 https://youtu.be/3yESVVTsJkk</td>
<td>Case 2: The referral came from school due to concerns of poor home conditions and behaviours of a child.
 

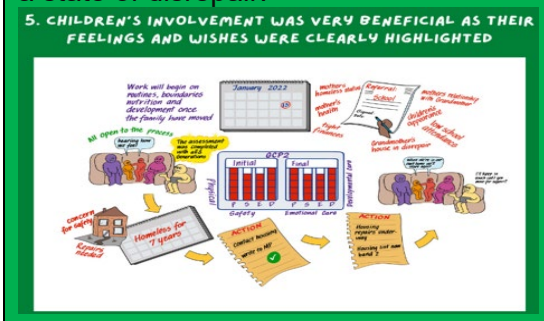
2 https://youtu.be/kUjh14Yh6OA</td>
</tr>
<tr>
<td>Case 3: Referral came from the health visitor with regards to the child's development and housing conditions.</td>
<td>Case 4: Referral from School, family already on an Early help plan, concerns about condition of accommodation, history of antisocial behaviour with the children's father is affecting new accommodation</td>
</tr>
</table>

3 https://youtu.be/H8JSCGKuK00

being found.

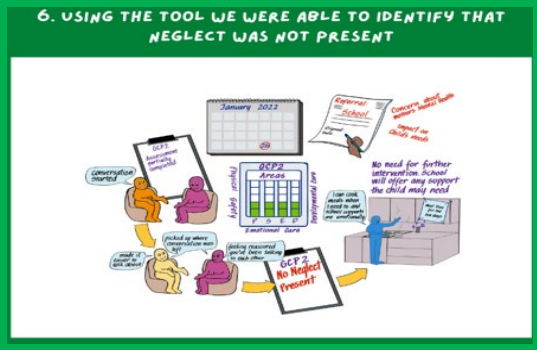
4 https://youtu.be/8fYJkAnvq4w

Case 5: Referral due to homelessness of mother following breakdown of relationship with her own mother. Mum's health with is poor; suffers with COPD. Children living with grandmother. Low attendance at school. Children can present as unkempt, finances are very tight, and the house is in a state of disrepair.



5 https://youtu.be/sNvTV3MQuKE

Case 6: This referral was made through school due to concerns about the mother's mental health impacting on her parenting capacity and meeting the child's needs.



6 https://youtu.be/lSJQvgJjrZY

Next steps and plans for the year ahead for the Tackling Neglect Subgroup:

During 22 -23 The Tackling Neglect subgroup will:

- **Continue to deliver on the mandate as provided and monitored for progress by the SCSP, as well as:**
  - raise the profile of the group,
  - Build and maintain the momentum following the conference, the launch of the Tackling Neglect Strategy, and establishment of this subgroup,
  - Grow the membership ensuring that it is representative and able to communicate to all agencies, as well as children, young people and families.
  - Establish a dataset to assist us in understand the extend/range and areas of prevalence of neglect
- Forge stronger connections to the work and activities of the Early Help Partnership

Early Help

The provision for early help for children and families in Sandwell fits within the remit of work undertaken by the Children & Families Strategic Partnership. The arrangements sees a subgroup in place made up of multi-agency representatives from across multiple statutory community and voluntary sector services, who together are known as 'the Early Help Partnership' (EHP)

The group is Chaired and driven by large under the auspice of the affiliated Sandwell Community & Voluntary Organisation (SCVO)) representing in excess of 500 local groups.

The relationship between the EHP and the SCSP have its basis from legislation, in that; through the EHP 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 should work with organisations and agencies to develop joined-up early help services based on a clear understanding of local needs. With the SCSP having a statutory duty support the EHP via the production and publication of a threshold document, setting out the local criteria for action in a way that is transparent, accessible and easily understood, including the process for the early help assessment and the type and level of early help services to be provided.
The SCSP are also mandated to:

- assess the effectiveness of the help being provided to children and families, including early help and have access to data and intelligence for this purpose.
- Evaluate and evidence the impact of the work of the safeguarding partners and relevant agencies, including training, on outcomes for children and families from early help to looked-after children and care leavers.

In June 2021, shortly after the arrival of a new 'Chief Officer' for Sandwell Children's Trust (SCT), the question of Early Help was posed to the SCSP: seeking to establish if the SCSP are aware of the position of EH in Sandwell. Where are we up to, and what do we need to do?

Data presented justified the challenge showing:

1. High demands for EH support.

HIGH LEVEL YE	Mar19	Mar20	Mar21	Grand Total
Grand Total	3357	3194	3149	9700

2. A depleting resource bank of allocated 'lead professionals' registered on the EH recording system.

Year	Total
Jan-16	1645
Jan-17	1521
Jan-18	922
Jan-19	1295
Jan-20	1161
Jan-21	1060

3. The numbers of staff attending EH training decreasing year on year.

2018	2019	2020	2021	Total
48	34	46	12	140

The SCSP recognised the position of the EH approach was unsustainable and agreed changes required to ensure that children only enter our statutory system when it's appropriate to do so.

The commitment made by the SCSP included to:

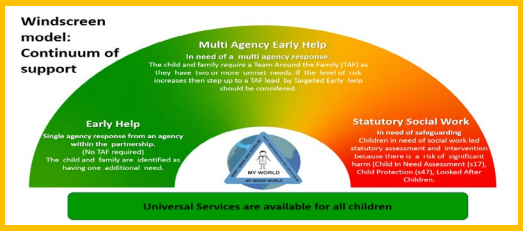
1. increase oversight and scrutiny of early help and its effectiveness,
2. ensure the EHP review the definition of early help, what this means in terms of a joined-up approach to early help across the borough,
3. review its levels of need and what this means for families accessing services at the earliest possible point
4. oversees a multi-agency review of our front door, with a specific focus on: integrated systems & processes; evidence-based referrals; and how best to work with and advise our partners where there are potential safeguarding concerns
5. to access independent insight, scrutiny and challenge in undertaking the above review.

What did we achieve by the end of March 2022

- Multi-agency Early Help workshops attendance from schools, the voluntary sector, police, youth service, education service, school nursing, health visiting, Sandwell Children' Trust, public health, community safety, CAMHS, GP's
- Multi-agency Task and Finish Group to create /shape action plan
- Consult with stakeholder groups
- Consult with Children & Young people
- Devised Early Help Strategy and action plan.
- Consulted with SCSP in refreshing the 'Windscreen Model'.
- Completed the review of 'Front-Door' and associated action plan

Launch the 2022 – 2024 Early Help Strategy in March 2022,

"*Early Help in Sandwell means 'providing support as soon as the problem emerges, from the early years in a child's life and right through to their teenage years (or up to 25 years in the case of young people with Special Education Needs and Disabilities). Early Help is known to be effective in preventing issues and problems becoming acute, chronic and costly to the child, young person, the family and the wider community. Reducing the need for intrusive and more expensive statutory services is also key to help sustainably manage resources across all partner agencies. Early Help requires a whole-family approach, involving both children's and adult services. Early Help is therefore a collaborative approach, not a service.*



4. Independent Scrutineer Activity & Reflection

The report to this stage captures a quantity of the activities undertaken by the SCSP and its subgroups during 21 -22. As reference in the introduction, the SCSP have within its structure, the role of an 'Independent Scrutineer. To ensure a line of sight across all our activities, the 'Safeguarding Partners agreed an annual programme of scrutiny for the period 2021-23; the programme is reviewed and revised in response to new/emerging issues identified at a local or national level.

Below, the Independent Scrutineer, Liz Murphy talks about her role in Sandwell, and goes on to report on the activities undertaken as part of the annual programme of scrutiny:

Review of ongoing support provided to children born during lockdown once the period of statutory social work involvement ended. This work was in response to a letter received from the children's minister and was complimented by a multi-agency audit that more closely analysed the quality and impact of the service provision to a sample of this cohort of children.

Review of multi-agency front door to include understanding and application of local thresholds document

Review of domestic abusing screening arrangements and the follow up response to children exposed to domestic abuse.

In relation to arrangements to identify and review serious child safeguarding cases, I have been invited to participate in the two rapid reviews that were completed during the reporting period. I have also had some oversight of completed Serious Case Reviews/ Child Safeguarding Practice Reviews if they are presented to the Sandwell Children Safeguarding Partnership and I am in attendance to present an item.

In addition, the Independent Scrutineer also chairs the Quality, Performance, Practice and Assurance (QPPA) subgroup and regular reports of the outcome of the activity undertaken to evaluate the effectiveness of safeguarding practice in the borough are made to the Chairs Consultation Forum and/or Sandwell Children Safeguarding Partnership

In terms of high-level feedback on findings from each review/evaluation, Independent Scrutiny activity has found:

- *Committed and knowledgeable practitioners from across the Partnership in MASH and involved in Domestic Abuse triage arrangements. They work collaboratively because they recognise the value of multi-agency working.*
- *Consistent evidence that statutory thresholds are appropriately applied by Sandwell Children's Trust at the front door.*

- *A comprehensive domestic abuse needs assessment has been completed and identifies the need for a holistic family support model to be developed.*

- *There are 2 thematic areas for development arising from independent scrutineer activity:*
    - *The need to develop collective responsibility for the delivery of early help including for children and families who "step down" from statutory safeguarding intervention. This would mean early help becomes a shared endeavour/way of working as opposed to being seen as a "service" provided by Sandwell Children's Trust COGs (now known as Strengthening Families).*
    - *Linked to the above, the need to develop a shared and consistent application of the threshold for statutory social work intervention amongst partners who make referrals to Sandwell Childrens Trust. The quality of referrals is also an area for development for partner agencies*.

The Independent reflects on the other activities undertaken by the SCSP and the wider work of the subgroups during 2021 - 22 and offers the following:

Some of the challenges/barriers to either making progress in implementing and/or evidencing impact of actions taken to drive improvement include:

- *Time period required between planning/implementation and evaluation phases to be able to measure impact of action taken*
- *For some activity, clarifying and /or strengthening governance arrangements*
- *Embedding an outcomes focused approach to performance management and quality assurance*
- *Maturity of the partnership arrangements/culture of partnership working*

As outlined above, partners have put in train a series of actions to respond to the findings of Independent Scrutiny and they have also reviewed the governance arrangements during the period covered by the report.

Through the QPPA subgroup, the partnership has been developing an outcomes focused quality assurance framework. This took longer than anticipated and will now be implemented in 2022-23; the delay can be attributed in part to the need to clarify the types of information partners can provide to support an outcomes focused approach. The revised quality assurance framework is intended to support a shift away from "process" driven responses and is indicative of a partnership that recognises the complexity of its work.

Enabled by the Independent Chair, statutory partners are continuing to develop both the leadership and challenge they provide, and this will serve to further develop a culture of shared ownership and responsibility for delivering and evaluating the impact of safeguarding services to children and families in Sandwell.

One final reflection from the Independent Scrutineer is for statutory partners to consider is how system and practice learning from National Child Safeguarding Practice Reviews e.g. "Safeguarding children under 1 from non-accidental injury caused by male carers" informs action taken at a local level either within individual organisations/sectors or at a partnership level.

5. Snapshot across Single Agency Activities

This year's annual report of Sandwell Children's Safeguarding Partnership predominately focuses on the activities covered by the SCSP over the period.

However, and as critical for safeguarding and promoting the welfare of children, there are lots of really good work happening all over Sandwell and provided by multiple organisations.

Let's hear from a few:

YJS Prevention

The Prevention offer for Sandwell is encapsulated in the Early Help Strategy.

Moving forward we want to be able to clearly articulate the prevention offer specifically in relation to youth justice as police colleagues in Sandwell have developed a sophisticated prevention offer that includes Early Help Police officers and School Liaison officers as well as an officer specifically dedicated to our Pupil Referral Units. The work undertaken by them ensures that young people have their identified needs met and will also seek to integrate them into positive activities in the community.

DECCA Evidence of impact

In mid/late December 2021 DECCA received a referral for a young person using heroin and crack cocaine. Working in partnership with Cranstoun, the adult equivalent to DECCA, we were able to access their prescribing service and get the YP on to a substitute medication prescribing regime before the Xmas break. This, and the 1:1 work we did, provided support for the YP immediately and started the process of change.

DECCA and Cranstoun have continued to work in partnership since then to meet the needs of the YP. The YP has been mainly drug free, a major achievement, and somewhat of an anomaly, for a class A drug user, with only one relapse, confirmed via a drug test, in the last 3 months. All other tests have been negative for class A drugs use so we can clearly evidence this fantastic achievement.

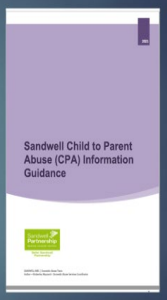
Building the relationship with the young person has been key to these successes. DECCA made the decision to allocate this case to the Treatment Coordinator, who has over two decades experience of working with clients such as this. His approach has ensured that the young person has been able to be honest and open about their issues, has been honest if they have struggled (including admitting when they did relapse), and that has allowed all parties to work together in collaboration, rather than pulling in different directions.

Impact for children and families:

- Hospital admission episodes for alcohol specific conditions – Under 18s, in Sandwell (18.3 per 100,000 population) is lower than the national average of 30.7 per 100,000 population.
- Hospital admission due to substance misuse – 15-24 year olds, in Sandwell (63.3 per 100,000 population) is lower than the national average of 84.7 per 100,000 population.
- 14, 515 young people within Universal Education.
- 1045 young people within Alternative Educational settings – 671 of those worked with 'on the street' in partnership with the Detached Youth Service (DYS).
- 100% of clients discharged from Specialist Treatment have met their care plan goals.
- 488 adults trained – general awareness.

Some of the highlights captured from Partner across Sandwell 21 -22

In 2021, following the Recommendation from a Domestic Homicide Review (DHR) Sandwell's Domestic Abuse Partnership Produces a first Midlands Child to Parent Abuse Information Guidance for Practitioners



Education Undertaking duties to Safeguard and Promote Welfare

Section 175 of the Education Act (2002) requires that Local Education Authorities and the governing bodies of maintained schools and FE colleges have suitable arrangements in place to ensure they are discharging their duty to Safeguard and promote the welfare children and young people.

The MASH Education team have reviewed the self-assessment audits to reassure Sandwell Children Safeguarding Partnership that they are discharging their duty to safeguard and promote the welfare of children.

The analysis report has focused on seven key themes:

- Understanding of Threshold
- Exploitation
- Neglect
- Training of staff
- Curriculum
- Early Help
- Policies
- Mental Health and wellbeing

Work in making improvements will continue in to 2022

Listening to the voice of Father's & Progressing Learning from Serious Incidents

Actions completed by Health:

We have undertaken audit to review maternity cases to ensure all family/father's details and level of involvement are documented.

This is also an area of focus on the Under 1's Action plan monitored by BC ICB (Sandwell place)

We include all recommendations from CSPR review in our quarterly Newsletter and any updates recent findings, service developments shared via our Safeguarding Children Operation Group.

At the 'Safeguarding Today' event – Action for Children presented on their service developments to be inclusive of fathers and significant males. Their father's group now volunteer led.

From SCT - In January 2022 after a productive consultation process….
Sandwell's Locality Model goes live
The model establishes a number of **Assessment & Intervention Teams, plus Child Protection and Court Teams** in three localities, highlighted below along with the respective Heads of Service

Smethwick & Oldbury	West Bromwich & Wednesbury	Tipton & Rowley Regis

From West Midland Police, Ian Green Chief Superintendent. Sandwell Neighbourhood Policing Unit told us what his teams are doing to keep young people safe in communities:

- *"From a police point of view we are trying to protect everyone and trying to be fair, I think at times that can not come across, so if you look at some of the things we do around interacting with young people using some of our powers around stop and search, I think that at times it can be difficult to 'sell' why we're doing it to young people who are on the end of it. I have to say we are always trying to make everyone feel safe and protected, at times that can get misconstrued, if you look at the reason or us being in a lot of public spaces and searching young people its not because we are trying to annoy young people its unfortunately because we have seen people murdered on the streets we knives and stuff and that brings its own problems when we start to search people, we start to criminalise them, if they've got low level amounts of drugs on them. It can be a difficult position to be in policing to be in a space where we're trying to support people but when we do end up dealing with it its very black and white in the law, if we find someone with drugs we have to do something – what that something* ***is getting better with early help."***

From West Midland Police, Detective Chief Inspector, Dez Lambert - Public Protection Unit – Black Country Child Abuse told us how police have been working with other agencies to keep children safe in the last year:

"One thing that we do that all agencies do is we share information as well, so when we have a concern for a child come to the attention of one of the agencies it will sometimes get referred thought to the MASH, the Multi Agency Safeguarding Hub, I then have a team of people who work in West Bromwich that do research. So we will find out what we know about that young person, what we know about their family, what we might know about the person that might be causing them harm or a risk and we'll share that information with other agencies and they'll do the same as well and together we'll make a decision about who is going to own the safeguarding concern and what are we going to do about it, so that's something that all agencies do."

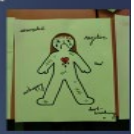
SHAPE Engaging with children and young people all across Sandwell.

During Anti Bully week 2021: SHAPE, Youth Services and PC Treasure visited 9 primary and secondary schools, as well as Sandwell College as part of our annual anti-bullying roadshow.

We presented a workshop around this year's theme of #OneKindWord and looked at how kindness is shown to us, and how we show kindness to others.

Every session was a real success and was thoroughly enjoyed by all children and young people who took part.

Our Primary School sessions included a variety of activities for children to get involved in including: the crumpled paper activity, understanding how a person being bullied may feel, bullying debates and bullying scenarios.



If there are any young people who are interested in joining SHAPE Youth Forum, they can complete the online application form by clicking here!

6. SCSP Business Team

A final piece before moving to the conclusion, the SCSP have a dedicate business team that supports the operational key statutory functions whilst also driving forward and delivering on the priorities ensuring effective joined-up services for children and families who are involved in the safeguarding systems. Together the 21/22 business team enhanced the quality control, delivered direct partnership services, explored innovating partnership approaches and consistently reviewed to improve the processes and structures to ensure success in delivery. Inside the business unit is depicted

7. Conclusion and Horizon Setting

Despite the considerable environmental challenges, the SCSP, driven by an Independent Chair, and the business unit, have remained committed and have delivered the functions outlined in the local MASA to safeguard and promote the welfare of children in Sandwell.

Over the last year, progressed has been made, but there are a number of areas that need to be progressed and developed further.
The report demonstrates work of the SCSP does not have a 'stop point' for much of the work, and the activities captured in this report remain in- progress, and forms part of the Partnerships commitment to consistently review, learn and improve. This is particularly so in respect of work arising from LCSPR's, MACFA's and in reviewing the MASA's and we know that the year ahead is also likely to further add to this as we await a due 'Ofsted Inspection' of our provision of children social care services.
Understanding the priority area for EH is required given that this work is driven via the Children & Families Strategic Board with a line of sight for assurance purposes to the SCSP. there is no doubt that the work and activities being undertaken by the tackling neglect subgroup and occurring being progressed by the EHP are inter related. The current position may need to be redefined so not to duplicate resources and find that by applying better joining up may prove advantage and pooled resources.

We know there is work required to do in strengthening our relationship with community, voluntary and faith sector services; with this the SCSP have agree to invest in a dedicated 'short-term' post to support us in making those direct links.

Our plans for 2022 – 2023 and beyond

We have work to do following the 'thematic review' undertaken through CEB, issues of importance for us at a local level but equally also recognised as a priority for national government around disparity. Partners need to drive this forward over next 12 months.

A review of the 'front-door', partners response to 'risks', the links and accountability for 'early help' and ensuring children are getting the right support at the earliest point in response to their needs, is an area currently receiving heightened attention, and work underway to intensify the focus to improve the understanding and application of its thresholds, from early help, through to statutory social work and will be revising to improve its guidance and training to apply to all agencies and organisations.

The areas for attention as covered by the Independent scrutineer be address in the coming year.

SCSP Priorities and areas for improvement in 2022 - 2023

- Focus on Front Door, Early Help and the responsibilities of all agencies
- 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'
- Neglect
- Exploitation
- Domestic Abuse

Themed areas:

- 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,
- 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 following;
    - heightened national interest in serious safeguarding incidents
    - McAllister review
    - local pending Ofsted inspection

The final word from the SCSP Annual Report 21/22 comes from Chief Superintendent Ian Green as he response to a question posed by a young people, who ask:
"What is your favourite thing about working in Sandwell" Here's what Ian said:

8. Glossary of terms:

AHT – Abusive Head Trauma
BC CDOP – Black Country Childs Death Overview Panel
CAMHS – Child and Adolescent Mental Health Service
CCG – Clinical Commissioning Group
CEB – Child Exploitation Board
CIN – Child in Need
CME – Child Missing Education
CMFE – Children Missing From Education
CSPR – Child Safeguarding Practice Review
CWD – Children with Disabilities
DASP – Domestic Abuse Strategic Partnership
DCI – Detective Chief Inspector
DECCA – Drug Education, Counselling and Confidential Advice - Service for Young People
DHR - Domestic Homicide Review
DSL – Designated Safeguarding Lead
EH – Early Help
EHCP – Education Health Care Plan
EHP – Early Help Partnership
EMHW – Emotional Mental Health & Wellbeing
GCP2 – Graded Care Profile
GP – General Practitioner
ICB – Integrated Care Board
ICON – **I**nfant **C**rying is **O**K – **N**ever shake the baby
JAR – Joint Agency Response
JTAI – Joint Target Area Inspection
KS – Key Stage
L&D – Learning and Development
LADO – Local Authority Designated Officer
LCSPR – Local Child Safeguarding Practice Review
MACE – Multi Agency Child Exploitation
MACFA- Multi Agency Case File Audit
MARF – Multi Agency Referral Form
MASA – Multi Agency Safeguarding Arrangements
MASH – Multi Agency Safeguarding Hub
NAI – Non-Accidental Injury
NSPCC – National Society Prevention Cruelty to Children
PEP- Personal Education Plan
QAF- Quality Assurance Framework
QPPA – Quality of Practice, Performance and Assurance
SAR – Service Access Request
SCR – Serious Case Review
SCSP – Sandwell Childrens Safeguarding Partnership
SCT – Sandwell Childrens Trust
SCVO - Sandwell Community & Voluntary Organisation
SEND -Special Educational Needs and Disabilities
SHAPE – Children in Sandwell want to be, **S**afe, **H**ealthy, to **A**chieve, and have **P**ositive **E**xperiences
SLPR – Sandwell Learning from Practice Reviews
SUDIC – Sudden Unexpected Death in infant /Child
TAF – Team Around the Family
TED – Tell, Explain, Describe
WMP – West Midlands Police
YJS – Youth Justice Service