Agenda item 8

Health and Wellbeing Board

6 December 2022

Walsall Safeguarding Partnership (Children and Adult's) Annual Reports 2021-22

For Assurance

1. Purpose

It is important that the Health and Wellbeing Board (HWBB) is sighted on the work, priorities, assurances or developments being progressed by the Walsall Safeguarding Partnership. Shared areas of interest and the opportunity for shared understanding have led to the Walsall Safeguarding Children Partnerships (WSCP) Annual Review of Effectiveness and the Walsall Safeguarding Adults Board (WSAB) Annual Report being presented as part of the routine interconnectivity and agreed governance between the WSP and HWBB.

2. Recommendations

2.1 That the HWBB members note the content of the WSCP Annual Review of Effectiveness and the WSAB Annual Reports.

2.2. That the HWBB members consider, as part of future business, any opportunities for collaboration on joint issues.

3. Report detail

Walsall Safeguarding Partnership

3.1 In response to an independent review of the partnership arrangements in 2021-22, the priorities for the Walsall Safeguarding Partnership (WSP) had been streamlined to provide a more focused partnership approach to joint children and adult arrangements.

3.2 Part of the role of the WSP is to assess the effectiveness of local safeguarding arrangements in agencies working with adults and children. During 2021 WSP carried out a number of activities to elicit this assurance this is detailed below in section 3.15 and 3.25. (Further details is set out for children's on page ? and for adults page 6 of the respective reports).

3.3 Partnership focus on safeguarding has continued through regular meetings between statutory partners despite the challenges brought by the pandemic.

Attendance at multi-agency meetings continues to improve, the virtual or in-person meetings (hybrid / blended approach) continues to allow for greater flexibility and engagement of partner members to scheduled meetings

3.4 Three priorities were identified across the adult and children's agenda, with Neglect, Self-Neglect and All Age Exploitation being key for the Partnership. These priorities had been determined through our review of partnership data, our understanding of practice from case reviews and audits and wider partnership discussion about issues which required a joint spotlight.

3.5 There has been a delay in the launch of the regional combined Section 11 and Care Act self-assessment Tool and online platform but this is being progressed for completion by the end of autumn 2022.

3.6 The Safeguarding Executive Group, supported by the Independent Chair and Business Manager, undertook a SWOT analysis (Strengths, Weaknesses, Opportunities and Threats) with a supporting action plan and reviewed the current areas of the partnership which were operating effectively or required additional development

3.7 There are improved links with the Community Safety Partnership with the Chair being part of the Safeguarding Executive Group, the Community Safety Partnership Manager co-Chairing the Exploitation Subgroup and the Independent Safeguarding Partnership Chair meeting regularly with Community Safety colleagues.
The children and adults reports highlights the strength of the partnership in a number of key areas

Walsall Safeguarding Children Partnership (WSCP)

3.8 It is a statutory requirement that Safeguarding Partnerships publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area. It is the statutory responsibility of the local authority, police, and health agencies to jointly oversee multi-agency arrangements to safeguard children

How effective have our arrangements been?

3.9 In October 2021 Ofsted undertook an Inspection of Local Authority Children's Services. Their overall effectiveness was graded 'Good'.

3.10 The report recorded 'An ambitious and stable senior leadership team is dedicated to the delivery of the Walsall Right 4 Children Transformation Programme, launched in September 2018. Since the previous inspection in 2017, outcomes for children and their families have been improving and children's services are now good.'

3.11 In May 2021 the CQC published its findings on key areas of practice inspected within the Walsall Healthcare NHS Trust. The three domains assessed in the unannounced March 2021 inspection – safe, responsive and well-led – were

rated as “Inadequate”; downgraded from “Requires Improvement.” The overall rating for Walsall Healthcare NHS Trust remains “Requires Improvement.”

3.12 As a Safeguarding Partnership there is now a clearer line of sight and increased connectivity between the work streams of the partner’s activity such as practice reviews and workforce development.

3.13 As we started to come out of the pandemic, the review into the tragic deaths of Arthur Labinjo Hughes and Star Hobson the 2021/22 financial year was significantly challenging for the partnership and local services, however Partners continued to work closely together to ensure that children in Walsall were safeguarded.

3.14 There does continue to be evidence that children are being identified and kept safe in Walsall (please see data on page 10 of full report):

a. **Partnership Priority: Neglect** –
   - There has been a revision to the revised strategy and action plan and development of an outcomes framework.
   - More children are being supported through Early Help and less children (11% compared to 16% last year) are having a social care Child and Family Assessment due to Neglect.

b. **Partnership Priority: Exploitation** –
   - Development of an all aged Exploitation Strategy and related training to 190 delegates
   - Progress continues to be made with the All-Age Exploitation pathway and included the development of an Exploitation Hub.
   - We have identified, screened and worked with more young people at risk of Exploitation.

c. Early Help demand has increased by 53% 592 in 2021 compared to 281 in 2019 and there remains a positive impact of Early Help services for children and families.

d. There has been a slight increase in referrals to MASH 3501 for period 1st April 21- 31st March 2022 compared to 3431 the same period in 2020/21 and remains appropriately lower than the previous year 4401.

e. There remains a positive reduction seen in the number of children subject to child protection plans 199 2021/222 from 389 in 2019.

f. There remains a positive increase of the number of families supported through the Family Safeguarding Model 697 children have been supported from 333 families

g. The pre-birth assessment guidance is being used effectively and is monitored through regular audit activity (impact of SCR 7 recommendation

h. Staff who responded to satisfaction survey felt their organisation ensured they were competent and supported to carry out their safeguarding responsibilities

3.15 Providing additional assurance to the partnership on the quality of services to our Children and families has been an additional key area of focused activity for the partnership. There has been a range of activity that has provided the partnership some confidence in our arrangements this includes,

- Section 11 assurance event (opportunity for partner agencies to demonstrate assurance of their statutory duties),
- '4th Partner'- service user quality assurance with partners,
- findings from the 2021 practitioner survey and,
- Measuring impact from Walsall Child Safeguarding Practice Reviews.

Learning from Case Review and Audits

3.16 During 2021-2022, 4 cases were referred for consideration of a Child Safeguarding Practice Review, of the 4 referrals considered, 1 progressed to a LCSPR. No children's reviews were completed or published. 8 action plans relating to previous Serious Case Reviews (SCRs) or Rapid Reviews were completed within the year

3.17 The multi-agency audit programme continues to obtain learning in order to improve practice and saw improvements in the case ratings. During the year there were three multi-agency audits carried out, one was linked to the safeguarding priorities, child sexual abuse and injuries in non-mobile babies (as a direct result of case review learning). During Q2 the audit process was reviewed to include a revised MAA audit template and process to enhance the learning system.

3.18 During 2021 a new process for measuring the impact from case reviews was agreed and commenced. This was something which the partners had identified as an important focus in the 2021-22 Annual Report. The process is broken down into the below 5 approaches. On occasion one or more of the approaches can be used dependent on the action that is being quality assured.

3.19 The WSP learning offer includes specific training resulting from child reviews i.e. bruising in non-mobile babies (W12 & RRs) / working with fathers (W5, W7, W10, Practice Reflection Workshop on Connected Carers W11). WSP have also launched the ICON programme across the partnership as we set out to do in the 2021-22 annual report (linked to SCR's W5, W7).

3.20 Links have been further strengthened between the Multi-Agency Audit Group and Practice Development Group (PDG) as the Practice Improvement Lead attends the audits and there is a standing agenda item on PDG for feedback from audits.

3.21 There is a robust arrangement to ensure the Partnership receive learning in real time from audits and reviews by way of feedback to practitioners and managers, Key Messages newsletters, website updates, 7 min briefings, webinar's and new training courses being developed.

3.22 ***Areas for focus and improvement in 2022-2023***

1. Review of the Safeguarding Partnership Arrangements to ensure they are fit for purpose across the children's and adult's strategic agenda.
2. Full Section 11 Audit to be completed during the next year, utilising the West Midlands Audit Tool.
3. To deliver the proposed forward plan for practice development activity, informed by the learning gained from Child Safeguarding Practice Reviews, Safeguarding Adult Reviews and National Reviews; the outcomes of audits and aligned to the Partnerships Key Priorities, alongside the regular training schedule for the year.
4. Continue to progress the All Age Exploitation Strategy and Child Neglect Strategy as key priorities under the children agenda and measure their impact through the outcome framework.
5. Strengthen the Think Family approach, in particular children's staff knowledge around the Self-Neglect Pathway and Mental Capacity Act.
6. Additional scrutiny work to be commissioned in 2022-23 to explore if it is possible to identify any changes or improvement in practice as a result of a previous SCR recommendations and actions.
7. Additional scrutiny work to be undertaken in relation to robustness of the functioning of the MASH, application of Right Help Right Time Guidance and use of single agency Early Help to meet need at the earliest opportunity.
8. Re-establish capacity within the Business Unit and further the children and young people's engagement agenda

Walsall Safeguarding Adults Board

3.23 Safeguarding Adults Boards have specific duties as set out in Schedule 2 of the Care Act 2014 (3). This includes producing Annual Reports, Strategic Plans and undertaking Safeguarding Adults Reviews.

3.24 Each year the Walsall Safeguarding Adults Board publishes an Annual Report setting out its work and achievements over the last 12 months.

3.25 As identified in last years' annual report, in response to an independent review of the Partnership Arrangements in 2021-22, the priorities for the Walsall Safeguarding Partnership (WSP) this year have been streamlined to ensure a focused partnership approach. Three priorities were identified across the adult and children's agenda, with Self Neglect and All Age Exploitation being key for the Safeguarding Adult Partnership/Board.

3.26 In addition to the three identified priorities the partners have also focused on improving the arrangements for undertaking safeguarding adult reviews and the quality of the reports and the dissemination of learning from the reviews. There in addition has been a focus on improving performance data and quality assurance activity.

- Care Act 2014 compliance (opportunity for partner agencies to demonstrate assurance of their statutory duties),
- '4th Partner'- service user quality assurance with partners,
- findings from the 2021 practitioner survey and,
- Measuring impact from Safeguarding Adult Reviews (SAR).

3.27 The Partnership work has been affected by the pandemic. However the partnership has continued to make good progress, and the use of hybrid working for many of its business arrangements has been successful.

3.28 **How effective have our arrangements been?**

a. As a Safeguarding Partnership there is now a clearer line of sight and increased connectivity between the work streams of the partner's activity such as practice reviews and workforce development. Forward plans, standing agenda items and report templates across the meeting and subgroup structure have ensured issues and assurance are shared and understood from frontline practice through to senior leadership.

b. There are improved links with the Community Safety Partnership with the Chair being part of the Safeguarding Executive Group, the Community Safety Partnership Manager co-Chairing the All Age Exploitation Subgroup and the Independent Safeguarding Partnership Chair meeting regularly with Community Safety colleagues.

c. The All Age Exploitation Strategy was finalised and agreed by partners, as was set out in last years' Annual Report as a priority.

d. The multi-agency audit programme continued to obtain learning in order to improve practice and saw improvements in the practice which was reflected in improved case ratings.

e. A new framework for evaluating the impact of learning from case reviews and audits has been agreed and commenced.

f. Care Act peer challenge activities took place.

g. Positive feedback was received via the Practitioner Survey.

h. Partners have identified a number of cases which they felt warranted further exploration via consideration of a SARLearning from Case Review and Audits

Learning from Reviews and Audit

3.29 There were 10 referrals for safeguarding adult reviews during 2021-2022 fortunately there were no SARs brought forward from the previous year for completion. There were no SARs published during this year.

3.30 The Practice Review Group has identified themes arising from referral this includes:

- service users with a learning difficulty,
- self-neglect,
- multi-agency communication and risk management
- application of the Mental Capacity Act

3.31 During the year there were 4 multi-agency audits carried out, each linked to the safeguarding priorities and emerging themes from reviews or data. The audit themes are detailed below:

a. **Qtr 1 Caused Enquiries -** The topic was chosen due to an emerging theme within the multi-agency dataset which highlighted that there is a high percentage of reports that do not meet the agreed return timescale.

b. **Qtr 2 Safeguarding Concerns that were NFA -** The topic was chosen due to an emerging theme within the multi-agency dataset which highlighted the conversion rate is very low.

c. **Qtr 3 Adults with Learning Disabilities -** The audit topic was chosen in line with case review findings. The audit highlighted that although there was some good practice with the understanding and application of the Mental Capacity Act and Making Safeguarding Personal, however there remains inconsistences in practice in these areas.

d. **Qtr 4 People in a Position of Trust -** The audit focused on the effectiveness of agency practice in dealing with allegations against staff and considered compliance with People in a Position of Trust Regional Guidance and was carried out during 2 assurance activities.

3.32 Unfortunately there was less cases graded ‘Good’ or ‘Outstanding’ compared to last year. A summary of the learning from audits is as follows:

- Consistent dissemination of Caused Enquiry terms of reference and this being placed on case files
- Information sharing
- Quality information documented on case files
- Use of multi-agency referral form and outcome of referrals
- Seeking views and lived experiences

Further details regarding audit learning outcomes is detailed on page11 of the WSAB annual report.

4. Implications for Joint Working arrangements:

a. The requirements of the partnership arrangements are set out in the Care Act 2014 and Working Together 2018.

b. The Business Unit which supports the arrangements is joint funded through the Local Authority, Clinical Commissioning Group and West Midlands Police.

5. Health and Wellbeing Priorities:

5.1 This annual report and the priorities and work of the Safeguarding Partnership has associations to all of the HWBB priorities, to a greater or lesser extent. The success or otherwise of safeguarding practice will directly impact on individuals abilities to achieve other positive outcomes sought by the HWBB (and Marmot principles), such as being ready to start school and access education, good mental health, making positive contributions to communities.

5.2 Safeguarding: This report is an overview of safeguarding partnership activity, assurance and priorities.

Background papers

The overview detailed above is taken from the full Annual Report for the Children's Safeguarding Partnership, which can be accessed on the WSP website here, and are embedded below.

103067
Safeguarding Adult

103066
Safeguarding Child

Author

Janet Russell – Walsall Safeguarding Partnership Interim Business Manager
Organisation

☎ 01922 658366
✉ Janet.Russell@Walsall.gov.uk