



Strong Partnerships Safeguard Children

WALSALL SAFEGUARDING CHILDREN BOARD

ANNUAL REPORT

2016-2017

(1st April 2016 to 31st March 2017)

Better Together for Children

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WSCB	<i>Ratified 06/12/17</i>
Children & Young People Partnership Board	<i>Date TBC</i>
Health & Well Being Board	<i>Date 11/12/17</i>
Chief Executive – Walsall Council	<i>Date</i>
Leader of Walsall Council	<i>Date</i>
Local Police and Crime Commissioner	<i>Date 7/12/17</i>

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FOREWORD – Alan Critchley, Independent Chair

I am pleased to present my second Annual Report for the Walsall Safeguarding Children's Board.

The safeguarding partnership in Walsall is a strong one with excellent commitment from all statutory partners. This is demonstrated by their attendance at the board itself and their input into the sub-groups where the bulk of the work has been done. We have also benefitted from the input of a youth representative on the board itself and involvement in others aspects of our work.

In previous years the Board has been held back by historical underfunding but I am delighted to say that this has now been addressed by the partnership, in particularly the Local Authority and the CCG who provided increased funding within the year and a commitment to adequately fund the Board for the immediate future.

The main question for a Local Safeguarding children Board is how safe are children and young people in the area? From the work that we have done we can say that safeguarding arrangements are, at least, adequate. Our auditing has identified some good work; where there are improvements to be made we have been clear what these are. Where we are not yet strong enough is on measuring the impact of what we have done and this will be the focus in the next reporting period. As I write this in the autumn of 2017 we are making significant progress in this respect.

There are challenges to working in Walsall with more poverty and deprivation than many other places. What Walsall does have, that no amount of money will buy, is a strong identity and a real commitment to safeguarding the children, young people and their families and carers.

On behalf of the safeguarding partnership, my thanks to those of you who work directly in the community. Thank you!



Alan Critchley

Independent Chair Safeguarding Board

Introduction

An LSCB's annual report should include:

- A rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, causes of those weaknesses and the action being taken to address them as well as proposals for action.
- Lessons from reviews undertaken in reporting period as detailed in Chapters 4 and 5.
- Information on the outcomes of regular assessments on effectiveness of the response of Board partners to Child Sexual Exploitation.
- Analysis of how LSCB partners use their data to promote service improvement for vulnerable children and families including in respect sexual abuse.
- Appropriate data on children missing from care and how LSCB is addressing the issue.
- Contributions to LSCB by partner agencies and details of what LSCB has spent, including Child Death Reviews, Serious Case Reviews and other specific expenditure such as learning events or training.

Working Together 2015

This annual report provides an accurate reflection of WSCB's assurance that partnership arrangements in Walsall effectively safeguarding children. It outlines statutory expectations alongside what went well, what the challenges were and the way forward in 2017-18.

The key principles underpinning statutory guidance outlined in *Working Together 2015* are:

- Safeguarding is '**everyone's responsibility**' – for services to effectively safeguard and promote children's welfare each professional and organisation should play a full part. This includes effective coordination and challenge by LSCB's.
- **Child centred approach** should be based on a clear understanding of the needs and views of children for services to be effective.

Walsall's response to these principles are addressed throughout this report

ABOUT WALSALL

A few things about Walsall: -

- It is a Metropolitan Borough Council in the West Midlands.
- Walsall's population is predicted to increase to 284,700 in 2011 – an increase of 5.1% from 270,900 in 2012.
- There was an increase in births from 3,417 in 2004 to 3,816 in 2012, declining in 2013 to 3,715 but increased again in 2014 to 3,748. This increase will impact on usage of local health and council services such as children centres and primary schools.
- Child poverty figures (2011) show Walsall had 16,145 children aged under 16 years – 29.2% of all children in Walsall - living in low income families.(England average 20.1%)
- Walsall's infant mortality rate per 1000 live births is decreasing but has not improved as fast as similar areas across England.

Walsall's Child Health Profile (March 2017) indicates the health and well-being of children in Walsall is mixed compared to the average across England:

- Infant mortality is higher.

- Child mortality rate is similar.
- Child poverty is higher with 30% of children in Walsall, under 16 years, living in poverty.
- There are higher levels of childhood obesity in Walsall.
- Teenage pregnancy rates remain high although average rate has reduced well in last 3 years.

“Challenges facing children in their early years in Walsall are substantial. They have a ‘poor start in life’ with high infant mortality rates and poor educational attainment at ages 3-5, together with high levels of obesity... Improving child safety and safeguarding including tackling a wide range of issues, including abuse and neglect, accidental injury and death, bullying, crime and anti-social behaviour and ensuring a safe home environment. A substantial minority of children experience risk each year in Walsall and it is important that safeguarding is treated as a high priority to ensure children are identified and appropriately protected” (Walsall JSNA)

THE ROLE AND RESPONSIBILITIES OF WALSALL SAFEGUARDING CHILDREN BOARD

Section 13 Children Act 2004 requires each local authority to establish an LSCB for their area and specifies the organisations and individuals who should be represented on LSCB's. LSCB's have a range of roles and statutory functions.

Section 14 Children Act 2004 sets objectives of LSCB's which are to;

- a) Coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area, AND
- b) Ensure the effectiveness of what is done by each such person or body for those purposes.

Regulation 5 – Local Safeguarding Board Regulations 2006 sets out LSCB functions as:

1. Developing policies and procedures for safeguarding and promoting child's welfare including: -
 - Action to be taken when concerns about a child including thresholds for intervention
 - Training of persons who work with children or in services affecting the safety and welfare of children.
 - Recruitment and supervision of persons working with children
 - Investigations of allegations concerning persons who work with children
 - Safety and welfare of children who are privately fostered.
 - Cooperation with neighbouring children's services authorities and their board partners
2. Communicating to persons and bodies in area the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so.
3. Monitoring and evaluating effectiveness of what is done by the authority and their Board partners individually, and collectively, to safeguard and promote the welfare of children and advising on ways to improve.
4. Participating in the planning of services for children in the area
5. Undertaking reviews of serious cases and advising the authority and Board partners on lessons to be learned.

LSCBs may engage in other activities that facilitate, or is conducive to, achieving its objectives.

'Working Together to Safeguard Children (2015)' guidance currently sets out how organisations/individuals should be working together to safeguard and promote the welfare of children and governs the scope and requirements of LSCBs.

'The Wood Review' - regarding LSCB arrangements - was published March 2016 - alongside the Government response in May 2016. This will result in current legislation requiring areas to have a 'LSCB' ceasing and new arrangements requiring the local authority, police and health – in local areas - to lead and work together to ensure arrangements are in place to provide assurance that children in the area are effectively safeguarded. During 2016-17 WSCB held a workshop to consider the local implications.

Walsall Safeguarding Children Board (WSCB)

Walsall Safeguarding Children Board (WSCB) was established as the statutory mechanism for agreeing how the relevant organisations in Walsall cooperate and work together to safeguard and promote the welfare of children and be assured this work is effective.

WSCB's terms of reference - reviewed annually - details the scope of the Board and expectations of Board members. WSCB Membership and Board attendance is detailed in Appendix 1. Membership complied with statutory guidance with the exception that no lay members were on the Board. A lay member was recruited for 2017-18.

Lay members will operate as full LSCB board members of LSCB, participating as appropriate on the Board itself and on relevant committees. Lay members should help to make links between the LSCB and community groups, support stronger public engagement in local child safety issues and an improved public understanding of the LSCB's child protection work. A local authority may pay lay members. **Chapter 3 - Working Together 2015**

Board members are of a senior position in their organisation, able to make decisions and access resources to support WSCB's business. Board members chair WSCB sub-groups to support delivery of the WSCB Business Plan.

Attendance is monitored by organisation. Members unable to attend meetings are required to send an appropriate substitute from their organisation. Attendance in 2016-17 was generally good from most organisations. Actions were put in place late 2016-17 to address and monitor attendance at Board and sub-groups which will continue into 2017-18.

WSCB's constitution is a dynamic document continually reviewed by the Board clarifying governance arrangements and setting out partner responsibilities in the discharge of their duties as WSCB members. It also details the legislative framework, the Board's purpose and strategic governance arrangements. The Board's underpinning principles are;

- Keep the safeguarding and welfare needs of children at the centre of everything it does;
- Maintain its **independence** from all agencies and structures (including CYPP, HWB, and Walsall Borough Council) to promote an equal partnership;
- Operate a challenge and assurance function to partner members and external organisations;
- Involve children, families, carers, frontline practitioners and managers in work;
- Develop strong working relationships with strategic partners to promote clear roles, responsibilities and governance arrangements;
- To be open and transparent in the work that it undertakes;
- To be a learning and development Board that seeks continuous improvement.

During 2016-17 the Board met quarterly and covered a wide range of business including progress reports from sub-groups - regarding work plans and WSCB priorities - and assurance reporting. A Development Day in January 2017 reviewed WSCB's Business Plan and priorities for 2017-18.

WSCB Independent Chair

Every LSCB should have an independent chair who can hold all agencies to account. It is the Chief Executive's responsibility to i) appoint/remove chair in agreement with Panel of LSCB partners and lay members, and ii) to

hold chair to account for effective working of LSCB. The LSCB Chair should: -

- Work closely with all partners particularly Director of Children’s Services.
- Publish annual report on effectiveness of child safeguarding arrangements and promoting welfare of children in the local area regarding the preceding financial year. The report should be submitted to Chief Executive, Leader of the Council, Local Police and Crime Commissioner and Chair of Health and Well Being Board.
- Have access to training and development opportunities including peer network.
- Have LSCB business manager and other discrete support as necessary for them/LSCB to perform effectively.

Chapter 3 Working Together 2015

The Independent Chair – for WSCB and Walsall Safeguarding Adults Board (WSAB) - started in September 2015 with arrangements in place to meet above requirements.

Chairs Group

The Chairs Group was established for sub-group chairs to meet with the Independent Chair and Safeguarding Board Manager prior to WSCB Board meetings. It is a leadership group supporting the ‘*virtuous circle*’ in fostering the planning, audit and challenge across both WSCB and WSAB. During the year the Chairs Group;

- Reviewed and considered the business support for both safeguarding boards and the budget to support this work to ensure both meet their statutory functions.
- Raised issues around the progress of the Business Plan and working of the Board and sub-groups to enable the Board to progress its priorities.

WSCB Business Plan 2016-18

The Business Plan 2016-18 - a dynamic document - highlights the Board’s key priorities. It is reviewed to ensure it remains relevant and responsive to Board business being designed to support delivery of identified priorities and statutory responsibilities.

The Business Plan is monitored quarterly by the Safeguarding Board Manager. The WSCB scorecard monitors its’ impact and progress on strategic priorities. WSCB’s Business Plan 2016-18 identified the strategic priorities for 2016-17 detailed below:

Priority 1

Improve the effectiveness and impact of WSCB in ensuring children and young people are safe.

Rationale: WSCB has identified a range of development activities so that it operates within a clear and well-established governance framework, holds partners to account and delivers on its statutory functions.

Priority 2

Increase the responsiveness and impact of the help and support provided to children, young people and families, including children with disabilities and mental health issues.

Rationale: Local intelligence indicates that there is a need to develop i) a shared understanding and application of thresholds, ii) embed the Early Help offer including role of Lead Professional and iii) improve the contribution of partner agencies to multi-agency safeguarding forums.

Priority 3

Coordinate how partners work together to protect children from harm caused by Domestic Abuse, Parental Substance Misuse and Parental Ill Health.

Rationale: Against the national trend, the most common category of Child Protection Plans is emotional abuse and exposure to Domestic Abuse is a significant factor impacting on the safety and well-being of children and young people.

Priority 4

Improve the recognition and response to neglect

Rationale: Neglect is a feature in fifty per cent of cases referred to Local Authority Children’s Social Care.

Priority 5

Coordinate how partners work together to reduce the risk and threat of harm caused by sexual exploitation and missing episodes.

Rationale: Child sexual exploitation (CSE) and being missing from home / care are key safeguarding risks facing children and young people and WSCB has the statutory responsibility to coordinate a local response.

Priority 6

Continue to improve the ability of local and professional communities to safeguard children and young people.

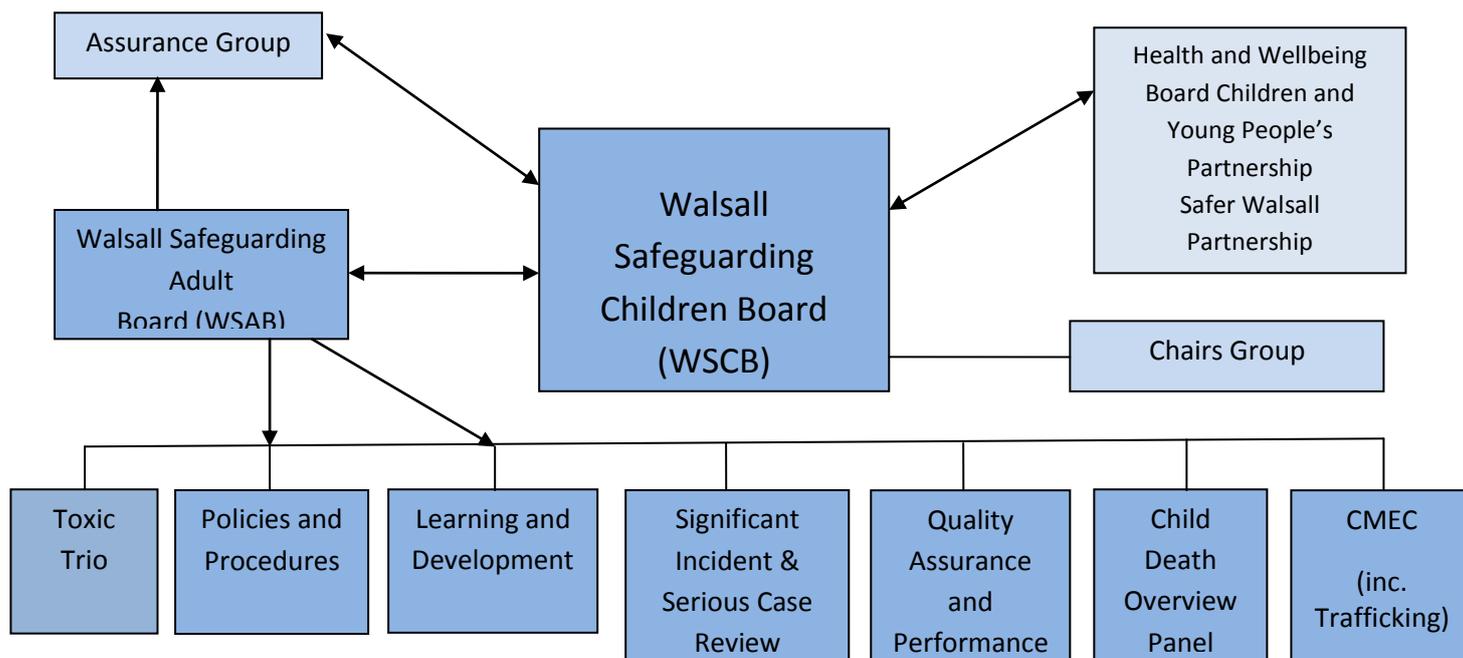
Rationale: Children and young people will be safer when more people know how to identify and act on safeguarding concerns and WSCB has a statutory responsibility to carry out learning reviews.

Sub-Groups

WSCB’s sub-groups support the progress of the work across the partnership against its’ statutory responsibilities, Business Plan and strategic priorities. They are chaired by a WSCB member and have multi-agency membership. Sub-group chairs ensure work plans are in place and provide regular progress report to Board.

The Policy and Procedures, Learning and Development and Quality Assurance and Performance sub-groups cover both the WSCB and WSAB. In 2015-16 the Policies and Procedures, and Learning and Development sub-groups merged into one. This arrangement was not sustained due its’ broad remit and resulted in a return to the previous two sub-groups covering both Boards.

Details of the work of all sub-groups during 2016-17 are detailed from page 14.



Governance and Accountability Arrangements

WSCB maintains strategic working arrangements with WSAB, Health and Well-being Board, Children and Young People’s Partnership Board and Safer Borough Partnership Board. WSCB is involved Children and Young People’s Plan preparation with its strategic objectives informing the WSCB Business Plan.

WSCB’s Chair is a member of the Children and Young Peoples’ Partnership Board

(CYPP) reporting WSCB's achievements to the Partnership and providing challenge to partnership on how it is fulfilling its safeguarding children responsibilities on behalf of the WSCB. The Chair maintains close links with the Walsall Health and Well-being Board.

WSCB's annual report is shared the Chief Executive, Leader of the Council, the local Police and Crime Commissioner and with Chief Officers of Partnership organisations.

WSCB has a unique statutory role with responsibility for scrutiny, quality assurance and challenge role in respect of how organisations, individually and collectively, promote the welfare and safety of children living in Walsall.

Walsall Council's Chief Executive holds WSCB Chair to account for the effective working of the WSCB. The WSCB Chair works closely with the Council's Director of Children's Services, who has statutory responsibility for improving outcomes for children and delivering high quality children's social care functions. Ofsted inspect the effectiveness of the WSCB as part of the inspection of local authority partnership functions.

The WSCB Business Plan agreed by the Board, annually, is available to all partner members. The role of partners is to hold organisations, and officers, to account for their contribution to the effective functioning of the WSCB and delivery on its' Business Plan.

Strategic Partnership Links

There is an *Inter-Board Protocol* with the Children and Young People's Partnership Board (CYPP) and the Health and Well-Being Board. Elected members sit on all of the Boards.

CYPP's links with WSCB are strengthened by: -

- WSCB chair being member of CYPP.
- The Director of Children's Services is CYPP Chair and a member of the WSCB.

Health & Well Being Board-

- During 2016-17 the WSCB Chair contributed to the '*Walsall Plan: Health & Well Being Strategy*' to strengthen safeguarding aspects to ensure safeguarding was explicit.
- Health and Well Being Board and WSCB priorities are appropriately aligned and reflected in the WSCB Business Plan for 2017-18.

The Assurance Group is small group of chief / senior officers from Walsall Council, police and health chaired by Chief Executive at Walsall Council. The group provides independent scrutiny of WSCB business and individual partner's performance regarding safeguarding.

The links with **Walsall Safeguarding Adults Board (WSAB)** are strong with both Boards having the same Independent Chair and Safeguarding Board Manager. Support from the Safeguarding Business Unit ensures a consistent joined up approach to safeguarding across Walsall and more effective working on joint agendas. WSCB and WSAB Board meetings are held on the same day with transitional arrangements and common areas of interest discussed at the meeting mid-point to ensure children and adult safeguarding agendas are joined up. Some of the sub-groups support work across both Boards. The support and management arrangements across both Boards were new in 2016-17. With no identified additional resources the Children's Safeguarding Business Unit assimilated WSAB work.

The WSCB Annual Report 2016-17 will be presented to the above Boards and key officers in line with Working Together requirements.

WSCB is assured strategic links across key partnership boards ensures WSCB has influence on strategic priorities, contributes to the wider partnership agenda, and that safeguarding is integral to higher level strategic planning in Walsall.

Business Support

To provide effective scrutiny the LSCB should be **independent**. It should not be **subordinate** to, or subsumed within, other local structures... LSCB chair should have LSCB business manager, and other discrete support, as necessary for them and LSCB to perform effectively **Working Together 2015**

The Safeguarding Business Unit is located within Walsall Council with line management arrangements for the Safeguarding Board Manager from the Head of Safeguarding within Walsall Council.

The reconfiguration of WSCB's business support in 2015-16 resulted in the following structure;

- The Independent Chair (WSCB and WSAB) contracted for 6 days a month.
- Safeguarding Board Manager (Strategic Lead for both WSCB and WSAB)
- Training Coordinator (2 days a week for WSCB)
- 2 FTE Administrative Officers (administrative support for WSCB and WSAB).
- 0.5 FTE Data Analyst / Performance Officer.

During 2016-17 no Child Death Overview Panel (CDOP) Coordinator was in post and the Performance Officer was on maternity leave. Attempts to cover business support functions were not adequate and impacted on the Board in progressing the multi-agency scorecard and preparation of child deaths cases prior to submission to CDOP.

The limited resources to support both Boards impacted on the delivery and progress of core business and developmental work during the year. In December 2016, the Board reviewed the business support structure and partners budgetary contributions to rectify this. Additional resources were agreed in year and additional resources pledged for 2017-18 from local authority and Walsall CCG to establish a new Safeguarding Business Unit to ensure: -

- Increase in management and leadership capacity to assist Safeguarding Board Manager in addressing both WSCB and WSAB business.
- CDOP and quality assurance roles were strengthened

The challenge in 2017-18 is to promptly progress recruitment to business unit roles to effectively deliver on Board business. To prevent delay interim arrangements are required.

Financial Arrangements

During 2016-17 the Board agreed to fund an additional £200,000 required to strengthen the business support arrangements. It is difficult to separate out direct WSCB and WSAB costs due to some of the joint functions across Boards. The CCG and Walsall council agreed to meet additional costs.

Table: WSCB Income 2016-17 and 2017-18

Partner Organisations / Income	2016-17 Contribution £	2017-18 Contribution £
Walsall Council - Current Net Budget	88,072	105,536
NHS Walsall	5,000	5,000
Probation Service (NPS and CRC)	3,000	3,000
West Midlands Police	15,170	15,322
CAFCASS	550	550
CCG	25,000	25,000
CCG Additional	4,000	30,000
Additional Internal Income (Training)	2,240	
TOTAL	143,032	184,408
Walsall Council - Additional Contribution to cover agency and additional resources	22,194	200,000

Table: WSCB Expenditure Statement 2016-17 / 2017-18

Expenditure	2016-17 Actual £	2017-18 Projected £
Employee Costs (WSCB)	104,607	290,888
Independent Chair Costs (WSCB)	26,583	21,600
Workforce Development SLA	13,500	18,000
Section 11/ 157 / 175 Tool	3,000	3,000
Chronolator Tool (WSCB and WSAB)	1,160	1,160
Serious Case Review	6,569	15,000
Development Day / Conference	1,810	7,000
Car Allowances (WSCB and WSAB)	687	1,279
Consultancy Costs		22,080
Other - catering, ICT, room hire, membership fees etc (WSCB and WSAB)	2,810	2,810
PHEW – Online Child Protection Procedures	4,500	1,591
TOTAL	165,226	384,408

Moving Into 2017-18...

Work regarding financial arrangements for 2017-18 onwards will need to include:

- Recruitment to the new Safeguarding Board Business Unit
- Explore areas to mainstream, or join up, work to reduce future costs of management arrangements, training delivery, Child Protection Procedures and Section 11 audits.
- Budget monitoring to ensure it remains adequate to meet delivery of WSCB business.
- Ensure WSCB is assured support arrangements do not compromise the Board's independence.

Learning and Development

LSCBs should maintain a local **Learning and Improvement Framework** that is shared across local organisations working with children and families to enable organisations to be clear about their responsibilities, learn from experience and improve services. Framework should support work of the LSCB and partners so that: -

- Regular reviews are conducted where there is multi-agency learning and this learning is actively shared so that there is a growing understanding of what works well.
- Action results in lasting service improvements that safeguard and promote child's welfare protecting them from harm.
- There is transparency about issues arising from individual cases and the resulting actions from organisations in response, including sharing SCRs with public. Multi-agency working learning to be shared with other agencies.
- There is an understanding as to why the situation happened in a case what action will be taken to learn from review findings.
- Reviews can include: -
 - Serious Case reviews
 - Child Death reviews
 - Review of child protection incident which does not meet SCR criteria
 - Review or audit of practice in one or more agencies.
- All reviews should be guided by the principles:
 - Culture of **continuous learning and improvement** across the partnership to draw on what works and promote good practice;
 - **Proportionate** approach according to the scale and complexity of the issues;
 - SCR should be led by individuals who are **independent** of the case and organisations under review;
 - Professionals must be fully involved in reviews and invited to contribute their **perspective without fear of blame**;
 - Families including surviving children should be invited to contribute to reviews.
 - Final SCR reports **must be published** to achieve **transparency**.

Improvement must be **sustained** through regular monitoring and follow up to make a real impact on **improving outcomes** for children.

Chapter 4 Working Together 2015

WSCB's work on Learning and Development is detailed in this section and in the work of Learning and Development and Quality Assurance and Performance Sub-Groups.

About WSCB's learning and development

- WSCB deliver an annual multi-agency training programme informed by WSCB priorities, local performance data and emerging national and local trends.
- An agreement is in place with Children's Services Workforce Development, within the local authority to deliver the annual training programme and E-learning offer. The WSCB Training Coordinator - in post since September 2015 – supports the work of the Learning and Development Sub-Group and leads on coordinating additional multi-agency learning activities that complement training provided through Children's Services.
- WSCB is involved in the Black Country LSCB's Training Initiative which was established to share resources, reduce duplication and achieve efficiencies by delivering an agreed multi-agency training programme. This was rolled out in 2016-17.
- During 2016-17 WSCB Learning and Development offer included: -
 - Classroom based courses - informed by local performance data, WSCB's key priorities, emerging national and local trends and an ongoing training needs analysis.
 - E-Learning – including 7 modules purchased by Virtual College.

- Additional key learning events included:
 - Multi-agency threshold training
 - Child Sexual Exploitation
 - Child Death Overview briefings
 - Serious Case Review and Significant Incident Learning Event
 - Sexually harmful behaviour
 - Restorative Practice workshops

Multi-Agency Training Programme

Table: WSCB's face to face / classroom training 2016-17

Name of Course	No. courses planned	No. of attendees
Child Sexual Exploitation (Level 1)	5	83
Safeguarding Children and Young People (Level 1)	3	89
Safeguarding Children and Young People Refresher (Level 1)	2	33
Safer Recruitment (Level 2)	3	42
Introduction to Domestic Violence (Level 1)	2	49
Supporting Parents with Learning Disabilities (Level 2)	2	21
Drug and Alcohol Awareness and Parental Substance Use (Level 2)	1	14
*One further session cancelled due to trainer sickness		
Advanced Child Protection (Level 2)	2	42
Advanced Child Protection Refresher (Level 2)	2	50
Bullying Awareness (Level 1)	2	48
Disguised Compliance and Safeguarding Children (Level 2)	2	84
Introduction to Parental Mental Illness	2	36
Total	28	591

E-Learning

Seven courses were on offer linked to some of the WSCB priorities and learning from SCR etc. Of 280 licenses available 51 courses were completed mainly on adult safeguarding.

What worked well?

- Feedback from training was overall very positive with key aspects including: -
 - Topics covered and information shared was relevant to professional / daily practice.
 - Training had increased their understanding, refreshed knowledge and improved their practice when dealing with issues.
 - Their overall learning would impact on their future practice.
- Agency attendance at the range of training courses was good across statutory agencies and parts of the community and voluntary sector.
- Some WSCB courses were over-subscribed with waiting lists.
- WSCB Learning and Development Strategy for 2017-19 was developed ready for approval and implementation in 2017-18.
- Although Walsall joined the Black Country Training Initiative later during the year Walsall hosted and led delivery on some training events including 'Substance Misuse and Parental Mental Ill Health' and 'Core Working Together Safeguarding' Level 2/3.

What were the challenges?

- Low take up on E-Learning despite promotion from Learning and Development Sub-Group.
- WSCB needs to understand why the community, voluntary and faith sector participation in the learning and development offer is low and review current delivery arrangements to increase future engagement and participation.
- Learning and Development Sub-Group recognises arrangements to evaluate training and its' impact on practice and outcomes for children and young people requires further development.
- Challenges from the Black Country Training Initiative included: - i) oversubscription on courses due to high demand, ii) identifying and securing trainers from Walsall for the regional training pool, and iii) additional pressures on WSCB Training Coordinator's time impacted on local learning and development offer.

WSCB moving into 2017-18 will...

- E-Learning package will be de-commissioned and replaced by new courses and learning opportunities to support multi-agency working regarding making good quality referrals using MARF, case recording and information sharing.
- Develop and implement a more robust evaluation of the WSCB learning and development offer regarding quality of training, impact on practice and outcomes for children, young people and families.
- Strengthen the SLA with Children's Services to ensure a relevant and effective learning and development offer is in place across the whole partnership including community, voluntary and faith sectors.

THE SUB-GROUPS

Learning and Development Sub-Group***What worked well?***

- Service level agreement with Children's Services ensured delivery of a comprehensive multi-agency training programme complemented by a range of learning and development opportunities led by the WSCB Training Coordinator.
- Courses and learning events were well attended and received positive feedback.
- A range of activities ensured learning from SCR, child deaths and other review / audit processes were cascaded across the workforce.
- The joining of the adult and children learning and development sub-groups have given a whole family focus to better protect children.
- Work on a new process to evaluate impact of learning and developmental activities on professional practice was completed for implementation in 2017-18.
- WSCB receives a detailed annual report regarding training and development opportunities.

What were the challenges?

- It is difficult to evaluate impact of learning activities on practice and outcomes for children.

- A strengthened training needs analysis should inform annual training programme.
- Improving the timeliness of review outcomes to inform training needs.
- Learning Modules had a very low take up rate.
- There is limited take up from community, voluntary and faith sectors.

Moving forward in 2017-18...

- Continue to deliver a comprehensive training programme to support WSCB on progressing its' priorities and ensuring the workforce is confident and competent.
- Implement the new process to evaluate the impact of training on professional practice.
- Strengthen multi-agency engagement in identifying training needs.

Quality Assurance and Performance Sub-Group

WSCB is committed to continuously improving outcomes for children, young people and families. The Quality Assurance and Performance Sub-Group is responsible for overseeing WSCB's quality assurance programme by ensuring learning is disseminated across the partnership and regular reports are available for WSCB scrutiny on the scorecard and audit activity.

To assure WSCB that partnership arrangements are effective and continuously improving a range of quality assurance activity are undertaken. The audit activity of partners' also plays a key role in this. This includes;

- **Multi-agency audits** - the core audit activity of WSCB has an established annual programme in place. The WSCB priorities determine the audit activity and themes.
- **Service Reviews** - require individual agencies to report any learning from reviews undertaken by their individual agency so as to consider the learning across partnership.
- **Single-agency audits** - are reported to the Quality Assurance and Performance Sub-group by exception. WSCB requires individual agencies to report on relevant key learning points from audit activity undertaken within their agency.
- **Assurance workshops** - informal multi-agency discussions, on a topic or issue that assure WSCB of the effectiveness of single and multi-agency arrangements. A series of assurance workshops were undertaken throughout 2016-17. The scope, findings and judgements of these are detailed at the relevant points in this report.

During 2016-17 the multi-agency audit programme undertook 4 audits on a total of 60 cases where a number of agencies were involved. Themes and overall judgements are summarised below. Due to capacity issues within the Safeguarding Business Unit support from the Head of Safeguarding, Walsall Council, ensured this programme was completed. The audits judged 45% of cases to require improvement and 24% as good and identified key learning points regarding good practice and areas for development. Audit findings are detailed within relevant areas of this report.

Table: Summary of Multi-Agency Audits 2016-17 and judgements

THEME	No of cases	Overall Judgement		
		Inadequate	Requires Improvement	Good
Q1 – Early Help	15	5 (33.3%)	6 (40%)	4 (26.6)
Q2 – Child Sexual Exploitation	15	2 (13%)	8 (53.33%)	5(33.3%)
Q3 – Domestic Abuse	15	0	6 (40%)	9 (60%)
Q4 – Child Sexual Exploitation Review	15	2 (13%)	7(47%)	6(40%)
Overall Total No / %	60	9 (15%)	27 (45%)	24 (24%)

Service Reviews were undertaken regarding Early Help and MASH with the outcomes presented to the WSCB. Individual agency action plans were developed to address specific recommendations.

What worked well?

- The multi-agency audit programme was completed and learning identified.
- The learning improvement framework for the Board was revised.
- A scorecard - based on North Yorkshire model – was put in place with the sub-group reviewing and updating the Board on the data, analysis, and process.
- A schedule of performance and assurance reports (by agency and topic) was established around the WSCB meeting cycle.
- The Section 11 audit process was completed during 2016-17 with a requirement from WSCB for all agencies to complete. This received a 100% completion rate, by early 2017-18, having been supported by an interim programme manager. (Page 35)
- The section 175/157 process for schools was implemented towards end of 2016-17 supported by a new online programme. (page 36)
- Practitioner forums took place to receive feedback from frontline professionals on practice issues and involvement them more in the improvement loop regarding multi-agency audits. Feedback has been given to practitioner forums in a “You said we did” format to provide assurance concerns or issues were actioned.
- A learning and improvement log was monitored and ensured audit findings were embedded. This will continue in 2017-18 where an annual review of audit findings will be undertaken will produce an overview report to help inform WSCB’s scorecard and learning and development activity across the partnership.
- WSCB commissioned a review of the Multi-Agency Safeguarding Hub (MASH) arrangements was undertaken in autumn 2016 resulting in recommendations. (Page 28)

What were the challenges?

- The absence of a performance officer within WSCB impacted on the development, and implementation, of the scorecard. The agreement to expand capacity within the Safeguarding Business Unit will resolve this issue by increasing capacity by 0.5FTE.
- Toxic Trio Sub-Group identified in April 2016 the limited capacity across the partnership to progress the data collation activity.
- The scorecard pre-dominantly includes children’s social care data currently. Further work is required to ensure a more multi-agency data set is populated and analysed with partners taking responsibility to provide required data. Further work is also required to triangulate quantitative data with qualitative data i.e. voice of the child, parents and professionals and research. This would ensure a more detailed analysis to provide assurance to WSCB on the impact and outcomes of multi-agency safeguarding working.

- 3/4 of multi-agency audits identified lack of engagement of some key agencies in the process.

“The role of WSCB in terms of quality assurance, accountability of performance and challenge on delivery is a recognised area for development and the new chair sees this as a priority. The recent challenge in submission of section 11 audits to timescale is an indication that this function is yet to be fully realised in practice”

CSE Peer Review July 2016

- Single agency audits and practice were presented to the sub-group and Board enabling WSCB to provide challenge. This process requires improvement and engagement of all partners to provide WSCB with adequate assurance.
- At the start of 2017-18 plans were implemented to chase up outstanding Section 11 Audits and to arrange peer challenge sessions to commence in May 2017.
- Messages from children are not routinely collated and shared across partnership and the partnership does not triangulate quantitative data with what children tell us.

Moving forward in 2017-18...

- Youth of Walsall (YOW) representatives will pilot inspection programme within Accident and Emergency Department of local hospital.
- To consider alternative ways to undertake Section 11 audit to ensure 100% compliance from agencies.
- Implement new Section 157/175 audit tool with schools to achieve 100% completion.
- To continue practitioner forums and align with multi-agency audit themes to triangulate findings with practitioner feedback and support analysis of performance scorecard.
- Progress the voice of child agenda ensuring collated messages/themes from single and multi-agency work inform the analysis behind the performance data set/scorecard.
- Continue work on embedding Learning and Improvement Framework to help analysis of scorecard to monitor help provided to children and families (including Early Help).
- Learning from multi-agency audit programme is embedded within the learning and development offer and sub-group work plan for 2017-18.

Toxic Trio Sub-Group

The sub-group was set up in April 2016 in recognition of the significant impact that the Toxic Trio has on all public services in Walsall and in particular the increased demand in Children's Services with increasing numbers of requests for Early Help, children on child protection plans and children becoming looked after.

Walsall recognised the need to have a more coordinated and strategic approach with single accountable governance to assess impact, commission services, and to coordinate operational response with the overarching aim of reducing prevalence and risk.

Aiming to ensure effective multi-agency working for families where mental health, substance misuse and domestic abuse co-exist given they are known indicators of increased risk of harm, the purpose of the group is threefold to;

- Understand the local prevalence and impact of the risks associated with the Toxic Trio on Walsall families.

- Set the strategic vision for the joint commissioning and delivery of services to reduce the risks associated with the Toxic Trio for families who require support and intervention.
- Ensure the delivery and monitor the effectiveness and impact on children, young people families, reporting progress and performance to the safeguarding boards.

Plans for 2016-17 were to; i) seek funding to resource the developments required to have a Toxic Trio Strategy in place and to determine the requirements for future support, and ii) facilitate joint working and priority setting across other strategic boards in Walsall.

What worked well?

- Black Country Women's Aid was commissioned to provide a new Independent Domestic Violence Advocacy service (IDVA) for victims of domestic abuse from April 2016 which was promoted in the WSCB newsletter.
- The appointment of a dedicated children and young person advocate based at the Cedar Centre in Walsall to work directly with children and young people within the wider early help and social care system when impacted by domestic abuse.
- A newly commissioned Perpetrator Programme was reported on resulting in exploring a commissioned service for 14-16-year olds who were perpetrators and victims of domestic abuse.
- The collation and consideration of evidence of impact and outcomes of three recently commissioned services – namely IDVA, perpetrator programme, Safe Families.
- The local authority used £5,000, secured from Safer Walsall Borough Partnership, to provide additional capacity to undertake Toxic Trio data analysis, service mapping, and gap analysis and produce evidence to support the development of a Toxic Trio strategy.

What were the challenges?

- Appropriate and consistent representation from all agencies on sub-group.
- Work on new neglect and toxic trio strategies was not completed.

Moving forward in 2017-18...

- To align neglect and toxic trio strategies and implementation plans promptly

Children Missing and Exploited Sub-Group (CMEC)

This section should be read alongside response to Priority 5 to ensure a complete overview of partnership working. The chair of the sub-group is a Detective Chief Inspector who is West Midlands Police Lead for Child Abuse in Walsall.

A few things about the CMEC Sub-group

- This strategic sub-group aims to have oversight of the identification and safeguarding of victims of CSE in Walsall and bring perpetrators to justice. This is achieved through increased awareness of CSE to encourage reporting by victims, their families and service providers, and to employ a range of tactics to both safeguard victims and pursue and manage perpetrators. This is to be delivered through the development of a partnership CSE strategy and delivery plan.
- The remit of the group extends to those children and young people who are missing from home, education and/or care and who are trafficked.

- The sub-group works closely with CMOG (Children Missing Operational Group) which oversees all operational activity to manage offenders and locations. The CMOG chair attends and reports to the CMEC sub-group.

What worked well?

- Chair of sub-group commissioned the development of a CSE Problem Profile for Walsall which was completed in February 2017 and will be refreshed annually.
- Progress within the group ensured effective delivery on Priority 5 in relation to CSE.
- CMEC, CMOG and MASE meetings worked together to ensure related issues to CSE were addressed. I.e. return home interviews were utilised to screen for risk of CSE.
- The sub-group ensured regional and national best practice was adapted and implemented including the use of the CSE Toolkit and Regional CSE Framework.
- A range of good quality training was delivered across the partnership to ensure the workforce was knowledgeable, confident and competent regarding CSE. This was aimed at professionals working with children and families as well as hotels and taxi drivers.
- Inputs and events have been held at educational establishments to support staff in identifying CSE risk factors and raise children and young people's awareness of CSE.
- Walsall supported regional CSE awareness and media campaigns, including social media, to support the regional CSE action plan and West Midlands Police Operation Sentinel.
- CSE offenders have been convicted in court for Walsall offences in past year which resulted in significant sentences.
- MASE meeting attendance has improved with meetings now having a dedicated chair.
- The development of CSE dataset based on Bedfordshire model was progressed
- LGA undertook a Peer Review of CSE arrangements and recommendations were implemented.
- Work was undertaken to complete a multi-agency CSE strategy.
- Street Teams are commissioned to complete return home interviews for a child returning from a missing episode and offer a range of education programmes for children and young people aimed at reducing risk
- The number of victims identified through referrals increased and the proportion those identified at Significant or Serious Risk of CSE reduced. This provided assurance that activity to identify risk, then to reduce that risk has been effective.
- The number of male children and young people identified at risk of CSE has increased following activities by Street Teams to encourage reporting and referrals in what is typically an under represented area of risk.

Partnership CSE Training 2016-17

- WSCB ran 4 multi-agency courses on CSE attended by 83 participants from a range of partners.
- Walsall CCG ran group CSE training attended by 106 professionals including 97 GPs, 8 practice nurses and 1 Healthcare Assistant.
- Walsall Children's Services held training facilitated by Loudmouth Theatre group who performed 'Working for Marcus' to relay key messages regarding CSE.

CSE Problem Profile 2016

Scope – To gain an understanding of CSE across Walsall Policing area with an emphasis on crime, potential perpetrators, victims and locations recorded / identified in 2016 (1/1/16 to 31/12/16) and where possible to compare with data collected for 2015.

Key Findings

Offences

- There was an increase, of reported offences using CSE marker in 2016 compared to 2015, of 4 offences.
- Main modus operandi is grooming by older males (36%) and then online grooming (30%)
- Highest crime type was Rape of Female aged 16 years or over reflecting seriousness of CSE related crime and reporting.
- Wider spread of offences recorded compared to 2015

Potential Perpetrators

- Potential perpetrators maybe identified through intelligence or through description of, as yet, unidentified suspects. They may also be a confirmed suspect linked to crime and under investigation, or even convicted of CSE related offence. The earlier in the process a potential perpetrator can be identified the earlier preventative action can be taken.
- Potential perpetrators of CSE come from all ethnic backgrounds and ages. The most represented profile of potential perpetrators – managed through CMOG in 2015 and 2016 – were Asian and White males aged between 18-24 years, with the profile of confirmed suspects (those under investigation for specific crime) of CSE crimes being White North European males aged 16 to 20 years.

Victims

- Not all identified children/young people who are at risk of CSE are/become victims of crime. Interventions are put in place to help reduce the risk of them becoming victims.
- Children at risk of CSE in Walsall come from all backgrounds with the most common profile being White British females aged between 14-16 years.
- 32% victims state they use illegal substances.

Locations

- A CSE 'location' can be a park where young meet and consume alcohol, a hotel where CSE offending could take place, takeaways where young people meet, a children's home where some of the most vulnerable children may reside, or the home address of a potential CSE perpetrators.
- 8 potential CSE locations were identified in 2016 compared to 13 in 2015. All of these were referred to CMOG to be managed through the partnership through either civil or criminal interventions, or support and training as appropriate.
- Main locations were open spaces and private residences

Issues / Themes

Links regarding being missing or excluded from education were highlighted for 71 of the 137 victims with identification of potential CSE with 9 schools accounting for over 50% of victims.

Recommendations

1. Engagement with schools to understand why some schools have such a high number of victims who are at risk of CSE.
2. Make use of online media and other media created to serve a warning to children and adults of the dangers of online grooming and sexual exploitation.
3. Ensure details in relation to victims, offenders and locations are shared between appropriate agencies so that the complete picture of CSE for Walsall is know and preventative plans can be put in place.

CSE Multi-Agency (Audit April to June 2016)

[2 cases – 'Inadequate' 8 cases 'Requires improvement' 4 cases 'Good']

Good Practice

- Evidence of good multi-agency working in 5/15 cases (1 in 3) audited.

Areas to Develop

- Some single agency files lacked clarity and little evidence of information being 'triangulated across agencies'.
- Agencies need to communicate with each other regarding new arrivals of children who are at risk of CSE.
- Invitations and attendance at MASE meetings is inconsistent.
- Agencies are sharing information with each other.
- Some evidence of professionals focusing on CSE to detriment of other risks or issues in child's life.
- Further progress needed for WSCB to be assured that operationally issue/risks relating to CSE are fully understood and shared in a way that leads to positive change for the child/victim.

CSE Multi-Agency Review Audit (January to March 2017)

[2 cases – 'Inadequate' 7 cases 'Requires improvement' 5 cases 'Good']

Good Practice

- Evidence of good multi-agency working in 6/15 cases.

Areas to Develop

- Communication across agencies
- Lack of management oversight and supervision
- Lack of challenge by professionals led to drift and delay in assessing risk and interventions to protect a child.

What were the challenges?

- The sub-group's primary focus was on CSE with some limited work being undertaken regarding missing children and very little in relation to trafficked children.
- There is some confusion regarding the functions and remit of this sub-group with CMOG and MASE.
- Training across children's workforce needs to include more focus on issues relating to being missing and trafficked children.
- Need to understand more about interrelation of CSE with other issues such as trafficking and missing within Walsall.

Moving forward in 2017-18...

- Refresh Problem Profile in relation to victim, offender, and location annually as minimum.
- Robust monitoring of support for children at risk of CSE, missing and who are trafficked.
- Further multi-agency audit to assure WSCB that interventions and safety plans for children at risk of CSE are consistent and effective, as well as return home interview following a missing episode.
- Continued implementation of CSE Strategy, using the balanced scorecard to track impact.
- Ensure CSE training programme for professionals, hotels, taxi drivers etc, continues.
- To retain and develop focus on children who go missing and who are trafficked to understand issues missing and trafficked children in Walsall.
- Use of performance scorecard to help understand the impact of interventions on children's outcomes regarding CSE.

Policy and Procedures Sub-Group

The sub-group supports WSCB to fulfil its responsibilities and functions as set out in *Working Together 2015* regarding policy and procedures. This includes overseeing the development and revision of WSCB policy and procedures and contributing to the review and development of the regional safeguarding procedures as required.

What went well?

- The successful implementation of the West Midlands Safeguarding Procedures Project resulted in the launch of the online procedures on 1st April 2017. WSCB was one of 9 safeguarding boards that developed regional multi-agency procedures to provide policy consistency at a reduced cost.
- The sub-group developed, or ratifying, several procedures adopted by the region.
- The functionality of the new procedures website will enable professionals to access procedures on 3 levels: -
 - Level 1 – overarching core child protection procedures
 - Level 2 – subject specific procedures agreed at regional level
 - Level 3 – procedures that are area specific including referral guidance, local levels of need and named contacts.

What were the challenges?

- Ensuring local developments do not duplicate or add another layer to regional procedures
- Maintaining up to date policies and procedures by ensuring they are regularly reviewed and are current given the broad remit of this work.

Moving into 2017-18...

- WSCB will continue to attend Regional Safeguarding Procedures Group (RSPG) which has a rolling programme in place to refresh and update West Midlands procedures.

Significant Incident & Serious Case Review Sub-Group (SCSIC)

This sub-group has delegated responsibility for managing Serious Case Reviews (SCR's) and Significant Incidents in Walsall. Referred cases are considered with regular updates provided to the sub-group for scrutiny before presentation to the Board. The Safeguarding Business Unit routinely monitors and tracks progress of all cases, administering all aspects of the process in behalf of SCSIC and the Board.

The Significant Incident and Serious Case Sub-Group considers all multi-agency referrals including those that the Local Authority considers to be a notifiable incident or meets the Serious Case Review criteria. The sub-group's terms of reference and membership meet statutory requirements should a SCR need to be commissioned. Any case considered to meet the SCR criteria is referred to the LSCB Chair for a final decision before notifying the National Panel.

A notifiable incident is one involving the care of a child that meets any of the following criteria: -

- a child has died (including suspected suicide) and abuse or neglect is known or suspected;
- a child has been seriously harmed and abuse or neglect is known or suspected;
- a looked after child has died (including cases where abuse or neglect is known or suspected)
- a child in a regulated setting or service has died (including cases where abuse or neglect is not known or suspected).

Local authority should report any notifiable incident to OFSTED and relevant LSCB(S) within 5 working days of incident.

All cases that meet the criteria for Serious Case Review will also meet requirements for a notifiable incident.

Not all notifiable incidents will meet serious case criteria.

Working Together 2015

A serious case is one where abuse or neglect of a child is known or suspected; and either –

- (i) The child has died; or
- (ii) The child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Key LSCB function is to undertake reviews of serious cases and advise the authority, and Board partners, on lessons to be learned.

Local Safeguarding Children Boards (LSCB) Regulations 2006 (Regulation 5)

- In addition to the above the death of a child in custody, on remand or following sentencing, in YOI, secure training, secure children's home or detained under Mental Health Act 1983 or if aged 16-17 years and subject to Deprivation of Liberty Order under Mental Capacity Act 2005
- Cases that meet the above criteria must always trigger a CSR requiring the LSCB to commission a Serious Case Review.
- Final decision regarding SCR – or an alternative type of review - lies with LSCB Chair
- Since 2012 a **National Panel of Independent Experts on Serious Case Reviews** was established to advise LSCB' on the initiation and publication of SCR including application of SCR criteria, appointment of reviewer, and publication of SCR reports.

Chapter 4 Working Together 2015

What went well?

- Feedback on the *Serious Case Review and Significant Incident Learning* event in February 2017 was very positive. 74 professionals attended including children's services practitioners, health visitors, midwives, GP's and representatives from adult services.
- Posters were produced for display across partner agencies relaying key messages learned during 2016-17. Handy pocket size booklets were produced and shared across the partnership.
- A new Serious Case Review (W5) was completed within timescales and waiting publication after the completion of criminal proceedings.
- A new methodology for Serious Case Reviews, which involved practitioner participation, was implemented and positively received.

Learning Reviews

Child A

Subject to Child Protection Plan until February 2015. Referred for consideration as serious incident in September 2015. Considered at SCSIC and Multi-Agency Review undertaken in early 2016 and resulting action plan agreed at SCSIC and Board. Review identified following learning: -

- Lack of record keeping in some agencies
- Lack of recognition of mother as a child herself at the time
- Absence of meaningful assessment of and engagement with father – a minor - by any professional.
- Care Group lacked understanding of domestic abuse and working with resistant families.
- Failure by some services to follow recognised procedures.

The learning points informed an action plan that was monitored by SCSIC.

Child B and Child C

During 2016-17 two further incidents were referred which had some similarities to Child A

A Table Top Review of Child B and C - for completion in 2017-18 - will require each agency to evaluate their involvement with each child and consider the cases in relation Child A's Review and action plan.

- A CSE learning Review was started regarding young person's experiences in transition between children and adult services. This will be completed in 2017-18.
- A toolkit was developed to ensure a more consistent approach to managing the SCR/Learning Review process and was trialled with new cases. The feedback will be reviewed and final toolkit launched in early 2017-18.

What were the challenges?

- Learning events were not well attended by community, voluntary or faith sector.
- There needs to be more pace from all partners in completing actions following reviews with more robust challenge from WSCB to partners regarding lack of progress.
- WSCB needs to assured the impact of learning activities on practice and outcomes for children is evaluated.

WSCB can be assured the arrangements for considering and completing a learning or serious case review are in line with statutory requirements, are robust and provide challenge across the partnership. Further progress is required to ensure that actions plans are followed through in a timelier manner and impact on professional practice and outcomes for children and families are measurable.

Moving into 2017-18...

- Further work is required to ensure community, voluntary and faith sectors are aware of, and are supported to appropriately respond to, the learning from serious incidents and that they understand the resulting expectations on them.
- Multi-Agency learning events– to cascade learning - in relation to learning from Child A, B and C reviews to be held early 2017-18.
- Ensure prompt implementation and robust monitoring of action plans from case reviews.
- To identify work required to measure impact of learning on professional practice and outcomes for children and families.

The Child Death Overview Panel (CDOP)

The LSCB is responsible for ensuring that a review of each child death is undertaken by a Child Death Overview Panel (CDOP). CDOP will have a fixed core membership drawn from organisations on LSCB but flexible to co-opt other relevant professionals as required.

- a) Collecting and analysing information about each child death with a view to identifying any-
- Case giving rise to the needs for a review mentioned in regulation 5(1) (e) i.e. Serious Case Review;
 - Matters of concern affecting the safety and welfare of children in the area
 - Wider public health or safety concerns arising from a death or from a pattern of deaths in the area

AND

- b) Putting in place procedures for ensuring that there is a coordinated response (includes rapid response arrangements) by the authority, their Board partners and other relevant persons to an unexpected child death
This means WSCB must ensure: -

- All child deaths within their area are reviewed by CDOP
- A Child Death Overview Panel is in place to review child deaths once all partner information is collated (Individual agencies complete Form B which are collated into Form C and presented to CDOP)

The purpose of a child death review is to learn lessons for future practice. The local CDOP, established in Walsall in 2008, is a joint panel with Wolverhampton and complies with statutory requirements. LSCBs responsibilities for CDOP are detailed in *Chapter 5 -Working Together 2015, Regulation 6 of Local Safeguarding Children Board Regulations 2006, and Section 14(2) of Children Act 2004.*

CDOP takes strategic responsibility to ensure that in Walsall:

- Comprehensive and multi-disciplinary/agency reviews of all child deaths (unexpected and expected) are undertaken to help understand how and why children die. Findings are used to take actions to prevent other child deaths and promote children's welfare.
- Recommendations are made, where appropriate for WSCB, or relevant bodies, to action to prevent future deaths,
- CDOP co-operates with regional and national initiatives to identify lessons learned.

A few things about CDOP arrangements in Walsall...

- CDOP is a multi-agency, multi-disciplinary panel that reviews all deaths of children over 24 weeks gestation to enable completion of a Form C for each child. Forms C's are informed by collating information from Form B's that are completed by individual agencies that have provided services to the child before and around the time of death.
- CDOP is supported by the Form C Preparation Group which quality assures Form B's to prepare each Form C prior to CDOP.

- In the absence of a substantive CDOP Administrator post, CDOP activities were supported by the Safeguarding Business Unit. Administration duties associated with Rapid Response needs (receiving and processing child death notifications, convening and administrating Rapid Response meetings) were not compromised. However, there was an impact on processing and managing information for child death reviews by CDOP which affected CDOP's ability to perform efficiently and effectively.
- WSCB receives the CDOP Annual Report and progress reports on CDOP business.
- Matters are escalated to the Independent Chair appropriately.

About child deaths in 2016-17

- 28 child deaths were reported as for review by the CDOP in 2016-17.
 - In a six-year reporting period the number of local child deaths reduced. 2016-17 saw an increase of 7 child deaths. The reduction in child deaths overall is positive.
 - 46% of the child deaths were expected deaths.
 - Eleven child deaths occurred during the neonatal period (under 28 days of age). This was 39% of the child deaths for review. This was the same number for 2015-16.
 - Multi-agency Rapid Response meetings were convened accordingly in line with established procedures for unexpected child deaths.
 - 61% of the child deaths were reviewed and completed by CDOP by 31st March 2017.
- Fifteen child death reviews were completed and submitted for the mandated Department for Education Annual Return for 2016-17.
 - This is a significant improvement on the performance rate since 2015-16. Actions have been taken to improve timeframe for completion of individual child death reviews in 2017-18.
 - The reviews that were completed related to:
 - 1 child death that occurred during the 2014-15 reporting time-frame
 - 11 child deaths that occurred during the 2015 – 2016 reporting time-frame
 - 3 child deaths that occurred during the 2016 – 2017 reporting time-frame
 - Modifiable features were identified in 67% of the child death reviews compared to 29% in 2016-16. This is a considerable improvement achieved by ensuring more comprehensive information from agencies/services for learning purposes.

What worked well?

- CDOP met more frequently with more comprehensive detail informing the agenda.
- A full programme of Form C Preparation Group meetings enabled better informed and meaningful discussions on individual child death reviews.
- Engagement of colleagues across the partnership with the escalation process used periodically to improve attendance and/or contribution by certain disciplines. This will continue to be monitored closely in 2017-18.
- Performance frameworks to monitor child death review activity and to pursue lines of enquiry were established and maintained,
- A learning tracker was developed to support awareness-raising activities.
- Arrangements were agreed to ensure learning from Root Cause Analysis helped support partnership learning and development activities and also identified emerging themes.
- Mandatory Department for Education return was submitted on time for 2015-16.
- CDOP Annual Report 2015-16 was accepted and endorsed by WSCB in autumn 2016.
- Two multi-agency/multi-disciplinary learning events were delivered and evaluated well.

- Form C Preparation Group saw an improvement in the quality of Form B's completed and them being submitted more promptly.
- Local CDOP guidance and a process chart were developed and adopted by partners.
- Maintaining close links with Public Health informed the local agenda to reduce Infant Mortality Rate through on-going engagement in CDOP activities by Public Health.

What were the challenges?

- Absence of CDOP Coordinator post delayed CDOP completing child death reviews.
- Concern regarding the accrued backlog of child death reviews was periodically escalated by CDOP Chair to the WSCB Chair and Board. A review of local arrangements made recommendations to WSCB to enable the CDOP to operate efficiently and effectively.
- By April 2017 specific actions had been taken to address concerns including:
 - Inclusion on the WSCB risk register regarding outstanding work,
 - Approval of funding to re-establish CDOP Coordinator post.
 - Escalation to WSCB Chair of the need to expedite recruitment,
 - Additional support of Walsall CCG Safeguarding personnel to attend CDOP.
 - Additional support from Local Authority to attend to outstanding needs.
- The additional impact of CDOP Chairs workload from the additional work within the Form C Preparation Group.
- The prompt submission of completed Form B's requires improvement by some partners.
- Although the combined membership of CDOP and Form C Preparation Group enabled child death reviews to progress the regular attendance of some key agencies/ professionals requires improvement. This was monitored and escalated by CDOP chair appropriately. Close monitoring of partner agency engagement will continue in 2016-17.

Moving forward in 2017-18

- Submission of the Department for Education return on time.
- Establishing and maintaining robust oversight of the progress of child death review activity.
- Production of the CDOP 2016/17 Annual Report.
- To build on the improvement of the quality and timeliness of submitted Form Bs.
- Develop understanding of the quality of Rapid Response activities.
- Assurance that i) learning from CDOP review of child deaths is being applied and ii) local public health strategies are informed by/and inform CDOP business and other multi-agency forums as applicable.
- Maintain accessible, current information on WSCB website.
- Refresh terms of reference and other CDOP documents to ensure they remain current.
- Review CDOP Chairs workload given additional demands of Form C Preparation Group.
- Determine CDOP Chairing and Vice-Chairing arrangements post 2017.
- CDOP to continue to engage in regional agenda and respond accordingly to any progression of the government response to *Wood Report*.
- Continue engagement with the regional Maternity and Infant Health work stream of the Black Country and West Birmingham Sustainability and Transformation Plan.

Monitoring Effectiveness

This section looks at the key aspects of single and multi-agency work that provide assurance to WSCB of the effectiveness of multi-agency safeguarding arrangements for children in Walsall. This links to key statutory requirements and delivery on WSCB priorities detailed from page 37.

Early Help

The provision of early help services should form part of a continuum of help and support to respond to the different levels of need of individual children and families. **Working Together 2015**

A few things about Early Help in Walsall 2016-17

- The 0-19 Early Help locality offer enables timely provision of the right interventions.
- The Early Help Hub receives contacts from professionals and members of the public and triages all enquiries to ensure no safeguarding issues are present. Each request is then assessed and Early Help coordinates cases to go to one of four locality panels.
- If an Early Help Assessment is required contact will be with the family within 5 days, assessment completed within 15 days and multi-agency plan in place within 25 days. Plans are reviewed every 4-6 weeks. Any agency can take lead role for assessment.
- Early Help Hub has a locality group programme to enable prompt interventions thus ensuring more timely intervention and better management of demand.
- Locality Partnership Panels draw on wider partners to ensure effective early help offer and identify partnership solutions for complex cases.
- There were 4,985 requests for Early Help compared to 3,128 in 2015-16.

Table: Top 5 Early Help Child's Needs -Identified at Contact –

Identified Child's Need	No / %
1. Information Request	1596 (30%)
2. Domestic Abuse to parent / carer / household member	729 (14%)
3. Physical Abuse	555 (11%)
4. Neglect	473 (9%)
5. Emotional Abuse	205 (4%)

- A total of 1,004 Early Help assessments were completed. (1,404 in 2015-16).

Service Review – Early Help (September 2016) – ‘1,000 case review’

Review of 892 children's cases (502 families) in receipt of Early Help services from multi-agency practitioners.

The review identified priorities that the Early Help Steering Group has progressed with regular reporting from Early Help lead into the WSCB Quality Assurance and Performance Sub-group. The priorities are: -

- Strengthening information sharing across the partnership to ensure early identification and partnership actions in supporting vulnerable children and young people.
- Strengthening the role of the Voluntary and Community Sector (CVS).
- Strengthening Early Help offer to children affected by adult mental health, disability and child mental health.
- Enable the workforce across the partnership to be able effectively respond to review findings.

- Early Help overview for 2016-17 indicates that since '1000 Case Review' Early Help has had a focus on '**providing the right interventions at the right time**' achieved by consideration at point of allocation, presenting need and history if family would benefit from Early Help Assessment
- The number of re-referrals to Early Help within 12 months is not known for 2016-17.

What went well?

- Schools took on the role of lead professional more than in previous years (38.9%).
- New 0-5 child health contracts planned for 2017-18 will ensure health visitors take lead professional role for 0-5-year olds. In preparation Lead Professional training was delivered to clinical leads and will ensure all health visitors are trained by 1st June 2017.
- Early Help Strategy prioritised need for voluntary sector to take a more active role.
- The majority of schools took up Early Help offer of half-termly supervision to schools leading to significant improvements in management oversight of Early Help cases, quality of assessments and plans with schools fulfilling lead professional role appropriately.
- The service has started to gain parental views regarding interventions

The school advisor is fundamental part of our school, we welcome supervision and the bespoke training. It has made us feel more confident within Early Help

I struggled alone through the EHA until the arrival of the school advisor who is always available to offer help and assistance and co-ordinates early help extremely well with a passion

What were the challenges?

- There were fewer positive closures – cases closed or stepped down to single agency or universal services - of early help cases compared to previous year (62.4% in 2016-17 compared to 83.2% 2015-16)
- To ensure a wider range of agencies take on 'lead professional' role.
- Further analysis needed to confirm thresholds are appropriately and consistently applied.

Moving into 2017-18...

- To continue to present Early Help data to Quality Assurance and Performance sub-group and WSCB and use to inform WSCB scorecard and analysis.
- To progress towards seeking the views of children in terms of impact of interventions to include regular reporting to WSCB.

Multi-Agency Safeguarding Hub (MASH)

A bit about MASH arrangements...

- MASH is a multi-agency hub intended to involve all statutory and non-statutory safeguarding partners in an integrated workplace to deliver partnership assessment and decision making in relation to concerns about children at risk. The core partners who

should be co-located in the MASH are Children's Social Care, Police, Health, Education and Probation. It is designed to deliver three specific outcomes: -

- Early identification and understanding of risk
- Victim identification and intervention
- Strategic harm identification and reduction.
- 5 key elements have been identified to ensure MASH pathways for children are effective;
 - All notifications relating to safeguarding/welfare of a child go through the hub.
 - Co-location of professionals from core agencies research, interpret and determine what is proportionate and relevant to share.
 - The hub is 'fire walled' to keep MASH activity confidential and separate from operational activity whilst providing confidential recording system.
 - An agreed process for analysing/assessing risk, based on the fullest information and dissemination of a suitable information product to the most appropriate agency for necessary action.
 - A process to identify victims and emerging harm through research and analysis.

A few things about multi- agency arrangements to safeguard children during 2016/17

- The Walsall MASH has been operational since early 2016 and is located within Children's Services. The Emergency Response Team (ERT) responds to referrals outside of office hours (evenings and weekends) as well as public holidays.
- Partnership representation in the MASH includes Children's Social Care, Police, Probation, Education Welfare and Early Help. Health are engaged with the MASH outside of the secure area.
- Referrals are made through the Multi-Agency Referral Form (MARF) submitted by secure email and is entered onto Children's Services IT system (MOSAIC) where an initial recognised RAG rating is given (RED AMBER GREEN)
- Social workers deliver MARF training across partnership.
- 13,943 contacts were made to MASH (2,108 per 10,000 of 0-17 population. That is 1 in 5 young people. This is an increase from 2015-16 where there were 10,803 contacts at rate of 1,673 per 10,000.
- 47.6% of contacts to MASH were within 12 months of previous contact (48% in 2015-16).
- 66.7% of MASH contacts resulted in NFA (no further action) by children's social care (75.7% in 2015-16). Of those NFA'd 1,369 were directed to Early Help Hub and 133 to single agency early help. (861 and 482 respectively in 2015-16).

MASH Service Review (Autumn 2016)

WSCB commissioned a review of MASH arrangements - by social work consultant and original designer of MASH model - to cover three core areas:

- Process and legality – Governance and consent – Voice of the victim in the process
- Pathways to services – Early intervention opportunities.
- Partnership involvement, integrated working,

Review Findings

- Referrals – inconsistent quality of MARF's, some MARF's submitted through unsecure accounts or fax, excessive amount of time spent in MASH ensuring referrals were fully and correctly articulated.
- No partner engagement in early stage of referral to MASH
- MASH and Early Help have close links but services are not integrated.

Good Practice

- Appropriate out of hours cover
- Effective and better decision making regarding referrals
- Operates a safe MASH model adhering to 'no delay' principle

Areas to develop

- To ensure referral pathways are secure
- MASH to include IDVA (Independent Domestic Violence Advocate), housing representation mental health

What went well?

- The MASH Review found
“Walsall MASH model is operating effectively and making better decisions concerning child safeguarding referrals as a result of its partnership information and design.... It is in the opinion of the review team a safe MASH model attempting to always work very much to the ‘no delay’ principle for children and families” MASH Review 2016
- The section 11 audit showed a good level of staff confidence regarding knowing how and when to share information legally and ethically to safeguard children (88%)

What were the challenges?

- The section 11 audit showed a lower level of confidence regarding effective inter-agency working and information sharing (71% but as low as 12% in some agencies)
- Health professional to sit inside the MASH area
- The MASH Review Team identified some issues/concerns which were addressed with DCS and resulted in immediate changes to practice within MASH and Early Help Hub.
- CSE Peer Review found
“MASH arrangements not yet reaching their potential ... whilst the MASH did deliver co-location Further work is required so that the MASH becomes a fully integrated unit”.
- WSCB needs to understand more about the connection between the number of contacts resulting in NFA (66.7%) by children’s social care, the number who do not receive any early help service (2/3 of contacts) the number of repeat contacts made within 12 months (47.6%) to be assured children and family access the right support at the right time and are effectively safeguarded.

From 2017-18 WSCB will...

- Further develop scorecard to ensure robust data analysis from wider range of partners.
- Analysis of impact and outcomes, including re-referrals into Early Help and MASH, to be included in performance scorecard.

Local Authority Designated Officer (LADO)

Organisations should have in place arrangements that reflect the importance of safeguarding and promoting the welfare of children, including....

- Clear whistle-blowing procedures... referenced in staff training and codes of conduct, and a culture that enables issues about safeguarding and promoting the welfare of children to be addressed...
- Safe recruitment practices for individuals whom the organisation will permit to work regularly with children...
- Clear policies in line with those from the LSCB for dealing with allegations against people who work with children.

Local authorities should...

- Have a **designated particular officer**, or team of officers, to be involved in the management and oversight of allegations against people that work with children. (Should be a qualified social worker)
- Put in place arrangements to provide advice and guidance on how to deal with allegations against people who work with children to employers and voluntary organisations.
- Ensure that there are appropriate arrangements in place to effectively liaise with police and other agencies to monitor the progress of cases and ensure they are dealt with as quickly as possible.

Walsall's LADO's function meets the *Working Together 2015* requirement to have **designated particular officer**. The LADO produces an annual report providing an overview of the management of allegations/concerns regarding people working in position of trust. The report summarises and analyses relevant data and highlights key areas for development. WSCB's *Allegations of Abuse against Persons Who Work with Children (Including Allegations against Carers and Volunteers)* procedures, are based on the requirements in *Working Together 2015*.

Allegations may relate to a person who works with children who has:

- Behaved in a way that has harmed a child, or may have harmed a child;
- Possibly committed a criminal offence against, or related to, a child; or
- Behaved towards some child(ren) in a way that indicates potential risk of harm to them.

About allegations and contacts during 2016-17...

- 298 contacts to LADO compared to 294 in 2015-16.
- Some contacts raised issues about professional boundaries.
- Majority of contacts – 62% in total - related to physical abuse and neglect. Contacts relating to sexual abuse increased mainly in relation to appropriate professional boundaries (classified under sexual abuse). The LADO will continue to report on this in future and use to inform overall analysis.
- 42 (14%) of the 298 contacts resulted in a position of trust meeting held when there is a credible allegation of harm and ongoing investigation.
-

Table 3: Outcomes of cases progressing to a Position of Trust meeting

Allegation Outcome	Unsubstantiated	Substantiated	Unfounded/False	Ongoing	Malicious
Number	24	6	7	5	0
%	57%	14%	17%	12%	0%
2015/16 %	37%	24%	18%	16%	0%

Case Study - Proportionate Management of Allegations

A children's residential setting had a series of allegations from a new young person in the unit who presented significant challenges to staff. The LADO initially had oversight of these challenges but eventually there needed to be some principles for this individual young person to ensure a proportionate response and that any concerns were identified but there was not a full investigation where it was clearly not warranted.

This approach was agreed with the social worker and home management - any doubt as to the actions of staff would still be referred through to LADO. Where reasonable safeguards were met along agreed principles and it was clearly not a credible allegation, this would be managed at a lower level to provide a better response for the young person.

The LADO visited the home to reinforce safe practice receiving positive feedback. Ofsted commented in their inspection report on the home's positive engagement with the LADO in respect of this situation.

What went well?

- Since appointing a permanent LADO, in 2013-14, there's been a strong emphasis on awareness raising across all sectors and a robust consistent approach.
- Mosaic functionality is improving enabling a more detailed analysis of contacts etc.
- Education referral pathway is strong and schools utilise LADO for advice/guidance.

- 2016-17 saw an increase in contacts for foster carers showing strong referral pathways.
- Contacts regarding faith sector almost doubled to 19 (6%) of all contacts.

Case Study - Professional Boundaries

Members of a Christian religious group were having social media contact with a young person who helped out at the setting. One individual hugged the young person (and others). The adults had come from overseas and it seemed likely that they had not clearly understood local expectations. Whilst there was no indication of harm following investigation a parent had become very concerned by the behaviour, partly because the setting had managed the situation for some months without referring to statutory agencies. The LADO explored with the setting the gaps in training and advice was given to certain members of the community in positions of trust, the need for prompt referral to ensure transparency was emphasised as was the need for a robust response even where it is felt harm had not occurred but where it is perceived. This is particularly important with concerns of a sexual nature and the potential for grooming through seemingly minor boundary breaches. In addition to this the LADO newsletter addressed issues of professional boundaries and the use of touch and training has been updated to reflect the learning for all organisations.

- The analysis of contacts to the LADO enables learning on how to further safeguard children. This is utilised to inform i) discussions and decision making and ii) training and awareness raising across partnership to ensure better identification of risky behaviour.
- The LADO newsletter is a key way to deliver messages about safeguarding across the children's workforce partnership reaching over 300 individual settings and organisations.
- The National LADO conference (March 2017) - hosted in Birmingham by Regional LADO network. Walsall's LADO chaired the Conference Planning Committee and provided closing remarks. 108 local authorities, statutory and voluntary agencies attended.
- Information leaflet was developed (issued April 2017) for those subject to an allegation.
- Training available for senior leaders in education settings and partner agencies was supported by site visits to partners requiring a more targeted approach.
- LADO reports monthly to Director of Children's Services to provide assurance of management of allegations arrangements.
- The openness and transparency of the LADO's annual reporting support this by identifying key issues and areas for development.

Staff were receptive to your passion for residential care and your understanding of the complexity of group living from children who are displaying emotional outbursts and struggling with their complex issues

To have a LADO who advises on the process at the same time as offering a balanced view on circumstances filed my team with support that the LADO and POT meetings are not blame meetings but professional fact finding and decision making was desired outcome only in the best interests of the children

What were the challenges?

- Reduction in Early Years contacts, due to sector changes, is indicative of underreporting. Increased focus on the sector with briefings etc saw referrals increase and is expected to continue in 2017-18 as referral pathways are strengthened.
- The reduction in contacts regarding health staff and low rate of contacts related to sports settings requires further clarification.
- Further work is required with the faith sector to increase awareness of safeguarding, appropriate behaviours and expectations of staff and volunteers.

WSCB is assured arrangements to manage allegations against staff are robust and effectively safeguard children and young people.

Moving into 2017-18...

- LADO to present Annual Report 2016-17 to WSCB for information and scrutiny.
- LADO to update WSCB on progress against recommendations in 2015-16 annual report.



Quality and Effectiveness of Arrangements and Practice

Restorative Practice

- The term restorative practice is used to describe a way of behaving that focuses on building, maintaining and repairing relationships based on a commitment to working with people, rather than doing things to / for them. It is based on strong evidence suggesting that working with / alongside families - rather than making decisions about them in isolation (doing to / for them) - improves the outcomes for children and their families.
- Restorative practices enable those who work with children and families to focus upon building relationships that create change requiring challenge as well as support.
- Restorative Practices can be used for a range of formal and informal meetings, both formal and informal.
- Walsall Social Care and Early Help are adopting an approach of “high challenge, high support” to maximise a family’s strengths to ensure that changes are realised and maintained over time.

What went well?

- Children’s Social care implemented this approach to engage and support their work with children and families during interventions and **improve** outcomes for children to ensure a consistent response.
- Four multi-agency workshops were held by WSCB on the approach.
- Range of training events and resources have been promoted across children’s social care to support the Restorative Practice approach.

What were the challenges?

- There is a lack of partnership understanding of the approach and no partnership sign up to use the approach as appropriate.

From 2017-18 WSCB will...

- Champion the Restorative Approach across the partnership to further develop the initiative begun by Children’s Social Care.

Thresholds

- Important there are clear criteria for taking action and providing help across the full continuum of need.
- Having clear thresholds for action which are understood by all professionals and applied consistently, including for children returning home from care, should ensure that services are commissioned effectively and that the right help is given to the child at the right time.

- The LSCB should agree with Local Authority and its' partners the levels for the different types of assessment and services to be commissioned and delivered. This should include the when a case should be referred to Local Authority's Children's Social Care for assessment and / or statutory services.
- Local Authority's social care has the responsibility for clarifying the process for referrals.
- The LSCB should publish a **threshold document** that includes the process for the early help assessment and the type and level of early help services to be provided.
- The criteria including the level of need for when a case should be referred to the Local Authority 's Social Care for assessment and for statutory services under: -
 - Children in Need (Section 17 – Children Act 1989)
 - Children where reasonable cause to suspect child suffering / or likely to suffer, significant harm (Section 47 – Children Act 1989)
 - Children subject to Care Orders (Section 31 – Children Act 1989)
 - Duty to accommodate Child section 20 – Children Act 1989)
- Clear procedures and processes for cases relating to Child Sexual Exploitation. **Working Together 2015**

The WSCB thresholds guidance identifies thresholds for referring children and families for additional/specialist support. It was agreed in November 2015.

What went well?

- Five multi-agency training events focusing on WSCB thresholds document (between May and July 2016). 103 staff (92% of the targeted cohort) attended. Most participants felt the training would improve their practice in application of thresholds to referrals, decision making and escalation of cases.
- From July 2016 monthly thresholds training was delivered.
- The '1000 Case Review'(completed July 2016) evidenced appropriate application of thresholds. Review also noted a high number of cases closed due to disengagement. Work undertaken since demonstrates cases are appropriately stepped up to social care where no evidence of capacity to change or reduced risk.
- The MASH Review found that the RAG rating process used within MASH was: -

“Fundamentally in tune with the levels of need document for the partnership”

AND

“It is believe given the current processes in place that all threshold cases requiring statutory response are forwarded through responsive processes, without delay into the appropriate business areas and the requisite partners are involved” **MASH Review 2016**

What were the challenges?

- Thresholds training was attended by statutory sector i.e. children's services, education, NHS and police.?
- Evidence suggests an inconsistent application of thresholds meaning children may not be safeguarding promptly.

Assurance Workshop – Children with Disabilities

The workshop focused on multi-agency safeguarding arrangements within Walsall for children and young people with disabilities. The workshop found: -

- Need to link strategically regarding application of thresholds across various services i.e. schools. Agencies do not always make referrals promptly – unclear if this is about high thresholds at Early Help / MASH or how agencies apply them before making referral.
- Sometimes children with low level need are not referred.
- Some anxieties about response to referrals in MASH and social workers not knowing thresholds.

- WSCB is unable to evaluate the impact of training on practice in applying thresholds.

WSCB is assured it has threshold guidance for the partnership. Further assurance is required that professionals across partnership are using and applying guidance consistently.

From 2017-18 WSCB will...

- Review the thresholds guidance and its application in practice to ensure it remains fit for purpose and is consistently applied consistently across the partnership.
- WSCB will review its multi-agency Learning and Development activities to ensure staff are confident and consistently apply thresholds appropriately.

Section 11 Audit

Section 11 Audit

- Section 11 of Children Act 2004 places duties on a range of organisations and individuals to ensure their functions – and any services that they contract out to others are discharged having regard to the need to safeguard and promote the welfare of children. This includes: -
 - Clear line of accountability for commissioning and / or the provision of services designed to safeguard and promote the welfare of children
 - Senior Board level lead to take leadership responsibility for organisation's safeguarding arrangements.
 - Culture of listening to child and taking account of their wishes and feelings in individual decisions and development of services
 - Clear whistle-blowing procedures... referenced in staff training and codes of conduct.
 - Arrangements setting out processes for sharing information with other professionals and LSCB.
 - Designated / named professional lead for safeguarding
 - Safe recruitment practices for individuals whom organisation will permit to work regularly with children.
 - Appropriate supervision and support for staff including undertaking safeguarding training.
 - Clear policies in line with LSCB's on dealing with allegations against people working with children
- All LSCB's are required to monitor and evaluate how agencies working with children fulfil their statutory obligations in relation to Section 11.
- Organisations with these responsibilities need to provide WSCB with assurance that they are fulfilling their statutory safeguarding obligations and that their arrangements are effective. The Section 11 audit contributes to the performance management and quality assurance activity to assure WSCB arrangements are effective.

Working Together 2015

WSCB historically has monitored Section 11 compliance - across the partnership - every two years requiring organisations to complete an online self-assessment and produce an action plan to address areas for development. This demonstrates single agency compliance with Section 11 requirements. Difficulties in achieving full compliance by all agencies in 2015/16 resulted in WSCB requiring all organisations to complete the Section Audit in 2016-17.

About the 2016-17 Section 11 Audit;

- Required 15 organisations to complete an online audit tool regarding the requirements of section 11. BY the summer 2017 there was 100% compliance.
- The quality, range, analysis and supporting evidence in completed audits varied.
- Analysis of the audit process identified the following issues and themes for agencies to: -
 - Update single agency safeguarding policy and procedures
 - Strengthen children's voices in service planning and design.
 - Deliver staff awareness raising training/briefings on E-Safety.
 - Need for service wide CSE awareness raising for staff and parents/carers.
 - Promote greater understanding of LADO role and managing allegations
 - Provide assurance and evidencing that contractors are section 11 compliant.

Peer challenge events are planned from May 2017 to pair up agencies to consider key questions regarding individual agency audits and offer challenge. The Safeguarding Board Manager will facilitate this process and the outcome of sessions reported to WSCB.

What went well?

The analysis of the Section 11 audit process in 2016-17 provided WSCB with assurance of safeguarding arrangements in respect of: -

- Senior management commitment to importance of safeguarding children.
- Organisations having clear statement of their safeguarding responsibilities towards children and these are available to staff.
- Service development takes account of need to safeguard and promote welfare.
- Safe recruitment.
- Staff know when and how to share information in legal and ethical way.

What were the challenges?

- Securing timely compliance across the partnership.
- A regional task and finish group is developing a regional Section 11 audit tool. Other LSCB work nationally on Section 11 process has considered less traditional approaches.

Moving into 2017-18

- Moving forward WSCB should consider its' options to ensure the right approach for the partnership regarding Section 11 audit process.

Section 157/175 Audits

Section 157 / 175 Audits Education Act 2002

Schools and colleges are one of the organisations named within section 11 audit process. In addition to this Section 157 / 175 of the Education Act 2002 places duties on educational establishments in relation to safeguarding and promoting the welfare of pupils. To meet these duties schools should have in place arrangements as set out in the statutory guidance – namely *Working Together (2015)* and *Keeping Children Safe in Education (2015)*

A few things about Section 157/175

- Schools and colleges are required to meet the requirements of section 175/157 audits similar to section 11. WSCB revised its online audit tool used for Section 175/157 in 2016-17 to address changes in legislation/guidance and specific safeguarding risks.
- All education establishments for children and young people (including schools, and colleges) are expected complete the online tool in order to self-evaluate under the criteria set out in Sections 157/ 175.
- The tool was available to all Walsall schools 1st March 2017 for completion by April 2017.
- By April 2017 101 – out of 130 – schools/colleges had completed the audit, 3 had started an audit and 26 had not. The themes /learning from this audit were identified and presented to April WSCB Board. Proposed actions included need to: -
 - Share findings/recommendations from local, regional and national SCR and significant incidents.
 - Ensure all governors, including chair, attend safer recruitment training.
 - Offer support to parents/carers re online safety sessions.
 - Require all staff to complete basic *CSE, FGM, Honour Based Violence and Forced Marriage* and *Domestic Abuse* awareness training.

- Schools not compliant with Section 175/157 to be contacted by WSCB chair

A detailed report of the audit process, responses and findings will be presented at WSCB during 2017-18 and detailed in the WSCB Annual Report 2017-18.

Meeting our priorities

Priority 1

Improve the effectiveness and impact of WSCB in ensuring children and young people are safe.

Rationale: WSCB has identified a range of development activities so that it operates within a clear and well-established governance framework, holds partners to account and delivers on its statutory functions.

To fulfil its statutory functions LSCB's should use data and, as a minimum, should;

- Assess the effectiveness of the help being provided to children and families including early help.
- Assess whether LSCB partners are fulfilling statutory obligations set out in 'Working Together 2015'
- Quality assure practice, including joint audits of case files involving practitioners and identifying lessons to be learned
- Monitor and evaluate the effectiveness of training including multi-agency training to safeguarding and promote the welfare of children.

Local authorities and Board partners should provide LSCB with data to enable it to fulfil its statutory functions.

Working Together 2015

This section should be read alongside the previous section on monitoring effectiveness.

The WSCB performance scorecard tells us...

- 1/3 of all contacts to Children's Social Care resulted in NFA
- 1,895 Children in Need (1,636 in 2015-16) – rate of 435 per 10,000 0-17 population almost double England average of 228 and more than statistical neighbours at 397.
- 4,940 contacts resulted in 1,514 section 47 inquiries, of these 564 Initial Child Protection Conferences took place, of which 92.8% resulted in child being in need of Child Protection Plan.
- 95.4% of Child and Family Assessments were completed within 45-day timescale.
- 88% of Child Protection Conferences were held within timescales.
- The number of children and young people on Child Protection Plan reduced from 408 in 2015-16 to 333 in 2016-17.
- 603 children subject to Child Protection Plans that were ceased during 2016-17 compared to 529 in 2015-16.
- 3 out of 4 children subject to Child Protection Plan had statutory visits within 10 working days and all had allocated qualified social worker.
- 3,967 core groups took place during the year compared to 2,723 in 2015-16.

	31 st March 2016	Q1 April to June 16	Q2 July to Sept 16	Q3 Oct to Dec 16	Q4 Jan to Mar 16
No. Children on Child Protection Plan	408	427	440	352	333

- The data on the scorecard that was not available promptly includes: -
 - Total number of referrals stepped up to tier 3
 - The level of information, or basis for analysis, to provide WSCB with assurance that partnership working effectively safeguards children in Walsall.

- Repeated contacts / re-referrals within 12 months and conversion rates for MASH referrals i.e. those that lead to strategy meetings, number of strategy meetings leading to Section 47 enquiries, number of Section 47's leading to child protection conference, no of conferences leading to Child Protection Plan, and number of children on Child Protection Plans for over 12 months or in subsequent plan.

What went well?

- Evidence that reduction of children subject to Child Protection Plans is positive and evidence to provide assurance appropriate application of thresholds and interventions effectively safeguard children and young people identified most at risk.
- Clear actions have been agreed to maintain and progress outcomes monitoring within framework to assure WSCB can be assured that safeguarding arrangements effectively safeguard children in Walsall.

What were the challenges?

- Scorecard has gaps regarding data for young people with disability and/or mental health issues transferring to adult services, access to provision and threshold criteria post 18.
- Although the scorecard progressed during the year further development is required to ensure it reflects more multi-agency data, data analysis including views of children, families and professionals, and good practice / research evidence.

From 2017-18 WSCB will...

- Continue to progress work on ensuring it is able to measure effectiveness of multi-agency safeguarding arrangements in Walsall to provide assurance they are effective.



Priority 2

Increase the responsiveness and impact of the help and support provided to children, young people and families, including children with disabilities and mental health issues.

Rationale: Local intelligence indicates that there is a need to develop i) a shared understanding and application of thresholds, ii) embed the Early Help offer including role of Lead Professional and iii) improve the contribution of partner agencies to multi-agency safeguarding forums.

Children with Disabilities**A few things about children with disabilities in Walsall...**

- 179 contacts made to Early Help identified child with disability in 2016-17. 68 referrals were made to Children's Social Care (1.5% of all referrals)
- There is no clear definition or comprehensive list/register for Children with Disabilities.

Disabled Children – Assurance of Allegations Against Staff Arrangements Appropriate

A referral was made to LADO about a highly respected and trusted staff member identified via whistle-blowing for alleged physically and emotionally abuse towards a number of vulnerable children with little communication. Further investigation led to reports from other colleagues indicating potential abuse over a period of months. The case is subject to an ongoing police investigation.

What was highlighted was that there were no concerns about the individual's recruitment whose practice – for years - was exemplary with senior staff completely unaware of a possible problem.

The LADO worked with the setting to understand what it was about the culture that may have meant that concerns went unnoticed by senior staff and why other staff failed to 'whistle blow' promptly. This included a briefing to the staff team reinforcing safer cultures. An item was included in the LADO newsletter challenging managers to think about how, and whether, they would identify abuse even if it were covertly perpetrated by their most trusted staff member.

What went well?

- Dedicated Disabled Children and Young People's Team, based in Children's Social Care, provides social work support to children with more complex needs and their families. The team commissioned a bespoke 5-day training programme for team to ensure a continued focus on robust assessments and child's voice was embedded in interventions and provision.
- A dedicated residential short break provision was rated good at last inspection.
- Good Early Help offer with a transition worker to ensure support on deprivation of liberty issues are followed up and addressed.
- Complex Needs Panel meets regularly to; i) ensure ensuring appropriate care packages for children are in place, ii) undertake re-assessment of needs and, iii) set up legal Panel when appropriate.
- WSCB learning and development offer supported this priority through: -
 - Multi-agency training on *Supporting Parents with Learning Disabilities*.
 - E-Learning course on *Safeguarding Children with Disabilities*.

What were the challenges?

- No agreed partnership definition of disability.
- With no clear definition or a children with disability list/register it is not possible to identify all children living in Walsall with a disability or if assessments routinely consider disability.

From 2017-18 WSCB will...

- Re-evaluate the Board priorities to reflect the developments required for children with disability within Walsall to ensure they are effectively safeguarded.

Children with Mental Health Issues

Dudley and Walsall Mental Health Trust are a partner on the WSCB Board and support the work of a number of sub-groups. The Trust provides support to adults and children requiring specialist mental health support / provision in Walsall. They have specialist CAMHS provision and I- CAMHS which provides intensive support to children who may require in patient treatment.

WSCB learning and development offer supported this priority through E-Learning course on *Self Harm and Suicide*.

Priority 3

Coordinate how partners work together to protect children from harm caused by Domestic Abuse, Parental Substance Misuse and Parental Ill Health.

Rationale: Against the national trend, the most common category of Child Protection Plans is emotional abuse and exposure to Domestic Abuse is a significant factor impacting on the safety and well-being of children and young people.

The co-existence of mental health, substance misuse (drugs and alcohol) and domestic abuse are common features within families where harm occurs and their presence are indicators of increased risk of harm to children.

During 2016-17...

- 729 (14%) contacts made to Early Help related to domestic abuse, 163 (3%) to substance/alcohol use of parents/household, 84 (2%) parental illness/disability, and 132 (3%) household members with mental health issues.
- The Toxic Trio Sub-Group was established to address the complexities of these interrelated issues.

What went well?

- WSCB ran multi-agency training on *Introduction to Domestic Abuse, Drugs and Alcohol Awareness and Parental Substance Use* and *Introduction to Parental Mental Illness*.
- An E-Learning course was available across the partnership on *Parental Mental Ill Health*.



Domestic Abuse – Multi-Agency Audit (October to December 2016)

[0 cases judged 'Inadequate' 6 cases judged 'Requires Improvement' 9 cases judged 'Good']

Good Practice

- Evidence of good multi-agency working in 9 out of 15 cases

Areas to Develop

- Need to improve communication between agencies regarding invitations to meetings and information sharing.
- Lack of management oversight and supervision impacts upon effective planning for children.
- Missed opportunities to engage with families.
- Capturing the voice of the child.
- Insufficient recording to capture the issues in a way that enables the reader to understand child's journey.
- Ensuring plans are on file and are SMART.

What were the challenges?

- The performance scorecard needs to reflect data from statutory and commissioned services for parental mental ill and substance misuse. This should include reporting on identification of service users who are parents and have children.

From 2017-18 WSCB will...

- Develop a neglect strategy that includes domestic abuse, parental mental ill health and parental substance misuse.

Priority 4

[Improve the recognition and response to neglect](#)

Rationale: Neglect is a feature in fifty per cent of cases referred to Local Authority Children's Social Care.

During 2016-17...

- 9% of Early Help contacts identified child's needs as neglect.
- Work was undertaken on developing a multi-agency neglect strategy

What went well?

- An E-Learning course on *Awareness of Child Abuse and Neglect* was available.
- Children's Social Care started to use the Graded Care Profile – an evidence based model – to help identify and assess neglect.

What were the challenges?

- Development of a multi-agency neglect strategy alongside an agreed partnership approach and tools were not progressing promptly.

WSCB cannot be assured that partnership arrangements identify neglect early on and that interventions prevent delay in safeguarding child(ren) from neglect.

From 2017-18 WSCB will...

- Agree and promote a new multi-agency neglect strategy to ensure that children experiencing neglect are identified early on and receive the appropriate support needed
- Ensure the WSCB scorecard include effective measures regarding neglect including repeat referrals, extent of any potential drift or delay in identifying neglect and re-referrals.

Priority 5

Coordinate how partners work together to reduce the risk and threat of harm caused by sexual exploitation and missing episodes.

Rationale: Child sexual exploitation (CSE) and being missing from home / care are key safeguarding risks facing children and young people and WSCB has the statutory responsibility to coordinate a local response.

This section should be read alongside the CMEC Sub-group detailed on from page 18.

A few things about CSE in Walsall

- At end of March 2015 West Midlands police increased data collation to include more details of all offenders, facilitators, victims and locations in relation to CSE which will result in a more detailed and informed data set for CSE moving forward.
- MASE meetings support multi-agency consideration of child's need and risk of harm from CSE. MASE meetings are held for children placed out of borough.
- There is an established CSE Pathway.
- The problem profile – commissioned by the CSE Sub-group chair - gives an understanding of CSE in Walsall.
- The WSCB performance scorecard includes those children and young people identified at risk of CSE and MASE meeting data. During 2016-17...
 - 52 Early Help contacts identified child's needs as CSE.
 - 151 children and young people were screened as at risk of CSE. 120 'at risk', 27 'at significant risk', and 4 at 'serious risk' of CSE. Risk levels for 65 children/young people were reduced. 92 new children/young people were identified at risk during the year.
 - 129 MASE meetings were held to consider 146 individual children/young people.

Case Study

Alex was referred to Street Teams due to his involvement with two young girls who were already known to them. The girls' mother was involved at various times in selling sex, and had groomed her daughters who were now grooming others, including boys. Alex did not recognise he was being abused. Street Teams asked to be involved to promote safety, and to help Alex to understand the risks with this family, as it was felt that he did not understand the implications of his involvement and would not listen to his social worker, or his foster carer. He also disclosed that he was gay and as a result, Street Teams worked specifically on the risks of attending adult LGBTQ venues and online dating website with chat rooms and how these areas of vulnerability might lead him into abusive situations.

Street Teams spent many weeks looking at subjects such as internet safety, identity, friendships and relationships. It was important for Alex to understand what safe and unsafe relationships were and how to distinguish between the two. Alex progressed well during these sessions and at the same time had become stable within his foster care and at school. Working through his relationship needs was important to him and he elected to go to an appropriate LGBTQ group to widen his circle of friends and for the potential of relationships, rather than meeting strangers online. All contact was broken off with the family for which he was first referred.

Alex is currently studying for his GCSEs and his grades are on track. He is still in foster care and meets with his maternal and paternal parents on weekends where he stays overnight. Alex informed Street Teams that he wants the 1:1 sessions which he has found very supportive to continue. He has fed back that he is wiser and more mature in his approach to internet usage and now understands that putting explicit pictures of him online is an unwise action that carries consequences.

A bit more about CSE in Walsall...

- Policies and procedures are localised from regional procedures for all partners.
- Two CSE Coordinators – 1 based within police and 1 within Walsall Council - are a useful resource and evidences partnership commitment to resource an effective CSE response.
- Multi-agency CSE training is available and well received.

Child Sexual Exploitation Peer Review – 18th to 20th July 2016

WSCB and Walsall Council commissioned a Peer Review on CSE arrangements undertaken by LGA to help identify areas of good practice and areas for development.

The review led to a planning workshop to develop actions in response to the peer review recommendations.

What went well?

- The WSCB learning and development offer included classroom based multi-agency training on CSE, and additional training events on CSE.
- Work was progressed on a new CSE Strategy and Work Plan drawn up following the planning workshop that resulted from peer review.
- The CMEC Sub-Group supported the progress of work regarding this priority.

Street Teams

CSE Education Programme in Schools 2016-17

- 34 sessions were completed with 1275 pupils aged 11 to 19 years.
- 46% of attendees were male, 50% were female (4% unknown)
- Children and young people said the three top things they took away from the sessions were; i) safety awareness (51%), ii) I can talk to someone else (7%); iii) not to trust unknown adults / strangers (6%)

CSE 1 to 1 Work 2016-17

- 68 (76%) who were at high risk of CSE and known to CMOG completed awareness raising work.

From 2017-18 WSCB will...

- Ensure that the CMEC sub-group leads on progressing work in this area.
- The CSE problem profile continues to be further developed to enhance our understanding of CSE in Walsall and its interface with other vulnerabilities children may experience.

Case Study

Nicola was referred to Street Teams due to concerns that she was at "high risk" of sexual exploitation due to her use of alcohol, unknown whereabouts during the early hours, and non-school attendance. It was believed that she was having sex with boys her age, but had no boyfriend and concerns about her safety and sexual health.

Through discussions with Nicola, it soon became apparent that she was mixing with other "high risk" girls and was being groomed by them. Nicola disclosed times where her friend (already known to Street Teams) encouraged her to drink alcohol and get into cars with older men who she said touched her in ways she didn't want them to and was scared. Nicola admitted to using drugs, self-harming, attempted suicide and suffering with severe depression.

Street Teams worked alongside education, social care, housing and The Beacon to build an effective support package for Nicola. A new training provider was engaged, supported accommodation secured, The Beacon addressed the drug and alcohol concerns and Street Teams allowed Nicola to talk freely, at her own pace about her experiences. Through Street Teams intervention her risk of CSE reduced as her awareness grew. Nicola has moved away from the abusive relationships through increased self-esteem and confidence. Street Teams continued to support Nicola through disclosure to police and the investigations are continuing.

Priority 6

[Continue to improve the ability of local and professional communities to safeguard children and young people.](#)

Rationale: Children and young people will be safer when more people know how to identify and act on safeguarding concerns and WSCB has a statutory responsibility to carry out learning reviews.

As of 31st March 2017;

- 2,516 children were identified through assessment as needing a specialist children's service. (2,662 at 31st March 2016).
- 333 children were subject of a Child Protection Plan. (408 at 31st March 2016)

- 4 children and young people lived in privately arranged fostering placements (2 in 2016).

WSCB's learning and development offer included a range of face to face training, e-learning and learning events to continue to enhance multi-agency working and the ability of local and professional communities to safeguard children and young people. This included lessons learned from SCR and CDOP.

During 2016-17...

- There was a comprehensive multi-agency training programme

What went well?

- Partners deliver a good level of single agency training and participate in WSCB's multi-agency training.
- A number of key annual reports i.e. LADO, IRO, Youth Justice and key service reviews i.e. Early Help and MASH were submitted to Board for scrutiny and key reviews.

What were the challenges?

- Engagement of the community, voluntary and faith sectors in WSCB business is an area for development to ensure staff and volunteers are enabled and supported to identify and respond to safeguarding concerns in an appropriate and timely manner. For example, there is a need to increase the take up community and voluntary sector on training.
- Evidence suggests that despite a number of briefings etc, across partnership agencies and the community, they may not be identifying and / or referring young carers and those children who are privately fostered to social care for an assessment.
- The multi-agency training offer did not provide training links to all WSCB priorities and did not evaluate of the impact of training on practice.

From 2017-2018

- WSCB needs to be assured that current workforce is knowledgeable, confident and competent in safeguarding children.
- The Multi-agency training and learning opportunities need to cover core safeguarding training and WSCB priority areas.
- Progress against this priority needs to be more detailed and robust.

Voice of the Child

Effective safeguarding systems are child centred. Often failings in safeguarding systems are because the needs and views of the child have been lost or the interests of adults have been placed ahead of the child. Embedding the voice of the child in single and multi-agency working supports a child centred approach.

Children are clear about what they want from an effective safeguarding system.

Vigilance – Adults notice when things are troubling them

Understanding and Action – To understand what is happening; to be heard and understood and to have that understanding acted upon.

Stability – To be able to develop an on-going stable relationship of trust with those helping them

Respect – To be treated with the expectation that they are competent rather than not

Information and Engagement – To be informed about, and involved in, procedures, decisions, concerns and plans

Explanation – To be informed of the outcome of assessments and decisions and reasons when their views have not met with a positive response.

Support – To be provided with support in their own right as well as a member of their family

The WSCB Business Plan 2016-18 recognises that understanding the experiences and needs of Walsall children and young people is central to the Board's work and stated it would use feedback from children and young people to develop and influence services as well as to evaluate the effectiveness of safeguarding services.

“Our aim is to understand how well children and young people are listened to, helped and protected”

What worked well?

- WSCB has a young person representative on the Board.
- Sub-groups are required to consider the 'voice of the child' within work plans.
- WSCB in February 2017 discussed four strands of voice of child work including: -
 - Re-visit the WSCB's approach to ensuring partners engage and listen to the voice of children.
 - Need to include in multi-agency audits.
 - Ensure young people engage with Board
 - Confirming individual agency position statements on 'voice of child'

Disabled Children and Young People's Team

Team has commissioned a bespoke 5-day training programme to ensure a continuous focus on the voice of the child / young person throughout interventions and services.

“Feedback from families and young people is also a rich data source and at the present time although there is undoubted commitment to hearing and recording the voice of young people and families this information is currently not collated and used to inform CSE service development” CSE Peer Review 2016

What were the challenges?

- There is no overarching strategic approach to engagement and participation of children at individual case planning, service delivery of strategic planning levels. This means there are no systems or processes that share learning and routinely actively engage children and young people.

Moving into in 2017-18...

- WSCB to strengthen its approach to listening to the voice of the child to be assured that children are effectively safeguarded through partnership arrangements in Walsall.

Priority Groups



As well as monitoring core child protection activity, in line with statutory responsibilities, and its' strategic priorities, WSCB ensured it focused attention on vulnerable children during 2016-17. Below details progress during for particular groups detailed in the Business Plan.

Children Missing from Home / Care / Education

What we know about children who are missing during 2016-17...

- There were 7 contacts to Early Help Hub regarding missing child and 1 to MASH.
- 140 children were missing form education during the year.

Indicator	2015-16 Outturn	2016-17 Outturn	Q1 -2016 Apr-Jun	Q2 - 2016 Jul-Sep	Q3 2016 Oct-Dec	Q4 2017 Jan-Mar
No. children recorded as missing from education	87	140	94	90	127	140
No. Children/young people reported missing in Walsall area	n/a	Not available	Not available	39*	119	119

What went well?

- Following potential under-reporting of children reported missing* in quarter 3 led to more robust reporting built into Mosaic.

Street Teams – Missing Work 2016-17

- Worked with 146 children and young people who had 303 missing episodes in the year
- 47 children / young people were missing on more than one occasion.
- 43 children and young people reported missing were referred to other services regarding CSE.
- Led 8 'Runaway Assemblies' for pupils in schools attended by 678 pupils.

What were challenges?

- There is limited data regarding children and young people who go missing in Walsall. The numbers known about by Street Teams is not reflected within Early Help or MASH contacts.

- It is unclear about the numbers outcome of assessments identifying young people who go missing.
- WSCB in February 2017 identified a number of actions to strengthen partnership working. This included;
 - Need to recognise when some children are missing from school there is link to CSE. Children's Services to undertake strategic work regarding exclusions. Protocol Panel to include link to CSE/missing.
 - Children who are unable to attend mainstream schools' due to medical, social emotional needs can attend specific local school.
 - Need for a deep dive regarding children's absences from schools in areas.

Children and young people who are looked after

At 31st March 2017 there were 648 looked after children and young people (627 in 2015-16). This equates to 98 per 10,000 0-17 population, which is high compared to England average of 60 per 10,000 and statistical neighbour at 86.9.

8 looked after children were unaccompanied asylum seeking children.

There were 183 newly looked after children at rate of 27.7 per 10,000 in line with England average of 27.6 and below statistical neighbour average of 31.7.

162 children and young people ceased being looked after a rate of 25.4 per 10,000 just below England average of 27.4 and statistical neighbour average of 31.6 per 10,000.

Walsall has a Virtual School of 3 workers consisting of a Virtual School lead, two key workers and part time careers adviser. The team focuses on looked after children aged 5-16.

72% of looked after children had up to date Personal Education Plans.

The report regarding looked after children for 2016-17 was not available at the time of completing this report.

Toxic Trio and Impact on Looked After Children Numbers – July 2016

Context – The toxic trio indicators – families that feature 1 or more of the toxic trio indicators (namely domestic abuse, parental substance misuse, parental mental ill health) are more likely **to have their children looked after**

- Majority of looked after children come from most deprived wards in Walsall.
- 13.2% of looked after children in 2015-16 were reported due to one or more of toxic trio effects, with 8 having all three aspects present.
- Those with all three toxic trio themes present were more likely to be male, White British, and have been in care 3 to 5 years or more.
- In 2014-15 - 90% of front door contacts became a Section 47, became referrals, 88% led to Initial Assessments, 16% became a Child Assessment, 13% were subject to Section 47, *5 became subject to Child Protection Plan with 2% of front door contacts resulting in LAC.
- Although the link between substance abuse, mental health and domestic abuse if well reported it is difficult in Walsall to determine the extent all 3 aspects have occurred together resulting in LAC admission.

Walsall Council Findings

- The location of Looked After Children prior to being accommodated can be strongly related to wards with highest levels of multiple deprivation.
- 2% of Toxic Trio front door contacts became LAC.
- Different aspects of toxic trip front door contacts are evident in different wards.
- Domestic abuse incidents and substance misuse are strong indicators of LAC in Walsall but mental

health rates are not well correlated.

Police Findings

- Domestic abuse incidents in Walsall have increased over time since 2014.
- No season trends present but most reported on Sunday.
- June 2016 there were 282 domestic violence incidents. 91.1% incidents were in households where there were children, with 68.1% of these being present during the incident and 24.5% were witnessed by child.
- Referrals came from the post deprived areas.

Information Findings

Information gaps need to be closed for example would like to know if all toxic trio themes are evident in family.

Privately fostered children and young people

A few things about private fostering in Walsall

- As with many areas Walsall has previously relied on posters and newspaper articles to raise public and professional awareness of private fostering. However, the 'Private Fostering: better information, better understanding' (Ofsted 2014) noted awareness raising campaigns did not impact on self-referrals. In response WSCB and partners followed the report recommendations to focus on those professionals who are more likely to encounter a privately fostered child to ensure they are aware of what private fostering is and that they know what to do if they suspect a child to be privately fostered.
- In addition to this work with Walsall Children's Services Admission Team have routinely screened for privately fostered children since 2013.
- School improvement officers raise the issue of private fostering with schools.
- In June 2016 WSCB received a progress report regarding activity in 2015-16. This identified the need to raise awareness of private fostering across both children's and adult's workforce.
- Despite awareness raising activity no referrals were made to Early Help regarding new private fostering arrangements.
- 1st April 2016 saw 3 private fostered children in Walsall, this was 4 by 31st March 2017.

Table: Number of children/young people privately fostered and initial visits/subsequent visits in timescale check final data report

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	2016-17 Outturn
No. cyp	3	2	4	4	4	6	3	4	4	6	4	4	4
Initial Visits in 7 days in period	0% 0/0	0% 0/1	50% 1/2	0% 0/0	0% 0/0	0% 0/1	0% 0/0	100% 1/1	0% 0/0	0% 0/0	0% 0/0	0% 0/1	33.3% 2/6
Subsequent Visits	0% 0/0	100% 1/1	100% 1/1	50% 2/4	0% 0/0	0% 0/1	0% 0/2	100% 1/1	50% 1/2	0% 0/5	0% 0/2	0% 0/0	31.6% 6/19

Children's Social Care were sole source of identifying new private fostering arrangements.

At present WSCB cannot be assured that all children and young people in Walsall who are privately fostered are safeguarded. There is no assurance most privately fostered children and young people are identified, they do not have their needs assessed promptly, and do not receive the support they need in line with statutory requirements.

Children and young people with emotional health and wellbeing needs

WSCB did offer multi-agency face to face training on An Introduction to Parental Mental Illness and Drug and Alcohol Awareness and Parental Substance Misuse. In addition to this e-learning courses were available across the partnership on Parental Mental Health and Self Harm and Suicide.

Unaccompanied children and young people

Only 4 children /young people had needs as unaccompanied asylum-seeking child identified as a need from Early Help contacts. There were 4 contacts to Early Help regarding unaccompanied asylum seeking children. At 31st March 2017 there were 8 unaccompanied asylum seeking children looked after.

Young people in custody

The Strategic Lead for Youth Justice Services sits on the WSCB and the Board requests an annual report on Walsall young people in custody. This focuses on young people held in police custody and those who are remanded or sentence to custody through the Youth or Crown Court. Walsall Youth Justice Service, in partnership with the Social Care Emergency Duty Team, provide appropriate adults for young people who are arrested and interviewed by the Police and ensure that they are treated fairly and their rights, as children, are understood. The Police monitor the number of Walsall children who are kept in Police cells overnight and requests made to transfer young people into alternative local authority secure accommodation.

The number of Walsall young people who receive custodial sentences remain low and the Youth Justice Service actively works towards reducing the number and has in place a reducing custody action plan. This is a nationally reported key performance indicator monitored by the Youth Justice Service Performance and Partnership Board. During 2016/17, 12 young people received 16 custodial sentences. 8 young people received a remand into the secure estate on 11 occasions. The Youth Justice Service works closely with Social Care to ensure that remanded young people receive Looked After status and the appropriate services and support.

The annual Youth Justice Board National Standards audit confirmed that Walsall Youth Justice Service comfortably met the standards of work in the areas of Court, remand and bail management, custodial sentences.

Young people at risk of radicalisation

The Counter Terrorism and Securities Act 2015 places legal obligations on 'specified authorities' and introduced the Prevent Coordinators role into areas with a heightened level of risk. The Prevent Coordinator meets quarterly under Home Office guidance. Delivery is understandably variable across the country but most of the challenges and barriers are common to all areas. Walsall has a Prevent Coordinator and more recently has a Prevent Education Officer in post – and receives a small amount of Home Office funding for projects designed to address these issues or mitigate risk. Delivery is supported by the Prevent Delivery Group and Contest Group.

Although small there are both local and national groups who have a clear stated aim of bringing the strategy down. Unfortunately, they often criticise professions in an attempt to do this. Numerous surveys indicate they are mainly vested interest groups who enjoy little or no community support. Following a recent challenge by one of these groups nationally the government strengthened its commitment to the strategy, stating all challenges were unfounded and Prevent was absolutely necessary and legitimate in safeguarding vulnerable people.

Channel is a multi-agency panel offering coordinated help and support to those considered at risk of radicalisation. The role and 'thresholds' for inclusion changed last year and they are now completely embedded within its operation.

A few things about Walsall...

- The number of referrals (which is confidential) is small and in line with national trends. Home Office consider Channel to be 80-90% successful, requiring no further intervention following completion.
- Prevent Duty requires areas to complete a risk assessment and have a plan in place to address issues raised in risk assessment. This is informed by Counter Terrorism Local Profile (CTLP) which is a restricted document. Most partner organisations, including schools are required to have an individual plan contributing the overall area plan.
- In response to the 2016-17 CTLP identifying young people to be at greatest risk the Prevent Delivery Group prioritised schools and colleges putting a focus of teachers, lecturers, and governors. Walsall has adopted two projects that support schools and teachers through drama and interactive discussions and build greater resilience in communities.
- The 'risk picture' in Walsall is informed by a range of documents, reviews and processed that includes: -
 - Counter Terrorism Profile (CTLP)
 - Contest Board
 - The Prevent Delivery Board – a multi-agency group tasked with delivering against the local Prevent Plan.
 - Prevent assurance process, a scrutiny process independently chaired and tasked with assessing overall local delivery
 - Ofsted inspection reports
 - Channel process. Multi-agency panel tasked with supporting vulnerable individuals.
 - Walsall Council's Cohesion Review (2015)
- From the above 4 main themes emerge: -
 - Amongst some communities a strong desire remains to travel to potential conflict zones.
 - Risks posed by 'self-motivated individuals'
 - Increased vulnerability to certain places and communities, especially from an emerging Far Right threat
 - Dangers of radicalisation in local education establishments.

PREVENT – Assurance Workshop – Early 2016

A WSCB Assurance Workshop in 2016 identified areas of work to progress during 2016-17. The workshop was a multi-agency round table discussion to provide assurance of the effectiveness of the partnership approach to fulfilling its' prevent duty.

What went well?

- Awareness raising and training ensured;
 - 37% of Walsall Council workforce completed online training. 300 (7%) of workforce with priority functions also completed WRAP. More internal WRAP facilitators have been trained with aim of increasing these figures.
 - All Walsall schools in received a minimum of one full WRAP session resulting in over 4,000 teaching staff trained.
 - 5 awareness sessions delivered to @100 school governors at various locations.
 - There are around 20 WRAP facilitators within Walsall schools and termly Prevent updates are arranged with plans to continue in the future.
 - Walsall Healthcare Trust ensured 670 (43%) of staff completed WRAP training.
 - 88% staff in Dudley and Walsall Mental Health Trust completed WRAP training
 - Black Country Partnership Foundation Trust has improved their compliance with training dramatically since being issued with contract notice by the lead CCH. In response they have ensured 97% of staff (out of 900) are WRAP trained.
- Walsall's Prevent Strategy is well embedded and supported by a Prevent Delivery Group. Work is currently in progress to persuade certain non-relevant authorities to adopt the strategy.
- Early Help contacts identified radicalisation/extremism as a need for 9 children / young people.
- All statutory agencies in Walsall have Prevent Plans.
- Prevent Steering Group reports to Contest which in turn reports to the Community Safety Partnership
- Prevent Coordinator reports quarterly to WSCB's QA&P Sub-group on attendance at Channel Panel, compliance with Counter Terrorism Act and supplies a narrative on Walsall Issues and trends
- Whilst it must be noted that the majority of data and detail regarding radicalisation is restricted the following assessment can be made regarding the impact of arrangements in Walsall
- It is difficult to be accurate in assessing effectiveness. However there has been a significant reduction in the volume of terror related incidents and domestic extremism since the Prevent Delivery Plan has been in place.
- Referrals to Channel are in line with national trends. All referrals have a rigorous risk and vulnerability assessment undertaken by Counter Terrorism Unit with individuals not being removed from Channel until there is a significant reduction in risk and vulnerability. This project is between 80-90% successful showing a clear impact in this area of work

Street Teams 2016-17

PREVENTION EDUCATION - Sessions aimed at building resilience from primary school level.

- Of 151 sessions run 6079 children and young people – aged 9 to 18 years – attended.
- 56% were female, 41% male (3% unknown)

This work has highlighted the need for a full time Prevention Worker within schools.

BUILDING RESILIENCE - a programme to gauge awareness of radicalisation/if young people have accessed extremist material.

- 24 sessions were held and attended by a total of 459 young people aged 11 to 19 years.
- 88% were male and 11% female (1% unknown)
- 89% said they would know where to get help if needed regarding this issue.
- Young people said their top three learning points from the programme were;

- How to spot the signs of grooming (27%)
- Know what radicalisation is (15%)
- How to stop radicalisation / How to report radicalisation (8%)

Young people at risk of female genital mutilation (FGM)

WSCB did not offer any multi-agency face to face training on FGM. An e-learning course that included FGM was available across the partnership via the Home Office.

An Assurance Group started to consider FGM in an assurance workshop that was held in February 2016. This will continue into 2017-18.

What went well?

- WSCB held an assurance workshop to consider effectiveness of arrangements in Walsall regarding FGM. This work will continue into 2017-18.
- There is robust process to ensure relevant health staff are trained to identify women who have experienced FGM and identify relevant safeguarding risks to children. The Health processes ensure a re-checking of information and appropriate notifications to the national panel and MASH should it be required.

What were the challenges?

- WSCB is not able to be fully assured at present that the extent of FGM within Walsall is known and, as a consequence, whether those children at risk or subjected to FGM are identified and safeguarded.
- The workforce and community/voluntary sector need a greater understanding of FGM and its safeguarding implications and need to feel confident in making referrals.
- It is felt many women in Walsall who may have been subject to FGM go to Birmingham to access resources.

Moving into 2017-18

- WSCB needs to be assured – through performance data reporting and assurance workshops – that all agencies with a duty to report are fulfilling their statutory duty.
- WSCB needs to be instrumental in ensuring appropriate level of awareness regarding FGM is developed across the partnership, this includes multi-agency awareness raising sessions and materials, inclusion in multi-agency level 2 and 3 and more specific multi-agency training on FGM within Learning and Development Programme
- The NHS England data published should be incorporated into the WSCB scorecard

West Midlands Police and Crime Panel (18th January 2017)

Report presented to WSCB confirming progress implementing recommendations of scrutiny inquiry into FGM
Scrutiny Inquiry Report – FGM (June 2015)

The inquiry considered role of Police and Crime Commissioner in facilitating integrated working between agencies to prevent and respond to FGM in West Midlands region. The inquiry identified 5 steps were required and eight recommendations were made. The five steps included: - i) Educating and empowering communities; ii) Educating and empowering practitioners; iii) Working together consistently across region; iv) Prosecuting and; v) Providing therapy and support.

Progress Report (January 2017)- Noted Walsall's progress against the 8 recommendations: -

- Walsall NHS Hospital Trust within Level 1 and 3 safeguarding training ensures all midwives receive awareness training and are encouraged to complete NHS England online training. Training is delivered to key staff in identified work areas, on awareness raising and national reporting requirements. These key staff will offer support to staff within their clinical areas following identification or disclosure of FGM and

ensure reporting onto national platform.

- Walsall Children's Services noted incidence of FGM is extremely small as there are no residents from the communities known to practice FGM within borough. 3 adult women known to be cut. All professionals with mandatory duty to report FGM have confirmed they know their duty to report. All schools, health and social care can access a range of online e-learning tools via Virtual College online learning. Low numbers indicate a proportionate response required
- Walsall Healthcare NHS Trust has FGM policy that includes clinical pathways, links/information to support staff considering safeguarding concerns for unborn, or other female children, in household, notifying relevant agencies if aware of FGM, importance of mandatory reporting and development of a local project team to implement a process to increase awareness and knowledge including community groups.

Young people at risk of forced marriage

WSCB did not offer any multi-agency training on forced marriage. An e-learning course that regarding forced marriage was promoted across the partnership from the Home Office.

Children and young people who are trafficked

WSCB did not offer any multi-agency training on children and young people who were trafficked. An introductory e-learning course focusing on human trafficking and modern slavery was available across the partnership.

CMEC Sub-Group need to ensure trafficked children are included in 2017-18 work plan.

Children at risk of CSA

We know that in Walsall in 2016-17...

- 15% children subject to Child Protection Plans at 31st March 2017 for CSA concerns.

What went well?

Child Sexual Abuse (CSA) – Assurance Workshops

Remit

- From July WSCB led 3 assurance workshops - in 2016-17 - to consider Child Sexual Abuse.
- Workshops considered; i) prevalence of CSA in Walsall, ii) understanding if the referral mechanisms and pathways were adequate, and iii) to make a judgement on effectiveness of Walsall's response to CSA.

Prevalence

- In July 2016 -16 children and young people were on Child Protection Plans for CSA - higher than previously but considerably lower than expected.

What was going well?

- Sexual Health services complete proforma which if completed appropriately identifies CSA and referrals to MASH

What are the challenges?

- Behaviours indicative of CSA not always identified as CSA is difficult to identify and is under-disclosed, particularly in relation to young men.
- Prosecutions are difficult to achieve.
- Link between CSA and neglect acknowledged but concern about practitioners not always making the link.

The way forward in 2017-18

- NSPCC 'Pants' awareness raising work in schools
- Mapping of local services and pathways

The WSCB held assurance workshops to self-evaluate effectiveness of multi-agency arrangements in Walsall -**Street Teams – Work related to CSA 2016-17**

EXPOSURE – Programme for secondary schools in response to over sexualised behaviour due to pornography (not CSE or sexually harmful behaviour). Will be rolled out to Junior Schools in 2017-18.

- 35 sessions run attended by 996 young people aged 13 to 18 years.
- 42% of young people were male, 57% female (1% unknown)
- It found that 43% had watched pornography at some point, and 22% watched pornography currently.
- 63% of those accessed pornography on their mobile phones and 26% on computers.
- The top three things young people said they learned from the programme were;
 - Safety Awareness (18%)
 - Porn rewires the brain (16%)
 - Do not watch porn (15%)

RELATIONSHIPS – Programme looking at healthy relationships

- 336 young people, aged 13 to 18 years, attended 17 sessions of the programme
- 76% were female, 18% were male (6% unknown)
- The top three things children and young people said they learned from the programme were;
 - They know the difference between healthy and unhealthy relationship
 - Safety awareness
 - I can talk to someone else.

GROOMING – Programme to raise awareness of grooming amongst young people.

- 454 young people, aged 14-15 years, attended 16 sessions of the programme.
- 36% were male, 60% female (4% unknown)
- The top three things young people said they learned from the programme were;
 - I can talk to someone else (21%)
 - I have a choice (8%)
 - Safety awareness (8%)

LSCB Effectiveness and Risk

WSCB's Risk Register

From April 2016 both Walsall's safeguarding boards established a joint risk register which was reviewed and updated via sub-groups. This identified key issues and areas of potential/actual risk that impact on multi-agency workings regarding safeguarding in Walsall.

The register includes details of the potential risk, the level of risk (identified through matrix that considers probability and consequences if risk not addressed), current controls, actions agreed to mitigate and deadlines to mitigate risk.

During 2016-17 14 risks were logged on the risk register with half of which were identified as high risk requiring immediate attention /action. Risks identified as high included;

- Inadequate analysis of safeguarding risks in Walsall was highly probable due to lack of multi-agency data available to Board resulting in Board being unable to focus on highest safeguarding risks. Mitigating actions were agreed. This risk continues into 2017-18.
- Multi-agency none attendance at sub-groups. Mitigating actions were agreed and put in place and continued into 2017-18.
- Reviews of significant incidents and serious cases not completed in a timely manner. Mitigating actions were agreed including creation of a new post to support SCR (and Safeguarding Adult Reviews and Serious Incidents for WSAB).
- Lack of appropriate capacity to ensure CDOP processes are efficient and effective – with a certain probability and major consequences. Mitigating actions were agreed including

creating a new post to support CDOP. By end of March 2017 a new post was created, with funding agreed, for 20 hours per week that merged requirement of SCR, serious incidents and CDOP with plans to recruit to post in early 27-18.

Partners

Walsall Borough Council

The last inspection of Walsall's safeguarding arrangements for the protection of children took place in June 2012 where the local authority was judged to be inadequate and services for looked after children judged to be adequate. A further inspection in July 2013 found arrangements for protection of children to be adequate. In January 2015 the improvement notice was lifted.

An assistant director within Children's Chairs the Serious Case and Incident Sub-Group.

Walsall Council provides accommodation and supervisory support for the Safeguarding Business Unit with Safeguarding Board Manager being line managed by Head of Safeguarding and chair by CEO.

Walsall CCG

The CCG Safeguarding Nurse chairs CDOP.

CCG representatives attend the Board and various sub-groups.

Walsall Healthcare Trust

Safeguarding lead chairs the policy and procedures sub-group

The Trust contributed to the LSCB priorities during 2016-17

Safeguarding Lead chairs the Policy and Procedures Sub-group and contribute to other sub-group work.

Street Teams

CSE peer reviewers were "impressed" by the scope of the Street Team's initiative including support for over 18's and felt "There is a real additional value". Street Teams draw a significant amount of additional funding to offer a wider menu of acute and preventative services to Walsall community.

During 2016-17 it secured funding to undertake Communities Against Sexual exploitation (CASE) initiatives with faith, marginalised and ethnic minority groups.

As majority of its' provision is externally funded the WSCB should ensure that the Street Teams work is embedded in its strategic and business planning and that their funding sources are monitored to ensure future sustainability.

Street Teams Work 2016-17

SEXUAL HEALTH– Programme run for young people promoting awareness of sexual health issues.

The 10 sessions run saw a total of 143 young people, aged 11 to 18 years, attend.

89% were female, 10% male (1% unknown)

The top three things young people said they took away as learning were;

Safety awareness (54%)

I have new information (40%)

I am better informed (40%)

INTERNET SAFETY – Programme raising awareness of internet safety

The 43 sessions run saw a total of 1168 young people aged 6 to 16years attend.

39% were male, 58% female (3% unknown)

The top three things young people said they took away as learning were;

Safety awareness (59%)

I have new information (40%)

I am better informed (40%)

Conclusion

Key Summary

What worked well

- The Business Plan clearly outlined the WSCB priorities and core business for the year.
- The Board has wide partnership representation with majority of partners actively engaged in Board business i.e. through chairing of sub-groups
- Despite the resource issue effecting capacity the Board progressed some business well.
- The Board has realistic perspective of it's' performance having completed a thorough self-assessment indicating where the Board is in terms of delivering on its statutory responsibilities and local priorities and identifying areas for development.
- Partners stepped up when presented with the challenge of an under resourced Board with the CCG and Walsall Council giving additional resources to those agreed in 2016-17 and committing to an increase in contributions for 2017-18. to increase the capacity.
- WSCB has strong emphasis on challenge through a range of mechanisms i.e. challenge log, Chair effectively challenging partners or key individuals on specific issues.
- Links with WSAB were strengthened through joint Board meetings and identifying joint issues or agendas i.e. around the area of transition.
- WSC continues to participate in regional work i.e. regarding Black Country Training?? and regional child protection procedures.

What were the challenges

- The limited business resources to support WSCB business impacted on the pace and scope of the work undertaken and progressed during the year.
- Partners need to take more ownership for driving work forward and not be reliant on WSCB to lead on work requiring development.
- Development of multi-agency scorecard and data analysis has progressed but requires further work to provide a wider range of multi-agency data and the robust analysis required to provide WSCB with assurance of effectiveness of safeguarding arrangements and the impact on outcomes for children and families.
- Voice of the Child Work progressed slowly and is an area requiring further development to embed it within WSCB business.
- Engagement with the community, voluntary and faith sectors is a key area for further development.

Moving forward in 2017-18

WSCB should ensure;

- *More pace in delivery against core business and priorities.
- *Sub-groups progress work with more pace ensuring annual work programmes include statutory business, actions contributing to WSCB priorities
- *Voice of Child work is further developed and embedded within core business, sub-group work and delivery of priorities.
- *Quality assurance arrangements are strengthened including a more multi-agency based scorecard, and more in depth analysis and evaluation of the impact of multi-agency training on practice.

Conclusion - What difference have we made?

WSCB made some progress during 2016-17 but this was not at the required pace or across the breadth of work required. The completion of a detailed self evaluation ensured a clear and realistic understanding of the Board's strengths and weaknesses which is a foundation to build upon in 2017-18.

Although WSCB is assured that some multi-agency safeguarding arrangements in Walsall are effective there are key areas where there is no, or limited, assurance. The additional resources, improved partnership engagement and WSCB's ambition will provide basis to move forward so from 2017-18 onwards WSCB knows what impact it has made. Currently WSCB cannot be fully assured that all key safeguarding arrangements in place in Walsall effectively safeguard children and promote their well being. Plans in place for 2017-18 aim to address this. This will include robust reporting to Board and further development of the multi-agency scorecard.

The engagement of key agencies – mainly local authority, health and police – in supporting WSCB in delivery against its statutory responsibilities and priorities is a good foundation for future developments in response to changes due to the 'Wood Review'

WSCB has the beginnings of an effective partnership which needs to continue to develop and move forward with more pace. This should be achievable through additional resources and sustained partner engagement.

Into 2017-18 and beyond

WSCB's Business Plan 2016-18 was refreshed following a Board development day to identify its' strategic priorities for 2017-18 which are detailed below.

Priority 1

Ensure leadership, management and governance arrangements deliver strong local leadership that measurably improves outcomes for vulnerable children.

Rationale: WSCB has identified a range of development activities so that it operates within a clear and well-established governance framework, holds partners to account and delivers on its statutory functions.

Priority 2

Increase the responsiveness and impact of the help and support provided to children, young people and families, including children with disabilities and mental health issues.

Rationale: Local intelligence indicates that there is a need to develop i) a shared understanding and application of thresholds, ii) embed the Early Help offer including role of Lead Professional and iii) improve the contribution of partner agencies to multi-agency safeguarding forums.

Priority 3

Coordinate how partners work together to protect children from harm caused by Domestic Abuse, Parental Substance Misuse and Parental Ill Health and / or Neglect.

Rationale: Against the national trend, the most common category of Child Protection Plans is emotional abuse and exposure to Domestic Abuse. This is a significant factor impacting on the safety and well-being of children and young people.

Rationale: Neglect is a feature in 50% of cases referred to Local Authority Children's Social Care.

Links to Health and Well Being Board: Walsall Plan priorities – 'Tackle the harm to individuals and communities caused by substance misuse' and 'Reduce the harm to individuals and communities caused by all types of violent behaviour'

Priority 4

Reduce the risk and threat of harm caused by sexual exploitation and missing episodes.

Rationale: Child sexual exploitation (CSE) and being missing from home / care are key safeguarding risks facing children and young people and WSCB has the statutory responsibility to coordinate the local response to CSE.

Priority 5

Continue to improve the ability of local and professional communities to safeguard children and young people.

Rationale: Children and young people will be safer when more people know how to identify and act on safeguarding concerns and WSCB has a statutory responsibility to carry out learning reviews.

Links to Health and Well Being Board: Walsall Plan Priorities – ‘Enable children and young people to be better protected and safeguard themselves’; ‘Improve emotional health and well-being of children and young people

Priorities will again be supported by key actions detailed in Business Plan Actions for 2017-18 by the work of the Board and sub-groups. In addition to the strategic priorities WSCB will continue to focus on the key priority groups identified in 2016-17.

APPENDIX 1

Walsall Safeguarding Children Board Meeting Attendance April 2016- March 2017

ORGANISATION	Jun-16	Sep-16	Dec-16	Feb 17	Total (%)
Independent Chair	√	√	√	√	100%
Lead Member /Councillor	√	×	√	√	75%
Walsall Council Executive Team	√	√	√	√	100%
Walsall Council CS Social Care (Chair of SCSIC)	√	√	√	√	100%
Clinical Commissioning Group	√	√	√	√	100%
Walsall Healthcare NHS Trust	√	×	√	√	75%
Walsall College	√	√	√	√	100%
CAFCASS / Family Justice Board	√	×	×	√	50%
West Midlands Police (Chair of CEMC)	√	√	√	√	100%
National Probation Service (Walsall/Wolverhampton)	√	√	√	√	100%
Community Rehabilitation Company (Walsall/Wolverhampton)	×	√	×	√	50%
Lay Membership (Gap in due to recruitment)	×	×	×	×	0%
Youth Support Services	×	√	√	√	75%
Young Person – (Engagement via other forums)			×	×	N/A
Walsall Council Public Health	√	√	√	√	100%
Dudley & Walsall Mental Health Partnership Trust	×	√	×	×	25%
Adult Safeguarding	√	√	√	√	100%
Schools	√	×	√	√	75%
Education	√	√	×	×	50%
NHS England (Not required to attend every meeting)	×	×	√	×	25%
CDOP Chair	√	√	×	√	75%
WSCB	√	√	√	√	100%

REFERENCES

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Toxic Trio in Walsall and Impact on Looked After Children (LAC) Numbers – Dr.J.Collins July 2016.

“If only someone had listened” Office of the Children’s Commissioner inquiry into Child Sexual exploitation in gangs and groups- Final report, November 2013

CSE Peer Review – Child Sexual Exploitation Peer Diagnostic Pilot – Walsall Council 18-20 July 2016 Feedback Report (LGA)

Walsall Joint Strategic Needs Analysis Refresh – August 2017

Wood Review -

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