Walsall Safeguarding Partnership

Right for Children, Families and Adults

Walsall Safeguarding Children Partnership

Annual Report 2021-22

Contents

Foreword – Sally Hodges

Welcome to the Children's Annual Report of Walsall's Safeguarding Partnership. This report covers the period between 1 April 2021 - 31 March 2022.

Our vision:

Walsall Safeguarding Partnership aspires to be a learning organisation in order to deliver our shared responsibility to safeguard children, young people and adults at risk.

The core purpose of the Walsall Safeguarding Partnership is to:

- Provide effective and informed leadership to the local safeguarding system;
- Deliver our shared responsibility for the safeguarding of children, young people and adults at risk in the borough;
- Promote positive working relationships with each other and children, adults and families;
- Identify and act on learning
- Provide assurance to the Walsall community

Without doubt 21-22 has been a challenging year for everyone committed to safeguarding children, young people and families.

The impact of the pandemic and the review into the tragic deaths of Arthur Labinjo-Hughes and Star Hobson have further illustrated the necessity for children to be 'seen, heard and helped'. We cannot understate the importance of these basic principles of getting this right for children and families through listening to concerns they express and acting promptly on these.

The partnership has taken time to reflect on the learning from the pandemic and these tragic cases to ensure they drive our improvement journey going forward.

Despite the challenges COVID 19 continued to throw throughout the year, the partnership has continued to make progress against it's key priorities. The development of a hybrid working approach for many of its business arrangements has been successful. However, the lack of face to face events, and the opportunity for exchange of views, conversations and networking, has been felt by many, and the partnership is considering reintroducing events more in the coming year. As we move forward, we need to ensure that these operating environments do not hinder safeguarding practice and we will review our meetings framework to take this into account.

During the year, we have maintained close oversight on arrangements led by the Police, Health and the Local Authority in Safeguarding Children. We maintain a clear focus on our Child Safeguarding Practice Reviews and on learning from our assurance activity. There is always, of course, more to do and more that should be done to continue to improve safeguarding services and become an effective learning system.

The Partnership would like to thank agencies for the work they have done to keep our communities safe and to respond to the needs of children at risk of abuse and neglect in Walsall. We should also thank all the local communities who have supported the safeguarding of children in Walsall over the last year.

Sally Hodges
Independent Chair and Scrutineer
Walsall Safeguarding Partnership

Walsall at a glance

Population is 286,716 (ONS-2020 mid-year estimate) of which 69,375 (24.2%) aged 0-17yrs

Deprivation levels are high

Deprivation (IDACI) – Walsall ranked 19th most deprived nationally.

2 of Walsall 3 constituencies in top 50 highest levels of child poverty

4.2% babies born with Low birth weight, compared to 3.1% in West Midlands and 2.9% nationally

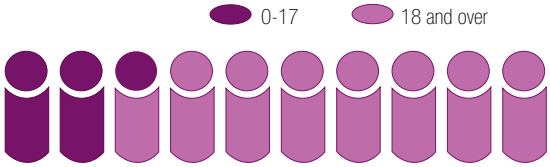
Children and young people have more health challenges than their peers

Infant Mortality Rate - 6.2per 1,000 (2020) compared to West Midlands at 5.5 and 3.8 in England

Teenage Pregnancy 2.5% of 15-17yr olds (1.8% West Midlands & 1.6% Nationally in 2019)

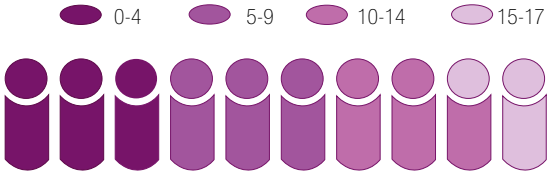
Rate of hospital inpatient admissions for Mental Health issues - 7.9 rate per 10,000 (2020-21) 8.6 in West Midlands and 8.8 Nationally

Rate of hospital admissions for alcohol related issues 1.5 per 10,000 (2017/18 to 2019/20) compared with 2.6 West Midlands and 3.1 nationally

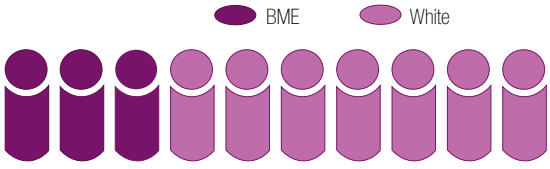


24.2% of the population are children and young people

2020 mid-year population estimates

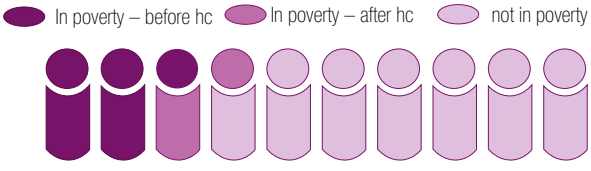


28% of Children are aged 0-4, **29%** are aged 5-9, **28%** are aged 10-14 and **15%** are aged 15-17



31.2% of Children are from BME backgrounds

2011 Census



39% Live in poverty after housing costs May 2021

What the safeguarding partnership has focussed on during 2021/22.

In response to an independent review of the partnership arrangements in 2021-22, the priorities for the Walsall Safeguarding Partnership (WSP) this year have been streamlined to ensure a focused partnership approach. Three priorities were identified across the adult and children's agenda, with Neglect and All Age Exploitation being key for the Children's Partnership. These priorities were determined through our review of partnership data, our understanding of practice from case reviews and audits and wider partnership discussion about issues which require a joint spotlight.

Below is our partnership plan:

Walsall Safeguarding Partnership 2021-2022

Find out more about our arrangements Here: https://go.walsall.gov.uk/walsall-safeguarding-partnership/Arrangements

Priorities: Neglect, Self Neglect, Exploitation

Neglect.

1. To improve the awareness and understanding of neglect and the delivery of effective preventative support
2. To improve the recognition and assessment of children and young people living in neglectful situations before statutory intervention is required, including the use of appropriate assessment tools.
3. Improve the effectiveness of interventions and reduce the impact of neglect.
4. A strategic commitment and leadership that drives good practice and improvement in tackling neglect.

Self Neglect:

1. Undertake a needs analysis.
2. Develop a Self Neglect Strategy
3. Revise the Self Neglect Pathway.

All Age Exploitation:

1. Gather evidence and intelligence regarding the risk and prevalence within Walsall to identify further work required.
2. Agree the partnership Exploitation Strategy.
3. Develop delivery plans against the Strategy.
4. Review the Strategy based on the above information and activity.
5. Capture a qualitative narrative influenced and shaped by experts by experience.
6. Agree multi-agency data scorecard to support the impact/ outcome focus of the refreshed strategy.

Work-streams

Performance and Quality Assurance activity:

Ensuring subgroups routinely feed assurances and areas of concern into PQA subgroup in order that progress can be monitored and quality assured.

Provide assurance, scrutiny and challenge to agencies in ensuring they are fulfilling their statutory obligations.

To receive performance reports in to measure the improvement and impact in safeguarding practice

Measuring the impact of case review and audit outcomes on multi-agency practice

To ensure a high level of professional skill and development through the Practice Development Subgroup and the delivery of the learning opportunities

Practice Review activity:

Efficiently undertake review of those cases where it is appropriate to do so. Obtainine and reflecting on learning, sharing learning and improving practice where needed.

Practice Review Subgroup will work with the Performance and Quality Assurance Subgroup to evaluate outcomes and impact of the work

Utilise regional and national learning to develop our local esponse and approaches.

Practice Improvement activity:

Undertake a training and development needs assessments across the partnership.

Establish closer working relationships / processes with other

suberoups to deliver a practice improvement programme that draws on our understanding of safeguarding issues and learning from reviews across the Borough.

Develop a training strategy to support the partnership priorities 2021/22.

Working with the Walsall Community : our 4th partner

In addition to our three identified priorities the partners have also focused on key areas of statutory activity to quality assure and improve our collective safeguarding response, for example undertaking Child Safeguarding Practice Reviews and disseminating the learning and the collation and review of multi-agency performance and quality assurance data.

In November, 74 managers attended the Safeguarding Partnership Priorities and Next Steps event which covered achievements and future plans for the partnership, key priorities, learning from reviews and multi-agency practice development.

'The event made it clear what the strategic priorities & vision are for the next 12 months, and how these will be achieved. It gave very clear expectations and opportunities for engagement' (Black Country Healthcare NHS Foundation Trust)

The Wood Review of Multi Agency Safeguarding Arrangements was published in May 2021 and the Safeguarding Executive Group, supported by the Independent Chair and Business Manager, undertook a SWOT analysis (Strengths, Weaknesses, Opportunities and Threats) with a supporting action plan and reviewed the current areas of the partnership which were operating effectively or required additional development. As identified in the 2020-21 annual report the WSP has progressed the implementation of this action plan such as improving the connectivity between the subgroup work streams and connectivity with other strategic Boards such as the Safer Walsall Partnership (Community Safety).

Part of the role of the Walsall Safeguarding Partnership (WSP) is to assess the effectiveness of local safeguarding arrangements in agencies working with adults and children. This is where all local agencies and organisations who provide services to children and adults are asked to provide assurance to the extent to which they meet the safeguarding arrangements and standards set out in statutory guidance.

During 2021 WSP carried out a number activities to elicit this assurance, below is outlined some of the assurance gained from Section 11 assurance activity, service user quality assurance with partners, findings from the 2021 practitioner survey and measuring impact from Walsall Child Safeguarding Practice Reviews.

Whilst Walsall Safeguarding Partnership wait for the development of combined S11/Care Act Tool and online platform, it was agreed to hold assurance meetings with agencies that had submitted their S11 in 2019, rather than complete a full S11 Audit. However, to ensure compliance with S11, the assurance questions for the session were developed to reflect key areas from the regional audit tool along with quality assuring findings from reviews, audits and practitioner and 4th Partner feedback. This ensured partner agencies were able to provide assurance of their statutory duties.

Areas of assurance

- Section 11 compliance across agencies that were asked to participate was particularly strong in:
    - Governance arrangements
    - Quality Assurance
    - Ensuring staff are competent to carry out their safeguarding responsibilities
    - Children and young people influencing change
- YSP (Young People's Safeguarding Partnership) were assured that staff they spoke with had a good understanding of their role in safeguarding.
- CCG are monitoring GP practice improvements in relation to learning from SCRs (Serious Case Reviews) and CSPR's (Child Safeguarding Practice Reviews) in W6, W7 and W9.
- Learning from W10 SCR recommendations have been embedded, particularly around Professional Curiosity and Offender Management.

Impact:

- Learning is disseminated in a timely way across the partnership by way of 'Key Safeguarding Messages' - 57% (131) of survey respondents confirmed this
- 86% (198) of practitioners received regular supervision (impact of SCR W6 recommendation)
- 51% (118) were aware of the Children's Resolution and Escalation Policy – an improvement on 43% 2019 survey (Impact of an SCR W6 recommendation)

- The pre-birth assessment guidance is being used effectively and is monitored through regular audit activity (impact of SCR 7 recommendation)
- Staff who responded in the survey felt their organisation ensured they were competent to carry out their safeguarding responsibilities
  - **Public Health:** 'Everyone is trained and kept up to date with any changes, the team uses reflective practice to go over cases and issues as lessons learned from each other.'
  - **Probation**: 'Safeguarding is core to the organisation.'
  - **CAMHS:** 'There is good support for clinicians from the safeguarding team.'
  - **Health Visitor:** '[Good Practice] Safeguarding supervision. Regular meetings with safeguarding team.'
  - **Midwife:** '[Good practice] Safeguarding Supervision.'

Progress on our Children's Priority areas:

1. Child Neglect Strategy

   Following a neglect stock take in January 2021, the Partnership identified it was important to refresh and re-energise activity around neglect.

   The refreshed strategy published in October 2021 aims to offer an analysis of the Walsall context, the impact of neglect on children in Walsall, and what the Partnership is going to do to strategically improve practice and services to children and families.

   The refreshed strategy is based on four key principles:

   1. Collective understanding of the issues around 'neglect' from a child, family and community point of view across Walsall
   2. Outcome focused strategic priorities and an action plan (short and long term) which focusses on securing better lives for children, families and future generations
   3. Making decisions driven by evidence, including celebrating and embedding what works well (linked to creating opportunities for a bottom up approach – what works from a practitioner point of view to support them in delivering better support to prevent and / or address issues around neglect effectively)
   4. Effective collaborative multi-disciplinary partnership working

   The partnership has also developed a Child Neglect detailed action plan and an outcomes framework.

2. All Age Exploitation

   Following the sign off of the All Age Exploitation Strategy. Exploitation Awareness Fortnight was held in March 2022.

   190 delegates attended across 14 sessions that focused on 'All age Exploitation' workshops.

   100% of delegates felt the right themes/subjects were covered.

   When asked how they have embedded learning in to practice this is what they said:

   'The terminology used is different on the street to what professionals use. I have started working with a child who is being exploited, the training has given me knowledge of the language he uses and what is meant by it. This has really helped me to connect with the Young Person. (Early Help Team – West Locality)

   'I have used the idea of the three B's- Being (initial contact), Becoming (engaging), and Belonging. It has created lots of discussions with foster carers. It was good information, and have shared with some carers which has aided to dismiss myths and unhelpful views, but raised an awareness/ understanding of how some birth parents (especially women's) lifestyles take this direction. (Fostering Services)

   'I have made a referral into the Hope Project, I didn't know this existed so it has been really helpful and hopefully the adult I work with will have positive outcomes as a result of working with this service.' (Walsall CAMHS)

What has this meant for children & families in Walsall?

Partnership Priority: Neglect – more children are being supported through Early Help and less children (11% compared to 16% last year) are having a social care Child and Family Assessment due to Neglect.

Partnership Priority: Exploitation – we have identified, screened and worked with more young people at risk of Exploitation.

Early Help demand has **Increased** by 53%
592 in 2021 compared to **281** in 2019

Top 3 Early Help **presenting needs:**
Challenging Behaviour
Domestic Abuse
Emotional Well Being

62% (558) CYP had 3 or more presenting needs. Of these, **25%** (140) have **complex** needs (5 or more) 48% Increase compared to 4% in 2019

Timeliness of (865) Early Help Assessments has increased - 87% completed in the 25 day target - Up from 56% in 20-21

3,501 ***Referrals*** received by MASH between 1st April 2021 & 31st March 22 compared to **3,431** last year and **4,401** the previous year

Family Safeguarding Model
697 children supported from **333** families

Top ***presenting needs*** to Social Care (CFA) :
Domestic Violence (32%)
Emotional Abuse (23%)
Mental Health (20%)
Neglect-5th (11%)

63.5% Contacts to Social Care were completed within **48 hours**
43.6% Completed within **24 hours**

Timeliness of Assessments
88.9% completed within 45 days 90.2% in 2021

80.2% Children (aged 5yrs & over) Seen alone as part of their assessment, 75% 2021

199
Children subject of a **Child Protection Plan** 31st March 2022 compared to **389** in 2019
23.9% CP Plans latest category of abuse **Neglect**
83.9% ICPC held within 15 days of Strategy Discussion - **83.1%** Led to a **Child Protection Plan up** from 80.4%

93% Child views heard at ICPC

49% Child attended ICPC
Up from 31%

333 Children & young people screened, **291** at risk of **Criminal or Sexual Exploitation**
211 'at risk', 70 'Significant', 16 'Serious'
(297 all types of Exploitation)

The number of Missing CYP has ***increased*** 360 compared to 233 in 20-21
1,044 episodes where Walsall had responsibility for Return Home Conversation

86% RHC's **Offered** and **68%** were accepted
604 Return Home Conversations took place
68% of these were completed within 72 hrs remaining fairly static since last year

The work of 4th Partner

In 2019, our Youth Safeguarding Partners (YSP) who represent our children and young people (4th Partner) completed inspection visits and focus groups with practitioners in line with the Section 11 Children Act Audit. There was some excellent feedback from this activity, which contributed to a challenge event for our partners to reflect on their Section 11 compliance and safeguarding responsibilities.

During August and October 2021 YSP held these focus groups again, on a virtual basis, during which young people asked practitioners questions relevant to the Section 11 Audit, questions relating to themes arising from Audits and Case Reviews as well as topics that are important to them. YSP met with staff from West Midlands Police, Youth Justice, Children's Social Care, Health Visiting and School Nursing Teams and gave the below feedback regarding each agency:

Police:

'I think they are doing a good job overall, better impression this time around as answered the questions well – they were very knowledgeable.

We were concerned that they didn't know what the Right Help Right Time document was – however they understood MASH /Safeguarding processes and explained this throughout the answers to the questions.

We would like more assurance that different departments are talking to one another about safeguarding children and young people.'

Social Workers

'I was supported previously and was good, useful and needed – my experience is social workers able to change people's lives. They listen to young people and be patient.'

Youth Justice

'All the staff were honest about the struggles they face, especially during Covid. They seemed genuine people.'

School Health Nurses and Health Visitors:

'They were able to answer the questions really well and all attendees had their say'.

'Although I wouldn't have a need to go to a school health nurse, thinking about someone who would, then they would be a good person to speak to.'

Work on the communications and engagement agenda was not progressed as far as had been anticipated following the departure of a key staff member within the Business Unit during the year. This will be a priority to address in 2022-23.

Learning from Case Reviews and Audits

Local Child Safeguarding Practice Reviews (LCSPR)

- Within the year 2021-2022, 4 cases were referred for consideration of a Child Safeguarding Practice Review.
- 1 of these was also notified to the National Panel and Ofsted as a Serious Child Safeguarding Incident and therefore a statutory Rapid Review was undertaken. It was agreed by the partners that a LCSPR was not appropriate in this case and the National Panel agreed.
- Of the 4 referrals considered, 1 progressed to a LCSPR.
- There was also 1 further LCSPR from 2019-20 which continued to be progressed during the year. This will be published in May 2022 (W13 'Sam').
- No children's reviews were completed or published.
- 8 action plans relating to previous Serious Case Reviews (SCRs) or Rapid Reviews were completed within the year.

Learning from these cases, including good practice, in relation to traveller's mental health, suicide prevention, thresholds and recognition of needs or abuse – Right Help, Right Time, non-accidental injuries and bruising in non-mobile babies, Think Family, working with fathers and cross border working are all being taken forward by the Partnership.

Multi-Agency Audits (MAA)

During the year there were three multi-agency audits carried out, one was linked to the safeguarding priorities and two were as a direct result of case review learning. During Q2 the audit process was reviewed to include a revised MAA audit template and process to enhance the learning system.

7 minute briefings were disseminated for each audit which included learning for all partners, in an accessible format. Recommendations were followed up during the year.

Practice in the cases shows continued improvement and was graded as follows:

	Outstanding	Good	Requires Improvement	Inadequate
2021-22	0%	60%	40%	0%
2020-21	4%	61%	30%	4%
2019-2020	0%	23%	62%	15%

Key learning from the audits included:

Q1 Neglact

This audit reviewed how effective the multi-agency partnership is in addressing the needs and safeguarding concerns for children experiencing Neglect which is a key priority for WSP. Overall practitioners were able to identify neglect appropriately and referrals to CSC were appropriate. There was a clear understanding of neglect by practitioners and a focus on the impact. Audits highlighted some good quality relationship-based working from involved professionals. However, there is a need for work to be better coordinated as a multi-agency approach to understanding and assessment. There was also limited use of the Graded Care Profile 2 Tool for assessing and working towards change where neglect is the key concern.

Q2 Review of the process

The process was refined to revise the audit tool and the process to better ensure that front line practitioners from all agencies have a line of sight to the work of the Partnership, case workers are actively involved with the auditing process and are invited to participate in the audit discussion for their case. This brings the case to life, enabling individual practitioners to reflect on their part in partnership working and creates individual learning along with the multi-agency themed learning and actions for single agencies.

Q3 Child Sexual Abuse

This audit reviewed how effective the multi-agency partnership is in addressing the needs and safeguarding concerns for children who have experienced or are at risk of sexual abuse. The question set was developed in response to the findings from an unpublished Walsall Case Review and a Rapid Review. Risks were appropriately recognised with timely responses coordinated between agencies. The harm experienced and risk of harm to the child was considered and understood, decisions were made appropriately, demonstrating effective safeguarding and the right courses of action being taken for children. Assessments seemed to focus on work completed by a single agency, plans did not have enough multi-agency input. However, there were examples of good work being done by professionals to work with children and family members and multi-agency working had made a difference for children.

Q4 Injuries in non-mobile babies

This audit reviewed how effective the multi-agency partnership is in responding to babies or young infants who have experience a non accidental injury and quality assured how findings from recent Walsall reviews have been implemented. Overall, these audits found that multi-agency working was effective in the identification and management of the safeguarding concerns identified and that specific decision-making was timely and purposeful. This meant that vulnerable babies and children were safeguarded. However, there was less focus on the shared multi-agency practice that followed in working with the family, and there appear to be opportunities for shared learning and developmental work.

To complement practitioner briefings, learning from the cases is also shared within a Practice Reflection Workshop. Practice Reflection Workshops provide some vital time out for any practitioner working with children or adults to embed good practice through reflecting on a case study from the audit.

A practitioner from Children's Services who attended Quarter 2 Practice Reflection Workshop said 'Following the workshop I will write more effective plans - sometimes I think we can be a little vague, or perhaps just not specific enough, but that doesn't benefit anyone, so it's important to create a plan that everyone is reading will be able to understand and know what needs to happen, why it needs to happen, and when it needs to happen.'

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

- **Approach 1** - Agencies will be asked to provide evidence on a single agency basis how the implemented action(s) has made a difference to practice and if there is any further action/risk to the partnership.
- **Approach 2** - Where there is a natural fit, themes from the reviews/audits will be included in the current multi-agency audit schedule (set at the beginning of the year).
- **Approach 3** - Additional specific audits / deep dives may be required if there is a recurring theme from case reviews or audit findings.
- **Approach 4** - Assurances triangulated within the biennial S11 assurance events.
- **Approach 5** - Agencies may be asked to attend an 'enquiry panel' where senior Managers will be asked to provide assurance on a number of their actions which have been marked complete.

Assurance was requested for completed actions around key recommendations from Case Reviews by using approaches 1 and 4 above. Further approaches will be used in the coming year.

How have we collated and shared learning?

- An initial meeting with subgroup chairs was held to support greater connectivity between the subgroups, this led to a revision of the Terms of References for the subgroups.
- Business Unit processes and systems were enhanced i.e. case review action tracker, forward plan for Operations and Scrutiny Group and Performance and Quality Assurance Subgroup (PQA), regular meetings with subgroup leads from the Business Unit for PQA/Practice Development Group (PDG)/Practice Review Group (PRG).
- The Business Unit structure was reviewed to ensure there was appropriate support for the subgroups and key work streams. The Business Unit leads now meet regularly to bring together and align work streams and ensure a joined up approach to forward planning (e.g. learning from reviews being followed up in the multi-agency audit programme).
- The Children's 2021-22 audit plan was linked to findings from previous practice reviews i.e. Child Sexual Abuse, Neglect and Injuries in non-mobile babies.
- Children's audit learning was routinely shared by PDG through quarterly Practice Reflection Workshops, using one of the cases from each audit to demonstrate the learning and facilitated by the children's practitioners involved in the child's life.
- The 2021 Practitioner Survey, led by PQA, included questions which were linked to both Childrens and Adults case review and audit learning i.e:
    - Are you aware of the Walsall Safeguarding Partnership Children's Resolution and Escalation Policy?
    - How confident are you about implementing the MCA in your practice?
    - Do you receive regular supervision? Does this include: reflection on practice/professional support/ personal support/reflect on training?
- Section 11 Assurance Challenge events were held in November 2021 which incorporated questions to measure impact from reviews and probe the findings from the 2021 Practitioner Survey.
- A new framework for evaluating the impact from case review actions was implemented (see embedded document below) which had 5 approaches to measuring impact, with reports in to PQA and PRG on an annual basis (first report presented January 2022 to PQA).

- In December 2021 a learning event from child reviews was held which covered learning on the following themes:
  - Child Sexual Abuse
  - Under 2's
  - Bruising in non-mobile babies
  - Connected Carers
  - Information sharing
  - Multi-agency working and case coordination
  - Think Family
  - Professional Curiosity
  - Professional Challenge
  - Mental Health
  - Pathways and referrals
- The WSP learning offer includes specific training resulting from child reviews i.e. bruising in non-mobile babies (W12 & RRs) / working with fathers (W5, W7, W10, Practice Reflection Workshop on Connected Carers W11). WSP have also launched the ICON programme across the partnership as we set out to do in the 2021-22 annual report (linked to SCR's W5, W7).
- Links were further strengthened between the Multi-Agency Audit Group and Practice Development Group as the Practice Improvement Lead attends the audits and there is an agenda item on PDG for feedback from audits.
- The Partnership have received learning from audits and reviews by way of Key Messages newsletters, website updates, 7 min briefings, webinar's and new training courses being developed.

Some examples of how we have disseminated learning:

SCR W11: theme Connected carers / out of area change in policy

- top tips, 7 Minute briefing, learning from reviews newsletter,
- Practice Reflection workshop,
- MA Audit (improved working between WHT & LA noted), 7 minute briefing developed from the audit learning and shared
- Learning from Reviews event

Following the practice reflection workshop a social worker from Children's Services stated the impact the training had on her:

'It reminded me that children who are placed with connected carers are not automatically safe from harm. Visits, meetings, assessments etc. should still be conducted within timescales and monitor placement progress and any issues. I have been reminded of the importance for post placement support and importance of professional curiosity which I now use more of within my practice'.

SCR W12: theme Injuries in non-mobile babies

- Specific briefing on injuries in non-mobile babies
- Learning from reviews newsletter
- Injuries in non-mobile babies webinar held
- Revised guidance included in multi-agency procedures
- Multi-agency Audit in Quarter 4 2021-22
- Injuries in non-mobile babies leaflet produced and disseminated

How effective have our arrangements been?

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

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

In May 2021 the CQC published its findings on key areas of practice inspected within the Walsall Healthcare NHS Trust. The three domains assessed in the unannounced March 2021 inspection – safe, responsive and well-led – were rated as "Inadequate"; downgraded from "Requires Improvement." The overall rating for Walsall Healthcare NHS Trust remains "Requires Improvement."

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

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

There continues to be strong links with the Family Safeguarding Board, with attendance at the board and regular updating reports on the impact of the model and progress of establishing sustainability being considered at Operations and Scrutiny Group.

The All Age Exploitation Strategy and Child Neglect Strategy were finalised and agreed by partners.

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

Positive work has taken place, with improved outcomes, in relation to children experiencing Neglect and those at risk of Exploitation.

Areas for focus in 2022-2023

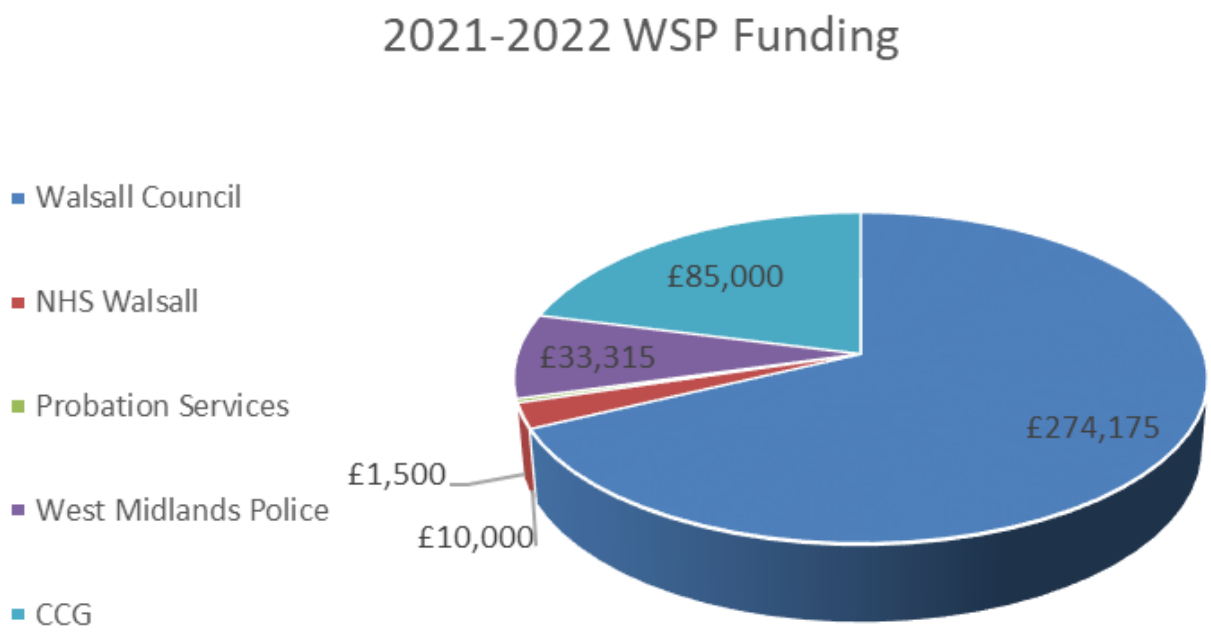
- Review of the Safeguarding Partnership Arrangements to ensure they are fit for purpose across the children's and adult's strategic agenda.
- Full Section 11 Audit to be completed during the next year, utilising the West Midlands Audit Tool.
- To deliver the proposed forward plan for practice development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

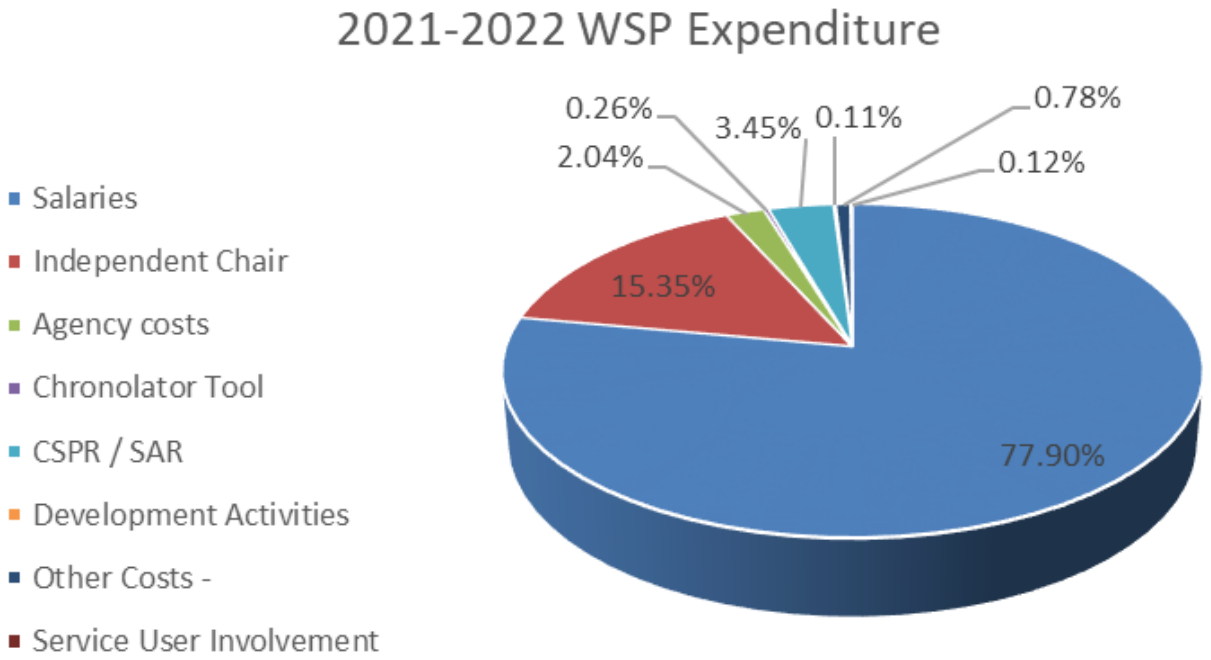
Appendix 1: Financial Summary

In 2021-22 the Partnership had £404,000 pooled into a partnership budget. This money was contributed by the Statutory Partners, plus the local Healthcare Trust and Probation. The majority of the resource was used to pay for Business Unit staffing. Other costs include the Independent Chair, Regional Procedures and online products used for business processes, service user involvement, consultancy and training.

Due to previous carry forward and underspend in the current year, £279,044 is held in reserves. Planning for utilising this in 2022-23 is taking place and will include the commissioning of a Safeguarding Adult Consultant to support the Partnership. Also, due to the high number of SAR's commenced by the Adult Partnership in 2021-22 there will also be an increase in expenditure associated with Independent Reviewers in 2022-23.

The charts below show the proportion of the contributions by organisation and also the percentage split of the expenditure.





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