

## **Walsall Safeguarding Children Board**

### **Annual Report 2018-19**

#### **Executive Summary**

##### **Overview**

This report provides an overview of safeguarding activity and, in particular, the volume of safeguarding referrals made to the Local Authority Children's Services and the support provided to children assessed to need statutory social work intervention to promote their safety. There has been progress in ensuring that more of the cases referred to the Local Authority are the ones where children need a social work service; this indicates that there is a greater understanding the local thresholds. However, there is still work to do to ensure that there is sufficient capacity within the Multi-Agency Safeguarding Hub (MASH) to complete health checks. The data tells us that there is also further work to do to ensure that the right cases progress beyond the MASH e.g. 57% of child protection enquiries resulted in no further action.

In terms of multi-agency contribution to Child Protection activity, this has been audited on a regular basis. The findings indicate that the quality of safeguarding practice is improving; areas for further development include information sharing and contribution to the delivery of child protection planning. The rate of repeat child protection plans has reduced which suggests that the help being provided to the most vulnerable children and their families has become more responsive to their needs.

Neglect has been a priority for the Walsall Safeguarding Partnership and through the Council's Walsall Right for Children Programme, there have been conversations with parents who have helpfully shared their experiences; they tell a powerful story of the importance of workers building relationships with them. It is recognised that there is a need to increase the pace of the delivery of key aspects of the neglect strategy. To be successful, this will require partner agencies to embrace the important role they play in responding to the early signs of neglect.

Another priority has been child exploitation; the Board set out to broaden its response to exploitation so that the focus was wider than child sexual exploitation. This approach is to be commended as we know that children can be exploited in a various ways e.g. criminal exploitation. Positively, there has been an increase in referral made to the National Referral Mechanism which is a national protection scheme that affords criminal justice agencies the opportunity to respond to those who exploit children as perpetrators of trafficking and remove the need to rely on a complaint or disclosure of exploitation from a child victim. The data indicates that there is work to do to increase the timeliness of interviews offered to children who go missing from home or care. It has been suggested that exploring further how perpetrators can be brought to justice

will aid the partnership to deliver the “pursue” element of its approach to tackling exploitation.

The governance of the response to Domestic Abuse has been agreed as sitting with the Safer Walsall Partnership and the Safeguarding Children Board, along with the Safeguarding Adult Board, has advocated for the production of a Domestic Abuse strategy to bring pace and purpose to the local response to those affected by domestic abuse. In so doing, it is recognised that there needs to be greater synergy and coordination between the Safeguarding Boards and Safer Walsall Partnership across this as well as other agendas e.g. organised crime.

In terms of the Board’s challenge and scrutiny role, progress has been made. Performance data is routinely presented to the Board, audits take place, governance arrangements have been strengthened and discussions evidence an increased culture of mutual challenge. There is further work to do to develop the multi-agency training offer; this will enable the Board to better support front line staff to act on the learning from audits and serious case reviews. The value of multi agency training is well evidenced however, to date, it has not been an approach that has underpinned the work of the Safeguarding Children Board in Walsall and a change in culture and approach is therefore required.

An important part of the Board’s work during 2018- 19 has been to respond to the requirements of statutory guidance ( Working Together 2018) which requires the development of new partnership arrangements for safeguarding. With effect from 29<sup>th</sup> September 2019, Safeguarding Children Boards, for whom the Local Authority has been responsible for, will be replaced by Safeguarding Partnership arrangements. The Police, Clinical Commissioning Group and Local Authority will have a shared and equal responsibility for Safeguarding Partnership arrangements. Partners in Walsall have agreed the core purpose and ambitions of the new **Safeguarding Partnership** as well the behaviours the behaviours that they should expect to see at all levels of the partnership and running through the relationships with each other as well as with children and their families.

## **Conclusions**

### **How safe are children in Walsall?**

There has been evidence of improvement within the year. This includes:

- a reduction in referrals to MASH which led to no further action
- improved outcomes at Early Help
- positive reductions seen in the number of children subject to a second or subsequent child protection plan, particularly for neglect.

- A positive Ofsted focused visit regarding services to [Care Leavers](#)
- Less cases judged inadequate and more judged to be good through the multi agency audit process

Rating	2017-18	2018-19
Good	32%	37.5%
Requires Improvement	45%	45%
Inadequate	23%	17.5%

Area's for further development include:

- A revision and re-launch of the Threshold guidance to ensure children and young people receive the right help at the right time, including a focus on understanding of relevant support prior to a MASH referral and application of thresholds within the MASH.
- Continued focus on practice in high impact areas such as Neglect, Child Sexual Abuse and Exploitation.
- Reviewing the multi agency safeguarding training offer, opportunities for practice improvement and the capacity to deliver on this across the partnership (see 'Are we a Learning System' below).
- Seeking a further reduction in the number of MASH referrals and Section 47 enquiries which lead to no further action for Children's Services.

How strong is partnership working?

Again there has been evidence of improvements within the year. For example:

- The Chief Nurse for Walsall Healthcare Trust and the Director of Public Health are now regular attendee's at Board meetings and a Named GP for Safeguarding has been appointed by the CCG.
- There is greater challenge at Board meetings by and of partners (e.g. regarding the health contribution to MASH).
- There have been regular meetings of the new Safeguarding Leadership Group which has developed shadow arrangements during the year in preparation for the new arrangements in summer 2019.
- The response to Neglect is improving but progress in implementing the Strategy has been slower than intended.
- Some progress has been made in relation to the identification of child sexual abuse with higher numbers of children being made subject to a Child Protection Plan but further work is required on the partnership strategy.

Area's for further development include:

- Collective ownership and accountability of safeguarding practice and Board priorities across the partnership e.g. attendance at, and effectiveness of, Core Groups, driving forward agenda's such as the Neglect Strategy and Right Help,

Right Time across all agencies, and Child Protection Conference attendance by some partners (e.g. GP's).

- Implementing the agreed arrangements for health staff in MASH as soon as possible.
- Visibility of safeguarding and the partnership arrangements needs to improve and this forms part of the partnership vision for the coming year.
- Further engagement with the voluntary and community sector.
- Ensuring greater consistency of practice.
- There is not yet a Domestic Abuse Strategy for the partnership, which is a significant risk that requires addressing.

### Are we a learning system?

We are not yet operating as an effective learning system. There is more to be done to achieve this. This will include:

- Reviewing the multi agency safeguarding training offer, opportunities for practice improvement and the capacity to deliver on this across the partnership.
- Evaluating the impact of training.
- Acting on audit findings to drive practice uplift

Engaging with children and young people in a meaningful way (as our 4<sup>th</sup> partner in the new arrangements)

### Opportunities

- The WR4C (Walsall Right For Children) Transformation Programme, launched in September 2018, is driving forward Children's Services vision to ensure that the right children are in the right place with the right support for as long as it's needed to ensure that they are safe from harm, happy and learning well.

To realise the WR4C vision we need to do things differently and this will involve:

- moving to a locality model
  - focusing on connecting practitioners with communities and local resources
  - getting to know children and families well to enable them to become more resilient and stay together.
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- The new safeguarding arrangements, in line with Working Together 2018, offer an opportunity to re-align the leadership and accountability for the safeguarding agenda and develop a new vision for the partnership.
  - The new arrangements also offer the opportunity to renew the partnership governance structure.
  - Increased capacity will be created to support the delivery of a robust multi agency Practice Improvement programme.

- In spring 2019 the Walsall partnership applied to participate in the DfE Strengthening Families, Protecting Children Programme.

Through this programme, £84 million will be invested over 5 years to support up to 20 local authorities to improve work with families and safely reduce the number of children entering care.

Walsall has applied to implement the Family Safeguarding Model.

This programme supports a whole-system change to a local authority's child protection approach, focusing on promoting children being brought up in their families, by meeting the needs of both the children and the adults around them.

This includes:

- developing multi-disciplinary teams including adult care workers
- use of motivational interviewing
- implementing a 'workbook', a single data tool for all professionals

If the bid is successful it will offer Walsall the opportunity to enhance its approach to locality working and 'Think Family'.

### **Priorities and Next Steps in 2019-20**

- Complete and launch the CSA strategy.
- Finalise the multi agency Practice Improvement Strategy and revise the associated learning and development programme.
- Complete and launch the Criminal Exploitation Strategy and Pathway.
- Build capacity across the partnership and within the business unit to deliver multi agency training.
- Continue to focus on the implementation of the Neglect Strategy.
- Implement the New Safeguarding Partnership Arrangements.
- Pursue the Family Safeguarding model, regardless of whether the DfE bid is successful.
- Develop our approach to embedding learning from performance, audit and reviews.
- Ensure children, young people and service users are actively engaged in the partnership.
- Increase the visibility of the Safeguarding Partnership.
- Launch and embed the principles and practice contained within the revised Threshold Guidance – Right Help, Right Time.
- Continue to ensure strong safeguarding leadership across the partnership.

# Walsall Safeguarding Children Board

Annual Report 2018 – 2019



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## **1. Foreword by the Independent Chair**

Welcome to the Walsall Safeguarding Children Board Annual Report 2018-19

The Safeguarding Children Board is designed to bring together the range of organisations that work with children and young people and/or adults who are parents or carers. In so doing, it aims to:

- Strengthen the culture and delivery of multi agency working to safeguard children and young people;
- Understand how well agencies are safeguarding children and young people;
- Identify ways to improve how children are safeguarded; including through the review of cases where a child has died or been seriously harmed.

This report provides an overview of safeguarding activity and, in particular, the volume of safeguarding referrals made to the Local Authority Children's Services and the support provided to children assessed to need statutory social work intervention to promote their safety. There has been progress in ensuring that more of the cases referred to the Local Authority are the ones where children need a social work service; this indicates that there is a greater understanding the local thresholds. However, there is still work to do to ensure that there is sufficient capacity within the Multi-Agency Safeguarding Hub (MASH) to complete health checks. The data tells us that there is also further work to do to ensure that the right cases progress beyond the MASH e.g. 57% of child protection enquiries resulted in no further action.

In terms of multi-agency contribution to Child Protection activity, this has been audited on a regular basis. The findings indicate that the quality of safeguarding practice is improving; areas for further development include information sharing and contribution to the delivery of child protection planning. The rate of repeat child protection plans has reduced which suggests that the help being provided to the most vulnerable children and their families has become more responsive to their needs.

Neglect has been a priority for the Walsall Safeguarding Partnership and through the Council's Walsall Right for Children Programme, there have been conversations with parents who have helpfully shared their experiences; they tell a powerful story of the importance of workers building relationships with them. It is recognised that there is a need to increase the pace of the delivery of key aspects of the neglect strategy. To be successful, this will require partner agencies to embrace the important role they play in responding to the early signs of neglect.



Another priority has been child exploitation; the Board set out to broaden its response to exploitation so that the focus was wider than child sexual exploitation. This approach is to be commended as we know that children can be exploited in a various ways e.g. criminal exploitation. Positively, there has been an increase in referral made to the National Referral Mechanism which is a national protection scheme that affords criminal justice agencies the opportunity to respond to those who exploit children as perpetrators of trafficking and remove the need to rely on a complaint or disclosure of exploitation from a child victim. The data indicates that there is work to do to increase the timeliness of interviews offered to children who go missing from home or care. It has been suggested that exploring further how perpetrators can be brought to justice will aid the partnership to deliver the “pursue” element of its approach to tackling exploitation.

The governance of the response to Domestic Abuse has been agreed as sitting with the Safer Walsall Partnership and the Safeguarding Children Board, along with the Safeguarding Adult Board, has advocated for the production of a Domestic Abuse strategy to bring pace and purpose to the local response to those affected by domestic abuse. In so doing, it is recognised that there needs to be greater synergy and coordination between the Safeguarding Boards and Safer Walsall Partnership across this as well as other agendas e.g. organised crime.

In terms of the Board’s challenge and scrutiny role, progress has been made. Performance data is routinely presented to the Board, audits take place, governance arrangements have been strengthened and discussions evidence an increased culture of mutual challenge. There is further work to do to develop the multi-agency training offer; this will enable the Board to better support front line staff to act on the learning from audits and serious case reviews. The value of multi agency training is well evidenced however, to date, it has not been an approach that has underpinned the work of the Safeguarding Children Board in Walsall and a change in culture and approach is therefore required.

An important part of the Board’s work during 2018- 19 has been to respond to the requirements of statutory guidance ( Working Together 2018) which requires the development of new partnership arrangements for safeguarding. With effect from 29<sup>th</sup> September 2019, Safeguarding Children Boards, for whom the Local Authority has been responsible for, will be replaced by Safeguarding Partnership arrangements. The Police, Clinical Commissioning Group and Local Authority will have a shared and equal responsibility for Safeguarding Partnership arrangements. Partners in Walsall have agreed the core purpose and ambitions of the new [Safeguarding Partnership](#) as well the behaviours the behaviours that we should expect to see at all levels of the partnership and running through our relationships with each other as well as with children and their families. In my view, the Safeguarding Children Board ends 2018-19 having made reasonable progress against many of its agreed priorities and with evidence of impact being demonstrated in some areas.

In whatever role you have played, thank you for your contribution to safeguarding children during 2018-19 and also to the work of the Walsall Safeguarding Board during its 13 year existence. For 2019-20, I would ask that you act as a champion for the priorities of the Safeguarding Partnership.

These are:

- To support the local and professional community to ensure that children and families receive the Right Help at the Right Time.
- To support the local and professional community to recognise, respond to and reduce the impact of neglect in a child centred way.
- To seek assurance regarding transition arrangements for agreed vulnerable groups, between children and adult services.

Very best wishes

Liz Murphy

Independent Chair, Walsall Safeguarding Children Board

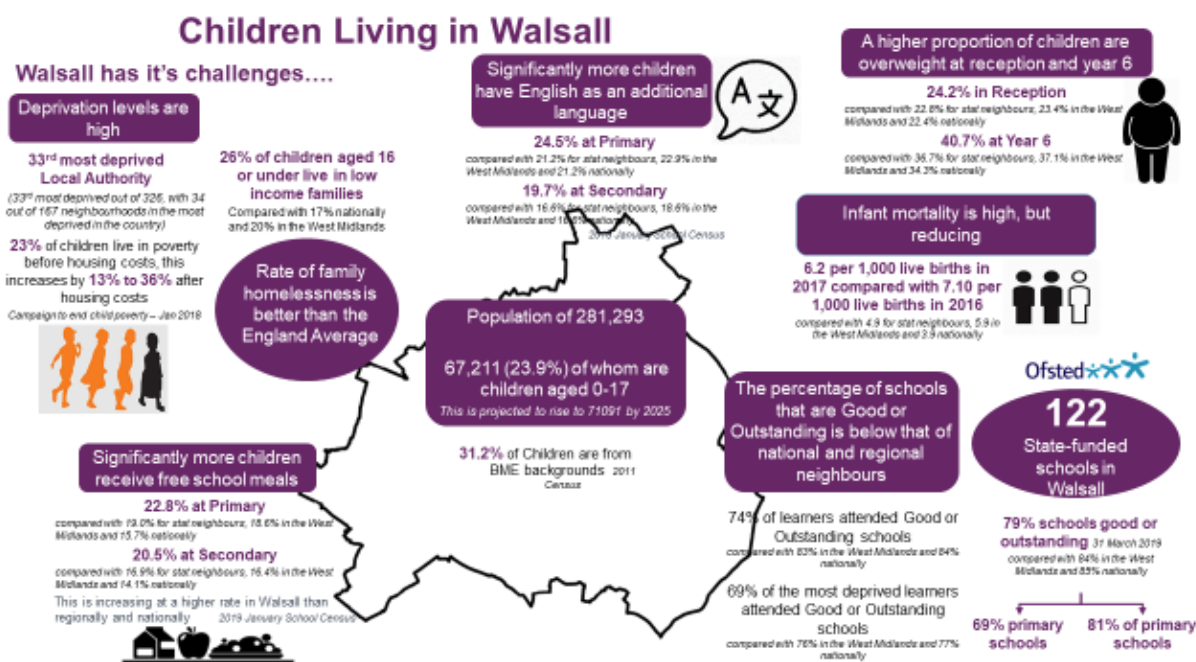
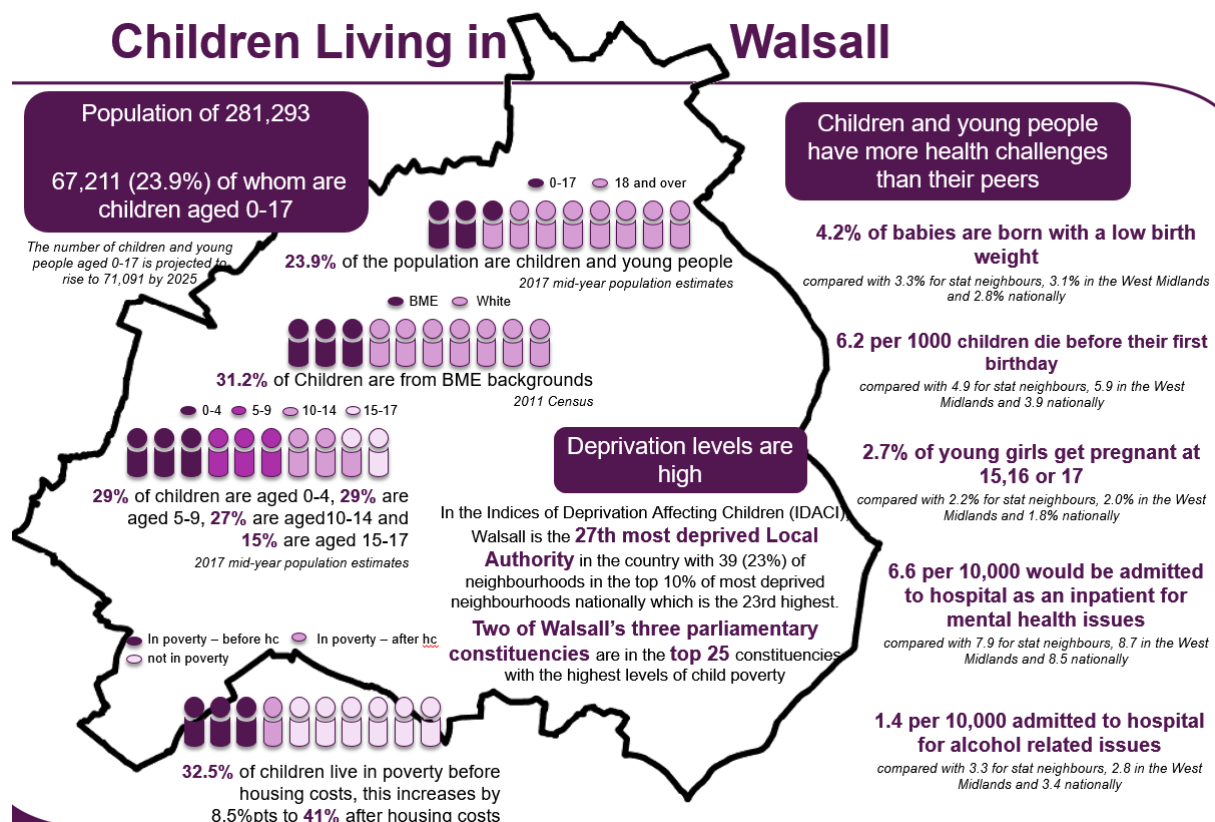
## Introduction

Section 13 Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board (LSCB) for their area and specifies the organisations and individuals who should be represented on it. LSCB's have a range of roles and statutory functions, including developing local safeguarding policy and procedures and scrutinising local arrangements.

During 2018-19 the Board met quarterly and covered a wide range of business including progress reports from sub-groups, work plans and WSCB priorities, assurance reporting and Serious Case Reviews. In Walsall the LSCB consists of a Board of senior agency representatives including the Lead Member for Children Services, an Operations Group, or smaller group, of statutory partners and sub group chairs, into which 6 subgroups report. The structure of the WSCB can be found in Appendix 1, with attendance at meetings and the business unit budget detailed in appendix 2 and 3 respectively.

Following the publication of Working Together 2018, the Board began to develop plans to establish Multi Agency Safeguarding Arrangements and the published plans can be found [here](#) and additional information in Appendix 4.

## 2. Local Context



## Our Year in Figures

### Headlines:

- There were 5,135 referrals to the Multi Agency Safeguarding Hub.
  - 5143 Child and Family Assessments were completed.
  - There were 307 Section 47 enquiries (an investigation carried out when a child is thought to be suffering significant harm).
  - There were 1929 'Children in Need' <sup>1</sup>.
  - 389 children were subject to a Child Protection Plan.
  - 614 children were Looked After Children.
  - 54 Looked After Children went missing, which equated to 492 missing episodes.
- 
- Early Help (EH)
    - 2018/19 saw a 5.8% increase in the number of requests for early help compared with 2017/18
    - 67% were via the Early Help Hub, 15.5% were via MASH, 10.8% via step-down from social care assessment and 6.6% stepped down from children in need review.
    - There were 843 re-referrals during 2018/19
    - In 2018/19 18.6% of referrals to Early Help were re-requests within 12 months. This is lower than the out-turn for 2017/18 (25.5%).
    - Domestic violence to a parent or carer (18.1%) and Socially unacceptable behaviour (child) (15.2%) and Mental Health (parent/carer) (14.0%) are the three main reasons for referral.
    - 64% of EH cases were recorded as having a positive outcome (e.g. Step Down, needs met).
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- Referrals to the Multi Agency Safeguarding Hub (MASH)
    - The Rate of referrals per 10,000 is 764 and has reduced slightly from 778 (2017-18). As it has, for the previous 3 years, it remains significantly higher than the statistical neighbours and England averages (677 and 533). It is thought locally this is due risk averse practice and a lack of appropriate application of the Threshold Guidance.
    - 5135 Referrals in 2018-19 is a 2% decrease from 2017-18 (5229 Referrals)

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<sup>1</sup> The Children Act, 1989 states a child will be in need if:

- they are unlikely to achieve or maintain or to have the opportunity to achieve or maintain a reasonable standard of health or development without provision of services from the Local Authority;
- their health or development is likely to be significantly impaired, or further impaired, without the provision of services from the Local Authority;
- they have a disability.

- The number of referrals per 10,000 resulting in no further action has reduced – this is the lowest in 5 years. It is slightly higher than the statistical neighbour average. This is a positive direction of travel and reflects the Boards work to ensure the right children are being referred for specialist Local Authority (LA) assessments, whilst other support is managed by partner agencies.
- Factors identified at assessment
  - Domestic Violence continues as the main factor (44%) but has decreased by 6% from 2017-18.
  - 61% of the domestic abuse assessments resulted in no further action for Children's Social Care.
  - Neglect has increased the most, up from 18% (2017-18) to 30.5% (2018-19), this is positive given the Board's focus on identification and management of Neglect.
  - The rate of Section 47 enquires continues to rise and is at 306.5 per 10,000. This is comparable to other averages, but the Walsall rise has been more significant in the past 4 years, in 2015-16 the rate was at its lowest with a rate of 205 per 10,000 and has increased year upon year.
  - The percentage of section 47 enquiries that lead to an ICPC in 2017-18 was 42% however, in 2018-19 this was 31%.
  - 57% of Section 47 enquiries led to no further action for children's social care, compared to 46% on 2017-18 (this did not include those children who were already Looked After or on a CPP).
- Child Protection
  - 89% of ICPC's (Initial Child Protection Conferences) were completed within 15 working days of a strategy discussion and performance is consistent with 2017-18 but is higher than our statistical neighbours and England averages. This shows a positive and timely response to concerns regarding potential significant harm.
  - The rate of ICPC per 10,000 in the year has significantly decreased from 117 per 10,000 (2017-18) and is now more in line with statistical neighbours.
  - The reduction in ICPCs is in contrast to the increase in section 47 enquiries.
  - ICPC Attendance:
    - Police attended 38.8%, and sent reports to 94.4%.
    - Health attended 93.1% of those applicable and sent reports to 921
    - Education attended 77.2% of those applicable, and sent reports to 77%.
    - GP's did not attend any ICPCs and sent reports to 16%
    - Allocated Social Worker attended 95% and provided reports to parents (at least one day prior to the ICPC) in 87% of cases.
  - The number of child protection plans started within 2018-19 has decreased from 2017-18 which saw an unexpected increase in year. The rate 86 per 10,000 is in line with statistical neighbours but significantly higher than the England average of 58.
  - Following a significant increase in 2017-18, the number of children who have started a child protection plan for a second or subsequent time has decreased this year from 25% in 2017-18 to 19% in 2018-19 taking Walsall below both

statistical neighbours and England which are both 20%. This is a positive direction of travel and suggests concerns are being better addressed first time.

- 87% of children have their views represented at the Initial Child Protection Conference.
- Categories of abuse (as listed in Child Protection plans)
  - Neglect continues to be the highest category (46%).
  - Emotional abuse has increased to 42%, which is 15% higher than 2017-18. It is also higher than both statistical neighbours (34%) and England (35%) averages.
  - Where the initial reason has changed to the latest category
    - Neglect remains the highest with 50%, however its 5% lower than the 55% recorded in 2017-18.
    - Emotional abuse continues to increase from 33% (2017-19) to 40% (2018-19).
  - The number of child protection plans ending this year has remained relatively stable at 90% whereas the stat neighbour average continues to rise.
  - The number of child protection plans reviewed in timescale has increased this year to 98.2% from 96.2%. This is consistently above the comparator rates.
- Looked after Children (LAC)
  - The number of LAC has reduced from 636 in 2017-18 to 614 in 2018-19.
  - 75.6% were in foster placements, this is a decrease from 78% the previous year.
  - 36% of the children becoming looked after in the year were aged 10-15.
  - 78% of children became looked after due to abuse, neglect or family dysfunction.
  - 6.9% of LAC had a missing episode, this is a decrease on the previous year (9% in 2017-18). It is also lower than the statistical neighbours (11%) and England average (11%).
- Private Fostering
  - Numbers of children being identified as Privately Fostered remain low. In 2018-19 there were approximately 1-2 per quarter.
- Health services
  - The number of children attending A&E due to deliberate injury (including self harm) was 161. This was an increase from 2017-18 when the number was 132.
  - There were 0 children admitted to an adult mental health bed in 2018-19. This is a positive reduction from 6 the previous year.

- Local Authority Designated Officer (LADO) – allegations against staff

Contacts to the LADO by sector (see table below)

Sector	Number of contacts 2018-19	Percentage of contacts 2018-19	No of contacts change from 2017-18	No and % of contacts progressing to a Position Of Trust meeting
<b>Education</b>	165	58%	+34 (↑26%)	23 (14%)
<b>Foster Care</b>	34	12%	-14 (↓29%)	17 (50%)
<b>Walsall Local Authority carers</b>	18	6%	-4 (↓18%)	10 (56%)
<b>Independent foster carers</b>	15	5%	-7 (↓32%)	7 (47%)
<b>Other Local Authority carers living in Walsall</b>	1	.4%	+1	
<b>Other (former/prospective carers)</b>	0	0%	-4	
<b>Early Years</b>	24	8%	+7 (↑41%)	0
<b>Residential care</b>	20	7%	-21 (↓51%)	3 (15%)
<b>Walsall Local Authority</b>	4	1%	-7 (↓64%)	0
<b>Independent</b>	16	6%	-14 (↓47%)	3 (19%)
<b>Health</b>	12	4%	+5 (↑71%)	2 (17%)
<b>Faith</b>	8	3%	-7 (↓47%)	1 (13%)
<b>Social Care</b>	7	2%	+2 (↑40%)	0
<b>Transport</b>	5	2%	-6 (↓55%)	1 (20%)
<b>Others</b>	10	4%	-3 (↓23%)	3 (30%)
<b>Voluntary sector</b>	3		-1	
<b>Sports</b>	0		-3	
<b>Supported accommodation</b>	3		-	
<b>Police</b>	2		+2	
<b>Other</b>	2		-1	



## Type and outcome of referrals to the LADO

### **Contacts by abuse type**

Abuse type	Number of Contacts		2018/19 Contacts progressing to a POT meeting and % of contacts in that category
	2018/19	2017/18	
Physical	171 (60%)	175 (61%)	27 (16%)
Emotional	53 (19%)	38 (13%)	12 (23%)
Sexual	45 (16%)	62 (22%)	8 (18%)
Neglect	14 (5%)	11 (4%)	3 (21%)
Multiple	2 (1%)	2 (1%)	0

Outcome	Number	Percentage 2018/19	2017/18 comparison
Substantiated	21	42%	30%
Unsubstantiated	16	32%	53%
Unfounded/False	2	4%	7%
Ongoing	11	22%	10%
Malicious	0	0%	0%

### **Outcomes at Position of Trust meetings**

### 3 Progress Against Our Priorities

**Priority 1** To support the local and professional community to recognise and respond to neglect in a child centred way

#### **Intention:**

What we wanted to achieve and the actions underpinning this priority:

- Neglect is identified and assessed consistently well across the system – LSCB partners to implement Graded Care Profile 2 (GCP2), including at Early Help level of need.
- Neglect is tackled holistically via a whole family approach
- Increased professional challenge and curiosity
- Families are enabled and empowered to make positive and timely change and to identify support where possible from their own networks
- Professional practice supports timely and effective interventions to reduce risk and promote positive change within families
- Assessment, intervention, decision-making, recording is focused on the lived experience of the child

#### **Implementation:**

- GCP2 training was delivered to GP's
- 61 professionals attended multi agency training on Understanding Neglect.
- Preparatory work in relation to the development of Building Resilient and Inclusive Communities and Schools (BRICS) has commenced as part of a partnership with children, young people, parents and carers, education, health and social care to promote trauma and attachment aware practices and promote nurturing and restorative approaches.
- Delivery of Summer Programme/Schools Out and Summer Residential Camp for children across the school holidays providing support to families with free activities and lunch clubs and provision of school uniforms. The Summer residential camp supported children identified by Locality Panels as those who would have difficulties with transition into Yr11 or children who were carers.
- A multi agency steering group has met to drive forward the Neglect Strategy.
- A '7 minute briefing' on Professional Curiosity was produced and circulated across the partnership and uploaded to the website.
- Neglect Champions are being identified across the health economy and community sector to lead best practice.
- Since the GCP2 training programme commenced in 2016, training has been delivered to:
  - 116 Social workers
  - 60 Early Help practitioners
  - 10 Health staff
  - 20 education staff

- Children's Social Care commenced a Walsall Right for Children (WR4C) programme of transformation (in Sept. 2018), which includes:
  - a move away from a current process driven Social Care practice model which 'does to and for' to a more collaborative model that 'works with' families.
  - a move away from silo working to a more integrated approach across partners, reducing the amount of 'hand offs' for families enforced by the current model.
  - a focus on creating resilience in families and managing risk more supportively
  - making changes that are underpinned by evidence
- As part of the WR4C programme staff engaged 143 individuals or families in 'The big Conversation' to collate their views on key areas of work.

**Impact:**

- Although a number of practitioners have completed the GCP2 training, the initial use of the tool has been slow to be implemented. Of 57 practitioners who were asked following their GCP2 training, only 11 had used the tool in their work.
- It has also been difficult to monitor the number of GCP2's that have been completed due to this having to be self-reported. Changes to Mosaic (Children's Services electronic recording system) and file audits will help alleviate this to some degree in 2019-20, although this will mostly be in relation to cases where Children's Services are the lead professional.
- Professionals who attended the GCP2 training have reflected on the training and use of the tool:

*'I will use it when assessing and working with vulnerable families to identify neglect and prolonged issues.'*

*'The tool will be useful during assessment. Also increased knowledge in assessing neglect will be useful to support colleagues during supervision.'*

*'It will enhance my work in parent support by being able to identify areas in which children and parent need support.'*

- The number of referrals to MASH with a primary reason as Neglect has increased by 2%.
- However the number of neglect referrals that led to No Further Action has reduced by 2% - this is positive and shows improvements in identification.
- As in 2017-18, Neglect remains the most common reason for a Child Protection Plan (56%).
- The number of repeat child protection plans for neglect has reduced by 50%. This is a significant improvement and shows interventions are having a positive impact.
- A deep dive by Children's Social Care revealed the following barriers to implementation of GCP2 which are being reviewed and addressed:

- Training provides a opportunity for practitioners to develop their knowledge and skills, but without the right follow up support and challenge in place there is limited impact on their actual practice.
  - Systems and policies do not always support the use of new tools in practice (e.g. mosaic, caseloads)
  - Too much training and introduction of too many tools can be putting extra demands on practitioners or can be experienced as confusing and prevent practitioners from emebdding all of the new required knowledge and skills (what do they prioritise?)
- A pictoral repersentation of the 'Big Conversation' is being used to further shape the transformation programme, WR4C.



### Good Practice evidenced in Multi Agency Audits:

- Good multi-agency working was evident in a number of cases.
- A number of cases demonstrated good effective planning.
- Some evidence that relevant agencies were active at core groups and involved in decisions.
- Early identification ensured intervention and planning could begin at an early stage.

## Areas for improvement recognised in Multi Agency Audits:

- Information sharing between agencies was poor in many cases.
- Case recording was poor in many cases leading to a lack of robust evidence.
- Lack of evidence of the voice of the child.
- Some poor planning.
- Some evidence that de-escalation happened too soon.

### Case Study

GCP2 was completed regarding two children who were subject to a child in need plan due to concerns expressed by the children's school regarding home conditions, school attendance and the young person's behaviour. The social worker completed this assessment to identify what specific support was required for the children's needs to be met.

The GCP2 was completed within 6 weeks and involved regular visits to see the father and the children. The tool allowed the social worker to work in a restorative manner with the parents and children. The father and young people were included in the discussion around the grading; the father was also encouraged to grade himself using the tool. Open and honest discussion took place, which allowed the father to reflect.

The father was able to see the areas of parenting he did well and areas of parenting where he required support. It also highlighted to the parent, the immediate, short term and long-term actions he needed to complete. The GCP2 enabled the father to have a better understanding of the concerns, hence enabling change.

The GCP2 is going to be reviewed to identify change since it was first completed, which will assist in further empowerment of father and monitoring of the situation for the children.

**Priority 2 To support the local and professional community to recognise and respond to child sexual abuse (non CSE) in a child centred way**

**Intention:**

What we wanted to achieve and the actions underpinning this priority:

- Increased professional curiosity and challenge amongst the workforce
- Child Sexual Abuse (CSA) is identified in a timely way
- Staff are skilled and able to appropriately intervene
- Children are provided with information that increases their knowledge of appropriate behaviour
- Clear and accessible pathway for children/families for therapeutic support services

**Implementation:**

The NSPCC PANTS campaign continued in 2018-19 with the delivery of schools and professionals sessions, parents and foster carers briefings and a celebration event in October 2018. This campaign reached a significant number of children, families and professionals. With the help of the friendly dinosaur Pantosaurus, talking PANTS is a simple way to educate children on how to keep safe.

**Children**

- Over 7500 + children reached by the campaign

**Parents**

- Estimated number reached through direct face to face sessions: 204 plus
- Parent information sessions at local schools, local church groups, faith and community groups: 35

**Professionals**



- Over 670 professionals reached throughout the duration of the campaign
- A Celebration event was held to mark the first year of the campaign and 72 local professionals attended (Oct 2018)
- Presentations took place to over 50 early years providers and childminders.

- Presentations to school staff and other professionals working with families and children, including youth workers, those working in youth justice, family support workers and school nurses.
- Voluntary sector organisations have been provided with information to support their capacity to share PANTS within local communities via their newsletter and information packs.
- A 'PANTS WEEK' of activity to renew awareness for the campaign will be held in autumn 2019.

#### Other area's of work:

- 61 professionals attended multi agency Child Sexual Abuse training.
- 34 professionals attended 'Children Who Display Sexually Harmful Behaviour' training
- Children's Services commissioned CSA training for all social care staff and have also delivered training on the use of the Weddell tool which is now embedded and its use is evident in children's records (see case study below). [Weddell is a programme of awareness, information and support for non-abusing partners and parents].
- Bespoke training was delivered to Walsall GP's by a Consultant paediatrician in relation to recognition of CSA.
- A working group has met to develop a Child Sexual Abuse Strategy (yet to be finalised).

#### Impact:

- Referrals to MASH for Child Sexual Abuse Concerns have remained the same.
- However, Child Protection Plans for CSA have increased by 50% compared to 2017-18, this is positive as it shows risk is being identified and acted upon.

#### PANTs campaign impact:

- Children at Rushall Primary school produced a film about what they had learnt in relation to the PANTS messages, which was used for the partnership celebration event with professionals.
- 100% of professionals that attended the PANTS launch said they would read the PANTS guide, visit the website, or talk to someone else about PANTS.
- 100% of attendees that completed evaluation forms following the school parent workshops, strongly agreed or agreed that they now knew where to get information and advice about keeping their child safe from abuse.
- On average, 97% of attendees that completed evaluation forms following the school parent workshops, strongly agreed or agreed that they now felt

confident about having conversations with their children about keeping safe from abuse.

- 100% of parents at the school parent sessions said there was now a HIGH to GOOD probability that they would have a PANTS conversation with their child.
- Information about PANTS is now included in the welcome packs for new foster carers and has been shared via local newsletters.

### **CSA Multi Agency audit:**

#### **Good Practice:**

- Support and outcomes for children and young people who are victims of sexual assault is for the most part good. In the period of the audit (last six months) there is evidence that the children and young people are safe and that intervention is at the appropriate level.
- Direct work with children and young people is good, with support provided to disclose abuse
- Schools in particular provide good support to victims of sexual abuse, and in one case there was a particularly strong example of extremely robust work by an Academy who had worked closely with a young girl to support her when she would not accept more 'conventional' interventions.
- ABEs (Achieving Best Evidence interviews – used to gain evidence for criminal proceedings) are usually completed – although not always in the presence of a social worker or appropriate adult.
- Sexually harmful behaviour is recognised and appropriate therapy services are offered. Record keeping within individual agencies, in relation to that agencies intervention is generally good.

#### **Area's for improvement:**

- Some cases showed good evidence of more recent work and intervention, however, in at least three of the six cases audited, there was evidence of historical issues which may have left children at risk for longer than was necessary or there were delays in assessment processes.
- Much of the practice, while doing enough to keep the children and young people safe, is process driven within individual agencies
- There was little evidence that information sharing across local authority or health areas was robust.
- There was evidence in some cases, that opportunities to intervene earlier may have been missed due to a lack of sophisticated analysis of risk presenting as part of the bigger picture. There is a tendency to focus on the immediate needs of the child without any consideration of the long-term impact of sexual abuse on the child's mental well-being – intervention is reactive.



- There was no evidence of bespoke support for foster carers or school staff in understanding what to look for in terms of delayed trauma (physical or emotional) for children who have suffered sexual abuse or how to support these young people in any specialist way.

### **Case study: Neglect and Sexual Abuse**

A sibling group of 3 children aged 5, 2 and 1yrs, were on a child protection plan, for concerns relating to neglect, possible sexual abuse and the 5yr old being treated significantly differently e.g. her bedroom had no light, light bulbs removed, windows covered, locks on the outside of her bedroom, no age appropriate stimulation, excrement all on the floor and stored in toys, pale, withdrawn etc.

The engagement was child led which lead to Olaf the Snowman being a critical part of this child's support network while she was talking to police and social workers.

A detailed analytical chronology provided crucial evidence of the cumulative harm experienced.

There is good evidence of challenging other professionals re: their assessments based only on parental self-report & made without seeing the 5yr old alone or her living environment.

There was also excellent partnership working which resulted in West Midlands Police carrying out a 'safe & well' check following the 5yr old saying Daddy was still at home despite orders in place to stop this occurring and finding father hidden in the property.

Following the successful use of the new Weddell assessment tool, all 3 children were removed and the change in the 5yr old child has been incredible. She has shown great courage during contact and is protective of her younger siblings. She is very vocal now and has a clear understanding of what good care is. She has started to make sense of the care she received whilst with her parents, which has now resulted in telling her foster carers what is acceptable, so they are kept on their toes!

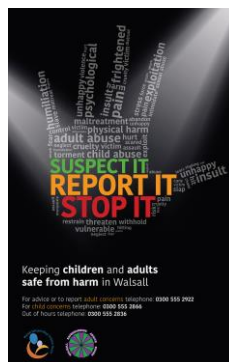
**Priority 3 – To support the local and professional community to recognise and respond to all types of exploitation and missing in a child centred way**

**Intention:**

What we wanted to achieve and the actions underpinning this priority:

- Increase our understanding of children and young people who go missing from home or care.
- Understand how children are exploited in Walsall
- Increase awareness of trafficking
- Use trauma informed practice and thinking to respond to vulnerable children
- Ensure young people at risk/being exploited are supported
- Disrupt and prosecute offenders

**Implementation**



- In November 2018 this awareness raising image was featured in Walsall's Health and Community Guide. 40,000 copies of the guide were distributed to GP surgeries, health centres and clinics.
- The Local Authority (LA) Exploitation Lead attended Walsall College to present a briefing to managers and Safeguarding leads.
- A Multi-Agency Risk and Vulnerability Panel has been established to support those children who are being criminally exploited.
- In May 2018, Walsall Healthcare Trust (WHT) hosted Sammy Woodhouse, a survivor of CSE and activist against child sexual abuse who came to share her experiences and support practitioners in their understanding of this type of abuse and the response that children should receive from professionals. This was well attended by professionals across the partnership
- Sammy Woodhouse was also hosted by West Midlands Police to deliver training to staff and in schools.
- In March 2019 - Frontline staff from WHT and community services worked in partnership with Street Teams to further raise awareness of child exploitation, via awareness raising sessions.
- Walsall Contraception and Sexual Health Services have introduced a Young Persons Child Sexual Exploitation Assessment Care Pathway

- Further awareness raising in respect of CSE in partnership with the voluntary sector took place to coincide with CSE awareness day.
- Street Teams worked with 70 young people (54 female and 16 male) over a continued period of time within the year, which includes support provided to 42 young people affected by CSE, 19 service users in transition, 7 young people affected by gangs, 2 boys displaying inappropriate sexualised behaviour. They also supported 19 families (56 individuals including parents and siblings) affected by CSE.
- Street Teams also provided 148 education and prevention programmes to over 6,000 school children / pupil referral units to raise awareness of the risks of exploitation and delivered 23 training sessions to 1,706 professionals, parents and volunteers.
- The 3 year Police and Crime Plan identifies a number of objectives to tackle crime related to children and young people including underreported and often hidden crimes, such as Child Sexual Abuse, Child Maltreatment, CSE, Modern Slavery and Trafficking and FGM.
- The service to children who go missing (e.g. return home interviews) returned to the LA, having previously been commissioned from another provider.
- Specialist police Operations have been undertaken to disrupt and prosecute offenders.
- The Board has not used or developed data to further its understanding of children who are missing or exploited but this will be an area of focus in 2019-20.
- The Board does not yet have an agreed Criminal Exploitation Strategy and Pathway which is a gap and priority for next year.

## **Impact**

### **Missing Children Data: 2017-18 and 2018-19**

Description	Qtr. 1		Qtr. 2		Qtr. 3		Qtr. 4	
	17/18	18/19	17/18	18/19	17/18	18/19	17/18	19/19
Number of missing cyp reported in the period	58	87	53	71	36	Not available	70	Not available
Number of missing episodes reported in the period	145	169	83	163	81	132	130	147
RHI completed (both within timescales and outside)	78 54%	101 60%	45 57%	78 48%	65 80%	58 44%	73 56%	69 47%

During the past 12 months the following outcomes were achieved for Street Teams [commissioned CSE Service] service users:

- 65% Improved their choices and behaviour
  - 51% Improved their Safety and Security
  - 40% Reduced their drugs and alcohol use
  - 52% Improved their health and well-being (including sexual health)
  - 60% Improved their safety online
  - 50 % Improved their safe relationships
  - 45% Improved their relationships with their family and other adults
  - 54% Improved their education/learning attendance
- 
- There has been an increase in the number of NRM referrals for children who have been exploited (from 9 in 2017 to 26 in 2018). This shows positive use of a national protection systems.
  - There have been at least 13 suspects arrested or otherwise questioned in relation to CSE related crimes.
  - There were 2 CSE related crimes with 'positive outcomes' (e.g. a charge, caution, community resolution). One related to a male convicted of abduction of a child subject to a care order (CSE victim) and the other was a community resolution for a 17 year old male who had engaged in online sexual activity with a child aged 13. There was also a third arrest for an international matter but the suspect was deported to serve a sentence abroad.
  - West Midlands Police (WMP) have applied for 2 sexual risk orders against offenders who have targeted Walsall children (1 was unsuccessful, another is ongoing).
  - There have been 9 Child Abduction Warning notices served on various potential perpetrators (one of which was breached, leading to the successful prosecution above).
  - Unfortunately there has not been a reduction in the number of missing episodes as intended. In fact there has been an increase from 444 in 2017-18 to 492 in 2018-19.
  - However, the number of children going missing more than once (in 2018-19) was 4.7%, which was lower than the England average of 7.2% (in 2017-18).  
[Walsall data for 2017-18 not available, England data not available for 2018-19]

#### **Case Study:**

Josie is a young person who last year was 'high risk CSE', went missing on a weekly basis and subject of an ongoing complex investigation. She was refusing education and the challenges of care at home meant Child Protection plans for her siblings and a planned reception into care for Josie. Through the support provided to her in a co-ordinated way through her safety plan and in a multi-agency approach, her missing episodes reduced (none in 5 months); there has been repair to her relationship with

her mother and siblings to the point they are now having positive family time. She has engaged and re-entered education and is now talking aspirationally about her future. She has started to attend her MASE (multi agency sexual exploitation meeting) and commented that “I feel listened to and I understand now why everyone was so worried about me”. The impact of the intervention is not only that is she safe but she ‘feels’ safe and recognises what being safe means.

**Priority 4 - To challenge individual and collective performance and use feedback from children, young people and frontline staff to deliver improvements in safeguarding outcomes for children and young people**

**Intention:**

What we wanted to achieve and the actions underpinning this priority:

- Increase the level of challenge amongst WSCB members
- Use feedback from children and young people to evaluate the effectiveness of the local safeguarding system
- Improve our use of multi-agency performance data
- Establish practice forums to support appropriate application of WSCB thresholds
- Improve the functioning of core groups
- Analyse the findings of single agency audit findings
- Complete s11 and s175//157 audits

**Implementation**

- A joint children's and adults development session was held in March 2019 to set the strategic direction and vision for the forthcoming year(s).
- An improved format for the performance report has meant more meaningful discussions are now taking place regarding local 'risks'.
- Children's Services have undertaken a 'Big Conversation' to systematically gather feedback from parents, children and young people which is being used to shape services going forward.
- The agenda and minutes of Safeguarding Board meetings, and subsequent actions, evidence an increase in professional challenge at a senior level. For example the lack of health professionals taking on the Lead Professional role in Early Help was challenged via the Early Help Steering Group.
- There is evidence of on-going challenge between professionals in respect of individual children, e.g. social care to health visitors in respect of neglect cases, school challenging social care regarding Thresholds for intervention.
- A Young People's Safeguarding Group has been formed to build a forum and connected mechanisms for ongoing discussion and challenge from young people into Board activity.
- The partners have recognised the need for additional capacity in the area of engagement and have agreed the funding for a dedicated post.
- A programme of multi agency audit activity was undertaken (including CSA, Domestic Abuse, CSE, Neglect).
- Core Group practice was audited, including direct observations, was undertaken in 2018-19 (findings presented to Board in June 2019).
- A Section 11 Audit was undertaken in Qtr 4, and responses received from all 13 required agencies.

- A new multi agency course was introduced – ‘Effective Professional Challenge and Developing Professional Curiosity’ and was attended by 23 professionals
- Increased funding and recruitment has taken place to the role of Named GP for Safeguarding Adults and Children.
- Health capacity in the MASH has not been resolved within the timescales that WSCB were advised and agreed.
- A mapping exercise was undertaken to explore the opportunities to and forums to engage and consult with children and young people across the partnership.
- Development activity has taken place in readiness for the new Partnership Arrangements to be launched in Sept 2019, as part of these arrangements the vision is that children, young people and adults will be the 4<sup>th</sup> partner.
- WMP works closely with the elected Youth Commissioners who represent the Police Crime Commissioner (PCC) and are an essential part of the WMP and the PCC youth engagement strategy. They undertake project work and leadership training, looking at key areas of policing that affect young people. They meet regularly with their local NPU Commander and are involved in various consultations feeding back the voice of young people.
- Police officers in Walsall worked with students at two local secondary schools to produce an emotive banner of pledges against knife crime, which was later displayed at Walsall Football Club.
- The Section 157/175 audit will be undertaken in Qtr 1 of 2019-20 and will include comparative analysis of the audit undertaken in the previous year.



### Impact

- The number of referrals to the Multi Agency Safeguarding Hub which led to ‘no further action’ is at its lowest rate for 5 years.
- Ongoing professional dialogue and challenges in relation to ‘thresholds’ has meant work has commenced and will be completed in 2019-20 on re-writing the ‘Threshold Guidance’. However this has not been as timely as the partnership aspired too.

- There has been some improvement in the number of Early Help cases where health practitioners are acting as Lead Professional, however this remains low and is being monitored via monthly quality and contract meetings. Staff are being supported by the Early Help team with training to ensure they are confident and competent in the role.
- A CQC inspection of Walsall Healthcare Trust Maternity Services in August 2018 rated the service as 'Requires Improvement', previously having been Inadequate. Positive progress was noted in Maternity staff safeguarding training compliance rates which had significantly improved since the last inspection. As of 30 May 2018, midwives, support staff and medical staff safeguarding training compliance exceeded the trust target of 90% for all levels of adult and children's safeguarding which they were required to undertake.
- There are still not sufficient health staff available to support the optimal functioning of the MASH.
- The 2018/19 West Midlands Police Peel (police effectiveness, efficiency and legitimacy) Assessment found:
  - Overall Judgement – **Inadequate**
    - How effective is the force at crime recording reported crime – **Inadequate**
    - How efficiently do the systems and processes in the force support accurate crime recording – **Requires Improvement.**
    - How well does the force demonstrate the leadership a culture necessary to meet the national standards for crime recording – **requires Improvement**

In respect of crime recording WMP were asked to provide an assurance report on these issues to the LSCB in March 2019. A number of remedial actions were outlined and progress update provided, including:

- All Child Abuse staff having undertaken training including face to face workshops for those in MASH and the Central Referral Unit (CRU) - who are key to identifying offences when they are reported by the public or other agencies.
- CRU staff will be trained to record offences directly in the near future.
- Recent audits show vast improvements – for example the most recent shows 93.2% compliance for child abuse non-crimes.
- The Public Protection Unit (PPU) have a bespoke improvement plan and attend all GOLD meetings.
- Improvements are being made in the recording of domestic abuse. This is reflected in both audits and the volumes of crimes recorded against non-crimes. This can still improve.



<b>Crime Data</b>				
Walsall	Total Recorded Crime (child abuse)	Positive Outcome (e.g a charge, caution, community resolution)	% Walsall	% Black Country
<b>2017-2018</b>	<b>928</b>	<b>191</b>	<b>21%</b>	<b>Not available</b>
<b>2018-2019</b>	<b>1052</b>	<b>141</b>	<b>13%</b>	<b>12.9%</b>

- Walsall has seen a reduction this year in 'positive' outcomes for recorded crimes, although it is on a par with the Black Country average and last year was noted to be an unusually 'high' figure.
- For West Midlands Police force, all areas have seen a rise in crime. All areas have seen a reduction in positive outcomes.
- Following feedback from managers and professionals the Escalation Procedure will be revised and relaunched in 2019-20.
- There is some evidence of impact following the multi agency audits for example as a result of the Domestic Abuse audit the process for 'triaging' incidents referred to the MASH has been revised to include a wider professional dialogue. However further impact analysis is required in the coming year to support the partnership in its vision to become a learning system.

#### **4. Serious Case Reviews and Child Safeguarding Practice Reviews**

The Walsall Safeguarding Children Board has not yet published its 'New Arrangements' and therefore continues to work to the Serious Case Review definitions in Working Together 2015, as per the national guidelines. However, this year has introduced some of the new methodology outlined in Working Together 2018, such as the Rapid Review meetings.

Walsall has also adopted the format and templates which have been launched in the West Midlands by Birmingham LSCB, to support the review process, following Birmingham's pilot of the new Child Practice Reviews having obtained DfE early adopter funding and support.

Within the period of this annual report the LSCB:

- have completed and published 2 reviews – SCR W7 and W8,
- have published a third review – SCR W5
- received an interim report and additional learning review – SCR W6 which will be completed once the criminal proceedings are finished
- commenced 3 new reviews in the year – SCR W9, 10 and 11
- had a further one referral which was considered but did not progress to SCR.

Key learning and themes have been identified and include:

- the voice of the child and when children talk about their lived experience there should be adequate credence given.
- domestic abuse and the need to recognise the increased risks associated with separated couples, when one party starts a new relationship.
- recognising the importance of staff supervision and it being used to support critical thinking and reflective practice.
- the connectivity between children and adult focused services (Think Family) and the importance of liaison between the two where there are issues which may affect the welfare of children.
- understanding the nature of a parents 'learning disability' and having this formally reviewed as early as possible (not just for care proceedings) to appreciate how this impacts on their parenting and provide relevant support.
- the need for professionals to challenge each other and use the escalation procedure where appropriate.
- when sexual abuse is known or suspected, children should be offered therapeutic support, regardless of whether they are displaying external behavioural signs of trauma.
- record keeping and the importance good records play in defensible decision making.

Once completed, reviews are published on our Safeguarding Children Board [website](#).

Multi agency action plans are in place for all reviews and are monitored via the Practice Review Sub Group. The action plan for W5 has been completed and W6, W7 and W8 are in progress.

Learning has been shared via LSCB newsletters, updated multi agency training programmes, on the LSCB website and a large multi agency briefing session is planned for June 2019.

The SCR's which commenced in this year will be completed and monitored by the new Safeguarding Partnership arrangements.

## 5. Additional Safeguarding Work-streams and Responsibilities

### **Child death reviews**

- A full report into the Child Death Review process will be produced separately and shared with the Board.
- However, in summary, 42 deaths were notified to Walsall LSCB in 2018-19. 10 were not reviewed due to being under 24 weeks gestation not currently reviewed by CDOP<sup>2</sup>, leaving 32 for review of which 17 were reviewed in year with 15 cases carried forward into 2019/20.
- This is a slight increase on last year when 41 notifications were received.
- There were notably more notifications received in Walsall than for our CDOP partner, Wolverhampton, who received 27 (2017-18) and 24 (2018-19).
- The number of deaths that were **reviewed** by CDOP during the 2018/19 reporting period included **31** Walsall and **22** Wolverhampton children. This includes children who had died in previous years.
- The most frequent category of death is once again 'Category 8', which describes the full range of perinatal and neonatal events which may result from complications of the pregnancy and delivery. There has been an increase in 'Chronic medical conditions' and a noted decrease in 'Sudden unexpected, unexplained death'.
- In 34% of cases factors of a modifiable nature were identified. These include:
  - Alcohol/substance misuse by a parent/carer
  - Smoking by the parent/carer in a household
  - Smoking by the mother during pregnancy
  - Co-Sleeping
- April - May 2018 saw the launch and successful Black Country application to the Safeguarding Reform Project Board Early Adopters Programme (funded by Department for Education/ Department of Health and Social Care / Home Office). The successful bid identified an aim of joining up the 4 Black Country CDOPs into a Strategic Black Country CDOP. The programme was time limited until the end of March 2019, with funding managed by Dudley Metropolitan Borough Council.

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<sup>2</sup> The review of premature births under 24 weeks (any death where a death certificate has been issued) will be considered within the new arrangements for CDOP post April 2019.

- A Steering Group continued to oversee the development and delivery of an action plan, with recommendations to be made to the key decision makers and networks.
- The new Child Death review arrangements will 'go live' in September 2019.

### **Domestic Abuse**

- It was agreed by the Assurance Group that the leadership and governance for the Domestic Abuse agenda be directed by the Community Safety Partnership, whilst it remains relevant and connected to the safeguarding agenda.
- In December 2018 the Partnership were advised that a 6 month review of the Domestic Abuse strategy was to commence and the strategy would be re-launched in summer 2019.
- The revised Domestic Abuse strategy has not yet been seen or agreed by the partnership.

### **Safeguarding Procedures**

- Walsall has continued to participate in the Regional Safeguarding Procedures consortium.
- This year, the second of a three year contract, the Walsall Safeguarding Board Business Manager chaired the meetings, supported by Wolverhampton.
- The procedures were updated following the publication of Working Together 2018 and a programme of review for the subject specific chapters was completed.

### **Multi Agency Safeguarding Training**

- The Safeguarding Board have offered a programme of multi agency training.
- From 1<sup>st</sup> April 2018 to 31<sup>st</sup> March 2019, 22 courses (total 44 sessions) were delivered and attended by 956 delegates.
- This year saw a decrease of 12% in attendance compared to the previous year. This will be explored and addressed in 2019-20.
- This year's programme, across the children's and adult's workforce, has included six new and two modified courses being delivered in response to the learning from serious case reviews/significant incidents, outcomes of audits, feedback from practitioners and review of the regional training offer. The amendments included:
  - Introduction to Stalking and Harassment Training (New)
  - Domestic Abuse Awareness (Modified to joint children and adult course)
  - Domestic Abuse Advanced (Modified to joint children and adult course)
  - Deprivation of Liberty Safeguards (DoLs) & Mental Capacity Act (MCA) Awareness (New)
  - An Understanding of Harmful Practices: Managing the Risk and Reporting – FGM/HBV/Forced Marriage (New)
  - Vulnerabilities of children who are not living with their parents; your roles and responsibilities (New)
  - Safeguarding Children/Young People & Adults at Risk (New)

- Safeguarding people with Learning Disabilities; Dementia & Mental Health Problems (New)
- In recognition of the importance of practice improvement the Learning and Development Sub Group commenced work on revising the Practice Improvement Strategy.
- The revision of the strategy will be followed by a review of the programme offer.
- The partners have also committed to supporting the programme with a training pool.
- The business unit will have further capacity in 2019-20 with a new full-time role of Practice Improvement Lead joining the team.

## 6. Conclusion

### 6. Summary: Evaluation of the Safeguarding System

#### How safe are children in Walsall?

There has been evidence of improvement within the year. This includes:

- a reduction in referrals to MASH which led to no further action
- improved outcomes at Early Help
- positive reductions seen in the number of children subject to a second or subsequent child protection plan, particularly for neglect.
- A positive Ofsted focused visit regarding services to [Care Leavers](#)
- Less cases judged inadequate and more judged to be good through the multi agency audit process

Rating	2017-18	2018-19
Good	32%	37.5%
Requires Improvement	45%	45%
Inadequate	23%	17.5%

#### Area's for further development include:

- A revision and re-launch of the Threshold guidance to ensure children and young people receive the right help at the right time, including a focus on understanding of relevant support prior to a MASH referral and application of thresholds within the MASH.
- Continued focus on practice in high impact areas such as Neglect, Child Sexual Abuse and Exploitation.
- Reviewing the multi agency safeguarding training offer, opportunities for practice improvement and the capacity to deliver on this across the partnership (see 'Are we a Learning System' below).
- Seeking a further reduction in the number of MASH referrals and Section 47 enquiries which lead to no further action for Children's Services.

#### How strong is partnership working?

Again there has been evidence of improvements within the year. For example:

- The Chief Nurse for Walsall Healthcare Trust and the Director of Public Health are now regular attendee's at Board meetings and a Named GP for Safeguarding has been appointed by the CCG.
- There is greater challenge at Board meetings by and of partners (e.g. regarding the health contribution to MASH).
- There have been regular meetings of the new Safeguarding Leadership Group which has developed shadow arrangements during the year in preparation for the new arrangements in summer 2019.
- The response to Neglect is improving but progress in implementing the Strategy has been slower than intended.

## 6. Conclusion

- Some progress has been made in relation to the identification of child sexual abuse with higher numbers of children being made subject to a Child Protection Plan but further work is required on the partnership strategy.

Area's for further development include:

- Collective ownership and accountability of safeguarding practice and Board priorities across the partnership e.g. attendance at, and effectiveness of, Core Groups, driving forward agenda's such as the Neglect Strategy and Right Help, Right Time across all agencies, and Child Protection Conference attendance by some partners (e.g. GP's).
- Implementing the agreed arrangements for health staff in MASH as soon as possible.
- Visibility of safeguarding and the partnership arrangements needs to improve and this forms part of the partnership vision for the coming year.
- Further engagement with the voluntary and community sector.
- Ensuring greater consistency of practice.
- There is not yet a Domestic Abuse Strategy for the partnership, which is a significant risk that requires addressing.

### Are we a learning system?

We are not yet operating as an effective learning system. There is more to be done to achieve this. This will include:

- Reviewing the multi agency safeguarding training offer, opportunities for practice improvement and the capacity to deliver on this across the partnership.
- Evaluating the impact of training.
- Acting on audit findings to drive practice uplift
- Engaging with children and young people in a meaningful way (as our 4<sup>th</sup> partner in the new arrangements)

## 6. Conclusion

### Opportunities

- The WR4C (Walsall Right For Children) Transformation Programme, launched in September 2018, is driving forward Children's Services vision to ensure that the right children are in the right place with the right support for as long as it's needed to ensure that they are safe from harm, happy and learning well.

To realise the WR4C vision we need to do things differently and this will involve:

- moving to a locality model
  - focusing on connecting practitioners with communities and local resources
  - getting to know children and families well to enable them to become more resilient and stay together.
- 
- The new safeguarding arrangements, in line with Working Together 2018, offer an opportunity to re-align the leadership and accountability for the safeguarding agenda and develop a new vision for the partnership.
  - The new arrangements also offer the opportunity to renew the partnership governance structure.
  - Increased capacity will be created to support the delivery of a robust multi agency Practice Improvement programme.
- 
- In spring 2019 the Walsall partnership applied to participate in the DfE Strengthening Families, Protecting Children Programme.

Through this programme, £84 million will be invested over 5 years to support up to 20 local authorities to improve work with families and safely reduce the number of children entering care.

Walsall has applied to implement the Family Safeguarding Model.

This programme supports a whole-system change to a local authority's child protection approach, focusing on promoting children being brought up in their families, by meeting the needs of both the children and the adults around them. This includes:

- developing multi-disciplinary teams including adult care workers
- use of motivational interviewing
- implementing a 'workbook', a single data tool for all professionals

If the bid is successful it will offer Walsall the opportunity to enhance its approach to locality working and 'Think Family'.



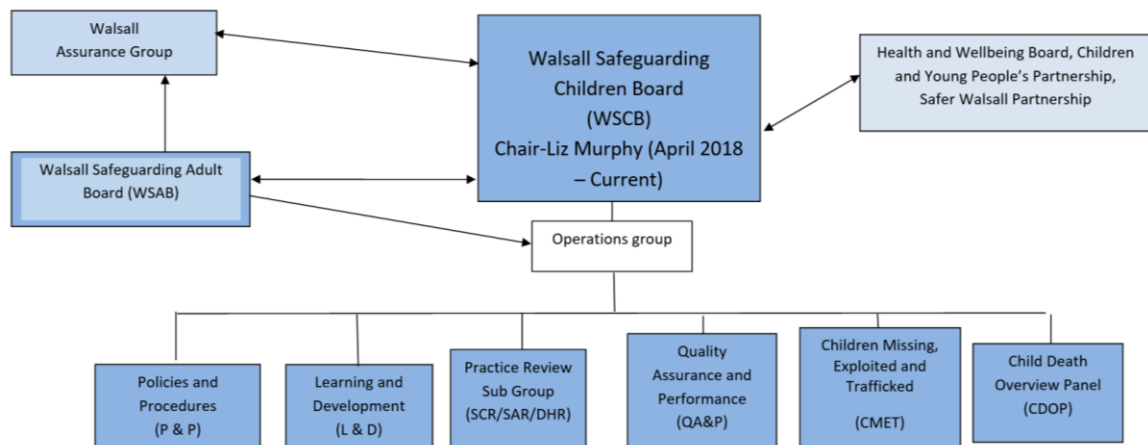
## 6. Conclusion

### **Priorities and Next Steps in 2019-20**

- Complete and launch the CSA strategy.
- Finalise the multi agency Practice Improvement Strategy and revise the associated learning and development programme.
- Complete and launch the Criminal Exploitation Strategy and Pathway.
- Build capacity across the partnership and within the business unit to deliver multi agency training.
- Continue to focus on the implementation of the Neglect Strategy.
- Implement the New Safeguarding Partnership Arrangements.
- Pursue the Family Safeguarding model, regardless of whether the DfE bid is successful.
- Develop our approach to embedding learning from performance, audit and reviews.
- Ensure children, young people and service users are actively engaged in the partnership.
- Increase the visibility of the Safeguarding Partnership.
- Launch and embed the principles and practice contained with the revised Threshold Guidance – Right Help, Right Time.
- Continue to ensure strong safeguarding leadership across the partnership.

# Appendices

## 1. Structure



## Appendices

### 2. Walsall Safeguarding Children Board - Meeting attendance April 2018 – March 2019

Organisation / Member	June 18	Sept 18	Oct 18	Dec 18	Mar 19	Total (%)
Independent Chair	✓	✓	✓	✓	✓	100%
Lead Member/Councillor	x	✓	x	x	x	20%
WSCB Business Unit	✓	✓	✓	✓	✓	100%
Children's Services, Walsall Council	✓	✓	✓	✓	✓	100%
Clinical Commissioning Group	✓	✓	✓	✓	✓	100%
Education / Schools	✓	✓	✓	✓	✓	100%
Walsall Healthcare NHS Trust	✓	✓	✓	✓	✓	100%
Walsall College	✓	✓	x	x	✓	60%
West Midlands Police	✓	✓	✓	✓	✓	100%
National Probation Service	x	✓	✓	✓	✓	80%
Lay Member	✓	✓	✓	✓	✓	100%
Designated Doctor for Safeguarding	x	x	x	x	✓	20%
Public Health, Walsall Council (new member from June 2018)		✓	✓	✓	✓	80%
Dudley & Walsall Mental Health Partnership Trust	✓	✓	✓	✓	✓	100%
CRC (Reducing Reoffending Partnership)	x	✓	x	x	x	20%
Youth Justice	✓	✓	x	✓	✓	80%
CAFCASS	✓	x	x	x	x	20%

# Appendices

## 3. Budget

	BUDGET 2018/19		OUTTURN 2018/19	
	Childrens & Adults		Total	Variation
	Total			
Funding		£	£	£
Walsall Council Contribution		(55,633)	(55,633)	0
Walsall Council Additional Investment		(200,000)	(200,000)	0
NHS Walsall			(10,000)	0
Probation Services (NPS & CRC)		(4,500)	(1,500)	3,000
West Midlands Police		(30,594)	(30,594)	0
CAFCASS		(550)	(550)	0
CCG		(40,000)	(40,000)	0
CCG Additional (One off)		0	(15,000)	(15,000)
Other Training		(7,146)	(1,080)	6,066
Other CDOP		0	0	0
		<b>(348,423)</b>	<b>(354,357)</b>	<b>(5,934)</b>
Costs				
Salary Costs		196,565	194,129	(2,436)
Chair Costs		43,200	43,742	542
Agency		0	5,942	5,942
Consultants Costs		2,750	4,000	1,250
Workforce Development SLA		20,000	15,000	(5,000)
Section 11/157/175 Tool		3,000	0	(3,000)
Chronolator Tool		1,580	850	(730)
SCR / SAR		32,000	32,655	655
Development Day / Conference		16,000	0	(16,000)
Development Activities		60,000	15,316	(44,684)
PHEW - Online Child Protection Procedures		686	0	(686)
Other Costs - Catering, IT, Room Hire, Membership Fees etc.		3,487	8,962	5,475
		<b>379,268</b>	<b>320,596</b>	<b>(58,672)</b>
Carry forward to 2019-20			<b>50,000</b>	50,000
<b>Forecast Outturn Over / (Under)</b>		<b>30,845</b>	<b>16,239</b>	<b>(14,606)</b>

## Appendices

### Appendix 4. New Arrangements

In September 2019 the Safeguarding Children Board, in partnership with the Safeguarding Adult Board, will launch their new arrangements in line with Working Together to Safeguard Children.

Transitional arrangements will commence in summer 2019 with a view to the new arrangements being 'live' in early September.

The partnership arrangements can be found [here](#) .