Walsall Safeguarding Children Partnership

Annual Report 2022-2023

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Section 1

Foreword

Safeguarding Partners

This report aims to highlight the work undertaken and the commitments made, by all Statutory Safeguarding Partners to deliver high quality services and to protect the children and young people of Walsall.

It reflects the actions taken against the identified priorities from last year, and endeavours to demonstrate good progress made in many areas. But it also recognises that there is further work to be done and is not complacent about the need to continually strive for better performance and understanding of safeguarding issues arising in the Borough.

There is a strong commitment to safeguarding children and young people in Walsall and this is demonstrated in the improvements made in the priority areas of Neglect, Self-Neglect and All-Age Exploitation, and the report highlights many achievements made throughout the year. It also shows that as a Partnership we are always examining our practice and approach through audits and reviews which shows us where there are areas for further improvements. We know that we need to make greater progress in certain areas, and this is shown, for example, in the exploitation work where we need to strengthen our efforts in understanding our position and improving our processes and the clarity of governance on these issues.

Great progress has been made in the area of neglect, in our shared understanding of it, and in the development of Hubs, but we also know that this needs refreshing, and a planned event for May 2023 will be at the centre of this reinvigoration.

In November 2022 a Joint Targeted Area Inspection (JTAI) inspection took place which examined primarily services at the front door and essentially took a detailed look at how the partnership was working. This external scrutiny was welcomed and was very positive in confirming the strength of Partnership arrangements, commitment and willingness to take matters forward.

The report has identified that the priorities need to remain the same for the coming year so that we can continue to enhance our understanding and embed learning as we go forward. This report has also identified that we need to consider an additional priority around Child Sexual Abuse (CSA) for the coming year.

Sally Hodges

Independent Chair & Scrutineer

Section 2

Introduction

Business Unit / Independent Chair Scrutineer

The Children and Social Work Act 2017, The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018 and Working Together to Safeguard Children 2018 guidance legislate for all local areas to publish Multi-Agency Safeguarding Children's Arrangements (MASA), led by three statutory agencies. Locally these are the Local Authority - Walsall Council, Black Country Integrated Care Board and West Midlands Police.

Walsall Safeguarding Partnership (WSP) has a combined Multi-Agency Safeguarding Arrangement of Walsall Safeguarding Children's Partnership (WSCP) and Walsall Safeguarding Adults Board (WSAB) and is required to produce an annual report which provides an assessment of the effectiveness of local safeguarding arrangements in working with adults and children.

Working Together 2018 (WT 2018) requires safeguarding partners to publish a report at least once in every twelve-month period and send copies to the Panel and the What Works Centre for Children's Social Care (WWCSC).

This annual review of effectiveness report sets out what the Partnership (and the organisations that make up WSCP) have done, in the last year of operation, to keep children and young people safe. The report covers the period from 1st April 2022 to 31st March 2023.

The purpose of the safeguarding arrangements, is as set out in Chapter 3: Working Together to Safeguard Children 2018, to support and enable local organisations and agencies to work together in a system where:

1. Children are safeguarded, and their welfare promoted,
2. Partner organisations and agencies collaborate, share, and co-own the vision for how to achieve improved outcomes for vulnerable children,
3. Organisations and agencies challenge appropriately and hold one another to account effectively,
4. There is early identification and analysis of new safeguarding issues and emerging threats,
5. Learning is promoted and embedded in a way that local services for children and families can become more reflective and implement changes to practice,
6. Information is shared effectively to facilitate more accurate and timely decision making for children and families.

Section 3

Our Purpose

It is important to note that WSP is not involved in operational practice. Our overarching purpose is to ensure that agencies work in partnership to deliver joined-up services that safeguard children and young people from abuse, neglect, and exploitation. We do this by:

- Gaining assurance that local safeguarding arrangements are in place as defined by the Children Act 2018 and Working Together 2018 statutory guidance.
- Working collaboratively to prevent abuse and neglect, where this is possible.
- Ensuring partner agencies know what to do and are effective when abuse and neglect has occurred and give timely and proportionate responses.
- Gain assurance that practice is child-centred and considers the voice and lived experience of children, young people and their families or carers.
- Striving for continuous improvement in safeguarding practice and supporting partner agencies to embed learning from local regional and national reviews and multi-agency audits.
- Work across other statutory / strategic multi-agency partnerships to ensure any cross-cutting themes arising from our respective safeguarding activity, (performance data or assurance work) are identified and addressed.

Our Vision is for all agencies to work together and effectively build resilience and empower communities in responding to abuse, neglect, and exploitation, and to widely promote the message that safeguarding is everybody's business in that:

- Abuse of children (our 4th Partners) is not tolerated.
- People know what to do if abuse happens or is suspected.
- We will ask, listen and act on the experience of our 4th Partners, parents and carers to ensure the right help at the right time at the right quality.
- There will be no wrong door so we are assured that all organisations and staff will be proactive in their learning and development and in working together effectively to recognise and respond to abuse, neglect and exploitation.

The vision for all children and adults in Walsall is:

WSP recognises that the ability to protect oneself from abuse, neglect or harm will vary from person to person in the diverse communities across Walsall. WSP will support our 4th partner through meaningful inclusion and promotion of equality and diversity amongst our partner organisations and their service delivery. WSP will work to best practice ensuring the Partnership is culturally competent, respects difference, celebrates diversity and is committed to removing barriers that discriminate in safeguarding practices and outcomes. We are committed to working inclusively with our 4th partner to ensure equal access to information and advice and ensuring their assessed needs for help and support is provided at the right time at the right quality and is consistently delivered by WSP member organisations and services.

WSP Ambition

Walsall Safeguarding Partnership has agreed that its shared ambitions for 2023-2026 are:

a. Improving our visibility with and amongst local communities and across the partnership;

b. Embedding core values of equality, diversity and inclusion in all tiers of the WSP sub-structure and multi-agency safeguarding practice;

c. Developing a stronger culture of working together to keep children, young people and adults at risk safe;

d. Increasing the involvement (ask, listen and act) of children and, young people and adults in our work;

e. Developing a culturally competent, confident, knowledgeable, and curious workforce who are supported to work together and deliver their safeguarding responsibilities;

f. Ask, Listening and acting on the experiences of practitioners and the learning from data and assurance activity, to improve the quality of the safeguarding response to children, young people, and adults in need and at risk.

Section 4

Walsall at a Glance

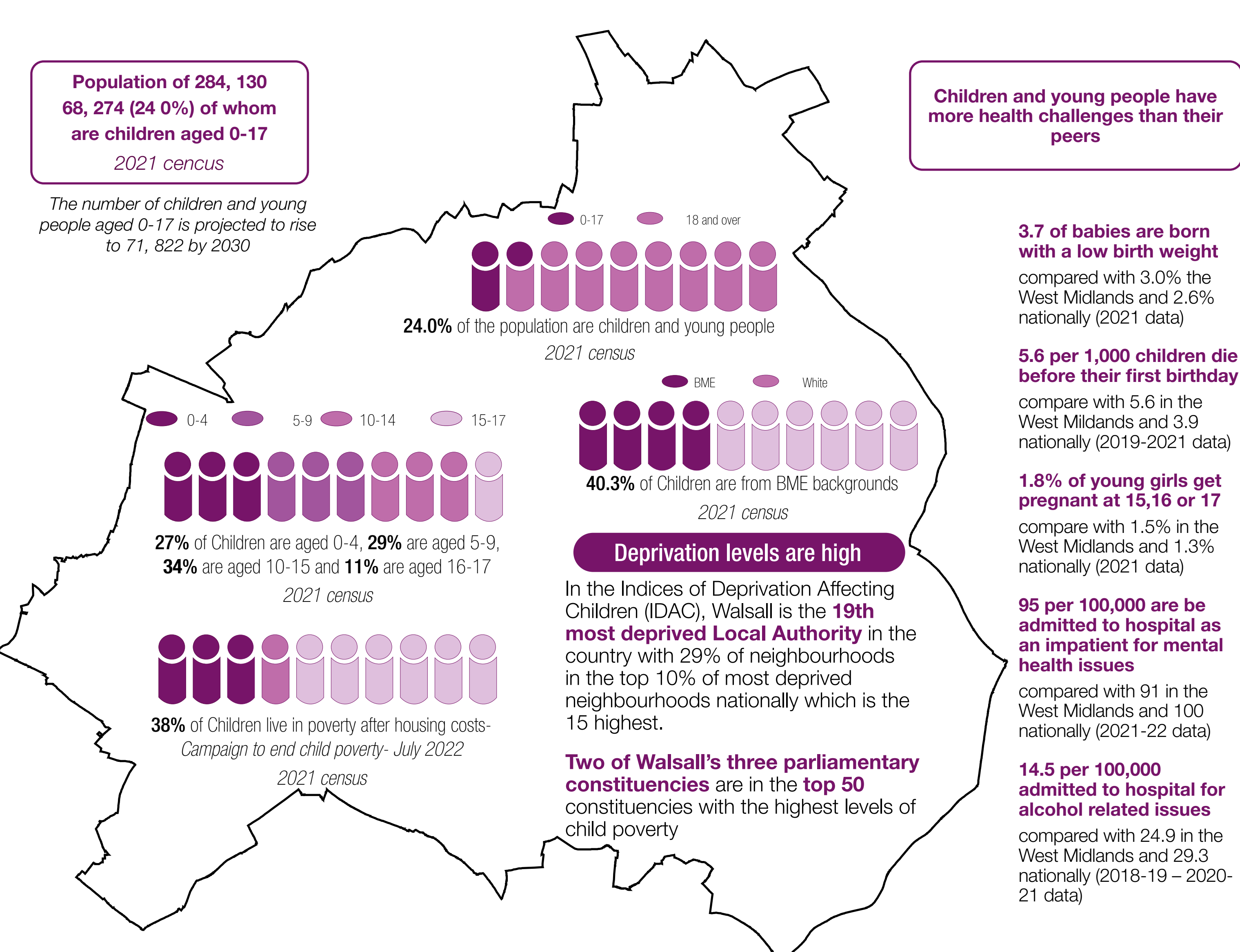
Population

Walsall has an estimated population of **284,130** and is a culturally diverse town where people of Indian, Pakistani and Bangladeshi background form the largest minority ethnic groups.

White British comprise the largest ethnic group at approximately 67.4% of the borough population, and more broadly the wider White ethnic category at 71.4%. Minority Ethnic groups have seen substantial increases, now accounting for 32.6% (1 in 3) of Walsall's population.

Walsall is expected to see continued and consistent population growth, projected to **increase by 7%** to an estimated **304,400 by 2030**

Children Living in Walsall



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In January 2023, WSP collaborated with Safer Walsall Partnership and the Youth Justice Board to respond to the rising concerns about youth and violent crime. Walsall has seen a series of serious youth violence incidents over the past 12 months leading to 14 young people being on remand and 7 children serving a custodial sentence within the secure estate. 11 remands occurred between December 2022 and February 2023.

Following the scale of young people and young adolescents arrested in one of the recent murders, the Youth Justice Board instigated a meeting with Safeguarding Partnership and Community Safety partners to seek assurance that:

- We are effectively supporting the 7 young people remanded into custody.
- There is an effective partnership plan to respond and safeguard children, young people and the wider community.
- Effective structures are in place to review and identify medium and long-term learning as a partnership.

The Chairs and Support Officers of Youth Justice Board, Safeguarding Partnership and the Safer Walsall Partnership agreed to develop a collaborative to ensure we maximised opportunities to effectively respond to incidents as well as focus on proactive system change following the learning from the incidents – the work of this group will be starting in April 2023. The responsibility for reducing youth violence sits with Safer Walsall partnership but the Safeguarding Partnership is working in collaboration to ensure that individual children and young people involved, are being appropriately safeguarded.

Section 5

What is Safeguarding Children

The Legislation

The Children Act 2004, as amended by the Children and Social Work Act 2017, places new duties on key agencies in a local area to work together, and with other partners locally, to safeguard and promote the welfare of all children in their area.

“Everyone who comes into contact with children and families has a role to play.”

Safeguarding and promoting the welfare of children is defined as:

- protecting children from maltreatment;
- preventing impairment of children’s health or development ensuring that children grow up in circumstances consistent with the provision of safe and effective care;
- taking action to enable all children to have the best outcomes.”

The Context

Individuals, organisations and agencies must ensure effective safeguarding is achieved by putting children at the centre of the system and by every individual and agency playing their full part. A child-centred approach to safeguarding is fundamental to safeguarding and promoting the welfare of every child. This means:

- Keeping the child in focus when making decisions about their lives and working in partnership with them and their families.
- Following the principles of the Children Acts 1989 and 2004 - that state that the welfare of children is paramount and that they are best looked after within their families, with their parents playing a full part in their lives, unless compulsory intervention in family life is necessary.
- Recognising that children may be vulnerable to neglect and abuse or exploitation from within their family and from individuals they come across in their day-to-day lives. Practitioners should put the needs of children first when determining what action to take.

WSP do not operate in isolation of other multi-agency partnerships and boards within Walsall. Cross partnership collaborations have been established with Safer Walsall Partnership (Community Safety Partnership) – Walsall’s Health and Wellbeing Board and Youth Justice Board. All Boards and Partnership in Walsall are committed to working together to share and receive information that will maximise effectiveness and reduce duplicity in our effects to keep our citizens safe.

Section 6

Improvement Areas Identified from 2021-2022 Annual Report

a. Review and restructure of the Safeguarding Partnership Arrangements.

In 2020 Penny Thomas, Independent Chair, Birmingham Safeguarding Children Partnership, undertook a review of the effectiveness of WSP arrangements with a view to look at the strengths, limitations, opportunities, and threats of the joined-up arrangements.

A review and proposed restructure of the WSP was agreed, with implementation commencing in quarter 4. WSP has been realigned with a separation of functions to provide greater focus of the children and adults agenda respectively through the additional appointment of a Chair.

b. Full Section 11 to be completed utilising the West Midlands Audit Tool.

There was a delay in the launch of the regional tool which resulted in the full Section 11 audit being scheduled for completion between April and June 2023-2024

c. To deliver the proposed forward plan for practice development activity, informed by partnership learning.

Section 12 Workforce Learning and Development sets out the improvement work undertaken to strengthen the multi-agency learning offer and activity undertaken across the business year.

d. Continue to progress the All-Age Exploitation Strategy and Child Neglect Strategy as key priorities and measure their impact through the outcome framework.

Work within the respective subgroups has been undertaken over the last 12 months to strengthen arrangements for Neglect and All-Age Exploitation as detailed in Section 7 Progress Against Priorities.

e. Strengthen the Think Family approach.

Section 9 /a. Performance data and Family Safeguarding Model of the annual report details how post pandemic the strengthening families approach continues to deliver positive outcomes for children and families.

It is worth noting that since the introduction of Family Safeguarding there has been a significant reduction in the number of children becoming subject of a child protection plan and entering care. Where children are entering care, they are being supported to return home to their parents more quickly.

f. Additional scrutiny work to be commissioned in 2022-2023 to explore if it is possible to identify any changes or improvement in practice as a result of previous Serious Case Review recommendations and actions.

Jane Wonnacot was commissioned by WSP to identify the extent to which these actions have had a positive impact on practice. The evaluation was commissioned in June 2022 with an agreement that the focus would be on three specific practice issues that had been identified from a previous review W6 and issues that also emerged as themes in more recent cases:

- Working with neglect
- Child Sexual Abuse within the family
- Working with learning disabled parents.

The finding of the scrutiny work identified there is ample evidence of both partnership and single agency activity focused on improving practice in the areas of neglect and child sexual abuse. Audits show that this is beginning to have an impact on referrals and assessments and focus groups were able to describe changes to practice. This included school staff referring to training that had focused attention on the voice of the child and social workers feeling more confident in working with child sexual abuse.

There was minimal evidence of changes or improvements in work with learning disabled parents.

The outcome of this review is to be considered in work to be progressed on the revision of the Child Sexual Abuse and Neglect strategies.

Adults safeguarding will give specific focus to work to improve practice with learning disabled parents.

g. 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.

A review of the front door arrangements was completed in October 2022 to consider the functioning and robustness of MASH following the merge of the Early Help hub and MASH in 2021, creating one front door. This was informed by a data analysis of pre and post merge contacts received to the front door which highlighted key areas of focus for the review.

A range of audit activity has been completed at part of the review, including scrutiny of application of thresholds in line with the RHRT guidance across the partnership and at the front door, to ensure timely and appropriate responses to children's needs in Walsall. The audits considered the quality, appropriateness and timeliness of referrals to the front door and the subsequent decision making within MASH, ensuring the right help and support was offered to children, young people and their families at the right time. Whilst there was assurance of robust, appropriate and timely decision making at the front door, inclusive of partnership screening and consideration of family history, it did highlight some further work required with the partnership in terms of early intervention and appropriate application of threshold.

In response to these findings, the RHRT training was updated, with more focus on early identification of need and exploring what help and support is required at the earliest opportunity across the partnership, with a particular focus on level 2 single agency Early Help. In addition, a RHRT training refresher was introduced. Bespoke training has been delivered to GP's and A&E, and a podcast focusing on RHRT is being developed for West Midlands Ambulance Service and other 'Blue Light' services. 'Time to Talk' sessions within localities continued to be held every 8 weeks, bringing partners together who coordinate and support with the development and delivery of Early Help to children, young people and families in Walsall, providing opportunity to build locality knowledge, strengthen partnerships and enhance understanding around key priority areas to continue to support early identification and early intervention. Domestic abuse Practitioners (DAP) were introduced within localities to offer early intervention and support families at level 2 single agency early help, who are experiencing domestic abuse and parental conflict.

The Joint Targeted Area Inspection (JTAI) in November 2022 provided additional scrutiny of the front door arrangements and effectiveness of the partnership, and reported;"Children who need help and protection receive a coordinated and effective multi-agency response at the 'front door' in Walsall. Senior leaders ensure that there is a culture of continuous and shared learning across the partnership, which is successfully disseminated to staff. This helps to support identification of risk and needs for children, at the earliest opportunity, and promotes improvements in services for children and their families".

Section 7

Progress against our Priorities for 2022-2023

WSP Priorities 2022-2023

Priorities: Neglect, Self Neglect, Exploitation	Work-streams		
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 the impact/outcome focus of the refreshed strategy.	• 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 skill and 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. Obtaining and reflecting on learning, sharing 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 response and approaches.	• Practice Improvement activity • Undertake a training and development needs assessments across the partnership. • Establish closer working relationships/ processes with other subgroups 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

Priority 1 - Neglect

This is the second year of strategic focus on Neglect for the Safeguarding Partnership. The Neglect Subgroup is chaired by the Director of Early Help Commissioning and Partnerships. In 2022 the subgroup delivery plan aimed to focus on 4 strands of work.

Walsall Neglect Strategy 2021 - 2024

Be Part of Making a Difference

To view the full strategy scan here

Our Guiding Principles

Training
Everyone in Walsall needs to recognise neglect and understand the impact it has on children and the role they can play in addressing neglect.

Seeing & Hearing Children
Listening to children in every way possible – by talking with them, listening to them and seeing them.

Taking Action
Children identified that having at least one adult or a network of adults that listen; that they can trust and that offer support is key to good help.

Why is tackling neglect important?

Neglect is the most common form of child abuse.

Neglect is featured in around three quarters of serious case reviews.

Neglect can cause lifelong harm to a child's health, development and wellbeing.

Neglect can be difficult to recognise and measure.

Our priorities

Priority One: To improve the awareness and understanding of neglect and the delivery of effective preventative support.

Priority Two: 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, including GCP2.

Priority Three: Improve the effectiveness of interventions and reduce the impact of neglect.

Priority Four: A Strategic commitment and leadership that drives good practice and improvement in tackling neglect.

Action Taken

Since the launch of the strategy, we have:

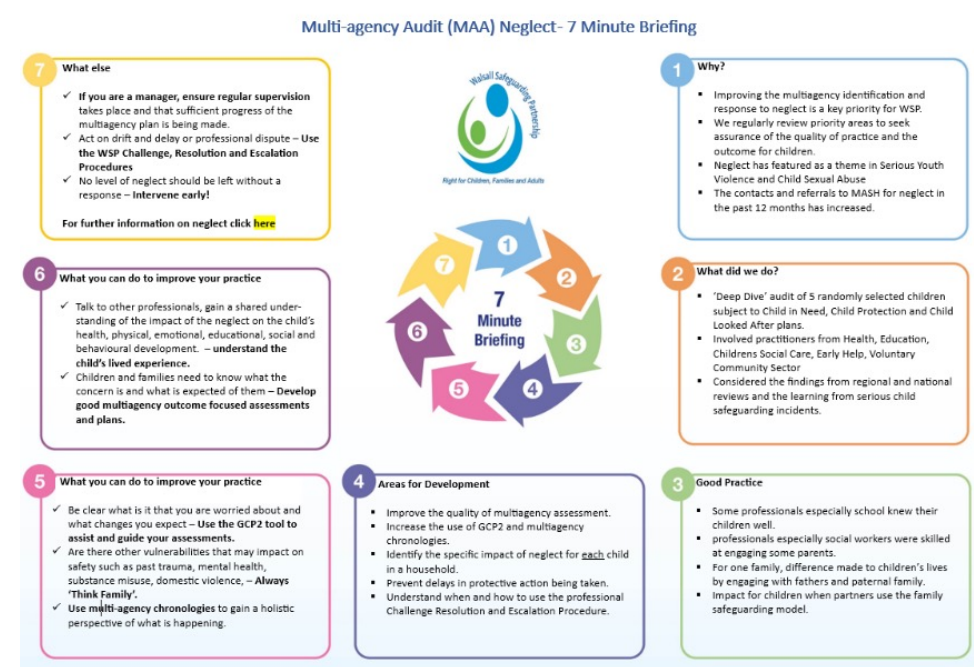
- Developed a multi-agency action plan setting out SMART key actions across each of the priorities.
- Developed our multi-agency neglect outcome framework so we can measure our collective impact. This will be implemented as of april 2023.
- Continued to develop our training offer to deliver awareness, understanding and response to neglect. In the last 12 months we have focussed on early years providers and the voluntary and community sector.
- Utilised the early help action campaign (aware, care, think don't ignore or do nothing) to ensure we action on the guiding principles children and young people identified.
- Maximised opportunities through big programmes like holiday activity and food programme to ensure we maximise opportunities to identify and support children and families early.
- In order to strengthen practice across the partnership, we have secured partnership resource to recruit a Neglect Practice Improvement Coordinator. This post will be directly responsible to work across the partnership in developing a resource hub, training programmes, practice reflection sessions that will support practitioners in implementing effective practice in working with families where neglect is a identified need. This will include the consistent use of the Graded Care Profile (an evidence-based tool in identification and working with families in addressing neglect). This post will be in place by June 2023.
- We are working with the police to see how there Aware App (a mobile based app) can be used to better identify neglect and can be upscaled to be used by a wide range of agencies.
- We have embedded a 'think family' approach as part of the adult neglect strategy to ensure we identify effectively any children who may be impacted by adult self-neglect.
- The Partnership has considered how the development of the Family Hubs can provide opportunities for effective support to families to prevent child neglect especially in those areas were we currently see low uptake of preventative programmes.

Next Steps

The steering group is currently planning a practitioner "Neglect Matters" event in May 2023 to continue to raise awareness, take stock on progress and refresh the action plan.

Walsall is one of 75 Local Authorities to receive support and funding for development of Family Hubs. The focus of the work has been on children 0 – 2: those born during the pandemic, to improve 4 areas of parenting practice:

1. Parent support and home learning: those first-time parents – information and support, identifying those needing additional support for targeted programmes.
2. Breast Feeding.
3. Peri-mental health: parents/carers in wider sense – workforce supervision/ support.
4. Parent/Carer Panel: co-production and led by parents to drive forward, peer to peer support.



Remaining Challenges

Further work is to be planned in 2023-2024 to re-visit and raise awareness of Neglect as a WSP priority across the children and adult's workforce.

A launch event is planned for May 2023 across disciplines to raise awareness on identification, assessment practices including the use of the NSPCC graded Care Profile 2 tool (GCP2), effective intervention approaches and outcome focussed planning.

It is also recognised that further work needs to be undertaken to ensure the voice of our children and their families is proactively sort and informs the approaches taken to address any improvement plans and to support practitioners to engage, assess and plan intervention to reduce risk and meet needs of children and young people.

Priority 2 - Self Neglect and Hoarding

This is the second year of strategic focus on Self-Neglect and Hoarding. The group is Chaired by the Head of Service Manager from Adults Services and is attended by a range of statutory partners and relevant agencies including the voluntary and community sector agencies.

Rationale

Under the Care Act 2014 self-neglect and hoarding are formally recognised within a safeguarding remit in England, therefore requiring responses from Local Authorities and their partners. Triggering instances from childhood, such as abuse, poverty, mental ill-health and sometimes physical health problems were cited as primary causes of self-neglect and/or hoarding.

The impact of self-neglect ranges from serious health implications, poor hygiene and personal care, social isolation, poor living conditions, and fire risk. In circumstances where adults with care and support needs are identified as having self-neglecting and hoarding behaviours, they would become subject to a Section 42 safeguarding enquiry. A Section 42 safeguarding enquiry is the action taken by organisations to respond to abuse and neglect concerns in relation to an adult with care and support needs, who is unable to protect themselves from abuse and neglect or the risk of it.

Any person or agency can bring its concern or make a referral to the lead agency (the LA), through which multi-agency working is organised, so that fuller assessments and safeguarding planning can take place.

Self-neglect differs from other safeguarding concerns as there is no perpetrator of abuse, however, abuse cannot be ruled out as the reason some individuals become self-neglectful or hoard.

In Walsall an additional strand to this area of work relates to the wider 'Think Family' approach. A 'Think Family' approach refers to the steps taken by children's, and adult's practitioners to identify wider family needs which extend beyond the individual they are supporting.

For safeguarding children, this means where, for instance, practitioners are aware that children are living with parents/carers with self-neglecting and or hoarding behaviours it is also important to assess the whole family, their needs and risk and to share and request information to inform assessments, support, protection, or care planning for both the child and adult.

Self-neglect and hoarding are behaviours that have been hard to define, measure and address. In Walsall contact and referral rates remain low, yet self-neglect and hoarding is the most frequent type of abuse identified in multi-agency audit, local regional and national reviews.

Strategic Intention

Walsall's strategic intention was to raise awareness of the issues across the adult's workforce in order that persons living with self-neglect and hoarding can be identified for assessment and support to reduce need and risk. The interface with children's safeguarding was also recognised and it was also essential that adult workforce recognised and knew when and how to respond where it was apparent that there were children living with adults in these circumstances. The importance of multi-agency collaboration across children and adults' disciplines was understood to safeguard both children, young people and adults with care and support needs. The partnership wanted assurance that practitioners were equipped:

- To create an adult Self-Neglect and Hoarding Strategy and Toolkit – which also references 'Think Family'; and the response for children within households.
- To undertake a needs analysis of self-neglect and hoarding in the Borough.
- To identify the training and development needs across the Partnership.
- To learn from SARs in the Borough and elsewhere.
- To establish the priorities for the forward plan 2023-2024.
- To operate a Partnership Self-Neglect and Hoarding Panel/Forum for cases to be referred for discussion where a Partnership approach is required to identifying and managing risks by working together in respect of individuals.

Self-Neglect

- To support the development of the Self-Neglect strategy a Self-Neglect Needs Analysis was undertaken last year but further multi agency response were required
- Current data is limited but following further needs analysis this will help inform discussions on specific KPI measures that may be asked for in future to develop a scorecard to support assurances on this priority

What is working well?

Figures show increase in Self Neglect identified as abuse type in Q4 = 12, where self-neglect was identified at conclusion of Section 42 Enquiry as the type of abuse, rising from 5 in Q3 and on par with 11 in Q2,12 in Q1. The annual total is 41 slightly down from the 47 reported in 2021-22

What are we worried about?

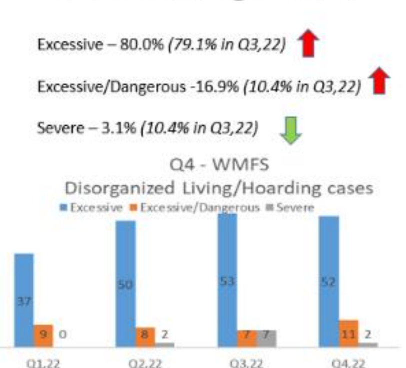
During Q4 there was only 1 x referral to the self –neglect panel, a further decrease compared to two in Q3 and five in Q2. The panel numbers remain low regarding self neglect pathway. Hoarding Data in two levels increased compared to Q3 period of, however there was a reduction in severe levels this quarter. The total for 22-23 of 238 Hoarding cases has increased compared to 197 in 2021-22

Is there anything else we need to know or do?

Data collection exercise was undertaken during Q3,agencies are asked to collate a snapshot of information on adults they are currently working with, who may be at risk of self neglect. The results were collated and analysed with a report going to Self-Neglect group in March 2023 – Update required

One Self-Neglect Panel referral was received during January to March 23. A total of 8 in the last 12 months

WMFS Hoarding Data Q4



In Quarter 4 of 2022-23 **12** x Concluded Section 42 Enquiries identified Self-Neglect as type of abuse (*2.5%*) compared to **5** in *Q3 (2.0%)*,**11** in Q2 (3.8%) and **12** in Q1 period (*4.8%*)

41 Enquiries identified Self-Neglect in 22-23 decreasing from **47** in 21-22

Action Taken:

Walsall partners recognised that self-neglect and compulsive hoarding are highly complex matters and require a collaborative and integrated approach to effectively respond to those individuals who live this experience.

The 'needs' assessment highlighted a range of challenges across the Partnership due to how organisations record and measure citizens in the Borough who self-neglect and hoard. There was 'anecdotal' activity from agencies but effectively measuring this provided many challenges in the Borough to strengthen the programme of work planned. The subgroup did, however, receive intelligence from the outcomes of multi-agency audits, and Safeguarding Adult Reviews regionally and nationally to inform the local picture and response.

An independent consultant was commissioned to support the Partnership in its development of a practitioner toolkit.

There is a multi-agency Self-Neglect and Hoarding Subgroup which meets bi-monthly to progress the identified plan.

The subgroup has also established a multi-agency Self-Neglect and Hoarding Panel.

Impact

The Self-Neglect and Hoarding Toolkit has been developed, there has however been significant delay due to a range of factors including changes in staffing and representation across the partnership and lack of timely contributions from partners. There is to be a re-launch of the multi-agency response to self-neglect and hoarding to include raising the awareness of the toolkit and the multi-agency panel.

Unfortunately, referrals into the self-neglect and hoarding panel have remained very low across the year, yet the issue remains a prevalent theme in audits and review outcomes.

The practitioner toolkit has been developed at the end of the business year, it is too early to report on the difference this has made to referral rates and help and support identified as in need or at risk.

Remaining Challenges

Further work is to be planned in 2023-2024 to re-visit and raise awareness of self-neglect and hoarding as a WSP strategic priority and launch the practitioner toolkit and the panel resource across the adults workforce.

The priorities strategic intention needs to be revisited to consider the following as the key drivers for improvement across the partnerships workforce:

To stop abuse and neglect wherever possible (for adults and children with lived experience).	To prevent harm and reduce the risk of abuse / neglect to adults with care and support needs.	To promote an approach that concentrates on improving life for the adults concerned and enables them to make choices and have control about how they want to live.
Develop partnership training specifically where substance misuse is a factor, demonstrating embedment into practice across the partner organisations.	To raise public awareness so that communities, alongside professionals, play their part in preventing, identifying, and responding.	To develop and agree a consistent set of data measures to better understand prevalence, use of the tool and wider multi-agency performance.
To recognise indicators of hoarding and self-neglect and provide preventative measures to help people to stay safe but stay in control.	To provide information and support in accessible ways so that people know how to raise a concern and report abuse or neglect.	To have the resource to prevent and address what has caused the hoarding and / or self-neglect.

Priority 3 - All Age Exploitation

Rationale

WSP recognised that exploitation does not stop on a person's 18th birthday. Where a child is experiencing exploitation at 17 years and is seen as a victim, it becomes more apparent that services needed to recognise and respond to the very likelihood that the same young person will continue to be vulnerable to the risk of exploitation and will continue to require support and or protection after their 18th birthday. It is for this reason WSP have agreed to an 'all age approach' to tackle exploitation in the Borough.

What this means is that Walsall Safeguarding Children's Partnership and Walsall Safeguarding Adults Board have committed to a collaborative approach to identify, respond and protect children and adults with care and support needs from all types of exploitation.

Strategic Intention

A strategy and delivery plan has been in place since 2020. During 2022-2023 the following objectives were the focus of the subgroups work:

1. **Build Strong Foundations:** Understand the "who," "what," "when," "where," and "how" associated with it. This involves analysing data and intelligence, engaging with our communities, analysing the evidence and implementing a public health approach.
2. **Primary Prevention:** Recognise when intervention is needed at an early stage and put appropriate measures in place, for example early years support.
3. **Secondary Prevention:** Recognise those who are vulnerable to violence and exploitation and intervene (individuals and communities) to prevent further harm. Encourage a culture of professional curiosity, training staff about contextual safeguarding and trauma informed practice.
4. **Tertiary Prevention:** Support those who have been harmed and intervene to support them to cope, recover and rebuild their lives.
5. **Enforcement and Criminal Justice:** Work in cross cutting ways, developing innovative practice, delivering effective enforcement across the borough and maximise the safety of individuals vulnerable to exploitation.

Action taken:

Actions to deliver the objectives included the following:

- Produce and implement a Delivery Plan for the All Age Exploitation Subgroup that would then inform the work of the Children/Adults Working Groups and Exploitation Panel.
- Produce an exploitation problem profile for Walsall.
- A Task and Finish Group around Modern Slavery Human Trafficking to be set up to move the agenda forward.
- Review of effectiveness and governance arrangements around the Multi-Agency Safeguarding Hub (MASH).
- Development of a dashboard to provide information /reassurance to the group on exploitation work.
- Delivery of an Exploitation Conference.
- Review of the Telford Enquiry and 'what next' discussion.

Community based work within the Exploitation Hub:

Over the last twelve months, Mike Collyer (youth worker within the Exploitation Hub) has led on work within the Mossley area, working with a proactive group of residents around the issue of gangs and exploitation. The group has grown to become self sufficient and has set up as a Community Interest Company, applying for local funding to support children and families and to deliver youth work type of interventions to support young people.

The Exploitation Hub has also extended its work within schools offering support to parents in parent and carer workshops raising awareness of exploitation, signs to look out for and what to do if they have any worries their child may be vulnerable or at risk of exploitation. In addition, this work has included awareness building around missing young people and what to do to prevent missing episodes and how to respond if their child goes missing. This work has been led by Keiron Atkinson (youth worker in the Exploitation Hub).

The team continues to support children with positive engagement, Mike has been working with Bay 10 Studios to support young boys and men around the issue of criminal exploitation, young people have written, produced and performed new material reflecting on their experiences within their local areas. There has been a focus on reflective work, particularly around mental health and how this is impacted by grooming and control by adults around them.

The team has also continued to offer detached outreach work in partnership with Street Teams, Youth Connect and EYES, targeting locations that have been high risk for children, including transport hubs, high footfall spaces and shopping centres. This work has supported additional work to grow within the community safety teams within the council.

Exploitation continues to be an area for community development and workers within the hub offer support to housing providers around locations that have been invaded (Cuckooed). There has been a significant rise of this type of exploitation post periods of lockdown.

Impact

The ongoing operational work around exploitation continues, however the way in which this is directed, how reassurance is provided and how gaps are identified remained a major source of discussion during the year. Significant work was undertaken to understand the full picture of governance and interrelated activity between the Safeguarding Board and the Safer Walsall Partnership. This led to a Walsall Safeguarding Partnership Exploitation Diagnostic Report being written and discussed at the Safeguarding Leadership Group. This report led to an agreement that greater strategic direction was required, and this should be achieved through producing a problem profile, strategic needs assessment to understand the overall picture of exploitation in Walsall and a delivery plan and scorecard for ongoing monitoring and action management.

The WSP was subject to a Joint Targeted Area inspection in November 2022. The Inspection outcome was published in January 2023. The JTAI report summarised the following as key strengths and impacts from local arrangements to identify and respond to exploitation.

“Risks to children from sexual or criminal exploitation are recognised well at the front door. The daily Exploitation Triage meeting is a well-attended multi-agency meeting that explores effectively the risks faced by children when they are reported as missing. Information is shared effectively in order to help professionals’ understanding of risks and actions, which helps inform decision-making.“

“The Chair of the Exploitation Triage meeting rotates between its core members, which is inclusive and indicative of confidence in the commitment and capability of the participants in the meeting. This ensures that responses to child protection are a shared responsibility across all partners.”

Remaining Challenges

A significant amount of work has been undertaken to further develop on the Strategic Needs Assessment, review the WSP multi-agency strategy and the subgroups delivery plan to help drive forward the work in 2023-2024.

The Chair and Co-Chair arrangements for the All Age Exploitation Subgroup and Adults Delivery Group changed through the year leading to some lack of continuity. The Safeguarding Business Unit have developed a robust framework for Chairs and Co-Chairs of groups which will assist in this issue moving forward.

Work continues to be undertaken with the Business Insights Team to develop on the WSP scorecards to support the progression of work.

Child Sexual Abuse

Ofsted published a Joint Targeted Area Review (JTAI) report in February 2020 and considered the analysis of findings from other local authority inspections into the "Multi-Agency Response to Child Sexual Abuse in the Family Environment". The report focused on the following areas of practice:

- child sexual exploitation and children missing from home, school or care;
- the response to children living with domestic abuse;
- the response to older children experiencing neglect;
- child exploitation (including sexual and criminal exploitation).

The report calls on professionals to give sexual abuse a higher priority in local areas, through improved training and awareness-raising of the problem, and states that, "more needs to be done to prevent the sexual abuse of children in the family environment and when it does happen, agencies must work better to protect and support victims and families".

WSP has had a focus on child sexual abuse since 2019 and has worked with the Centre of Expertise to develop the CSA multi-agency Strategy 2020-2023. The strategy included a focus on awareness raising, training and development work, strengthening practice and pathways.

In quarter 4 of the business year the WSP Executive Group were presented with information which suggested that further work needed to be undertaken around Walsall's identification and response to Child Sexual Abuse (CSA). The work has been aligned with the review of the CSA Strategy a priority to improve multi-agency oversight and management of child sexual abuse. The review of the Child Sexual Abuse Strategy will also consider any crosscutting issues for the adult safeguarding agenda.

Section 8

WSP Business Unit Review

In 2020 Penny Thomas, Independent Chair, Birmingham Safeguarding Children Partnership, undertook a review of the effectiveness of WSP arrangements with a view to look at the strengths, limitations, opportunities and threats of the joined-up arrangements. The benefit of the joined approach is well understood, and it does provide a greater opportunity to respond more effectively and where possible to promote an 'All-Age Approach' to safeguarding in Walsall. This review was conducted with due consideration to responsibilities under the Care Act 2014 and Working Together 2018. The review identified a number of areas for improvement for WSP.

The Pandemic impacted on the implementation of the recommendations from the review. On the 23rd December 2022 a decision was made to progress with a full review of the Business Unit. This would include a review of the current establishment and a potential of changing job descriptions to ensure that the Business Unit staff can effectively meet the complex and emerging demands of the children and adults safeguarding agendas.

The review led to WSP arrangements being more closely aligned, the governance streamlined and the Business Unit working to support the new arrangements.

Difficulties in terms of recruiting to vacant roles in the Business Unit.

An awareness that staffing capacity and skillset in respect of the respective children and adult agenda was not sufficient to effectively support the potential development of work.

There is an increasing need to progress the integration of the children and adult agenda and the WSP Business Unit functions to support an all-age safeguarding agenda particularly in relation to the agreed shared priorities.

Section 9

Our Performance Data - Children in the Safeguarding System and Core Areas for Practice Development

Family Safeguarding Model

In 2018 Walsall Children's Services developed the Walsall Right4Children transformation programme, which aims to get services and support right for all children across Walsall. One component of this was the Family Safeguarding Model which is a multi-disciplinary approach to supporting meeting the needs of parents whose needs may be compromised owing to vulnerabilities such as domestic abuse, and poor mental health. Walsall adopted the Family Safeguarding Model with a 'go live date' of the 1st April 2020, but was delayed until 1st September due to the start of the pandemic. Despite this major setback our implementation journey began with support from the SFPC team. The implementation of the model coincided with a council wide transformation and modernisation programme which provided the context in which to embed the Family Safeguarding Model, a whole scale change in safeguarding response to children and families centering on the value base that children's needs are best met within their own family.

The Family Safeguarding Model has allowed practitioners to focus on the whole family and make it easy for parents to access coordinated support they need from one team. The model is underpinned by Prochaska and DiClemente's theory of the cycle of change which conceptualizes behavioural change as a cyclical process. Practitioners utilise strengths-based working and motivational interviewing to support families in modifying behaviour that places children at risk of harm. Family safeguarding provides specially designed individual and group work programmes and a detailed parenting assessment, summarised in shared multi-professional case records. To date there has been several successful national evaluations of the Family Safeguarding model and the Walsall model has been evaluated by the' What Works Centre'.

Impact

1. Since the introduction of Family Safeguarding and different ways of working, there has been a significant reduction in the number of children becoming subject of a child protection plan and entering care. Where children are entering care, they are being supported to return home to their parents more quickly.
2. As the data below shows, there has been a 26.2% reduction in children becoming subject of a CP Plan since 2019-20 rising to 28.0% for children aged 12 and under. This is a reduction of 396, 372 of whom are 12 and under becoming subject of a plan.
3. The proportion of children who enter care following a child protection plan is reducing from 25.4% in 2019-20 to 17.9% in the 12 months to 31st December 2022. For children aged 12 and under, this has reduced from 27.7% to 19.5%. This reduction, alongside the reducing numbers of children becoming subject of a plan means that the number of children entering care after a period of CP planning has reduced by 232 children, 202 of whom are 12 and under.
4. Children entering care overall has also reduced by 33.1% for all children and 38.4% for children under 12 compared with 2019-20. This is an overall reduction of 214 children, 179 of whom are 12 and under, entering care.
5. Where children are entering care, they proportion of time spent in care continues to decrease. Of the children who entered care in 2019-20, just 17.8% left care within 9 months. This reduces to 11.9% for children 12 and under. However, in 2021-22, 27.9% of all children who entered care and 19.0% of those 12 and under left care within nine months – this may rise further as children who entered later in 2021-22 have not yet hit the nine-month mark.

"I wanted to write to let you know how great SC has been with supporting our children at OC. She is organised, efficient and lovely with the children. She also communicates with us, which is so vital when working with outside agencies.

We are really impressed with the work she is doing and the service BCWA offer is excellent so thank you."

A Walsall Head Teacher

Early Help

- Contacts to Early Help - 2,612, Level 3 EHA requests 1,619
- Timeliness of Early Help contacts 85.22% - this has decreased from 89% in 2021-22
- Top 3 referring agencies 2023 are –Schools (22.09%), Police (21.98%) Health – other primary health services (18.11%)
- Top 3 presenting needs - emotional wellbeing of child/general behaviour/ emotional wellbeing of parent/carer
- Emotional wellbeing of parent has replaced Domestic Abuse to parent/carer compared with 2022 top 3 needs (1. Behaviour, 2. Emotional well-being of child, 3. DA parent/ carer)

Overview of Children in Need

- Overall, the CIN Census has seen a 1.0% increase in the number of records loaded to the system this year.
- Number of referrals
  - The Rate of referrals per 10,000 is 481 which is a decrease from 496 (2021-22). It is lower than the statistical neighbours (624), England (534) and West Midlands (503) averages.
    - 3335 Referrals in 2022-23 which is a 3.1% decrease from 2021-22 (3440 Referrals)
- The number of referrals per 10,000 resulting in no further action (3) has decreased from 2021-22 (4) this is the lower than England average (8) and statistical neighbour average (10) but similar to West Midlands (3).

Completed assessments

- The rate per 10,000 for completed assessments within the year is lower than our statistical neighbour (632), England (533) and West Midlands (542) averages. The Walsall 2022-23 rate is 491 this is lower than in 2021-22 (497).
  - 3,405 assessments were completed in 2022-23 which is a 1.2% decrease from 2021-22 (3,448 Assessments).
- 90% of Walsall's assessments in 2022-23 were completed with 45 working days, this is similar to 2021-22. Our performance is now higher than those of our statistical neighbours (80%) England (84%) and West Midlands (82%) averages.

Factors identified at assessment

- Domestic abuse: concerns about the child's parent(s)/carer(s) being the subject of domestic abuse continues as the main factor (37%) but has decreased by 2% from 2021-22.
- Emotional abuse continues to be high with 27% in 2022-23 which is a 1% drop from 2021-22.
- The biggest decrease this year is Alcohol by the parent which has decreased from 12% in 2021-22 to 9% in 2022-23.
- The rate of Section 47 enquires has decreased in 2022-23 and is at 153.5 per 10,000. This is lower than England average (180), statistical neighbour (209) and West Midlands averages (196).

Child Protection

- Initial Child Protection Conference (ICPC)
  - 84% of ICPC's were completed within 15 working days of a strategy discussion and performance is the same as in 2021-22 and is higher than our statistical neighbours (83) England (79) and West Midlands averages (82).
  - The rate of ICPC per 10,000 in the year has decreased significantly from 60 in 2021-22 to 47 per 10,000 in 2022-23 and is now significantly lower than our stat neighbours (75), England (61) and West Midlands averages (63).
  - The number of children subject of a child protection plan as at 31st March 2023 is 167, this is a rate of 24 per 10,000, which is significantly lower than our statistical neighbours (53), England (42) and West Midlands (43) averages.
  - The number of child protection plans started increased with a rate of 50 per 10,000 in 2021-22 compared to 47 in 2020-21. The rate of 50 per 10,000 puts us significantly lower than our statistical neighbours (74) and England average of 53.
  - The number of children who have started a child protection plan for a second or subsequent time has increased slightly this year from 28% in 2021-22 to 33% in 2022-23 taking us above statistical neighbours, England and West Midlands averages (22% and 23% respectively). However, numbers are small, and any small increase/decrease will have an effect on the percentage.

The Local Incentive Scheme (LIS) was commissioned in September 21 with the objective to align payments across the system and improve Primary Care engagement with Children and Adult Safeguarding systems. Throughout 22/23 audits have been completed and presented at PQA. This highlights health contribution and commitment to improving Primary Care engagement with regards to ICPC processes.

Categories of Abuse

- Neglect and Emotional Abuse continue to be the highest categories **at initial assessment (36% and 47% respectively).**
- Emotional abuse is significantly higher than England (38%) Statistical neighbour (40%) and West Midlands (44%) averages.
- **Where the initial reason has changed to the latest category**
  - Emotional abuse continues to be the highest category at 51% but has decreased from 2021-22 where it was 54%.
  - Again, emotional abuse is significantly higher than England (41%) statistical neighbour (43%) and West Midlands (47) averages.
- The number of child protection plans ending this year has decreased (331) in 2022-23 from 350 in 2021-22.
- The number of child protection plans reviewed in timescale has decreased marginally this year from 90.5% to 89.1%.

Children with Care Experience (former Children Looked After) and Care Leavers (NEET) status

Dashboard data over recent months has identified that:

The number of Children in Care saw a slight downward trend between August and December 2022 from 653 to 643. However, there was an increase during January from 643 to 655, and February 2023 saw a further slight increase to 656.

16.2% of Walsall's CLA are placed 20 plus miles from their home address. This has increased since January this year, continuing the overall upward trend during the last 12 months. The percentage with long term placement stability increased from 68.0% to 68.6%, following several decreases over the last six months.

9.1% of the CLA population have had 3 or more placements within a year. This has increased slightly from 8.9% in January, however, this figure has seen little change over the last six months.

In regard to performance measures, our monitoring arrangements for individual children is also outlined within performance data such as timeliness of statutory visits, effectiveness of care planning and through the statutory review process and key data in regards to health assessments.

The dashboard in regard to these areas identified that:

Currently, 80.8% of children in care (CiC) have an up-to-date health assessment, which has decreased slightly from 81.5% during January 2023.

In regard to ensuring children's views being included in care planning, it was positive that the child's views were recorded at 100% of CiC reviews in February 2023, which had increased slightly from 98% in January 2023.

In regard to attending Statutory Reviews, CLA attended 83.0% of reviews during February, which represents an increase compared to 77.8% in January.

The percentage of children seen alone at CLA statutory visits increased from 89.7% during January to 92.8% in February. The percentage of over 5s seen alone has also increased from 90.5% in January to 94.3% during February. These percentages do fluctuate from month to month and are a key performance indicator for managers to monitor.

The number of care leavers increased from 225 at the end of January 2023 to 230 as of the 28th February 2023. This figure has fluctuated but the fluctuations remain within a relatively small range between 225 and 243.

The percentage of care leavers in education, employment or training for the 19 -21 age group has decreased in the last 3 months and is a key priority of those working in the leaving care service. Walsall continues to engage with both local and national initiatives to support care experienced people gain education, training and employment opportunities.

The proportion of care leavers in suitable accommodation remained high during February. Those that are not in suitable accommodation are largely our young people in custody.

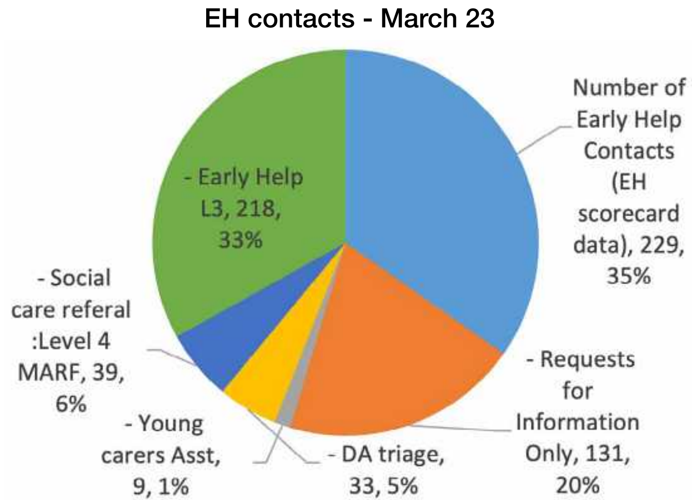
Other Key Areas of WSP Focus in 2022-2023

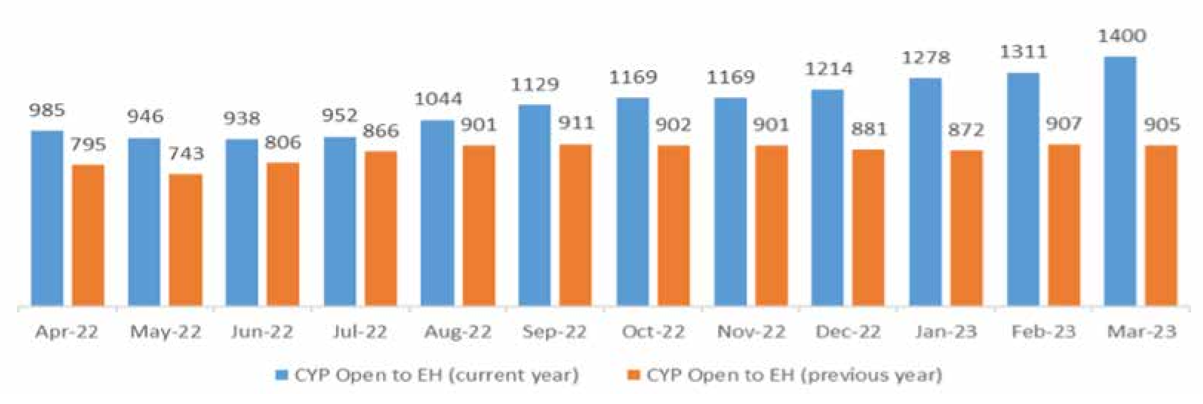
Right Help Right Time

Walsall Safeguarding Partners oversee, receive regular performance reports, review and dissemination of the Right Help Right Time Thresholds Document. The RHRT Threshold Guidance brings together the Partnerships shared ambition to provide the right level of help at the right time so children and families can have their needs met outside of statutory safeguarding processes, where appropriate.

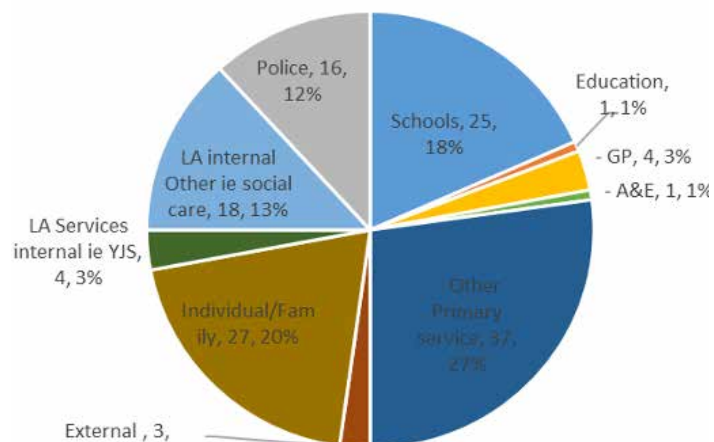
There were 299 contacts directly for Early Help Support. The largest proportion of contacts received in March 23 came from children and young people aged between 10 and 15 years old. 49% were relating to female children and the largest proportion of contacts were for children and young people from a white ethnic background.

EH contacts - March 23





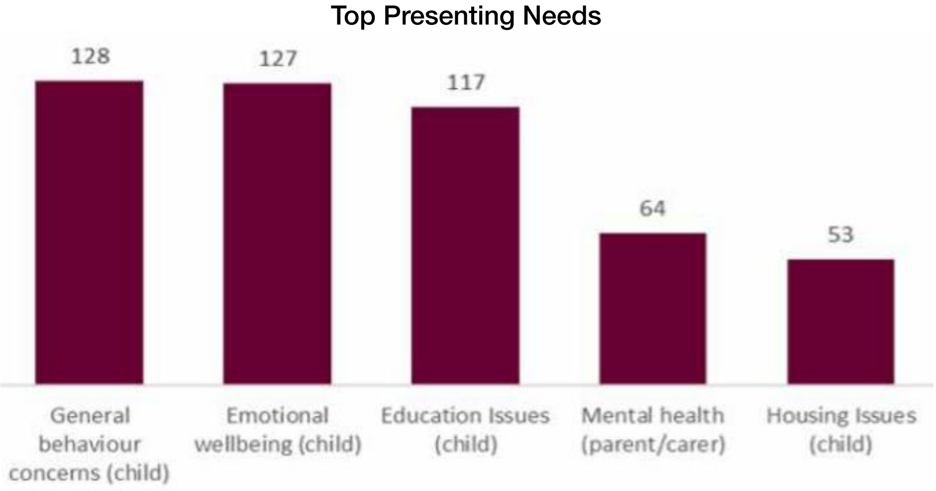
NFA referral source Q4 (Excl Info Requests)



The source of contacts has mostly come from schools (74) health services - other primary service (56) and Police (67)

There has been a steady increase in children and young people open to Early Help over the last 9 months increasing from 952 in July 2022 to 1,400 in March 2023. When comparing March 23 figures with March 22 figures there has been a significant increase from 905 in March 22 to 1,400 in March 23. Presenting needs: March saw general behaviour concerns (child) as the top presenting needs, emotional wellbeing (Child), education issues (child), mental health (parent/carer) and housing (child) completed the top 5 presenting needs in March.

Top Presenting Needs



Most children have had between 1 and 5 presenting needs identified, however, there are 35 children that have had 6 or more needs identified with 24 having 6, 6 having 7, and 5 having 8 needs or more identified.

The Right Help, Right Time Continuum of Need has been in place since 2019 and is being reviewed to incorporate the changes within Early Help arrangements, to reflect the 'supporting families' guidance, and the changes to the Front Door arrangements post the merger of the Early Help Hub and MASH. This will be done early into the next business year 2023-24, in consultation with front line practitioners who use the guidance in their day-to-day practice.

Multi-Agency Safeguarding Hub (MASH)

WSP continues to seek assurance on the effectiveness of its MASH arrangements. Recent analysis was undertaken by Childrens Services and considered performance data pre and post the merger of the Early Help Hub in its arrangements. The analysis highlighted key areas of focus for the Front Door review which included:

- repeat contacts,
- Domestic abuse triage outcomes and,
- Level 4 social care contacts that resulted in no further action.

Visits were undertaken to Leeds and Wolverhampton MASHs to explore their Front Door arrangements and further consider any learning that could be taken from other Local Authority MASH arrangements.

The JTAI inspection also gave additional opportunity to improve the Front Door arrangements. The improvement plan arising from the outcome of the review and JTAI will give specific focus to improving the effectiveness of MASH in ensuring timely and appropriate responses to children, young people and family needs. The improvement plans are monitored and reviewed within the MASH Management Group to ensure timely progression of action points.

As a result of the findings all MASH practitioners and partners were given training in relation to parental conflict and use of domestic abuse risk assessment tools to support appropriate decision making at the Front Door in response to domestic abuse.

Domestic abuse practitioners (DAP) have been embedded within localities and are supporting families where there are lower-level domestic abuse concerns identified at level 2 single agency support.

Surveys were sent out to MASH practitioners to obtain their feedback post Front Door merger and to understand what they felt worked well and identify areas of strength and areas for development. Whilst returns were low, practitioners shared a number of positives since the merger of the Front Door. They include the following points:

- A timelier response to children and young people's needs.
- More robust arrangements being in place to move between differing levels of need, with Early Help and Social Care practitioners being under one Front Door.
- Reduction of families having to re-tell their circumstances and experiences to multiple practitioners.
- The new arrangements supported timely decision making at the Front Door.

In 22/23 the Designated Nurse for Safeguarding Children in Walsall lead on the development of a Black Country Wide MASH Service Spec (including KPIs) and Health Standard Operating Procedure for health MASH Staff. We were asked to present this work at the Regional NHSE conference in December 2022 and on the MASH National Working Group which was chaired by Helen Adams (OHID) to highlight best practice.

Electronic Multi-Agency Referral Form (eMARF)

There was some inconsistency in terms of how referrals were received into the MASH and the quality of referrals, with some referrals being made by email or telephone call and not being followed up with a MARF. The partners developed and launched an eMARF on 28/11/22 in order to achieve more consistency in terms of quality of referral information being received from partners. The eMARF also ensured that mandatory fields were to be completed reducing the opportunity for essential information not to be recorded.

Section 10

How feedback from children and families has informed our work and influenced service provision.

WSP understands the importance of ensuring meaningful involvement of the child, young person or their parents and carers in decision making, planning and evaluation of services that intervene in their lives. The following provide a summary of activity undertaken to 'Ask, Listen and Act' on the voices and lived experience of children young people and families and to improve services and practice.

Children With Care Experience

During 2022-23 we have seen continued positive co-production activity with the children in our care. We have 3 children in care councils and as part of their work over this year they have co-produced an action plan driving forward a number of changes across the council and have helped to shape changes to the working of the corporate parenting board. Young people continue to play an active role in the recruitment of all permanent staff to Children's Social Care and offer training to practitioners, managers and members. In 2022 we saw the development and implementation of our participation and language that cares action plan and they are both clear practice priorities for Children's Social Care. In 2022/23 we commenced the development of our family advisory board and have recruited a small but dedicated group of parents, we are working with them to recruit more parents and carers and spend time developing trusting relationships to enable them to support us effectively in our co-production moving forward.

A key concern for young people, as reported to the Corporate Parenting Board, was mental wellbeing. To respond to this concern, partner members requested information on the therapeutic support provided to children in care who are at greater risk of suffering poor emotional wellbeing or mental health than their peers not in care, often resulting from their early childhood experiences and trauma.

Therapeutic support to children in care is provided through the FLASH service and so the current service specification and how it meets the needs of the children has been reviewed. The multi-agency Corporate Parenting Board receive assurance that the service specification included key performance indicators and that these will provide both quantitative and qualitative information about the impact of the service and outcomes for children, this will include children referred to service and stepping down from specialist Child Adolescent Mental Health Service.

In line with Corporate Parenting Boards Participation Strategy, we are pushing forward in regard to the following engagement and co-production activities:

- Increase the number of children we consult and engage with across our care and safeguarding population. Timetable of consultation activity and participation events and activities clearly linked to Quality of Practice Framework.
- For children and young people to consistently participate in their conference and reviews. Training and resources to be co-produced to support young people to Chair their meetings/reviews.
- Co-production with children and young people of age-appropriate consultation, communication tools and resources to promote understanding of rights and processes. Roll out of direct work toolkits.
- Increase numbers of children and young people involved in recruitment and training. Begin to embed parents/carers into the recruitment and training offered.
- Ensure all workforce attendance at Total Respect Training and support children, young people and parent/carer's input into the development and delivery of wider training programme.

The Integrated Care Board have also listened and acted on the voices of children with care experience and based on their feedback they have ensured:

- Free prescriptions for eligible care leavers
- A Health Application for Care Leavers that links to the NHS app.

All health assessments include the voice of the young person, and this is actively reviewed as part of the quality assurance process of these assessments.

Work with Fathers

Funding from the OPCC was secured in November 2022 to deliver a Fathers Peer Support Group and the MindKind Projects now deliver this crucial engagement and support. The Father's Peer Support Group facilitated by MindKind Projects have engaged over 30 fathers in Walsall. Fathers are telling us that the advice, support and space to chat has supported them towards better wellbeing, better parenting and improved relationships with loved ones. MindKind Projects have been delivering Saturday Dad's Stay and Play Groups from Walsall Family Hubs and this has been a much-needed resource for Dad's who tell us they don't always feel comfortable attending Stay and Plays often frequented by predominantly women. The Co-Founder and Lead Mental Health Social Worker for MindKind Projects also presented at the Family Safeguarding Working with Fathers Launch alongside fathers from the group. MindKind Projects continue to talk to professionals across Walsall about the importance of taking a trauma informed approach and by using recordings of interviews with the fathers they have been able to amplify the voices of our local fathers.

Section 11

Opportunities to Learn and Improve

Walsall Safeguarding Partnership scrutinises, evaluates and where necessary challenges the effectiveness of local safeguarding arrangements through its statutory functions and reviews. In doing so, WSP ensures that through continuous learning that services to safeguard and promote the welfare of children and adults with care and support needs in Walsall focus on improved outcomes.

Performance and Quality Assurance

Learning from Multi-Agency Audits (MAA)

Undertaking MAA audits enable WSP to review the quality and impact of safeguarding practice. Generally, WSP undertake four themed multi-agency audit rounds, one theme per quarter where the multi-agency practice in relation to five children and their families are evaluated.

The themes are identified due to strategic priorities, response to the findings of Child Safeguarding and Learning Reviews, Joint Targeted Area Inspections (JTAIs) Walsall data and intelligence. A report detailing findings from the audits is produced and as part of the learning from each audit; a 7-minute briefing will be developed and agreed by the PQA Subgroup. The audit reports routinely form part of WSP meetings where partners can scrutinise and challenge the findings. Learning from the briefing is shared using a range of different forums such as Practice Reflection Workshops, conferences, webinars and wider practice development.

During 2022-2023, the MAA audits focused on three themes including self-harm, neglect and exploitation with the latter being a theme twice in the year. Exploitation was a focus for WSP due to the preparations required as part of the JTAI inspections and all three are strategic priorities. As detailed in Table 1 below, overall, the grading of multi-agency practice has largely remained consistent during 2022-2023 with 85% being graded as good or requires improvement. Positively, this figure increased to 100% in Q2 when self-harm was the theme. In three of the audit rounds, the quality of multi-agency practice has been rated as inadequate representing 15% of the overall cohort.

Year/Quarter 2022/2023	Theme	Outstanding	Good	Requires Improvement	Inadequate	Total
Q1	JTAI-Exploitation		2	2	1	5
Q2	Self-Harm		2	3		5
Q3	JTAI -Exploitation		1	3	1	5
Q4	Neglect		2	2	1	5
Total			7	10	3	20

Table 1: Multi-Agency Children Audit Gradings 2022-2023

When the MAA audit gradings in 2022-2023 are compared against previous years, on average there has been a reduction of approximately 25% rated as a good and an increase of 10% of graded as requires improvement when compared to the previous year. At the same time, there has been, a 15% increase of cases rated inadequate when compared to 2021-2022.

Year/Quarter	Outstanding	Good	Requires Improvement	Inadequate
2022-2023	0%	35%	50%	15%
2021-2022	0%	60%	40%	0%
2020-2021	4%	61%	30%	4%
2019-2020	0%	23%	63%	15%

Table 2: Comparison of annual audit grades for Children MAA from 2019-2023

There are several factors that need to be taken into consideration. Audit grades relate to the quality of multi-agency working rather than overall practice. In addition to the multi-agency work rated as good, there could be positive elements of single and partnership agency working as well as areas for development particularly in those rated as requires improvement. Developing a bank of good practice Partnership examples which can be used as part of training and wider communication would be beneficial. Whilst this is a small sample size, due to the ‘deep dive’ nature of the evaluation of multi-agency practice, these findings often align with those identified by other WSP work such as learning reviews and other quality assurance activity. Robust multi-agency practice is an important part of achieving good outcomes when working with children. It should also be noted that no child was found to be at risk of harm through the MAA and that we have ensured necessary action has been taken to address inadequate judgements with the relevant organisations involved.

Understanding the reasons for the changes in grading are more complex and will require further analysis. Some possibilities include the themes chosen are not only priority areas locally when working with children and families, they often reflect challenges in practice regionally and nationally. Work has also been undertaken by the Business Unit to strengthen the Performance and Quality Assurance Framework. As part of the MAA process, this will involve incorporating the lived experience of children, increasing the involvement of practitioners as part of the assurance, measuring impact and influencing and informing service improvement. This could also provide further insight into possible solutions as well as the issues from a different perspective. Consideration of how this links with other partnership quality assurance activity could also be a consideration.

The next section provides an overview of the practice including good practice and areas for development. See appendix 1.1 for more information. Following this, are an overview of the themes and a summary.

Q1: Exploitation multi-agency audit completed June 2022 (Exploitation to check progress around practice against key WSP priority and JTAI Preparation).

Audit rating:

Year/Quarter 2022/2023	Theme	Outstanding	Good	Requires Improvement	Inadequate
Q1	JTAI-Exploitation		2	2	1

Q1 Exploitation

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 exploitation. All-Age Exploitation is a key priority for WSP, and the audit activity was undertaken in preparation for the Joint Targeted Area Inspection of the multi-agency response (JTAI). Risks were appropriately recognised, and timely responses identified which were supported by the Exploitation Hub and the use of the Toolkit. This enabled a better understanding of the needs of the child to be developed enabling purposeful support to be provided which made a difference to them and their families.

However, where vulnerabilities were identified, the Partnership response could have been improved. In some circumstances, better co-ordination of multi-agency working, information sharing between key agencies would ensure the timely provision of support. Ensuring a consistent approach to mapping would enable a contextual safeguarding approach to be adopted not focusing on the child's lived experience, protective factors but disruption linked to perpetrator/s.

How did we share learning?

- Several 7-minute briefings distributed on key themes.

  7 Minute Briefing – Information Sharing shared across the Partnership.
  7 Minute Briefing – 7 Golden Rules (Information Sharing) – shared across the partnership.
  7 Minute Briefing – on communication shared across the partnership.

- An exploitation conference arranged for March 2023 was cancelled due to the need to undertake some diagnostic activity. This work is still being progressed and a rescheduled date needs to be identified.
- An exploitation 7-minute briefing needs to be developed and will be completed by August 2023.

Q2: Self-Harm multi-agency audit completed September 2022 (linked to CSPR's)

Year/Quarter 2022/2023	Theme	Outstanding	Good	Requires Improvement	Inadequate
Q2	Self-Harm		2	3	

Q2 Self Harm

This audit reviewed how effective the multi-agency partnership is in addressing the needs and safeguarding concerns for children who self-harm. This was also linked to the findings from some Child Safeguarding Practice Reviews. Generally, children experiencing self-harm and their mental health needs was seen in the context of social, familial, and environmental factors, and previous experiences and trauma, instead of just as a presenting concern or behaviour in of itself. Professionals were skilled in working with children and family members who were at points of challenge and crisis and the support provided included different services.

Developing a better understanding of children's lived experience based on their identity particularly in relation to Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) and understanding their history would have enabled purposeful direct work to be undertaken. Plans would be improved if they were consistently developed and owned by the multi-agency group rather than the lead agency. Timely provision of specialised support where a need has been identified for a child would also improve the partnership response.

How did we share learning?

- A Practice Learning Event linked to self-harm will be taking place at the end of September 2023.
- A self-harm 7-minute briefing will be produced by August 2023.

Q3: Exploitation: multi-agency audit completed October 2022 – Exploitation to evaluate progress around practice against key WSP priority and JTAI Preparation).

Year/Quarter 2022/2023	Theme	Outstanding	Good	Requires Improvement	Inadequate
Q1	JTAI-Exploitation		2	2	1
Q3	JTAI -Exploitation		1	3	1

Q3 Exploitation

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 exploitation. This audit activity was repeated in preparation for JTAI. Exploitation was recognised and for the most part relevant assessments were completed and tools utilised. Positive examples of skilled professional work from several agencies with children, young people and families who were at points of crisis and had experienced trauma and adversity. Good examples of agencies engaging well with children and families were identified.

Multi-agency practice with some children would be improved by robust and timely information sharing between professionals to develop a better understanding of their history, current interventions and changing circumstances. Assessments and multi-agency planning whilst evident need to consistently be informed by a good understanding of the child's identity and vulnerabilities due to their special educational and mental health needs. Evidence of professionals reviewing the child's plan where specialist support was required alongside disruption planning was also required. Collectively, this is more likely to have resulted in robust plans for some children being developed based on a better understanding of their circumstances to improve their outcomes.

How did we share learning?

- An exploitation conference arranged for March 2023 was cancelled due to the need to undertake some diagnostic activity. This work is still being progressed and a rescheduled date for the conference will be identified.
- An exploitation 7-minute briefing needs to be developed and will be completed by August 2023 combining the findings from both audits.

Q4: Neglect: multi-agency audit completed February 2023 (Evaluate the effectiveness of the response to Neglect a Year on from the previous multi-agency audit)

Year/Quarter 2022/2023	Theme	Outstanding	Good	Requires Improvement	Inadequate
Q4	Neglect		2	2	1

Q4 Neglect

The audit reviewed how effective the multi-agency partnership is in addressing the needs and safeguarding concerns for children within sibling groups experiencing neglect which is a key priority for WSP. Generally, professionals from different agencies were skilled at working with children and parents, building, and developing relationships when the need for statutory support was identified. Professionals were adept at engaging family members although some were reluctant to work with agencies. Use of the Family Safeguarding Model resulted in a continued focus upon the difference being made to children's lives and a 'Think Family' approach.

However, the quality of multi-agency assessment of neglect could have been improved using the Graded Care Profile 2 and chronologies enabling a shared understanding of the specific impact of neglect for each child when considering their health, physical, emotional, educational development, and wellbeing. In a few circumstances, practice would have been improved by timely action being taken where vulnerabilities were identified using the professional escalation processes. Ensuring that professionals consistently evidenced purposeful child centred practice informed by multi-agency plans developed, owned, and shared with families also needed to be better evidenced.

How the learning was shared

- Several 7-minute briefings distributed on key themes.

  7 Minute Briefing – on Information Sharing shared across the Partnership.

  7 Minute Briefing – on 7 Golden Rules (Information Sharing) shared across the partnership

  7 Minute Briefing – on communication shared across the partnership.
- An exploitation conference arranged for March 2023 was cancelled due to the need to undertake some diagnostic activity. This work is still being progressed and a rescheduled date needs to be identified.
- An exploitation 7-minute briefing needs to be developed and will be completed by August 2023.
- A Practice Learning Event linked to self-harm will be taking place at the end of September 2023.
- A self-harm 7-minute briefing will be produced by August 2023.
- A 7-minute briefing was developed and distributed as part of the Neglect Conference scheduled for May 2023.
- Learning from the neglect MAA was part of the agenda of the Neglect Conference and shared with delegates.
- A consultation with practitioners using 'Mentimeter' was undertaken, and the findings will inform practice learning and development.
- The Neglect Conference is to be recorded and the learning about the MAA and the other themes will be available on the partnership website for practitioners to access.

Children's Multi-Agency Audit Themes 2022-2023

The table below provides an overview of the cross-cutting themes over the year when the good practice and areas of development are considered.

Practice area	Overall Multi-Agency Audit Themes and Findings 2022/2023
Identification and response to risk	**Quality of referrals and use of professional escalation and challenge:** Where risks were clearly identified, purposeful and timely information sharing evidenced, thresholds were correctly applied and resulting in assessments, being undertaken (Q1 and Q2). However, in a few circumstances, where vulnerabilities were identified, referrals for statutory involvement were not accepted and children were remained in neglectful situations without the right support being provided at the right level. Where professional disagreement was a factor, the use of professional escalation was not evidenced.
Assessment	**Variability in the quality of multi-agency assessments:** Overall, in Q1, assessments were robust when exploitation was a factor due to the use of the toolkit and consultation with the Hub. In Q4, positive practice was noted where the Family Safeguarding Model was used resulting in the risks, needs being in assessing risks and planning. However, across most of the audit rounds, the quality of the assessments was variable. Practice would have been improved by using chronologies to understand the child's history in the context of their family and their identity. Consideration of previous professional involvement and the use of evidence-based tools such as GCP2 were needed to develop a shared understanding of the risks, needs and impact on the individual child.
Child and Family Engagement	**The importance of purposeful professional interventions based upon a good understanding of the child's lived experience:** Across all four audit rounds, the quality of child and family engagement by practitioners across several agencies practice was found to be positive. Skilled professionals from several different agencies were able to work through varied and challenging relationship dynamics, to work in a trauma informed way to provide appropriate support. Multi-agency practice would be improved by consistently ensuring relationships with children and their families and the interventions provided are informed by better understanding of their identity, additional needs, lived experience and preferred method of communication. In turn, this is more likely to ensure that these relationships were translated into purposeful practice that made a difference.
Decision making and Management oversight	**Robust management oversight and decision making:** Overall, these areas were deemed to be appropriate across three of the audit rounds ((Q1-3) evidenced through timely strategy discussions, regular supervision where the needs of the child, effectiveness of the support and actions followed up and progress being made were considered. In the final audit round, whilst there was difference of opinion it was agreed that decisions should have been made sooner. Practice would have been strengthened had more reflection and analysis been evidenced about the timescales for change for the child, a shared understanding of the risks, and impact reducing drift and delay and escalation where required.
Planning	**Development of child centred, multi-agency plans which make a difference:** The quality of multi-agency plans was identified as an area for improvement across all the audit rounds. In Q1 and Q2, some plans were good, identifying support that children and families required, support provided and the role for different agencies resulting in purposeful intervention. Most would be improved by being child centred, multi-agency and evidenced that they been developed with the family. Plans also need to be informed by an understanding of the child's identity, specify how their needs would be met and ensure better co-ordination to prevent drift and delay in better outcomes being achieved.
Multi-agency working	**Importance of robust multi-agency working:** There were positive examples of multi-agency working identified in most of the audit rounds (Q1,3 and 4) where partners worked effectively together. However, when assessing the quality of practice overall issues such as the lack of information sharing, better co-ordination of multi-agency working, and drift and delay were identified. Delay in being able to access the necessary assessments relating to health and education and timely provision of support was also a factor (Q2 and 4).
Impact for the child	Where identification and response to risks was timely, thresholds were appropriately applied, and purposeful interventions were provided based on meaningful engagement of children and a better understanding of what life was like for them and the help and support required to make a difference to their lives. Use of professional escalation, consistent use of evidence-based tools and multi-agency plans and interventions based on a deeper understanding of the culture, identity and background of children would further strengthen practice.

Summary

Overall, the overview of multi-agency practice during 2022-2023 evidenced that most practice is graded as good or requires improvement with child and family engagement identified found to be the most positive. Development of the case examples where the impact of this work can be shared could be one way in which the learning could be shared more widely. There are also some re-occurring cross-cutting practice themes where partnership assurance activity, action plans are being developed or where the links with other assurance work could perhaps be strengthened. Findings have identified the importance of continuing to adopt best practice principles, compliance with pathways, guidance, evidence-based tools alongside the importance of purposeful and quality of multi-agency interventions that make a difference.

Multi-agency audits provide an important view into the effectiveness of our safeguarding system and has identified some positive practice and possibly highlighted how factors such as workforce challenges can impact on the effectiveness of multi-agency working. This further illustrates the crucial role that partners across the system, but particularly as part of Performance and Quality Assurance process, play in identifying, addressing, and mitigating these factors.

Throughout the year, partners have evidenced their commitment to MAA and provided feedback about the process particularly some aspects of the methodology. Introducing the views of children and families and involving practitioners will be required. Improving some aspects of the process particularly in relation to panel and report writing, the impact on the timeliness of sharing the learning, closing the loop and action plans. It also needs to be acknowledged that there have also been changes to staffing in relation to the MAA Chair and Quality Assurance Manager both who have oversight of the process. A plan has been identified to ensure that any outstanding learning is completed, shared, and a review of the process will take place. Both the Business Unit Leads and Partners from the MAA and Practice, Learning and Development Subgroups have identified the need to strengthen the links between these groups, consider the multi-agency practice learning offer in light of the findings and evidence the impact.

Learning from case reviews is a statutory function required to be in place for all Local Safeguarding Partnerships. In Walsall this function is delegated, overseen and monitored by the WSP Practice Review Group.

The subgroups' purpose is to coordinate the local framework for reviewing, serious child safeguarding cases as set out by Working Together 2018, and Safeguarding Adult Reviews (SARs) in line with the Care Act 2024. The group focuses on identifying the improvements to be made to the adults and children's safeguarding system and also seeks to prevent and reduce the risk of recurrence of similar safeguarding incidents.

Key priorities for the group during 2022-23 were:

1. To improve the timeliness of the learning from the Safeguarding Adult review Process
2. To review the process for Review Referrals including the implementation of adult reviews in rapid time
3. To improve the oversight of the Practice Review Group and the Executive of the cases in progress and their status, including those where publication may be delayed due to criminal proceedings.
4. Streamline tracking and monitoring of recommendations across the Multi-Agency System
5. To review and enhance the dissemination of learning from all reviews including the National Panel LCSR completed on Arthur Labinjo-Hughes and Star Hobson.
6. Enhance the confidence and expertise of the group membership.

The Solihull JTAI completed following the death of Arthur Labinjo- Hughes was critical of the ways in which the learning from case reviews was shared across the system. This prompted a review of the current processes in place to ensure that learning was shared effectively with all partners.

This resulted in the review of the Safeguarding Partnership website which was updated with a clearly identifiable tab for 'Learning'.

- **A new website** is to be launched in 2023-24.
- **A Communications Strategy** was developed by the Partnership which addresses the dissemination of learning from reviews.
- **A quarterly newsletter from the Partnership** was developed and circulated summarising significant learning.

Through 2022-2023 7 cases were heard at rapid review with 6 deemed not meeting threshold to progress onto a local child safeguarding practice review (LCSPR). One case was referred for consideration and was notified to the National Panel and Ofsted as a Serious Child Safeguarding Incident. This case progressed to a LCSPR and will continue to progress through 2023-24. There were two alternative reviews and 1 tabletop review for a child sexual abuse incident. Four of the cases that did not meet criteria identified child neglect as a key theme. WSP approved the commission of an independent reviewer to complete a thematic review, which will focus on barriers to effective implementation of the Neglect Strategy in practice. At the time of writing the review had not concluded.

There was three reviews in the system which due to delays in forensic experts advice resulted in the significant delay in drawing reviews to a conclusion, this has raised concern for the WSP.

- one children's review was completed in the year leading to publication in April 2022 (W13 "Sam")
- There was 1 LCSPR from 2021 and 1 SCR from 2018 which are pending completion during the year. This case is delayed due to criminal proceedings.
- There was 1 SCR (from 2019) during the year where criminal proceedings came to a close and no further prosecution was made. The case is pending the outcome of the coroner's inquest before the review can be completed.

Partnership Learning and its Dissemination and embedment into practice

The outcome of reviews is also promptly applied and featured in **WSP learning and training material**. Partner representatives of the practice development group are responsible to ensure the learning is taken back into their own organisation and any single agency learning is updated accordingly.

The use of 7 minute briefings

All learning from reviews is disseminated across the children and adult's workforce through 7-minute briefings. This is a well-known approach based on a technique adapted from the FBI!   Research suggests that seven minutes is an ideal time span to concentrate, and learning is more memorable as it is simple and not clouded by other issues and pressures. 7-minute briefings are sent out in WSP newsletters, prior or post publication of reports, at practitioner events, and policy or procedure development and launch events.

Walsall Safeguarding Partnership
Learning from Case Reviews

March 2023

As a Safeguarding Partnership we have a duty of care towards children and adults with care and support needs, to explore how practice can be improved through changes to the system established though learning gained from multi agency reviews.

In this edition we focus on the learning from our Walsall Safeguarding Reviews for adults and Rapid Reviews for children.

Safeguarding Adult Reviews

The Care Act 2014 states that Safeguarding Adult Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, or the adult is still alive, and the adult has experienced serious abuse or neglect, and there is concern that partner agencies could have worked together more effectively to protect the adult.

Local Child Safeguarding Practice Reviews

Local Child Safeguarding Practice Reviews (LCSPRs) (formerly Serious Case Reviews [SCRs]) in England are undertaken when a child dies (including death by suspected suicide), and abuse or neglect is known or suspected. Additionally, Local Safeguarding Partnerships (formerly LSCBs) may decide to conduct an LCSPR if a child has been seriously harmed and, in accordance with the guidance in Working Together 2018, there is learning for the local area.

Rapid Review for Referral Consideration

When a case might meet the criteria for a CSPR, a Rapid Review meeting is convened to consider initial agency information.

Similarly, when a case is referred for consideration of a SAR, the Practice Review Subgroup will consider what agencies know about the situation.

Sometimes learning can be identified at these meetings and actions agreed to improve practice, without the need to progress to a SAR or CSPR.

Walsall Safeguarding Partnership, Right for Children, Families and Adults   www.WalsallSP.co.uk

National Learning

The circumstances into the sad and untimely death of Arthur Labinjo-Hughes and Star Hobson have been a key focus for Walsall safeguarding partners.

In response to the learning from the Solihull JTAI a review was undertaken of the current mechanisms to disseminate information and learning, this resulted in:

1. the review of the Safeguarding Partnership website which was updated with a clearly identifiable tab for 'Learning'.
2. A new website is to be launched in 2023-24.
3. A Communications Strategy was developed by the Partnership which addresses the dissemination of learning from reviews.
4. A quarterly newsletter from the Partnership was developed and circulated summarising significant learning. The review of the Safeguarding Partnership website which was updated with a clearly identifiable tab for 'Learning'. A new website is to be launched in 2023-24. A Communications Strategy was developed by the Partnership which addresses the dissemination of learning from reviews. A quarterly newsletter from the Partnership was developed and circulated summarising significant learning.

Local learning

The review of MASH arrangements resulted in:

- The ICBs Designated Nurse for Safeguarding Children in Walsall led on the development of a single specification for MASH, a single set of KPIs and both were added to the contract with Providers across the Black Country during 2022-23.
- A review of the safeguarding supervision arrangements for the cohort of staff undertaking this work.
- Shared Health Care – One Health Care Record was introduced in MASH.

MASH in Walsall was the first area to use One Health Care Record to increase ease of access to a number of health records including Primary Care

Subgroup Developments

The work of the subgroup is aligned to the West Midlands Regional Procedures for coordinating rapid review and child safeguarding practice reviews.

The Chair of the subgroup raised a concern of the low number of cases progressing on to LCSPR following rapid review, this led the PRG to review its governance and its local referral pathway. Following consultation with partners, it was agreed that in the new business year the PRG will introduce a multi-agency pre discussion panel (involving the three statutory partners agencies), for considering cases referred for Rapid Review. This is to prevent referrals that did not meet the criterion for Rapid Review being presented and promote timelier single or multi-agency response to the issues that were being presented, outside of the case review process.

To improve the oversight of all group members and the Executive in relation to reviews in the system at varying phases of completion, the Business Unit redesigned a summary report detailing all the cases currently subject to review making it easier to monitor and track progress. It in addition streamlined the tracking and monitoring of recommendations from reviews across the multi-agency system.

The Business Unit relaunched a shared area where the actions/ recommendations from all reviews can be tracked. These can be updated by a variety of multi-agency partners (although Police cannot access the site currently).

Streamlining the tracking and monitoring of recommendations from reviews across the MA system

This provides a valuable mechanism for group members to update recommendations/ avoid unnecessary duplication and is also a very useful assurance tool for the Partnership.

There is also a central repository for evidence of implementation.

Drift or delay can be seen easily and addressed.

Impact has been assessed from verbal feedback from subgroup Members, the Chair of PRG and the Business Unit.

Discussions with the subgroup members and observation has identified variability in confidence the need to build time in the groups arrangements to focus on development of the group members to confidently explore matters of equality, diversity and inclusion (EDI) and make decisions regarding the criteria for statutory reviews in cases presented to the panel.

The chairing arrangements for child rapid reviews has also been delegated to the Black Country ICB Designated Dr for Safeguarding, this provides opportunity to consistently apply thresholds and consider any learning from across the black country in the to cases presented to the subgroup.

The Practice Review Group will change its subgroup name in the new business year to the **Joint Case Review Group** to better reflect its responsibilities for also overseeing the rapid review processes for safeguarding adults reviews (SARs) as well as serious child safeguarding incidents.

Remaining challenges/improvement required

- Improving EDI in case review discussions and capturing data to assist identifying profiles and target intervention and support
- Development of the capability, confidence of the group
- Capturing impact of actions taken is challenging and an area for focused improvement in 2023-24

Section 12

Workforce Learning and Development

Strategic Intention

Learning is promoted and embedded in a way that local services for children and families can become more reflective and implement changes to practice evidence of the impact of the work of the safeguarding partners and relevant agencies, including training, on outcomes for children and families from Early Help to children looked after and care leavers.

Walsall Safeguarding Partnership is keen to promote a learning culture for its workforce to enable them to be reflective and responsive to the needs of children young people and families. The Practice, Learning and Development (PLD) Subgroup oversees the coordination of multi-agency training, the embedment of learning arising from national and local reviews and policy changes and multi-agency audit outcomes.

The subgroups priorities across the year have been informed by the following:

- Impact evaluations from training events. Pre-evaluation forms completed on the day of attendance at training to self-measure prior knowledge/skill. Post-session evaluation form at the end of the training events to self-evaluate the learning that has taken place and to commit to actions to implement the learning. Post course impact evaluations sent out eight weeks after the course to the delegate to ascertain how learning from the training has been applied in practice and what the outcomes have been.

- Reflective workshops have also been undertaken and professional knowledge utilised to decide upon the priority areas. Data, performance information and statistics based on local needs have also informed decision making, alongside the identified themes and concerns highlighted within DHRs, SARs and CSPRs. The priority areas were also informed by multi-agency audits which have been undertaken and the identified findings.

- The outcome of WSP multi-agency audits. Following the audit, a report and learning notes are provided highlighting areas of good practice and areas for improvement. The audit reports routinely form part of WSP meetings where partners can further challenge and scrutinise the findings. There is a robust audit cycle in place with identified themes linked to the WSP strategic priorities and includes learning from case reviews and emerging data themes.

- To develop a new learning management system that is accessible to all partners, that would enable reporting systems and impact systems in place to support with the impact of training.

Action taken:

ICON awareness events took place within Walsall to raise awareness in relation to infant crying, how to prevent serious illness, injury or even the death of young babies because of abusive head trauma and which is linked to shaking a baby.

An ICON voice over radio advert (Bauer Music) was commissioned by all four Safeguarding Partnerships across the Black Country footprint to run from 19-30 September 22. The advert reached 65,000 on Greatest Hits Radio and a further 77,000 on Free Radio and was an innovative way to promote the ICON message across the wider system.

WSP responded robustly to the learning arising from the national review in relation to Star Hobson and Arthur Labinjo-Hughes. The Executive Director of Childrens Services and Independent Chair of the Safeguarding Children's Partnership launched a large-scale learning event on 16th June 2022 to all frontline practitioners, managers and senior managers across the partnership. 346 people attended the event. This was recorded and has been accessed on the website 324 times. The aim of the event was:

- To understand what happened to Arthur and Star during their short lives.
- To understand how agencies acted to safeguard Arthur and Star.
- To understand the recommendations and learning about how local and /or national safeguarding practice and systems should change.
- To have a better understanding of what changes have been made in Walsall so far and what we need to continue to work on.
- To share further learning opportunities that are available to practitioners around the learning from the report.

Evaluation

As part of the evaluation of this event we asked delegates 'how they intended to use the reflective questions used as part of the session to inform their practice and generate conversations with colleagues?' Here were some of the responses:

- "I plan to have discussions in our teams Reflective Practice meeting next week, as the information shared today, also transfers into the supervision and support of connected families we are working with. This specifically includes the disguised compliance, avoidant behaviours, and manipulation that we can at times experience. The training areas will also be really helpful to all the team."
(Walsall Fostering Support and Development Team)
- "I will encourage my team to be curious and consider information they are given in circumstances that don't seem to sit quite right and encourage them to discuss these feelings and thoughts with the team to gauge professional opinion."
(Manager of Early Years setting)
- "I will ensure this is discussed with GPS via GP Forum, share the video with them, very informative session." (Integrated Care Board)
- "I found this very informative from both a national and local perspective, was good to hear about the work that is happening in Walsall, I will ensure the video is disseminated across the force and advocate the need to share information as this is paramount when working with partner agencies."
(West Midlands Police)

Further Action Taken

Following the Launch the partnership held a series of successful workshops attended by the children's workforce across the months of June and July 2022. The themes of the workshops included the following:

- Child Protection Medicals
- MASH Process
- More than words – Voice of the Child
- Hot Potato session – what are we most concerned about
- Beyond Disguised Compliance
- Solution Circles
- Coercive Control
- Working in Diverse Communities
- Cultural Genograms

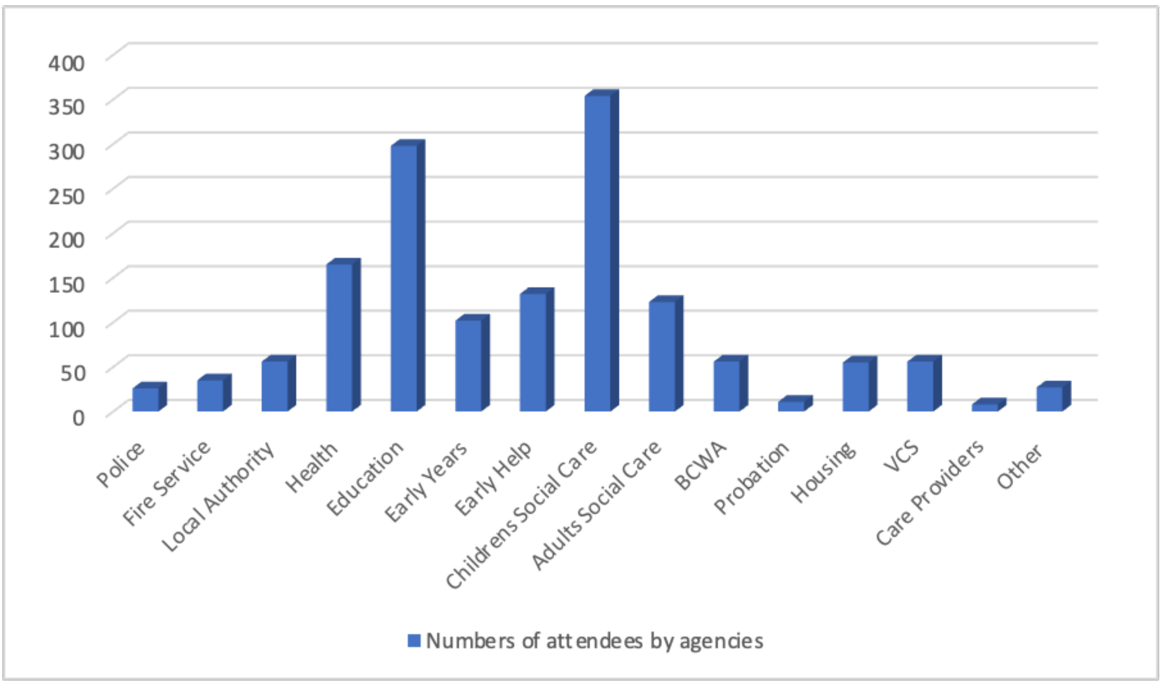
Impact

One of the key areas for development in 2023-2024 is to develop and implement a framework to assess the impact of workforce learning on practice and its impact on 4th Partner (children and their family) outcomes.

Highlights

- 52 events either face to face or virtual have taken place.
- 1,504 attended virtual or face to face training.
- 920 completed evaluations which include post evaluation or Impact evaluations.
- 19 videos or webinars have been added to the website.
- Video recordings have been accessed 1,194 times.
- 1,123 eLearning modules have been completed – however, these are predominately by Walsall Council employees due to external partners being unable to access the Learning Management System.

Attendance by agency



Event Impact statements

"I found it really useful to learn more about the multi-agency audit process and the learning. I will use this moving forward when working with families where there is likely sexual abuse taking place, ensuring I use a restorative approach of working with the family. I will take what I have learnt back into my team."

Social Worker (Learning from Audits, Theme: Child Sexual Abuse)

"I found this webinar really informative especially the information from the Fire Service around what support they can offer and hoarding classification. I know feel more equipped to give advice to members of my team and feel more confident in signposting to appropriate services that can support adults I work with."

Social Worker (Identification and support for adults that are at risk of harm due to fire Webinar)

"Since attending the Understanding Neglect training, I have furthered my training by attending the Lead Professional and have taken on Early Help role in school. I was able to identify there was neglect, complete the Early Help Assessment and support with the use of GCP2."

School Practitioner (Understanding Neglect)

Subgroup Developments

It was identified that the subgroup required police representation to ensure that their perspective and the learning from reviews was being shared within this organisation. Subgroup members are unaware of how identified learning from reviews has been received within the police and there is a lack of assurance that actions from reviews are being addressed. A meeting is arranged with a police colleague to identify a representative to attend future meetings.

It was identified that since the Policies and Procedures group stopped meeting approximately twenty-four months ago that there were several local and regional policies that required attention. A mapping activity has commenced to check the review dates of these policies and create a plan to prioritise the order in which the policies are overseen by the subgroup.

The subgroup recognise that previously there have been delays in identifying and delivering training due to the length of time taken to complete SARs and reviews. The subgroup has recognised the need to be more pro-active and forward thinking. Therefore, we are receiving regular reports regarding all SARs, DHRs, CSPRs and Rapid Reviews to identify early, potential themes and learning which can be explored to consider if there is sufficient existing training within all organisations, if agencies are able to share their training offer with other agencies or if training in this area needs to be commissioned.

In Quarter 4 of the year the subgroup members were consulted with on the new Performance Management and Quality Framework. The representatives expressed commitment to their organisations engaging in future identified audits and to engaging in this process to enable the effectiveness of action plans to be measured in relation to impact. The subgroup is aware that there will be future themed audits which are evidence led, and which will identify areas for learning, but also celebrate good practice.

A thorough Learning Needs Analysis will be conducted next year to inform future priorities and focus.

Remaining challenges:

- Multi-agency training needs analysis to further inform the development of the training offer is required.
- Strengthen governance of subgroup i.e., secure police membership.
- Review Policy and Procedures in line with plan.
- Respond to learning from reviews identified early in the review process as well as final outcomes of reviews.
- Complete Training Needs Analysis to inform work-force development requirements.
- Increase the engagement with practitioners and the 4th partner to help the partnership to understand the impact of the training and learning across the safeguarding system on outcomes for children, young people and families.

Section 13

What scrutiny arrangements are in place and why have these been adopted? How successful have they been?

The role of independent scrutiny is to provide assurance in judging the effectiveness of multi-agency arrangements to safeguard and promote the welfare of all children in a local area, including arrangements to identify and review serious child safeguarding cases. This independent scrutiny will be part of a wider system which includes the independent inspectorates' single assessment of the individual safeguarding partners and the Joint Targeted Area Inspections. (Working together 2018)

The programme of independent scrutiny has existed through the appointment of an Independent Chair and Scrutineer Chairing and having oversight of the joint Performance and Quality Assurance (PQA) Subgroup and Operations and Scrutiny Subgroup. This was an active way for the Chair to gain insight and understanding into the quality of frontline practice.

Prior to the JTAI outcome in January 2023 the WSP Executive Group approved the recommendation from the Operations and Scrutiny Subgroup to strengthen the Partnerships governance arrangements and appoint an additional Independent Chair and Scrutineer so that there would be separate representation for the WSCP and WSAB into the Executive Group. This also supported the Executive Group to agreement review and restructure the WSP governance and subgroup arrangements. The intention was to provide focused attention to the improvement required for the children's and adult's agendas but also enabling more focussed deliberation on matters where service and practice are inextricably linked and required a joined-up approach for improvements to be effective.

The children and adults Independent Chair and Scrutineer (ICS) attended all meetings of the Safeguarding Executive Group and was provided the opportunity to report on issues emerging from the activity across the Partnerships subgroups. The ICS agreed with the plans to split the functions relating to the adults and children's agenda and the additional appointment of an ICS to create separate representation for adults and children's safeguarding matters.

WSP have worked with the ICS to provide clearer detail on the Scrutiny Plan for the Partnership. The appointment of the additional Chair was enacted in quarter 4 of the business year with a gradual introduction to the changes to the partnership's governance and subgroup arrangements. It is expected that in 2023-2024 there will be a continued and more focussed response to independent scrutiny across the Partnership's activity.

Section 14

How effective have our arrangements been?

Joint Targeted Area Inspection (JTAI) November 2023

On the 7th November 2022 services were subject to a Joint Targeted Area Inspection (JTAI). The inspection was carried out jointly by Ofsted, the Care Quality Commission (CQC) and His Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS).

The inspection focused on the of the multi-agency response to the identification of initial need and risk.

Walsall Council along with West Midlands Police and Integrated Care Board (local NHS services) make up the Walsall Local Safeguarding Children Partnership. The inspection looked at areas where children at risk may become known to the authorities such as the Emergency Department at Walsall Hospital, the West Midlands Police Control Room and the Multi-Agency Safeguarding Hub (MASH).

The Inspectors identified that work needed to be undertaken to improve information sharing across the health community. Health partners have been working hard to provide a timely introduction to the Health and Care Record in MASH which pulls together health information across numerous systems and will increase the effectiveness and timeliness of information sharing between partner agencies.

There is also identified areas for improvement in relation to supervision and management oversight, both West Midlands Police and Health colleagues, have respectively produced improvement plans to strengthen the areas of concern in their organisations.

Overall, Inspectors found that children who need help and protection in the Borough receive a coordinated and effective multi-agency response. They also stated that there was, 'strong and stable leadership across a range of partner organisations identified as enabling the right help to be provided to children and young people at the right time'. It further highlights that children in Walsall are supported by a comprehensive multi-agency Early Help offer which gives them access to a range of support and services, when they need it.

Inspectors also found that Social Workers like working for Walsall and say that they have opportunities for learning and development.

This was a positive outcome for Walsall partners and of course the children and families living in the Borough. WSP continue to work to improve its multi-agency arrangements and WSP has a specific JTAI Action Plan to further improve multi-agency arrangements and the safeguarding system.

Section 15

Conclusion - How safe are the children / adults of Walsall?

Walsall Safeguarding Partnership is committed to improving its Multi-Agency Safeguarding Arrangements for children and their families, and adults with care and support needs across the Borough. Our principal aim is to provide the right help at the right time at the right quality upon first contact in accordance with our vision and values, to prevent abuse and neglect. Where there is risk and harm, we want to be able to respond robustly in a timely manner, with effective support services to minimise impact and, ensure we learn and improve from our experiences.

The annual review of effectiveness has demonstrated that there are effective Multi-Agency Safeguarding Arrangements in place. We, however, are not complacent and will continue to review, streamline, and improve our processes and services to ensure these arrangements remain effective, now and into the future.

Section 16

Strategic Plan 2023-2025

Walsall Safeguarding Partnership has operated as a joint children and adults partnership model since 2019. The model has enabled the Executive Group to have a clearer understanding of the issues that impact on children and young people, adults with care and support needs, and their families. WSP have worked hard to make improvements to interfacing children and adult safeguarding practice and services, create efficiencies and minimise duplicity across the safeguarding system.

Each partner member contributed their views to areas of focus in the forthcoming year, the list below is not inclusive of all the activity taking place but does demonstrate the breadth of activity that contributes to safeguarding children and adults in Walsall.

The key priority areas identified for the WSCB in 2022 – 23 continue to be the main priority areas for further development and embedment for the Partnership in 2023/24.

- **Priority 1 - Neglect**
- **Priority 2 - Self Neglect and Hoarding**
- **Priority 3 – All Age Exploitation**
- **Priority 4 – Child Sexual Abuse**

Following a review of the WSP arrangements, the Business Unit has begun work with Partnership Chairs and Members to strengthen leadership and governance in all layers of the WSP sub-structure. This is to continue through 2023-2024.

A focus for 2023/24 is improving the communication between the Safeguarding Partnership and the other Boards/Partnerships to avoid duplication in terms of discussions at subgroup meetings and streamlining audit activity and expectations.

In addition, the Safeguarding Executive Group reached agreement that work to improve multi-agency oversight and management of child sexual abuse would be the 4th Priority. The review of the Child Sexual Abuse Strategy will consider any cross-cutting issues for the adult safeguarding agenda.

The Priorities will inform the production of the WSP Strategic Plan which will be reviewed annually to enable the Partnership to be responsive to emerging issues as they arise.

The summary plan below sets out WSP ambitions and strategic priority areas of focus for 2023-2025 alongside summary actions that will help the partnership subgroups to devise plans to oversee activity that helps to keep children, young people, and adults, be and feel safe and protected from abuse and neglect.

Ambition / Priority	Description	Reason	Impact
1. Governance and Leadership - We want to, strengthen arrangements to learn from the Partnership's experiences, promote a culture of continuous multi-agency professional development and improve how we help and support children and adults in Walsall.			
a. Be led by a clear vision for the future for Walsall which creates an inclusive culture which is open to scrutiny and is accountable.	Review vision to ensure it is embedded in all layers of the multiagency safeguarding arrangements (MASA), commits to Equality Diversity and Inclusion Adopt jointly owned governance arrangements that allow for a co-ordinated approach to the partnerships safeguarding activity. Embedment of the WSP operating frameworks to include: • Induction of existing and new members. • Clarify expectations via Scheme of Delegation. • Improve data and intelligence via embedment of Performance and Quality Assurance Framework. • Strategic Challenge, Escalation and Resolution. Provide a common framework for all subgroups to operate in order to focus work on the right priorities/actions and ensuring consistent evidenced based reports are provided as assurance to the Partnership. To improve the communication between the WSP and other Boards or Partnerships.	• Promotes a culture of collaboration, and accountability for all aspects of the system and at all levels of the partnership. • To ensure we build on or established clear relationship and governance arrangements to support our partnership working. • Ensure that our partnership strategic improvement plans progress. • Want to ensure productive series of meetings that co-ordinate and drive forward key elements of the system. These meetings are all informed by the same end goal, adopt joint approaches for partnership practice. • Support partner member confidence and understanding in strategic safeguarding activity. • To improve consistency across WSP subgroups. • To reduce duplication of discussion and provide improved strategic coordination of identified issues	• Improved safeguarding arrangements for children and families in Walsall. • Improved strategic arrangements through quality subgroups that are consistently in expectations and delivery on their respective agendas. • Improved alignment and information sharing between subgroups. • Minimise risk of duplicity of activity across the safeguarding system and cross partnership. • Cross partnership alignment linking intelligence, evidence from data or quality activity to ensure effective collaborations plans and commissioning of services. • Drives improvement planning in key areas for improvement. • Improved outcomes in the areas where actions and measures are in place. • Greater clarity of ownership, responsibilities, and expectations. Streamlined and targeted safeguarding activity and support.

Ambition / Priority	Description	Reason	Impact
1. Governance and Leadership - We want to, strengthen arrangements to learn from the Partnership's experiences, promote a culture of continuous multi-agency professional development and improve how we help and support children and adults in Walsall.			
b. To promote greater awareness and engagement of safeguarding within communities and across organisation including the private and voluntary sector	• Develop and launch new WSP website. • Integrate ask listen act approach and seek views on the lived experiences for 4th partners, practitioners, and managers.	• Improve accessibility to safeguarding information. • To assess whether the safeguarding systems and arrangements are working effectively. • Customer experience and expertise to actively inform improvements at all levels.	• Improved opportunity to establish what difference is being made to the lives of children and their families. • An improved confidence of children and families to engage with services and evidence of improved outcomes.

c. To ensure WSAB and WSCP has assurance that local safeguarding arrangements are in place as defined by the Care Act 2014/ Children and Social Work Act 2017 and are effective.	• WSAB / WSCP to continue to meet its statutory responsibilities and review and build on sub-structure.
	• Work with partners to strengthen WSAB preparedness for forthcoming CQC inspection.
	• Continue to promote strong links between children and adults safeguarding and between the various strategic partnership boards that are required by law.
	• To strengthen governance and reporting arrangements on interfacing safeguarding themes relating to:
	  • Domestic abuse
	  • Person in a position of trust (PiPoT)
	  • Other strategic partnerships
		• Core business to demonstrate compliance and quality of services.
		• Supports preparation for CQC inspection.
		• Links between the various strategic partnership/ boards demonstrate members are clearer about how and what we contribute to issues that affect families and communities.
			• Improved safeguarding arrangements for adults with care and support needs and their friends and families in Walsall.

d. WSP Business Unit Review to re-establish capacity within the Business Unit and further the children, young people and adult's safeguarding agenda.	Local Authority to undertake and implement findings of the Business Unit review.	• Independent Review completed in 2020 – recommendations to be enacted. • Reviewing arrangements provide effective challenge regarding resources and promote discussions regarding the priority and sustainability for services to the WSP.	• An effective and well-resourced Business Unit enables the WSP to perform and function effectively

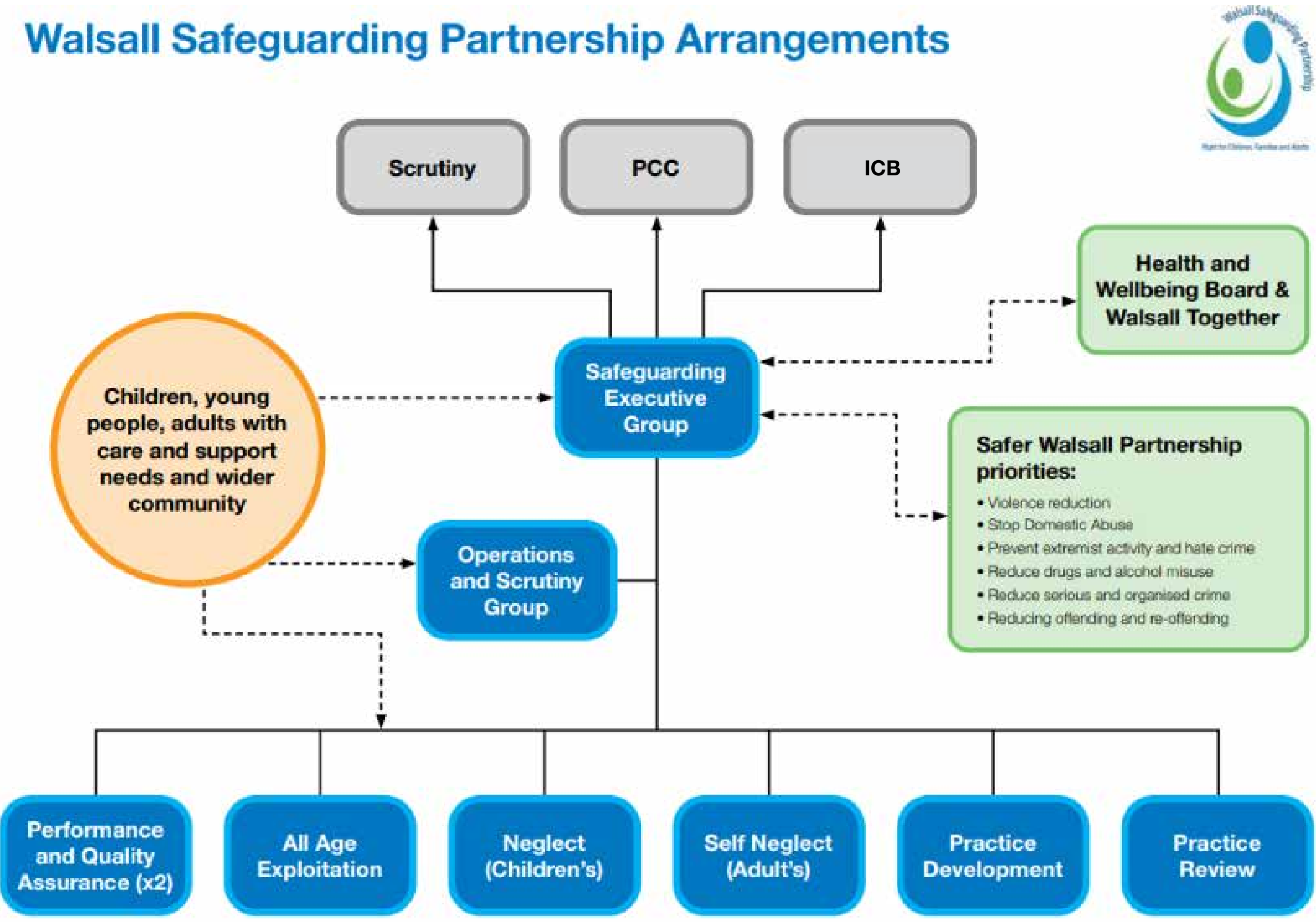
Ambition / Priority	Description	Reason	Impact
1. Governance and Leadership - We want to, strengthen arrangements to learn from the partnerships experiences, promote a culture of continuous multi-agency professional development and improve how we help and support children and adults in Walsall.			
e.WSP Performance and Assurance to be intelligence and data led when planning developing and reviewing services for adults. To include S11 and Care Compliance Audits and Education Safeguarding Assurance Audits S175/157.	• Build on score card/ dashboard and consistently provide data and intelligence to the PQA Adults Subgroup to inform future strategic planning. • To develop and agree a multi-agency action plan to improve the processes to assess multi-agency and single agency safeguarding activity using partnership data and assurance activity.	• A unified performance and quality framework will allow senior leaders to assess system efficacy. • Sets standards for practice, leadership, and accountability. • To promote targeted approach to service and practice where required. • Better understand the impact of the specific work the WSAB carries out arising from reviews and audits.	• Better planning and better quality evidence and data provided, with improved alignment to other subgroups and partnerships audiences. • Assured of consistent safeguarding practice across schools. • Improved communication between schools and other agencies. • Safeguarding practice is challenged and developed. • Improved knowledge for participating schools, again, improving outcomes for children and families.
f.WSP Practice, Learning and Development. Ensuring review (to include training needs analysis) and delivery of robust training programmes and competency framework, including learning from reviews.	Develop adult learning and development offer and the system to quality assurance learning and its impact on practice and outcomes on adult safeguarding. Learning to be informed by themes and local policy and procedures in relation to: • Self-neglect and hoarding. • Making safeguarding personal. • Assessing complex needs - Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). • Multi-agency safeguarding transitions for young people at risk. • Learning arising from audits, SARs and DHRs. • Domestic Abuse.	• Adults training offer is under-developed. • To improve confidence, awareness and response to specific themes arising from data, assurance activity and intelligence. • Needs to be informed by Training Needs Analysis. • To promote learning and a culture of safeguarding practice.	• Able to drive forward quality safeguarding practice and interventions with targeted training needs analysis. • Safeguarding practice will reflect learning from experience of 4th partner.

g.Local Child Safeguarding Practice Reviews (LCSPR), Safeguarding Adult Reviews (SAR) and Domestic Homicide Reviews (DHR).	• Enhance multi-agency learning and development from the themes arising from reviews locally, regionally and nationally. • Improving EDI in case review discussions and capturing data to assist identifying profiles and target intervention and support. • Development of the capability, confidence of the group • Capturing impact of actions taken is challenging and an area for focused improvement in 2023-2024.	• Core business with the Children's Act 2017 and Care Act 2014. • Understanding how learning from LCSPR, SAR, DHR, MAA drive improvements internally and across the partnership. • Improved and safer services. • Better outcomes for adults with care and support needs.	• Practitioners are confident in their practice, they will embrace learning from cases with openness, without judgement or criticism being the focus. • Multi-agency subgroups, managers and practitioners will be aware of their areas of strength and weaknesses in relation to multi-agency working and are motivated to take action where weaknesses and gaps are identified.
Priority 1: Neglect			
• To improve multi-agency oversight and management of neglect.	• Develop and hold a learning / launch events and materials with the purpose of raising awareness, embedding, and promoting a culture of safeguarding practice informed by local policy and procedures in relation to neglect. • Promote the sustained use and development of the application of GCP2 and trained trainers.	• Neglect continues to be the highest category of abuse in Walsall. • Requiring a launch of new guidance and additional support and awareness. • Raise community awareness and engagement	• Consistent multi-agency safeguarding practice to identify and respond to neglect. • Earlier support for families vulnerable to the risk of neglect. • Increasing numbers of the used of GCP2 assessment tool. • Children and families are identified earlier for intervention, therefore, children not exposed to neglectful circumstances longer than necessary and improving outcomes. • Reduced repeat cycle of involvement with agencies as parents take on board improved parenting practices and standards to keep their children safe.

<table>
<tr><td colspan="4">Priority 2: Self-Neglect and Hoarding</td></tr>
<tr><td>To improve multi-agency oversight and management of adults with lived experience of self-neglect and hoarding.</td><td>Rethink of Self-Neglect and Hoarding Panel
Improve practitioner recognition and response.
Develop and hold a learning / launch event and materials with the purpose of raising awareness, embedding, and promoting a culture of safeguarding practice informed by local policy and procedures in relation to self-neglect and hoarding</td><td>Low volume of referrals and use of multi-agency panel identified by frontline practitioners.
Requiring a launch of new guidance and additional support and awareness.
Increase identification and response.
Reduce deaths from self-neglect and fires links to hoarding.</td><td>Improved knowledge and understanding for all practitioners.
Consistent multi-agency safeguarding practice to identify and respond to Self-neglect and Hoarding.
Increase contacts and referrals and use of multi-agency panel.
Improved outcomes for adults with care and support needs.
Reduction in serious safeguarding incidents.</td></tr>
<tr><td colspan="4">Priority 3: All Age Exploitation</td></tr>
<tr><td>To improve multi-agency oversight and management of adults with lived experience of All-Age-Exploitation.</td><td>Commission of Strategic Needs Assessment for inform review of Strategy.
Produce a Delivery Plan and associated score card to reassure partners and ensure monitoring of priorities is possible. This may require an interim plan whilst the needs assessment is produced</td><td>Exploitation does not stop on a person’s 18th birthday.
Apparent that services needed to recognise and respond to the risk of exploitation to young adults that require support and or protection after their 18th birthday.</td><td>Improved confidence, knowledge and understanding for all practitioners.
Consistent multi-agency safeguarding practice to identify and respond to Exploitation.
Transitional support is effective between adult and children service providers.</td></tr>
<tr><td colspan="4">Priority 4: Child Sexual Abuse</td></tr>
<tr><td>To improve multi-agency oversight and management of Child Sexual Abuse (CSA).</td><td>Review of the Child Sexual Abuse Strategy to consider the improvement required and any interfacing themes to be addressed within adults safeguarding.</td><td>Difficulties in understanding the scale of offending and the number of victims and survivors due to under-reporting, under-identification and a lack of robust survey data has been identified.
Several cross-cutting themes linked with sexual abuse which are also a priority in different partnerships including: neglect, violence against women and girls, modern slavery, serious youth violence and exploitation.</td><td>Improved confidence, knowledge and understanding for all practitioners.
Consistent multi-agency safeguarding practice to identify and respond to CSA.
Early identification and support to prevent harm and early intervention to break cycle of CSA across generation of families.</td></tr>
</table>

Appendices

Appendix 1. WSP structure 2022-2023



Appendix 2. Financial Summary

The work of WSP is supported by the WSP Business Unit and is funded by contributions from the respective statutory partner agencies.

A single funding arrangement is in place for WSP and the joint arrangements for the Safeguarding Adults Board and Safeguarding Children Partnership.

The contributions from partners for WSP for 2022/23 is set out below:

There was a reserve balance of £299.427 which was carried forward from 2021-2022.

Income 2022-23

Organisation	Contribution £
WM Police	33,651
ICB	97,500
Probation	1,500
Walsall Council – Adults and Children	239,446
Total Income WSAB and WSCP	**372,097**

Expenditure 2022-23	Budget £	Actual Expenditure £
STAFFING		
Employees (permanent)	213,123	121,626
Agency & Consultants	0	147,340
TOTAL STAFFING	**213,123**	**268,966**
NON - STAFFING		
Professional Services (Chair costs, consultancy etc.)	68,200	50,065
CSPR / SAR & Other scrutiny work	25,036	21,719
Development activities	10,000	5,794
Other service costs (website, memberships etc.)	28,785	29,723
TOTAL NON-STAFFING	**132,021**	**107,301**
INCOME		
Contributions from partners	(122,094)	(142,651)
Other income		(10,400)
TOTAL INCOME	**(122,094)**	**(153,051)**
NET POSITION	**223,050**	**223,216**

There was a reserve balance of £299.427 which was carried forward from 2021-2022. Expenditure is broadly in line with the previous year, except for a slight increase in the staffing expenditure due the interim appointments mid-year to cover the vacant Business Manager post and the Partnerships commitment to redesign its website.

Appendix 3. Glossary of Acronyms

Abbreviation	Meaning
AMPH	Approved Mental Health Professional
BIA	Best Interest Assessor
CA 2014	Care Act 2014
CCE and CSE	Child Criminal Exploitation and Child Sexual Exploitation
CE	Child Exploitation
CQC	Care Quality Commission
CSA	Child Sexual Abuse
CSP	Community Safety Partnership
CSPR	Child Safeguarding Practice Review
CYP	Children and Young People
DA	Domestic Abuse
DASH	Domestic Abuse, Stalking and Harassment and 'Honour' Based Violence
DAODS	Domestic Abuse Disclosure Scheme (Clare's Law)
DHR	Domestic Homicide Review
DO	Designated Officer (Managing Allegations)
DoLS	Deprivation of Liberty Safeguarding
DSL	Designated Safeguarding Lead
EDI	Ethnicity, Diversity and Inclusion
EHCP	Education, Health, and Care Plan
ESG	Executive Safeguarding Group
FGM	Female Genital Mutilation
FOI	Freedom of Information
GCP	Graded Care Profile
HBV	Honour Based Violence
HMI/HMICFRS	His Majesty's Inspector/His Majesty's Inspectorate of Constabulary & Fire and Rescue Service
HWBB	Health and Wellbeing Board
ICB	Integrated Care Board
IDVA	Independent Domestic Abuse Advisor
IMCA	Independent Mental Capacity Advisor
JCRG	Joint Case Review Group
JTAI	Joint Targeted Area Inspection
JSNA	Joint Strategic Needs Analysis
LADO	Local Authority Designated Officer (Managing Allegations)
LCSPR	Child Safeguarding Practice Review
MAA	Multi-Agency Audit
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
MASA	Multi-Agency Safeguarding Arrangements
MASH	Multi Agency Safeguarding Hub
MDS	Modern Day Slavery
MDT	Multi Disciplinary Team
MCA	Mental Capacity Act
MSP	Making Safeguarding Personal
NRM	National Referral Mechanism
PiPOT	Person in a Position of Trust
PLD	Practice, Learning and Development
PRG	Practice Review Group
PQA	Performance and Quality Assurance
PQAIF	Performance Quality Assurance and Improvement Framework
QA	Quality Assurance
RHRT	Right Help Right Time
RR	Rapid Review
S.42	Section 42 Enquiry (Care act 2014)
S.47	Section 47 Enquiry (Children Act 1989)
SAR	Safeguarding Adult Review
SARC	Sexual Assault Referral Centre
SFPC	Strengthening Families Protecting Children programme
SLG	Safeguarding Leadership Group
SNH	Self-Neglect and Hoarding
SPB	Safeguarding Partnership Board
SWP	Safer Walsall Partnership
TAF	Team Around the Family
VAWG	Violence Against Women and Girls
UASC	Unaccompanied Asylum-Seeking Child
WNB	Was not Brought
WSP	Walsall Safeguarding Partnership
WT 2018	Working Together 2018
YJS	Youth Justice Service

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