Walsall Council

Health and Wellbeing Board

Tuesday 26 January 2021 at 4.00 p.m.

Digital meeting via Microsoft Teams: Public access: https://youtu.be/Yaw7Vv7Q2IQ

Membership:

Councillor S. Craddock (Chairman)
Councillor R. Martin
Councillor T. Wilson
Councillor I. Robertson
Ms. K. Allward, Interim Executive Director Adult Services
Ms. S. Rowe, Executive Director Children's Services
Mr. S. Gunther, Director of Public Health
Dr. A. Rischie (Vice-Chair)] Clinical
Mr. G. Griffiths-Dale] Commissioning Group
Vacancy] representatives
Ms. M. Poonia, Healthwatch Walsall
Ms. J. Malone, West Midlands Fire Service
Chief Supt. A. Parsons, West Midlands Police
Ms. D. Lytton, One Walsall
Mr. R. Beeken, Walsall Healthcare NHS Trust
Ms. F. Shanahan, Walsall Housing Partnership/Walsall Housing Board
Ms. M. Foster,Black Country Healthcare NHS Foundation Trust
Ms. J. Holt, Walsall College
NHS England

Quorum: 6 members of the Board

Democratic Services, The Council House, Walsall, WS1 1TW
Contact name: Helen Owen, Telephone (01922) 654522
helen.owen@walsall.gov.uk
www.walsall.gov.uk.

Memorandum of co-operation and principles of decision-making

The Health and Wellbeing Board will make decisions in respect of joined up commissioning across the National Health Service, social care and public health and other services that are directly related to health and wellbeing, in order to secure better health and wellbeing outcomes for the population of the Borough, and better quality of care for all patients and care users, whilst ensuring better value in utilising public and private resources.

The board will provide a key form of public accountability for the national health service, public health, social care for adults and children, and other commissioned services that the health and wellbeing board agrees are directly related to health and wellbeing.

The Board will engage effectively with local people and neighbourhoods as part of its decision-making function.

All Board members will be subject to the code of conduct as adopted by the Council, and they must have regard to the code of conduct in their decision-making function. In addition to any code of conduct that applies to them as part of their employment or membership of a professional body. All members of the board should also have regard to the Nolan principles as they affect standards in public life.

All members of the board should have regard to whether or not they should declare an interest in an item being determined by the board, especially where such interest is a pecuniary interest, which an ordinary objective member of the public would consider it improper for the member of the board to vote on, or express an opinion, on such an item.

All members of the board should approach decision-making with an open mind, and avoid predetermining any decision that may come before the health and wellbeing board.

The Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012

Specified pecuniary interests

The pecuniary interests which are specified for the purposes of Chapter 7 of Part 1 of the Localism Act 2011 are the interests specified in the second column of the following:

Subject	**Prescribed description**
Employment, office, trade, profession or vocation	Any employment, office, trade, profession or vocation carried on for profit or gain.
Sponsorship	Any payment or provision of any other financial benefit (other than from the relevant authority) made or provided within the relevant period in respect of any expenses incurred by a member in carrying out duties as a member, or towards the election expenses of a member. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Regulations (Consolidation) Act 1992.
Contracts	Any contract which is made between the relevant person (or a body in which the relevant person has a beneficial interest) and the relevant authority: (a) under which goods or services are to be provided or works are to be executed; and (b) which has not been fully discharged.
Land	Any beneficial interest in land which is within the area of the relevant authority.
Licences	Any licence (alone or jointly with others) to occupy land in the area of the relevant authority for a month or longer.
Corporate tenancies	Any tenancy where (to a member's knowledge): (a) the landlord is the relevant authority; (b) the tenant is a body in which the relevant person has a beneficial interest.
Securities	Any beneficial interest in securities of a body where: (a) that body (to a member's knowledge) has a place of business or land in the area of the relevant authority; and (b) either: (i) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or (ii) if the share capital of that body is more than one class, the total nominal value of the shares of any one class in which the relevant person has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

Schedule 12A to the Local Government Act, 1972 (as amended)

Access to information: Exempt information

Part 1

Descriptions of exempt information: England

1. Information relating to any individual.

2. Information which is likely to reveal the identity of an individual.

3. Information relating to the financial or business affairs of any particular person (including the authority holding that information).

4. Information relating to any consultations or negotiations, or contemplated consultations or negotiations, in connection with any labour relations matter arising between the authority or a Minister of the Crown and employees of, or office holders under, the authority.

5. Information in respect of which a claim to legal professional privilege could be maintained in legal proceedings.

6. Information which reveals that the authority proposes:

   (a) to give any enactment a notice under or by virtue of which requirements are imposed on a person; or

   (b) to make an order or direction under any enactment.

7. Information relating to any action taken or to be taken in connection with the prevention, investigation or prosecution of crime.

8. Information being disclosed during a meeting of a Scrutiny and Performance Panel when considering flood risk management functions which:

   (a) Constitutes a trades secret;

   (b) Its disclosure would, or would be likely to, prejudice the commercial interests of any person (including the risk management authority);

   (c) It was obtained by a risk management authority from any other person and

   its disclosure to the public by the risk management authority would constitute a breach of confidence actionable by that other person.

Agenda

1. **Apologies and Substitutions**

2. **Minutes:**

   (a) Health and Wellbeing Board – 13 October 2020
   - To approve the minutes as a correct record –enclosed

   (b) Local Outbreak Engagement Board Sub-Committee – 2020
   1 September, 6 October, 20 October, 16 November, 3 December.

   These are for information to the Board as the parent body. They are published on the Council's Committee Information webpages. The link is here

4. **Declarations of interest**

   [Members attention is drawn to the Memorandum of co-operation and principles of decision making and the table of specified pecuniary interestsset out on the earlier pages of this agenda]

5. **Local Government (Access to Information) Act, 1985 (as amended)**: To agree that the public be excluded from the private session during consideration of the agenda items indicated for the reasons shown on the agenda.

6. **Safeguarding matters**

   a) Annual Adults Safeguarding Board report
   - Report and Foreword by Chair of the Safeguarding Board

   b) Annual Children's Safeguarding Board report
   - Report and Foreword by Chair of the Safeguarding Board

   c) Family Safeguarding Model (for discussion)
   - Report of Director – Children's Social Work

7. **Joint Strategic Needs Assessment – Refresh**
   - Progress report of Director of Public Health

8. **Walsall Plan – Health and Wellbeing Board Priorities 2019/20**

Priority 2– Improving Wellbeing – getting Walsall "on the move".

- Progress report of Chief Executive, Walsall Hospitals NHS Trust

9. **Better Care Fund reporting**
    - Update report on reporting process for 2020/21 and 2021/22

10. **Special Education Needs and Disabilities Local Area Improvement Programme**
    - Progress report of Director of Access and Inclusion, Children's Services

11. **Black Country Child Death Overview Panel**
    - Report of Director of Public Health

12. **Work programme**
    - Copy enclosed

13. **Date of next meeting** – 27 April 2021

https://youtu.be/Yaw7Vv7Q2IQ

Health and Wellbeing Board

Tuesday 10October 2020 at 4.00 p.m.

Virtual meeting via Microsoft Teams

Held in accordance with the Local Authorities and Police and Crime Panels (Coronavirus) (Flexibility of Local Authority and Police and Crime Panel Meetings) (England and Wales) Regulations 2020; and conducted according to the Council's Standing Orders for Remote Meetings and those set out in the Council's Constitution.

Present:
Councillor S. Craddock (Chair)
Dr. A. Rischie, Clinical Commissioning representative (Vice-Chair)
Councillor I. Robertson
Miss K. Allward, Interim Executive Director, Adult Social Care
Ms. S. Rowe, Executive Director Children's Services
Mr. S. Gunther, Director of Public Health
Ms. M. Poonia, Healthwatch Walsall
Chief Supt. A. Parsons, West Midlands Police
Ms. D. Lytton, One Walsall
Mr R. Beeken, Chief Executive, Walsall Healthcare NHS Trust
Ms. M. Foster, Black Country Healthcare NHS Foundation Trust
Ms. F. Shanahan, Housing Sector
Ms. J. Holt, Walsall College

In attendance: Mr. D. Fradgley, Walsall Healthcare NHS Trust

704/20 **Welcome**

At this point, the Chairman opened the meeting by welcoming everyone, and explaining the rules of procedure and legal context in which the meeting was being held. He also directed members of the public viewing the meeting to the papers which could be found on the Council's Committee Management Information system (CMIS) webpage.

705/20**Apologies**

Apologies for non-attendance were submitted on behalf of Councillor T. Wilson and Mr. G. Griffiths-Dale.

706/20**Minutes**

(a) **Health and Wellbeing Board**

Councillor Craddock moved approval of the minutes of the meeting on 23 June 2020 which was put to the vote by way of a roll-call of Board members.

The motion subsequently declared carried and it was:
Resolved

That the minutes of the meeting held on 23 June 2020 copies having been sent to each member of the Board be approved and signed as a correct record.

(b) **Local Outbreak Engagement Board Sub-Committee**

The minutes of the meeting of the Local Outbreak Engagement Sub-Committee on 16 July 2020 were submitted for information:

(see annexed)

Resolved

That the minutes be noted.

707/20At this point in the meeting, Councillor Craddock asked the Director of Public Health, Mr S. Gunther and the Interim Director of Communications, Mr J. Elsegood, to update the Board on the local position with regard to the Covid-19 Pandemic as the situation had moved on since last reported to the Outbreak Engagement Board.

Mr Guntherconfirmed that, as with other areas nationally, Walsall had seen an increase in the number of cases with the rate now being 126 per 100,000 population and that this was largely due to community transmission through households. He commended activity providers, the hospitality sector and local businesses who were, on the whole, doing a good job. With regard to Care Homes, he said that the Council, working with its partners was providing enhanced support to homes and similarly with advice and support for schools and education settings.

Mr Elsegood updated on tiers and alert levels, with Walsall entering level 2 – high alert, because of its positivity rates. He briefly set out the rules around this in terms of local restrictions and advised that this information had been posted on the Council's website.

Councillor Craddock related some instances where there had been breaches in the rules which he said was unacceptable and stressed that the police would intervene and take action against the offenders.

In response to a question around young people gathering in the town centre without appropriate face coverings, Ms J. Holt, Walsall College, advised that whilst student behaviour in the college was excellent, there was some concern about students socialising without complying with restrictions outside college.

Councillor Craddock urged everyone to take care and follow the government guidance.

708/20 **Declarations of interest**

There were no declarations of interest

709/20 **Local Government (Access to Information) Act, 1985**

There were no items to be considered in private session.

710/20 **Walsall Plan Priority 1 – Prevention of Violence**

Chief Superintendent Parsons presented an update on the progress of measures to deliver the actions relating to this priority.

(see annexed)

Ch. Supt. Parsons highlighted the changes since the last meeting. He advised that the lead officer for this priority had moved on due to a promotion and that her replacement was still to be identified however interim arrangements had been put in place in the intervening period to ensure that work on this was maintained.

In presenting the report, Ch. Supt. Parsons cautioned that in reading the data, members need to be cognisant of the impact that the Covid-19 pandemic may have, for example in relation to Domestic Abuse. In this respect, he advised that rates of domestic abuse were higher nationally as well as locally and he was flexing staff to meet that challenge. In response to a question from Councillor Craddock regarding the delay to the establishment of the domestic abuse strategic group, Ch. Supt Parsons explained that due to the increased rates, this had been moved to a different workstream.

Ms. J. Holt, Walsall College, commented on the work of the Violence Reduction Unit and commended the engagement with the college which had had a marked impact on the young people, in particular, with the support and training provided to staff to support students with mental health needs. The Board noted that the work of the unit with the college on knife crime had also been successful and that the college was working with the Black Country Women's Aid to press awareness of Domestic Abuse and encourage students to come forward to enable them to receive the support they need. Ms. Shanahan, Housing Sector representative, also advised that she was involved in a strategic partnership meeting looking at ways of working together on domestic abuse matters.

Councillor Craddock thanked Ch. Supt. Parsons for his report.

711/20 **Walsall Together update on progress and engagement**

Mr D. Fradgley, Walsall Together lead, presented a report which provided an update on the development of Walsall Together:

(see annexed)

In presenting the report, Mr Fradgley highlighted the significant effort during the current Covid-19 pandemic to support care homes, the intermediate care system and the provision of a stroke rehabilitation system at short notice. He also gave feedback from the recent Care Quality Commission review which had recognised that joint working relationships in Walsall were mature and effective and that decisions were taken quickly which had resulted in strong PPE managementand had enabled care to be directed and provided to the vulnerable first. In addition, the review found that Walsall Together was recognised as established and would be reported nationally; no evidence of barriers had been found; planning of patient's care needs had been impressive; and there had been excellent communication systems during this challenging time.

Councillor Craddock said that he was overwhelmed by the positive feedback from the CQC and added that the review had identified that only Walsall had arrangements in place under s.75 of the Care Act and that other authorities were looking to replicate this model.

In response to a question from Councillor Craddock on the success or otherwise of the transformation regarding the implementation of the new patient records arrangements, Mr R. Beeken, Chief Executive NHS Foundation Trust, said that considered the implementation of the patient administration model involving the transfer of millions of items of data without a major hitch had been the best technical transformation and implementation of a new system in his career. He said that whilst the functionality of the system was being fully utilised yet, work was ongoing to progress this.

Other comments made during the discussion included:

Provision of Hollybank House Stroke Rehabilitation Unit – it was suggested that members of the board should have sight of the outcome of the audit of success referred to in the report.

Social Prescribing – It was noted that Walsall Housing Group, the Primary Care Network, Making Connections Walsall, and others, were all social prescribing bodies and work was being done to bring those models together to understand where there may be some congestion in accessing the services. Volunteering through One Walsall's portal had been good.

Support to the vulnerable – Walsall Housing Group had secured £100,000 from Barclays bank to provide support bags to customers and these would be given as "kindness bags" to those who were particularly vulnerable.

The Chairman thanked Mr Fradgley and Ms. Allward, Interim Executive Director Adult Social Care, for their work on this. Mr Fradgley took the thanks on behalf of all the teams involved.

At this point, Mr R Beeken left the meeting. Ms M Foster, Black Country Healthcare NHS Trust attended.

712/20 **Future Commissioning in the Black Country and West Birmingham**

The Vice-Chair, Dr A. Rischie gave a presentation which formally advised the Board on the merger of the four local NHS Clinical Commissioning Groups (CCGs) i.e. Walsall, Dudley, Sandwell & West Birmingham and Wolverhampton in order to bring a single commissioning vehicle to the region.

(see presentation annexed)

In presenting the new arrangements, Dr. Rischie pointed out that notwithstanding this merger, there would still be five designated local place-based leads. He confirmed that the current managing Director of Walsall CCG, Mr G. Griffiths-Dale, also a member Walsall's Health and Wellbeing Board, would be Walsall's place based lead. Dr Rischie emphasised that these new regional arrangements were not to realign services but related solely to commissioning of services.

In response to questions, Dr. Rischie explained that in terms of decision making, the new arrangements would provide a better bargaining influence with major stakeholders and would enable more resilience working together for a better commissioning model. He added that the new regional CCG would be held to account through the assurance framework required by NHS England. With regard to the patient voice, he said that patient groups had been involved in the design and that each local place lead would continue to work with patient groups and local Healthwatch about any local changes which affect local services.

The Interim Executive Director, Adult Social Care, Mrs K. Allward said that as a social care commissioner she supported this move for people of Walsall which would on the whole be good however, she sought assurance that decisions for local people in relation to place based services would remain "at place"; and that there would still be opportunities for the local place to influence decisions taken at a regional level. Dr. Rischie confirmed that this

would be via the local clinicians connection and by participating attendance from local partnerships. He also confirmed that the new constitution for decision making was being prepared and that the draft would be circulated to stakeholders before final approval.

Dr Rischie recognised that the presentation was late to the Board and that the deadline for comments had passed however, comments about governance could continue to be made via the address identified on the presentation and would be fed into ongoing dialogue.

Councillor Craddock thanked Dr. Rischie for the presentation.

713/20**Work programme**

The work programme was submitted:

(see annexed)

Mr Gunther gave brief feedback from the recent Board development session which had focussed on the work of the Board, its priorities and the potential to link priorities across partner organisations.

Ms. Allward commented that it was important to note that the needs of the population in Walsall had changed significantly during the current pandemic and some things we already knew about the population had come more starkly into view, particularly in relation to health inequalities. She considered that the Health and Wellbeing Board was well placed to ensure that there was a collective system response to this.

Resolved(by assent)

That the work programme be noted.

The meeting terminated at 5.30 p.m.

Chair:

Date:

Walsall Safeguarding Adult Board

and

Walsall Safeguarding Partnership

Annual Report 2019 – 2020

Contents

Foreword by the Independent Chair

Thank you for taking the time to read Walsall Safeguarding Partnership Annual Report which covers the period 1st April 2019 to 31st March 2020.

The report is published by Walsall Council, West Midlands Police and Black Country and West Birmingham Clinical Commissioning Group. Local arrangements to support the co-ordination, quality assurance and continuous improvement of activity to safeguard individuals across the life course were introduced during the period covered by this report; these arrangements incorporate the statutory functions of the Safeguarding Adult Board.

In this report, partners provide an overview of work completed to progress locally agreed priorities supported by their analysis of the impact of this work.

Data shows that the volume of safeguarding concerns reported to the Local Authority has remained consistent compared to the last couple of years and there has been a small increase in the number of Section 42 enquiries completed. In terms of categories of abuse that adults are at risk from, the top 3 were neglect (30%), physical abuse (19%) and psychological abuse (14%). 89.3% of the adults involved in Section 42 enquiries were asked about their desired outcomes at the outset of the safeguarding process, this is a slight decrease from the 2018-19 outturn of 90.8%. The percentage of adults who expressed their desired outcomes has steadily increased across the last three years and 95.3% of adults considered their desired outcomes were fully achieved and/or partially achieved in 2019-20. Making Safeguarding Personal reflects the ambition of the Safeguarding Partners that adults with care and support needs become the 4th partner in the local arrangements.

Self-neglect is a local priority, and the year began with a conference that launched a Self-Neglect Pathway. The pathway provides a framework for partners to work together to support adults whose needs fall below the Statutory Safeguarding Framework. The conference, and work to respond to self-neglect, has been informed by the voice and experience of adults including Lily's Story which can be found on YouTube.

Improving the quality of care provided to adults with care and support needs is an area of work that partners have prioritised during 2019-20. The Local Authority launched a Quality in Care Team in November 2019; the remit of this team is to improve the quality of care in all commissioned services for the benefit of Walsall Service Users by working with all relevant stakeholders and partners to provide an integrated quality improvement, monitoring and compliance service. A Quality Improvement, Monitoring and Compliance Framework has been developed and implemented; this means that concerns can be promptly identified using a range of data and plans are promptly put in place to improve the quality of services. In addition, the Clinical Commissioning Group (CCG) has conducted planned and unplanned assurance visits to care providers and provided support to care providers during the year. The Local Authority, Clinical Commissioning Group and other partners worked well together to share information and co-ordinate support to care providers as the country went into national lockdown in March 2020 due to the global pandemic.

Tackling exploitation and supporting children to transition to adult services are other priority areas of business. Whilst work has been carried out in these areas, this report identifies that the pace and impact of this work needs to be intensified. To assist, the Safeguarding Partners commissioned West Midlands Employers to facilitate a development programme aimed at supporting partners to develop an all-age response to exploitation. This programme commenced in March 2020 and the outputs will be taken forward in 2020-21.

Another area of work that the partners have identified that needs further development is co-ordination of work to seek and use the voice of adults with care and support needs to inform service development and quality assurance activity.

In terms of Safeguarding Adult Reviews, the report provides an overview of the work completed and provides some examples of how learning has been acted on. The ongoing development of an adult safeguarding learning and development offer will create further opportunities to disseminate learning from serious incidents to front line staff.

Like other areas, Walsall has identified the need for a consistent approach to completing/recording mental capacity assessments. Learning has also been identified in relation to the completion of 'caused enquiries' as well as the need for a multi-disciplinary team approach to providing support to individuals with care and support needs. Walsall Together creates the opportunity for practitioners to work together in a more joined up way and the first few weeks of the pandemic illustrated the contribution that the local community has to make to supporting adults to live safely in the borough; both of these are assets that can make a significant contribution to future safeguarding activity and outcomes.

The report concludes with an evaluation of:

- how safe adults are in Walsall,
- the strength of partnership working and
- the extent to which the partnership is operating as a learning system.

This is an open and transparent evaluation and appropriately identifies the progress made as well as the ongoing areas of development in relation to either practice/service development or the Partnership's delivery of its statutory functions. A review of the new Partnership Arrangements is planned for 2020-21 and this will provide the opportunity to evaluate if any developments are needed.

I will close by recognising the work of the committed professionals who either, work directly with adults with care and support needs and their families/carers, or who have a specialist role in safeguarding in partner agencies; thank you for the work you have done and continue to do to safeguard adults in Walsall and for your swift and creative response to the safeguarding challenges brought by the pandemic.

Liz Murphy

Independent Chair

Walsall Safeguarding Partnership

1. Introduction

This report covers safeguarding adult activity in Walsall for 1st April 2019 – 31st March 20. The strategic governance arrangements for this year took two separate forms. For the first part of the year, the Walsall Safeguarding Adults Board (WSAB) was in place as the statutory body with responsibility for quality assuring local practice. Following the publication of Working Together 2018, partner agencies began to develop plans to establish Multi-Agency Safeguarding Arrangements and published their plans on 1st September 2019, launching the new Walsall Safeguarding Partnership which incorporates the statutory functions of the SAB. Further information on the detail of these arrangements can be found here.

During 2019-2020 the Board/Partnership met quarterly and covered a wide range of business including progress reports from subgroups on work plans and WSAB/WSP priorities and assurance reporting. Statutory responsibility of the Board/Partnership sits with Walsall Council, West Midlands Police and Walsall Clinical Commissioning Group who fund the Board between them with contributions from Walsall Healthcare Trust and Probation Services. There are also a range of other partners engaged in adult safeguarding who attend the Board/Partnership meetings. Appendix 2 provides further information.

The statutory functions of the Safeguarding Adults Board (SAB) are:

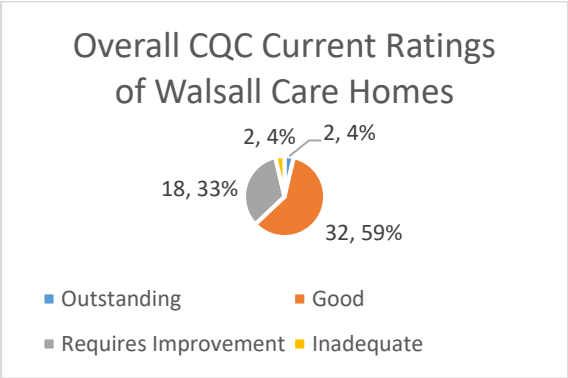
- To publish a Strategic Plan
- To publish an Annual Report detailing what the SAB has done to achieve its objectives and implement its plans
- To conduct Safeguarding Adult Reviews (SARs) in accordance with Section 44 of the Care Act

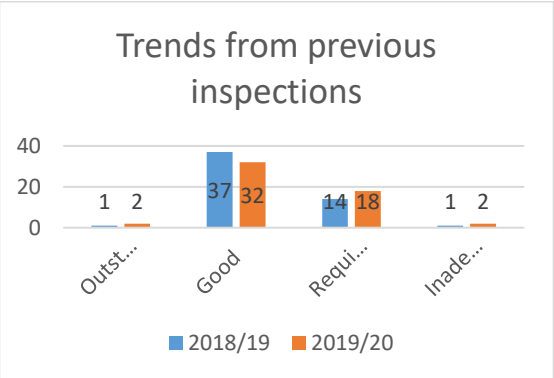
This report seeks to outline how partners in Walsall have delivered these functions.

2. Local Context (infographics page)

- 215,300 adults live in Walsall.
- 110,800 female (51.5 %), 104,500 male (48.5%).
- 50,159 are aged 65 years and over.
- Over 65 year olds live largely in the East Locality in the least deprived areas of Walsall.
- Walsall has a diverse population. The number of non-UK born residents in Walsall increased by 3.7% (or 9,900 people) between the 2001 and 2011 censuses.
- Walsall's older population (> 65) is expected to increase by 12.4% by 2024 (from the 2011 census).
- 2011 census on ethnicity data shows that Walsall has a higher percentage of BAME per population overall than England (14.6% BAME), Walsall CCG has 21.1% BAME.
- The 2015 Index of Multiple Deprivation now ranks Walsall as the 33rd most deprived English local authority (out of 326).
- As the UK population gets older, an increasing number of workers are providing care towards the end of their working life for family members. One in four older female workers, and one in eight older male workers, have caring responsibilities.
- Walsall suicide rates per 100,000 increased from 8.2 in 2016-18 to 9.0 in 2017-19, which is better than the England average of 10.1. Walsall ranks 3rd in comparisons to our statistical neighbours which range between 8.0 and 14.6.
- The percentage of adults with long term mental health issues (age 16yrs+) has increased at 2019 to 10.2% from 2018 8.7% and is above West Midlands England average.
- The rate per 100,000 population for alcohol-related harm hospital admissions is 688. This represents 1,814 admissions per year.

- The rate per 100,000 for self-harm hospital admissions is 182. This represents 520 admissions per year.
- The rate per 100,000 of statutory homelessness is better than the England average.
- The rates per 100,000 of under 75 mortality rate from cardiovascular diseases, under 75 mortality rate from cancer and employment (aged 16-64) are worse than the England average.
- There are currently 58 care home providers in the Walsall borough. Overall CQC ratings reflect 2 x Outstanding, 32 x Good, 17 x Require Improvement, 2 x Inadequate and 5 are awaiting an inspection.



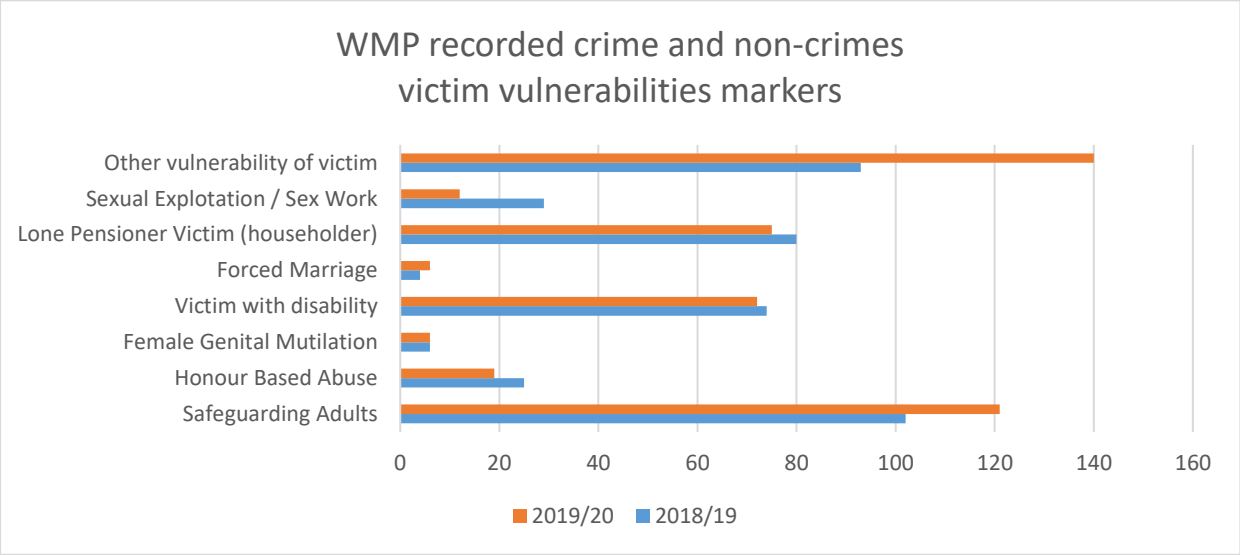


- Trends in the CQC ratings from previous inspections show that 22% of providers have improved, 16% have declined and 38% have sustained their previous rating.
- The remaining 24% of providers are awaiting an inspection. From November 2019 to March 2020 a total of 57 concerns were received by the Quality in Care Team, 44 of these were during Q4 period and the primary reason for concern was delay in care or treatment and secondly supervision as concern themes.
- Occupancy rates of Care Homes as at February 2020 show an average of 87.2%, with LD and Mental Health settings having highest rates.

3. Performance and Effectiveness of Local Safeguarding Services

- Safeguarding concerns throughout 2019/20 remain steady, there was a slight overall decrease in the number of safeguarding concerns notified to the Local Authority from 2,342 (2018-19) to 2,311 (2019/20).
- This related to 1,670 individuals (1693 in 2018-2019).
- Of the 2,311 concerns received, the top 3 types of risk were neglect (30%), physical abuse (19%) and psychological abuse (14%). (NB Financial abuse is 4th at 13%).
- Of the 2,311 concerns received during 2019/20, 27.48% (635) progressed to a S42 enquiry, an increase of 3.44% compared to the previous year.
- Source of risk: 58% of cases were someone known to the adult; 37% related to service providers.
- Where a risk was identified, it was reduced or removed in 89.8% of cases. Compared with 88.5% on the previous year.
- Concerns relating to Self-Neglect have decreased to 3% in 2019-20 from 4% in 2018-19.
- During the year, West Midlands Fire Service (WMFS) responded to 62 incidents which it considered 'significant or serious', which was more than double the 25 reported last year. These involved 47 with serious injury and 15 were fatal (across the whole region).
- With regard to these incidents, 54% of the individuals lived alone and 54% were over the age of 65, showing a decrease from last year (73.9% in 2018-2019), however data shows a continuing trend for the age group 65-80 year olds who had the highest number during the year.
- Smoking (14) and cooking (10) remain the highest proportion of the suspected causes of fire.

- 34% of individuals were in receipt of care packages and 44% were known to Social Care or mental health services, both showing reductions from last year.
- West Midlands Fire Service undertook 3,775 Safe and Well checks in Walsall in 2019-20, compared to 4,041 last year.
- WMFS had 116 cases of self-neglect (including hoarding) reported where advice and guidance was given
  Of those:
  - 27 instances of dangerous and excessive storage - blocked exits etc.
  - 24 cases of dangerous and excessive storage
  - 7 cases of severe hoarding
  - 58 cases where there was no evidence of disorganised living
- The below graph represents recorded crime by West Midlands Police – across the force (including non-crime incidents) where a special interest marker was added in relation to a victim vulnerability. More than one marker can be added for each crime. Some of these recorded offences may also include child victims as well as adults, but for the majority these all involved adults as victims. The exception is FGM where all recording incidents involved children deemed to be at risk (source – WMP crimes portal system searches).



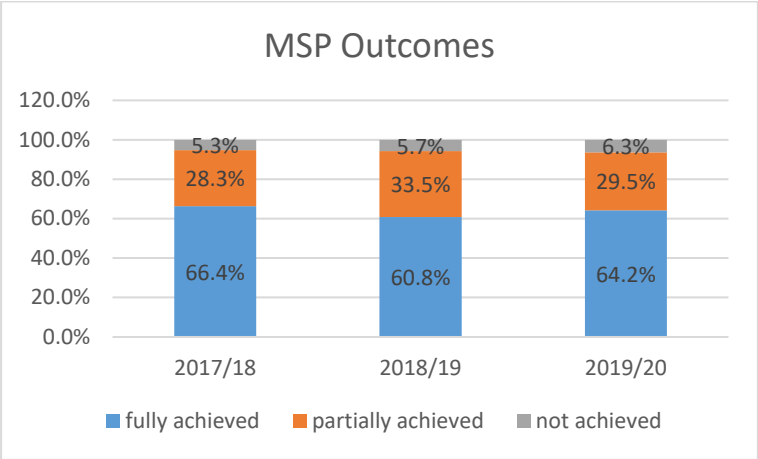
Making Safeguarding Personal[1] (MSP)

- 89.3% of the adults involved in S42 enquiries during 2019/20 were asked about their desired outcomes at the start of the process, a slight fall from the 90.8% of adults in 2018/19.
- Positively, the percentage of adults who expressed their desired outcomes has increased across the last three years.

2017/18	2018/19	2019/20
65.40%	81.5%	89.3%

- In 2019/20 Adults who considered their desired outcomes were *fully* achieved and/or *partially* achieved was 93.7% (531 adults). It should be noted that there are occasions when an adults outcomes cannot be achieved for safety reasons or are unrealistic (e.g. police prosecution or staff dismissal), therefore there will always be a small proportion of outcomes which cannot be realised.

[1] **Making Safeguarding Personal**. A personalised approach that enables **safeguarding** to be done with, not to, people. Practice that focuses on achieving meaningful improvement to people's circumstances rather than just on 'investigation' and 'conclusion'.
'all 2019/20 figures should be regarded as provisional subject to validation by NHS Digital'.



- Our multi-agency audits tell us that there is some good practice in relation to embedding a Making Safeguarding Personal approach, however there are inconsistencies of undertaking and clearly recording mental capacity assessments to ensure there is defensible decision making for adults who may lack capacity.

Deprivation of Liberty Safeguards (DoLS)

- In 2019/20 the Local Authority received 1,117 DoLS applications, of which 62.1% were completed by year end, compared with 854 DoLS applications received in 2018/19, of which 56.2% were completed by year end.
- Of the 1,117 applications received in 2019/20, 24.1% were granted and 38.0% were not granted; this compares to 10% granted and 46.4% not granted in 2018/19.
- All cases are prioritised and 'RAG' rated depending on urgency.
- There were 423 (in year) applications still outstanding at end March 2020, 477 in total.

	2018/19	2019/20
DoLS applications received in year *	**854**	**1,117**
Of which Granted	83	269
Of which Not Granted	397	425
Assessment criteria failed	12	9
Change of circumstances	282	294
Deceased	97	120
Withdrawn	6	2
Of which incomplete	374	423
% of DoLS received during year completed by year end	56.26%	62.13%

4. Progress against our 2019 – 2020 Priorities

Our Priorities

Priority 1: To support the local and professional community to respond to **Self-Neglect** in a person centred way.

Intention:

- To raise awareness of self-neglect in the local and professional community
- To develop and implement a Self-Neglect Pathway for professionals
- To establish a panel where self-neglect cases can be discussed on a multi-agency basis

Implementation:

- The Partnership held a Self-Neglect conference looking at the challenges for safeguarding adults when self-neglect is identified and to give practitioners the understanding and practice tools they need to be able to effectively manage the issues arising in their day-to-day role. The conference was attended by 100 professionals across the morning and afternoon sessions.
- WSP worked in partnership with LouDeemY Theatre Company and Walsall College following the conference to produce a video on self-neglect - 'Lily' - which is shared on YouTube and used in training sessions.
- As part of the Self-Neglect pathway a Multi-Agency Panel (commenced during 2018-2019) meets monthly. It provides an opportunity for collaborative working and aims to prevent the need to progress into the formal safeguarding processes.
- In addition to the Self-Neglect and Hoarding Panel, the Vulnerability Forum is in place and is attended by multiple agencies to discuss adults where anti-social behaviour is a feature and explore support options.
- A practice reflection workshop was delivered in November to embed learning through case studies and to raise awareness of, and application of, the pathway.
- ASC have held staff briefings, to provide operational, strategic and learning updates to staff on the Self-Neglect Pathway.
- A self-neglect awareness raising advert was featured in Walsall's Health and Community Guide in November 2019. 40,000 copies of the guide were distributed to GP surgeries, health centres and clinics

- To further increase the visibility of the issues of self-neglect, the website was refreshed with a specific page on Self-Neglect for professionals and one for adults and carers in Walsall.
- Quarterly Partnership newsletters continued to raise the profile of self-neglect, safeguarding adults; disseminate key messages from audits and provide updates and news for safeguarding partners.
- Self-neglect has been included in the Walsall Healthcare Trust's Safeguarding Level 3 training for 2019/20 with reference to the self-neglect pathway.
- A multi-agency audit in quarter 3 considered early vulnerability for patients with repeated admissions to hospital or who were not attending appointments to access the treatment they needed. The aim was to ascertain if there were any opportunities to intervene earlier and whether there was a need for a referral for safeguarding or additional support by single agencies. Key findings included:

    - Two cases were person-centred with application of the Mental Capacity Act 2005 clearly documented. There was a focus on enablement and promoting independence.
    - However there were inconsistencies (3/5 cases) of undertaking and clearly recording mental capacity assessments to ensure there is defensible decision making for adults who may lack capacity.
    - There is a clear need for a multi-disciplinary team meeting for individuals with complex health issues.
    - Agencies need to ensure they are having conversations with family with regard to care and treatment decisions and before raising a safeguarding concern in-line with Making Safeguarding Personal.

Impact:

- 7 cases were presented to the self-neglect panel during the year and multi-agency support was provided to practitioners who are working with individuals that are self-neglecting, this support was provided to prevent escalation to S42 or a safeguarding process.
- Training evaluations from the WSP self-neglect workshops highlighted an improved awareness and confidence in practitioners identifying and supporting individuals that may be self-neglecting.

"Having a refresher in this subject has been of great benefit for me, to put it back in the forefront of my mind, especially around a specific case I am currently working with."

"Workshop has given me more awareness and confidence with identifying self-neglect to ensure the right support is offered to that person and the right time."

- Training evaluations from WHT training highlighted an increased knowledge of self-neglect within the Trust.
- Developing a multi-agency dataset available for self-neglect prior to S42 concerns is an area of development.

Case Study

G is a female, older adult, who lives in a housing association property with her son, B. G has care and support needs as a consequence of physical impairments and comorbidities, and receives a personal budget from Walsall Council which is used to fund daily domiciliary support. Concerns were raised in relation to G and B self-neglecting. It is reported that G and B consume significant amounts of alcohol, which has led to concerns regarding conditions within the property. There have also been a number of small house fires.

Progress has been made by partner agencies building trusting relationships and working collaboratively with G and B at their own pace. They are both able to make independent decisions and wish to remain living together.

A Section 27 review has been completed, to ensure that G is only supported by a small number of staff, to build trusting relationships and to ensure ongoing situation monitoring.

The allocated lead professional attended the self-neglect panel, which led to referrals to community mental health for B for additional support.

Although concerns still remain, practice to date has adhered to all safeguarding principles, notably prevention, proportionality and empowerment. This has led to a reduction in the severity of concerns, and thorough MSP compliance, as reported by G and B themselves.

At the time the outcomes the individuals wanted were '*to retain their relationship but not necessarily to remain living together. Both wanted the other to be safe and to be able to live with minimal professional intrusion'.*

Priority 2: Improving the standard of care to Service Users by quality assuring safeguarding practice **in Care Homes and by Care Providers**.

Intention:

- Developing a Quality in Care dashboard to support an evidence based approach to risk stratification, quality improvement activities, and support quality improvement.
- Increase capacity in the quality monitoring of commissioned services.
- Improve the standards of care within Walsall Care Homes.
- Oversight and scrutiny via the Quality in Care Board.
- Maintaining quality and safety in care as well as continuing to improve care.

Implementation:

- CCG have undertaken planned and unplanned assurance visits during the year.
- CCG Safeguarding and Quality Team have continued to offer and provide support to care homes during year.
- The Quality in Care Team (QiCT), an integrated Health and Social Team, was formed in November 2019 as part of a six month pilot of quality improvement initiative.
- QiCT work closely with the CCG Quality and Patient Safety Manager and CCG Designated Nurse for Adult Safeguarding.
- The Quality Team began playing an integral role in Walsall's response to supporting care homes as the pandemic began. Supporting homes by delivering urgent PPE, medication and food supplies.

- QiCT designed a local capacity tracker encompassing all the data and intelligence Walsall system partners required.
- The Local Capacity Tracker is integral in identifying homes level of need. All system partners are benefitting from the use of the tracker.
- The QiCT is undertaking daily calls with care homes to give assurance to system partners acting as an early warning system of any problems.
- Prior to Covid-19 restrictions, all Older Peoples' Residential Homes have had a quality audit visit from the Team and improvement plans put in place where concerns have been identified.
- Improvement plans have been analysed for recurrent themes. This has resulted in targeted training and support to improve quality of care and reductions in avoidable harm.
- A Quality Improvement, Monitoring and Compliance Framework has been developed and implemented.
- In line with the Quality Improvement, Monitoring and Compliance Framework all residential homes have been RAG rated for level of support required, 8 required weekly visits from the team, 7 required fortnightly visits, and nine required monthly visits.
- All 58 homes are engaged with the QiCT through the daily tracker calls (this figure encompasses Older Peoples Residential and Nursing Homes, Learning Disability and Mental Health Homes).
- Revision of the monitoring toolkit and reporting form, along with streamlining the self-assessment process commenced in year.
- HealthWatch carried out 11 'Enter and View' visits to social care settings during the year. A number of recommendations were reported to the Walsall Health and Wellbeing Board in relation to improving care, particularly
    - Monitoring health and safety checks/issues
    - Replace tired décor/furniture
    - Carers to have caring roles only rather than multiple roles
    - Secure regular dentist and GP visits for residents
    - Residents having the opportunity to go out more often

  There was a plan to visit an additional 2 homes by the end of March 2020 but due to the COVID-19 outbreak all 'Enter and View' activity was suspended.
- During the year 26 staff from care homes/providers attended WSP training on Section 42: Caused Enquiry, DoLS & MCA Awareness, the Self-Neglect Conference and a Financial Abuse Practice Reflection Session.
- The Local Authority DoLS Lead presented an update on DoLS and LPS at the provider forum to ensure that both providers and residential and nursing homes are kept updated of the developments in this area.
- Walsall Healthcare Trust reinforced the role and responsibilities of staff to escalate concerns regarding quality of care. This encouraged staff to submit safeguarding concerns as necessary if they have any concerns around care provision.
- A multi-agency audit in quarter 2 considered the safeguarding practice in Domiciliary Care and found some good practice in relation to embedding a Making Safeguarding Personal approach and the Mental Capacity Act. However there were some inconsistencies in the use of, and delays in the timeliness of, the completion of Caused Enquiries.

Impact:

- All Older People's Residential Homes now have Improvement Plans in place and are receiving support in line with their categorisation as outlined in the Quality Improvement, Monitoring and Compliance Framework.
- QiCT have introduced frailty scores within homes. The homes are now aware of which residents are moderately frail and severely frail. The impact for the resident is that their health needs are recognised through screening, to enable care planning by care professionals to manage long-term conditions and avoid inappropriate hospital admission.
- The findings from the Quarter 2 audit led to a recommendation on improving the use of the Caused Enquiry Template with clear terms of reference and timescales and the paperwork for Caused Enquiry was therefore amended and circulated to partners. This also ensures partners/agencies are embedding MSP and identify adult's outcomes.

Case Study

The Quality Team at Walsall CCG received a request to assist Adult Social Care with 3 safeguarding concerns received from health services (WMAS and 111). The safeguarding concerns were in relation to events 2 days prior regarding a resident in a nursing home with a significant hypoglycaemia (low blood glucose sugar), which led to two subsequent calls of escalation for assistance to the paramedic crew. There were underlying clinical elements to the case in relation to the effective clinical monitoring and management of the patient, and the Adult Social Care Access Team wished to consult health colleagues regarding the impact of the concerns raised.

An assurance visit was undertaken by the CCG Clinical Quality and Patient Facilitator involving discussion with the manager, staff and a review of the records of the resident in question as well as two further insulin dependent diabetic residents. There was an open and transparent review and evidence of prompt multidisciplinary input. Assurance was gained and where learning was identified regarding the monitoring and management of the resident, the home responded immediately to the recommendations made as well as commencing a comprehensive review.

Feedback was provided to all parties regarding the findings and processes put in place. The Quality Team at the CCG and the Local Authority Quality in Care Team continue to work collaboratively with the home and training has been scheduled for staff in early recognition and escalation of deterioration, using the background of the case as a scenario to support learning.

Priority 3: To gain assurance regarding **transition arrangements** for agreed vulnerable groups between children and adult services.

Intention:

- To have effective transition between services provided to children and those working with adults (e.g. disabilities teams, Mental Health).
- Embed our approach to 'Think Family / A Whole Family Approach', including further developing our multi-agency training to reflect this priority.
- Embed in practice the Exploitation Transition Protocol.

- Delivery of multi-agency Exploitation Training (including transition planning).

Implementation:

- The Youth Offending Service 'T2A' (Transition to Adulthood) transition process was reviewed across the Black Country cluster in June 2019. The 'T2A' process ensures that young people are identified at the earliest and most appropriate opportunity to transition them from Youth Justice Services to Adult Services.
- The Local Authority Learning Disabilities and Transition Team have a dedicated Lead Adult Practitioner for Transition offering consistency in approach and leading on the operational Transition Meetings with stakeholders.
- Direct work and joint reviews take place within Adult Social Care before the children's worker ceases their involvement, to support a smooth transition for the young adult and identify any issues at an early point.
- The Dudley and Walsall Mental Health Trust revised their "Joint Working Protocol" to encompass the learning from multi-agency reviews for adults and children. This protocol aims to ensure good co-ordination and communication between Adult Mental Health and Children Mental Health Services.
- Walsall Healthcare Trust continue to hold initial discussions regarding care and transition of children with a learning disability and Acute Learning Disability Liaison Nurses attend the transition meetings.
- The Black Country Partnership Foundation Trust recruited a Specialist Safeguarding Practitioner, to support the Safeguarding agenda across both the Adult and Children's teams which has further underpinned the application of a 'Think Family' approach.
- WSP completed a practitioner survey in October across Adults and Children's agencies to quality assure safeguarding practice and assess the 'Think Family Approach' and 384 practitioners took part to give their views.
- Street Teams continue to run a project to support and enable vulnerable young people approaching/experiencing transition into adulthood who have experienced Child Sexual Exploitation (CSE) and are at risk of abuse to understand the risks that they face and how to make changes to improve their lives.
- WSP held 2 Practice Reflection Workshops on Transition and Special Educational Needs and Disability Transition across adults and children's agencies. These were attended by Adult Social Care, West Midlands Fire Service, Children's Services, Walsall Community Health, Police, One Walsall, Walsall Housing Group, Schools, The Beacon, Dudley and Walsall Mental Health Trust, Early Help Localities, Troubled Families, Department of Work and Pensions, Walsall College and Occupational Therapy staff.
- A Think Family Conference was held with 198 participants across two half day events. The aim was to promote a joined up approach across services, supporting practitioners to think about all the needs of all individuals within a family or household.
- WHT's Learning Disabilities Team deliver Level 3 training with a focus on Transition from children's to adult's services and the impact on the individual and the parents.
- A 7 minute briefing on 'Think Family' was developed and shared with the partnership.
- Adult Social Care provided training to children's services with regard to developing awareness and knowledge on DoLs (Deprivation of Liberty Safeguards) ahead of the expected changes that the implementation of Liberty Protection Safeguards will bring.

- 5 Adult Social Care mandatory staff briefings have been held between November 2019 and January 2020, to provide operational, strategic and learning updates to staff regarding safeguarding. This included the Exploitation Transition Guidance.

Impact:

- Over 2019/20 Street Teams have provide support to 18 individuals in transition.
- Feedback from the practice reflection workshops evidenced that attendees felt more confident when discussing cases and due to improved knowledge they can advocate for children and families during the transition process.
    - *"Now I have an increased knowledge base, I am able to ensure there is a smooth transition for children into adulthood by looking at this earlier and knowing what services are available to support."*

- 84.7% of practitioners who attended the Think Family Conference said they now think about all members in the family rather than just the individual they are working with.
- There has been little evidence of progress in embedding the Exploitation Transition Protocol.
- Not all respondents to the practitioner survey knew how to refer to MASH, Early Help and Adult Social Care which suggests there is more work to do to embed a 'Think Family' approach
- A multi-agency audit measuring the effectiveness of safeguarding practice in relation to transitions arrangements for agreed vulnerable children and adults is yet to take place.

Still to do in 2020-2021

- Develop the All-Age Disability Model, which will enable the Adults Learning Disabilities and Transition Team to be co-located with the Children with Disabilities Team and Special Educational Needs Team. This will enable there to be improved joint working, networking and sharing of information for those at risk of harm.
- Embed the Exploitation Transition Protocol.
- Gain more assurance that agencies are embedding a think family approach in practice through audit activity.

Case study

A is a young person living in Walsall. A has a number of comorbidities including learning difficulties, Autism, ADHD, Epilepsy and Encephalopathy, A attended a state funded Special School throughout childhood and has been under a number of health services through their life. Following a number of safeguarding concerns, A became subject to a Child Protection Plan in 2008 and again in 2009. A became a Looked after Child in 2013 and remained under the care of the local authority until their 18th Birthday, whereby A transitioned to Local Authority Adult Services.

During the time A was a Looked after Child, they continued to access secondary health care services for their health care needs and received annual Looked after Children Health Assessments.

Due to A having a significant learning disability and being non–verbal, the Looked after Children's nursing team liaised with the special school A attended to ensure they remained at the centre of the care they received, this was made possible by working in partnership with education and A to produce a pictorial health assessment.

For continuity, the Looked after Children Nurse ensured A remained on their caseload. This enabled the therapeutic relationship to be maintained. The nurse attended Looked after Children's reviews with the Local Authority and supported the foster carer to support A's transition to adult services. Both Social Care and Adult Health Services were well planned to ensure that no delay occurred for A. The pictorial health assessment was shared to support A, while under the care of secondary adult services for ENT, Clinical Physiology and Orthopaedics. A received a health history document, elements of which are pictorial to enable A to understand their healthcare needs as they move into adult services.

Priority 4: To tackle exploitation and supporting those children and adults who are victims of exploitation and/or go **Missing**.

Intention:

- Develop strategic and operational links between adults and children's services in relation to exploitation.
- Develop an all age exploitation strategy.
- Embed in practice the Exploitation Transition Protocol.
- Delivery of multi-agency Exploitation Training.
- Implementation of an all-age Exploitation Hub.

Implementation:

- An Exploitation Practice Development Workshop to raise awareness about the exploitation of adults and sharing of a national SAR was held.
- ASC have held staff briefings, to provide operational, strategic and learning updates to staff regarding the Exploitation Transition Protocol.
- CCG hosted a multi-agency Modern Day Slavery Conference in November 2019 to raise awareness of adult exploitation.
- The Exploitation Subgroup is developing a data scorecard to better understand the local trends and picture of exploitation.
- 430 crimes of exploitation were recorded across the West Midlands, of those there was a total of 19 in Walsall. 10 of these were adults aged 18 years and over, 9 were children. Labour Exploitation makes up 40% of primary exploitation types across West Midlands, with Criminal second at 31%. But in Walsall of the 19 recorded crimes, 53% is found to be criminal and labour exploitation is 11%. However, this is not split into adults and children.
- Walsall has engaged with WMEmployers and the Game Changer Partnership to facilitate a 3 day 'Impactful Partnership Programme'. The focus of this being Exploitation, with an opportunity to reflect on how the partnership works together to deliver on this agenda.
- In relation to S42 enquires there were 6 for Sexual Exploitation and 2 for Modern Slavery.
- 5 ASC mandatory staff briefings have been held between November 2019 and January 2020, to provide operational, strategic and learning updates to staff regarding safeguarding. This included sharing the Exploitation Transition Guidance.
- During 2019/20 scoping of an All-Age Exploitation Pathway has been completed.
- Procurement during 2019/20 commenced for bespoke exploitation training, with a focus on trauma informed practice, for ASC practitioners.

Impact:

- There has been little evidence of progress in embedding the Exploitation Transition Protocol.
- An All-Age Exploitation Strategy and Pathway is yet to be developed across adult's and children's services.

Still to do during 2020-2021

- Establish a multi-agency, all-age, Exploitation Hub.
- Launch an Exploitation Screening Tool and Pathway.
- Establish an Exploitation Panel (as part of the Pathway).
- Further develop the data scorecard to include more data about adults that are being exploited.
- Further work to gain the voice of adults who have been exploited is required.
- Further work is required to embed the Herbert Protocol across the Partnership, in particular care providers for adults that go missing.

5. Engagement with our 4th Partner – Children, Young People and Adults

In 2019/20, the Partnership created a Joint Engagement Strategy (2020-2022). This strategy is aimed at all organisations within Walsall whose staff and volunteers provide services to children, young people and adults with care and support needs. The aim of the strategy is to help the partnership achieve the vision of having children, young people and adults as equal partners alongside the Local Authority, Health and Police. The strategy outlines 4 key steps to achieve engagement: consultation, representation, decision-sharing and co-production.

For participation with adults, it was agreed that working with existing groups was a better way to progress participation rather than creating a new group. A mapping activity gathered which groups already existed and could be engaged with in the future. Some of these groups were attended, to understand their remit and what sort of work they do.

Still to do for 2020/2021

- Commence engagement for adults with care and support needs, collecting baseline data and responding to themes that arise for example.
- Seek opportunities to maximise the Partnership's involvement in existing engagement opportunities.
- Invest in resource for Engagement within Safeguarding Partnership, exploring options of either a job role or commissioning a service.

6. Reviews

Safeguarding Adult Reviews

What is a Safeguarding Adult Review (SAR)?

The Care Act 2014 introduced Statutory Safeguarding Adult Reviews, and mandates when they must be arranged and gives Safeguarding Adult Boards flexibility to choose a proportionate methodology.

The overall purpose of a SAR is to promote learning and improve practice, not to re-investigate or apportion blame.

The objectives include establishing:

- Lessons that can be learnt from how professional and their agencies worked together.
- How effective the safeguarding procedures are.
- Learning and good practice issues.
- How to improve local inter-agency practice.
- Service improvement or development needs for one or more service or agency.

Within the period of this annual report the SAB have:

- Completed and published 2 reviews (SAR 3 & SAR 4) (both commenced in the previous year).
- Considered one further referral which did not progress to a SAR.
- Disseminated the lessons learnt from SAR 3 and SAR 4 during an event in January 2020.

Learning from SAR 3 & 4 included:

- Changes in behaviour may indicate a deterioration in a person's mental health and a possible increase in the level of risk, therefore, agencies noticing any changes should be identified shared and monitored, whilst also ensuring this information is used in assessments.
- There should be an inclusive approach to multi-agency working to ensure that all relevant agencies are involved in case planning who can either contribute direct knowledge of the service user's situation and / or who can offer specialist advice and support.
- Where several agencies are involved in providing support to a service user, there should be an explicit agreement at the outset about their respective roles, the focus of their involvement, and triggers for information sharing which reflect the statutory responsibilities of the care co-ordinator through the Care Programme Approach.
- Assessments and care plans should identify the potential to impact on a person's mental well-being, and conversely take account of mental health symptoms or treatment programmes which might affect physical health.
- Information held by agencies should be accessible to crisis responders who attend an individual's home.
- There is a need to increase the ability, and focus, of professionals on identifying indicators of possible fire risks, ensuring their inclusion in risk assessments, and reporting these to the Fire Service to seek their advice and involvement to identify ways of minimising the risks.
- It is essential that agencies have contact information for family members in the event of an emergency, or where the involvement of the family needs to be considered

where a service user lacks capacity to make a decision about their care and treatment and a “best interests” decision process needs to be applied.

- There is a need to consider a multi-agency approach to self-neglect, risk management and communication with people who do not easily engage.
- Clarification should be made to enable a greater understanding regarding when referrals are to be made as a Safeguarding issue and when it is for Care and Welfare issues.
- All relevant agencies need to ensure there are arrangements in place where practitioners could refer concerns about adults who do not engage or are at risk of self-neglect.

Activity/Impact:

Multi-agency engagement in SAR 3 and SAR 4 has enabled effective partnership learning and developments.

For example, further promotion and development of the self-neglect pathway and monthly meeting forum; and development by ASC of internal resources to improve legal literacy in practice (quick reminder guides, MSP tools), in part due to lessons learned from SAR 3.

Adult Safeguarding Workshops have been facilitated and delivered to 70 ASC staff. Workshops covered and embedded practitioner knowledge surrounding key legal duties including the S42 duty, S68 advocacy, S6 and S7 duties of co-operation. The sessions also refreshed practitioner knowledge surrounding signs and indicators of potential abuse/neglect and explored links to MCA and MSP.

Advanced practitioners from adult social care now attend weekly Multi-Disciplinary Team Meetings with Commissioner Requested Services Teams; and a Complex Case Forum (fortnightly) enables better case discussions and planning of service provision which improves communication and co-ordination of services.

Risk Assessment Tools were identified in SAR4 by ASC as requiring review. This progressed into the development of a new Risk Enablement Approach and Supportive Tool Kit. Which was develop and introduced in November 2019, has been built into the ASC client record system and one day training sessions have been delivered to staff to support the approach from October 2019. The impact of this will be reviewed and reported in 2020/21.

A Self-Neglect Partnership Event was delivered to front line staff by Adult Social Care (ASC) and Dudley and Walsall Mental Health Trust to share findings from Safeguarding Adult Review (SAR 3) and also to highlight and promote the Self-Neglect Pathway.

As a direct result of SAR3 and regional and national learning, WMFS launched its Fire Safety Guidance eLearning package in the autumn of 2019. The launch was centred around Continuous Professional Development events relating to serious and fatal fires and were held across the West Midlands. The Walsall events were attended by almost 70 professionals. There was an increase in referrals to WMFS following the training.

The WMFS eLearning package has been developed to provide support and guidance to those professionals who work with the most vulnerable to fire, people within our communities. It is a free to access online resource and can be found here.

All SARs are published on the Safeguarding Adult webpage and learning for all reviews is shared through the quarterly newsletters.

Learning Disabilities Mortality Reviews

The Learning Disabilities Mortality Review (LeDeR) is a national programme that supports local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives.

LeDeR reviews continue to demonstrate that people with a learning disability are more likely to die, nationally, on average over 20 years earlier than the general population.

Walsall Activity from 1st April 2019 – 31st March as taken from the Annual Black County LeDeR Report:

Notifications	**16**
Reviews Completed	**5**
Reviews In Progress	**9**
Waiting for sign off	**2**
Unallocated	**0**

During the year there has been a focus on increasing the number of available reviewers. There was an increase in the number of staff who have received training as well as availability to undertake the reviews. Additional funding from NHSE enabled agency reviewers to help clear the backlog and at the end of March 2020 all reviews were being allocated within three months.

Since January 2020, performance activity is also monitored monthly against the targets set nationally (and monitored by the Regional LeDeR Steering Group): 3 months for allocation and 6 months for completion. This supports the monthly levels of activity to be proactively managed to reduce the likelihood of late allocations and also highlights where unexpectedly high numbers of notifications may impact on performance.

2019/20	**Q2**	**Q3**	**Q4**
Number of notifications	22	24	22
% assigned within 3 months	77%	79%	100%

(NB this is Black Country and West Birmingham CCGs data)

Reviews across the Black Country and West Birmingham as identified in the Annual LeDeR Report identified the following learning which was applicable to Walsall. The learning across the Black County and West Birmingham reflected both regional and national learning:

- Differing epilepsy pathways across the Black Country and West Birmingham.
- Lack of monitoring of the reasons for “Did Not Attend” (DNA) resulting in discharge from clinics; non-compliance with NICE guidance on management of high risk patients.
- Recognising Deterioration and End of Life Care and a lack of training for providers.
- Application of the Mental Capacity Act (2005).
- Use of health passports/advance care decisions.
- Quality of recording of Annual Health Checks, including referencing and monitoring of health action plans.

The full report can be accessed here, all learning and related actions is monitored and progressed by the Black Country LeDeR Steering Group

7. Additional Work Streams / Areas of Responsibility

West Midlands Emergency Services Safeguarding Adult Group

- During 2019/20, the West Midlands Emergency Services Safeguarding Adult Group has continued to meet.
- Outcomes from these meetings include a Regional Safeguarding Adults Care Act Compliance Self-Assessment, a Regional Training Levels document and a Multi-Agency Case File Audit Tool.
- Engagement of Board representatives and representatives from West Midlands Police, West Midlands Ambulance and West Midlands Fire Service (WMFS) has enabled the emergency services to respond to requests for information, assurance and performance data from Boards more efficiently and effectively; by being able to complete, for example the Care Act Self-Assessment once and it, along with updates on progress against the RAG rating, be received by all 7 Safeguarding Boards.

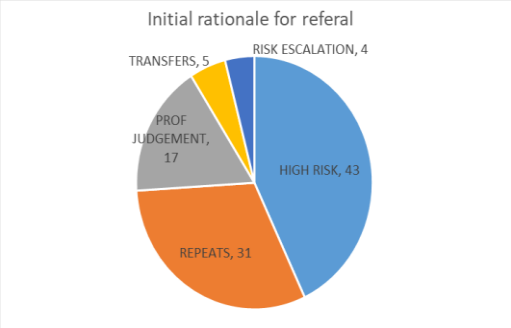
Domestic Abuse

- The revised Domestic Abuse Strategy was due to be relaunched in summer 2019 but had yet to be finalised at year end.
- A new Domestic Abuse Steering Group is to be established for 2020-21.

MARAC

A **MARAC** is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors.

- 571 referrals received of which 491 met the threshold for MARAC, 435 of these were heard at MARAC.
- 79% referrals came from police and 81% were risk assessed before referral, compared with 2018-2019 there was a 12% reduction in referrals overall.
- 56 repeats were info only, 31% overall repeat rate, (during 2018-2019 – there were 27% repeats).
- 80 referrals were withdrawn due to duplication, threshold not met or victims left the area.



- Walsall made up 9% of the demand across West Midlands Police Force area.
- 72 highest risk cases subject to peer review via a regional Complex Case review.
- Year on year referrals were down by 12% and repeats were up by 4%. Of the victims, 96% were female and 4% were Male, 2% were LGBT and 31% were BAME cases. The age range was predominantly 25 years – 54 years old.

IRIS Project

- The IRIS (Identification and Referral to Improve Safety) Project provides training to GPs to recognise and report if there are concerns about Domestic Abuse with a patient. IRIS continues to run for its second year, there have been 130 referrals for patients experiencing, or whom have experienced, domestic abuse averaging 10.8 patients' referrals each month. (This compares with 146 patients referred in 2018 and averaging 12.16 per month in 2018).
- The majority (86%) of IRIS referrals came directly from Walsall GP's, or self-referrals on advice from the GP. (This compares with 91% in 2018).
- During 2019 IRIS have identified 18 high risk patients and made 9 referrals direct to MARAC in Walsall. This has enabled safeguarding interventions to be planned and co-ordinated across local (and sometimes regional) agencies.
- 12 safeguarding concerns were raised, 4 to Adult Social Care, 7 to Children's Social Care, 1 formal referral being made to Early Help.
- During 2019 IRIS have completed 162 DASH assessments, this includes new assessments and reviews of existing patients.
- As a result of the IRIS project, 215 one-to-one support sessions were offered to patients. Unfortunately, 66 appointments have been offered but were cancelled or not attended by patients.
- IRIS signposted 60 patients to the police to complete reports regarding domestic abuse, stalking, harassment, breach of Non-Molestation Orders and to access Claire's Law.

Homelessness

The Local Authority offers a comprehensive Housing Advice and Homelessness Service which meets the requirements of the Homelessness Reduction Act (2017). On average homeless people die aged 44 years. Rough sleeping is the most visible form of homelessness and this group of people suffer from multiple physical and mental health problems.

During the year:

- 1,097 households were assessed as being owed a homeless duty, although the number of people provided with housing advice will be significantly higher.
- The main reasons for homelessness are family and friends no longer willing to accommodate, losing private rented accommodation, and domestic violence.
- In 50% of cases the Local Authority were able to prevent homelessness, and aims to increase this percentage where possible.
- In 2016, Walsall's rough sleeper count was 26, and through significant investment in the Local Authority rough sleeper services, this has reduced to 6 in 2019.
- This work has included:
    - Funding a pilot of an Eviction Prevention Officer with our major landlord whg, which has seen whg's evictions drop to their lowest level in recent years.
    - Commissioning whg to provide 76 flats and intensive housing management for our homeless young people.
    - Funding Fry Accord to provide a 27 bed domestic violence refuge service.
    - Providing a Housing Independent Domestic Violence Advisor (IDVA) service, who works with victims and survivors of domestic abuse, primarily dealing with their housing options and providing support.

- The local Authority have an Outreach Service that is on the streets every day, and by 31st March 2020, 55 entrenched rough sleepers have been housed and supported through a flagship Housing First scheme provided by Fry Accord.

Multi Agency Safeguarding Training

The partnership have offered a programme of multi-agency training. This year's programme, across the children's and adult's workforce, has included the development of Partnership eLearning Modules and several Practice Reflection Workshops which have included the themes of:

- Self-Neglect
- Transition
- SEND Transition

From 1st April 2019 to 31st March 2020:

- 21 training events across the children's and adults partnership (total 69 face to face sessions and 3 eLearning Modules) were delivered and 1,231 delegates have successfully completed this training.
- This year saw an increase of 28.7% in attendance compared to the previous year.
- In addition 298 people attended the conferences.
- 9 training events specifically for adults, 137 delegates attended.
- 2 eLearning Safeguarding Adults Levels 1 & 2 were developed and went live during the year.
- 307 Hours of training and development was accessed of which:
  - 30.5 hours of training and development was accessed for specifically adults courses.
  - 86 hours of training and development was accessed in addition to the 30.5 hours above for joint adult and children's courses.
- The Practice Improvement Strategy and Competency Framework has been revised and agreed.
- The partners have also supported the programme with a training pool, with 69 practitioners from across the partnership leading training events.
- The Business Unit has successfully recruited a new full-time role of Practice Improvement Lead to support this area of work.

Areas of work for 2020-21

- To embed Impact Evaluations across the Partnership as part of management oversight and supervisions.
- To revisit the Practice Improvement Strategy and Competency Framework, to explore any gaps in the learning and development offer.
- To develop joint children's and adult courses in relation to Exploitation and Domestic Abuse.

Care Act Compliance Audit

The Care Act Compliance Audit was completed in 2019. An initial analysis report was presented in October 2019 to Leadership Group which indicated a high level of reported compliance with the standards, however, it highlighted the following areas for further assurance:

1. Although Partners are working to embed Making Safeguarding Personal (MSP), there is not enough evidence to support that services users have their voice heard or recorded in relation to safeguarding enquiries.
2. Some agencies need to develop the full suite of policies and procedures to support safeguarding.
3. Further evidence of how agencies are embedding the learning from local and national reviews within their agency to ensure this is effective in improving outcomes for adults with care and support needs.

Agencies submitted action plans to outline how they intended to address areas which did not meet the required standard and an event to quality assure the responses will be held in 2020-21.

8. Conclusions and Priorities for Next Year

How safe are adults in Walsall?

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

There continues to be evidence of awareness of the safeguarding adults agenda as the number of safeguarding concerns that are being raised has remained steady from 2018-2019.

Adults continue to be consulted with and their desired outcome of the safeguarding concern achieved, this is also balanced with risk enablement and this year more desired outcomes have been achieved.

The introduction of the Quality in Care Team has meant that care standards are monitored and improving.

The numbers of individuals where a risk was identified, was reduced or removed in 89.8% (compared with 88.5% during 2018-2019) of cases showing positive outcomes for adults in Walsall.

Therefore the areas for further development include:

- Developing a Partnership response to adult exploitation as part of an All-Age Exploitation Strategy.
- Continue to improve and sustain the provision of good quality care within Walsall in line within managing the impact of COVID-19.
- Ensuring appropriate safeguarding referrals are made to ASC using the Decision Making Support Tool.
- Effective and consistent approach to Making Safeguarding Personal prior to making safeguarding concerns.
- Effective and consistent application of the Mental Capacity Act.

- Plan for the implementation of Liberty Protection Safeguards supported through a strategic implementation group.
- Pathways into all services need to be clear and adults with care and support needs who are at risk or experiencing abuse and neglect need to receive the same response by Police as any other adult or child. (HMIC Poor Relation report).
- The sharing of information amongst partners around Modern Slavery and Human Trafficking (adult) concerns requires improvement.

How strong is Partnership working?

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

- The Chief Nurse for Walsall Healthcare Trust and the Director of Public Health have been regular attendee's at Board meetings.
- There have been regular meetings of the new Safeguarding Leadership Group which has developed shadow arrangements during the year in preparation for the New Arrangements that became effective in September 2019.
- There is regularly good attendance and contribution from partners to the Performance & Quality Assurance and the Multi-Agency Audit Groups.
- Leadership Group meetings are interactive and developmental and do not simply process papers and reports and monitor progress, led by a reflective Independent Chair.
- Walsall Together was launched to transform the health and social care services in Walsall.
- The response to Self-Neglect is improving but progress in implementing the Pathway has been slower than intended.
- In 2019/20, the partnership developed a Joint Engagement Strategy (2020-2022). This strategy is aimed at all organisations within Walsall whose staff and volunteers provide services to children, young people and adults with care and support needs

Areas for further development include:

- The Local Authority Front Door for safeguarding concerns needs to be reviewed as the conversion rate for concerns is lower than 30% and consideration given to a MASH which will also support the pathways and responses by agencies.
- Collective ownership and accountability of safeguarding practice and Board Priorities across the partnership e.g. driving forward agenda's such as adult's exploitation, self-neglect and transition to adulthood for vulnerable groups.
- Ensuring an equal voice for all partners – by partners fully understanding and effectively upholding their partnership roles.
- Further engagement with the voluntary and community sector.
- Ensuring the views adults with care and support needs are sought and used to shape strategy, planning and service delivery needs further development as laid out in the Engagement Strategy.
- Ensuring greater consistency of practice.
- There is not yet a Domestic Abuse Strategy for the Partnership, which is a significant risk that requires addressing.
- Consideration of establishing a local Modern Day Slavery Strategic Group.

Are we a learning system?

We have shared learning from reviews and audits to the workforce through practitioner face to face briefings, newsletters and training however, we are not yet operating as an effective learning system. There is more to be done to achieve this. This will include:

- Reviewing the multi-agency safeguarding training offer, opportunities for practice improvement and the capacity to deliver on this across the partnership.
- Evaluating the impact of training.
- Acting on audit and review findings to drive practice uplift and inform future audit activity.
- Engaging with Adults with Care and support needs in a meaningful way (as our 4th partner in the new arrangements).

Opportunities

- The new arrangements offer the opportunity to renew the Partnership Governance Structure and work more closely with other Partnership Boards (such as Safer Walsall Partnership – Community Safety).
- Increased capacity will be created to support the delivery of a robust multi-agency Practice Improvement Programme with the appointment of a full time Practice Improvement Lead – following a successful secondment during 2019-20.
- Walsall will be launching the Family Safeguarding Model. This programme supports a whole-system change to a Local Authority's child protection approach, focusing on promoting children being brought up in their families, by meeting the needs of both the children and the adults around them. This includes:

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

This will offer Walsall the opportunity to enhance its approach to locality working and 'Think Family'.

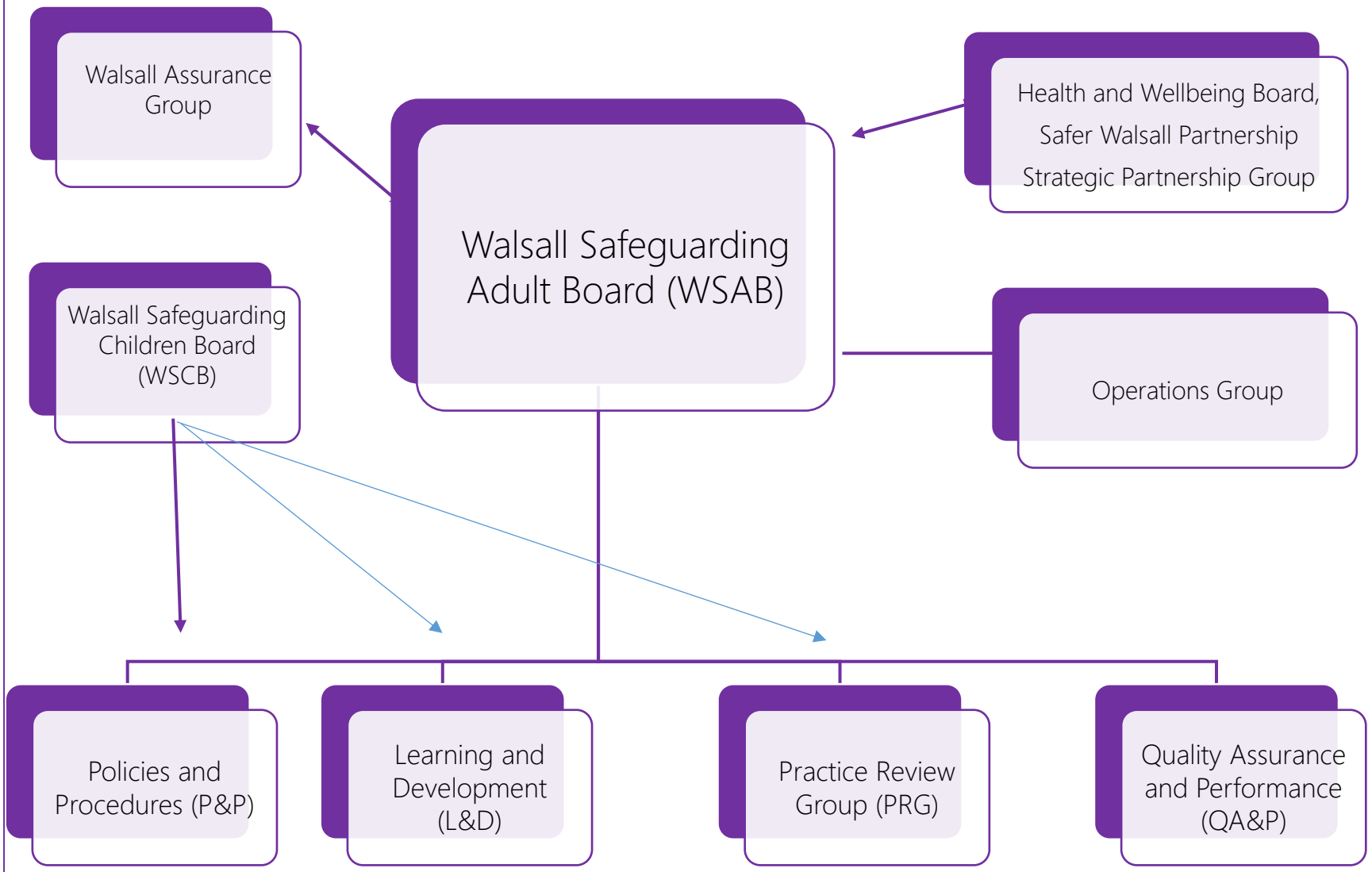
Priorities and Next Steps in 2020-21

- Develop an All-Age Exploitation Strategy and Pathway.
- Finalise the multi-agency Practice Improvement Strategy and revise and deliver the associated learning and development programme.
- Roll out of "support to all, bed based care" including the Mental Health and Learning Disability homes (this is phase 2 of the Quality in Care Home Pilot).
- Build capacity across the partnership and within the Business Unit to deliver multi-agency training.
- Continue to focus on the implementation of Self-Neglect Pathway.
- Review the New Safeguarding Partnership Arrangements.
- Launch the Family Safeguarding Model.
- Develop our approach to embedding learning from performance, audit and reviews.
- Ensure adults with care and support needs are actively engaged in the Partnership.
- Increase the visibility of the Safeguarding Partnership.
- Provide strong safeguarding leadership across the Partnership.

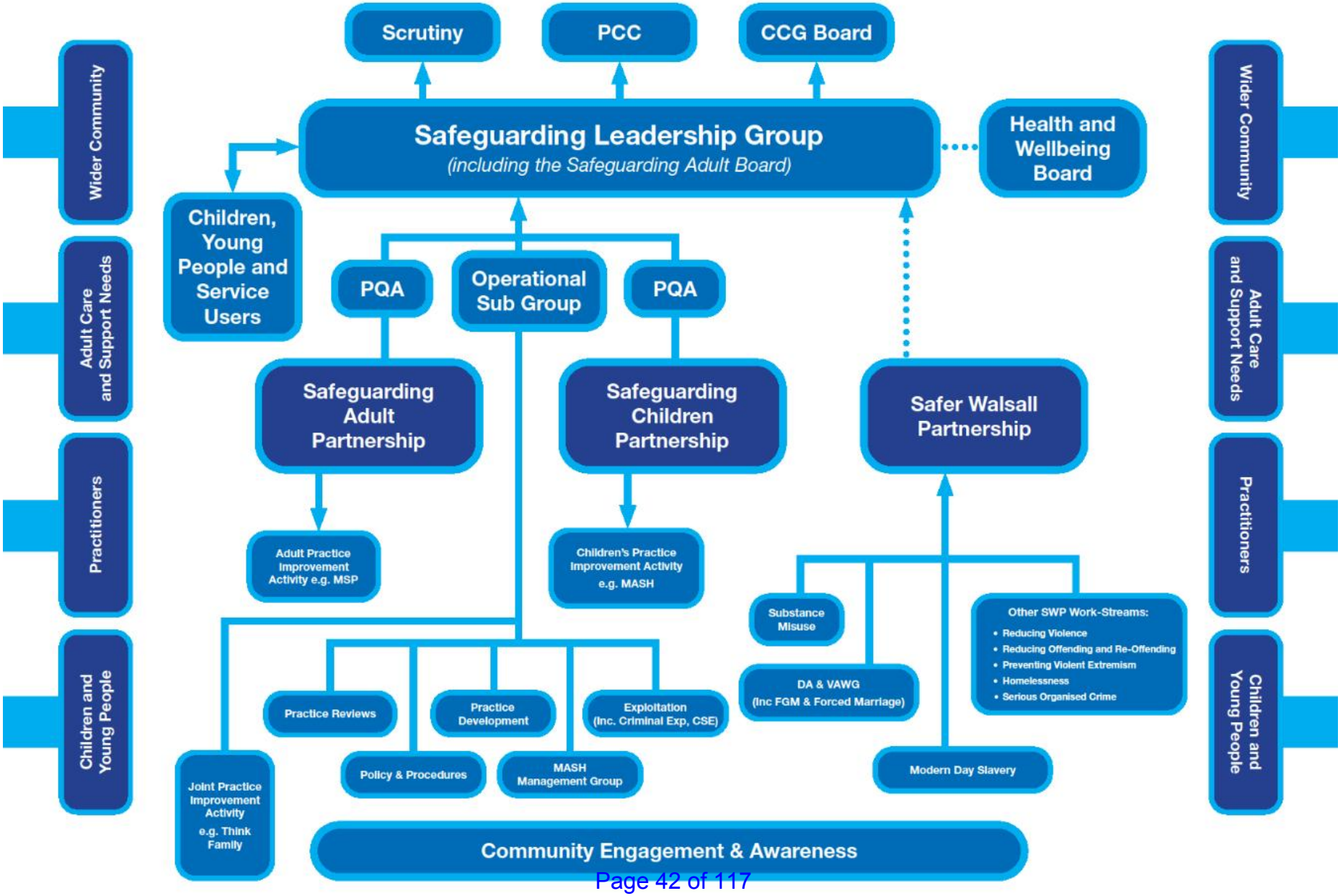
In producing this report, the Partnership has recognised there are opportunities to work more collaboratively across agencies, including in reporting on our activity, progress and impact. Next year, we intend to revise our approach to producing the Annual Report. This will include a stronger focus on the service user experience and the impact of our work on safeguarding outcomes for Walsall citizens.

Appendices

Appendix 1. Walsall Safeguarding Partnership Structures



Appendices


Scrutiny
PCC
CCG Board
Wider Community
Safeguarding Leadership Group
(including the Safeguarding Adult Board)
Health and Wellbeing Board
Wider Community
Children, Young People and Service Users
Adult Care and Support Needs
PQA
Operational Sub Group
PQA
Adult Care and Support Needs
Safeguarding Adult Partnership
Safeguarding Children Partnership
Safer Walsall Partnership
Practitioners
Adult Practice Improvement Activity e.g. MSP
Children's Practice Improvement Activity e.g. MASH
Practitioners
Substance Misuse
Other SWP Work-Streams:
• Reducing Violence
• Reducing Offending and Re-Offending
• Preventing Violent Extremism
• Homelessness
• Serious Organised Crime
Children and Young People
DA & VAWG (Inc FGM & Forced Marriage)
Practice Reviews
Practice Development
Exploitation (Inc. Criminal Exp, CSE)
Children and Young People
Joint Practice Improvement Activity e.g. Think Family
Policy & Procedures
MASH Management Group
Modern Day Slavery
Community Engagement & Awareness

Appendices

Appendix 2. Walsall Safeguarding Adults Board - Meeting attendance April 2019 – March 2020

Organisation / Member	June 19 (BOARD)	October 19 (PARTNERSHIP)	January 20 (PARTNERSHIP)	Total (%)
Independent Chair	✓	✓	✓	100%
Lead Member/Councillor	Apologies	✓	✓	66%
WSAB Business Unit	✓	✓	✓	100%
Adult Social Care, Walsall Council	✓	✓	✓	100%
Clinical Commissioning Group	✓	✓	✓	100%
Walsall Healthcare NHS Trust	✓	✓	✓	100%
Walsall College	✓	Apologies	Apologies	33%
West Midlands Police	Apologies	✓	✓	66%
National Probation Service	Apologies	✓	✓	66%
West Midlands Fire Service	✓	✓	Apologies	66%
Lay Member (role not continuing after end September 2019).	✓			100%
Health Watch	✓	✓	Apologies	66%
Public Health, Walsall Council	✓	Apologies	✓	66%
Dudley & Walsall Mental Health Partnership Trust	✓	Apologies	Apologies	33%
Black Country Partnership Foundation Trust	✓	Apologies	✓	66%
Housing-whg	Apologies	✓	✓	66%
One Walsall	Apologies	Apologies	Apologies	0%

Appendices

There were 6 Leadership Group meetings between July 2019 and March 2020.

Organisation/member	Total % attendance
West Midlands Police	100%
Adult Social Care	67%
Children's Social Care	100%
CCG	83%
Access and Achievement (Education)	67%
Public Health	100%
One Walsall (VCS)	50%

Appendices

Appendix 3. Budget

	Budget 2019-20 Total	Actual 2019-20 Total
Funding	**£**	**£**
Walsall Council Contribution	(51,584)	(51,584)
Walsall Council Additional Investment	(200,000)	(200,000)
NHS Walsall	(10,000)	(10,000)
Probation Services (NPS & CRC)	(3,000)	(1,500)
West Midlands Police	(30,594)	(31,209)
CAFCASS	(550)	(550)
CCG	(40,000)	(70,000)
CCG Additional (One off)	(15,000)	(15,000)
Other Training	0	(3,105)
Other CDOP	6,264	1,620
	(344,464)	**(381,328)**
Costs		
Salary Costs	254,190	250,263
Agency	0	13,644
Consultants Costs	4,000	4,586
Workforce Development SLA	25,000	10,319
Section 11/157/175 Tool	3,000	0
Chronolator Tool	1,580	850
SCR / SAR	38,008	25,327
Development Day / Conference	0	3,627
Development Activities	0	2,727
PHEW - Online Child Protection Procedures	686	686
Other Costs -	6,000	11,395
Online booking system	2,000	0
Service User Involvement	10,000	621
	344,464	**324,044**
Carry forward to be request/(use of reserve)		**57,374**
Forecast Outturn Over / (Under)	**0**	**90**

Walsall Safeguarding Children Board

and

Walsall Safeguarding Partnership

Annual Report 2019 – 2020

Contents

Foreword by the Independent Chair – Liz Murphy

Thank you for taking the time to read Walsall Safeguarding Children Partnership Annual Report which covers the period 1st April 2019 to 31st March 2020.

The report is published by the 3 statutory partners: Walsall Council, West Midlands Police and Black Country and West Birmingham Clinical Commissioning Group. These agencies are jointly and equally responsible for putting in place effective arrangements to support the co-ordination, quality assurance and continuous improvement of activity to safeguard children in the borough.

In the year, and in response to changes to statutory guidance, significant changes were made to strategic safeguarding partnership arrangements for children and young people; the details of these changes are set out in the report. Learning from 'early adopter' sites was used to inform the development of the arrangements in Walsall and the shared ambition of statutory partners for children and young people to become the 4th partner in the local arrangements is an indicator of the commitment to listen to and learn from children. A review of the new partnership arrangements will be completed in 2020-21 and this will provide an opportunity to evaluate the impact of the changes.

Walsall Council's Children's Social Care has during this period operationalised a locality based delivery model that has been informed by the views of parents/carers and is designed to promote stronger multi-agency working whilst at the same time, making best use of the community based assets including schools and the voluntary sector. West Midlands Police have made changes in the year to the way they deliver their public protection services; these changes were designed to be more responsive to children who are victims of child abuse. The Clinical Commissioning Group has continued to work with primary care and other health providers in relation to a wide range of safeguarding issues. An example is the 'Our Voices, Our Shoes' conference that was co-produced and facilitated by young people and professionals. The Conference covered issues of substance misuse, gangs and exploitation, domestic abuse and living with mental health issues.

In support of the shared ambition to improve outcomes for vulnerable children and families, Walsall Council made a successful application to the Department for Education to secure funding to implement the Family Safeguarding Model in Walsall. Family Safeguarding is one of three innovation projects within the Department for Education Strengthening Families, Protecting Children programme. The model will enable specialist services to work more collaboratively with parents/carers on the issues that impact most on their parenting capacity and so support children to be cared for in their family.

Statutory partners made the decision that the governance of the Family Safeguarding Model would sit with the Walsall Safeguarding Children Partnership and an external evaluation of the Local Authority and Partnership's readiness to implement Family Safeguarding Model resulted in Walsall being selected as the first area in the country to implement the model.

In this report, partners provide an overview of work completed to progress locally agreed priorities supported by their analysis of the impact of this work. Data shows that the work to implement a revised "right help, right time" framework has had a positive impact on children and families as

more families who receive early help support are stepping down to universal level of need due to positive outcomes being achieved at the early help level of need. In addition, there is evidence of a better understanding and application of statutory thresholds in the Multi-Agency Safeguarding Hub (MASH); there is however, further work to do to ensure that partner agencies are referring those children who require a statutory safeguarding service to the MASH. There has also been a significant reduction in the number of child protection enquiries completed bringing Walsall much more in line with national comparative data. In addition, a focused inspection visit by Ofsted during this period found that the Multi Agency Safeguarding Hub (MASH) was providing a timely and appropriate response to those children who require a statutory social work service.

Audit activity carried out during the year evidences the positive impact of multi-agency working for children and families however, partners have identified that, whilst there has been good progress over the last two years in relation to strengthening the quality of multi-agency working, there is further work to do to ensure that all children and families consistently receive a good and joined up safeguarding response.

The last few weeks of the period covered by this report saw the country go into national lockdown because of a global pandemic thus creating unprecedented circumstances for services as well as children and families. Partner agencies rose to the challenge of sustaining safeguarding services, whilst at the same time, responding to emerging need. Agencies worked together to risk assess and determine who was best placed to respond to the most vulnerable children and arrangements were put in place for partners to regularly meet to share information about the delivery of safeguarding services. Another strength of the Partnership's response to the pandemic was the arrangements put in place to communicate key messages to front line practitioners, supported by a comprehensive virtual learning and development offer.

Developing the response to neglect is a priority for the Partnership and to support the delivery of the aims of the neglect strategy, a discussion took place at the inaugural meeting of the Safeguarding Children Partnership in October 2019. This identified the need to review membership of the Neglect Steering Group, clarify the role/responsibilities of Neglect Champions and review the local learning and development offer. Progress has been made in developing a tiered training offer, a Neglect Champions Group has been established and the NSPCC have been involved in work to plan a local awareness campaign. Given much of the work that has taken place during the year has been developmental, there is yet limited evidence of the tangible impact of the Neglect Strategy on practice and outcomes for children and families and this is a recognised priority for 2020-21.

Like other partnerships, Walsall has recognised the need to respond to all forms of child exploitation and arrangements to discuss, on a multi-agency basis, children being criminally exploited were piloted in the year. In recognition of the need to strengthen the oversight and implementation of the Child Exploitation Strategy Delivery Plan, a focused set of actions were agreed in November 2019, including the development of a child exploitation pathway; the agreed actions were to be completed by end of March 2020. Whilst not completed by the end of March 2020, a child exploitation pathway is now in place. One of the challenges in safeguarding children who are being criminally exploited is to respond to them as *victims* of abuse; this can be complicated by the fact that these children can be coerced into criminal activity. Providing a victim/child centred response, along with improving the response to children who go missing from home/care, are areas of ongoing focus for partner agencies.

The statutory safeguarding partners have implemented the revised statutory arrangements to review and learn from serious child safeguarding incidents and an overview of the work completed is

included in the report. Feedback from the National Panel has been used to refine the approach to completing Rapid Reviews. Whilst some of the learning from serious incidents lends itself to a specific action e.g. amending multi-agency procedures, much of the learning requires a continuous programme of practice or service development e.g. the Family Safeguarding Model will promote a "think family" approach between services that work with children and those that work with adults who are parents/carers. In future reports, partners will have the opportunity to more fully describe the impact of actions taken in response to the learning from serious child safeguarding incidents.

As required by statutory guidance, the report details the work carried out by young people to influence service provision. To use young people to "inspect" services brought an additional element of scrutiny to the partnership arrangements and this is to be commended, as are the young people who completed this work.

The report concludes with an evaluation of:

- how safe children are in Walsall
- the strength of partnership working and
- the extent to which the partnership is operating as a learning system.

This is an open and transparent evaluation and appropriately identifies the progress made as well as the ongoing areas of development in relation to either practice/service development or the partnership's delivery of its statutory functions.

I will close by recognising the work of the committed professionals who either, work directly with children and their families, or who have a specialist role in safeguarding in partner agencies; thank you for the work you have done and continue to do to safeguard children in Walsall and for your swift and creative response to the safeguarding challenges brought by the pandemic.

1. Introduction

This report covers safeguarding children activity in Walsall for 2019-20. The strategic governance arrangements for this year took 2 separate forms. For the first part of the year the Local Safeguarding Children Board (LSCB) was in place as the statutory body with responsibility for quality assuring local practice. Following the publication of Working Together 2018, partner agencies began to develop plans to establish Multi Agency Safeguarding Arrangements and published their plans on 1st September 2019, launching the new Walsall Safeguarding Partnership. Further information on the detail of these arrangements can be found here and additional information in Appendix 4.

2. Local Context / Our Year in Figures

Infant mortality rate has increased from 6.2 (last year) per 1,000 live births to 9.4. Compared to 3.9 nationally.

4.16% of all births in Walsall are considered Low birth weight, compared to 2.86 nationally.

Under 18 conception rates per 1,000 girls (15-17) has increased from 27 in 2018-19 to 30 in 2019-20.

31% of children in the Borough are from BME Backgrounds.

24% of primary school children have English as an Additional Language (EAL)

21% of secondary school children have EAL

26% of children are overweight in Reception, this rises to 40% in Yr. 6

27% of Primary school children are entitled to free school meals (up from 23%)

29% of children live in low-income families (up from 26% in 2018-19).

Ofsted rated 80% of Walsall schools as ‘Good’ or better

Headlines:

On 31st March 2020, there were:

- 1,265 'Children in Need' [1]
- 240 Child Protection Plans were open
- 671 children in care.

Between 1st April 2019 and 31st March 2020:

- The number of child protection plans started within 2019-20 has decreased from 2018-19. The rate of 65 per 10,000 is in line with our statistical neighbours (64) but significantly higher than the England rate of 56.
- The number of children who have started a child protection plan for a second or subsequent time has increased this year from 19% in 2018-19 to 24% in 2019-20 taking us above both statistical neighbours and England (18% & 21% respectively).
- 10,178 contacts were made to the Multi Agency Safeguarding Hub (MASH), resulting in 4,368 referrals to social care. This is a 17.6% decrease from 2018-19.
- 4,392 Child and Family Assessments were completed. This is a 17.1% decrease from 2018-19. At the time of writing there was no published comparator data.
- 1,257 Section 47 enquiries were held (an investigation carried out when a child is thought to be suffering significant harm).
- The number of children who had a missing incident during the year has tripled due to changes in police recording. Approximately 100 episodes per month were recorded in 2019-20.
- 10% of looked after children went missing in 2019-20. Compared to 7% that went missing in 2018-19.
- West Midlands Police recorded 1,331 crimes with a category of child abuse, with an additional 1,312 child abuse incidents which were deemed to be non-crimes (safeguarding concerns)

Early Help (EH)

Between 1st April 2019 and 31st March 2020:

- There were 4,531 requests for Early Help – a 0.4% decrease compared to 2018-19. Of these requests for help:

[1] The Children Act, 1989 states a child will be in need if:

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

    - 59.1% were via the Early Help Hub
    - 25.3% were via MASH
    - 10.2% were via step-down from social care assessment
    - 5.4% were stepped down from children in need review.
- 285 requests for support (6.3%) were repeat requests for families who had previously received support within the last 12 months. This is a decrease from 8.4% in 2018-19.
- The three main reasons for support were:
    - Challenging behaviour concerning the child (10.8%)
    - Domestic violence concerning the parent/carer (9.8%)
    - Mental Health (parent/carer) (7.2%).

- Outcomes for children, young people and families receiving Early Help support are improving following support and intervention.
    - 77% felt that there had been a positive outcome for them, this is an increase of 12% pts compared with 65% 2018-19.
    - 4.2% had a neutral closure (where the case is closed due to the family moving out of borough or the child turning 18) - compared to 6.3% the previous year.
    - 18.5% of families receiving support had a negative closure (where the case is stepped up to social care, the family disengages or refuses to consent to support) – a decrease, compared with 27.4% in 2018-19.

<u>Referrals to Social Care</u>

- The Rate of referrals per 10,000 is 641 which is a decrease from 753 (2018-19). It remains significantly higher than the England averages (545) and slightly higher than the statistical neighbour average (614).
- There were 4,368 Referrals in 2019-20 which is a 17.6% decrease from 2018-19 (5,135 Referrals).
- Concerns about a lack of appropriate application of thresholds led to a revision and relaunch of the Right Help, Right Time (Threshold) Multi Agency Continuum of Need Guidance in September 2019.
- The number of referrals per 10,000 resulting in no further action (7 per 10,000) has reduced – this is the lower than both England and statistical neighbour averages (8 per 10,000).

<u>Factors identified at assessment</u>

- Domestic Violence continues as the main factor (56%) and has increased by 12% from 2018-19.
- Neglect has decreased the most, down from 30% (2018-19) to 15% (2019-20).

<u>Section 47 Enquiries</u>

- The rate of Section 47 enquiries has seen a significant decrease in 2019-20 and is at 184 per 10,000. Which brings Walsall below the statistical neighbours (195) but higher than the England averages of 168.

Child Protection

- 93% of Initial Child Protection Conferences (ICPCs) were completed within 15 working days of a strategy discussion – an improvement on 88% in 2018-19 and significantly better performance than our statistical neighbours (81%) and national performance (79%).
- The rate of ICPCs in the year has significantly decreased from 99 per 10,000 in 2018-19 to 69 per 10,000 in 2019-20 and is now lower than our statistical neighbours (75) and more in line with England average (65). The reduction is in line with the decrease in Section 47 enquiries.
    - This reduction in the number of children being discussed at ICPC reflects the work done across the service to change culture in the way we work with families in preparing for the implementation of Family Safeguarding. Children's Services have undertaken a number of themed audits in respect of children discussed at a strategy meeting who did not then progress to an ICPC to assure ourselves that the application of the threshold was correct.
    - There has also been a focus on delivery of Right Help Right Time training to assist partners in the correct application of the threshold for referral. The October 2019 Ofsted inspection of our Front Door arrangements confirmed that most children received an appropriate response in a timely manner.

- ICPC Attendance:
    - Police attended 70% of ICPCs and submitted reports to 93% of meetings.
    - Relevant health practitioners (predominately school nurses and health visitors) attended 82% of those meetings applicable and submitted reports to 83%.
    - GP engagement in ICPCs remains low and further work will be carried out in 2020/21 to better understand the reasons for this and to work with GPs to improve engagement.
    - Education attended 73% of applicable ICPCs, and submitted reports to 77%.
    - Allocated Social Workers attended 95% of meetings and provided reports to parents (at least one day prior to the ICPC) in 90% of cases.
- The number of child protection plans started within 2019-20 has decreased to 65 per 10,000 population aged 0-17 from 86 per 10,000 in 2018-19, however, this remains higher than statistical neighbours (64 per 10,000) and the national rate (56 per 10,000).
- The proportion of children who have become subject of a child protection plan for a second or subsequent time has increased from 19% in 2018-19 to 24% in 2019-20. However, in Walsall this remains lower than statistical neighbours (20%) West Midlands (20.6%) and England (21%).
- 93% of children have their views represented at the Initial Child Protection Conference compared to 87% last year.

Categories of Abuse (as listed in Child Protection plans)

- Neglect and emotional abuse continue to be the largest categories recorded on child protection plans (45% and 44% respectively).
- The proportion of children who are subject of plans due to emotional abuse is higher than the proportion nationally (35%) and among statistical neighbours (32%) averages. However, this is likely to be linked to high rates of domestic violence as this is the category of abuse that would be used for children who are subject of a plan due to living in a household with domestic violence when that is the over-riding reason for the plan.
- We have seen some shifts in categorisations for the reason children are on a plan with fewer children being categorised under neglect and an increase in the proportion of children categorised as being subject of a plan for emotional abuse. This is due to a refinement in the use of the definitions resulting in some children who previously would have been categorised as neglected when living in a home where domestic violence was present, now being recognised as children who are living in emotionally abusive households.
- The number of child protection plans ending this year has decreased from 606 in 2018-19 to 535 in 2019-20.
- The number of child protection plans reviewed in the timescale has decreased slightly to 95.3% from 98.2% in 2018-19 but performance remains consistently above the comparator rates.

Children in Care

- The number of children in care has increased from 614 as at 31st March 2019 to 671 as at 31st March 2020
- 78.2% of children in care were living in foster placements, an increase from 75.6% the previous year.
- 31% of the children becoming looked after in the year were aged 10-15.
- 81% of children became looked after due to abuse, neglect, or family dysfunction.
- 9.7% of children in care went missing from their placement on at least one occasion, an increase compared with 6.9% the previous year. Despite the increase we are in line with statistical neighbours (10%) but remain lower than the national percentage (11%).
- 2018-19 saw a significant reduction in the number of looked after children starting to be looked after. The number of new starters returned to more expected levels in 2019-20; the overall increase is broadly in line with regional neighbours, who also saw an increase in the number of looked after children.

Private Fostering

- Numbers of children being identified as privately fostered remain low. In 2019-20 between two and seven children per quarter were identified as privately fostered.

Health Services

- The number of children attending A&E due to self-harm continues to increase with 179 children attending in 2019-20 compared with 161 in 2018-19 and 132 in 2017/18.
- There was one child admitted to an adult mental health bed in 2019-20. There were none in 2018-19.

MARAC (Multi Agency Risk Assessment Conference)

- Overall MARAC referrals reduced by 12% compared to 2018-19, which contrasts with the increase in DA referrals to MASH.
- Repeat notifications increased by 4%.

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

Sector	Number of contacts 2019- 20	Percentage of contacts 2019-20	No of contacts change from 2018	No and % of contacts progressing to a Position Of Trust meeting
Education	64	40.5%	-101	22 (34%)
Foster Care	31	19%	-3	16 (51%)
Walsall Local Authority carers	7	4%	-11	
Independent foster carers	22	11%	+7	
Other Local Authority carers living in Walsall	2	1%	+1	
Early Years	11	7%	- 13	3 (27%)
Residential care	14	9%	-8	8 (57%)
Walsall Local Authority	6	3%	+2	
Independent	8	3%	-8	
Health	12	7%	-	3 (25%)

Faith	5	3%	-3	0
Social Care	7	4%	-	2 (28%)
Transport	2	1%	-3	0
Others	10	6%	-	0
Voluntary sector	2		-1	
Sports	2		+2	
Supported accommodation	0		-3	
Police	0		- 2	
Other	6		+4	

There were 60 Position of Trust meetings held during 2019/20, meaning that 38% of the contacts accepted progressed to a Position of Trust meeting. This compares to just 17% in the previous year.

Of these, 29 were held and found to be Unsubstantiated; 17 were Substantiated and 5 were felt to be Malicious.

A change in recording practice was made at the beginning of 2019/20 following advice from the National LADO network. As a result, records are no longer created in respect of individuals where the employer is seeking advice regarding issues that relate to contractual matters or matters relating to employee behaviour that does not impact on care provided to children by the employee and where there is no safeguarding concern. Whilst these discussions will still take place it has impacted on the recorded numbers of 'contacts' and explains the significant drop in referrals from education and associated reduction in referrals from other agencies.

3. Progress against Our Priorities

Priority 1: To support the local and professional community to ensure that children and families receive the **right help** at the **right time (RHRT)**

Intention: what we wanted to achieve during 2019-2021

- Relaunch the Threshold / Right Help, Right Time Guidance
- Revise the multi-agency training strategy and programme (including the RHRT training)
- Launch the multi-agency CSA Strategy
- Effective communications strategy to deliver key messages
- Further develop and embed the process for working with children and young people as our 4th partner
- Effective functioning of the MASH and revise the MASH operating protocol

Still to do during 2020-2021

- Embed a Child Exploitation Pathway (including a performance monitoring framework)
- Ensure appropriate police referrals to MASH in relation to Domestic Abuse
- Launch and embed the Family Safeguarding Model
- Ensure Early Years and Health practitioners are accessing the multi-agency training
- Response to Ofsted Focused Inspection:

  - the timeliness of early help assessments and interventions
  - the consistency, timeliness, and quality of return home interviews
  - the prompt availability of health information in the MASH.

Implementation:

- The partnership agreed its strategy for Preventing and Responding to Child Sexual Abuse.
- 14 Right Help Right Time training sessions were facilitated and a launch event held to promote the new Continuum of Need document. These were attended by 437 practitioners.
- In addition to the training sessions, a Practice Reflection Workshop, focused on RHRT was attended by a further 20 practitioners.
- IRIS is a General Practice based domestic abuse support and referral programme. During 2019, 130 patients accessed support via telephone, email and 1 to 1 support through IRIS. Of these, 16% were either pregnant or caring for a child up to the age of 6 months old. 45% of all those referred to IRIS were caring for a child under eighteen. As a result, there were 7 referrals to MASH and 1 to Early Help via IRIS.

- The availability of health information when screening new contacts sometimes led to delays in responding quickly to children's needs (Ofsted Focused Inspection).
- Staff within the Access Service in Access and Achievement have worked to refine the Local Authority's tracking and enquiry systems in relation to those children and young people that are resident in Walsall but that are currently missing education. This process has led to the development and implementation of a RAG rated tracking system for all those children that are open to the Local Authority as children missing education. The Access Service has begun to utilise this RAG rating to identify the most appropriate actions or interventions that may be required in order to ensure that the correct support is provided to these children and young people at the most appropriate time.
- A week of activities took place in October 2019 to remind children and parents about the key messages of the NSPCC PANTS campaign. The programme has been delivered in Walsall for 3 years and this was an opportunity to run a week of events to raise the profile once again. Sharing messages about 'Privates are Private, Your body belongs to You and Talk about Secrets that Upset You'. Social media and local news channels reported on the school assemblies, library events, stalls in local Matalan stores and visits from 'Pantosaurus'.

- PANTS films were also shown during October at Walsall Arena & Arts Centre, during the trailers and intervals of films being shown to the public.
- The Early Help Locality Team continues to provide training, help and support to ensure all practitioners are confident and competent in the Lead Professional role.
- There has been an improvement in the number of Early Help children, young people and their families being supported by Health Services, where Health Practitioners are acting as Lead Professional within the Early Help Partnership. School Health have recently received Lead Professional training and this partnership has been and continues to be strengthened.
- In 2019 Walsall police launched the Police Cadet Programme locally. Police Cadets had been trialled in other areas in WMP and based on the success and uptake has now been expanded. There is one cadet unit in Walsall based in a secondary school. This involves volunteer cadet leaders – both police officers/staff and volunteers from outside of policing – running a youth support

programme for 13-17 year olds with a focus on policing and public service. Any child can be referred into the programme, including young people with additional safeguarding needs or subject to Early Help. There are plans to expand into a second cadets unit in the next financial year. The Walsall Neighbourhood Policing Unit (NPU) commander has now taken on the role of Police Cadet Lead for the force and the Walsall Child Protection Lead provides the safeguarding training for the cadet leaders.

- WMP have 4 Police Community Support Officers embedded with the Early Help Hubs to ensure there is information sharing and police contribution to the Early Help agenda where required.

Impact:

- The number of referrals to social care decreased by 15% from 5,135 in 2018-19 to 4,368 referrals in 2019-20. This indicates that the right thresholds are being applied to contacts received by the MASH more consistently; however, the number of contacts to the MASH remain high and increased from 9,760 in 2018-19 to 10,178 in 2019-20. This suggests that while Right Help, Right Time is being applied within the MASH, there is still work to do to embed an understanding of thresholds within partner organisations who continue to make contacts which do not result in a referral to social care.
- Despite the reduction in referrals, the proportion of referrals resulting in no further action has increased from 3% in 2018-19 to 7% which indicates that there is also further work to do to embed children's social care thresholds in MASH decision making.
- October 2019 Ofsted Focused Inspection found the quality of work in responding effectively to contacts has improved since the last inspection in 2017.
  - children and families receive a timely response to initial identified needs and concerns
  - the local authority response to most children at risk of harm or in need of help is appropriate, although, for some children, consideration of Early Help support could be given sooner by referring agencies
- The availability of health information when screening new contacts sometimes leads to delays in responding quickly to children's needs (Ofsted Focused Inspection)
- At least 2 children were safeguarded from sexual abuse following a PANTS assembly at school
- 618 children were considered as part of Safety Plans following MARAC (Multi Agency Risk Assessment Conference).

Comments from a practitioner (teacher):

"I attended the Practice Reflection Workshop on RHRT to gain a better understanding of multi-agency understanding and to allow myself time to reflect and learn from others, I intended to use the training initially by having more professional curiosity and asking more in-depth questions, also to be more aware of the family as a whole rather than just the child. I have shared the training with my team members and encouraged them to attend as part of a team meeting. I feel from attending my practice has improved as I have increased confidence and

knowledge, I have an increased awareness of pathways and process which reduces delay and improved workflow when I have supported families, now I am fully aware of them."

Case Study

Following an NSPCC PANTS assembly, a child realised that what was happening to her was not ok and she wanted it to stop. She later refused to go to the house of the perpetrator, which led to a disclosure of sexual abuse. The police and children's services became involved and the child and her sister were safeguarded.

Priority 2: To support the local and professional community to recognise and respond to neglect in a child centred way

Intention: what we wanted to achieve and the actions underpinning this priority:

- Neglect is identified and assessed consistently well across the system
- Neglect is tackled holistically via a whole family approach
- Increased professional challenge and curiosity
- Families are enabled and empowered to make positive and timely change and to identify support where possible from their own networks
- Professional practice supports timely and effective interventions to reduce risk and promote positive change within families
- Assessment, intervention, decision-making, and recording is focused on the lived experience of the child
- Launch the Look, Say, Sing, Play campaign (NSPCC)

Still to do during 2020-2021:

- Implement the Family Safeguarding Model (FSM)
- Pilot of the NSPCC pre-birth assessment tool
- Measure and evidence impact

Implementation:

- Rebecca Claybrook (Social Worker) won an NSPCC 'Elephant Practitioner Award' which acknowledges the motivation, enthusiasm and effectiveness of practitioners using the GCP2. Becky is leading by example and spreading the message in Walsall about the benefits of GCP2.
- A 3 Tier training model and competency framework is now in place for Neglect.

Neglect Training Model

- 49 practitioners completed the Basic Neglect Training – eLearning
- 46 practitioners completed the Understanding Neglect Training
- 122 practitioners completed Graded Care Profile 2 Training

- A Practice Reflection workshop took place in January 2020 and was attended by 22 practitioners from across the partnership, including Walsall Healthcare Trust, Police, One Walsall, Walsall Housing Group, Schools, The Beacon, Dudley and Walsall Mental Healthcare Trust, Early Help Localities, Troubled Families, Department of Work and Pensions, Walsall College and Occupational Therapy.
- Newsletters and poster were produced and circulated across the Partnership to provide information and raise awareness.
- Look, Say, Sing, Play is an NSPCC campaign aimed at parents and carers of children under two, to help them have higher quality interactions with their baby throughout their daily routines; by giving them the understanding, tools, and confidence they need to make this happen. Ultimately helping parents give their child the best start in life – both by building their brain and strengthening the bond between parent and child. This was launched in Walsall in July 2019 and attended by 50 professionals. A subsequent parent session at the Art Gallery was attended by 100 parents.
- The Early Help School Ready Team staff delivered a number of engaging workshops and activities to parents showing how fun and simple building brains can be as well as signposting them to all the free online resources and tips.
- After the success of the launch a number of Look, Say, Sing, Play briefing sessions were delivered to professionals in the localities and roadshows at a number of Lidl stores to reach out to the public. Children centres have started to deliver the session plans with families to help parents feel confident in using the tools and tips and to date all sessions have been well received with parents responding positively to the information shared, including during the lockdown period when virtual sessions were accessed.

- A multi-agency neglect audit was undertaken in quarter 4 but has not yet been formally reported on due the outbreak of the Covid 19 pandemic.
- Neglect Champions were identified across the partnership to drive improvements in practice and met once before lockdown. The aims of the Champion role are to:

➢ receive and disseminate information about neglect to staff;
➢ ensure that staff are aware of the neglect training available from the partnership;
➢ signpost practitioners to appropriate help and advice;
➢ report back to their agency on how well neglect is being addressed in their team/service area.

- The successful bid to implement the Family Safeguarding Model in Walsall should see a positive impact on some of the most vulnerable children suffering from neglect.

Impact:

- The neglect strategy has yet to deliver the positive outcomes which were hoped for and demonstrating impact is not yet possible.
- The strategy will be revised in 2020-21; however as partners we need to do more in relation to the use of GCP2 and tackling neglect prior to it becoming a child protection concern.
- It is acknowledged that we also need to capture the impact of our work on this across the partnership.
- Many practitioners who complete the GCP2 training do not yet go on to complete the tool in practice. Feedback from practitioners, post training, indicates a mixture of reasons for this including not seeing this as their role to lead on. Therefore, there is work to do on organisational ‘sign up’.
- The only agency currently able to record completed GCP2 tools is Children’s Social Care, which in part contributes to the point above about evidencing impact.
- The percentage of Child Protections for Neglect has changed from 50% to 42%; this reflects refinement in the use of the categories.
- West Midlands Police recorded 192 crimes of ‘Wilful Neglect’ in Walsall in 2019/20, which was an increase from 134 the year previously – a 43% increase. This in part was due to changes in recording following feedback from a HMIC inspection.

Practitioners' feedback after Neglect training:

- *"It has increased my confidence and general understanding of issues affecting other teams and improving joint working when working with children where I feel neglect is present"*
- *"I now have an increased awareness of what services can support, and how the GCP2 can support the identification of neglect, since completing the workshop I have contributed to a GCP2 and am confident to do this, understanding why my contributions were so important"*

Parents who attended Look, Say, Sing, Play sessions said:

- *"Really enjoyed the singing session"*
- *"Simple & easy ideas"*
- *"I will now try and talk to my child more during activities and use different language"*
- *"Like the idea of what I already have at home and not having to buy new or expensive toys"*

Case Study

Sam (social worker) worked with a health visitor in relation to the Jones family. The health visitor had formed a good relationship with both parents who were initially reluctant to engage with professionals. The health visitor had a good understanding of the neglect and the concerns raised and worked with Sam to complete the GCP2.

Sam stated that without the GCP2, the parents would not have fully understood the concerns about their parenting. The GCP2 assisted in breaking down the concerns and allowing the parents to understand the impact of their behaviour on their child; it allowed the father in particular to reflect on the situation. It also allowed the parents to feel 'in control' as they were involved in grading themselves which helped to engage them in the assessment. The GCP2 assessment identified that although there were concerns, these were at a level which could be supported by universal services and family members without the need for social work intervention.

Priority 3: To gain assurance regarding transition arrangements for agreed vulnerable groups between children and adult services.

Intention: What we want to achieve and the actions underpinning this priority

- An all-age exploitation strategy
- Effective transition between services provided to children and those working with adults (e.g. disabilities teams, Mental Health)
- Embed in practice the Child Sexual Exploitation and Criminal Exploitation Transition Strategy
- Delivery of multi-agency exploitation training (including transition planning)

- Embed our approach to ‘Think Family / A Whole Family Approach’, including further developing our multi-agency training to reflect this priority
- Ensure seamless transition between Youth Offending Service and Probation (following SCR W10)
- Implementation of an all-age Exploitation Hub

Implementation:

- The Youth Offending Service ‘T2A’ transition process was reviewed across the Black Country cluster in June 2019 to ensure compliance with the national protocol for transitions and the Youth Justice Board’s ‘standards for children in the youth justice system 2019’- standard number 5 ‘transition and resettlement’.
  The new 12 stage ‘T2A’ (Transition 2 Adulthood) process ensures that the seconded Probation Officers to each of the Black Country Youth Offending Services’ work closely with both the National Probation Service and Community Rehabilitation Company to identify young people at the earliest and most appropriate opportunity to transition them from youth justice services to adult services.
- 2 Practice Reflection Workshops were facilitated for practitioners on Transition and SEND Transition.
  These were attended by 18 Adult social care staff, West Midlands Fire Service, Children’s Services, Walsall Community Health, Police, One Walsall, Walsall Housing Group, Schools, The Beacon, Dudley and Walsall Mental Health Trust, Early Help Localities, Troubled Families, Department of work and Pensions, Walsall College and Occupational Therapy staff
- Walsall has engaged with WMEmployers and the Game Changer Partnership to facilitate a 3 day ‘Impactful Partnership Programme’. The focus of this being Exploitation, with an opportunity to reflect on how the partnership works together to deliver on this agenda and begin to develop an all-age exploitation strategy.

Impact:

- Walsall’s HMIP inspection in youth offending identified partnerships as a strength of the service and found good evidence of the close working relationships with Social Care. These partnerships have contributed to the findings that outstanding desistance work occurred for children and young people in Walsall, supported by excellent (lower) re-offending rates.
- Practitioner comment following the Practice Reflection Workshop:
  “Now I have an increased knowledge base, I am able to ensure there is a smooth transition for children into adulthood by looking at this earlier and knowing what services are available to support.”

Case Study

A is a 21 year old young person. A has a number of co-morbidities including learning difficulties, Autism, ADHD, Epilepsy and Encephalopathy, A attended a state funded Special School throughout childhood and has been under a number of health services through their life. Following a number of safeguarding concerns, A became subject to a Child protection plan in 2008 and again in 2009. A became a Looked After Child in 2013 and remained under the care of the local authority until their 18th Birthday whereby A transitioned to Local authority Adult services.

During the time A was a Looked After child they continued to access secondary health care services for their health care needs and received annual looked after children health assessments.

Due to A having a significant learning disability and being non –verbal, the Looked After Children's nursing team liaised with the Special school A attended to ensure they remained at the centre of the care they received, this was made possible by working in partnership with education and A to produce a pictorial health assessment.

For continuity, the Looked After Children Nurse ensured A remained on their caseload. This enabled the therapeutic relationship to be maintained. The nurse attended Looked After Children's reviews with the local authority and supported the foster carer to support A's transition to adult services. Both social care and adult health services were well planned to ensure that no delay occurred for A. The pictorial health assessment was shared to support A while under the care of secondary adult services for ENT, Clinical Physiology and Orthopaedics. A received a health history document, elements of which are pictorial to enable A to understand their healthcare needs as they move into adult services.

Priority 4: To tackle exploitation and supporting those children and adults who are victims of exploitation and/or go missing

Intention: what we wanted to achieve and the actions underpinning this priority:

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

Implementation:

- Carrying a knife is associated with criminal exploitation and young people within the youth justice system are more likely to be involved in County Lines drug running. The Youth Justice Service (YJS) have continued their

partnership with the Street Doctors charity to teach young people basic First Aid to help save the lives of their friends if they are the victim of violence. This is a powerful intervention which challenges the young person's perception of stabbing and being stabbed whilst teaching them a potentially lifesaving skill.

- The YJS has also formed partnerships with the James Brindley Foundation and the St. Giles Trust to add different dimensions to their work to address knife crime. The YJS are working with the Foundation to utilise the 'Full Circle Knife Crime Programme' with young people on the periphery of the youth justice system. St. Giles Trust have supported the YJS with knife crime workshops to provide 'lived experience' mentoring, to help young people understand the personal consequences for carrying a knife and engaging in violent crime.
- Walsall has engaged with WMEmployers and the Game Changer Partnership to facilitate a 3 day 'Impactful Partnership Programme'. The focus of this being Exploitation, with an opportunity to reflect on how the partnership works together to deliver on this agenda.
- The Designated Nurse for Safeguarding led a partnership group which successfully submitted a bid to be part of the Tackling Child Exploitation (TCE) Support Programme. This programme is an investment by the Department for Education and aims to support local areas to develop an effective strategic response to child exploitation and threats from outside the family home, including child sexual exploitation and child criminal exploitation, including county lines drug trafficking. The bespoke support programme will begin in Walsall in 2020 and have a focus on community engagement and resilience.
- The Exploitation Subgroup has developed a data scorecard to better understand the local trends and picture of exploitation. Various agencies report into this scorecard to track activity, outcomes, and the information flow in relation to victims, locations, and perpetrators for all types of exploitation.
- As part of ongoing partnership work, a daily triage has been established and now takes place to discuss the most at risk victims. This triage meeting is attended by the Children's Services Exploitation Team, Return Home Interview Officers and police representatives from FCID, PPU, Locate and Neighbourhood Policing. Discussions have taken place to bring in additional partners including Adult Social Care, Street Teams, Early Help, and health colleagues. This is a real opportunity to advance contextual safeguarding to support victims and identify perpetrators of exploitation. It is also an early opportunity to identify new victims and supports safety planning for children, identification of locations of concern and identifies any gaps in intelligence sharing.
- Street Teams supported 107 young people (60 female and 47 male) over a continued period of time, which includes support provided to 55 young people affected by CSE, 27 young people affected by Criminal Exploitation, 18 service users in transition, 14 young people affected by gangs and 3 young people displaying inappropriate sexualised behaviour. Additionally, there were 10 young people (all male) who were on the waiting list for support.

- Street Teams also supported 21 families (78 individuals including parents and siblings) affected by CSE.
- Street Teams provided 126 education and prevention programmes to over 7,000 school children / pupil referral units to raise awareness of the risks of exploitation and delivered 55 training sessions to 2,128 professionals, parents, and volunteers.
- There was an overall reduction in the number of crimes recorded by the police where CSE was included as a marker. In 2018/19 there were 45 crimes as well as 122 CSE incidents recorded which were not deemed a crime. In 2019/20 this reduced to 38 and 62 respectively. The sharp decrease in non-crime matters reflects a reduction in young people who are deemed medium or high risk of CSE and subject to MASE meetings as each referral will usually result in a non-crime record being created.
- In 2018/19 the most frequent CSE offence type recorded was online child sexual exploitation (15) or rape offences (7). In 2019/20 the most commonly recorded CSE offences were online exploitation (10) and Trafficking (8). Almost all Trafficking offences were recorded due to a young person being referred to the National Referral Mechanism. The reduction in rape offences, and the increase in NRM-driven Trafficking recording, is a positive step in reducing harm to young people and increasing safeguarding measures through appropriate referrals.
- In acknowledgement of the need to strengthen the focus on children at risk of exploitation, the Healthcare Trust invested in sending two nurses from its safeguarding children service to a five day course on contextual safeguarding at the University of Bedfordshire. It is expected that they will use their knowledge in this field to support the Partnership as well as the Trust.

Still to do during 2020-2021

- Develop an all-age exploitation strategy
- Further develop and embed the Exploitation Hub.
- Launch an Exploitation Screening Tool and Pathway.
- Expand CMOG and MARVP into an Exploitation Panel (as part of the pathway) to direct operational activity in relation to all forms of child exploitation and not just CSE.

Impact:

- Despite some positive steps across the partnership, such as the TCE bid and Impactful Partnership Programme the progress on the all-age Exploitation agenda has been slower than intended.
- The Exploitation Delivery Group did not meet for a period of time, the delivery plan against the strategy was not in place for a prolonged period and there was a delay in establishing a shared pathway.

- A meeting was held in November 2019 to agree on the partnership priority tasks for the next 6 months however these were not completed in the agreed timescale.

- Due to a change in West Midlands Police reporting procedures in the categorisation of missing episodes, the number of children reported missing was 5 times higher this year compared to 2018-19. Previously no notifications were made for children deemed at no apparent risk or “absent” with the change in procedures all children previously deemed absent or no risk will be placed on the missing person system and referred to the local authority. These referrals will then result in Return Home Interviews. The impact is that a large number of children who previously would not have received this RHI will now receive one and have chance to share information and receive support.
- The number of individual’s reported missing to MASH increased in 2019-20, from 129 in 2018-19 to 350 in 2019-20.
- 49% of young people received a Return Home Interview, the same figure as the previous year, however it was positive that this was sustained given the huge increase in numbers. 51% of young people did not receive a Return Home Interview, with the main reason (74%) being either they declined the interview or had gone missing again with the following 72 hr period.
- Of the services users engaged with Street Teams (in relation to CSE), by the end of the intervention:

  71% Made safer choices

  61% Improved their safety and security

  46% Reduced their drugs and alcohol use

  56% Improved their health and well-being (including sexual health)

  66% Improved their safety online

  62% Improved their safe relationships

  56% Improved their relationships with their family and other adults

  60% Improved their education/learning attendance

  The number of young people considered at ‘serious’ risk of CSE reduced by 50% (some of this was related to data cleansing).

Case Study:

From a Street Teams service user:
'I just wanted to say a big thank you for all your help and support for both my daughter and myself. Without Street Teams I don't know what I would have done trying to deal with and understand the complexity of CSE. We need more people like you in the world who genuinely care about these young girls. It's clear you put 100% effort into your job and want to see them overcome the trauma and dilemmas they're faced with. Just know that you made a big difference to [my daughters] life and I know she will forever feel grateful that you were a shoulder for her to lean on in a time of her struggle. God Bless.'

J is a child in care; he has been in care for a long time and lives with other children in a local care home and often goes missing. He has an older brother who has also been in care and is vulnerable to exploitation when he goes missing. A lot of local practitioners from partnership agencies know J and his brother – mostly as young people who have been involved in anti-social behaviour. Over the last few months, J has gone missing on a regular basis, often because he is bored and does not like to be at the children's home, although sometimes he goes missing to spend time with his family members and friends.

J will often accept his Return Home Interview and has built an open and engaging relationship with the worker, R, who has been able to meet him and talk about any potential concerns that J has. She has also supported him to understand how risky the community can be for vulnerable children. R has built a relationship with J and his care home, his Social Worker and his Youth Justice worker ensuring that valuable information can be shared across J's professional network, without the need for him to keep telling different workers what has been going on or happening in his life, something that J has struggled with previously.

There is now a solid safety net for J when he goes missing, sharing information with others to enable risk assessments and missing trigger plans to be updated and in a timely way. J recently moved placements after a period of missing and asked to speak to R about how he feels about the new placement. He outlined that he felt comfortable having R as his worker when he goes missing and understands the concerns that his social worker has for him and his safety whilst out in community. R will continue to work with him when he does goes missing even if he does live out of the local borough.

4. Our 4th Partner – Children, Young People and Adults

In 2019/20, the partnership created a Joint Engagement Strategy (2020-2022). This strategy is aimed at all organisations within Walsall whose staff and volunteers provide services to children, young people and adults with care and support needs. The aim of the strategy is to help the partnership achieve the vision of having children, young people and adults as equal partners alongside the Local Authority, Health and Police in shaping the work of the Safeguarding Partnership. The strategy outlines 4 key steps to achieve engagement: consultation, representation, decision-sharing and co-production.

Youth Safeguarding Partners (YSP)
The Youth Safeguarding Partners group was established at the end of 2018/19. YSP have continued to be engaged with the Partnership, meeting 12 times during 2019/20. These meetings take place approximately every month for 2 hours. The work plan is flexible depending on YSP members' interests however it has mainly focused on establishing the group identity and purpose, expanding membership, completing safeguarding assurance and check and challenge for various pieces of work.

Section 11 visits

The largest engagement activity in 2019/20 was part of the Section 11 Audit. YSP members expressed a willingness to 'inspect' services they may be in contact with and see how they create an environment that is suitable for young people. Keeping to the safeguarding agenda, the Section 11 Audit process provided a perfect opportunity for our young people to complete this activity and contribute the findings to a wider assurance event with all key partners involved.

YSP members devised some questions they felt were important to ask every agency e.g. "how do you ensure you are listening to me and not just my parent/carer?" "What would you do if I told you I hadn't been fed for two days?"

Further questions were asked which were specific to each agency, depending on how services rated themselves within the Section 11 Audit. During the visits, the young people also received a tour of the building and gave notes on how they felt the spaces could be improved. The young people gave feedback on the day but also wrote notes that could be triangulated with the audit responses and the practitioner survey.

- 7 visits across 6 organisations took place by YSP (Dudley and Walsall Mental Health Trust, National Probation Service, Walsall Children's Social Care, Walsall Healthcare Trust, Walsall Youth Justice Service and West Midlands Police).
- 17 feedback forms were completed by YSP in total, across the 7 visits.
- Specific follow-up from DWMHT found that CAMHS had implemented improvements suggested by YSP to their waiting rooms.
- Walsall Healthcare Trust invited YSP to be involved in future engagement activities for the new A+E building.

Other activities within the year:

- Children, young people and professionals were brought together from across the 4 areas within the Black Country, to work in partnership and co-produce an innovative and unique conference, funded by NHSE - 'Our Voices, Our Shoes' which saw young people supporting and facilitating the event, which covered issues of alcohol and substance misuse, gangs and exploitation, domestic abuse and living with mental health issues.

  The conference saw 157 children, young people and professionals jointly exploring how health services can be delivered more effectively. 127 pledges were made by the delegates of ways that the learning and messages they had been given on the day, were going to be taken in to their daily personal and working lives, in order to make changes and support this vulnerable group.

- YSP held a re-launch event to attract new members with presentations to the Independent Chair and Head of Safeguarding from Local Authority Children's Services.

- In May 2019, a new Anti-Knife Crime Project was launched. It is a partnership between various voluntary and community sector organisations being led by One Walsall. 'At the cutting edge' held a special production event to showcase the skills and talents of young people in Walsall in facing up to concerns around the prevalence of knife crimes across the borough.
- This event was part of a wider project looking to:
  - reduce the number of incidents of knives being carried to school
  - reduce the number of injuries received from use of knives
  - change perceptions about personal safety and the need to carry a knife.

- Other work has also included membership of a regional engagement group to share ideas and progress the engagement agenda for both children and adults:
  - mapping existing engagement activity and opportunities for next year for both children and adults

- establishing a network of schools participating in the School Nurse Champions programme with the aim to add Safeguarding priorities as part of this offer.

Areas of work for 2020/2021

- Increased engagement for adults with care and support needs
- Embed engagement of safeguarding into existing School Nurse Champions to increase young people's engagement and expand YSP membership
- Seek opportunities to maximise the Partnership's involvement in existing engagement opportunities' (e.g. votes for schools, Street Teams, the work being undertaken as part of the TCE bid)
- Gathering feedback from children and young people on their experience of safeguarding services
- Invest in resource for Engagement within the Safeguarding Partnership, exploring options of either a job role or commissioning a service.

5. Serious Case Reviews and Child Safeguarding Practice Reviews

Walsall launched its new arrangements in September 2019. Therefore, half of the financial year the Board was working to Working Together 2015 guidance in relation to Serious Case Reviews and then moved to Working Together 2018 in September for Child Safeguarding Practice Reviews.

Within the period of this annual report the partnership:

- commenced SCR W12
- have completed 3 reviews – SCR W9, W10 and W11,
- have published – 0 reviews (W10 and W11 are delayed due to ongoing criminal proceedings)
- once SCR 9 had been completed and all the information had been gathered a decision was taken by the Leadership Group and agreed by the National Panel that the SCR criteria was not met. Therefore, this SCR will not be published primarily because of the impact on the family. However, the learning has been shared and acted upon as relevant.
- have contributed to 2 out of Borough SCR's.
- have undertaken 1 Rapid Review

Other Reviews:

- Undertaken 2 Learning Reviews.

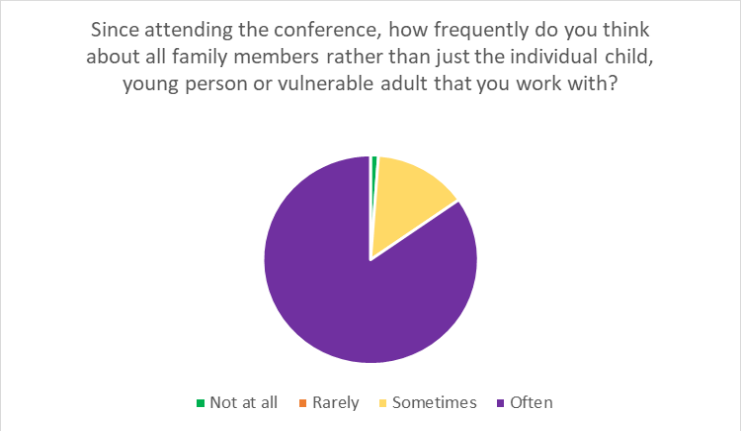
Once completed, reviews are published on our Safeguarding Partnership website. Multi-agency action plans are in place for all reviews and are monitored via the Practice Review Subgroup.
Key learning and themes have been identified and include:

- Professional curiosity about apparently 'absent' fathers.
- The need to harness the Third Sector when working with families who appear 'hard to engage' with statutory services.

- The need to ensure full understanding of a parent's history, including their childhood or time in care, when undertaking assessments of their current parenting capacity.
- Information sharing between agencies about risk, including risky adults and offenders.
- Understanding the motivation for connected carers to foster children from within the family and the pressure they may be under and how this may differ from the motivation and pressures of those who become career foster carers.
- Learning of national interest was shared with the National Panel and Ministry of Justice about the lack of community supervision for violent offenders who have served their full sentence but do not meet the threshold for MAPPA.

Learning has been shared via newsletters, 7 minute briefings (e.g. neglect, domestic abuse), updated multi-agency training programmes (including face to face, online courses and practice reflection workshops), on the Partnership website and a large multi-agency briefing session took place in June 2019. Policies and procedures have also been changed as a result of learning from the above.

In January 2020, the partnership hosted a Think Family conference to promote a joined-up approach across services, supporting practitioners to think about all the needs of all individuals within a family or household. The conference was attended by 198 professionals across two, half day events.



Not at all = 1.8%

Rarely = 0%

Sometimes = 14.1%

Think Family Conference feedback

Practitioner Comments:

"We are currently working with a young person and their behaviour is impacting on the rest of the family. By using the whole family approach, we are trying to ensure that the whole family is supported."

"When discussing cases I am more able to advocate for children and families due to improved knowledge."

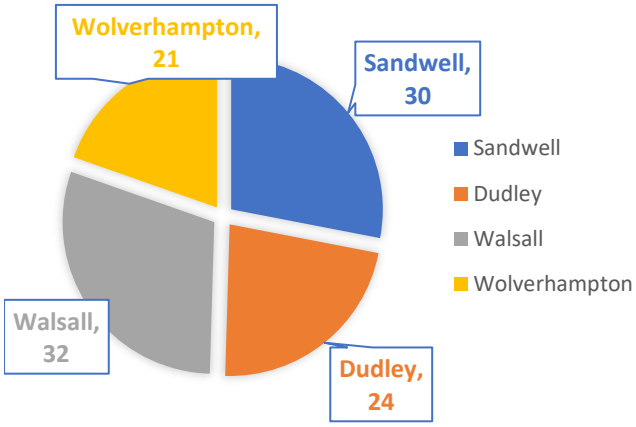
"Now I have an increased knowledge base, I am able to ensure there is a smooth transition for children into adulthood by looking at this earlier and knowing what services are available to support."

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

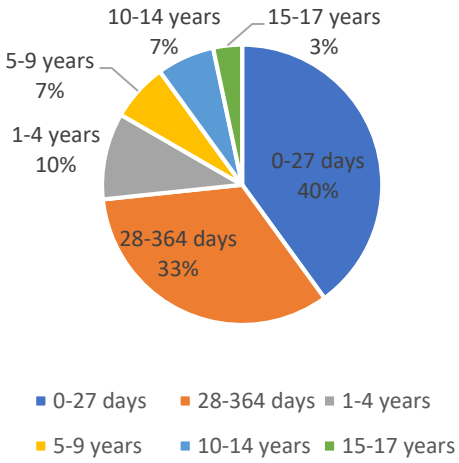
6. Additional Safeguarding Workstreams and Responsibilities

Child Death Reviews

- The new Child Death review arrangements went 'live' in September 2019 and are now part of a joint Black Country arrangement.
- As required by Working Together 2018, all relevant information relating to Child Deaths was successfully transferred over from the LSCB to the CCG and Public Health.



- There were 107 Black Country child deaths reported in 2019 – 2020; 32 of these were Walsall residents.



- 40% of the deaths in Walsall occurred in the 0-27-day (about 4 weeks) age group which is slightly lower than the national average for this age group which is 42%.
- 7 of the 32 deaths notified in this timescale in Walsall were unexpected and a Joint Agency Response was carried out.

84 deaths were reviewed in total across the Black Country. 30 of these reviewed deaths were Walsall resident child deaths. 33% of these deaths were identified as having modifiable factors.

These were identified as:

Smoking during pregnancy or smoking in the household; high BMI of expectant mums; consanguinity; alcohol misuse; late booking of pregnancy; sharing of information; safe sleeping practices; poor housing conditions.

Local interventions:

Newsletters are disseminated following every panel outlining learning.

Hospitals across the Black Country are all hoping to be 'smoke free' by the end of 2020 and support strategies for expectant mums who are smokers are being implemented through Local Maternity Systems.

Public Health Walsall are working with health agencies on several Infant Mortality Reduction workstreams.

Domestic Abuse

- The revised Domestic Abuse strategy was due to be relaunched in summer 2019 but has not yet been agreed by the Safer Walsall Partnership.
- A new Domestic Abuse Steering Group is to be established for 2020-21.

Safeguarding Procedures

- Walsall has continued to participate in the Regional Safeguarding Procedures consortium.
- This year has seen the final year of the 3 year contract with the current service provider. It has been agreed that this will be extended for an additional year in 2020-21 to enable the contract to be re-tendered.

Section 11 Audit

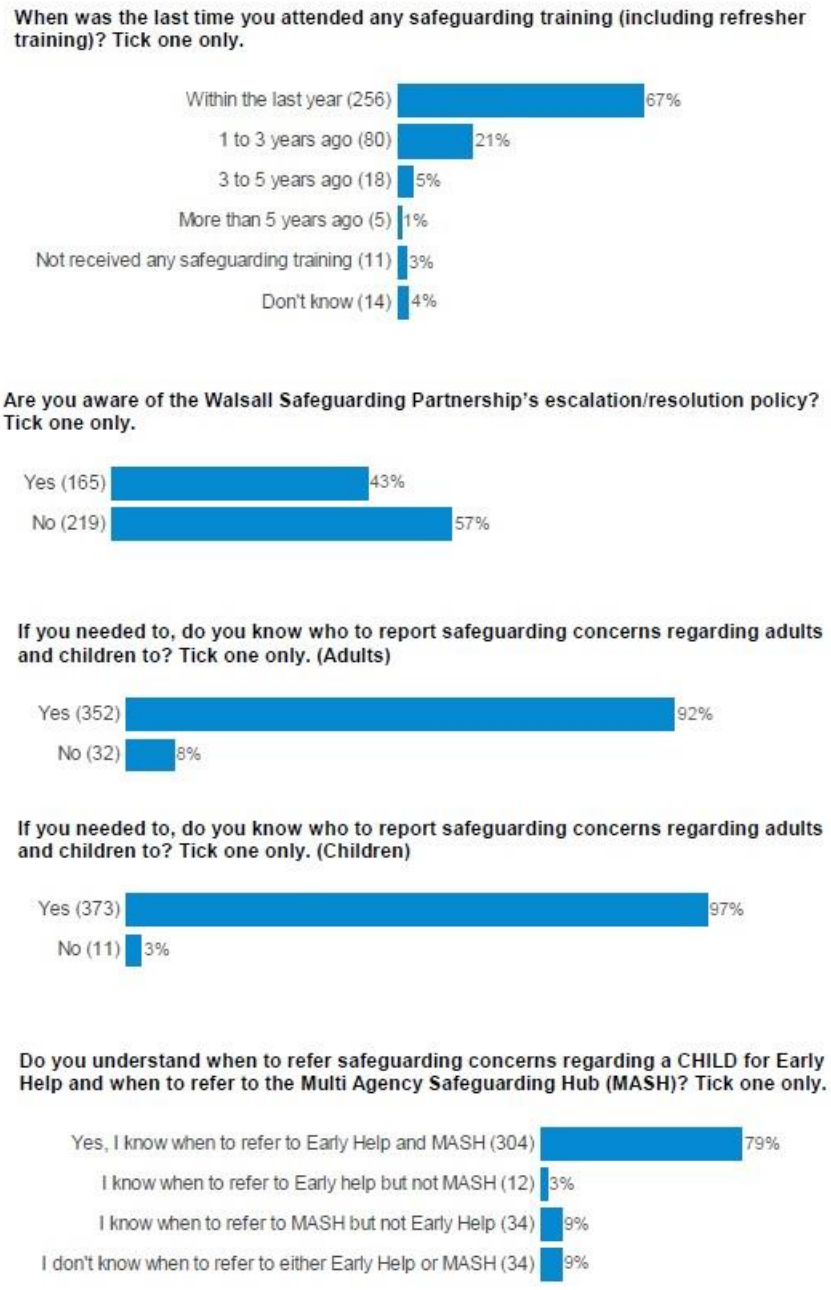
The Section 11 Audit was completed in March 2019. An initial analysis report was presented in July 2019 to Leadership Group which showed a high level of reported compliance with the Section 11 standards however, it highlighted the following areas for further assurance:

1. Assurance of how each agency are embedding the Neglect Strategy (completed though challenge event)
2. Impact of safeguarding training, embedding SCR learning into practice (completed through challenge event)
3. Further evidence of how the voice of the child is shaping service delivery (completed through the YSP Visits)
4. Further evidence of how agencies are evaluating outcomes from the perspective of the child or young person (completed through the YSP Visits)

Agencies submitted action plans to outline how they intended to address areas which did not meet the required standard.

In November 2019, a practitioner survey was undertaken to further quality assure the

initial findings reported by the agencies in their s11 audit returns. There were 384 responses across adults and children's safeguarding workforce. The findings of the surveys were analysed and used to form the set of challenge questions for a peer challenge session. Some of the responses can be seen below:



Some of the responses to the above questions are also played out in audits and reviews, such as use of escalation and data measures, and such as the reduction in MASH referrals.

Later in November an assurance and challenge event took place where partners came together to discuss, challenge, and hold each other to account.

Recommendations from the challenge and assurance event will be included in each agency's Section 11 action plan and monitored on a six monthly basis by PQA.

Multi Agency Safeguarding Training

- The partnership has offered a programme of multi-agency training.
- From 1st April 2019 to 31st March 2020, 21 Training Events (total 69 face to face sessions and 3 eLearning Modules) were delivered and 1,231 delegates have successfully completed this training.
- This year saw an increase of 28.7% in attendance compared to the previous year; in addition, 298 people attend the conferences.
    - 307 hours of training and development was accessed
    - 114 delegates booked a space on the training but did not attend
    - This year's programme, across the children's and adult's workforce, has included the development of 3 Partnership eLearning Modules and 5 Practice Reflection Workshops with the themes of:
        - Right Help Right Time
        - Self-Neglect
        - Transition
        - Neglect
        - SEND Transition

- The Practice Improvement Strategy and Competency Framework has been revised and agreed.
- The partners have also supported the programme with a training pool, with 69 practitioners from across the partnership.
- The Business Unit has successfully recruited a new full-time role of Practice Improvement Manager, to support this area of work.

<u>Areas of work for 2020-21</u>

- To embed Impact evaluations across the partnership as part of management oversight and supervisions.
- To revisit the Practice Improvement Strategy and Competency Framework, to explore any gaps in the learning and development offer.
- To develop joint children's and adult courses in relation to Exploitation and Domestic Abuse.

7. Summary: Evaluation of the Safeguarding System

How safe are children in Walsall?

Evaluating the multi-agency audit from June 18 to practice at the end of 19-20 shows a range of practice improvements.

There has also been evidence of some other improvements within the year which includes:

- An appropriate reduction in referrals to MASH
- Positive impact of Early Help services (as evidenced in the data at the beginning of the report)
- A positive Ofsted inspection of the 'front door'
- Positive reductions seen in the number of children subject to child protection plans.
- Less cases judged inadequate through audit, however as the majority were judged as 'requiring improvement' this means a reduction in those that were 'good'.

Rating	2017-18	2018-19	2019-20
Good	32%	37.5%	23%
Requires Improvement	45%	45%	62%
Inadequate	23%	17.5%	15%

Areas for further development include:

- The development of an all-age exploitation pathway, hub, and screening tool to support the identification and response to children who are victims of all forms of exploitation as there are inconsistencies between pathways for CSE and CE and there remain issues in reporting missing children at "no apparent risk" to the local authority promptly.
- Ensure consistent application of the Right Help Right Time Continuum of Need
- Continued focus on practice in high impact areas such as Neglect, Child Sexual Abuse and Exploitation.
- Continue to develop our approach to identifying learning across the system and implementing it (see 'Are we a Learning System' below).
- Launch the Family Safeguarding Model.
- Utilise the TCE programme to enhance our response to exploitation.

How strong is partnership working?

- The successful TCE bid was submitted and coordinated by the CCG ensuring an inclusive partnership approach.

- External evaluation of the strength of partnership working has been positive e.g. successful TCE bid and FSM (due for launch April 2020 – this was delayed until October 2020 due to Covid 19).

- In addition, the partnership has created a pool of multi-agency trainers to support practice development.

- Partner agency contributions to learning reviews is positively commented on by external reviewers.

- The Ofsted LA Focused Inspection noted 'Leaders have a good understanding of their strengths and areas for improvement, with aspirational plans in place to effect positive change.'

- There is generally good attendance and contribution by all partners at meetings across all levels; however, progress in implementing key work streams is an area for development.

- There is a financial commitment to the partnership arrangements with a jointly funded Business Unit.

- Partners report they find meetings are interactive and developmental and 'do not simply process papers and reports.'

- The investment in the Impactful Partnership Programme shows a commitment to developing local leaders.

- There is a mutual commitment to improving practice through investment in the post of a Practice Improvement Lead. The post is hosted by WHT but based within the Business Unit and will enhance learning and development across the partnership.

- There are well established relationships between senior leaders which are utilised to resolve issues and escalations in a dynamic timeframe and to do so in a professional and supportive manner.

- There is a commitment to developing new ways of working, especially through a strong connection with Walsall Together, the integrated care partnership aimed at improving the health and wellbeing outcomes of the local population.

- Some evidence of impact of challenge, but work to do, to ensure more timely impact; the governance role of the Operational Subgroup is critical in this.

- There has been evidence of positive working arrangements, however, there have also been challenges. For example:
  - The new Safeguarding Arrangements, in line with Working Together 2018, have offered an opportunity to re-align the Leadership and accountability for the safeguarding agenda and develop a new vision for the Partnership. However, this year has been a time of change in strategic arrangements and, also, in the leadership and structure of CCG and health providers which has led to variations in the membership or consistency of attendance of some meetings.

- The frequency of newly established partnership meetings was less than planned which is not ideal. The wider 'Childrens Partnership' group did not meet between October 2019 and April 2020.
- There has been challenge at Board and Leadership meetings by and of partners e.g. regarding the health contribution to MASH.
- The response to Neglect is improving but progress in implementing the Strategy has been slower than intended in some agencies.
- There is representation by the Public Protection Unit at relevant meetings, but the unit services 4 LA areas and capacity can be an issue. There are plans to review this in 2020-21.

Areas for further development include:

- Finalising the agreed arrangements for health economy contribution to MASH.
- Further engagement with the voluntary and community sector including the implementation of our Engagement Strategy.
- There is not yet a Domestic Abuse Strategy for the partnership, which is a significant risk from last year that requires addressing.
- Resolving the impact of one agencies systems on the practice within another e.g. Police missing notifications.
- Appointment of a Designated Doctor is a priority.
- Ensuring an equal voice and accountability of all partners – this will only happen if all partners fully understand and effectively uphold their partnership roles.
- Effectively utilise and build on the leadership development that has already been undertaken.
- Continue to enhance the involvement of children and families in the work of the partnership.

Are we a learning system?

Rapid Reviews (RR's) and local Child Safeguarding Practice Reviews (CSPR's) will be conducted and overseen by the Practice Review Subgroup, within the new arrangements. A recommendation from the RR panel will be made to the Independent Chair, for their scrutiny, regarding whether a case will progress to a CSPR or whether all relevant learning has been identified. Resulting multi-agency action plans are developed and included within a thematic tracker. The thematic tracker was developed to help reduce duplication of activity or repetition of previous ineffective actions and to focus the partnership on areas of concern which are arising from multiple reviews.

- The partnership have produced several 7 minute briefings on issues which have been identified through reviews (e.g. Professional Curiosity, Think Family) and there has been a regular Neglect Newsletter produced to share good practice and ensure a maintained focus on this area.
- The multi-agency training programme has been shaped by learning from audits and reviews and the priorities within the partnership e.g. webinars on neglect and domestic abuse. Improvements have been made (e.g. including

front line practitioners in audits and the role out of Practice Reflection Workshops based on identified learning themes) but we are not yet operating as an effective learning system. There is more to be done to achieve this including strengthening the functioning and oversight role of PQA Subgroup, strengthening the audit methodology and learning from elsewhere.

This will include:

- A further review of the multi-agency safeguarding training offer, opportunities for practice improvement and the capacity to deliver on this across the partnership.
- Evaluating the impact of training.
- Engaging with children and young people in a meaningful way (as our 4th partner in the new arrangements)
- Embedding and ensuring that learning translates into impact for families, as currently we cannot consistently evidence the impact of learning on practice and outcomes.
- Regularly sharing single agency audits with partners and subgroups; West Midlands Police have created capacity to implement an internal audit schedule and this will include sharing the findings with the Safeguarding Partnership.

Opportunities

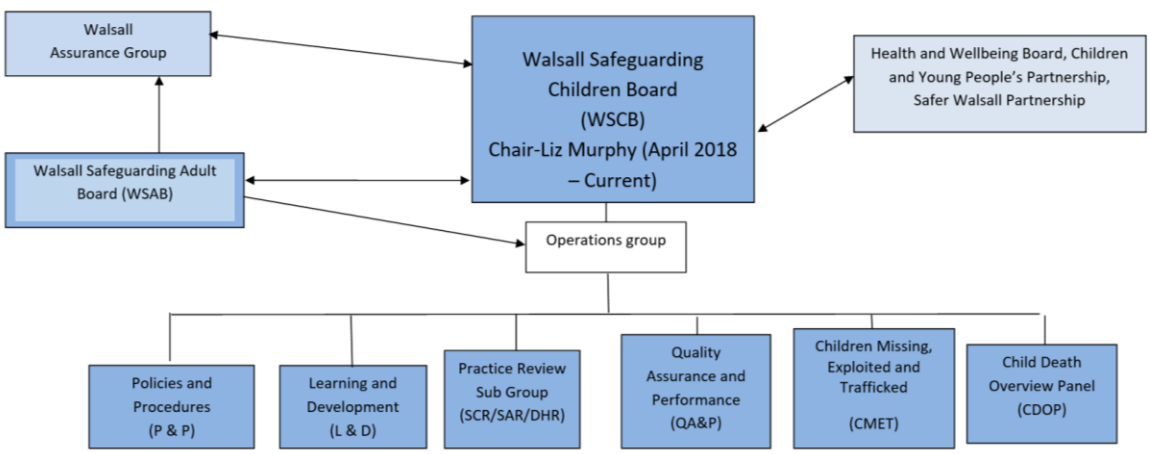
- The new arrangements offer the opportunity to renew the partnership governance structure and work more closely with other partnership boards (such as Safer Walsall Partnership – Community Safety).
- Increased capacity will be created to support the delivery of a robust multi-agency Practice Improvement Programme with the appointment of a full time Practice Improvement Manager – following a successful secondment during 2019-20.

Priorities and Next Steps in 2020-21

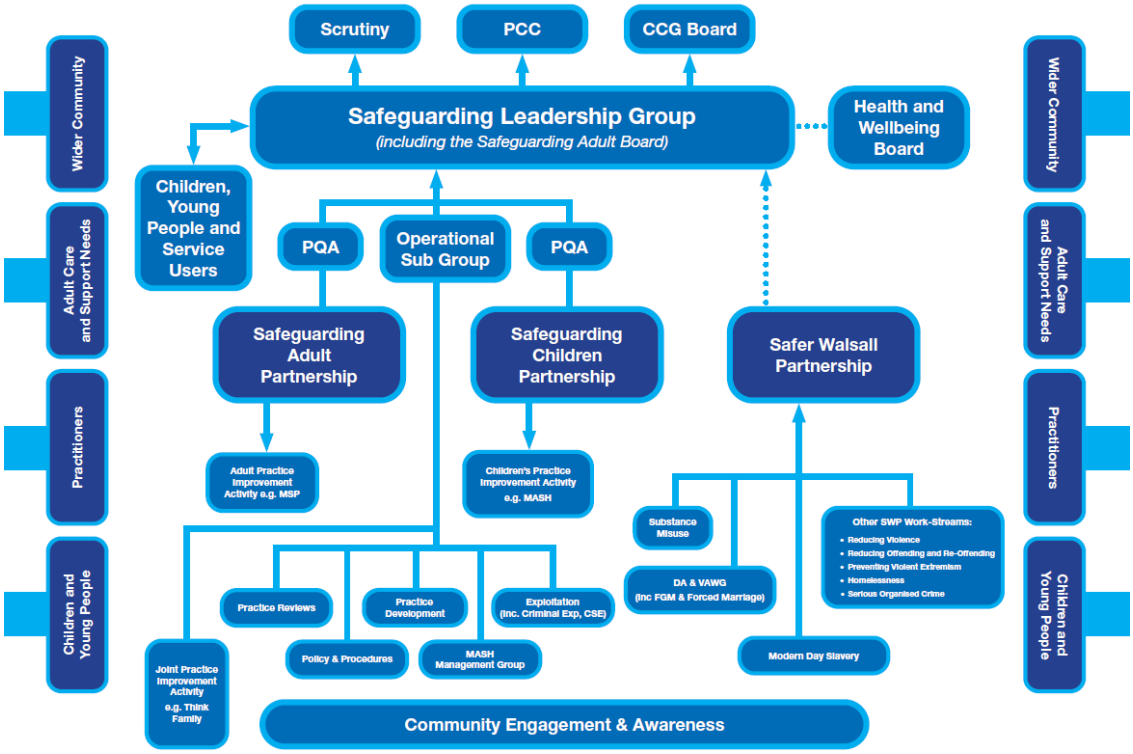
- Launch the CSA strategy and begin work on the action plan.
- Launch the Criminal Exploitation Pathway and Assessment Tool.
- Increase the pace of implementation of the Neglect Strategy following the review of the strategy.
- Review the New Safeguarding Partnership Arrangements.
- Implement the Family Safeguarding Model.
- Continue to develop and refine our approach to embedding learning from performance, audit, and reviews.
- Ensure children, young people and service users are actively engaged in the partnership.
- Increase the visibility of the Safeguarding Partnership.
- Continue to ensure strong safeguarding leadership across the partnership.

Appendices

Appendix 1. LSCB Structure



New arrangements structure



Appendices

Appendix 2. Walsall Safeguarding Children Board / Partnership - Meeting attendance April 2019 – March 2020

2 meetings were held (June 2019 and October 2019), January 2020 and March 2020 were postponed.

Organisation / Member	Total % attendance
Independent Chair	100%
Lead Member/Councillor	0%
WSCB Business Unit	100%
Children's Services, Walsall Council	100%
Community Safety Partnership	0%
Clinical Commissioning Group	100%
Education	100%
Walsall Healthcare NHS Trust	100%
Walsall College	100%
West Midlands Police	100%
National Probation Service	100%
Designated Doctor for Safeguarding	0%
Public Health, Walsall Council	100%
Dudley & Walsall Mental Health Partnership Trust	100%
CRC (Reducing Reoffending Partnership)	50%
Youth Justice	100%
CAFCASS	0%
Housing	50%

There were 6 Leadership Group meetings between July 2019 and March 2020.

Organisation/member	Total % attendance
West Midlands Police	100%
Adult Social Care	67%
Children's Social Care	100%
CCG	83%
Access and Achievement (Education)	67%
Public Health	100%
One Walsall (VCS)	50%

Appendices

Appendix 3. Budget

	Budget 2019-20 Total	Actual 2019-20 Total
Funding	**£**	**£**
Walsall Council Contribution	(51,584)	(51,584)
Walsall Council Additional Investment	(200,000)	(200,000)
NHS Walsall	(10,000)	(10,000)
Probation Services (NPS & CRC)	(3,000)	(1,500)
West Midlands Police	(30,594)	(31,209)
CAFCASS	(550)	(550)
CCG	(40,000)	(70,000)
CCG Additional (One off)	(15,000)	(15,000)
Other Training	0	(3,105)
Other CDOP	6,264	1,620
	(344,464)	**(381,328)**
Costs		
Salary Costs	254,190	250,263
Agency	0	13,644
Consultants Costs	4,000	4,586
Workforce Development SLA	25,000	10,319
Section 11/157/175 Tool	3,000	0
Chronolator Tool	1,580	850
SCR / SAR	38,008	25,327
Development Day / Conference	0	3,627
Development Activities	0	2,727
PHEW - Online Child Protection Procedures	686	686
Other Costs -	6,000	11,395
Online booking system	2,000	0
Service User Involvement	10,000	621
	344,464	**324,044**
Carry forward to be request/(use of reserve)		**57,374**
Forecast Outturn Over / (Under)	**0**	**90**

Appendices

Appendix 4. New Arrangements

In September 2019 the Safeguarding Children Board, in partnership with the Safeguarding Adult Board, disbanded the LSCB and launched their new arrangements in line with Working Together to Safeguard Children.

The Partnership Arrangements can be found here.

Walsall Council

Item 6c

Health and Wellbeing Board

26 January 2021

Family Safeguarding and Sustainability

1. Context

Family Safeguarding in a partnership project “co-owned” by a number of partners including Black Country Partnership NHS Foundation Trust, Walsall CCG and Walsall Together. These partnersplayed a vital and active role in the scoping and start-up of Family Safeguarding. Since “go live” there is emerging Walsall data suggesting a positive impact which mirrors national research. We now need to establish an approach to sustainability in collaboration across the partnershiphealthcare is central to this in terms of identifying a sustainable funding solution and there will also be benefits to the wider Walsall system partnership.

2. Background

The Family Safeguarding Model, grant-funded by the Department of Education was launched in Walsall on the 1st September 2020 and brings a whole-system partnership-led change approach tackling the impact of the ‘trio of vulnerabilities’ of parents (domestic abuse, substance misuse and mental ill-health) on children’s lives. Specialists (including mental health practitioners) work in unified safeguarding teams to share information, to provide support, and to prevent parents reaching crisis stage. This provides better outcomes for children by keeping families together, addressing root causes, and preventing children from entering the care system. There is a wealth of evidence available externally which supports this.

3. Current situation

a. Clear sign up from partners to support the model going forward (evidenced by signed pledges).
b. Established outcome framework commended nationally.
c. Over 170 children already being supported.
d. Clear case examples of parents improving their health and changing outcomes as a result of the intervention of the specialist adult workers.
e. Robust data showing a reduction in the number of children on a child protection plan.

f. Sustainable funding for the adult specialist workers (four from the NHS) yet to be identified.
g. Emerging learning about an integrated cross-partnership practice model which is already informing other models of delivery for the health economy.

4. Outcomes

Below are the outcomes for the family safeguarding model in Walsall which clearly relate to the outcomes across the health economy in terms of the better start to life and improved mental health (those especially relevant are in bold). Additionally there is a specific outcome focussed on partnership working between the local authority, health and others.

Families remain together at home where it is safe to do so.	Families receive the right level of support, when they need it, for the right amount of time	Fewer families experience issues relating to the trio of vulnerabilities and receive better support (Domestic Violence, Mental Health, Substance Misuse)	Improved engagement in school and improved academic attainment	Professional collaboration across partnership organisations provides a holistic, joined up service for children and families.
1) Fewer children move into care proceedings 2) Fewer children become looked after. 3) More children who come into care are reunited with their families.	**1) Fewer children are re-referred into statutory services following an intervention.** 2) The duration that children receive statutory services is relevant and appropriate. **3) The amount of time families wait for specialist interventions is reduced.**	1) Domestic violence decreases within families in Walsall. **2) Parents affected by substance misuse are supported to manage these well.** 3) **Parents are more resilient and receive timely support for mental health issues**. 4) Families are more resilient	1) Attendance at school is improved and fewer children are excluded. 2) Academic attainment and outcomes for children and young people improve. 3) Children and young people are able to and are accessing education, employmen	1) Relationships across partner organisations and professionals improve 2) Multi-disciplinary team working is effective. 3) Staff are motivated, confident and have the skills they need staff retention improves.

			t and training.	

The key health outcomes for Walsall which link specifically to family safeguarding being

a. Population health; there is robust national evidence and local case studies showing that family safeguarding is improving academic attainment of vulnerable children and improving the mental health of all family members leading to a good start in life and improved health and happiness.
b. Accessible coordinated and responsive care; National evidence and reports from Walsall staff are already showing that families appreciate the improved coordination and support of family safeguarding. The support is offered at an earlier stage reducing morbidity and improving health outcomes, especially those associated with looked after children and parents with drug and alcohol, mental health and domestic violence.

5. Supporting evidence

National research shows a clear reduction in costs for partner organisations in terms of time spent with families on child protection plans and specialist services for looked after children. We are commissioning specific work in Walsall to enumerate these benefits and consider wider impacts.

We have nearly completed a partnership-dashboard to evidence key performance indicators which will measure both the improved outcomes and cost reduction, these are largely based on findings from other areas which have implemented family safeguarding. However we acknowledge we are in unprecedented times and as such baselines/norms could be difficult to establish. Crucial measures for health partners include:

a. Reduction in accessing of mental health crisis services; home treatment teams and psychiatric liaison.
b. Reduced referral to and accessing both GPs and outpatient appointments.
c. Reduced number of accident and emergency attendances.

6. Recommendations

a. Health and wellbeing Boardto consider what outcomes they would be seeking to achieve to want to invest in this model going forward.
b. Health and Wellbeing Board to identify the mechanisms for how any future contributions to the sustainability of Family Safeguarding can be agreed.
c. Health and Wellbeing Board to identify strategic connections and opportunities to embed the approach and share the learning.

d. To invite the board to enter into further discussion outside of Health and Wellbeing Board to consider the contents of this report to develop a plan for sustainability, to enable a further more detailed paper to be considered at the April meeting which sets out proposals for sustainability.

Report Author
Helen Billings
Family Safeguarding Programme Lead
19.01.2021

Health and Wellbeing Board
26th January 2020

Agenda item 7

Walsall's Joint Strategic Needs Assessment

1. Purpose

The purpose of this report is to update the Board on the progress of the ongoing JSNA.

2. Recommendations

- 2.1 That the health and Wellbeing Board (HWBB) note the JSNA related material on the Walsall Insight Website page
- 2.2. That the HWBB note the indicators on the Public Health Outcomes Framework 3x3 Performance Matrix.

3. Report detail

- In the last report to the board, we proposed that the JSNA refresh would follow the following 5 themes:
    - Healthy Start
    - Adult Wellbeing
    - Ageing Well
    - Place
    - Economy

- The Public Health Outcomes Framework (PHOF) 3x3 performance matrix was introduced and is used to facilitate the identification and shaping of strategic priorities. The matrix can be accessed here:

Figure 1. Walsall's PHOF Performance Matrix

- The 3x3 matrix arranges the PHOF indicators as a simple matrix to gauge where Walsall is performing **better than statistical neighbours & improving**vs **worse than statistical neighbours & deteriorating**, and all permutations in-between.

- A workplan has since been developed to determine key data/information sources and appropriate partners to update each chapter and theme.

- Power BI software is being utilised to present Walsall's JSNA with all work on the JSNA being presented in this way. As an example, Chapter 1 has been completed using this platform , to give the end user a more dynamic experience. This can be viewed at the link here:

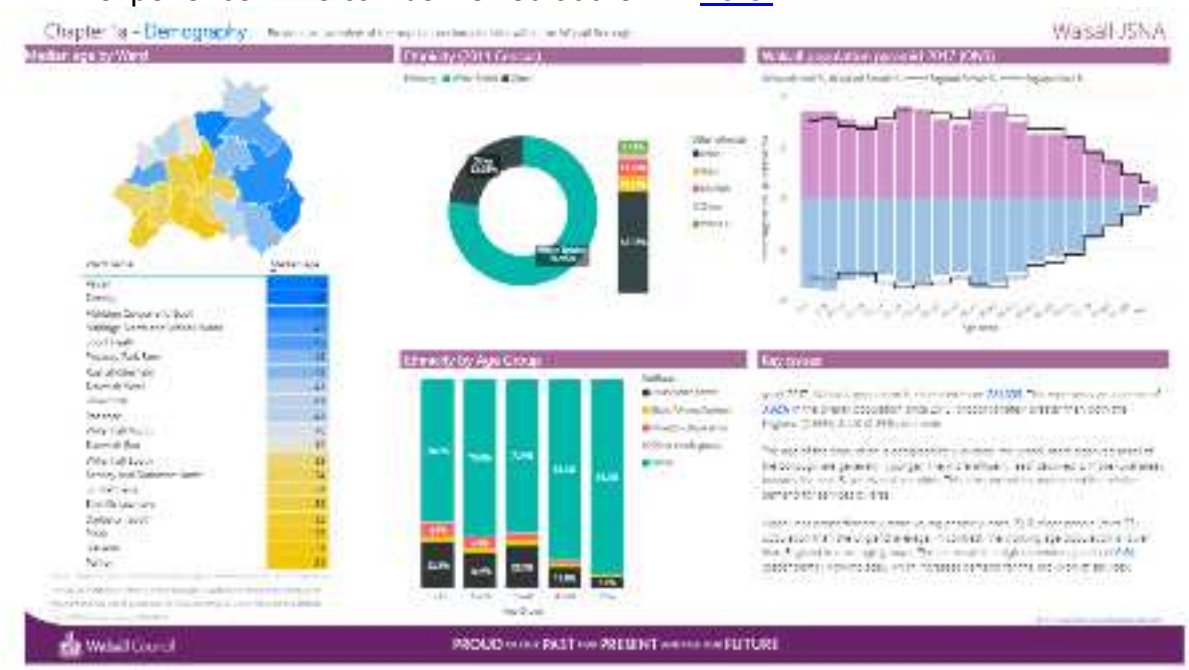


Figure 1. Chapter 1 of the JSNA on Walsall Insight Website

- However, due to the COVID -19 pandemic, which has placed unprecedented pressure on all partners, the timeframe for the refresh has been delayed, but has commenced again recently and will be used to feed into priority setting for the Walsall plan.

4. Implications for Joint Working arrangements:

There are no financial, legal or other resource implications of this report.

5. Health and Wellbeing Priorities:

- It is the responsibility of the HWBB to have a JSNA and use it to inform the HWBB health and Wellbeing Strategy.

- By using the Intelligence derived from the JSNA and the 3x3 matrix, the HWBB can be confident that they are making evidenced based decisions, and will contribute to the Walsall Plan from their perspective as a partner.

Background papers

The Walsall JSNA is available as a key topic page on the Walsall Insight Website at this link.

Author

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Walsall on the Move Priority **Agenda Item 8**

15 January 2021

Work-stream Update

1. Purpose of the report

To provide an update on the progress to date with regards to the Walsall on the Move priority, aimed at improving physical activity within Walsall Borough and improving health and wellbeing by encouraging a smoke free environment.

This report will feed into the Health and Wellbeing Board.

2. Report detail

2.1 During 2020 many of the scheduled meetings did not take place due to the COVID pandemic and emergency response. Meetings which took place where on 23 January, 20 August and the last meeting was 17 September 2020.

2.1.2 At the January meeting a discussion took place to agree priority outcomes with partners and to identify plans for the long term future.

2.1.3 All partners where tasked with detailing their current activity and position by January 2020 under the Headings:

- Workforce Wellbeing including Travel Plan in the workplace
- Smoke Free Sites and best practice sharing through the partners
- Walsall on the Move – Physical Activity

3. Actions to date

The following has been progressed to date:

3.1 Developed a draft Walsall on the Move pledge

3.1.1 Set-up a repository for policies

3.1.2 It was agreed a joint survey and communications for our colleagues in each workforce be rolled- out, however this has been put on hold.

3.1.3 It was agreed a partnership event for Autumn 2020 which was not progressed

3.2 Current position under the following headings:

- Workforce Wellbeing including Travel Plan in the workplace

All organisations agreed to have a published travel plan however this has been delayed.

- Smoke Free Sites and best practice sharing through the partners

All organisations have implemented Smoke Free sites from April 2020.

- Walsall on the Move – Physical Activity

During the COVID pandemic and the restrictions with social gathering this impacted on developing and sharing physical events. Whilst July and August local initiatives and group activities have begun againthis was short-lived.

Discussions at the August and September meetings it was suggested that an event be planned for January 2021 such as a '500 mile virtual walk' be organised and that we would build upon this as we progress towards a new normal.

The introduction of the Tier system and then national lockdown has halted progressing this.

4. Implications for Partnership Working and Resourcing

There are no current implications for the partnership working arrangements however there will be a need to be mindful of the COVID pandemic, and any further local or national outbreak that would take resources and attention away from the priority in the short to mid-term.

Contact details: Catherine Griffiths – Director of People & Culture – Walsall Healthcare NHS Trust. Catherine.griffiths@walsallhealthcare.nhs.uk

END

Health and Wellbeing Board
26 January 2021

Agenda item 9

BETTER CARE FUND 2020/21 ASSURANCE UPDATE

1. Purpose

This note provides an update in relation to the 2020/21 Walsall Better Care Fund and Improved Better Care Fund programme.

2. Recommendations

2.1 That the Health and Wellbeing Board receivesthe update and is assured the Walsall Better Care Fund programme (BCF) has been subject to review of performance and spend during financial year 2020/21 in the absence of normal national reporting requirements.

3. Report detail

3.1 During 2020, the national BCF teamadvised mandatory quarterly reporting would be suspendedto support local areas in focussing priorities towards their response to the pandemic, COVID-19. This meant local BCF Managers would not attend Health and Wellbeing Board to present quarterly BCF returns as per previous financial years.

3.2 Alongside the suspension of national reporting, the national team also advised BCF2020 policy and planning requirements and guidance would not be published during this period. In the absence of guidance, local areas were asked to roll-over 2019/20 programmes into 2020/21 to supportcontinuity of provision, social care capacity, system resilience and spend from ring-fenced BCF pooled budgets based on local agreement in 2020 to 2021, pending further guidance.

3.3 To support the review of spend across programmes during 2020/21, the 2020 BCF policy statement published on 3 December 2020, requested local areas to complete an expenditure template.
The template will outline income and expenditure, including mandatory minimum contributions from the Clinical Commissioning Group (CCG), and the use of the Improved Better Care Fund (iBCF) grant and Disabled Facilities Grant(DFG). The completed document with local BCF expenditure will be presented to members in April 2021.

4. Local position

4.1 As a result of the suspension on reporting, Walsall BCF quarterly returns have not been presented to members during financial year 2020/21, however monitoring of the programme has continued through agreed and established governanceroutes, whichremain in place.
Partners have continued to receive assurance and updates in relation to BCF performance and spend through detailed highlight reports presented to members of Walsall BCF Integrated Commissioning and Performance Group, and funding updates, issues with risk share, potential overspends and updates regarding additional COVID-19 funding through Walsall Joint Commissioning Committee Finance sub group.
Locally commissioning leads have focussed on specific schemes that have supported the local COVID-19 response and funded via BCF:

- The Integrated Equipment Store,
- Use of Discharge to Assess step down beds
- The use of re-ablement hours
- The Disabled Facilities Grant

These schemes have been aligned to COVID-19 funding provided by NHSE, allocated to Walsall Adult Social Care to support the system and managed by Walsall CCG. The Integrated Group also continues to monitor the local dashboard, being aware of the number of packages of care, utilisation of beds and length of stay.

4.2 Both Walsall BCF Integrated Group and the Finance group are sub groups of The Joint Commissioning Committee (JCC). All meet monthly to discuss matters relating to BCF. In relation to spend and performance of schemes, the JCC receive monthly updates regarding the monitoring of the 2020/21 programme, use of the COVID-19 fund and have been assured of performance across specific schemes through detailed reporting.

4.3 Moving forward, 2021/22 planning will begin, in line with published planning requirements from the national team expected before March 2021.
Governance will remain in place for BCF, with assurance and approval taking place at JCC level and operational updates, review of performance and spend through agreed JCC sub groups.

Background papers

2020 BCF Policy Statement
Better Care Fund: policy statement 2020 to 2021 - GOV.UK (www.gov.uk)

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Health and Wellbeing Board

Agenda Item 10

26 January 2021

Report of SEND Local Area Improvement Programme

1. Background

1.1. Following the SEND Local Area Inspection of Walsal Council by Ofsted and the CQC it was found that there were 9 areas of concern and that a Written Statement of Action (WSoA) was needed from the Council. The Statement of Action was deemed 'fit for purpose' by Ofsted in October 2019 and was published on the council's website: http://go.walsall.gov.uk/education/sendi.

1.2. The actions within the WSoA have been split across four workstreams: Co-production and Engagement, Improving Outcomes, EHCP Assessment Processes and Joint Commissioning.

1.3. A Local Area Improvement Board (LAIB) was established to oversee the implementation of the WSoA and meets monthly. The LAIB is independently chaired by Vicki Whittaker-Stokes – a parent and foster parent of children with SEND who has SEND needs herself and vice chaired by Teresa Tunnell, deputy chair of FACE – Walsall's parent and carer advocacy group for SEND. The board is also attended by the workstream leads, the relevant strategic leads from the LA, CCG, the chair of the Strategic Education and Inclusion Board (SEIB) and the portfolio holder for Education and Skills.

2. Governance

2.1. Over the past 12 months, the governance in relation to the WSoA has been reviewed and refined and continues to be improved.

2.2. The workstream leads along with other key operational leads who work in areas outlined in the statement of action meet on a monthly basis to discuss in detail progress of key actions, next steps and to resolve any issues in relation to the development of SEND services and the implementation of the WSoA.

2.3. The four workstream leads then prepare a highlight report for the LAIB outlining key achievements, key areas of concern and a general update. These reports are corroborated and supported by more detailed documents and an overview from the Programme Lead.

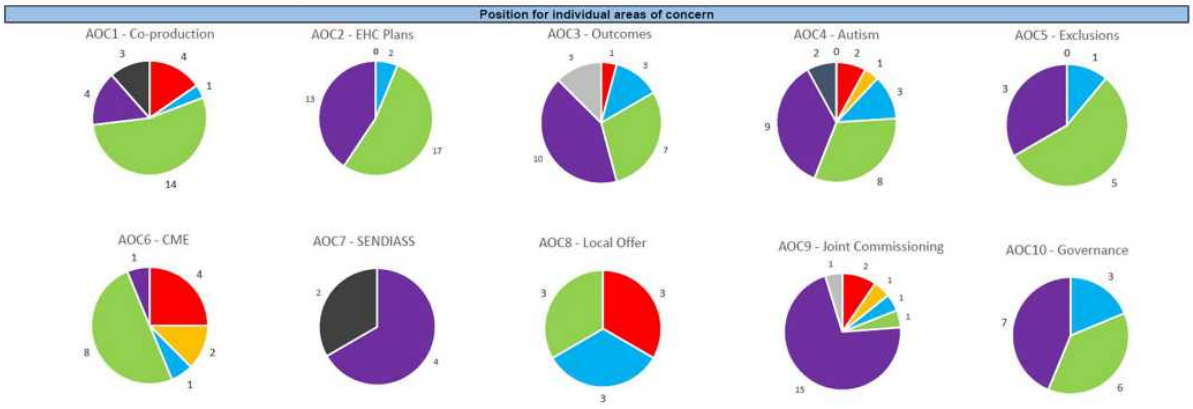
2.4. A recent Governance Review of the Board which included interviews with key members about how well they thought was working and what could be improved, identified a number of recommendations which were approved by the Board at the December meeting – these recommendations will be implemented over the coming months. One of those recommendations was to strengthen the links between the LAIB and the Health and Wellbeing Board.

2.5. Walsall's progress in delivering the statement of action and the effectiveness of the Board are monitored by the Department for Education (DfE) and Care Quality Commission (CQC) on a quarterly basis via their attendance at the LAIB. The outcome of these monitoring visits are shared via a letter from Pat Tait, our DfE lead and have always been positive, however, they also feature a number of recommendations for further improvement which are acted on between monitoring visits.

3. Progress against the WSoA and risk management.

3.1. Significant progress has been made against the actions outlined in the WSoA with 135 (73%) of the actions either completed or completed and embedded. 9% of actions are beyond milestone and these are being closely monitored via a risk log with assurances provided to the LAIB that there are mitigating actions in place. Where there are blockers to progress, these are discussed at LAIB with recommendations made in relation to next actions as to how issues may be resolved.

Not Started	Beyond Milestone	Delayed	Paused - Covid Exception	In Progress	Complete	Complete and Embedded	Closed	
0	16	4	4	18	69	66	7	Current Action RAG Ratings
Not Started	Beyond Milestone	Delayed	Paused - Covid Exception	In Progress	Complete	Complete and Embedded	Closed	
2	14	3	0	27	89	42	7	Previous Period Action RAG Ratings (October Board)



3.2. In addition to risks relating to specific actions, overarching risks to the programme are identified and raised with the Board where necessary. A recent risk was in relation to the capacity of Health colleagues to contribute to key areas of work – following a discussion at Board and the commitment from strategic leads to seek and implement solutions there has been a significant improvement in this area.

4. Key areas of progress

4.1. Covid-19 has caused a number of challenges in relation to the implementation of actions and the drive to improve the SEND offer for children and families in Walsall. Despite this, significant improvement has been made in a number of key areas.

4.2. Our Inclusion Strategy and Accessibility Strategies have now been written in co-production and consultation with partners and parents and carers. These have now been finalised and are due to be finally signed off by the LAIB at the February board.

4.3. We have also recently completed a public consultation on our revised high needs funding formula. High needs funding is accessed by schools based on the assessed needs to pupils. Now that the consultation is completed, the funding formula will be finalised and implemented.

5. Co-production and engagement

5.1. Co-production and engagement has improved over the past 12 months. As well as the LAIB being chaired by the deputy chair of FACE, regular Zoom sessions are also in place for parents, organised by FACE and the lead for co-production and engagement and attended by professionals from the council or partner agencies depending on the theme. Generally, two sessions on each theme are

held, one in the morning and one in the evening across a couple of weeks to maximise the opportunity for parents to be involved.

5.2. A survey was recently carried out with parents and carers of children with SEND in Walsall asking them for their feedback in relation to EHCP processes and this evidenced some positive feedback:

- 209 (69%) felt fully involved in EHCP process
- 136 (46%) felt child or children fully involved in process
- 143 (49%) felt there were opportunities for child or children's voice to be heard
- 219 (73%) had EHC process explained to them
- 225 (75%) felt they were able to ask questions throughout the process
- 201 (67%) felt their views were considered during process
- 145 (49%) felt their child or children's views were considered during process
- 202 (68%) felt their expertise and experience were valued throughout process
- 214 (78%) thought that the EHCP clearly set out support to be put in place

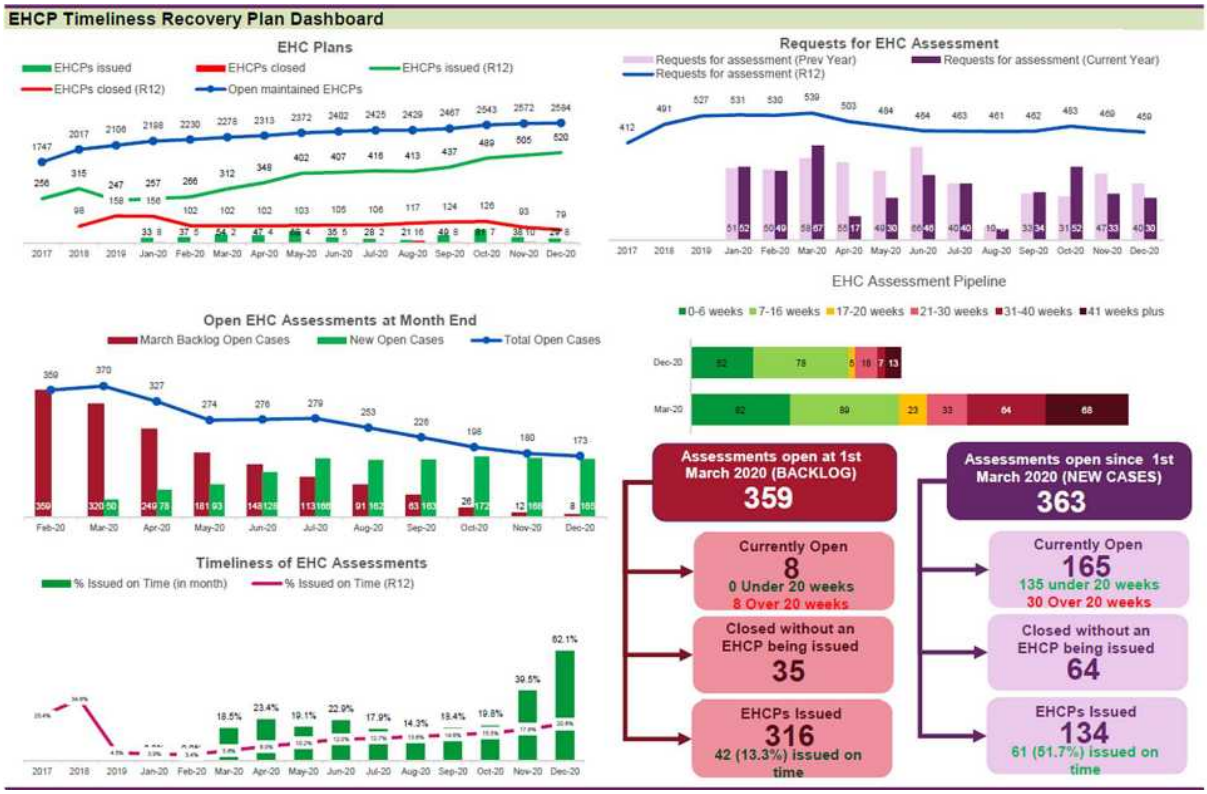
5.3. An action plan has been developed to take forward the learning from the survey and implement further improvements.

5.4. The local offer has been thoroughly reviewed with much of the information updated. Work is now taking place to implement a revised look and feel to improve navigability and ease of use.

6. Education, Health and Care Plan Assessment Processes

6.1. One of the key areas for improvement identified in the WSoA was in relation to Education, Health and Care Plan (EHCP) Assessment processes. Timeliness of EHCP assessments was outside statutory requirements (20 weeks) and the inspection highlighted that there was not clear information for parents and carers about what the process entailed.

6.2. A large backlog of assessments was identified and at the beginning of March 2020 and additional resources were put in place to clear the backlog. This work was completed at the end of October 2020. Throughout the year, both the backlog and new requests for assessment were closely monitored with a detailed dashboard and report being presented at each LAIB for discussion. Now that the backlog has been cleared, timeliness of newer assessments is rapidly improving.



6.3. An electronic, web based system for supporting EHCP assessments has been implemented (EHC Hub). This was piloted over the summer and implemented for all new cases from 01st November. It will now start to be rolled out for use with EHCPs that are being reviewed.

6.4. An Operational Partnership Group has been set up which meets monthly. Part of the role of this group is to ensure that EHCP assessment processes are joined up and to also undertake audits and dip samples of assessments, advices and plans to ensure that improving performance is underpinned by improving quality.

7. Future Work

7.1. The implementation of the WSoA is due to continue until September 2021– discussions are now beginning of what the future of SEND improvement will look like beyond the life of the WSoA. Between now and September, there will be an ongoing and continued focus on implementing the remaining actions and ensuring that those that have been completed are embedded in the day to day way of working.

7.2. As the result of the inspection in 2019 was a WSoA, there will be a requirement for a further inspection. This was due to take place at some point from October

2021 – however, due to Covid-19 this is likely to be delayed as full inspections have been paused since March 2020. However, Ofsted are undertaking voluntary assurance visits to focus on the Local Area's response to supporting children and young people with SEND through the Covid-19 process, plus another key area of focus. Walsall have volunteered to take part in an assurance visit. This will take place at some point from March onwards, with the specific date to be agreed with Ofsted in the coming weeks.

Helena Kucharczyk
Head of Performance Improvement and Quality
LAIB Programme Lead.

Health and Wellbeing Board
26January 2021

Agenda item 11

Black Country Strategic Child Death Overview Panel

1. Purpose

This report sets out to

- Update the Walsall Health and Wellbeing Board on progress of establishing a Black Country Strategic Child Death Overview Panel (BC CDOP)
- Outline some of the challenges that remain
- Provide a summary of data from 2019 – 2020

2. Recommendations:

The Health and Wellbeing Board partners are asked to:

2.1 Note the below update and challenges
2.2 Accept future reports from the Strategic Child Death Overview Partnership and any accompanying recommendations for learning.
2.3 Relate relevant learning from unexpected deaths to their organisations and make changes accordingly

3. Report Detail

3.1 Background and Context

The purpose of a CDOP is to identify the cause of child deaths in an area and to learn and share lessons that may prevent future deaths.Their role is also to consider whether action should be taken in relation to any matters identified. Where it is identified that action should be taken by a person or organisation, they are informed.

The responsibility for ensuring child death reviews are carried out is held by 'child death review partners', who, in relation to a local authority area in England, are defined as the local authority for that area and any clinical commissioning groups (CCGs) operating in the local authority area as set out in the Children Act 2004 (the Act), as amended by the Children and Social Work Act 2017.

3.2 The Black Country Child Death Overview Panel

In the Black Country the child death review partners are the Black Country Local Authorities and Clinical Commissioning Groups:

- Wolverhampton Council; Sandwell Council; Walsall Council; Dudley Council
- Wolverhampton CCG; Sandwell and West Birmingham CCG; Walsall CCG; Dudley CCG all of whom are combining into one strategic CCG.

Appendix 1 describes the review process for the Black Country and its oversight by the Black Country Child Death Strategic Partnership.

3.3 Progress over the past yearwithin the Black Country CDOP

- An Independent Chair has been recruited to Chair both the Strategic Partnership and the Operational Panels
- An administrator has been recruited to support with the Child Death processes
- A budget for CDOP reviews and strategic/business functions has been secured on a partnership basis
- Two operational panels now review deaths on a Black Country footprint; neonatal and non-neonatal. An independent neonatologist attends the neonatal panel to offer an impartial view. This is reciprocated and a neonatologist from Wolverhampton attends Staffordshire's neonatal panel.
- A lay member has been recruited to the operational panels to offer a parental perspective.
- The operational panels are attended by professionals on a rota basis who feed back any learning and opportunities through professional networks. Members are expected to represent their geographical area and professional role.
- Panels are reviewing up to 15 deaths at each meeting.
- All four hospitals in the area are carrying out Child Death Review Meetings
- Peer audits have been scheduled to ensure legislation is being adhered to.
- The four CCGs are combining into one Black Country CCG, and so will be incorporating the child death review processes.
- The electronic notification and data collection system, eCDOP, has been embedded into practice. Data from eCDOP flows into the National Child Mortality Database and so contributes to a reliable national picture of child deaths.
- A combined Annual Report is available from 14 December 2020
- A Business Plan has been developed and progress is monitored by Strategic Partners such as safeguarding leads in the CCG and local authority.
- Learning is shared with partners and identified actions taken forward

- Through the National Child Mortality Database, the Black Country has fed into real time data supporting the national understanding of the impact of the current pandemic

3.4 Black Country CDOP Challenges:

The progress that has been made over the past 12 months during very difficult times has been enormous and has surpassed many expectations. However, the challenge now is to reflect upon processes and embed them into practice.

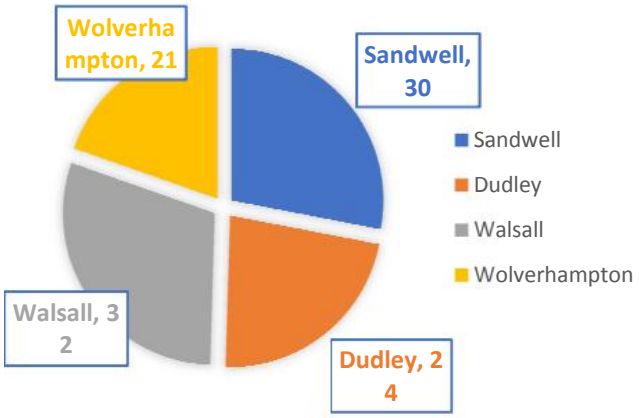
Challenges also remain with obtaining information from areas external to the Black Country, particularly Birmingham.This has been escalated to wider partners and strategies have been put in place to mitigate these and monitor progress.

There also needs to be consistency with the way the local areas support the child death review process. Wolverhampton has no administration support and at present this is being sourced from the central team which has implications on case progression and workload.

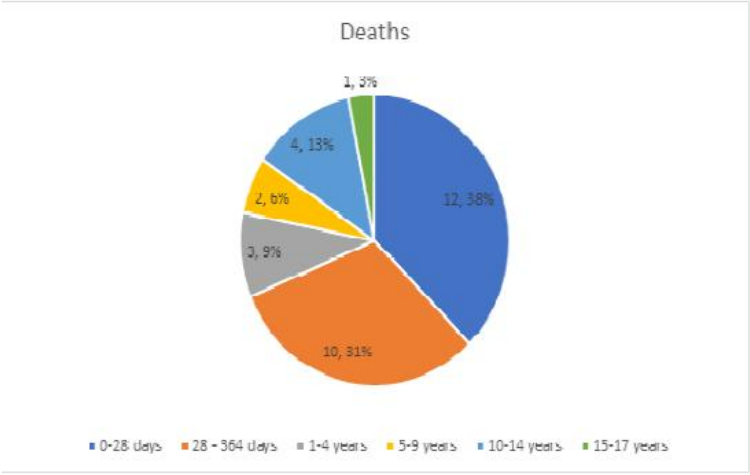
3.5 Summary of Local Data 2019 – 2020

3.5.1 In 2019/20 the Black Country saw 107 deaths. Out of these, Walsall saw 32 deaths. 12 of these were in the first 28 days. The majority of these deaths were seen in babies who were born a very low birth weight due to prematurity or with congenital anomalies This is lower than the national average for this age group at 42%.Deaths in children 28 to 365 days is however higher at 31% in Walsall as opposed to 21% nationally.

BLACK COUNTRY DEATHS NOTIFIED 2019 - 2020



Black Country Deaths (Figure 1)

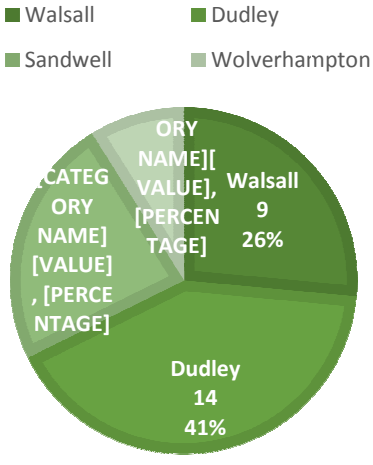


Walsall Deaths(Figure 2)

3.6.1 Unexpected Deaths

9 deaths notified in this timescale in Walsall were unexpected and a Joint Agency Response was carried out

Unexpected Deaths in Black Country(Figure 3



The analysis of all unexpected deaths across the Black Country (Figure 3)showed:

- 60% were attributed to co-sleeping
- 50% were intoMum taking medication for depression
- 60% in dirty/poor home conditions
- 90% in homes where there was maternal smoking/smoking in the home
- 30% Sofa sleeping
- 10% Alcohol abuse
- 30% Substance misuse
- 20% Low birth weight
- 20% Overcrowding
- 60% Child snuffly/ill previously
- 20% Bumpers/pillows in cot
- 10% Unsafe feeding practices

3.7Local Action resulting from the Black Country Analysis

As a result of this analysis, a region wide focus group has been formed to address theseissues. Work is taking place in Walsall and across the Black Country to focus on the following areas:

- Safer Sleeping

- Maternal smoking during pregnancy
- Smoking in the household
- Consanguinity
- Late booking and as a consequence to this delay of support services
- Maternal obesity
- Deprivation
- Neglect

In addition, a preconception campaign has been taken forward in primary care to support parents to enter pregnancy as healthily as they can be.

Work is required by partners to raise awareness of these issues and their implication for the health of a child

3.8Planned Work

3.8.1 Safer Sleep Support

As seen in point 3.6.1 describing unexpected deaths, unsafe sleeping practices such as co sleeping, sofa sharing, alcohol abuse or bumpers and pillows were identified as major drivers for infant mortality. (10 of the 33)

From a recent national report, “Out of Routine” 2020, we have also gained new learning around the causes of infant mortality. These include insecure housing and parental stressors such as deprivation or domestic abuse. This highlights the requirement for new partners such as housing and landlords who have a role to play in preventing uncertain housing tenure to engage with the infant mortality reduction agenda.

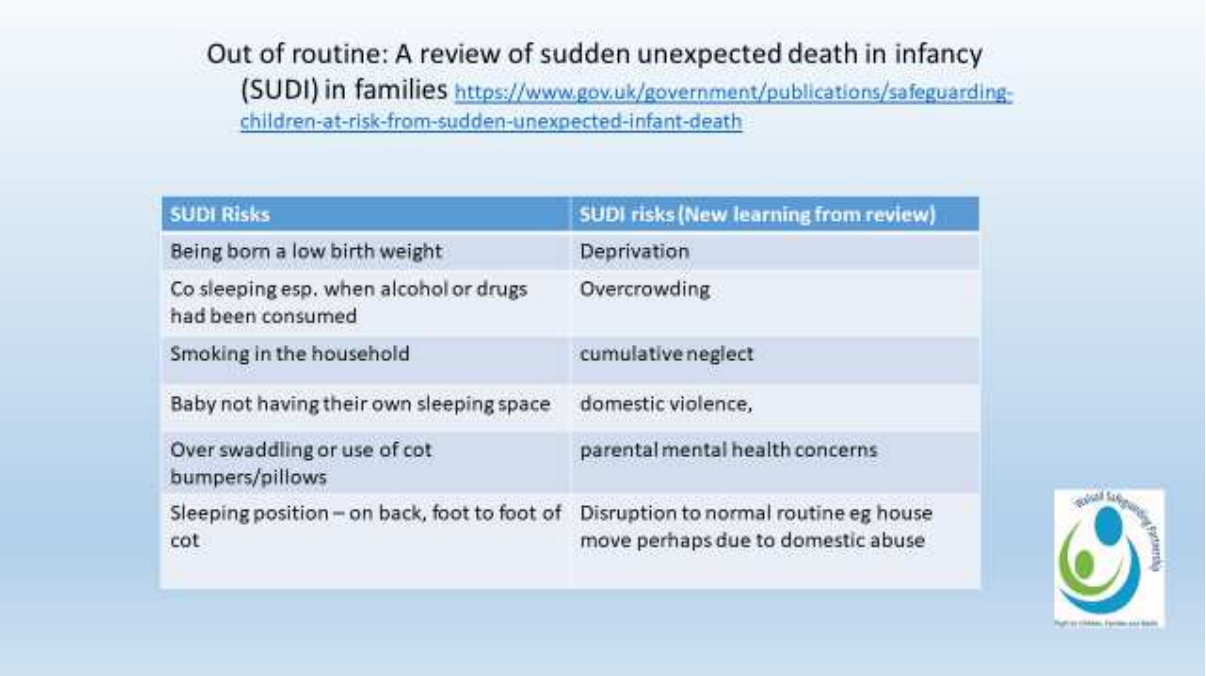


Figure 4 Out of routine A review of sudden unexpected death in infancy 2020

The Black Country Child Death Overview Panel are leading on a Black Country wide safer sleep campaign. A campaign will be developed with frontline staff such as maternity, health visitors, social workers and GPs to share best practice and ensure that information is given to parents, received and understood and followed up where needed.

Birmingham Safeguarding Partnership have recently released videos on social media called 'Who's in charge?' which highlight the risks of alcohol consumption when caring for a young child and contributes to awareness of safer sleeping practices.

https://www.bhamcommunity.nhs.uk/about-us/news/latest-news/whos-in-charge-video-campaign/

The links to these videos have been shared with Walsall safeguarding partners, the neglect steering group and neglect champions and Housing Groups.

3.9Regional Next Steps and Objectives

Over the next year, the Black Country Child Death Overview Partnership will seek to work with Walsall Health and Wellbeing Board Partner agencies to;

- take forward campaigns to combat child deaths and in particular to reduce infant mortality. This will also include developing, ratifying and implementing a the Black Country Sudden Unexpected Death protocol.
- Share regular awareness bulletins of unexpected child deaths. In 2020 – 2021 there are plans to develop a Black Country wide on call health response for unexpected deaths.
- Ensure professionals working within the child death arena have bereavement support so that parents are supported using best practice and the practitioners are supported in their role
- Disseminate learning from child deaths (e.g. team communications, social media or word of mouth)
- Support the consolidation of the new Black Country CCG
- Develop and contribute to strategies being developed and rolled out (Safe Sleeping/ICON)

In addition, they will work with the Walsall Safeguarding Partnership to submit and ratify the CDOP annual report.

4. Implications for Joint Working arrangements:

4.1 Within Walsall, our priority is to continue to reduce infant mortality. This requires commitment and activity from all partners who have contact with new parents to;

- Partners such as Childrens Services, GPs, Midwives and Health Visitors to embed and support safer sleeping practices
- The above but also police, housing teams and benefits support teams to reduce the impact of the issues which contribute to parental conflict and therefore neglect, for example financial or housing insecurity, parental mental health or domestic abuse
- Pharmacists, GPs and community teams to promote preconception care
- All agencies including the voluntary and community sector who meet with new parents to ensure that safer sleep and good parenting is promoted

4.2 Health and Wellbeing Priorities:

4.2.1 The key Health and Wellbeing Board priority is to Maximise People's Health and Wellbeing and Safety and in particular the focus of the report is to Improve Maternal and New Born Health.

4.2.2Work to reduce child deaths and in particular infant mortality is a role for all in Walsall and not just the statutory sector. Voluntary and community teams are being asked to support actions to identify and reduce neglect and support parenting. Peer supporters are also supporting all work to encourage and increase breastfeeding.

4.2.3 Marmot's approach to addressing health inequalities as set out in Fair Society, Healthy Lives requires action across the social determinants of health and beyond the reach of the NHS. It also shows the importance of intervening in early childhood as well as addressing the social factors affecting health. Central to the Marmot Review is the recognition that disadvantage starts before birth and accumulates throughout life. Children born in disadvantage are more likely to be affected by infant mortality and accidents. Through CDOP learning, objective 1 will be achieved; Giving every child the best start in life

4.2.4 Safeguarding: Recommendations and actions arising from this report directly supports safeguarding and will benefit the most vulnerable sectors in the community.

5 Background papers

BCCDOP AR 20192020 FINAL.pdf

The Annual Report for the Black Country CDOP, 2019 – 2020.Black Country

Author

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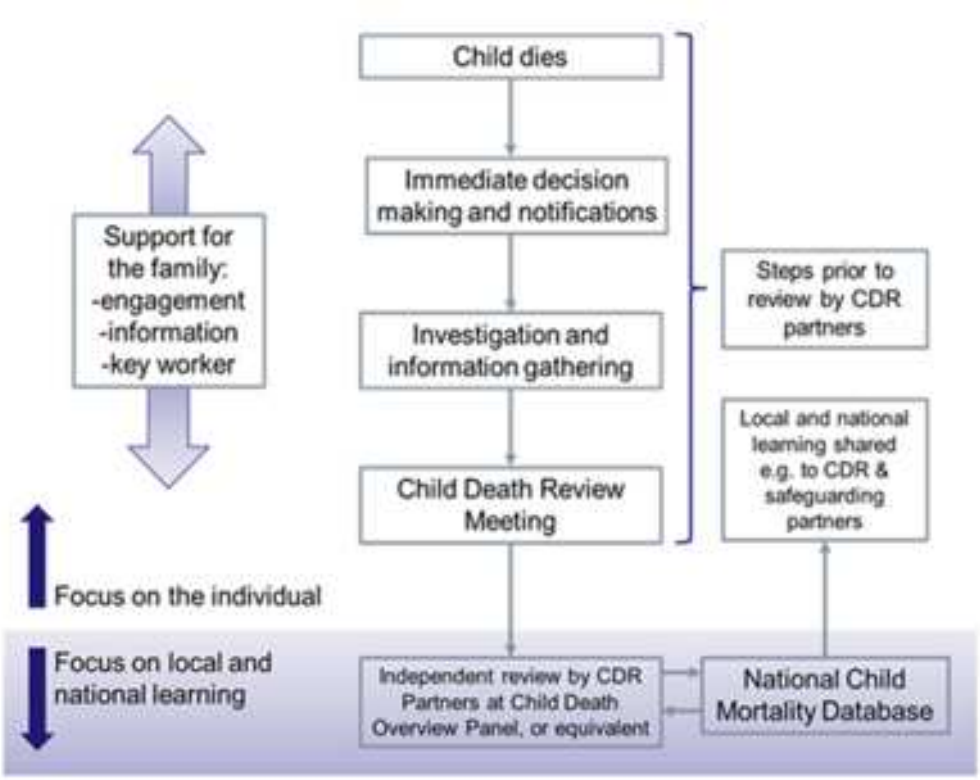
Appendix 1

Black Country Child Death Overview Panel Process

The processes followed by the Black Country Child Death Overview panel are currently outlined within "Working Together to Safeguard Children 2018: Chapter 5 Child Death Review Processes and Child Death Review: Statutory and Operational Guidance 2018"
https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england

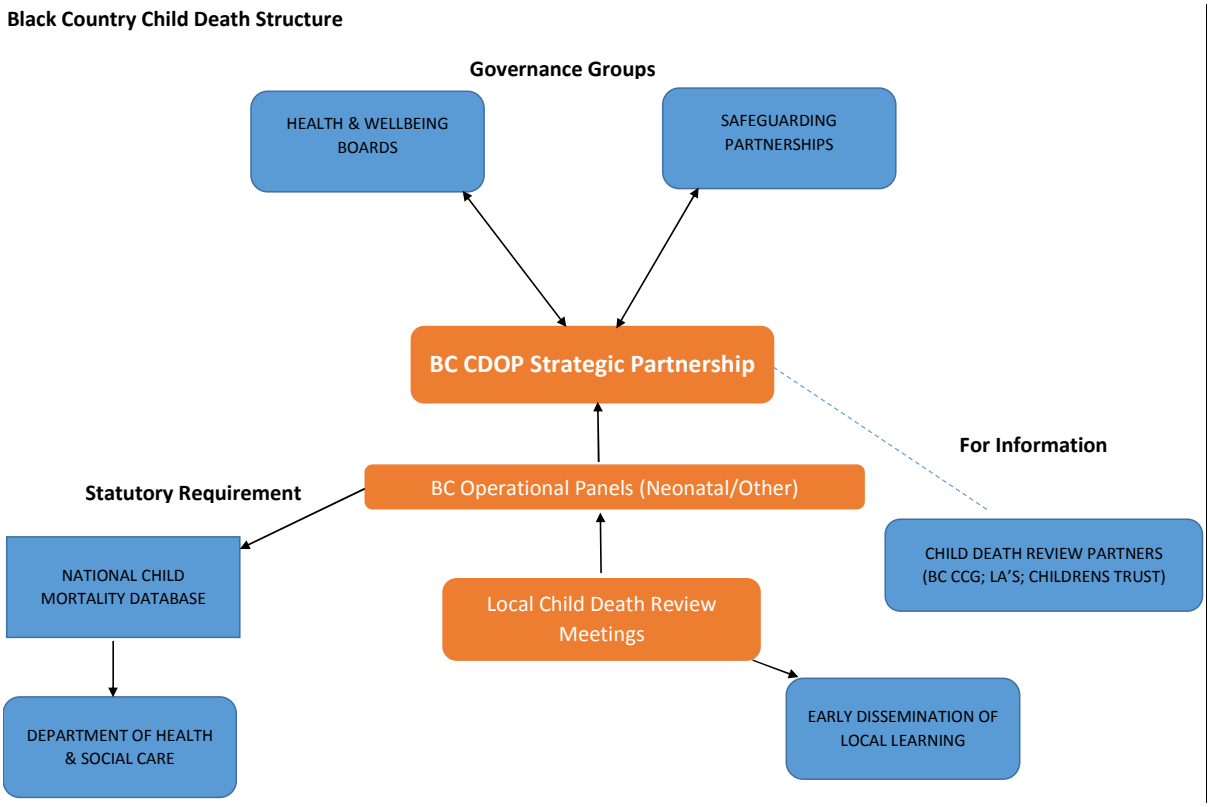
The partners have made arrangements to review all deaths of children normally resident in the local area and, where it is considered appropriate, for any non-resident child who has died in their area.

They are summarised as follows: (Figure 1)



The Strategic Child Death Overview Panel is responsible for ensuring that these processes and reviews are carried out as outlined in legislation. The local implementation of this national guidance is depicted in figure 2.

Figure 2 Black Country Child Death Governance Structure: (Figure 2)



Health and Wellbeing Board – Work Programme 2020/21

	REPORT ITEM	LEAD	July	13Oct	26 Jan 2021	27 April
WALSALL PLAN PRIORITIES	**P1: Prevention of Violence**	WM Police				
	P2: Improving Wellbeing – focus on getting Walsall 'on the move'	CEO WHT				
	P3: Improving the Environment of our Walsall Town Centre	ED E&E /DPH				
PUBLIC HEALTH	**Review of Public Health Commissioning Intentions**	DPH				
	Walsall Plan Refresh	DPH			Progress reported in JSNA update	
	Infant Mortality	DPH				Progress Reported in DPH report
	Director of Public Health Annual Report	DPH				For information
	JSNA Update	DPH				
	Health Protection Annual Report	DPH				
	Pharmaceutical Needs Assessment	DPH				
CHILDRENS' SERVICES	**SEND Report**	ED Children's				
	Annual Report of Children's Safeguarding	ED Children's				
	Annual Progress Report	ED Children's				

Health and Wellbeing Board – Work Programme 2020/21

ADULT SOCIAL CARE	**Better Care Fund (dates subject to National BCF Support Team Directives)**	ED ASC	Q1	Q2	Q3	Q4 and finance reporting
	Local Authority Commissioning/ Spending Plans	ED ASC				Annual Review
	Annual Report of Adults Safeguarding	ED ASC				
PARTNERS PROGRESS AND ENGAGEMENT	**Walsall Together**	WHT Board Member		Progress Report		
	CCG Commissioning/ Spending Plans	Chief Officer CCG				Annual Review
	Healthwatch	Chair Health watch	Annual Report			Progress on Projects /Public Engagements
	Police Service	Police Rep				Annual Report
	Fire Service	Fire Rep				Annual report
	Voluntary Sector (One Walsall)	CEO One Walsall				Annual Report
SPECIAL REPORTS TO BOARD	**CAMHS**	CCG				Progress Report
	LONG TERM PLAN	CCG				
	CDOP ANNUAL REPORT	DPH				
	PH OUTCOMES FRAMEWORK (PHOF)	DPH				Included in DPH Annual report

NOTE: This is a 'working'document. The dates are provisional and are dependent on agreement from Lead Officers in accordance with reporting schedules

KEY:

ASC	Adult Social Care	**BCF**	Better Care Fund	**CCG**	Clinical Commissioning Group
DPH	Director of Public Health	**ED**	Executive Director	**HWB**	Health and Wellbeing
VS	Voluntary Sector	**WMCA**	West Midlands Combined	**WT**	Walsall Together

			Authority		