Walsall Safeguarding Partnership
(Safeguarding Adult Board)
Annual Report
2021 - 2022

Walsall Safeguarding Partnership

Right for Children, Families and Adults

Contents

Foreword

Welcome to the 2021-2022 Adult Annual Report of Walsall's Safeguarding Partnership. I took over as independent chair when Walsall had made a commitment to ensuring there was an all-age safeguarding organisational framework in place. Following the initial review completed in 2020 key changes were implemented to support the development of the outcomes we set for safeguarding. There has been the establishment of an Executive and a Leadership Board as recommended by the 1st review, and these new arrangements have been bedding down in this frst year.

Our new arrangements are now subject to independent review to consider whether the anticipated effectiveness has been realised and at the time of writing this report is in the early stages. Going forward we recognise as we develop that outcomes can be improved further through the work in our priority areas, which are exploitation and self-neglect.

There is no doubt that partnership work has been affected by the pandemic. However the partnership has continued to make progress, and the use of hybrid working for many of its business arrangements has been successful. However, the lack of face to face events, and the opportunity for exchange of views, conversations and networking, has been felt by many, and the partnership is considering reintroducing events more in the coming year. As we move forward, we need to ensure that these operating environments do not hinder safeguarding practice and we will review our meetings framework to take this into account.

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

The Partnership would like to thank agencies for the work they have done to keep our communities safe and to respond to the needs of adults at risk of abuse and neglect in Walsall.

Sally Hodges
Independent Chair and Scrutineer
Walsall Safeguarding Partnership

Walsall 'at a glance'

There are 20 Wards within 4 Localities in the Walsall Borough, 63% of the Walsall population are aged over 18yrs, of these, 23% are aged 65yrs or over.

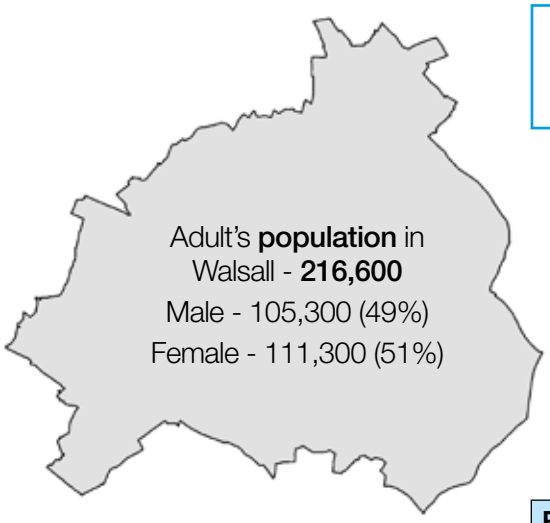
Adults aged over 65yrs live predominantly in the East Locality. Streetly Ward has the highest population of over 65's closely followed by Aldridge and Pelsall, which are typically more affuent ar eas and least deprived areas of Walsall.

Life expectancy in Walsall remains lower than regional & national comparators, females 82 years old, males 78 years old. However, females have a lower 'healthy' life expectancy of only 58.4.yrs of 'good' health. females in Walsall live 30% of their life in 'poor health' compared to males at 25%

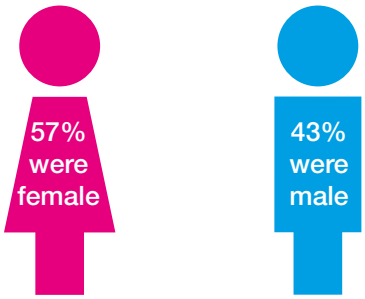
56.8% adults are physically active in Walsall, this is signifcantly worse than the national average of 66.4% (2019-20)

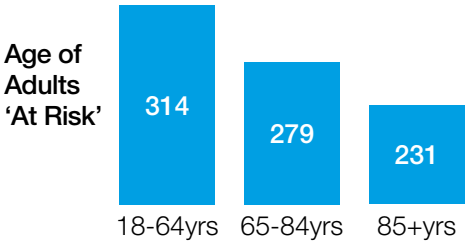
Sources; Public Health England – LA Health Profle-fngertipstool

Walsall Insight – www.walsallintelligence.org.uk



Individuals progressed to S42





Ethnicity of Adults at S42	
White/ British	86.2%
Asian/ British	7.5%
Black/ British	2.8%
Mixed/Multiple	1.1.%
Other/Unknown	2.4%

Concerns	Enquiries	Conversion
3,525 (2,563-20/21)	984 (766-20/21)	27.9% (27.9%-19/20) (29.7%-20/21)

89%
Adults were asked & expressed Desired Outcomes
(86% 20-21)

Top 3 Types of Abuse at Section 42 remains same		
457 Neglect	291 Psychological	230 Physical

MSP - 59.4%
Desired Outcomes were fully achieved
(Up 57.3% in 20/21)

Self-Neglect was identifed as ***type of abuse*** in **5.1%** of S42 Enquiries. (Increase to 46 from 35 in 2021)

20.1% (at S42) identifed **Exploitation**
(Sexual Exploitation & Financial abuse)

26 Referrals to Self-Neglect Panel

88% Risk Removed or Reduced

73.6%
"I feel as safe as I like"
84.6%
"My Care & Support services help me in feeling safe" (2019-20)

Source of Risk at S42 Conclusion		
Known to Individual	Provider	Unknown to Individual
51% (464)	44% (401)	4% (40)

- Concerns are reports into the local Adult Safeguarding process for consideration for a safeguarding enquiry
- An enquiry is any action that is taken (or instigated) by a local authority, under Section 42 of the Care Act 2014, in response to indications of abuse or neglect in relation to an adult with care and support needs who is at risk and is unable to protect themselves because of those needs

What the Safeguarding Partnership has focussed on during 2020/21

As identifed in last years' annual r eport, in response to an independent review of the Partnership Arrangements in 2021-22, the priorities for the Walsall Safeguarding Partnership (WSP) this year have been streamlined to ensure a focused partnership approach. Three priorities were identifed acr oss the adult and children's agenda, with Self Neglect and All Age Exploitation being key for the Safeguarding Adult Partnership/Board. These priorities were determined through our review of partnership data, our understanding of practice from case reviews and audits and wider partnership discussion about issues which require a joint spotlight.

Below is our partnership plan:

Walsall Safeguarding Partnership 2021-2022

Priorities: Neglect, Self Neglect, Exploitation

Neglect.

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

Self Neglect:

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

All Age Exploitation:

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

Work-streams

Performance and Quality Assurance activity:

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

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

To receive performance reports in to measure the improvement and impact in safeguarding practice Measuring the impact of case review and audit outcomes on multi agency practice

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

Practice Review activity:

Eff ciently undertake review of those cases where it is appropriate to do so. Obtainine and ref ecting on learning, sharing learning and improving practice where needed.

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

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

Practice Improvement activity:

Undertake a training and development needs assessments across the partnership.

Establish closer working relationships / processes with other

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

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

Working with the Walsall Community : our 4th partner

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

Part of the role of the WSP is to assess the effectiveness of local safeguarding arrangements in agencies working with adults and children.

During 2021 WSP carried out a number of activities to elicit this assurance. Below is an overview of the assurance gained from Care Act assurance activity, service user quality assurance conversations, fndings from the 2021/22 Practitioner Survey and work undertaken to measure impact from Walsall adult case reviews.

The Care Act places duties on a range of organisations, agencies and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard adults with care and support needs.

Whilst Walsall Safeguarding Partnership wait for the development of a combined regional Section 11/Care Act Audit Tool and online platform in 2022-23, it was agreed to hold assurance meetings with agencies that had submitted their Care Act (CA) response in 2019. However, to ensure compliance with the Care Act, the questions for the assurance meetings were developed to refect key ar eas from the regional audit tool along with quality assuring fndings fr om reviews, audits, practitioner surveys and 4th Partner feedback. This ensured partner agencies were able to refect on and pr ovide assurance of their statutory duties.

Care Act Compliance across agencies that were asked to participate was particularly strong in relation to:

- Governance Arrangements
- Quality Assurance
- Refective Practice
- Management Oversight
- Professional Challenge

What do staff say?

- Learning is disseminated in a timely way across the Partnership, including via the 'Key Safeguarding Messages' newsletter - 57% of staff survey respondents confrmed this.
- 86% of staff across the Partnership advised they received regular supervision.
- 73% of staff across the Partnership felt 'there are clear and accessible systems for staff voices to be heard and infuence change within their organisation'.
- 58% felt confdent a Making Safeguar ding Personal approach is embedded into their safeguarding practice, however during the Care Act Assurance discussions agencies felt there was still more work to do on this area.
- The survey evidenced that staff felt they were well supported within their organisations and by partners, with comments including:
  'Good advice available from the safeguarding team when I have contacted them for guidance or to discuss an issue' - Adult Mental Health.
  'The frst port of call is always Fir e Control and they prompt crews on what to do next when they are unsure.' - Fire Service
  'Daily discussions if needed about safeguarding issues' - GPs
  'Excellent operational lead, good information dissemination, support and training'- Housing
  'We have good relationships with adult and children social care services' - The Beacon
  'I know if I have any issues or concerns I can approach any of our partners who will support me / our department and escalate concerns if needed' – Police.

In November 2021, 74 managers attended the Safeguarding Partnership Priorities and Next Steps event which covered achievements and future plans for the partnership, key priorities, learning from reviews and multi-agency practice development.

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

Following the sign off of the All Age Exploitation Strategy (identifed as an area for focus in the 2020-21 Annual Report) Exploitation Awareness Fortnight was held in March 2022.

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

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

When asked how they have embedded learning into practice, this is what they said:

'I have shared the information with our safeguarding champions and made the information available to all Staff to access to ensure they are aware of the services available and the referral process.' Steps to Work

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

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

What has this meant for adults in Walsall?

- The number of Individuals with a safeguarding concern raised during the year has increased by 28%.
- Safeguarding enquiries have, therefore, also increased, however conversion rates have reduced back down to 2019/20 rates, having gone up slightly in 20-21.
- Referrals from 'health' has doubled. The Ambulance service has the largest proportion of 'health' referrals at 38.3% (565 /1477).
- Concerns leading to Caused Enquiries increased – possibly in line with referral rates.
- 2021/22 saw a signifcant incr ease in Caused Enquiries being led by care provider services having almost doubled (118 to 220) since last year, as did numbers for Walsall Healthcare Trust (55 up to 109).
- Overall timeliness of agencies returning Caused Enquiries is poor – the increase in referrals may have impacted on this.
- Abuse types remained consistent with last year (with neglect/ psychological / physical/ fnancial as the highest categories) with neglect making up 50.5% at concluded Section 42 enquiry.
- A person's own home remains the top location of abuse.
- Source of risk from 'those known to the adult' has reduced, with an increase in 'providers' as the source of risk from 38% to 44%.
- There has been a decrease of 6% for female adults where concerns progress to Section 42 from 63% down to 57% and increase in males 'at risk', meaning the 21-22 data is now more in line with the population fgur es (51% female).
- Number of people identifed as Hoar ding by West Midlands Fire Service:

Hoarding Data	Q1	Q2	Q3	Q4	2021-22
Excessive	32	37	21	67	157
Excessive/Dangerous	13	2	5	10	30
Severe	7	1	1	1	10
Totals	52	40	27	78	197

Positive Impact:

- There has been an increase in the number of Self-Neglect cases identifed and r eferred (46, up from 35 in 2020-21).
- Referrals from family/relative/carers have almost doubled, potentially indicating safeguarding messages are effectively communicated to the public.
- Increase in referrals to Self-Neglect Panel (26) up from (21) last year.
- Making Safeguarding Personal (MSP) - 89 % of people were asked about and expressed their desired outcomes – this has gone up from 86% last year.
- MSP – Increase in Desired Outcomes being achieved – was 57.3% last year, now up to 59.4%.
- 87.6% people have had the risk removed or reduced, which is up from 82.3 last year.

2021/22 data should be regarded as provisional pending validation and publication by NHS Digital

Communication and Engagement

The Walsall Safeguarding Partnership Arrangements set out to include a 4th Partner, in addition to the 3 required in legislation. Children, young people and adults within Walsall (including adults with care and support needs and those who have not) are vital in holding the 3 statutory agencies to account.

This engagement and contribution has and will continue to take a variety of forms and our ambition is to establish regular safeguarding groups who will undertake their own work programme including inspection activity, network via established forums and undertake bespoke consultation activities.

During 2021 WSP began this work by consulting with adults with care and support needs about their knowledge of safeguarding by way of attending the following groups:

- Walsall Dementia Café (Adult Mental Health)
- A residential care home (older adults)
- Midland Mencap (Learning Disability)

Although there is still more work to do to engage with adults with care and support needs who have been through a safeguarding process, the following feedback was given when we asked adults about their experiences with services:

- 'The Police were excellent when I had a mental health break down'
- 'Social worker was helpful when I was younger (I am now independent) – helped to get through secondary school'
- 'Insensitive towards me by staff'
- 'I didn't have a good experience with workers when I was trying to report fnancial abuse'
- 'During Covid it has been diffcult to get access to my GP'
- 'I didn't always feel listened to by the worker and their manager'
- 'I prefer speaking to people in person and before Covid that was the most common way'
- 'Technology is helpful for some people, not everyone'
- 'need to remember the carers (paid) and they are individuals with different reactions/skills'

This information will be used as a baseline to develop our response further in 2022-23.

A survey was also developed to seek the views of people with care and support needs to understand their awareness of safeguarding, how adults are able to access information about safeguarding and their experiences of safeguarding services. This survey will be launched during 2022.

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

Learning from Case Reviews and Audit

Safeguarding Adult Reviews (SARs)

- 10 referrals were received during 2021-22 for consideration of a SAR. 5 of these progressed to commissioned reviews.
- 0 SARs were carried forward from 2020-2021, therefore 0 SARs were completed or published within the year.
- The action plan for 1 previous SAR was completed.
- Of the reviews recently commenced, the Practice Review Subgroup have noted themes in relation to service users with a learning diffculty, self-neglect, multi-agency communication and risk management and application of the Mental Capacity Act.
- Once these reviews have been completed, they will be published and the learning disseminated across the Partnership.
- Action plans are monitored within the Business Unit and overseen by the Practice Review Subgroup.

Learning from Multi-Agency Audits

During the year there were 4 multi-agency audits carried out, each linked to the safeguarding priorities and emerging themes from reviews or data. Caused Enquiries and Position of Trust being areas of focus identifed in last year's Annual Report.

Key learning from the audits included:

Qtr 1 Caused Enquiries	Qtr 2 Safeguarding Concerns that were NFA
The topic was chosen due to an emerging theme within the multi-agency dataset which highlighted that there is a high percentage of reports that do not meet the agreed return timescale. The audit looked to quality assure the Caused Enquiry process. Some improvements need to be made so that agencies are receiving the Caused Enquiry Terms of Reference and that this is recorded on the adult's fle by ASC. There were also a number of cases where the report was not sent to ASC within the timescales laid out in the Terms of Reference or the provided template used, therefore, not all areas of the enquiry were always responded to. There were also some improvements required in relations information sharing with partners not party to the Caused Enquiry but with a need to know this information, such as GPs and also feeding back outcomes to the agency that has undertaken the Caused Enquiry. However, this audit identifed some good practice with agencies identifying learning whilst carrying out the enquiries which then resulted in practice change.	The topic was chosen due to an emerging theme within the multi-agency dataset which highlighted the conversion rate is very low. In all cases there was either not enough information contained within the form, basic information missing, incomplete referrals received, referrer not always clear on process, or what they are trying to achieve by making the referral. In 5 of 13 referrals, old forms were being used, Police were not using forms and sending through emails. In 7 of 13 referrals the outcome was not consistently shared or not retained on records when sent through to the referring agency. There was good evidence in 4 of the 13 referrals of whereby the capacity of an individual was considered and/or demonstrated at the point of making the safeguarding referral. In 2 of 13 cases, where in addition to consent, a person's individual wishes and outcomes was established at the point of the referral. There was good evidence of information sharing in all cases, proportionate timely and triangulated making for a smoother process, which lead to informed and timely decision making.
Qtr 3 Adults with Learning Disabilities	**Qtr 4 People in a Position of Trust**
The audit topic was chosen in line with case review fndings. The audit highlighted that although ther e was some good practice with the understanding and application of the Mental Capacity Act and Making Safeguarding Personal, however there remains inconsistences in practice in these areas. There were missed opportunities for information sharing between partners, however it is recognised that case by case and proportionate information sharing should be followed. There was a signifcant amount of discussion about involving GPs and sending outcomes for all safeguarding to them and the Learning Disability Team. This is not currently a practice of the Local Authority as it is not deemed proportionate information sharing where the GP is not involved in the safeguarding episode.	The audit focused on the effectiveness of agency practice in dealing with allegations against staff and considered compliance with People in a Position of Trust Regional Guidance and was carried out during 2 assurance activities. A desktop review of the responses from 5 agencies concluded that agencies have a policy in place and are following procedures for managing allegations against staff, however, more assurance was required in terms of agency's own policies and procedures being compliant with the West Midlands Regional Guidance and a meeting of all agencies involved was required to identify further learning. This will take place during 2022.

There were less cases graded at 'outstanding' and 'good' compared with last year.

Case grades:

	Outstanding	Good	Requires Improvement	Inadequate
2019-2020	11%	47%	32%	11%
2020-2021	5%	42%	47%	5%
2021-2022	0%	10%	80%	10%

7-minute briefngs wer e disseminated for each audit which included learning for all partners in an accessible format. Recommendations were followed up during the year by the Performance and Quality Assurance Subgroup (PQA).

How have we collated and shared learning?

- An initial meeting with subgroup Chairs was held to support greater connectivity between the subgroups, this led to a revision of the Terms of Reference for the subgroups.
- Business Unit processes and systems were enhanced i.e. case review action tracker, forward plan for Operations and Scrutiny Group and Performance and Quality Assurance (PQA), regular meetings with subgroup leads from the Business Unit for PQA/Practice Development Group (PDG)/Practice Review Group (PRG).
- The Business Unit structure was reviewed to ensure there was appropriate support for the subgroups and key work streams. The Business Unit leads met regularly to bring together and align work streams and ensure a joined up approach to forward planning (e.g. learning from reviews being followed up in the multi-agency audit programme).
- The adults audit plan for the year linked to fndings fr om Safeguarding Adult Reviews (SARs) i.e. Making Safeguarding Personal (MSP), Mental Capacity Act (MCA), self-neglect and fr e risk.
- The 2021 Practitioner Survey, led by PQA, included questions which were linked to case reviews and audit learning i.e:
    - How well do you feel the MSP approach is embedded into your organisation's safeguarding practices?
    - How confdent ar e you about implementing the MCA in your practice?
    - Do you receive regular supervision? Does this include: refection on practice/pr ofessional support/ personal support/refect on training?
- Care Act Assurance Challenge events were held in November 2021 which incorporated questions to measure impact from reviews and probe the fndings fr om the 2021 Practitioner Survey.
- A new framework for evaluating the impact from case review actions was implemented which had 5 approaches to measuring impact, with reports in to PQA and PRG on an annual basis with the frst r eport presented in January 2022 to PQA.
- Links were further strengthened between the Multi-Agency Audit Group and Practice Development Group as the Practice Improvement Lead attends the audits and there is an agenda item on PDG for feedback from audits.
- The Partnership has received learning from audits and reviews by way of Key Messages, website updates, 7 min briefngs, webinars and new training courses being developed.

Example of how learning has been embedded:

WMFS recommendations and learning from the Clara SAR has resulted in changes to the specifcation and functionality of the new safe & well and complex needs offcer IT system. A specifc example of this is:

The recommendation that if an emergency incident occurs involving an individual with a Complex Needs Offcer (CNO) allocated to them, that the curr ent/last CNO involved is notifed of the incident. This is now an automated notifcation within the specifcation and functionality of the new IT system.

How effective have our arrangements been?

- As a Safeguarding Partnership there is now a clearer line of sight and increased connectivity between the work streams of the partner's activity such as practice reviews and workforce development. Forward plans, standing agenda items and report templates across the meeting and subgroup structure have ensured issues and assurance are shared and understood from frontline practice through to senior leadership.
- There are improved links with the Community Safety Partnership with the Chair being part of the Safeguarding Executive Group, the Community Safety Partnership Manager co-Chairing the All Age Exploitation Subgroup and the Independent Safeguarding Partnership Chair meeting regularly with Community Safety colleagues.
- The All Age Exploitation Strategy was fnalised and agr eed by partners, as was set out in last years' Annual Report as a priority.
- The multi-agency audit programme continued to obtain learning in order to improve practice and saw improvements in the practice which was refected in impr oved case ratings.
- A new framework for evaluating the impact of learning from case reviews and audits has been agreed and commenced.
- Care Act peer challenge activities took place.
- Positive feedback was received via the Practitioner Survey.
- Partners have identifed a number of cases which they felt warranted further exploration via consideration of a SAR.

The Forward Plan for 2022-23:

a. A forward plan for practice development activity, informed by the learning gained from Safeguarding Adult Reviews and National Reviews; the outcomes of audits and aligned to the Partnerships Key Priorities has been drafted. Alongside this plan is the regular training schedule for the year. This will require the support of partner agencies to fnalise and deliver.

b. Appoint an Adult Safeguarding Consultant who can bring capacity and knowledge to support the partnership in driving forward adult priority areas such as consideration of SAR criteria and the development of a Self-Neglect Strategy.

c. Completion of the regional Care Act compliance audit by all required agencies.

d. Finalise and launch the revised Self-Neglect Pathway, which has been carried forward since 2020-21.

e. Re-establish capacity within the Business Unit to further the community communication and engagement agenda.

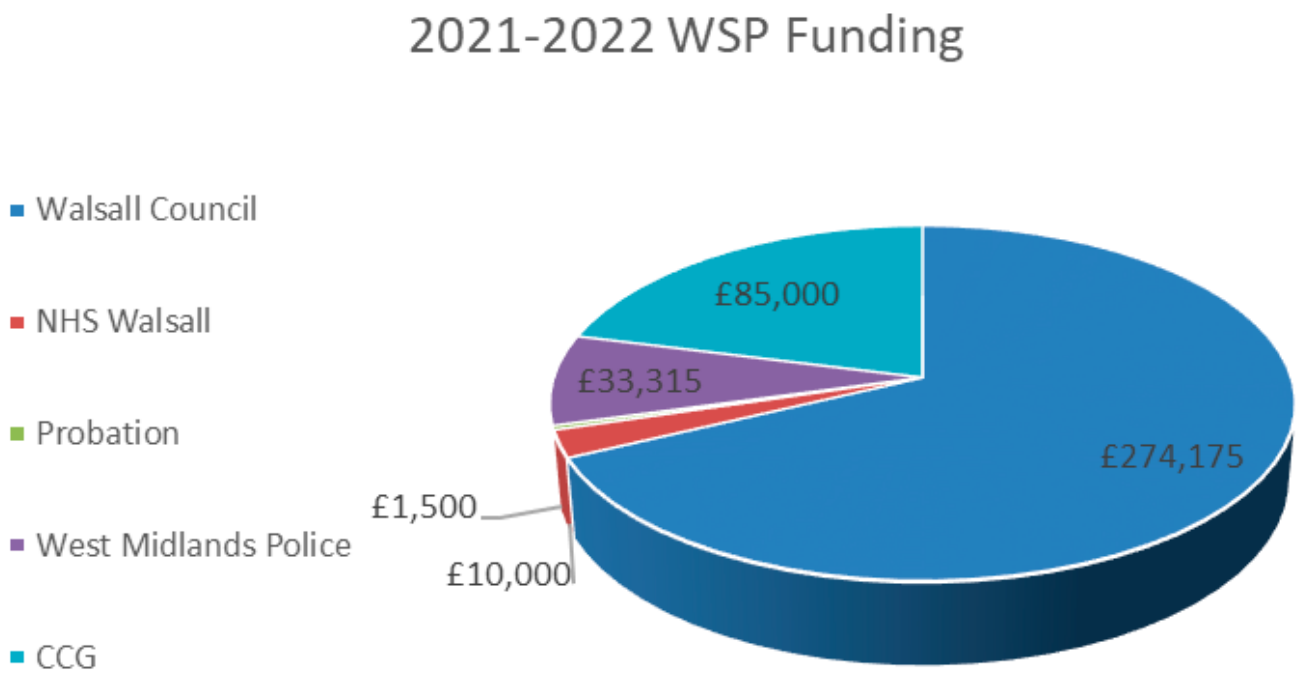
f. Develop a local Learning Disability Partnership Board

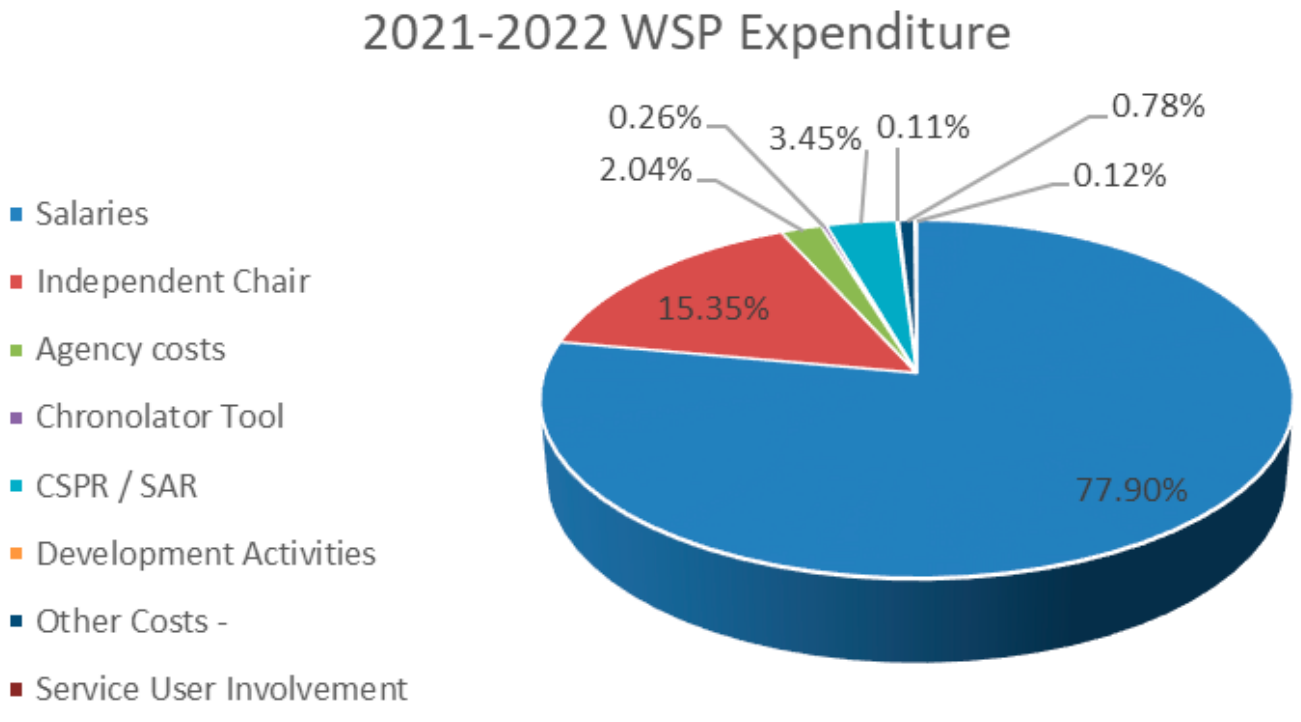
Appendix 1: Financial Summary

In 2021-22 the partnership had £333,000 pooled into a partnership budget. This money was contributed by the Statutory Partners, Plus the local Healthcare Trust and Probation. The majority of the resource was used to pay for Business Unit staffng. Other costs include the Independent Chair, Regional Procedures (children) and online products used for business processes, service user involvement, consultancy and training.

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

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





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For more information or to report an Adult Safeguarding Concern please visit our website: www.WalsallSP.co.uk