**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:

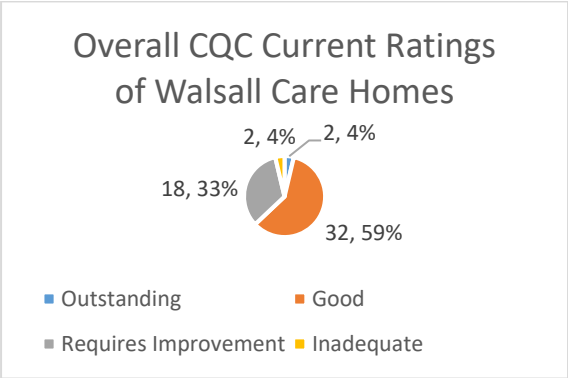
- To publish a Strategic Plan
- To publish an Annual Report detailing what the SAB has done to achieve its objectives and implement its plans
- To conduct Safeguarding Adult Reviews (SARs) in accordance with Section 44 of the Care Act

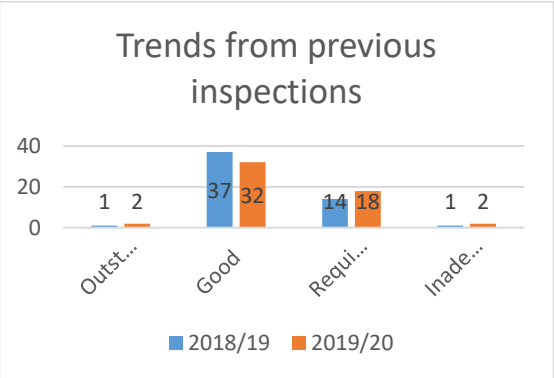
This report seeks to outline how partners in Walsall have delivered these functions.

# 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.



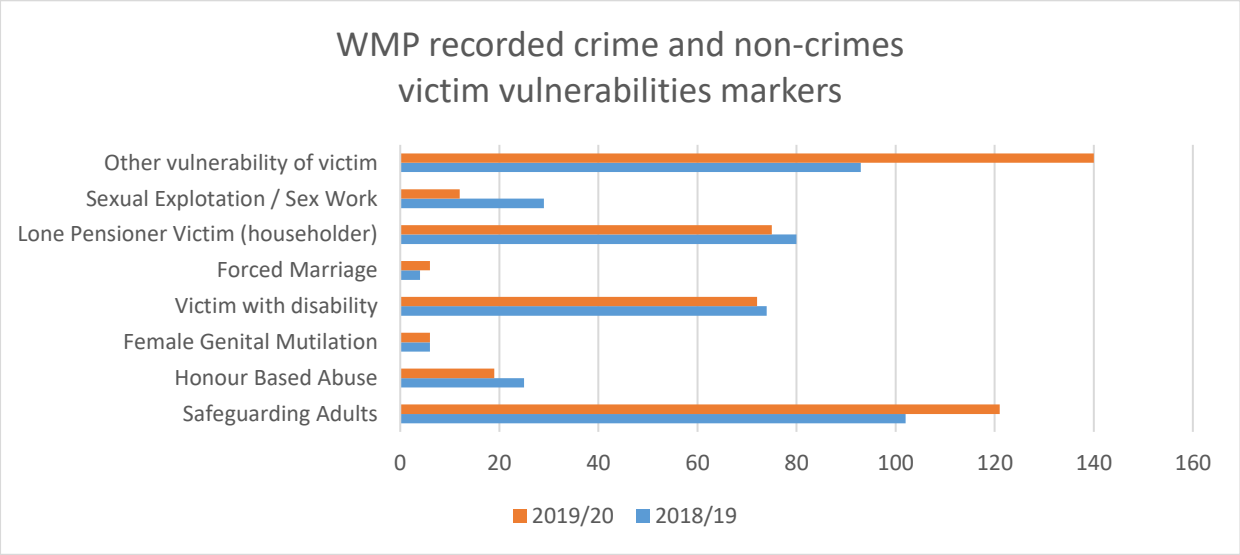




- Trends in the CQC ratings from previous inspections show that 22% of providers have improved, 16% have declined and 38% have sustained their previous rating.
- The remaining 24% of providers are awaiting an inspection. From November 2019 to March 2020 a total of 57 concerns were received by the Quality 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 4$^{th}$ 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).



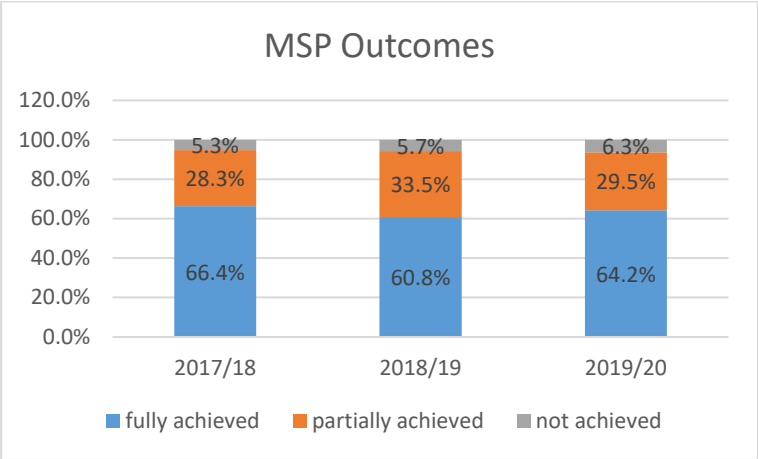

**Making Safeguarding Personal[1] (MSP)**

- 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.

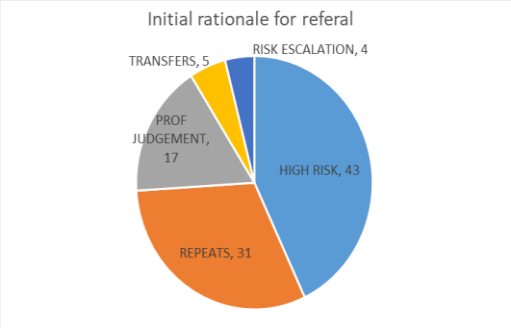
### Domestic Abuse

- 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'.

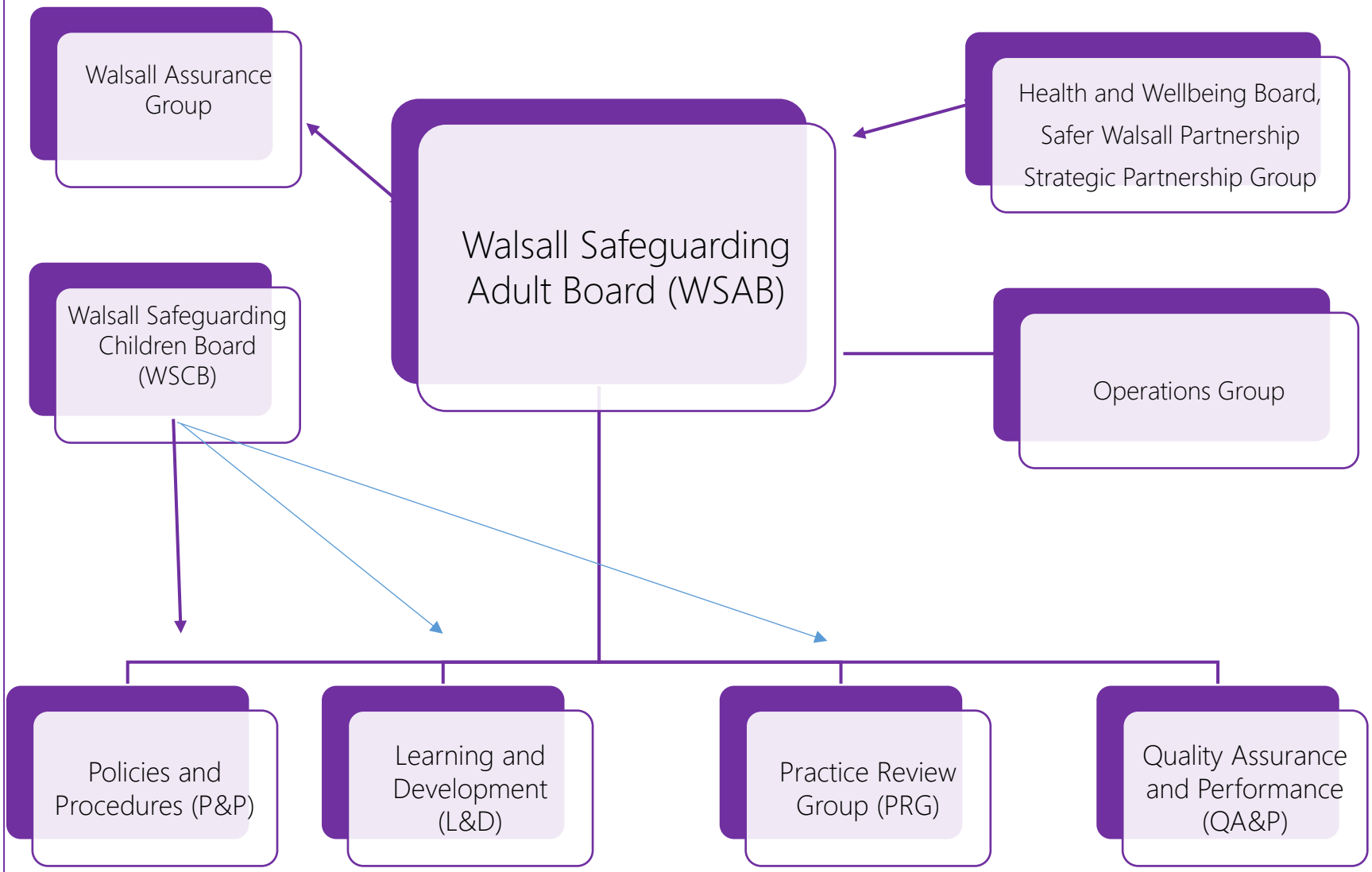
**Priorities and Next Steps in 2020-21**

- 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.

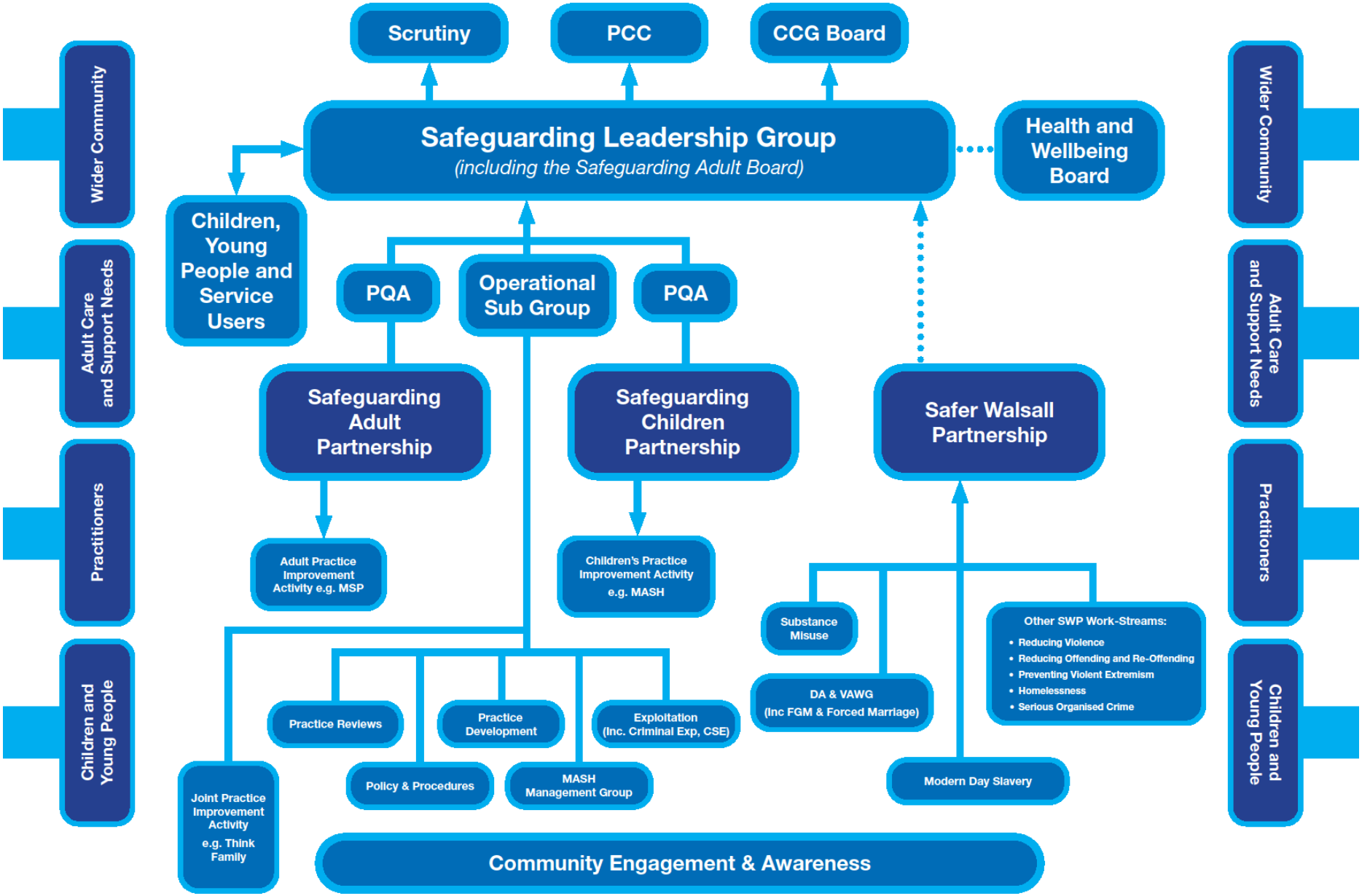
In producing this report, the Partnership has recognised there are opportunities to work more collaboratively across agencies, including in reporting on our activity, progress and impact. Next year, we intend to revise our approach to producing the Annual Report. This will include a stronger focus on 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
DA & VAWG
(Inc FGM & Forced Marriage)
Children and Young People
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** |