Walsall Safeguarding Adults Board

(part of Walsall Safeguarding Partnership)

Annual Report

2022 - 2023

Walsall Safeguarding Partnership

Right for Children, Families and Adults

Contents

Foreword

It is my pleasure to introduce Walsall Safeguarding Adults Board's Annual Report for 2022-2023, a year that continued to present complex challenges to the partnership and to the individual agencies who work together to meet the needs of the borough's vulnerable adults.

The partners from the statutory and voluntary sectors worked together to address the range of issues; sharing information, effort and resource so that those most in need had that essential help and support.

I would want to place on record my thanks to Sally Hodges, the outgoing Independent Chair, for her leadership and advocacy alongside the practitioners who have worked so hard to protect and safeguard the people of Walsall. This report provides a comprehensive account of the work undertaken and progress made during the last year.

Our priorities of Neglect, Self-Neglect and All-Age Exploitation set the direction of our business plan and associated activity. Our aim was, and remains, to influence the way services are provided so as to improve outcomes for those with whom we work. The principles of 'Making Safeguarding Personal' underpin everything we do.

The issues we faced in 2022-2023 have continued into the current year, and as we publish this report the months ahead will again present our safeguarding services with renewed challenges. Walsall Safeguarding Adults Board welcomes the introduction of an inspection framework under the Care Quality Commission, and the spotlight this will shine on local services.

The Board will continue to work together with our partners to meet the care and support needs of the people of Walsall.

Derek Benson
Adult Safeguarding Independent Chair and Scrutineer

Introduction- Walsall Safeguarding Adults Board (WSAB)

Role and Purpose

Walsall Safeguarding Partnership (WSP) is the Executive Leads Board which comprises of Executive Director of Adult Social Care, Chief Superintendent West Midlands Police, Executive Director Children's Services and the Chief Nurse Black Country ICB. WSP is the collaboration of Walsall Safeguarding Children's Partnership (WSCP) and Walsall Safeguarding Adults Board (WSAB) the two main partnerships responsible for safeguarding across the borough. WSAB, like WSCP, has an Independent Chair, which adds independent oversight and scrutiny.

WSAB – Safeguarding Leadership Group (SLG) leads on the arrangements to safeguard adults with care and support needs and oversees and coordinates the effectiveness of the safeguarding work of its member and partner agencies. The SLG brings together partner agencies who have a responsibility for adult safeguarding and comprises of a core membership of statutory partners from West Midlands Police, Integrated Care Board, Walsall Adults Services, and members from a range of organisations, including West Midlands Ambulance Service and West Midland Fire Service, and voluntary agencies. The Partnerships membership reflects that safeguarding activity and interventions can only be effective where there is collaboration and shared commitment.

WSAB was led by Independent Chair Sally Hodges until December 2022 and thereafter, as a result of WSP Executives decision to split the functions of the Independent Chair, by Derek Benson as Independent Chair and Scrutineer.

The Care Act 2014 requires each SAB to publish an annual report. The annual report outlines the achievements and challenges of the Safeguarding Adults Board, its subgroups and partner agencies over the period 2022 to 2023.

Our Purpose

It is important to note that the SAB is not involved in operational practice. Our overarching purpose is to ensure that agencies work in partnership to deliver joined-up services that safeguard adults with care and support needs from abuse, neglect and exploitation. We do this by:

- Gaining assurance that local safeguarding arrangements are in place as defined by the Care Act 2014 and its statutory guidance.
- Working collaboratively to prevent abuse and neglect, where this is possible.
- Ensuring partner agencies are effective when abuse and neglect has occurred and give timely and proportionate responses.
- Gain assurance that the principles of Making Safeguarding Personal (MSP) are central to safeguarding, and practice is person-centred, and outcome focused.
- Striving for continuous improvement in safeguarding practice and supporting partner agencies to embed learning from local and national SARs, other learning reviews and multi-agency audits.
- Work across other statutory / strategic multi-agency partnerships to ensure any crosscutting themes arising from our respective safeguarding activity, (performance data or assurance work) are identified and addressed.

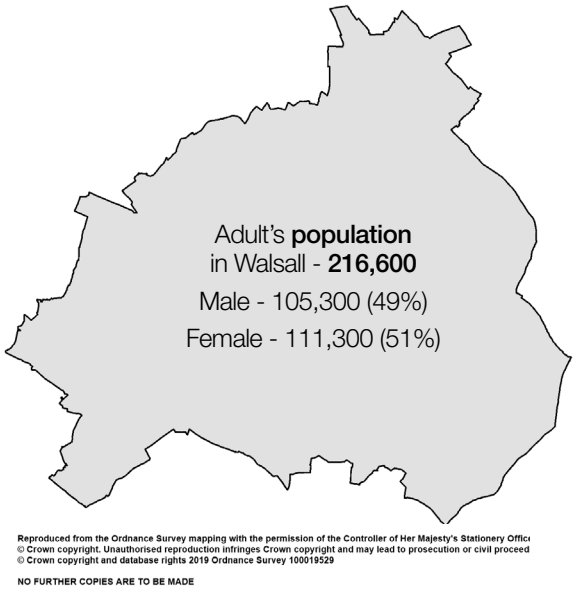
Our Vision is for all agencies to work together and effectively build resilience and empower communities in responding to abuse, neglect, and exploitation, and to widely promote the message that safeguarding is everybody's business in that:

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

The vision for all children and adults in Walsall is:

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

Walsall 'At a glance'



There are 20 x 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, typically more affluent areas 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 significantly worse than the national average of 66.4% (2019-20)

Sources; Public Health England – LA Health Profile-fingertipstool

Walsall Insight – www.walsallintellinge.org

What is Adult Safeguarding?

It means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.

Safeguarding includes people and organisations working together to:

- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs
- Stop abuse or neglect wherever possible
- Safeguard adults in a way that supports them in making choices and having control about how they want to live
- Promote an approach that concentrates on improving life for the adults concerned
- Address what has caused the abuse or neglect.

The Legislation

The Care Act 2014 is a hugely important piece of legislation in adult safeguarding. Applying to England, it sets out how an individual's care and support needs should be met, and defines the responsibilities of local authorities – including the NHS.

The act sets out statutory responsibilities for the care and support conducted between health and local authorities. The two must work in partnership to ensure the safety and wellbeing of all adults at risk – shifting the focus from response to prevention. This means preventing abuse and neglect from occurring at all.

The safeguarding duties apply to an adult who:

- has the needs for care and support (whether or not the local authority is meeting any of those needs) and;
- is experiencing, or at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

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

Safeguarding Activity

Partnership Data

What is working well? Continued trend in provider services leading on caused enquiries, timeliness is showing improvements but further improvements on this could be made DV disclosures scheme increase in applications reflects positive outcome as it shows increased awareness and 'right to know' process Detailed programme of activity undertaken by Walsall Healthcare Trust including the development of a Safeguarding Champions Programme to cascade to their teams/wards

What are we worried about?
Lack of data on LeDeR measures in review at present - This impacts on PQA's ability to understand the progress of work being undertaken to improve care and services for people with learning disabilities and autism and reduce health inequalities. No visibility in the dataset regarding equality diversity and inclusion

- WMP – Q4 arrange or attempt to facilitate travel with a view to exploitation decreased to 3 x offences with 13 x cases within the year, a decrease compared to 39 recorded in 21-22. Forced labour figure increased by 1 x offence in Q4, as did holding a person in slavery –

Is there anything else we need to know or do?
Continuing governance issues between Safer Walsall Partnership and Walsall Safeguarding partnership relating to domestic abuse, exploitation and modern slavery (theme also identified in the children PQA report). Linkages between relevant governance and assurance bodies require clarification.

WM Fire Service Serious Incident & fatalities Total ***decreased*** from 21-22

Rolling 12mth data	Q4 Mar 22	Q1 Jun 22	Q2 Sep 22	Q3 Dec 22	Q4 Mar 23
Serious injury	22	23	17	17	16
Fatalities	19	14	12	11	14
	41	37	29	26	30
SAW Rates	388	319	291	263	245

✓ **Healthwatch**

Assured robust process in place to identify escalate concerns appropriately. Virtual visits taking place with face to face planned from Q2 onwards

West Mid's Police

211 x Domestic Violence Disclosure Applications in past 12 months (*as at Mar 23*)
Increase in Q4 with 67 compared to 51 (Q3) and overall is increasing

Zero FGM offence reported in Q4 **One** in total for 22-23 year

Modern Slavery offences increased in Q4 in both Hold a person in slavery *and* require a person to perform forced or compulsory labour

West Mid's Fire Service

45% Safe & Well referrals received from Partners

Q4 Completed Safe & Well checks **697**
(Rates Decreased during Q4 (245) compared to 319 in Q1

*Fatal Incidents in last 12 months increasing as at March (14) Serious Injuries reduced by 1 (16) However total is **reducing(30)** compared to last year (41) Proportion of injuries(53%) to fatalities (47%) fairly consistent 21-22*

Safeguarding Activity

What is working well? ASC framework refreshed with enhanced safeguarding element to monitor CQC ratings in care homes. Change in measures including care home ratings will ensure partnership responsibility for assurance of safety.50% increase in concerns from nursing homes may indicate improvements in reporting of abuse. Positive Improvements in the Timeliness of Caused Enquiries returned with 2 x agencies reaching 100% in Q4

What are we worried about? **S42 conversion rates decreased overall.** 22..8% in Q4 increased very slightly from 22.6% in Q3. 22-23 ytd figure is 21.6% This is higher than regional comparator (15.2%) but lower than published SAC 21-22 Walsall figure (28.1%) and nationally (34% England,21-22). **16% increase** in referrals from last year but resource has not changed which may account for some delays at safeguarding process. Walsall 4th highest for concerns in region. Capacity issues within BCIB delayed completion of lateral checks

Remedial actions: BCIB will be convening a meeting in June to discuss the issues linked to lateral checks to determine how this can be addressed. Update will go to September PQA

- On rolling 12 month basis the Top 3 Abuse types **Neglect remains as main feature** followed by Psychological Abuse and Physical on par with last year. Financial Abuse has dropped below Physical Abuse as 'Top 3' during previous qtr. In Q4 period Financial abuse now ranks 4th with 50, below Physical abuse with 78, this ranked 2nd in Q2 Summer period
- **Own home** continues to be the main location of abuse Q4 saw a large increase in number by 43. (q1=96,q2=90,q3=82,q4=125) however, the annual total of 393 is less than 463 reported in 2021-22

1053

Concerns were received between 1st Jan and 31st Mar 23 a rolling total of 4,097 shows an ***increase*** from **3,983** at end of Q3 **and** 21-22 figure of 3525 - **%** led to enquiry ***increased*** *this qtr, but YTD at 21,6% lower than national average (34%)*

240

Safeguarding Enquiries concluded from 1st Jan to 31st Mar 23, compared to **219** in previous Quarter but equal to **240** in Q4 of last year

244 **Concerns led to Caused Enquiry (r12)**

78% led by Residential/Nursing or Domiciliary Providers

Q4-Referral Sources

Combined Health Services 458 (43.5%)
Ambulance 188 (17.9%)
Residential/Nursing 179 (17.0%)
Mental Health Services (rank 4th) 81 (7.7%)

Conversion rates increased to 22.8% in Q4. This still remain Low across the partnership at 23 YTD = 21.6%

Police Referrals increased 166 (*rolling total as at Mar 23*)

Partner Conversion rates
Health Services 19.0%
Police 15.5%

Top x 3 Abuse Types
12 month rolling Mar 23

Q4,Neglect x 165 – 35.3% *(444 roll)*
Psychological x 93 – 19.9% *(243roll)*
Physical x 78 – 16.7% (189 roll)

Q4,Financial x 50 – 10.7% (181 roll)

Adults at Risk

- 1053 **Safeguarding concerns** raised during Q4 related to 848 Adults, some of which **had multiple concerns raised.** A total of 2,660 individuals throughout year has increased from 2,335 in 21-22
- The age group of **81-90yrs continues to be highest risk**, an increased in number by 27 in Q4,
- Numbers of adults with a concern raised from 'Other Ethnic Group' increased slightly in Q4 to 52. This had doubled to 52 in Q2 compared to 24 in quarter 1 and slightly less in Q3,48. This makes up 6.2% of the adults in Q4 and for the 2022-23 year – 5.9, which is disproportionate to the 2021 census population data with only 2.1% identifying as 'Other Ethnicity' in Walsall.
- More visibility in the dataset is required on equality, diversity and disability inclusion
- 93.7 % of adults **desired outcomes were fully or partially achieved in Q4,** but a decrease in total this year with 93.1% compared to last years figure overall of 95.2%. Number of adults who did not have their desired outcomes achieved in Q4 was **6.3%** (6.8% in Q3,6.3% in Q2 and 5.8% in Q1 and 4.7% at 21/22 YTD)
- *MCA at S42 Enquiry shows number of adults with no capacity who were supported by independent rep in Q4 was 85.5% a decrease from 92.1% reported in Q3.The 22-23 figure of 87.2% was improvement on previous year 22 figure of 75.3%*
- Risk Outcomes –**risk remained** increased largely in Q4 to 26.4% from 9.0% in Q3. In 22-23 year, 32.1% identified No risk as the outcome.

848 Individual Adults with Concerns raised to ASC

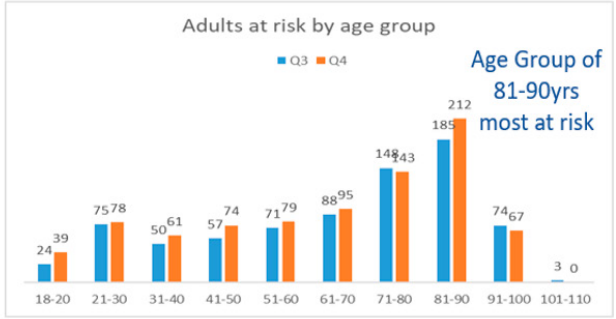
44.3% Male
54.7% Female

MSP

59% Adults who were asked & expressed their Desired Outcomes, were **Fully** Achieved throughout 22-23, remaining ***static*** compared to 21-22

MCA

85.5% Adults who lack capacity had advocate support in Q4



ETHNICITY – Q4 saw a small increase in numbers for Concerns received for Adults in category of Other Ethnic group, a similar proportion to Q3 (6.1%) However figures are still disproportionate to Walsall 2021 Census population data in Walsall identifies only 2.1%. In 22-23 5.9% adults with concern raised were from Other Ethnic Group

Walsall's Response – Agreed Priorities for 2022-2023

Find out more about our arrangements here

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 influenced 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 fulfilling their statutory obligations.

To receive performance reports in to measure the improvement and impact in safeguarding practice

Measuring the impact of case review and audit outcomes on multi-agency practice

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

Practice Review activity:

Efficiently undertake review of those cases where it is appropriate to do so. Obtaining and reflecting on learning, sharing 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 response and approaches.

Practice Improvement activity:

Undertake a training and development needs assessments across the partnership.

Establish closer working relationships / processes with other subgroups to deliver a practice improvement programme that draws on our understanding of safeguarding issues and learning from reviews across the Borough.

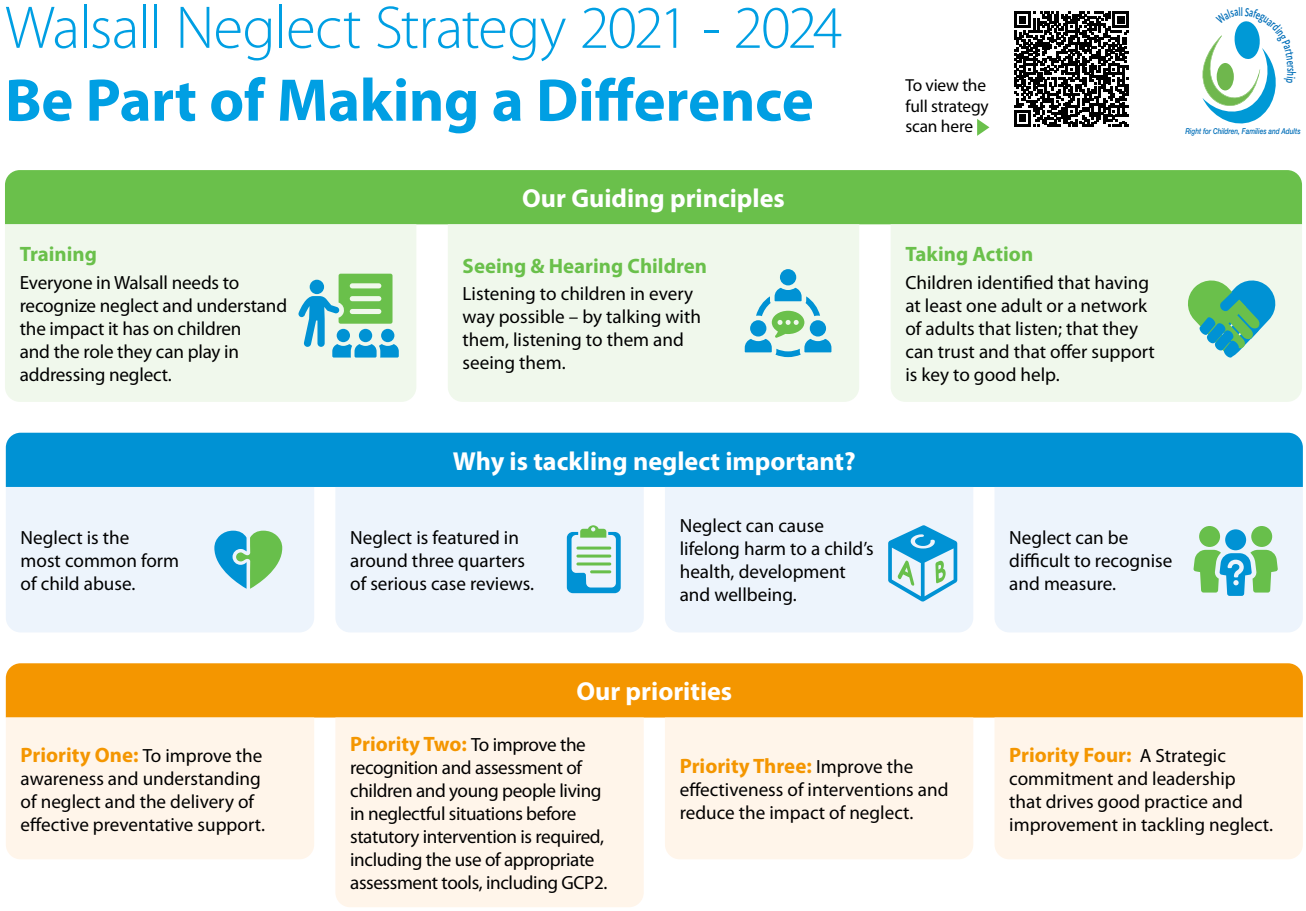
Develop a training strategy to support the partnership priorities 2021/22.

Working with the Walsall Community : our 4th partner

Report on Progress

Priority 1 - Neglect

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



Action Taken

Since the launch of the strategy, we have:

- developed a multi-agency action plan setting out SMART key actions across each of the priorities.
- developed our multi-agency Neglect Outcome Framework so we can measure our collective impact. This will be implemented as of April 2023.
- continued to develop our training offer to deliver awareness, understanding and response to neglect. In the last 12 months we have focussed on Early Years providers and the Voluntary and Community Sector.
- utilised the Early Help ACTION campaign (Aware, Care, Think don't Ignore Or do Nothing) to ensure we action on the guiding principles children and young people identified.
- maximised opportunities through big programmes such as the Holiday Activity and Food Programme to ensure we maximise opportunities to identify and support children and families early.

- In order to strengthen practice across partnership, we have secured partnership resource to recruit a Neglect Practice Improvement Coordinator. This post will be directly responsible to work across the Partnership in developing a resource hub, training programmes and practice reflection sessions that will support practitioners in implementing effective practice in working with families where neglect is an identified need. This will include the consistent use of the Graded Care Profile (an evidence-based tool in identification and working with families in addressing neglect). This post will be in place by June 2023.
- We are working with the police to see how their AWARE App (a mobile based app) can be used to better identify neglect and can be upscaled to be used by a wide range of agencies.
- We have embedded a 'Think Family' approach as part of the Adult Neglect Strategy to ensure we identify effectively any children who may be impacted by adult self-neglect.
- The Partnership has considered how the development of the Family Hubs can provide opportunities for effective support to families to prevent child neglect especially in those areas were we currently see low uptake of preventative programmes.

Next Steps

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

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

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

Remaining Challenges

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

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

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

Priority 2 - Self Neglect and Hoarding:

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

Rationale

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

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

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

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

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

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

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

Strategic Intention

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

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

Self- Neglect

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

What is working well?

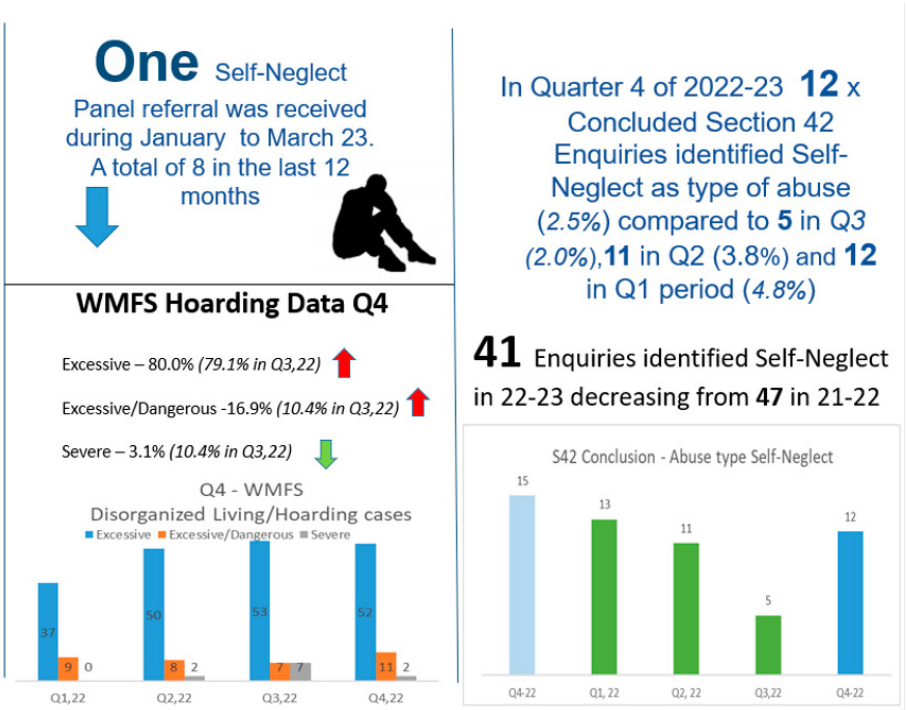
Figures show increase in Self Neglect identified as abuse type in Q4 = 12, where self-neglect was identified at conclusion of Section 42 Enquiry as the type of abuse, rising from 5 in Q3 and on par with 11 in Q2,12 in Q1. The annual total is 41 slightly down from the 47 reported in 2021-22

What are we worried about?

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

Is there anything else we need to know or do?

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



Action taken:

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

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

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

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

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

Impact

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

Unfortunately, referrals into the Self-Neglect and Hoarding Panel have remained very low across the year, yet the issue remains a prevalent theme in audits and review outcomes.

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

Remaining Challenges

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

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

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

Priority 3 - All Age Exploitation

Rationale

Age related issues such as dementia or mental impairment, worsening cognitive thinking skills, and physical frailty can make it more difficult for older adults to make sound decisions and ask questions, in turn making them easier to exploit. WSP recognised that exploitation happens amongst older people through abuse of trust and can include financial exploitation - being exposed to rogue traders and scams or coercion and pressure - taking over the home of a vulnerable person in order to establish a base for illegal drug dealing (this is known as cuckooing). WSP are also aware young people transitioning from Children's Services to Adults Services that exploitation for young people does not stop on a person's 18th birthday. Where a young person is experiencing exploitation at 17 years, and is seen as a victim, it becomes more apparent that services need to recognise and respond to the very likelihood that the same young person will continue to be vulnerable to the risk of exploitation, and will continue to require support, and or, protection after their 18th birthday. It is for this reason WSP have agreed to an 'all-age approach' to tackle exploitation in the Borough.

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

Strategic Intention

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

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

Action taken

Actions to deliver the objectives included the following:

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

Community based work within the Exploitation Hub:

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

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

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

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

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

Impact

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

Remaining Challenges

The lack of a Strategic Needs Assessment, an out-of-date Strategy a partially completed Delivery Plan and no scorecard hampered the group in moving forward significantly with their agenda. A significant amount of work was carried out with the Safeguarding Business Unit to understand the issues and develop a plan around resolving this issue.

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

Lack of data and input form Business Insights staff prevented progress on scorecards, however, this is being resolved now that corporately the Councils Business Insights team is becoming more stable, and a member of staff has been identified to support the work.

Exploitation - Adults

- There is currently no Partnership Exploitation Scorecard established. The revival of an 'All age Exploitation' scorecard and data measure is being discussed by the Exploitation Delivery groups as part of the outcomes framework to identify a set of meaningful data measures for adults and children informed by multi-agency KPI's.
- VRU Exploitation Dashboard provides some quarterly information for the regional and National statistics. NRM referrals in west midlands police force is given by age & Exploitation type where location of exploitation is Walsall.
- Overall National referrals in Q3 (431) had 35% who were aged 25yrs and over (73-17% were of unknown age)
- WMP made 42 x NRM referrals in Walsall over last 12 months with top 3 types of Exploitation overall being Criminal 36%,Labour 27% and Sexual 16.%. Of these 13 adults aged over 18yrs across the year.
- Criminal exploitation in walsall over last 12 months was found in a majority of cases (62%) sexual was found 21%and labour reduced 7.1% from 33% total at Q1
- County Lines dashboard data (2019-2022)gives a Walsall Local Authority figure of 254 persons entrenched in County lines ranking 5th least in the west midlands region and of these 254 individuals 115 (45.2%) aged 13ys-17yrs old 139 (54.7%) between 18yrs and 53yrs old

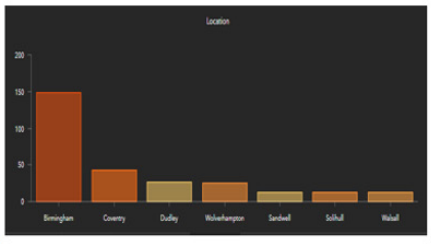
NRM

285 referrals by WMP in Q4 23 of these **12** had location **Walsall =** one third of these were male adults aged between 21 & 31yrs old, the remaining were children aged 14-17yrs old

50.1% of these were adults aged 18yrs+ an *increase* from 33% in past 12 months rolling year totals

(Dec 22) Rolling 12 months Data;

Criminal = 75%
Labour =8.3%
Sexual = 16.7%



2 x Concluded S42 Enquiry found Sexual Exploitation as type of abuse in Q4, a total of **7** in 22-23 showing a *DECREASE* from **13** *in* 21-22 ,

In Q4 = 50

Concluded S42 Enquiries identified Financial Abuse *(indicating Exploitation)* as Type of abuse, ***decreasing*** from rolling 12mnth total of **184 as at** Mar 23, down from **191** Dec 22 and **188** at Sept 22 and now ranks 4th place(q4)

Priority 4: Child Sexual Abuse

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

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

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

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

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

WSP Business Unit Review

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

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

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

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

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

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

How We Learn

Learning from the Outcome of Multi-Agency Audits

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

The themes are identified due to strategic priorities, response to the findings of Safeguarding Adult Reviews (SARs), Walsall data and intelligence.

During 2022/2023, the MAA audits focused on four priority areas including: fire risk and safety, self-neglect, exploitation, and domestic abuse which are either priorities or require some focus due to the findings from Safeguarding Adult Reviews and Domestic Homicide Reviews.

Table 1 provides an overview of the grading of audits from 2022/2023. Overall, there is a mixed picture when the grading of multi-agency practice is considered. Across all the audit rounds, the multi-agency practice with one audit has been graded as good and within two (Q1 and Q3), gradings of requires improvement have been identified. Inadequate ratings have been a feature in three of the four audit rounds with self-neglect and domestic abuse having the highest proportion. Evidence that any remedial actions have been completed from Q2-Q4 are completed and noted within the reports.

Year/Quarter 2022/2023	Theme	Outstanding	Good	Requires Improvement	Inadequate	Not Graded	Total
Q1	Black Country Fire Audit		1	1		1	3
Q2	Self-Neglect		1		3	1	5
Q3	Exploitation			2	1	2	5
Q4	Domestic Abuse		1		3	1	5
Total			3	3	7	5*	18 (13) **

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

****In Q1, the regional audit required each region to submit returns on three adults with 12 adults considered.**

When the MAA audit gradings in 2022-2023 are compared against previous years it needs to be noted that this relates to the multi-agency work with 13** rather than 18 adults with care and support needs, which represents 73% of the overall total. From this figure, as outlined in Table 2, 46% of the work has been rated as good or requires improvement. When grading from 2022-2023 is compared with 2021-2022 there has been a reduction of 24% in work rated as good and 11% in those rated as requires improvement. More significantly there has been an increase of 43% of multi-agency practice rated as inadequate.

Year/Quarter	Outstanding	Good	Requires Improvement	Inadequate
2022-2023*	0%	23%	23%	54%
2021-2022	0%	47%	32%	11%
2020-2021	5%	42%	47%	5%
2019-2020	11%	10%	80%	10%

Table 2: Comparison of annual audit grading for Adult MAA from 2019-2023. In 2022-2023, the sample size was smaller than previous years.

There are several factors that need to be taken into consideration. Audit grades relate to the quality of multi-agency working rather than overall practice. In addition to the multi-agency work rated as good, there could be positive elements of single and partnership agency working as well as areas for development particularly in those rated as requires improvement. Developing a bank of good practice examples of partnership working which can be used as part of training and wider communication would be beneficial. Had the work been graded in relation to the multi-agency practice in relation to 5 adults, this could have impacted on quarterly and annual figures. This further supports the need to review the methodology to align some aspects with the children MAA.

Whilst this is a small sample size, due to the 'deep dive' nature of the evaluation of multi-agency practice, these findings reflect those identified by other WSP work such as learning reviews and other quality assurance activity. Robust multi-agency practice is an important part of achieving good outcomes when working with adults with care and support needs. Understanding the reasons for the changes in grading are more complex and will require further analysis. Some possibilities include the themes chosen are not only priority areas locally when working with adults with care and support needs, they often reflect challenges in practice regionally and nationally.

Work has also been undertaken by the Business Unit to strengthen the performance and quality assurance framework. As part of this incorporating the lived experience of adults with care and support needs, involving practitioners as part of the assurance, measuring impact and influencing and informing service improvement. This could also provide further insight into possible solutions as well as the issues from a different perspective. Consideration of how this links with other partnership quality assurance activity could also be a consideration. The next section provides an overview of the practice including good practice and areas for development. Following this, are an overview of the themes and a summary.

Q1: Black Country Fire Audit multi-agency audit completed June 2022

Year/Quarter 2022/2023	Theme	Outstanding	Good	Requires Improvement	Inadequate	Not Graded	Total
Q1	Black Country Fire Audit		1	1		1	5

Q1: Black Country Fire Audit

The audit topic was chosen as an area of focus following local and regional case review findings where issues of fire safety were identified. Undertaken with Dudley, Wolverhampton and Sandwell Adult Safeguarding Partnerships and West Midlands Fire Service. The audits highlighted that there was some good practice with evidence of understanding and application of the Mental Capacity Act in the context of fluctuating capacity, Making Safeguarding Personal and multi-disciplinary meetings.

However, it was identified that there were earlier missed opportunities to prevent fires by professionals identifying possible indicators, ensuring that this was included as part of assessments, and reporting to the Fire Service seek their advice and involvement to identify ways of minimising the risks. Co-existing factors such as hoarding, mental and physical health needs were also identified. Practice would have been strengthened by consistently ensuring the application of making safeguarding personal. Communication and information sharing could have been improved if it resulted in better co-ordination of multi-agency working and care planning with key partners involved with the adults.

How did we share learning?

- A 7-minute briefing combining the findings across the region was developed and shared.
- A virtual Fire Safety learning event for practitioners across the West Midlands Region was held by WSP on the 22.11.22 as part of Safeguarding Adults week. This was attended by 205 practitioners.

Q2: Self-Neglect: multi-agency audit completed September 2022 (linked to CSPR's and evaluating the pathway)

Year/Quarter 2022/2023	Theme	Outstanding	Good	Requires Improvement	Inadequate	Not Graded	Total
Q2	Self-Neglect		1		3	1	5

Q2 Self Neglect

Self-Neglect was identified as an audit topic to evaluate the effectiveness of the pathway developed to support partners when working with adults with care and support needs and in response to case review findings. Recognised as a complex area of practice, the audit identified some good practice in relation the identification and use of the self-neglect pathway, understanding and application of the Mental Capacity Act and Making Safeguarding Personal. Multi-agency work identified co-existing risks and the need for support from partners specialist services. Where professional disagreement was evidenced, this escalated, was considered, and resolved.

The quality of practice would be improved by consistent use of the Self-Neglect Pathway, Risk Assessment and Tools by partners to explore the impact. Mental capacity was often assumed rather than assessments undertaken and discussions surrounding independent advocates evidenced. This would have enabled a better understanding of the personal history and lived experience of adults supporting a better understanding of root causes as well as presenting behaviours that may lie behind behaviour to strengthen engagement with professional support. Recording of the enquiries need to better evidence decision making, and multi-disciplinary team meetings held to enable a shared responsibility across agencies linked to responding to the needs and risks to adults, whilst balancing this with respecting their autonomy and desired outcomes.

How did we share learning?

- An Adult Safeguarding conference will be held in October which will focus on self-neglect and hoarding, there will also be videos and other practice learning tools developed.
- A 7-minute briefing will be developed in August and findings shared as part of the conference.

Q3: Exploitation: Multi-agency audit completed October 2022 – (evaluate the quality of practice in relation to exploitation a key safeguarding Partnership priority

Year/Quarter 2022/2023	Theme	Outstanding	Good	Requires Improvement	Inadequate	Not Graded	Total
Q3	Exploitation			2	1	2	5

Q3 Exploitation

All-age exploitation is a priority in Walsall. This topic focused on the effectiveness of multi-agency practice where adults with care and support needs may be at risk of exploitation or were being exploited. Positive practice was noted in terms of making safeguarding personal, adopting a trauma informed approach, risk assessment and some examples of engaging some adults.

Where mental capacity was questioned, robust management oversight was required to determine whether an assessment was required, evidence that independent advocacy was discussed with the impact of coercive control and grooming considered. Ensuring that all key agencies were involved in the safeguarding enquiry, referrals to the Exploitation Hub were consistently made and robust multi-agency working evidenced throughout would have resulted in more focus on the safeguarding concerns, safety planning and contextual factors.

How did we share learning?

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

Q4 Domestic Abuse Multi-agency audit completed May 2022

Year/Quarter 2022/2023	Theme	Outstanding	Good	Requires Improvement	Inadequate	Not Graded	Total
Q4	Domestic Abuse		1		3	1	5

Q4 Domestic Abuse

The audit focused on domestic abuse. Professionals were all aware of the domestic abuse risks and there were some positive examples of risk assessment and management being undertaken in complex situations. Support options were also provided to some adults evidencing a focusing on reducing or minimising risks and the impact of the domestic abuse.

Practice could be strengthened where mental capacity was questioned by consideration of the impact of coercive control. Better collaboration and co-ordination opportunities between professionals was required to develop a better picture of the domestic concerns and any other co-existing factors. Developing a deeper understanding of the culture, identity and background of adults would have enabled both protective factors and potential risks to be understood and addressed. Information sharing and seeking whilst present needed to consistently demonstrate 'professional curiosity' 'by looking beyond the 'presenting issues, consider barriers to disclosure particularly in carer/cared for relationship and use multi-agency meetings to inform dynamic risk assessments and safety planning.

How did we share learning?

- The overview report has recently been completed on the 14.07.23 and will be submitted to the next PQA and shared with Safer Walsall Partnership who have governance of domestic abuse.
- A domestic abuse 7-minute briefing will be developed by August 2023.

Adult Multi-Agency Audit Themes 2022-2023

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

Practice area	Overall Multi-Agency Audit Themes and Findings
Making Safeguarding Personal (MSP)	**Compliance with making safeguarding personal principles:** There were some good examples of practitioners using flexible and person-centred approaches to understand the perspective of adults, empower and promote active participation in decision making. Mental capacity was considered at appropriate decision points, assessments were undertaken, and outcomes were recorded. Engagement and involvement of the family, network, and advocates as appropriate enabled the views of adults to be heard. Partners identified that there were inconsistencies not only in the application of mental capacity act but also within the context of dynamics linked to coercion and control. Independent advocacy was also not routinely discussed. Evidencing how engagement with adults informed by their culture, identity and background would have resulted in a better understanding of their lived experience, strengths and risks enabling a more robust person-centred MSP approach to be developed. This was identified as an area of practice improvement.
Information Gathering	**Importance of robust information gathering as part of the safeguarding enquiry:** Where good practice was identified, positive examples of consent, information sharing and seeking were identified. This was applied in an appropriate and proportionate way resulting in both risks and needs being viewed holistically. However, across most of the audit rounds, some key involved professionals such as the G.P were not part of the information gathering and, in some circumstances informed about the outcome. Different agencies held different information which was not always brought together and considered. Had this occurred, this would have strengthened the quality of information gathering, assessments and enabled a more robust picture of the needs and risks to adults being developed. Understanding whether all the relevant lines of the safeguarding enquiry had been identified and pursued was complicated in some audits due to the quality of the recording.
Risk Management	**Understanding and responding to specific forms of abuse and neglect:** Generally, professionals were aware of the presence of risks when working with adults with care and support needs. Where good practice was identified, risk management was informed by an understanding and response to the abuse and neglect using the appropriate pathway, tools with a person-centred approach to address the risks. In most audits, pathways, and risk assessment tools (fire safety, self-neglect, exploitation) were not consistently used at the earliest opportunity. Obtaining, triangulating, and analysing key information would have evidenced the application of professional curiosity to develop a holistic view of the specific nature of the risks and impact on the adults. The lack of involvement of some professionals also impacted on the ability to develop a comprehensive and shared understanding of the risks to inform the plan. Within these audits, the quality of recording was also identified as an issue and management scrutiny needed to be better evidenced.
Multi-agency working	**Importance of robust multi-agency working: T**here were some positive examples of multi-agency working identified where partners communicated effectively, resulting in timely information sharing and multi-disciplinary team meetings being held. These meetings strengthened the quality of multi-agency working the response to risk and decision making. However, across all the audit rounds improving the quality of multi-agency working was identified as an area of practice development. This was particularly in relation to timely information sharing, co-ordination of decision making about needs and risks and when the safeguarding process was concluded. Better use of the multi-disciplinary team meeting process with adults would have provided professionals with better opportunities to consider a proportionate response to the risks in the context of the desired outcomes identified by adults. Feedback to referring agencies on the outcomes of safeguarding concerns and subsequent actions could be more consistent.
Impact for adult	Due to the complexities of individual circumstances, where practitioners demonstrated the necessary balance between procedural compliance person-centred interventions, the impact for adults was evidenced and generally better outcomes achieved.

Summary

Overall, the overview of multi-agency practice during 2022/2023 has evidenced a mixed picture with an increased number of audits being rated as inadequate. Further discussions are required to review the findings and consider the action required. Positively, 50% of multi-agency practice has been graded as good or requires improvement. Development of good case examples where the impact of this work can be shared could be one way in which the learning could be shared more widely. There are also some re-occurring cross-cutting practice themes and links with partnership assurance activity and action plans focusing on these areas need to be considered. Findings have identified the importance of continuing to ensure compliance with legal frameworks, pathways, guidance, evidence-based tools alongside the importance of purposeful person-centred intervention and robust multi-agency working that makes a difference to the lives of adults with care and support needs.

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

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

Partnership Learning and its Dissemination and Embedment into practice

Learning from case reviews is a statutory function required to be in place for all Local safeguarding adults boards. In Walsall this function is delegated, overseen and monitored by WSPs Practice Review Group.

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

Key priorities for the group during 2022-23 were:

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

Safeguarding Adults Reviews (SARs)

WSAB carries out Safeguarding Adult Reviews into cases where individuals with care and support needs have been seriously harmed or died, and abuse or neglect is suspected. The reviews are focussed on identifying how multi-agency safeguarding systems and practice can be improved in the future.

During 2022/23 WSAB had 2 referrals for SARs, less than in 2021/22, but in line with previous years. WSAB continued work on three other SARs started in the previous year some of which were completed during this business year.The Criteria for Safeguarding Adult Review (SAR), Section 44 Care Act 2014

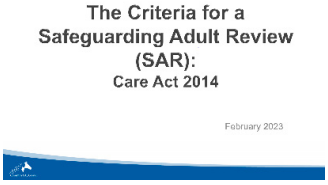
1. A SAB must arrange for there to be a review of a case involving an adult in its area with **needs for care and support** (whether or not the local authority has been meeting any of those needs) if -

   (a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

      i. The adult dies and the SAB knows or suspects that the death resulted from abuse or neglect, or

      ii. The adult is alive and the Board knows or suspects that the adult has experienced serious abuse or neglect

In February 2023, Walsall partners were given the opportunity to take part in learning with Coventry Safeguarding Adults Board to help partners consistently apply the legal framework correctly to individual cases presented for consideration for a SAR. In addition, the rapid review panel for adult referrals has, from quarter 4 of the year, been chaired by the Independent Chair and Scrutineer for the SAB. The training has increased the confidence of group members application of the legal criteria for a SAR, resulting in no further cases being commissioned that did not meet the criteria for review.



The introduction of the local process of SARs in rapid time has been received well by partners, with learning from the reviews being identified at a much earlier stage and reviews being concluded quicker than in the traditional approach to SARs. Further improvements are to be made to the approach to enable scope for increased scrutiny and independence of the work.

Domestic Homicide Reviews (DHRs)

Domestic Homicide Reviews are undertaken when there has been the death of a person aged 16 or over, where it appears to have been caused from violence, abuse or neglect by (a) a person related to the victim or with whom there was or had been in an intimate personal relationship, or by a member of the same household as the victim. The reviews are held with a view to identifying whether there are lessons to be learnt from the death. Domestic Homicide Reviews are overseen and commissioned by Safer Walsall Partnership (SWP). This partnership aims to implement projects to protect communities from crime and creating safer, stronger and resilient communities. Keeping people safe from harm, reducing offending and preventing re-offending throughout Walsall. WSAB works closely with SWP to share information and learning arising. There are two DHRs opened to the safeguarding review processes, both of which were commissioned in the previous year. Emerging themes from these reviews have included the following:

- Visibility and understanding of Domestic Abuse involving an adult child and a parent
- Coercive control within this type of abusive relationship
- Recognising and supporting male victims of Domestic Abuse
- Making Safeguarding Personal v Duty of Care
- Mental health and capacity
- Identifying relapse and escalation of risk
- Professional curiosity
- Agency DNA (did not attend) policies
- Multi-agency sharing of information

National Learning

The circumstances into the sad and untimely death of Arthur Labinjo-Hughes and Star Hobson have been a key focus for Walsall Safeguarding Partners. **The Solihull JTAI** completed following the death of Arthur Labinjo- Hughes was critical of the ways in which the learning from case reviews was shared across the system. This prompted a review of the current processes in place to ensure that learning was shared effectively with all partners. This resulted in the following:

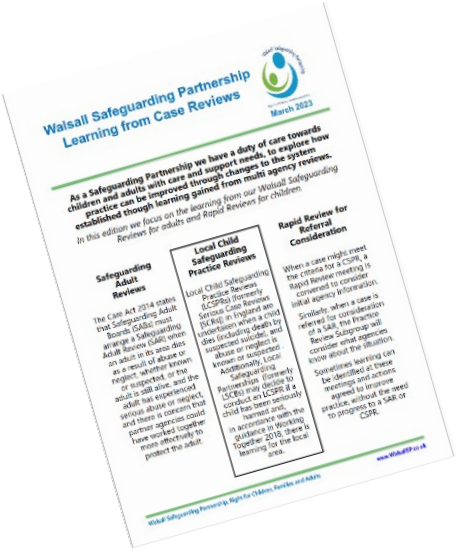
- **A new website** is to be launched in 2023-24 - the review of the Safeguarding Partnership website which was updated with a clearly identifiable tab for 'Learning'.
- **A Communications Strategy** was developed by the Partnership which addresses the dissemination of learning from reviews.
- **A quarterly newsletter from the Partnership** was developed and circulated across the children and adult's workforce summarising significant learning from reviews.

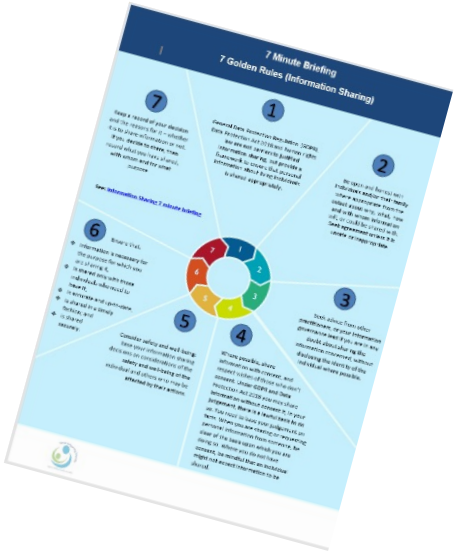
The use of 7 minute briefings

Key messages in regard to outcome of reviews is promptly applied and featured in WSP learning and training material. Partner representatives of the Practice Development Subgroup are responsible for ensuring the learning is taken back into their own organisation and any single agency learning is updated accordingly.

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

The 7 minute briefings published in 2022-23 can be found on the training pages of the WSP website: **https://walsallsp.org.uk/adults/training-learning/adults-training-learning/7-minute-briefings-adults/**





How feedback from adults with Care and Support Needs and their friends and families has informed our work and influenced service provision.

WSP understands the importance of ensuring meaningful involvement of the adults, their friends and families or carers in, planning and evaluation and decision making of services that intervene in their lives. It is for this reason that WSP have identified the need to promote this activity across its sub-structure.

Healthwatch undertook citizen engagement assurance activity linked to the cost of living (Dec 22-Feb 23) which was the first attempt at engagement by this group regarding matters which could contribute specifically to how people are living currently, which includes activity which would be seen as 'risky'.

Practitioners provide 4th partner feedback from assessment undertaken for consideration when attending the Self-Neglect and Hoarding Panel and have reported the challenges in working with people who self-neglect or hoard.

Analysis of adult services data suggests that in Making Safeguarding Personal (MSP) that 59% of adults at risk were 'asked, listened to and had actions progressed', this has resulted in their desired outcomes being fully achieved. It is acknowledged that there is more to do to meaningfully Ask, Listen and Act on 4th partner voices and to ensure this is consistent and considered to improve services and practice. This must include robust arrangements to obtain regular feedback from family, friends and wider community citizens in the Borough, for partners to be assured of the effectiveness of the adult safeguarding system.

Subgroup Developments

The work of the subgroup is aligned to the West Midlands regional procedures for coordinating rapid review and child safeguarding practice reviews and safeguarding adult reviews. The subgroup in addition has developed its own process to undertake SARs in rapid time.

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

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

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

Streamlining the tracking and monitoring of recommendations from reviews across the multi-agency system

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

There is also a central repository for evidence of implementation.

Drift or delay can be seen easily and addressed.

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

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

The chairing arrangements for SARs has been delegated to the Independent Chair Scrutineer, this provides opportunity to consistently apply thresholds and consider any learning from across the black country in the to cases presented to the subgroup.

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

Remaining challenges/improvement required

Action: Improving EDI in case review discussions and capturing data to assist identifying profiles and target intervention and support

Development of the capability, confidence of the group

Capturing impact of actions taken is challenging and an area for focused improvement in 2023-24

Workforce Learning and Development Feedback on single and multi-agency training information

Strategic Intention

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

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

- Impact evaluations from training events. Pre-evaluation forms completed on the day of attendance at training to self-measure prior knowledge/skill. Post-session evaluation form at the end of the training events to self-evaluate the learning that has taken place and to commit to actions to implement the learning. Post course impact evaluations sent out eight weeks after the course to the delegate to ascertain how learning from the training has been applied in practice and what the outcomes have been.
- Reflective workshops have also been undertaken and professional knowledge utilised to decide upon the priority areas. Data, performance information and statistics based on local needs have also informed decision making, alongside the identified themes and concerns highlighted within DHRs, SARs and CSPRs. The priority areas were also informed by multi-agency audits which have been undertaken and the identified findings.
- The outcome of WSP multi-agency audits. Following the audit, a report and learning notes are provided highlighting areas of good practice and areas for improvement. The audit reports routinely form part of WSP meetings where partners can further challenge and scrutinise the findings. There is a robust audit cycle in place with identified themes linked to the WSP strategic priorities and includes learning from case reviews and emerging data themes.
- To develop a new learning management system that is accessible to all partners, that would enable reporting systems and impact systems in place to support with the impact of training.

Action taken

Subgroup Developments

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

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

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

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

A thorough learning needs analysis will be conducted next year to inform future priorities and focus.

Remaining challenges/improvement required:

- Strengthen adults workforce training offer to develop more focus training linked to priorities and informed by the training needs analysis
- Strengthen governance of subgroup ie secure police membership
- Review policy and procedures in line with plan
- Respond to learning from reviews identified early in the review process as well as final outcomes of reviews
- Complete training needs analysis to inform work-force development requirements
- Increase the engagement with practitioners and the 4th partner to help the partnership to understand the impact of the training and learning across the safeguarding system on outcomes for children, young people and families.

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

Independent Scrutiny

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

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

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

Both children and adults Independent Chair and Scrutineers are in attendance at all meetings of the Safeguarding Executive and are provided opportunity to report on issues emerging from the activity across the Partnership.

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

Inspection Readiness

The Government's Adult Social Care white paper **"People at the Heart of Care"** sets out the Government's vision for Adult Social Care and included new assurance, improvement, and data measures to support local authorities to deliver this vision

The Health and Care Act 2022 puts Care Quality Commission (CQC) assessment of local authorities on a statutory footing. This creates a new duty for the CQC to review local authorities' performance in discharging their adult social care functions under the Care Act 2014. This new duty is due to come into effect from April 2023.

WSAB has begun to coordinate activity to respond to the new duty in the Health and Care Act 2022 for CQC to independently review and assess how Local Authorities are delivering their Care Act functions.

The assessments will be based on a new single assessment framework. The attached is the **Interim Guidance on the CQC approach to Local Authority Assessment** which has been approved by the Secretary of State for Health and Social Care as required by the Health and Care Act 2022. This will be used to assess all types of services in all health and care sectors at all levels during the pilot phase of implementation.

The assessments will focus on how local authorities discharge their duties under Part 1 of The Care Act (2014). This will focus on 4 themes:

- How local authorities work with people
- How local authorities provide support
- How local authorities ensure safety within the system
- Leadership

The Act also sets out duty to review and assess Integrated Care Systems and the co-production of safeguarding activity with LGA, ADASS, DHSC and key stakeholders to ensure successful development and rollout.

CQC readiness- Regional Approach

- Regional approach led by WM-ADASS building on experience of sector led improvement activity in the region
- Completed regional self assessment tool – Oct to Dec 2022
- Buddy reviews undertaken Dec 2022 with Warwickshire and Staffordshire
- Regional workshop 31st January identified key themes in areas for improvement and future events will support with sharing of best practice across the region
- Engagement events with portfolio holders and safeguarding board independent chairs are being arranged
- CQC assurance 2 day in person reviews being undertaken currently, Walsall are supporting with undertaking 2 reviews in the region

Whilst preparation for CQC assurance is of itself an important milestone, it is important to see preparations for CQC through a wider lens of continuous service improvement and business as usual. A further programme of work is planned through 2023-2024 to further understand the 'Walsall Story', improve adult safeguarding arrangements and to prepare for CQC inspection.

Conclusion - How safe are adults with care and support needs in Walsall?

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

There remains strong commitment to our collaborative workstreams that has needed our attention, while the annual review of effectiveness has demonstrated that there are effective Multi-Agency Safeguarding Arrangements in place, this annual review report has to also acknowledge that there is more we can do to support our partners with the strategic developments and to further improve partnership working. We will, therefore, continue to review, streamline and improve our processes and services to ensure these arrangements remain effective, now and into the future.

Forward Priorities and Strategic Plan 2023-2025

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

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

The key priority areas identified for the SAB in 2022 – 2023 continue to be the main priority areas for further development and embedment for the partnership in 2023 -2024.

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

Following a review of the WSP arrangements, the Business Unit has begun work with Partnership Chairs and Members to strengthen leadership and governance in all layers of the WSP sub-structure. This is to continue through 2023-2024. In addition, the Safeguarding Executive Group reached agreement that work to improve multi-agency oversight and management of child sexual abuse would be the 4th Priority. The review of the Child Sexual Abuse Strategy will consider any crosscutting issues for the adult safeguarding agenda.

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

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

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

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

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

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

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

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

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

Appendices

Appendix 1. Financial Summary

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

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

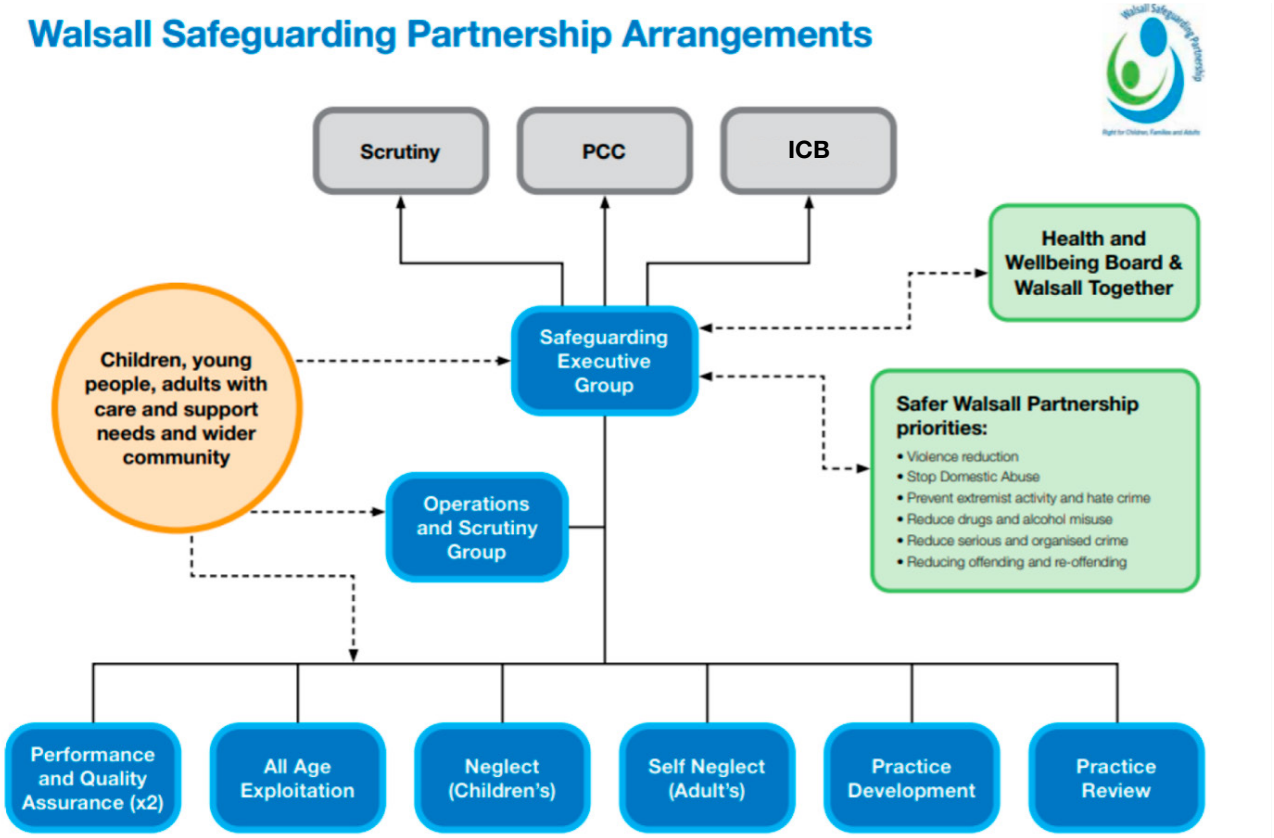
The contributions from partners for the WSP for 2022/23 is set out below:

Income 2022-23	
Organisation	**Contribution £**
WMP	33,651
ICB	97,500
Probation	1,500
Walsall Council – Adults and Children	239,446
Total Income WSAB and WSCP	**369,597**

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

Expenditure 2022-23	**Budget £**	**Actual Expenditure £**
STAFFING		
Employees (permanent)	213,123	121,626
Agency & Consultants	0	147,340
TOTAL STAFFING	**213,123**	**268,966**
NON - STAFFING		
Professional Services (Chair costs, consultancy etc.)	68,200	50,065
CSPR / SAR & Other scrutiny work	25,036	21,719
Development activities	10,000	5,794
Other service costs (website, memberships etc.)	28,785	29,723
TOTAL NON-STAFFING	**132,021**	**107,301**
INCOME		
Contributions from partners	(122,094)	(142,651)
Other income		(10,400)
TOTAL INCOME	**(122,094)**	**(153,051)**
NET POSITION	**223,050**	**223,217**

Appendix 2. WSP Structure 2022-2023



Appendix 3. Glossary of Acronyms

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

Walsall Safeguarding Partnership

Right for Children, Families and Adults

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

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