WALSALL SAFEGUARDING PARTNERSHIP

ANNUAL REPORT

Walsall Safeguarding Partnership

Right for Children, Families and Adults

2023 - 2024

A review of the effectiveness

of the multi-agency safeguarding

arrangements for children and

young people in Walsall

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Introduction from our Statutory Safeguarding Partners

We are pleased to present Walsall Safeguarding Partnership Annual Report covering the 1st April 2023 to 31st March 2024, which is produced on behalf of the partnership by the Delegated Safeguarding Partners. This report is focused on the partnership's work in relation to **Safeguarding Children**. You can access our Annual Report for Safeguarding Adults here [WSP Annual Reports - Walsall Safeguarding Partnership (walsallsp.co.uk)]

We want to start by taking the opportunity to thank all our front-line practitioners and managers, who work tirelessly to improve outcomes for children, families and adults with care and support needs on a daily basis. It is their commitment, dedication, and care that enables the partnership to translate its strategic priorities into operational practice to keep children, families and adults with care and support needs safe.

In March this year we said goodbye to our Independent Scrutineer, Sally Hodges. We want to thank Sally for the support and robust challenge that she has given to us as Delegated Safeguarding Partners and to the wider partnership over the past 3 years. We are grateful to have worked with someone with such passion and commitment for driving improvements in safeguarding practice.

This annual report provides a summary of our collective achievements as safeguarding partners, an analysis of the impact our work has had for children, families and adults with care and support needs and notes areas for development that require further work in order to strengthen multi-agency safeguarding practice and our local arrangements.

This is year two of our three-year strategic plan and progress against our priorities is outlined within the report. In 2025 we will continue to test the long-term impact of our work in these areas whilst identifying new priorities for the partnership. We have also worked together to prepare for key changes at a national level with the publication of the revised "Working Together 2023" guidance in December and the introduction of Care Quality Commission (CQC) Inspection framework for Adult Social Care. The partnership conducted a full review of its governance framework to enable us to make the necessary structural changes to our Business Unit so that we are in the best position to meet these new requirements. We are pleased to have appointed a new Head of Safeguarding Partnership to support us in implementing those changes. In the forthcoming year we will concentrate on embedding the revisions and testing the impact so that as Safeguarding Partners we have confidence that our arrangements are effectively safeguarding children, families and adults with care and support needs.

			
Phil Dolby Chief Superintendent West Midlands Police	**Colleen Male** Executive Director Children & Families Service Walsall Council	**Sally Roberts** Chief Nursing Officer / Deputy Chief Executive Officer Black Country Integrated Care Board	**Kerrie Allward** Executive Director Adult Social Care & Public Health Walsall Council

What is Walsall Safeguarding Partnership

Walsall Safeguarding Partnership (WSP) has a joint Multi-Agency Safeguarding Arrangement combining Walsall Safeguarding Children's Partnership (WSCP) and Walsall Safeguarding Adults Board (WSAB). Working Together 2023 and Care Act 2014 is statutory guidance that places responsibility on the partnership to produce a report each year which evaluates the effectiveness of our local safeguarding practices for children and adults with care and support needs.

Working Together 2023 says that organisations and agencies must work together to ensure that information about a child and their family is shared effectively, risk of harm is correctly identified and understood, and that children and families receive targeted services that meet their needs in a co-ordinated way.

The Local Authority, the Integrated Care Board and the Police (referred to as the three Statutory Safeguarding Partners) have a joint and equal responsibility for ensuring that we fulfil these expectations. In Walsall our Safeguarding Partners are Walsall Local Authority, Black Country Integrated Care Board and West Midlands Police.

Our Ambition

Walsall Safeguarding Partnership has agreed that its shared ambitions for 2023-2025 are:

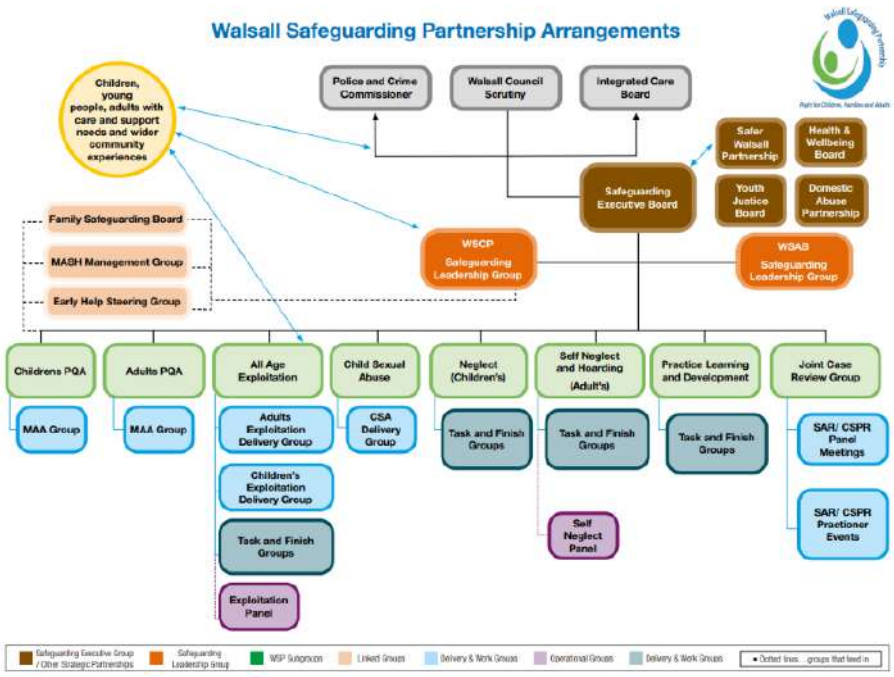
a. Improving our visibility with and amongst local communities and across the partnership
b. Embedding core values of equality, diversity and inclusion in all tiers of the WSP sub-structure and multi-agency safeguarding practice
c. Developing a stronger culture of working together to keep children, young people and adults with care and support needs safe
d. Increasing the involvement (ask, listen and act) of children, young people and adults in our work
e. Developing a culturally competent, confident, knowledgeable, and curious workforce who are supported to work together and deliver their safeguarding responsibilities
f. Ask, listening and act to the experiences of practitioners and the learning from data and assurance activity, to improve the quality of the safeguarding response to children, young people, and adults with care and support needs.

Our Partners (known as relevant agencies)

Safeguarding is everyone's responsibility and Safeguarding Partners cannot effectively keep children and families safe without strong multi-agency safeguarding arrangements and information sharing involving other services that work closely with children and families. 'Relevant agencies' are those organisations and agencies whose involvement the safeguarding partners consider are required to safeguard and promote the welfare of local children. As part of the evaluation of our arrangements we have recognised that there is scope to improve engagement with education (including early years, schools and further education setting) as well as Voluntary and Community Sector providers. Our existing arrangements are currently being updated to reflect the changes we are making, including to our list of identified relevant agencies, and this will be published in line with Working Together 2023 requirements on our website Arrangements - Walsall Safeguarding Partnership (walsallsp.co.uk) by December 2024. Our current arrangements and information about how our partners contribute to the work of the partnership is outlined throughout this report.

In Walsall we work with the following organisations and services.

Our Current Framework



Working Together to Safeguard Children 2023 sets out the responsibilities of the three safeguarding statutory partners, and within that those of the Lead Safeguarding Partners (LSPs), who are named as the Chief Officer of Police, the Chief Executive of the Local Authority and the Chief Executive of the local Integrated Care Board (ICB). At the time of writing, work is taking place at a regional level in the West Midlands to establish how best the co-ordinate the work of the LSPs so that they can effectively discharge their functions as set out in legislation whilst taking into account that demands on the Chief Constable who has seven partnerships to cover.

Each LSP should appoint a delegated safeguarding partner (DSP) for its agency to take decisions on behalf of the LSP and hold their sectors to account. In Walsall, the DSPs form an **Executive Group.** Due to our joint arrangement with the Safeguarding Adult Board, Adult Social Care is also represented. Executive Membership consists of the three Delegated Safeguarding Partners (DSPs) who are:

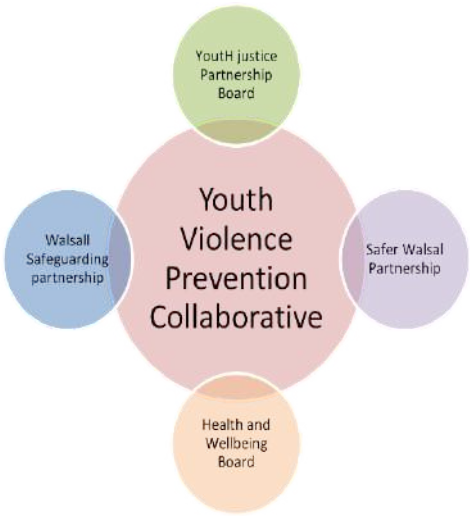
1. Chief Superintendent – Public Protection Unit, West Midlands Police
2. Executive Director of Children and Families, Walsall Council
3. Chief Nursing Officer / Deputy Chief Executive Officer, Black Country Integrated Care Board.

Plus,

- Executive Director of Adult Social Care and Public Health, Walsall Council
- Independent Scrutineer (Children's)
- Independent Chair (Adults)
- Head of Safeguarding Partnership.

Our relationship with other Boards and Partnerships

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) to progress work in relation to the Exploitation of children and adults. In response to a rise in Serious Youth Violence, Safer Walsall Partnership commissioned a Serious Violence Needs assessment which was completed in April 2023. It recommended "A review of strategic boards should be undertaken, i.e. Safer Walsall Partnership, Walsall Safeguarding Partnership, Youth Justice Partnership, Health and Wellbeing Board and Walsall Together as well as Education, to consider their roles and functions in relation to violence prevention". On the 11th April Chairs and support officers of Youth Justice Partnership, Safeguarding Partnership and the Safer Walsall Partnership agreed to develop a collaborative to ensure we maximised opportunities to effectively respond to incidents as well as focus on proactive system change following the learning from those incidents.



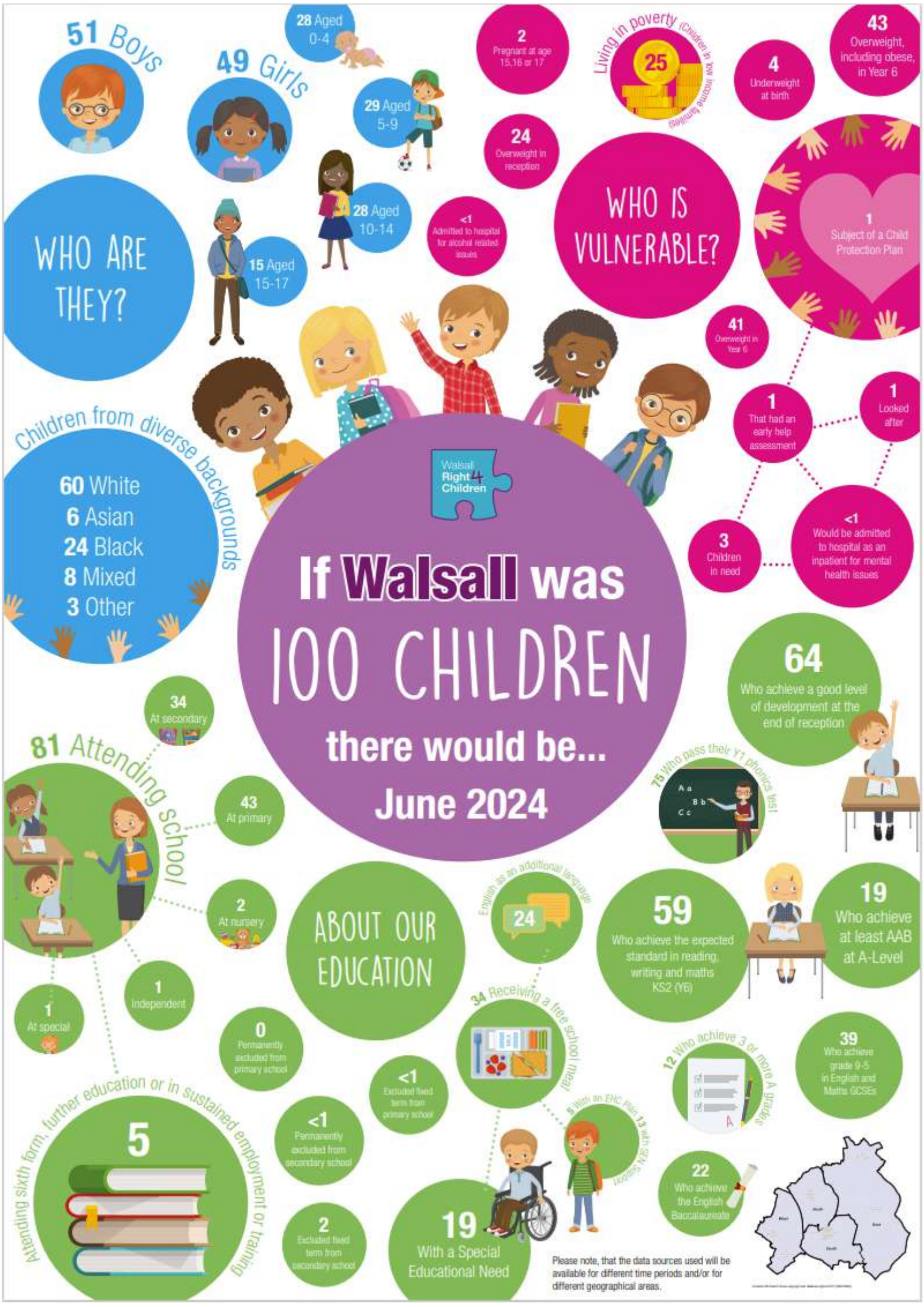
Walsall Together worked with the Partnership to share information about known health inequalities which can often have a close link with neglect.

Child Death Review Process (CDOP)

Child Death Review partners, Walsall Local Authority and Black Country Integrated Care Board (ICB) hold responsibility for the delivery of the Child Death Review Process as set out in the Children Act 2004, as amended by the Children and Social Work Act 2017. The WSP have maintained a close working relationship with the Black Country CDOP with a representative from the WSP Business Unit attending the strategic meetings and CDOP presenting their Annual Report to the partnership. For further information about the Child Death Review Process and its purpose please visit: Black Country Child Death Overview Panel :: Black Country ICS

Walsall at a glance

If Walsall was made up of 100 children the demographics would look like this.



Walsall has an estimated population of 284,130 and is expected to see continued and consistent population growth, projected to increase by 7% to an estimated 304,400 by 2030**.** Walsall is made up of four localities – North, South, East, Central and West.

Accessing Education in Walsall

There are 78 Registered Childminders in Walsall and 133 settings (Day Nurseries, Pre-Schools, Maintained, Academy, Independent Nurseries and Nursery Classes in Schools). There are 115 schools – 86 Primary Schools, 19 Secondary Schools, 7 Special Schools and 3 Pupil Referral Units. Young people and Adults can access further education at 3 sites across the Town, this includes University provision at the Walsall campus of the University of Wolverhampton.

As at 31st March 2024 there were 629 children registered as Electively Home Educated (this means they are taught at home not in school) which is an increase from 491 the previous year and reflects the rise nationally. WSP is aware of the national attention that home-schooling has attracted and at the time of writing awaits the publication of the Child Safeguarding Practice Review Panel's Briefing on learning from reviews where Elective Home Education is a feature. In 2024-2025 WSP intend to seek assurance that children who are home-schooled and at potential risk of harm are visible to services and have appropriate safeguarding in place where required.

Education is currently represented at the WSP via Local Authority officers from the Education and Early Help Directorate, and teaching staff in the Neglect Sub-Group. In 2024 to ensure we are fully embracing the aspirations of Working Together 2023 we will be establishing a 'Safeguarding in Education Sub-Group' that will report to the WSP Executive. This group will represent early years, all school settings and further education in addition to key partners who actively support education providers.

Accessing Health Services in Walsall

The Black Country Integrated Care Board (ICB) is a statutory NHS organisation responsible for developing a plan for meeting the health needs of 1.26 million people in the Black Country. It manages the NHS budget for the area and arranges for the provision of health services locally. It is part of the Black Country Integrated Care System (ICS), known as Healthier Futures, working to bring health and social care services closer together for the good of our communities.

Walsall Healthcare NHS Trust provides local general hospital and community services. It is the only provider of NHS acute care in Walsall, providing inpatients and outpatients at the Manor Hospital as well as a wide range of services in the community.

Black Country Healthcare NHS Foundation Trust delivers mental health services for children and adults, specialist learning disability services and community healthcare services for the population of the Black Country.

Local Authority Public Health commission 0-19 Services including Health Visiting and School Nursing. In addition, they also commission Sexual Health Services, infection control support and alcohol and drug services.

General practices in Walsall within each Place are organised into Primary Care Networks (PCNs). PCNs enable practices to pool resources, share expertise and deliver a broader range of services. Walsall has 50 GP practices working across seven PCNs.

Health Services are active members on all partnership sub-groups and are represented through the statutory partner Black Country Integrated Care Board and in addition wider members include Public Health, Black Country Healthcare NHS Foundation Trust and Walsall Hospital NHS Trust.

Other Service Providers

The area is covered by one Council – Walsall Local Authority and one Police Force – West Midlands Police (which also covers another 6 areas in the region). Other regional partners include West Midlands Fire Service, West Midlands Ambulance Service, and National Probation Service (Midlands Division). These services are represented at many of the meetings of the Partnership. There is also a thriving Voluntary, Community and 3rd Sector provision operating in Walsall, some of whom are directly involved in the work of the partnership e.g. Healthwatch, Walsall Housing Group (WHG), Sexual Assault Referral Centre (SARC), Change Grow Live-The Beacon, Street Teams, St Giles and Black Country Women's Aid. Our ambition in 2024 is to develop our relationships with these providers and establish improved links with the partnership through our governance arrangements.

Progress against our Priorities for Children, Young People and Adults with Care and Support Needs

The 2023-25 WSP priorities are:

- **Child Neglect**
- **Self-Neglect & Hoarding**
- **All-Age Exploitation**
- **Child Sexual Abuse (added July 2023)**

Each priority area has a dedicated sub-group to drive forward the aims and objectives of the WSP strategic plan. In the latter part of the year each sub-group worked with the new Head of Safeguarding Partnership to refresh their workplans to support members in ordering their approach to tasks and affording the Safeguarding Leadership Group (SLG) greater oversight of their timely progression. Some of the sub-groups were supported by delivery groups which created inconsistency and the additional challenge of co-ordination and information sharing between the respective groups and the SLG. The WSP Executive accepted the recommendation from the Head of Safeguarding Partnership for a further review of the sub-group structure and functions, which continues into 2024.

Priority 1 – Child Neglect

This is the third year of strategic focus on Neglect for the Safeguarding Partnership. The Neglect Sub-group is Chaired by the Director of Early Help, Commissioning and Partnerships and supported by the WSP Neglect Lead, which is a fixed-term role within the WSP Business Unit appointed by the WSP for a two-year period in August 2023.

> "The document review provided evidence of a great deal of partnership activity, particularly in relation to neglect. The strategy is linked to a clear action plan which has been followed up by audit activity providing a feedback loop regarding practice change".
>
> **Jane Wonnacott, Independent Consultant Evaluation of Learning from W6 SCR presented to WSP Executive July 2023**

See, Hear and Respond to Child Neglect Conference – 'Be part of making a difference'

The Neglect Sub-Group, supported by key speaker Bridgit Griffin, Independent Consultant, delivered a conference to 109 practitioners from 28 different agencies in May 2023. The conference objectives were to:

- To raise awareness of the WSP Neglect Strategy
- Enable practitioners to understand the context of Neglect in Walsall
- Share learning from Local and Regional Multi-agency Audits and Safeguarding Reviews
- To promote early identification and response to neglect
- Promote the use of evidence-based tools such as including Graded Care Profile 2 and Aware App

Practitioners were asked **how they would describe neglect?** Such a broad range of responses highlights the complexities in supporting families where neglect is a feature but also illustrates the opportunities to intervene at the earliest opportunity which is a key message the conference promoted.

AWARE APP – West Midlands Police colleagues launched the Aware App at the conference. 75 practitioners attended that workshop and 69% completed the evaluation, rating the input as 9/10 usefulness. Colleagues said they'd now ask Police use of the AWARE app informed decision-making and responses to children. You can view the session on the AWARE APP [WSP Child Neglect Conference Workshop 1 AWARE APP (youtube.com)]

for if

Group Supervision – 69 practitioners attended the workshop on group supervision and 69% completed the evaluation rating the usefulness 8/10. Practitioners and Manager's noted the importance of supervision and the benefits to be had from group reflection with education colleagues keen to understand how the pilot might operate if rolled out across education.

Escalation Policy – One of the key challenges identified in the conference was a lack of confidence and / or knowledge of the WSP Escalation Policy (49/ 75 responses to a survey). In response, the WSP Practice Development Sub-Group refreshed the Escalation Policy and relaunched it in February 2024 at a conference launching the Right Help, Right Time revised Threshold Document. The Escalation Policy in Walsall is now known as 'Finding A Solution Together (FAST)' and can be accessed here [FaST - Finding a Solution Together - Walsall Safeguarding Children (walsallsp.co.uk)]

Feedback

'I am glad that I put myself forward to come to this conference as it is good to get involved and to be able to take back information to my colleagues.' – ***West Midlands Ambulance Service***

'Fantastic conference and gained a lot from this. Thank you' – ***Shepwell School***

'Really fascinating presentations. I feel I have learnt a lot from the day. I look forward to learning more about the Aware App'. – ***Walsall Healthcare Trust***

'Really enjoyed the day. As a new employee with Walsall, it was lovely to meet my Social Work colleagues. Additionally, it was good to see such support from Partner Agencies'. – ***Social Care, Children's Services***

Health Inequalities and links to Neglect

The sub-group received a presentation from colleagues in Walsall Together on the information they hold about health inequalities and the links to neglect. The input supported the group to focus on areas that could indicate potential neglect, such as poor oral health and missed health appointments. The group recognised the importance of removing barriers to facilitate attendance at appointments These areas will feature in the refreshed Neglect Strategy that is due for completion in 2024.

Neglect Workshop – August 2023

In August the WSP held a workshop with sub-group members to reflect on progress they have made against the workplan and learning from the Neglect Conference. The group summarised their position like this:

Refreshing the Neglect Strategy 2023

18th August Workshop Discussion

What We Have Achieved!

- Joint Training- Neglect has been integrated in core training eg Right Help Right Time, Early Help, time2talk. Received positive feedback.
- Started to think about:Support through key programmes eg Family HUBS, HAF, Poverty. And taking action .
-We are a Matured Partnership. Evidenced through the – Steering Group and The See, Hear and Respond to Child Neglect Conference- setting a good foundation.
- Have a Dedicated Neglact Resource- Neglect Lead Role!
- Conference and the Time2Talk sessions that followed- Positive multi-agency conversations.
- We are a Learning Partnership

Multi-Agency Audits.

Child-Centred focus.

More conversation re-impact on child.

Changing practice across the partnership

The Gaps/ Improvements

- Need to more practitioners as part of the training pool.
- Quality Assurance around the training.
- Education membership gap.
- Mental Health engagement could be improved.
- Links between neglect and oral hygiene- better identification and action- work with dentists.
- Links between neglect and education- duty around attendance in September.
- Use of link to working with inequalities. Gap in early years.
- Links between other key agenda's eg. neglect/ self-neglect- Greater engagement with education
- Cultural change – practitioners feel they are waiting for families to reach thresholds.
- Using data to provide support planning/ mitigation

What we Know

- Temporary Accommadation- Invisible children, information not being timely shared. Children placed by other Local Authories.
- Data on invisible children. - No vaccination 6-8 weeks, No Health Check Attendance- Not in 2 year old places. Triangulated support through family hubs.

Pilot?

Our Priorities

- Data sharing to help us to drive tactical decisions.
- Insights – what information would be helpful

Training

- Current offer.
- Build neglect as a core/ child centred focus.
- GCP2 training + support + champions

Supervision- pilot..

Toolkit to help with actions.

Think about how to help, professional curiosity to identify neglect when it is not obvious.

AWARE APP

Fathers strategy + work

Diversity- for those that English is a second language

Steering group representation – Education. WalsallAll, Resilient Communities.

Champions-

Community champions- bring the Family Hub Spokes together to a think and challenge event around neglect.

Practitioner champions.

Graded Care Profile 2 (GCP2) Training – In September 2023 the WSP Executive endorsed the recommendation from the sub-group to rollout GCP2 across the workforce. The Sub-Group supported by the Neglect Lead established an GCP2 implementation group to support the rollout, and 16 multi-agency trainers were trained by NSPCC in February 2024 and this will continue in 2024. This decision was taken based on feedback from the Independent Evaluation of learning from the W6 SCR that previous efforts to embed GCP 2 had not as yet been fully realised.

Training – The sub-group supported by the Neglect Lead developed an e-learning course on Child Neglect which was launched in February 2023 and can be accessed here **eLearning : Child-Neglect-Awareness---Level-1 (event-booking.org.uk)** At year end there were 239 signed up of which 179 had successfully completed the course and 42 were in progress. The e-learning course is intended to improve basic knowledge and understanding and be accessible, free of charge, to anyone that supports children's and families.

"There is evidence throughout of a focus on improving practice through training and reflective supervision. There has been a large investment into GCP2 training but results of audits indicate that this is not always being used in practice"

Jane Wonnacott, Independent Consultant
Evaluation of Learning from W6 SCR
presented to WSP Executive July 2023

WSP Website – In December the partnership refreshed its website with new resources and information on child neglect Neglect - Walsall Safeguarding Children (walsallsp.co.uk)

Challenges & Next Steps in 2024-2025 – The sub-group recognises that it lacks data and intelligence about the full extent of neglect within Walsall and this will be a priority for 2024 in order that our strategic decision making is based in evidence and that the impact of our work can be tested. The sub-group is currently working on developing a Neglect Toolkit, including a screening tool, to support practitioners in identifying neglect.

Priority 2 - Self Neglect and Hoarding

This is the third year of strategic focus on Self-Neglect and Hoarding. The group is Chaired by the Group Manager from Adult Social Care and supported by the Independent Chair, Derek Benson.

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 deemed essential that the adult's workforce recognise and know when and how to respond when there are children living with adults in these circumstances. To support this aim, a member of Children's Social Care attends the Self-Neglect Sub-Group and a member of Adult Social Care attends the Child Neglect Sub-Group.

Self-Neglect & Hoarding Conference *'Be part of making a difference'*

The Self-Neglect & Hoarding Sub-Group, delivered a conference, supported by key speaker Michael Preston-Shoot, Independent Consultant, who presented the National Perspective. The conference was attended by 192 practitioners from 14 different agencies in October 2023. The conference objectives were to:

- To raise awareness of Self-Neglect & Hoarding, the Strategy and Toolkit.
- To support practitioners to identify, assess and manage risk through the
- Self-Neglect & Hoarding toolkit.
- Raising awareness about the work of the self-neglect panel and how to refer
- Promoting a strength-based approach by working alongside adults who self-neglect and/ or hoard.

To view the full recording of Michael Preston-Shoots presentation to the conference here
FULL VERSION Presentation with Professor Michael Preston Shoot for Self-Neglect & Hoarding (youtube.com)

Feedback

A very useful and informative conference. Useful handouts.

Conference was excellent. Nice to feel like not so alone with dealing with things and where to turn.
It was refreshing to see how many agencies in the Walsall borough came together at the conference to discuss the experiences and share good practice.

The Conference was well organised and relevant to me as a member of the Adults Safeguarding and sponsors, I have more tools to address self-neglect and hoarding referrals.

Walsall Wellbeing Outcomes Framework – was presented to the sub-group in September 2023 by colleagues from Walsall Together. The sub-group considered how this could be embedded into the approaches of all local services in order to promote the importance of good mental health and wellbeing.

Self-Neglect & Hoarding Panel - Referrals into the Self-Neglect and Hoarding Panel have remained relatively low across the year, although it was encouraging to see that following the conference in October, referrals increased from 3 in Quarter 1 to 9 in Quarter 3. The group, led by Adult Social Care, reviewed the panel functioning in quarter 4, including the referral form for panel and are now actively monitoring referrals.

Challenges & Next Steps for 2024-2025 – The sub-group recognises that it lacks data and intelligence about the full extent of self-neglect and hoarding within Walsall and this will be a priority for 2024 in order that our strategic decision making is based in evidence and that the impact of our work can be tested. The sub-group intends to work more closely with frontline practitioners to more fully understand how self-neglect presents itself and the challenges and barriers to supporting adult who self-neglect and/or hoard. This will inform a refresh of the Neglect Panel and the Self-Neglect Strategy.

Priority 3 – All-Age Exploitation

This is the second year of strategic focus on All-Age Exploitation. The group is Co-Chaired by Superintendent West Midlands Police and Head of Community Safety and Enforcement, Walsall Council.

Rationale

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

In early 2023 a series of reflective challenge conversations with the Independent Chair took place with regard to the performance of the All-Age Exploitation Sub-Group. The conversations identified that there had been a drift and delay in resolving issues such as governance between Walsall Safeguarding Partnership and Safer Walsall Partnership which had impacted on the progression of the exploitation agenda. Three key areas of activity were identified as not having progressed, these were:

- Development of a strategic needs assessment (SNA)
- Development of a multi-agency dashboard so that data and intelligence could be gathered to inform the group
- Development of an All-Age Exploitation Strategy.

The conversations led to completion of a diagnostic report being prepared by the WSP Business Unit which included various recommendations informed by partners views. The report resulted in the Independent Chair of Safeguarding Adult Board being asked by the WSP Executive to provide leadership and scrutiny to the work of the All-Age Exploitation Sub-Group which has seen progress made, although it is acknowledged that wider governance decisions in respect of Modern Slavery and the Exploitation agenda remain unresolved.

Progress against priorities

- The Sub-Group conducted a 'True for Us' exercise in line with the recommendations from the Independent Enquiry into Child Sexual Abuse in Telford. This review has informed the groups workplan.
- In October 2023 Dr Helen Lowey, Independent Consult in Public Health was commissioned to complete the Strategic Needs Analysis on behalf of the sub-group. This work will continue into 2024.
- Following the appointment of the new Head of Safeguarding Partnership and Head of Service for MASH, Exploitation and Adolescents with Complex Needs in March 2024 priority was given to developing a draft dashboard for the group and a full review of the terms of reference for the Sub-Group and the Exploitation Panel commenced.
- To support the submission of intelligence between Panel and Sub-Group a revised information and intelligence report template was endorsed for use.
- The work completed by Youth Justice Service on Disproportionately (see section 5 of the report) was presented. This informed decisions to ensure that data captures the demographics of victims and perpetrators
- In March 24 Safer Walsall Partnership commissioned an independent review of its response to Modern Slavery. This will inform work in this area in 2024 and decisions about governance.
- The Sub-Group supported County Lines Intensification week in March 2024 which saw 16 arrests for drug and weapon related offences.

Challenges and Next Steps for 2024/2025 – The work completed this year to address membership, consistency of attendance and governance structures has positioned the sub-group well to progress the priorities actions going forward. The WSP Executive recognised the risks linked to drift in progression of the actions for this sub-group. The Head of Partnerships with support from the Chair and Co-Chair have developed a workplan and risk register which is now actively overseen by the sub-group and Safeguarding Leadership Group. In 2024/2025 there will be a greater emphasis on outputs, clear timeframes, and addressing areas that currently lack detail such as the governance of modern slavery and the outstanding strategic needs assessment. Positively, at year end, the Independent Chair advised the WSP Executive that "there was renewed confidence that the recent revisions and targeted workplan for the group would result in the necessary progress being achieved".

Priority 4 - Child Sexual Abuse (CSA)

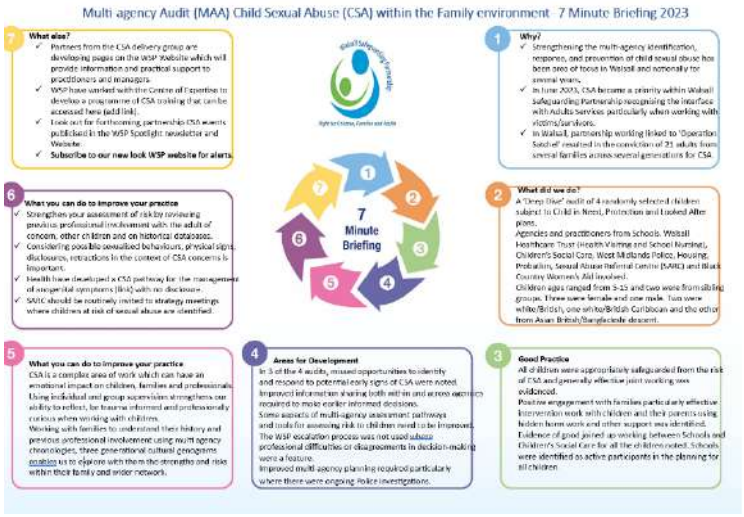
WSP has had a focus on child sexual abuse since 2019 and has worked with the Centre of Expertise to develop its CSA Strategy 2020-2023. The strategy included a focus on awareness raising, training and development work, strengthening practice and pathways. Learning from Operation Satchel, Child Safeguarding Practice Reviews, Safeguarding Adult Reviews and a CSA focus for the National Panel led the WSP Executive to agree that further work needed to be undertaken around Walsall's identification and response to Child Sexual Abuse (CSA) and so a sub-group with a specific focus on sexual abuse within the family environment was formed in September 2023.

The sub-group is Co-Chaired by Director of Children's Services, Walsall Council, Designated Doctor for Safeguarding Children, Black Country ICB and Designated Nurse for Safeguarding Children, Black Country ICB,

Whilst the CSA subgroup is in its infancy the impetus for change and commitment of the partnership is demonstrating strengths in commitment to making the changes needed in order to safeguard children from harm. Significant activity has been undertaken in a short period of time in order to deliver strategic partnership priorities of:

- Ensuring that there is strategic commitment across all agencies to understand, prevent and reduce the impact of CSA.
- Improve the capability of the multi-agency workforce to recognise and act on the signs of CSA.
- Improve the effectiveness of assessment, planning and interventions to reduce CSA and respond in a consistent and timely way.
- Evaluate our practice and systems through the use of our quality assurance mechanisms.

Development of Anogenital Symptoms Management Pathway – this was developed by the Designated Doctor for Safeguarding Children, included in local procedures and briefed out to frontline practitioners in January 2024. The Designated Doctor also provided a session explaining the medical examination in suspected child sexual abuse to allow professionals to better support children and families.



Multi-Agency Audit on Child Sexual Abuse – The WSP conducted a multi-agency audit on child sexual abuse within the family environment in July 2023. Learning from the audit is detailed in Section 6 of this report. The learning was shared with the CSA Sub-Group to inform its workplan.

Training and Awareness – In response to W6 SCR the WSP has worked with the Centre of Expertise on Child Sexual Abuse to provide a suite of training to support the partnership in identifying and responding to child sexual abuse, alongside more specialist training for practitioners. Courses can be accessed at Event List : Child Sexual Abuse (event-booking.org.uk) Promotion of the Sexual Assault Referral Centre (SARC) has also been undertaken across the multi-agency workforce. Children's Social Care where recognised for the additional training they have provided to their workforce. The WSP needs to seek assurance that all agencies prioritise attending the training that is now available to the partnership.

> "The child sexual abuse strategy is in place and there is evidence that training has been implemented within children's social care. There is less evidence within the documents of a multi-agency approach to practice development.
>
> **Jane Wonnacott, Independent Consultant Evaluation of Learning from W6 SCR presented to WSP Executive July 2023**

Challenges & Next Steps for 2024-2025 – Like the other sub-groups, there is recognition that members need to develop its intelligence in respect of child sexual abuse in Walsall both in relation to victims and perpetrators. Moving into 2024 the group has agreed the following areas of work:

- An independent review of the work undertaken in respect of CSA to date and its impact on practice
- Development of a CSA pathway in line with that of the Centre of Expertise on Child Sexual Abuse
- Development of a CSA Dashboard to inform intelligence for the partnership
- Refresh of the CSA Strategy
- Delivery of a Multi-Agency Conference to launch the pathway and revised CSA Strategy.

How the Voice of Children and Families have Shaped our Work

Disproportionality Strategy 2024-2027

Reducing the over-representation of Black and Mixed ethnicity children within the Justice system remains a key priority for YJS. Walsall Youth Justice Service (YJS) developed a strategic plan to significantly reduce disproportionate over-representation of Black and Mixed Ethnicity boys within the Youth Justice Service over the next three. The YJS, working with Open Lens Media, delivered a 16-week employability and personal development programme which provided intense group and 1:1 support to five Black and Mixed Heritage boys within the YJS. The programme also delivered empowerment sessions with local external mentors and advocates to deliver sessions aimed at empowering the boys.

What we learned from their lived experiences:

- **Negative interactions with authority figures in education** – All of the boys expressed difficult encounters with the education system and teachers, some of which had resulted in suspension or exclusion. They spoke about feeling unfairly treated in relation to their white counterparts and being unsure of how to express themselves at times due to feeling frustrated about their circumstances. The boys took accountability in areas they felt responsible but largely discussed feeling unheard or pre-judged before they had been given a chance.
- **Primary school** – The boys unanimously expressed that leaving primary school was a significant turning point. They highlighted that the transition between primary and secondary was difficult and many of their issues began at this point. Further discussion as to why this was the case highlighted that each of them experienced significant events at this age, such as the breakdown in parental relationships, moving to live in a different area or not having learning difficulties recognised at the time.
- **Fatherlessness** – A few of the boys had a relationship with their father and some of them expressed a disconnect with their father's role in their lives and their search for identify in some cases. They each identified other male role models that they looked up to. Often these were media personalities that they drew some affinity with or in one instance another male family member. However, their examples were often far removed from their current circumstances.
- **Navigating peer relationships** – The boys spoke candidly about making choices in life and what that meant for them consequently. They often spoke of their close peers as family and the codes of conduct that they have had to adopt growing up in their respective areas and amongst their said peers. Whilst aware of some of the impacts of the choices they could make, they spoke about feeling trapped within 'the system' and often feeling backed into a corner of choices due to not seeing a positive or achievable way out.
- **Negative experiences with the police and judicial system** – The majority of the boys spoke of negative encounters with the police. However, the boys expressed this was nothing new and as a result had built up some level of distrust towards the police when it came to supporting their communities. Much of their experience was also spoke of inherently, as they had adopted some of their viewpoints from the experiences of their peers and family members as well as from their own.
- **Living in areas of extreme deprivation** – the boys spoke fondly of the communities that lived within their areas, although they recognised that they were living within areas of deprivation. They expressed the communal approach to friendship and neighbourliness was encouraging and that they would like to see more money invested into improving the quality of their areas as well as the outcomes for the young people living within them.

Open Lens Media jointly consulted with the boys, Walsall YJS and partners to produce a documentary film called Reformation 2. The film explored the lived experiences of Black and Mixed Heritage boys within Walsall and the systemic issues that contribute to their experiences with the YJS. The film presents the causes, contributions, and solutions to reducing the over representations of Black and Mixed Heritage boys in the Youth Justice System through the commentary of senior heads of services and YJS team members. It also touches on the findings of the Thematic report and the roles mentoring, alternative provision and support play in working with the subject group. You can view the documentary here https://youtu.be/Q5iZBZQBtt4

What difference has it made?

The boys showed a significant increase in their levels of confidence and aspirations post project. In the initial stages of the project, their communication was minimal, and they were unwilling to articulate their goals or aspirations. However, as the sessions progressed and they were able to self-reflect, each of the boys opened up and were able to better express their thoughts and emotions towards their futures which allowed them to further explore their goals in their 1:1 sessions. Their candid sharing of their experiences has helped the partnership to identify areas of the strategy that it can further promote. The strategy and findings from the project were shared with the WSP Neglect Sub-Group to ensure learning about the boys' experiences influenced the refresh of the Neglect Strategy, particularly the importance of having a good educational experience.

'It takes a Village' documentary" - In Walsall there were **266 care leavers** (as at 31st March 2024), who, at some point in their childhood, have been in the care of the council and left after turning 18 years old. Walsall Council and partners such as police, health, housing, and education organisations act as Corporate Parent to those in the council's care and it is their responsibility to prepare young people for adulthood and help them to live stable and safe lives. 'It Takes a Village' is a documentary, produced by Open Lens Media, to support the Council and partners to better understand the everyday challenges faced by young care leavers. Filming for the documentary took place during **National Care Leavers Week in October 2023** and was screened at the Light Cinema in Walsall on 20 February 2024. The film focuses on the experiences of Zoe Morgan, Head of Service for Corporate Parenting and Leaving Care at Walsall Council, who spent some time away from her usual home and work life to live in the shoes of a care leaver. The film portrays Zoe's attempt to understand some of the difficulties young people face and how the council can improve its service. Contributors to the documentary also included Transition and Leaving Care staff, separated migrant children and young care leavers.

Learning from Practice Review and Audit Activity

In situations where children, young people or adults have died or have been seriously harmed and abuse or neglect is thought to be a factor, Walsall Safeguarding Partnership is responsible for making arrangements for agencies to come together to consider how effectively services safeguarded the individual; what worked well and what lessons can be learned to prevent similar incidents from happening to children, young people and adults with care and support needs in the future. These reviews are expected to show where things might have been done differently to improve outcomes and it is an expectation on partnerships that learning from such reviews are published.

Serious Incident Notifications and Rapid Reviews

'Serious Safeguarding Incidents' involving children are notified to the Child Safeguarding Practice Review Panel (referred to as the 'National Panel') and it is a requirement of Working Together 2023 that a 'Rapid Review' is then considered / completed. Referrals can be made by any agency wishing to highlight a serious incident for consideration of notification. It should be noted that a Serious Incident Notification may be for more than one child but will be counted as only one notification/referral.

Since the introduction of Rapid Review requirements in Working Together 2018 the referrals to WSP on average are stable. This year there was a slight reduction compared to the previous year (5 compared to 7 in 2022/23). However, the percentage of Rapid Reviews undertaken as a result of the referrals is higher.

Below is a breakdown of the referrals received by Walsall Safeguarding Partnership during 2023-2024 and their current status:

Activity	Volume
Total number of referrals in 2023 - 2024	5
Number of referrals which met criteria for a Rapid Review (children only)	4
Number of referrals that progressed to a statutory review in this period (Local Child Safeguarding Practice Review)	1
Number of reviews completed and awaiting publication	3
Number of ongoing reviews	2
Number of reviews published in this period	1

Of the five referrals submitted to the partnership, four were notified as 'serious incidents' to the National Child Safeguarding Practice Review Panel, and Rapid Reviews were completed, one was not deemed to meet the criteria for notification. The four notifications relate to children who were all residents of Walsall. Their ages range from under 12 months to 17 years. All four children were male. One Child was British Indian, two were White British and one was Dual Heritage.

The reviews featured Non-Accidental Injury, Domestic Abuse, Fabricated and Induced Illness and Parental Mental Health. The learning from these reviews were shared with the National Panel and locally across the Partnership via 7-minute briefings and learning newsletters which can be located on the WSP website at

- 7 Minute Briefings - Walsall Safeguarding Children (walsallsp.co.uk)
- Learning Newsletters - Walsall Safeguarding Children (walsallsp.co.uk)

Local Child Safeguarding Practice Reviews

Between April 2023 and March 2024 the WSP published the recommendations from a legacy Serious Case Review (SCR W6).

SCR W6

The decision was taken by the WSP not to publish the full report in order to protect the anonymity of the victims. **SCR W6** is a review of the circumstances relating to the multi-agency response to neglect and complex sexual abuse of several children over a number of years. The serious case review was completed in 2018 and examined the learning arising from the quality of multi-agency practice between 2004 and 2014. The delay in publishing the recommendations from the review was due to the ongoing criminal investigation which concluded in Spring 2023.

The recommendations focused on strengthening safeguarding supervision across agencies, increasing staff confidence in responding to child sexual abuse, reviewing and embedding the Child Neglect Strategy, seeking assurance that Pre-Birth and Non-Accidental Injury guidance is understood and embedded and that when required agencies utilise the Escalation Policy. A detailed action plan has been overseen by the Joint Case Review Group and Child Sexual Abuse Sub-Group since 2021. All actions have

been completed and as can be seen by the work of the CSA Sub-Group and audit activity across that period the impact of the action taken is regularly reviewed and additional actions identified when the intended impact cannot be demonstrated.

To read the full list of recommendations for SCR W6 click here: Child Safeguarding Practice Reviews - Walsall Safeguarding Children (walsallsp.co.uk)

In June 2022 the WSP commissioned an independent evaluation of the impact of learning from SCR W6. A reference group was established to support the evaluation and met on three occasions. Documentary Evidence, meetings with practitioners, team managers and senior managers across the partnership were also engaged to inform the findings.

FINDINGS FROM THE INDEPENDENT EVAULATION OF IMPACT SCR W6

- ***Although Neglect is a formal partnership priority, Child Sexual Abuse is not and this is a barrier to system change*** – this is because CSA had been a priority for the partnership in 2017-2019. In response to this finding the Independent Scrutineer recommended to the WSP Executive that another targeted period of focus would be beneficial giving rise to the CSA Sub-Group in September 2023.
- There is ample evidence of both partnership and single agency activity focused on improving practice in the areas of neglect and child sexual abuse. **Audits show that this is beginning to have an impact on referrals and assessments and focus groups were able to describe changes to practice**. This included school staff referring to training that had focused attention on the voice of the child and social workers feeling more confident in working with child sexual abuse.
- Practitioners are aware of (and appreciate) the training opportunities and information disseminated by the partnership. However, at times the amount of information/e-mails can feel overwhelming and important information might be missed. **Practitioners identified the 7-minute briefings as useful partnership information.** In 2024-2025 consideration of other forms of disseminating key learning will be prioritised
- Evidence suggests that chronic and severe neglect would be identified earlier and social work assessments more thorough although the **GCP2 may not be used as a tool to support early work with the family** and **Schools would be more attuned to hearing the "voice" of the child.**
- Evidence suggests that where social workers and police officers were made aware of the possibility of child sexual abuse **there would be a more proactive and prompt response today**.

A further three reviews have been completed but await publication pending the conclusion of criminal proceedings. Two of the three reports are legacy Serious Case Reviews (SCRs) dating back to referrals in 2018 and 2019. The WSP has shared it's concerns as to the passage of time which analysis indicates is due to a combination of length of police investigation, CPS charging decisions and waiting times for court hearings. The WSP has identified this issue as a barrier to publication and a challenge when sharing learning, which it understands to be a national issue. In July 2023 the WSP Executive met with the CPS to seek resolution as far as was possible, but for some reviews the challenge persists. The WSP has ensured action plans pertaining to the reviews have been progressed to completion and learning shared within the Partnership pending publication of the final reports.

Learning from Multi-Agency Audits (MAA)

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

The themes are identified due to strategic priorities, response to the findings of Child Safeguarding and Learning Reviews both locally and nationally and data and intelligence. A report detailing findings from the audits is produced and as part of the learning from each audit; a 7-minute briefing is developed and disseminated.

The following audits have been completed during this period:

- Child Sexual Abuse
- Transitions into Adulthood
- Adolescents receiving support at Level 3 Early Help
- First 1001 Days

The table below details the overall grading of multi-agency practice. Positively no practice was deemed to be 'inadequate' during this period, although we have seen a decrease in practice assessed as 'good'.

Table 1: Multi-Agency Children Audit Gradings 2023-2024

Year/Quarter 2023/2024	Theme	Outstanding	Good	Requires Improvement	Inadequate	Total
Q1	Child Sexual Abuse			4		4
Q2	Transitions		1	5		6
Q3	Adolescents and Early Help		1	4		5
Q4	First 1001 Days		2	3		5
Total			4	16		20

When the MAA audit gradings in 2023-2024 are compared against previous years, on average there has been a reduction by 15% of audits rated as good compared to the previous year; more significantly an approximate 40% reduction from 2020/2022. Conversely there has been an 30% increase in audits marked requiring improvement compared to the previous year which reflects that no audits were graded as inadequate during this period, unlike last year.

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

Year/Quarter	Outstanding	Good	Requires Improvement	Inadequate
2023-2024	0%	20%	80%	0%
2022-2023	0%	35%	50%	15%
2021-2022	0%	60%	40%	0%
2020-2021	4%	61%	30%	4%
2019-2020	0%	23%	63%	15%

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. Whilst this is a small sample size, due to the 'deep dive' nature of the evaluation of multi-agency practice, we have confidence that these findings align with those identified by other WSP work such as learning reviews and other quality assurance activity. Robust multi-agency practice is an important part of achieving good outcomes when working with children. It should also be noted that no child was found to be at risk of harm through the MAA and that we have ensured necessary action has been taken to address any areas of practice requiring improvement.

Understanding the reasons for the changes in grading are more complex. It should be acknowledged that the themes chosen are done so in recognition that some areas of practice require strengthening locally as well nationally and regionally. Comparisons to practice during the Covid Pandemic also need to be done acknowledging that the partnerships approach to quality assurance was adjusted during that period in light of the lockdowns. Going forward the partnership intends to compare audits on the same themes over the same time period to ascertain where improvements have been made and what stubborn challenges still persist in practice.

Q1: Audit on Child Sexual Abuse

This audit was undertaken to provide an insight into the effectiveness of multi-agency practice where there are concerns about child sexual abuse. This topic was chosen following the learning from SCRW6 and the outcome of criminal proceedings in relation to Operation Satchel.

Assurances included:

- **Child and Family Engagement** - There was evidence of effective engagement with children and their families across the audits. This included positive practice by Children's Social Care with a child's mother to explore her childhood and lived experience in order to affect change in her thinking about the perpetrator. There was evidence of effective intervention and engagement from Black Country Women's aid with children undertaking safety planning and positive relationships between a school and a child's mother which enabled them to facilitate a positive connection with other support services.
- **Joint Working** – There was evidence of good joined up working between schools and social care for all of the children considered and the school were seen as an active participant in the planning for all children. This practice needs to extend to other key partners in health and police.
- **Management of Risk** - We were satisfied that at the point of the audits the children considered were being appropriately safeguarded from further risk of child sexual abuse. Once risk was identified and understood there was generally effective joint working to ensure immediate safeguards were put in place.

Gaps in Assurance:

- **The Identification of Risk and Referral** – when an adult discloses historical sexual abuse agencies must identify and assess any contact the alleged perpetrator may have with a child or vulnerable adult, irrespective of whether the Police take action. Referral to Children's Social Care is expected practice.
- **Length of police Investigation** – In 50% of the audits a protracted police investigation (2 years and 12 months) appeared to have impacted effective assessment and therefore management of risk. Whilst the partnership acknowledges the importance of comprehensive investigation, it is imperative that Police share any information with Children's Social Care that

could be pertinent to the assessment of risk. The WSP should also seek assurance from West Midlands Police that timeliness of investigations is reflective of the complexity of the case.

- **Lack of Escalation** – This learning reflects that from previous multi-agency audits. In two audits school and probation felt their referrals should have progressed to assessment; children social care highlighted a delay in the perpetrator work commencing by probation in another audit, and the length of investigation and limited communication from Police was noted in two audits but no agency utilised the escalation procedure.

This audit led to the priorities within the CSA sub-group to:

- Enhance the training to the multi-agency workforce in relation to CSA – Completed
- Develop a CSA Pathway – Ongoing
- Refresh the CSA Strategy – Ongoing
- Ensure that all children with an open police investigation have a named Investigating Officer as point of contact - Completed

Q2: Transitions into Adulthood

This audit was undertaken to provide an insight into the effectiveness of multi-agency practice where young people are transitioning to adulthood. This audit was held in partnership with Adult Social Care to understand the areas of strength and challenges arising in these transitions for young people.

Assurances included:

- **Management Oversight** – The majority of audits evidence good management oversight. It was also noted that the use of the recently introduced complex needs panel offering senior management oversight of the transition process for young people from children's to adult's social care, whilst in its infancy, was seen to be promising. It was evident that drift in assessment by Adult Social Care had been addressed via this panel and there was now a clearer plan for assessment and intervention.
- **Multi-Agency Working and communication** - There is evidence of good communication and multi-agency working to support most of the young people as they approach transition and for several of the young people this has resulted in robust transition plans.
- **Relationships with children** - There is evidence that practitioners across the partnership have invested time, effort and energy into building meaningful and positive relationships with children.

Gaps in Assurance:

- **Mental Capacity Assessment** - There was a lack of clarity from practitioners about who should be completing mental capacity assessments to inform the assessment of need by both adults and children's social care, and Children's Social Care practitioners advised they did not feel equipped to undertake the assessment.
- **Contingency Planning** – Whilst planning in itself was relatively positive, one of the key issues identified was a lack of contingency and parallel planning for these young people in terms of their transition and next steps into independence. This should include better consideration of the family network both in assessment of and planning for transition into adulthood.
- **Timeliness of referral** – Children's Social Care and CAMHS must ensure timely referral to Adult Social Care to enable assessment and planning.

This audit led to the following actions:

- Development a joint training plan for adult and children's social care to enable all practitioners to better understand each other's legislative and practice frameworks – Completed
- Development of a transitions pathway so there is a clear understanding of expectations – Completed.
- Provision of Mental Capacity Act and Deprivation of Liberty training for Children's Social Care in order to develop a competent and confident workforce in carrying out Mental Capacity Assessments for young people aged 16 and 17. – Completed.

Q3: Audit on Adolescents receiving support at Level 3 Early Help

This audit was undertaken to provide an insight into the effectiveness of multi-agency practice for adolescents aged 13 and over who are currently being support at Level 3 Early Help.

Assurances included:

Timely Referrals - referrals were generally timely and appropriate and there was a consensus that the families were being held at the right threshold for support.

Multi-Agency Planning - there was evidence of SMART plans that were generally focused on the right level of intervention for the family.

Relationships with children and families - there was evidence of excellent engagement work with families which resulted in some positive outcomes for the children and families.

Gaps in Assurance:

Think Family – the partnership must ensure it is always thinking family and considering the differentiated needs of children of different ages, taking into account the experiences of older siblings in informing our understanding of their lived experiences and considering the family networks outside of the home.

Knowledge of roles and responsibilities - Greater awareness is required across the safeguarding system of the school nursing offer and how this can be accessed.

This audit led to the following actions:

- Promotional work required by school nurse service to ensure all services are clearly aware of the offer and the referral process.
- CAMHS to complete assurance activity regarding the risk assessment of those children on waiting lists and report to PQA via agency report.
- Assurance work relating to supervisions to be completed by Early Help to inform their understanding of practice and feedback to PQA via agency report

Q4: First 1001 Days

Assurances included:

Working with Fathers – There was evidence within this audit that professionals had engaged with both parents and there was evidence that ICON had been discussed with Dad

Relationships with children and families - There is evidence that practitioners across the partnership have invested time, effort and energy into building meaningful and positive relationships with children and parents. This has been a strength within all audits conducted this year.

Gaps in Assurance:

Was Not Brought - Missed Opportunities within Health 0-19 service to robustly follow-up non-attendance at appointments.

Lack of Escalation – Despite sharing concerns during audit for one of the children, there had been no escalation.

Information Sharing – In a number of the audits, the GP had not been communicated with and was therefore unaware of the nature of the concerns for the child.

Section 11 and Care Compliance Audit

The Section 11 and Care Compliance Audit Tool was developed regionally to streamline work and avoid replication for agencies that share a geographical proximity. On the 27th February 2023 the West Midlands Regional MASA group launched the online audit tool for the completion of organisation/agency self-assessments in accordance with Section 11 Children Act and Section 43 of the Care Act 2014. The audit was completed by the agencies in the first quarter of 2023/24 and analysed by the WSP ahead of an assurance event on 9th August 2023. Hosted by the Independent Chair and Scrutineer for the Adult and Children Partnerships, the event provided a “check and challenge” opportunity for partners to reflect on the grading in their self-assessments and to discuss what action was needed to address areas for improvement.

The services which attended the assurance event are outlined below. Each organisation that completed the audit has an individual action plan arising from the audit and the discussions arising from the assurance event. In 2024/2025 progress against the action plans will be tested via dip-samples and visits to some of the agencies. In 2025/26 the audit will be completed again.

Black Country Healthcare NHS Foundation Trust	**Black Country ICB**	**Change Grow Live (Walsall Substance Misuse Service)**	**Walsall Council - Adult Services**	**West Midlands Ambulance Service**	**West Midlands Fire Service**
West Midlands Police	**Walsall Housing Group**	**Walsall Council - Youth Services**	**Walsall Council Sports, Culture & Leisure**	**Walsall Healthcare Trust (WHT)**	
Walsall Council - Public Health	**Walsall Council - Housing**	**Walsall Council - Childrens Services**	**Walsall Council (Licensing authorities)**	**Street Teams**	**Probation Service (Walsall and Wolverhampton)**

Workforce Learning and Development

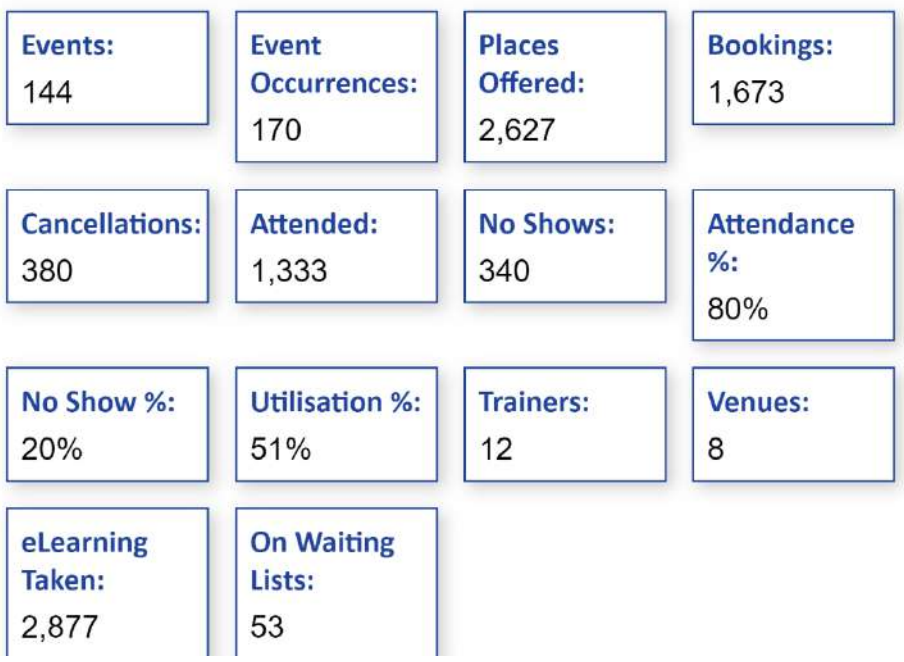
Strategic Intention

Walsall Safeguarding Partnership is keen to promote a learning culture for its workforce to enable them to be reflective and responsive to the needs of children, young people and families. The Practice, Learning and Development (PLD) Sub-Group 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 training provided by WSP is aligned with the WSP priorities, learning from local and national CSPRs, SARs and multi-agency audit activity and incorporates relevant guidance from Working Together 2023, Care Act 2014 and Children's Act 2004.

Below is a flavour of some of the courses we have provided this year (not an exhaustive list). We are grateful to our regional partners in the Violence Reduction Partnership for the provision of Exploitation and Trauma Informed Practice training and sessions on serious violence; National Colleagues at the Centre of Expertise for Sexual Abuse for delivery of the CSA range of courses and our local substance misuse service – Change, Live, Grow (CGL) for courses on drug and alcohol awareness and hidden harm. The WSP also operates a multi-agency training pool made up of Children's Social Care, Local Authority Exploitation Team and Early Help practitioners. One area of focus for 2024 is to expand contributions to that pool from other organisations.

Courses delivered face to face or virtual	**E-Learning**
Right Help, Right Time (Threshold)	Adults Safeguarding Awareness Level 1
Right Help, Right Time Refresher (Threshold)	ICON – Babies Cry You Can Cope
Intra-familial Child Sexual Abuse	Children's Safeguarding Awareness Level 1
Speaking to children about sexual abuse	Private Fostering Module
Spotting the signs and indicators of child sexual abuse	Understanding Mental Capacity Act Level 2
Hidden Harm Training	Understanding Neglect Level 1
Outcome Star – Voice of the Child	
Serious Violence Duty Briefing	
Exploitation Webinar	
Drug and Alcohol Awareness – New and Emerging Trends	
Supporting Families Coordinator (Lead Professional) Training	
Learning from Safeguarding Adult Reviews (SAR's)	
Harmful Sexual Behaviour (HSB)	
Launch of the working with Father's Strategy	

We've seen a significant increase in the training and development activity provided through the partnership this year. We've almost tripled the number of events scheduled, rising from 52 in 2022/2023 to 144 this year, a number of which have been conference events. 1,673 bookings were made of which 1,333 attended (80% completion rate) which is positive. E-learning also increased from 1,123 in 2022/23 to 2,877 this year. Training attendance is largely multi-agency but we have noted from the independent evaluation of W6 that Children Social Care are the service which access most opportunities so greater targeted and assurance seeking of other statutory services needs to occur in 2024/25.



Event Impact Statements

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.

Some feedback from this year's events include:

'*The learning will enhance my practice with individual parents and help address their specific needs.'*- **Domestic Abuse Practitioner, Probation Services, Trauma Informed Training - What is Trauma?**

'I thought the course was very well presented, I enjoyed the subject matter as it was very thought provoking.'- **Advanced Practitioner, Mental Health, Trauma Informed Training - What is Trauma?**

'I thoroughly enjoyed the training and learnt so much from other professionals. It was interesting to know how different thresholds are in different sectors. Would highly recommend this training to my colleagues and will use this in my day to day practice. Thank you so much.'- **Social Worker, Children's Services, working together to meet the needs of children & young people who have displayed Harmful Sexual Behaviour (HSB)**

'This workshop was so necessary and should be mandatory for all health and social care organisations and partners'- **Social Worker, Adult's Services, Learning from Safeguarding Adult Reviews (SARs)**

'*It is always beneficial to attend a training session when real life experiences and good practice are shared'*- **Infant School**, **Child Sexual Abuse Workshop: Hearing and Responding to allegations/disclosures and the role of the professional network**

Right Help, Right Time Launch February 2024

The Right Help, Right Time (RHRT) Threshold Guidance was developed with partners and launched in October 2019. The guidance required reviewing and refreshing in line with evolving and current safeguarding practice in Walsall. The MASH Management Group were delegated responsibility for the review of the guidance and was guided by evidence and intelligence gleaned from a range of activities.

The consultation period for the review of the document was between June and September 2023 and this included:

1. Review of feedback from RHRT training.
2. Feedback from practitioner on their views, i.e. any barriers to using the guidance/its application in practice.
3. Learning arising from audits and performance data.
4. Consideration to the learning and changes to the Early Help Supporting Families Programme.

The revised threshold was relaunched at a conference in February 2024 with 162 practitioners. It can be accessed here Right Help Right Time - A Multi-Agency Guidance on the Continuum of Need (walsallsp.co.uk)

Independent Scrutiny and Assessment of Partnership Effectiveness

This year the WSP received independent scrutiny of its children's safeguarding work from **Sally Hodges, Independent Scrutineer** and of its adults safeguarding work from **Derek Benson, Independent Chair**. Given the departure of the Children's Independent Scrutineer the Executive have taken the decision to trial a shared arrangement in 2024/2025, intending to recruit one Independent Person to provide the scrutiny function across the children's and adults arrangements.

The Independent Chair and Independent Scrutineer have chaired the Performance and Quality Assurance (PQA) Sub-Groups given the risks identified with the lack of partnership data and intelligence throughout this report. They also chair the Safeguarding Leadership Groups for Adults and Children and attend the WSP Executive, in which they to present their assurance and challenge report.

In the absence of the scrutineer at the time of writing this annual report, below is a summary of the assurances and challenges presented to the WSP Executive and the action taken:

- It was highlighted to WSP Executive that work in respect of CSA would benefit from more targeted oversight via the introduction of a CSA sub-group following learning from the W6 Independent Evaluation. **WSP Executive made CSA the fourth priority in 2023-2024**
- It was highlighted that whilst a robust neglect strategy has been developed, further work is required to ensure that it is embedded in practice and improved outcomes for children evidenced. **Executive noted that further promotion of the strategy would be highlighted at 'See, Hear and Respond to Child Neglect Conference' and through the additional Neglect training offer and that this area would continue to be monitored.**
- The challenges in developing a robust data dashboard was escalated by both Children's and Adult scrutineer / chair. **Executive requested a diagnostic report from the Business Unit from which a new Quality Assurance Framework was developed. Work to develop and embed data and intelligence into the work of the partnership continues into 2024 as the partnership recognises there is opportunity for continued growth. Executive have added this to their risk register.**
- Lengthy and significant delays in obtaining expert reports and post-mortem reports in suspected serious child safeguarding incidents, infanticide, and child homicide cases was discussed with the Executive as a contributing factor for the two serious case reviews which cannot be published due to ongoing criminal justice processes. It was understood that the problem has arisen due to the complex national commissioning arrangements and the availability and recruitment of Forensic Post-mortem and Specialist Health Consultants nationally. **WSP Executive wrote to the Secretary of State to highlight the challenges this presented.**
- Continuing governance issues between Safer Walsall Partnership and Walsall Safeguarding Partnership relating to domestic abuse and exploitation have been reported by both the Adult and Children's Chair / Scrutineer. **This issue remained unresolved at year end. There are plans to hold a development session with both partnerships in which this issue will be addressed. Executive have added this to their risk register.**

Working Together states that independent scrutiny can be delivered through a range of methods and structures. Some additional scrutiny that the WSP welcomed during this period includes:

Neglect Conference – Bridget Griffin, independent consultant supported our Neglect Conference, speaking about the learning from a national Child Safeguarding Practice Reviews and supporting reflection about how practice in Walsall aligns itself with these best practice principles. Outcomes from this event informed the Neglect Sub-Group action plan.

SCR W6 learning themes independent evaluation – In addition to what has been noted throughout this report; the evaluation made a number of observations about the wider partnership systems and governance:

- "The overarching impression from the document review was of strong leadership from the multi-agency partnership with strategic direction and priorities owned at a senior level".
- "Audit processes are well developed and integrated into system improvement".
- "Supervision policies – single and multi-agency are in place".

Priorities for 2024-2025

The key priority areas identified for the WSCB in 2023 – 24 continue to be the main priority areas for further development and embedment for the Partnership in 2024/25.

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

Following the restructure of WSP arrangements, the Business Unit has begun work to review the WSP governance including all layers of the WSP sub-structure. This is to continue into 2024-2025 in order to test whether the new arrangements are effective in fulfilling the requirements of Working Together 2023.

A focus for 2024/25 is improving the communication between the Safeguarding Partnership and other Boards/Partnerships to avoid duplication in terms of discussions at sub-Group meetings and to ensure that resources are used to best effect when addressing areas of practice where there is a shared interest.

Appendices

Appendix 1. Financial Summary

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

The contributions from partners for WSP for 2023/24 is set out below:

Income 2023-24

Organisation	Contribution £
WM Police	33,988
ICB	97,500
Probation	1,500
Walsall Council – Adults and Children	244,662
Walsall Healthcare Trust	10,000
Total Income WSAB and WSCP	387,650

Expenditure 2023-24	Budget	Actual Expenditure
	£	£
STAFFING		
Employees (permanent)	258,091	146,769
Agency & Consultants	0	301,521
TOTAL STAFFING	**258,091**	**448,290**
NON - STAFFING		
Professional Services (Chair costs, consultancy etc.)	60,000	57,891
CSPR / SAR & Other scrutiny work	20,717	20,491
Development activities	15,000	20,721
Other service costs (website, memberships etc.)	21,005	20,328
TOTAL NON-STAFFING	**116,722**	**119,431**
INCOME		
Contributions from partners	130,151	142,988
Walsall Local Authority	244,662	244,662
Other income		16,100
S31 Grant		47,300
TOTAL INCOME	**374,813**	**451,050**
NET POSITION	**0**	**116,671**

There was a reserve balance of £299.260 which was carried forward from 2022-2023. Expenditure is broadly in line with the previous year, except for a slight increase in the staffing expenditure due the ongoing interim appointments to cover the vacant Business Manager. There was also a Section 31 Grant from the Department for Education to support the embedding of Working Together 2023

Walsall Safeguarding Partnership

Right for Children, Families and Adults