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6 January 2023

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Dear Walsall Local Safeguarding Partnership

Joint targeted area inspection of Walsall

This letter summarises the findings of the joint targeted area inspection (JTAI) of the multi-agency response to identification of initial need and risk in Walsall.

This inspection took place from 7 to 11 November 2022. It was carried out by inspectors from Ofsted, the Care Quality Commission (CQC) and His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS).

Headline findings

Children who need help and protection receive a coordinated and effective multi-agency response at the 'front door' in Walsall. Senior leaders ensure that there is a culture of continuous and shared learning across the partnership, which is successfully disseminated to staff. This helps to support identification of risk and needs for children, at the earliest opportunity, and promotes improvements in services for children and their families.

What needs to improve?

- The collation of information about children's health needs so that they are consistently analysed effectively by a health practitioner in the multi-agency safeguarding hub (MASH).
- The MASH's communication with general practitioners (GPs) and the consistency in using health information they provide about children.

- The consistent attendance and participation of partners at strategy meetings so that relevant knowledge and information about risks to children are shared effectively.
- The supervision and quality assurance of multi-agency referral forms (MARFs) sent into the MASH by West Midlands Police.

Walsall Safeguarding Partnership (WSP)

Strong and stable leadership across the partnership has successfully embedded the 'Right Help, Right Time: A Multi-Agency Guidance Continuum of Need'. This ensures that children receive a timely and proportionate response when needs and risks are identified in the front door. Professionals in all agencies working in early help and in the MASH understand this guidance and apply it effectively.

The WSP has responsibility for children and adult safeguarding arrangements, with oversight from an Executive Board that has created relevant and appropriate subgroups to deliver its business plan. An Operations and Scrutiny Group, chaired by an independent scrutineer, is pivotal in ensuring that information is fed into the Executive Board. A strength of the subgroups is that they are chaired by a range of professionals, which reflects the shared partnership responsibility for safeguarding children.

Leaders in the safeguarding partnership share and receive comprehensive performance data and information about the front door via the MASH Management Group. This information helps leaders to understand current operational and strategic priorities, which supports them to target a programme of multi-agency audit activity. There is a positive culture of completing multi-agency audits and learning across the partnership, which is welcomed by staff. Audits accurately identify areas for improvement and strengths in practice.

The Operations and Scrutiny Group proactively requested assurance from the MASH Management Group about the front door practice in the context of the findings of the Solihull Joint Targeted Area Inspection. The MASH Management Group reviewed whether the areas for improvement and priority actions were relevant to Walsall's front door. This activity demonstrates strong strategic oversight and governance of the MASH across the partnership and the alignment between the MASH Management Group and the Performance and Quality Assurance subgroup.

Staff across the partnership report positively on the quality of multi-agency training and learning that is disseminated from the WSP. Seven-minute briefings and WSP newsletters are easy to read and help to support staff's understanding and learning from local reviews. Helpful prompts assist staff to consider how they can implement

the learning into their own frontline practice and decision-making to meet children's needs or to identify initial risks.

The WSP does not have a process to share intelligence about criminal investigations into online child abuse. West Midlands Police (WMP) and partners know this work needs to be progressed, but an agreed process to securely share intelligence is not in place. This would help to identify unknown children at risk from abuse at an early stage, so that they can be protected.

The effectiveness of the partnership response to children at risk of and subject to exploitation is reduced due to lack of data and information from partner agencies. Currently, it is only WMP data that is used to inform the child exploitation profile in Walsall, and this may limit the understanding of the problem and the identification of solutions to reduce exploitation risk. The WSP has identified resources to support the appointment of a post to assist with this sharing of information, but this is not yet in place to support current practice.

Main findings

Children in need of help and protection who are referred into the MASH receive a quick and coordinated response from co-located multi-agency professionals.
The quality of information about children in most contacts and MARFs is sufficiently detailed. Information provided by schools is often particularly strong, providing comprehensive information about children's needs and risks. Managers and partners in the MASH are clear about the timescales for decisions about interventions for children, and they use the Right Help, Right Time guidance in their recorded rationale for decision-making.

Parental consent to MASH agency checks is appropriately sought by social workers, and when consent is overruled, the rationale for this is clearly recorded in children's records. Social workers have access to adult social care records, and this complements their ability to gather additional information about children's needs. Some professionals report that they need to be tenacious in chasing feedback about the outcome of some contacts into the MASH, to find out about decisions for children.

Children's family histories, including histories gathered from partner agencies as part of MASH checks, are well considered and responses to requests for information from professionals are timely. There is detailed and appropriate information-sharing from the police into the MASH, with effective use of Connect, and the automated information document that can be created from the police crime recording system. Health information provided by both Walsall Healthcare NHS Trust and Black Country Healthcare NHS Foundation Trust named nurses is concise and relevant for all known

members of a child's household, as well as family members at different addresses where appropriate.

Safeguarding risks for children are well identified by adult substance misuse practitioners at The Beacon. Staff understand the impact of parental behaviour and vulnerabilities on children, and records demonstrate strong professional curiosity. Referrals into the MASH are of good quality. They are child-focused, contain clear analysis of risks and capture children's views effectively. This enables multi-agency professionals at the front door to be well sighted on the impact of parental substance misuse on the lived experience of individual children.

The quality of information provided in some contacts and MARFs to the front door is not always of consistently good quality. For example, when police officers send MARFs to the front door, they are not linked to WMP's information systems, meaning the quality of information has no supervisory oversight. This is a missed opportunity for quality assurance by leaders and reduces accountability and opportunities for learning. Front line police officers also report that the MARF takes too long to complete. Senior leaders across the partnership have identified the need to improve on the consistency of quality of contacts into the MASH and have plans for the imminent introduction of a revised e-MARF online form.

Risks to a small number of children are not always fully identified by WMP control room staff in their initial assessments. This means responses to vulnerability are not always prioritised as they should be, so they are not referred to the MASH. Some children are not seen by the police quickly enough or get the help they need in time. WMP supervisory practice does not always identify these children or reassess risk when there are delays in response. During this inspection, WMP leaders acted quickly in response to this finding, and these children were seen and visited.

MASH checks and access to GP information about children's health needs are only sought if there is a specific rationale. MASH health professionals do not have access to GP recording systems and do not routinely contact GPs for information when risks to children escalate. In addition, the interpretation and analysis of mental health information to support decision-making at the front door are inconsistent. This means that when children's needs do not warrant the convening of a strategy meeting, mental health information is analysed by a social worker rather than an appropriate health practitioner, and this risks misinterpretation of information.

There are challenges for some health partners in accessing children's information to help inform MASH checks. This is due to poor IT systems, and as a result, record-keeping in public health nursing is weak. Information is available for staff, including those in other WHT services, but its accessibility to find the most important and pertinent information quickly is a significant challenge.

Children are supported by a comprehensive multi-agency early help offer which helps them access a range of support and services when they need it. Regular locality partnership meetings and co-location of early help multidisciplinary teams, including family support workers, health visitors and school nurses, help promote communication and information-sharing about children's needs. There is strong engagement by school staff as lead professionals completing early help assessments. Opportunities for networking through the 'Time to Talk' initiative are well received by many school leaders, with engagement particularly strong in the primary phase.

WMP has invested in the employment of additional staff to the new role of early help officers. These police officers are focused on multi-agency work in the local early help offer. The officers work locally with the Walsall partnership, but WMP has clear terms of reference for this initiative, and they will be monitoring the impact of the scheme centrally. This is a positive indicator of police understanding the benefits of the multi-agency offer of early help provision within the community to reduce crime, vulnerability, and the escalation of harm to children.

The majority of domestic abuse incidents involving children in the preceding 24 hours are identified by the police screening team, whose members quickly provide the MASH with children's essential basic details. The daily Domestic Abuse Triage meeting has good multi-agency representation and engagement from partners, who share information effectively. This knowledge is then used to inform decision-making about what further actions and interventions are needed when children are identified to be at risk of harm. The quality of most referrals to the Domestic Abuse Triage meeting is appropriate, although there is some work to do on the consistency in quality of police referrals.

Operation Encompass is a successful method of police informing schools about children who are vulnerable to domestic abuse. The policy for Operation Encompass is comprehensive and has been reviewed and appropriately reinforced with training and guidance for school staff. School leaders say that the notifications they receive as part of Operation Encompass are valuable in helping them to provide support for vulnerable children and their families. One school leader captured the perceptions of many, describing the service as 'fantastic'.

When children are identified to be at risk of significant harm out of office hours, the emergency duty team (EDT) provides a quick and appropriate response. The EDT service is easily accessible to partners and members of the public when they are concerned for children. Social workers visit children and liaise appropriately with partner agencies to arrange strategy discussions to agree next steps when child protection concerns are identified. EDT social workers can access children's records, and this ensures that all contacts and information are passed on to the MASH for follow-up actions the next working day.

When risks to children escalate, strategy meetings do not consistently include all professionals who hold relevant knowledge and information about children. This reduces the effectiveness of shared accountability for decision-making, with some information about children potentially missed. Some strategy meetings in the MASH are discussions between only children's social care and the police. During this inspection, senior leaders proactively undertook a review of strategy meetings and introduced a new process with immediate effect.

The vast majority of strategy meetings include relevant and appropriate partner agency representation. This enhances the quality of information-sharing to help inform next steps. Children's family histories are purposefully shared to help inform known and unknown risks to children. When concerns about risks of harm to children increase, appropriate actions are agreed and decisions about child protection investigations are comprehensively recorded, with a clear rationale.

Risks to children from sexual or criminal exploitation are recognised well at the front door. The daily Exploitation Triage meeting is a well-attended multi-agency meeting that explores effectively the risks faced by children when they are reported as missing. Information is shared effectively in order to help professionals' understanding of risks and actions, which helps inform decision-making.

The chair of the Exploitation Triage meeting rotates between its core members, which is inclusive and indicative of confidence in the commitment and capability of the participants in the meeting. This ensures that responses to child protection are a shared responsibility across all partners.

Capturing and embedding children's views, wishes and their lived experiences to fully inform decision-making are inconsistent across the partnership. While there is some good-quality practice in obtaining the voice of children, the WSP has identified this as a priority action for the partnership.

The AWARE prompt is a useful tool to guide frontline police officers in how to seek the voice of children. This is a good local initiative that had just been launched within WMP as this inspection was carried out. It had not therefore been fully communicated to all the potential users in the police force or been promoted to safeguarding partners.

There is inconsistency in the police workforce's understanding of the body worn video (BWV) policy when responding to incidents where vulnerable children are present. BWV can provide high-quality evidence and information about child abuse and neglect and capture children's voices so this can be seen by other professionals to help their decision-making. However, BWV is not always consistently used in practice for this purpose.

Most children are visited quickly by social workers in the duty and assessment teams, and, when appropriate, children are spoken with alone. Assessments are written to the child, and this enhances the quality of information provided about their experiences. There is strong consideration of children's identity, diversity and culture in assessments, and partner information about children is appropriately included and considered as part of the analysis and identification of risk. Assessments are mostly concluded quickly, meaning that next step interventions are being implemented swiftly for children and their families.

There is insufficient staff capacity in the health visitor service. This has been appropriately challenged by the WSP and some mitigation in this gap in provision is provided by school nurses. This has ensured that children subject to child protection processes continue to have their health needs identified and monitored. School nurses attend initial child protection conferences on behalf of health visitors, for school-age children and those under the age of five. This ensures that children are monitored and receive appropriate multi-agency intervention. However, there is more to do to increase health visiting capacity.

Safeguarding supervision for health professionals is inconsistent in health services. GPs, midwives, health visitors, school nurses and adult substance misuse practitioners receive effective safeguarding supervision in line with a clear and comprehensive supervision offer. This provides the opportunity for supportive, restorative and challenging reflection. However, staff in the acute trust (emergency department and paediatrics), child and adolescent mental health services and adult mental health services do not receive consistent formal supervision to support their safeguarding practice. This limits the opportunity for all children in Walsall to access care, support and intervention from practitioners who are challenged in their safeguarding practice and contribution to the multi-agency response. Safeguarding teams within provider organisations are aware of the variability and are developing appropriate plans to strengthen this offer, but this has yet to be embedded.

Frontline workers report that they work in a supportive, multi-agency environment. Social workers like working for Walsall and say that they have opportunities for learning and development, and that they feel well supported by their managers and multidisciplinary team in the MASH.

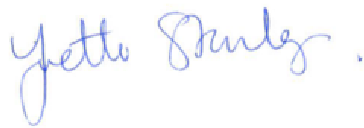
Next steps

We have determined that Walsall Council is the principal authority and should prepare a written statement of proposed action responding to the findings outlined in this letter. This should be a multi-agency response involving the individuals and agencies that this report is addressed to. The response should set out the actions for the partnership and, when appropriate, individual agencies. The local safeguarding

partners should oversee implementation of the action plan through their local multi-agency safeguarding arrangements.

Walsall Safeguarding Partnership should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by Friday 18 April 2023. This statement will inform the lines of enquiry at any future joint or single-agency activity by the inspectorates.

Yours sincerely



Yvette Stanley
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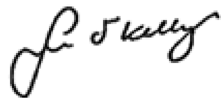

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