WOLVERHAMPTON
SAFEGUARDING TOGETHER

Annual Report 2024 - 2025

WOLVERHAMPTON SAFEGUARDING

CITY OF WOLVERHAMPTON COUNCIL

WEST MIDLANDS POLICE

NHS Black Country Integrated Care Board

Contents

Foreword

Welcome to the annual report covering the work of Wolverhampton Safeguarding Together Partnership (WST) in 2024 to 2025. The Local Safeguarding Children Board and the Safeguarding Adults Board were merged in April 2019 and the Wolverhampton Safeguarding Together, known as WST was formed.

From April 2024, Alison Hinds, Director of Children's Services took over the role of Chair and will continue to take forward the leadership of the partnership, ensuring that it is strengthened to safeguard the welfare of children and vulnerable adults.

Alison writes "We are pleased to present Wolverhampton Safeguarding Together Partnership's Annual Report covering from the 1st April 2024 to 31st March 2025. This has been produced on behalf of the partnership by Amy Weir, Independent Scrutineer. It provides independent oversight and assurance of our safeguarding practices. This report is focused on the partnership's work in relation to safeguarding children, young people and adults with care and support needs.

We want to start by taking the opportunity to thank all our frontline practitioners and managers, who work tirelessly to improve outcomes for children, young people 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 the citizens of Wolverhampton safe.

As the Lead Safeguarding Partners, we share equal responsibility for providing strong, collaborative leadership focused on continuously improving our multi-agency safeguarding arrangements to protect and promote the welfare of children, young people and adults with care and support needs.

We have also worked together to prepare for key changes at a national level with the introduction of the Care Quality Commission (CQC) Assessment framework for Adult Social Care and the publication of the revised "Working Together 2023" guidance for safeguarding children and young people.

In April 2024, Wolverhampton Safeguarding Together Partnership published its, Strategic Plan 2024 – 2026 setting out its shared vision and strategic safeguarding priorities for the next two years".

Alison Hinds
Executive Director of Families

Reporting a Safeguarding Issue

No excuse for abuse of children, young people or adults.

Report it!

All agencies in Wolverhampton work together to protect children, young people and adults with care and support needs from abuse. If you want to tell somebody else that you trust, like a GP, nurse, police officer or care worker then they will pass on your concerns to us.

To report abuse or neglect, please contact:

For safeguarding concerns about children and young people:

Monday to Thursday, 8:30am - 5pm - Fridays, 4:30pm	01902 555392
Out of hours	01902 552999

For safeguarding concerns about Adults (over 18 yrs):

Monday to Thursday, 8:30am - 5pm - Fridays, 4:30pm	01902 551199
Out of hours	01902 552999

There is also helpful information on the Wolverhampton Safeguarding Together website.
Go to: **www.wolverhamptonsafeguarding.org.uk**

In an emergency always call 999

Partner Organisations

City of Wolverhampton Council, Children's Social Care

City of Wolverhampton Council, Adult Social Care

NHS Black Country Integrated Care Board

West Midlands Police

Black Country Healthcare NHS Foundation Trust

City of Wolverhampton Council, Education Services

Healthwatch Wolverhampton

Probation Service

The Royal Wolverhampton NHS Trust

West Midlands Ambulance Service University NHS Foundation Trust

West Midlands Fire Service

Wolverhampton Homes

Wolverhampton's Voluntary and Community Sector (represented by Wolverhampton Voluntary and Community Action)

Independent Scrutineer's Overview

This annual report covers the period 1st April 2024 to 31st March 2025. It evaluates the effectiveness of the arrangements to safeguard the needs of children, young people and adults with care and support needs as required by the statutory guidance Working Together to Safeguard Children 2023 and by The Care Act 2014.

The statutory guidance for children requires that the focus of the report is on multi-agency priorities, learning, impact, evidence, and improvement, and scrutinises how well this is done. In this report this is the focus for both adults and children's services provided by WST.

In this year, there has been a continued focus on implementing the new requirements from Working Together 2023. It has placed additional responsibilities upon safeguarding children's partnerships to make arrangements for independent scrutiny so that there is objective and rigorous analysis of local arrangements which drives continuous improvement and provides assurance that arrangements are working effectively for children, families, and practitioners. WST recognises that work is required to embed this going forwards.

From the evidence provided, WST have continued to ensure that it is meeting its statutory responsibilities and working together to keep children, young people and adults with care and support needs in Wolverhampton safe. This is evidenced by commitment which all the partners have shown in contributing to the report. There is evidence from case examples provided and comments made by staff and service users about how they appreciate and value the work of WST to keep children and adults with care and support needs safe and to strengthen families.

Governance

WST is fully addressing the governance arrangements as required in Working Together to Safeguard Children 2023 and The Care Act 2014. The three statutory safeguarding partners in relation to a local authority area are defined as the:

- Local Authority
- Integrated Care Board
- Police

The Children and Social Work Act 2017 has provided partners in Wolverhampton with the opportunity to develop strengthened partnership safeguarding arrangements.

The review of the work of WST during 2024-2025 to inform the Annual Report has evidenced that it is meeting the requirements of Working Together to Safeguard Children 2023 and the Care Act 2014 by working effectively to maintain, strengthen and develop the safeguarding arrangements for children, young people and adults with care and support needs across the Wolverhampton area.

Independent Scrutiny

Working Together to Safeguard Children 2023 requires independent scrutiny of partnership activity. WST has demonstrated a strong commitment to carrying out scrutiny and independent audit activities using independent experts to identify learning and to inform the work of WST. The effectiveness of these scrutiny arrangements is regularly assessed.

Quality and Effectiveness of the Partnership

The partnership is built upon the foundations of strong relationships between the partners at all levels within and across agencies. The strategic priorities for 2024-2026 have been developed in response to national requirements, regional developments, and locally identified needs and activities. They also reflect needs that emerged during the period of the previous plan and were informed by the experiences of children, young people and families and adults who have received services as well as practitioners, through a range of activities including audits, individual stories and consultation with representative organisations.

This report describes the progress of the work of WST during the first year of the two-year strategic plan for 2024-2026 and therefore it has considered what progress has been made during that first year in addressing the key priorities agreed.

Where further work from the previous priority groups needed to be taken forward it has been adopted either by other groups within the partnership or by partner agencies' internal plans where the work aligns, to ensure that it continues to be progressed and embedded.

Evaluation of Progress since 2023/24

Last year's review made recommendations about areas for further development by WST. These are listed below with commentary on the progress made.

Ensure that experts by experience have a greater role in influencing and developing the work of the priority groups and the wider partnership

- There is a dedicated member of the Business Unit taking this work forward and this is working well.

Embed across the partnership, the early help work undertaken with adults including a neglect strategy and neglect tool for adults.

- The Neglect and Self-neglect Priority Group is leading this work. The adult neglect strategy has almost been completed. A hoarding tool and a multi-agency panel for consideration of those cases are in place.

Embed across the partnership, the WeCan neglect tool for children.

- The children's Neglect strategy has been updated and a WeCan screening tool has been developed to encourage and support early identification of concerns. It is planned that a multi-agency event will be held to promote the launch of these tools. Trauma Informed Supervision is further enabling consideration of cumulative harm and trauma, especially in relation to chronic neglect situations.

Additional analysis of the impact of the training provided at an individual and partnership level and cross-referencing against quality assurance and improvement activities to provide assurance about the difference that training has made to the lives of children, young people and adults.

- All training is followed by a post course evaluation survey to enable impact and learning to be identified. Some examples of feedback received are set out in the training section.

Summary of Findings

WST has had another positive year in taking forward its plans and in making a measurable and demonstrable difference to the lives of families, children, young people and adults with care and support needs in Wolverhampton. The achievements and feedback received about this are set out in the report.

There have been positive outcomes from external scrutiny. This has included an Ofsted Focused visit to Children's Services in October 2024, CQC Inspection in mid-2025 and the LGA Peer Challenge Review carried out in September 2024 which commented on the quality of partnership working – "There was remarkable consistency in the feedback from partners about the maturity of their relationships with the council, and their can do, 'solutions mindset' of its staff"'.

The WST Partnership has been working successfully with other local partnerships to develop new regional Lead Safeguarding Partners (LSP) arrangements which has been an additional consideration over and above the local, immediate priorities.

WST's governance arrangements are robust and have been tried and tested. The culture of learning, self-awareness and continuing critique is demonstrated through the range of Scrutiny and Quality Assurance which are in place.

Wolverhampton Safeguarding Together Partnership creates the conditions to develop a learning culture driving best collaborative practice to deliver the best possible outcomes for children, families and adults.

Recommendations for 2025/26

1. Continue to develop and evidence how Equality, Diversity and Inclusion (EDI) are overarching features of the work of WST.
2. To continue trying to ensure that people with lived experience have a greater role in influencing and developing the work of the priority groups and the wider partnership. The Scrutiny arrangements need to ensure that the voices of children and families are considered as part of scrutiny.
3. Progress National Social Care Reforms and Families First for Children with the full collaboration of WST stakeholders.
4. Continue with Statutory Responsibilities in relation to Statutory Reviews. Explore innovative methods when completing reviews (in line with Statutory Guidance), continue to share learning and best practice.
5. Continue progress in implementing the new Lead Safeguarding Partners (LSP) arrangements whilst ensuring that there is continuity in the focusing on the dedicated work of WST.

The WST Partnership

The WST Partnership has statutory responsibility for both children's and adults' safeguarding in the Wolverhampton local authority area. Wolverhampton Safeguarding Together Partnership convenes safeguarding partners, the Police, Integrated Care Board and Local Authority, alongside Education and the Voluntary sector to work in close collaboration to safeguard and promote the welfare of all children, young people and adults with care and support needs in Wolverhampton.

Governance

In accordance with the requirements of Working Together 2023, the WST Partnership has been working with other local partnerships to develop new regional Lead Safeguarding Partners (LSP) arrangements following the West Midlands Police area footprint for an annual meeting and more locally the Black Country model area for quarterly meetings. The first meetings will be held in Autumn 2025.

The WST Memorandum of Understanding was agreed and signed off during the year. The document was reviewed, and it was agreed. The Terms of Reference that were agreed regionally are included as an appendix.

The Multi-agency Safeguarding Arrangements (MASA) are comprehensive. They have been signed off and published.

The WST Quality Assurance Framework was reviewed and approved.

The WST Executive Group continues to be the overarching local high level strategic governance board for both the safeguarding children and safeguarding adults' agendas and consists of senior officers from the three statutory partners, with the local authority also representing Education. Its primary focus is on safeguarding systems, performance and resourcing and is chaired by one of the three strategic partners in rotation. The group has been able to respond flexibly to arising issues and to ensure that the views of early years, schools and colleges are represented.

- Education FFCP Role: Introduction of the Strategic Education role from September 2024 to March 2026 to strengthen the voice of education in the partnership.
- Education is represented in the Safer Wolverhampton Partnership.
- Education practitioners from all sectors are represented at WST priority groups.
- The Strategic Education Lead is a member of the WST Executive group.
- Education is being trialled as the fourth statutory safeguarding partner as part of the Family First Children Pathfinder.

From 1st September 2024, a dedicated post holder has represented education to test this as part of the arrangements for the Wave One Families First for Children (FFC) pathfinder programme. This has worked well to ensure that the engagement of early years, schools and colleges is included in the work of WST.

The business support arrangements for WST have been further developed in 2024/25. The learning development post has been increased to full-time to provide continuity on learning and development but also to encompass communications and engagement of people with lived experience. A Senior Analysist has been appointed to improve the data collection.

Additional scrutiny is provided through externally commissioned activities undertaken by independent experts who are able to provide challenges about current systems and processes and make recommendations for further action. Working Together 2023 provides the opportunity for enhanced scrutiny arrangements and the partnership recognises that this is an area for development.

Scrutiny and Assurance Arrangements

The Scrutiny and Assurance Co-ordination Group reports to the Executive Group and is responsible for progressing the Executive Group's business priorities through the strategic plan. Under the Care Act 2014, this also acts as WST's statutory Adult Safeguarding Board. This group authorises the policy, process, strategy and guidance required to support the Executive Group's priorities and achieve effective safeguarding.

The group has wider partner membership and includes health, education, voluntary and community sector (including links to faith communities), housing and probation services. Supporting the Executive Group and the Scrutiny and Assurance Co-ordination Group are the priority groups which drive the priorities of the strategic plan, sub-groups which are responsible for developing key elements of multi-agency work and where required, task and finish group(s) to respond to emerging issues.

This work is also informed by the experiences of children, young people and families and adults who have received services as well as practitioners, through a range of activities including audits, individual stories and consultation with representative organisations. The partnership recognises that this needs to be strengthened further so that the voices of children and vulnerable adults are central, and there is commitment to progress this.

A Senior Analyst has been appointed by WST who is leading on the development of the Quality Assurance and Data dashboards to inform the work of the Priority Groups, Scrutiny and Assurance and the Executive Group.

Financial Arrangements

Financial Contributions

Wolverhampton (Joint Children & Adults budget):

West Midlands Police: **£32,425 (Children £16,159 / Adults £16,266)**

Integrated Care Board: **£80,154**

Local Authority: **£154,100**

Strategic Plan 2024 - 2026

The strategic plan for 2024 – 2026 sets out the Executive Board's strategic vision, ambition, purpose, principles, and safeguarding priorities for the following two years. WST have reflected and celebrated what was achieved over the previous two-year priority period and agreed to refocus their priorities to:

- Cumulative Harm & Trauma
- Neglect / Self-Neglect
- Transitional Safeguarding

WST drives best collaborative practice for good outcomes for families, children, young people and adults with care and support needs, this is reflected in the strategic plan. The WST system:

- Sets standards and procedures for multi-agency practice.
- Promotes working together in practice supported by behaviours of respect and trust.
- Assures sound quality practice with a positive impact on outcomes for children, young people, and adults.
- Provides a programme of learning and development which supports leadership and practice, as well as from reviews of serious incidents such as Child Safeguarding Practice Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews.
- Models a culture of evaluation, learning and development.
- Communicates effectively with the wider safeguarding system of organisations and individuals, including voluntary organisations and those who experience services.
- Drives progress through subgroups and priority work streams who are accountable to the Scrutiny and Assurance Co-ordination Group, who in turn report to the Executive Group.
- Sets out the strategic intent of Wolverhampton Safeguarding Together Partnership in making this vision a reality. It underlines the statutory objectives to co-ordinate and ensures the effectiveness of safeguarding arrangements.

The Strategic Plan provides information on how the agreed strategic priorities for 2024 - 2026 will be driven in line with the revised multi-agency safeguarding arrangements as set out in Working Together 2023 and the responsibilities of Safeguarding Adult Boards set out in the Care Act 2014, in compliance with statutory requirements. The purpose of these local arrangements is to support and enable local organisations and agencies to work together in a co-ordinated and systemic way which safeguards and promotes the welfare of children, young people, and adults with care and support needs.

The Strategic Plan focuses on the specific role and remit of the safeguarding partnership in gaining assurance that that welfare of children, young people and adults with care and support needs are safeguarded and protected, as set out in Working Together 2023 and the Care Act 2014.

Key Priorities for 2024 - 2026

The strategic priorities for 2024 – 2026 have been agreed in response to national requirements, regional developments, and local need. They have taken account of the outcomes from the annual events in October 2023 and January 2024 as well as learning from Child Safeguarding Practice Reviews and Safeguarding Adult Reviews.

The priority work-streams will be monitored through scrutiny and challenge of the Executive Group. This plan and the work of Wolverhampton Safeguarding Together Partnership is further complimented by the Scrutiny and Assurance Co-Ordination Group.

The work of Wolverhampton Safeguarding Together Partnership, which is to ensure that activity to protect children, young people, and adults with care and support needs from harm is fully co-ordinated and effective and fits within the wider context of the work and remits of the following:

- Emotional Mental Health and Wellbeing Board
- Safer Wolverhampton Partnership Board
- Child Death Overview Panel
- Children and Families Together Board
- One Wolverhampton
- Families First for Children Pathfinder (FFCP) Programme Board

All members, as part of their role and responsibilities, are champions in their own agency to support and progress the work of the strategic priorities and ensure staff within their own agencies are actively involved in its successful delivery.

Key Achievements

Scrutiny Activities

Several scrutiny activities completed in 2024 continue to be reviewed to ensure compliance with legislation.

- Compliance with section 11 of the Children Act 1989 and the Care Act 2014
- Compliance with section 175 of the Education Act 2002
- In preparation for the 2025 CQC Inspection of Adult Services audits and compliance checks were undertaken, and the outcome of the inspection was positive

Quality Assurance

A range of areas to audit were identified during the year. The findings were considered and action put in place.

A Senior Analyst has been appointed by WST who is leading on the development of the QA and Data dashboards to inform the work of the Priority Groups, Scrutiny and Assurance and the Executive Group.

The MASH (children's and adults) and the FFCP Dashboard were presented to the March 2025 Scrutiny and Assurance and Executive Group meetings.

The data required for the Neglect / Self-Neglect priority group is data that is readily available, with the dashboard being developed and presented in May 2025. Other sets of data will be provided when available including for the Transitional Safeguarding and Cumulative Harm and Trauma Priority Groups where data is less readily available, and the Senior Analyst is discussing this further to understand how this can be improved. In the meantime, assurance will be sought via a variety of audits, dip samples and surveys.

Mock Joint Targeted Area Inspection (JTAI)

Multi-agency response to children who are victims of domestic abuse

The purpose of the audit was to gain assurance that should the partnership receive notification of a Joint Targeted Area Inspection (JTAI) that partners are prepared to respond and that there is a robust multi-agency response to children who are victims of domestic abuse.

Good Practice:

- There was evidence of collaborative working and information sharing across most agencies.
- Some good examples of lived experience for both children and their parents / carers.
- There were good examples of agencies documenting risks and escalations and responding appropriately.
- DASH Risk Assessments were completed where appropriate.
- There was evidence of pathways and processes being followed.
- Evidence of agencies showing persistence to engage with families despite challenges such as non-attendance / missed appointments.

Areas for Improvement:

- While there was some evidence of the voice of the child, this was inconsistent within documentation and records.
- While there were some good examples of lived experience, the impact of domestic abuse was not always considered when working with a child / family.
- GPs were not always aware of the domestic abuse related risks.
- Referrals to CAMHS were not always viewed holistically, therefore not taking into consideration the impact of the domestic abuse on the child and their mental health.
- There are significant delays with the Operation Encompass notifications to social care and education. Health are not included within these notifications and often aren't aware of the domestic abuse risks.
- The voice of the father was absent in most cases.
- Education aren't invited to attend MARAC meetings and often aren't aware of the outcome.

Recommendations:

- Further work is to be undertaken to ensure that the voice of the child is captured within all records and documentation.
- Agencies need to take into consideration the impact of domestic abuse on a child / family and further explore their lived experience to ensure their needs are fully understood and the appropriate level of support is offered.
- There is a need for better information sharing with GPs to ensure they are aware of any domestic abuse risks for a child / family.
- West Midlands Police to consider including GPs in their Operation Encompass notifications.
- Further work is to be undertaken to ensure that fathers views are sought and are included in any assessments / documentation.
- CAMHS are to ensure that when making decisions on referrals, the lived experience of a child is considered, i.e the impact of domestic abuse on their mental health.
- West Midlands Police are to provide assurance to WST regarding the timeliness of Operation Encompass notifications.
- Consideration is to be given to including education in MARAC meetings to allow them to contribute to any discussions and be fully sighted on the risks identified and the outcome of the meetings.

Escalation Policy

This has been reviewed and updated. It includes a provision that WST would commission an independent person to review a dispute is this was not resolved following the Escalation Policy procedures.

Annual Review and Report

This has been completed by an Independent Scrutineer to ensure that an appropriate degree of challenge is applied to consider the WST's work over the year.

Priority Groups

This is the first reporting year of the 2024-2026 strategic plan and therefore this report focuses on the initial steps and early activity during this first year.

The priority groups are chaired by senior leaders from agencies representing both children and adults' services to ensure that the work considers the needs of all citizens in Wolverhampton. Meetings have been held regularly with consistent attendance and valuable contributions from partner agencies.

Cumulative Harm & Trauma Priority Group

Key Achievements

- A survey was created and shared with agencies to understand how Cumulative Harm & Trauma is embedded within organisational policies.
- The Task and Finish Group reviewed the responses and discussed how to deal with gaps in the information received.
- It has been identified that research and development is required from the priority group to develop a better shared understanding of trauma informed practices and how to embed them within policies and practice and this is in process.
- The group has engaged with Barnardo's which coordinates the West Midlands Trauma Informed Coalition.

Next Steps:

- The group is taking forward the adoption of the Barnardo's West Midlands Learning and Development Framework which helps organisations benchmark their progress in becoming trauma informed. The framework includes the following themes:
    - knowledge and awareness
    - informed language
    - safe environments
    - staff well-being
- Continuing work with Barnardo's to build on their pilot for Learning and Development which was completed in Wolverhampton and implementing the proposed pathway of work.
- WST have commissioned Trauma Informed training which is being rolled out in March 2025.
- Training for trainers will be rolled out based on the Barnardo's model.
- A dip audit framework is being developed to check the quality of practice and to enable evidence of progress and embedding to be gathered.

Neglect / Self-Neglect Priority Group

Key Achievements:

- The WeCAN Children's Neglect Toolkit was reviewed following feedback from agencies that the toolkit was too lengthy, and this was the reason for it not being completed; it was agreed that a screening tool would be developed that will be used to support professionals in identifying and responding to neglect. The screening tools will accompany Early Support Plans and where there is an escalation in risk the full WeCan Assessment Tool will be completed.
- The Children's Neglect Strategy has also been reviewed and updated to ensure that several issues are highlighted - FFCP (Family Help), the importance of robust transition planning and the importance of distinguishing between poverty and neglect. The strategy was signed off March 2025.

Next Steps:

- An Adult Neglect Strategy is being developed. The final draft was to be signed off in May 2025 by the priority group meeting just after this reporting period.
- WST commissioned Safer Together to deliver Complex Neglect and Self-Neglect Training sessions. The first two sessions were held in February and March 2025

Transitional Safeguarding Priority Group

Key Achievements

- Completion of a mapping exercise to understand what policies and procedures agencies currently have in place with regard to Transitional Safeguarding.
- Further work is being undertaken to understand any gaps and to ensure that there are robust processes in place to ensure a smooth and effective transition across all agencies.
- A MACE to Adult Exploitation Audit was conducted to evaluate how well the adult exploitation process for transition is being followed.
- An audit tool has been developed and signed off.

Next Steps:

- The next audit will focus on the transition between:
- Children to adult's social care
- CAMHs to AMHs
- Transitional Safeguarding bite-size sessions to be delivered across the workforce.
- WST to consider commissioning a more in-depth training session to include the learning from statutory reviews.

Learning from Statutory Reviews

The One Panel is a multi-agency senior officer group that has delegated responsibility from WST to consider referrals for statutory reviews for Safeguarding Adults (SARs), Child Safeguarding Practice Reviews (CSPRs) and Domestic Homicide Reviews (DHRs). The One Panel initiates local multi-agency Learning Lessons Reviews and makes recommendations against the statutory criteria for reviews to the Executive Group, National Panel and the Home Office.

Children

Working Together to Safeguard Children 2023 details when a statutory review should be undertaken and the responsibility for how the system learns lessons from serious child safeguarding incidents lies at a national level with the Child Safeguarding Practice Review Panel and at a local level with the safeguarding partners. Serious child safeguarding cases are those in which:

a. Abuse or neglect of a child is known or suspected.

b. The child has died or been seriously injured.

In some instances, the criteria may not be met for a child safeguarding practice review to be undertaken, however, the safeguarding partnership may feel that there is learning to be derived and may choose to undertake some form of learning activity which is good practice.

During the reporting period under review (April 2024 – March 2025) there have been 5 rapid reviews held with their outcomes detailed below:

Gender	Age (at the time of incident)	Ethnicity	Criteria Met
Male	17	White & Black Caribbean	No
Female	15	White European	No
Male	8 Months	White British	No
Female	1 year, 5 Months	White & Black African	Yes
Male	5	White British	No

Adults

The Care Act 2014 states that a safeguarding adult review (SAR) should be undertaken when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

During the reporting period under review (April 2024 – March 2025) there have been 5 rapid reviews held with their outcomes detailed below:

Gender	Age (at the time of incident)	Ethnicity	Criteria Met
Male	50	White British	Yes
Female	29	White British	No
Male	19	White B- Irish Traveller	No
Female	22	Other White origin	No
Male	18	White British	Yes

WST follow the Children's Safeguarding Practice Review process as set out in Working Together to Safeguard Children 2023 and utilise rapid reviews to enable safeguarding partners to determine the outcome of SAR referrals. We will:

- Gather the facts about the case, as far as they can be readily established at the time
- Discuss whether there is any immediate action needed to ensure the adult's safety and share any learning appropriately
- Consider the potential for identifying improvements to safeguard and promote the welfare of the adult.
- Decide what steps they should take next, including whether or not to undertake a Safeguarding Adult Review

Publications

Where the criteria for a Local Child Safeguarding Practice Review (LCSPR) or Safeguarding Adult Review (SAR) is not met but learning is identified, a Learning Lessons Briefing will be developed to disseminate the learning across the partnership.

Children

Marcus – Learning Lessons Briefing

Marcus was just over 3 months old when he was taken to the Emergency Department by paramedics having a seizure. Investigations undertaken at the time of his presentation later showed he had been exposed to cocaine which was likely to have been the cause of his seizure.

Learning

- Lack of a clear picture from anyone about the children's day-to-day life at home.
- There was a lack of professional curiosity from professionals; initial questions would be asked almost as a tick box exercise, but no further attempts were made in understanding the impact of the answers received.
- Not all involved professionals were invited to multi-agency meetings or kept up to date with concerns and progress.

The full briefing and learning identified can be read here.

Leah – Learning Lessons Briefing

When Leah was 15 months old, she was taken to an Emergency Department with a fatal, apparently inflicted head injury. Post-mortem examination identified further significant injuries which had been sustained over a period.

Learning

- Professionals involved were not thinking family.
- Professionals need to be mindful that earlier court assessments and reports may not reflect current situations and should not be relied on as reassurance about current parenting capability and the safety of children.
- Child in Need (soon to be Family Help) meetings should involve all frontline professionals involved with the family and not rely on.

The full briefing and learning identified can be read here.

Natalia – Learning Lessons Briefing

Natalia and her Mum moved to Wolverhampton from Eastern Europe in 2015. They were isolated in the community with no social circle and a strained relationship. Natalia was found lifeless in her bedroom having left a suicide note. Also in the house were numerous notebooks documenting her unhappiness over several months.

Learning

- Professionals involved were not thinking family.
- Professionals need to be mindful that earlier court assessments and reports may not reflect current situations and should not be relied on as reassurance about current parenting capability and the safety of children.
- Child in Need (soon to be Family Help) meetings should involve all frontline professionals involved with the family and not rely on.

The full briefing and learning identified can be read here.

Adults

Thomas – Safeguarding Adult Review

Thomas, who had mild learning disabilities, autism and Emotionally Unstable Personality Disorder, was given care and support by a number of local agencies.

After Thomas' death, a Serious Incident Review was completed by West Midlands Ambulance Service, and a Learning from Lives and Deaths - People with a Learning Disability and Autistic People Review was also carried out.

Wolverhampton Safeguarding Together commissioned the Safeguarding Adult Review to look at how agencies had interacted with and supported Thomas and to address any additional learning not covered by the earlier reviews.

Key Findings

Key Finding 1 – Clear, and robust multi-disciplinary plans are made to support, positive and safe in-patient to community discharges. This should include, at the earliest opportunity a lead professional and clear roles and responsibilities across all health and social care professionals involved in the Multi-Disciplinary Team around the person. The person's voice must be heard.

Key Finding 2 – All agencies should ensure that they practice within legal frameworks required to protect and uphold the rights of adults with a learning disability (and autistic adults) when they live in their own home/in their community. Agencies and professionals should ensure they have sufficient legal literacy, appropriate to their role, to support decision making. Upholding the rights and safeguarding adults with care and support needs, may be managed through different the legal frameworks in the community, than those within in-patient settings.

Key Finding 3 – All health and social care professionals involved in a person's discharge planning, should include consideration of risks and issues that require alternative management plans in the community (different to plans in place in in-patient environments). This could include consideration of managing relationships/contact with family, finances, and use of food to manage emotions and feelings. Dates for discharge should be agreed when a care and support plan is agreed, appropriate to manage community risks. This should be subject to review.

The full briefing and learning identified can be read here.

Beth – Safeguarding Adult Review

Beth was 22 years old when she died from an overdose of drugs. Beth had experienced complex trauma and adversity throughout her childhood and adolescence. She had been the victim of Child Sexual Abuse (CSA), the trauma of which understandably adversely impacted her mental health and wellbeing. This culminated in her being sectioned firstly under Section 2, and then under Section 3 of the Mental Health Act (1983) when she was 17 years old. Beth remained under section as an inpatient for three years and was discharged from hospital in July 2020 on a Community Treatment Order at the age of 20. Beth was also further exploited in adulthood and disclosed that she had been subjected to further acts of sexual violence. She had made a disclosure of rape prior to her death. Beth would often self-medicate, resorting to the use of illicit and street bought substances as a means of managing the unpleasant symptoms of her trauma and mental health. This increased Beth's levels of vulnerability and added an additional layer of complexity for practitioners to consider when formulating plans to keep Beth safe from further harm. The review made a number of recommendations to WST in relation to the following themes:

- Improved discharge processes including information sharing prior to discharge of a patient from psychiatric services, completion of an adult exploitation tool and financial management.
- Transition from CAMHS and tier 4 services to adult mental health in-patient facilities.
- Management of Community Treatment Orders.
- Pro-active provision of support from agencies rather than expecting the adult to seek support.

The full briefing and learning identified can be read here.

Amelia – Learning Lessons Briefing

A Learning Lessons Briefing was published in relation to "Amelia" who was a young woman who had a complex background of abuse from an early age and had an extensive history of involvement with mental health services. The briefing made six recommendations which are aimed to improve practice in the community and in-patient settings to support people with mental health difficulties.

Recommendations

- The Mental Health Trust's Clinical staff on the identified wards to re-engage with the suicide prevention training programme.
- The Mental Health Trust's Home Treatment Team risk assessment policy to be reviewed to ensure consistency in approach. Home Treatment Team are to consider a more flexible approach for patients to be reviewed via video consultations.
- The Mental Health Trust are to revisit the clinical handover processes through training and supervision. Information around self-harm and psychological factors must be documented on ward handovers.

The full briefing and learning identified can be read here.

Patrick – Safeguarding Adults Review

Patrick, a man in his 50s, who lived with his wife and brother-in-law had a diagnosis of schizophrenia, a learning disability and a hearing impairment. He was sadly found dead at his home in April 2024.

Prior to his death, he had received support from a number of services including the Community Psychiatric Nursing Service, the District Nursing Service, the Phlebotomy Service, Primary Care Home Visiting Service and Adult Social Services.

Recommendations

- The partnership should seek assurance that professional curiosity and the Think Family approach are promoted, encouraged and supported by its member agencies.
- The partnership should undertake a piece of work to understand the barriers and enablers to identifying self-neglect and hoarding and the challenges for professionals in convening multi-disciplinary teams across the partnership.
- The partnership should review the training provided about the tools for self-neglect and hoarding and consider whether this requires further action to embed the use of the tools across the partnership.

The full briefing and learning identified can be read here.

Safeguarding in Numbers 2024 – 2025

Children's Data

Open Child Protection Plans by Initial Category of Abuse

The annual data collection published by the Department for Education is not yet publicly available at the time of writing this report and therefore it is not possible to provide analysis about how Wolverhampton's data compares with the data in England overall and regional and statistical neighbours.

Year	Number of children subject to Child Protection Plan
2021 - 2022	**267**
2022 - 2023	**248**
2023 - 2024	**228**
2024 - 2025	**213**

The number of children subject to a child protection plan has remained largely consistent with previous years, though it declined from 228 to 213 in 2024–2025, with a rate of 33 per 10,000.

Initial category of abuse	LA 2024-25 (%)	LA 2023-24 (%)	LA 2022-23 (%)	LA 2021-22 (%)
Neglect	69	84	45	66
Physical Abuse	1	4	3	-
Sexual Abuse	1	0	0	-
Emotional Abuse	28	13	12	31
Multiple	1	0	40	0

The data indicates a reduction in the number of children subject to a child protection plan under the categories of physical abuse and neglect. Emotional and sexual abuse have seen a slight rise compared to the previous year. Although neglect had increased over the previous four years and continues to be the highest category, the latest data shows a reduction.

Open child protection plans by sex				
Breakdown	LA 2024-25	LA 2023-24	LA 2022-23	LA 2021-22
Male	103	126	126	127
Female	97	94	106	124
Unknown	13	8	16	15
Indeterminate	0	0	0	1
Total	**213**	**228**	**248**	**267**

Over the past four years, data consistently indicates that a higher number of males than females have been subject to a child protection plan.

Adults' Data

Number of Safeguarding Referrals

	2024-25	2023-24	2022-23	2021-22	2020-21
Individual Safeguarding Concerns	**2,687**	**2,542**	**3,012**	**2,448**	**2,484**
S42 Enquiries	**360**	**422**	**766**	**418**	**425**

In total, 2,484 safeguarding concerns relating to individuals were recorded for 2024–2025. This marks a decrease from the previous year and is the first reduction since 2021–2022.

Types of Abuse

Concluded Section 42 Enquiries				
Counts of Enquiries by Type and Source of Risk	Source of Risk			
S42 Enquiries	Service Provider	Other - Known to Individual	Other - Unknown to Individual	Total Section 42
Physical Abuse	28	90	9	127
Sexual Abuse	7	24	3	34
Psychological Abuse	19	163	9	191
Financial or Material Abuse	17	132	10	159
Discriminatory Abuse	0	8	0	8
Organisational Abuse	25	4	0	29
Neglect and Acts of Omission	81	68	2	151
Domestic Abuse	-	99	-	99
Sexual Exploitation	1	18	5	24
Modern Slavery	0	17	2	19
Self-Neglect	-	41	-	41

In 2024–2025, there were 425 Section 42 enquiries relating to individuals, representing a slight increase from the previous year. The primary concerns identified were related to psychological abuse, which was the most frequently reported type of abuse committed by someone known to the individual.

Age of Individuals Involved in Section 42 Enquiries

	Age Band						
Counts of Individuals by Age Band	18-64	65-74	75-84	85-94	95+	Not Known	**Total**
Individuals Involved in Safeguarding Concerns	1,346	341	488	429	83	0	**2,687**
Individuals Involved in Section 42 Safeguarding Enquiries	188	46	61	59	6	0	**360**

Individuals aged 18–64 continued to represent the largest proportion of those subject to Section 42 enquiries, making this age group the most prevalent in safeguarding concerns.

Learning Development and Training

WST continue to provide a range of multi-agency children's and adults' safeguarding training to organisations working across Wolverhampton to promote shared learning across the partnership and to support the continuous development of improved safeguarding practice.

The offer includes the provision of Safeguarding Lead training, and to support the delivery of the children's Safeguarding Lead training WST hosts a training pool which is made up of volunteers from across the partnership who have extensive safeguarding knowledge and are experienced in training delivery. The adults Safeguarding Lead training is commissioned from an external provider.

Training for Children's Safeguarding Leads

- A Shared Responsibility
- Thresholds to Support
- Working Together to Safeguard Children
- Safeguarding Leads 2 Yearly Update

Training for Adult's Safeguarding Leads

- Safeguarding Adults (Making Safeguarding Personal and Section 42 enquiries)

In addition to the safeguarding lead training, the following multi-agency training sessions were delivered for the period under review

- An introduction to Adverse Childhood Experiences and Trauma Informed Practice
- Complex Neglect
- Exploitation Awareness
- Learning Lessons Briefing - Beth
- Managing Allegations
- Multi-Agency Restorative Practice
- Professional Curiosity
- Self-Neglect
- Trauma Informed Practice

These sessions are aligned with the WST priorities, learning from local and national CSPRs, SARs and multi-agency audit activity and incorporate relevant guidance from Working Together to Safeguard Children 2023, Care Act 2014 and Children's Act 2004.

Sessions are a blend of online and in person delivery and range from short bite size sessions to full day training.

Attendance at Training

Schools continue to make up the greatest proportion of training attendance and this is attributable to the requirements for Designated Safeguarding Leads to attend children's safeguarding lead training and bi-yearly refreshers to meet Ofsted standards.

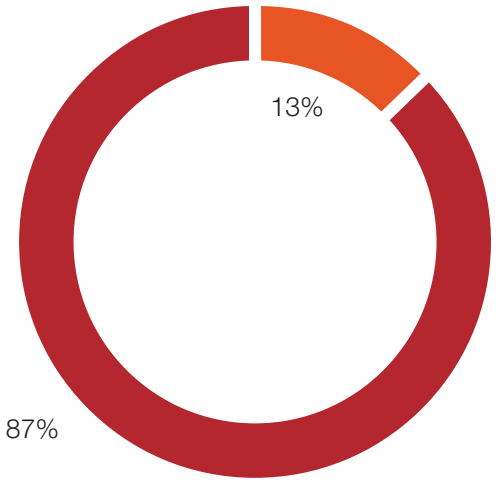
HAF (Holiday Activities and Food) Providers are also required to attend safeguarding lead training which can be linked to the increase in the voluntary sector booking and attendance.

Attendance from Emergency Services, Health, Local Authority colleagues has increased from the previous year which is positive to see.

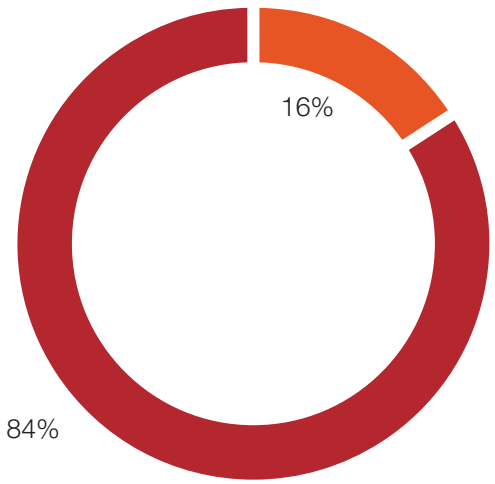
Assurance has been sought from agencies who do not regularly attend training sessions to ensure that they are providing safeguarding training internally.

	2023 - 2024		2024 - 2025	
Service Area	**Booked**	**Attended**	**Booked**	**Attended**
Education	780	703	871	738
Emergency Services	3	2	12	9
Health	33	23	150	120
Local Authority	76	54	213	180
Private Providers (not education)	40	29	79	58
Probation	5	3	5	4
Voluntary	102	92	232	196
Non Specific	7	6	4	3
Total	**1,046**	**912**	**1,566**	**1,308**

Overall attendance 2023 - 2024



Overall attendance 2024 - 2025



Attended Did not attend

As a measure to maximise attendance and learning, a £30 non-attendance fee is invoiced to agencies when individuals do not attend booked sessions or cancel in accordance with the terms and conditions. It is difficult to evaluate the reasons for non-attendance as we do not always receive this information but where we do, most are attributable to safeguarding issues within the setting, workload or absence.

Private providers are charged £25 per half day course and £50 for a full day course when attended. Private providers who have not previously attended WST training sessions are given two free introductory sessions and therefore not invoiced for attending these.

Any revenue received from training charges is used to fund future training sessions and resources.

	2023 - 2024		2024 - 2025	
Partner free places issued	887	-	1212	-
Introductory free places issued	41	-	45	-
Half days training fees invoiced	41	£1,025	40	£1,000
Full day training fees invoiced	14	£700	16	£800
Non-attendance fees invoiced	63	£1,890	128	£3,840
Fees waived	57	-	125	-
Total	**1,046**	**£3,615**	**1,566**	**£5,700**

Training Evaluation

All learners are asked to complete a post course evaluation survey to enable us to improve training delivery. This asks for feedback on the quality of the session and a rating of knowledge, skills and confidence from before and after the session.

Here are some examples of feedback received:

'Staff at this venue are however ALWAYS so friendly and helpful and the facilities (toilets, kitchen) are very good. Location is very good as well due to availability of the Tesco supermarket to get refreshments.

'The training was excellent. It was thorough and exceptionally informative, and jam packed. The trainer, as always, was marvellous. I really enjoy how she delivers training, and this is my second training session of hers that I have attended. She knows so much and never makes you feel uncomfortable when asking questions. No question to her ever goes unanswered. She is warm, open and welcoming'.

'My only criticism is the venue. The room size is great, but the acoustics were very poor due to the high ceiling and a number of us were struggling to hear the trainer, there was also a play group taking place in the adjoining room - which had open windows. The projector had to be placed at an angle due to the sunlight and there were no window coverings to combat this'.

'I felt this was a useful and interesting training course. I preferred this to previous DSL training sessions I have attended, as the trainer linked the information to her own experiences. I liked that the course was online as it can be hard to get out of the setting'.

'Really enjoyed both trainers' inputs. It was really helpful and insightful and helped me to gain some clarity around what would be required of me at a Child Safeguarding Practice Review. Allowed me the space to cement the practice and importance of record keeping and review what we might need to address here'.

For the year ahead (2025-2026), all learners attending sessions will receive an additional post course evaluation survey to see ascertain how learning from the training has been applied in practice and what the impact has been.

eLearning

WST has access to e-learning via The City of Wolverhampton Council's learning management system on a guest basis for organisations for whom providing training may be challenging. This is important in supporting all agencies to fulfil their safeguarding responsibilities and demonstrates strong partnership practice.

The courses available include:

- Prevent[1]
- Female Genital Mutilation[1]
- Forced Marriage [1]
- Intermediate Safeguarding Awareness
- Basic Safeguarding Awareness
- Child Sexual Exploitation
- Corporate Parenting
- CWC Exploitation Package
- An Introduction to Restorative Practice
- Missing Persons eLearning
- ICON Shaking Babies eLearning
- Domestic Abuse Awareness

WST has provided access to the Brook Traffic Light Tool to unlimited individuals across the partnership for a period of 12 months. This will support practitioners to assess potential Harmful Sexual Behaviour. In the year 471 practitioners from a variety of agencies have completed the Brook Traffic Light Tool eLearning, where access has also been extended for a further 9 months.

1 We are unable to provide statistics for these courses as they are provided and administered by the Home Office.

Places Booked per eLearning Course	Q1	Q2	Q3	Q4	YTD
Basic Safeguarding Awareness	43	19	15	15	92
An Introduction to Restorative Practice	21	4	3	5	33
Brook Traffic Light Tool	80	116	79	196	471
Child Sexual Exploitation	26	8	2	6	42
Corporate Parenting	19	7	1	4	31
Exploitation Package	19	5	2	2	28
Domestic Abuse Awareness	24	5	4	7	40
ICON Shaking Babies eLearning	13	1	1	2	17
Intermediate Safeguarding Awareness	31	10	18	9	68
Mental Health, Dementia and Learning Disability	23	4	3	1	31
Missing Persons eLearning	14	2	2	3	21

Learning Events

In November 2024, Wolverhampton Safeguarding Together Partnership and Safer Wolverhampton Partnership hosted the annual Learning Event at Molineux Stadium with excellent attendance and participation by partner agencies. Guest speakers attended to discuss learning from recent CSPRs, SARs and DHRs and topics including cumulative harmand trauma, and neglect and self-neglect.

Feedback from the event is always positive and highlights the benefits of the learning and networking.

The partnership also coordinated the annual 'Safeguarding Week' campaign in November 2024 which saw representatives from partner agencies come together to deliver the message that 'Safeguarding is everyone's business' and 'Everybody has the right to feel safe'. Activities during the week included public engagement sessions and online learning, along with a social media campaign.

Conclusion and Next Steps

This report has demonstrated the significant work undertaken by the partnership during 2024 to 2025. It is driven by the passion and dedication of all partners. The partnership has undertaken a number of independent scrutiny activities to provide assurance of the safeguarding arrangements and has continued to make improvements in response to findings and emerging safeguarding issues.

These are key questions to ask to evaluate the effectiveness of multi-agency safeguarding arrangements:

How effective are the multi-agency safeguarding arrangements in getting a clear line of sight on single agency and multi-agency safeguarding practice?

WST has a thorough and clear multi-agency framework and system which operates across the year for sampling and checking out how well practice is being managed to keep children and vulnerable adults safe and for evaluating the effectiveness of that practice. This focuses on the interconnections and joint working between services and the effectiveness of the communication and relationships between the services and the staff involved always keeping the needs of the child, adult and family at the forefront.

Partnerships with statutory agencies, businesses and the private sector appeared consistently strong, with one partner commenting that 'Wolverhampton is a blueprint for how good partnership working should be done.' The 'maturity' of partnerships was frequently referenced. (LGA Peer Challenge 2024)

Do the arrangements support the staff to do their best and to have space for reflection and learning from practice?

There are both multi-agency and single agency processes in place to support staff and to encourage reflection. Learning from practice is a major focus of activity with many examples of WST providing training and information as soon as possible with 7-minute briefings, workshops and a whole Partnership conference once a year.

"The training was excellent. It was thorough and exceptionally informative, and jam packed. The trainer, as always, was marvellous. I really enjoy how she delivers training."
(WST Training attendee)

How do the arrangements have a positive impact on the lives of children, adults and families as well as multi-agency working and front-line practice?

I have been provided with comments from children, families and adults about the positive and life-changing impact which the WST services have had on them.

"A big thanks because at one point in my life, they really did save me."
(Young Person Power 2 Trauma Informed Team)

"I'm very confident with the family plan. I refused the help before, but now we have a family plan in place I know what support my family are willing to offer."
(Parent)

The multi-agency safeguarding arrangements (MASA) are clear and show a high commitment to getting it right for all those involved in supporting children, families and adults.

Next Steps / Recommendations

The partnership has identified the priorities for 2024 onwards and should consider the areas for development identified in this report.

1. Continue to develop and evidence how Equalities, Diversity and Inclusion (EDI) are overarching features of the work of WST.
2. To continue trying to ensure that experts by experience have a greater role in influencing and developing the work of the priority groups and the wider partnership. The Scrutiny arrangements need to ensure that ensuring that the voices of children and families is considered as part of scrutiny.
3. Progress National Social Care Reforms and Families First for Children with the full collaboration of WST stakeholders
4. Continue with Statutory Responsibilities in relation to Statutory Reviews. Explore innovative methods when completing reviews (in line with Statutory Guidance), continue to share learning and best practice.
5. Continue progress in implementing the new regional Lead Safeguarding Partners (LSP) arrangements whilst ensuring that there is continuity in the focusing on the dedicated work of WST.

Challenges for 2025 to 2026

- It is early days in terms of evaluating the Priority Groups' impact. This has just started though, and all of the groups have clear plans in place and have made progress on the issues for each group.
- There are gaps in the WST data available from all agencies but there are plans and opportunities to improve this.
- Some partners are particularly the ICB are undergoing significant organisational change, and this may have implications for WST.

Partner Statements

The statements from partner agencies of WST provide summaries of the ways in which agencies have fulfilled their safeguarding responsibilities during 2024-2025 to safeguard and protect Wolverhampton's most vulnerable citizens.

This section outlines the principal activities, accomplishments, and challenges experienced by Wolverhampton's safeguarding partners during the period 2024-25. The focus remains on the safeguarding of vulnerable children, young people, and adults.

Children's Services (City of Wolverhampton Council)

- Enhanced collaborative working and formally recognised education as a statutory partner.
- Children's Services focused on implementing National Social Care Reforms, strengthening partnerships, rolling out new youth services, and increasing staff roles in domestic abuse and substance misuse topics. Trauma-Informed Supervision and tackling neglect remain priorities.
- Challenges include rising SEND needs, costs for vulnerable children, and securing stable accommodation for children in care.

Adult Services (City of Wolverhampton Council)

- Implemented new safeguarding tools and guidance within MASH, including the appointment of an independent Domestic Abuse Officer.
- Established training sessions and safeguarding reflection groups to improve professional practice.
- Adopted a quality assurance framework and trauma-informed methodologies.
- Challenges: Managing higher referral volumes, enhancing regional provider ratings, and refining safeguarding protocols.

NHS Black Country Integrated Care Board (ICB)

- Extended Prevent training and policy initiatives to mitigate risks of radicalisation.
- Developed comprehensive safeguarding frameworks, supervision systems, exploitation responses, and improved information sharing with primary care and general practitioners.
- Achieved significant compliance in safeguarding training (over 90%), and launched new support for children in care and neurodiversity pathways.
- The IRIS programme for domestic abuse identification is being expanded; GP engagement in child protection conferences has significantly increased.

West Midlands Police

- Exhibited robust leadership and partnership in child protection, evidenced by positive inspection outcomes.
- Prioritised interventions addressing domestic abuse, child exploitation, and missing persons through multi-agency collaboration, dedicated teams, and proactive measures.
- Challenges: Limited criminal justice resources and the necessity for greater consistency in processes and data management.

Education (City of Wolverhampton Council)

- Strengthened multi-agency engagement and safeguarding training for education professionals.
- Actively participated in partnership campaigns addressing neglect and harmful sexual behaviours.
- Challenges: Continued difficulties in effective inter-agency information sharing.

Probation Service

- Focus on public protection, reducing re-offending, and continuous improvement through mandatory training, quality frameworks, and partnership representation.
- Advanced safeguarding and domestic abuse protocols, staff development, and performance monitoring.
- Challenges: Adapting to evolving government sentencing policies and persisting resource constraints.

Black Country Healthcare NHS Foundation Trust

- Transitional Safeguarding services are now operational, aiding young people moving from children to adult mental health services.
- The Trust emphasises trauma-informed care, cumulative harm awareness, and robust safeguarding training, with plans for further development in these areas.
- Complex cases panels are being established for high-risk, multifaceted cases, and there is active participation in multi-agency safeguarding efforts.

The Royal Wolverhampton NHS Trust

- Adopted a “think family” approach by integrating adult, children, and maternity safeguarding teams.
- Expanded specialist safeguarding support for general practitioners and improved participation in practice conferences.
- Extended the PCN Safeguarding Lead role in recognition of its effectiveness.

West Midlands Ambulance Service

- Continuing to manage increased demand both in Safeguarding and across the Trust.
- Maintaining strong relationships with external agencies.
- The Safeguarding team’s new web has site has been launched and positive feedback has been received from various staff members across the Trust.
- Challenges: Implement a new Safeguarding Supervision Framework across all staff and levels of safeguarding training.

West Midlands Fire Service

- Achieved high completion rates in safeguarding training (over 94%).
- Focused professional development on neglect, hoarding, and trauma, supported by an enhanced quality assurance process.
- Challenges: Improving feedback mechanisms for safeguarding referrals.

Wolverhampton Homes

- Maintained stable numbers in temporary accommodation and elevated property standards.
- Continued efforts to strengthen multi-agency collaboration and information sharing.
- Challenges: Securing suitable property availability and reducing durations in temporary accommodation.

Healthwatch

- Increased public awareness and engagement in safeguarding, with ongoing oversight despite system changes and resource challenges.

Voluntary, Community, Social Enterprise & Faith (VCSEF) Sector

- Active contributions to safeguarding policy development, staff training, and community engagement, with emphasis on up-to-date knowledge and collaboration.

Overall Themes & Challenges

- Strengthening multi-agency partnership working, information sharing, and trauma-informed practice is central.
- Key challenges include rising demand, resource pressures, cross-agency communication, and the integration of learning from reviews into frontline practice.

In summary, Wolverhampton's safeguarding partnership has made demonstrable progress in enhancing collaboration, training, and response to emerging risks. Nevertheless, challenges persist regarding capacity, information sharing, and meeting the increasing needs of vulnerable individuals within the community.

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