



WOLVERHAMPTON SAFEGUARDING TOGETHER PARTNERSHIP

Annual Report 2025 – 2026



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
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Out of hours	01902 552999
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For safeguarding concerns about adults (over 18 yrs):

Monday to Thursday, 8:30am - 5pm - Fridays, 4:30pm	01902 551199
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Out of hours	01902 552999
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There is also helpful information on the Wolverhampton Safeguarding Together Partnership website.

Go to: www.wolverhamptonsafeguarding.org.uk

In an emergency always call 999

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Executive Summary

This annual report summarises the work of Wolverhampton Safeguarding Together Partnership during 2025 – 2026 and provides assurance on the effectiveness of multi-agency safeguarding arrangements for children, young people and adults with care and support needs. It highlights progress against the Strategic Plan 2024 – 2027, the contribution of statutory and wider partners, learning from scrutiny and reviews, and the continuing commitment to improving outcomes for people in Wolverhampton.

The report shows that WST has maintained strong partnership governance, continued to develop its priority groups, strengthened scrutiny and quality assurance activity, and responded to key national reforms including Families First for Children, Working Together guidance and adult social care assurance. Key areas of progress include trauma-informed practice, neglect and self-neglect, transitional safeguarding, child sexual abuse, learning from statutory reviews, safeguarding training and partnership engagement.

The partnership also recognises continuing challenges, including organisational change, the need to strengthen the voice of children, adults and families, further development of data and information-sharing systems, and continued assurance that learning is embedded in practice. The recommendations and next steps set out in this report provide a clear direction for 2026 – 2027.



Foreword

Welcome to the annual report covering the activity of Wolverhampton Safeguarding Together Partnership (WST) between April 2025 to March 2026.

From April 2024 to March 2026, Alison Hinds, Director of Children's Services, served as Chair, continuing to provide leadership across the partnership and strengthening arrangements to safeguard children, young people and adults with care and support needs.

From Chair of Wolverhampton's Safeguarding Together Partnership

We are pleased to present Wolverhampton Safeguarding Together Partnership's Annual Report covering from 1st April 2025 to 31st March 2026. 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 daily. It is their commitment, dedication, and care that enables the partnership to translate its strategic priorities into operational practice to keep the residents of Wolverhampton safe.

As Delegated 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 2026 guidance for safeguarding children and young people. In January 2026, Wolverhampton Safeguarding Together Partnership published its revised Strategic Plan 2024 – 2027 setting out its shared vision and strategic safeguarding priorities.

Alison Hinds
Executive Director of Families
WST Executive Chair 2024-2026

Section 1: Independent Scrutineer's Overview

This annual report covers the activity and effectiveness of the Wolverhampton Safeguarding Together Partnership (WST) between 2025 and 2026.

It evaluates the effectiveness of the arrangements to safeguard 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.

From the evidence provided, WST has 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 the commitment which all the partners have shown in contributing to this report.

WST and each of the statutory partners have ensured that data is collected to show what the impact is of the local safeguarding activity. In Wolverhampton, there is high safeguarding demand with cases of high complexity and overlapping vulnerabilities which require consistent multiagency responses to achieve the best possible outcomes.

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, young people and adults with care and support needs safe.

WST has fully implemented the governance arrangements required by Working Together to Safeguard Children 2023, including arrangements for independent scrutiny. The three statutory safeguarding partners for a local authority area are the Local Authority, Integrated Care Board and Police. The Care Act 2014 established Safeguarding Adults Boards in each local authority area and confirmed the same three statutory safeguarding partners.

The review of the work of WST during 2025 – 2026 to inform the Annual Report has evidenced that it is meeting the requirements of Working Together 2023 and the Care Act 2014 by working effectively to maintain, strengthen and develop the safeguarding arrangements for children 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 shown a strong commitment to scrutiny and independent audit, commissioning independent experts to identify learning and inform partnership development. These arrangements are reviewed regularly to ensure they remain effective. To strengthen independence and reduce reliance on a single scrutineer, WST uses a range of Independent Scrutineers. This model is distinctive and is viewed locally as effective, offering access to broader expertise, supporting consistent independence and enabling WST to plan scrutiny activity across the year by matching each task to appropriately skilled and experienced individuals.

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 – 2027 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 adults with care and support needs who have received services as well as practitioners, through a range of activities including audits and consultation with representative organisations.

This report outlines the Partnerships progress during the second year of the 2024 – 2027 Strategic Plan and considers the extent to which the agreed priorities have been delivered.

Evaluation of Progress since 2024 – 2025

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

1. Continue to develop and evidence how Equalities, Diversity and Inclusion (EDI) are overarching features of the work of WST.

A Task and Finish Group was established to oversee the partnership response to the national report It's Silent: Race, Racism and Safeguarding Children. The group has developed and monitored an action plan focused on strengthening the consideration of race, racism, culture and intersectionality within safeguarding practice, reviews and decision-making across the children's and adults' workforce.

Laurelle Brown Training and Consultancy has been commissioned by Wolverhampton Safeguarding Together Partnership to lead the development of an Anti-Racist and Equity-Informed Safeguarding Pledge and wider "Stronger Together" programme. Her work includes delivering a launch event, designing and analysing practitioner engagement and

surveys, facilitating co-production sessions with practitioners and senior leaders, incorporating young people's views, developing the partnership pledge and providing consultancy support to embed the learning into governance, accountability and safeguarding practice.

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 the voices of children and families are considered as part of scrutiny.

The partnership remains committed to strengthening the involvement of people with lived experience in shaping and influencing the work of the priority groups and the wider safeguarding agenda. The partnership recognise the significant value that the lived experiences of children, young people and adults with care and support needs. bring to informing our priorities, decision-making, and service improvement.

While the partnership continue to work towards achieving greater and more meaningful participation, they acknowledge that this is a complex and ongoing challenge. Engaging a diverse range of voices in a consistent, representative, and sustainable way requires careful planning, resources, and appropriate methods of involvement.

A recent example of this approach can be seen through the Hoarding Improvement Programme, where the partnership has sought to incorporate the views and experiences of people with lived experience of hoarding to inform service development, professional practice and partnership responses. This work has highlighted both the value and the challenges of ensuring that the voices of those directly affected are heard and translated into meaningful improvements.

Despite these challenges, the partnership is committed to identifying and developing opportunities to strengthen participation and ensure that the voices of children, young people and adults with care and support needs are embedded within scrutiny processes and considered as a key part of evaluating the effectiveness of safeguarding practice and partnership activity.

3. Progress National Social Care Reforms and Families First for Children Programme (FFCP) with the full collaboration of WST stakeholders.

There has been significant progress on implementing the Social Care Reforms and FFCP. All the partners have collaborated to develop effective new arrangements. The Multi-agency Child Protection Team (MACPT) is well established, and it has a wide range of partners involved. Education continues to be represented at all levels of the partnership.

As a first wave pathfinder local authority, it is at the forefront of national reforms of children's social care, implementing and testing the Families First for Children model. (Ofsted Inspection 2026).

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.

The partnership has continued to fulfil its statutory responsibilities in relation to Child Safeguarding Practice Reviews (CSPRs), and Safeguarding Adult Reviews (SARs), ensuring that all cases are considered in line with national requirements and local governance arrangements. Recent reviews have continued to identify opportunities for learning and service improvement, with findings shared across the partnership to strengthen safeguarding practice and improve outcomes for children and young people, and adults with care and support needs.

In June 2025, the Child Safeguarding Practice Review Panel published updated guidance for safeguarding partners, reinforcing the importance of timely decision-making, meaningful involvement of children, families and practitioners, consideration of intersectionality and children's lived experiences, and the use of reviews as a mechanism for system learning and improvement rather than individual blame.

In response, the partnership has reviewed and strengthened its CSPR processes to ensure they remain aligned with national expectations. This includes enhanced oversight of Rapid Review decision-making, greater emphasis on capturing the voice and lived experience of children and families throughout the review process, improved practitioner engagement, and a stronger focus on understanding systemic factors that contribute to harm. The partnership has also continued to explore proportionate and innovative review methodologies, where appropriate, to maximise learning and support meaningful practice improvement.

Learning from local and national CSPRs and SARs continues to be disseminated through multi-agency briefings, newsletters, and partnership training.

The partnership remains committed to further developing its review processes, promoting a culture of continuous learning, and ensuring that lessons identified through reviews lead to sustainable improvements in safeguarding practice and better outcomes for children, young people and adults with care and support needs.



5. Continue to progress the implementation of the new Local Strategic Partnership arrangements, while maintaining a clear focus on WST's dedicated safeguarding work.

The required changes to strategic safeguarding arrangements have been managed and implemented in line with national expectations. The first annual regional Lead Safeguarding Partners meeting took place in October 2025.

The Black Country Delegated Safeguarding Partners (DSP) will meet three times a year, with the first meeting held in September 2025.

WST continues to strengthen education's role within safeguarding arrangements. The Strategic Education Lead for FFCP attends Executive Group meetings, in an advisory capacity, as well as Priority Group meetings. The Education Safeguarding Provider Group also continues to develop, with members representing the education sector at Priority Group meetings.

Section 2: The Partnership

The Partnership has statutory responsibility for both children's and adults' safeguarding in the Wolverhampton Local Authority area. It 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.

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

In accordance with the requirements of Working Together 2023, the partnership has worked collaboratively with other local partnerships to develop new regional Lead Safeguarding Partners (LSP) arrangements.

The WST Memorandum of Understanding was reviewed, updated and endorsed by LSPs and DSPs; the Multi-agency Safeguarding Arrangements (MASA) were signed off and published; and the WST Quality Assurance Framework was reviewed and approved.

The Escalation Policy has been reviewed and updated. It includes a provision that WST would commission an independent person to review a dispute if this was not resolved following the Escalation Policy procedures. There has been positive feedback from partner agencies about the effectiveness and ease of use of the system.

Education continues to play an important role within Wolverhampton Safeguarding Together Partnership arrangements. The Strategic Education Lead continues to represent and strengthen the voice of education in the partnership, while education practitioners from all settings are represented at WST priority groups.

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 which 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 responsible for developing key elements of multi-agency work and, where required, task and finish groups to respond to emerging issues.

The business support arrangements for WST have been further developed during 2025 – 2026. The learning development post has been increased to full-time to provide continuity on learning and development, while also encompassing communications and engagement of people with lived experience.

The Senior Analyst appointed by WST in 2025 has been leading on the development of the Quality Assurance and Data dashboards to inform the work of the Priority Groups, Scrutiny and Assurance Co-ordination Group and the Executive Group.

Additional scrutiny is provided through externally commissioned activities undertaken by independent experts who can provide challenge about current systems and processes and make recommendations for further action.

This work is also informed by the experiences of children, young people and adults with care and support needs 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, young people and adults with care and support needs are central, and there is commitment to progress this.

Financial Arrangements

Financial contributions – Wolverhampton (Joint Children & Adults budget):

- **West Midlands Police:** £33,398 (Children £16,644 / Adults £16,754)
- **Integrated Care Board:** £80,154
- **Local Authority:** £154,100

The table below summarises expenditure for this period, excluding staffing costs.

2025-2026	
Independent Scrutiny & Statutory Reviews	£51,655
Training	£7,094
Computer Licenses, Regional Agreements, Website, Room Hire & Campaigns	£10,249

Section 3: Strategic Plan 2024 – 2027

The 2024 – 2027 Strategic Plan sets out the Executive Group's strategic vision, ambition, purpose, principles and safeguarding priorities. Following reflection on progress over the previous two years, the partnership agreed to continue its existing priorities for a further year and introduce a new priority focused on Child Sexual Abuse. This was developed in response to the National Panel's briefing on child sexual abuse and learning from a local mock Joint Targeted Area Inspection.

Priority Groups

- Cumulative Harm & Trauma
- Neglect / Self-Neglect
- Transitional Safeguarding
- Child Sexual Abuse

The partnership drives best collaborative practice for good outcomes for families, children and adults and this is reflected in the strategic plan which:

- 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 with care and support needs.
- 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 priorities for 2024 – 2027 have been agreed in response to national requirements, regional developments, and local need. They have taken account of the outcomes from the annual event in November 2025 as well as learning from Child Safeguarding Practice Reviews and Safeguarding Adult Reviews.

The work of the Priority Groups is monitored have been monitored through the scrutiny and challenge of the Executive Group. This plan and the work of Wolverhampton Safeguarding Together Partnership is further monitored by the Scrutiny and Assurance Co-ordination Group.

The work of Wolverhampton Safeguarding Together Partnership 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.



Section 4: Quality Assurance and Independent Scrutiny

Independent Scrutiny

Embedding Learning from Statutory Reviews

Wolverhampton Safeguarding Together Partnership commissioned an Independent Scrutineer to undertake an independent review of how learning from statutory safeguarding reviews has been implemented, embedded and sustained across the partnership. The review provided an objective, evidence-informed assessment of the partnership's approach to learning and continuous improvement, with a focus on whether lessons from reviews are translating into practice and improving safeguarding outcomes.

The scrutiny activity used a triangulated methodology, drawing on document analysis, a partnership-wide staff survey and reflective practitioner forums to gather evidence from across the safeguarding system. This approach enabled the review to consider both organisational processes and the experiences of frontline practitioners, identifying strengths in partnership working, multi-agency relationships and information sharing, while also highlighting challenges relating to workforce capacity, engagement and system pressures.

The findings were presented to partnership governance groups, including the One Panel, Scrutiny and Assurance Co-ordination Group and Executive Group. The review concluded that existing systems support learning from reviews, whilst identifying opportunities to strengthen how the partnership evidence impact

and tests whether learning has been embedded in practice. In response, Wolverhampton Safeguarding Together Partnership committed to further assurance activity, including a Partnership Assurance Event, to gather evidence of impact, celebrate areas of strength and identify further improvement opportunities.

This independent scrutiny has provided valuable external challenge and assurance to the partnership, supporting its commitment to learning, accountability and the continual improvement of safeguarding practice across Wolverhampton.

Annual Report

The Annual Report has been completed by an Independent Scrutineer with significant experience in multi-agency safeguarding and strategic leadership. This provides appropriate independent challenge and assurance on the partnership's work during the reporting period.

Quality Assurance Activity

Multi-Agency Response to Neglect Audit (Children's)

A multi-agency audit of neglect cases was undertaken in June 2025 to provide assurance regarding the effectiveness of safeguarding responses to children experiencing neglect in Wolverhampton. The findings highlight committed practice by individual agencies but identify recurring issues in multi-agency coordination and information sharing.

The audit found examples of strong practitioner commitment and child-focused practice across agencies. Positive features included timely safeguarding responses to identified risks, effective capture of the child's voice, good direct work with children and families, use of interpreters where required, and evidence of practitioners adopting a Think Family approach. Schools were frequently recognised for providing extensive practical and emotional support, maintaining trusted relationships with children and families, and advocating for their needs. There was also evidence of good partnership working in strategy discussions, prompt referrals, thorough assessments, and effective support in response to domestic abuse, mental health, housing, and health-related concerns.

The audit reinforced the need for strengthened multi-agency information sharing, improved holistic assessment and professional curiosity, greater application of the Think Family approach, and more effective communication and handover arrangements at case closure. Partnership actions will focus on addressing these themes through policy development, training, improved systems and strengthened multi-agency practice.

Child Sexual Abuse in the Family Environment – Mock JTAI Audit

In March 2026, Wolverhampton Safeguarding Together Partnership undertook a multi-agency mock Joint Targeted Area Inspection (JTAI) to test partnership readiness for an inspection focused on child sexual abuse in the family environment. The audit provided assurance that children were safeguarded effectively, risks were reduced promptly, and agencies worked collaboratively to protect and support children and families.

The audit found significant strengths across the partnership. In all cases, safeguarding concerns were recognised and responded to appropriately, with timely decision-making, effective risk management and strong multi-agency coordination. Children and young people were consistently listened to, with their voices clearly reflected throughout assessments, planning and intervention. Professionals demonstrated trauma-informed and relationship-based practice, ensuring children were not required to repeatedly recount their experiences and were supported to disclose at their own pace.

Schools demonstrated particularly strong professional curiosity and played a key role in identifying concerns, responding swiftly to disclosures and providing ongoing pastoral and practical support. Direct work with children was of a high standard, including the use of creative approaches such as body mapping, trusted adult work and emotional wellbeing interventions. Specialist support services including Children and Young People's Independent Sexual Violence Advisor (ChISVA) provision and Sexual Assault Referral Centre (SARC) referrals were utilised effectively in several cases, providing tailored support to children and their families.

The audit identified recurring challenges in information sharing with health partners, particularly primary care, with GPs often not routinely informed of safeguarding interventions or involved in multi-agency processes. Further improvement is also needed to increase practitioner understanding of SARC pathways, and ensure children consistently access appropriate therapeutic support following abuse. Partnership actions will focus on addressing these themes through policy development, training, improved systems and strengthened multi-agency practice.

Inappropriate Referrals Dip Sample – Adults

A dip sample audit of 10 recent referrals to the Adult Multi-agency Safeguarding Hub (MASH) was undertaken to assess the appropriateness of safeguarding referrals, decision-making, and adherence to safeguarding processes. All were found to be inappropriate safeguarding referrals to the Adult MASH.

The audit identified several strengths including appropriate decision-making by MASH staff, effective signposting to relevant services, and generally clear documentation of decisions and rationale. Areas for improvement included the lack of routine feedback to referring agencies such, inappropriate use of referral forms by some professionals, and inconsistent recording of decisions with reference to legal frameworks and statutory duties. Recommendations focused on strengthening feedback mechanisms, providing multi-agency training on safeguarding referral thresholds and pathways, and improving the recording of decision-making to enhance transparency and accountability.

Section 11 and Care Act Audit

The 2025 Section 11 and Care Act Audit achieved a 100% response rate from partner agencies and provides assurance that organisations across Wolverhampton are meeting their safeguarding responsibilities for children, young people and adults with care and support needs. The findings demonstrate strong safeguarding arrangements across all agencies, with well-established leadership, governance, workforce development, safer recruitment processes, information-sharing arrangements, and a clear commitment to multi-agency working.

Partners evidenced robust safeguarding infrastructures, effective quality assurance activity, strong policy frameworks, and a culture of continuous learning. The audit also highlighted positive practice in capturing the voice of children, young people and adults with care and support needs, with many agencies demonstrating meaningful engagement and co-production approaches.

While most areas were rated as Good or Outstanding, the audit identified several common challenges, particularly around workforce capacity, increasing safeguarding demand, participation in multi-agency activity, and the development of quality assurance frameworks within some organisations. Importantly, agencies were able to identify these areas for development and have established actions and improvement plans to address them.

Overall, the audit provides assurance that agencies are fulfilling their statutory safeguarding duties and demonstrates a proactive, reflective partnership committed to continuous improvement and strengthening safeguarding outcomes for children, young people and adults with care and support needs across Wolverhampton.

Section 175 / 157 Audit

Wolverhampton Safeguarding Together Partnership completed its 2025 Section 175/157 Safeguarding Audit to provide assurance that education settings are meeting their statutory safeguarding responsibilities and embedding effective safeguarding practice. A total of 108 settings participated, representing an increase in engagement compared to the previous audit, with only three settings not responding.

The findings demonstrate a strong level of compliance across Wolverhampton's education sector. All responding settings reported having key safeguarding roles in place, up-to-date safeguarding, Prevent, attendance, safer recruitment, and staff conduct policies, alongside comprehensive safeguarding training arrangements.

The audit also highlighted strengths in online safety, safeguarding recording systems, and the growing adoption of trauma-informed approaches. A quality assurance dip sample of ten settings provided further assurance that safeguarding arrangements were robust and aligned with statutory requirements.

The audit identified areas for ongoing development, including ensuring all settings incorporate self-harm and suicide considerations within safeguarding policies, strengthening arrangements for children affected by suspensions and exclusions, increasing uptake of trauma-informed practice, and promoting consistent lockdown procedures. Overall, the audit confirms that education settings across Wolverhampton continue to demonstrate a strong commitment to safeguarding children and young people.



Section 5: Key Achievements of WST Priority Groups

This is the second reporting year of the 2024 – 2027 Strategic Plan and therefore this report focuses on the activity and progress within the second 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 residents in Wolverhampton. Meetings have been held regularly with consistent attendance and valuable contributions from partner agencies.

All Priority Groups continue to make an impact on practice, and this comes from the commitment and connection of their chairs and all the participants.

Cumulative Harm and Trauma

The priority group has worked with Barnardo's Trauma Informed Practice Central Team, commissioned by the West Midlands Violence Reduction Partnership, to support transformation in how trauma is understood and addressed across services, communities and leadership structures.

Key Achievements:

- Established a Wolverhampton-based trainer cohort to deliver trauma-informed CPD.
- Delivered trauma-informed workshop activity for senior leaders, elected officials and strategic managers.
- Delivered a Secondary Trauma session for decision makers and professionals.
- Developed a Trauma Informed Progress & Assurance Tool with supporting workshops and a how-to guide.
- Ensured Cumulative Harm and Trauma is considered throughout all audit activity.

Next Steps:

- Continue to deliver Trauma Informed Practice training across the partnership.
- Continue to ensure there is a focus on Cumulative Harm and Trauma throughout all audit activity.
- Use the Trauma Informed Progress and Assurance Tool to seek assurance from agencies on how trauma-informed practice and systems are being embedded and to support ongoing development.
- Review the Priority Group's impact and ensure all workplan objectives are achieved.

Neglect and Self-Neglect

The priority group is progressing work to strengthen multi-agency identification, assessment and response to neglect, self-neglect, hoarding and complex neglect.

Key Achievements:

- WeCAN Screening Tool developed for submission alongside Electronic Multi-agency Referral Form (eMARF) and Early Support Plans.
- WeCAN Assessment Tool and the Advance Practitioners Neglect Tool reviewed and amalgamated into a more user-friendly assessment tool.
- Children's Neglect Strategy reviewed and updated.
- Adults Neglect Strategy developed and endorsed.
- Complex Neglect and Self-Neglect training continue to be commissioned and delivered with positive feedback.
- WST commissioned Ian Porter, Psychologist at Hoarders Helping Hoarders, to lead the Hoarding Improvement Programme, which included a multi-agency launch event, training, and co-facilitator workshops along with the development of a hoarding practice guide for frontline practitioners.
- People with lived experience have informed all aspects of the Hoarding Improvement Programme.

Next Steps:

- Continue to promote and encourage the use of both children and adults neglect strategies.
- Launch the WeCAN Screening Tool and Assessment Tool.
- Develop and implement peer support sessions for those who exhibit hoarding behaviour.
- Finalise and publish the hoarding practice guide.
- Develop a Self-Neglect Assessment Tool for practitioners.
- Review the Priority Group's impact and ensure all workplan objectives are achieved.

Transitional Safeguarding

The partnership is participating in a 12-month national Test and Learn programme focused on strengthening transitional safeguarding using a Human Learning Systems approach. The work aims to improve outcomes for young people and young adults moving between children's and adults' systems.

Key Achievements:

- Dez Holmes from Research in Practice delivered a partnership workshop to help the Priority Group identify and focus on key areas of need – Exploitation and Homelessness.

- Following the partnership workshop, we were invited to participate in a Human Learning Systems project led by Research in Practice and Resonant Collaboration.

Next Steps:

- Continue to work with Research in Practice and Resonant Collaboration to further progress the work of the priority group following the Human Learning Systems approach.
- Undertake audits to identify strengths and any areas for improvement.
- Ensure the voice of people with lived experience is present throughout our work.
- Adapt practice and systems based on learning identified.
- Share and embed learning locally.
- Review the Priority Group's impact and ensure all workplan objectives are achieved.

Child Sexual Abuse

The Child Sexual Abuse (CSA) priority group has been established to strengthen partnership focus, governance and strategic response to child sexual abuse.

Key Achievements:

- Terms of reference and membership reviewed and endorsed.
- Workplan developed and endorsed.
- Task and Finish Group convened to develop a CSA Strategy.
- The Centre of Expertise on Child Sexual Abuse has rolled out a Response Pathway across the West Midlands which Wolverhampton has adopted and promoted locally.
- The partnership continually promotes The Centre of Expertise on Child Sexual Abuse resources and webinars.
- The partnership conducted a mock JTAI audit focusing on Child Sexual Abuse within the family environment (see page 16).

Next Steps:

- Finalise and publish the CSA Strategy
- Develop a multi-agency data dashboard to support in understanding the local need.
- Develop a multi-agency training package to upskill the workforce in identifying and responding to CSA.

Section 6: Learning from 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.

The One Panel works within a 'Think Family' framework, recognising the family as a system. When supporting one family member, the needs of others should also be considered and explored so that the wider family context is understood and addressed. This approach is reflected in all reviews.

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.

Child: Oscar (5)

In early 2025, five-year-old Oscar was left with his Godparents while his mother and her partner went shopping. They returned late in the evening intoxicated, with blood on their bodies and clothing, following an earlier incident captured on CCTV in which Mum's partner assaulted her outside a pub.

A further altercation took place at the Godparents' home, during which Oscar's Godfather was assaulted. Mum and her partner then left, leaving Oscar with his Godparents while his Godfather remained unconscious.

Paramedics later attended and found Oscar beside his deceased Godfather, with blood on his clothing. It is unclear how much Oscar witnessed.

Oscar and his family had been known to agencies since infancy, with concerns including neglect, emotional abuse, domestic abuse, parental mental health difficulties, and alcohol and substance misuse.

The Learning Lessons Briefing and learning identified can be [read here](#).

Child: Kymani (17)

Kymani was 17 when he was arrested and charged with a serious violent offence following the death of a teenager in a public place in Wolverhampton.

He had lived in Wolverhampton with his family since 2020 and was known to several agencies. Kymani had also been a victim of serious knife crime. Agencies were working to reduce risks to him, his involvement in anti-social and criminal activity, and the risk he posed to others. He was not in education, employment or training and had been permanently excluded from school due to persistent disruptive behaviour.

The Learning Lessons Briefing and learning identified can be [read here](#).

Adults

The Care Act 2014 states that a Safeguarding Adult Review (SAR) should be undertaken when an adult in its area dies because 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 2025 – March 2026) there has been one rapid review held.

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.

Adult: Patrick (50)

Patrick was a 50-year-old man who lived with his wife and brother-in-law. He had a diagnosis of schizophrenia, a learning disability, and a hearing impairment. Patrick received support from a range of health and social care services, including community mental health, primary care, district nursing, and adult social care. He was found deceased at home in April 2024.

The review identified significant concerns relating to self-neglect, neglect, and potential hoarding behaviours. Professionals repeatedly observed poor personal hygiene, deteriorating physical health, untreated leg ulcers, unsanitary living conditions, and a home environment affected by mould, clutter, and strong odours. Despite these concerns, opportunities were missed to fully explore Patrick's circumstances, assess his mental capacity, apply professional curiosity, and coordinate a multi-agency response.

The Learning Lessons Briefing and learning identified can be [read here](#).

Adult: Helen (18)

Helen sadly passed away at the age of 18 as a result of liver failure, hepatic necrosis and paracetamol toxicity.

Helen and her father had left the family home due to concerns relating to domestic abuse between Helen's father and mother, which resulted in them being homeless and staying with family and friends. Helen's father returned to the family home, however, Helen did not, and at the time of her death she was residing in temporary accommodation.

Concerns were raised around Helen's general vulnerability due to her poor mental health and ability to live independently. The review looked into agencies' involvement with Helen in the 14-month period leading up to her death, during which her situation became increasingly complex, marked by a transition from child to adult mental health services, escalating mental health crises, and significant housing instability.

The review concludes that Helen's life journey reflects both her resilience and the dedication of professionals who supported her through complex challenges, including mental health needs, emerging physical health conditions, housing instability, and family conflict. There were notable examples of good practice, but also opportunities to strengthen transition planning, embed trauma-informed approaches, and enhance holistic care coordination to ensure consistent, joined-up support.

The Safeguarding Adult Review and learning identified can be [read here](#).

Adult: Joshua (19)

Joshua was 19 and had autism, learning difficulties, epilepsy and complex health needs requiring specialist care.

He lived with his family, although household arrangements were unclear due to complex family dynamics, including alcohol misuse and domestic abuse. Reliant on others to attend appointments, Joshua missed health reviews and did not receive the specialist support he needed.

He attended a special school between 2015 and 2021 but remained at home during the Covid-19 pandemic; no safeguarding concerns were noted, although he had significant absences linked to the family's frequent travel as members of the travelling community.

He was found unresponsive at home and later died in hospital from sudden death in epilepsy. The coroner noted reduced Epilim levels, suggesting his epilepsy may not have been well managed.

The Safeguarding Adult Review and learning identified can be [read here](#).

Adult: Hope (29)

Hope was 29 when she died in January 2024 from an overdose, recorded by the coroner as Venlafaxine toxicity.

She had epilepsy, a history of drug and alcohol misuse, and previous contact with agencies following concerns about the neglect of her five-year-old son.

In June 2023, she was referred to the Mental Health Liaison Service after being found outside her flat intoxicated, under the influence of drugs and with superficial cuts to her wrists. Although she had a reported history of self-harm and suicidal thoughts, she did not attend a diagnostic assessment and therefore had no formal mental health diagnosis.

The Safeguarding Adult Review and learning identified can be [read here](#).



Section 7: Safeguarding in Numbers

Children's Data

Number of children subject to a Child Protection Plan as of 31st March 2026

Year	Number of children subject to Child Protection Plan
2022 – 2023	248
2023 – 2024	228
2024 – 2025	213
2025 – 2026	157

Open Child Protection Plans by Initial Category of Abuse

Initial Category of Abuse	2025 – 2026	2024 – 2025	2023 – 2024	2022 – 2023
Neglect	80%	69%	84%	45%
Physical Abuse	2%	1%	4%	3%
Sexual Abuse	3%	1%	0%	0%
Emotional Abuse	15%	28%	13%	12%
Multiple	0%	1%	0%	40%

Open Child Protection Plans by Sex

Breakdown	2025 – 2026	2024 – 2025	2023 – 2024	2022 – 2023
Male	43%	48%	55%	51%
Female	51%	46%	41%	43%
Unknown	7%	6%	4%	6%
Indeterminate	0%	0%	0%	0%

Key changes in this year's data:
The data shows a significant reduction in the Child Protection cohort, an increase in Neglect as the initial category of abuse, and a shift in the cohort profile, with females now representing the majority.

Adult's Data

Number of Safeguarding Referrals

Measure	2025 – 2026	2024 – 2025	2023 – 2024	2022 – 2023	2021 – 2022	2020 – 2021
Individual Safeguarding Concerns	2,697	2,687	2,542	3,012	2,448	2,484
S42 Enquiries	477	360	422	766	418	425

In 2025 – 2026, 5,266 EMARFs were raised. Following screening, 2,697 individual safeguarding concerns were identified, compared with 2,687 in 2024 – 2025. This indicates a broadly stable level of safeguarding activity across the city, although 2,569 referrals, representing 49%, were identified as inappropriate.

Although overall concern volumes remained consistent, statutory safeguarding enquiries increased significantly. Section 42 enquiries rose from 360 in 2024 – 2025 to 477 in 2025 – 2026, an increase of 32.5%.

Types of Abuse

Concluded Section 42 Enquiries				
Type of Abuse	Service Provider	Other - Known to Individual	Other - Unknown to Individual	Total Section 42
Physical Abuse	40	99	8	147
Sexual Abuse	1	28	0	29
Psychological Abuse	23	152	5	180
Financial or Material Abuse	9	140	10	159
Discriminatory Abuse	0	7	1	8
Organisational Abuse	28	14	1	43
Neglect and Acts of Omission	127	73	7	207
Domestic Abuse	0	103	0	103
Sexual Exploitation	0	14	1	15
Modern Slavery	0	11	2	13
Self-Neglect	0	84	0	84

Neglect and acts of omission remained the most frequently recorded abuse type in 2025 – 2026, reflecting wider Adult MASH trends where neglect and self-neglect continue to be the most common safeguarding risks. This highlights the ongoing need for early identification, preventative work, effective care planning, and robust oversight of care and support arrangements.

Age of Individuals Involved in Section 42 Enquiries

Measure	18 – 64	65 – 74	75 – 84	85 – 94	95+	Not Known	Total
Individuals Involved in Safeguarding Concerns	1,412	316	460	439	70	0	2,697
Individuals Involved in Section 42 Safeguarding Enquiries	224	72	93	70	17	1	477

Adults aged 18 – 64 represented the largest group involved in safeguarding activity, demonstrating that safeguarding concerns affect adults across the life course and are not limited to older age groups. Older adults also accounted for a substantial proportion of activity, highlighting the need for safeguarding responses that are proportionate and tailored to different age-related needs.

Ethnicity of Individuals Involved in Section 42 Enquiries

Measure	White	Mixed / Multiple	Asian / Asian British	Black / African / Caribbean / Black British	Other Ethnic Group	Refused	Undeclared / Not Known	Total
Individuals Involved in Safeguarding Concerns	1,890	39	293	261	37	31	146	2,697
Individuals Involved in Section 42 Safeguarding Enquiries	349	18	45	31	2	2	30	477

Most individuals involved in safeguarding activity were recorded as White, with activity also recorded across Black, Asian, Mixed and Other ethnic communities. This reinforces the need to understand safeguarding experiences across Wolverhampton's diverse population, improve ethnicity data completeness, and continue work on disproportionality so services remain equitable, accessible and responsive.

Section 8: Learning Development and Training

The partnership provides a range of multi-agency safeguarding training for children's and adults' services across Wolverhampton. The training promotes shared learning across the partnership and supports the continued development of effective safeguarding practice.

The offer includes Safeguarding Lead training. Children's Safeguarding Lead training is supported by a WST training pool made up of partnership volunteers with strong safeguarding knowledge and training experience, while 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 Children'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

- Complex Neglect
- Exploitation Awareness
- Learning Lessons Briefing – Patrick
- Managing Allegations
- Multi-Agency Restorative Practice
- Professional Curiosity
- Self-Neglect
- Trauma Informed Practice Foundations
- Secondary Trauma and Impact Training for Professionals
- Trauma Informed Workshop - Trauma Informed Progress and Assurance Tool
- Hoarding - Inside Out Workshop
- Gypsy and Traveller Inclusive Services
- ICON for Practitioners
- National Centre for Domestic Violence Protective Order Training
- Empowering Everyday Decisions – Applying the Mental Capacity Act in Your Daily Role
- WST Learning Event

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

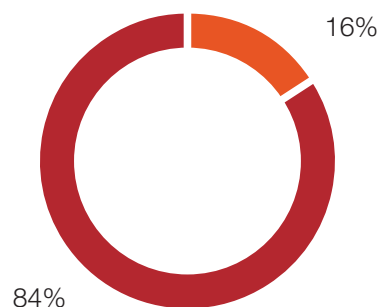
Schools continue to make up the largest proportion of training attendance, and this is attributable to the requirements for Designated Safeguarding Leads to attend children’s safeguarding lead training and bi-yearly refreshers to meet Ofsted standards.

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. They have been separated out for recording purposes this year, but it may be that some HAF providers still select their service area under Voluntary.

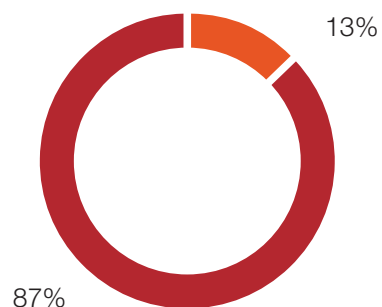
Attendance from Emergency Services, Health, Local Authority and Probation colleagues has continued to increase compared to previous years which is positive to see.

	2024 – 2025		2025 – 2026	
Service Area	Booked	Attended	Booked	Attended
Education	871	738	970	865
Emergency Services	12	9	32	26
HAF Providers	-	-	7	5
Health	150	120	200	170
Local Authority	213	180	568	474
Private Providers (not education)	79	58	70	55
Probation	5	4	11	11
Voluntary	232	196	262	228
Non Specific	4	3	0	0
Total	1,566	1,308	2,120	1,834

Overall attendance 2024 – 2025



Overall attendance 2025 – 2026



■ Attended

■ Did not attend

To maximise attendance and learning, agencies are charged a £30 non-attendance fee when delegates do not attend booked sessions or fail to cancel in line with the terms and conditions. Reasons for non-attendance are not always provided, but where known, they are most commonly linked to safeguarding issues within the setting, workload pressures or absence.

Private providers are charged £25 for a half-day course and £50 for a full-day course when they attend. Providers new to WST training are offered two free introductory sessions and are not charged for these.

Income from training charges is used to fund future training sessions and resources.

	2023 – 2024		2025 – 2026	
Partner free places issued	1,212	-	1,696	-
Introductory free places issued	45	-	22	-
Half days training fees invoiced	40	£1,000	60	£1,000
Full day training fees invoiced	16	£800	17	£800
Non-attendance fees invoiced	128	£3,840	205	£3,840
Fees waived	125	-	120	-
Total	1,566	£5,700	2,120	£8,500

Training Evaluation

All delegates 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.

Feedback from Training

'I am new to the concept of becoming a DSL and I found the case studies to be a wonderful introduction to the role. This gave me an idea of what to expect when I have to record evidence and how to use the knowledge of the thresholds of need, to support the reasons for the referral. To clarify the type of support services I am requesting for the children and families at the early intervention stages. It was helpful to train alongside the more seasoned DSLs to glean from their expertise'.

A Shared Responsibility

(Children's safeguarding lead training part 1)

'This was a really informative session. It has been a while since I have dealt with Hoarding and having this training session as a refresher will enable me to be able to deal with hoarding related issues more professionally and assist tenants and provide additional support'.

Hoarding Inside Out Workshop

For the year ahead (2026-2027), all delegates will receive a Story of Difference template where they are able to share a story of how the training has been applied in practice, impacted upon their role and person that they are working with.

'All of it, but I think my favourite was the shared lived experiences. It was so informative. I'm yet to come across professionally but I know of situations. I feel much better equipped to deal with this now'.

Hoarding Inside Out Workshop

'The discussions around disruption and realistic safety planning were very thought provoking'.

Contextual Safeguarding

'The speaker was engaging and warm which made all of the session very enjoyable. He talked about his personal experience which brought the topic to life'.

Empowering Everyday Decisions – Applying the Mental Capacity Act in Your Daily Role

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 available course and uptake are listed below:

Places Booked per eLearning Course	Q1	Q2	Q3	Q4	YTD
An Introduction to Restorative Practice	9	7	14	5	35
Basic Safeguarding Awareness	13	13	19	17	62
Brook Traffic Light Tool (funded until Dec-25)	30	46	112	-	188
Child Sexual Exploitation	7	4	16	6	33
Corporate Parenting	6	2	12	2	22
Exploitation Package	4	2	8	1	15
Domestic Abuse Awareness	8	7	11	4	15
ICON Shaking Babies eLearning	4	1	6	1	12
Intermediate Safeguarding Awareness	9	5	12	8	34
Making Safeguarding Personal	0	2	3	3	8
Mental Health, Dementia and Learning Disability	0	0	0	0	0
Missing Persons eLearning	6	1	7	2	16
Prevent ¹	-	-	-	-	-
Forced Marriage ¹	-	-	-	-	-
Female Genital Mutilation ¹	-	-	-	-	-

¹ Statistics for these courses are not available as they are provided and administered by the Home Office.

Events

In September 2025, the partnership hosted an awareness-raising stall at the University of Wolverhampton to promote the ICON initiative, which aims to prevent abusive head trauma in infants. Through engagement with both staff and students, we supported the implementation of ICON “champions” within the university, helping to ensure the initiative continues to be promoted and embedded across the setting going forward.

In November 2025, WST 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 housing and homelessness, mental capacity and cumulative harm and trauma.

As a new addition to this year's event, a marketplace enabled local organisations to promote their services and network with colleagues from across the workforce. Feedback remained positive, highlighting the value of both the learning and networking opportunities.

‘Professor Keith Brown was amazing; his style and delivery was so good and impactful. I could relate to what he was saying about his mom and the info on LPA was so insightful as now have this myself for my elderly dad.’

‘I think it will support the importance of the voice of the person you are working with to give value around the decisions that need to be made around the next steps for them. Also, it will be incorporated into my contextual approach in safeguarding.’

‘Market place was an excellent addition. enabling further conversations with agencies.’

‘Brilliant event, great to be face to face and have chance to network and talk to people outside my area’.

The partnership also coordinated their annual ‘Safeguarding Week’ campaign in November 2025 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.

In December 2025, WST held the ‘Wolverhampton: We need to talk about Hoarding’ event. This launched work to improve support for people in Wolverhampton who exhibit hoarding behaviours and was attended by people with lived experience. The event aims are listed below, with development continuing through the ongoing input and support of people with lived experience.

- Challenge (and change) the way people think about 'hoarding'
- Get a feel for some of the current systemic issues and a multi-agency perspective on the professional context of various practices/experiences
- Briefly introduce the structure, process and outcomes of a psychosocial and peer support group-based intervention
- Launch the Wolverhampton Hoarding Improvement Programme

Section 9: Summary, Conclusion and Next Steps

Wolverhampton Safeguarding Together Partnership has had another positive year in delivering its priorities and making a measurable difference to the lives of children, young people and adults with care and support needs. The achievements, impact and feedback received are set out throughout this report.

This report demonstrates the significant work undertaken by the partnership during April 2025 to March 2026. The partnership's progress has been driven by the passion, dedication and commitment of all partners, who recognise that safeguarding cannot be delivered by any single agency in isolation. Partner agencies described a positive, can-do culture and a shared commitment to working together to improve outcomes for local people.

Both the partnership and the wider local system have adopted a restorative practice approach that places strong relationships at the centre of effective practice. Agencies work collaboratively, with a shared expectation that partners will both support and appropriately challenge one another. This strengths-based approach reflects a collective belief that the best outcomes are achieved through effective partnership working.

Wolverhampton Safeguarding Together Partnership continues to create the conditions for a strong learning culture, supporting effective multi-agency practice and helping partners deliver the best possible outcomes for children, young people and adults with care and support needs. Independent scrutiny activities have provided valuable assurance and learning throughout the year, alongside external inspection activity including the Adult Social Care Care Quality Commission (CQC) Inspection in mid-2025 and the Ofsted Children's Social Care Inspection in January 2026. The partnership has continued to make improvements in response to findings, learning and emerging safeguarding issues. Once inspection findings are published, they will be considered by the Executive Group to ensure partners respond collectively, strengthen practice and further improve outcomes.

WST remains outward-looking and actively seeks support from other organisations to bring additional expertise into the partnership. It also works to maximise available funding, using resources flexibly and responsibly while identifying opportunities to secure additional funding streams.

In summary, Wolverhampton Safeguarding Together Partnership has made demonstrable progress in strengthening collaboration, embedding learning and responding to emerging risks. While challenges remain around capacity, information sharing and meeting the increasing needs of vulnerable individuals within an increasingly diverse community, the partnership remains committed to continuous improvement and delivering positive outcomes for those it serves.

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

1. 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, young people and adults with care and support needs safe, and for evaluating the effectiveness of that practice. This evaluates the effectiveness of multi-agency partnership working, including communication, coordination, and professional relationships between practitioners and services, ensuring that the needs of the child, young person and adult with care and support needs remain the primary focus throughout.

A good example of the effectiveness of safeguarding activity is the operation of the MASH. It is a prime example of partnership working. It continues to bring together professionals from various partners to jointly assess children's and adult safeguarding referrals.

There is clear evidence from all partners that this supports clear communication and timely sharing of relevant information between organisations. This positive partnership working fosters trust and formalises processes for exchanging critical information whilst respecting confidentiality and legal requirements.

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

Multi-agency and single-agency processes are in place to support staff reflection and learning. WST places a strong emphasis on learning from practice, providing timely training, Learning Lessons Briefings, workshops and an annual learning event.

3. 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?

Feedback from children, young people and adults with care and support needs highlights the positive and, in some cases, life-changing impact of WST services.

"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 demonstrate a strong shared commitment to achieving the best outcomes for children, families and adults.

Next Steps / Recommendations

The partnership reviewed progress against its priorities in 2026 and agreed to extend them for a further year.. A new priority group focusing on Child Sexual Abuse was also established in late 2025.

WST 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 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 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 2026 - 2027

Policy and practice development: maintaining momentum and pace remains a key challenge. Some Priority Groups have made a significant impact on practice development and improvement, while others are still implementing workplans. Although it is too early to fully evaluate their overall impact, there is emerging evidence of progress.

Management of change: As in the previous year, some partners, particularly the ICB, continue to experience significant organisational and staffing change, with implications for WST. Partners are working collaboratively to mitigate the impact, although this remains ongoing.

Strengthening the voice of children, young people, adults and families remains a key focus for WST: Systems are in place to gather feedback from children, young people and adults with care and support needs about their experiences of multi-agency support. This provides valuable insight for the partnership and helps ensure safeguarding responses remain person centred and informed by local lived experience.

Promoting effective use of the WST Escalation Policy: This remains an important focus for partnership working. Examples show that using the policy can positively influence practice and outcomes for children, young people and adults with care and support needs. Further work is needed to ensure professionals across agencies are confident in applying the policy appropriately and that organisations actively promote its use.

Section 10: Partner Statements

This section summarises how WST partners fulfilled their safeguarding responsibilities including the key activity, achievements and challenges reported between April 2025 and March 2026. It reflects partners' continued contribution to safeguarding Wolverhampton's most vulnerable residents, with a focus on children, young people, adults with care and support needs, and families.

Children's Social Care

Achievements and Impact

- The January 2026 Ofsted inspection of local authority children's services (ILACS) judged Wolverhampton as 'Good' overall, with services for children in care and care leavers rated 'Outstanding'.
- Embedding of Children's Social Care reforms 'Families First for Children' and strengthening of the Family Help Teams delivering an effective targeted support offer for those families that need it in Wolverhampton.
- Reduced numbers of Children in Care and Reduced number of children on a Child Protection plan.
- Closer scrutiny of the universal offer through the relaunched early support offer. This has identified areas for opportunity, i.e. focused use of the crisis resilience fund as well as areas for future development around a more coordinated approach with the family hub.
- Development and expansion of the MACPT (Multi-agency Child Protection Team) that is well governed via both a governance board and operational group that scrutinises local and partner data in the Child Protection space and oversees performance and development. The number of children on a Child Protection plan has continued to steadily decline.
- Joined up work with homeless colleagues has led to a focus on Temporary Accommodation as a vulnerability and a coordinated multi-agency support offer developed including co location of staff. This has led to increased oversight and support to families at risk of homelessness – with a report presented to Children's Scrutiny board.
- Launch of the new Child Impact Report and training of staff to improve response to private law applications.
- Discussions have started around Transitional Safeguarding arrangements with links between children's and adults.
- The Principal Social Work team have worked closely with WST around CSA and looking at how we embed recommendations from the National Panel Report.

- Trauma informed supervision template has been rolled out to the workforce in CSC and feedback so far is that this is having a positive impact for some people. Advanced Practitioners have been rolling out trauma informed practice training for agencies, and we continue to work as a multi-agency partnership to further roll out trauma informed practice.

Challenges

- Plan to strengthen quality of advice and signposting to universal and Best Start in Life hub offer through the development of an integrated families front door in 2026/27.
- Auditing of MASH 24 to be strengthened in 2026/27
- Develop more reportable data linked to WST priorities within the eclipse system as this is a current challenge.
- Strengthen our responses in respect of DARDR's and how these are fed back into practice along with learnings from CSPR's and SAR's.

Adult Social Care

Achievements and Impact

- Adult Social Care has been restructured into three new service areas, each led by a designated Head of Service: The new structure has strengthened the frontline safeguarding response by promoting timely, dignified and safety-focused support for adults at risk, with a stronger emphasis on prevention and early support. This helps ensure people receive support from the right service or team at the right time, reducing the need for crisis intervention.
 - Safeguarding and Ageing Well
 - Disabilities and Mental Health
 - Early Support
- The restructure has also effected change in moving the transitions/preparing for adulthood function from Children's Services into the new Disabilities Team within Adult Social Care thus creating a more seamless and person-centred pathway into adulthood.
- Led and contributed to thematic workstreams, particularly around self-neglect and neglect.
- Worked collaboratively with health, police, education, and the voluntary sector to strengthen integrated safeguarding responses.
- Continuing to lead information sharing meetings with Care Quality Commission (CQC), health and other partners

- Adult Social Care continues to have a strong influence across the wider safeguarding system. With regular attendance at Multi Agency Risk Assessment Conference (MARAC), One Day One Conversation (ODOC), Domestic Abuse Operational meetings and a notable 97% Multi Agency Public Protection Arrangements (MAPPA) attendance rate, the highest in the West Midlands demonstrating reliable partnership working and clear system leadership.
- The Care Quality Commission's assessment of Adult Social Care, following its June 2025 on-site visit, resulted in an overall rating of Good, with Safeguarding scored at 3, meaning 'Evidence shows a good standard'. The report recognised robust safeguarding systems and processes, effective multi-agency working through Wolverhampton Safeguarding Together, clear safeguarding thresholds, strong leadership oversight and a well-trained workforce committed to Making Safeguarding Personal.
- Making Safeguarding Personal - safeguarding outcomes remain strong. 87.5% of people fully or partly achieved the outcomes they wanted, expressed outcomes were recorded in 91% of cases. Effective multi-agency working, evidenced through audits/dip-sampling.
- Increased identification and response to self-neglect and complex safeguarding risks.
- Strong alignment of work to WST strategic priorities.
- Positive feedback from practitioners on learning and development opportunities.

- Learning from reviews continues to highlight the importance of:
 - Professional curiosity
 - Multi-agency communication
 - Early identification of risk
- Multi-agency audits and SAR learning are systematically shared through:
 - Practitioner forums
 - Reflective sessions and 7-minute briefings

Challenges

- Strengthening multi-agency data sharing and performance dashboards.
- Enhancing joint training and workforce development, particularly around trauma-informed practice.
- Improving consistency of practice across agencies.
- Better integration between children's and adults' safeguarding systems and processes.
- Further developing early help and prevention approaches.
- Promoting and providing advocacy

Black Country Integrated Care Board

Achievements and Impact

- The ICB's Designated Adult Safeguarding Lead is the lead for the ICB Prevent Work Stream. Progress has continued throughout 2025/2026, with excellent engagement from key partners (Local Authority, Home Office and Providers).
- The first Black Country wide Counter Terrorism Local Profile briefing took place at Walsall Football Club on 5th February 2026.
- Wolverhampton Place Progress includes Contest Board, Wolverhampton Prevent Delivery Group and Safer Wolverhampton Partnership
- Training, support and signposting has been provided for GPs with concerns regarding Prevent
- Safeguarding Assurance Work Stream: Main acute providers have adhered to the larger provider Safeguarding and Children in Care Dashboard for 2025/2026. This has been analysed by the ICB's BI Team and reported quarterly at the Quality and Safety Committee.
- The Safeguarding Assurance Framework report has been submitted quarterly for all larger providers for 2025/2026
- Safeguarding and Children in Care Dashboard, MASH Dashboard and ICB SG Assurance Framework has been updated for 2026/2027 and shared with ICB contracts team ahead of contract negotiations.
- Neglect and Self Neglect Workstream - Work at pace to review current tools and usage.
- Provider policies were reviewed around Was Not Brought (WNB)/ Did Not Attend (DNA) and found to be comprehensive. A Safer 7 was produced and disseminated.
- Exploitation workstream: Artificial intelligence and Online Abuse event held 24/09/2025, 105 multi agency attendees.
- Transitional Safeguarding: ICB fully involved with a new learning partnership with Resonant Collaboration and Research in Practice being launched, bringing together Human Learning Systems (HLS) and Transitional Safeguarding (TS)
- Cumulative Harm - Audit of agencies understanding and use of trauma-informed practice - Training offered through Barnardo's who have developed a Trauma Informed Audit Tool, that will support self-directed progress in embedding trauma informed principles to all aspects of an organisation's routine functions.
- Good uptake of training, but likely to have long-term impact rather than short term changes identifiable.
- Child Sexual Abuse Priority Group - The ICB Safeguarding Team are fully engaged with this group, it is chaired by the ICB's Designated Doctor for Safeguarding Children/Child Death

Challenges

- Identify and implement learning from place and system audits, statutory reviews and national reviews,
- FFCP: Roll out to primary care - 68% of Wolverhampton practices have signed up to the FFCP pathways and Local Authority Eclipse access. Continue to support the need for further practices to sign up.
- Primary care: Provide responsive and effective safeguarding support to primary care including through IRIS training, GP self-assessment, GP forums, WST multi-agency case file audits, mock JTAI learning and recommendations from statutory reviews. Strengthen compliance with safeguarding training.
- Information sharing, technology and AI: Embrace change, encourage the wider use of NHS spine via the single unique identifier within local authority to enhance information sharing and alleviate provider pressures, including MASH.
- Exploitation Nurse and MACPT posts. One exploitation post filled from 01/04/2026, the second post is being advertised. 1 x WTE admin support is in place. In the meantime, Designated Nurses at place continue to offer support, as required.

West Midlands Police

Achievements and Impact

- Operation Jigsaw - the force is ensuring that officers and staff accurately record children's demographic information to better assess risks to children. Data in relation to the recording of ethnicity and gender is now included in the Force performance panel packs and scrutinised and tracked weekly.
- WMP Multi Agency Referral Form (MARF) embedded in the CONNECT system has been updated to include a section on SEND, to improve the quality of information. A request has been submitted to ensure the ethnicity field is mandatory - this is currently sat with our CONNECT productivity team as an action
- Force Contact implemented a protocol that where a child/young person is subject to a scheduled appointment, this must take place within 24 hours. Ensuring that THRIVE assessment reflects the assessment of risk and safeguarding over those 24 hours.
- New Hydrant Programme and NCA guidance for first responders + investigators, specifically around FMSE / on-line CSE.
- CSAE intelligence threat desk established within WMP, providing specialist support to CSE investigations and officers.
- Led the Trauma Informed Strategic Partnerships Programme, with the aim of transforming how trauma is understood and addressed across services, communities and leadership structures (linked to Wolverhampton Safeguarding Together and the strategic priority of Cumulative Harm & Trauma).

- Evidence in the reduction of missing episodes to known high risk and highly vulnerable children, especially of risk to child sexual exploitation.
- WV LPA have created a Missing Persons lead post during 25/26, which has helped both improve daily connections and problem-solving opportunities between local authority teams and the Public Protection/Locate Team and prevent and reduce missing person episodes and broader vulnerability. This work has now been fully adopted into the LPA Prevention Hub.

Challenges

- Increasing demand and complexity of local issues
- Managing competing priorities

Education (City of Wolverhampton Council)

Achievements and Impact

- Strengthened information sharing and representation:
Effective information-sharing mechanisms between the WST Safeguarding Partnership and the education sector continue to be strengthened through the dedicated roles of the Education Safeguarding Officer and Strategic Education Lead for FFCP. This has ensured that education safeguarding leaders remain informed of key contextual developments, while also providing a clear and influential voice for education within multi-agency decision-making structures.
- Improved consistency in safeguarding responses:
Targeted safeguarding training delivered to Local Authority education, SEND, and inclusion teams has supported practitioners to develop a shared understanding of safeguarding procedures. This has resulted in more consistent, timely, and effective responses to safeguarding concerns affecting children and young people across the city.
- Embedding high-quality safeguarding policy and practice:
Safeguarding standards across the education sector have been strengthened through the provision of annual training materials and exemplar policies. This has supported schools and settings to maintain robust, up-to-date safeguarding frameworks aligned with local and national expectations

- Section 175 / 157:

The education sector continued to work with WST to deliver the 2025 Section 175/157 safeguarding audit, achieving a 98% submission rate. This improved on the previous cycle and provided strong assurance that schools and settings have effective safeguarding arrangements and appropriately trained Designated Safeguarding Leads.

- Adoption of trauma-informed and restorative approaches:

Education settings have continued to embed trauma-informed and restorative practices within safeguarding policies and day-to-day practice. This has enhanced practitioners' ability to respond to children and young people lived experiences, improve engagement, and support better safeguarding outcomes.

- Increased workforce capability through training:

A total of 865 education practitioners accessed safeguarding training through the WST Partnership during this reporting period, including Designated Safeguarding Lead training mandatory two-yearly refresher sessions and key themes such as Neglect and Exploitation. This is a 19.6% increase on the previous year. This has significantly strengthened safeguarding knowledge, confidence, and leadership capacity across the education workforce.

- Stronger multi-agency collaboration and influence:

Education representation across all WST priority groups has ensured the sector actively shapes safeguarding priorities and supports effective partnership working. Education professionals have also contributed to WST audits, providing constructive challenge and reflection to strengthen safeguarding practice, accountability and consistency across agencies.

- Contribution to key safeguarding tools and guidance:

Education professionals have made significant contributions to the development of updated partnership resources, including the Neglect Assessment Tool and the Threshold of Support and Need guidance. This has ensured these tools support consistent multi-agency practice.

Challenges

- Ongoing barriers to effective information sharing:

Despite progress, systemic challenges remain in achieving consistent and timely information sharing between social care, health, and education. Addressing these barriers are a critical priority for education to further strengthen multi-agency safeguarding responses collaboratively as a partnership.

- Managing increasing complexity of safeguarding concerns

Probation Services

Achievements and Impact

- Strong multi-agency partnership working through SAB engagement, MARMs and complex lives panels.
- Effective learning culture, embedding SFO and Death Under Supervision learning into practice and governance
- Established specialist provision for women, delivering trauma-informed support.
- Improved coordinated risk management for individuals with complex needs.
- Enhanced access to services and partnership interventions through co-location and collaboration
- Increased staff awareness of safeguarding responsibilities following policy implementation
- Transitional Safeguarding: Improved consideration of risk at transition points (e.g. custody to community, Probation Reset). Cumulative Harm & Trauma: Development of trauma-informed approaches, particularly within women's services
- Neglect / Self-Neglect: Strengthened focus on risk to self and safety planning
- Child Sexual Abuse: Improved safeguarding checks and multi-agency information sharing regarding children.
- Improved coordinated risk management for individuals with complex needs.

- Greater focus on risk to self (suicide, self-harm, substance-related deaths).
- Enhanced access to services and partnership interventions through co-location and collaboration
- Increased staff awareness of safeguarding responsibilities following policy implementation
- Transitional Safeguarding: Improved consideration of risk at transition points (e.g. custody to community, Probation Reset). Cumulative Harm & Trauma: Development of trauma-informed approaches, particularly within women's services
- Neglect / Self-Neglect: Strengthened focus on risk to self and safety planning
- Child Sexual Abuse: Improved safeguarding checks and multi-agency information sharing regarding children.

Challenges

- Managing increasing demand in the context of sustained demand and increasing case complexity.

Black Country Healthcare Foundation Trust

Achievements and Impact

- During the reporting period, Black Country Healthcare NHS Foundation Trust demonstrated a clear trajectory of improvement in safeguarding capability, characterised by strengthening governance arrangements, increasingly sophisticated use of safeguarding intelligence, and deeper integration within multi-agency partnership systems, including those within Wolverhampton Safeguarding Together.
- Restructuring and stabilisation of the safeguarding system through the Management of Change programme.
- The evidence drawn from the Trust's safeguarding dataset, annual reporting and partnership engagement activity demonstrates that the work of Wolverhampton Safeguarding Together, supported by Black Country Healthcare NHS Foundation Trust, has had a tangible impact on safeguarding practice, multi-agency coordination and, by extension, the lives of vulnerable adults, children and families.
- At a system level, the most consistent and reliable indicator of impact is the sustained, high level of safeguarding activity across all domains, including MASH, MARAC, safeguarding advice, Prevent, and statutory review engagement.

- This is particularly relevant in Wolverhampton, where safeguarding demand is characterised by high complexity and overlapping vulnerabilities, requiring ongoing multi-agency intervention rather than single-point responses. Within multi-agency safeguarding hubs and partnership environments, BCHFT's contribution has had a measurable impact on the quality of safeguarding assessments and decision-making.
- The increasing maturity of safeguarding governance and audit processes provides further evidence of impact.

Challenges

- A central area for development relates to the need to move from activity-based assurance toward outcome-based assurance.
- A second key area for improvement concerns the further development of integrated safeguarding intelligence.
- Workforce capability and consistency of safeguarding practice remain critical enablers of effective safeguarding, and the evidence points to ongoing variability in this area.
- Related to this is the importance of strengthening safeguarding supervision as a mechanism for assurance.

Royal Wolverhampton NHS Trust

Achievements and Impact

- The strong governance arrangements in place during 2025-26 have ensured that safeguarding practice across the Trust is consistent, robust, and compliant with statutory and regulatory requirements.
- Regular and timely assurance reporting has provided clear evidence that patients are protected through adherence to the Mental Capacity Act (2005) and CQC standards, while the systematic review of policies ensured staff are guided by up-to-date procedures. Overall, this has led to improved safeguarding outcomes, strengthened organisational assurance, and increased confidence from internal and external stakeholders.
- The Trust has implemented a dedicated Transition Nurse role in alignment with WST priorities, strengthening its approach to transitional safeguarding and supporting improved outcomes for young people moving into adult services.
- The Safeguarding Team has actively collaborated with several Wolverhampton Safeguarding Together (WST) workstreams, including cumulative harm and trauma, transitional safeguarding, and neglect and self-neglect. This partnership approach demonstrates strong system leadership and a shared commitment to continuous improvement across organisational boundaries.
- RWT Named Nurses (Children) are commissioned to provide specialist safeguarding cover within the Wolverhampton Multi-Agency Safeguarding Hub (MASH), supporting the timely screening and management of safeguarding children referrals, including those relating to domestic abuse.
- short timescales, this work was prioritised by service managers and team leaders, with all required audits completed and returned within the stipulated deadlines.
- In relation to transitional safeguarding, the Trust has identified this as a key priority and has taken steps to strengthen its approach, recognising that vulnerable young people moving between services remain at heightened risk of unmet need and system fragmentation.
- About cumulative harm and trauma, the Trust's safeguarding model has evolved to better reflect the reality that risk is rarely singular or episodic.
- In the context of neglect and self-neglect, particularly within adult populations, safeguarding activity has remained consistently high, with frontline practitioners frequently seeking specialist advice on thresholds and intervention strategies.
- In relation to child sexual abuse and exploitation, the evidence demonstrates that BCHFT has continued to play a critical role within multi-agency frameworks, including MASH, MARAC, MAPPA, and Channel panels.

Challenges

- Further assurance can be gained by continuing to undertake the Section 11 and Care Act audits to enhance organisational assurance, support compliance, and drive targeted improvements in safeguarding practice through robust monitoring and action planning.
- Managing increasing and more complex demand

Wolverhampton Homes

Achievements and Impact

- Transitional safeguarding. During 2025/2026, WH Young Person Team continued to work closely with partner agencies, to support young people including those transitioning to independent living from a care setting. 153 young person's tenancies were monitored during the period a 12.5% increase compared to the previous year, while 71 of them received active support to enable them to sustain their tenancy a 27% increase compared to the previous year.
- Wolverhampton Homes Handy Person Service was also made available to young people moving into their own home, to help with work that essentially turn a property into a home – putting up shelves, curtain poles, putting together flat pack furniture and so on.
- The team also attends the Oasis Drop-in Sessions to provide housing-related advice and guidance and work with young people and those who support them to assist in the transition and then sustainment of their home, mitigating the risk of homelessness even when facing challenges such as rent arrears, anti-social behaviour, etc.
- Cumulative harm & trauma - Unstable or inadequate housing can be a significant source of stress and trauma, particularly for children and families. Conversely, trauma, especially experiences of childhood adversity (like neglect or abuse), can make it harder to maintain stable housing. This interplay creates a cycle of vulnerability where housing instability can exacerbate the effects of trauma, and trauma can further undermine housing stability.
- Wolverhampton Homes is responsible for the management of the housing register and allocation of council owned property which becomes available to let. There are some 8200 households on the housing register, this has stabilised through 2025/2026 through the introduction of the housing options checker to ensure applicants receive instant feedback on whether they may be eligible for a live application in addition to link to housing advice.
- Involvement in child practice reviews has enabled Wolverhampton Homes to learn from situations where children have been harmed by trauma. Our Domestic Abuse team work with households experiencing domestic abuse, many of whom include children. Wolverhampton Homes worked with 845 households in 2025/2026 where domestic abuse was being experienced an increase of 31% increase on the number of notifications received the previous year.

- Our response to domestic abuse continued to improve in 2025/2026, with activity being embedded across the company as follows: Gold Domestic Abuse Housing Alliance accreditation achieved
- Our Safeguarding Policy has been reviewed, signed off and launched and Safeguarding procedures for adults and children have been reviewed in line with new Safeguarding Policy
- New Safeguarding champions & DA champions have been recruited & trained to provide additional advice and guidance to staff
- Neglect / Self Neglect - establishment of more robust procedures for identifying and responding to potential abuse and neglect, ensuring that individuals at risk receive timely and appropriate support.
- A prime example of partnership working is the MASH which continues to bring together professionals from various partners to jointly assess safeguarding referrals. Wolverhampton Homes is a partner in the MASH and as such there is clear evidence that this supports clear communication and timely sharing of relevant information between organisations.

Challenges

- Multi-agency working is mandated in legislation, policy, and guidance, there are challenges in its implementation. There are considerable benefits such as sharing resources and expertise but there are also key barriers, including (on occasion) uncertainty of agency roles, remits, and responsibilities. Ongoing challenges, such as information sharing in an appropriate and timely manner, are often cited within various serious practice reviews and inspections.
- Wolverhampton Homes and the partnership could focus on further collaboration across to improve information sharing and ensuring a consistent application of procedures and thresholds. Continued emphasis on the development of joint training that bring professionals together to enhance understanding from each other's perspectives is always welcomed, with an appreciation of the need to respond to those delivering housing services as an equal partner.
- High demand and shortage of supply - there are huge levels of demand as the number of available homes remains low. This is a key challenge and will hinder our ability to respond to housing instability for some households which is of particular concern for those households with issues exacerbated by trauma.

West Midlands Ambulance Service

Achievements and Impact

- Roll out of the new and updated Level 3 safeguarding training for new entrants (AAP's), and upskilled
- CFR's & PTS staff from Level 2 to 3 Safeguarding training.
- Positive feedback received from several Domestic Homicide Reviews in relation to the contribution of
- our clinicians, particularly regarding timely identification and initial reporting of domestic abuse to the
- police, which has supported effective multi-agency safeguarding responses.
- Supported Managers and HR team with concerns around sexual safety allegations including participating in multiple meetings.
- Supported and assisted with the roll out of the Sexual Safety framework.
- Continue to enhance and promote the Safeguarding Webpage which is accessible to all staff.
- Supported national work to update adult safeguarding practice within JRCALC.
- Keynote speaker at National conferences (Sexual safety/AACE & Serious Youth Violence/CFR Trauma).
- Implemented and continue to deliver Safeguarding Supervision to the workforce.

- Implementation of the updated Home Office Prevent portal training package for all staff.

Challenges

- Strengthening engagement with safeguarding boards and partnerships
- Enhancing quality assurance and thematic audit work.
- Delivering updated Prevent training in line with Home Office requirements.
- Embedding learning from: LCSPRs, SARs, DARDs, CDOPs and Section 42 enquiries
- Improving organisational learning through the Professional Standards Learning Group (PSLG), Senior Clinical leads (SCL) & Education Training Safeguarding Assurance Group (ETSAG).
- Review and enhance WMAS referral systems including the outcome functionality.
- Ensure the health and wellbeing of the safeguarding team by the uptake of safeguarding clinical supervision.

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City of Wolverhampton Council, Civic Centre, St. Peter's Square, Wolverhampton WV1 1SH