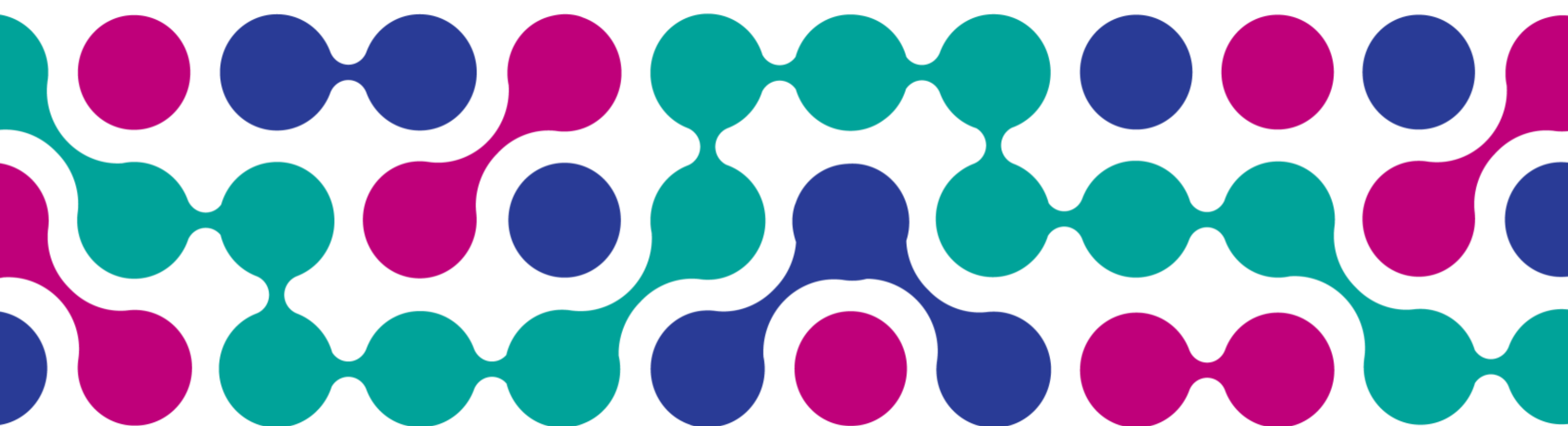
Bath and North East Somerset,
Swindon and Wiltshire
Integrated Care Board

BaNES, Swindon and Wiltshire Integrated Care Board Safeguarding Annual Report

2022/2023



Contents

Contents 2
Introduction 3
1. Statistory Requirements 3
1.1 Safeguarding Governance Arrangements & Accountability 3
1.2 ICB Structure 4
2. BSW ICB Safeguarding Team 5
2.1 Achievements 5
3. Legacy of the Impact of Covid 7
4. Primary Care 7
5. BSW Wide issues: 8
5.1 Liberty Protection Safeguards (LPS) 8
5.2 Specialists Placements -Mental Health /Learning Disability / Autism 9
5.3 Safeguarding and Migrant Populations 9
5.4 Responding to National Safeguarding Statutory Review Findings 10
5.5 Safeguarding Unborn Babies and Under 1s 10
6. Safeguarding Partnership Working 11
Table 1. Partnership Priorities (2022-2023) 11
6.1 Statutory Audits 12
7. Progress against set priorities 22-25 12
Table 2 Progress on Priorities 12
8. Domestic Abuse 14
Table 3. Strategic Priorities for Domestic Abuse 14
8.1 Multi-Agency Risk Assessment Conference (MARAC) 15
9. Serious Violence Duty 16
10. Prevent 16
11. BSW Statutory Reviews 17
Table 4. Number of reviews and main themes by locality 17
12. Additional Priorities Identified this Year for 2022 – 2025 19
13. Conclusion 20
14. Appendix 1 21

Introduction

This Safeguarding annual report celebrates the work of the BaNES, Swindon and Wiltshire (BSW) Integrated Care Board (ICB) Safeguarding Team and their partnership working with both NHS commissioned providers and multi-Agency Partners across 2022-2023.

The BSW ICB safeguarding team have remained committed to our shared vision from our three-year Safeguarding and Vulnerability Strategy 2020-2023:

''We will be proactive to enable safeguarding arrangements that make a positive contribution to help and protect those who are vulnerable by working closely with our health providers and other agencies who provide services to our community.
We will promote a Safeguarding Culture throughout the ICB at all levels demonstrated through all its functions and its roles so that everyone can say, understand and act, to demonstrate that Safeguarding is everybody's business.''

As the strategy is reviewed and refreshed, key new ICB and ICP developments will inform its development in 2023. These include the development of the BSW ICB Joint Forward Plan and the ratification of BSW ICB's three strategic objectives:

- Focus on prevention and early intervention
- Fairer Health and Wellbeing Outcomes
- Excellent health and care services

This report reviews the work of the previous year and provides assurance that the ICB has discharged its statutory responsibility to safeguard the welfare of adults & children effectively across the health and social care system.

1. Statutory Requirements

1.1 Safeguarding Governance Arrangements & Accountability

On 1st July 2022, all the duties and responsibilities for safeguarding transferred from the CCG to the ICB. At the same time NHSE reviewed and republished its Safeguarding Accountability and Assurance Framework (SAAF) in recognition of anticipated changes relating to domestic abuse, liberty protection safeguards and tackling serious violence. During this year all ICB's continued to progress work following the recommendations from the SAR Joanna, "Jon" and Ben. Additionally, the National Director for Mental Health made a new request that all ICBs review all arrangements regarding the safety and wellbeing of our population that are placed within other geographical locations. This was driven by the recognition of the additional vulnerabilities highlighted by Panorama expose and the preventable deaths of individuals as a result of neglect. Lessons about

the subsequent commissioning and oversight of care delivery have been recommended with plans in place to embed and be assured that services are effective.

Under the SAAF framework each ICB is required to demonstrate clear lines of accountability and leadership to ensure statutory duties are met. ICB safeguarding leadership is driven by the Designated Professionals both at place within the Integrated Care Alliance (ICA)'s and at system level. They provide safeguarding leadership and expertise within the emerging Integrated Care Partnership (ICP) and to meet the needs of the multi-agency Safeguarding Partnerships. They provide subject expertise to support the Executive Lead for Safeguarding.

Underpinning our safeguarding roles are the Intercollegiate Documents (RCPCH, 2019, RCN 2019, 2020), Mental Capacity Act and Prevent Competency Frameworks which detail safeguarding roles and competencies. It is an expectation that these are fulfilled to meet our statutory duty.

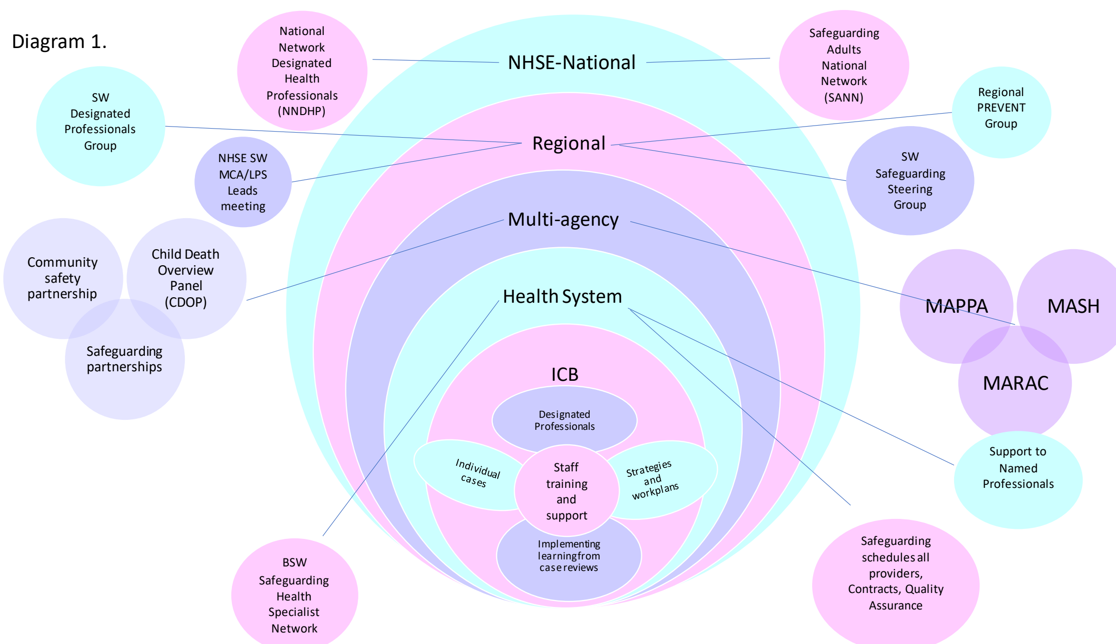
Following several national reviews most noticeably 'The Independent Review of Children's Social Care' (May 2022) and the Child Protection in England National Panel Review into the deaths of Arthur Labinjo-Hughes and Star Hobson, the Department for Education published 'Guide for Children and Young People: Stable Homes, Built on Love' (February 2023). The Independent Inquiry into Child Sexual Abuse (October 2022) also published its final report during this year. The resulting publications set out the government's strategy to reform children's social care. They outline the vision for and the plans to achieve a decisive multi-agency child protection system. They also indicate that to achieve this, all Partners including the ICB will need to review their leadership arrangements. Highlighted is the need for developing systems to be trauma informed and trauma sensitive in their delivery. Proposals include strengthening multi-agency leadership and amending guidance to local authorities, police and health (the three statutory partners) to clarify their roles and responsibilities. This will ensure leaders with the right level of authority are making key decisions and providing effective accountability.

1.2 ICB Structure

The ICB are an equal statutory partner in each Safeguarding Partnership. The accountability for safeguarding within the ICB sits with the Chief Executive Officer and they have delegated their responsibility for safeguarding to the Chief Nurse. The Chief Nurse is supported by an Associate Director of Strategic Safeguarding and Designated Professionals. Designated Safeguarding Professionals are either a joint post covering children and adults (Swindon & BANES) or two separate posts (Wiltshire) and a Designated Doctor for safeguarding children (BaNES & Wiltshire). The Designated Doctor for safeguarding children has remained vacant throughout this year. Each locality is supported by safeguarding admin support, specialist nurses/professionals for safeguarding, and a Named GP where appointed.

The ICB are supported by the NHSE regional safeguarding team, their governance architecture is outlined in Appendix 1.

Safeguarding is often described as the golden thread that runs through all services. Diagram 1 depicts the structure and complexity of safeguarding activity and how the ICB is central to this. To add to the complexity each of the Safeguarding Partnerships and Community Safety Partnerships have multiple standing subgroups which in turn may have a variety of task and finish groups to deliver on specific safeguarding activity.



2. BSW ICB Safeguarding Team

The Designated Professionals work together as a wider BSW wide team and also in local teams within each ICA linking with local safeguarding partnerships and commissioned healthcare providers.

2.1 Achievements

Throughout 2022/23 there have been several achievements the safeguarding team are proud of:

- A revised BSW wide safeguarding schedule (2023-2026) was agreed for all NHS commissioned services, irrespective of size or the value of their contract, to ensure a standardised approach to safeguarding standard setting across BSW.
- Each contract has an assigned ICB safeguarding lead to work within contract monitoring processes and to attend contract review meetings.

- Arrangements for provider support meetings transitioned to a Network of Specialist Safeguarding Leadership at both system and place levels with new terms of reference. This reflects the changing cultures required by the Health and Care Act 2022.
- The safeguarding team have reviewed its governance arrangements. This assures the ICB that issues, risks and compliance with its own statutory responsibilities as an employer are in place.
- Improved working and safeguarding interface with Continuing Healthcare, contracts, and quality teams.
- ICB Safeguarding Adults, Safeguarding Children and Children Looked After Policy was updated this year ensuring the ICB is compliant with current legislation and guidance.
- A new MCA Policy for BSW was ratified.
- The Prevent Policy was reviewed.
- ICB compliance for PREVENT training levels 1& 2 are 95% for all three areas.
- A bespoke training programme was developed to meet the ICB's statutory requirements to provide its staff with the necessary safeguarding training. Level 3 training has been delivered to those in patient facing roles in the ICB and those in a commissioning and quality role (51 members of staff) and this work continues.
- BSW wide webinars and accelerated online access has been implemented.
- The “Child in Need standards” in Swindon has been signed off and implemented.
- The “Health at Strategy Discussions” policy in Swindon has been signed off and implemented.
- A review of existing multi-agency guidance relating to injuries to non-mobile children across BSW was completed and finalised. One policy is now in place across B&NES, Swindon and Wiltshire bringing consistency to professional practice within this vulnerable group.
- Pan BSW Safeguarding Discharge Planning Protocol’ for children has been developed.
- Learning from the Safeguarding Adult Review (The Joanna, Jon and Ben SAR) has been implemented.
- BSW have developed resources supporting their understanding about the safeguarding for migrant populations, including those with mental health concerns.
- The impact of domestic abuse on children is considered and recorded for every child at MARAC, following the publication of the Domestic Abuse Act 2021.
- The Voice of the Child and Service User are considered in all policy decisions and strategic developments.
- The IRIS Training programme is delivered to all GP practices across BaNES.
- The ICB Safeguarding Team have been involved in sixteen statutory reviews during 22/23.
- A pilot of MCA training was funded across BSW. The outcomes of the programme led to 100% improvement in knowledge for those attending. Projects to implement that knowledge into practice are in the process of being evaluated.

3. Legacy of the Impact of Covid

COVID had a profound impact on the nation's health and wellbeing, including access to health services. As a result of services reconfiguring to address the immediate needs of the pandemic, many health interventions or reviews ceased to be available or relied upon virtual or telephone communication.

Virtual contacts or no contact resulted in safeguarding 'blind spots', with professionals only seeing part of the picture and being over reliant on what was reported by the individual or their carers. Although the full extent of the impact of COVID may never be known, what emerged across BSW relatively quickly was a noticeable increase in anxiety and emotional health/mental health needs of young people/adults, and with it a higher demand for already stretched services.

Some new ways of working emerged as a result of the pandemic, which have brought efficiencies, but it is important to continue to review outcomes to ensure that the desired results are achieved.

4. Primary Care

The ICB Named General Practitioners, work closely with all Practices across the BSW Primary Care footprint. Across BSW, a self-assessment audit (including Children's Act Section 11 and Care Act duties) is submitted by each surgery annually.

In addition, a programme of supportive quality assurance visits to all surgeries has been established, with plans to visit each surgery every three years. At each visit the self-assessment audit is reviewed and a development plan is formulated. Generally, practices have engaged well with the process and appreciated the support. In the past year eight Practices in Swindon have been visited and eight in BaNES.

There are plans to implement safeguarding supervision for Practice Safeguarding Leads in Primary Care across BSW, this is being undertaken by the Named GPs. In turn the Safeguarding Leads will be expected to facilitate safeguarding supervision for their practice staff. To date safeguarding supervision has taken place for five surgeries in Swindon.

Safeguarding lead training, provided by the locality teams, has continued over the past year with two sessions in Swindon, six sessions in BaNES (four adult and two children) and five courses (3 sessions per course) in Wiltshire. In addition, two training sessions for the Primary Care safeguarding administrators has been delivered in BaNES and twelve self-directed training packages were completed.

5. BSW Wide issues:

5.1 Liberty Protection Safeguards (LPS)

The ICB co-ordinated a BSW Liberty Protection Safeguarding Health Steering group across this year to:

- Identify the common needs of the patients and organisations.
- Demonstrate a coordinated BSW Health approach to delivering LPS.
- Develop clear key messages to support understanding across BSW Health providers.
- Make practice suggestions for transferability between Health organisations as well as between Health and Local Authority Responsible Bodies.

In April 2023, the government paused on the implementation of LPS, although the group had already made substantial achievements including:

- Ensuring that all those affected by the proposed introduction of the LPS were kept informed of the national and regional developments.
- Creating links across Leads within BSW NHS services and Local Authorities.
- Circulating job descriptions, audit tools, process maps, and project plans.
- Submitting feedback on the national consultation.
- Contributing to a range of national working groups that included the development of a national training strategy for the implementation of LPS.
- Taking part in a national conference, hosted by Bath University.
- Funding Wiltshire Health & Care to deliver an MCA course for 9 BSW professionals.
- Submitting the NHSE Maturity Matrix with plans in place to manage those in receipt of CHC funding.

The plans for introduction of LPS are now on hold. The steering group has maintained its purpose by becoming an MCA Community of Practice. To ensure that this is a collaborative working arrangement, the Chair has passed from the ICB to Wiltshire Health and Care.

5.2 Specialists Placements -Mental Health /Learning Disability / Autism

Nationally and locally there has been an increased recognition of the vulnerability of people of all ages placed in specialist hospital accommodation. This was highlighted in October 2022, in a Panorama programme on the abuse and neglect of patients with mental health needs in Greater Manchester. In addition, at the same time the first report from the National Inquiry into the abuse and neglect of children with disabilities accommodated by the Hesley Group in Doncaster was published.

As a result of increased awareness locally, safeguarding support and intervention to BSW residents living in three separate placements was intensified. In addition, ICB staff contributed to a Safeguarding Adults Review, following the death of a Wiltshire resident placed in North Somerset.

Oliver McGowan training has been included as mandatory training across the health workforce to raise awareness of the needs of those with learning disabilities and autism.

5.3 Safeguarding and Migrant Populations

There are a range of national resettlement schemes under which people from countries such as Afghanistan, Hong Kong and Ukraine are supported to resettle in the UK. A number of these schemes operate within BSW:

- Asylum Seekers -3 hotels in Swindon,1 in Wiltshire
- Afghan Relocation Assistance Policy (Resettlement programme)-2 hotels in Swindon
- Those fleeing Ukraine - in all three localities

Supporting these schemes has required significant resource by the ICB, NHS commissioned services and primary care. Access to healthcare is provided on the same basis as for anyone else in the population, but with an initial enhanced offer of healthcare checks. There were initial concerns about the mental health needs of some of those accommodated. This led to resources from a safeguarding perspective being developed. In 2023/2024, these will be finalised and made available to all Health services across BSW. Their aim will be to support awareness of the safeguarding risks and promote legal literacy specifically for this population.

The BSW safeguarding team have ensured potential safeguarding issues have been highlighted and safeguarding referral pathways are known by the respective accommodation sites.

5.4 Responding to National Safeguarding Statutory Review Findings

The ICB have a duty to implement and be assured that all learning from National Reviews is embedded. Over the past year learning has been implemented following the publication of the learning from National Safeguarding Practice Review into the Murders of Arthur Labinjo-Hughes and Star Hobson.

As a result of the findings each of the three Safeguarding Partnerships have reviewed their local arrangements and as a direct result of the published report the ICB has:

- Reviewed health resources in MASH
- Undertaken MASH audits in each locality across BSW
- Reviewed information sharing agreements and protocols across the three Partnerships
- Disseminated learning from the Review throughout all ICB training packages
- Introduced a BSW wide policy on suspected bruising or injuries in children who are not independently mobile

5.5 Safeguarding Unborn Babies and Under 1s

National research has long established the increased risk to under 1s from abuse and neglect. In both Wiltshire and Swindon, a Thematic Review into Significant Physical Injuries in Under 1s has been published by the local safeguarding partnerships.

In 2020 the Child Safeguarding Practice Review National Panel published Out of Routine, a review of sudden unexpected death in infancy. This was followed in October 2021 with The Myth of Invisible Men - a report looking in detail about how fathers were engaged in safeguarding processes. Work is underway to respond to the learning from these thematic reviews and safeguarding unborn babies and under 1s is a key priority for all partners across BSW.

BSW ICB Safeguarding Team are leading this group. Their purpose is to drive system change and improvement across the Integrated Care Partnership in the safeguarding of Unborn Babies and under 1s.

The aims of this Group are:

- To coordinate activity and system improvements in safeguarding under 1s across BSW including the mapping of existing activity relating to safeguarding under 1s across the 3 partnership areas, identification of gaps and prioritisation of work to take place.
- To understand existing related workstreams and how their work can support this agenda.
- To coordinate and have oversight of response to relevant local and national learning from case reviews on behalf of the partnership.
- To review existing multi-agency guidance relating to injuries to non-mobile children across BSW. This was completed and finalised.
- Sharing and mapping of learning from case reviews on unborn babies and under 1s to identify practice themes to inform priorities Practice development/CPD.

6. Safeguarding Partnership Working

A statutory Safeguarding Partnership in each locality is responsible for coordinating and improving its safeguarding arrangements and activity. The ICB, the Local Authority and the Police as equal partners must agree on all decisions made by the Partnerships and share equal responsibility.

Table 1. Partnership Priorities (2022-2023)

Swindon (SSP)	Wiltshire (SVPP)	BANES (BCSSP)
Children under 2 years old, unborn babies and working with fathers and male partners	Safeguarding Under 1's	Safeguarding Under 1's
All age Exploitation	Exploitation and Contextual Safeguarding	Exploitation and Contextual Safeguarding including domestic abuse
Neglect	Transitional Safeguarding	Transitional Safeguarding
Adult Self-Neglect	Domestic Abuse	Capturing Voice of Users
		Self-Neglect and application of Mental Capacity Act
		Effective Safeguarding Partnerships

There is some alignment between all three Partnerships and their priorities. Key areas focus on exploitation, under 1's, self-neglect, capturing the voice of children and families, creating effective partnerships and transitional safeguarding.

6.1 Statutory Audits

Section11 and Care Act audits are undertaken every three years. Each of the localities undertook a full Section 11 & Care Act audit in 2022/3. In between each full audit the Partnerships conduct 'walk about' exercises to review and strengthen safeguarding practice. In Swindon, these were at the maternity department of GWH, NSPCC, Carers Centre and Gable Cross Custody Suite. BANES took part in a five-Partnership peer review process within Avon & Somerset. Quality assurance 'walk abouts' have been re-established in Wiltshire, commencing in 2023.

7. Progress against set priorities 22-25

Several priority actions were identified in our 2021/22 safeguarding annual report. The progress has been steady and is on track to be completed by 2025.

Table 2 Progress on Priorities

PRIORITY	COMPLETED	IN PROGRESS	NOT COMMENCED	ACTION NEEDED
1.Development of MCA legal literacy within the ICS		✓		The team plan to scope the need of ICB staff to undertake MCA legal literacy training.
2.Development of a BSW wide non-mobile baby policy with safeguarding partnerships	✓			
3.Review of Health resources into MASH		✓		BaNES Local Authority plan to review MASH is underway
4.Review of Health resources into MARAC	✓			
5.Review of Safeguarding Schedules	✓			

6.Establishing a standard approach for safeguarding QA visits to providers		✓		A standardised QA visit template for all NHS commissioned services is currently being developed.
7.Development of succession planning for safeguarding roles within the ICS		✓		There is a national scarcity of safeguarding expertise making succession planning difficult. The rewrite of the intercollegiate documents for safeguarding and national statutory guidance Working Together for Safeguarding Children will determine what the future staffing requirements will be.
8.Review MAPPA assurance in BANES	✓			
9.Development of a localised learning framework based on emerging SCIE quality markers for conducting SARs		✓		A proposal was suggested to the ICB to commission training by SCIE for a cohort of local potential SAR reviewers using the SCIE learning together model. A decision on the funding is awaited. In reviewing this priority, it is now necessary to consider the impact of the Patient Safety Incident Response Framework (PSIRF) on safeguarding incident reporting, statutory reviews and learning.
10.Development of a single information sharing agreement		✓		A NHSE consultation on sharing safeguarding information is currently live and the ICB will await the outcome to take this priority forward.
11.Continue to progress plans for a safeguarding dataset		✓		The aim of this priority is having a system that draws in the data we already collect from existing safeguarding schedules and dashboards to give a single system overview. A proposal is being developed to test out a digital quality assurance system.
12.Work with HR and OD to implement the safeguarding training strategy		✓		This work is ongoing
13.Work with HR to ensure that an enhanced DBS checks are in place for the ICB safeguarding team. Ensure all safe recruitment processes are in place.	✓			

8. Domestic Abuse

Last year the Board were informed of the new domestic abuse legislation (Domestic Abuse Act 2021). Coordinating compliance with this Act sits with the Community Safety Partnerships (CSP) and their domestic abuse arrangements at a multi-agency level along with the individual organisational duties and responsibilities. Each of the three CSPs have been prioritising the requirements of the Act and establishing their strategic priorities and outcome goals going forward.

Table 3. Strategic Priorities for Domestic Abuse

Swindon	Wiltshire	BANES
Strategic priorities		
Reduce the incidence of domestic abuse by improving early intervention and prevention by focussing on early help and specialist services for victims, families and perpetrators	Driving change	As part of the BaNES Violence Reduction Partnership, Protecting the most Vulnerable from Harm This includes Violence against women and girls; County Lines; Exploitation; Hate Crime; Modern Slavery; Cuckooing; Prevent and Fraud
Improve the response to domestic abuse by promoting awareness and training to help communities, professionals and specialist services respond effectively and consistently	Prevention and early identification	Strengthen and improve local communities to improve outcomes for local people. Neighbourhood policing; promoting resilience; and reducing impact of ASB
Align joint commissioning activity across partner agencies to make the best use of resources to deliver high quality and responsive services for victims, survivors, children, young people and perpetrators that focus on risk reduction and recovery	Provision of services and support	Avon and Somerset Domestic Abuse Stakeholders are working together to uphold standards and best practice
	Protection and justice	
Outcomes seeking to achieve		
• Increased the number of victims reporting domestic abuse either to the Police or through a third party • Reduced the number of repeat victims of domestic abuse • Reduced the number of serial perpetrators • Improved the timeliness of information sharing between agencies • More agencies involved in multi-agency case management	• Children and young people can recognise and form heathy relationships • People experiencing and at risk of experiencing domestic abuse are supported to be and feel safe • Everyone can rebuild their lives and live free from domestic abuse • Supporting and disrupting perpetrators to change their behaviour and break the cycle of	A better understanding of the prevalence and impact in BaNES of VAWG; county Lines; Exploitation; Hate Crime; Modern Slavery; Cuckooing; Prevent and Fraud A needs assessment will identify gaps in service and provide opportunities to bring consistency in the offer to our victims. MARAC services across A&S, have been improved. Good practice and joint assurance work has helped bring consistency of service to our victims.

• Improved understanding of referral pathways to specialist support services • Improved housing options for victims including staying in their own home and provision of move-on accommodation • Increased the options for victims to access education, training and employment • Increased the use of civil actions to support victims and disrupt perpetrators	domestic abuse; and to enhance the safety of victims and their families with the support they receive • Communities, professionals and employers are able to recognise domestic abuse at the earliest opportunity and have the confidence to take action	Plans to work with perpetrators to disrupt cycles of abusive behaviour. And to ensure the effectiveness of rehabilitation programmes. DA Boards and services have captured the victims voice by sharing their lived experiences, which has influenced future support for survivors. It is planned to continue and strengthen this work. Developing and communicating consistent and innovative messages – raising awareness of services, training, and initiatives both internally and externally

8.1 Multi-Agency Risk Assessment Conference (MARAC)

The purpose of a MARAC is to ensure the most high-risk domestic abuse cases are discussed and actions taken to increase the safety of the victims. The core MARAC agencies are police, IDVA services, housing, children's services, the Probation Service, Primary Care, mental health, substance misuse service and adult social care.

The arrangements and resources into MARAC differ across the ICB locality areas due to differences in demand, different police forces and arrangements for collation of information ICB provision to represent primary care.

The ICB has invested in ensuring information from primary care is presented to MARAC, as this two-way information is vital to supporting the MARAC arrangements. The ICB has reviewed health resource and support to the three MARAC`s within BSW, in addition an independent review of Wiltshire MARAC was undertaken by Oxford Brookes University.

A significant time commitment is required across the health system to collate and share information for MARAC. Further developments include:

- Monitoring Core Health Provider attendance and raise any concerns through CRM meetings.
- Highlighting to CAMHS when young people open to them are going to be discussed at MARAC to ensure the child is heard as a victim, in their own right. (Domestic Abuse Act 2021).
- Collating Primary Returns data by locality to evidence their contribution.

9. Serious Violence Duty

The Serious Violence Duty (SVD) was introduced as part of the Police, Crime, Sentencing, and Courts (PCSC) Act 2022. Under this Duty, the police, local authorities, fire and rescue authorities, youth offending teams, ICB's and probation services are required to work together to understand serious violence in their area and formulate a strategic response to the issues identified. Existing plans and strategies must be considered when developing the SVD strategy to reduce duplication.

The SVD Guidance came into effect from January 2023, with an implementation date of January/March 2024. The ICB as a relevant partner has a duty to collaborate with other partners to prevent and reduce serious violence in the area, and to consider the needs of victims of abuse in our Joint Forward Plans (JFP's). The ICB Accountable Officer should ensure that there is appropriate representation to the Serious Violence Partnership this representative will be expected to:

- Facilitate the sharing of relevant anonymous health data and information
- Support the development and implementation of a strategy to identify and mitigate risks and agree an approach to preventing and managing serious violence, in the community

10. Prevent

The Counter-Terrorism and Security Act 2015 sets the standards for all NHS funded organisations including the ICB and is supported by the Prevent Competency Framework which was re-published in September 2022.

The thirty-four recommendations from the independent review of Prevent (February 2023) will drive the revision of the Counter-Terrorism and Security Act, and will be led locally through the Prevent Boards where the ICB is represented.

To provide assurance training compliance is routinely sought and BSW have the second highest compliance rate in the South-West region, which has been a sustained response across the year. ICB compliance is at 95%.

Following the publication of the revised Prevent Training and Competency Framework, the ICB Safeguarding team have facilitated meetings with the three Acute Trusts (RUH, SFT, GWH) to implement the Framework.

ICB Prevent Leads have also maintained their learning and knowledge through attendance at the regional South-West Health Prevent Network and the NHSE Prevent Conference.

BSW continues to be one of the lowest reporters of Prevent concerns and across BSW referrals to Channel Panel are low, however, cases that have been discussed not required further progression the next level. Although on a par with the South-West BSW must remain vigilant to the threat.

11. BSW Statutory Reviews

This year there have been sixteen statutory adult and children reviews of which 75% relate to children. The majority of reviews conducted for children were 'Rapid Reviews'[1] which aim to identify any learning instantly. The findings from a Rapid Review are submitted to the National Child Safeguarding Practice Review Panel, who advise on whether a full local child safeguarding practice review (LSCPR) is required (locally or nationally). The low number of LSCPR's this year suggest Rapid Reviews have either been of high quality, or there is no new learning to be achieved.

Prevention of sudden infant death in under 1's sleeping whilst co-sleeping or out of routine or away from home, parental substance misuse particularly cannabis and parental mental health have been themes from children's reviews.

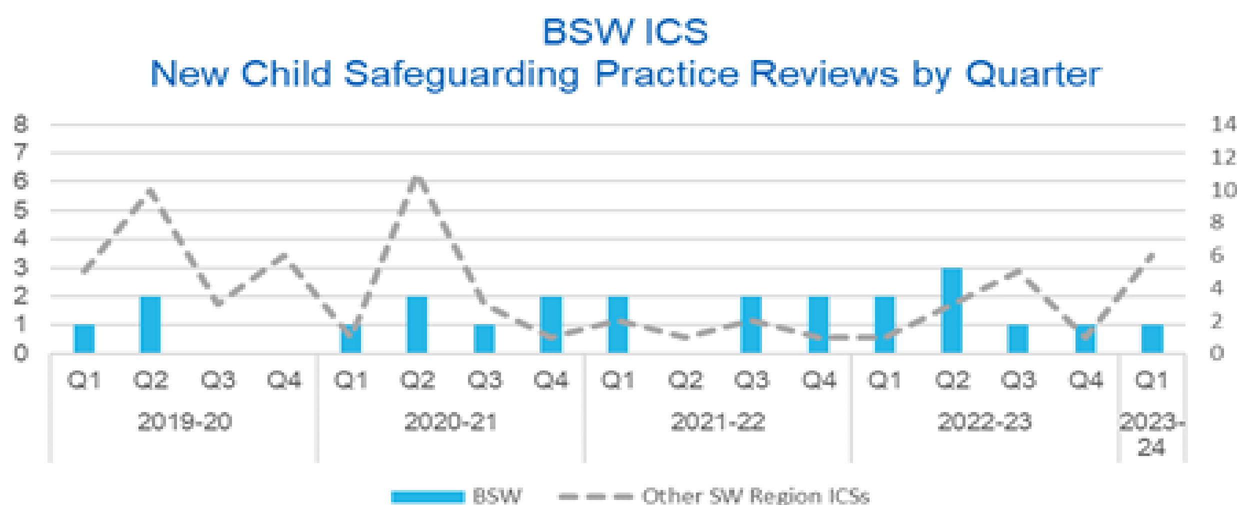
Professional curiosity, and application of the Mental Capacity Act have been key features within safeguarding adult reviews, especially where mental health, learning disabilities and substance or alcohol use are factors within the case.

Table 4. Number of reviews and main themes by locality

Statutory review by type and locality	Rapid Review (RR) (children)	Local Child Safeguarding Practice Review	Safeguarding Adult Review	Domestic Homicide Review	Themes
Swindon	**2**	**0**	**2**	**0**	SAR: Mental Capacity Act Assessments, Reasonable Adjustments, Transition processes Independent advocacy, Ways of working due to Covid Adult Social Care referrals - timeliness SAR: Non-accidental injury in elderly people Caused enquiries. Section 42 Safeguarding enquiries Escalation Processes Independent Advocacy RR: Intra familial domestic abuse Whole family Working - think family, Re-assessments when family circumstances change Curiosity around cannabis use Information Sharing
Wiltshire	**5**	**1**	**1**	**0**	Under 1/ Sleeping out of routine/ substance misuse / Parental Mental Health/ Supervision SAR: alcohol addiction, trauma, learning disability, autism, complexity of needs, self-neglect, mistrust of services, availability of suitable placements, application of the Mental Capacity Act (2005).
BANES	**2**	**2**	**1**	**0**	Mental health, Domestic Abuse not explored, professional curiosity Shortage of resources Staff turnover Professional lack of engagement with fathers Professionals lack of identifying and acting on 'critical moment' opportunities around lengthy school exclusions

[1] Rapid Reviews (RR) are conducted under Working Together to Safeguard Children
A guide to inter-agency working to safeguard and promote the welfare of children 2018. The timescale for conducting a rapid review is 15 working days from the date of the decision to conduct one.

Graph 1. Comparison to other SW ICS's - Children



Graph 2: Comparison to other SW ICS's - Adults

In the first 6 months of 2022/3 there appeared to be an increase in both CSPR's and SAR's. However, this data must be interpreted with caution as the numbers are so small. Of significance,

however, was the fact that there were no Domestic Homicide Reviews in BSW (see Graph 3 below) over the last two-year period. The ICB raised the profile of this with safeguarding partners and subsequent cases were identified and reviewed.

Graph 3 Comparison to other SW ICS's -DHR

12. Additional Priorities Identified this Year for 2022 – 2025.

In addition to the priorities set for 2022-2025 and outlined in last year's report, the following have been added:

- Update ICB Safeguarding webpages.
- Improve information sharing through the use of new digital technology such as 'Teamnet'.
- Strengthen the strategic direction from a Health perspective into the Community Safety Partnerships and sub-groups. This includes the SVD, Prevent, MAPPA, MARAC, Modern Slavery, and Safer Streets
- Work with HR and OD to implement the safeguarding training strategy

- Collaborate with quality commissioners to develop relevant training and oversight for the independent practitioners; dentists, pharmacists, optometrists following devolved responsibilities from NHSE to the ICB

- Roll out safeguarding supervision in Primary Care across BSW

- Develop a process of safeguarding involvement in the review of all BSW ICB policies

13. Conclusion

This report celebrates the achievements of the BSW ICB Safeguarding Team and highlights priorities for the forthcoming year. It provides assurance to the Board that the ICB is meeting its statutory requirements and outlines how this is achieved both at system and locality level.

Within the new structures and vision for greater collaborative working, the Safeguarding Team are aspirational about future safeguarding outcomes for the local population.

As safeguarding practice evolves, in line with changes to both statutory and legislative developments, there is a greater focus on serious violence and its impact on both children and adults. In order to keep people safe, it is essential that we embrace these new developments whilst continuing to focus on the fundamental elements of safeguarding and embed evidence - based practice.

The report highlights the variability of both population and safeguarding presentations in each locality. Further work is required to align the three locality areas and yet recognise each areas uniqueness. The safeguarding team will continue to look to maximise its resources, work differently and innovatively as we meet existing and emerging needs .There have been significant improvements made within Primary Care with yet more work to do to achieve parity across the three localities.

The report details the BSW wide work, developments and efficiencies of working at scale across the three localities: LPS, BSW wide policy developments, support to specialist placements, migrant populations and responding to the National Panel Child Safeguarding Practice Review of Star and Arthur.

The number of statutory reviews by type and locality has been reported, along with the main themes from them. These reviews impact on routine practice by virtue of their unpredictability. They are intensive both during the review process and subsequently when embedding the learning across health systems.

This report has outlined what has been achieved despite recruitment challenges, new legislative requirements, and the new ways of working as we moved from a CCG to an ICB. The plan for the forthcoming year, has been outlined and reflects some of the anticipated legislative changes and local priorities to ensure improved safeguarding outcomes for the local population.

14. Appendix 1

SW Safeguarding Governance Architecture linked to the NHS England Quality Risk Response & Escalation Guidance & ICBs