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

BaNES, Swindon and Wiltshire Integrated Care Board Safeguarding Annual Report

2023/2024

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1. Introduction

Welcome to the annual safeguarding adult and children report of the safeguarding team of Banes and North-East Somerset, Swindon and Wiltshire Integrated Care Board (BSW ICB). It covers the period of April 2023 to March 2024.

The report aims to provide a national and local context to safeguarding developments during this period and outlines how BSW ICB is meeting its statutory safeguarding responsibilities.

The safeguarding of children, young people and adults who are at risk is a fundamental obligation for everyone who works in the NHS and its partner agencies. BSW ICB safeguarding team works collaboratively with internal ICB colleagues and external statutory and non-statutory partners, including as the statutory partner for Health within the three local combined adult and children Safeguarding Partnerships of Bath and North-East Somerset, Swindon and Wiltshire. The safeguarding of adults and children involves a range of activities spanning the prevention of harm to those at risk, through to actions taken when harm occurs. Our role is to ensure that services are in place to respond to adults and children who are at risk of abuse or neglect, or who have been harmed, and deliver improved outcomes for the most vulnerable people in the local population.

Our plans continue to include a response to any new or emerging legislation or statutory guidance. For this year, we have worked with our partners to implement the changes to Working Together 2023, which is the statutory guidance for safeguarding children. We also will respond to the Victim and Prisoners Bill; should this be required.

BSW ICB is asked to note the contents of this report and accept this report as assurance that as an organisation we are meeting the statutory requirements for safeguarding children and adults.

Safeguarding and Vulnerability Strategy
The 2020-23 Safeguarding and Vulnerability Strategy, provides the strategic safeguarding framework for the ICB. Our shared vision:

> ***''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''***

A shared set of goals reflecting our Designated areas of responsibility and contribution include:

- Training
- Communication and Information Sharing
- Making Safeguarding Personal
- Policies and Procedures
- Governance
- Multi-Agency Working
- Children Looked After

Across BSW identified strategic priorities are delivered for each area of responsibility for this reporting period. Although the intent was to review and refresh our safeguarding vulnerability and strategy plan annually, with the restructure of the safeguarding team in response to Project Evolve, the strategy will be refreshed in 24/25.

2. Statutory Requirements

2.1. Safeguarding Governance Arrangements & Accountability

Integrated Care Boards (ICB's) have a statutory duty to put in place appropriate arrangements to safeguard children, children looked after, and adults at risk within their areas.
This includes:

- Ensuring that the ICB's internal safeguarding arrangements are robust, and that safeguarding is embedded throughout practice
- Being assured that the safeguarding arrangements of all commissioned services are safe and effective
- Co-operating with local safeguarding Partnership arrangements
- Securing the expertise of Designated Professionals on behalf of the local health system
- 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) to meet the needs of the Multi-Agency Safeguarding Partnerships and subject expertise to support the Executive Lead for Safeguarding.

2.2. Safeguarding Accountability and Assurance Framework, 2024

The update to the Safeguarding Assurance and Accountability Framework (SAAF) published in June 2024, reflects how safeguarding for both children and adults has

transformed in recent years with the introduction of new legislation, and the creation of duties and responsibilities which need to be incorporated into the widening scope of NHS safeguarding practice.
All health organisations are required to adhere to the following arrangements and legislation:

Legislation for all

- The Crime and Disorder Act 1998
- Female Genital Mutilation Act 2003
- Sexual Offences Act 2003
- Mental Capacity Act 2005
- UN Convention on the Rights of Persons with Disabilities 2006
- Mental Health Act 2007
- Children and Families Act 2014
- Modern Slavery Act 2015
- Serious Crime Act 2015
- Mental Capacity (Amendment) Act 2019
- NHS Constitution and Values (updated Jan 2021)
- Domestic Abuse Act 2021
- Serious Violence Duty 2023
- Prevent Duty 2023

The SAAF sets out

- the safeguarding roles and responsibilities of all individuals working in providers of NHS-funded care settings and NHS commissioning organisations
- Reflects imbedding of integrated care systems, integrated care partnerships, provider collaboratives, primary care networks, and local maternity and neonatal systems
- Aligns to the NHS England operating framework
- Provides further direction on ICB oversight and accountability for Safeguarding
- SAAF part of wider change and delegation from NHSE to ICBs
- Digitalisation of assurance mechanisms for statutory and non-statutory reporting

In line with the cultural context of ICB's and integrated care systems, now more than ever, organisations are required to co-operate and work together within new demographic footprints to seek common solutions to the changing context of safeguarding.

2.3. ICB Structure

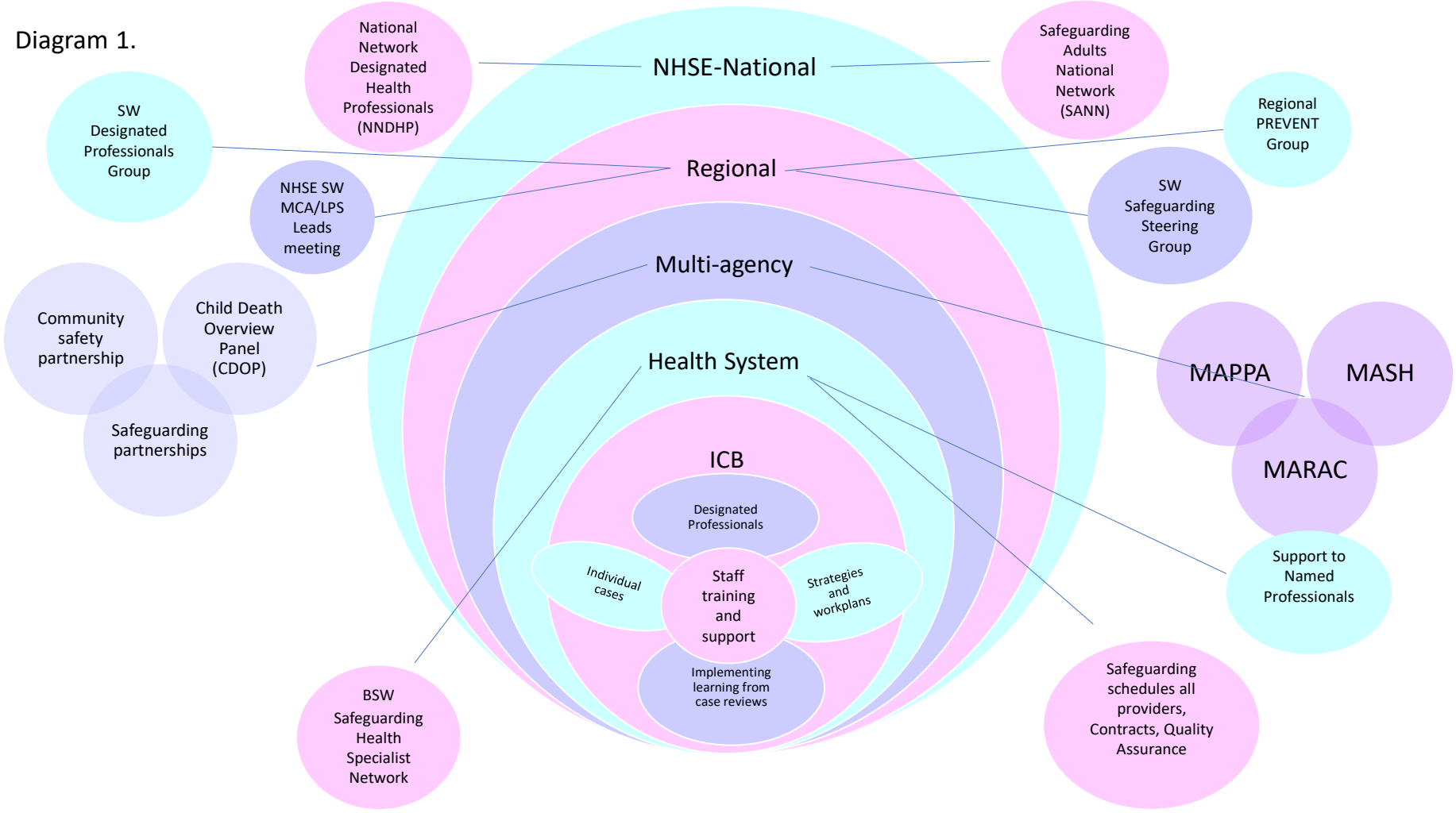
The ICB are an equal statutory partner in each Safeguarding Partnership. The accountability for safeguarding within the ICB sits with the Chief Executive Officer who has delegated their responsibility for safeguarding to the Chief Nurse. The Chief Nurse is supported by an Associate Director of Strategic Safeguarding and Designated Professionals. Designated Safeguarding Nursing 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 in Swindon was appointed in August 2023 and Named GP for Adults in BaNES, appointed in September 2023. The Named GPs for both children and adults provide a link between the ICB and Primary Care and support frontline staff in their safeguarding through the delivery of training and undertaking quality assurance visits with each Practice. They are the conduit for sharing good practice and supporting primary care to improve safeguarding practice. Each of the three localities are supported by a safeguarding team of health professionals, named GP's and admin support.

However, in recognition of the ICB's ambition to further develop and streamline the organisation Project Evolve was launched in October 2023, the aim being to work with our partners across the health, social care and community and voluntary sectors to deliver real, transformative change to the health and care system for our local communities. As a result of this consultation, the safeguarding team has been undergoing structural change that at this point is not complete.

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

Diagram 1.


National Network Designated Health Professionals (NNDHP)
NHSE-National
Safeguarding Adults National Network (SANN)
SW Designated Professionals Group
Regional
Regional PREVENT Group
NHSE SW MCA/LPS Leads meeting
SW Safeguarding Steering Group
Multi-agency
Community safety partnership
Child Death Overview Panel (CDOP)
Safeguarding partnerships
Health System
MAPPA
MASH
MARAC
ICB
Designated Professionals
Individual cases
Staff training and support
Strategies and workplans
Implementing learning from case reviews
Support to Named Professionals
BSW Safeguarding Health Specialist Network
Safeguarding schedules all providers, Contracts, Quality Assurance

3. BSW ICB Safeguarding Team

The Designated Professionals work together as a wider BSW wide team and in local teams within each ICA linking with local safeguarding partnerships, community safeguarding partnerships and commissioned healthcare providers. The team are committed to working collaboratively with our statutory, non-statutory and VCFSE partners to effectively safeguard our population. Safeguarding is the "golden thread" that runs through all our services, and we are determined to ensure we fulfil all of our statutory duties utilising a transformational and preventative approach that ensures learning is fully understood and embedded across our system

4. Achievements

Throughout 2023/24 there have been numerous achievements that the safeguarding team are proud of:

- The 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.
- The Network of Specialist Safeguarding Leadership at both system and place levels is thriving and reflects the changing culture of the ICB and Provider relations as required by the Health and Care Act 2022.
- The safeguarding team have reviewed its governance arrangements in response to Project Evolve and the new SAAF, 2022. This assures the ICB of compliance with its own statutory responsibilities as an employer are in place.
- The Safeguarding Team contributed to Health & Care Professional Leadership in BSW – Your Big Conversation which was launched in August 2023
- Improved working and safeguarding interface with Continuing Healthcare, contracts, and quality teams.
- The ICB Patient Safety Incident Response Policy was launched in March 2024, replacing the Safety Incident Framework. This policy has a broader scope and moves from a reactive to a pro-active stance when managing safety incidents. The focus is on compassionate engagement and involvement of those affected by patient safety incidents, a system-wide approach with the focus on the quality of the investigation and the support offered to staff.
- ICB Safeguarding Adults, Safeguarding Children and Children Looked After Policy was updated this year separating each policy into Adults, Children and Children Looked After documents for ease of reference for colleagues.
- A new Respect Policy for Health and Social Care in BSW was reviewed from a safeguarding and Mental Capacity Act perspective and ratified.
- The Voice of the Child and Service User are considered in all policy decisions and strategic developments.
- The Prevent Policy has been reviewed and republished.
- The Contest Strategy for the Avon and Somerset Police area has been refreshed and published in 2023.

- The Wiltshire Neglect Framework has been refreshed and although primarily focused on children it does include information on self-neglect in adults and who to contact.
- Wiltshire and BaNES are piloting Graded Care Profile in Maternity services in 2024/5
- BaNES launched Child Exploitation Risk Assessment Questionnaire (CERAQ8), in partnership with Children's Social Care. It is a form to be used by health practitioners who have *'time limited'* contact with children under the age of 18 to help them quickly identify children at risk of sexual exploitation and other types of exploitation.
- A BSW ICB Safeguarding Induction Resource Document was refreshed.
- A 'digital flag' in the patient record has been implemented across all services to ensure staff know a patient has a "learning disability or autism" in order Reasonable Adjustments are made.
- A Flow Chart explaining how to determine Parental Responsibility was shared across the BSW Network of Safeguarding Practitioners.
- ICON an evidence-based programme designed to help parents and carers to understand the normal crying pattern of infants and help them develop successful coping mechanisms to deal with this, has been agreed and will be launched in 2024.
- ICB compliance for PREVENT training levels 1& 2 remain at 95%
- A bespoke safeguarding Level 3 training programme was developed for Primary Care staff to ensure consistency across the BSW footprint.
- The ICB Safeguarding Team have been involved in twenty-six statutory reviews during 23/24, of which recommendations have been implemented and associated learning embedded.
- Clear, Hold, build for Swindon & Wiltshire, a Home Office initiative to tackle Serious & Organised Crime was launched in June 2023.
- In May 2023 Standing Together, a national domestic abuse charity was commissioned by the Home Office to identify and understand domestic abuse interventions in place across healthcare. Questionnaires were distributed across BSW and although return rate was small the report recommended 'A coordinated response to preventing domestic abuse and reducing the long-term impacts would have benefits for individual and populational health as well as providing future cost savings across health and societal systems.
- The majority of GP Practices in BaNES have now received the IRIS Training programme with some now receiving refresher training.
- An Icon is now available and used on System1 in all GP practices in BaNES to pull relevant information for MARAC conferences.
- There is an improved offer of domestic abuse training in Primary Care in Wiltshire, including DASH risk assessment tool.
- Work has been undertaken across BSW to improve consistency of coding for domestic abuse on System1.
- Learning from a Deep Dive by AWP staff into Domestic Homicide Reviews and suicide has been shared across the BSW Safeguarding network.

5. Legacy of the Impact of Covid

Although the full extent of the impact of COVID19 may never be known, the aftermath has had a residual effect on some of the most vulnerable people and communities. It has impacted most significantly on young people who missed out on education and felt isolated by the restrictions of the pandemic and isolated elderly people who were the most vulnerable. COVID 19 has resulted in 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.

Nationally concerns continue to be raised about the increased vulnerabilities of certain groups from the impact of Covid 19, and it has become a standing key line of enquiry in local reviews. Whilst BSW area reviews have not found that it is a single cause of harm, the impact is being felt in other ways.

The safeguarding team hold most of their meetings virtually, including the bi-monthly meetings of Named Leads in BSW NHS commissioned services, safeguarding training, and Primary Care Safeguarding Lead meetings. Whilst the loss of personal contact as a benefit to communication is acknowledged, the virtual nature has enabled good attendance and at times, involvement in meetings on a national level that would be far more difficult in person.

6. 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 surgeries in Swindon and BaNES 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 all, but three Practices have received a quality assurance visit in BaNES. A Named GP for Safeguarding was appointed for the Wiltshire Locality in February 2024, this post was vacant for some time, and we will seek to establish assurance visits over the coming year.

Common themes that were identified in practice visits include: lack of awareness of safe recruitment training and how to access it; the need to align policies across all practices; variations in how health visitors are linked to and collaborate with primary care, the inconsistency of 'tasking' on System1 between public health nursing and General Practice.

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. In BaNES, the Practice Safeguarding Leads access supervision on an ad hoc basis from the Named GP's and also provide supervision to their practice staff on the same basis.

Safeguarding lead training, provided by the locality teams, has continued over the past year with two sessions in Swindon, six sessions in BaNES (three adult and three children) and five courses (3 sessions per course) in Wiltshire.

7. BSW Wide issues:

7.1. Liberty Protection Safeguards (LPS) and Mental Capacity Act (MCA)

In April 2023, the government paused on the implementation of LPS, and the plans for introduction of LPS are now on hold. The BSW LPS Health steering group has however maintained its core purpose to improve the application of the Mental Capacity Act by becoming a BSW Health 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. Membership includes everyone who is leading on the MCA from within any NHS funded organisation within BSW.

The first priority of the group was to complete a BSW colleague survey about the most effective learning methods for MCA, which in turn produced a workplan for the group. The constitution focuses on leadership to improve various aspects of practice within each attendee's organisation. An MCA Masterclass delivered by Tim Spencer-Lane around Mental Capacity and hospital discharge: Wiltshire County Council v RB & ORs [2023] case (https://www.bailii.org/ew/cases/EWCOP/2023/26.html) was delivered in September 2023. Michael Preston-Shute and Tim Spencer-Lane have continued to support the community. Local colleagues, from RUH Safeguarding team, Salisbury Medical Practice and a GWH Paediatrician have brought reflective cases to the community which has developed learning.

The BSW ICB has commissioned MCA training for colleagues across BSW services and has commenced a programme within the RUH.

BSW ICB has led on the development of a training matrix to map MCA and dols training across the south-west region.

BSW ICB is also part of a regional group developing training and supporting literature to support organisations best practice in applying MCA for 16- and 17-year-olds.

7.2. Caring for children and young people fit for discharge from acute hospitals but with no forward placement available

It has long been recognised paediatric wards can be inappropriate locations for young patients with mental health needs/emotional dysregulation, for they are designed to

meet the physical needs of children with acute illnesses. In addition, aspects of the physical space may pose a risk to a young person e.g. not being anti-ligature in design. They are often busy and noisy environments with unwell children and visiting families and can be over stimulating to a young person who is distressed. Measures taken to keep a young patient safe can sometimes be highly restrictive, including increasing the number of staff observing the patient (sometimes security staff), removing physical hazards and dangers, removing access to activities on the ward which are available to other patients, and limiting leave from the ward.

Throughout 2023-24, there have been an increasing number of young people resident on paediatric wards for extended periods of time. This applies particularly to children looked after and care-experienced children and young people, who are known to be four times more likely to have a mental health difficulty than those not in care. They are often admitted to acute paediatric wards, and when fit for discharge find there is no available forward placement and remain on the ward for extended periods. Nationally it is recognised at this current time there is a lack of onward placements to children's mental health beds, due to both a shortage of beds and a shortage of skilled mental health staff available to care for them. So, although a child may be ready for discharge from an acute hospital setting, they may not be ready for discharge home. This can be very distressing both for the young person and their family as well as all professionals involved, it has therefore been important to listen to the voice of the young person in order to adapt the environment wherever possible.

In addition, BSW ICB have worked closely with the three Acute Trusts and Local Authorities to improve the outcome for these young people and also support ward staff, who may be significantly impacted in managing distressed young people, a role for which they are not trained or equipped to do.

7.3. Specialist Hospital Accommodation

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. Additionally, there were recommendations from a more local review specifically for the BSW ICB commissioned by Somerset SAB (Safeguarding Adults Review: Learning from the circumstances of the deaths of Abi and Kate) - Kate (a pseudonym) was a Wiltshire patient.

The recommendations to reduce out of area placements align with the BSW MH Strategy 24/29 and whilst working to the national target of zero out of area placements by March 25, other recommendations are being actively implemented. Safeguarding has an integral involvement in the regular review of existing placements, Mental Health Multi-Agency Discharge Events, and where new applications are still being made.

Improvements to the transparency of information shared about the expectation of people and their families and the information provided to them are now a standard consideration in the discussion about new referrals.

The specialist placement application form for the BSW Funding Panel has been amended to include improved documentation compliance with Mental Capacity Act & Best Interest decision-making standards, including Court of Protection aspects.

Safeguarding supervision is delivered to ICB colleagues from the Specialist Placements/ Acquired brain Injury and section 117 funded aftercare. Its focus is usually on complex aspects of mental capacity and assurance arrangements around services where the Local Authority is conducting organisational enquiries and learning from relevant statutory reviews.

Safeguarding Partnerships have received assurance reports about the progress being made towards ensuring the safety and well-being arrangements for people from BSW placed into other counties.

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.

BSW ICB safeguarding team have reviewed residential placements meeting the Hesley criteria within the BSW footprint. Training slides that incorporate the learning from the Hesley and Greater Manchester reviews around Closed Culture have been created and shared with our providers to include these in their safeguarding Level 3 training. However, there are remaining actions for quality and commissioning teams on the monitoring of ICB commissioned placements and the commissioning of health advocacy.

7.4. Intrafamilial Sexual Abuse

In response to several safeguarding concerns in the Wiltshire locality a task finish group was established to achieve a better understanding of the management of intrafamilial sexual abuse. The key aims were:

- ❖ to explore practitioner knowledge around intrafamilial sexual abuse
- ❖ to map resources for victims/ offenders across Wiltshire
- ❖ to consider resources / frameworks for learning/ practice across the SVPP partnership.

The ICB were asked to review 25 cases with primary care and although this work is ongoing preliminary findings include:

- the need for multiagency audits to ensure joined up working
- improvement required to evidence outcomes of actions
- multiagency pathways are needed to ensure children who are sexually abused access the right medical and psychological care

The review has highlighted a significant need around therapeutic interventions for children who sexual abuse their peers. This has been raised with ICB mental commissioners and NHSE Sexual Violence Commissioners.

7.5. BSW Statutory Reviews

This year there have been 26 statutory adult and children reviews of which 18 relate to children. Most 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).

7.6. 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	**3**	**9**	**2**	**4**	There were twenty children's cases for consideration, for Statutory Review of which eleven were deemed not to meet criteria. There were four adult referrals for a Statutory Review of which two did not meet threshold There were six cases considered for a domestic homicide review of which two did not meet threshold.
BANES	**2**	**1**	**1**	**0**	Professional lack of engagement with fathers; Care Experienced young person, with multiple placements; Understanding Emotional Dysregulation and emerging personality disorders; Knife Crime Impact of Domestic abuse; Trauma informed care; mental capacity; voice of the victim

[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.

The findings from the Reviews reflected national learning and include neglect and self-neglect; serious violence related incidents; mental capacity, under 1's, lack of engagement and knowledge surrounding fathers and familial sexual abuse.
Prevention of sudden infant death in under 1's sleeping whilst co-sleeping or out of routine or away from home, was another theme combined with parental substance misuse particularly cannabis and parental mental health. 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.
The three Safeguarding Partnerships have reviewed their local arrangements in response to learning from both National and Local Statutory Reviews the ICB has:

- Routinely undertake MASH audits in each locality across BSW, with a specific focus on the voice of the child
- Reviewed information sharing agreements and protocols across the three Partnerships including sharing information around Fathers and in relation to Serious Violence.
- Strengthened advice regarding Co-sleeping through CDOP panel
- Deep-Dive into child sexual abuse in Wiltshire
- Piloting of Graded Care Profile Neglect toolkit in Maternity in Wiltshire and BaNES
- Review of Multi-agency Risk Management Process in BaNES
- The Wiltshire Neglect Framework has been refreshed and although primarily children also includes information on self-neglect in adults and who to contact.
- Disseminated learning from statutory reviews throughout all ICB training packages

8. Safeguarding Unborn Babies and Under 1s system improvements

Research nationally has established the increased risk to under 1s from abuse and neglect. Local case reviews across BaNES, Swindon and Wiltshire have also identified this risk, with both Wiltshire and Swindon publishing thematic reviews relating to serious injuries in this cohort of children. Across the individual safeguarding partnerships work has previously taken place to respond to the learning from these reviews, however the response has lacked oversight and coordination in order for it to be most effective and impact on practice.

A steering group has been chaired by BSW ICB and members have included representatives from BSW ICB, the three safeguarding partnerships, children's social care, community and acute health services, public health and the police.

Outputs of the group have focused on improvements of response to the under 1's and have included the development of a BSW bruising in non-mobile babies' policy; development of BSW Pre-birth protocol; development of BSW Faltering growth Policy; development of a Safer Sleep policy and a focus on professional curiosity and '*working with fathers'*. ICON interventions, Preventing Abusive Head Trauma in Infants has also been adopted across BSW. The high point was an Under 1's Virtual Summit held 4th March 2024 attended by over 300 professionals from statutory and voluntary organisations across

9. Safeguarding Partnership Working

Bath and North-East Somerset, Swindon and Wiltshire Integrated Care System (BSW Together) published 'Our Integrated Care Strategy 2023-2028'. The strategy sets the direction of the Integrated Care System for the next five years, outlining how the partnership through working together can help children and adults in BSW to live healthier for longer. It has three objectives:

- Focus on early intervention and prevention
- Fairer health and well-being outcomes
- Excellent health and care services

Central to the strategy is a focus on reducing health inequalities across the BSW population. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, shaping our mental health, physical health, and wellbeing. By working in partnership to tackle inequalities across the life course ensures that every resident can live longer, healthier, happier lives free from harm and abuse.

The 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.

9.2. 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 Including Serious Violence	Exploitation and Contextual Safeguarding including Serious Violence	Exploitation and Contextual Safeguarding including domestic abuse
Neglect	Transitional Safeguarding	Transitional Safeguarding
Adult Self-Neglect	Domestic Abuse	Capturing Voice of Users
Transitional Safeguarding	Social, Emotional and Mental Health	Self-Neglect and application of Mental Capacity Act
Restructure BCSSP to deliver Statutory Duties		Effective Safeguarding Partnerships

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

10.Progress against set priorities 23-25

BSW Safeguarding Implementation Plan

The BSW Safeguarding Team developed an implementation plan for 2023-5, to reflect both ongoing work but also new and emerging safeguarding duties. Much of this work remains in progress due to the consultation Project Evolve which impacted on delivery. The key objectives of the implementation plan include:

- Undertake training analysis of healthcare staff requirements to meet Serious Violence Duty
- March 24
- Safeguarding Audit to demonstrate learning from case reviews
- Establish links between victims of abuse and serious crime and broader health inequalities work
- Ensure the safety and wellbeing of our vulnerable population placed in residential and therapeutic providers both within and out of area
- Continue leadership regarding the vulnerability of under 1's and work with partners to have differentiated system that improves outcomes for this vulnerable group.
- Identify further vulnerable groups and work with partners on system improvement
- Ensure the voice of the child and /or service user is heard and understood
- Ensure all relevant policies and strategies across the ICB reflect the voice of the child/adult in relation to safeguarding

What will be different for our population in 5 years' time?

The impact of this work will be that BSW ICB will have greater insight into the predictors of vulnerability that lead to poorer outcomes to abuse and serious crime. As an ICB we will be able to demonstrate more responsive commissioning to address inequality at an early stage and learn from the trauma of abuse

Several priority actions were identified in our 2022/23 safeguarding annual report. The progress has been steady and is on track to be completed by 2025.

10.1. Table 2 Progress on Priorities

PRIORITY	COMPLETED	IN PROGRESS	NOT COMMENCED	ACTION NEEDED
1.Development of MCA legal literacy within the ICS	✓			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.
2.Development of a BSW wide non-mobile baby policy with safeguarding partnerships	✓			
3.Review of Health resources into MASH	✓			A review of the ICB contribution into MASH is complete
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 has been developed
7.Development of succession planning for safeguarding roles within the ICS	✓			This is now complete with the New Structure that has been developed partly as a result of project Evolve. There is a Designated Nurse for adults and children across BSW and in the new structure there will be a locality-based Band 8a professional.
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. Although this action is on hold as there is insufficient ICB digital resource to action it.
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.	✓			
14. Update ICB Safeguarding webpages	✓			Complete across all localities
15. Improve information sharing through the use of new digital technology such as 'TeamNet'.	✓			Complete across all localities
16. 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 has started to restructure subgroups and improve representation
17. 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		✓		Discussions have started but no training commenced as yet
18. Roll out safeguarding supervision in Primary Care across BSW		✓		This has started but has not progressed due to workforce pressures and changes in Primary Care Teams

11.Domestic Abuse

In February 2023, the Home Secretary included violence against women and girls (VAWG) within the strategic policing requirement (SPR), which means that the national policing response to violence against women and girls should be on a par with terrorism and serious and organised crime.

Domestic Abuse remains a priority across the BSW population with 1:5 of the population experiencing Domestic Abuse in their lifetime and in 2022 1.7 million women were victims with a domestic abuse related call being made to the police every 30 seconds. (ONS,2022).

The Domestic Abuse Act 2021, extended coercive and control offence to include post separation abuse, created a new offence of non-fatal strangulation/suffocation, placed Clare's Law (Domestic Violence Disclosure scheme) on a statutory footing and prohibited all health professionals for charging for a letter to support a victim of domestic abuse to get legal aid.

As a result, we have seen increasing numbers of referrals for coercion and control and stalking and harassment and non-fatal strangulation highlighted in MARAC referrals.

11.1. 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	The Director of Public Health chairs the Community Safety Partnership and sits on the BCSSP Executive Board.
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 • 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	• 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 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	A better understanding of the prevalence and impact in BaNES of VAWG; county Lines; Exploitation; Hate Crime; Modern Slavery; Cuckooing; Prevent and Fraud An ongoing needs assessment as part of the Violence Reduction Partnership work which highlights hotspots and also gaps locally. Review of MARAC services leading to improved oversight of cases to inform future work and priorities Through good practice and joint assurance work this will continue to support a consistent service to our victims. Plans to work with perpetrators to disrupt cycles of abusive behaviour have not progressed in this financial year. DA Boards and services have captured the victims voice by sharing their lived experiences, it is planned to continue and strengthen this work. The new structures within the BCSSP safeguarding partnership has strengthened the assurance of the Community Safety Partnership

11.2. 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. The lead responsibility for MARAC has transferred from public health to the police which has resulted in some ongoing logistical issues with regard to sharing information which are being worked through and the expectation that all staff will be present for the entirety of the MARAC meeting each week.

A significant time commitment is required across the health system to collate and share information, in BaNES a digital system has been introduced in Primary Care whereby all health information is made available and so prevents multiple health partners downloading information.

12. 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 specified authority 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

The BSW ICB Chief Nurse and the ICB safeguarding team are representatives on the Violence Reduction Unit (VRU) in BaNES locality, Swindon Community Safeguarding Partnership and Wiltshire Community Safeguarding Partnership. Community Safety Partnerships (CSPs) and VRU's have an explicit role in evidence based strategic action on serious violence and these partnership meetings will be the driver for delivering the serious violence duty (SVD) and safeguarding Statutory Duties. The ICB, as a Specified Authority, will work with Relevant and Specified Authorities to collaborate on a multi-agency approach to prevent and reduce serious violence and align with BSW ICB Joint Forward Plan. The Duty is a key part of the government's programme of work to collaborate and plan to prevent and reduce serious violence: taking a multi-agency approach to understand the causes and consequences of serious violence, focusing on prevention and early intervention, and informed by evidence

13.Prevent

Prevent is a fundamental part of the UK's counter-terrorism strategy, known as Contest. Prevent aims to stop people becoming terrorists or supporting terrorism. It does this by tackling the ideological causes of terrorism, intervening early to support those susceptible to radicalisation, and enabling people who have already engaged in terrorism to disengage and rehabilitate

The "Independent Review of Prevent", published on 8 February 2023, was conducted by Sir William Shawcross and the thirty-four recommendations were all ratified and will be led locally through the Prevent Boards where the ICB is represented.

Following the publication of the revised Prevent Training and Competency Framework, the ICB Safeguarding team facilitated meetings with the three Acute Trusts (RUH, SFT, GWH) and all three have revised their training and implemented the new Framework.

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. Internally, ICB compliance against levels one and two of the Prevent Training and Competency Framework is at 95%.

In addition, 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. In response to the low reporting of Prevent concerns across primary care, the newly appointed named GP for BaNES has taken on the Prevent Lead for BaNES Primary Care and has started awareness raising sessions and including a greater emphasis on training to GP Leads.

BSW continues to be one of the lowest reporters of Prevent referrals. Multi-agency conversions of referrals to Channel Panel are low.

In BaNES: there have been only 7 Prevent referrals in the previous 12-months with 9 referrals made since June 2023. The age profile is 14-25 years and usually white male. There has been 1 referral to Channel Panel in the last quarter that was taken forward.

In Wiltshire: there have been 27 Prevent referrals over the past year and no referral to Channel.

In Swindon there have been 26 Prevent referrals with one case proceeding to Channel

14. Child Death Overview Panel

BaNES Child Death Overview Panel (CDOP) transferred from the West of England (BNNSG) CDOP to Swindon and Wiltshire CDOP on the 31st of March 2024. By moving to a BSW CDOP, this aligns with the footprint of the Integrated Care Board and supports joined up working and shared policies where appropriate. The BaNES safeguarding and public health staff will now support the Swindon and Wiltshire CDOP, and because of the aligned panel the Designated Doctor will only be required to attend one CDOP meeting instead of two each month. Thus, providing a more sustainable model for future working practice. Any ongoing cases will continue to be completed by West of England but any new or as yet not started cases will be transferred to the new BSW Panel.

As of 1st July 2023, CDOP are no longer required to inform LeDer of children with a disability.

15. 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. The outcome of Project Evolve has strengthened a BSW wide approach to safeguarding and the aligning of safeguarding systems and policies wherever possible.

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.

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 details the BSW wide work, developments and efficiencies of working at scale across the three localities: Ongoing system wide work focusing on the Under 1's, ensuring the voice of children, adults and their families are heard, Intrafamilial Sexual Abuse, BSW wide policy developments, support to Acute Trusts when caring for young people fit for discharge with no forward placement, the importance of understanding mental capacity, self-neglect particularly with vulnerable adults and our response to the serious violence duty.

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 ongoing Project Evolve consultation. 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.

16.Appendix 1

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