Wiltshire Safeguarding Vulnerable People Partnership

Annual Report 2021-2022

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Chapter 1: Introduction and context

This is the SVPP's third Annual Report. The safeguarding arrangements have continued to evolve and have strengthened the links with the Community Safety Partnership.

In January, the Independent Chair stepped down and the safeguarding partners committed to take on the chairing of the SVPP Executive going forward; held in the first 12 months by the local authority.

The impact of the pandemic continues to be felt by all agencies in relation to capacity and resourcing and this has at times presented challenges for the partnership to push forward work in a timely way, for example embedding the work of the new Practice Development group.

Last year we set out to ensure that safeguarding systems and safeguarding leadership are an integral part of developing a safe and effective ICB and with their introduction delayed until July 2022 this will be a focus during 2022-2023.

Whilst we have been able to embed new ways of working introduced during the pandemic, many of which support partnership working, all organisations continue to experience significant pressures which can impact on their ability to proactively engage with partnership work. Continuing to have a flexible and responsive partnership helps us respond to such challenges whilst focussing our activity on some key areas of work.

We have however been able to further develop our case review processes, receiving very positive feedback on our rapid reviews for children from the national Child Safeguarding Practice Review Panel, improve our communication with partners through our new website and improve partnership working with schools.

Chapter 2: Responding to our forward plan 2019-2020

In last year's report we committed to drive forward work in the following areas:

Safeguarding of Under 1yrs

Under 1s remain one of our most vulnerable groups in Wiltshire with 9 of the 14 notifications to the national CSPR Panel submitted since 2018 relating to children under 1. In response a Safeguarding Under 1s Steering group was established in January 2021 to ensure better oversight of and the ability to further develop the work taking place to safeguard them and share existing and developing best practice in this area. This group sits across the ICB footprint - BaNES, Swindon and Wiltshire - in recognition of the role of health in this agenda and that families in Wiltshire will travel to one of 3 acute hospitals across this footprint, only one of which is in Wiltshire.

To date this group has been able to:

- Map existing service provision for under 1s and their families - as well as identifying focussed provision from which learning can be shared it has also identified a lack of clarity on the commissioning and use of Dads Pad and inconsistent use of ICON across BSW. Knowing where the gaps or inconsistencies are will now enable us to address these.
- Analysed the learning from case reviews relating to under 1s across BSW to understand themes and key practice issues which can then be addressed through further guidance or training for example.
- Improve our understanding of barriers to working with and engaging fathers by learning from existing practice in this area, including from the Dads Matter Too Project in Wiltshire.
- Led work on developing a joint policy on injuries to non-mobile babies to ensure consistency of messages and response across BSW.
- Have oversight and scrutiny of our response to the findings from the national CSPR Panel reports, the Myth of invisible men and Out of Routine.

Domestic Abuse

The duties set out in the Domestic Abuse Bill have been incorporated into the Domestic Abuse Local Partnership Board in Wiltshire. In addition, a robust health needs assessment has informed the new Improvement Plan 2022-2024. This sets out clear strategic priorities and outcome measures to evidence impact. In addition, further impact on this agenda can be evidenced through:

- the creation of a DA Military Forum in recognition of the specific needs of this community in Wiltshire and this group creates an opportunity for agencies to build relationships and networks and raises awareness of domestic abuse and the impacts within military families.
- a focus on employers having appropriate support and guidance in place for staff who are victims of domestic abuse.
- development of a data dashboard.

A new Perpetrator and Offender Group has also been established and the impact of this has been to develop a DA Perpetrator Focussed Strategy in Wiltshire for the first time.

Criminal Exploitation

We set out in the previous annual report the creation of a Pan Wiltshire all age Exploitation Subgroup, sitting across both the Wiltshire and Swindon safeguarding partnerships. During 2021-2022 a decision was made to create separate groups focussed on children and adults reporting into one strategic group to increase effectiveness and focus on key issues; and in recognition that understanding of exploitation and related practice in adults is less embedded than for children.

This agenda remains a key focus however requires a clear strategic direction to further drive activity and outcomes and ensuring all agencies are actively engaging with the work needed through the subgroup. Ensuring the strategic group has clear line of sight to operational practice and the mechanisms in place, to support this agenda, such as the Safer Young People Group, is necessary to provide assurance that we are protecting children and adults from this form of abuse in Wiltshire and to better enable us to evidence impact of this work. Working across Swindon and Wiltshire has brought benefits and challenges and the partnership will need to decide how work can best be taken forward in Wiltshire.

Operationally work to safeguard children and young people from exploitation has been further driven forward by the piloting of the risk outside the home child protection conference process, supported by the DfE. This is innovative work, and Wiltshire is the only area nationally to pilot this, offering a different approach where the risk is extrafamilial, working closely with parents as safeguarding partners. Whilst this new approach continues to be tested, internal auditing and feedback from the contextual safeguarding research team at Durham University suggests this is a promising alternative child protection pathway for children at risk of significant harm outside of the home. The process has so far demonstrated evidence of supporting advocacy of children and protective parents and focussing planning on the source of harm. Wiltshire will continue to test this approach and develop the contextual interventions available through our further partnership with Durham University and it's 'Planning for Safety' research strand. Through this research strand, Wiltshire's approach is also being tested by 3 other local authorities, demonstrating the lead role Wiltshire has nationally in developing practice in this area.

In addition, the roles and functions of the Vulnerable Adolescent Risk Management and Vulnerable Adolescents Contextual Safeguarding panels have been reviewed to ensure effectiveness. In response to the learning from these meeting structures, and with consideration of Wiltshire's strength-based approach, the Safer Young People groups have been developed: the Safer Young People Context Meetings provide locality based multi-agency oversight to groups and contexts of concerns; whilst the Safer Young People Partnership Group provides strategic oversight of exploitation and other forms of harm outside the home. A review completed in 2022 found that these meetings are successful in pulling together shared aims and language around extra-familial harm and provided an essential platform to share information between the professional networks. The approach was found to support planning which addresses the risks in the context where harm occurs, which is vital when working to safeguard adolescents.

Understanding the protective nature of being in education has led to an improved focus on children missing education and children who are electively home educated or who are subject to CiN or CP. The impact of this work, which is ongoing, is that it has improved our ability to know who the most vulnerable children are and put in place additional plans to support and protect them. This data is used to inform targeted work to ensure these pupils are receiving a full-time suitable education, through the extended duties of the Virtual School, Attendance Strategy and Targeted Education Service.

Leadership and Culture

The move by the safeguarding partners to take on the chairing of the SVPP Executive demonstrates their willingness to provide strategic leadership. This was also a focus of the Southwest Regional Improvement Alliance event: The role of safeguarding partnerships in regional sector lead improvement in July 2021, bringing together safeguarding partners from across the region for the first time. This event helped inform scrutiny practice across the region. Partners identified that the focus should be on peer challenge, learning from and sharing best practice from reviews and independent scrutiny. This new network will be further built on in 2022 to help strengthen partnerships and their impact across the southwest.

Progressing a DfE funded pilot to improve our data analysis and intelligence-led approach to safeguarding

The SVPP received funding from the DfE to take forward work to make better use of data and intelligence in the system informed by the voice of children and families and practitioners. We were unsuccessful in recruiting to a Data Analyst role to take forward the work to collate and analyse intelligence and how this can inform and improve the safeguarding system, however we have been able to:

- complete the design, testing and launching of a new website which is now live – it is the intention that this function as the site for all case based and research learning including the development of podcasts and interviews available to practitioners to download and listen when convenient.
- explore the ability to set up chat rooms to support frontline practice and member engagement.
- work with schools and designated safeguarding leads to ensure the website meets their specific needs and as a way to better engage the education sector in the work of the partnership.

The final area of focus set out in last year's report relates to a programme of independent scrutiny, which in 2022-23 will include independent scrutiny of the progress against the partnership priorities.

Chapter 3: SVPP Development and Impact

Improving communication with practitioners and partners

Our Safeguarding Plan set out our ambition to "ensuring users and the wider community are properly engaged in the work of the SVPP". The Community Voice and Engagement Officer post has supported engagement with service users and practitioners and improved and sustainable communications across the partnership during the past 12 months.

This post has delivered a new partnership website bringing together the existing SVPP website, Wiltshire Safeguarding Adults Board (WSAB) website and creating information on the work of the Community Safety Partnership (CSP) for the first time. This has:

- provided centralised communications across the partnership and is helping us to build an identifiable brand.
- improved navigation and user experience and therefore ability of access information, including learning from case reviews.
- creation of an e-newsletter as a more effective way to share safeguarding news and partnership updates.
- the ability to set up member only forums and work is currently taking place to consider how we can use this to support subgroup members and provide induction information to help new members understand their role within the partnership.
- improved our ability to monitor use and an analysis of website usage, showing that the new site has an average of over 2000 views per month with the majority of people visiting the Learning Hub and News pages
- added to our ability to use a range of media through which to disseminate learning and information, such as webinars and podcasts

This post has also mapped voice activity across the partnership and provided a number of recommendations on which work is currently taking place to ensure voice informs the work of the SVPP.

Communication between the SVPP and wider stakeholder has also been improved through our Stakeholder Network meetings; established in January 2022 to strengthen communication between the SVPP and its partners. This meeting has a broad remit and is open to all practitioners and managers, including volunteers, who work with children or adults in the county. Network meetings this year have focussed on: learning from case reviews including the CSPR national Panel report on Myth of Invisible Men; Information sharing and provided the opportunity for attendees to discuss safeguarding issues they are experiencing in their own practice.

Improving our oversight and governance of multi-agency safeguarding training

A new Practice Development Group was established in January 2022, to provide governance of the multi-agency training offer for both the children's and adults workforce. Progress has not been at the pace we would have wanted due to operational pressures, however such a governance structure has not previously been in place and the groups is making headway with:

- identifying areas for practice development and make recommendations regarding the facilitation and commissioning of appropriate training resources
- ensuring the regular review and evaluation of the training, ensuring training content is current and relevant and aligns with SVPP priorities and wider agendas to create safer communities
- improving the learning loop from case reviews and audit activity back into practice
- exploring learning opportunities with neighbouring partnerships.

Improving our ability to work closely with early years, schools and colleges

A new Education Safeguarding Committee has been established improving the links between the SVPP and education settings, including early years. This is a significant addition to the partnership and has already evidenced impact through:

- improved oversight and governance of safeguarding training provided for schools
- improved line of sight into children missing education and electively home educated children
- improved our ability to feed relevant learning from case reviews into the education system
- improved oversight of safeguarding complaints to Ofsted
- improved understanding of local themes from Ofsted inspections enabling plans to be drawn up to address these
- driving the response to and support for schools in relation to peer-on peer abuse.

Improving our ability to work across the partnership structure

Restructuring of the strategic roles within the SVPP Business Support team and the creation of Partnership Lead posts have enabled a clearer strategic focus and the ability to work across the three agendas: safeguarding of children; safeguarding of vulnerable adults; community safety partnership. These roles now work to ensuring the necessary integration across the three agendas, preventing duplication and enabling learning from case reviews to more effectively be shared across the multiagency safeguarding arrangements.

Chapter 4: Practice Reviews – activity and impact

The Partnership Practice Review group (PPRG), which is our local mechanism for the identification and reviewing of all case reviews for the partnership including serious child safeguarding cases, is now well embedded. The introduction of a Development Plan and key performance indicators have enabled further improvements to the case review process this year including:

- Clarifying and improving links to the LeDeR process in Wiltshire to ensure relevant learning is shared and duplication of review processes avoided.

- Implementation of a standardised process for publication of final reports for statutory reviews to include the publication of a briefing, summary slides for agency use and virtual briefings to improve and better support the sharing of learning by the partnership and within agencies.
- Reintroduction of the requirement on agencies to tell us how they have disseminated learning and any impact.
- Workshops with practitioners who have been involved in case reviews to ensure our guidance for participants is clear, and that they feel supported and safe to participate in case reviews at both an agency and partnership level.
- Introduction of a case data tracker to enable better oversight of timeliness of notifications and publication of reviews and will enable further analysis of themes and characteristics of cases.
- Introduction of a case learning tracker enabling improved oversight of the actions in response to recommendations and learning and their impact.

The PPRG Development Plan for 2022-23 will focus on improving family involvement in case reviews, improving timeliness of publication of statutory reviews, and further embedding the case learning tracker and ability to evidence impact on practice. Where the publication of the final report is outside the expected 6 months' work will have already started on taking the learning forward to ensure it is implemented quickly.

Consideration has been given to the dip in referrals to the case review group with no cases relating to children referred in the last 2 years that have not been notified. Whilst the PPRG will not review cases that do not provide new learning we need to be assured that all partners are aware of and feel able to refer cases into the group including near misses and examples of good practice. Regional benchmarking in relation to rapid reviews and CSPRs is taking place but we remain an outlier in relation to the commissioning of SARs. Further communications reminding partners about the referral process have been put in place and a wider partners meeting planned for November 2022 will provide a further opportunity to discuss this with partners.

Case reviews relating to children

During 2021-2022 there were 3 referrals into the PPRG, and all of these notified to the CSPR Panel. Two of these cases progressed to a CSPR. Whilst it remains a local authority duty to notify in Wiltshire, we have embedded a multi-agency discussion to inform the decision about whether a notification is made. This has created ownership of and responsibility for this process by all safeguarding partners.

LCSPR Long term sexual abuse of children in care (Rapid Review 1)

This case related to disclosure of long-term sexual abuse within a long-term fostering placement by foster carer father. The LCSPR found that: there were no systemic practice issues; few, if any, indicators that the children were being sexually abused prior to the disclosure; and there were no concerns about the placement which was considered to be stable and providing a good quality of care. No practitioner considered the possibility of sexual abuse; it was "unthinkable".

One of the strengths of this review was the voice of the two sibling victims who were interviewed by the report author. They provided insights into the grooming behaviour of the perpetrator as well as important insights into the disclosing of abuse: one of the siblings told us that she wanted to be in control of the disclosure and would have been unlikely to disclose even if asked directly; that she "put on an act to hide the abuse"; and she worried that she would not be believed.

Much of the other learning from this case is not new but this case has reinforced the following:

- That a child who is being sexually abused may not show any obvious symptoms that suggest they are being abused.
- That all professionals need to be able to consider the 'unthinkable' about carers who they may know well and who they may work closely with and be alert to the possibility of sexual abuse.

- Schools are a key part of the system of providing a general environment where children know who they can talk to about sexual abuse and what will happen if they tell someone.

In response the report and response to recommendations have been reported into the Corporate Parenting Panel and work is taking place with staff from schools about what more education settings can do to support children to disclose harm and abuse.
The CSPR was published within 8 months of initiating the review.

Rapid Review 2: Sudden unexpected death of a 1-year-old child in the context of significant risk of physical harm.
This case highlighted the importance of organisational memory in order for the system to be alerted to known offenders who are not under probation or MAPPA review case reviews. The impact of this is that the system should be better able to identify such individuals at the earliest opportunity following work by police and social care agencies to put in place flags on their systems.

Learning in relation to safe sleeping is being responded to by the new Safeguarding Under 1s Steering group as referenced in Chapter 3.

The national CSPR Panel described the rapid review report for this case as "exemplary", further providing evidence that we have a high quality and robust process for rapid reviews in Wiltshire. This case did not progress to a LCSPR.

LCSPR Eva (Rapid Review 3) – non-accidental injuries to a 3-month-old baby resulting in her death (published August 2022)
This local case reflected some if the issues set out in the CSPR Panel Report, The myth of invisible men, and the key learning in this case related to the understanding and assessment of the risk of problematic cannabis use and its impact on parenting capacity. In response the development of training and further guidance is underway.

An interview with the report author has been made available as a webinar and this has proved to be a very successful way of sharing learning on a case review with over 260 views to date and we will continue to expand the use of different mediums for sharing of learning.

The CSPR was published within 9 months of initiating the review with some delay in publication in order to avoid sensitive dates.

Wiltshire was also involved in a further rapid review following the death of a Wiltshire child in a residential mental health hospital in another local authority area. The rapid review was completed by the partnership in which the hospital was located, on the advice of the CSPR Panel. Learning from this case has led to improvements in the pathway for information sharing on children that are in hospital and are receiving education provision.

The Joint communication from CSPR Panel and DfE received in December 2021 prompted a further analysis of practice in relation to case reviews for children as set out in the table below, providing further assurance to the SVPP Executive in relation to our arrangements in Wiltshire for the identification and reviewing of serious child safeguarding cases, as set out in Working together 2018.

Activity	Response/ Wiltshire Position (as at April 2022)
All serous incident notifications must be sent to the Panel within **5 working days** of the local authority becoming aware of the incident	10 notifications made since June 2018 All made within 5 working days
Rapid Reviews should be submitted to the Panel within **15 working days** of the safeguarding partners becoming aware of the incident	8 Rapid Reviews completed since June 2018 7 submitted within 15 working days (date set out by the Panel) 1 submitted on day 16

Full Reports should be sent to the Panel and the Secretary of State **seven working days** in advance of the publication date. Local CSPRs should be **published within 6 months of initiation*.**	CSPR Thematic Review into significant physical injuries in under 1s – published 6 months after initiation CSPR Family N – published 9 months after initiation *Initiation of CSPR defined locally as: date of receipt of the letter from the CSPR Panel following submission of the rapid review. Case data tracker now in place to improve tracking of timeliness of notifications, rapid reviews and publication of reports.
Complete/incomplete and unpublished SCRs sent to safeguarding partners, the panel and DfE	No incomplete SCRs outstanding.

Safeguarding Adult Reviews

As part of the Safeguarding Adult Board responsibilities of the SVPP, the partnership is required to commission Safeguarding Adult Reviews (SARs) when an adult with care or support needs dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult.

Two referrals were received by the PPRG in relation to adults during 2021-2022, none of which met the threshold for a SAR. Both cases related to suicide/sudden deaths and further join up with the Suicide Reduction Group and their real time tracking of suicides/sudden deaths will enable any safeguarding themes to be identified.
One SAR was published in 2021-2022, as set out below.

SAR Adult L

This case was referred to the SVPP following the death of a vulnerable 59-year-old woman with significant physical and mental health needs and a diagnosis of terminal alcoholism. Adult L had multiple hospital admissions and a history of addiction to opiates. She had also made allegations of domestic abuse against her husband; frequently cancelled appointments to address her care and support needs; and lived in conditions considered to be unhygienic and unsafe. This review found that:

- for adults with care and support needs, consideration needs to be given to any risks posed by those who care for them, and that seemingly unwise choices could be the result of coercion and controlling behaviour by another person.
- practitioners find it difficult when working with adults who display high risk behaviours who are deemed to have mental capacity but are actively resistant to intervention.

Recommendations included:

- Increasing awareness of how coercive and controlling behaviours may inhibit people disclosing or revealing the extent of domestic abuse. Work is underway to develop a DASH risk assessment for adults with care and support needs with a supporting toolkit to assist conversations about the dynamics of domestic abuse.
- Consideration of services for adults adopting the SVPP 'Case Resolution Protocol' to support cases where levels of risk may be severe and the way forward not clear.
- Reviewing and disseminating the High-Risk and Self Neglect multi-agency procedures to include clear pathways for convening professionals' meetings, escalation of concerns and arrangements for agreeing on lead agency and key worker to coordinate practice. Both documents were updated, and their use assessed using a questionnaire and feedback from practitioners was that both procedures were effective. In addition, a webinar on self-neglect was held as part of the SVPP Safeguarding Week, using SAR L as a case study to raise awareness of the procedures and explore best practice in managing cases with longstanding and complex needs.

Non-statutory reviews relating to adults with care and support needs

The partnership is proactive in reviewing cases referred into the PPRG which do not meet the threshold for a statutory review, where the potential for new learning is identified. Learning from these non-statutory reviews is disseminated to partner agencies for internal dissemination only.

Case 1: A death of an adult with learning disabilities in a care home. This case had been subject to a LeDeR review and although did not meet the criteria for a statutory SAR the PPRG felt there were opportunities to learn from practice. Learning from this case highlighted: the complexity of navigating services that support adults with learning disabilities; diagnostic overshadowing; and the need for greater awareness about routes to escalate safeguarding concerns.

Learning from SARS (national): responding to SAR Joanna, Jon & Ben

Following the requirement that all CCGs review the care of all individuals with a learning disability and/or autism in a mental health hospital, the CCG Programme Manager presented an update to the Partnership Practice Development Group in February. Findings of all the reviews for the 26 BSW residents identified as being in a hospital setting as of 31st October 2021 and meeting the criteria set. There will be a national response to the regional summaries, but initial findings suggest that several individuals who do not need to be in hospital, have been for some time, and the challenge is how to create the capacity within the system to discharge them to homes of their own. It is important to note that the concerns identified in the SAR might well apply to individuals in a range of settings, and not just within hospital care.

Domestic Homicide Reviews

DHR Ellie was published in November 2021 and relates to the murder of a teenager by her ex-boyfriend. The learning from this case has focused on support for and awareness raising with young people in relation to the signs and symptoms associated with domestic abuse and coercive control and highlighting healthy relationships.

Two further reports have been submitted to the Home Office Quality Assurance and whilst we await feedback response to the recommendations are under way.

Chapter 5: System Assurance

As previously stated, the Independent Chair, Mark Gurrey, stepped down in January 2022. He has continued to provide some independent oversight through his involvement as author of CSPR Eva, published in August 2022.

Meetings with the senior safeguarding partners have continued pan Wiltshire. This has ensured that they have a direct line of sight into the effectiveness of partnership arrangements and specific safeguarding issues. Although a clear programme of independent scrutiny has yet to be set out there is a commitment to independent scrutiny of progress against the priorities in 2022-2023.

External scrutiny of the systems has taken place through the following inspections:

Ofsted Focussed visit on the experience of care leavers which concluded that leavers are supported by a "passionate, skilled and stable workforce" with care leavers receiving the "right support, at the right time, to help them make progress in their lives".

HMICFRS Police Inspections – PEEL Inspection and national Child protection Inspections identified a number of recommendations for the force as referenced on page 13.

The SVPP Executive now review quarterly updates on inspections that have taken place to improve oversight of this element of external scrutiny and any key safeguarding concerns identified through this process.

A partnership risk register has also been established to ensure the SVPP executive are sighted on significant risks across the safeguarding system, and this will be further embedded over the next 12 months.

Children's Safeguarding

Areas of focus and activity remain driven by either national agendas or issues raised locally, led by the Families and Children's Systems Assurance group (FCSA).

Child Death Process

The child death process in Wiltshire is well embedded and effective, however there was a challenge back to the Child Death Overview Panel to improve the quality of their annual report and to address the backlog of actions and oversight of this. There is a new Chair in place, and actions have now been addressed and updated and the revised annual report sets out key learning points and actions to address these more clearly. Gaps in attendance at the panel have also been addressed.

Everyone's Invited

There was a prompt and effective response to Everyone's Invited, with exceptional meetings held to ensure a joined-up partnership response and identify specific actions for the Wiltshire schools named. Information from Operation Hydrant was fed into the meetings and provided access to all the testimonies, informing our response, which included:

- Letter sent to all schools making them aware of the website and recommending action they could take in relation to peer-on-peer abuse; all independent and secondary schools directly contacted as a follow up to the letter to ensure they were sighted on it.
- Individual contact with all schools named and relevant follow up.
- One Independent School in Wiltshire received more than 20 testimonies and a Safeguarding Review was carried out led by Directors from Children's Social Care and Education and Skills at Wiltshire Council.
- Police reviewed intelligence on all schools named.
- Review of relevant PHSRE resources for schools by the Healthy Schools Coordinator.

The direct work with schools was led by the School Effectiveness Team supported by the Young People's Service which provided additional expertise in relation to contextual safeguarding:

Backlog in the Child Internet Exploitation Team

Operationally, police raised the backlog in their Child Internet Exploitation Team in relation to online sex offender referrals. Police were challenged to why they had not raised this with the partnership as this was potentially leaving children at risk of harm. The backlog has been proactively addressed with clear oversight of the plan to reduce the backlog, within the FCSA, whilst acknowledging the unprecedented demand. In addition, work was undertaken to review all cases that were waiting to be reviewed to ensure there were no children at risk of harm whilst further capacity and a new operating model were put in place to enable earlier sharing of information with partners to inform risk assessments.

Improving Line of sight

There has been a challenge to partners to improve the exception reporting and therefore system assurance about how well the system and its constituent parts are working, including commissioned services for children. Improved line of sight is being embedded and this includes areas identified though the Solihull JTAI Report prompted by the murder of Arthur Labinjo Hughes and the national CSPR Review Child Protection in England.

Adult Safeguarding

Following restructure of the SVPP in 2020 to better coordinate the partnership functions in relation to adult safeguarding the Safeguarding Adults' System Assurance (SASA) Group has been further developing to provide assurance to the SVPP that systems in relation to the safeguarding of vulnerable adults are working effectively. Key areas of work and impact are set out below:

- Regular review of data from the Adult MASH to consider the number and nature of referrals that are taken to a s42 enquiry. The SASA group scrutinise data and request assurance on any areas of concern. For example, concerns relating to low numbers of self-neglect referrals were explored and the group received assurance that local practice guidance recommends self-neglect cases should be worked in long term teams.

- Scrutiny of MASH Audit feedback: the report highlighted the lack of available specialist provision and the impact this had on referrals. The group received assurance from commissioners that barriers to accessing health funded placements were being addressed.
- The group received a report on quality improvement work in hospital discharge from Wiltshire Council and the ICB. The work focused on how discharge to assess processes have improved on their MCA adherence and whether we are assured that best interests in MCA and decision making is effective within the discharge to assess process. The group were assured that there is a robust multi-agency quality assurance oversight of the processes around hospital discharge and discharge to assess.
- Following reviews of the Safeguarding Adults Collection (SAC) return to NHS Digital the group discussed the impact of COVID on safeguarding referrals. The SAC showed more safeguarding concerns raised this year than the previous year with an increasing number of cases where the source of risk was a service provider. The group received assurance that the increase was likely due to the number of hospital discharges to care homes and the group has identified hospital discharge as a priority area for further scrutiny in its strategic plan.

In addition, the SASA group has maintained oversight and scrutiny of the system relating to adult safeguarding, in particular relation to:

- Oversight of the implementation of Integrated Care System (ICS) to ensure that safeguarding was being considered within the ICS structure. This was an issue raised by the southwest Safeguarding Adults Board (SAB) Chairs Network. The group requested a response from the Integrated Care Board (ICB) to provide detail on the new arrangements and assurance that safeguarding was being considered.
- Scrutiny of BSW CCG Primary Care Safeguarding Contract. The group were given details of some of the common challenges experienced by GP practices and an initiative started last year by the MASH nurse to look at how many practices were invited to and attended safeguarding meetings. It was identified that just over 50% of GPs were returning information or attending meeting for safeguarding enquiries. The group have requested further audits of GP engagement in order to monitor improvements.
- Oversight of Implementation of Liberty Protection Safeguards (LPS) Guidance. The group received readiness reports from LPS Leads but the guidance implementation date has now moved from April 2022 to an unspecified date. The group will resume the request for update reports once the new implementation date is set.
- The issue of SAB engagement with prisons was highlighted by the SVPP Chair and has been discussed at the SAB National Chair Network. The group received a report from the Head of Ongoing Support at Wiltshire Council outlining operational work with Erlestoke Prison. The group were provided with assurance that the working relationship between the local authority and the prison is positive and proactive and where concerns have been raised these have been addressed.

Supporting the safeguarding of under 1s - Parents as Service Users Audit

The Thematic Review of Under 1s Audit Report undertaken by the SVPP highlighted that parents, or those in parenting roles, who represent a risk to children, are often either in need of or are in receipt of services in their own right. When that is the case, there is evidence that there is often insufficient linkage between children's and adults' services. To try and understand how organisations in Wiltshire routinely assess the parenting roles (and wider familial risks) of adults who access services, an online questionnaire was sent to adult facing agencies. Most agencies confirmed that they routinely ask about family status when working with new service users. The majority of agencies responding said that they recorded children's information within their systems and could provide reports to identify service users who are parents. Learning from this audit further informs the system wide work to improve safeguarding of under 1s led by the Safeguarding under 1s group.

Chapter 6: Impact of multi-agency training

The multi-agency training offer continues to be successful, with consistently high feedback from delegates rating courses as 'excellent' or 'good'. Over 900 practitioners accessed a SVPP training event in 2021/22. In August 2021 a new Learning Management System was introduced providing improved access to practitioners to book on courses and an improved ability to gather and report on feedback on the quality and impact of training.

Practitioner comments:

> As a Deputy DSL this course will have a huge impact upon my confidence when working with families and children who are experiencing domestic abuse. (Domestic Abuse)

> This training will have a positive impact upon my work. I have gained knowledge of tools which can support working with young people who may have experienced sexual harm, which will be beneficial in my practice (Sexualised Behaviour Course)

> This training has refreshed my knowledge about Neglect and will support me to recognise and react appropriately to neglect and support families to provide a safe emotional and physical environment for their children to thrive in. (Neglect)

SVPP Safeguarding Week

The SVPP held its first Safeguarding Week in October 2021. The purpose of the week was to raise awareness of safeguarding, create opportunities to share learning from case reviews, and talk to local practitioners about some of the changes that have taken place within the partnership over the past year. The week of events aimed to bring together a wide range of accessible (virtual) learning opportunities with the objective of reaching sectors and stakeholders that may not traditionally have accessed events through the SVPP. A total of 11 sessions were held and 147 delegates attended. There was underrepresentation from the education sector, but this is likely to be pressure on staff capacity to attend due to the impact of covid.

Feedback from evaluations surveys told us that 100% of delegates rated the overall quality of the workshops as 'good' or 'excellent'. Comments included:

'I really enjoyed looking at strengths-based approaches in the making safeguarding personal training' (Making Safeguarding Personal)

'Excellent, great training, well done trainers'
(Managing High Risk).

Another safeguarding week is planned for 2022 where it is hoped there will a wider range of learning opportunities and improved attendance from a broader range of agencies.

Chapter 7: Next steps and priorities for the partnership

Our priorities for 2023-2026 are:

Safeguarding Under 1's
Domestic Abuse
Transitional safeguarding
Exploitation and Contextual Safeguarding
Social, emotional and mental health

Independent scrutiny is also a priority and will include an independent review of progress against these in 2023.

In addition we will set out an annual strategic plan for children and adults safeguarding, to include action plan against each priority by which we can measure progress and impact. This will enable all partners to be clear on the focus of our work and activity.

Wiltshire Police have been placed into HMICFRS 'ENGAGE' status following their National Child Protection Inspection (NCPI) and 2022 PEEL inspections and the SVPP will work with them to support improvements.

We will also continue to work closely with the Families and Children's Transformation programme (FACT), including joint workforce development and supporting the piloting of a Family Help Model.