Wiltshire Council

AGENDA SUPPLEMENT (1)

Meeting: **Children's Select Committee**

Place: **Council Chamber - County Hall, Bythesea Road, Trowbridge, BA14 8JN**

Date: **Tuesday 26 November 2024**

Time: **10.30 am**

The Agenda for the above meeting was published on 18 November 2024. Additional documents are now available and are attached to this Agenda Supplement.

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This Agenda and all the documents referred to within it are available on the Council's website at www.wiltshire.gov.uk

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9 **Safeguarding Vulnerable People Partnership (SVPP) Annual Report** *(Pages 3 - 30)*

DATE OF PUBLICATION: 20 November 2024

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Wiltshire Safeguarding Vulnerable People Partnership

Annual Report 2023-2024

Contents

1. Foreword by the Independent Scrutineer	Page 2
2. Partner agency contributions and engagement	Page 3
3. Responding to our strategic priorities	Page 4
4. Response to Working Together 2023	Page 9
5. Practice reviews – activity and impact	Page 10
6. System Assurance	Page 15
7. Impact of multi-agency training	Page 22
8. External Scrutiny	Page 25
9. SVPP Budget – Partner Contributions	Page 26
10. Next steps and priorities for the partnership	Page 27

1. Foreword by the Independent Scrutineer

I am very pleased to offer my contribution in my first year as Independent Scrutineer for the SVPP, having started in October 2023. My role and approach is to remain as objective as possible whilst acting as a critical friend when required; identifying both the strengths of the partnership and the challenges, as the partners navigate the statutory requirements within their safeguarding responsibilities. I have advised and supported where required, through conversations with strategic leads, attending strategic level meetings, chairing the Safeguarding Adults System Assurance group and completing regular update reports for the SVPP Executive. Going forward I intend to offer more assurance through participation in multi-agency audits and the regular reviews of decision making on referrals sent to the Partnership Practice Review Group.

Through reviewing policies, procedures and activities I have identified the strength of a fully engaged leadership across all the partners, which can be demonstrated by the comments made by OFSTED, see page 24. This partnership has been ably supported by an excellent Business Support Team, who have gathered the information and detail which has informed this report. This collaborative approach has largely delivered well on its priorities, in addition to the safeguarding workplans for children and adults, that have helped to focus on those areas that need further development, see pages 16-18.

As you will see there are many positive changes in how the report is presented this year compared to previously, with more focus on the engagement of all safeguarding partners, see page 3. I am particularly pleased to see that there is a realisation and commitment to looking at "what still needs to be done" against all the priorities. It has rightly identified that there are still areas of safeguarding that require further focus, for instance the development of an all-age exploitation strategy, so it can mirror the great work in this area that has already been evidenced in relation to exploitation of children. Over the next year I will support partners in reviewing progress against these areas that require further development and continue to offer scrutiny, as the partnership continues in its journey of continual improvement. Part of that continued improvement going forward is to have future reports reflect a wider spectrum of voice activity and how it impacts on practice and informs the partnership in the coming year. The conversations I have had both in groups and with leaders, appreciate and support, how important it is that service users and those with lived experience have their voice heard.

Audit activity both previously and going forward continues to be an area that the partnership looks to help inform practice and to test how well they are doing. A good example is the audit that took place across BSW focusing on the vulnerabilities of under 1s (page 6). The partnership recognises that these audits require further check and tests going forward so I am pleased to see a further audit planned for 2025.

It is widely acknowledged, both locally and nationally, that there has been a significant rise in the number of referrals for case reviews across all types. The information on the two published DHRs within the report, evidences the positive impact on practice and progress of outcomes and is also reflected in the Adults Safeguarding Workplan in relation to reviews. This report also identifies that the system assurances are in place and can be highlighted through positive action like the safeguarding walkabouts. These are a fantastic tool to improve engagement with safeguarding support services, with the aim to improve better outcomes for both practitioners and service users, which the feedback suggests it does.

Looking forward I would still like to see an improvement in attendance and participation in the Safeguarding Week training sessions in 2024, but with the earlier planning that has taken place this should help support this action.

Finally, the external scrutiny that has taken place during this period, shows a transparent partnership willing to embrace challenges going forward, knowing that these reviews help inform the safeguarding partnership approach across the network, but more importantly recognises the tireless effort of both practitioners and leaders across the whole of Wiltshire who continue to support those most vulnerable within our communities.

David Williams, Independent Scrutineer

2. Partner agency contributions and engagement

Stakeholder Networks and Senior Partners meetings have continued to provide opportunities for partner engagement. In addition to what is set out in the following report and participation in subgroup activity, here are some headlines on the impact of the SVPP and partner engagement:

Royal United Hospital Bath Maternity Services are leading the pilot of the GCP2a (antenatal) tool on behalf of Wiltshire(for more information see page 17).

Great Western Hospital NHS Foundation Trust (GWH) use the SVPP priorities to inform their Integrated Safeguarding Strategy. The Trust is also working on an initial assessment proforma for adult patients to include a routine enquiry question regarding being safe at home, as a response to learning from case reviews and has been part of the National Referral Mechanism pilot (see page 5) to inform their internal spotlight on child exploitation.

Adult Social Care are promoting a culture of professional curiosity for practitioners encouraging them to seek to explore and understand what is happening in someone's life as a response to learning from case reviews. Their strategic actions are also informed by learning from case reviews.

They have also been proactive in raising awareness of the SVPP within Wiltshire Council by inviting SVPP Business Unit to deliver presentations during Wiltshire Council's Social Care Week events, as part of their induction for staff and at Adult Social Care Roadshows.

HCRG Care Group who provide our community health services for children support the Integrated Front Door quality assurances audits. In addition, they have responded to learning from a DHR to raise awareness of male victims of DA and the dynamic as a victim and perpetrators. This has also led to a review of safeguarding training; They are also making improvements to their recording templates to enable their ability to better capture details of father and information on any risks/vulnerabilities.

Police have put in place an Organisational Learning Board to oversee implementation of recommendations from case reviews and impact.

Spurgeons (providers of Children's Centres) have developed action plans in response to learning from case reviews which are monitored and tracked within their organisation. This has changed how they record their work, specifically in relation to writing case records from a child's perspective and instigated improved management oversight and audit practice within the organisation.

3. Responding to our strategic priorities as set out in our Strategic Plan 2023-2026

Domestic Abuse

What has been done

Prevalence of DA in Wiltshire remains high with data indicating it is increasing. There were 4413 DA related contacts into MASH with 1435 of these resulting in a referral to children's social care, an increase on last year; referrals into Fear Free, Wiltshire's commissioned DA Services, also continue to grow with 2869 referrals from adults. This landscape is well understood by the Domestic Abuse Local Partnership Board (DALPB) which has continued to embed a 'Line of Sight' approach to support scrutiny and oversight of the system response to DA in the last 12 months. Quarterly workshop style meetings have further improved engagement and partnership working in this area of business. There has been a focus on:

- Timeliness of Encompass notifications due to backlogs in triaging of police notices into the Children's MASH. Police have been proactive in responding to any backlog with additional capacity identified to provide an immediate response; additional recruitment is now in place and a new app, due to go live in the autumn will improve the submission of notices.
- The effectiveness of MARAC – an independent review by Oxford Brookes University in 2022 and the Wiltshire Police PEEL inspection both generated a number of recommendations relating to the functioning and effectiveness of MARAC. In response the Police are now the lead agency, and a multi-agency MARAC Oversight Group has been established to improve assurance in relation to the MARAC process. This group is leading on implementing the actions identified from the findings of Police Inspections and working with the DALPB to set out a strategic improvement plan in response to the findings from the Oxford Brookes Review.
- 3,500 Domestic Abuse Violence Disclosure Scheme (DVDS) applications were reviewed by Wiltshire Police after concerns were identified about quality of research undertaken. By January 2024, all affected applications had been triaged; where disclosures had already been made, there was no evidence that further disclosures had been missed. Two cases were identified where a failure to disclose resulted in harm, and these have been reported to the Independent Office for Police Conduct.
- DA Matters training has been rolled out across Wiltshire Police to improve knowledge and understanding of DA especially in relation to coercive control, resulting in a more effective and more consistent response: over 1,360 police staff have received the training and there is a commitment to continue to provide this to their officers.
- In Year 3 (2023-24) of the DLUHC Domestic Abuse Safe Accommodation Grant, Wiltshire utilised their allocation to fund a number of posts/provisions, all of which reflected identified local areas of need. These allocations included: support for children and young people who have witnessed domestic abuse and specialist support for victim-survivors with complex needs or those impacted by the Trilogy of Risk; support in safe accommodation for victim-survivors and their children; specialist support for male victim-survivors and for victim-survivors in the military community.

What needs to be done

The demand on MARAC continues so further consideration to how we can enable it to be as effective as possible in the context of our broader system wide response to DA is needed. This includes proposals to commission an audit of repeat referrals to MARAC in 2024-25 to better understand our system response in this area.

Explore our understanding and system response to the prevalence of elder adult abuse - this will be the main focus of a workshop in September 2024.

Strengthen our work on perpetrators through the Perpetrator and Offending Steering Group by:

- Establishing a Line-of-Sight approach to improve oversight and the group's ability to provide assurance in relation to practice and service provision for perpetrators.
- Development of a dashboard to inform an evidence-based approach
- Developing a map of current support for perpetrators of DA in Wiltshire, its effectiveness and any gaps
- Increase uptake of perpetrator behaviour change support

Exploitation

What has been done

In September 2023, a new model of partnership working was implemented with two Working Groups set up on adults and children respectively, reporting into a Strategic Exploitation Subgroup.

Partnership activity relating to the exploitation of children and young people remains strong with effective mechanism in place and there is good understanding of what this looks like in Wiltshire: the Emerald Team (child exploitation team) has mostly worked with children aged 14-15 years, and these were most commonly males; the team are seeing more referrals relating to criminal exploitation rather than sexual exploitation, which is a shift.

- The continued piloting of Risk Outside the Home (ROTH) as a fifth category for child protection has enabled innovative working with children most at risk of exploitation, using a contextual safeguarding model. During 2023/24, 106 children were considered at the ROTH panel and the numbers and application of threshold have remained consistent over the year. In their Inspection report, 2024, Ofsted noted that "*Children at risk of extra-familial harm, including youth violence, are supported by skilled and tenacious social workers who understand their needs and the risks to them very well. The style of children's plans and the focus on seeing risk through a strengths-based lens is having a very positive impact in helping children and parents to focus on the actions that increase safety for children.*"
- The multi-agency Safer Young People Context meetings continue to ensure sufficient management oversight of young people families and contexts associated with extra-familial harm on individual and group interventions, and monitor the effectiveness of interventions, support, outcomes, and impact. This group has directly impacted on outcomes for children with 7 young people supported and funded to pass their Constructions Skills Certification Scheme Card, building their self-esteem and confidence, and increasing their employability and for some leading them to take further qualifications. Feedback from the parents of these young people has also evidenced the impact and their appreciation of the support provided.
- Wiltshire and Swindon are part of the national pilot of the National Referral Mechanism (NRM) devolved decision making, with the pilot site going live in March 2023:
    - Since the panel has been in place, there has been a 50% increase in referrals to the NRM relating to children: 16 in 2022–23 and 24 in 2023-2024
    - A webinar was provided to CPS staff to improve their understanding of the process, and this has resulted in improved channels of communication to ensure the outcome is the right one for the child and that there is a child first approach, and improved decision-making timeframes
    - Children who have a conclusive grounds decision are now referred into Escape Line for an 'expert by experience' mentor to carry our tailored intervention around the child exploitation

Adult Exploitation remains less developed and more focussed activity is needed in this area to increase partner engagement and momentum to drive improvement

What needs to be done

- Develop an all-age Exploitation Strategy in Wiltshire
- Ensure strong links between the Children and Young People's Exploitation Group and the Education Safeguarding Committee
- Increase awareness and understanding of adult exploitation across the workforce and improve the impact of the adult exploitation subgroup
- Understand what training is provided by agencies in relation to adult exploitation
- Development of a scorecard to provide an evidence-based approach

Safeguarding unborn babies and under 1s

What has been done

Safeguarding partners agreed the creation of the BaNES, Swindon and Wiltshire (BSW) Unborn Babies and Under 1s Steering group which has now been in place since January 2022. The group has coordinated activity and system improvements in relation to safeguarding unborn babies and under 1s across BSW. Key impact in the last 12 months:

- A very successful BSW unborn babies and under 1s virtual summit delivered a range of workshops and reached over 300 practitioners across BSW on the day and more widely with knowledge being shared across agencies: feedback described the summit as "*excellent*" and "*clear and informative*"; "*I have already shared with my team the different attachment names and examples of capturing the voice of the unborn child.*"
- Changes to practice in the children's MASH now mean that all pregnant mothers and fathers to be, are flagged by police when they come to their attention, including through intel and risks to unborn babies and under 1s continue to be part of monthly MASH audits
- Differentiating our response to this vulnerable group - inclusion of a specific paragraph on the vulnerabilities of under 1s for the first time in our thresholds document
- A multiagency case audit across BSW, focussed on vulnerabilities of under 1s, identified strengths as multi-agency working and information sharing once risk understood; and areas for improvement as working with fathers, information sharing and professional curiosity
- Responding to learning from case reviews - ICB have explored ways to improve sharing of information on fathers with GPs – this is in response to learning from case reviews which identified that GPs were not always aware of men becoming fathers as this information is not routinely shared. However, there are significant information governance barriers to this in the system and this is now being raised nationally
- Sharing of learning from the evaluation of the Dad's Matter Too Project in Wiltshire to further improve our understanding of best ways to engage and work fathers
- Supporting all agencies to deliver safe sleep messages - raising awareness across the system through regular communications to all agencies, improved website content and development of a BSW policy and guidance

In addition, safeguarding partners have continued to support this agenda through:

- Agreement for Wiltshire to be a pilot site for GCP2A (antenatal tool) which will enable us to better assess parental strengths and areas for support in the antenatal period to enable parents to provide the best care for their babies
- Further commitment to preventing abusive head trauma through the agreement to commission ICON across BSW – an implementation group is now in place led by the ICB

Safeguarding partners have now agreed that this group will step down from October 2024 and a final report will provide a summary of activity and impact and key areas of work to continue to take forward and drive improvement in.

What needs to be done

We will continue to keep a focus on this agenda when the Steering Group steps down. The final report will set out key areas of work to take forward and where this work and oversight will sit, to include:

- Working with and engaging fathers
- Repeat of the under 1's audit in 2025 to see if we can evidence practice improvement in the themes identified in the audit completed in 2023.
- Key metrics on unborn babies and under 1s to be included on the children's safeguarding dashboard to ensure continued oversight of issues emerging
- Publication of a BSW Pre Birth Protocol, supporting consistent practice across the ICB footprint
- Publication of a BSW SUDI Policy and pathway for the wider workforce to support the provision of key safe sleep messages to parents by all who have contact with them.

Transitional Safeguarding

What we have done

The focus of this work in Wiltshire has continued to be on a small group of complex young people aged 16-24, typically displaying high risk behaviours, led by the Families and Children's Transformation Project (FACT). Significant progress has been made including agreement of the creation of a new provision in 2024-2025, within Wiltshire Council Adult Social Care to work with this cohort. The new arrangements will support early planning, provide relationship-based support, safeguarding oversight and risk management arrangements including through the National Referral Mechanism. There has been explicit identification of vulnerabilities specific to those with SEND who are also vulnerable to exploitation and work to understand what they need to ensure they stay in education or employment. The project is also exploring how partners can best share information related to risk and vulnerability and how we can ensure that transitions at 18 for this cohort are well planned and effective. This is a real step forward for improving outcomes for these individuals and Wiltshire is at the forefront of national developments on this.

What needs to be done

- Continued support for this agenda and ensuring all relevant agencies are involved in the development of the new provision and associated processes so that we improve outcomes for these vulnerable individuals.
- Ensure appropriate housing provision with support is available for this cohort.
- Evidence impact of new provision and practice
- Establish governance and oversight of this agenda under 'business as usual' arrangements when the FACT project closes 31st March 2025.

Page 80

Social, emotional and mental health

What we have done

Work in relation to understand and improve services and support in relation to this priority continues to be led by the ICB through the Mental Health Learning Disability and Autism Board. An all-age Mental Health Strategy is in development and will include current performance assessment based on mental health service benchmarking and national best practice; demand and capacity modelling to support future service approach and priorities for mental health services in next 5 years.

More widely Wiltshire Public Health hosted a first Self-harm Summit in November 2023 – A Call for Action, attended by over 80 delegates and evaluated as increasing understanding of self-harm by attendees. A Self-Harm Insight Report has set out next steps to improve partner response. The Suicide Reduction Group have established a real time Suspected Suicide System Process to capture information and help in the identification of emerging themes. The outcome of this work is fed into the Partnership Practice Review group to support identification of system wide themes. The research into links between suicide and perpetrators of domestic abuse has also been shared with partners to raise awareness of this theme.

There has been scrutiny of the quality improvement journey of Avon and Wiltshire Partnership (AWP) NHS Foundation Trust, providers of our adult mental health services, following recent CQC inspections and an organisational abuse enquiry. The scrutiny response has been through the ICB Quality Improvement Group which is monitoring the action plan as part of the enhanced level of surveillance in place and providing regular assurance updates.

What needs to be done

Continued oversight of improvement journey for AWP and system wide demand and capacity.

Improve content on SVPP website in relation to mental health.

We have also focused on other key safeguarding priorities, as set out below:

Violence against women and girls (VAWG)

In response to the National VAWG Strategy, a mapping exercise was carried out for the first time in Wiltshire to understand the breadth of the activity and our response across the partnership to date, focusing on prioritising prevention; supporting victims; pursuing perpetrators; strengthening the system.
The exercise told us that:

- There has been strong engagement from across partners with the Wiltshire Police VAWG conferences that have been held over the past 2 years
- Street Safe allows anonymous reporting where someone feels unsafe to allow proactive intervention
- Proactive policing approach to reduce sexual offences in Wiltshire
- Wiltshire's Safety at Night Charter in place to proactively improve the night-time economy and make Wiltshire/Swindon safer
- Partnership awareness campaigns through 16 days of action
- Wiltshire Police led VAWG-related education sessions in Wiltshire schools.
- Using the voice of Wiltshire captured in surveys to inform response

The impact of this is that we now have a baseline in Wiltshire from which to measure further activity and developments and evidence impact. An action plan to reopen to the gaps identified, including a commitment to carry out an annual audit of VAWG related work across the partnership. We also need to clarify oversight and governance of this agenda within the arrangements.

Child Sexual Abuse

This year the Child Sexual Abuse Task and Finish Group has worked to provide system assurance about the partnership's oversight of CSA following the Local Safeguarding Practice Review LCSPR Long term sexual abuse of children in care.

Outcomes

- We know what services are available to victims and their families in Wiltshire, are assured of their effectiveness and have identified any gaps in terms of capacity.
- We understand the prevalence of CSA related crime in Wiltshire, including prosecution rates, and have in place key indicators that can inform development of a dashboard for safeguarding children.
- We are assured that children with a disability at risk of or subject to sexual abuse in the family environment are being identified and protected

Outputs: Key data indicators for ongoing monitoring; CSA practice framework including service provision for raising awareness and signposting, and local data to provide context will be available on the SVPP website by autumn 2024

Whilst this group will now stand down they have identified a number of recommendations about future pieces of work to continue to ensure system assurance, this will include seeking assurance from partner agencies about how they have disseminated, embedded the CSA framework within their workforce and evidence of impact; this request will include assurance in relation to evidencing that practitioners across the workforce understand the increased risk of CSA for children and young people with a disability and enabling their voice; and a multi-agency audit with a focus on CSA to be completed in 18 months' time to evidence impact of CSA framework/awareness raising.

4. Responding to new requirements in Working Together 2023

Wiltshire have been in a strong position to respond to the new requirements set out in Working Together 2023, supported by the commitment of the safeguarding partners to effective multiagency safeguarding arrangements. Our Lead and Delegated Safeguarding Partners are committed to their joint and equal duties and have met with the DfE Facilitators to discuss these new roles and responsibilities. They have also committed to carry out the national *MASA Health Check* in the next 12 months to enable us to be as effective as possible. In addition:

- The Lead Safeguarding Partners (across Swindon and Wiltshire) have continued to meet in 2023-2024 to ensure they maintain strategic oversight of key business, learning from case reviews and discuss partner contributions and funding; they have committed to continuing to meet 3 times per annum going forward. The SVPP Executive Chair also attends these meetings to ensure they are in a position to provide feedback to the LSPs and escalate any issues or risks as needed.
- Delegated Safeguarding Partners are senior leaders and have been chairing the SVPP Executive since 2021, rotating on an annual basis; the Executive meets a minimum of 6 times per year
- An Independent Scrutineer has been in place since October 2023 and has provided regular feedback to the safeguarding partners ensuring that safeguarding practices are effective and aligned with best practice and supporting the continuous development and enhancement of the partnership's approach to safeguarding.

We are working closely and directly with headteachers to identify strategic education representation, having attend both the secondary and primary headteachers forums to set out the ask and expectation, and hope to have this in place from September 2024. The Education Safeguarding Committee has been in place since 2022 and has provided a key link between education and the safeguarding partners and strengthening the role of this group will further improve the strategic role of education in the arrangements.

Working Together 2023 provided an opportunity to review our current arrangements to assess individual organisational responsibilities (Section 11) and have reinstated a number of elements. Safeguarding partners have agreed that going forward the Section 11 process in will consist of:

- **Section 11 Compliance statement** – all agencies will be asked to complete this on a biannual basis and for 2024-25 they will be asked to provide assurance in relation to the new requirements set out in Working Together 2023
- **Deep dives** – a programme of deep dives will be set out on an annual basis, which some partner agencies will be asked to participate in; the areas of focus will be informed by learning from case reviews, audit activity, data and intelligence and national reports/research messages
- **Safeguarding Walkabouts** - a programme of walkabouts will be set out on an annual basis
- Where agencies participate in Section 11 assessment carried out by other safeguarding partnerships, we will request that these are also shared with us

We will report on the outcome of Section 11 2024-2025 in the next annual report.

We have yet to be able to fully demonstrate how the experiences of children and families shape the delivery of local arrangements. There is a significant amount of voice activity that takes place across partner agencies, and we have previously mapped this putting us in a strong position from which to take this forward. To ensure this is prioritised voice is included in both the children and adults safeguarding strategic plans for 2024-5. We are on track to publish our updated safeguarding arrangements in December 2024.

Supporting the Serious Violence Duty

Partner agencies have engaged well with the duty which is led by the joint Swindon and Wiltshire Serious Violence Steering group. The needs assessment has enabled a comprehensive understanding of what this means for Wiltshire and learning from local case reviews has further informed this. A number of pilot projects have been put in place as follows:

- Focused deterrent approach to group offending in targeted hot spots
- Street Doctors training for young people to help them to know what to do if a young person sees someone stabbed on the street and how they can potentially save a life.
- Funding training to further support a trauma informed approach

We anticipate being able to better evidence the impact of this work in 2024-5.

5. Practice Reviews – activity and impact

The Partnership Practice Review group (PPRG) is our local mechanism for the consideration of all case reviews for the partnership including serious child safeguarding cases. This year has seen another increase in activity and referrals to the PPRG; from 15 in total during 2022-2023 to 24 this year. The increase has been seen in the number of referrals relating to adults for consideration of a SAR. To support sharing of learning from case reviews we delivered a virtual briefing on an analysis of learning from case reviews 2022-2023 to safeguarding leads across partner agencies in October 2023; this will be embedded going forward.

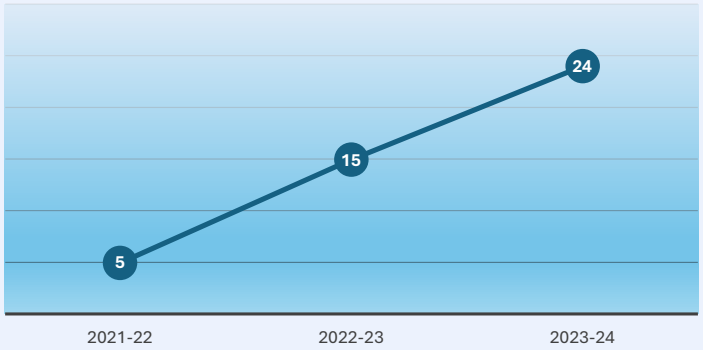
As the data on page 11 shows, the number of case referrals in the last 12 months has risen significantly; this has meant that:

- There is increased demand on the SVPP Business Support Team to commission and coordinate case reviews in addition to business as usual and reduces their capacity to respond to the recommendations from previously published reviews
- Increased demand on partner agencies to provide summary information to inform discussion making, in addition to their participation in active case reviews
- Increased costs to the partnership

Wiltshire will not be alone in this, and we consider the most appropriate and proportionate methodology for each review and whether it will provide new learning in our decision making. Additional capacity has also recently been added to the SVPP Business Support Team, with a Partnership Support Officer to specifically focus on case reviews and the next 12 months will evidence if this is sufficient to meet demand. In addition, there have been challenges in finding independent reviewers adding to delay in starting 3 of our statutory reviews. To manage demand and ensure the right cases are considered, there is a triage process for all referrals to the PPRG which includes feedback to the referrer if a case is not progressed for consideration of a case review; these cases will now be audited by the Independent Scrutineer to provide assurance about the triage decision making.

Nationally we can compare ourselves with national data on serous incident notifications and this indicates that we are in line with other safeguarding children partnership. Equivalent data is not available for DHRs or SARs however feedback from regional and national networks indicate we are not an outlier.

Number of Referrals received



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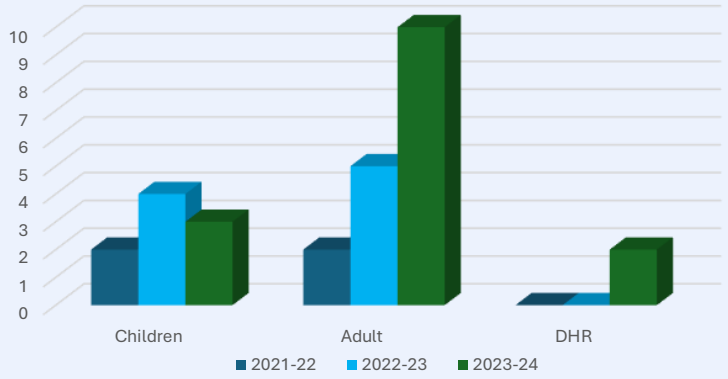
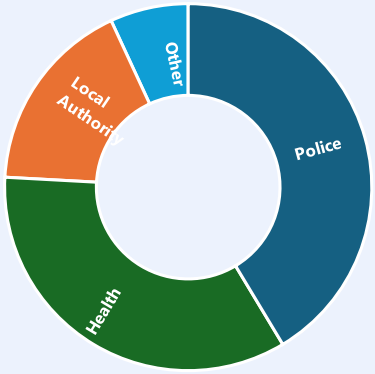
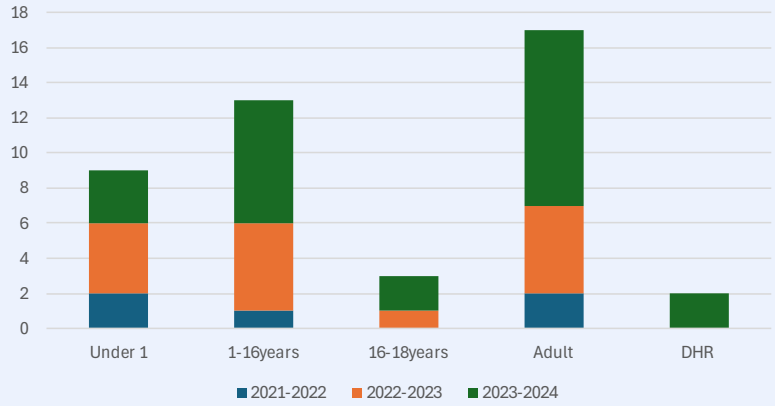


Referral Source



Referrals by age



Cases relating to children

We have notified 2 cases to the national CSPR Panel, within the statutory timeframes.

Rapid Review 1: death of a 5-week-old in the context of concerns about safe sleeping arrangements and parental neglect. Known to social care, baby subject to CIN (assessed prebirth) due to family history and known vulnerabilities. • Themes: safer sleep guidance not followed when out of routine • Recommendation: no CSPR, agreed by panel.
Rapid Review 2: suspected non accidental injuries to a 17-day old baby. Family was open to support from a Family Key Worker. • Themes: cannabis use by mother; understanding and assessing the adults in a child's life; nonattendance and disengagement with services; sharing of police intel in relation to cannabis use. • Recommendation: no CSPR, agreed by panel.

Analysis of the learning from these cases has identified that there is more to do in relation to embedding the GCP2 tool to support the assessment of parental capacity and neglect and continued to reinforce and raise awareness of safe sleep messages. A pathway and policy on Sudden and Unexpected Death in Infancy (SUDI) will be published in 2024-25 in response to this learning.

In addition, we have discussed 5 other children referred for consideration for a case review and carried out local learning reviews in relation to 4 of these children

- Suicide of a young person (local learning review commissioned)
- Two young people arrested /convicted for murder/manslaughter (local learning review commissioned)
- Physical abuse of an 18-month-old in the context of concerns about abuse (local learning review commissioned)

Learning briefings will be shared with partner agencies but will not be published.

Safeguarding Adult Reviews

Safeguarding Adult Reviews (SARs) are undertaken where an adult with care and support needs has died or suffered serious harm, and it is suspected or known that the cause was neglect or abuse, including self-neglect, and there is concern that agencies could have worked together more effectively to protect the adult. In addition to the new cases referred this year there are two other SARs in progress.

Four referrals were received by the PPRG in relation to adults during 2023-2024, two of which met the threshold for a SAR.

Referral 1: Adult with multiple health conditions who died in hospital following a long lie at home. Concerns around self-neglect, declined support, concern around ability of adequate care being provided by family. Concern around capacity to make decision to decline/refuse care. This case is subject to a SAR.
Referral 2: Adult died in hospital showing evidence of neglect/self-neglect, malnourishment and suspected sepsis. Themes: adult with care and support needs when discharged from hospital was unable to receive care package due to rurality. Family was main carer; all other input was refused by the adult. This case did not meet criteria for a SAR – professionals briefing was held in relation to self-neglect and rurality.
Referral 3: Adult with care and support needs died in hospital with evidence of serious neglect/self-neglect.

This case was referred for consideration following the death of an adult in hospital with sepsis and evidence of serious neglect/self-neglect. Adult was assessed as being capacitated in relation to her care and support needs. Care provided by spouse. Known to a number of agencies with a history of refusing help and support. This case did not meet criteria for a SAR however relevant lines of enquiry to be included within a SAR already in progress with similar themes.
Referral 4: Adult resident of a care home with multiple health needs died after refusing food for 2 weeks. Adult with diabetes, possible learning disability died after refusing food for 2 weeks. She was deemed to not have capacity to manage her care and support and health needs and a best interest decision was made. She was unable to return home due to high care needs which she did not accept and was non-compliant with care and refused to eat. This case did not meet the criteria for a SAR. Although the adult had care and support needs there was insufficient evidence of neglect or abuse.

Self-neglect has been highlighted this year as a significant theme, in line with the findings from the national SAR Analysis. As well as being included in the Safeguarding Adult Workplan, it was the focus on the Adults Safeguarding Partner Workshop in June 2024 and there will be a BSW Virtual Conference on self-neglect in November 2024-25. Mental Capacity Assessment is also a consistent theme and activity to drive practice improvements is set out in the Adult Safeguarding Workplan for 2024-25.

Domestic Abuse-Related Death Reviews (Domestic Homicide Reviews)

During 2023-2024, two referrals were made to the PPRG relating to DHRs.

Referral 1: This case was referred for consideration of a DHR as the victim died by suicide following reported domestic abuse from his partner and her family. The referral highlighted the difficulties of multi-agency working when there are counter-allegations between the victim and alleged perpetrator, as well as citing the unique nature of DA support with male victims, especially single fathers of children with additional needs. This case will be subject to a Domestic Abuse-Related Death Review.
Referral 2: This case was referred for consideration to the PPRG as the victim died by suicide following reported physical and financial abuse from her partner, as well as coercion and controlling behaviours. The referral highlighted the impact of this on the victim's mental health, as well as the system response to young adult repeat victims of DA. This case will be subject to a Domestic Abuse-Related Death Review.

The decision to commission DHRs for these referrals aligns with the new Home Office guidance published in February 2023 stating that DHRs would be renamed Domestic Abuse-Related Death Reviews, to include suicide and therefore better reflect the impact that DA can have on a victim. The SVPP will be working to strengthen partnership links between DHRs and work on Wiltshire's Suicide Prevention Strategy in order to ensure that the learning from DHRs informs this wider work.

Published case reviews

DHR Krystyna and Elzbieta

Krystyna and her husband, moved from Poland to the UK and had three daughters together, including Elzbieta. The relationship between Krystyna and her husband became abusive, with him becoming increasingly controlling and violent. They separated and, six weeks later, he fatally stabbed both Krystyna and Elzbieta in their home.

Recommendation	What have we done

Promote awareness of economic abuse as a method of coercive control.	• Training delivered to 21 frontline professionals to cascade learning within organisation. • FearFree have seen an increase in referrals sighting specifically economic abuse as a concern every year since the end of 2021. • SVPP multi-agency DA training now has more specific learning on economic abuse and coercive control and improved economic abuse content and guidance on SVPP website.
Routine enquiry into domestic abuse where housing agencies become aware that an individual has separated or is undergoing relationship breakdown.	• Wiltshire Council now have a dedicated DA Housing Officer who works with cases where DA is identified. • Sovereign Housing Association have a DA Champion in all localities to provide DA-specific knowledge. • Increase in referrals from housing bodies to Fearfree (89 in 2021-2022 to 98 in 2023-2024).
Assurance that routine enquiry into domestic abuse, where health indicators are present, is being undertaken and embedded into local procedures.	• Increase in referrals from health services to FearFree: 117 in 2021-2022 to 132 in 2023 to 2024.
Increase awareness of DA and support services available amongst Polish communities. Assurance that services are meeting the needs of Polish victims.	• Task and Finish Group established to seek assurance about support offer for minoritised groups. • Referrals into FearFree for White European people (they do not specify a country) have decreased since 2021/2022 (192 to 152)
Dedicated domestic abuse training for support assistants in schools should be provided.	• Information about marginalised communities added to Designated Safeguarding Lead training
CSP should promote the DA Toolkit for Employers and promote membership of the Employer's Initiative on Domestic Abuse amongst its partner agencies	• PH have developed a website page dedicated to Workplace Health for business across Wiltshire which included a focus on domestic abuse and a toolkit for employers.

DHR Emily

Emily was a young woman who had struggled with her mental health and substance abuse throughout her life. She was raped as a teenager. She maintained contact with her attacker and lived with him for a short period, moving back in with her parents at the start of the first COVID-19 lockdown. She disclosed that she had been a victim of domestic abuse, and Emily's parents were concerned about her worsening mental health and possible substance use after a period of abstinence. Emily was found deceased in her bed; the coroner recorded a verdict of accidental overdose.

Recommendation	What have we done
Improved understanding of the referral process for Adult Social Care.	• Webinar on making adult safeguarding referrals held Oct 21. • Updated information available on SVPP website regarding making an effective referral – promoted via SVPP Newsletter
The SVPP should promote the use of the DASH risk assessment as the primary tool for assessment of risk in relation to domestic abuse and seek assurance that it is being used appropriately and consistently across the partnership.	• DASH and MARAC multi-agency training to run via SVPP from Spring 2022 with 217 practitioners trained since then, with take up monitored by the DALPB; evidence fo a correlation between an increase in referrals to MARAC from agencies where this training has been delivered. • Non-police referrals into MARAC and our support services are high - a useful indicator also of DASH being used by a wide source of partners.
Promote learning about the multi-faceted aspects of family members and carers supporting adults with complex needs.	• Now included as a standard enquiry on the SVPP's walkabouts to agencies to highlight and assess awareness.

6. System Assurance

The safeguarding partners have collectively ensured they are sighted on and assured about key safeguarding issues both locally and nationally:

- Right Care Right Person – regular reports into the SVPP Executive have helped to ensure that all key partners were part of strategic implementation discussions and oversight of impact as it has gone live and provided ongoing assurance. There is in recognition that although impact has been low to date continued oversight is key to ensure this continues as it becomes business as usual.
- Incident at the Countess of Chester Hospital discussed and assurance provided that there are appropriate mechanisms and oversight are in place that would identify such concerns at the earliest opportunity, including establishing a System Mortality Group to provide a learning from deaths report.
- Review of Domestic Violence Disclosure Scheme (DVDS) by Wiltshire Police following identification of issues with the quality of research undertaken; over 3,500 records were reviewed with police dedicating additional resource and providing regular reports to ensure that any risks as a result were identified and responded to. An independent IOPC investigation is ongoing.
- MARAC – following a review of MARAC in 2022-2023 safeguarding partners agreed that Wiltshire Police would take over as lead agency this transition has now taken place however was delayed due to challenges in relation to contributions from other partners to support coordination and administration of this mechanism and was escalated to the Lead Safeguarding Partners to resolve. The focus is now on further improvements to the functioning of MARAC and an improvement plan is being developed.
- The Partnership Risk Register has provided a record of identified risks to the system and mitigating actions in place; risks recorded this year include DVDS review, rollout of Right Care Right Person and changes to national guidance in relation to the sharing of DVDs disclosures by probation.

- Response to international recruitment within care providers and concerns about modern slavery – concerns were initially raised by Primary Care colleagues which led to a joint response demonstrating that all 3 safeguarding partners understand the risks faced by people who are vulnerable: one provider who was impacted commented, "*this was an amazing piece of cross team collaboration to get the job done and ensure that our customers are safe and remain well supported at home.*" There is ongoing partnership working through the Modern-Day Slavery Forums.

In addition, the safeguarding partners have been transparent in their sharing of internal challenges which may impact the safeguarding system. For example, Wiltshire Police have provided updates on the improvements made and change still needed following the findings from inspections that placed with into ENGAGE. In addition, they shared the challenge of having a new and inexperienced workforce and the additional oversight and scrutiny needed as a result.

The Families and Children's System Assurance group (FCSA) and Safeguarding Adults System Assurance group (SASA) are in place to provide assurance to the SVPP Executive that the system to safeguard children and adults respectively are working effectively and improving outcomes. They have met jointly in 2023-24 to ensure more effective and timely oversight of areas that sits across the system, for example multi-agency safeguarding training, the risk register and walkabouts. This will continue going forward.

Safeguarding Walkabouts

A new programme of multi-agency safeguarding walkabouts is now embedded with 3 having taken place this year, providing assurance in relation to safeguarding practice within agencies. The programme now includes joint children and adults' walkabouts which have provided to be very successful in providing all age system assurance and also increasing understanding across children and adults' services. The framework for the walkabout now includes questions in relation to voice activity and cultural competence in response to learning from case reviews and is further tailored to include specific lines of enquiry for exploration relevant to the organisation. Walkabouts are intended to be a two-way conversation and feedback from both the participants and the hosts has been very positive and value in supporting improvements to the safeguarding system.

Walkabout outcomes:

- Marlborough College – evidence of significant improvements to safeguarding and culture within the college following testimonials reports through Everyone's Invited; participants were able to speak to a wide range of staff and students alone and triangulate their responses to gain that assurance.
- Connect Specialist Substance Use Services in Wiltshire (commissioned by Wiltshire Council Public Health) – this was joint children and adult's walkabout and provided assurance in recently commissioned new service evidencing that safeguarding is central to the organisation at both an operational and strategic level. It identified further work to do to support practitioners in Connect with understanding adult safeguarding thresholds.
- Fear Free Specialist Domestic Abuse Services (commissioned by Wiltshire Council Public Health) – highlighted their commitment to safeguarding and the challenges of the demand on DA services and the pressure staff can feel as a result.

Actions are monitored with oversight through the Joint FCSA and SASA subgroup. A programme of future visits is in place which includes Army Welfare, Housing Providers and walkabouts are part of our Section 11 arrangements as set out on page 9.

Children's Safeguarding

The FCSA can evidence an improvement in the quality of exception reporting into the group by both Police and ICB, further improving the line of sight into frontline practice. The development of a multiagency dashboard will further improve this in 2024-2025.

In addition to the areas of focus set out in the Workplan FCSA have ensured that they are assured about any impact on or risks to children as result of the backlog of Police PPNs within the Integrated Front Door and its impact on Encompass notifications to schools. Placement sufficiency has been a significant challenge in Wiltshire, as it is nationally, and the provision of 3 new Children's Homes in Wiltshire evidences the importance given to the need for sustainable provision for this vulnerable cohort of children and young people. SEND has had increased focus, with neurodiversity emerging as a theme within our case reviews, within our electively home education cohort and significant and unsustainable demand in the system in relation to diagnosis and support. The SEND Transformation Plan is due for publication in 2024-25 and there is also an anticipated SEND Inspection, both of which will evidence whether Wiltshire's response to this is effective and sufficient. We will be able to report on the impact of this in 2024-25.

Outcomes from the Children's Safeguarding Workplan 2023-2024	
Outcome	Progress and impact
1. *Improve our response to neglect by publishing a Wiltshire Neglect Framework, further embedding the GCP2 and introduce the GCP2a.*	Wiltshire's Neglect framework provides practice guidance, and a webinar is available which includes learning from case reviews on neglect – numbers accessing the webinar and traffic to the neglect page on the website are being tracked to evidence impact: 32 webinar views and 1305 hits to date. Wiltshire is now a pilot site for GCP2a, the bid was supported by the safeguarding partners and learning from this will further enhance our safeguarding response to vulnerable unborn babies and under 1s. GCP2 training is now part of the FACT Family Help Workforce Strategy which it is hoped will give it more impetus and increase take up, impacting on the use of the tool. This remains an area for ongoing focus and discussions about oversight of this are taking place currently.
2. *Focus on improving practice in relation to ensuring we are considering the day in the life of the child in all our work, we are curious in our practice, and we escalate concerns*	7-minute briefings from case reviews are focussed on practice and are well received by practitioners. Professional curiosity remains a persistent practice issue is carried forward into the work plan for 2024-2025 as well as a review of our current case resolution policy.
3. *Embed line of sight to frontline performance, including the children's MASH*	• Line of sight is now well embedded with clear timeframes for reporting into the Family and Children's system assurance group, improving system assurance and ensuring a focus on the whole system including children looked after. • The MASH Oversight Board is now a Strategic group with an operational group sitting underneath it and provide further assurance in relation to the foundation of MASH but also the wider Integrated Front Door functions.

	• There has been a strong focus in improving the number of early support assessments being completed and registered: evidence of this impact can be seen in the data with an increase from 60% of ESA's being registered in April 2023 to 95% in March 2024, with a clear increasing trend seen across the 12 months.
4. *Ensure links with commissioning are strong in particular for specialist services, to ensure safeguarding is front and centre to the commissioning process*	We have completed walkabouts on two commissioned services this year with commissioners sighted on the whole process including the report. In addition, commissioners provide exception reports into the FCSA. The additional review carried out by Wiltshire Council in response to children with complex needs placed in residential settings has further evidence strengthened commissioning arrangements.
5. *Review and consideration of recommendations from Child Protection in England and Independent Review of social care & any subsequent implementation requirements.*	Our response has been incorporated into the implementation plan for Working together 2023, including our new section 11 arrangements as set out on page 8.
6. *Support the development of the FACT Family Help Model*	The Families and Children's Transformation project (FACT) has led on piloting family hubs with regular reporting into the FCSA. Discussion is now taking place about how this work can become business as usual and any additional oversight /steering of this required within the partnership arrangements.
Improve our contact with schools as safeguarding partners (see also no.6)	As set out on page 8 we are progressing ensuring we have strategic education representation within our arrangements and strengthening the links to the Education safeguarding committee and wider school network. The Safeguarding Partners have been a key speaker at the Schools Safeguarding Conference for the past 2 years. Assurance in relation to safeguarding in schools is provided through the Section 175 audits. Early years settings also complete a safeguarding audit which is best practice. The result of the audits for academic year 2022-2023 show: • 54% of schools rated themselves highly effective, with 425 rated as effective, in line with results from the previous year's audit: to check and test the self-assessment 25 schools that have not been visited in the last 2-3 years are selected from the audit outcome for a detailed follow up every year. The impact of this process has supported building positive relationships with schools and ensuring rag-ratings are accurate. • There was an 89% return rate for early years settings with 58% rating themselves as highly effective, an increase on last year. It has been more challenging to established quality assurance of their self-assessments due to capacity within the local authority, but the plan is that these will begin in 2024-25. Any settings rag rated red are automatically visited by the early years safeguarding leads. • Oversight of children electively home educated and missing education has been robust with further analysis identifying that 30% of the EHE cohort have ASD, further informing plans to ensure sufficient support is in place for both schools and parents, alongside sufficient and appropriate school places for these children.

8. *Develop our understanding and oversight of child sexual abuse: understand the current context at a local and national level; ensure we are sufficiently supporting practice in this area*	See update on page 8.

Wiltshire Overview Report of Children in Residential Settings, Wiltshire Council

Further assurance was provided to the safeguarding partners following an additional multi-agency review of 12 children (11-17 years old) took place between May and June 2023, which supplemented the work carried out in response to the national Child Safeguarding Practice Review Panels review, Safeguarding children with disabilities in residential settings, and their request to Directors of Children's Services to initiate urgent assurance action.

The findings included:

- All children were seen in both their school and home settings; good evidence of child voice, also views of parents and care providers.
- No immediate or significant concerns raised as part of these reviews and areas for improvement were already known and being monitored.
- The Children's Commissioning Team have secured funding for 2 new posts with these roles being focused solely on quality assurance including Supported Accommodation placements ready known and monitored.

This review evidenced good practice in responding to national learning and going above and beyond to ensure very vulnerable children are safe. This review recommended continued review of Wiltshire's vulnerable children living at distance and ensuring that everyone understands their roles in assuring themselves of the quality of care and as a result all children living away from home are now part of the audit report managing system.

Adult Safeguarding

Scrutiny of the safeguarding system for adults continues to be a key area for development and preparations for the new adult social care inspections will support further improvements. In 2023 the group developed a Safeguarding Adults Workplan which set out its annual priorities with key areas of work. To support this the group also put in place a Line-of-Sight document to provide greater assurance in relation to front line activity. This will further embed, and we expect to see its impact in 2024-2025. Frequent updates and assurance have been provided by the ICB in relation to oversight of our Wiltshire patients placed out of county in Mental Health Hospitals; the Edenfield Hospital Review prompted the NHSE Mental Health Director to contact all ICBs to request additional assurance following the Panorama expose into Greater Manchester Mental Health NHS Foundation Trust. These updates have included reports on the improvements to preventing abuse and neglect within the processes for agreeing funding for those patients whose needs for specialist hospital care could only be met outside of the county following the North Somerset SAR, Learning from the circumstances of the deaths of Abi and Kate.

Further improvements in engagement with wider services for adults has been achieved through establishing Adult Safeguarding Partnership Workshop, the first of which took place in September 2023. The purpose of the Workshop was to explore how the SVPP can increase its engagement with wider partners and was attended by 17 representatives from a variety of statutory and voluntary agencies. Outcomes included a request for more awareness around modern slavery, hoarding, self-neglect, in addition to more opportunities for joined up working. Further events are already planned for 2024-5 including one with a focus on self-neglect and hoarding.

Outcomes from the Adult's Safeguarding Workplan 2023-2024	
Outcome	Progress
Develop safeguarding data and intelligence that will provide an understanding of themes, trends and analysis.	• Line of sight document is now in place to provide better assurance in relation to front line activity. • Safeguarding Walkabouts for adult services established to support system assurance. • Exception reporting is now a standing agenda item evidenced through minutes. These reports will include outcomes of partner audits going forward.
Development of quality assurance plan based on themes and trends identified by safeguarding data and learning from local and national case reviews	• Line of sight will be our key QA mechanism going forward, alongside safeguarding walkabouts. • Workplan 2024-25 to include actions on self-neglect and MCA as these continue to be key themes from case reviews
Seek assurance through multi agency audit activity that Making Safeguarding Personal (MSP) is embedded into practice through safeguarding concerns and enquiries.	• The data received and reviewed at SASA meetings from the Performance and Outcomes Group and the Adult MASH Quality Assurance Meetings provide evidence of the voice of the individual. • Outcome of multi-agency Adult MASH audits is included within exception reporting to SASA. • MSP included in Line of Sight so will be specifically reported on going forward
Support dissemination of learning from Safeguarding Adult Reviews and other statutory reviews to ensure that learning is embedded across the partnership	• No SARS were published in 2023-2024. • Learning from a number of local learning reviews has been shared on the following themes: rurality and access to services; self-neglect; responding to complex needs and substance use with 73% of delegates who attended the virtual briefing to share rated it as "excellent". • Knowledge within agencies of learning from SARS/Local Learning Reviews is explored through safeguarding walkabouts
Improve engagement with and learning from organisations and ensure meaningful feedback is sought and used to adapt priorities and ways of working.	• Adult Services Partnership Meeting held September 23. The next meeting is planned for June 2024. • User voice is part of 2024-2025 workplan, alongside plans to create an adult practitioner forum. • Adult Safeguarding Partners Meetings which will meet twice per year.
Develop a 'line of sight' process that includes reporting outcomes of partner inspections and/or safeguarding investigations	Line of sight is in place and now needs to be developed to include wider multi-agency reporting, including data, to give a greater assurance of safeguarding: included in workplan 2024-2025.
Further develop the multi-agency adult safeguarding training offer to include best practice guidance in mental capacity assessment, what constitutes a safeguarding concern and making safeguarding personal	• MCA Training will be in 2024-2025. • There remains work to do to increase the multiagency safeguarding training offer for the adult workforce and is included in the workplan for 2024-25.

	• Stakeholder Networks and Senior Partner Meetings have had a greater focus on adult safeguarding, including learning from a case review in relation to rurality and self-neglect.
Improve understanding of vulnerabilities and risks experienced by young people that are transitioning into adult services	See update on page 7. The oversight of this strategic priority will sit with FCSA/SASA going forward.
Review multi agency safeguarding adult policies and practice guidance in line with learning from case reviews and quality assurance activity. This will include Persons in a Position of Trust and guidance in relation to 'think family' practice	• Plan in place for timely review of all policies to include national guidance and policy updates. • The High-Risk Professional Guidance has been refreshed and a short webinar produced to explain the process. • The Persons in Position of Trust Policy (PiPOT) is being progressed regionally to establish a SW policy.

An emerging theme is the line of sight into care providers and their understanding of the role of the SVPP. There is already work in place to attend the Providers Forum to improve this understanding and support engagement with and understanding of the case review process. SASA will ensure that exception reporting on the outcome of CQC inspections are also part of the line of sight going forward.

Impact of Safeguarding Enquiry Audit presented to GP Safeguarding Leads

Further evidence of collaboration and sharing of system assurance was provided by a presentation of findings from an Adult MASH Audit to a GP Safeguarding Leads Meeting in January 2024. The audit was conducted following a request from Primary Care for a list of adults open to section 42(2) enquiries from Adult Social Care. This led to the Named GP for Safeguarding Adults and Children working with Adult Social Care to collect data around primary care involvement in adult safeguarding enquiries, supported by the Designated Professional for Safeguarding Adults and Specialist Nurses in the ICB.

The methodology used was a random selection of 10 cases, all closed to safeguarding within the previous quarter. The audit considered:

1. What was the nature of the abuse?
2. Was primary care involved in the S42 enquiry?
3. What was the outcome of the S42 enquiry?
4. Could outcome have been different if primary care was involved?

The immediate impact of this was an increase in notifications of safeguarding to GPs in relation to resident-on-resident incidents and falls, enabling them to bring forward any health reviews of the individuals involved in the safeguarding. Longer term impact is that GPs are now notified of Section 42 enquiries where they could bring additional benefits to the enquiry.

A further audit in May 2024 has led to an additional question for care homes to confirm that they have shared the safeguarding concern with the GP, and this will enable outcomes to be measured in future audits which are planned later in 2024 and will be presented to the Safeguarding Adults' System Assurance group.

7. Impact of multi-agency training

The SVPP multi-agency safeguarding training offer continues to provide high quality learning opportunities, with 85% plus of delegates on our instructor led courses rating the course as good or excellent, with most courses achieving 90%. This feedback has been consistent over the past few years. This year we have made more use of webinars and virtual briefings, with over 300 views of new webinars recorded. This included the partnership hosting a webinar on the launch of the new Wiltshire Family Hubs for professionals, which was very well attended with over 100. We will continue to develop this offer as a user-friendly way to access training and workforce development.

An emerging challenge is the decrease of attendance on the day on courses, dropped to 70% attendance on average on the day, with many running under capacity or even having to be cancelled due to low turnout. This does not represent good value for money or resource and will be focus of the Practice Development Group in 2024-2025 who will continue to look at barriers to attendance on the day and how these can be overcome; this drop in attendance on the day was also mirrored in Safeguarding Week. Plans for further development of the programme include hosting events from the Disclosure & Barring Service and Safer Internet Live, launch of a new Early Support Assessment course and a Mental Capacity Act course. During 2023-24 we have seen an increase in the awareness of and increase in take up by colleagues from adult services and as our offer to support this workforce grows, we expect to see this increase further in 2024-2025.

"I will now have a better understanding of levels of risk, types of abuse and the importance of information sharing and a multi-agency approach to child protection."

"I can see how as a school we now fit into the bigger picture of keeping children safe in the community and beyond. It's been very helpful to see the challenges facing our pupils once they leave the school environment."

95% of Attendees* rated course delivery and clarity as 'Excellent' or 'Good'

*** Attendees who completed course evaluations**

Improved knowledge, confidence and access to helpful resources

Enhance my knowledge to give the best support to my families

Please describe how the training will have an impact on the quality of your work.

Really well run course

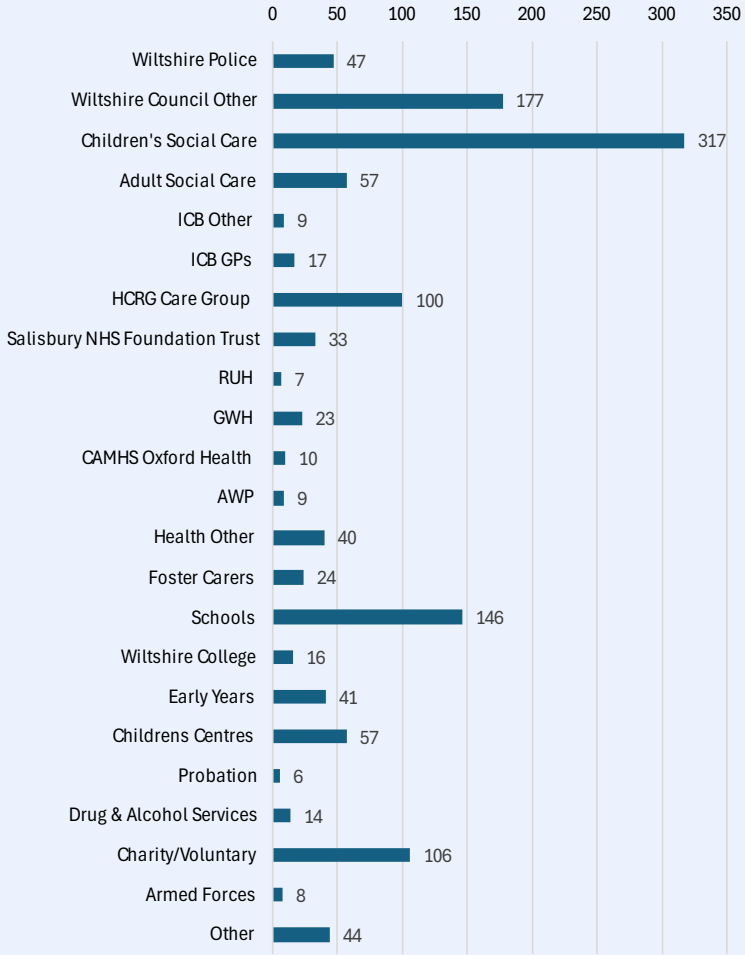
It was a really good interactive day and great to work alongside people from other professions.

Comments from course attendees

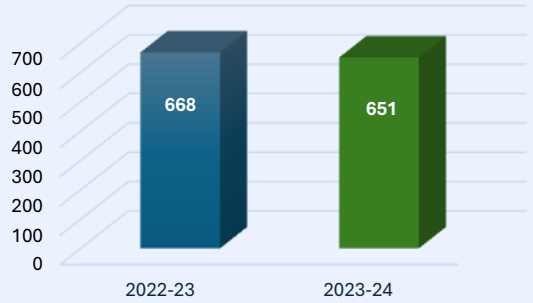
A great course, I learnt a lot

Would recommend others to attend

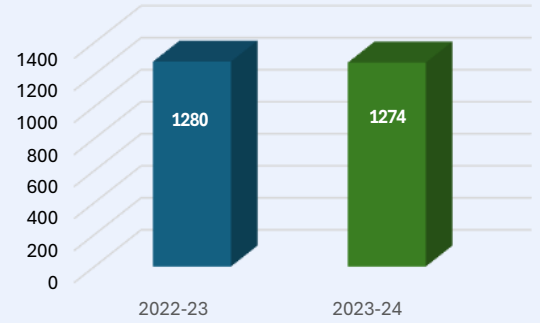
Course Attendance by Agency (Includes One-Off Events)



Core Course Attendance



E-Learning Modules Accessed



"It gives me a new tool to use to assess levels of neglect which is objective rather than neglect being considered in a subjective way by using personal views and expectations of what is 'good enough'"

"'I feel more confident to complete a DASH, I feel more confident to add additional notes and to ask for a MARAC if I feel that the DASH isn't reflecting the danger of a situation."

Safeguarding Week 2023

12 sessions ran across the week
391 delegates booked on with 291 actually attending: attendance overall was 56% of those who booked on

Understanding Transitional Safeguarding
Understanding and preventing radicalisation
Safeguarding risks to people seeking asylum
Tackling Poverty – how it can affect parenting
Relational Leadership within the Children's Sector
Learning from case reviews: An overview of local learning from case reviews in Wiltshire 2022-23
Child Sexual Abuse and the Independent Inquiry and impact on all professionals working with children
Tackling Modern Slavery webinar
Introducing the Safeguarding Vulnerable People Partnership (SVPP)
Child exploitation: contextual safeguarding and the national referral mechanism.
Introduction to the GCP2 Neglect Tool
Applying Trauma Informed Practice to Child Protection Planning
Ways of Writing Workshop

Attendance and engagement was disappointing and we will be promoting and planning the programme earlier for 2024 to improve engagement and participation including in agencies stepping forward to deliver sessions during the week. There is also increase oversight of the programme and engagement by safeguarding partners through the joint FCSA and SASA meetings.

8. External Scrutiny

External scrutiny by inspection bodies further informs safeguarding partners of how well the safeguarding system in Wiltshire is working.

Ofsted Inspection of Wiltshire Council local authority children's services September 2023 – rated as Outstanding.
This outcome built on the findings from the two previous Oxford Brookes Evaluations of Support and Safeguarding completed in 2019 and 2022.
Highlights of the inspection report include:

- Children in need of protection receive swift and effective response from the Integrated Front Door (IFD) team of workers from children services and from partner agencies.
- IFD provides seamless service to children and families during the evening and at weekends. For almost all children, appropriate and timely action is taken by workers to help protect and support them at times of increased concerns and crisis.
- When strategy meetings lead to child protection (CP) enquiries, they are timely and comprehensive.
- CP conferences are timely and well attended, and lead to strength-based that focus on increasing protective factors and reducing harm.

The report also highlighted that:
"Strategic partnerships in Wiltshire are strong. The local authority is central to a number of high-performing strategic and operational partnership boards and forums, including the Safeguarding Vulnerable People Partnership, that regularly measure and evaluate the impact of partnership working for children. There is effective support and challenge between leaders and managers when partnership working, and services are not making the positive difference they need to for children. The family judiciary, the Children and Family Court Advisory and Support Service (Cafcass) and key partners, including police and schools, report positively about the quality of practice, strong partnership working and the impact of services for children."

Adult Social Care Peer Review, September 2023 - areas identified as working well included effective prevention work, good plans and developments for improvement, enthusiastic knowledgeable teams and supportive leadership culture. Whilst recommendations included a strong focus is needed on assurance work, including case files audits to support quality and consistency in practice and to evidence impact of change the peer review provided positive assurance in relation to safeguarding systems and learning ahead of anticipated CQC inspection in autumn 2024.

Independent Safeguarding Review of the Southwest Ambulance Service (SWAST) – Wiltshire partners participated in the regional review, feeding in the challenges that have existed with engaging with SWAST particularly in relation to capacity to participate in case reviews and quality of referrals into the Integrated Front Door and Adult MASH. The outcome of the review has driven organisational wide improvements including additional local safeguarding resource. SVPP have already seen improved engaged with participation in the SVPP Stakeholder Network and Senior Partners meeting for the first time.

Independent Safeguarding Audits of Salisbury and Bristol Diocese have taken place this year. Both dioceses have a number of parishes and schools within Wiltshire. Although the final reports and recommendations have yet to be received, they have both approached the audits with an open and transparent approach.

Wiltshire Health and Care (providers of community health services) – rated requires improvement, however inspection recognised that there are robust arrangements in place in relation to safeguarding. Concerns identified related to inpatient provision.

CQC Inspection of RUH, Bath – a number of safeguarding alerts triggered a CQC unannounced inspection in Aug 2023. Significant allegations resulted in a review which identified learning in relation to:

- Safeguarding processes and staff awareness
- Timeliness of response to incidents/allegations
- Work force and staff welfare including freedom to speak up
- Night cover leadership and culture; micro-cultures within permanent teams

There is now a clear quality assurance framework in place to drive improvements forward.

Wiltshire Police – have continued to drive an improvement programme following the findings of the HMIC Inspection of Child Protection and Peel Inspection in 2022. Further inspections this year have noted improvements including:

- improving the effectiveness of its strategic plans;
- improving how effectively vulnerable people are protected; and
- improving how it identifies vulnerable people at the first point of contact.

There is still work to do in relation to management of serious and violent offenders and missing children. Findings from this additional scrutiny has meant that at the time of publication of this report Wiltshire Police had received notice that they are no longer in the national Engage enhanced monitoring process.

9. SVPP Budget – partner contributions

Partner contributions have reduced this year with one health provider now no longer contributing. Contributions from Probation Service have however been re-established. There has been a challenge to the ICB in relation to the level of their contribution in Wiltshire compared to other partnership areas they cover, which remains under review. Although there remains an underspend in reserve the current level of contributions do not cover the current outgoings. There are also ongoing discussions between the Lead Safeguarding Partners about the equity of contributions, with the local authority continuing to contribute substantially more than the other safeguarding partners.

PARTNER FUNDING 2023-2024	
Salisbury District Hospital NHS Foundation Trust	£13,800
Wiltshire Constabulary	£47,700
ICB BSW	£60,800
Wiltshire Council	£161,500
Probation	£2,000
Total	£295,000

10. Next steps and priorities for 2024-2025

The current strategic priorities will be reviewed in 2025, in readiness for new priorities from 2026. This review will be informed by the health check on the effectiveness of multi-agency safeguarding arrangements that we will undertake with partners in 2024-2025, as well as data and intelligence and learning from case reviews.

The focus of the work of the Independent Scrutineer will include scrutiny of our multi-agency audits planned for 2024-2026; multi-agency auditing has been limited over the last few years.

Current work on a Community Safety Partnership transformation will also impact on and inform current arrangements and will be reflected in the updated safeguarding arrangements due for publication in December 2024.

We will want to ensure ongoing oversight of key emerging themes such as neurodiversity and also ensure that there is a good understanding and scrutiny of the impact of the operational changes being made nationally to the Probation Service and capacity issues within the criminal justice system.

We need to improve how voice and lived experience informs our work in relation to both children and adults safeguarding.

We will respond to the outcome of the CQC inspection of adult social care inspection that will take place in 2024 and 2025 and ensure safeguarding activity relating to adults is at the core of the work of the SVPP.

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