Wiltshire Safeguarding Vulnerable People Partnership

Annual Report 2020-2021

1. Introduction and context

This is the second annual report of Wiltshire's Safeguarding Vulnerable People Partnership (SVPP). In last year's report, 2019-2020, we committed to be "unrelentingly focussed on practice and front-line service delivery. We must not allow ourselves to slip to an agenda which is characterised by processing of papers, receiving items for information or simply for noting". The SVPP Executive has stuck to this commitment and remains a small, senior group which has continued to meet regularly throughout the response phase of the pandemic and maintained a strategic focus.

Despite the impact of covid-19 there has remained a focus on the effectiveness of the partnership arrangements and some significant changes to how it works have taken place during this time and we have delivered on our commitment to review both the Community Safety Partnership (CSP) and the Wiltshire Safeguarding Adults Board (WSAB). The outcome of these reviews is set out below.

2. Responding to our forward plan 2020 - 2021

Last year's Annual Report set out four key priorities. Set out below is an overview of activity and its impact:

Under 1s

This vulnerable group were identified as a priority following 4 notifications to the CSPR panel about under 1s during 2018-2019 and the publication of our Thematic Review into Significant Physical Abuse to Under 1s. The actions set out in this review are wide ranging and system wide and implementation has not been straightforward. Our work was furthered added to by the publication of the second national review 'Out of Routine'.

In January 2021 identified the following areas for initial focus:

- Improve transitions and care pathways through the local maternity system networks and across maternity, health visiting and neonatal services
- Look to progress the shared care record
- Review the Injuries in Non-Mobile Babies Protocol
- Establish if we are confident that adult services know which of their service users are parents? – audit of adult facing services led by the Safeguarding Adult System Assurance group (SASA)

There is significant work already taking place to support working with under 1s, for example the roll out of the Five to Thrive approach and launch of the Dad's Matter Too Project. However, given the priority focus there remains further work and the third national review 'The Myth of Invisible Men' published September 15th has added more challenges to us as a partnership in this area.

Following a recent agreement this work will now be led by Health through the CCG (and the new Integrated Care System.) Focusing on the wider footprint will ensure greater traction as is required and is designed to limit any unnecessary duplication and easy dissemination of best practice across Wiltshire, Swindon and BANES.

Criminal Exploitation

The publication of the CSPR Panel's Report on adolescents and criminal exploitation, *It Was Hard to Escape: Safeguarding children at risk from criminal exploitation*, set out a number of key challenges and questions for local partnerships and in response Wiltshire and Swindon Partnership Executives met twice to consider these. A joint self-assessment against the questions was commissioned and identified areas of strength and areas for development; this work has informed the delivery plan for the new Pan Wiltshire Exploitation group which met for the first time in November 2020. This is an all-age group however within its first year there has been a focus on 0-25, particularly in relation to transition from children to adult services.

The Exploitation agenda is supported by the work to develop a contextual safeguarding approach within Wiltshire, and this has continued at pace, supported by the University of Bedfordshire. Permission from the Department for Education has been gained to pilot the use of a fifth category, *risk outside the home,* within the child protection process as a differentiated pathway for children who are at risk of serious harm, who may not 'fit' into the traditional child protection process due to the emphasis this process ordinarily has on the family and harm attributed to the actions or neglect of parents/ carers. This pilot is now live and there will be ongoing review of its value and impact and whether it can inform wider national guidance in relation to practice in this area.

This pan Wiltshire approach will test the effectiveness of cross border strategic working and thus determine whether further opportunities to work in this way will be explored by the partnerships in the future.

The remaining two priorities, *how we work with families* and *early support and prevention* have had less focus from the SVPP and we acknowledge that these areas lacked clarity thus affecting our ability to provide assurance in relation to them.

3. SVPP Development and Impact

Changes to the Wiltshire Safeguarding Adults Board

There have been significant developments in the safeguarding adults board since the publication of its last annual report. In July 2020 the board began a process of reviewing its structure including the groups that led on quality assurance, policy and procedures and safeguarding adult reviews. The Chair of the WSAB had retired after five years in post providing an opportunity to review the functioning of the board whilst considering the impact of Covid-19 and the subsequent demands placed on partners. The review also considered the longstanding aspiration of partners to adopt a wider view on the safeguarding system.

The review highlighted several issues, including poor engagement of partners in aspects of its work, a lack of focus and challenge, difficulty in evidencing impact of partnership activity and limited sharing of learning from case reviews. To address these issues, the board was restructured to:

- Meet the statutory requirements of safeguarding adults' boards whilst enabling better synergy across the safeguarding system by bringing the governance of WSAB within the SVPP Executive structure
- Strengthen collaborative working across the partnership reducing duplication, making better use of the skills, knowledge and capacity of members by reviewing and where required reducing the number of subgroups to ensure clear and focused activity was retained
- Create a stronger focus on quality assurance activity by establishing the Safeguarding Adults Systems Assurance group (SASA Group), which is described further below
- Enable improved shared learning across both adult and children's safeguarding systems and workforces through the joining up of case review processes in the development of the Partnership Practice Review group (PPRG)

As a result of the restructure the WSAB Executive group was disbanded and governance of the WSAB moved to the SVPP Executive, with the SVPP Chair taking on the role as chair of the adult board. This has moved the partnership closer to the intentions set out in its Safeguarding Plan to "think family, think community" and to create a system wide view of safeguarding at a senior level. A newly established SVPP Partnership Practice Review Group (PPRG) retains the statutory duty of SABs to commission safeguarding adults' reviews (SARs) but also considers Domestic Homicide Reviews and Child Safeguarding Practice Reviews. More is said about this development in the next chapter.

A key mechanism for improving quality assurance within partnership working has been the development of the Safeguarding Adults Systems Assurance (SASA) Group. This replaced the WSAB Quality Assurance Subgroup that had a large membership, had several chairs in a short period of time and as a result had struggled to progress its

workplan. The SASA group has a small, senior membership designed to create a sharper focus on scrutiny of the effectiveness of adult safeguarding. The group has strong links to the Partnership Practice Review Group to bring together learning from case reviews and quality assurance activity to improve practice.

To understand the effectiveness of the new groups and the impact of the changes made to the WSAB, including the functioning and impact of the SASA group, the terms of reference will be reviewed at the end of 2021. The review will consider feedback from chair of subgroups and members of the workstreams, and the wider stakeholder network.

Creating a Partnership Practice Review group (PPRG)

Further significant structural changes have been made to the process for practice review within the arrangements. A new Partnership Practice Review group was established in September 2020, bringing together the existing processes for Safeguarding Adults Reviews (SARs), Child Safeguarding Practice Reviews (CSPRs) and more recently Domestic Homicide Reviews (DHRs). This has been established to:

- Provide better visibility of cross cutting themes and ability to explore ways to improve practice across the system and demonstrate impact
- Reduce duplication and use skills and knowledge and capacity more efficiently
- Enable better sharing of learning across both adult and children's safeguarding systems and workforce
- Coordination through one centralised process will enable better oversight and management of reviews, actions and recommendations and demands on partner agencies

Case discussion and decision making about referrals are often not straightforward and this is testament to the passion of and commitment to improving the safeguarding system by members of the group. Ensuring all members of this new group were confident in their roles was key and as part of this a development session, with Michael Preston Shoot, took place to improve knowledge and understanding of safeguarding adult reviews. Work has also taken place to clarify the governance arrangements for each of the three statutory review processes, setting out of the methodologies for reviews, bringing in frameworks to support decision making with sufficient case information, improve timeliness of reviews and the sharing of learning and the recording of case data. This will provide a more confident foundation from which to further embed this group and assure the partnership.

We have improved how we track responses to recommendations and are able to look across the wider partnership structure to request action from and within existing subgroup structures where relevant. This strengthens the understanding that our response to practice review is a shared responsibility and needs to sit across the SVPP. Our priority is now to embed how we track our response to learning and recommendations and most importantly the impact of this.

Community Safety Partnership Review

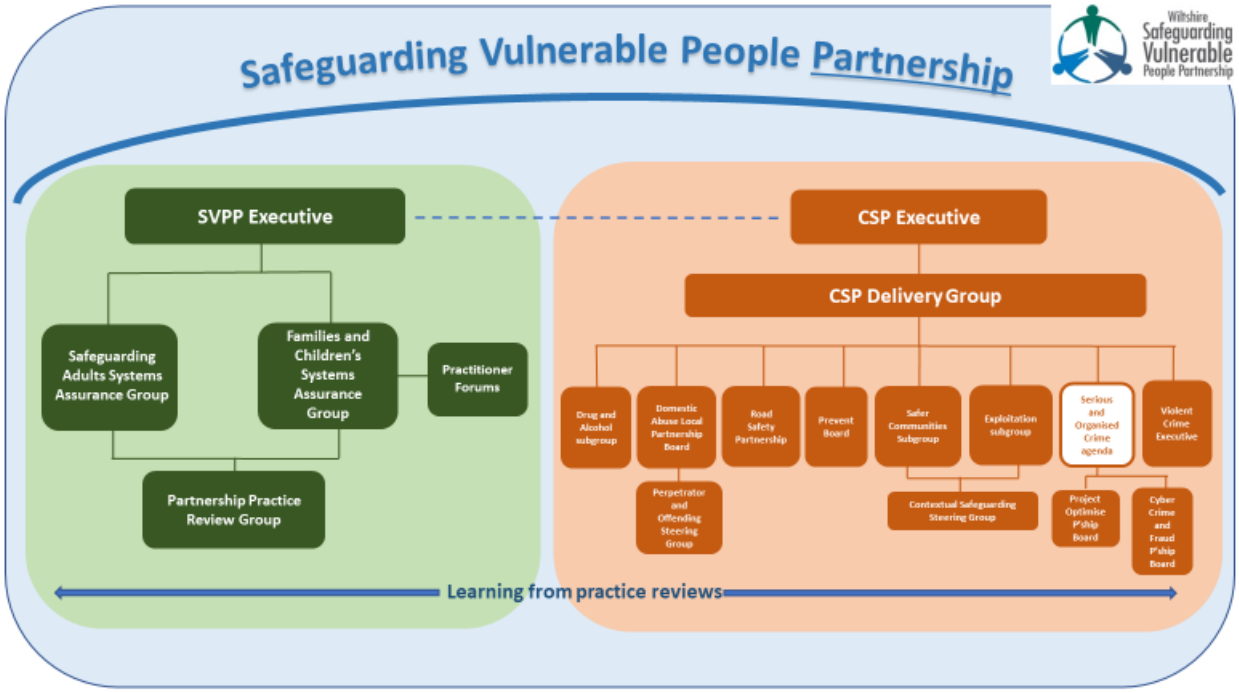
A local review of the CSP which was commissioned in September 2020. This partnership sits within the broader SVPP structure and with a new CSP Chair in place it was an opportunity to review its function, impact and its relationship with the SVPP Executive; a well-functioning CSP can only support the wider partnership structure.

The review set out to identify ways to strengthen the partnership and its effectiveness and build on the work and structures already in place and recommendations were represented in March 2021. The review has:

- Ensured all key areas of business are covered and governance is clear, for example the Contextual Safeguarding Steering group has been moved to strengthen links into the Pan Wiltshire Exploitation Group and a newly established Safer Communities group, enabling it to broaden the application and therefore impact of this approach
- Ensured the CSP Chair is a standing member of the SVPP Executive in their own right to enable continued strong links, join up of the two agendas and reporting on key safeguarding areas of business such as domestic abuse and exploitation.

- Established a Delivery Group - this group has already met and will help to ensure the effectiveness of the CSP subgroups, reduce duplication and support better collaborative working across areas of business
- Identified work to embed an outcomes framework to better evidence impact

The review also set out recommendations in relation to the domestic homicide review (DHRs) process and it was agreed that a rapid review would be carried out on receipt of a referral for a DHR, in order to ensure any decision to commission a DHR is based on sufficient information and to test out new methodologies for the final report. This is intended to enable us to both feel confident about the decision to commission a DHR and to complete the reviews more quickly. The process for these statutory reviews has been further strengthened by bringing them in to the new Partnership Practice Review Group. We have yet to test this new approach and therefore it is too early to fully assess the impact of this and other changes as a result of the CSP review however we would expect to be able to report on this in next year's report.



4. Practice Reviews – activity and impact

Rapid Reviews and Child Safeguarding Practice Reviews (CSPRs)

Since the changes set out in Working Together 2018 work has taken place to ensure there is a clear and robust process for notifications to the CSPR Panel. In Wiltshire best practice is that any decision to notify a case is made with the three statutory partners. This has improved transparency, shared ownership of the decision and the threshold for notification.

During 2020-2021 two notifications were made to the CSPR Panel initiating one rapid review. One of the notifications related to a LAC child, whose cause of death was medical and there were no concerns in relation to abuse or neglect. We agreed with the CSPR Panel that a rapid review was not necessary in this case.

The second notification led to CSPR Family N published in May 2021. The circumstance of this review related to the disclosure of sexual abuse by a child who, along with their siblings, was subject to a Supervision Order at the time. The perpetrator is now in jail. The review focussed on care proceedings, working with resistance and 'stuckness' and working with child sexual abuse. The recommendations reflect the learning from these themes and include actions to:

- Produce a practitioner briefing on working with sexual abuse including patterns of sexual abusers' behaviour
- Produce a glossary and explanatory note for partner agencies setting out some of the basic terms and processes within care proceedings
- Explore the extent to which supervision is available to their staff and the potential to establish a group supervision approach to dealing with stuck child protection work and we will free up our staff as needed and as appropriate to act as group supervisors to practitioner groups who seek outside consultation and assistance in moving work on

This last action has also been identified as learning in adult reviews therefore the response will be system wide and progress will be tracked by the PPRG.

Safeguarding Adult Reviews

Wiltshire's Safeguarding Adults Board 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. During this year one SAR was published as set out below.

SAR Adult H

In August 2020 the partnership published SAR Adult H . This case was referred to the WSAB after a resident of a care home was sexually assaulted another resident. After police investigations it emerged that the male resident had a number of convictions, serving sentences for serious sexual offences against minors. This information was not known to the care home or the local authority who placed the male resident. The case was referred to the WSAB to assess how partners can learn from what happened to Adult H and ensure that, in future, adults at risk are better protected from harm.

The review found that beyond the failure to share information, assumptions were made about the relationship between the individuals concerned and the level of risk. A recommendation from the review was that regardless of the care and support needs of the persons involved, an alleged sexual assault should have resulted in the police being called immediately. The findings of this review were discussed by partners at the desktop review session, the WSAB Executive Board and a copy of the report sent to the National Police Chiefs' Council lead for the Management of Sexual Offenders and Violent Offenders for information. Advice for practitioners was shared through the WSAB Staff Guide on when to call the police.

Domestic Homicide Reviews

During this time the DHR into the murder of a teenager has been ongoing and due for publication shortly. 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 healthy relationships.
Two further DHRs are currently ongoing.

Non- statutory reviews

The partnership is proactive in reviewing case 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 has been disseminated to partner agencies for internal dissemination with key learning included within relevant multi-agency safeguarding training.

Case 1: A 15-year-old who was admitted to hospital in acute alcohol withdrawal. She was known to professionals and was on a child in need plan. This case highlighted the fact that nationally there are no residential detox beds for children under 16. This has been raised nationally through Drug and Alcohol Steering group of the CSP.

Case 2: A complex case over a number of years involving an adult with autism and a learning disability with a history of committing sexual assaults as a child and an adult. This case highlighted the challenges where an individual poses a risk to the public yet are deemed not to have capacity, not fit to plead and there is insufficient evidence to prosecute. A practitioner event used the characteristics of this case to discuss how assured we are that a similar case would be better managed now and identified a number of recommendations to take forward.
Case 3: This review explored practitioners understanding of neurodiversity and how this can impact on the capacity of an individual to parent and what support is available to help them.

In addition, the SVPP commissioned a Thematic Rapid Learning Review, in response to 4 serious domestic abuse related incidents, involving knives or similar weapons, in Wiltshire, during the period of lockdown from 23rd of March 2020 until July 2020; one of which resulted in a double homicide. Whilst some of the individuals involved were well-known to services, and had been referred through MARAC previously, others were not, and the thematic review was commissioned to understand the potential impact of Covid- 19 and lockdown measures on the need for support or intervention for those individuals/families.

The thematic review did not find evidence of any specific impact of Covid-19 or lockdown in these cases but did identify learning in relation to identifying and responding to escalating behaviour; recognition of risk of violence to wider family members; challenges of working with non-engaging /non-complaint families in the context of remote working. Two of these cases have also been subject to statutory review processes: CSPR Family N and an ongoing DHR in relation to the double homicide.

Learning from case reviews remain a significant area of activity for the SVPP and going forward there is a recognition that to ensure that reviews, identification of learning and response to it is timely there needs to be acknowledgment of this as a core function of the partnership. Capacity to deliver on this within the SVPP Business Support team and wider partners agencies is critical to the effectiveness and ultimately the impact of this.

5. Children's safeguarding

The Families and Children's Systems Assurance Group (FCSA) focusses on the effectiveness of the safeguarding systems for children and has further embedded its role in relation to this. During the response phase of the pandemic the group took on the role of providing a view on partnership working to safeguard children for the SVPP Executive. It has worked closely with the Vulnerable People Safeguarding Group (VPSG), a Gold response group stepped up to focus on the system response to the pandemic. The VPSG escalated concerns to the FCSA where necessary: for example, the National Probation Service guidance preventing any home visiting which was at odds with other national covid-guidance; concerns in relation to the court backlog and its impact on victims. It also highlighted the dip in safeguarding referrals for children leading to the safeguarding review described on page 8.

The FCSA has maintained oversight and scrutiny of the system to safeguarding children, in particular:

- Oversight of and accountability for notifications, the rapid review process and reports
- Increased scrutiny of children electively home educated and missing education
- Oversight of the effectiveness of Child Death Overview Panel
- Oversight of roll out and use of the new early support assessment
- Led the response to Everyone's Invited
- Feedback from Practitioner Forums
- Multi-agency audit on children living with parents who misuse substances

The partnership recognised early that an understanding of the latent demand in the system as a result of Covid and the different ways services were operating and lack of visibility of children, was needed in order to plan and prepare. The modelling outlined predictions and intelligence gathered on the factors likely to impact children, young people and their families post Covid-19 lockdown. There was recognition that this work had to be live and dynamic and was a way through which to provide a 'best guess' on future demand and key to the partnerships ability to identify any increases as early as possible to alert the partnership.

The FCSA highlighted the need to develop a model for measuring this demand and initial modelling anticipated a surge in referrals to children's social care from September 2020 as more children returned to school. However, this surge was not seen and as this concern remained, a wider system review was commissioned.

Covid -19 Safeguarding Review

In response to concerns about the drop in contacts with social care and visibility of children during lockdown a safeguarding review was carried out.

All schools and agencies, including services for adults, were asked to participate and respond to the following:

- *How any change to delivery of service impacts on the level and nature of contact with children and families*
- *Where contact has reduced whether changes can safely be made to increase contact going forward and to catch-up for contacts which have been missed*
- *Where the level of direct (face to face) contact with children cannot be increased what other actions can be taken to enhance the level and quality of indirect contact*
- *To review Covid and post Covid referral rates your agency/service has made to children's social care and where there is a marked change to consider the actions that need to be taken now*
- *Where gaps remain, with services unable to deliver face to face services or catch-up for missed contacts (for example waiting lists), tell us about them to help inform the strategic assessment and other actions that can be taken in mitigation*

What it told us

Overall responses demonstrated that agencies recognised the concern and understood the request for this review. Responses evidenced reflection and responsiveness and therefore provided a level of assurance to the partnership. Although it was initially intended to identify any current gaps and concerns, the information also provided a focus for our response as we come out of lockdown. An increase in contacts with social care was seen in the months following this review.

Another impact of the work on demand modelling has been to rethink our Data Analyst group. This group was established along with the FCSA in 2019, with its purpose being to: triangulate and assess data and quality information; to use this data and intelligence to lead the discussion and focus for the partnership and to drive and inform activity. The group had a significant role supporting the demand modelling however there has been recognition that as a group it had struggled to find a wider role and impact, pre-covid. Therefore, it has been agreed that this group will no longer meet as a standing group. FCSA accepted that the ability of the Data Analyst Group to horizon scan and identify areas for further work had been limited and that the evidence base for insight needed to be redefined. Going forward analysts will be identified to complete standalone deep dives/project-based work as required and this is forming part of a revised approach and framework for scrutiny and assurance for the FCSA.

Graded Care Profile 2 (GCP2) Audit

Wiltshire has been using the GCP2 assessment tool since February 2019. Numbers of assessments completed remain low however recording of this is hampered by its reliance on self-reporting by practitioners. One of the key elements of the GCP2 Implementation Plan was to evaluate the use of the tool and agencies were asked to complete two audits with practitioners who had completed the assessment during the period Q3/4 2019-2020 and Q1/2 2020-2021. The audit findings and learning are set out below. However, the tool remains underused

across the system (based on quarterly data) and could be a key intervention in how we come back from the pandemic and support parents and family functioning post lockdown and in managing the potential latent demand in the system. Response to the learning will be taken forward by the FCSA.

GCP2 Audit

Findings:

Feedback on use of the tool was largely positive, good practice was identified and analysis of the responses highlighted the following benefits

- Enabling constructive discussion with parents, including a focus on strengths
- Child focused - helped parents see the impact on the child
- The audit returns were all on under-fives which highlighting how GCP2 could be most useful within early help/intervention
- The tool helped identify strengths and weaknesses and therefore target support and services better
- Families felt this was a good visual tool and easy to understand the concerns and see the positives

Learning:

- Some relevant professional groups are still unaware of tool
- GCP2 is an effective early intervention tool that can target the support and services needed
- Completing it with another professional can be supportive and enable different perspectives and expertise informs the assessment

"*Using the assessment helped identify the family's strengths and weaknesses, which in turn helped to identify which other professionals needed to be involved in the case to meet the needs of the family." (Practitioner)*

6. Adult safeguarding

As a result of Covid-19 and the review and subsequent restructure of the safeguarding adult board, WSAB did not publish an annual report in 2019/20. However, a summary of activity during this period is detailed below.

- **Peer Assessment:** The board carried out its annual self-assessment, engaging partner organisations in reflecting on progress and barriers in adult safeguarding over the previous twelve months. The findings highlighted:
    - lack of confidence amongst the workforce about the new Liberty Protection Safeguards (LPS)
    - the need for further guidance, information and training about domestic abuse and self-neglect

  This led to the revision of WSAB guidance on domestic abuse and self-neglect. Scrutiny of the implementation of LPS is being overseen by the newly formed Safeguarding Adults Systems Assurance Group. Further assessment to review actions from this peer assessment will take place in September 2021.
- **SAR Adult E** was published in June 2019. In this case there were concerns about Adult E's discharge from an acute hospital to a community hospital. The review made several recommendations in relation to how agencies worked together to protect those with learning disabilities by sharing information, through application of Making Safeguarding Personal (MSP), the Mental Capacity Act 2005 (MCA) and appropriate provision of advocacy services.

A key development following the WSAB review in July 2020 and subsequent restructure has been the development of the Safeguarding Adults' System Assurance (SASA) Group. The specific role of the group is in relation to all partnership activity that contributes to the safeguarding of vulnerable adults; to provide assurance to the SVPP that those systems are working effectively and to assess the impact of partnership activity on

vulnerable adults. The group formed in November 2020 and is still developing its work plan, part of which is to consider how data will inform quality assurance activity based on multi-agency intelligence from group members and information gathered across the partnership.

The group regularly reviews data from the adult MASH and considers types of safeguarding concerns and the numbers of referrals that are taken to a s42 enquiry. The decision-making and recording structure for safeguarding referrals has been clarified in recent guidance published by the LGA/ADASS (Sept 2020). Understanding what constitutes a safeguarding concern and how to support effective outcomes | Local Government Association. The guidance encourages Safeguarding Adults Boards to understand what happens when a referral is 'not a safeguarding concern' or a 'safeguarding concern'. As a direct response, a multi-agency Task and Finish group has been established, under the governance of the SASA group, to develop clear referral pathway to support practitioners to complete safeguarding referrals and know where to access support if a referral is 'not a safeguarding concern'. A pathway, flowchart and learning briefing will be published on the partnership website and used in training from September 2021.

In addition to activity detailed above, the SASA group has maintained oversight and scrutiny of the system to safeguarding adults, in particular in relation to:

- NHS Digital's COVID 19 Adult Safeguarding Insight Project
- Analysis of local Safeguarding Adult Review themes and learning
- Safeguarding in care homes
- Quality assurance of hospital discharges
- Implementation of Liberty Protection Safeguards Guidance

The group has also overseen the development and publication of local policies and procedures: Persons in a Position of Trust; Hoarding Protocol; High Risk Professionals Meetings Guidance. The documents have been published on the WSAB website and shared through the SVPP newsletter.

Voice/customer feedback

Reported to the SASA Group in December 2020, Healthwatch Wiltshire undertook a survey of people's experience of safeguarding. They received feedback from 16 people and published their report: Your experiences of the adult safeguarding process | Healthwatch Wiltshire. The survey had limited responses, likely due to Covid-19, but identified areas to address such as improving consistency of response/feedback, improving information available to people involved in the safeguarding process and use of advocates. The report resulted in an action plan that has been overseen by the SASA group.

With the support of the Centre for Independent Living WSAB hosted meetings for Service User's group to ensure those who use services were informing the work of the WSAB. Through the course of the year members took part in the consultation about the restructure of the WSAB, had a presentation from, and were able to feedback to the CCG on its response to Covid-19 and also held discussions about experiences of carers and services users during lockdown.

7. Independent scrutiny

SVPP has been independently chaired throughout this period and that chairing offers a scrutiny of partner contribution. In particular, during the year there has been critical examinations of:

- Arrangements to meet the needs of vulnerable children and adults during Covid
- How staff have been supported through the pandemic
- Support for residents in care homes
- Preparations for any surge in service demands as the lockdown eased and in particular the re-opening of schools

- All rapid reviews, local child safeguarding practice reviews and national reviews, especially 'Out of Routine' report into SUDI
- The development of our response to domestic abuse
- With Swindon and BANES, scrutinised the contribution of Avon Wiltshire Mental Health Partnership (AWP) to the safeguarding system and ensured a greater focus from them on their safeguarding duties for both adults and children
- With the Swindon scrutineer, we have instituted quarterly meetings with the Chief Constable, the Chief Operating Officer of the CCG and the two local authority Chief Executives to ensure a direct line of sight to them on safeguarding issues in their partnerships. An early focus is on leadership and culture.

8. Delivery and Impact of multi-agency training

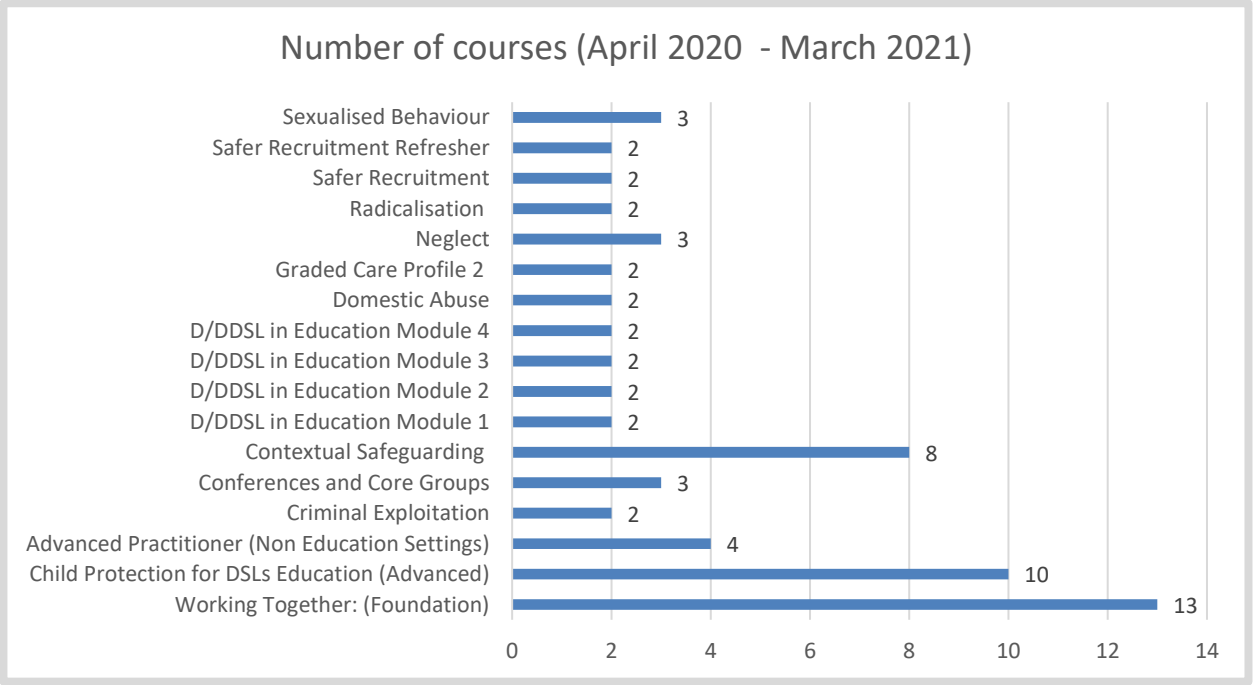
The multi-agency training offer continues to be successful in Wiltshire, with consistently high feedback from delegates rating courses as 'excellent' or 'good'. A selection of comments from delegates is included below. There is a robust system for gathering evaluation data following attendance at training that gathers delegates feedback on the quality and impact of training.

The training will have a direct impact on my work as a Family Keyworker working with young people and their families. It has greatly increased the way in which I observe and interpret situations within my work.

Although I had a "good" knowledge of the subject I really felt that this contributed to my understanding and confidence and the course was really well delivered

During Covid-19 all face-to-face training courses were suspended and a programme of virtual delivery started in July 2020. During the time courses were cancelled we bought additional eLearning licences to offer more online courses and supported covid community volunteers by providing free safeguarding eLearning for volunteers. The impact of covid-19 meant a total of 41 courses were cancelled in 2020/21. A total of 744 people accessed training through the SVPP in this period nearly 70% fewer than the year before.

In the next year there will be significant developments within the training programme. This means moving away from delivery of the traditional 'foundation', 'advanced' type courses to a more responsive, flexible learning model that will allow swift dissemination of learning from case reviews in easily accessible webinars and short training sessions.



Although the transition to entirely online delivery made after lockdown restrictions was not easy, training has continued to be graded by delegates as high quality demonstrating the positive impact that online delivery can have. Providing flexible options has the potential to increase the number of staff who can engage with training and therefore as a partnership we can be more responsive in our learning programme. We plan to develop more online training courses, including through podcasts and webinars, for both children's and adults' workforce that focus on learning from case and practice reviews in 2021/22.

9. Next steps and future priorities

The coming year will see a focus on a number of key priorities.

1) Safeguarding of Under 1yrs
2) Domestic Abuse
3) Criminal Exploitation
4) Leadership and culture
5) The scoping and implementation of a full programme of independent scrutiny
6) Progressing a DfE funded pilot to improve our data analysis and intelligence-led approach to safeguarding

Integrated Care System

The development of Integrated Care Systems (ICS) are central to the NHS Long-Term Plan to local organisations together to redesign care and improve health. Safeguarding systems and safeguarding leadership are an integral part of developing a safe and effective ICS and the SVPP will work with the CCG to seek assurance that both children's and adult's safeguarding and recommendations from the Wood Review are embedded within new arrangements.

Wiltshire Safeguarding Vulnerable People Partnership (wiltshirescb.org.uk)

https://www.wiltshiresab.org.uk/