NHS England South West

South West Safeguarding Annual Report 2023/2024

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Contents

Foreword

Welcome to the third edition of the NHS England South West Safeguarding Annual Report. This year has been busy since the announcements of the Stable Homes, Built on Love: Implementation Strategy and consultation around the Children's Social Care Reforms 2023. Working together to safeguard children 2023 (replacing the 2018 version) was published along with a suite of statutory guidance on 15th December 2023.

The Annual Report provides an update on progress made against our 23/24 priorities and our safeguarding activity including statutory review data, awards and celebrations, key achievements, and challenges across our seven ICS areas and provides an outline of our future priorities. Between February 2023 and the end of March 2023, we have undertaken seven bespoke Integrated Care System (ICS) Safeguarding Revisits. The process and themes are discussed later in this report.

Whilst NHS England is an arm's length body, we do make a difference for our population by working with our systems to influence, shape and empower our national leaders and local systems, for example, to tackle some of the specialist professional workforce issues. Our report outlines some of the challenges and outcomes for South West systems and highlights our systems awards.

Before we move into the main body of the report, we would like to introduce you to the South West Regional Safeguarding Team. NHS England has undergone a process of change. In October 2023, we moved under the leadership of Jill Crook, Director of Nursing for Professional and System Development. Our former Director of Nursing Leadership & Quality is currently seconded to Devon ICB as their Interim Chief Nurse.

The South West Regional Safeguarding Team are pleased to present this Annual Report and look forward to continuing to work together with our partners over the coming year.

Sue Doheny
Regional Chief Nurse

Dr Rosie Luce
Assistant Director of Nursing
(Regional Safeguarding Lead) (RSL)

South West Regional Safeguarding Team

Sue Doheny, Regional Chief Nurse

Jill Crook, Director of Nursing Professional and System Development

Dr Rosie Luce, Assistant Director of Nursing
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Safeguarding and MCA Professional Lead

Joanne May,
Safeguarding Officer

Acknowledgements

We would like to take this opportunity to acknowledge the continued support of the South West Commissioning Support Unit (CSU) and specifically the Business Intelligence team; Kirsty Hall and Elen Hall, who have continued to provide us with comprehensive and timely data analysis during 2022/23.

Awards

Over the past year, the following awards were received by those working in safeguarding:

- Jill Crook, Director of Nursing for Professional and System Development was awarded the British Empire Medal (BEM), for services to people with a learning disability and autistic people, especially via the Transforming Care Programme.
- In NHS Devon ICB, the Interpersonal Trauma Response Service roll-out to GPs received a Parliamentary Award in July 2023.
- Michele Thornberry, Head of Safeguarding NHS Devon ICB, received the Westcountry Women Award for combatting violence against women and girls during 2023.

Further key achievements/celebrations:

Gloucestershire ICB Safeguarding children's team members won the ICB Staff Award for their work around the Joint Targeted Area Inspection (JTAI) multiagency inspection of children's services in June 2023.

Cornwall and Isles of Scilly (CIoS) ICB; as part of the joint forward plan to address the needs of victims of abuse, made victims of domestic abuse a priority and funded a primary care domestic abuse support, until at least March 2025. CIoS ICB have seen the difference that this ongoing commitment has made, with a five-fold increase on the number of referrals made by general practice to domestic abuse services.

CIoS ICB have worked with partners in Safer Cornwall to create and implement action plans to embed learning arising from domestic homicide reviews. Support was provided around the delivery of the tripartite conference focussed on ending domestic abuse, sexual violence, and violence against women and girls. The conference launched the

tripartite strategy for domestic abuse and sexual violence. The national domestic abuse commissioner was a keynote speaker and gave her support to the ambitious nature of the strategy.

In the past twelve months, CIoS ICB has supported Cornwall Council's adoption of 'Care Experience' as a protected characteristic and is supporting the initiatives to promote the needs of care experienced young people, improve placement, sufficiency and increase access to timely medical assessments for prospective carers. This will further a trauma informed approach across services supporting emotional wellbeing and mental health of our children in care.

CIOS ICB also supported the development of the ICON programme in Cornwall through attendance at learning events, support and participation at conferences whilst continuing to assess and embed learning and development.

Unborn and Under 1 system improvements

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

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

Outputs of the group have focused on improvements of response to the under 1's and have included the development of a BSW bruising in non-mobile babies policy; development of BSW Pre-birth protocol; development of BSW Faltering growth Policy; development of a Safer Sleep policy and a focus on professional curiosity and 'working

with fathers'. ICON Interventions, Preventing Abusive Head Trauma in Infants has also been adopted across BSW.

The high point was an Under 1's Virtual Summit held 4th March attended by over 300 professionals from statutory and voluntary organisations across BSW, with Key Note talks from Sue Smith on ICON and Anna Peace on Safer Sleep. The ICON programme has been adopted across BSW.

Introduction

It has been a busy year since the announcement of the Stable Homes, Built on Love: Implementation Strategy and consultation around the Children's Social Care Reforms 2023. A suite of statutory guidance was published on 15th December, including the Working together to safeguard children 2023, which replaces the 2018 version.

On the 18th December 2023, the government published their response to safeguarding children with disabilities and complex needs in residential settings (Hesley Doncaster). Many of the failures identified by the Panel are part of the children's social care and Special Educational Needs and Disabilities (SEND) systems that are already beginning to reform. The circumstances in these institutions bring into even sharper focus the importance of reforms in the SEND and alternative provision improvement plan, strategy for children's social care, Stable Homes, Built on Love, and in NHS England's long-term plan to improve the lives of disabled children.

NHS Safeguarding have developed the NHS Safeguarding Integrated Data Dashboard (NHS SIDD) which was launched in March 2024. The data in this dashboard, which flows from NHS providers, are to become part of the NHS Standard Contract. Assurance of statutory health assessments for looked after children data reporting is to become a provider data report by March 2025.

At the time of writing, we await several implementation plans to be published. These are;

- Safeguarding.

- Children and young people, building on what is in place already as part of the Children and Young People plans.
- SEND.
- Learning Disability & Autism.
- Mental Health.
- Secure Estates.

The South West are planning to coordinate plans in region and to provide updates through to the South West Regional Quality Group. Owing to the 2024 parliamentary elections, plans and strategies have been delayed until later in the summer.

The South West workforce

One of our core objectives for 2023/24 was to make progress in delivering the key ambitions in the NHS Long Term Plan. Building and developing the workforce for now and the future is fundamental to the work we undertake in the South West. The specialist safeguarding and child protection workforce challenges have therefore remained a priority for the South West region since 2020. As a result, we begin this section of the report with progress around the NHS Safeguarding workforce profile, moving into work undertaken to improve succession planning, upskilling and maintaining safeguarding competencies for our safeguarding workforce. We finish this section with our ongoing safeguarding workforce challenges and ICB plans to make further improvements.

Readers should also note that during 2023 we had completed the initial work set out under South West Safeguarding Workforce, Learning & Development Reference Group and paused this meeting until later in 2024 following NHS England's restructure process. Ongoing oversight was reported directly through to the South West Safeguarding Steering Group during the period that this group was paused. We have now stood up the South West Safeguarding Workforce, Learning and Development Reference Group with an initial meeting held in June 2024.

South West NHS Safeguarding profile

In 2020, our NHS safeguarding workforce profile demonstrated over 55% of our safeguarding workforce was aged over 50, with 10% being aged 60-69. This was significantly higher than the overall workforce in the South West which had only 35% aged over 50. The most recent data analysis using workforce data from March 2024 demonstrated that 49% of our safeguarding workforce is aged above 50, with 10% being aged 60-69. However, the data also shows that the total South West safeguarding workforce overall headcount has increased 57% in the period 2020 (261) to 2024 (410), with the whole-time equivalent increasing a similar amount (55%) from 231.8 in 2020 to 359.9 in 2024.

Table 1: South West Safeguarding workforce

Year	2020	2023	2024
Head count number	261	354	410
Whole time equivalent	231.8	313.9	359.9
Aged over 50	55%	50%	49%
Age 60-69	10%	8%	10%

Succession planning and upskilling

Ensuring that we can continue to work toward keeping people safe through workforce succession planning and securing opportunities to upskill the South West workforce remained a key priority in 2023 and beyond. Collaboration with the former Health Education England (HEE), now the NHS England Workforce Training and Education directorate (WTE), resulted in a successful bid and subsequent development of two regional accredited safeguarding modules, which commenced in Autumn 2021. These are 'Risk and Decision Making for Safeguarding Adults and Children' and 'Safeguarding Supervision'. They are 20-credit, masters-level modules which were offered to those in a safeguarding role to develop practice and further academic qualifications to support career progression.

In 2022 we undertook three separate task and finish groups with designated and named safeguarding professionals for adults, children and children looked after, to undertake a

gap analysis in relation to the Intercollegiate Guidance Roles and Competencies for Health Care Staff (for adult, children and children looked after). All designated and named professionals must achieve a set of competencies as outlined in these documents and the group identified those which are difficult to achieve.

The regional team financially supported systems with funding to support a blended approach to learning via accredited and non-accredited learning and development. With the support of the South West Safeguarding Workforce, Learning and Development Reference Group and the South West Regional Looked After Children Network, we successful commissioned Bond Solon to pilot and deliver a Legal Literacy in Looked After Children and Adoption course. This training aimed to improve understanding the legal frameworks that underpin our safeguarding roles and responsibilities as well as highlighting the importance of a human rights-based approach. This also improves the ability of the safeguarding workforce to advocate for improved outcomes for this group, who face disproportionately negative educational, social and health outcomes. The two-day virtual training delivered by Bond Solon occurred in January, March and April 2023 and March 2024. Further dates are scheduled for November 2024.

Community Care Inform

Digitally supporting safeguarding professionals in their daily work life continues to be both a priority and a key challenge for systems and the region. Since 2022, we have been successful in commissioning Community Care Inform, an online resource that can be accessed from any device, in work and outside work, and provides a wide breadth of resources to support safeguarding professionals in their daily work. It keeps licence holders up to date with knowledge to support clinical decision making and to improve patient care. We receive regular reports which includes number of licence-holders, usage & summary of hot topics. (Awaiting further information).

Ongoing challenges

Designated doctors for safeguarding children and children looked after

Both the previous and current Working Together to Safeguard Children statutory guidance requires ICBs, formerly CCGs, to “employ, or have in place, a contractual

agreement to secure the expertise of Designated Practitioners".[1] Paediatricians are frequently employed by NHS providers and therefore arrangements are sometimes made between ICBs and NHS Providers to fulfil this requirement. When consultant paediatricians leave post, usually owing to retirement, the ICBs are finding it increasingly difficult to find replacements from those employed by NHS providers and, or recruit independently. We also note that as several of our ICBs enter the 2024/25 financial year with financial pressures and further restructuring of directorates and teams.

Both ICBs and NHS providers need to avoid conflicts of interest, for example the Designated Doctor also holding the Named Doctor function. This would be a conflict of interest because, in effect, the Designated Doctor needs to be in a position to hold provider representatives, including Named Doctors to account and bring professional challenge. We are not aware of any combined posts being held in the South West region.

In some areas, the designated doctor role is filled by public health doctors. There are no known public health doctors undertaking these roles in the South West.

To improve workforce and succession planning, a paper was taken to the South West Safeguarding Steering Group (27th February 2024) and the Regional Quality Group (20th March 2024) specifically connected to ICB Specialist Safeguarding & Child Protection Clinical Roles. The paper and recommendations were accepted. One of the recommendations was that ICBs should develop safeguarding workforce plans by 1st October 2024. Through our ICS safeguarding visits, we also heard about some of the solutions such as paediatric registrars undertaking clinical fellowships in the child protection arena. We therefore enter 2024/25 looking forward to hearing about other solutions to maintain and attract interest for future safeguarding roles in the ICB/ ICS workforce plans.

[1] See para Working Together to Safeguard Children (2023 as amended) edition, page 112, para 239.

South West ICS Safeguarding

During 2023/24, the South West Regional Safeguarding Team have continued to work with and support the Integrated Care Boards (ICBs) as they addressed financial challenges and moved into restructure and change programmes.

Themes and considerations from ICS/ ICB visits

The South West Regional Safeguarding Team carried out its third annual safeguarding visits to the seven NHS Integrated Care Systems. The visits took place between February and April 2024. As with previous years, a set of Key Lines of Enquiry were agreed and circulated which focussed on system safeguarding including effective partnership working. Each ICB decided how to arrange the visit and which partners to invite. Where NHS and other statutory safegaurding partners did attend, this added a richness to the discussions reflecting how working in partnership is essential to fulfilling statuory safeguarding duties.

These system visits are conducted in line with the NHS England South West core skills and such as taking a supportive approach, continuous improvement and making the best use of data. The visits form part of the overall picture of safeguarding including our regional governance (see appendix 1), system led professional networks, national and regional returns, participation in national communities of practice and networks as well as one to one meetings between ICB chief nurses, heads of safeguarding and MCA leads and the South West Regional Safeguarding Team. The visits are a useful forum to consolidate what is known and consider progress and barriers with system leaders.

Following the visits, formal letters are written to the chief executive, chief nurse and head of safeguarding for each ICB reflecting the key areas arising from discussions. These letters are also submitted as evidence toward the NHS England statutory process of ICB annual reviews. The following were themes emerging from this year's visits:

All ICBs and partnerships mentioned the impact or concerns about potential impact of budget reductions, budget position and operational pressures on:

- Ability to work together/ consistency of relationships.

- Consistency of health representation in partnerships.
- Impact of local authority pressures on preventative safeguarding.

Some systems also mentioned:

- Impact of operational pressures within NHS providers.
- Impact of operational pressures within social care and police partners.
- sustaining momentum in a period of changes, including changes in leadership.

Each ICB is working with health partners to ensure health systems have appropriate representation and avoid duplication in partnership initiatives. This included discussions about:

- Representation at strategy meetings for children.
- Health contribution to Multiagency Safeguarding Hubs.
- Information flow to MARAC from primary care.
- The benefits of an all-age approach.

Learning from safeguarding reviews came up in four out of seven system summary letters. Discussions included:

- Shared recognition of the need to improve learning from reviews.
- Need to improve embedding learning within primary care.
- How oversight/ assurance can include checking if change has been sustained.
- Recognition that safeguarding needs to inform the commissioning cycle.
- Work towards aligning learning processes with Patient Safety Incident Response Framework (PSIRF) principles.

Other topics arising from this year's visits included:

- Early high-level conversations about implementing Working Together 2023.
- Consideration of how safeguarding teams can support Pharmacy, Optometry and Dental (POD) and how safeguarding is reflected in POD oversight arrangements.
- On-going work to co-develop assurance and reporting with NHS partners.
- Challenge in recruiting named GP and designated Doctors for safeguarding children and children in care.

- A growing concern in adult safeguarding is people who self-neglect and how impaired executive function can impact ability to make decisions about care.
- Systems working together to implement and monitor the impact of Right Care Right Person on those in need of safeguarding.

Working in partnership, collaboration and providing ongoing support to ICBs

The South West Regional Safeguarding Team also continues to support ICBs and system safeguarding workforce through a range of forums and one to one support. A selection of these are described below:

The South West Designated Safeguarding Professional Forum

Within the South West, the regional Head of Safeguarding Transformation co-ordinates and chairs the South West Designated Professionals Forum attended by ICB Designated Nurses and Doctors for Adults, Children and Children in Care across the region. The forum met quarterly throughout 2023/24. In addition to the usual updates, news, case discussions and business-as-usual items, other topics, discussions, and external presentations have included:

- Discussion on the consultation Stable Homes, Built on Love: Implementation Strategy and Consultation.
- Patient Safety Incident Response Framework (PSIRF).
- Safeguarding in Pharmacy, Optometry and Dental (Commissioning).
- Forensic child and adolescent mental health services (CAMHS) and Prevent.
- Consultation discussions including:
    - Domestic Homicide Reviews – changes to primary legislation.
    - Statutory Duty to report Child Sexual Abuse call for evidence.
    - Children's safeguarding information sharing.
    - Working together statutory guidance.
    - public consultation on the definition of child to parent abuse.

The Forum also has continued to keep links with and hear updates from the other South West safeguarding networks: namely the Safeguarding Adult Health Network, Looked After Children Network, Maternity Network and Named GP Network. The latter do not attend the

Designates Forum because they are not chaired by designated professionals, but the Forum seeks updates from people within who are also part of those Networks.

The South West Prevent Health Network

Prevent is one of the four elements of CONTEST, the government's counter-terrorism strategy. It aims to stop people becoming terrorists or supporting terrorism. The Home Office works with local authorities, health and a wide range of government departments and community organisations to deliver the Prevent strategy.

Following publication of the Independent Review of Prevent in February 2023, there have been several developments and changes resulting from the 33 recommendations in the report. One key update has been the revised Prevent duty guidance which was published and came into force on 31st December 2023. The guidance applies to England and Wales. The Prevent Duty requires specified authorities such as health, education, local authorities, police and criminal justice agencies (prisons and probation) to help prevent the risk of people becoming terrorists or supporting terrorism. The Prevent duty guidance doesn't create any new responsibilities for the health sector but sets out how the health sector can work in partnership and build capabilities to understand and manage risk. The guidance provides up to date information on resources and further guidance available to the sector. It also sets out recommendations on training to help reduce the risk of people becoming terrorists or supporting terrorism. A national response to the health section of the guidance has been produced by NHS England and is available on the NHS futures safeguarding workspace.

In addition to the revised prevent duty guidance, on 9th October 2023 the revised Channel duty guidance 2023 was officially launched. It has been carefully developed to reflect policy and strategy developments, including CONTEST 2023 and the renewed Prevent duty guidance (above), valuable insights from the recommendations provided by the Independent Review of Prevent (IRP), and feedback from practitioner engagement. Channel is a programme which focuses on providing support at an early stage to people who are identified as vulnerable to being drawn into terrorism.

Within the South West, the regional Head of Safeguarding Transformation continues to co-ordinate and chair the South West Health Prevent Leads network attended by ICB and Provider leads across the region. The Home Office Prevent Advisers chair a South West regional Prevent Sector Leads Partnership attended by the regional Head of Safeguarding. There have been a number of changes in the national Department of Health and Social Care Prevent Team, but the national Prevent Partnership continues to meet. In addition, a new National Prevent Strategic Leadership Forum has been established. At a system level, health organisation's will also be part of their local Prevent partnership which will report into their respective Community Safety Partnerships. This is where local priorities set out in counter-terrorism local plans will sit.

During 2023/24, each of the police force counter-terrorism local profiles (CTLPs) for the five South West police force areas contained recommendation for 'health' as below:

Referral numbers from GPs and hospitals are typically low across the region. The Health Sector should review their Prevent referral numbers and reporting processes for GPs and hospitals in order to identify and mitigate any issues; and to identify any gaps in Prevent/Safeguarding awareness training.

Health have liaised with police counter terrorism leads to understand the data behind this and through several discussions at the South West Health Prevent Network, some of the actions and signposting in regard to GPs have included:

- ICBs have a role in communicating Prevent messages with GPs. This may be via the ICB Prevent lead or the Named GP for safeguarding or both. Due to the number of practices, this may be achieved by utilising Primary Care Networks and existing GP forums where safeguarding is already discussed in order to get messaging out and to keep awareness up.
- NHS England South West send out regular communications including the national NHS England Prevent newsletter where key relevant messages can be taken and used in local messaging.
- GPs are signposted to the Prevent training on RCGP: Royal College of General Practitioners - Online Learning Environment : Search results (rcgp.org.uk).

- Materials like the new Prevent video (available on YouTube here: Prevent Duty in Healthcare link) can be used to raise awareness, facilitate short training or lunch and learn sessions, etc.
- NHS England South West have sent call outs for GP Prevent case studies across the region, none have been shared to date.
- NHS England reminded our South West health Prevent colleagues to utilise the ACT Early resources to support Prevent awareness and communication within organisations and across local systems. We also provided an example from another part of the country where these resources have been utilised successfully in GP surgeries by displaying the short ACT Early Counter Terrorism animations on their patient information screens situated in surgery waiting areas.

The police force counter terrorism recommendation has been taken to the national Department of Health and Social Care (DHSC) led Prevent Partnership meeting to see whether there were ideas from other regions in response to this recommendation. Nothing above what we have already done in the South West was shared.

Whilst it is not possible to publish the data in this report, the South West counter-terrorism policing team confirmed at our most recent Health Prevent network meeting (24th April 2024) that the number of Prevent referrals from health in the South West has increased over 2023/24 (including specifically in the community and GP category). The average referral rate from health in the South West now exceeds the national average.

At the time of writing this report we are expecting 2024/25 counter terrorism local profiles to be available for the 5 south West police force areas (expected around July 2024 – post general election).

As of end of 2023/24, South West NHS Providers have reported meeting the 85% target of staff who are up to date with their Prevent level 1 and 2 Basic Prevent Awareness Training (BPAT) and the higher level 3 Workshop to Raise Awareness of Prevent (WRAP equivalent) training. The South West average for the last 4 financial years can be found in able 2 below.

Table 2: Prevent training compliance in South West NHS provider trusts

Year	2020/21	2021/2022	2022/2023	2023/2024	Target
Level 1 and 2 (BPAT)	89%	86%	85%	**85%**	**85%**
Level 3 (WRAP)	77%	83%	86%	**85%**	**85%**

Mental Capacity Act and Deprivation of Liberty (MCA and DoL)

In April 2023, it was announced that any timetable for implementation of the Liberty Protection Safeguards (set to replace the deprivation of liberty safeguards with a revised Mental Capacity Act Code of Practice) would depend upon a decision by the next government. This prompted national and regional forums to take stock and re-focus on what ongoing improvement is still required around the Mental Capacity Act (MCA) and Deprivation of Liberty (DoL).

The South West Liberty Protection Safeguards (LPS) NHS Regional Group changed its name to the MCA and DoL South West Health Network. It began meeting quarterly and inviting one representative from each NHS trust as well as ICBs and other agreed stakeholders. A working group completed a South West Mental Capacity Act Training Framework and began to collate training resources mapped to the safeguarding intercollegiate document training levels within the NHS Futures online platform. Network members are currently doing focussed work on raising awareness and skill around consent when working with children and young people. There is also an informal peer sub-group of those working directly with Community Deprivation of Liberty in ICBs.

The ADASS South West LPS lead finished their role in February 2024. Leading up to this, the South West regional DoLS network and the South West MCA Health Network worked together on a number of items including:

- A joint virtual event in October 2023.
- A joint community deprivation of liberty prioritisation tool.
- An adaptable guidance document looking at the interface between deprivation of liberty safeguards and the Mental Health Act, and
- a discussion tool looking at best practice around mental capacity and hospital discharge.

Members of the MCA and DoLS South West Health Network also had a chance to contribute to the thematic review of safeguarding adult reviews in the South West that included learning about the Mental Capacity Act. This was published by ADASS in January 2024.

The Quarter 2 ICB safeguarding heat map developed by the NHS England national safeguarding team with support from NHS England regional MCA leads focussed on Mental Capacity and Deprivation of Liberty. It set out Key Lines of Enquiry (KLOE) under three main topics:

- ICB Governance and Risk Oversight – Internal MCA practice.
- Community Deprivation of Liberty.
- ICB Oversight of Provider MCA/DoLs practice.

As was the format of heat maps at that time, ICBs were asked to rate themselves red, amber, or green against the KLOEs and list mitigations that are in place. All areas in the South West rated themselves Amber meaning: requirements only partially met or only some Key Lines of Enquiry fully met but gaps are clearly understood with plans in progress to address. There is recognition amongst regional MCA leads that this is a subjective and imperfect measurement, but as the title of the tool suggests, was intended to be a "temperature check" of the system against these KLOEs. It is hoped that this will be used to further conversations and inform system improvement plans. The South West Regional safeguarding team has asked ICBs to submit copies of their improvement plans by 1 October 2024.

Safeguarding within Direct Commissioning

The NHS England South West Quality & Patient Experience team have reported that they have continued to deliver the quality monitoring & assurance function for specialised services, specialised mental health services (including provider collaboratives) and Section 7a public health services (screening & immunisation and child health information system (CHIS)).

The NHS England South West Quality & Patient Experience team provided expertise to the 2023/24 mental health provider collaborative assurance meetings with the South West Provider Collaborative (SWPC) and the Dorset, Hampshire, Isle of Wight Adult Eating Disorder Provider Collaborative (DHIoW AED PC). This included scrutiny and challenge around safeguarding arrangements and processes within the collaboratives.

They continue to provide clinical quality expertise to the deaths in custody process, gaining assurance that robust safeguarding processes are in place and directing improvement plans where gaps in assurance are identified and have also provided expertise around the future delegation of specialised services and Section 7a public health services.

Safeguarding within Pharmacy Optometry and Dental (POD)

Responsibility for commissioning primary care: pharmacy, optometry and dental (POD) services transferred from NHS England to Integrated Care Boards (ICBs) on 1 April 2023. In the region, the quality monitoring and assurance function of POD services is delivered by the Quality & Patient Experience Team on behalf of the seven South West ICBs. This function is delivered through the Collaborative Commissioning Hub (CCH).

ICBs are accountable for ensuring that services safeguard and protect children, young people and adults in line with statutory guidance and legislation, which is formally discharged to them by NHS England in delegation. A South West POD Quality Framework is in place. This sets out the arrangements for quality monitoring and assurance of POD services and includes a RASCI which was developed to inform how safeguarding will be managed following delegation of POD services. ICB safeguarding teams are supported by the CCH Quality & Patient Experience team who can navigate and signpost, in addition to ensuring that commissioning processes and contracts take proper account of safeguarding requirements.

The CCH Quality & Patient Experience team have undertaken clinical quality visits to POD providers, ensuring that safeguarding policies and procedures form Key Lines Of Enquiry and providing advice and support to practices.

During 2023/24, there have been unfilled vacancies in the Quality & Patient Experience team. They expect to recruit to these roles by Autumn 2024, which will enhance the safeguarding function.

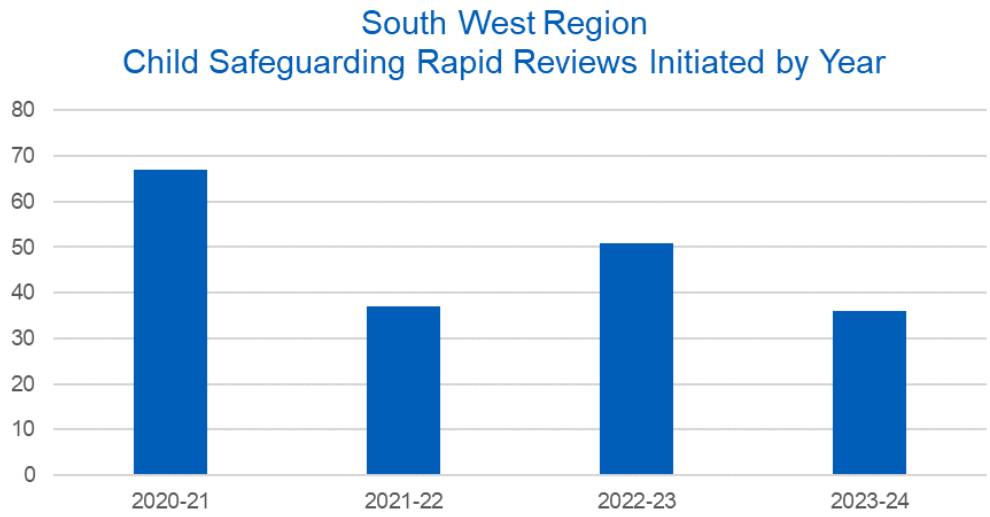
Statutory Safeguarding Reviews across the South West

The regional team continues to develop its oversight of statutory safeguarding reviews. In 2023/24 ICBs have continued to complete quarterly returns which report the number of new, open/ongoing and closed reviews in their respective systems. These are subsequently collated, analysed, and reported at the NHS England South West Safeguarding Steering Group. The NHS England National Safeguarding Review Tracker Tool (S-CRT) was launched in 2022 and South West ICBs have be populating the tool. There remains variation in what the ICBs report in the quarterly return and what they input into the national tracker. The South West Regional Safeguarding Team are undertaking some initiatives to improve the quality and consistency of ICB inputting into the national tracker.

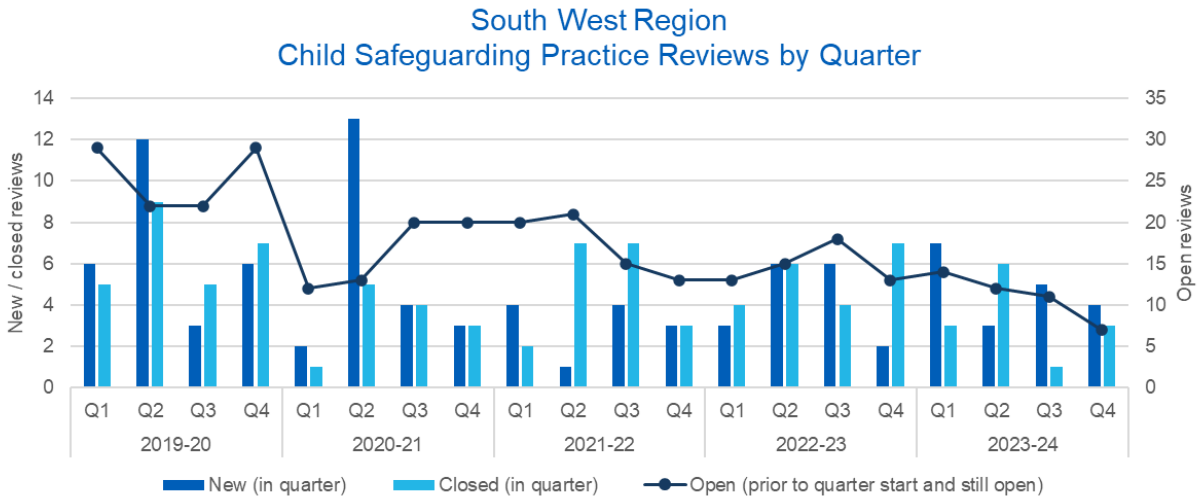
We are keen to embed improvement methodology to themes arising from statutory safeguarding reviews and have undertaken discussions across directorates and with systems to progress this approach. We acknowledge that further work with systems is needed to identify the best areas of work to focus on as a region in 2024/25 and beyond.

Regional Child Rapid Review and Child Safeguarding Practice Reviews (CSPRs)

The below chart shows the number of Rapid Reviews initiated by systems in the South West Region over the last four financial years. The number has been variable. There were 36 rapid reviews initiated in 2023/24, which is the lowest figure of the last four financial years. In comparison, there were 51 rapid reviews initiated in 2022/23 and 67 in 2020/21. 2020/21 had generally high numbers of rapid reviews, with this period being impacted by the Covid-19 pandemic.



The number of new CSPRs across the South West region declined between 2019/20 and 2021/22; however 2022/23 and 2023/24 have seen annual increase. There were 19 new CSPRs in 2023/24, a rise from 17 in 2022/23. The number of open reviews decreased quarter on quarter in 2023/24, implying a higher rate of cases being closed and finalised compared to previous the year.



Themes from Regional Child Rapid Review and Child Safeguarding Practice Reviews (CSPRs)

Themes arising from South West local children's safeguarding reviews over the last 12 months (based on themes provided by ICBs) include:

- Knife crime and serious violence.

- Extra Familial Harm.
- Missing Children (particularly Children in Care) and linked to exploitation.
- Involvement of and lack of information on individuals in the household (e.g. background of fathers).
- Non-accidental injury in under 1s.

The Child Safeguarding Practice Review Panel is independent of the government and oversees the commissioning of reviews of serious child protection cases in England. The Panel produces an annual report but is not published until the January after the end of the financial year. Therefore the most recent published report is Panels 2022/23 Annual Report published in January 2024. This identifies themes from reviews across the country, many of which have parallels with the South West reviews.

Contextual safeguarding has been a focus across South West partnerships during 2022/23 with new practice principles being published and circulated. Several systems are now doing focussed work on knife crime prevention (BNSSG, BSW and Somerset). The regional team have refreshed our missing person protocol which prompts systems to use CP-IS to maximum effect in sharing information about missing children.

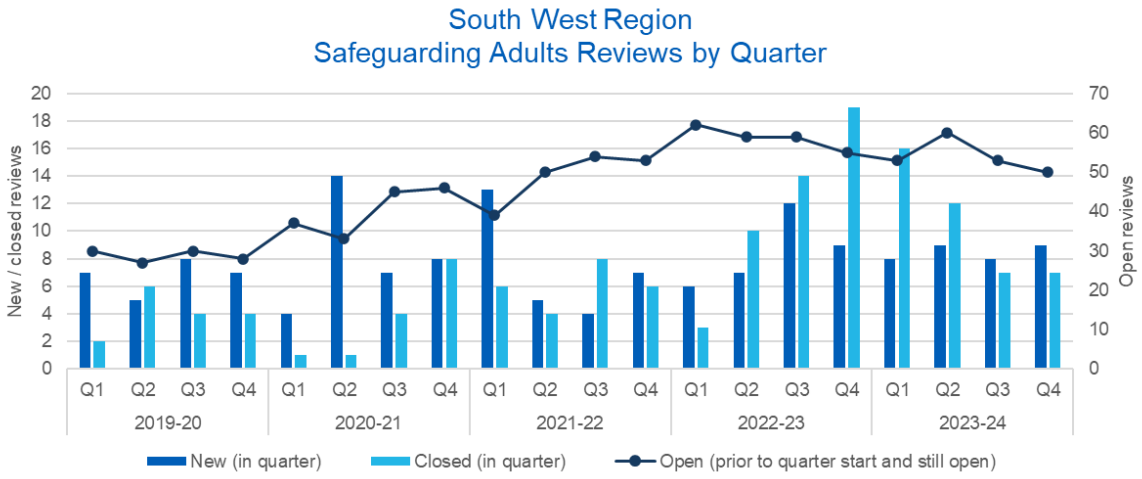
Two systems have completed focussed work on sharing information about other parents and adults in the household (Somerset and BSW).

Somerset carried out a deep dive exercise around non-accidental injuries which led to assurance that there was no increased risk. The region gathered assurance in line with a Health Services Safety Investigations Body (HSSIB) publication regarding measures in place to identify non-accidental injuries in the emergency department as well as starting to gather data on reported non-accidental injuries in infants and non-mobile children from ICBs to assist with regional benchmarking to help identify any concern.

Regional Safeguarding Adult Reviews (SARs)

The chart below shows the number of new, closed, and open SARs by quarter. The number of open SARs had generally been increasing over time (to a peak of 62 at the end of quarter 1 2022-23). However, the last three quarters of 2022/23 have seen that

trend stabilize and the number of open SARs start to decline. For quarter 4 2023/24, there were 50 SARs open, compared to 55 in the same period in 2022-23. There has been a consistent level of 8 - 9 new SARs in each quarter of 2023/24. The total number of new SARs in 2023/24 has remained stable against the previous financial year (at 34), now the joint highest annual figure of the last five financial years.



Themes from regional Safeguarding Adult Reviews (SARs)

The most common themes arising in the region for safeguarding adult reviews over 2023/24 include:

- Self-neglect.
- Application of the MCA.
- Alcohol & Substance Misuse.
- Sexual and Criminal Exploitation.
- Impact of Adverse Childhood Experiences (ACEs).
- Impact of Domestic Abuse and Interfamilial domestic abuse + coercion and control.
- Homelessness.
- Think family - others within the household of the adult at risk.
- Systems in-place to support people with dual diagnosis.
- How people who self-fund their services are safeguarded.

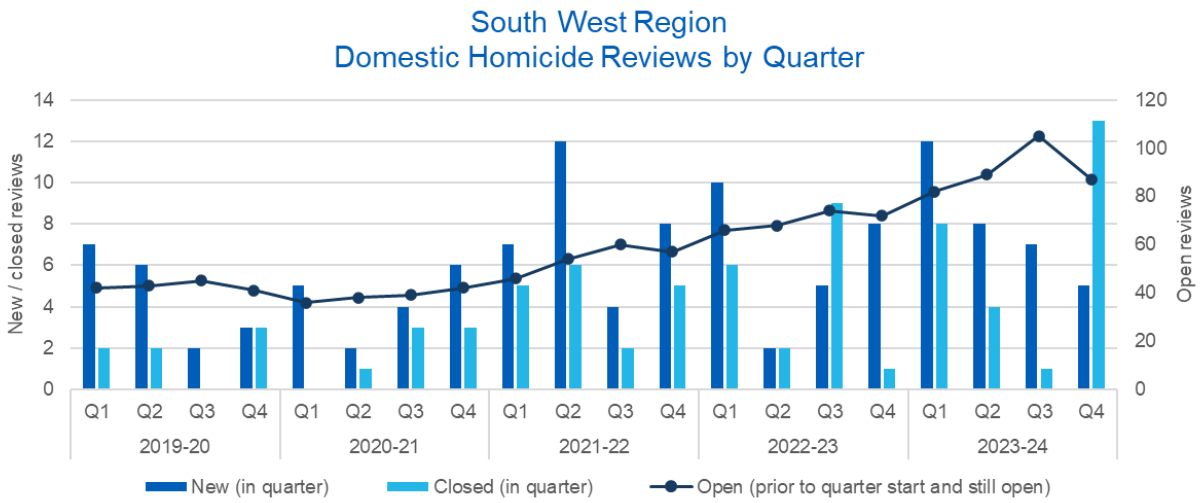
There is no equivalent of the Child Safeguarding Practice Review Panel or associated annual report produced for SARs; however in May 2024, the second national analysis of Safeguarding Adult Reviews (SARs) was published. The analysis covers SARs completed between April 2019 and March 2023. It sets out some common themes, good and poor practice, as well as making recommendations for improvement.

The National Network for Chairs of Adult Safeguarding Boards have also developed a national SAR library. SARs have been arranged by the year of their completion and publication. Each folder also contains a headline summary of the SARs for that year, identifying the type(s) of abuse/neglect and up to three themes. This is designed to facilitate searches of the library.

During our ICS site visits this year, we heard that each system and partnership is carefully considering how best to learn from reviews, meaningfully embed change and monitor progress. There is a tension between resource put toward conducting reviews and the time needed to successfully influence system change. There is wide acknowledgement of the need to conduct proportionate reviews which consider the need for change alongside systemic and organisational barriers. The regional team will continue to promote the aims of the NHS Patient Safety Incident Response Framework (PSIRF) and continuous improvement approach, while helping to identify any key themes that would benefit from ICBs working together or a regional approach.

Regional Domestic Homicide Reviews (DHRs)

The chart below shows the number of new, closed and open DHRs by quarter over time. The number of open DHRs by quarter has steadily increased since quarter 1 2020/21 (with small dips in two of the quarters), although the last quarter of 2023/24 shows a decline in open DHRs. The number of new DHRs had risen since quarter 2 2022/23 and into quarter 1 2023/24 but has subsequently fallen in the remaining three quarters of 2023/24. The number of review closures has not generally kept pace with the number of new reviews, thereby resulting in the gradual rise in the number of open reviews. However, there was a higher than usual number of review closures in quarter 4 2023/24. This led to the reduction in the number of open DHRs in quarter 4 2023/24, to 87; however, that is still higher than the 72 open at the end of 2022/23.



Themes from Regional Domestic Homicide Reviews (DHRs)

Themes arising from South West DHRs over the last 12 months (based on themes provided by ICBs) include:

- Suicide as a result of domestic abuse.
- Support for parents when children are removed as associated trauma.
- Understanding the impact of past trauma.
- Substance use disorder and mental health needs, and the need for strengthened pathways between domestic abuse services and other services such as general practice.
- Clinical enquiry not being used when appropriate/ lack of professional curiosity. Gaps in the response to disclosures. A positive example of one GP contacting the DHR Chair as she'd identified a potential risk concerning a patient named in the DHR. The GP was praised by the Chair for her diligence and safeguarding approach.
- Support for, and identification of, male victims due to biases.
- Recognising bi-directional abuse.

There is now also a national DHR library available to find and view domestic homicide review reports that are available to the public. It is searchable and allows filtering by a range of criteria. This library should assist authors and DHR panel members to consider if a recommendation has arisen in a previous review.

Each Community Safety Partnership is tasked with monitoring the implementation of lessons from reviews. As noted in the previous section, ICBs are concerned that disproportionate effort is put into reviews compared to the resource required to imbed learning and practice change. The regional team have noted this in the consultation on the draft updated DHR statutory guidance.

Provider and ICB domestic abuse and sexual violence (DASV) leads have the opportunity to share examples of best practice and new initiatives through the DASV space on NHS futures which is coordinated by the national DASV programme team within NHS England. We have also linked the regional leads with their local authority public health counterparts in the South West Public Health Violence Prevention Network.

Regional priorities for 2024/25

System challenges and Priorities

For the purpose of this annual report, each ICB was asked to highlight their top challenges and priorities for the coming year. Below is a summary of the responses received[2]. The full list as submitted is included in appendix 2.

Common themes emerging

We compared common themes arising from site visits, statutory reviews and the challenges and priorities identified by integrated care board heads of safeguarding. The following issues arose across those discussions:

- Serious Violence
- Domestic Abuse
- All-age exploitation
- Think family/network
- Self-neglect and the Mental Capacity Act
- Trauma aware practice
- Oversight and Assurance
- Health representation in partnership meetings

[2] Some responses are based on information shared at ICB site visits.

- Safeguarding support to Pharmacy, Optometry and Dentistry

Regional challenges and Priorities

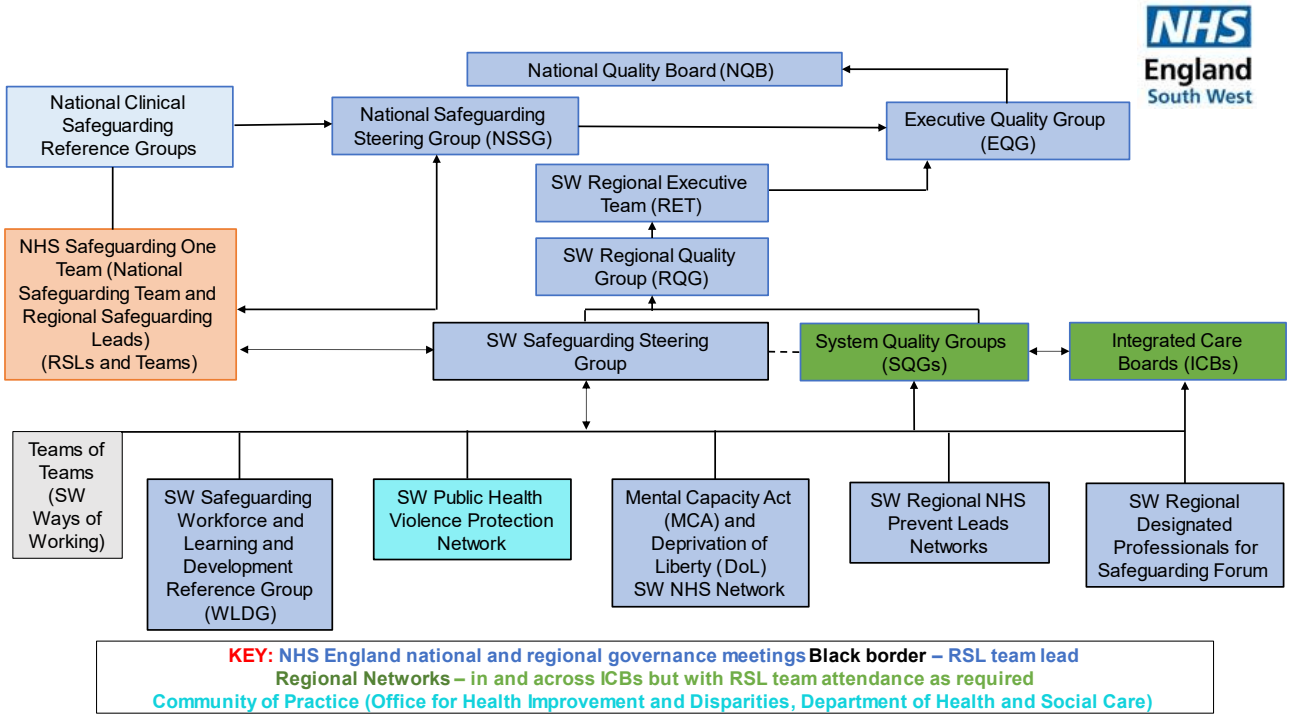
Regional challenges around reduced funding, changing workforces, restructuring both within national and regional NHS England and ICBs will inevitably continue into 2024/25 and beyond. The NHS Operational Framework challenges us to continue to work through how we can best empower and supporting local system partners to deliver on their safeguarding responsibilities. For ICB safeguarding teams, this means working collaboratively with systems and partners to strengthen system oversight and ensure ICSs implement current and emerging statutory functions such as the children's social care reforms.

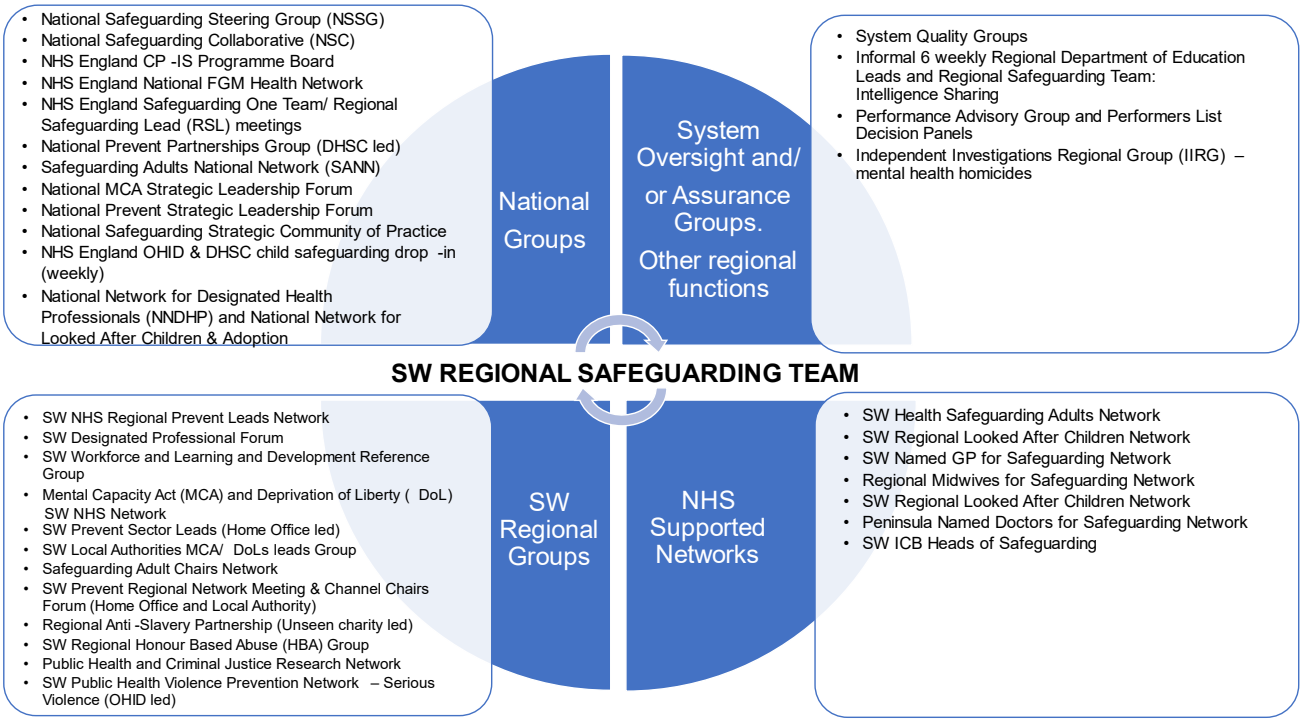
The regional safeguarding workplan will continue to include standing workstreams reflecting the Safeguarding Accountability and Assurance Framework including promoting learning from reviews, child sexual abuse and exploitation, modern slavery, FGM, Prevent, Domestic Abuse and Sexual Violence and the Mental Capacity Act. We will discuss how we can best utilise annual system visits to support oversight and continuous improvement. Our priorities for 2024/25 have been aligned with our national and regional plans. We will also have a particular focus on:

- Supporting systems with implementation of children's social care reforms.
- Improving governance on information sharing.
- Analysis of data to inform system priorities.
- Working with the NHS Continuing Healthcare (CHC) team to obtain regional oversight to ensure Community Deprivation of Liberty backlogs are reduced across the South West region. ICBs are being asked to put plans in place to comply with Article 5 of the Human Rights Act by identifying those that require a community deprivation of liberty process and reducing the number of those waiting for an application to the court of protection for authorisation.
- Improving South West Specialist Safeguarding & Child Protection Clinical Roles including ICBs specialist safeguarding & child protection workforce plans being in place by 1st October 2024. [Plans may be named differently, but they should address the clinical and specialist NHS workforce challenges in the system.]

The South West Regional Safeguarding Team looks forward to having further discussions with systems in the year ahead to identify further areas of work that could benefit from regional support, collaboration or coordination to promote continuous improvement.

Appendix 1: South West Safeguarding Governance Architecture





Appendix 2: South West ICB Challenges and Priorities

ICB	Challenges	Priorities
Cornwall and Isles of Scilly (CIoS)	• Vacancies in named GP and designated doctor post. • Reduction in running cost allowance for ICBs. • Industrial action.	• Joint forward plan priorities • Neglect • Exploitation • Rights of the child • Trauma Aware • Mental Capacity • Serious violence • Domestic Abuse
Devon	• Restructure, new ways of working. • Improving Community Deprivation of Liberty and Court of Protection applications. • Understanding needs and support offer to Pharmacy, Optometry and Dentistry. • Trialling Safeguarding adult reviews in rapid time. Legacy multiple action plans. • Vacancies in Designated Doctor Safeguarding Children post.	• Greater alignment of Partnership processes and workstreams. • Closer working with Population Health Management team – contribute to prevention and inequalities agenda – High Intensity Users, self-neglect. • Domestic Abuse and suicide work, Older People, and learning disabilities.
Somerset	• Ensuring Primary Care are fully engaged in Strategy discussions, Child Protection Case Conferences, MARAC, Topaz and Channel Panel and can access domestic abuse notifications for adults without children, ideally with a digital solution. • Lack of dental access for vulnerable children and adults.	• Revise ICB Individual Management Review (IMR) process to ensure Primary Care lead on writing / signing off IMRs written on their behalf, to ensure greater involvement in DHR and SAR process and recommendations. • In partnership with multi-agency partners, explore how the ICB can meets its statutory duties in relation to the Serious Violence Duty, taking into account the learning from the recent JTAI.

	• Identifying a solution to the national issue of risk of data breaches in relation to adoption, changes to NHS numbers and the requirement to open new Health records and transfer relevant information post adoption.	• Review children looked after service from a medical and nursing perspective.
Dorset	• Designated doctor for child safeguarding succession in the context of a national shortage of paediatricians wanting to take on the function. • Children in care have double the rate of dental caries but are half as likely to receive dental care, how are we responding to this in Dorset? • Co-ordinating a system approach to NHS England prospective notes access programme.	• In adult safeguarding: preventative safeguarding, assurance on safeguarding practice, and delivery of 'Making Safeguarding Personal'. • In child safeguarding: reducing the harm from violence and neglect and improving mental health. • In community safeguarding: reducing the harm from violent crime, domestic abuse, sexual offences, rural crime, and fraud, and working with communities to reduce anti-social behaviour.
Bath and North East Somerset, Swindon and Wiltshire (BSW)	• Project evolve and impact of organisational restructure and change which has created additional uncertainty within the organisation and additional workload in terms of the consultation process. • Increasing incidents of serious violence across the system and need to take a public health approach to serious violence and focusing on what lies behind the issue. • High number of significant harm in under 1s leading to some systemwide work including a virtual summit held March 2024.	• Undertake a training analysis of healthcare staff requirements to meet Serious Violence Duty. • Develop learning framework for statutory reviews based on SCIE quality markers. • Develop and deliver strategic safeguarding and children looked after and care experienced young people workplans. • Strengthen assurance of our vulnerable population placed in residential and therapeutic providers both within and out of area.

Bristol, North Somerset and South Gloucestershire (BNSSG)	• Performance in relation to timeliness of Initial Health Assessments by the Children in Care health provider is still a challenge. Further recording of data in relation to the process is now underway to seek assurances and highlight the barriers to the statutory timeframes. • There has been a significant surge in Rapid Reviews in relation to peer-on-peer serious youth violence and a familial homicide. This has been particularly challenging for the system owing to the nature, content and pace at which to process information for the statutory review process. • Ascertaining 'health data' to contribute to local partnership/board arrangements for children and adults continues to be a challenge in relation to identifying metrics that are easy to access and useful to the partnership.	• Progressing the Systemwide Safeguarding Transformation Programme following on from the Local Government Association Review and recommendations. • Serious Violence Duty, supporting the Office of the Police and Crime Commissioner for Avon and Somerset Police in their governance arrangements and Violence Reduction Partnership Executive Board. • Implementing the children's reforms and exploring system wide opportunities as a result of the changes and revised Working Together to Safeguard Children 2023.
Gloucestershire	• Significant resource invested in team however there remains some outstanding capacity issues for statutory posts as per Intercollegiate Documents. This is noted on risk register but under current financial constraints this is unlikely to be resolved during 2024. • The Gloucestershire Safeguarding Children Partnership (GSCP) is sighted on issue of provision of child protection medical assessments for all	• Continued commitment to the integration of core functions within the current three safeguarding services of ICB, Gloucestershire Hospital Foundation Trust (GHFT) and Gloucestershire Health and Care Foundation Trust (GHC). Launch of our Health Safeguarding Integration Strategy. • To further embed integrated safeguarding supervision across the ICS and monitoring compliancy of mandatory safeguarding and children in care

	types of abuse, including neglect and have published an updated child protection medical assessments protocol in late 2023. The ICB is engaged in ongoing discussion with the CEO/CMO and Chief Nurses from both the Trust and ICB to ensure no child is put at risk who needs an assessment, with mitigation in place until resolved. • Understanding the complexity of commissioning arrangements of multiple providers and how safeguarding standards are embedded and assurance sought- GSCP/GSAB supporting this in response to a recommendation from Child X CSPR published March 2024.	training at all levels across the ICB. • Have in place a well embedded rolling programme of safeguarding assurance to all commissioned providers- including Primary Care (GP's and NHS Trusts). • Embedding learning from adult and children's statutory safeguarding reviews to ensure we prevent further harm to our most at risk of abuse and neglect.