



NHS SHROPSHIRE, TELFORD & WREKIN INTEGRATED CARE BOARD

ADULT SAFEGUARDING

&

CHILDREN'S SAFEGUARDING

ANNUAL REPORT

2024– 2025

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Introduction from Ivan Powell Shropshire's Safeguarding Adult Board Independent Chair and Children's Independent Scrutineer.



I am privileged to be the Independent Chair of the Safeguarding Adult Board and the Independent scrutineer of children's safeguarding arrangements for Shropshire. Prior to the changes put in place by Working Together 2023 I was chair of the children's board. Those developments defined the independent scrutineer's role within the child safeguarding partnership was to provide an objective assessment of multi-agency working practices, ensuring an effective, child-centred, and whole-family approach. My adult safeguarding role is to collaboratively lead the Safeguarding Adult Board, give advice, support and encouragement and provide constructive challenge, hold main partner agencies to account and ensure that interfaces with other strategic functions are effective whilst also acting as a spokesperson for the SAB.

In both of those capacities I am pleased to provide this introduction to Shropshire Telford and Wrekin Integrated Care Board's safeguarding annual report. I am confident that through the leadership in place the ICB has provided strong evidence about the implementation of Working Together 2023 and has continued to offer innovation whilst driving much of the adult's agenda.

The ICB has critical statutory functions to fulfil, and the safeguarding designated leads are excellent partners who provide a critically important role in leading the health elements of safeguarding practice. They are sources of expert knowledge who are frequently called upon by the board. I think this report demonstrates the scope of activity and leadership they offer in developing joined up safeguarding approaches to our most vulnerable adults and children.

I invite you to read this report with interest and challenge. I found it logical in describing the challenges and responses undertaken in 2024- 2025 and clear sighted in identifying key areas for development in the following year.

1.0 Foreword

Safeguarding is central to all roles and responsibilities within the Shropshire, Telford and Wrekin Integrated Care System. This report seeks to provide an overview of the actions to fulfil the Integrated Care Board's statutory safeguarding duties. Using the approved format of previous annual reports, it summarises key developments in 2024-25 and identifies the priority areas for 2025-2026.

In the last year, there have been significant changes in safeguarding children and adults including the upcoming Social Care reforms and Families First Partnership Programme. Within adult safeguarding there has been a reset of priority areas and the strategic actions to deliver upon those areas. This includes local and national drivers. There have been major developments in the Prevent Duty as well as self-neglect as the main theme of Safeguarding Adult Reviews. Domestic Homicide Reviews continue to recognise awareness of the better understanding of "suspected victim suicide."

Significantly the announcements from the Department of Health and Social Care and NHS England will see a major restructuring of the role of the ICB. A [new blueprint](#) has been created exploring what a future ICB will focus upon as it seeks to reduce its functions and operational costs by over 50%. This will include reviewing the safeguarding roles the ICB performs whilst maintaining a commitment to the statutory partnership arrangements. These changes are likely to be confirmed in quarter 3 of 2025-26 and consequences will be explored in next year's annual report.

In 2024 – 2025 there has been significant work undertaken with management structures across both partnerships; including the implementation of the Lead Safeguarding Partner and Delegated Safeguarding Partner roles as per Working Together (2023) changes to ensure we fulfil the statutory duties and provide a high-quality service delivery model. Within the ICB safeguarding team, the Designated Nurses have established their new role in leading the SEND and child death agenda across the partnership system, as well as successfully recruiting into the role of Designated Doctor for Safeguarding Children, Specialist Nurse for Child Death, CDOP Administrator and received a start date for the Designated Doctor for Child Death. In adult safeguarding the ICB has continued to lead on several key statutory elements despite a 44% reduction in adult safeguarding staffing resources. Work includes the adult statutory case review group, adult review learning and training group, the Domestic Homicide Review processes and Mental Capacity Act and Deprivation of Liberty Safeguards and the Community Safety Partnerships. All of which features in this report.

Our safeguarding duties are very much a partnership between the ICB, the Police, the Council(s). This report focuses upon the contribution of the ICB to ensure we meet our shared goals as well as evidencing our accountability to the people of Shropshire, Telford & Wrekin, partners and others. For the Community Safety Partnership workstreams the statutory "responsible authorities" partnership is extended by the inclusion of West Mercia Probation Service and Shropshire Fire and Rescue Service.

We hope this annual report is read with interest and challenge by all those groups and individuals with a stake in this vital work. It seeks to take account of the issues we have identified; demonstrate how we performed and vitally identify how we must keep taking this work forward next year.

2.0 Partnership Arrangements

The Statutory Safeguarding Boards in Shropshire operate under the title of the Shropshire Safeguarding Community Partnership. This brings together both the Children and Adult Safeguarding Boards and the Community Safety Partnership into one integrated and unified structure. Following the changes to Working Together to Safeguard Children (2023), the independent chair for Shropshire is now the independent scrutineer and they continue to be the Independent Chair of the Safeguarding

Adult Board. This has provided continuity and context about our journey from an independent chair with a leading national role. In Telford and Wrekin's statutory safeguarding partnership there is an independent chair for adult safeguarding and a separate scrutineer for children's safeguarding who are now both established in their role and have applied rigour and innovation across the system. The Telford and Wrekin Independent Chair of the Safeguarding Adult Board has continued to drive the priority setting agenda in the borough as will be highlighted in this report.

Following the Working Together to Safeguard Children Document (2023), there have been significant changes within the partnership arrangements in both areas, with the opportunity to align for those key statutory partnerships. The Lead Safeguarding Partner for Health is our Chief Executive Officer for Shropshire, Telford & Wrekin ICB; Simon Whitehouse with the Delegated Safeguarding Partner being our Chief Nursing Officer; Vanessa Whatley. This demonstrates the senior leadership, oversight and investment within safeguarding across both partnerships.

As part of the evolving multiagency safeguarding arrangements, there will be developing roles and responsibilities in relation to the independent scrutiny of the safeguarding children's partnerships, strategic planning and budgetary matters. Within adults there has been continuous review of the key structures which has been manifested in Telford and Wrekin by a redesigned set of strategic priorities and in Shropshire there has been a reinvigorated approach to the key subgroups, changes to the chair of the Community Safety Partnership and developments with more accountable action plans led by the business unit.

3.0 Accountability and Assurance Arrangements

Crucial to the accountability and assurance arrangements for the ICB safeguarding activity is a blend of guidance and scrutiny measures.

As well as the work of the respective local statutory partnerships the Integrated Care Board and NHS trusts are guided by the Safeguarding children, young people and adults at risk in the NHS Safeguarding Accountability and Assurance Framework (2024).

The Framework was revised in 2024 and includes the implementation of effective safeguarding assurance arrangements via section 32 of the NHS Standard Contract, the Safeguarding-Commissioning Assurance Toolkit and the NHS Safeguarding Case Review Tracker. This includes:

- Child Protection-Information Sharing (CP-IS) systems
- NHS contribution to local safeguarding partnerships
- Prevent
- Modern Slavery and Human Trafficking
- FGM
- Domestic abuse guidance
- Serious violence duty for ICBs
- Liberty Protection Safeguards guidance (when launched)
- Mental Capacity Act and Deprivation of Liberty Safeguards

The Framework reinforces the ICB role in working with our NHS commissioned providers to support and seek assurance about the delivery of effective safeguarding services. The [Safeguarding Children, Young People and Adults at risk in the NHS; Safeguarding Assurance and Accountability Framework](#) has been a helpful benchmark to use to ensure the ICB and NHS Trusts are adhering to the principles of best practice.

4.0 SAFEGUARDING AND THE ROLE OF NHS ENGLAND

The ICB is required to submit to NHS England evidence of the organisation's compliance with the Safeguarding Commissioning Assurance Toolkit. The requirements range over the following 7 domains:

- ✓ Leadership & Organisational Accountability
- ✓ Training
- ✓ Safer Recruitment
- ✓ Inter-agency working
- ✓ Implementation (sharing and learning good practice)
- ✓ Patient Engagement
- ✓ Supervision

During 2024-2025, NHS England requested all ICBs to make submissions each quarter on a range of topics. NHS England fed back that the ICB operate a "mature" safeguarding system and via a series of "safeguarding conversations" with the ICB exploring our submissions NHS England have provided positive feedback. The quarterly submissions of the Safeguarding Commissioning Assurance Toolkit has included assurance around executive leadership within the ICB, board accountability is the shared responsibility of the Chief Executive (Lead Safeguarding Partner) and Chief Nursing Officer (Delegated Safeguarding Partner). This is in addition to the wider governance and leadership arrangements via regular assurance reports presented to the Systems Quality Group of the ICB which is chaired by the Chief Nursing Officer.

NHS England scrutinise the Safeguarding Commissioning Assurance Toolkit returns and do not allow any extensions to the programme of review. Fig. 1 below shows the themes of each quarterly review in 2024-25

Fig.1

Safeguarding Commissioning Assurance Toolkit subject area 2024 - 2025	
Q1	Child Death Reviews and child death doctor compliance
Q2	Modern Slavery processes and modern slavery statement
Q3	Multiagency safeguarding arrangements
Q4	Statutory case review process assurance

5.0 Adult Safeguarding Key Activity Workstreams

The following section includes a summary of some of the key adult safeguarding activities undertaken in 2024-2025. It provides updates on progress and partnership action to address key areas.

5.1 Mental Capacity Act, Deprivation of Liberty Safeguards and the Liberty Protection Safeguards.

The ICB continues to support the system wide actions to enhance practice with those who may lack capacity for specific decisions or who may need support to make their own choices through chairing the multi-agency MCA and DOLS system wide group. The previous year saw a revision of the MCA Policy with a new section on executive capacity.

We still eagerly await a new code of practice to the MCA which was intended to incorporate the Liberty Protection Safeguards. The previous government had passed legislation to replace the Deprivation of Liberty Safeguards (DOLS) with the Liberty Protection Safeguards (LPS). LPS would represent a major change for all NHS Trusts and the Integrated Care Board as it conveys a new duty of “responsible body” on the NHS transferring some statutory duties from the Local Authorities. Despite considerable preparatory work the LPS were repeatedly paused, and the new government has stated that they would decide whether it would implement them. Therefore, this work stream has been remained in abeyance.

However, the Association of Directors of Social Services have recently published a [position statement](#) in which they have provided a pathway for implementing the LPS incorporating a multi-stage approach beginning with improvements to the DOLS processes. They have also suggested that any changes will be initially implemented in the Midlands. Therefore, the ICB through its leadership of the Mental Capacity Act and DOLS multi-agency group has liaised with key partners and will be responsive to developments. Therefore, LPS will need to remain as part of future considerations.

In the meantime, a lot of activity has continued through the work of the multi-agency MCA/DOLS group. This ICB led group has a wide membership across adult social care, health, advocacy organisations, the police and the independent sector. Some key activity of the group over the last year has included:

- ✓ Learning from Safeguarding Adult Reviews and the MCA
- ✓ SATH new arrangements to manage DOLS in acute settings
- ✓ DOL and 17- and 18-year-olds
- ✓ Community DOLS
- ✓ MCA and assessing capacity pertaining to sexual relationships
- ✓ DOLS card (a one-page A5 guide to DOLS)

Following on from the extensively used MCA and Making Safeguarding Personal A5 card – which provide a one-page guide on these topics the group have now produced an A5 card guide on DOLS. Please see the card below. Front line staff had asked for this card and the aim is to distribute it widely.

Understanding Deprivation of Liberty Safeguards (DoLS)

The DoLS scheme ensures that individuals who may **lack capacity to consent** to their care and/or treatment in care homes or hospitals are not deprived of their liberty unlawfully and their rights are protected

DoLS explained



Who DoLS Apply to:

- Adults aged 18 and over
- Individuals with conditions like dementia, brain injury or learning disabilities
- Those living in care homes or hospitals under restrictive arrangements



How to Recognise a Potential DoLS:

- The Person is not free to leave the care setting
- Continuous supervision and control are in place
- The individual is unable to make decisions regarding their care or treatment due to lack of mental capacity



Your Role as a Provider:

- **Identify** potential deprivation of liberty in care arrangements and request authorisation from the local authority
- **Collaborate** closely with local authorities for DoLS authorisations
- **Ensure** continuous supervision and control are in place when necessary

6 Assessments undertaken under DoLS

Age Assessment | Mental Health Assessment | Mental Capacity Assessment
Best Interest Assessment | Eligibility Assessment | No refusals Assessment

See reverse for more information. A Shropshire, Telford & Wrekin MCA Multiagency group initiative

DoLS legislation **cannot** be used as a means to limit contact with families or to prevent a person from living with their family or being discharged to the care of their family



Legal Bodies in relation to DoLS:

- **Managing authorities:** Care homes and hospital settings which are responsible for identifying residents who may be deprived of their liberty and requesting approval
- **Supervisory bodies:** Local authorities and Welsh health boards which are responsible for arranging assessments and granting approvals for deprivation of liberty

What to expect from the DoLS assessments:

- The mental capacity assessment may be undertaken by a best interests assessor or a Section 12 doctor
- The mental health assessment will be completed by a Section 12 doctor
- The maximum authorisation period is 12 months, which will vary depending on the situation
- Conditions may be attached to the approval which will relate to the specific deprivation of liberty



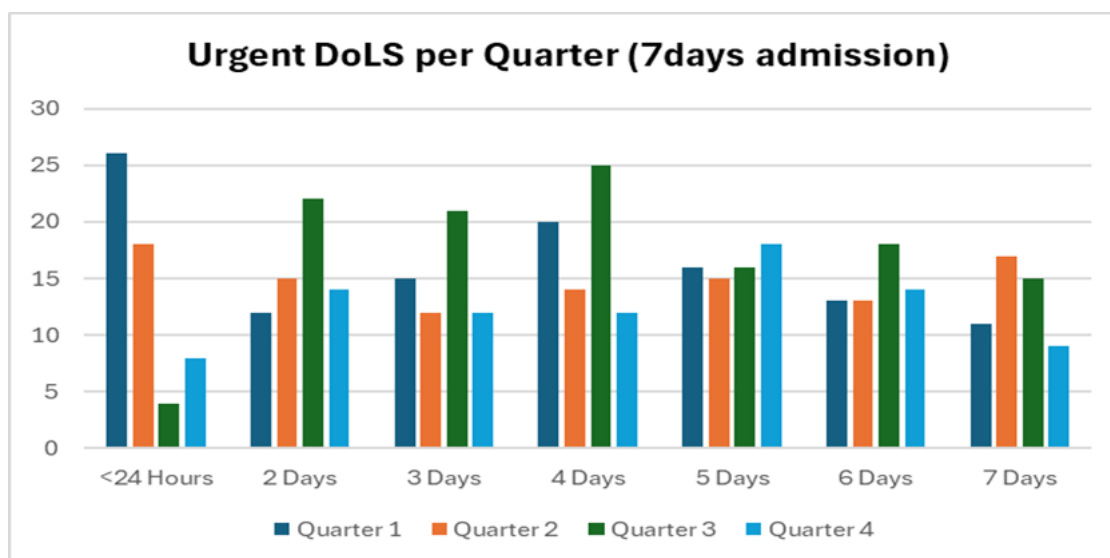
Person's Rights once DoLS are authorised



- Access to an **Independent Mental Capacity Advocate (IMCA)**
 - **39A IMCA**: Supports the best interest assessment when there is no one appropriate to consult
 - **39C IMCA**: Steps in when the current RPR role ends and no appropriate person is available
 - **39D IMCA**: Assists the family in the RPR role
- **Right to challenge an approval** within the Court of Protection, known as Section 21A challenge
- **Right to request a review** to ensure necessity and that conditions are being met,
- Appointment of a **Relevant Person's Representative (RPR)** who advocates on behalf of the person
- **Right to request details** about any conditions attached to the approval as outlined in Form 5 or equivalent documents from the local authority

Shrewsbury and Telford Hospital Trust have continued to build on its strong compliance with DOLS assurance work. The total number of Deprivation of Liberty Safeguards Authorisations completed by

the Trust was 1300. In July 2024 a new DoLS Policy and Procedure was introduced. This was widely discussed at the MCA/DOLS group. It was anticipated that there would be a drop in the usage of DoLS as a result based on case law and the DOLS code of practice. The anticipated reduction slowed significantly over the winter months as length of stay increased but appears to be performing as anticipated as the hospital flow has increased with Q4 showing a drop of 30% DoLS usage within first 7 days post admission compared to Q3 [please see the table below].



The new Trust policy has been widely shared across the region with several external providers contacting the Trust to request information about its use and practical implications. As a result of its implementation the Trust lead has worked with NHS England Midlands to produce a Guidance on using DoLS in Acute Trusts.

5.2 Supervision Arrangements

As defined in the [Safeguarding children, young people and adults at risk in the NHS. Safeguarding Accountability and Assurance Framework](#) and the [Adult Safeguarding: Roles and Competencies for Health Care Staff \(2024\)](#) supervision plays a significant role in the offer to the system. The intention is to act as a source of expert advice on safeguarding matters and help navigate partners through any impasse in complex cases. Each session is written up by the designated adult safeguarding lead and includes three sections: background, formulation and actions. The subject areas are used to inform wider developments such as responses to Court of Protection application guidance and topics for the GP Safeguarding Forum. There were 8 organisations or teams that sought supervision, advice or support and the range of topics is shown in the table below

Agency	Topic
ICB Individual Commissioning Team	Transitional Safeguarding (to adulthood)
ICB Individual Commissioning Team	MCA and Best Interest Decisions
ICB Individual Commissioning Team	Court of Protection application
ICB Individual Commissioning Team	Best Interest decision - dispute
ICB Individual Commissioning Team	Capacity to engage in risky behaviour

ICB Individual Commissioning Team	Package of care and disagreements about risk and best interest [multiple meetings]
ICB Individual Commissioning Team	MCA and meeting needs
ICB Individual Commissioning Team	MCA disagreements and use of advocacy
LA 1	Acuity, care package and risk
LA 2	Safeguarding and institutional whistleblowing
LA 3 same LA as LA 1	Responding to whistleblowing concerns
ICB colleague (not ICT)	ABI and placement breakdown
ICB colleague (not ICT)	Capacity to engage in risky behaviour
ICB colleague (not ICT)	Deprivation of Liberty under 18
RJAH 2 staff	General supervision [multiple meetings]
Shropshire Fire and Rescue Service	Responding to suicide concerns
Police	Care home – position of trust
GP	Person moving to new area with ongoing safeguarding concerns

5.3 Statutory Case Reviews

The ICB works with all partners across the system to fulfil the statutory duties associated with Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs). The Safeguarding Adult Boards and the Community Safety Partnership continues to oversee the governance of the cases, and this is augmented by case trackers undertaken by the Boards' business units. The ICB is also required to produce a separate case tracker for NHS England.

Completed SARs and DHRs are hosted on the respective partnership websites. This includes a summary of the learning. They can be found here

[Shropshire SARs](#)

[Telford and Wrekin SARs](#)

[Shropshire DHRs](#)

[Telford and Wrekin DHRs](#)

There have been a number of key themes identified from this work and notably these include:

- Self-neglect
- How to safeguard treatment resistant drinkers
- Carer strain
- Accumulative risks
- Suspected victim suicides in domestic abuse
- Multi-agency working and when to call multi-disciplinary meetings

The responses to these issues have included:

- Use of the [how to respond to self neglect guidance](#)
- Dedicated group to address responses to problem drinkers chaired by the substance misuse and alcohol commissioner
- Action regarding carer's assessments data and training
- Enhanced training about suicide in domestic abuse and changes to the Suicide Prevention Strategy
- Guidance including a YouTube Video on how and when to call a MDT (see below)

<https://www.youtube.com/watch?v=koWjl0QwRIE>



5.4 Self-Neglect

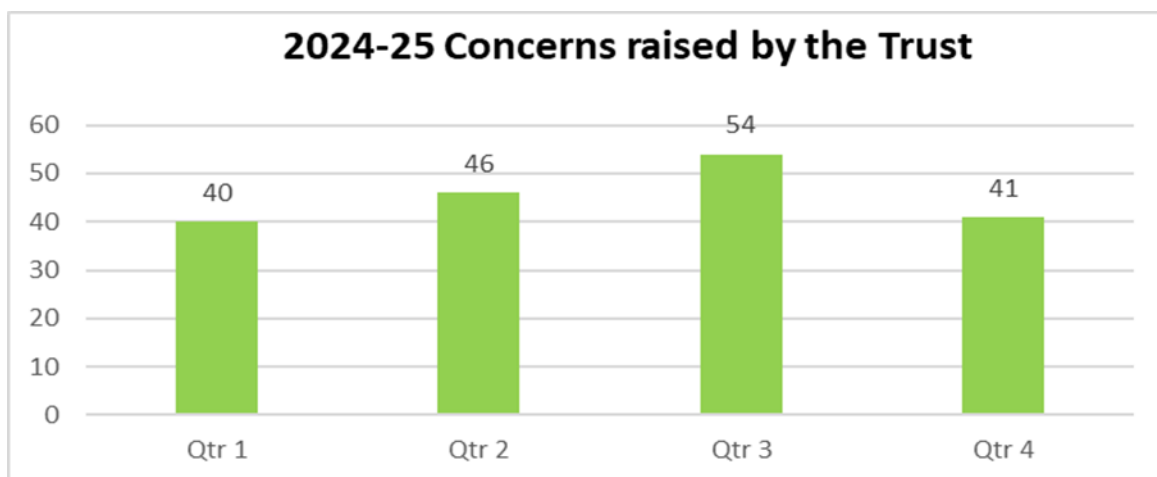
The impact of self-neglect has been the single largest category of Safeguarding Adult Referrals in Shropshire Telford and Wrekin. This accords with the national picture as 60% of all SARs nationally are about self-neglect. In Shropshire this has led to the creation of a practical series of tools to be used when working with a person who is experiencing self-neglect. There is now a major process to embed new practice when working with self-neglect which recognises the dilemmas around empowerment, consent and protection, legal restraints and complexities of using section 42 of the Care Act enquiry duties. In Telford and Wrekin, the SAB have determined that this is a key priority area for development in 2025 – 2026 and will be using Shropshire approach to help drive change.

5.5 Adult Safeguarding Themes and Trends Analysis

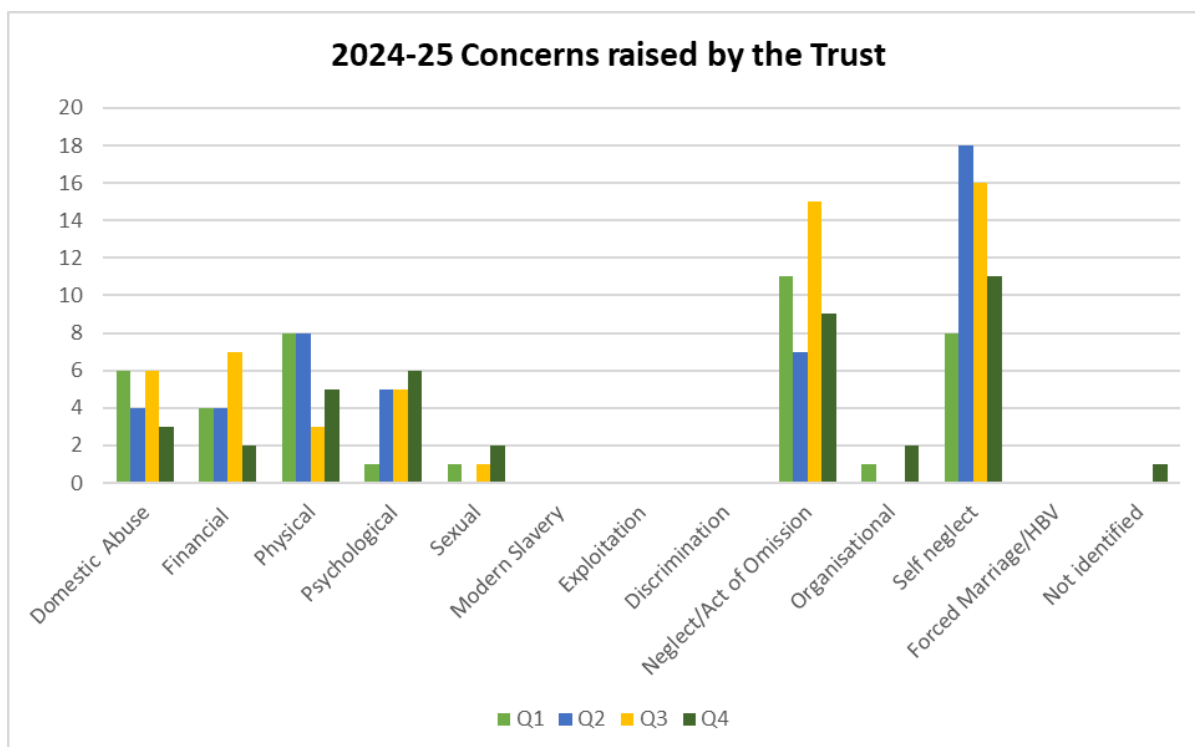
The ICB continue to work with our NHS Trust regarding key themes and trends from the referrals providers make to help keep the individuals safe in their care and the wider community. The ICB acts as a critical friend attending the Trusts internal safeguarding committees or by holding meetings with the providers to look at key developments. The Trusts' own annual reports demonstrates that work. Some of the challenges and responses the Trusts have undertaken include

- ◆ SCHT have undertaken 43 safeguarding specific quality visits across various sites and teams. They have sought to improve the Prevent Duty awareness through an audit on staff knowledge and have produced information on self-neglect.
- ◆ RJAH have improved processes to proactively identify, refer and support those living with domestic abuse. They have enhanced MCA and dementia training and have sought further assurance about low levels of referrals by having safeguarding screening questions when seeing patients.
- ◆ MPFT have strengthened their safeguarding supervision offer and maintain detailed data on themes. Training compliance remains consistently high, and the Trust have developed a suite of wider training resources for more directed learning. This has included 226 staff attending additional Prevent training delivered by Counter Terrorism Policing.
- ◆ SATH have continued to show excellent compliance with MCA and DOLS practice with regular audits. They have also created a new missing person's policy as part of the Right Care Right person agenda and have enhanced their identification of safeguarding concerns screening document.

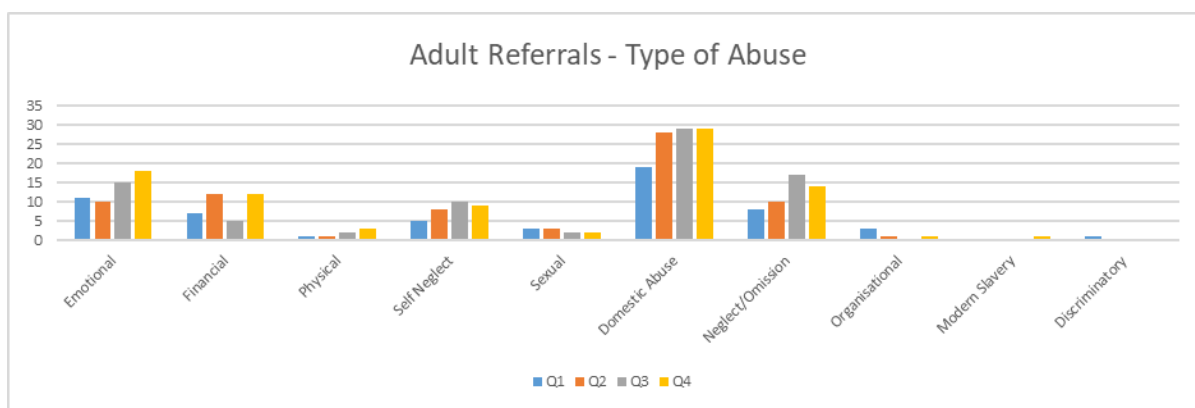
All Trusts keep data upon the themes and trends in adult safeguarding concerns raised as the following tables illustrate. In SATH the number of safeguarding concerns raised for the whole year was 181 which compares with 178 for the previous year. Please see the table below.



The categories of abuse show a particular concern about self-neglect which has helped inform the understanding of this issue as a key concern for the safeguarding boards [please see section 5.4].



Within MPFT the analysis of referrals emphasises that in addition to self-neglect domestic abuse within the mental health setting is the most significant issue. MPFT have sought to address this through the training and supervision offer and the appointment of a safeguarding domestic abuse lead. Please see table below showing categories of abuse identified in MPFT referrals.



5.6 Adult Safeguarding Dashboard

All NHS Trusts continue to complete a dashboard each quarter providing evidence of performance. There have been steady improvements in training compliance and MCA training has been enhanced. All Trusts have been consistently compliant in Prevent training [please see section 5.8]. A new area introduced in 2024- 2025 pertained to Freedom to Speak Up and the 5 national requirements. The dashboards and a wider report on how the safeguarding duties of the ICB and the NHS Trusts are the basis of a quarterly report to the Safety and Quality group.

5.7 Learning the Lessons from Statutory Case Reviews Template

Nationally and locally, there is evidence from statutory case reviews of the repetition of some learning that suggests we need to improve how as a system we get messages to front line teams to reduce the need to repeat learning. Self-neglect would feature highly in that category.

The ICB has led the consultation for a new template to promote whole team exploration of SAR recommendations which sets out evidence of how Teams have engaged with and applied the learning through a structured approach to the case learning by going through 5 questions from the review. Analysis of the new learning template will be a key activity in 2025 – 2026.

5.8 Prevent Duty and Channel Panel

Both Channel Panels experienced unprecedented increases in Prevent referrals. At their peak there was a 400% increase noted compared to the same period last year. This was in part related to the incident in Southport. Referrals rose relating to perceived grievances associated with right wing extremism as well as heightened recognition of the need to refer those who had a fixed interest in acts of extreme violence including school massacres. This followed the publication of the [Prevent learning review: Southport attack - GOV.UK](#) commissioned jointly by the Home Office and Counter Terrorism Policing. The ICB proposed that advice be given to all partners to ensure they were making referrals for those with such interests even when there was no evidence of an underpinning ideology. The ICB also delivered presentations on the Southport Prevent learning review.

5.9 Updates from priority areas identified from 2023 - 2024

Priority areas	How will this be achieved	Outcomes
Domestic Abuse	Compliance with the new statutory guidance for Domestic Homicide Reviews	– Home Office has delayed the introduction of the new guidance. The ICB has written to the HO seeking updates.
	Ongoing reporting and governance via the Domestic Abuse Local Partnership Board	✓ DALP activity has focused upon completion of the strategy and DHR work and has focused upon suicide and domestic abuse
	Specific workstream to enhance the Domestic Violence Disclosure Scheme	✓ Police now regularly report DVDS activity and improvements noted in disclosure rates and support in place
Safeguarding Commissioning Assurance Toolkit (SCAT)	Engagement with NHS Providers to produce the new NHSE required assurance	✓ New NHSE assurance now embedded by Trusts and the ICB
	Consolidate the existing SCAT performance	✓ Full compliance confirmed by NHSE
	Focus upon Prevent Duty	✓ Enhanced activity and audit in place. Better recognition of mixed uncertain or no ideology referrals

DOLS Practice	Work with SATH on Audit	✓ Audit shows consistent high compliance with capacity and DOLS documentation
	Partnership approach via the multi-agency operational group	✓ MCA and DOLS group working well see 5.1
ICT safeguarding support	Additional f2f bespoke training dates	✓ Training compliance achieved
	Introduction of regular group supervision sessions	✗ Group supervision not introduced staff prefer a 1:1 meeting as indicated in supervision update
Statutory Case reviews	Implement evaluation of case review system	✓ New governance in place for case sign off
	Arrange partnership case review event	✓ SAB led diagnostic review and new sign off processes
	Strengthen the embedding the learning approach	✓ SAB oversees embedding the learning meetings well established. ICB have proposed new front line learning process for 25-26

6.0 Children's Safeguarding Key Activity & Workstreams

6.1 Partnership working

There are 2 Designated Nurses for Safeguarding Children in post for the ICB, place-based covering Shropshire and then Telford and Wrekin, with both covering in each other's absence. The Designated Nurses work closely together for any system initiatives, workstreams and commissioning to ensure consistency across the health footprint. This includes capturing learning in one area and disseminating this across the other. With the new changes to Working Together to Safeguard Children (2023), there have been local changes within the ICB in relation to the Lead Safeguarding Partner (Chief Executive Officer) and the Delegated Safeguarding Partner (Chief Nursing Officer) and Designated Nurses have been an integral part of partnership working in line with these changes. This extends to the wider multiagency safeguarding arrangements.

Both Designated Nurses for Safeguarding Children play a key role within Shropshire Safeguarding Community Partnership and the Telford and Wrekin Safeguarding Children Partnership subgroups with chairing positions in both Child Safeguarding Practice Review Groups as well as attending wider community safeguarding groups such as the Domestic Abuse Strategic Board, Safer, Stronger Communities Board and Serious Violence Duty groups. These in turn support the delivery of key partnership priorities throughout the health economy.

Over the past 12 months, the bridging of the SEND (Special Educational Needs and Disabilities) and child death team within the safeguarding portfolio has increased the profile in all areas, forging positive relationships across both local authorities, and sharing learning across these areas. This has enhanced the learning during and from audits undertaken in addition to discussions in both the Safeguarding and SEND and Alternative Provision Partnership Boards; strengthening the interface between health services, education and children's services.

Key priorities for Shropshire, Telford and Wrekin include keeping children safe with a focus on exploitation, neglect and domestic abuse. Serious violence is also a significant aspect of the priorities

underpinned by the work around the Serious Violence Duty with the Designated Nurses working closely with the community safety partnership with a view of this being an all-age priority.

Over the last 12 months, Shropshire Safeguarding Community Partnership has focused on the learning from an independent review, identifying areas of learning, including the need to review the rapid review and Child Safeguarding Practice Reviews, as well as embedding the learning identified into practice. This has included the development of a quality and assurance group to oversee the work being undertaken. Telford and Wrekin Safeguarding Partnership thematic subgroups have focused on child exploitation and child sexual exploitation, neglect and domestic abuse. Further subgroups include; CSPR panel, Child Death Panel, Quality, Performance and Development subgroup attended include, Joint Targeted Area Inspection Working Group, Family Connect Strategic Board, Education Safeguarding Board, Early Help Operational Board and the Corporate Parenting Board which is attended by the Lead Designated Nurse for Children in Care.

The Child Mortality Group continues to develop and is now an effective system led programme which has supported the embedding of learning from child deaths. The Designated Nurses continue to be actively involved in this group and work closely with public health colleagues to identify actions that arise from the workshops to support sustained change and learning.

The Designated Nurses continue to be involved in Multiagency Case File Audits and operational meetings where required with the coordination taking place to ensure the appropriate representation attend these meetings.

6.2 Independent Inquiry Telford Child Sexual Exploitation (IITCSE)

An independent inquiry into child sexual abuse in Telford was commissioned and the report from this Inquiry was published in July 2022. The ICB continued to work on the health recommendations during this period and worked with system partners to ensure the learning was being embedded in all areas. There was a report published in July 2024, two years post the original report, where the independent chair reviewed the progress of the recommendations and the system wide partnership working.

From a health perspective, the chair recognised the work undertaken and formally agreed the recommendations that had been completed, and acknowledged the continuing work being progressed to complete the outstanding ones.

The sub-group established to monitor progress was stepped down, with the aim to have a review in a year, this meeting took place in March 2025, where health trusts shared their current status on the recommendations, and there is a plan to revisit this in 2026.

The ICB continued to work closely with the lived experience consultees, ensuring any progress of recommendations was shared with them and agreed by them, prior to taking them to the strategic implementation group for sign off.

In terms of the progress of the recommendations, all health trusts and the ICB have the CSE awareness training included as part of their mandatory training. This is being established through the Electronic Staff Record (ESR) therefore enabling compliance with this through the learning and development systems.

There continues to be a large amount of work still progressing in relation to the recommendations for Primary care, especially the use of a flag to alert GP practices when a child is at risk of exploitation and

registers with their practice. The recommendations have been discussed in both regional and national safeguarding meetings and are utilising local and national digital teams to support this progress.

6.3 Work undertaken during the reporting period

Updating Safeguarding Dashboards

Safeguarding Dashboards are collectively reviewed and updated annually to ensure the data required by the SAAF and any themes/areas requiring close monitoring are included. Changes made to this financial year include the addition of Child Sexual Exploitation training compliance as this was implemented as mandatory training from April 2024. Furthermore, number of referrals to IDVA service, number of DA disclosures where children under 18 was added, number of referrals to children social care added, number of early help referrals added, percentage of staff who require children's safeguarding supervision that have received supervision, advice or support, the number of child safeguarding concerns raised through complaints received by the trust, number of children not brought to appointments/did not attend where there were safeguarding concerns, number of open CSPRs/Rapid Review action plans which have outstanding actions for the trust to complete and number of safeguarding related training attended by staff members within the trust.

Early Help

There has been great progress within both Telford and Wrekin and Shropshire in opening family hubs (Telford and Wrekin) and Community Hubs (Shropshire) investing the support closer to the communities and neighbourhoods. This work will support the family help element of the Families First Programme due to be implemented by April 2026 as part of the wider social care reforms. Health services including public health nursing, SEND and Maternity Services form part of this work. Furthermore, the recent pilot of family networks within Telford and Wrekin will contribute to the wider piece of work being undertaken around a pillar of the Families First Programme; Family Group Conferencing which is to be referred to as "family conversations".

Both Designated Nurses promote early help being initiated and lead on by health professionals. An early help event was held in October 2024 which was attended by key stakeholders and leads of health services in an aim to raise awareness of early help, how we can support our families using early intervention and identify any challenges to services being unable to undertake early help assessments. An action plan was developed following the event and progressed. A key areas is in relation to the Early Help Form however following escalation and discussion of this in the Family Connect and Early Help Subgroups in Telford and Wrekin, in view of a new form and system being developed as part of the Families First Programme, it was agreed the current form will continue and health partners will be part of the development of the new form. Following the event, partnership data in both areas demonstrated an increase in Early Help activity from health services however this now requires further work to be undertaken noting a steady decrease. Safeguarding dashboards now capturing Early Help data will support the oversight of this activity from a health perspective.

Review of the Multiagency Safeguarding Hub (MASH) arrangements for health

The review of the Multiagency Safeguarding Hub (MASH)/front door across both Local Authorities; Family Connect (Telford and Wrekin) and Compass (Shropshire) was completed and an updated service specification has been drafted. There has been changes to the procedures within Shropshire Local Authority to include the commencing on PIT STOP (Partnership Integrated Triage) meetings being held which has been included in the service specification with the aim that the service will be able to participate in this shortly.

Child Safeguarding Practice Reviews

There has been a considerable amount of work undertaken by both Designated Nurses for Safeguarding Children in their statutory roles within the CSPR panels for both partnerships. During the reporting period, there has been significant progress made in outstanding actions from Child Safeguarding Practice Reviews and Rapid Reviews. In Telford and Wrekin there has been the publication of 3 reviews (CSPR 9, CSPR 10 & CSPR 17). Learning briefings have been completed for CSPR 9 and CSPR 17 due to the reports not being published in the public arena due to the sensitivity and protecting anonymity.

The Designated Nurse for Safeguarding Children arranged a CSPR event to seek assurance of learning being embedded across the partnership with a focus on reviews published in 2023-2024. This was presented back to the safeguarding children board and actions added to the collective multiagency action plan. Furthermore, within the reporting period there have been changes to the chairing arrangements, terms of reference and structure to include senior leadership and increased accountability within the group.

Shropshire Safeguarding Partnership continue to progress the actions from the independent review and initiated 4 spotlight sessions, using the learning from rapid reviews and Local Children's Safeguarding Practice Reviews (LCSPR) to look at the following themes: Neglect, extra familial harm, keeping children safe in the modern world, and Family Help. Each session had attendance from across health system and the actions and learning from this is continuing to be progressed through the partnership learning group.

Case Review Tracker

The Case Review Tracker has been completed within required timeframes by the Designated Nurses for Safeguarding Children. This is current and reflects the active cases where Rapid Reviews and CSPRs are being undertaken. There have been no NHSE High Level Briefing escalations required to be submitted during the reporting period.

Section 11 Audit

Following on from the audits completed in 2023/2024 as part of the previous Section 11 audit, there is a plan for the audit to be undertaken in the next financial year.

Joint Targeted Area Inspections (JTAI)

Work has been undertaken with the provider trusts and GPs in raising awareness and preparing in readiness for a potential JTAI. The Designated Nurses, as leads for coordinating health, have worked with both partnerships in understanding the position and direction and prepared required information as much as possible. Regular JTAI preparation meetings have been commenced and a presentation and communications shared with the GP practices to support awareness and understanding of these inspections.

A mock JTAI for the data element was carried out within the Telford and Wrekin Partnership which enabled the agencies to clarify their JTAI leads, be aware of the strict time scales agreed and understand the process if this were to happen. Shropshire Safeguarding partnership plan to carry out a mock JTAI in the next year and the Designated nurses have shared the guidance and paperwork in relation to health services in preparation for this.

Quality assurance and oversight

The Designated Nurses participated in a Mock Inspection undertaken at SATH which was well received and provided opportunities for further development as well as providing assurance of safeguarding children practices within the Emergency Department.

A quality visit was undertaken in both Multiagency Safeguarding Hubs (Family Connect and Compass) since the review of the MASH was undertaken and new service specification developed. Whilst it was acknowledged that the services specification had not at this point been signed off and incorporated into contracts, there had been significant improvements made to the structures, processes and strong leadership and management oversight.

The Designated Nurses now attend Contract Review Meetings for MPFT and SCHAT as well as the Safeguarding Committee meetings for SATH, SCHAT and RJAH. During the reporting period, the MPFT Safeguarding Committee meeting has been reestablished which has been a positive platform to seek assurance and oversight. Quarterly and annual reports are reviewed by the Designated Nurses and collectively reported upon within the ICB Safeguarding Children Quarterly reports.

Safeguarding is also in attendance at the smaller provider contract review meetings such as Axis and British Pregnancy Advisory Service (BPAS).

During the reporting period, there has been a safeguarding incident which highlighted challenges within the current Child Protection Medical procedures. This has instigated a multiagency discussion and action plan to be progressed. Further work requiring wider key stakeholders is required to be progressed into the new financial year.

6.4 Children Safeguarding Assurance from providers

Health Trust Providers complete a quarterly Safeguarding Children Dashboard which is submitted within the papers of the safeguarding committee meetings. These support in seeking assurance that provider services are meeting their responsibilities in relation to the SAAF. As outlined above, there have been developments in the safeguarding dashboard to capture key changes within safeguarding practice and areas requiring closer monitoring. As part of the dashboards, the number of safeguarding referrals made by the Trust are captured.

6.5 Rapid Reviews and Children's Safeguarding Practice Reviews (CSPR's)

The CSPR Panel is the multi-agency group that has delegated responsibility from the safeguarding partnerships to oversee the process and arrangements for identifying, commissioning and reviewing child safeguarding practice reviews and respond to serious incidents of harm in accordance with the Working Together (2023). The Designated Nurses are lead on behalf of the ICB as a key statutory partner alongside Police and Local Authority and chair the panels in both areas.

Referrals will be brought to the CSPR Panel's attention and following consideration, where appropriate a Rapid Review will be undertaken to maximise learning and ascertain if there are national implications or whether a Local Child Safeguarding Practice Review should be commissioned to identify and cascade learning to front-line practitioners.

Whilst there have been 2 Rapid Review referrals received for Telford and Wrekin, following review by the statutory partners, it was deemed they did not meet criteria for a Rapid Review to be progressed. However, one of the referrals resulted in a single agency review to be undertaken by Education which is currently in progress. The terms of reference for the Telford and Wrekin CSPR panel have been updated to reflect the opportunities to supporting learning in cases where the criteria for a Rapid Review is not met. During the reporting period, there has been progression of 2 CSPRs with practitioner meetings taking place during this time and a final draft of the reports being written by the authors. These reviews will be published in the next financial year.

There have been 5 Rapid Review referrals received for Shropshire and one of these met the criteria for a Local Child Safeguarding Practice Review to be undertaken.

There has been an independent review into Shropshire safeguarding with a focus on all reviews across adult and children's with actions identified. For the Children's CSPA sub-group, the partners have progressed this work to ensure all outstanding CSPA's are identified and commissioned, and this includes the identification of thematic reviews which need to be undertaken.

7.0 Safeguarding in General Practice

The ICB has continued to champion safeguarding developments in Primary Care. This work has been led by the Named GPs for Safeguarding Adults and Children, Dr Luen Wong and Dr Ella Baines. They provide safeguarding leadership and advice to general practice regarding statutory safeguarding responsibilities and offer support with complex safeguarding cases.

The Named GPs for safeguarding represent general practice at several strategic subgroups across Shropshire and Telford & Wrekin Safeguarding Partnerships. These include the Drug and Alcohol groups, Suicide Prevention Action Group and Domestic Abuse Local Partnership Boards. They help to review process, support positive change, produce guidance and inform policy. They promote meaningful engagement from general practice at Domestic Homicide Reviews, Safeguarding Adult Reviews and Rapid Reviews. The Named GPs support GP involvement in learning reviews with information gathering, help disseminating recommendations and implementing action plans from the learning reviews.

The Named GPs for safeguarding are responsible for an ongoing education programme open to all working in general practice. The STW GP Safeguarding Forums have increased in frequency to one every month on MS Teams. Topics over the last year have included Prevent, Self-Neglect, Domestic Abuse and Child Sexual Exploitation. Forums are recorded to allow access for clinicians who not able to attend. Following reflection on recent Domestic Homicide Reviews and domestic abuse related deaths, further training is planned for general practice to increase the awareness of the link between mental health problems and domestic abuse. The ICB Designated Nurses for Safeguarding Children have collaborated with the Named GPs to provide Level 3 Safeguarding Children training to general practice. The Named GPs have also held regular supervision sessions for GP practice safeguarding leads to discuss cases, share good practice and disseminate local information and guidance.

Important safeguarding updates, resources for GP practices and training opportunities have are sent out by the Named GPs in the Shropshire, Telford & Wrekin Practice bulletin via the ICB Primary Care team and by email through the ICB safeguarding administrator. Information has included links to video recordings of the GP Safeguarding forums and local training opportunities. With Public Health colleagues, we launched a Suicide Prevention Toolkit for Primary Care in April 2025.

The Named GPs work with the wider safeguarding community in Shropshire, Telford & Wrekin to promote multi-agency working and information sharing. They take part in NHSE Midlands Safeguarding Named Professionals forums to discuss safeguarding concerns and share good practice. The Named GPs also attend education sessions and supervision with the National Network for Named GPs. This allows them to share emerging themes and resources with local GP Safeguarding leads as they arise

nationally and regionally. They contribute to ICB quality assurance and audit work related to safeguarding in general practice.

8.0 Safeguarding Training in the ICB

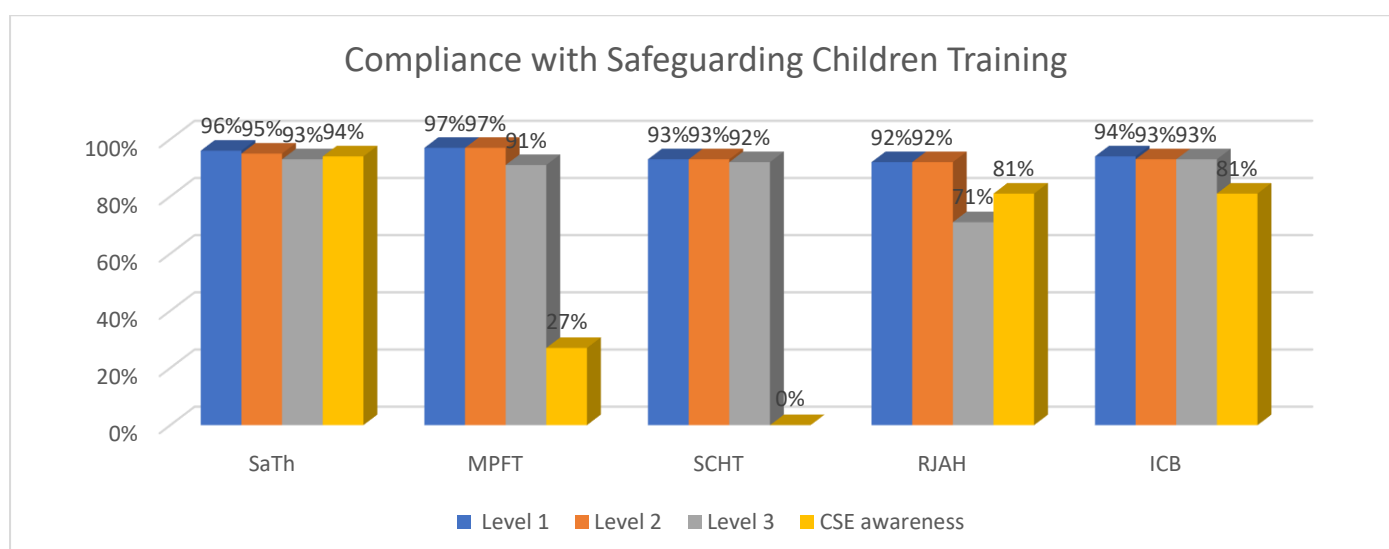
The table below shows that the ICB has complied with the mandatory safeguarding requirements at year end.

ICB Safeguarding Training – All Targets 90%	Compliance
Prevent Duty – basic awareness	92%
Prevent Duty – Level 3	98%
Deprivation of Liberty Safeguards	97%
Safeguarding Adults - Level 1	93%
Safeguarding Adults - Level 2	93%
Safeguarding Adults - Level 3	100%*
Safeguarding Adults - Level 4	100%
Safeguarding Adults - Level 5	100%
Safeguarding Children - Level 1	94%
Safeguarding Children - Level 2	93%
Safeguarding Children - Level 3	93%
CSE awareness training	81%

*Individual Commissioning Team new starters will necessitate additional bespoke training to commence when recruitment is completed.

All Designated Safeguarding leads are compliant with the Level 5 training requirements.

The below graph evidences the training compliance from the provider trusts which the ICB monitors through their dashboard data.



Provider reports have provided compliance of Level 4 Safeguarding Children Training for those staff groups who require this as per Intercollegiate Document.

There has been a challenge for trusts to record the CSE awareness training which is being progressed through the ESR systems. The overall compliance for SaTh and RJAH relates to the staff identified on their trajectory who are required to be compliant first.

9.0 Priority Areas for 2025-2026

Children's priority areas

Priority areas	How will this be achieved
IITCSE	✓ Completion of any outstanding recommendations ✓ Work with the partnership to seek how recommendations within the IITCSE can be progressed in line with the Casey Review recommendations ✓ Fully implement the CSE awareness training across all health services and embed compliance data recording ✓ Complete the final CSE impact training for staff groups who may have contact with CSE survivors ✓ Monitoring of the progress through quarterly reporting
MASH Review	✓ Continue to work with contracts and commissioning team to progress the MASH Service Specification through Contract Review Meetings ✓ Work with SCHT to ensure cover for PITSTOP ✓ Support SCHT to implement system access with other health Trust Providers to ensure a timely lateral check being completed ✓ Continue with the MASH Health meetings for both areas ✓ Continue to monitor MASH data dashboard with strategic oversight of service development
Early Help	✓ Further work to be undertaken to raise the profile, initiation and embedding of early help across the health economy ✓ Work with partnerships and local authorities to increase early help and prevention (family help) ✓ To attend and promote the attendance of provider leads to attend the Early Help Partnership Boards and Subgroups for oversight and integration into health services ✓ To monitor the data presented within dashboards around Early Help activity
Embedding learning from Rapid Reviews and CSPRs	✓ Continue to progress outstanding actions from CSPRs and Rapid Reviews in both areas ✓ To work with the partnerships of how to improve obtaining assurance from all agencies and services that changes have been embedded ✓ To continue to take a lead role as statutory partner in CSPRs and safeguarding reviews
Neglect	✓ To continue to work with the partnership to follow up actions from the spotlight workshops when neglect was identified as a key factor in rapid reviews, CSPRs and incidents ✓ To continue to monitor actions from safeguarding reviews that identify neglect as a factor to be in a position to provide assurance that learning and changes have been embedded ✓ To continue to participate in audit and MACFAs in relation to neglect

Team recruitment	✓ To conclude the recruitment of the position of Designated Doctor for Child Death
Child Protection Medicals	✓ Work with SATH, SCHAT and other key stakeholder to develop a robust process for Child Protection Medicals that provides resilience to the service
Families First Partnership Programme	✓ To work closely with the partnership to plan, develop and implement the required changes of Families First Partnership Programme into the health system
Safeguarding Supervision	✓ Work with Trust Providers to ensure supervision compliance is accurately captured within the safeguarding children dashboard

Adult's priority areas for 2025 - 2026

Priority areas	How will this be achieved
Domestic Abuse	✓ Via the DALP and Public Health enhance arrangements regarding DA related suicide. ✓ Ensure successful implementation of Domestic Abuse Related Death Reviews ✓ Ongoing reporting and governance via the Domestic Abuse Local Partnership Board ✓ Specific workstream to enhance the Domestic Violence Disclosure Scheme
Safeguarding Commissioning Assurance Toolkit (SCAT)	✓ Undertake comprehensive audit of compliance and leadership ✓ Complete the quarterly assurance returns ✓ Focus upon supervision advice and guidance returns ✓ Focus upon prevent Duty
MCA/DOLS /LPS Practice	✓ Contribute towards the LPS implementation agenda ✓ Develop the MCA & DOLS multiagency operational group
ICT safeguarding support	✓ Maintain training compliance ✓ Provide timely advice/support/supervision in complex cases
Self-neglect	✓ Introduce the TW self-neglect guidance ✓ Explore ways to improve compliance with self-neglect understanding and applications
Statutory Case Reviews	✓ Implement new front-line team learning template
Responses to Fire Safety deaths of those with care and support needs	✓ Support the renewal of the Task and Finish Group ✓ Work with partner agencies on key issues the coroner has asked the system to address

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10.0 Conclusion

This report tries to reflect the breadth of activity the ICB has undertaken to fulfil its statutory safeguarding functions. 2024- 2025 has been a busy year in safeguarding with significant challenges. The only thing we can guarantee is that 2025 – 2026 is likely to be more momentous as the ICB adapts to the changes yet to come. The ICB has sought to work collaboratively with the NHS trusts on critical developments and systems to safeguard children, young people and adults in their care. Notable achievements have included the responses to child sexual exploitation and embedding processes associated with SEND and child death arrangements. The ICB has helped lead the priority setting of the Safeguarding Adult Boards. There has been a new approach to Prevent arrangements responding to heightened awareness of those susceptible to extremist acts which has been acknowledged by the Home Office. The ICB led the local response to enhancing approaches and understanding of key areas within domestic abuse about suspected victim suicides. The system wide MCA and DOLS group augmented by audit work and sought to champion best practice in this area.

The report has identified the key priority areas for 2025 – 2026. Focus will be maintained on those critical activities.

There is recognition that safeguarding requires a partnership approach and the ICB as one of the statutory partners will continue to respond to the challenges from the joint independent chair and independent scrutineer as he holds partners to account. It is pleasing to see his introduction to this report as he confirms the level of assurance and responsiveness from the ICB.