Swindon Safeguarding Partnership

Annual Report 2020-21

safeguardingpartnership.swindon.gov.uk

Sue Wald	David Haley	Gill May	Mark Cooper
Corporate Director Adult Services, Health & Housing	Corporate Director – Children Services	Director of Nursing and Quality and Caldicott Guardian	Assistant Chief Constable - Crime, Justice and Vulnerability

Contents

Forward

Thank you for taking the time to read Swindon Safeguarding Partnership Annual Report which covers the period 1st April 2020- 31st March 2021.

A year on we are pleased to share progress made despite the challenging impact of the many facets of the Covid-19 pandemic. The report is published by the three statutory partners (Swindon Council, Wiltshire Police and Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group) who are responsible for putting in place effective arrangements to support the co-ordination, quality assurance and continuous improvement of activity to safeguard children, young people and adults with care and support needs.
The pandemic has tested and continues to test local services. However, the strength of relationships between practitioners and leaders at all levels has been built upon, allowing multi-agency working to adapt through a dynamic response to the rapidly shifting requirements of Covid-19 conditions. Effective joint working continued, although the medium-term impact of the new models of working during the pandemic is yet to be fully understood.
In this report, the statutory partners set out critical areas of development to improve the effectiveness of the statutory partnership arrangements including the need for a robust multi- agency quality assurance framework to support and using the learning from serious safeguarding incidents and auditing to make a difference to either practice or service provision.

This report also sets out the achievements and the work that has progressed at time of unprecedented pressures on services. These achievements are a reflection of the committed individuals who either work directly with children, adults and their families or those with a specialist role in safeguarding in partner agencies; on behalf of the 3 statutory safeguarding partners, thank you for the work you have done in 2020-21 and continue to do so.

Independent Scrutiny

Working Together 2018 determines that statutory partners for multi-agency child safeguarding arrangements should produce a report that:

- sets out what partners have done as a result of the arrangements, including on child safeguarding practice reviews, and how effective these arrangements have been in practice
- evidences the impact of the work of the safeguarding partners and relevant agencies, including training, on outcomes for children and families from early help to looked-after children and care leavers
- provides an analysis of any areas where there has been little or no evidence of progress on agreed priorities
- Details the decisions and actions taken by the partners in the report's period (or planned to be taken) to implement the recommendations of any local and national child safeguarding practice reviews, including any resulting improvements
- Sets out the ways in which the partners have sought and utilised feedback from children and families to inform their work and influence service provision.

I have reviewed the annual report produced by statutory partners against the above criteria; the report provides a description of activity undertaken in relation to local priorities. The activity has focused on producing guidance/procedures, briefings and learning opportunities for front line staff. All of which is to be commended. Statutory partners in page 5 of this report appropriately identify the challenges for the partnership which include strengthening the governance of work programmes and developing the scope of performance and quality assurance activity to be able to evidence the impact of the partnership's work and that of relevant agencies from early help to looked after children and care leavers.

The report provides a record of activity conducted by partners to learn from serious child safeguarding incidents. This includes the completion of a rapid review within the statutory timeframe. I have, in year, provided challenge to partners about the time taken to complete child safeguarding practice reviews and again on page 5 of the report, statutory partner appropriately identify this as one of the ongoing challenges they need to address. Whilst not explicit in the report, partners did consider the findings from the first national child safeguarding practice review which was a thematic review of criminal exploitation, and they completed a self-assessment against those findings. The report states that by the end of the period covered by this report, a plan of activity had been agreed by partners in relation to tackling all age exploitation; an overview of the findings and the planned activity is not included and should therefore be set out in the following year's report.

The Revisiting Safeguarding Guidance 2022 sets out that an effective Safeguarding Adult Board will:

• assure itself that safeguarding approaches within their area support the principles of personalisation

• work with partners and citizens to prevent abuse and neglect where possible

• ensure agencies and practitioners respond in a timely and proportionate manner when people raise safeguarding concerns

• Learn from and respond to safeguarding trends within their area

• Will ensure that individuals and organisations are competent in their delivery of safeguarding practice

• assure itself that safeguarding practice is continuously reviewed to ensure good quality and responsive practice, enhancing the quality of life of adults in its area

Swindon Safeguarding Partnership incorporates the functions of the local Safeguarding Adult Board and in relation to the activity outlined above, the report sets out that person centred practice is an agreed priority. Similar to the narrative in relation to safeguarding children priorities, partners have undertaken activity that has focused on producing guidance/procedures and briefings for front line staff. The partnership does not yet have an adult safeguarding learning and development offer, and this is a recognised area of development. Individual organisations do provide training for their staff to support staff to identify adults with care and support needs who are at risk of abuse or neglect.

Safeguarding performance data and local Safeguarding Adult Review (SAR) learning indicated that there was a significant delay in the response provided to adults with care and support needs when safeguarding concerns are referred to the Local Authority. The report provides a detailed narrative of the actions that were initiated to improve the responsiveness and quality of the safeguarding response. Data and learning from the 2 SARs completed during the period covered by this report identify thematic learning in relation to knowledge and application of mental capacity act, multi-disciplinary working and risk assessment as well as the response to adults who self-neglect. As a result of the learning from the local SARs, self-neglect remains a locally agreed priority. This means that there is evidence that safeguarding partners are using local data and learning to shape their priorities albeit and the time taken to complete statutory learning reviews has been protracted. As per the comments above, strengthening the governance arrangements and developing performance and quality assurance activity will enable the partnership to evidence the impact of its work. The voice and experience of local citizens is central to this, and the year ended with the performance and quality assurance meeting receiving a powerful and informative presentation on the experiences of adults of the local safeguarding system.

For both safeguarding children and adults with care and support needs, the report acknowledges the creativity and tenacity of front-line staff, managers, and leaders in agencies/services to continue to deliver services to the most vulnerable children and adults and their families/carers during the pandemic. It also recognises that the impact of the pandemic on children and young people and adults with care and support needs, including any “hidden harm,” is not yet known. This will emerge over time, and will require practitioners, services and the partnership to listen to the views and experiences of children, young people, their parents and adults with care and support needs and their families/carers. The DfE funded project referenced in this report, and other participation

work, provides a strong platform to do this and can also be used by statutory partners to inform the planned development programme to strengthen partnership culture and working. Whilst, and due to the pandemic, there has been a delay in this programme commencing, it is an indication that statutory partners are able to be open and challenge each other and embrace their leadership responsibilities. It is also a reflection of their ambition to work with their partners to deliver the best outcomes possible for the children, young people and adults who reside in Swindon.

Liz Murphy
Independent Scrutineer
February 2022

Introduction

This is the second annual report of the Swindon Safeguarding Partnership which came into effect July 2019. The Swindon Safeguarding Executive was established to oversee the new Multi-Agency Safeguarding Arrangements for children (formerly the LSCB) and adults at risk (LSAB). The duties and functions of the Partnership are set out in Working Together 2018 and Care Act 2014. The Partnership comprises a core membership of statutory partners from Swindon Borough Council (SBC), Banes, Swindon and Wiltshire Clinical Commissioning Group (CCG), Wiltshire Police, Education Representative and an Independent Chair. A range of schools, health providers, criminal justice services, voluntary and third sector organisations across Swindon also play a pivotal role in supporting improvements across Swindon's safeguarding system. Our ambition is for the partnership to deliver measurable and meaningful improvements in outcomes for children and adults at risk by:

- Creating a stronger culture of collective responsibility for safeguarding children and adults
- Acting on learning so that the partnership can continuously improve its support for children and adults at risk
- Activating and empowering the local community to be safeguarding partners
- Increasing the involvement of children and adults in the work of the partnership
- Developing a confident and knowledgeable workforce and use their expertise to shape our work
- Using our data to develop a shared narrative about the safeguarding needs of children and adults in Swindon

Agencies across the partnership aim to work together to:

- Deliver a shared responsibility for the safeguarding of children, young people and adults at risk in the Borough
- Provide effective and informed leadership to the local safeguarding system
- Promote positive working relationships with each other and children, adults, their unpaid carers and families
- Identify and act on learning
- Provide assurance to the Swindon community

Our 2019/20 Swindon Safeguarding Partnership Annual report outlined areas for improvement across both the children's and adult's safeguarding system. However, the declaration by the World Health Organisation (WHO) of the COVID-19 Pandemic in March 2020 and the subsequent periods of prolonged lockdown has impacted on the delivery of our programme of development. This annual report covers the time period from April 2020 to March 2021. The partnership's response to COVID-19 was swift to ensure minimum disruption to business continuity at the commencement of 'lockdown'. Partners worked together to produce a Standard Operating Process (SOP) to assess the impact of COVID-19

on safeguarding duties ensuring business continuity plans were in place so those most at risk were seen face to face. Strategy discussions, Child Protection Conferences and Section 42 Adult Safeguarding enquiries were facilitated remotely during the full lockdown. The COVID-19 response structure enabled a joined-up approach across the partnership for vulnerable and at risk children and adults with care and support needs.

Alongside the pandemic, the partnership continued to be affected by capacity issues both for individual agencies as well as the safeguarding partnership business support unit which presented challenges to the formation of the new partnership. However, partners have demonstrated flexibility and have worked collaboratively to support each other in managing the changing system pressures during the pandemic. At times, partner agencies had to prioritise single agency activities over the partnership work programme to ensure minimum disruption to business continuity.

A partnership organisational development programme had planned to address cultural challenges but unfortunately this was put on hold due to competing priorities presented by COVID-19.

Ongoing partnership challenges

- Further work to embed a robust quality assurance framework with effective and timely multi-agency audits, walk the floor activity and a shared Partnership performance dataset and dashboard. Progress has been impacted by the volume of Safeguarding Adult Reviews (SARs);
- Better engagement with children, families, and adults with care and support needs and their unpaid carers to influence and improve safeguarding practices and service delivery across the partnership;
- Progressing the use of SP business plan as a tool to evidence the impact of SSP sub-groups on practice and outcomes;
- Ensuring learning from serious safeguarding incidences is acted on in a timely manner and that reviews are completed in a timely and proportionate way;
- Providing assurance that the multi-agency safeguarding risk register is effective in managing risks associated with multi-agency safeguarding arrangements;
- Evidencing the impact of the multi-agency safeguarding Learning and Development Offer on practice and outcomes.

The pandemic has provided the opportunity to be more innovative in managing the partnership business by adopting new channels of communication, making better use of IT functionality and introducing virtual working. This has led to more efficient and effective working practices but it is recognised that the medium-term impact of these new approaches have yet to be fully evaluated.

There is clear ambition for Swindon Safeguarding Partnership to address the above challenges. We recognise it will take time to achieve functional change to maximise the impact of strengthened leadership whilst continuing to understand the longer ongoing

impact on services and the recovery from the COVID-19 pandemic. Stronger governance is now supporting better management and co-ordination of our priorities to secure improved safeguarding practices and outcomes.

Key Priorities

Swindon Safeguarding Partnership Strategic Plan 2020-2023 is informed by the priority areas for improvement outlined in the partnership's 2020/21 Annual Report. The Strategic Plan was approved by the Safeguarding Executive and oversight of its delivery is managed through the Partnership's Delivery Group.

Children's Partnership Priorities

Below are the three priorities identified by the partnership. The priorities have been informed from the analysis of last year's annual report, recommendations from serious and local cases reviews, information shared through organisation headline reports, and data shared at Performance and Quality Assurance subgroup. These priorities have been approved by the partnership governance structure via SSP Delivery Group and SSP Executive Group.

Children live in safety, free from neglect developing or improving/ strengthen response to children who are being neglected

The right decision is made at the right time for children & families

Children/young people and adults with needs are at the centre of decisions, which relate to their life

Activities to support the priorities

- MASH Opening mornings – These were continued through the pandemic but moved to a virtual platform to promote cohesive & multi-agency working to support children and families have a positive experience of the safeguarding system. The open mornings improved practitioner knowledge of the role of MASH. This has supported partner agencies to provide better quality information at the referral stage so a more timely and appropriate response is provided and more children, young people and families receive the right help at the right time.
- Swindon Multi Agency Safeguarding Hub Protocol was reviewed, updated and published. This has provided greater clarity in relation to roles and responsibilities and improved multi-agency working which was evidenced by Ofsted focussed visit in Dec 2019 *Child protection strategy meetings in the multi-agency safeguarding hub (MASH) are timely, with appropriate attendance from partners. There is effective information sharing and clear written minutes and action points for social workers to follow.*
- Professional Disagreement and Escalation 7 minute briefing was developed and promoted across the partnership to reduce drift and delay in case management and embed learning from Serious Case Reviews in Swindon.
- The SSP Escalation Policy was introduced in 2019 to support timely management and resolution. Stage 2 and above escalations were monitored by SSP BSU during 2020/21 of which three were resolved at Stage 2 and one at Stage 3. Three escalations were managed within the time frame of five working days, an explanation was provided for the delay in responding to the remaining escalation which was then satisfactorily resolved. The escalation policy has been effective in resolving disagreements between partners enabling partners to work collaboratively to improve outcomes for those children and young people affected.
- A Professional Curiosity presentation and resource pack was developed and promoted across the Partnership in response to a reoccurring theme in Swindon arising from Serious Case Reviews and Multi-agency audits. This was published in January 2021. Further work is planned to promote the tool across the Partnership as part of the continuous professional development offer and to gather evidence of the impact of the new resource pack
- SSP Neglect Framework and Practice Guidance was published alongside a Neglect 7 minute briefing. To improve awareness, understanding and the response to neglect amongst practitioners and support more consistency in decision making.
- Embedding multi-agency neglect and risk assessment tool Graded Care Profile 2 (GCP2) – Virtual training was delivered to 80 professionals across Swindon from a range of disciplines including health, care and education. Roll out will continue into 2021-22 and SSP will evaluate the short, medium and long term impact of using the GCP2 tool on practice and outcomes.
- Development of a cross Partnership Pan Swindon & Wiltshire all age Exploitation Sub-group to increase cross-border and partner cooperation in identifying and protecting individuals at risk of or experiencing exploitation.

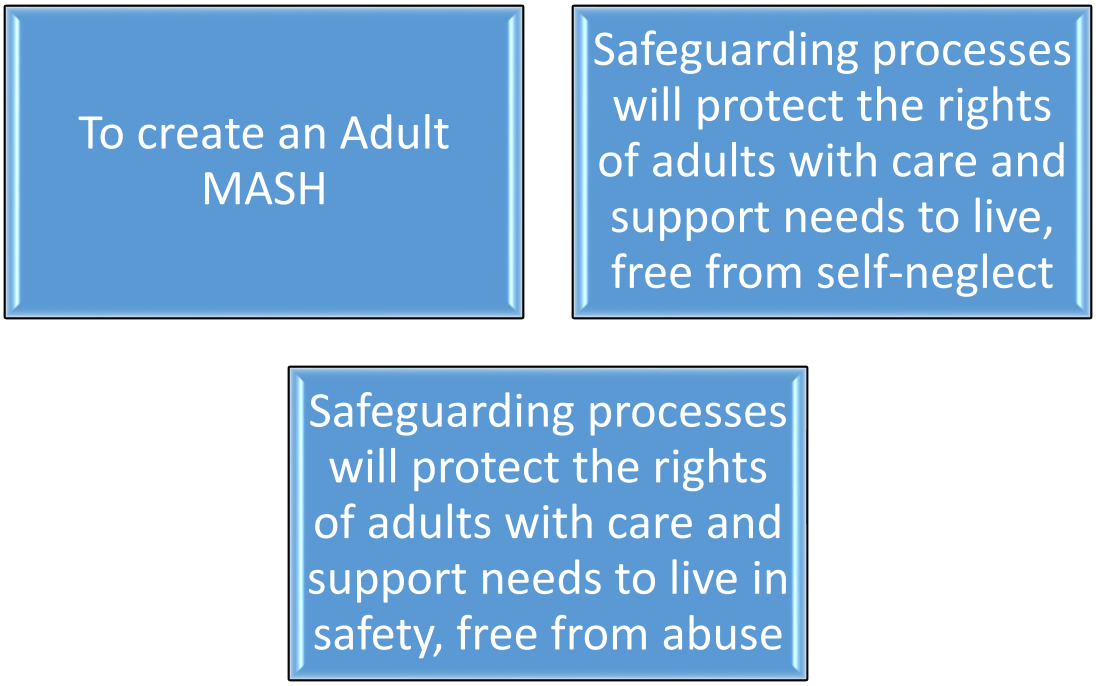
Partners Activities to support the priorities

Swindon Borough Council

- MASH multi agency quarterly audits have been completed throughout 2020/21 to provide a lens into practice in relation to the partnership referrals into MASH and the MASH response in terms of timeliness and quality. Audits reflect good quality referrals by partners and learning from audits are shared with partners routinely to further improve the quality and timeliness of referrals to MASH.
- Decision making and thresholds for referrals into MASH were tested as part of the OFSTED focussed visit in December 2020 which reported that: '*Decision making is timely and appropriate actions are taken to protect vulnerable children. Management oversight and the rationale for decision making is well recorded. Thresholds for statutory actions are appropriately applied, with managers and social workers demonstrating a clear understanding of risk'.*
- Children Services has strengthened recruitment processes, to ensure that children, young people and care experienced adults are involved in recruitment. The Directors of Children's Social Care and Inclusion and Achievement, Service Manager for Placements, and all members of the Participation Team have been recruited with children, young people and families as part of the interview panels.
- The Business Relationship with Dick Lovett Foundation thrives and the Lovett Foundation is working with the Borough to support initiatives such as "cooking on a budget" to develop independence skills. The Foundation again sponsored the Children In Care Achievement Awards which took place in November 2021
- Participation for children and young people in receipt of services has been developed throughout the pandemic and new members of the Children In Care Council have increased.

Adults Priorities

Three priorities were identified by the partnership informed from the analysis of last year's annual report, recommendations from serious and local cases reviews, information shared through organisation headline reports and data shared at Performance and Quality Assurance subgroup. These priorities have been approved by the partnership governance structure via SSP Delivery Group and SSP Executive Group.



Activities to support the priorities

- Police joined the Adult Safeguarding Screening hub in Sept 2020 leading to better multi-agency decision making at the front door.
- The Adult Social Care internal improvement plan has led to improved timeliness/quality of response to s42 concerns.
- Development and launch of new on-line Safeguarding Adults E-referral with interactive access to the threshold guidance. This has improved the quality of referrals supporting more timely and appropriate responses to safeguard adults in Swindon. This referral process is more interactive for professionals enabling them to access Threshold Guidance whilst making a referral ensuring relevant information is provided to support robust decision making.
- More adults being asked to express their desired outcome from the safeguarding process and a higher proportion of adults being supported to express an outcome in line with Making Safeguarding Personal (MSP).

- The SSP Adults Escalation policy was published and promoted across the Partnership in January 2021 arising from multi-agency audits which indicated the need for an adult policy to assist professionals to challenge decisions as and when appropriate.
- 7 minute briefings developed and promoted for Mental Capacity Act & Self-Neglect – to embed the learning from two Safeguarding Adult Reviews (SARs) and multi-agency audits. The impact of these documents on practice and outcomes are the focus of ongoing scrutiny.
- Development of a cross Partnership Pan Swindon & Wiltshire all age Exploitation Sub-group to increase cross-border and partner cooperation in identifying and protecting individuals at risk of or experiencing exploitation.

Partners Activities to support the priorities

Swindon Borough Council

Jan 2020: Safeguarding Improvement Plan

- Head of Service developed a Safeguarding Improvement Plan to address performance issues seen across the workforce and in Adult Safeguarding Data Set.
- A number of the updates below come from the Safeguarding Improvement Plan

March 2020: Covid-19 Impact

- Developed safe and effective remote working practices to ensure we protected the workforce during the pandemic whilst continuing to respond to those in need
- Developed robust risk assessments to enable face to face working, PPE (with guidance) made assessable to the workforce

June 2020: Mental Capacity Assessment, 2005 (MCA) learning event

- Number of peer reviews held with practitioners, who presented real MCA assessments and decisions to a panel of experts who facilitated a reflective conversation to promote learning
- Outputs used by Principle Social Worker (PSW) in future forums

July 2020: Building Workforce, reducing dependency on locum staff

- Commissioned two separate articles in Community Care magazine, with Swindon Borough Council (SBC) Safeguarding staff interviewed and quoted in full page articles, developed to run alongside the current job vacancies
- Internal and external agencies used to advertise posts for both temporary and *permanent* staff
- Market factor supplement added to all Enquiry Officer and Enquiry Manager posts from July 2020 to address recruitment challenges

June 2020: Partnership Working

- Established new and continued to support existing partnership interface meetings with SBC Housing, AWP, Great Western Hospital, Swindon Advocacy Movement, and First City Nursing Care to improvement collaboration and communication amongst partners

July 2020: Training Developments

- Refreshed and reran the Enquiry Officer and Enquiry Manager training following actions from independent audit completed by a Safeguarding Trainer/expert in Dec 2019 (S.Watson)
- MCA back to basics training (webinar) delivered by SBC legal services
- DoLS back to basics training (webinar) delivered by SBC legal services
- Legal privilege (webinar) delivered by SBC legal services

July 2020 – Nov 2020: Policy Development

- Started development of the Multi Agency Safeguarding Policy and Procedures
- Developed the Threshold guidance to support decision making at point of referral
- Established a Task and Finish group to develop Self-Neglect Policy and Guidance
- Led on the Task and Finish group that sought to implement the ADASS Framework across the partnership – this led to the development of the Caused Enquiry process
- Developed the Safeguarding online referral form (Safeguarding Concern) with links to the threshold guidance, to improve both qualitative and quantitative data collection and ensure timely response to need

Aug 2020: Additional Service Manager capacity

- Review of Safeguarding Service Manager completed, that led to a reduction in scope of role, to support greater focus on the ongoing Safeguarding improvement work

August 2020: Strength Based Working

- Commissioned the National Development Team for Inclusion to promote Strength Based approaches to ensure people are at the centre of what we do in the Swindon system by:

    - Developing a culture of trust and empowerment with active endorsement and modelling by all, with behaviours across the organisation that run counter to this being addressed
    - Developing clear narrative and messaging regarding the principles of Community Led Support, where genuine coproduction is embraced and modelled

- Reviewing and rethinking how success is defined and understood through evidence and learning
- Delivering outcome based support planning, to underpin promotion of independence and creativity
- Building on existing partnerships to embed new ways of working throughout the organisation and Swindon as a whole. Share the vision for change (below)

Sep/Oct 2020: Developing Adult Multi Agency Safeguarding Hub (MASH)

- Commitment to developing an Adult Multi Agency Safeguarding Hub (MASH) remained clear, despite the pandemic
- Adult MASH Service Specification (v12) and Information Sharing Agreement completed
- Member of Wiltshire Police joined Adult Safeguarding Screening Hub

Dec 2020: Escalation Policy

- Developed to support effective partnership working

Feb 2021: Development of the Adult Safeguarding Quality Assurance Board

- Adult Safeguarding Quality Assurance and Performance Board provides the formal governance framework to the safeguarding quality assurance process
- The Board will monitor, scrutinise and agree the Safeguarding performance dataset prior to reporting to Adult Performance Board, Corporate Management Team and Swindon Safeguarding Partnership
- The Board will review findings from case file and thematic audits, deep dives, walk the floor activities, observation of frontline practice, learning reviews, and peer reviews
- The Board will confirm how recommendations for improvement will be delivered, and how the Adult Safeguarding performance dataset needs amending to monitor and track the impact of the improvements

March 2021: Safeguarding Quality and Performance Framework (v3)

- In order to provide insight into operational quality and performance, a number of measures and associated Key Performance Indicators were identified
- Data used to report at both a high and a detailed level as required, against the Safeguarding organisation either as a whole or for individual team members

March 2021: Audit Improvements

- Independent Lead Auditor commissioned to undertake high volumes of audit work in area of Self Neglect to review effectiveness of new Self Neglect training, policy and guidance

Bath and North East Somerset, Swindon and Wiltshire (BSW) Clinical Commissioning Group (CCG), Swindon Locality Summary

- BSW CCG, as with all other NHS bodies, has a statutory duty to ensure that it makes arrangements to safeguard and promote the welfare of children/young people and adults.
- The CCG, the local authority and the local constabulary now have equal and joint accountability for children safeguarding responsibilities (Working Together 2018).
- The Director of Nursing and Quality, as executive lead for safeguarding, reports to the Chief Executive Officer and is responsible for the monitoring of safeguarding vulnerable clients across BSW CCG. The Director of Nursing and Quality ensures that the reporting of any safeguarding risks or achievements is highlighted to the Chief Executive Officer and Governing Body. The Director of Nursing and Quality is a member of the Safeguarding Adults Boards and Safeguarding Children Partnership across BSW.
- During the 2020/2021 year, members of the BSW Executive shadowed some of the groups of the SSP.
- 2020/2021 has been a year of challenge to the system as a whole and to its individual parts, notwithstanding the impact on all those working to safeguard others. Without a doubt, the system's ability to safeguard during this report year has been compromised by the circumstances we have been in, which is recognised locally, regionally, and nationally.
- The CCG produced guidance to support practitioners working within Covid, including guidance on virtual consultations in health care and separate guidance for Virtual Consultations in Primary Care, these were shared nationally; and Virtual Health Assessments for Children Looked After.
- Safeguarding continues to evolve and does so as BSW CCG evolves into Integrated Care Systems with Integrated Care Alliance structures; we will remain proactive in our promise to embed safeguarding firmly into healthcare practice as we transition to a new landscape.

- The CCG has informed their Executive Board, through their annual Safeguarding report.
- The Swindon locality of BSW CCG has been working closely with the SSP to develop and improve the quality of the MARACs. This has involved several meetings on a task and finish group attended by the Adult Safeguarding Lead and the Named GP. Changes recommended by the CCG have included suggestions for improvements to information governance and information sharing, e.g. time slots for each case to ensure that professionals only attend the cases relevant to their agency; and by advising that information should be shared during the MARAC rather than detailed information being sent before the MARAC via email to all on the circulation list. The CCG has also given input with regards ensuring alignment of actions to mitigate any identified risks. The CCG input has been based upon alignment to the 10 principles of an effective MARAC as published by Safer Lives. This work is ongoing into 21-22.
- Since February 2021, the CCG has been offering to represent Primary Care at the MARAC meetings. Information is shared directly from the GP record which the CCG has access to and documentation about the MARAC is then made within the GP record. A Data Processing Agreement has been set up.

Adult Multi-Agency safeguarding Hub (MASH)

- The CCG identified the need to provide a dedicated nurse resource within the SSP hub to provide specialist advice and contribution to managing referrals. This post will be recruited to following the securing of funding by the CCG and will be recruited to.

Swindon Suicide Prevention

- Learning from SARs during the last year has identified the need to support the health system in managing complex cases for people who do not meet the threshold to stay within secondary mental health care after referral.
- Additionally complex cases have highlighted a gap in the local services offer so a dedicated group has been set up and a report will be provided in the 2021-22 report.

Primary Care

- From April until June of 2020, the Named GP for Safeguarding was moved to operational safeguarding work to support practices during Covid. This enabled the Named GP to give the time to support at an operational level.
- In January 2021, a new IT template for Systmone was implemented across Swindon. This incorporated the key safeguarding codes that practices should be using and also contained key learning for anyone accessing the template. It has a tab for Child Safeguarding, Adult Safeguarding, Domestic Abuse, Contextual Safeguarding, Looked After Children and also a tab that Clinicians can use to document a Mental Capacity Assessment. This new template has received good feedback and it being widely used. To complement the template, the list of codes embedded within the template has also

been circulated to surgeries. In July 2021 this template was adopted for use and launched in BaNES.

BSW Priorities are:

- To begin to prepare systems and training for the introduction of the LPS and develop robust MCA processes
- Work with CCG data analysts to develop a BSW data set and dashboard
- Develop a BSW CCG Safeguarding training strategy for CCG staff and Primary Care staff.
- Work towards the co-development of a document to align Primary Care safeguarding coding, promoting safe online access, with information on how to store documents and developed agreed safeguarding templates.
- Undertake a mapping and gapping exercise of the MAPPA activity across BSW including communication with primary care.
- Ensure a greater recognition and response to domestic abuse in the context of health professionals working with adults in need of care and support or protection.
- Planning for Swindon Adult MASH by the end of December 2022.

Wiltshire Police

- The impact of Covid Wiltshire police experienced along with many agencies across the partnership unprecedented demand. Wiltshire Police also saw a rise in Domestic Abuse – especially an increase in the proportion of Domestic Abuse when balanced against all crime (nearly all other crime dropped). Domestic Abuse went from 18% of Wiltshire Polices business rising to 25% however the force recognises that the demand did not increase to levels that had been predicted by some of the non-government organisations. The greatest success from a policing perspective is that we maintained our statutory responsibilities throughout the national lockdown's 1, 2 and 3 (which cover April '20 to March '21)

- In terms of preventative work Wiltshire Police were able to carry out specific targeted hidden harm campaigns for children and Domestic Abuse victims during lockdowns. There was also a focus on perpetrators during lockdown 3 – attempting to signpost them to help and deter offending.

- One notable success is the creation of a pan Wiltshire all age exploitation sub group chair by Wiltshire Police which has been well attended by agencies across the partnership. The new group took shape in November 2020 but, in terms of outcomes, it had only really agreed terms of reference and a delivery plan by March 2021. But that is still a success in itself – given the ambition of what we were trying to achieve.

Activities & Learning

The Practice Review Sub-Group

The Practice Review sub group has oversight of and manages Swindon's Rapid Reviews, Child Safeguarding Practice Reviews (CSPR) and Safeguarding Adults Review (SAR) as well as non-statutory reviews for additional learning.

During 2020/21, the group met 10 times. The group has members from a range of agencies including Swindon Borough Council, Wiltshire Police, BSW Swindon Clinical Commissioning Group, (CCG) Great Western Hospital NHS, AWP and the third sector.

Rapid Review & CSPR's

During 2020/21 the Practice Review Group considered one referral with notification to the National Panel.

The Practice Review Group conducted a Rapid Review into the case to identify the immediate learning and subsequently recommended that a Child Safeguarding Practice Review should take place. The Rapid Review was completed within timeframes set by the national CSPR Panel. CSPR Panel reported this case raised an issue of national importance relating to non-accidental injury in young children which is the focus of their third national thematic review. The rapid review met the quality requirements set by the national CSPR Panel as outlined in their recent annual report.

The CSPR was not completed during 2020/21 due to delays relating to the need to develop a stronger SSP governance and accountability framework for to improve the conduct of these reviews and ensuing appropriate levels of escalation are used when delays in receiving information and that agencies are held to account.
The CSPR will be published early 2022 and the findings will be reported in the next year's annual report.

Rapid Review

11 week old non-mobile baby was found to have several injuries including bruising, redness and following a skeletal survey several fractures. These were deemed non-accidental injuries.

Key Findings
• Safeguarding of unborn/new born children - need to raise awareness of the unborn baby protocol across the partnership. This was also identified in the multi-agency unborn baby protocol audit • Professionals response to bruising in non-mobile babies - need to raise awareness of SSP Policy on Suspected Bruising or Unexplained Injury. • Holistic view of the family needs to be considered • Consistent approach to processes across GP surgeries with regards to the flagging of important information for GP's to review • Services not proactively engaging the father during assessement

Learning from Rapid Reviews

The themed learning from the rapid review conducted in 2020-21 and two previous rapid reviews conducted during 2019-20 indicated focussed work is required across the partnership in the following areas:

- Physical abuse to babies under 1 caused by fathers/men
- Lack of application/awareness of the bruising in non-mobile babies' policy amongst partner agencies
- Safeguarding of unborn/new born children and the application of the SSP policy and guidance when working with suspected cases of babies and under one's with non-accidental injuries

Actions undertake by the Partnership to address the learning arising from the reviews include:

- 7 minute brief on suspected bruising policy published on SSP website which also includes a helpful guide on childhood development stages to support practitioners with assessing risk. The brief also has a 'voice over' to enable it to be played at team meetings or practitioner development forums.
- A practitioner event held in February 2021 to promote the 7 minute briefing and awareness of the SSP Policy on Suspected Bruising or Unexplained Injury. Feedback from the event was that agencies found the briefing helpful and have been able to identify individual actions to take forward to improve their practice.
- Learning has informed the refreshed SSP Multi-agency training offer for 2021-22.
- SSP policies and guidance for health professionals attending/contributing to strategy discussions, SSP Policy on Suspected Bruising or Unexplained Injury in a child who is not independently mobile, and the SSP Multi-Agency Standards for Safeguarding

Children are being reviewed and updated reflecting the learning from the safeguarding incident reviews.

- Family Intervention Support Service (FISS) have scoped a dad's offer to address the gaps and challenges in supporting fathers or male/parent carers
- Mandatory staff training for the FISS service to highlight the importance of including fathers or male/parent carers from the outset.
- Developing a 'dad's movement' to provide challenge and support for professionals raising awareness about the need to include dads from conception and beyond and creating father champions.
- Virtual support launched in January 2021 to gather the views of fathers, share knowledge and provide peer support to improve practice in actively engaging and involving fathers.

Safeguarding Adult Review (SAR) Notifications

The Practice Review Group considered five SAR Notifications during 2020-21. This resulted in three new SARs commencing with publication planned in 2022.

Gender

60% Male

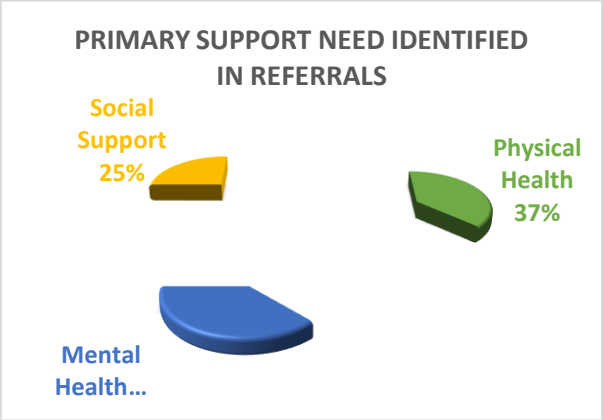
40% Female

Age

Average age of referral 61

The three most common types of abuse linked to the cases considered by the Practice Review Group were:

1. **Self-Neglect (3 out of 5)**
2. **Financial Abuse**
3. **Physical Abuse**



The types of abuse in Swindon mirrors national findings with the top five most prevalent forms of abuse being:

- Self-Neglect,
- Neglect or acts of omission,
- Physical abuse,
- organisational abuse; and
- Financial abuse

Nearly half of all SARs nationally relate to Self-Neglect. The learning locally highlights the ongoing need for professional development in relation to assessment of Mental Capacity which mirrors national learning from SARs. The National findings identified the care and support needs of individuals subject to SARs generally relate to Mental Capacity, Mental ill-Health, and Substance Misuse in particular alcohol misuse. These reviews highlighted:

- ✓ the need to know the person rather than just how their problems present;
- ✓ how the system responds to the person;
- ✓ over reliance on specialist services to manage all the presenting risks.

These themes reflect findings in Swindon but there were also additional themes identified locally include working with adults who self-neglect, informal/unpaid carers, appointeeship and the Money Management team and multi-disciplinary approach and collective responsibility to assessment and support.

SAR Reviews

There were two SAR reviews managed by the Practice Review Group during 2020-21. These reviews were conducted by an independent author Michael Preston-Shoot and published on the SSP Website in February 2021.

SAR Terry

Terry died in hospital in June 2019 aged 71 from liver cirrhosis accompanied by Hepatitis C. Terry experienced self-neglect, financial abuse, neglect by informal carers and alcohol misuse in the years leading up to his death.

Key Findings
• Lack of Professional curiosity • Making Safeguarding Personal – the need to improve consistency • Missed opportunities for mental capacity assessment, executive capacity, and impulse control relating to substance misuse. • Risk assessments were completed at different times and the risk of financial abuse or exploitation were never fully resolved • Need for improved Supervision and management oversight • No lead agency identifed reulted in concerns not being escalated • S42(2) enquiry; significant delay in progressing the second concern to the formal enquiry stage • Poor record-keeping of case notes • Role of informal carers – improved access to carers assessment • Clear plans and annual reviews of service users' financial affairs by Money Management Team

SAR Kieran

Kieran died at home in January 2019 following a period of illness. Kieran was diagnosed with mild learning disabilities around the age of 18 and first had contact with mental health services following his father's death 3 years later. He experienced self – neglect, hoarding, mental illness and exploitation in the years leading up to his death.

Key Findings

- Lack of Professional curiosity
- Making Safeguarding Personal – the need to improve consistency
- No care plan to address adult safeguarding concerns
- Risk assessments, and risk management and contingency plans, were not up-to-date and were not revised after key episodes
- Missed opportunities for mental capacity assessment, executive capacity
- Self-Neglect & Hoarding - policy needs updating
- Role of informal carers – improved access to carer's assessments
- Clear plans and annual reviews of service users' financial affairs by Money Management Team

Key pieces of work for the Partnership from the SAR's:

- Self-Neglect with updating SSP multi-agency policy update in 2021/22.
- New SSP multi-agency Self-Neglect training launch in 2021/22
- Improve understanding of Care Act legislation – Legal literacy training to be offered in new SSP L&D Offer.
- Professional Curiosity - Resource pack for sharing learning and improving practice launched in November 2020
- Money Management Team series of training completed including social work team, new referral form developed and desk-top review of all informal arrangements.
- Making Safeguarding Personal practice included in SSP L&D Offer.

Multi-agency Audits

The SSP planned seven multi-agency audits across Children and Adults services during 2020/21 with the audit themes relating to the learning arising from case reviews and other development areas identified by partners. COVID-19 and the uncertainty and pressure faced by partner agencies during the pandemic led to SSP Executive agreeing to pause multi-agency audit activity and to re-consider the partnership position during the year. In 2020/21, SSP conducted two multi-agency audits, one across Children's services and one across Adult services.

Adult Multi-agency Mental Capacity Act Audit

This audit was completed in July 2020 and focused on the application of the Mental Capacity Act Code by agencies when an adult who is the subject of a safeguarding enquiry lacks capacity for a specific decision. An audit tool was developed and nine partner agencies audited a case from their service and presented their findings to a virtual peer reflection workshop. The Peer Panel jointly review the case and identified strengths, examples of good practice and areas for improvement.

Purpose of the audit	Identified Learning
• Assess the extent to which staff in all relevant agencies apply the principles of the Mental Capacity Act when assessing mental capacity and making best interests decisions. • Establish the extent to which decision making is facilitated in a multi-agency context. • Identify and discuss situations where a referral may have to be raised despite a service user not consenting. • Identify strengths and areas where development and improvement may be needed	• SSP to support staff in developing knowledge with interface between Human Rights Act and Mental Capacity Act. • Training around the need to seek consent from individuals when completing Safeguarding referral • Clearer recorded evidence for reasoning behind decision-making relating to capacity assessments, including consideration to Human Rights Act. • SSP Self-Neglect policy needing update and promoting across Partnership • Lack of formal escalation

Work following the audit completed in 2020/21

• Learning Brief around Mental Capacity decisions including the importance of recording decisions and the reasoning behind them published on SSP website.

• Escalation process revised, formalised and shared across the partnership to empower staff with a clear process to formally challenge partner's decisions professionally.

Unborn baby protocol audit

The audit was completed in June 2020 and focussed on information sharing in relation to unborn babies, when concerns had been identified, and how this had made a difference. A sample of cases were randomly selected from Children's Services and the Maternity case management systems.

An audit tool was developed to review:

- how well needs were identified, assessed and addressed,
- how effectively partner agencies worked together/collaborated/shared information, staff supervision
- how parents were involved and how the voice of the child informed decision making
- Improved outcomes for the child

Cases were reviewed by single agencies against the audit standards. Results were shared with the audit group and each case was discussed to identify thematic learning.

Scope of the audit	Identifed Learning
• Information sharing between agencies, including (but not limited to) Children's Social Care/MASH, maternity and Primary Care during pregnancy; • Pre-birth assessment undertaken by Children's Social Care, Midwifery, Primary Care or another agency; • Referral and assessment for Early Help, including FNP and Baby Steps; • Referral and assessment for social care for concerns around an unborn child (Child in Need and Child Protection); • Resulting action; The outcome for the baby	• Increase staff awareness and application across the Partnership of the Unborn Baby Protocol • A key finding was the need for a single unborn baby protocol • Improved Information Sharing - ensure documentation is shared in accordance with policy timescales • Risk assessments - to consider whole family. • Improve use of SSP Escalation Policy • Voice of the Child - more focus in decision making • Fathers to be routinely considered during assessment in terms of their own needs

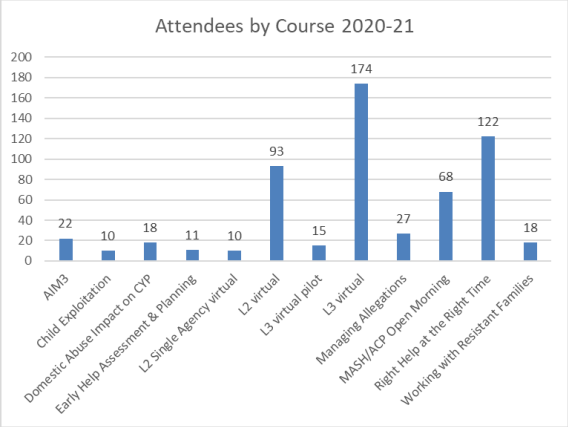
Work following the audit completed in 2020/21

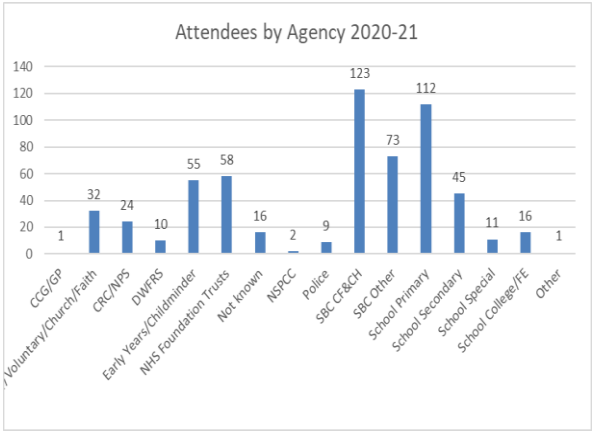
• Learning Brief around Mental Capacity providing information around the 5 principles and further links to Research In practice Guide and an Easy Read version

• Escalation process in relation to Children shared across the partnership and incorporated into SSP Multi-agency training programme module.

Training

Due to the COVID-19 pandemic the decision was made to suspend all SSP multi-agency training from April to August 2020. During this period SSP increased its online/e-learning offer from one course to over thirty. This learning is sourced from reputable providers and ensure business continuity in relation to ensuring professionals remained skilled and knowledgeable in safeguarding practices. Beyond August 2020, SSP replaced face to face training with a virtual classroom, however these were initially offered with reduced numbers of attendees which restricted the training offer.





A survey was sent to over 200 attendees following attendance at a multi-agency training course and 80% of respondents reported they agreed with the statement- *Participation in this training has supported me to make measureable improvement to my working practice*

Further work is required to understand the impact of training on frontline practice in the short, medium and long term and this is a priorty area being addressed by the Practice Development Group.

The partnership responded to the need to continue to share learning from reviews and audits despite lockdown. The SSP website was re-designed and information alongside 7 Mintue briefings and the SSP newsletter were accessible via the website. The following briefings were produced during 2020-21 enabling partner agencies to deliver training internally and give them the tools to do so.

7 Minute briefings published

Children's	Adults
Child Protection Conference Model	ARE Act – Independent Advocacy – S42 Enquiries
Early Help Hub	Coercive Control
Graded Care Profile 2	Harmful Gambling
Multi-Agency Child Protection Standards	Mental Capacity Audit
Private Fostering	Self-Neglect
Rapid Reviews	Swindon Advocacy Movement
Supporting Vulnerable Children & Families during COVID 19	Swindon and Wiltshire sexual assault referral centre (SARC)
Suspected Bruising in infants	

With my job role being so new to me, I still have little experience with professional curiosity and acting on it - this resource pack has given me much to think about and reflect on to take forward into my working practice.

Professional Curiosity Practice Brief – Professional working in primary education

Commented that learning resources on the website and how brilliant they were! She isn't from a safeguarding background and she found them so easy to understand and really informative

Feedback received from school governor

The SSP also developed a monthly newsletter to improve communication and share key local and national safeguarding learning and best practice to upskill colleagues and support their professional development. The newsletter reached a wide audience from all sectors across the partnership and the feedback has been positive.

Scrutiny Arrangements

The previous SSP Annual Report set out the challenges that impacted on the partnership's performance management and scrutiny arrangements during 2019/20. The SSP's Independent Chair/scrutineer provides a scrutiny function through the chairing of the Performance & Quality Assurance sub-group and provides quarterly update reports with key messages to both SSP Delivery Group and SSP Executive,.

The SSP Executive requested a cross agency Task and Finish group to review the independent scrutiny function and provide a steer for embedding robust scrutiny and constructive challenge going forward. The report was provided to the SSP Executive in March 2021 with recommendations for making the scrutiny arrangements more impactful for the partnership.

Reflections	Recommendations
•There is a potential conflict of interest in being the chair and the independent scrutineer •The three statutory partners have a strategic leadership role and should avoid over reliance on the independent scrutineer to chair key meetings •Exploration of future models for SSP's performance and scrutiny system will be informed by the Wood Report •Need to ensure future performance and scrutiny arrangements are resilient to change by developing the right mind-set, behaviours and skills across the partnership to deliver our safeguarding improvement journey •The partnership support unit continues improve processes and practices to support the safeguarding arrangements	•Independent scrutineer to continue to provide role for SSP with duties likely to change following Wood Review & scrutiny function matures •SSP Executive to be chaired by one of the three statutory partners •Executive Directors to not chair sub-groups to provide capacity to chair Partnership boards •Change of Delivery Group (sub-group) membership to improve focus on impact of practice. •Review Performance & Quality Assurance sub group membership to improve scrutiny & assurance function. •Memorandum of Understanding to be drawn up with potential conflict between independent chair and scrutineer role

SSP successfully bid for funding from Department of Education as part of the Multi-Agency Safeguarding: Implementing the Reforms in March 2021. The bid related to developing a robust multi- agency quality assurance and scrutiny framework which put children and families at the heart of evaluating our local safeguarding system and engaging them in assessing the impact of learning from serious incident reviews on practice and outcomes.

Our aim is to better utilise the skills and assets of individual young people as well as young people groups and forums to give them the opportunity to scrutinise, challenge and influence the safeguarding services they access. In addition, we aim to build on and be creative in the use of local and regional systems and leaders to provide external and peer

challenge. This work will happen through 2021-22 and will be reported in the next annual report.

Conclusion

During 2020-21, the Swindon Safeguarding Partnership has faced the challenge of further embedding the Safeguarding Arrangements following the national reforms in 2019 alongside managing the unprecedented pandemic with ever changing circumstances.

There is recognition the partnership need to strengthen the governance and accountability of the safeguarding partnership priorities and embed learning to improve practice and outcomes for children, young people and adults with care and support needs across the safeguarding system. Partnership will focus on progressing a system wide and life course approach to safeguarding with a focus on 'Think Family'.

Key areas for continuous improvement in the coming year relate to:

- embedding the neglect framework, improve the uptake of the Graded Care Profile2 tool, and strengthen multi-agency working & information sharing (e.g. non-attendance and engagement in education, missed appointments) when supporting children suffering from neglect
- promoting the use of Adult safeguarding plans with the voice of the adult with care and support needs clearly represented;
- child protection plans being of consistently good quality with clear outcomes and strongly representing the voice of children and families;
- enhancing practitioner knowledge through the development of better pathways, guidance, tools & training to improve practice and outcomes.
- Reviewing the implementation of the blended SSP multi-agency training and development offer ensuring that the learning is reflecting the local and national picture from learning
- Developing an evaluation framework for monitoring the impact of learning and development on safeguarding practices, service delivery and outcomes.
- Progressing the development of a Quality Assurance Framework for Swindon Safeguarding Partnership to provide assurance that partnership working is strong across the safeguarding system.
- Embedding the voice of children, young people, families' paid/unpaid carers and adults with care and support needs to scrutinise, challenge and inform the work of the Partnership maximising on the additional funding from the Dfe.
- Strengthening synergies with Youth Justice Board, Community Safety Partnership and other relevant boards to take a system wide view on improving the services provided to residents of Swindon whilst reducing duplication.
- Aligning priorities and pathways with the Integrated Care Alliance as CCG are disbanded