Swindon Safeguarding Partnership

Annual Report 2021-22

safeguardingpartnership.swindon.gov.uk

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Foreword

Thank you for taking the time to read Swindon Safeguarding Partnership Annual Report which covers the period 1st April 2021-31st March 2022.

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 strength of relationships between practitioners and leaders at all levels has continued to be been built upon, allowing multi-agency working to adapt through a dynamic response to the rapidly shifting requirements of Covid-19.

In this report, the statutory partners set out critical areas of development to continuously improve the effectiveness of the statutory partnership arrangements. This includes a robust multi-agency quality assurance framework to identify strengths and areas for improvement along with understanding and applying the learning from serious safeguarding incidents. This is supported by an audit programme which tests if learning is making a difference to practice, service delivery and most importantly outcomes for the residents of Swindon.

This report also sets out the achievements and the work that has progressed at a time of unprecedented pressures on services and looks towards 2022-23 as we recover from the pandemic and re-assess how we move forward. The partnership recognises the extraordinary commitment of the staff, volunteers and statutory and none statutory agencies across Swindon in ensuring that children, adults and their families are supported to live, safely within their communities. Thank you all for your hard work and continued commitment.

Swindon Safeguarding Partnership Executives

Gill May, Alison Barker, David Haley & Deborah Smith

Independent Scrutiny

As required by statutory guidance, I have reviewed the SSP Annual Report April 2021- March 22 which I received in March 2023. The report outlines the priorities agreed by the statutory safeguarding partners for the reporting period and describes some of the activity undertaken to improve the safeguarding support and services offered to children and adults with care and support needs. Much of the activity undertaken has focused on developing or updating guidance e.g. unborn baby protocol and self-neglect toolkit which whilst important, will not on their own deliver the required practice or system improvements including those identified through the review of serious child or adult safeguarding cases. To meet the requirements of statutory guidance, this report should also set out the actions taken to implement the learning from such cases. Capacity is identified as having impacted on the implementation of SSP's business plan and as above, a significant amount of activity to date has been process focused. The limitations of the performance management and quality assurance framework is also identified as impeding the ability of the statutory partners to evidence the impact of the partnership arrangements they have put in place on the safety of local citizens. Both issues were identified in last year's report thus indicating there are three critical issues for the statutory partners to provide assurance on:

- *The activity that is required to deliver improvements has been clearly defined for 2022-23, along with timeframes for completion and effective governance arrangements.*
- *There are named individuals responsible for leading the improvement activity and they can do so because their organisation creates the capacity for them to do so.*
- *The development and implementation of multi-agency performance management and quality assurance framework that provides a line of sight to the experiences of those in need/receipt of safeguarding services and how well those services keep individuals safe.*

During the reporting period, I have stood down as the Chairperson of the SSP Executive and Child and Adult Partnerships and operate exclusively in a scrutineer capacity. Partners have identified the need to refine the remit and responsibilities of this role as part of their revised performance and quality assurance framework and in the interim, I have remained the Chairperson of the Performance and Quality Assurance Group – children and the Performance and Quality Assurance Group- adults. These two groups have provided me with a line of sight to the effectiveness of the multi-agency safeguarding arrangements. I have regularly reported to the Executive group on the issues emerging from these two groups. Some of the strengths and/or promising practice that have been identified include:

- *SSP priorities reflect local challenges/need.*
- *The creation of an adult safeguarding learning and development offer for the multi-agency workforce.*
- *A social work in school's project.*
- *Feedback from an external auditor that the quality of safeguarding practice provided by adult social care services has improved because of an internal improvement plan.*
- *Planning for the implementation of Family Safeguarding Model.*

Strengthening Families Protecting Children programme

- *Engagement with adults with care and support needs to seek their views about the accessibility of adult safeguarding plans and creation of a template to be used to develop an adult friendly plan.*

The issues of concern or those that require further work reported to the Executive include:

- *Lack of SSP adult safeguarding procedures*
- *The quality/availability of data and intelligence presented to the performance and quality assurance subgroups*
- *Lack of assurance about the use and impact of adult safeguarding plans*
- *Time taken to complete statutory learning reviews i.e., Safeguarding Adult Reviews and Child Safeguarding Practice Reviews*
- *Assurance that health providers are contributing to strategy discussions, section 47 enquiries and child protection conference as required.*
- *Improving the quality of Public Protection Notices (PPNs) submitted by Police to MASH and addressing information sharing in respect of children living with domestic abuse with schools via Operation Encompass*
- *Understanding the reasons for an increase in the rate of child in need cases*

In addition, partners advised in last year's annual report that they had completed a self-assessment against the findings of the first national child safeguarding practice review which was a thematic review of criminal exploitation. At the same time, they advised that a plan of activity had been agreed in relation to tackling all age exploitation; an overview of the self-assessment findings and the planned activity is not included in this report, nor any information as to how the learning from the multi-agency audit conducted in year would be used, however exploitation is an agreed SSP priority.

I consider that the 3 critical issues that I have set out above will assist the three statutory partners to put in place work programmes that reflect their system leadership responsibilities. Coupled with the opportunity to work on a wider footprint to support best use of resources, and the implementation of plans to further develop the culture of partnership, the statutory partners should be more able to describe the work and evidence the impact of the Swindon safeguarding partnership arrangements.

Liz Murphy, Independent Scrutineer
7th March 2023.

Introduction

This is the third 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 Integrated Care Board (ICB), Wiltshire Police, 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.

This annual report covers the time period from April 2021 to March 2022. Our 2021/22 Swindon Safeguarding Partnership Annual report outlines areas for improvement across both the children's and adult's safeguarding system. Alongside addressing the impact of the pandemic, the partnership continues to be affected by capacity issues both for individual agencies as well as the safeguarding partnership business support unit. This has presented challenges for the delivery of Swindon's safeguarding improvement journey and development programme

Partners have worked flexibly and 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 was planned to embed the partnership behaviours outlined in Swindon's Safeguarding Partnership arrangements but this was deferred due to competing priorities presented by the impact of the pandemic on Swindon's safeguarding system.

During this reporting year there have been a number of national developments to which the Swindon Safeguarding Partnership has needed to respond. There have also been key developments at a local level.

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 term impact on services and the recovery from the COVID-19 pandemic.

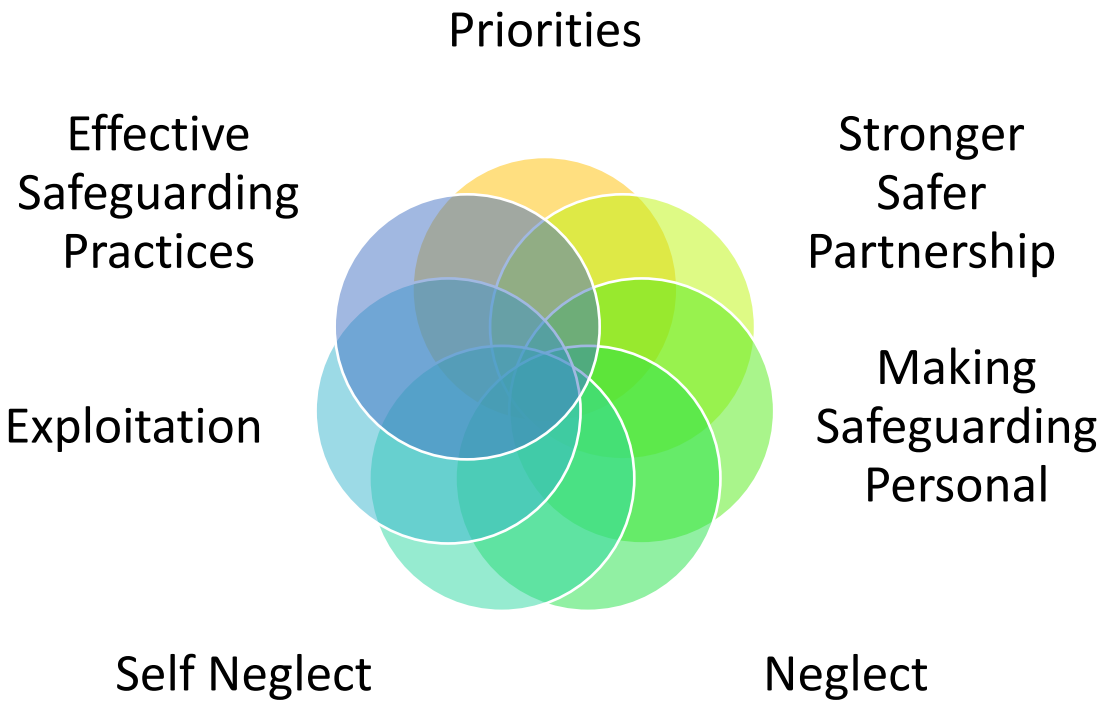
Partnership Priorities

The Safeguarding Partnership has identified and agreed a set of shared priorities detailed below Fig 1. These objectives cover complex areas of safeguarding which require a deeper collective understanding to inform a targeted and coordinated partnership response to achieve real impact on the lives of children and young people along with adults with care and support needs including their paid/unpaid carers living in Swindon.

These objectives have been identified from themes arising from the Partnership's existing scrutiny and quality assurance programmes, as well as findings from local and national learning reviews. The strategic objectives will remain the same for the three year period of the plan but the activities that sit underneath them will be reviewed and refreshed annually during.

The structure of the business plan allows the partnership to focus on key strategic areas of partnership activity but also remain flexible to respond to emerging needs and refine existing programmes of activity in line with feedback received from children young people adults with care and support needs including their paid/unpaid carers.

Fig 1



The sections below highlight examples of the work which has been completed. There will be a stronger focus on evidence, impact and outcomes for the partnership in the 23/24 report.

Activities to support the priorities:

Stronger & Safer Partnership

- Implementation of the SAFEGUARDING PARTNERSHIP Yearly Business plan and associated work. The partnership identified 6 new priorities and developed a business plan to support these.
- The Safeguarding Partnership Business Plan contains long-term strategic objectives spanning the period 2021-2024, and several shorter-term activities, typically covering a reporting year. These have been identified from the Partnership's existing scrutiny and learning review programmes and support the SAFEGUARDING PARTNERSHIP's statutory functions. The structure of the business plan allows the Partnership to focus on key strategic areas of activity but also remain flexible to respond to emerging needs, changes in national priorities etc.
- The Swindon Safeguarding Partners were successful in a bid to the DFE; this has enabled the employment of an apprentice Partnership Scrutiny & Challenge who will recruit, train and develop Young Champions to become confident and active members of the scrutiny function of the partnership. These young champions will look to provide challenge towards the local safeguarding system from the perspective of young people. Examining services, policies, practice and engagement to identify where changes can be made for the benefit of young people. They will also scrutinise the impact of learning from serious incident reviews and multi-agency audits on frontline practice and outcomes. There will also be an opportunity for the young champions to complete 'Walk the Floor' assurance visits and thematic assurance events to talk to practitioners and meet with children and families and provide agencies with the opportunity to showcase good practice, indicate how they listen to children and families as well as talk about further developments.

Making Safeguarding Personal

- The Safeguarding Partnership developed L&D Offer which will deliver multi-agency training highlights what 'good safeguarding practice' means, increased understanding and knowledge of the Care Act.
- The Safeguarding Partnership now provides multi-agency modular adult safeguarding training including mental capacity and best interest decisions
- The Safeguarding Partnership conducted a Care Act self-assessment audit of all relevant Partners. The audit required organisations to measure themselves against 10 standards in relation to their safeguarding responsibilities under the Care Act, depending on who they provide services to. Organisations were able to demonstrate what was applicable to their organisation, they had many key measures in place and areas of good practice. Within each of the 10 standards, at least one organisation identified an action for implementation or development of a sub-standard. The standards which resulted in the largest number of actions identified by agencies were leadership, Multi Agency working and information sharing and learning from audits and case reviews. However, it was generally the same 4 organisations who were identifying the majority of actions they would progress throughout the audit. The overarching themes from the audit provide assurance that organisations are meeting their responsibilities and where there is either nothing in place or what is in place could be of a higher standard, actions have been identified to improve this. The learning from case reviews and audits standard was included in the audit based on the learning from recent case reviews to ascertain what organisations have put in place. There will be further work done on the analysis of the findings, which will then inform the quality assurance work of the Safeguarding Partnership and potential walk

the floor activities. As part of the audit, organisations were asked to include examples of the evidence they would provide during a walk the floor assurance visit to demonstrate how they meet each standard.

- The learning plan incorporated learning from Safeguarding Adult Reviews in Swindon SAR Terry & SAR Kieran with key areas for learning identified, Multi-agency working, Mental Capacity Act and Mental capacity, Risk assessing and risk management, self-neglect, hoarding and adult exploitation. Following on from the two SAR's the Safeguarding Partnership published last year the partnership took the recommendations from the author and developed further its learning offer around Self-neglect and Mental Capacity Act. All learning from recent SAR's/audit's is applied in the development of the policy/training/resources

- Commissioned Swindon Advocacy Movement (SAM) to gather feedback via telephone interviews from people who have experienced the safeguarding process. SAM's report was fed back to Partners via Performance & Quality Assurance Group. SAM asked ten questions to five service users with care and support needs around their experiences of going through a safeguarding enquiry. The service users where able to feedback on their experiences, and this was shared with Adult Services who will use the feedback to help inform how they develop their approaches to safeguarding enquiries.

Neglect

- Reviewed SSP training offer on neglect – Considered gaps and other opportunities to promote best practice in multi-agency working to understand and respond to neglect.
- Graded Care Profile tool has been promoted across the partnership, training is offered to all staff to embed the use of the tool in practice. Graded Care Profile 2 (GCP2) helps professionals measure the quality of care provided by a parent or carer in meeting their child's needs, particularly where there are concerns about neglect. Using the GCP2 assessment tool, professionals score aspects of family life. This assessment helps identify areas where the level of care children receive could be significantly improved and support to improve decision making at all levels.
- SSP virtual learning event round child neglect, to provide a refresh for partners. To raise the profile of neglect, promote resources and guidance to support the identification and assessment of neglect.

Self-Neglect

- Revision of the SSP Self-Neglect policy & guidance including launching of the policy and guidance
- Self-Neglect specific training to be add to the SPP training offer. Safeguarding and self-neglect/hoarding (core module) and Safeguarding and self-neglect (specialist module)
- SSP virtual learning event around self-neglect, to provide a refresh for partners. To raise the profile of self-neglect, promote resources and guidance to support the identification and assessment of self-neglect.
- Mental Capacity Act training to be developed and offered to all professionals and their managers who work directly with adults with care and support needs to assist in understanding consent, capacity and information sharing.

Effective Safeguarding Practices

- Swindon Safeguarding Partnership (SSP) recognises that no one agency or professional can effectively keep a child safe and that children are best protected when professionals are clear about what is required of them individually and how they need to work together. It can be a challenging and complex area of work which requires a shared commitment, effective communication and, above all, a focus on achieving the best outcomes for the child. To further support all agencies across the partnership the SSP developed with partners its Child In Need CIN standards policy and promoted and published this via its newsletter and partnership meetings.
- SSP L&D – Professional Curiosity training This resource was developed following a thematic area of learning locally and in response the partnership has developed a detailed free resource that can be used by all agencies across the partnership, although the SSP recognises that this is an area that needs constant promotion and culturally needs to be embedded by partners across the SSP.
- SSP to launch new Children & Adult's L&D offer – to include all local learning from reviews/audit's – Further details of the training offer later in the report.
- Unborn/New born baby policy developed, implemented and shared across the Partnership including seven minute briefing developed, shared and added to website and relevant training in new L&D offer.

The Safeguarding Partnership Executive recognises there are some areas in the business plan that have not been progressed. The development of a robust multi-agency framework to capture and apply learning to practice, process and policies requires further work and development. This will be a priority for 23/24. The Safeguarding Partnership commissioned a deep dive in this area and a paper was received that reviewed the function of the partnerships and made recommendations in the following areas:

- scrutiny and assurance function
- lack of an annual scrutiny programme,
- more focussed and evidence led approach
- developing collective responsibility across all partners for quality and performance

- Improving the line of sight to front line practice with the better use of data.

As a response to the above the following is being progressed:

1. Walk the Floor assurance visits
2. Further development of a truly multi-agency dataset informed by partners with collective narrative to be able to provide assurance,
3. How challenge and line of sight on front line practice will evidence impact of the partnerships work on improving outcomes for residents locally.

Additionally, the partnership recognises that last year's annual report set out the ambition of promoting the use of Adult safeguarding plans with the voice of the adult with care and support needs clearly represented. The partnership recognises that this key piece of work has over the year faced drift and delay and has not been implemented with partners hampered by the delay in publication of key adult's policy document to support the agreed understanding locally of Adult Safeguarding action plans but does still remain a key piece of work the partnership will continue to progress.

The Partnership Executives have committed to ensuring the proposals from this review will be considered by the partnership during 2022/23 and will be used to inform the work of the partnership moving forward in next reporting year.

Activities & Learning

The Practice Review Group (PRG) has had oversight of and manages Swindon's Rapid Reviews, Child Safeguarding Practice Reviews (CSPR) and Safeguarding Adult Reviews (SAR) as well as non-statutory reviews for additional learning. The group is responsible for ensuring that local CSPR's and SAR's are completed to a high standard and within agreed timescales. Learning from these reviews is shared in a timely way with clear actions to ensure improvements are made in practice and in policy development. The revised quality assurance process will provide the assurance that changes in practice are being embedded. The group ensures learning from national children or adult reviews of significant importance are addressed by SSP.

Progress, Achievements and Evidence of Impact:

Rapid Review & CSPR's

Previous local learning from Rapid Reviews identified a need for more joint accountability in decision making when a notification of a serious incident is made to National Panel. The revised process now coordinates a meeting of the three statutory partner representatives within 5 days to review the information and jointly decide if the threshold for notification to the National Panel has been met. This has improved accountability across the partnership regarding notifications with the local authority still maintaining the legal responsibility for the notification.

The statutory partners reviewed four referrals during 2021-22. Two referrals were deemed as not meeting the criteria for notification with no new learning for the partnership. Two referrals met the criteria and progressed to LCSPR's and are ongoing. Early learning arising from these rapid reviews have already been disseminated so that improvements can be made without delay. The learning involved developing a Local Child Safeguarding Practice Review guidance to improve the governance of the process locally in Swindon. The revised document is now available on the Partnerships website for all agencies to access.

National Learning from the Child Safeguarding Practice Review Panel

In March 2020 the Child Safeguarding Practice Revie Panel (CSPRP) published its first national review; it was hard to escape: Safeguarding Children at risk from criminal exploitation. The review set out a number of key challenges and questions for local partnerships and in response the Swindon & Wiltshire Partnership Executives met on two occasions to work jointly across the two partnerships recognising that there are many partners that work across both areas, this required a joint response. A joint self-assessment against the questions set out by the panel was commissioned across the two areas and identified areas of strength and areas for development.

The partnerships agreed that this work would be delivered through a new Pan Wiltshire Exploitation group using this assessment to inform the groups work plan, which met for the first time in November 2020. This is an all-age group however within its first year there has been a focus on 0-25, particularly in relation to transitions from children to adult services.

This Pan Swindon & Wiltshire approach has tested effectiveness locally of cross border strategic working between the two partnerships and the Safeguarding Partnership

recognises that there have been challenges with the group with getting the right people around the table and on delivery of an all-age exploitation strategy.

In July 2020 the CSPRP published its second national review; Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm. This review set out recommendations and findings for government and local safeguarding partners to better protect infants from sudden unexpected death in infancy (SUDI). The aim to identify what might have been done differently and how to improve approaches to embed safer sleeping advice in families with children considered to be at risk of significant harm through child abuse or neglect.

Following the report, the Safeguarding Partnership requested an audit of local practice against the recommendations of the national report. In addition to this, Swindon SUDI cases notified to the Child Death Overview Panel (CDOP) during the reporting period 2016-2021 were also to be analysed to understand if there is additional learning to be shared from these sad deaths. The findings will be reported back to Swindon Children's Safeguarding Partnership board in 2022-23 and CDOP including Swindon's position in relation to the recommendations of the report, with recommendations for practice given.

In September 2021 the CSPRP published their third national review; The Myth of Invisible Men" - Safeguarding children under 1 from non-accidental injury caused by male carers. This review sets out recommendations and findings for national government and local safeguarding partners to better protect children under 1 year old from non-accidental injury. A qualitative study of 23 cases from 19 local areas regarding children who died or experienced serious harm, and their father or male carer was the known or suspected perpetrator.

Local response

Local case reviews across Bath & North East Somerset, Swindon and Wiltshire (BSW) have also identified this risk to under ones. In Swindon a CSPR that thematically reviewed 3 rapid reviews relating to serious injuries to infants under one year old, was published in early 2022 and Wiltshire published a Thematic Review into Significant Physical Injuries in Under 1s 2019 following four cases of injuries to under ones. These reviews have identified learning that can support improved safeguarding of under ones.

Following the national and local learning the Executives of the three partnerships agreed to set up an Under Ones Steering group as it was recognised that the under one's thematic area is a shared key priority and to jointly respond to the learning from these reviews. Working across the BSW Integrated Care Board (ICB) area will enable the alignment of practice, sharing of learning and best practice and will enable the group to be most effective in delivering improvements. This was initiated early in 2022 and will be reported in 2022-23 annual report.

Purpose	Initial tasks for the group will include:	Output
• To coordinate activity and system improvements in safeguarding unborn babies and under 1s across BSW • To understand existing related work streams and how their work can support this agenda • To coordinate and have oversight of response to relevant local and national learning from case reviews on behalf of the partnership • To establish some shared areas of focus, for example: • Injuries to non-mobile children guidance • Practice development/CPD	• Mapping of existing activity relating to safeguarding under 1s across the 3 partnership areas, identification of gaps and prioritisation of work to take place • Review of existing multi-agency guidance relating to injuries to non-mobile children across BSW to explore potential to develop shared guidance • Review of response to national CSPR Panel reports and recommendations for further work • Sharing and mapping of learning from case reviews on unborn babies and under 1s to identify practice themes and to inform priorities	• Modification of service provision • Changes to local practice • Strengthen induction and training packages • Update website information on under 1s • Focus moving from 'bruising' to 'vulnerability'; more consideration given to 'likelihood of suffering significant harm'

Safeguarding Adult Review (SAR) Notifications

The Practice Review Group considered four SAR Notifications during 2021-22; two did not meet the criteria set out in the Care Act and two notifications were agreed to be mandatory SARs. The two mandatory SARs, which are due for publication in 2022 have taken longer to complete than the recommended six months as set out in the LGA document 'Analysis of Safeguarding Adult Reviews'. This was due to a delay in commissioning the SAR's author and this has been identified as a development need for the partnership going forward.

Nearly half of all SARs nationally relate to self-neglect. Local learning 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.

These themes continue to reflect the findings in Swindon highlighting:

- 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.

SAR Reviews

The partnership published two SAR reviews managed by the Practice Review Group during 2021-22 one mandatory SAR and one discretionary SAR. These reviews have been published and are available on the SAFEGUARDING PARTNERSHIP website and are also available in the National SAR library.

SAR Alison

Alison was a 49-year-old woman who was found collapsed in a stream in woodland near her home in July 2020. It was determined that she had taken her own life. Alison reported a history of trauma as well as chronic mental health problems and a pattern of alcohol misuse. She had been engaged with the local Mental Health Services for at least 25 years. She also had poor physical health with chronic liver disease and asthma.

Key Findings

- Management of complex clients with personality disorders by both Adult Safeguarding & Mental Health Services - identifying a lack of services for this client group
- Need for a Care Programme approach - consistent, coordinated and multi-agency approach
- Clearer understanding between primary and secondary care mental health support
- Risk assessments failure to recognise level of risk in health setting - recognised in trusts Patient Safety Report
- Improved recognition on cognitive functioning and client mood being impacted by Hepatitis C during assessments of client
- Practitioners ensuring they use of the two stage test in Mental Capacity when completing assessments.
- Impact COVID-19 had on the ability of services to support Alison.
- The review also highlighted a need for follow up piece of work to address the specific issues highlighted in the report regarding exploitation.

SAR Andrew

Andrew was a 77-year-old male who in Sept 2020 was found unresponsive inside a property besides his adult son who was found deceased at the scene. Andrew subsequently passed away in hospital. Both deaths were ruled as suicide by the coroner. Andrew was open to Safeguarding Adults team within Swindon Borough Council with a Section 42 enquiry on-going at the time of his death. Andrew lived alone and had a number of health conditions. There is evidence began to show signs of self-neglecting behaviours including a deterioration in his living environment, the cancellation of a care package from domiciliary care agency and poor self-care. It was also recognised that there were similarities with this review and a previous SAR Honor published by Swindon LSAB in 2017.

Key Findings

- Lack of recognition of complexities of and plan to safeguarding against intergenerational domestic abuse
- Focus on social care needs as outcome for safeguarding activity at the expense of investigating abuse
- Professional curiosity and working with unwise decision making
- Effective Quality Assurance in safeguarding across agencies in Swindon
- Coercion and control and the impact on someone's mental capacity and ability to make effective decisions
- Better use by agencies of trauma informed practice when working with adults with care and support needs

Progress, Achievements and Evidence of Impact

The Partnership has developed Challenge Learning Events and will be conducting these challenge events on both SAR's with the intention to ascertain whether learning from these reviews has successfully been disseminated, acted upon and embedded across the multi-agency partnership. Reviewing each case highlights any good practice and additional areas for improvement.

It is critical for the partnership to understand the difference learning makes in the delivery of safeguarding across the partnership, how does this lead to better outcomes for vulnerable people, along with supporting the ongoing professional and practice development of staff.

The Challenge Learning Events will be conducted with practitioners, managers and those involved with the review; it will involve a panel of the senior managers, our young scrutineers and questions posed by the family, this will enable robust evaluation of the progress of the learning and how this has been embedded.

The Safeguarding Partnership Annual Report for 2020-21 identified several key pieces of work for the Partnership to focus on for 2021-22 following the two SAR's. This included updating Safeguarding Partnership Swindon Multi-agency Policy and Guidance on Responding to Self-Neglect.

This was completed and launched in Swindon in September 2021 across the Partnership including via a half-day virtual conference that was attended by over 350 people from all across the partnership from front line practitioners to senior managers. The policy was also supported with a seven minute briefing that has been shared at the conference via the partnerships newsletter and embedded into the partnerships new multi-agency training course.

It was identified in 2020-21 and as part of the two SAR's that there was a lack of training for self-neglect, this gap was addressed through the launch of 'Working with Self-Neglect' in 2021-22. The partnership now offers training on improving the understanding of Care Act legislation. Legal literacy training is now included in new Safeguarding Partnership learning and development offer, alongside 'Making Safeguarding Personal in Practice' and 'Learning from Safeguarding Adults' with further details of these in the training section of the annual report.

One of the central themes from SAR Terry and SAR Kieran was self-neglect and hoarding. The Safeguarding Partnership reviewed and improved the guidance on working with self-neglect and hoarding, producing two practice guides to support practitioners to recognise and respond to adults. Swindon 'Multi-agency Policy and Guidance on Responding to Self-Neglect', provides information to support an understanding of self-neglect, the pathways of support and information and resources for working with people experiencing self-neglect. The 'Hoarding Protocol' provides practitioners with specific information and resources on hoarding including a clutter index. Self-neglect was included as theme in the Safeguarding Partnership learning event, which delegates fed back as finding valuable for their practice. A workforce survey was undertaken to establish a broad baseline of challenges and barriers to understanding and working with self-neglect with the aim of supporting practitioners to improve their practice.

The Section 11 and Care Act Self-assessment multi-agency audit included some aspects of process and practice identified in the SAR recommendations. Agencies reported that they had improved on the collection of demographic data, the robustness of supervision and having a number of policies relating to self-neglect.

In the next financial year, a SAR learning reflection event for agencies will provide opportunities for them to demonstrate how systems and practices have changed in light of the learning from those reviews.

Performance & Quality Assurance

Through performance and Quality assurance SAFEGUARDING PARTNERSHIP group (PQA) the following has been achieved:

- Review of practice and service delivery in SBC Adult Safeguarding Team and performance indicators including timeliness and 'Making Safeguarding Personal', which indicated positive progress and the impact of the Adult Social Care improvement plan.
- Advocacy data, which promoted Adult Social Care engagement with Swindon Advocacy Movement (SAM) and raised awareness of when advocates are required when receiving services (there is evidence of more person centred and relationship-based practice – Case study example provided)
- Completed combined Section 11 & Care Act Self-Assessment. Walk the Floor Assurance Visits, using the information provided in the Self-Assessment are planned for 2022-23.
- Received report of Section 175/157 audit – provided good assurance about safeguarding support and challenge to education settings e.g. settings with high number of restraints
- Conducted two multi-agency audits. Adult multi-agency audit – 'Section 42 (2) enquiries and safeguarding plans' and 'Multi-agency audit of Criminal Exploitation Practice' using OFSTEDs Joint Targeted Area Inspection (JTAI) Criteria.
- Case study to children's PQA in September 2021 evidenced relationship-based practice with a child who was being exploited.

Key Issues/Learning
• Need improved line of sight and assurance about quality and impact of front line practice. What are the impact and outcomes of the partnership priorities areas focussed work? • Partnership needs to develop and improve it's engagement with regards to performance & quality assurance from front line staff • No walk the floor programme was delivered in 2021-22. Partners to ensure these are planned and carried out for the 2022-23 • Partners acknowledge there has been a delay in developing revised scrutiny and assurance model as outlined in the successful bid to the Dfe – To ensure the successful delivery in 2022/23 • The partnership continues to need to further develop the multi-agency dataset including improving the narrative and ensuring relative benchmarking to bring about further improvements to line of sight and assurance around impact. • To move away from a process focused approach of delivering audits to focus more acting on learning from audits and implementing the changes • Develop capacity/skills to conduct proportionate/focused multi-agency audits

Case Study – from Swindon Advocacy Movement (SAM)

SAM had sought views form Adults going through Safeguarding Enquiries with advocacy support.

SAM has found this a good way of working with the Adult Safeguarding Team to improve practice, which has also developed the relationship between SAM and the Adult Safeguarding Teams, which is leading to more making safeguarding personnel focussed practice.

The report provided evidence showing how practice is developing based on service user voice/perspective.

S was given every opportunity to join the meeting all during the process and the offer was that the advocate would visit S and join together. S always considered this option but usually declined which in itself is an empowered position "if people say something I don't like then I'll have a go at them so I feel it's better if I stay away." This case moved to an IMCA COA as a safeguarding outcome and once again. An initiation was extended to S to attend. She felt she did not want to but said "mind you I might change my mind" The decision was causing S to become anxious so a plan was made between the advocate and the manager of the Care Home to enable S to attend there and then when the meeting was actually happening if she felt like it there and then rather than having to decide. The SG EM & Social Worker (decision maker) were very happy to accommodation this flexible approach. S views had already been represented via an advocacy perspective, to see a BEST Interest decision being announced directly to the individual to whom the decision related to at the actual BI meeting & directly from the decision maker. The fact that she was allowed to just 'drop in' facilitated her attendance this would not have been possible in a face to face meeting/in person meeting. S said, in reply to the decision, "O' well that's good news then"

A good practice example that was shared with the Performance & Quality Assurance Group from the Social Workers in School Teams about a 13-year-old male who lives with mum, dad and his sister. This evidenced some exemplary practice across various team including the Edge of Care worker, Social Worker & Youth Justice Worker.

What are we improving?	What has been delivered?	What is the evidence?	The Impact
• Young person became open to SWIS due to escalating concerns in respect of poor behaviour; an acute risk of family breakdown and emerging worries indicative of risks linked to child criminal exploitation. • Key risks identified: • Missing episodes • Cannabis / alcohol use • Associating with a gang • School exclusions due to violence • Criminalisation • Refusal to engage with professionals at any level.	• Relationship based practice. A key focus of work was targeted at improving family relationships to enable the parents to appropriately manage the presenting behaviours. • Direct work with the young person was used to build a positive working relationship with the young person to understand his wishes and feelings and meaningfully assess his safety and wellbeing. • Intensive family support intervention was input from the Edge of care service. • Direct work regarding missing, child exploitation and substance misuse by EOC worker, YOT worker and SW. • Referral to multi-agency risk panel for quality assurance of CE risk management. • S20 accommodation at point of family breakdown. CLA Assessment and Planning. • Liaison with education to ensure appropriate package and access to EHCP. • Risk management plan. • Restorative and family conferences offered. • Reunification planning. • Multi-agency Child in Need Plan developed on return home.	• The Young person became temporarily looked after for a 2-month period followed by Child in Need planning. • Improving family relationships through use of restorative conference. • EHCP application made and mentoring with IPROVEIT • 6-month referral order managed by YOT. • Intensive family support via EoC included behaviour contract and graded care profile assessment. • Advice sought via Multi-Agency Risk Panel. • Risk management plan input.	• Young person was successfully returned to parents care with intensive support. • Relationships with professionals has significantly improved. Y/P has engaged in conversations about his experiences and views. • There have been no missing episodes since November 2020. • There has been no police involvement since February 2021. • Reduced incidents of violent behaviour within the home. • Recent successful family holiday demonstrating improved family relationships. • Risk of CE reduced, young person no longer heard at MARP Panel. • Young person has access to an EHCP and is engaged in education. • Young Person now engaged in positive activities – Boxing/the gym.

Multi-agency Audit

As in the previous year the impact of the pandemic and the pressure faced by partner agencies due uncertainty and ever changing demand impacted the Partnerships ability to conduct a fuller multi-agency audit programme. The Partnership conducted three multi-agency audits in the following areas:

1. Adult Multi-Agency Audit - Section 42 (2) Enquiries and Safeguarding plans
2. Multiagency Audit of CE Practice using JTAI Criteria
3. Joint Section 11 & Care Act Self-Assessment Audit

This was the first year the partnership conducted a combined Section 11 & Care Act Self-Assessment using a locally developed self-assessment tool across the partnership and also working jointly with our neighbour Wiltshire Safeguarding Vulnerable People Partnership to reduce impact of duplication for partner agencies who cross our borders and improve partnership working.

Adult Multi-Agency Audit Section 42 (2) Enquiries and Safeguarding plans

This audit was conducted during quarter one of 2021 and reported to the Performance & Quality Assurance group.

The scope for the audit was to understand why there were a lower number of adult safeguarding plans in comparison to the same period in the previous financial year and to review the three stages of the safeguarding adults process to consider the planning that takes place at each stage to manage risk and keep adults safe.

Purpose of the audit

- Consider the range of processes that are in place to protect adults at risk.
- Determine with a sample of cases if adults who need an adult safeguarding plan have one in place.
- Determine the actions that should be taken to ensure that safeguarding plans are in place when they are needed.
- In cases where there is no safeguarding plan, determine if one was needed and the reasons behind the decision to not put a safeguarding plan in place.
- Consider if the person's view impacted the outcome and processes undertaken.
- Understand how risks were managed in a multi-agency way.
- Identify strengths and areas where development and improvement may be needed.
- Give consideration to the findings of the recent SARs relating to Section 42 referrals, decision-making and enquiries.

Identified Areas of Strengths	Identified Areas of Learning
• Identified good use of advocacy in some cases • Making Safeguarding Personal principles were considered and adults were asked about their opinions & outcomes • Collaboration with Safeguarding Adult Investigation Team with a police presence in the screening hub is working effectively. • Information is sought from mental health colleagues where mental health is raised in the referral. This is something which has been improved since the 2019/2020 cases • Practitioners in the safeguarding team are being encouraged to have initial discussions with advocacy. • There were good examples of effective multi-agency working and information sharing	• Collaboration with partner agencies needs to take place to develop the process around contacting agencies early on in the safeguarding process • Improvement is needed to ensure that the relevant agencies that are required to be, are involved and aware of the outcomes, ongoing requirements and are in agreement of the next steps within protection plans and safeguarding plans. • Highlighted issues surrounding Safeguarding plans including which other agencies hold the Safeguarding plan, identify who is responsible for the plan and continuous monitoring • Escalation process if an adult is discharged from mental health services to ensure appropriate support in place

Work following the audit completed in 2021/22

• Two workshops were held with key partners around agencies responsibilities for the information provided and required for a safeguarding referral to improve referrals received into the Safeguarding Team. Following these workshops a multi-agency Practice Learning Briefing – Safeguarding is for Everyone – Know your role was produced and shared across the partnership via communication channels and the partnerships virtual conference and is available on the SAFEGUARDING PARTNERSHIP website.

• Following this audit ICB Safeguarding Leads joined the Adult Safeguarding Hub who now reach out to heath organisations to gather information, this has improved previous delays in gathering feedback on gaps in referrals. This has led to improved timeliness is gathering information at referral stage.

• Promotion of the multi-agency Escalation process shared across the partnership to empower staff with a clear process to formally challenge partner's decisions professionally.

• Swindon Advocacy Movement produced an information presentation on what advocacy is and the service they offer and how they can support in Section 42 enquiries, which was promoted across the partnership.

Multi-agency Audit of CE Practice using JTAI Criteria

A multi-agency group was set up to complete audits using the JTAI Criminal Exploitation criteria. The group had representatives from health, children's social care, police, education, YJS and probation.

Four audits were completed by agencies that had been involved with children that met the JTAI criteria. Multi-agency audit reflective discussions were held for agencies to share their findings and to collect data from their perspective using a grid mapping what has worked well, what had worked less well, what were the strengths in practice and what could we improve. Follow up meetings were organised to discuss findings, look at the impact on children and formulate actions for improvement.

Scope of the audit
• JTAI Criminal Exploitation criteria • Responding to all forms of child criminal exploitation at the point of identification • Assessment, planning and decision-making in response to notifications and referrals of children at risk of criminal exploitation, or who have been criminally exploited • Protecting, supporting and caring for children who are at risk or have been harmed by criminal exploitation, including the support and care of children looked after and/or care leavers • Preventing child criminal exploitation, including through awareness-raising and use of disruption activity (Disruption involves strategies and tactics designed by the police and other safeguarding partners to reduce risks to vulnerable children and interrupt the activity of those who are seeking to exploit them) • Identifying children at risk of sexual exploitation and the multi-agency response

Identified Areas of Learning
• Communication & Joined up working - Language improvement of caring language in reports • Enhance skills of staff working with parents who are uncooperative • Using all reachable moments • Children's and Adult's services to work better together to ensure best outcomes. To identify key trusted adult and professionals to support that adult (Team around the Adult and Child). • Better measurements to know we have been successful in our work with children at risk of or involved in Child Exploitation. A programme of annual multi–agency auditing focussing on four children with a six month closing the loop review. Clarity is needed regarding when we do or do not need consent. • School exclusions. The process for part time timetables and exclusions must include contextual safeguarding risk assessments and safety plans

Joint Section 11 & Care Act Self-Assessment Audit

The Swindon Safeguarding Partnership for the first time completed a joint Section 11 & Care Act Self-Assessment Audit with a self-assessment tool developed locally for statutory, non-statutory and third sector providers able to jointly assessment themselves against the Childrens Act 2004 and the Care Act 2014, where applicable.

Scope of the audit

- The audit was completed jointly with the Wiltshire Supporting Vulnerable People Partnership to incorporate organisations which span across Swindon and Wiltshire localities.
- For agencies to assess themselves against each standard as to what they have in place.
- Identify any areas where they need to introduce or improve measures
- Provide oversight of the quality of measures in place relating to Section 11 and Care Act responsibilities

Identified Areas of Development for Organisational Practice
• The standards which resulted in the largest number of actions identified by agencies were leadership, Multi Agency working and information sharing and learning from audits and case reviews. • During the panel meeting discussion SAM outlined how some actions that were previously red or amber have been progressed including referrals to SWA as part of induction training added, reviewing policies, safer recruitment training and appraisals to include safeguarding. • Trading Standards highlighted that it was the first time being included in the audit. Trading Standards is probably the regulatory service that deals with safeguarding the most. On reflection, more areas of the audit would be relevant e.g. training & induction, how to make referral to MASH, DBS checks, and these areas will be reviewed again

Identified Areas of Strengths of Organisational Practice
• **Leadership** • The majority of organisations have a Safeguarding Lead (this person would take overall responsibility for Safeguarding within the organisation and where organisations are large, with multiple departments or locations, each department or location or individual is clear as to who their responsible safeguarding lead is. • **Policy** • The majority of organisations have a Safeguarding Policy which has been reviewed within the three years and includes adults with care and support needs and children. • **Multi Agency working and information sharing** • 83% of organisations reported being aware of the SSP Adults Safeguarding Escalation policy. • **Governance** • All organisations reported that they have a quarterly internal "learning events review" meeting where significant or critical incidents within the organisation related to safeguarding can be reviewed. The organisation can evidence that actions following on from safeguarding learning events have been completed. • All organisations also reported being able to provide evidence that actions following on from safeguarding learning events have been completed. • **Safer Recruitment** • All organisations have recruitment processes that demonstrate the determination of the organisation to safeguard the adults with care and support needs listed at the organisation and they ensure that pre-employment checks including DBS check where relevant are completed before members of staff commence employment, including temporary staff / locums.

Work following the audit completed in 2021/22

• Work in the Youth Justice Service (YJS) has been completed with the implementation of a monthly performance report tracking referral order panels and monitoring the timeliness of this. The Whole Family Approach has been included in the Youth Justice Service assessment looking at parenting supporting via court. Since the implementation across YJS they now also have an established parenting offer that is seeing 60% of parents engage in a meaningful parenting intervention.

• Staff in the Youth Justice Service have been trained in Trauma Informed Practice, including receiving funding to train a staff member to be a trauma champion for two years. YJS continue to develop trauma informed practice and have recently received a £22,500 grant to develop this further. YJS have also been selected to be the next Enhanced Case Management (ECM) site and will be developing their trauma informed model further with Forensic CAMHS support

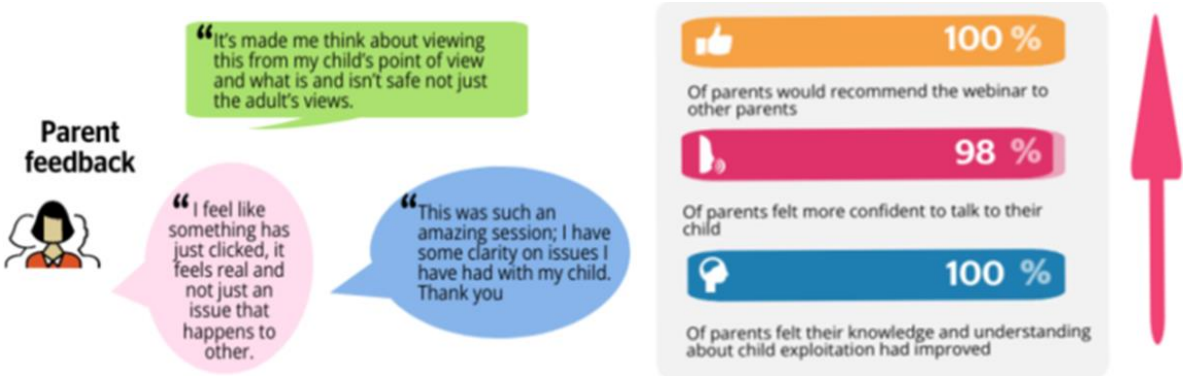
• Guide developed so there is a consistent approach to education and informing parents about child exploitation, particularly online grooming/use of media, which was uploaded to the SAFEGUARDING PARTNERSHIP website. Parents' guide to online exploitation. Training was provided locally to 176 parents by Parents Against Child Exploitation (PACE), this is a national charity supporting families whose children have been groomed, abused and exploited by offenders outside of the family.

• Local guidance has been developed - Using appropriate language for those subject to or at risk of exploitation - Making Words Matter

• Training has been delivered with GP's in Primary Care by ICB colleagues regarding the Multi-Agency Risk Panel (MARP) information sharing with GP's and improve feedback to GP's following meetings.

• All School exclusions and part time timetables now include a contextual/extra familial risk assessment and safety plan.

Section 11 and Care Act audit will be embedded into the revised Partnership and Quality Assurance Framework for 22/23.



Training

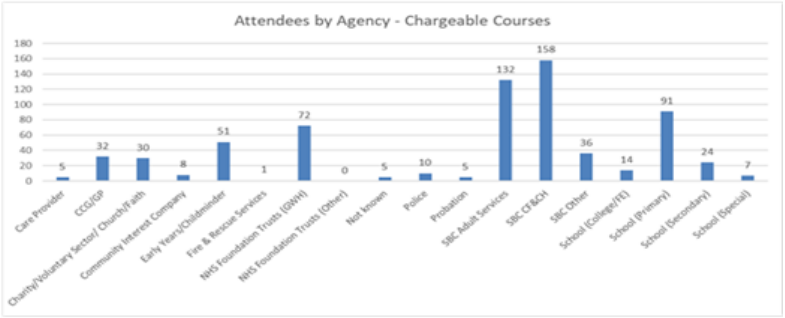
Due to the ongoing challenges with the pandemic the decision was made for all SAFEGUARDING PARTNERSHIP multi-agency training for 2021-22 to be held virtually to enable partners to continue to access training. This ensured professionals remained skilled and knowledgeable in safeguarding practices in a Covid safe environment.

Further work is required to understand the impact of training on frontline practice in the short, medium and long term and this is a priority area being addressed by the Practice Development Group. During 2021-22 the course evaluations sent to each participant have been developed to include questions on impact on practice and this was implemented late in 2021. Participants are asked to complete a questionnaire immediately following the training and are then sent a follow-up 4 to 6 months later to compare their responses and evidence whether the training has impacted on their practice.

In 2021-22 the Partnership moved away from training levels to develop a modular training programme introduced to allow professionals to select the most appropriate training for their own continuous professional development (CPD). Rather than attend the same level training every two to three years, to ensure their training is up to date the partnership is encouraging partners to select from a wider choice of training that maybe more specific to their role. The new model did take some time for partners to grasp and bookings were slower than previous years but there were also the ongoing challenges related to the pandemic and so we looking to 2022-23 to be able to compare.

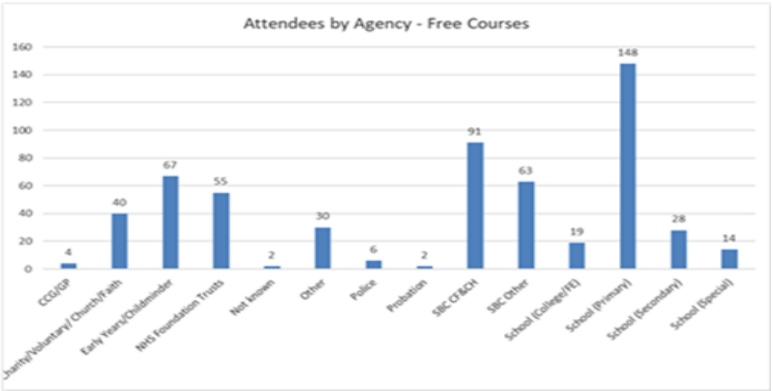
Overview Attendees by Agency (chargeable courses)

Agency	Attendees by Agency
Care Provider	5
CCG/GP	32
Charity/Voluntary Sector/ Church/Faith	30
Community Interest Company	8
Early Years/Childminder	51
Fire & Rescue Services	1
NHS Foundation Trusts (GWH)	72
NHS Foundation Trusts (Other)	0
Not known	5
Police	10
Probation	5
SBC Adult Services	132
SBC CF&CH	158
SBC Other	36
School (College/FE)	14
School (Primary)	91
School (Secondary)	24
School (Special)	7
Total	**681**



Overview Attendees by Agency - Free Courses

Agency	Attendees by Agency
CCG/GP	4
Charity/Voluntary/ Church/Faith	40
Early Years/Childminder	67
NHS Foundation Trusts	55
Not known	2
Other	30
Police	6
Probation	2
SBC CF&CH	91
SBC Other	63
School (College/FE)	19
School (Primary)	148
School (Secondary)	28
School (Special)	14
Total	**569**



The Partnership also launched the Swindon Early Years Designated Safeguarding Lead Safeguarding Partnership (EYDSLP). The Swindon EYDSLP is a tool to support Designated Safeguarding Leads (DSL) to access appropriate continuing professional development, to enable them to develop the knowledge and skills to be effective in the role of the DSL in an Early Years' setting. It also provides a template for recording and evaluating continuing professional development in safeguarding and child protection.

The Partnership also launched its Safeguarding Adult's course, which we had identified in the previous annual reports was an area for development for the Partnership. Throughout the year there was initially slow uptake on booking on to these courses, which the Partnership believes was impacted by the pandemic but also with the lack of familiarisation with the process and for professionals to be aware of the available training packages, we hope to see a much improved up take in courses for the year 22-23 and have collected evidence on the impact on frontline practice. It has been agreed that in 22-23, three new core modules will be added to the training programme: Domestic Abuse (DASH and MARAC), Children Looked After/Care leavers, and Prevent.

The Partnership responded to the need to continue to share learning from reviews and audits despite the challenges faced due to pressure on services due to the pandemic. The safeguarding partnership website was re-designed and information alongside seven minute briefings, learning resources and the safeguarding partnership newsletter were accessible via the website for partners to be able to 'help themselves' to access information and learning.

The following briefings were produced during 21-22 enabling partner agencies to deliver training internally, providing them with the tools to do so.

7 Minute briefings, Learning Resources published

The SAFEGUARDING PARTNERSHIP also developed its reach to share information with the continued use of 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 continues to be positive.

Children's	Adults
Capturing the voice of the child in records -	Adult carer awareness/Swindon Carers Centre support
Child sexual abuse - Intra-familial sexual abuse, harmful sexual behaviour, peer-on-peer abuse and consent	DASH risk identification checklist and MARAC
CSPR Annual Report Headlines 2020	Making Safeguarding Personal
GCP2 Antenatal	Online child exploitation - parents' guide
NSPCC Permanence Framework	Safeguarding is for everyone - Know your role
Making words matter - A practice knowledge briefing	Effective information sharing and consent
Practitioners guide to strategy discussions	Self-neglect
Risk outside the home (ROTH) - adopting a contextual safeguarding approach	Self-neglect - list of online resources
ROTH - Toolkit of resources for professionals	Self-neglect - Multi-agency resources for responding to self-neglect
Safeguarding unborn babies	Swindon Prevent and Channel Overview Slides
Safeguarding children - oral health	
Supporting vulnerable children and families during COVID-19	
Working with fathers	

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

Scrutiny Arrangements

The previous Safeguarding Partnership Annual Report set out the challenges that impacted on the Partnership's performance management and scrutiny arrangements during 2019/20. The Partnership'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 the Partnership's Delivery Group and Executive group. The Executives 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 Executives in March 2021 with recommendations for making the scrutiny arrangements more impactful for the Partnership and to be implemented in the year 2022/23.

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

The Safeguarding Partnership 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 groups and forums for young people 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 21-22 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 needs 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 and improvement of line of sight to front line practice. The Partnership does recognise that there has been drift and delay in some key pieces of work from the delivery plan but is committed to continuing to progress these key areas. The focus of the Partnership for 2022-23 is to revise the Partnership priorities to focus on the core delivery to be able to evidence impact and outcomes and to further develop the culture of accountability across the partnership.

Key areas for continuous improvement in the coming year relate to

- Promoting the use of Adult safeguarding plans with the voice of the adult with care and support needs clearly represented;
- 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.
- The Partnership continues to need to further develop the multi-agency dataset including improving the narrative and ensuring relative benchmarking to bring about further improvements to line of sight and assurance around impact.
- 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.
- To move from process focussed delivery and focus on acting on learning and implanting changes and evidencing the impact of those changes.