Swindon Safeguarding Partnership

Annual Report 2022/23

https://safeguardingpartnership.swindon.gov.uk/site/index.php

Contents

1. Introduction

Thank you for taking the time to read **Swindon Safeguarding Partnership Annual Report,** which covers the period 1st April 2022 - 31st March 2023.

The Swindon Safeguarding Partnership has continued to progress and evolve over the past year with development work underway to continue the improvement journey of the Partnership.

The annual report sets out the achievements of the Partnership over the last year and also recognises some of the challenges faced.

Despite the Covid-19 pandemic restrictions being lifted in December 2021, the impact of the pandemic remains prevalent, we have continued to be flexible and dynamic in how we are able to understand and respond to the increased need across Swindon.

The Partnership Executives would like to thank all partners from statutory and non-statutory services for their continued dedication to protect and support children, young people and adults with care and support needs across Swindon.

Gill May
Chief Nurse Officer
BSW Integrated Care Board
Swindon Safeguarding Partnership Chair

2. Structure of the Partnership

The structure of the Partnership has remained unchanged for the year 2022-23.

The Partnership's core membership continues to be made up of Statutory Partners from Swindon Borough Council (SBC), B&NES, 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.

There has been a change to the **Partnership Executives** this year with **David Haley**, Swindon Borough Council Corporate Director for Children's Services leaving his post and Lisa Arthey joining the Partnership in this role.

Gill May, Chief Nurse Officer, and Caldecott Guardian for B&NES, Swindon and Wiltshire Integrated Care Board (ICB) has continued to chair the Partnership supported by **Alison Barker**, Swindon Borough Council Corporate Director for Adults, Health and Housing, and **Deborah Smith**, Assistant Chief Constable – Crime, Justice and Vulnerability, who represent the other statutory partners as lead representatives.

The Executive Group has continued to meet bi-monthly and their core role has been to:

- ensure all elements of the Partnership are working effectively;
- To receive and respond to recommendations from Independent Scrutiny and any other sources of scrutiny and challenge.
- to set the budget and agree expenditure, to agree the Partnership's Business Plan and its Annual Report;
- To make decisions as to the commissioning of Child Safeguarding Practice Reviews (CSPR) and Safeguarding Adult Reviews (SARS).
- to ensure there is a response to new and emerging safeguarding issues;
- to understand the performance and impact of safeguarding services; and,
- ensure the views and experiences of children and adults at risk inform the work of the Partnership

Delivery Group

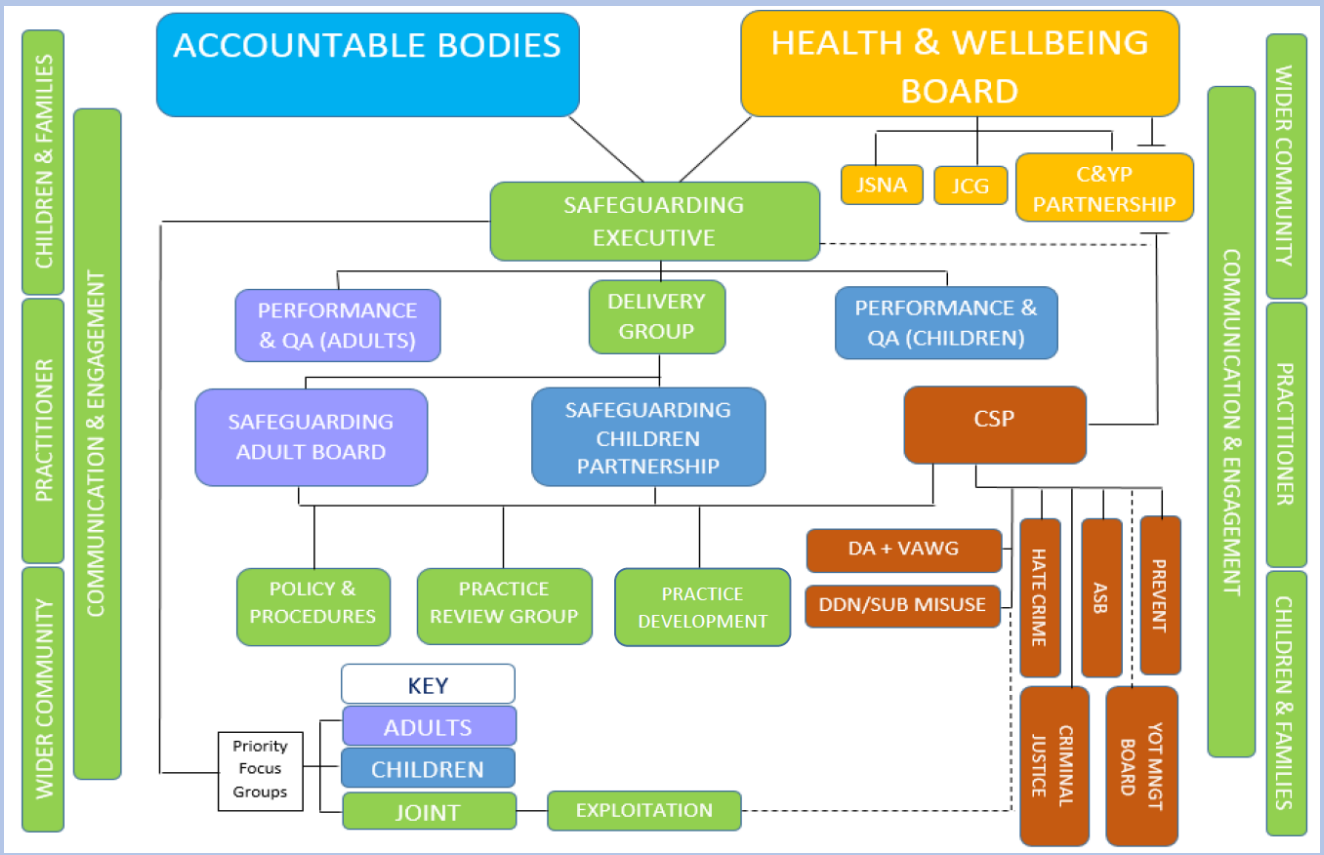
The sub-group, chairs group have supported the Executive by ensuring that:

- the Partnership's business plan is progressing
- each sub-group is working effectively;
- agencies are properly represented across them all; and,
- where the work of one sub-group can add value to that of another it is properly identified; and, that between them the priorities of the Safeguarding Partnership are being delivered

Partnership Sub-Groups

This year the sub-groups have focused on the Partnership's priorities and identified emerging risks across the safeguarding system. They consist of representatives from organisations that play a key role in delivering the identified improvements in services for children and families and adults with care and support needs. Each sub-group has a clear terms of reference and SMART action plans. For as long as the group is needed the sub-group chair would report into the Delivery Group.

The full Partnership's Multi-Agency Safeguarding Arrangements for Children and Adults at Risk can be read here



3. Participation

Strategy and Pledge

Participation and engagement of children and young people is at the heart of how we meet their needs and aspirations and how we develop and deliver our services in Swindon. We are committed to engage meaningfully with children and young people so that we know their needs and interests and learn from their experiences. Our wide range of participation and engagement activities seek the views and experiences of children and young people that are representative of our population in Swindon. We are committed to shape and deliver services based on what children and young people tell us and provide them with every opportunity to influence decision-making. It is important to us that we are accountable to them and we have processes in place to regularly feedback what we have done as a result of the feedback provided.

Children and Young People's Participation Strategy

A Swindon Safeguarding Partnership **Participation Pledge** has been co-produced by the Partnership Participation Network in consultation with children and families.

The Pledge is to help children and families by working with them to:

Involve them when we are trying to make things better

Listen to them

Support them

Work together to make sure they get the help they need

The Partnership commitment is to assure those involved in safeguarding have their voice heard and influence service delivery.

Whats next for 23-24?

- For the Partnership to ensure that participation and the views of experts by experience is embedded in the quality assurance framework for 2023-24 and that these views are influencing and impacting service delivery.

4. The Work of the Partnership

5. Stronger Safer Partnership

The Safeguarding Partnership has continued to implement and deliver the Partnership Business Plan for 2022-23. There have been challenges across the system which have meant the development of a Partnership Quality Assurance Framework to provide assurance that partnership working is strong across the safeguarding system has not been completed but this work is now underway and will be finalised ready for 2023-24.

This is also the case with the review of the Safeguarding Partnership dataset. Work still needs to be undertaken to ensure that the Partnership has an effective multi-agency performance dataset. The current dataset does not effectively provide assurance or a clear narrative around performance. We need to ensure that relative benchmarking is in place to bring about further improvements to line of sight and assurance around impact for children and adults in Swindon. This is currently under development and will be finalised ready for 2023-24 reporting.

There are now effective systems are in place for the identification, coordination, decision making and oversight of all case review processes including Rapid Reviews, Child Safeguarding Practice Reviews (CSPRs) and Safeguarding Adult Reviews (SARs).

Local practice guidance has now been developed and published:
local_child_safeguarding_practice_review_guidance and SAR_policy

What's next for 23/24?

- Partnership Executives to agree and endorse a Safeguarding Partnership Quality Assurance Framework
- The Safeguarding Partnership dataset is updated to ensure this has meaningful data and narrative that provides assurances that partners are working effectively to safeguarding children and adults.

6. Making Safeguarding Personal

The Care Act (2014) defines safeguarding adults as protecting an adult's right to live in safety, free from abuse and neglect. Making Safeguarding Personal aims to make safeguarding person-centred and outcomes focussed, and moves away from process driven approaches to safeguarding.

Swindon Safeguarding Partnership recognise that there is further development work needed across the Partnership to assure that all adults with care and support needs are being provided a person centred approach and that the views of adults are captured within adult safeguarding plans.

At this time there is a lack of assurance about the use and impact of adult safeguarding plans and this has been recognised within Adult Social Care improvement plan.

The Safeguarding Partnership has continued to offer safeguarding adults core training modules which have included:

Identifying_safeguarding_concerns_and_making_referrals_adults

Legal_training_2_-_best_interest_decisions_poa_vulnerable_adults_including_self-neglect_and_lps

Screening_section_42_enquiries_planning_meetings_adult_safeguarding_plans

What's next for 23/24?

- Promoting the use of adult safeguarding plans with the voice of the adult with care and support needs clearly represented in the plan
- Practice & service delivery in the Adult Safeguarding Team evidences improved outcomes for adults with care and support needs
- Swindon Safeguarding Partnership dataset provides assurance to the Partnership around the impact of adult safeguarding plans on outcomes

7. Neglect

During 2022-23, 55% of children on child protection plans in Swindon were on a plan for neglect. This is a slightly higher number of children than the national average and our statistical neighbour's average. We know that neglect causes great distress to children and leads to poor outcomes in the short- and long-term.

Swindon Safeguarding Partnership has published two Local Child Safeguarding Practice Reviews (LCSPRs) in 2022-23, Bella and Ben and Alan. One of the key themes in both of the reviews were issues with partners identifying, assessing and responding to the early indicators of neglect.

It was also identified that partners could work together more effectively to ensure children are protected from harm.

Both reviews made recommendations as to how the Partnership can make improvements to some of the systems that are currently in place. *Please see case review section for more details.*

It has been recognised that the Partnership needs to complete further analysis of neglect in Swindon to understand the prevalence of this and the links between neglect, domestic abuse, substance misuse and poverty across the multi-agency network enabling practitioners to identify and support families with an increased risk of neglect.

There have been some challenges embedding Graded Care Profile 2 (GCP2), NSPCC tool used for assessing and protecting children at risk or experiencing neglect. Further review in 2023 will be undertaken to look at the barriers to implementing this and whether there is the need for a more accessible assessment tool to be developed that can be used by partners without the need for specific training to meet GCP2 licence requirements.

What's next for 23-24?

- Partnership neglect sub-group to be developed to undertake needs assessment and further analysis to understand the prevalence of neglect in Swindon
- Neglect strategy, framework and practice guidance to be reviewed and updated to ensure that these documents provide further guidance on adolescent neglect and to include information on the Mental Capacity Act and children over 16.

8. Self-Neglect

During 2022-23 almost a quarter of all safeguarding concerns raised with Adult Social Care had a referral reason of self-neglect.

The Safeguarding Partnership recognised the need to raise awareness of self-neglect across the Partnership so undertook its first event focused on self-neglect. Part of this event was to review the reach and effectiveness of self-neglect training and resources across the partnership.

Activity included:

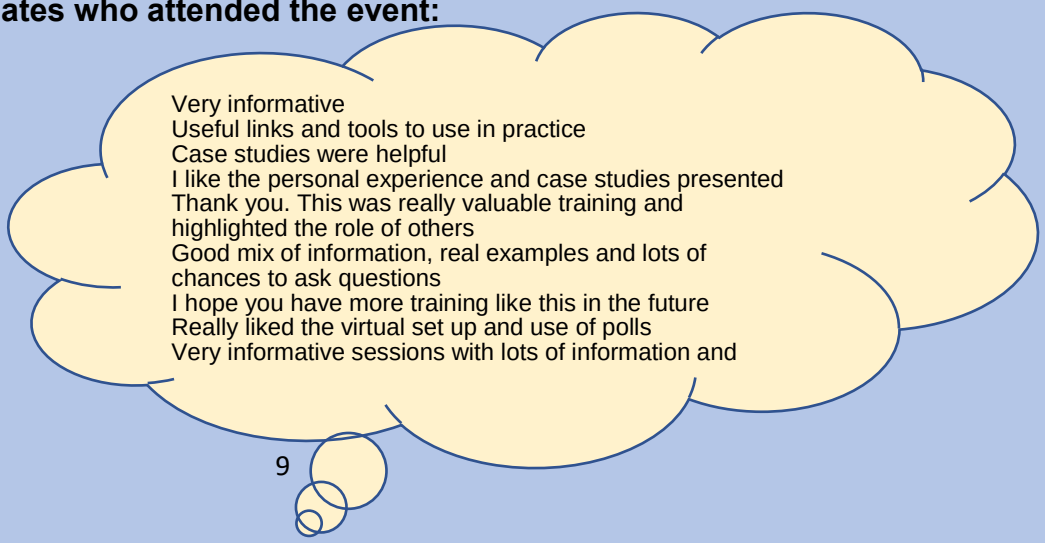
- A survey that was circulated across the partnership '*Identifying and responding to self-neglect in Swindon'*, to measure confidence and knowledge amongst partners.
- Delivered a *'Spotlight on self-neglect'* event for professionals. This event increased the confidence of delegates attending in understanding and identifying self-neglect and supporting those who adults who self-neglect.

Feedback from event was positive with the following responses received.

Question: What aspect of the learning has had the most impact for you today?

- How to approach people experiencing self-neglect and hoarding.
- Risk assessing and holding multi-agency meetings.
- Learning from SAR's
- How hoarders responds to help initially and how to encourage their cooperation or open up to you for help.
- Difference to people's lives that can be made with safeguarding interactions.
- Case studies were really informative into the hoarding/self-neglect from the adults view.
- More in depth understanding behind self-neglect and hoarding behaviour and understand what approaches will be effective.
- A better understanding of the individuals reasoning for having attachment issues/hoarding.
- To be more aware of the person's surroundings and how quick things can escalate.
- Ways and means of involving multi agency responses when you have identified potential self-neglect case

Feedback from delegates who attended the event:



Learning identified in both the survey and the webinar show the challenges professionals highlighted:

- Lack of capacity/time to access training/resources.
- Access to and the capacity of services to support professionals and clients.
- Taking time to understand the person's perspective – not always the time due to demands on the service and staff pressures.
- Lack of confidence in identifying self-neglect, knowledge of pathways and supporting those who self-neglect. *For those who attended the webinar increased levels of confidence were noted.*
- Concerns about attendance of professionals if a multi-agency meeting is convened and getting all agencies on board.

As a result of feedback a dedicated self-neglect webpage for professionals has been developed Self neglect - Swindon Safeguarding Partnership this includes Hoarding Guidance, which sets out a framework for collaborative multi-agency working in Swindon, using a 'person centred approach' model to support individuals demonstrating hoarding behaviours.

Also a bespoke newsletter was shared for all Partners to access Spotlight on self neglect and hoarding newsletter.

Self-Neglect has been a theme in both of the published Safeguarding Adult Reviews in 2022-23. SAR Brenda and SAR Brian. *Please Case Review section for more details.*

Recommendations from these case reviews have been developed into actions that will be progressed during 22-23. We know that self-neglect is the highest referral reason into Adult Social Care. It has been recognised that the Partnership needs to complete further analysis of self-neglect in Swindon to understand the prevalence of this across all agencies.

What's next for 23/24?

- To help close the learning loop, a repeat survey/follow up questionnaire will be sent to Partners who attended Spotlight event in late 2023 to review whether there has been any impact on practice.
- To analyse the prevalence of self-neglect in Swindon
- For self-neglect to continue as a Safeguarding Partnership Priority
- For the self-neglect risk assessment framework to be reviewed and updated
- A Self-Neglect sub-group to be set up to drive forward an updated business plan
- Recommendations from case reviews to be progressed by Practice Review Group

9. Exploitation

During 2022-23, the Safeguarding Partnership were engaged in the Pan Swindon and Wiltshire Strategic, Children and Adults exploitation steering groups. A delivery plan was agreed with the following strategic objectives.

1. Develop a shared approach to data and language, to enable a joined-up strategic and operational response.
2. Develop an agreed joint approach to how partners work together to tackle exploitation.
3. Local areas are involved in the disruption of criminal activities and the support of those at risk of exploitation.
4. Vulnerable people are supported during transitions between services (including young people, and adults without care and support needs).
5. Services working to tackle exploitation are subject to fair scrutiny and assurance systems to enable the best possible service delivery.

Child Exploitation

A Pan Swindon and Wiltshire Children's Exploitation working group was established with the purpose to drive forward the activity in relation to the exploitation of children including raising awareness and understanding of exploitation across the multi-agency network in order to improve identification and response. The core focus of the group was to:

- Maintain a focus on missing children and oversight of return home interview processes and other relevant activity to support them
- Ensure sufficient oversight of response to child sexual exploitation
- Use performance data to better understand the nature of exploitation in Swindon and Wiltshire including volume, demographic of victims, perpetrators and geography
- Support and monitor practice developments, including an approach informed by contextual safeguarding and transitional safeguarding
- Use intelligence to identify emerging areas of need within the children and young people exploitation agenda which require a partnership response
- be assured of and support the consistent and high-quality functionality of Vulnerable Adolescent Contextual Safeguarding Panels in Wiltshire (VACS) and Multi-Agency Risk Panel (MARP) meetings in Swindon
- Learn from practice reviews, locally and nationally and successful prosecutions

The group achieved the following:

- An agreed set of child exploitation data for Swindon and Wiltshire, including the recruitment of a data analyst to support the work of children service and police exploitation teams.

Adult Exploitation

The Safeguarding Partnership are aware that the Partnerships understanding of adult exploitation is less evolved that children's exploitation. A Pan Swindon and Wiltshire Adult Exploitation working group was set up in 22/23 to review adult exploitation with a focus on:

- Using performance data to better understand the nature of exploitation in Swindon and Wiltshire including volume, demographic of victims, perpetrators and geography
- Maintain a focus on vulnerable adults who go missing, or who may be at risk of exploitation
- Use intelligence to identify emerging areas of need within the adult exploitation agenda which require a partnership response
- Escalate any issues which can't be addressed at this level to the main Exploitation subgroup
- Deliver relevant pieces of work as set out in the Exploitation subgroup Delivery Plan

Due to system challenges and capacity issues within services across Swindon, the adult exploitation group was not effective in progressing any of the agreed objectives and it was identified that there needed to be a review of the group and its functionality and the other two groups.

Learning and Development

The Safeguarding Partnership has developed further training that includes impact of abuse and exploitation on children, young people and adults with care and support needs and provides professionals with tools and resources to assess risks.

There is a now a dedicated webpage for:

Financial and material abuse - Swindon Safeguarding Partnership
Exploitation of adults - Swindon Safeguarding Partnership

7 minute and practice briefs

Adult exploitation
Using appropriate language for those subject to or at risk of exploitation
Practice brief: exploitation and language - words matter
Parent carer resource child exploitation
Modern slavery human trafficking national referral mechanism (NRM)

What's next for 23/24?

- Review of all three exploitation groups to be undertaken by Wiltshire Police, with recommendations made to Partnership Executives as to how to progress this agenda.

- Agree an all age exploitation strategy across the Safeguarding and Community Safety Partnerships.

- Exploitation data to be included in the Partnership dataset for 23/24 to support analysis and provide partners with an understanding of what exploitation looks

like across Swindon. This will help to inform the strategic priorities in this area. This data should include financial and psychological abuse as this has been identified as an increasing theme in adult social care data.

10. Effective Safeguarding Practices

Children

Swindon Safeguarding Partnership recognises that, '*local organisations and agencies that work with children and families play a significant role when it comes to safeguarding children*' (Working Together to Safeguard Children 2018)

There are lots of challenges and complexities in safeguarding. We know that children and adults are best protected when professionals talk to each other, share worries and challenge each other when they don't agree with decisions being made. Above all, we should be listening to what children and adults are telling us, recognising and respecting their rights. There has to be a shared focus on achieving the best outcomes for the child and the adult.

In 2019, funding was approved by DfE Strengthening Families, Protecting Children and Swindon made a successful bid in 2019 to implement The Family Safeguarding Model. In May 2022 The Family Safeguarding Model was launched. Family Safeguarding takes a multi-disciplinary approach to working with families including Children and Families Social Workers and Family Support Practitioners, working alongside Adult Specialist Workers to provide help and support in relation to issues associated with parental domestic abuse, substance misuse and mental ill-health. Family Safeguarding teams work with children aged pre-birth to 17 where the issues relate to abuse and neglect of the children by their families. The effectiveness of the Family Safeguarding Model in Swindon is monitored by the DfE.

The progress so far has been:

- Family Safeguarding workbook and Family Programme is in use
- Family Programme being developed to be able to be used in Court
- Family Safeguarding/Group supervision in place
- Strengthened management tier and decision making forums
- Supported by DfE and Hertfordshire

Feedback from a family member in their experience was a social worker from the Family Safeguarding Team:

"*He always calls back, always responds to emails. Always replies to us when he is back in work if he's not in. We're completely satisfied. We couldn't have done what we did without him, couldn't ask for more. He has a great relationship with the children, he has been involved with us for 1yr and has built a relationship with the children."*

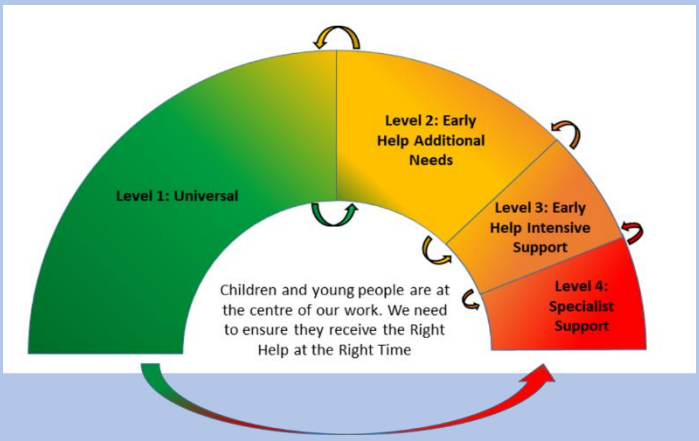
It is recognised that there have been some initial challenges in the recruitment of Adult workers and social worker turnover, which has had an impact on caseloads. There is a need for improvement to be made in the quality of the workbook and family partnership recording. There has been some inconsistency within family safeguarding supervision and there needs to be more engagement with partners to ensure that they are clear on the model and how

What's next for 23-24?

- Continued focus on recruiting remaining adult specialist workers.
- Stability within social work workforce
- Embedding of the new ways of working in practice
- Developing a sustainable model
- Further work with partners

Swindon Safeguarding Partnership have reviewed and updated the **Right Help at the Right Time Threshold Guidance** and produced a designated web page where the guidance, threshold document and training can be accessed here: [the right help at the right time - swindon s multi-agency threshold guidance]

The threshold levels have been updated to ensure that there is a graduated response to support for children in Swindon. This has been promoted across the Partnership with an implementation plan that has included a follow up questionnaire to give Partners the opportunity to feedback on the new guidance https://forms.office.com/e/ym8FnjKAdk



A clear message has also been promoted across the Partnership that threshold criteria should not be seen as rigid and fixed, but should be seen as an aide to decision making and professional conversations about the needs of the child and their family.

What's next for 23-24?

- Develop and undertake Right Help at the Right Time Threshold Guidance training to ensure that the new guidance is implemented across the partnership.

- Undertake a Right Help at the Right Time Threshold Guidance Partnership questionnaire to analyse how well this has been embedded across the Partnership.

Wiltshire Police National Child Protection Inspection (NCPI)

Wiltshire Police received a National Child Protection Inspection in March 2022 and a report was published in April 2023.

Thirteen recommendations were made as to how improvements could be made to how police respond to and look to protect children in Swindon.

An improvement plan has been shared with Partners and assurance has been provided as to how this is progressing.

What's next for 23-24?

- Wiltshire Police to provide regular assurance report to partners on the progress of the improvement plan and how this is impacting on outcomes for children

Operation Encompass

Operation Encompass aims to ensure that schools have timely information about all police attended incidents of domestic abuse. Swindon Safeguarding Partnership recognised that there was a need to improve 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. Wiltshire Police are in the process of trying to automate some of this process, which should provide an improvement in the process in 23-24 reporting.

What's next for 23-24?

- Number of Operation Encompass notifications and the timeliness of these to be included in the revised dataset to provide assurance that schools are being notified in a timely way so that children and young people are offered support in school.

Multi-Agency Safeguarding

Swindon Safeguarding Partnership 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. A set of standards for when Health attend strategy discussion was reviewed and updated to support this.

https://safeguardingpartnership.swindon.gov.uk/downloads/file/852/health_protocol_for_attendance_contribution_at_child_protection_strategy_discussions

Work has been undertaken across B&NES, Swindon and Wiltshire (BSW) to ensure that there is an aligned and consistent response to how agencies are looking to safeguard children under 1 year old and how we can change systems to be more inclusive and supportive of the ways we can work with fathers and male partners. Mapping work has been undertaken and is being analysed within the group to look at identifying current provisions and any gaps including where commissioned services may be needed.

The work of the group links to the recommendations from the Child Safeguarding Practice Review Panel report
The_myth_of_invisible_men_safeguarding_children_under_1_from_non-accidental_injury_caused_by_male_carers.pdf

The Pan BSW 'Under 1's Steering Group' has been leading this work to look at how we can protect children at risk of significant harm. This has included the updating of the following policies:
Bruising_in_non-mobile_infants bruising_in_non-mobile_infants_leaflet
Safeguarding_discharge_planning_protocol

And a dedicated web page for:
safeguarding_unborn_babies_under_1_s_and_working_with_fathers

The Safeguarding Partnership also took part in the promotion of the Lullaby Trust's Safer Sleep week in March 2023 taking the opportunity to raise awareness of safe sleeping within organisations across the Partnership.

The Partnership also recognised the need to have additional resource for practitioners for when working with parents with additional needs, a resource page has been developed for partners: supporting_parents_with_additional_needs.

What's next for 23-24?

- Review of Safeguarding Partnership priorities to include safeguarding children under 2 year's old, unborn babies and working with fathers and male partners
- To review whether there is multi-agency data that can be collected on working with this vulnerable group of children and for this to be included in the revised dataset to provide assurance
- Analysis across the Partnership to look at how we are working with and how we can be more inclusive of fathers and male partners in safeguarding work

Adults

Safeguarding Adults is governed by the Care Act 2014. This legislation requires local authorities to fulfil specific duties in relation to safeguarding adults. Swindon Safeguarding Partnership work together to protect adults with care and support needs who are at risk. Someone might be at risk because they have dementia, a learning disability, an illness or a physical disability. Whatever the persons care and support needs, the Partnership wants to make sure their views are heard and they are protected from harm.

To support multi-agency safeguarding, the Safeguarding Partnership Adult Safeguarding policy and procedures guidance was due to be reviewed and updated but due to challenges across the Partnership there have been delays in this being finalised and implemented. Further review and development work across Adult Services including the development of an Adult Services improvement plan, CQC self-evaluation and preparation and the development of an adult MASH will look to provide a clear needs assessment and a more robust response to adult safeguarding in Swindon.

What's next for 23/34?

- Finalise the Safeguarding Adult Policy and Procedures document
- Development of an adult MASH to ensure that adult safeguarding concerns are dealt with in a timely way.
- Assurance to be provided on the progress of improvement plan and CQC preparations.

In February 2023, experts with experience who attend the Learning Disability Partnership Board met with the Partnership's Business Support Unit Development Manager, the People and Partnership lead for SBC and a Neighbourhood Inspector for Wiltshire Police to discuss different types of abuse, where it can occur and how to recognise and ask for help.

The experts with experience provided a response at the beginning and at the end of the session.

The following questions and responses are as follows:

1. **What worries you the most about keeping safe?**

Beginning

Social Media- Facebook

Dark alleys and subways

No access to a mobile phone to call for help

Drunk people

Gangs

People using their bikes and scooters in the town centre

Everything becoming digitalised

Being forced to act in a way you don't want to

End

People's personal opinions/discrimination against disabilities and race

2. **Where does/can abuse take place?**

Beginning

Home

Public places

Care homes

Work places

End

Social Groups

Internet

Social Media

Anywhere

3. What stopped you from talking to somebody?

Beginning

Scared of the after effects

Scared of leaving the house

Threats from people

Scared of the person who is abusing you

End

What if it is the person you trust?

Staff not doing their job properly

Losing independence

People may struggle to understand me

4. What would help you feel safe?

Beginning

Learn Self Defence- build self confidence

See the Police patrolling

Going to places they feel safe

Better education in school around abuse and how to keep safe

End

Personal Alarms

More police in specific areas – bus station was common

Training with people you know and trust

Community Safety Partnership

One individual was able to recall a positive encounter with the Police whilst in custody describing them as:

‘Helpful, patient and explained everything really well’

Other feedback from the session:

‘It was great. I know what abuse is now’

‘The session was really interesting, I feel more confident now if I was to deal with abuse although it does still scare me’

‘A good session, I am more confident now and I think I could protect my friends and family too’

‘The police woman was great’

Feedback from the lead for the Learning Disability Partnership Board who met with the Learning Disability experts by experience following the safeguarding training session have recommended:

- More of these workshops for people with additional needs
- Developing a system to make it easier for people with additional needs to raise a safeguarding concern

What's next for 23/34?

- Swindon Safeguarding Partnership to consider working with a provider to develop a workshop that can be delivered by people with lived experience with appropriate support. It would focus on recognising what abuse is and what to do if somebody in a position of trust isn't treating them well.

11. Case Reviews 2022-23

The Safeguarding Partnership Practice Review Group (PRG) has continued to have oversight of and manage case review referrals into the Partnership. The group is responsible for ensuring that Local Child Safeguarding Practice Reviews (LCSPR's) and Safeguarding Adult Reviews (SAR's) are completed to a high standard and within agreed timescales.

In 2022-23, three LCSPR referrals were received and three rapid reviews were undertaken, full LCSPRs did not need to be completed. Four SAR referrals were received with two progressing to a full SAR.

Adults

The Partnership published two Safeguarding Adult Reviews (SARs) in 2022-23.

SAR Brenda

Brenda was aged 75 years when she died on 03/02/21 in hospital, after several weeks of accelerating deterioration at home. From Christmas Eve 2020, Brenda withdrew from essential activities of daily living. The first signs of this were neglect of the home environment with rotting food and milk and a build-up of unwashed dishes. By 14/1/21, the visiting community nurses were concerned about poor food and possibly poor fluid intake. Conditions were exacerbated by the results of unmanaged incontinence of faeces, visible about the home and on clothes, on the bed and on Brenda. Brenda lived alone, did not go out, and wanted to avoid Covid 19 exposure. Brenda was estranged from her son, for reasons that were not explored at the time. In the past he had arranged food deliveries for her but there was otherwise not a known history of family involvement with Brenda. On 2/2/21 when Brenda was extremely ill and being taken to hospital, her son could not be notified since there was no current telephone number on record

Themes:

- Mental Capacity Act
- Self-neglect
- Safeguarding Supervision
- Escalation

Recommendations:

1. The SSP through the L&D group should ensure there is multi-agency training available to all staff that promotes strength-based approaches to working with individuals who are considered to be self-neglecting.

   Action *- Ensure SSP training promotes strength based approaches. Action passed to Practice Development Group to ensure this is covered within Self-Neglect module.*

   Desired Outcome *- This is now covered within the Self-Neglect module. Adults who are experiencing self-neglect are supported using strength based approach.*

2. The SSP should seek assurance that the organisations involved on this review are raising awareness of key elements of the Care Act 2014 (especially as highlighted by this report: assessment, representation, the wellbeing principle, Section 19) amongst their staff using mechanisms such as supervision and professional development.

   Action *- Organisations will demonstrate they support staff knowledge and application of Care Act to improve practice. Partners will devise mini audit questionnaire on MS Forms and questionnaire will be circulated to agencies*

   Desired Outcomes *- Professionals will report impact on their practice and therefore positive outcomes for adults being supported.*

3. The SSP should seek assurance that all organisations involved in this review are auditing the knowledge and skills of their staff on the Mental Capacity Act, including executive capacity using mechanisms such as supervision and professional development.

   Action *– Assurance to be provided by organisations that within their own organisation, there is a commitment to and evidence of continuous professional development in relation to MCA*

   Desired Outcomes *- Organisations can evidence their internal practices in relation to MCA*

4. The SSP should seek assurance that all organisations involved in this review have safeguarding support mechanisms in place including safeguarding supervision where escalation and acting on a basis other than consent can be considered and actions agreed.

   Action *- Assurance to be provided that individual organisations have internal processes for supporting practitioners to discuss safeguarding cases and complex cases. Partners devise mini audit questionnaire on MS Forms. Questionnaire circulated to agencies*

   Desired Outcomes *- Organisations can evidence their internal practices in relation to safeguarding supervision and casework supervision.*

5. The SSP should review how the process in the self-neglect policy for multi-agency meetings, where there are concerns that a client may decline care despite their high level of need, is applied. A further practitioner survey could be

used to determine if there has been a change since the last practitioner survey completed as part of this review.

***Action** - More frequent use of multi-agency meetings to discuss need and risk where there are concerns that a client may decline care despite their high level of need. To be included in the next review of the Self-Neglect policy*

***Desired Outcomes** – the Self-Neglect Policy is updated to reflect the need for more frequent use of multi-agency meetings to ensure timely multi-agency decision making where there are concerns that a client may decline care despite their high level of need,*

6. GP Surgeries should review patients coded with "severe frailty" annually and create a care plan which includes actions if there is rapid deterioration. These adults can be identified using the "electronic frailty index", which uses data available in the GP electronic health records to identify and severity grade frailty. This enables the identification of older people who are fit, and those with mild, moderate and severe frailty. GP surgeries should ensure that they follow these processes.

   ***Action** – Action shared with named GP for ICB. Feedback and assurance on this action to come back to the Practice Review Group*

   ***Desired Outcome** – GPs will be able to identify older people who are fit, and those with mild, moderate and severe frailty and take actions should rapid deterioration be identified.*

7. Community Nurse health risk assessments should be made for people coded as of high frailty who are living in their own homes and where there are risks such as skin integrity, incontinence, very low food or fluid intake. The presence of these factors can indicate the need for a multi-agency approach

   ***Action** – Recommendation to be shared with GWH NHSFT and assurance to be provided that health risk assessments and high frailty coding is used.*

   ***Desired Outcome** - Frailty Risk assessments are routinely carried out in the community so that preventative measure can be put in place sooner.*

8. In order to promote and monitor their use, monthly data on the use of independent advocates should be shared at ASC Team Meetings and could be a KPI for the QAPB process.

   ***Action** – A single agency audit (Q3 22/23) is currently being undertaken in respect of advocacy by QA Team in adult social care. Due to capacity in QA team this audit is delayed but once finalised will be shared with SSP.*

   ***Desired Outcome** – Adults with Care and Support needs have access to independent advocacy at the earliest opportunity.*

SAR_Brenda_full_report

SAR Brian

Brian was a 43-year-old man who had mental health needs and a history of drug use. He lived alone in a flat, where he died in a fire on 7th February 2022. From July 2020 until his death, Brian was in contact with several agencies including the police, the ambulance service, mental and physical health services, and specialist drug services in response to self-neglect and drug dependency. Agencies struggled to engage with Brian who spent periods of time away from his flat, staying in hotels. Brian had been in prison on several times. Brian was considered by Avon and Wiltshire Mental Health Partnership Trust (AWP) to be at risk of harming himself from misadventure if his mental health presentation deteriorated. Drug use was found to worsen his mental health and increase his delusional paranoid thoughts. In 2020 Brian was diagnosed with autism spectrum disorder (ASD). He presented at this time with some ongoing depressive symptoms and was involved with probation services

Themes:

- Alcohol and substance misuse
- Trauma informed practice
- Self-neglect
- Mental Health

Findings

1. Brian presented several of the characteristics identified in the Alcohol Change UK 2019 report and the Stoke and Staffordshire "Andrew" SAR.

   Action - *Variance in knowledge and understanding of the elements raised in the Alcohol Change report and themes from SAR Andrew. Disseminate report to partner agencies for them to consider how the presence the characteristics identified in the Alcohol Change UK 2019 report and the Stoke and Staffordshire "Andrew" SAR might be spotted in future cases of alcohol and drug dependent adults and how this might lead to interventions that result in better outcomes.*

   Desired outcomes - *Increased awareness of characteristics, how they can impact on adults and how this can impact on practice.*

2. There is no training module on trauma informed practice with adults, particularly with people who use substances and self-neglect.

   Action - *Trauma informed practice training when working with children is available but not widely available for TIP when working with adults. PDG to revise* ***training offer and consider this module.***

   Desired outcomes - *Practitioners have the opportunity to develop their skills and knowledge in using these approaches with adults.*

3. Multi-agency approaches were not used and information was not always shared and when it was, such as when Brian was identified by GWH as a high intensity user, this did not influence approaches to him.

   Action - *Multi agency working and meetings are not always standard practice, despite evidence that this can promote positive outcomes for adults. Partner agencies should review policy and practice for information sharing between agencies and how they might best ensure integrated multi-agency approaches.*

Desired outcomes - *Improved consistency in multi-agency information sharing and approaches to case management.*

4. Suicide safety plans, as recommended by the Royal College of Psychiatrists for "any patient with suicidal thoughts or following self-harm", were not used for Brian.

   Action - *AWP provide assurance regarding the use of safety plans, as recommended by the Royal College of Psychiatrists for "any patient with suicidal thoughts or following self-harm".*

   Desired outcomes – *Safety plans are in place and being used for any patient with suicidal thoughts or following self-harm*

5. There is no framework for practice in complex cases. Such a framework might be useful to guidance practice where there are dual and even triple diagnoses and self-neglect

   Action - *Consistent themes from local SARs suggest there are a number of challenges in supporting individuals with multiple complex needs. Exploration of need for and benefit of a framework. Map existing work taking place already and identify gaps to potentially develop panel.*

   Desired outcomes – *for a Framework to be developed and in place for practitioners to use when working with complex cases.*

SAR_Brian_full_report

Children

The Partnership published two Local Child Safeguarding Practice Reviews (LCSPR) in 2022-23.

LCSPR Bella & Ben

In November 2021 Bella (aged nearly 4) was admitted to hospital after concerns were raised about her physical and emotional wellbeing by the pre-school she attended; at hospital she was found to have been severely neglected by her mother. Bella and her brother, Ben, aged 5, were found to be living in home circumstances that were hazardous for children; mother lacked support from either family or professionals at this time.

Themes:

- Neglect/Neglect of children with neuro-diversity
- Faltering Growth
- Early Help
- Cross Border working

Recommendations:

1. Swindon Safeguarding Partnership to ask partner agencies how they are assuring themselves that the workforce is enabled to recognise, name and respond appropriately to the early signs of children being neglected by their parents/caregivers and to consider when this neglect has become chronic in nature.

Action - *set up a Neglect T&F Group, and report back to PRG for further consideration if the work of this T&F Group does not cover any of the elements from this recommendation. Single agency assurances to be provided.*

Desired outcomes - *For practitioners in Swindon to feel confident in assessing, identifying and naming neglect, especially when in the early stages. For practitioners to feel confident in using tools to help identify neglect, whether this is low level or chronic. For practitioners to feel confident in how to respond to neglect when working with parents/carers.*

2. There needs to be some clarity sought about the connections between Early Support Plans (Wiltshire) and the Early Help Assessments and Plan (Swindon) and My Support Plans. What are the expectations, should they merge? How can information from one be shared with the other so that a holistic picture of children's needs emerges?

Action – *Early Help managers to liaise with colleagues in Wiltshire in relation to this action and to update Cross Border Protocol.*

Desired outcomes - *For there to be good information sharing and handovers of Early Help assessments and plans when a family move out of one local authority area into another. This is to prevent drift and delay in families receiving the support they need.*

3. Swindon Safeguarding Partnership should develop brief guidance and a pathway for addressing faltering growth in children. This can be used to raise awareness amongst professionals.

Action - *For there to be guidance and a pathway for professionals to refer to that addresses faltering growth in children.*

Desired outcomes - *This guidance and pathway should be used to raise awareness amongst professionals and provide clear guidance in how to respond in a timely and robust way where there are concerns about faltering growth.*

LCSPR_Bella_and_Ben_full_report

LCSPR Alan

Alan is a 17 year old young man who was severely neglected. He was not attending education, leaving the house or his room. Early Help support was in place but had not effected change for. Alan was estranged from his mother and his father was a single parent with his own care and support needs.

Themes:

- Adolescent Neglect,
- Use of the escalation policy at an earlier time
- Impact of Covid on parents engagement
- Identifying neglect at the earliest opportunity
- Thresholds and threshold challenges
- Using the Mental Capacity Act with young people of 16 to assess decision making

Recommendations:

1. The Safeguarding Partnership should conduct some checks to actively seek **reassurance and evidence** that the issues raised by this review are in fact being or have been addressed consistently and persistently on the ground, at an operational level and practitioner level. Specifically, they should explore the following:

    a) That agencies providing intervention at the early help level of need do not, in reality, feel like the 'Cinderella' service (as was quoted to me by one person) and that their voice is heard with authority and respect across the system
    b) That decisions about step-up and downs are not being taken solely on the grounds of threshold definition but are clearly and explicitly based on the needs of the child and family
    c) That decisions re step-up and downs are informed by multi-agency perspectives of those professionals involved with the child, such as education and health
    d) That those decisions are flexible and that there is a willingness to use the skills and expertise in both early help and social care together– that cases can be identified where families are receiving both early help and social care services contemporaneously when needed
    e) That the circumstances of Alan's case are worked through the new threshold guidance to provide a sense-check on whether they would now help lead to a different outcome for Alan.

    Action - *Practitioner questionnaire to be sent out to Early Help practitioners around their experiences of escalation when challenging social are decision making. Audit to be undertaken around b), c) & d). Threshold activity to be undertaken at the joint children and adult's partnership meeting.*

    Desired outcomes – *For professionals across Early Help Services to feel confident in challenging step up/step down decision making and to feel that their views are heard and respected. Across Swindon step-up and down decisions are not being taken solely on the grounds of threshold definition but are clearly and explicitly based on the needs of the child and family.*

2. Existing practice guidance on neglect is reviewed with a view to:

a) Adding some helpful guidance to practitioners designed to help them think about working with adolescents who are difficult to engage with and to help explore the boundaries between their right to some level of self-determination on the one hand and the need to more formally intervene in their lives on the other.
b) The guidance should extend to the use of the Mental Health Capacity Act and assessments around Gillick competency.

    Action - *To have an up to date neglect guidance and practice framework that is updated to reflect the recommendation from the review. Task and finish group to be set up with partners from the neglect sub-group to review the framework and guidance and incorporate recommendations.*

    Desired outcomes – *For professionals across the partnership to be aware of and have access to updated guidance and resources to support the early identification and assessment of neglect, specifically for when working with*

adolescent. For professionals to feel confident seeking advice and understanding how the Mental Health Capacity Act and assessments around Gillick competency support with decision making and safeguarding.

3. The escalation process and its implementation should be reviewed to:

   a) Ensure it encourages both the airing of concerns about children and an expectation that those concerns will be received positively and responded to proactively, accepting that raising concerns about children by one agency to another is a critical part of keeping children safe.
   b) The procedures should focus more on expected behaviours and responses, on promoting the importance of escalating concerns within the system and wanting those concerns to be proactively aired rather than an expectation that escalations simply means going up the management line until a resolution is reached.
   c) Such a review should include an examination of the escalation procedures set out by Wiltshire Safeguarding Vulnerable Partnership, which includes an approach to managing 'stuck' cases. A number of agencies cover both Swindon and Wiltshire and there is clearly some benefit in there being a similarity of approach by both partnerships.

   Action - *Escalation policy to be sent out for consultation and to be updated based on recommendations from the review and feedback from consultation.*

   Desired outcomes – *For all professionals across the partnership to be aware of the escalation processes and feel confident in formally escalating concerns when they disagree with decision making.*

4. I recommend that the partnership reviews its work more generally and explores the Working Together requirements set out below:

Working Together 2018 actively supports and expects the kind of approach implicit in what is set out in these preceding paragraphs. Chapter 3 sets out the need to establish Multi-Agency Safeguarding Arrangements and paragraph 9 contains the following expectations on safeguarding partners:

- Facilitate and drive action beyond usual institutional and agency constraints and boundaries
- Ensure the effective protection of children is founded on practitioners developing lasting and trusting relationship with children and their families

This should be evident in the work of the partnership at both a strategic and an operational level and that there is a flexibility and creativity in both the broader development of the partnership and in services to individual children and their families.

Action - New Working Together is due late 2023/early 2024. To reviewed updated guidance around multi-agency safeguarding arrangements and to progress recommendation once we are clear on updated expectations.

Desired outcomes – The Partnership would like all partners to develop lasting and trusting relationships with one another. The Partnership wants to look beyond organisational constraints and boundaries to build a culture which improves outcomes for all.

LCSPR_Alan_full_report

All action plans are produced from the recommendations from Partnership case reviews and these are monitored and progressed by the Practice Review Group. Any identified learning from these reviews is shared in a timely way with clear actions to ensure improvements are made in practice and in policy development.

What's next for 23-24?

- Safeguarding Practice Review group to continue to monitor and progress SAR and LCSPR action plans to ensure that the actions have been completed.

- Swindon Safeguarding Partnership will update its evaluation framework for monitoring the impact of learning and development on safeguarding practices, service delivery and outcomes. This will help to move the Partnership from a process focussed delivery to a focus on acting on learning and implementing changes, evidencing the impact of those changes on frontline practice, and outcomes for children and adults in Swindon.

12. Learning from National Case Reviews

Swindon Safeguarding Partnership ensure that any National Case Reviews published in the year are considered within the **Practice Review Group**. Findings and recommendations are considered in the context of the reviews and a benchmarking activity happens to analyse Swindon's position. The following National Case Reviews were looked at in 2022-23.

Serious Case Review 'David'

The Partnership were asked to consider SCR David due to its national implications. Partners in Swindon met to consider the National Panel's actions and recommendations and have assessed this against what is being carried out in Swindon. This specifically looked at issues around commissioning for placements, assessments and therapeutic support for children. Eight recommendations, mainly around the commissioning of services, were identified and are being actioned via the Learning Disability Board.

Child Q

The Partnership reviewed the findings from the National Review 'Child Q'. Police and education colleagues developed a briefing for education settings in Swindon that included learning from the review and police strip search guidance.

The briefing encouraged any school staff to consider whether the potential for a strip search through police involvement is necessary, and to ensure that other appropriate, less invasive approaches have been exhausted. It also promoted the importance of school staff being an advocate for the safety and wellbeing of pupils that are being searched. It also gave guidance on the responsibilities of school staff being an appropriate adult.

Having reviewed the learning and having looked at local data, Wiltshire police did not identify a need to revise their strip search policy.

A 7-minute briefing was developed to share across the partnership with the learning from this review with links to information around 'Adultification' and 'Words Matter', language to be used when working with exploitation.

Solihull Ofsted JTAI Report

An Ofsted, Joint Targeted Area Inspection (JTAI) was undertaken in Solihull following the death of Arthur Labinjo-Hughes. This National review was published in February 2022. The JTAI looked at how all local agencies in Solihull are working together to respond to the identification of initial need and risk to children.

Swindon Safeguarding Partnership reviewed the themes and findings from the report in two multi-agency meetings where partners benchmarked their service area against the findings and actions for agencies were identified and progressed.

Star & Arthur

The National review into the murders of Arthur Labinjo-Hughes and Star Hobson was published in May 2022. The report **'Child Protection in England'** was undertaken to look to understand how and why the public services and systems designed to protect them were not able to do so. The report looked at the main practice and system issues that featured in both children's short lives and sets out national recommendations for changes to child protection.

Five key issues were identified from the review and Partners were asked to complete an assurance report where they were asked to provide their agencies position and assurance against each of these areas. Each agency provided evidence of their position and identified actions for their agency to take forward. The action plan will be monitored into 2023-24 and agencies will be asked to provide assurance of how learning from this review has been embedded in practice.

Swindon Partners also delivered a training session and a Remembering Star & Arthur Recorded Webinar.

13. Performance and Quality Assurance

The Partnership Performance and Quality Assurance (PQA) groups for Children and Adults have had oversight of the following activity in 22/23:

- Received Section 175/157 education audit report: It was raised by education settings that children's mental health remains a significant concern for schools. Many settings are offering extensive support. Waiting lists for services are a concern for all settings. Suicide Prevention training was delivered to more than 300 people by Papyrus. A Designated Safeguarding Lead training programme accredited by the Safeguarding Partnership has been put in place.
- Police National Child Protection Inspection outcome and improvement plan and progress was presented
- Walk the Floor Assurance visits
- Review of NHS Safe and Wellbeing reviews – Findings of outcomes and analysis
- Primary Care Audit – finding and actions
- Adult Social Care Improvement Plan
- Swindon Advocacy Movement Annual Report
- Feedback from 'Keeping Myself Safe' session with adults with learning disabilities

What's next for 23-24?

- Adult and child police vulnerability data to be provided as part of SSP dataset

- Review to be undertaken of the effectiveness of Performance and Quality Assurance Group and the Partnership Quality Assurance processes due to the lack of functionality of the group, poor quality of data/narrative and lack of engagement from partner agencies.

- Partnership Executives to agree and endorse a Safeguarding Partnership Quality Assurance Framework

Multi-Agency Audits

Multi-Agency Ofsted Joint Targeted Area Inspection (JTAI) preparation work has been undertaken across the Safeguarding Partnership. It was agreed that the multi-agency audits would focus on the updated Ofsted JTAI theme of 'The Multi-Agency Response to Children and Families Who Need Help'.

Joint-targeted-area-inspection-of-the-multi-agency-response-to-children-and-families-who-need-help

Partners developed a multi-agency audit tool based on the scope of the inspection and relevant criteria.

Each agency involved in the process audited the child's file independently within their own agency alongside practitioners where possible and then joined a multi-agency

reflective feedback session hosted by the Business Support Unit. The feedback session considered what worked well/areas of strength, whether there were any concerning/complicating or challenging factors and what the learning and recommendations were for each agency.

There were eighteen multi-agency audits completed in January, February and March 2023. The children audited were identified from Ofsted Annex A child level data.

The following themes were identified as areas good practice or strengths within agencies and areas of concern or challenge and areas for development.

Areas of Strength	**Areas for improvement**
Thresholds	Multi-agency working/Information sharing
Child's Voice/Child's and Families Experience	Record keeping/IT systems
Partnership Working	Child's Voice
Supervision	Whole family assessments
	Supervision
	Children missing education
	Transitions

This multi-agency audit process has been newly developed within the Partnership with colleagues collaborating to develop an audit tool that can be used across all agencies. Feedback was provided during the March reflective feedback session from colleagues attending. It was fed back that the audit feedback sessions had been positive, balanced and open, with colleagues feeling that a safe space and learning environment had been created.

The audit process has identified some very positive practice throughout the partnership. It was evident that this had made a positive impact to the lives of children and their families. Building effective relationships with children and families has been a contributing factor to this. It is evident that for the majority of agencies the views of children are being captured and considered as part of ongoing work and that families felt supported with positive feedback being provided by them.

Despite this, almost 50% of the audits completed were graded as requires improvement. Children's Social Care, Early Help Services and Wiltshire Police had specific recommendations and are responsible for ensuring that areas for improvement identified are reviewed and actioned within their individual agencies. Actions plans will be monitored to gain assurance that the actions/recommendations have been progressed.

What's next for 23-24?

- Actions/recommendations for agencies will be monitored and assurance will be provided as to how these have progressed. A review will be undertaken as to whether there is any evidence of impact of these recommended actions.

Walk the Floor Assurance Visits

'Walk the Floor' assurance visits were undertaken by the Partnership Business Support Unit and Partnership Executives in November. This was a follow up assurance activity from the Section 11 and Care Act single agency audits where organisations assess themselves against a number of standards set out in Section 11 of the Children's Act and the Care Act 2014 in regard to safeguarding responsibilities.

Agencies were invited to nominate themselves for a walk the floor assurance visit. The visits were based on the Section 11 and Care Act audit returns completed by their agency. The Partnership shared the evidence that they would like to see during the visit (based on the audit return) and requested to speak to some members of staff, which were chosen by the organisation. The following agencies nominated themselves for an assurance visit:

- Swindon Carers Centre
- NSPCC
- GWH – Maternity Department
- Wiltshire Police – Custody Suite

Agencies were able to provide evidence of good practice within their organisations this included:

Safeguarding being discussed in team meetings	Good performance, training and professional development policies
Good multi-agency relationships between partners	Safer recruitment practices are follow and clearly defined
Good safeguarding supervision & supervision policies	Good examples of participation, service user evaluation and feedback, views of service users informing service delivery
Good quality safeguarding referrals.	Confidence is escalating safeguarding concerns
Up to date and relevant safeguarding policies and guidance	Good audit processes
Awareness of whistleblowing policies and how to use this	Know where to signpost to other agencies for support

Agencies were also able to provide evidence of where they had identified areas that needed development within their organisations this included:

Improvements needed in some areas of multi-agency working	Some issues with referral pathways
Need for services to be more accessible to harder to reach communities	Improvements around Equality, Diversity and Inclusion/Unconscious Bias work
Improvements needed in how to gain the voice of children and use this to shape service design	Promotion of the Escalation Policy and how to use this
Better take up of Multi-agency training offer	Better dissemination of Partnership policies and guidance

Each agency was responsible for their agency actions from the visits. These actions have been monitored by the Partnership. There is the expectation that actions will have been completed and agencies can provide evidence of this when the Section 11 and Care Act single agency audits are repeated in October 2023.

What's next for 23-24?

- Quality Assurance Framework for 23/24 to include Section 11 and Care Act single agency safeguarding assurance audits. Timeline to be produced for this piece of work.

14. Young Scrutiny and Challenge Champions

In 2021, the Swindon Safeguarding Partnership were successful in receiving funding from the DfE under the Multi-Agency Safeguarding: Implementing the Reforms funding stream. An apprentice project coordinator commenced in post in October 2021. In the course of promoting the project in 2022-23, three young people were recruited to become 'Young Champions'. The young people decided that they wanted to be known as Young Champions because they were championing the voice and rights of young people.

During the year the Young Champions have worked with colleagues across health, social care, education and the voluntary sector to share information and provide opportunities for their families to be involved in the work.

The Swindon Safeguarding Partnership commissioned training from a local organisation to provide training in participation, coproduction and skills for interviewing. The Young Champions also worked with the Independent Scrutineer to understand more about the role and their "Top Tips". As a result of the training and skills sessions, the Young Champions were able to develop two key pieces of work:

A 'walk the floor' assurance visit to the Custody suite within Gable Cross police station was carried out by two development managers in October 2022. This was in response to a partnership wide Section 11 and Care Act self- assessment audit. The Young Champions devised a number of questions that they wanted to be asked on their behalf. They asked *"Are officers trained to support young people with needs? E.g. anxiety, depressions, disabilities, health problems etc."*

The resulting question and discussion identified that there is a "Support Agency Referral Leaflet" that is passed to all adults and children and young people at the point of leaving the custody suite. This leaflet provides information about local services for children and young people. It was recognised that the leaflet was not children and young people friendly with missing local service information specifically around substance misuse support. There was not an easy read version of this available either. Agreed that it could be updated to provide information for young people as well, potentially co-produced by young people who have been in custody previously. This has been passed to the Youth Justice Service for their peers and Speech and Language Therapy to have input into improving the information.

The Young Champions input into the audit questions has directly resulted in this improvement work on the leaflet which will have a positive impact on young people leaving custody in the future.
Following this, the Young Champions designed and co-produced their own educational setting audit. They identified a number of questions relating to safeguarding as well as mental health support. One of young champions led the audit visit in her secondary school, which was very successful.

The information gathering involved:

- Creation of questionnaire, with specific questions for pupils and school staff around Safeguarding and mentalhealth and well-being support
- Interviewing Deputy Head (Designated Safeguarding Lead)
- Interviewing Inclusion Manager (Deputy Designated Safeguarding Lead)
- Interviewing Head of year 7, and Year 7 Student Manager
- Interviewing a pupil from, Year 7, Year 9, Year 10, and Year 12
- Tour of 'The Pod' (safe space for pupils, calm area to complete work, and area where support can be found)

The audit found that all the pupils clearly understood *'really well'* what safeguarding meant, and explained that they were taught about it in PHSE lessons. 'Designated Safeguarding Lead' was not a role that any of the pupils knew, it was discussed that this was *'probably just a name teachers use'.* This did not take away from the fact - from the pupils' perspective - the school offers a very safe and supportive environment for all pupils. All had a number of options when itcomes to staff support, and there is clear signage (posters) to remind pupils who they can talk to about safeguarding is- sues. The range of support available - staff and sixth formers - gives pupils flexibility and a variety of opportunities to discuss any concerns they may have about themselves or others. The audit also determined that all staff have an excellent knowledge of safeguarding, are clear on the procedure for supporting and reporting, and understand the importance of good safeguarding practice in their work. The school has avery pro-active approach to safeguarding, and ensure all concerns - no matter how small - are recorded. By doing this they can keep track of everything and hopefully prevent things getting worse ('early intervention'). The school put the pupil at the centre of all safeguarding work, using their words, keeping them safe. Following the audit, the young champions produced a leaflet of their findings which they shared with school and that young champions will continue to monitor any recommendations that were made.

The audit questionnaire, findings template and action plan were put into a toolkit resource available on the Safeguarding Partnership website. The toolkit has also been written into the Safeguarding Partnership's new Quality Assurance framework launching in 23/24. This toolkit also includes questions around mental health support. However, the audit tool can be expanded upon and co-produced by young people in individual settings to make it relevant to their service. The toolkit can be accessed here.

The project demonstrated the value and potential for a built-in scrutiny function which would provide a wide range of experience and perspectives across age ranges and the local community to ensure the Partnership can evidence it is meeting its aims and keeping the people of Swindon safe. Whilst there is not the resource or capacity to develop this at the present time, this is a model which could be implemented in the future, which would bring value and impact bring to the partnership in terms of challenge and scrutiny.

"It is important to hear young people's perspectives as the services that the Swindon Safeguarding partnership provide, directly affect children and young people. Therefore, it is vital that young people have the ability to voice their opinions to ensure that what the S.S.P helps young people. "I hope to help children, and young adults, slowly but surely with the other young champions/scrutineers.", Young Champion.

15. Learning and Development

During 2022-23, the Partnership Practice Development Group has continued to ensure that the Partnership learning and development offer is relevant and appropriate to meet the requirements of individual partner's continuous professional development. The new modular programme has now been embedded and focuses on core and specialist modules for the children and adults workforce.

In 2022-23 there had been an increase in course bookings from 2021-22. There has been an increase in the range of blended resources available to partners, this is in addition to the multi-agency training offer.

There has been the development of a video archive/recorded webinars section on the Safeguarding Partnership Video archive - Swindon Safeguarding Partnership this will enable those partners who are unable to attend specific training sessions to access a recording and resources after the event. This will allow for more accessibility and flexible learning. The following 7 minute and practice briefs have also been developed this year**.**

Safeguarding adults - Analysis of Safeguarding Adults Reviews from April 2017 to March 2019	Clare's Law - Domestic Violence Disclosure Scheme (DVDS)
Female genital mutilation practice brief	Making a good referral
Perinatal mental health	Non-Fatal Strangulation
Prevent duty	Suicide awareness prevention and local resources

What's next for 23-24?

- Swindon Safeguarding Partnership will develop its existing evaluation framework for monitoring the impact of learning and development on safeguarding practices, service delivery and outcomes. This will help to move the Partnership from a process focussed delivery to a focus on acting on learning and implementing changes, evidencing the impact of those changes on frontline practice, and outcomes for children and adults in Swindon.

- Improvement work will also be undertaken to look at the processes of collecting information on how attending training/accessing resources/recordings has impacted on practice.

- Practice Development Group to be reviewed and to look at how Partners within this group can have a greater role in closing the learning loop by taking learning back to their agencies, providing assurance of how learning has been disseminated and evidencing the impact on practice to improve outcomes for children, young people and adults.

- The group will also continue to develop resources in line with strategic priorities and any learning from local and national reviews.

16. Independent Scrutiny

In April 2023, Swindon Safeguarding Partnership's Independent Scrutineer stepped down from the scrutineer role after four years with the Partnership. They had been instrumental in helping to set up the Safeguarding Partnership and had supported in both the independent chair and scrutineer role.

This role has not been recruited to as Partnership Executives agreed to try a different model of scrutiny for 23/24, this has meant that 22/23 annual report has not been independently scrutinised.

Prior to leaving, the Independent Scrutineer had made the following recommendations for 22/23.

Performance and Quality Assurance activity:

1. Identify leads to develop an audit toolkit and development activity regarding the audit process to include report writing, and a scheme of delegation for implementing the toolkit with clarity of roles and responsibilities – *See page 29 & 30*
2. Determine when revised QA arrangements/independent scrutiny will begin - *See page 29 & 30*
3. Confirm who is leading the work to further develop multi-agency dataset – *Business Support Unit Strategic Manger had been identified to lead this work and this is progressing.*

Practice related:

1. Seek assurance from Designated Nurse that arrangements for sharing information from health providers in MASH/strategy discussions/S47s and CPCs is compliant with statutory guidance/inspection criteria – *Health attendance at Strategy Discussion Guidance was reviewed, updated & published November 2022.*
2. Confirm the arrangements for the performance monitoring of emotional health and wellbeing needs of children and young people – *CAMHS reporting to be added to the multi-agency dataset so that performance can be monitored and emotional health and wellbeing needs understood*.
3. Receive a report about the outcome of the self-neglect risk assessment tools agreed to inform decision making in relation to risk assessment framework – *See page 10*
4. Discuss how best to seek to understand the increase in adults who are being financially abused – *see page 12 & 13*
5. Receive assurance from ICB as to when the Designated Doctor vacancy will be filled – *This post is still vacant and has not yet been recruited to.*

What's next for 23-24?

- Partnership Executives to commission Independent Scrutineers to undertake specific areas of scrutiny work linked to the Partnership priorities for 23/24.

17. Conclusion

Swindon Safeguarding Partnership recognises that there has been minimal progress on some areas of the 2022/23 business plan. The system and capacity challenges discussed in the report have been one of the barriers to achieving this. There has been some changes in senior leadership within the Partnership and this will support further work to ensure that Partners are committed to engage in Partnership working and understand how their agency contributes to the Partnership multi-agency safeguarding arrangements.

The following key areas for continuous improvement remain unchanged for 23/24:

- Updating the 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.
- Promoting the use of Adult safeguarding plans with the voice of the adult with care and support needs clearly represented;
- Embedding the voice of children, young people, family's 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 implementing changes and evidencing the impact of those changes.

In line with statutory requirements and best practice the annual report and will be shared with:

- Child Safeguarding Practice Review Panel
- The Chief Executive, Swindon Borough Council
- Leader of the Council & Cabinet Portfolio Holders
- Chair of the Health and Wellbeing Board
- The Community Safety Partnership Executives

This report has been authored by Hannah Woloszczynska, Swindon Safeguarding Partnership Strategic Manager.

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Should you require the report in any other format to support accessibility please contact safeguardingpartnership@swindon.gov.uk