Swindon Safeguarding Partnership

ANNUAL REPORT

2024-2025

1. Introduction

Thank you for taking the time to read **Swindon Safeguarding Partnership's Annual Report,** which covers the period 1st April 2024 - 31st March 2025. The report focuses on the work and impact of the Partnership during this year. We hope you find the report interesting and informative.

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

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

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.

We recognise that all of the work you do can result in such positive changes for the children and adults we work with.

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

2. Multi-Agency Safeguarding Arrangements

The structure of the Multi-agency Safeguarding Arrangements in Swindon has been updated to reflect the changes in Working Together to Safeguard Children 2023. We have ensured that all functions of the Partnership align to the multi-agency principles for working with children and families along with arrangements for safeguarding adults.

The Safeguarding Partnership's core membership continues to be made up of Statutory Partners and a range of education settings, health providers, criminal justice services, voluntary and third sector organisations across Swindon who all play a pivotal role in supporting improvements across Swindon's safeguarding system.

Swindon Safeguarding Partnership Ambition

The Partnership will act with intent and purpose to deliver measurable and meaningful improvements in outcomes for children and adults with care and support needs. This means that the partnership will:					
Create a stronger culture of collective responsibility for safeguarding children and adults	Act on learning so that the partnership can continuously improve its support for children and adults with care and support needs	Activate and empower the local community to be safeguarding partners	Increase the involvement of children and adults in the work of the partnership	Develop a confident and knowledgeable workforce and use their expertise to shape our work	Use our data to develop a shared narrative about the safeguarding needs of children and adults in Swindon

Lead Safeguarding Partners

As defined in the Working Together to Safeguard Children 2023 and the Care Act 2014, the lead representatives of the Safeguarding Partnership are:

The Chief Executive of the local authority:
Sam Mowbray, Chief Executive, Swindon Borough Council (SBC)

Chief Executives for the Integrated Care Board (ICB) for an area, any part of which falls within the local authority area:
Sue Harriman, Chief Executive, BaNES, Swindon and Wiltshire ICB

Chief Constable of for an area, any part of which falls within the local authority area:
Catherine Roper, Chief Constable, Wiltshire Police

The funding arrangements for the Swindon Safeguarding Partnership and contributions are set out in the full Partnership's Multi-Agency Safeguarding Arrangements for Children and Adults with Care and Support Needs, which can be read here.

The Safeguarding Partners provide through financial or in-kind contributions the resources required to deliver effective multi-agency safeguarding arrangements. The Safeguarding Partners funding contributions for 2024/25 are as follows:

Swindon Borough Council	£128,000
Wiltshire Police	£47,700
BSW ICB	£82,000
Great Western Hospital	£17,700
Probation	£2000
Avon and Wiltshire Mental Health Partnership	£2000
Total	**£279,400**

In Swindon, the Lead Safeguarding Partners have delegated their responsibilities for the safeguarding arrangements to the following:

Delegated Safeguarding Partners

Swindon Borough Council – **Lisa Arthey**, Corporate Director Childrens Services

Swindon Borough Council – **Clare Deards**, Corporate Director Integrated Adult Social Care (DASS)

BaNES, SWINDON and Wiltshire Integrated Care Board – **Gill May**, Chief Nurse Officer

Wiltshire Police – There has been a change of Police representation with **Liz Coles**, Assistant Chief Constable, Crime, Justice and Vulnerability, taking over from **Mark Cooper**, Assistant Chief Constable in January 2025.

Jackie Fieldwick, Chief Executive Officer, Brunel Academies Trust has remained as the education representative on the executive group.

Gill May has continued to chair the Partnership this year. There was agreement from the Delegated Safeguarding Partners that the police representative would take over from Gill in January 2025 but this did not happen due to Mark leaving his role and Liz stepping into the safeguarding space. There is a plan for a change of Chair for 2025-26.

Partnership Structure for 2024-25

Lead Safeguarding Partners

SBC Local Authority, Chief Executive, **Samantha Mowbray**
Wiltshire Police, Chief Constable **Catherine Roper**
BSW ICB Chief Executive Officer, **Sue Harriman**

Delegated Safeguarding Partners

BSW ICB Chief Nurse, **Gill May – Partnership Chair**
SBC Local Authority Director of Childrens Services, **Lisa Arthey**
SBC Local Authority Corporate Director Integrated Adult Social Care (DASS), **Clare Deards**
Wiltshire Police, Assistant Chief Constable, **Liz Coles**
Education Representative, **Jackie Fieldwick**, CEO Brunel Academies Trust

Joint Multi-Agency Children and Adults Partnership Group

Safeguarding Partnership Priorities 2024/25

- All Age Exploitation – Children & Adults
- Neglect – Children
- Self-Neglect - Adults
- Levels of Need - Children

Safeguarding Partnership Sub-Groups 2024/25

Delivery Group

- Strategic All Age Exploitation Group – Children & Adults
- Self-Neglect Sub-Group – Adults
- Children's MASH Strategic Group
- Early Intervention, Youth and Communities Group
- Neglect Sub-Group - Children

Safeguarding Partnership Enabler Groups

- Practice Review Group
- Quality Assurance Group
- Learning & Development Group

What we have achieved in 2024-25 at a glance

ALL AGE EXPLOITATION

We hosted an all Age Exploitation Conference with experts by experience and launched our strategy to raise awareness about children and adults exploitation across Swindon

SELF-NEGLECT

We hosted a joint B&NES, Swindon and Wiltshire Spotlight event to raise awareness of self-neglect across these areas. Experts by experience co-delivered this with partners from across the localities. We also launched our co-produced self-neglect strategy and welfare and safety plan to support working with adults who self-neglect

WALK THE FLOOR AND QUALITY ASSURANCE

We completed walk the floor assurance visits to agencies across Swindon to review how they are working to safeguard children and adults. We also developed a multi-agency dashboard to support us to evidence outcomes for children and adults

CHILD FIRST APPROACH

The Child First Swindon manifesto was co-produced with Swindon's Young Changemakers, a diverse group of children and young people aged 12-25. We want to ensure that all children and young people have a voice, are heard and that their views are used to inform and improve the way we support and work with them

3. Scrutiny of the Safeguarding Partnership

For 2024-25, the Partnership Executives commissioned specific areas of scrutiny work. This included a scrutiny review into the progress of the recommendations from the deep dive into the effectiveness of learning and development, quality assurance, the arrangements for working with neglect across the Partnership; they also requested a Multi-Agency Section 42(2) scrutiny audit.

At the end of 2024-25, there were four outstanding actions on the learning and development and quality assurance scrutiny action tracker. Two of these are red and two are amber. The outstanding actions relate to updating the Partnership business plan, the progression of closing Safeguarding Adult Reviews and Local Child Safeguarding Practice Review actions and a new chair for the Partnership. The business plan is due to be updated for 2025-26 due to a change in priority area.

We have achieved the following relating to the effectiveness of learning and development and quality assurance recommendations:

- Increased the capacity within the Strategic Support Unit to support childrens work across the Partnership.
- Progressed all Safeguarding Adult Reviews and Rapid Reviews within timescales.
- Implemented a ‘Closing the Learning Loop’ Process to support the implementation and embedding of learning across the Partnership.
- Produced a robust quality assurance framework and multi-agency audit schedule.
- Implemented quarterly quality assurance group meetings, which were chaired by an independent scrutineer to support with scrutiny of Partnership data and performance.
- Children’s MASH Strategic group reinstated to ensure oversight of performance at the front door.
- Progressed historic SAR, Rapid Review and LCSPR actions.
- Agreed a risk register process for executive oversight.

An independent scrutineer was commissioned to complete a Section 42(2) audit. This looked at case complexity, timeliness and throughput of work and management capacity to oversee compliance with adult safeguarding duties. The report made seven recommendations for policy and practice improvement. There are two outstanding actions from the audit. One of the actions is red and relates to data reporting on the timeliness of section 42 by adult safeguarding, due to reporting issues with Liquid Logic this data, along with other adult data, has not been available and is a Partnership risk. The others action is amber and this relates to producing easy read versions of abuse awareness posters.

We have achieved the following:

- Ensured the quality assurance audit process within Adult Safeguarding includes:
  - S42(1) decision making to ensure suitable reasonable adjustments are evidenced to support adults with care and support needs, including those unable to protect themselves due to trauma or neurodiversity.
  - s42(2) protection planning is engaging with the adult at risk, independent advocacy and family or paid carers to ensure there isn't an overreliance on individuals to provide care or support where this is beyond their ability or where there is an ongoing risk of exploitation or abuse within the care relationship
- Revision of the Adults Policy and Procedures.
- Developed awareness posters with experts by experience for raising awareness about abuse for the public.

The scrutiny actions relating to neglect formed the work programme of the Partnership Neglect Group. At the end of 2024-25, there were two outstanding actions on the neglect work programme, these both related to the implementation of the neglect-screening tool across the Partnership and the challenges that the Partnership has in embedding this in practice. This is a priority area for the work of the sub group for 2025-26.

We have achieved the following:

- Gained the views of frontline practitioners helping to understand the barriers and dilemmas experienced in practice via questionnaires and via a practitioner forum with neglect as a theme.
- Developed 'level of need' training across the Partnership to include case studies with neglect as a theme within this training.
- Improved attendance of partner agencies at the neglect group.
- Gained the views of children and parents in multi-agency neglect audits.
- Delivered a case review learning event looking at themes from Tristan and Alan case reviews where adolescent neglect was a factor.

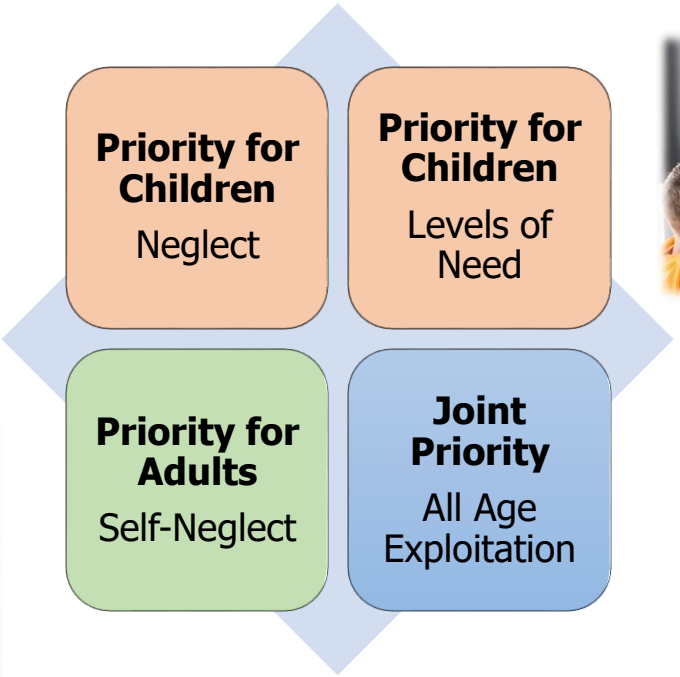
There are ongoing challenges across the Partnership relating to neglect and areas for improvement, which will require further scrutiny during 2025-26. This includes:

1. A clear and consistent understanding of the thresholds for intervention and the criteria for escalation among all partners, especially in cases of child neglect.
2. More effective communication and information sharing among partners, both within and across agencies, to ensure that all relevant information is available for decision making and risk assessment.
3. More robust challenge and professional curiosity among partners, to avoid accepting disguised compliance or minimising the impact of neglect on children.
4. More involvement and participation of children and families in the assessment and planning process, to ensure that their views and wishes are heard and considered.
5. More joint training and learning opportunities for partners, to enhance their skills and knowledge on child neglect and other safeguarding issues, and to foster a shared culture of accountability and responsibility.

4. Safeguarding Partnership Priorities 2024-25

The Delegated Safeguarding Partners have agreed the following strategic priorities for the year. There has been one change in the priority areas for this year, with 'Levels of Need' relating to children, replacing children under 2 years old, unborn babies, working with fathers and male partners. Although this is no longer a priority for the Partnership we recognise that this group of children are particularly vulnerable and there will still be work happening across the Partnership and across the B&NES, Swindon and Wiltshire around safeguarding children under 2 years old.

The other priorities remain the same as we recognise that locally there needs to be an ongoing strategic response to these key areas.



Priority 1: Neglect

Neglect has remained a priority for the Partnership for 2024-25. Local data continues to tell us that approximately half of all children on child protection plans in Swindon were on a plan for neglect; this is consistent with the previous year in Swindon and in line with national statistics.

There remain challenges across the Partnership when identifying and working with children who have been neglected and we have not yet been able to fully embed the Neglect Screening tool across the Partnership. Resources have been provided along with spotlight events, monthly Partnership theme and practitioner forums promoting the use of the tool and raising awareness of the factor that could contribute to a child's needs being neglected.

Neglect Group

The Safeguarding Partnership Neglect Group has continued to meet bi-monthly and has focused on the issue of neglect by helping to improve awareness, identification and assessment of neglect. The Group has looked at barriers to this happening and has sought out assurance from Partners on what they are doing across their organisations to support managers and practitioners when working with neglect.

The Group members had oversight of and supported the Partnership to complete the following activities:

1. Agreed a neglect dataset and dashboard along with an outcome based accountability scorecard that set out qualitative and quantitative measures and indicators relating to neglect so the Group could start to use data to look at any emerging trends and evidence impact for children.

2. Monitored and progressed a Neglect Group work programme consisting of recommendations and actions from neglect scrutiny work and progressed actions from Neglect audits.

3. Reviewed national statistics relating to Neglect using the NSPCC statistics briefing and NSPCC Too Little Too Late briefing paper.

4. Reviewed impact on practice from neglect spotlight events. Agree to provide training on how to complete the neglect screening tool.

5. The Group agreed a re-implementation plan to look to embed the Neglect Screening Tool across the Partnership. The Group made a request that a tick box is built into Liquidlogic system so that data can be captured by Children's Social Care. This will help to provide assurance that the screening tool is being used to evidence neglect and support referrals for children. Dip sampling provided by Children's Social Care was not able to evidence that the tool is being used when there are neglect concerns.

6. Reviewed dip sampling undertaken in MASH around identification of neglect at the front door and use of the screening tool to support referrals. This evidenced inconsistent identification of neglect, especially where there were other concerns such as drug or alcohol misuse, it was difficult for workers to identify neglect and they often categorised cases under broader issues such as parenting capacity. There was also under-utilisation of the neglect screening tool and variability in threshold decision making

7. Agreed the scope, audit tool and relevant agencies to take part in a repeat multi-agency audit to review whether there has been any improvement in practice. Audit was due to be undertaken in Q4 of 2024-25 but this was delayed due to a child sexual abuse audit needing to be prioritised.

8. Supported the production of guidance to support the Partnerships Response to Childhood Obesity in the Context of Neglect

The Partnership recognises that there has been limited progress in fully embedding the neglect screening tool and learning from audits/case reviews in practice across the Partnership. Despite lots of activity, producing recourses and tool kits, and offering training, we have been unable to evidence any impact from this work on children during 2024-25.

What is next for 25-26?

- The Partnership re-implementation plan to be progressed by the Neglect Group along with training on the neglect screening tool.

- Set up a professional network of Neglect Champions across the Partnership.

Priority 2: Levels of Need

MASH Strategic Group

The MASH strategic group met regularly throughout 2024-25. The group has had oversight of the MASH part of the Children's Social Care improvement plan and performance at the front door. This has included oversight of multi-agency audits completed within MASH and threshold decision making for children. Partners had been able to escalate concerns via the strategic group in relation to a MASH report relating to decision making for children who had been referred for concerns around child sexual abuse *(see section 5, Child Sexual Abuse for further details).*

Early Intervention, Youth and Communities Group

The Early Intervention, Youth and Communities Group met bi-monthly during 2024-25. The Group members had oversight of and supported the Partnership to complete the following activities:

1. Analysed the national review into the findings of the Multi-agency Response to Children and Families who need Help Joint Targeted Area Inspections.

2. Completed *'Multi-agency Response to Children and Families who need Help'* audits.

The focus of these audits was to look at the multi-agency response to children and families who need help.

The audit process identified some positive practice, evidencing the importance of relationship based practice, trauma informed interventions, multi-agency communication and professionals working together to support children and families. Families provided feedback as part of the audit process and shared that the support they had received has positively impacted their lives.

Despite this, over half of the audits were inadequate or required improvement to be good, which tells us that we are not always providing the right support at the right time and at the earliest opportunity for children. It is notable that ten children (83%) were previously known to Children's Social Care, therefore these children were not early help children at the truest form and some had historically been open to statutory services at Child In Need and Child Protection, and had previously had early help support in place.

There was evidence that early intervention services were working with some children and families with multiple and complex needs. For some families, circumstances had improved with support but then circumstances had declined once support stopped. For some children, there had been multiple interventions for their families, with limited sustained positive change.

There were a number of recommendations and actions from the audit that are being monitored by the group and being used to inform the groups work programme.

3. Held Early Help System Guide Partnership feedback sessions and Early Help Conversation consultation.

4. Agreed the Early Intervention Youth and Community offer for Harm outside the Home and the Harm outside the Home training offer.

5. Started to use early intervention data within the Group to help understand performance, emerging trends, and whether children are being offered support at the earliest opportunity to prevent escalation to statutory services.

What is next for 25-26?

- Review of the Early Intervention Strategy so that the priority areas align with the Partnership's priority areas.

- Finalise the Early Help System Guide.

Priority 3: Self-Neglect

We understand self-neglect to be a lack of self-care in a person to the extent that it can threaten personal health and safety, it can include not caring for one's personal hygiene, health or environment. This may result in harm to the person. It can also be the failure to seek out help and access services to support health and social care needs. Self-neglect can also be someone's inability or willingness to manage their personal affairs.

We have been unable to collect data relating to the number of referrals received into Adult Safeguarding for self-neglect due issues with data reporting in Liquidlogic.

All of Swindon's SARs during 2024-25 had self-neglect as a factor. This has led us to continue with Self-Neglect as a Partnership priority for this year and resources have been allocated to drive forward improvement via the multi-agency Self-Neglect Group.

Self-Neglect Group

The Safeguarding Partnership Self-Neglect Group has continued to meet bi-monthly and has focused on the issue of self-neglect by helping to improve awareness, identification and assessment of self-neglect. The Group has looked at barriers to this happening and has sought out assurance from Partners on what they are doing across their organisations to support managers and practitioners when working with self-neglect

The Group members have had oversight of and supported the Partnership to complete the following activities:

1. Produced and signed off the Multi-agency policy and guidance on responding to self-neglect

2. Co-Produced the Partnerships Self Neglect Strategy with adult scrutineers.

The Swindon Self-Neglect strategy is based around four core pillars: People, Prevention, Partnership and Practice.

These four P's build upon the learning from experts by experience, practitioners, services and our Safeguarding Adult Reviews in Swindon and reflect the areas of development that need to be taken forward across the borough.

Always Care Commitments:

People	**Always work with and alongside people who self-neglect**
Prevention	**Always work to prevent the risk of serious self-neglect**
Partnership	**Always bring partners together to support those at risk**
Practice	**Always develop and support best practice in Swindon**

3. Completed repeat multi-agency self-neglect audits.

The audit evidenced that several agencies graded themselves as requires improvement as most audits from partners showed a mix of good practice alongside areas of learning and practice that required improvement.

There were some great examples of practice, the few cases graded as ‘outstanding’, were where the partner was pushed into silo working whilst trying to bring effective Multi-Disciplinary Team meetings together. There was outstanding practice in those workers being tenacious and persistent in supporting the person but there remains concerns about how this impacted the individual who was not receiving the multi-agency support they required.

Best practice was not always consistent or in line with the self-neglect policy. There was evidence of improvements since the last audit, for example, the lead professional where there was a section 42 enquiry was now clear.

There still needs to be an improvement in consistent Multi-Disciplinary Team working across Swindon. There are numerous resources available and the guidance is clear, however the reality of achieving this in practice with increasing demand and pressure remains a challenge.

Practice quality has not been evidenced as consistent although there is clear evidence that when a professional takes hold of a situation then there is excellent practice to be seen.

4. Delivery of a Partnership spotlight event on Self-Neglect Learning from Reviews and a spotlight event on Self-Neglect Policy into Practice. These events were supported by experts by experience.

5. Delivery of a Pan BSW Self-Neglect Conference. Delivering consistent messages about self-neglect across the BSW footprint. This event was supported by experts by experience.

6. Oversight of the co-production of the Welfare and Safety Plan and Welfare and safety plan practitioner guidance.

7. Agreed a self-neglect dataset and dashboard along with an outcome based accountability scorecard that set out qualitative and quantitative measures and indicators relating to self-neglect so that the group could start to use data to look at any emerging trends and evidence impact for adults.

8. The Group had oversight of national guidance relating to rough sleepers, homelessness and the intersectionality of this with self-neglect.

The Partnership recognises that there is still work to do to fully embed the self-neglect policy, guidance, welfare and safety plan and learning from audits/case reviews in practice across the Partnership. Although there as a reduction in the number of Safeguarding Adult Reviews where self-neglect is a factor, audits evidence that there are areas of practice that still need to improve to ensure adults who are self-neglecting are receiving the right support at the right time.

What is next for 25-26?

- Assurance to be provided of whether organisations are successfully embedding the use of the self-neglect policy, guidance and welfare and safety plan across the Partnership.

- Further multi-agency audits to be undertaken to look at the intersectionality of adults who are misusing alcohol and self-neglect linked to SAR Robert.

Priority 4: All Age Exploitation

In Swindon we recognise that some children experience harm outside of the home and can be exploited criminally or sexually. We also recognise that susceptible adults can also be groomed, forced or coerced into doing something that they don't want to do for someone else's gain.

We want to work together with all partners to ensure that children, young people and susceptible adults across the Partnership are prevented from becoming victims of exploitation, perpetrators and/or groomed to facilitate exploitation.

All Age Exploitation Strategic Group

The All Age Exploitation Strategic Group met regularly throughout 2024-25. The Group members had oversight of and supported the Partnership to complete the following activities:

1. Launched the Swindon_Safeguarding_Partnership_All_Age_Exploitation_Strategy, which sets out the key priorities for the Partnership and how we will aim to support children and adults.

Priority 1 - Prepare

- Prepare for dealing with incidents of exploitation as a partnership to support any identified victims, prosecute any identified perpetrators and mitigate the impact on the community.

Priority 2 – Prevention

- Improve awareness, understanding and early recognition of exploitation across the Partnership.
- The Partnership has a clear understanding of exploitation.
- The Partnership is better able to recognise exploitation and the importance of early intervention, and practitioners are confident enough to respond promptly and effectively to address underlying factors.
- Members of the community are better equipped to recognise exploitation in all its forms and how to report it.
- Ensure the workforce (including public, independent, and community voluntary sector) receives appropriate learning and development opportunities relevant to their role.
- Commissioned service providers ensure their workforce is able to recognise exploitation and respond to it.
- Good quality data is available to inform problem solving. Agencies regularly problem-profile their local area to analyse and understand all the patterns of exploitation to which children and adults are subject to.

Priority 3 – Protection

- Improve individuals and communities resilience to tackle and reduce exploitation and the interventions to tackle exploitation.
- Effective, multi-disciplinary procedures, tools and pathways are embedded and reviewed over time to ensure effectiveness.
- Assessments and response to include consideration of the context in which exploitation takes place.
- Child protection plans and safeguarding plans are effective and kept under review.
- Support is made available in a timely manner to victims in their recovery.
- Language Matters - appropriate terminology is used when discussing individuals who have been exploited, or are at risk of exploitation.
- Professionals challenge each other and escalate as appropriate when there are professional differences of opinion and look to understand the importance of understanding and sharing risk across the Partnership.

Priority 4 - Partnership and Leadership

Secure a collective commitment to tackle exploitation across the partnership and demonstrate effective leadership in driving forward changes required

- Early identification and the effective response to exploitation is a priority across all organisations, both statutory and non-statutory.
- Develop a multi-agency strategy to support the delivery of an effective range of interventions to tackle exploitation.
- Promote a clear local partnership response to exploitation that takes a strength based approach.
- Leaders drive the importance of sharing information appropriately in order to tackle exploitation effectively.
- Leaders invest in the development and support of staff, including provision of regular supervision and the opportunities for them to reflect on practice. Those professionals who offer direct support to exploited children and adults might require further intensive training that is regular and reflective of the rapid changes in exploitation tactics. They must have regular opportunities to reflect on their practice with a skilled consultant or supervisor.

Priority 5 – Pursue

- Improve prosecutions and disruption of individuals and groups responsible for exploitation.
- Effective arrangements to identify, disrupt and increase arrests and prosecution of offenders involved in crimes associated with all forms of exploitation and the effective management of those in medium-high risk offending and deter those involved in lower level criminology are in place.
- Development of regional and local profiles.
- Deterring potential offenders through increased awareness and reducing opportunities.

2. Completed multi-agency audits for children and adults

Childrens Audit - The audit process identified some positive practice across the Partnership when working with children who are at risk of exploitation or who are being exploited.

There was some evidence that when consistent intervention had been provided from someone the children were able to build a positive relationship with, this had made a positive impact to the lives of children and the risk of harm had reduced for them.

There was evidence that the risk had reduced for three children who were cared for by the Local Authority. There was evidence of robust plans of support around them, which supported to improve outcomes, although in one case it was recognised that although risk had reduced there was still a level of concern due to the young person being NEET and using cannabis.

There was evidence that risk had not reduced for the children who were known to early help services. Early identification of exploitation was not fully assessed and was not evident in planning. There was limited evidence of multi-agency support in place for the children.

It was evident that the multi-agency support provided to children who were at risk of being exploited or who are being exploited was not consistent or robust enough to ensure that they are fully protected from harm. It was recognised that there needed to be an improved response to working with child exploitation across the Partnership.

Adult Audit - The audit process has identified some positive practice throughout the Partnership. It was evident that professionals worked with compassion and agencies worked hard to engage with people, showing a willingness to work together in a multi-agency way.

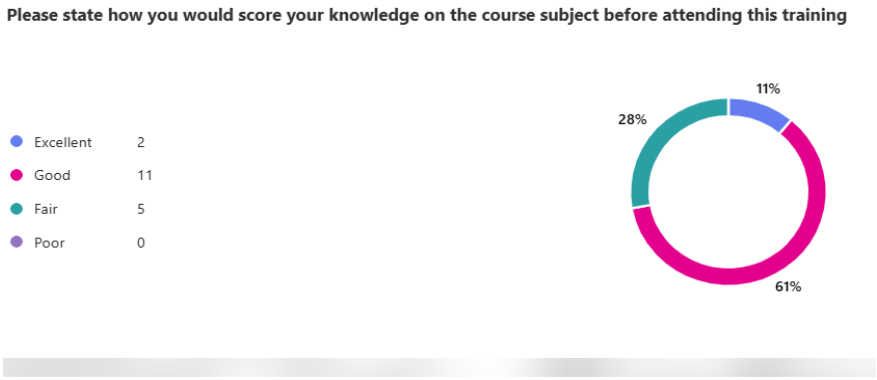
Some key themes that came out from the audit included the inconsistencies in understanding and categorising exploitation for adults, including the language used to record concerns for exploitation being inconsistent and unclear. There was a reoccurrence of these themes and significantly, a pattern of unclear pathways in how to respond to concerns for exploitation.

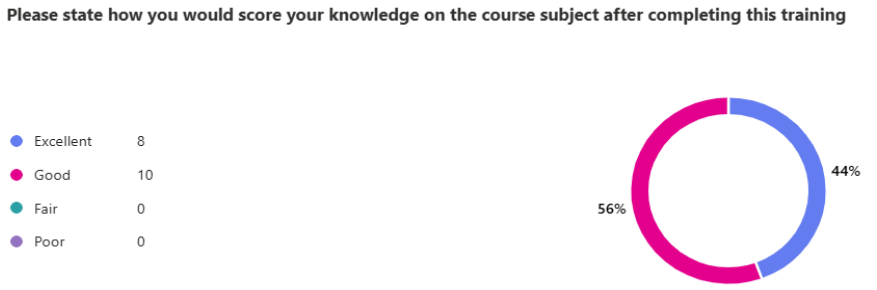
It was agreed that reporting and GDPR knowledge could be a barrier to how agencies respond to concerns. In addition, it was clear that ‘opt in’ services added a significant barrier to adults getting support for exploitation and it was agreed this method was ineffective. The audit group agreed that outreach was the most effective way to build relationships and support a person experiencing exploitation.

Recommendations and actions from the audit are being monitored by the group and being used to inform the Groups work programme.

3. The Group reviewed the responses of a practitioner questionnaire to help understand the experiences of professionals working with children and adults who are being exploited across the Partnership. Responses are helping to inform where gaps or barriers might be across the Partnership.

4. Organised an All Age Exploitation conference, which supported the launch of the All Age Exploitation Strategy. The conference also promoted Swindon's harm outside of the home approach for working with children and practitioners shared their journey of working with children who were being exploited. An adult expert by experience bravely shared their experiences of being exploited and a parent, who was an expert by experience, shared her son's story. The purpose of the event was to build professionals confidence in identifying, assessing and responding to exploitation, which we were successful in achieving.





5. Agreed an exploitation dataset and dashboard for children and adults along with an outcome based accountability scorecard that set out qualitative and quantitative measures and indicators relating to exploitation so that the group could start to use data to look at any emerging trends across Swindon and evidence impact for children and adults.

6. Launched and updated the Child Exploitation Risk Assessment Framework (CERAF) Child exploitation risk assessment framework and guidance to aid practitioners in their assessment of harm outside the home for children and young people.

7. Developed and launched an Adult exploitation screening tool and guidance to support professionals when working with adults where there are concerns they are being exploited.

The Partnership recognises that there is still work to do to fully embed the All Age Exploitation Strategy and learning from case reviews and audits in practice across the Partnership. Audits evidence that there are areas of practice that still need to improve to ensure children and adults who are being exploited are receiving the right support at the right time.

What is next for 25/26?

- Wiltshire Police to present police exploitation team restructure to the Partnership and for confirmation to be provided of which exploitation operational groups across safeguarding and community safety will report into the All Age Exploitation Strategic Group.

- Further multi-agency exploitation audits to be undertaken to understand whether there has been any improvement in practice across the Partnership.

5. Safeguarding Adults and Children

Swindon continues to experience a steady population growth. There has been an increase in the number of children living in Swindon. Swindon is also gradually aging; with an increase in people aged 65+. Both of these factors can impact on safeguarding resources Swindon Joint Strategic Needs Assessment.

Safeguarding Adults

"Safeguarding adults is not just about protection, it's about honouring every person's right to live with dignity, respect, and freedom from harm. Together, we can work to support adults to feel safe, valued, and empowered."

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.

Adults Strategy

In July 2024, The Adult Social Care Strategy 2024 - 2029 was published Adult Services Strategy 2024-2029 setting clear expectations for Adult Services in Swindon to ensure that the people they work with and for have "Lives, not Services". This was informed by the Adult Social Care White Paper "People at the Heart of Care" (2021), the principles of which underpin the strategy are choice, empowerment and personalisation. Adult Social Care is more than a gatekeeper of funded residential and domiciliary services; it exists to enable adults of all ages and with a range of conditions to live their best life, either at home, or somewhere away from their home. When done well it can be transformative. It is this transformation that the 2024 - 2029 vision and strategy for Adult Services seeks to inspire. Priority eight within the strategy sets out the aims for safeguarding adults, *"Ensuring your safety is everyone's concern".*

Safeguarding Partnership Adult Safeguarding Policy and Procedures

The Safeguarding Partnership Adult Safeguarding Policy and Procedures has been updated and is due to be published and shared across the Partnership in June 2025. This document provides information to partners in terms of the aims and principles of safeguarding, it includes the types of abuse people may experience and details concerning how to make safeguarding personal. The document also provides information about safeguarding adult procedures and an overview of undertaking a section four enquiry. The Principal Social Worker in adult social care plans to introduce this document within a forthcoming Practice Quality Forum, whereby representatives from each adult social care team will be tasked with disseminating this learning into their teams.

Adult MASH

The Multi-Agency Safeguarding Hub (MASH) has continued to operate in co-location with Children's MASH, the Police and ICB health representation.

Operational MASH meetings are held every six weeks, bringing together key partners including Swindon Borough Council (SBC), the Police, ICB, Avon and Wiltshire Partnership (AWP), Great Western Hospital (GWH), and the Quality Assurance team. These meetings provide a collaborative forum for discussing strengths, areas for improvement, and any concerns or developments requiring attention.

Daily huddles are maintained with Police and other available partners to support the timely exchange of information and development of clear, coordinated plans for individuals.

In preparation for the Care Quality Commission (CQC) review, the Local Government Association (LGA) conducted a peer challenge in March 2024 with the report being made available in May 2024. The resulting report commended the safeguarding team's triage processes and risk assessment methodology, noting a strong grasp of safeguarding principles and an ability to apply a person-centred approach to risk.

Strengthening data management has emerged as a key priority following insights from both internal and external audits. To support this initiative, ICT revolutions have been commissioned to improve the safeguarding data infrastructure. These developments will enable more effective identification of focus areas, both operationally and strategically in the years ahead.

Although the online safeguarding portal form is not yet implemented, progress has been made in its design, with implementation planned for late 2025 early 2026.

Adult Safeguarding Plans

Safeguarding plans are currently documented within the general enquiry text, with some recorded on separate, individual plans. Although the redesign of safeguarding forms has commenced, progress has been slower than initially anticipated due to various complexities and interdependencies. The development of safeguarding forms, processes and associated

data outputs are closely linked and must be completed in parallel. This integrated approach has resulted in an extended timeline for full implementation.

Liquid Logic

Safeguarding workflow configuration changes/form re-design
Adult Social Care will be compiling a new practice guidance document for safeguarding. This guidance document will then inform and highlight any changes to the Liquidlogic safeguarding workflow and the design of the forms with Safeguarding episodes.

Safeguarding Data/Reporting
The development of a new Safeguarding PowerBI dashboard is in progress. The first iteration of this report should be available for use in autumn 2025 and this will provide datasets required by the Swindon Safeguarding Partnership, KPI's and management information, caseload and throughput oversight and CQC metrics. Future iterations of this report will be considered to align with system development work that comes out of the development of practice guidance.

Safeguarding Portal Referrals
Support has been requested from external consultants to configure and go live with Liquidlogic's Client Portal functionality. The portal will contain two new safeguarding referral forms (one for self-referrals/members of the public, and one for professionals to complete). The new portal forms will be embedded within the Swindon Borough Council corporate website, so the experience of the referrer will not change. The main benefit of this new functionality is that the portal form will land directly into Liquidlogic to be processed, removing the need for information to be manually copied and pasted from an internal form into the case management system.

CQC

Following the introduction of the Health and Care Act in 2022, new regulatory powers were given to the Care Quality Commission to assess how local authorities meet their Care Act duties. CQC are using a single assessment framework to evaluate various services across health and care sectors.

In preparation, all local authorities have had the opportunity to assess their own performance against this framework by completing a self-assessment on four themes:

- **Working with people**
- **Providing support**
- **Ensuring safety**
- **Leadership**

During 2024, Adult Social Care completed a self-assessment following a number of engagement sessions across the Partnership involving people who are being supported and colleagues working across Swindon. The process identified strengths and effective collaboration in our strategic partnerships and opportunities to develop the Safeguarding

Policy and Procedure document. These have been included in the adult social care strategy and included in the adult social care improvement plan and service priorities.

On 13th November 2024, CQC notified Swindon Borough Council's Adult services of the commencement of the assessment process consisting of various stages and taking place over a period of up to six months.

The stages included:

- The submission of a comprehensive information return consisting of key evidence, information and data, the team submitted 204 pieces of evidence;
- a pre-meeting with senior leaders and representatives from CQC;
- case tracking activity to assess the lived experience of people drawing support from social care;
- remote activity with partners and providers including the voluntary and community sector
- the on-site assessment which took place the week commencing 24th March 2025 involving leaders, staff, partners, stakeholders and experts by experience.

The CQC inspection involved speaking to one hundred and thirty four people, including one hundred and four staff, nine external stakeholders, four Voluntary and Community Sector partners, seven experts by experience, six providers, three cabinet members and one shadow cabinet member. The inspection week included four staff drop ins, two manager drop ins, twelve team interviews, five group interviews, seventeen solo interviews, and two coproduction sessions.

SBC Adult Services welcomed the CQC assessment process in Swindon, the whole process has been a powerful catalyst for reflection and change, and it has been heartening to see how motivated the teams are by the opportunity to showcase their focus on delivering meaningful outcomes for the people we support.

SBC Adult Services are currently waiting to receive the final assessment report from CQC, which will include the scores for each of the quality statements within the four themes of the assessment framework, and an overall rating.

Rough Sleeping and Homelessness

Homelessness: legally, this is a person who is considered homeless if they do not have accommodation that they have a legal right to occupy, which is accessible and physically available to them (and their household) or which it would be reasonable for them to continue to live in. Rough sleeping is one form of homelessness.

Rough Sleeping: this is the most acute and extreme form of homelessness that is characterised by someone about to, or actually, bedding down in the open air (such as on the street, in tents, doorways, parks, bus shelters or encampments) or places not designed for habitation (including cardboard boxes, stairwells, cars and other makeshift and not fit for

purpose places). Rough sleeping does not include instances of those in hostels, shelters, recreational shelters such as campsites or spaces of protest, squatters, and travellers.

The Target Priority Group is made up of all people sleeping rough in an area who are furthest from having their rough sleeping resolved, have been in this position for some time and will remain so without a bespoke multi-agency intervention. The target priority group can include people currently sleeping rough, or those currently in off the street settings who are most likely to return to rough sleeping.

At the end of March 2025 there were seven people sleeping rough in Swindon on an average night. Seventeen individuals slept rough across the month of March. One of these individuals had accommodation available to them when sighted, one of them was a target priority group individual, one had no local connection and four had been evicted from emergency accommodation.

What has changed since 2024/25?

- Rough sleeper team manager is now the appointed group member of the Safeguarding Partnership; this has included giving regular updates on the service and the target priority group. There are live case studies brought to the Practice Review Group for learning.
- There is now representation from Great Western Hospital and SBC Adults Safeguarding Team at the monthly rough sleeper panel.
- SSOS is a 'Supra Outreach Service' co-ordinated by Change Grow Live (drug and alcohol service), which pulls in professionals to regular multi-disciplinary team meetings about clients that are rough sleeping with substance misuse. Regular multi-disciplinary team meetings will be encouraged for those with care and support needs or safeguarding needs; this has continued and is working well.
- The team will collate a list of referrals made of those rough sleeping or at risk of rough sleeping to safeguarding, mental health and Adult Social Care and the outcome of these referrals. This is tracked and escalation policy is used when required. Safeguarding Team has joined homelessness team on outreach a number of times to reach individuals that are more complex.
- An official count went ahead in November 2024; there was a total of seventeen individuals.
- There is now an operational outreach service five days a week.

What is next for 25-26?

- Homelessness Team are releasing a new homelessness guide to share with customers and partners.
- There is a face-to-face reception open at the council officer.
- Homelessness and safeguarding adults are working on a homeless mortality review process.

Safeguarding Children

'Nothing is more important than children's welfare. Every child deserves to grow up in a safe, stable, and loving home. Children who need help and protection deserve high quality and effective support. This requires individuals, agencies, and organisations to be clear about their own and each other's roles and responsibilities, and how they work together' Working Together to Safeguard Children 2023.

Children's Social Care Improvement Journey

There has been ongoing oversight and scrutiny of the Children's Social Care improvement journey led by the Independent Chair of the Improvement Board with DfE having oversight of this.

The Children's Social Care improvement board met six weekly throughout 2024-25, has had oversight, and has monitored progress of the improvement plan set out after the inadequate Ofsted inspection in July 2023.

During this period, there has been a deeper focus on practice across Children's Social Care, with monthly themed along with generic case audits looking at decision making and intervention and the impact this has had for children. Where it has been identified that decision-making and intervention has not been appropriate or effective this has been escalated and action has been taken to address the needs of the children with a SMART plan.

The improvement board have recommended areas of scrutiny as a result of specific interests in audits and finding from practice reviews. This oversight and scrutiny will continue during 2025-26 along with further Ofsted monitoring visits.

Ofsted Monitoring Visits

There have been three monitoring visits since the full Ofsted ILACS inspection in July 2023. The first focused on Children and Families Contact Swindon, and children's experiences at the 'front door' of Children's Services.

At the second visit, inspectors reviewed the progress made in the following areas of concern identified at the last inspection, this included child-in-need and child protection planning, including planning for disabled children, children who stepped down from child in need to early help services and children within the pre-proceedings phase of the Public Law Outline.

At the third visit, inspectors reviewed the progress made in the following areas of concern: Services to care-experienced young people aged 18 to 25 and services to separated migrant children aged 18 to 25.

All three of the monitoring visits identified areas where services provided to children had improved. There was also feedback provided from all three visits that there were still areas that needed to improve to be good. Swindon Ofsted Monitoring Visits

Children and Families Contact Swindon

In February 2025, there was a review of the 'front door'. This was after the implementation of 'Contact Swindon'. The thinking behind the Contact Swindon model of delivery was to bring early help into the front door into an integrated model to aid better decision making and to move away from the model of a Multi-Agency Safeguarding Hub towards MASH as a process within a more holistic front door.

The review identified that whilst elements of the implementation were positive, there were frequent changes of manager with associated changes to structure and process that had undermined its functioning. This had led to delays in children and families receiving a service and inconsistency in how thresholds of need were applied. It was also identified that whilst partners were co-located in the front door, they were not fully integrated and this has led to poor communication and a break down in working relationships.

'Contact Swindon' was changed to 'Children and Families Contact Swindon', which now consists of two interlinked collocated hubs each with a specific, defined purpose. They are the Triage Hub and the Safeguarding Hub. Incorporated within the Triage Hub is relevant early help/community expertise, which can deliver advice and support whilst assisting in the determination of thresholds alongside social work colleagues. This ensures that decisions about thresholds of need are made jointly between social care and early help.

There is ongoing monitoring of a MASH transformation plan via the Partnership's MASH Strategic Group and there will be further Ofsted monitoring of 'front door' services and the effectiveness of this during 2025-26.

Family Safeguarding Model

The Family Safeguarding Model implementation has continued throughout 2024-25. Children's Social Care has delivered training, including motivational interviewing training, supported practice implementation, and recruited to all of the adult safeguarding roles.

The Centre of Family Safeguarding Practice undertook a peer review in February 2025. The outcome of the review highlighted that staff remain positive about the Family Safeguarding Model in Swindon and the input from the adult practitioners in post is valued. Group supervision was taking place on a regular basis and there was some evidence of relationship-based practice (use of motivational interviewing). The peer review also highlighted that the adult practitioners were consistently recording within the monthly case summaries but didn't always attend the group supervision, that there was limited evidence of social workers summaries being used and that family programmes and not all plans appear to progress at pace.

A deeper dive was undertaken by the Family Safeguarding Practice Lead to look at each of the areas where improvements had been suggested. A number of recommendations relating to each of the areas had been identified and actions were agreed to progress this. The children's improvement board maintained oversight of Family Safeguarding and the impact this is having on children. This monitoring will continue in 2025-26 as part of the improvement journey.

Child Sexual Abuse

The 'National Review: Child Sexual Abuse within the Family Environment' *'I wanted them all to notice'* was published in November 2024. This identified systemic failings across services nationally to identify and respond when children are at risk of, or are already being sexually abused by someone in their family.

Issues highlighted included: not hearing children or understanding their needs, not understanding the context of parents'/carers' needs and vulnerabilities, challenges in recognising signs, appreciating risk, and responding to concerns of intrafamilial child sexual abuse.

Swindon's Safeguarding Partnership has taken a pro-active response to emerging national issues and reviewing practice within the area of child sexual abuse to strengthen the Partnership response to child sexual abuse, prevention, awareness raising, assessment and intervention.

Multi-agency training 'Developing an Understanding of Child Sexual Abuse' is an NSPCC course and local professionals have been trained to deliver this across the partnership to raise awareness and drive forward good practice for children and families at risk of or experiencing Child sexual abuse.

The Partnership has produced a web page dedicated to child sexual abuse with links to key documents, local resources and pathways to generate understanding and support best practice within this area.

The key findings from the National Review was presented to the Safeguarding Partnership in January 2025. The Partnership established a Task and Finish Group to review the recommendations from the National Review and the Partnership's response with required actions and recommendations.

At the time of the Partnership's presentation on the findings from the National Review in January 2025, Children's Social Care became aware of a small cohort of children who may have been at risk of sexual abuse, whom may not have had a sufficient response. In response to this, it was agreed that a quality assurance exercise was to be undertaken to provide assurance of actions taken and to ascertain a clearer picture of further work to be done across the Partnership.

As a pro-active response, it was agreed that contacts to Swindon's Children Social Care with the primary reason of child sexual abuse between 2022 and 2025 would be reviewed and audited. Additionally, a multi-agency audit of child sexual abuse would be undertaken.

The outcomes of these audits will be reported into the MASH strategic group and then subsequently to the Partnership Executive group. Similarly, the outcomes of these audits would be reviewed by Swindon Safeguarding Partnership Task and Finish Group for child sexual abuse and further inform that Partnership strategy/action plan and response.

What is next for 25-26?

- Recommendation made by Partners to Partnership Executives that Child Sexual Abuse is made a Partnership priority for 2025-26.
- Child Sexual Abuse Task and Finish Group to become a formal Child Sexual Abuse priority group for the Partnership.
- To progress recommendations from the NSPCC Snapshot undertaken in 2023 and from the National Review 'I wanted them all to notice'.
- To develop a Partnership Child Sexual Abuse Strategy.

6. Participation/Co-Production

The Safeguarding Partnership continues to recognise the importance of engaging children and adults in the work of the Partnership. We recognise that children and adults who contribute can help lead to more effective, inclusive and responsive systems.

Children and adults are able to provide the Partnership with insights into what has worked for them and what has not worked and how we might look to improve our response to them. Their input enables us to tailor policies and interventions to real needs and not just assumptions.

The Partnership have continued to build on Participation and co-production work. Mapping work has started across the Partnership to look at what participation work is already happening across organisations.

What is next for 25-26?

- For the Partnership to reset the Participation Network to ensure that this is working across both children's and adults and that this draws on the excellent work that is already happening across the Partnership; and,

- For the Partnership to review and update the Participation Strategy to ensure this is inclusive of adults and children and aligns with the ambition of Swindon Borough Councils Working Together Plan.

Adult Scrutineers

The adult scrutineers group have continued to meet quarterly over the past year with a break over Christmas, the group have consulted on the Self-Neglect Strategy and their voice and views were reflected throughout.

The group have also worked on developing some awareness posters for the public on different types of abuse and who to contact for support. These posters will also be available in easy read format and will be published and shared in 2025-26.

In addition, the scrutineers have supported with learning events and early conversations about the new Participation Network and its strategy and group name.

What is next for 25-26?

- Over the coming year the group will continue working to support the work of the Participation Network.

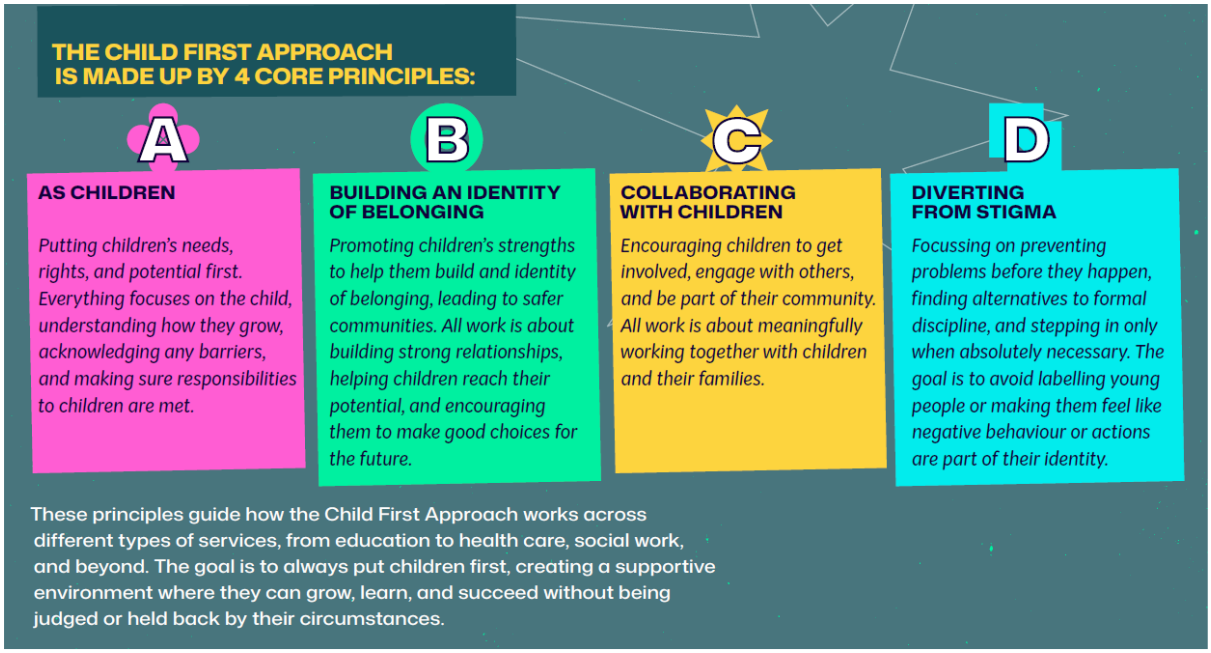
- Look at working on an anti-shame campaign.

Child First Approach

https://wayuk.org/child-first-swindon/

Swindon Safeguarding Partnership undertook two Rapid Reviews one in 2023 and one in 2024, which identified that practice had adultified the children and did not fully promote a pro-social identity for the children. Language, how we spoke to and about the children was also a key feature in the reviews. An action was for the Partnership to consider how it could learn from and adopt the 'Child First' approach used within Youth Justice Services.

In July 2024, the Safeguarding Partnership commissioned Swindon's Young Changemakers, who are a diverse group of children and young people, aged 12-15 with a range of experience, passions and skillsets, to co-produce a 'Child First' approach and subsequent manifesto to support the Partnership to embed the 'Child First' principles into policy and practice. The Swindon 'Child First' approach is made up of four core principles:



Organisations will be encouraged to sign up to the 'Child First' approach and guidance has been provided on how they can do this. To become a 'Child First' committed organisation, an application form will be completed and the Partnership Strategic Support Unit will review this

and issue the ‘Child First Committed’ logo for organisations to use. Organisations signing up to be ‘Child First Committed’ will need to provide evidence and assurance as to how they are going to implement the approach across their organisation.

How to implement a Child First Approach

If you want to adopt a Child First Approach, take action by doing these next steps:

1 REVIEWING POLICIES AND PRACTICES

Ask, is this policy, practice or decision really putting the child first? Or better still ask the child!

2 ADOPTING CHILD FIRST LANGUAGE

Use language that recognises that children are children. Remember, however, to ask each child how they would like to be referred to.

3 TRAINING AND RAISING AWARENESS

Train staff and volunteers on the principles and practice of a Child First approach. Ask children and young people to help design and deliver training.

4 EMBEDDING COLLABORATION

Build meaningful connections and partnerships across sectors and communities, collaborating with children and young people.

5 CAMPAIGNING AND ADVOCATING

Push for a Child First approach in meetings and events across different sectors. Meaningfully involve children and young people in the co-design and running of campaigns.

6 MONITORING AND ACCOUNTABILITY

Track progress against the Child First commitments, with transparency. Make sure there are ways to stay accountable to children and young people.

7 BECOMING CHILD FIRST COMMITTED

Follow Child First Swindon: Commitments and sign up to be Child First Committed and engage in regularly reviewing and learning on the topic.

ChildFirst COMMITTED

What is next for 25-26?

- Swindon's 'Child First' approach to be formally launched across the Partnership. Implementation plan to be agreed and the Young Changemakers to support with implementation.

- 'Walk the Floor' activity to be undertaken with Young Changemakers to review how organisations are embedding the approach into policy and practice.

7. Case Reviews 2024-25

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

The Group is also responsible for monitoring and progressing actions from case reviews to ensure that these are completed in a timely way and that learning is shared appropriately across the safeguarding system. The chair of the Learning and Development Groups is a member of the Practice Review Group to try to strengthen the link between these two groups.

In 2024-25, three referrals were received into the Partnership for consideration of whether the criteria was met for a Serious Incident Notification (SIN) to the Child Safeguarding Practice Review Panel. Of these three, one met the criteria for a SIN and this progressed to a Rapid Review. For this child, the Child Safeguarding Practice Review Panel agreed with the Partnerships decisions not to undertake a full LCSPR. The key areas in the Rapid Review were exploitation and child mental health.

The Practice Review Group had oversight and monitored the progress of the actions related to this Rapid Review, which included a Partnership reflective learning event, the development of 'Working with Young People Guidance', with a section on how to respond to young people who are arrested.

In 2024-25, seven referrals were received for consideration of whether the criteria was met for a mandatory SAR. Five referrals did not meet the criteria for a SAR and did not progress for any other learning review. One SAR referral met the criteria for a mandatory SAR. The SAR report is due to be published later in 2025.

Swindon have also been involved in a SAR being undertaken by Gloucestershire Safeguarding Adults Board. This SAR is also due to be published later in 2025.

The Partnership published four SARs in 2024-25.

SAR Richard

Richard was a white British man who lived alone in Swindon. He was 70 years of age. Richard was a qualified Physicist, having studied in Oxford University. In his younger years Richard worked in research, he enjoyed building amplifiers and computer programming. Richard was described by his sister as having a keen sense of humour and who loved to make ‘puns’. Richard enjoyed listening to music, particularly opera’s such as Wagner and Strauss. Richard also enjoyed listening to pop music such as Madonna.

Richard’s sister, who spoke with him regularly, explained that he was diagnosed with Paranoid Schizophrenia in his early 20s. She mentions that Richard did not accept his diagnosis and was often resistant to treatment. At times, he was very unwell and reluctant to receive visitors at home. His sister described him as challenging to engage with at times, due to his delusional beliefs, often being 'in his own world.' Additionally, she discussed how his deteriorating physical health affected his mobility and ability to manage tasks such as shopping, noting that he was often out of breath after walking short distances. Richard’s sister had expressed frustration over the lack of communication from professionals and agencies involved in supporting Richard and how she was never contacted regarding her brother.

Richard had longstanding needs related to his mental health and physical health due to Chronic Obstructive Pulmonary Disease (COPD). Richard was open to Avon and Wiltshire Partnership Trust (AWP), an integrated service with Swindon Borough Council at that time, which conducted annual reviews until their disaggregation in April 2023

Richard was highlighted to the Adult Safeguarding Team in August 2023, citing self-neglect and fire risks due to smoking. The Safeguarding Team closed the safeguarding concern and instigated a referral to Swindon Borough Council Mental Health Team.

There was evidence of concerns relating to the multi-agency response and so a SAR using the SAR in Rapid Time methodology was commissioned. This methodology was chosen to ensure learning could be identified and shared within the shorter timescale of twelve weeks.

Recommendation 1:

Swindon Safeguarding Partnership to reach out to front line practitioners to ascertain the effectiveness of multidisciplinary working across agencies. These findings should be fed back to the partnership to determine how to improve multi-disciplinary team meetings.

Recommendation 2:

Safeguarding Partnership to request evidence of how the SBC Mental Health Team accurately assess the risk of referrals to ensure timely allocation to the team.

Recommendation 3:

Safeguarding Partnership to request evidence from the SBC Mental Health Team around how the team are engaging with adults who have been referred to the service, and how they ensure the triage process is appropriate to the level of need and risk identified.

Recommendation 4:

All agencies to provide evidence of what processes they have in place to ensure handovers are clear and effective, when transferring internally between teams and external agencies, so that information is not missed. In all cases whereby self-neglect is a concern, a lead practitioner / agency to be explicitly identified as part of all handovers.

Recommendation 5:

Swindon Safeguarding Partnership to understand the barriers in practice to being professionally curious and ensure that this understanding informs the ongoing development work within the Partnership.

Recommendation 6:

SBC Safeguarding Team to provide evidence through dip sampling that the outcomes of safeguarding concerns and enquiries are communicated effectively to referring agencies and agencies involved in the safeguarding enquiries.

Recommendation 7:

Safeguarding Partnership to ensure safeguarding policy and procedures are explicit that in all self-neglect cases there is an identified lead professional or agency.

Recommendation 8:

Swindon Safeguarding Partnership Executives should request an update in 6 months' time on whether actions from all the above recommendations have had a positive impact on practice. If Executives are not assured of any positive impact, escalation to relevant organisations should be considered and whether there is a need for a risk management plan.

You can read the full report here

What has changed?

- Improved clarity and structures in handover processes internally and between partners.
- Clear Risk Prioritisation Tool and processes introduced and audited for effectiveness.
- SAB Managers Network Professional Curiosity Posters shared across Partnership.
- S42 independent scrutiny report undertaken and actions completed by Adult Social Care.

SAR Wendy

Wendy was 60 years old when she sadly passed away. Wendy was white British and was previously a nurse. Wendy had a visual impairment, and mental health needs including depression and anxiety. She loved her job and it was important to her, sadly she was dismissed from her nursing job. In 2011, Wendy was detained under the Mental Health Act and discharged in 2014. Between February and August 2015, she was hospitalised due to an episode of Psychosis, on discharge Wendy moved into sheltered housing.

Wendy was described by her sister as someone who was fiercely independent, could be stubborn/headstrong, determined and private. Wendy would not always tell the whole picture

of her reality and her sister felt this is in part because her independence was so important to her. Wendy would be in contact with her sister when she wanted to and would often be cheerful, upbeat and make jokes. Wendy's sister was not aware of much of Wendy's life and this seems to have been how Wendy wanted it, she never wanted to be a burden or put people out of their way. Wendy was described by a housing officer as someone who wanted to care about herself; she would purchase creams and lotions for her skin but did not use these.

Wendy was first bought to the attention of the Safeguarding Adults Team in August 2017 due to concerns about self-neglect including, poor personal care, nutrition and home conditions. A package of care was provided to Wendy in November 2017, which appeared to have a positive impact. In April 2021, Wendy was referred to Safeguarding Adults Team due to concerns about self-neglect. Wendy was reported to have capacity around her care and support needs. She was under the care of Mental Health team (since 2015).

There was a history of self-neglect and mental health decline, which impacted on her ability to look after herself. There was evidence of concerns relating to the multi-agency response to Wendy and so a SAR using the SAR in Rapid Time methodology was commissioned. This methodology was chosen to ensure learning could be identified and shared within the shorter timescale of twelve weeks.

Recommendation 1:

Safeguarding Partnership to request single agency assurance reports around the application of the Mental Capacity Act in practice and consider the development of Mental Capacity Act training and / or a guidance tool. This links to several local SAR recommendations, in particular to SAR Robert recommendation 3.a Swindon Safeguarding Partnership members to ensure that practitioners receive Mental Capacity Act training that emphasises the principle of "unwise decisions", *and requires a reasonable and proportionate response. Regular reviews of such instances by senior management ensure that frontline practitioners can access necessary support.*

Recommendation 2:

Safeguarding Partnership to understand the barriers in practice to being professionally curious and ensure that this understanding informs the ongoing development work within the Safeguarding Partnership.

Recommendation 3:

Safeguarding Partnership to develop a self-neglect peer support forum for practitioners across all agencies to access in order to seek advice, share learning and good practice and learn from others.

Recommendation 5:

Safeguarding Partnership to review training and learning resources to ensure that learning is available on the balance between capacity and duty of care.

Recommendation 6:

Safeguarding Partnership to be assured that risk assessments are being completed with individuals where there are concerns for self-neglect. Once published, the Welfare and Safety

Plan, which has been co-produced with experts by experience, should be widely promoted alongside the guidance for this tool.

You can read the full report here

What has changed?

- Four Mental Capacity Act webinars were held and recorded so this can be used as a resource. These webinars looked at carrying out assessments and the challenges of this. The recordings are on the SSP website for ongoing training for partners. The sessions were well attended with positive feedback.
- The Welfare and Safety Plan is in place and actively being utilised by partners, the use of these are being monitored through audit activity.
- A new adult's risk panel is in the process of being developed.
- A list of partner's roles and responsibilities across their agencies has been developed and uploaded to the SSP website for reference.
- Safeguarding supervision is now included across the partnership where this was missing before.
- Making Safeguarding Personal has been strengthened across Adult Social Care.

SAR Ethan

Ethan spent his younger years moving around a lot due to his father being in the RAF. When he was about 6/7 years old, they moved to Swindon. When in his early 20s Ethan met his girlfriend, who would go on to become his long-term partner, at the time Ethan was a photographer. They had two children but contact with his children was little and his relationship had ended. Prior to Ethan's father's death, he was his carer; they lived together in his father's home. When his father died in 2018 Ethan continued to live in the home, which he said was passed to him. Ethan had a housemate move in with him to help with bills. Ethan had a stroke some time before this and it is possible that this may have had an impact on his self-care, possibly leading to him self-neglecting. Ethan's family were not contacted throughout interventions with him and it does not appear professionals knew he had children.

One professional explained that Ethan "presented as a quietly emotional and proud man".
Ethan first came to the attention of Adult Social Care in February 2022 when a safeguarding referral was received for concerns for Ethan's environment and self-neglect. From this point in time there were two additional safeguarding referrals raised with concerns for Ethan's self-neglect and living environment. The Safeguarding Partnership identified concerns in how multiple agencies had responded to support Ethan and meet his needs. Although there was no history of Ethan being known at the point of the initial referral the delay in responding resulted in two additional safeguarding concerns being raised highlighted concerns for how the adult social care system was responding to such concerns. In addition, other agencies working with Ethan did not raise concerns when these were identified and did not always work together. There was some evidence of good practice that could be learnt from as well as points where responses were lacking and left Ethan in a vulnerable and unsafe environment.

Recommendation 1:
Adult Social Care to review the remit of Social Care teams and handover procedures to ensure that high-risk individuals are seen as a priority and that the most appropriate support can be actioned in a timely way.

Recommendation 2:
Safeguarding Partnership to have clear guidance on multi-agency meetings, when to hold these meetings and how to escalate when organisations are not engaging in this process.

Recommendation 3:
The Safeguarding Partnership to consider the development of a Multi-Agency Risk Meeting (MARM) for self-neglect cases, or the consideration of the development of an Early Self-Neglect Pathway.

Recommendation 4:
Single agency assurance requests to be sent out to partner agencies asking for evidence on how they are implementing the policy and guidance, how this is being used across their organisation and gain assurance on how agencies will evidence meassurable improvements in multi-disciplinary working. Any identified non-compliance should be escalated to Partnership Executives via the executive risk register.

Recommendation 5:
Agencies to provide evidence of how risk and concerns are recorded in case records and how this is managed within the organisation, especially where there is an adult with complex needs. Any identified non-compliance should be escalated to Partnership Executives via the executive risk register.

Recommendation 6:
Safeguarding Partnership to review and update the Professional Curiosity Resource pack. To re-circulate this across the Partnership and to gain assurance that this is being delivered in teams and is forming part of staff inductions.

Recommendation 7:
Safeguarding Partnership to develop a self-neglect peer support forum for practitioners across all agencies to access in order to seek advice, share learning and good practice and learn from others.

Recommendation 8:
Swindon Safeguarding Partnership Executives should request an update in 6 months' time on whether actions from recommendations have had a positive impact on practice. If Executives are not assured of any positive impact, escalation to relevant organisations should be considered and whether there is a need for a risk management plan.

What has changed?

- Assurances received from partners on how they are embedding the self-neglect policy and guidance in practice to support working with adults who are self-neglecting.
- Risk and concerns for welfare recording improved across partnership.

- Professional curiosity webpage created and resources added.

You can read the full report here

SAR Sally

Sally was a white, British woman aged 48 when her body was discovered in her home. The home environment had high levels of clutter and signs of serious self-neglect. For many years prior to her death, Sally was known to be at risk of exploitation, including cuckooing. A SAR using the SAR in Rapid Time methodology was commissioned, looking at the social and organisational factors that make it harder or easier for agencies to come together with an adult at risk to keep them safe.

Sally was socially isolated; she had been adopted as a young child. Her family reported she had been a bubbly, happy child but 'went off the rails' at around 13. She had her older children when she was 19-22 and they were later removed from her care. Around 2007, she was imprisoned for drug offences and settled in Swindon on release from prison. Her eldest child had limited contact with Sally, but not for the last 6 years. She remains close to Sally's adoptive parents and reports that Sally had been abusive to them, so they also had very little contact. Sally's younger children (from a subsequent relationship) are in the care of their paternal grandparents. Initially, her younger children did have limited contact, but this ended as Sally reportedly found it difficult to maintain due to her ill health.

Sally had several long-term significant health conditions. She was on a wide range of medication and was referred by her GP for specialist pain management support in November 2021 and for Mental Health support in 2022. Sally had historically misused alcohol and drugs, though was not believed to require ongoing support to address addiction at the time of her death. There was also a history of Domestic Abuse and she was known to MARAC. There were also reports of exploitation from informal carers, concerns for cuckooing and self-neglect.

In February 2024, Police attended Sally's home in response to a welfare concern raised by her housing officer. The officers used Section 17E powers to force entry and sadly found her deceased. The attending officers and a sergeant completed a thorough search of the property, confirming the door and windows had been locked from the inside and there was no sign of any forced entry (other than the force used by police to complete their welfare check) or any indication that an assault had taken place. It was therefore reported as a non-suspicious sudden death.

Recommendation 1: SSP should review the e-guidance reporting to ensure that concerns can be lodged, even if all the information is not known by the referring agency.

Recommendation 2: SSP should formalise reporting by multi-agency panels to capture data regarding the prevalence of multiple disadvantage (including trauma, addiction, domestic abuse and exploitation) and report of outcomes using the MSP measures. This should also include reporting on the use of engagement plans to evidence reasonable adjustments are made by services in line with the public sector equality duty for adults with complex needs. SSP partners could audit closed referrals, particularly where there is professional disagreement or escalation to ensure decision making is consistent with NICE guidance and

safeguarding best practice briefings. This will enable partners to provide SSP with assurance of safe systems.

Recommendation 3: Partner agencies should work with SSP to develop communities of practice in response to cuckooing. To enable a whole system approach, this should focus on:

- Direct practice: Providing MECC briefings, which highlight indicators for frontline practitioners and give details of s42 reporting pathways and local support available (including from voluntary sector agencies). Neighbourhood policing, housing officers, social prescribers and community pharmacists, district nursing and social care triage staff should be targeted for training opportunities including induction training, so the burden does not continue to fall on emergency responders.
- Team around the person: Linked to recommendation 2 and building on the Living Well pilots and Safety and Wellbeing plans, primary and secondary health leads should explore how health inclusion initiatives to address health inequalities could support identification of those at higher risk due to multiple disadvantage and ascertain adults at risk who require communication plans to alert statutory services if they are at imminent risk. All SSP partners should identify increased opportunities for assertive outreach to adults at high-risk of exploitation, but specific focus should be given to capacity within LiFT, SIS and ICT to provide this. SSP partners should also identify champions within their organisation who have support wider dissemination of good practice in response to cuckooing.
- Organisational support: Further clarification within self-neglect and safeguarding adults' policies (both SSP and partners internal policies to ensure consistency) about when concerns should trigger multi-agency consultation and when formal s42 enquiries should be undertaken in respect of cuckooing and/or self-neglect would enable consistent decision making. In addition, the adult MASH should consider hosting a case action tracker and monitor through a monthly panel to review cuckooing s42 enquiries and escalate cases that have not received support to assess capacity, their needs or received support to address psychological or practical support needed to stay safe. Regular membership of that panel should include primary care leads, neighbourhood housing, police and community safety and operational social care representative who are able to commit their agencies to complete necessary actions and provide relevant data/ case information.
- Governance: SSP partners should agree any information sharing protocols that might be necessary to enable the cuckooing panel to operate effectively. SSP should also agree oversight and assurance reporting mechanisms from multi-agency panel processes report regularly to the SSP executive so that strategic leaders can build an understanding of the severity and prevalence of exploitation (especially cuckooing) over time.

You can read the full report here

What has changed?

- A clear pathway for cuckooing concerns is now in place with an online referral form through to Community MARAC.

- E-guidance on when to make a referral has been updated and a new Decision Support Tool will be published on the website during 2025-26.

What is next for 25-26?

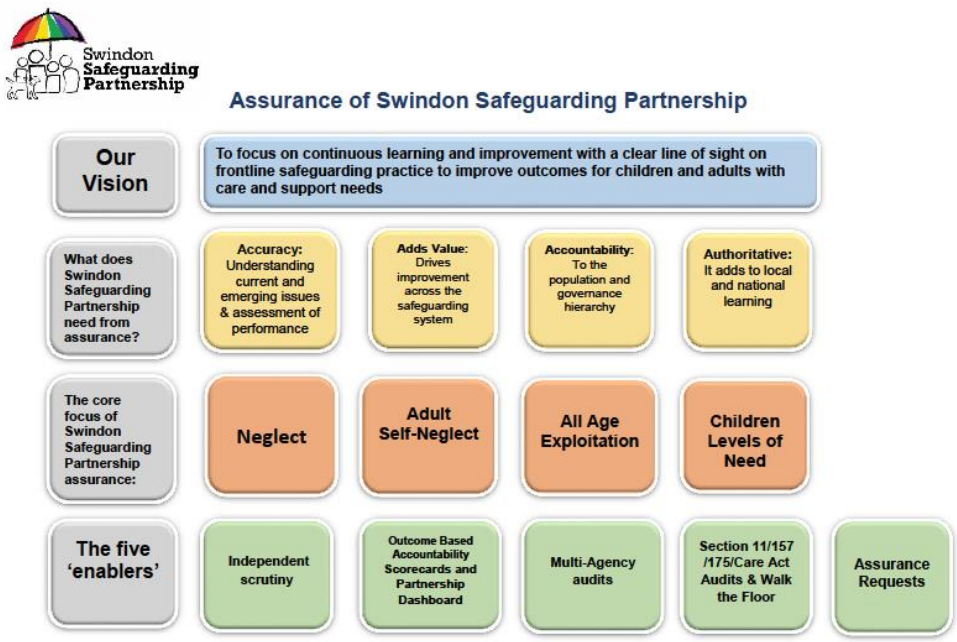
- Safeguarding Partnership Practice Review Group to continue to monitor and progress SAR and LCSPR action plans to ensure that the actions have been completed in a timely way and evidence is provided of the impact of these actions. Where there are concerns about the engagement from partner agencies or drift and delay in the progress of actions this will be escalated to the Partnership Executives.

- Practice Review Group will continue to strengthen the link with the Partnership Learning and Development Group to assure that the 'Closing the Learning Loop' process is adapted and used to ensure learning from local and national reviews is embedded across the Partnership.

8. Performance and Quality Assurance

The Safeguarding Partnership Quality Assurance Framework was produced and endorsed by the Partnership Executives for 2024-25, this sets out the Partnership's vision for quality assurance. We want to be assured that we have robust multi-agency safeguarding arrangements in place to protect children and adults with care and support needs.

The Quality Assurance Framework sets out the expected quality assurance activities for the year ahead. This included the agreed multi-agency audit schedule and areas of scrutiny.



Swindon Safeguarding Partnership Audit/Assurance Schedule 2024/25

Multi-agency response to the exploitation of adults
Multi-agency response to the exploitation of children
Multi-agency response to children and families who need help
Multi-agency response to children living with Neglect
Multi-agency response to adults who self-neglect

Quality Assurance Group

A newly established Quality Assurance Group met quarterly throughout 2024-25. This group was chaired by an Independent Scrutineer who provided oversight and scrutiny of data and performance provided in the Partnership's multi-agency dashboard. The Group has also had oversight of outcomes from multi-agency audits.

The Independent Scrutineer developed an ABQ reporting mechanism for the Partnership to adapt. The tool has been used to highlight areas from data that Partners need to be alerted to, should be assured by, acted upon, be curious about, bring insights on and where there may be issues related to the quality of data provided. This tool has supported the Partners to have a clear framework for understanding data and performance across the Partnership. This has enabled and supported challenging and constructive conversations amongst Partners and has supported to identify areas where the Partnership have completed deeper dives into specific areas.


Alert


Assure


Act and Advice


Be Curious


Bring in Insights


Quality of Data

Areas where deeper dives have been completed:

- Ethnicity and Harm – Children
- Early Years Safeguarding – Children
- Attendance at Child Protection Conferences – Children
- Repeat Referrals – Children
- Domestic Abuse – Children and Adults
- NRM Referrals - Adults and Children
- Partnership application of thresholds and decision making around thresholds – Children

Walk the Floor Assurance Visits

During 2024-25, partners completed five out of six planned 'Walk the Floor' assurance visits. The purpose of these visits were:

- To quality assure safeguarding arrangements in Swindon
- To provide intelligence to the Partnership about what is and is not working in terms of safeguarding arrangements across Swindon
- To support to resolve any issues relating to safeguarding across the Partnership
- To assist the Partnership in their common understanding of how child protection and adult safeguarding arrangements in Swindon operate across services
- To provide learning and development opportunities across the Partnership
- To provide an opportunity to share good practice

The following agencies were visited:

- Headway
- South West Ambulance Service Trust
- Swindon CAMHS
- SBC Community Health
- Avon and Wiltshire Mental Health Partnership

A visit to Swindon Probation Service was due to be scheduled but did not go ahead.

The visits were an opportunity to speak to staff across these organisations to gain further assurance relating to previous evidence provided for the Partnership's Children Act Section 11 and Care Act audits.

An analysis of the visits was completed and discussed within the Quality Assurance Group. Areas where improvement was needed and any actions will be followed up in the Children Act Section 11/Care Act audit due to be undertaken in 2025-26.

What is next for 25-26?

- Partnership Executives to consider employing a data analyst for 2025-26 to further support the data and performance work that has been developed.

- Children Act Section 11/Care Act audit to be undertaken during quarter three of 2025-26.

9. Learning and Development

"Learning and development in safeguarding is essential to ensure that individuals are equipped with the knowledge, skills, and confidence to recognize, respond to, and prevent abuse, neglect, and exploitation. It promotes early identification of concerns, ensures compliance with legal and regulatory requirements, and supports a consistent and professional approach to protecting vulnerable individuals. Ongoing safeguarding training helps to build a culture of safety and trust, empowers individuals to take appropriate action, and ultimately contributes to better outcomes for those at risk of harm."

During 2024-25, the Partnership Learning and Development Group has continued to ensure that the Partnership learning and development offer is relevant and in line with the Partnership strategic priorities and learning from local and national reviews.

This has been achieved by providing a blended learning offer, which meets individual partner's continuous professional development for the children and adults workforce. The offer has comprised of core and specialist modular training and alternative resources such as themed spotlight events linked to learning from reviews, recorded webinars and 7 minute and practice briefs.

The pattern of a reduction of bookings for chargeable courses alongside an increase in bookings for courses that were provided free of charge, continued in 2024-25. The overall number of bookings increased compared to 2023/24.

	2023/24	2024/25
Chargeable courses	508	413
Free courses	1130	1863
Total	1638	2276

During this period, the Group has continued to promote monthly safeguarding theme where each month awareness was raised of a particular safeguarding theme. Information and resources were collated into one accessible format. This is then promoted via email, the Safeguarding Partnership website Events - Swindon Safeguarding Partnership and social media. There has been favorable feedback from practitioners.

Quote from a professional from the Ministry of Defence:
'*The way the PowerPoint is laid out with an overview on the topic, key headings, with links to useful local resources is really helpful'.*

We have continued to develop our range of learning resources, for example bespoke webpages, such as Child Sexual Abuse - Swindon Safeguarding Partnership. Also continuing to add content to our video archive/recorded webinars section on the Safeguarding Partnership Video archive - Swindon Safeguarding Partnership. This enables partners to access a recording and resources at their convenience.

In 2024-25 we introduced practitioner forums, which were held on a quarterly basis and themed in line with the strategic priorities. This was an opportunity to gain the views of frontline practitioners on what it feels like to work across Swindon, to hear about good practice and some of the challenges faced. Practitioner forum - Swindon Safeguarding Partnership

In October 2024, sixteen professionals from partner agencies successfully completed the NSPCC Train the Trainer, Developing an Understanding of Child Sexual Abuse Training (DUCSA). This has meant that we were able to increase our training offer for CSA training. This multi-agency training has been met with favourable feedback. This training is particularly relevant following learning identified in the Child Safeguarding Practice Review Panel report 'I Wanted Them all to Notice'.

The following 7-minute and practice briefs have also been developed this year**.**
A number of the resources have been developed following learning from reviews.

Adultification - September 2024
Autism and learning disability Information and training August 2024
Disguised compliance - Updated July 2024.
Homelessness, rough sleeping and safeguarding adult's resource March 2025
Information sharing - 7-minute briefing – January 2025
Information sharing - seven golden rules – January 2025
Making a good referral - April 2024
Mental Capacity Act learning events recordings - January 2025
Sarah's Law and CSODS – child sex offender disclosure scheme - September 2024
Scams - December 2024
Working with resistance - Updated July 2024.

The Learning and Development Group have continued to review the multi-agency training offer considering, course demand, feedback on post course evaluations and observations by Learning and Development members. In November 2024, a training audit was circulated via the Learning and Development Group members and recirculated again in January 2025. The findings were presented to the Learning and Development Group. Overall, feedback about the training offer was positive and what was offered was felt to meet local demands /requirements. The majority of respondents indicated they were aware of and had accessed Partnership training and resources. Feedback from practitioners indicated that emails continued to be the preferred method of communication. Professionals are encouraged to sign up to the Partnership circulation list to receive early notification about events and Partnership news.

During 2024-25, in addition to the core training offer the Partnership delivered the following bespoke learning events, in response to learning from reviews and linked to the strategic priority of self-neglect:

- Self-neglect Learning Event
- Spotlight on Self-neglect – Policy into Practice
- Self-Neglect Virtual Conference hosted by B&NES, Swindon and Wiltshire (BSW)
- Practitioner Forum – Self-Neglect

Between November 2024 and February 2025, four Mental Capacity Act themed learning sessions were delivered and these were linked to learning from reviews for both adults and children.

A Learning from Children's Case Reviews – Alan and Tristan event was held bringing together learning from both of these.

An All Age Exploitation conference was held which included experts by experiences providing accounts of their experiences relating to being exploited and being a parent of a child who was exploited.

The Learning and Development Group has continued to support the implementation of the impact on practice/closing the learning loop framework 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.

This has been a challenging area to develop, particularly in relation to evidencing the impact on practice. The process continues to evolve and is subject of regular review within the Learning and Development Group meetings. There have been some examples of good practice adopted by agencies and this will continue to be monitored over the next year.

What is next for 25-26?

- The Learning and Development Group will continue to support the implementation of the impact on practice/closing the learning loop framework 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. One aspect of this will be to increase the feedback from professionals who have accessed the learning and resources to provide supporting evidence of the impact on practice and improved outcomes.

- The Learning and Development Group will continue to develop a range of blended learning resources, such as practice briefs and spotlight events in line with the Partnership strategic priorities and any learning from local and national reviews.

10. Conclusion

'Children and adults do not die in the arms of professionals.
Tragedy comes in the gap between them. As long as we see partnerships as an "add on" to the day job, this will continue to be the case.
We need to strengthen partnerships by putting both children and adults at the centre of good practice.'

Swindon Safeguarding Partnership have reflected on the work of the Partnership during 2024-25. There has been a lot of positive activity across the Partnership, which has helped us to understand and support safeguarding work across Swindon.

This activity has included developing and updating multi-agency policy and guidance, completing audits to look at practice and the experiences of those accessing support and we have started to use multi-agency data to support our understanding of the needs of children and adults in Swindon.

We recognise that there remain challenges across the Partnership and further work needs to happen around how we are supporting organisations to embed learning from audits and case reviews and how we continue to close the learning loop to be able to evidence impact on practice and subsequently better outcomes for children and adults.

We have ensured that we are engaging more meaningfully with children and adults to co-produce work across the Partnership. We want to keep this momentum going as we move into 2025-26. We want to ensure that children and adults we work with are collaborating with us on key projects and supporting us to have a lens on the safeguarding system from their perspective.

We acknowledge that there are still challenges preventing us from moving from a process focussed delivery but we are aware of what we need to do as a Partnership to further mature during 2025-26.

Despite some of the challenges experienced, there remains a strong commitment from Partners to continue to drive forward the work of the Partnership and to ensure that children and adults with care and support needs are offered the right help at the right time, protecting them from harm.

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

- National 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
- Healthwatch

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

The report was approved by the Partnership Executive on 15th September 2025.

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